



*Yn cefnogi grwpiau gwirfoddol a chymunedol  
Supporting voluntary and community groups*

CYSWLLT  
CYMUNEDOL  
ARFON  
COMMUNITY  
LINK



# ARFON COMMUNITY LINK SOCIAL IMPACT REPORT 2024/2025

“

*The support and information that I have received has definitely helped me to focus on the recovery of my mental health*

”



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



# Table of Contents

Introduction ..... 3

The continued need and demand for the Arfon Community Link Project..... 4

The National Framework for Social Prescribing in Wales..... 5

Project Inputs ..... 9

Outputs ..... 12

Outcomes ..... 19

Value ..... 25

SROI results ..... 28

Table 5 – SROI Headline Results ..... 29

Conclusion and Recommendations ..... 30



**Effaith Gymdeithasol 2024 -2025**  
**Cyswllt Cymunedol**  
**Arfon**  
Community Link 2024 -2025  
Social Impact



**Trosolwg mewn niferoedd / Overview in numbers**

- **1,938** - Nifer o unigolion sydd wedi cael eu cefnogi gan y prosiect ers 2016 / Number of individuals who have been supported by the project since 2016
- **223** - Nifer o unigolion sydd wedi cael eu cefnogi yn ystod 2024 - 2025 / Number of individuals who have been supported during 2024

**Ymgysylltu â Rhanddeiliaid a data / Stakeholder Engagement and data**

- **223** - Nifer o unigolion sydd wedi cael eu cefnogi yn ystod 2024 / Number of individuals who have been supported
- **68** (neu maint sampl o 30%) o unigolion gyda sgôr cychwyn a sgôr gorffen /68 (or 30% sample size) of individuals with a start score and a finish score

**Adenillion Cymdeithasol Ar Fuddsoddiad**

Forecast Social Return On Investment (SROI)



**Deilliannau / Outcomes**

- Mae 80% o'r unigolion a gefnogwyd wedi teimlo gwelliant yn eu hiechyd meddwl / 80% of individuals supported have felt an improvement in their mental health
- Mae 99% o'r unigolion a gefnogir bellach yn teimlo'n llai ynysig ac unig / 99% of the individuals supported now feel less isolated and lonely
- Mae 99% o unigolion yn teimlo bod eu hiechyd corfforol wedi gwella / 99% of individuals feel their physical health has improved

**Llwybr cyfeirio / Referral pathway**

- **14** Hunan-atgyfeiriadau / Self-referrals
- **92** o atgyfeiriadau gan feddygon teulu / GP referrals
- **16** o atgyfeiriadau gan fudiadau 3ydd sector / referrals from 3rd sector organisations
- **101** o atgyfeiriadau gan wasanaethau eraill y GIG / referrals from the other NHS services

## Introduction

The aim of the Arfon Community Link project is to support individuals to recognise what their needs are and what is important to them and assist to signpost to services within the community that can help them to improve their well-being. The project was established in 2016, and the project has needed to adapt to various challenges over the time including the Covid-19 pandemic and the Cost-of-Living Crisis, and the impact of both continues to be seen within communities. The financial pressures on individuals due to rising costs has particularly been the main reason for referral over the last year with this having an impact on mental well-being and isolation.

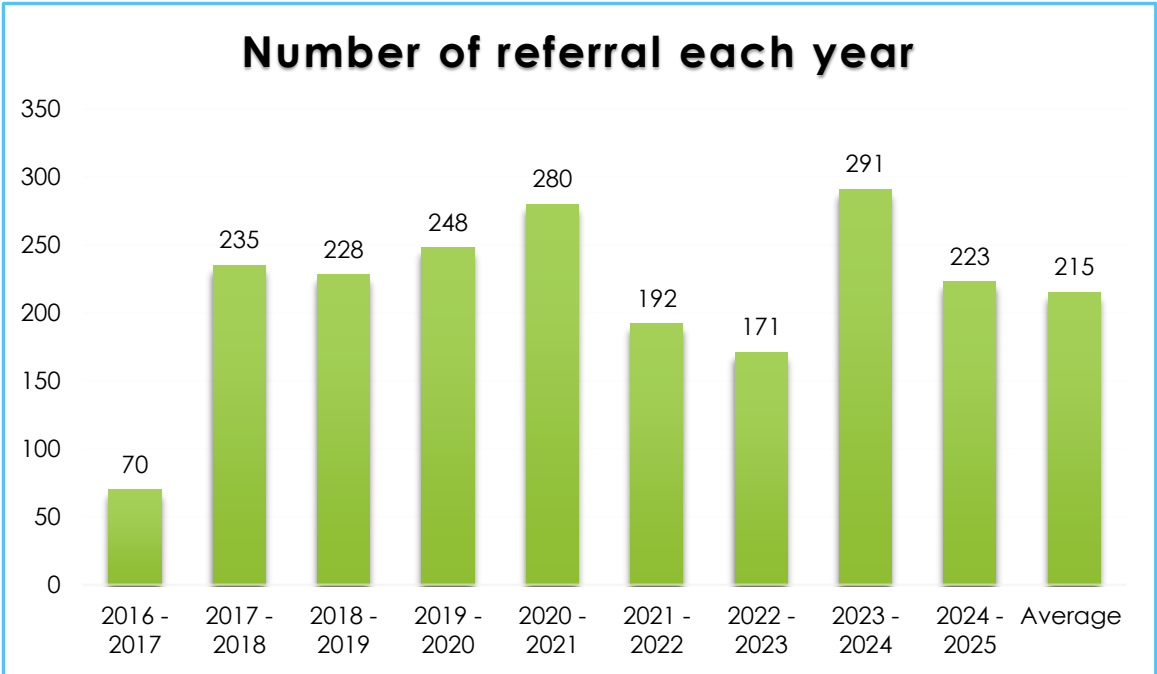
This report will evaluate the social impact of the Community Link project in Arfon provided by Mantell Gwynedd between April 1<sup>st</sup> 2024 – March 31<sup>st</sup> 2025, the last two month of the project will be forecasted. The evaluation is made through engagement with individuals receiving the services and referral organisations, and from examination of information and data available, appropriate estimations have been made, supported by secondary evidence.

The Arfon Community Link project has also been evaluated since 2016, with an annual social impact evaluation report written by accredited social value practitioners. All previous social impact evaluation reports can be found [here](#). In the 6 previous evaluations of the project, there has been a positive track record of improved outcomes for the clients in reducing isolation and loneliness, improved mental well-being, and improved physical well-being. These outcomes will be evaluated again in this year's report.

# The demand for the Arfon Community Link Project

Since the launch of the project in June 2016, **1,938 individuals** have been supported, with an average of 215 referrals per year (up to end of January 2025) and a total referral for 2024/2025 of 223. The graph below shows there is continuous and steady demand and the continuing need for the Arfon Community Link Project. The Community Link Officer now also receives regular referrals from Dwyfor & Meirionnydd. The project has continued to evolve and has had to adapt the service when needed due to the changing needs within the community and the people who receive the support.

In 2024 - 2025, the project still continues to be well-placed to support many referrals with different complex needs and cases. The Community Link Officer has built good working relationships with many third and public sector organisations and is able to offer support, guidance, and advice. It can effectively signpost clients to the relevant organisation based on their needs in an efficient and timely manner.



## The Social Prescribing landscape in Wales

The National Framework for Social Prescribing (NffSP) was launched in December 2023 in Wales and the definition for social prescribing is:

“Social prescribing is an umbrella term that describes a person-centered approach to connecting people to local community assets. Community assets include community groups, interventions, and services which could be delivered online or in person, as well as buildings, land, or even a person within a community.” (NffSP, P3<sup>1</sup>) ...Social prescribing has seen a period of growth and development over the last decade. However, within Wales, as in other countries, there has been a lack of standardisation and consistency both in the terminology associated with social prescribing and in the model adopted. This has resulted in confusion on the benefits it can offer amongst both the public and the workforce who deliver or encounter social prescribing. (NffSP, P21<sup>2</sup>).

There are several key areas in the National Framework of Social Prescribing that the Arfon Community Link project has already worked on since the inception of the project and are aligned with the core objectives of the NffSP (please see Figure 1 below). The Community Link Officer works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community, particularly those who are visiting healthcare professionals more often than average with non-clinical needs, increasing the shared understanding of all parties involved. The Community Link Officer at Mantell Gwynedd identifies the needs of the individual referred and together will agree on an action plan and then activities and services are offered within the community. As individuals become more engaged with services within their communities, reduced demand for statutory services such as the NHS and social services can be identified. Additionally, another core objective of the framework is to monitor, evaluate, and improve outcomes

---

<sup>1</sup> national-framework-for-social-prescribing, page 3, Welsh Government,(2023) ([www.gov.wales](http://www.gov.wales))

<sup>2</sup> national-framework-for-social-prescribing, page 21, Welsh Government,(2023) ([www.gov.wales](http://www.gov.wales))

## Figure 1 – The Core Objectives

(National Framework for Social Prescribing, Page 22<sup>3</sup>)

All three outcomes that have been evaluated by the project since 2016, are also



already aligned with, and meet the long-term goals set by the NFFSP ( please see figure 2 below). Further information and evaluation of the 3 outcomes will be discussed and analysed in more detail in the outcomes section of the report.

## Figure 2 – 5 Social Prescribing Long-Term Outcomes

Social Prescribing Long-term Outcomes	
1.	Improved population mental wellbeing and reduction in overall prevalence and inequalities within mental ill health
2.	Improved population physical wellbeing and reduction in overall prevalence and inequalities within physical ill health
3.	Improved population social wellbeing and reduction in overall prevalence and inequalities within poor social wellbeing, loneliness and isolation
4.	A system impact on the wider determinants of health
5.	Improved community wellbeing

(National Framework for Social Prescribing, Page 15<sup>4</sup>)

The project already has many of the referral paths identified in the framework for Wales (please see Figures 3 & 4 below). The majority of the referrals are mostly a healthcare referral pathway or self-referral pathway. The number of self-referrals

<sup>3</sup> national-framework-for-social-prescribing, page 22, Welsh Government,(2023)([www.gov.wales](http://www.gov.wales))

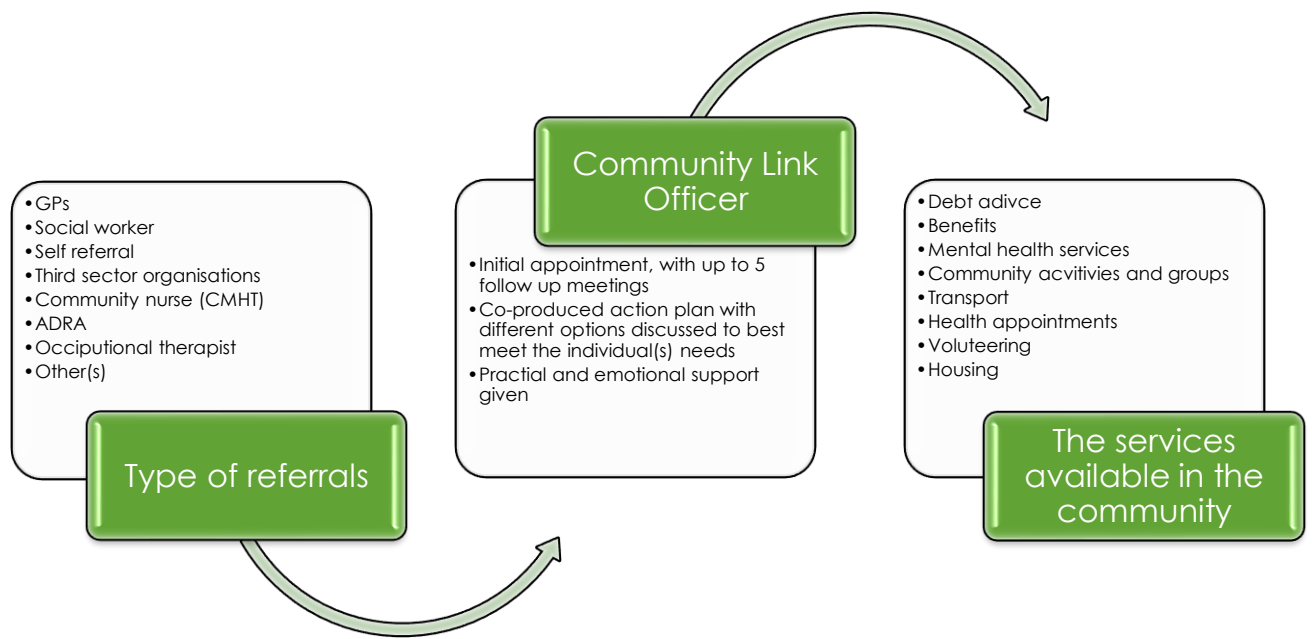
<sup>4</sup> national-framework-for-social-prescribing, page 15, Welsh Government,(2023)([www.gov.wales](http://www.gov.wales))

to the project has been steadily increasing over the last few years as more people became aware of the project through various communication channels, and the need for the project has increased year on year, either through a card given by a GP or a direct self-referral. In addition, there is a percentage of referrals from third-sector organisations also.

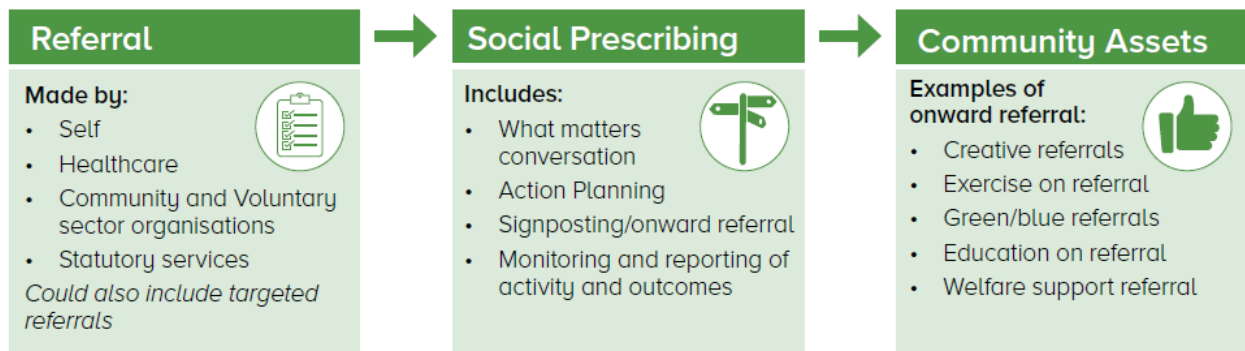
In some cases, the word of mouth of past individuals who have been supported by the Link Officer will encourage others to contact the project and get access to the support they need without having to visit a healthcare professional first, and this also contributes to reduced demand for statutory services. The Link officer has developed a reputation of being able to support clients and a quick timeframe over the years, and this can be a lifeline to the clients when they feel they are in crisis.

The Community Link Officer produces an action plan based on the client's needs, then refers, and signposts the clients to other community assets, while also monitoring and reporting on the progress of the clients through the Elemental platform.

### **Figure 3 - Process of Referral for the Arfon project**



**Figure 4 – The Social Prescribing Referral Pathway**



(National Framework for Social Prescribing, Page 17<sup>5</sup>)

<sup>5</sup> national-framework-for-social-prescribing, page 17, Welsh Government, (2023) ([www.gov.wales](http://www.gov.wales))

## Project Inputs

This service is free to those who receive it; however, some non-financial inputs are also necessary to ensure any changes. Their willingness to engage with the Community Link Officer and take action to integrate into the community and take part in the activities is essential to ensure any outcomes.

The financial input is managed by Mantell Gwynedd. A total financial input of **£66,471** is forecasted for the period of analysis, funded by Betsi Cadwaladr University Health Board (BCUHB). This includes **£61,917** in project funding and the additional **£4,555** of financial input is based on the need for healthcare professionals and other organisations to make referrals and spend time with the officer. It is appropriate to include an additional input that values this time contribution. Therefore, the approximate cost for each referral agent is calculated (table 1) for example, based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £42<sup>6</sup> is employed for referrals from this source. The total costs for the project can be seen in Table 2.

**Table 1 – Referral costs to the project the healthcare professionals**

Referral agent	Task	Value	Source
General Practitioner	Initial referral – estimated 10 minutes each.	£42 per GP appointment – used to represent 1 appointment per referral made (92 referrals X 42). Therefore, a total of <b>£3,880</b>	PSSRU Health and Social Care Costs, 2023 page 63

<sup>6</sup><https://kar.kent.ac.uk/100519/1/Unit%20Costs%20of%20health%20and%20Social%20Care%202022%20%28amended%2013%20July%202023%29.pdf>

<b>Community Mental Health Teams</b>	Initial referral – estimated 10 minutes each.	£48 per hour of individual-related work (49 referrals X (£48/6)). Therefore, a total of <b>£393.60</b>	PSSRU Health and Social Care Costs 2023, page 91
<b>Occupational Therapists</b>	Initial referral – estimated 10 minutes each.	£39 per hour of local authority-operated occupational therapists (band 5) 17 referrals X (£39/6)). Therefore, a total of <b>£106.40</b>	PSSRU Health and Social Care Costs, 2023 page 88
<b>Other NHS services</b>	Initial referral – estimated 10 minutes each	£40 per hour of individual-related work (Band 4)(22 referrals X (£40/6)). Therefore, a total of <b>£144</b>	PSSRU Health and Social Care Costs 2023, page 91
<b>3<sup>rd</sup> sector organisations</b>	Initial referral – estimated 10 minutes each	£11.44 per hour based on current living wage (16 referrals x (11.44/6)) therefore total of <b>£29.74</b>	Gov.co.uk <sup>7</sup>

<sup>7</sup> <https://www.gov.uk/national-minimum-wage-rates>

**Table 2 – Total Monetised Inputs for Arfon Community Link project**

<b>Stakeholder</b>	<b>Financial input</b>	<b>Non-financial input</b>	<b>Cost per individual</b>
<b>Individuals</b>	N/A	Willingness to take part and take action identified with the Community Link Officer	
<b>Mantell Gwynedd – manage funding by BCUHB</b>	<b>£61,917</b>	Strategic management, time, expertise	
<b>NHS</b>	<b>£4,555</b> in additional referral cost	£4,555 of value for the time taken to refer people to the Community Link	
<b>3<sup>rd</sup> sector services</b>	<b>£30</b>	Cost to refer 16 individuals to the project through various services	
<b>Totals</b>		<b>£66,471</b>	<b>£298 per individual</b>

## CASE STUDY 'C'

C's self-referral was initiated through the elemental Link, where they expressed a need for support in several areas, including housing, bereavement, long COVID, cost of living, isolation, and assistance with their smallholding, as well as issues related to an abusive relationship spanning several years. Following this, the Community Link Officer reached out to C to discuss the available resources and support.

During the discussion, the following actions were taken:

- A referral was made to Shelter for legal support.
- A referral was made for additional legal assistance.
- A referral was made to Citizens Advice Bureau (CAB) to assist with completing forms.
- Contact was established with Tir Dewi and the Royal Agricultural Benevolent Institution (RABI) to provide support for farmers.
- Communication was initiated with Live Without Fear for further assistance.

C was provided with an information pack that included resources on managing the cost of living, details about local hubs, and information about food banks that offer food packages and activities. Additionally, guidance was provided to address fatigue and long COVID, including health courses and mental health support hotlines. Dates and contact information for a bereavement support group were also included.

Subsequently, C provided feedback via email regarding their experience. They shared that they had been highly recommended the services of Mantell Gwynedd in 2024 and were advised to consult the Link Officer. Due to health challenges and other difficult circumstances, the Link Officer visited C's home and dedicated two hours to listening and exploring all available options. C expressed scepticism based on previous experiences of unfulfilled promises of support from others. However, the following working day, the Link Officer contacted C with a comprehensive list of organisations that could provide assistance.

The Link Officer, not only conducted thorough research on these organisations but also initiated contact with them, detailing the specific help C required to progress. C described Rhian's assistance as invaluable, enabling them to make significant strides in their mental, physical, and financial well-being. Furthermore, C appreciated the reassurance of being able to reach out to Rhian in the future. As a result of this positive experience, C has recommended both Rhian and Mantell Gwynedd to others in need of similar support.

## Outputs

The outputs for the Arfon Community Link project are the number of referrals made to the project and how many hours of support each person received from the Community Link Officer. Over the period April 2024 – January 2025, there were **186 referrals** based on data reported on the Elemental platform. This report will also include the forecasted number of referrals for February & March with an additional **37 referrals** included, as shown in Table 3. Therefore, for example, there were 12 self-referrals between April 1st 2024 and January 31st and an additional 2 have been forecasted for February and March 2025. The same calculation has then been made for all referral routes ( please see Table 3 below) given a total number of referrals for the project in the period of analysis of **223**.

However, to avoid overclaiming the social value created by the project from April 1st, 2024 - March 31st, 2025, **121 (60%)** of individuals who supported the project will be included in the value map. This is in line with the previous years' reporting with a similar percentage of individuals included in the value map. Thus, giving a good comparison on a year-on-year basis.

Table 3 below shows a breakdown of how the 223 individuals are referred to the project.

**Table 3 – Source of Referral**

Source of Referral	Number of Individuals referred between April 1 <sup>st</sup> 2024 to January 31 <sup>st</sup> 2025	Forecasted referral for 2025 (February 1 <sup>st</sup> – March 31 <sup>st</sup> )	Total number of referrals	Percentage of Referrals
GP	77	15	92	41%
Community Mental Health Team	41	8	49	23%

<b>Occupational Therapists</b>	14	3	17	7%
<b>Self-referral</b>	12	2	14	6%
<b>Re-referrals</b>	11	2	13	5%
<b>Other NHS services</b>	18	4	22	9%
<b>3<sup>rd</sup> sector organisations</b>	13	3	16	7%
<b>Total</b>	186	37	223	

Individuals benefit, on average, from 1–5 sessions via telephone, virtually, or face-to-face with the Community Link Officer. Contact is very much determined by their needs. The average number of sessions this year was 3 meetings, so usually 3 hours of contact per individual. Time would also be spent gathering information on the individual's behalf, arranging appointments, and making inquiries. However, it should be noted that during 2024/25 the Link Officer has been dealing with some very complex cases that sometimes can take months to complete. The total average hours provided to support everyone was therefore 5 hours per case. Following contact with the Community Link Officer, an action plan is jointly agreed upon, where individuals start getting involved in various activities and/ or organisations depending on their personal needs.

The Community Link Officer continues to work closely with the GPs from various surgeries across Arfon. There are **92 total referrals from GPs** (41% of total referrals) through a direct referral or a self-referral card were made to the Community Link Officer during the period of analysis, the highest referral path by a distance. This shows how important the Community Link project is to the GPs of Arfon, and how the GPs can trust the work of the Community Link Officer will help their patients deal with various complex matters.

## Feedback from various organisations

---

*We have been collaborating with the Mantell Gwynedd Social prescription project since it began. Rhian appropriately and promptly refers people who need housing advice and support to our project, providing all of the background information required. She provides ongoing support where needed. Rhian is always professional, but her kindness and concern for the people she helps really stands out. It is notable that her service is very popular, and she sees a wide range of people with different backgrounds and issues and treats everyone fairly. The service seems to reach people who have not sought help or support before but really need it. She seems to conduct a really large volume of work and has excellent knowledge of both sources of help and local services.*

### **Senior Independent Housing Support Worker, Shelter Cymru**

*The Social Prescribing service has played a vital role to our patients at Bodnant surgery, to be able to get support and access to numerous resources/help that is available in their local community. This service has improved outcomes for patients by giving them a sense of belonging when attending community groups. I've found the service approachable, informative and acts promptly on referrals. We, as a surgery frequently use the service and the feedback from our patients has been very positive.*

### **Practice Nurse, Bodnant**

---

Rwyf wedi cydweithio gyda Rhian Griffiths ers nifer o flynyddoedd bellach ac wedi derbyn nifer helaeth o gyfeiriadau ganddi er mwyn cefnogi a rhoi cymorth i unigolion sy'n gwynebu amgylchiadau anodd yn y gymuned. Drwy ein hymdrechion ar y cyd, rydym wedi gweld â'n llygaid ein hunain yr effaith gadarnhaol ar ansawdd bywyd, iechyd ac iechyd meddwl y rhai sy'n cael eu cyfeirio. Heb y cynllun yma, ni fyddem wedi dod ar draws yr unigolion yma. Byddai colli'r gwasanaeth yma yn golygu na fyddem yn medru rhoi cymorth i'r rhai mwyaf bregus. Rydym yn aml yn derbyn adborth gan unigolion yn ystod ein hymweliadau ninnau sut mae cefnogaeth gan y Cynllun Presgripsiwn wedi cyfrannu at welliannau sylweddol yn eu llesiant cyffredinol.

### **Case Worker, Caer and Repair**

---

---

'Mae'r Cynllun Presgripsiwn Cymdeithasol Arfon yn gynllun sydd yn hanfodol. Mae'r cymorth 1:1 mae Rhian yn rhoi i'r unigolion yn hynod o bwysig a heb Rhian dwi ddim yn siŵr ble fysa'r unigolion. Dwi wedi gweithio'n agos gyda Rhian i helpu'r unigolion i gael allan i'r gymuned. Mae'n glir i weld y datblygiad mae'r unigolion wedi neud ar lefel bersonol. Heb y cynllun yma fysa llawer iawn o unigolion yn gweld hi'n anodd cael allan o'r tŷ a delio gyda bywyd. Mae yna lawer o'r unigolion mae Rhian wedi eu cefnogi

wedi deud i mi faint o ddiolchgar maent o'u chymorth hi drwy'r Prosiect Presgripsiwn Cymdeithasol. Mae Rhian yno i'r unigolion yma i fod yn gefnogaeth iddyn nhw pryd mae pethau yn gallu cael yn anodd o ran iselder a hyder, ond mae cael y prosiect yma mewn lle yn gwneud gymaint o wahaniaeth i'r bobl anghenus yma. Dwi yn gobeithio y byddai y cyd weithio gyda Rhian trwy'r Cynllun Presgripsiwn Cymdeithasol Arfon am flynyddoedd i ddod i helpu fwy o unigolion i gael allan i'r gymuned i wirfoddoli.'

---

### **Helping Hand To Volunteers Officer, Gwynedd Volunteer Centre**

---

I would like to evaluate that communication is very important and this is what is still justified when working with Rhian Mantell Gwynedd. A clear picture is received of the situation and background of Clients and their difficulties or problems which are essential to enable us to be able to offer the best and most suitable service to their situation, and that is what is being realised between Mantell and Age Cymru Gwynedd and Môn, this means that it is possible to facilitate the procedure in every way for the sake of the experience of the Clients to receive a service from us, which means that there is less pressure on the NHS and Social Services and that vulnerable people do not "slip through the net" eventually. Also improving the standard of living and people's mental health by successfully claiming their benefits, Blue Badges, Melas on Wheels etc. There is always a good relationship of high quality.

### **Information & Advice Officer, Age Cymru Gwynedd and Môn**

*Mantell Gwynedd is an easy to access service which is proactive in its compassionate care and responses. I understand that sometimes there is a wait for input which is because of the demands upon the service. It is an invaluable support to the people I refer to Mantell Gwynedd and I know they are in safe hands in terms of having their needs met. I also know that Rhian will flag anything up with me in terms any concern about risks. I work in four busy GP surgeries seeing people in a mental health crisis (not urgent / emergency) and I often refer to Mantell Gwynedd for various types of support. I am always met with warmth and professionalism. Many thanks for your hard work and I hope that the funding continues and grows.*

**Advanced Occupational Therapist, Primary Care**

---

## Outcomes

All the data for the outcomes is collected and analysed through the Elemental platform. The Elemental software helps organisations to enhance the impact of their social prescribing programs via their digital social prescribing products and data collection services/database<sup>8</sup>. Using the 'health impact report' database, we can track the progress and level of change clients have or are going to experience throughout the year, using ONS Q1, 2, 3 & 4 for data collection surveys. The questions are set to measure people's well-being for life satisfaction, worthiness, happiness, and anxiety, and are a part of the Measuring National Well-being developed in 2011. The ONS are measured using pre and post score, measured on a 1-10 scale. For this analysis, only clients who have reported a pre and post score have been included, ensuring we are not overlooking the impact created by the project. The ONS metrics do not include improved physical health, for this outcome an internal measuring metric. A rating score of 1-10 was used to ensure the level of change experienced by the clients and to match the same reporting metrics reported on the Elemental platform. The three outcomes identified for the Arfon Community Link Project align with the long-term outcomes goals of the NFFSP ( please see Figure 2).

It is only by measuring outcomes that we can be sure that activities are effective for those who matter most to this project. The well-defined outcomes in the theory of change were:

- **Reduced loneliness and isolation**
- **Improved mental health**
- **Improved physical health**

These were the outcomes that need to be continuously managed. Through analysis of the ongoing quantitative indicators, consideration will be given as to how much change has occurred, also whether the theory of change is still

---

<sup>8</sup> <https://www.gov.uk/g-cloud/services/209867697068843>

relevant. As the project evolved, we needed to reassess and confirm the outcomes identified were relevant and still held up to the materiality test. With continuous engagement throughout the year with staff members and some clients, there is the confidence that the outcomes are still relevant and hold significant value for the clients.

### a) Reduced Loneliness and isolation

The primary objective of the project is to support individuals who have social and emotional needs and to reduce demand for statutory services. Loneliness and isolation can have an impact on many individuals of any age, gender, or other socio-economic factors. Individuals were asked about their level of social interaction, about feeling part of the community, and the impact on their mental well-being.

According to the Royal Collage of General Practitioners<sup>9</sup> *“All too often, GPs are the only human contact which chronically lonely patients have. Three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely”* This can be seen in the Arfon project with **92 total referrals from GPs** made to the Arfon project in the past year (41% of total referrals made to the project). The substantial amount of the referrals made to the project by GPs in the past year shows there is a still a significant amount of people in society still experiencing isolation and loneliness. Furthermore, the average age of a person supported by the Arfon Project is over 60 years old, and in a research report published by Age UK in 2024 states that loneliness is still widespread throughout Wales for older people, with the three following statements<sup>10</sup>:

- 75,000 older people say the TV or their pet was their main companion
- 100,000 older people speak to three or fewer people each week

---

<sup>9</sup><https://www.rcgp.org.uk/representing-you/policy/areas/loneliness#:~:text=All%20too%20often%2C%20GPs%20are,moments%20of%20meaningful%20connection%20matter.>

<sup>10</sup> <https://www.agecymru.wales/latest-news/age-cymru-marks-loneliness-awareness-week-with-a-story-of-how-one-older-man-keeps-connected-to-the-world/>

- *330,000 older people in Wales say a few minutes of conversation would make a huge difference to their week*

This is where the work of the Community Link Officer plays an important part, as she is able to speak and give time to clients to make them feel heard and listened to on a personal level. For many, dealing with the loneliness and isolation was identified as being of the most importance. The Community Link Officer then creates an action plan that is bespoke to each client, whether that is helping the clients find groups within the third sector to participate in or it may be more one-to-one time with the Community Link Officer to get down to the root cause of why the client is feeling lonely to begin with.

The Community Link Officer has also worked closely with the Helping Hand To Volunteers project at the Gwynedd Volunteer Centre to help tackle loneliness. The purpose of the project is to help people who need a little extra support to begin volunteering. Volunteering gives the clients an opportunity to get out of the house and socialise with others, and in turn helping them feel less isolated and lonely.

Based on the data collected, **99%** of individuals who completed the survey felt there was a positive change in feeling less alone and isolated and were re-engaging in the community because of being in contact with the Community Link Officer. The level of change experienced by the individuals surveyed is **60%**. This is equivalent to quite a lot of change experienced by the sample size, showing the positive impact of engaging with the Community Link Officer in helping reduce the isolation and loneliness felt by the clients. The data shows that the Community Link Officer is helping to tackle the loneliness and isolation problem and therefore helps reduce the pressure on NHS primary and secondary care services within the community.

### **b) Improved mental health**

By the time the clients speak to the Community Link Officer, many are already at a point of crisis, where they don't know where to turn to with their financial

situation. The cost-of-living crisis has been in effect since late 2021 and still continues to be a problem for many people in 2024 / 2025 because people have depleted their savings and have now fallen on hard financial times. Because of this the Community Link Officer has spent a lot of time dealing with clients who are experiencing low mental health because of financial problems including debts and housing problems. There are various ways the Community Link Officer supports the clients mental health with a holistic approach, for example, by working closely with the local Citizens Advice Bureau to help clients manage their debts, as financial anxiety is one of the biggest reasons people mental health drop according to the NHS<sup>11</sup>. Furthermore, she helps refer clients to organisations to provide legal assistance such as RCS, Shelter, CAB and Bangor University. The Community Link Officer also ensures the clients are on the best energy tariff they can be on, reducing their financial pressures where possible. Additionally, she also works closely with Shelter Cymru, ADRA a local housing association and the Single Point Of Access (SPoA) department in Cyngor Gwynedd for clients who have housing problems. The support given by the Community Link Officer goes a step further too, she also works closely and refers clients to the ICAN project, a project that helps people with their mental health.

Having someone to talk to at a point of crisis has a positive impact and reduces the chance of clients going into further decline. Therefore, it cannot be emphasised enough the positive impact the project has on improving the client's mental well-being. The Community Link Officer has the experience and relevant contacts with an abundance of third-sector organisations that can help to improve the client's situation, and as a result, improve their mental well-being.

From the data collected on Elemental, ONS 4 anxiety, **80%** of clients reported reduced levels of anxiety due to the support given by the project, with a level of change of **15%** or a reduction in anxiety levels of 1.5 on a 10-point scale.

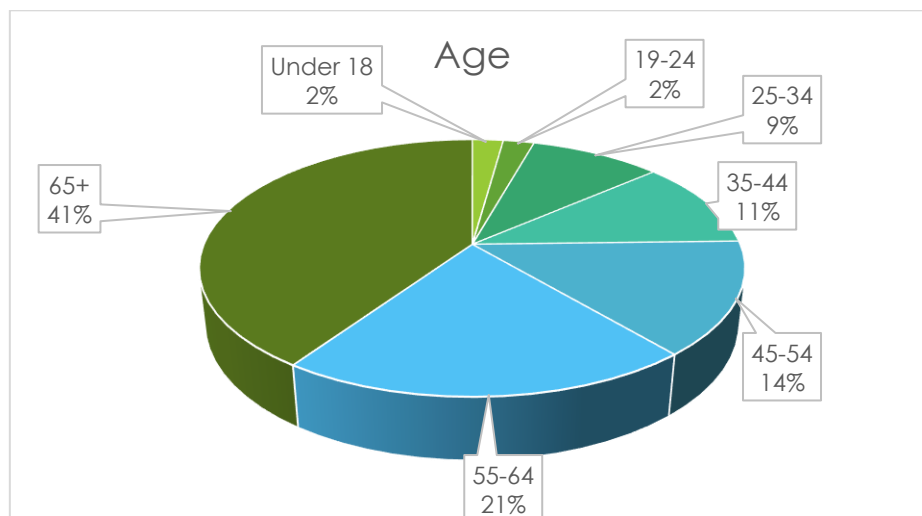
---

<sup>11</sup>[https://www.nhs.uk/every-mind-matters/lifes-challenges/money-worries-mental-health/#:~:text=But%20if%20you're%20finding,have%20enough%20money%20\(financial%20anxiety\)](https://www.nhs.uk/every-mind-matters/lifes-challenges/money-worries-mental-health/#:~:text=But%20if%20you're%20finding,have%20enough%20money%20(financial%20anxiety))

### c) Improved physical health

Many of the individuals referred to this project are living with various acute and chronic health conditions. This includes arthritis, stroke, fibromyalgia, diabetes, epilepsy, and mobility problems. Many are also living with a mental health condition which has had an impact on their physical health as a result.

Due to some of these conditions, individuals will still need to engage with health services, however, introducing small changes and ensuring they have the right information and support will allow them to manage their long-term conditions themselves and reduce their visits to the GP or other NHS services. The chart below shows that 41% of the clients referred to the project in 2024 are over the age of 65, therefore, this can limit the amount of change a person can experience in their physical health. In addition, this chart also shows the people of all ages are referred to the project, further showing the increasing demand for the project by the people of Arfon and beyond.



As part of the process, the Community Link Officer will develop an action plan based on the needs of the clients. Being able to develop a better understanding of a person's hobbies can help to refer the clients to the right group / organisation. Furthermore, as the Arfon project is based at Mantell Gwynedd (a County Voluntary Council) the Community Link Officer is able to increase their own knowledge of what activities and sessions are being held across Arfon. The Link Officer also works closely with the local GP practices ensuring the clients are

given exercise referrals and given the correct support for them, and in the end improving the clients overall physical health.

Another example of the way the project helps support the client's physical health is ensuring that those who suffers with arthritis are given independent resources and gadgets that best suits their needs. Due to medical reasons, sometimes some domestic tasks can be a big concern and can be a big barrier, therefore my doing some research and looking at alternatives, the project can help to remove some of the barriers allowing them to deal with other matters such as socialising.

The total number of clients experiencing positive change in their physical health is **99%** up from **46%** in the previous year's report. The amount of change on average is **45%** or a 4.5-point change on a 10-point scale.

### **No change or negative outcomes?**

As stated in the previous report, some clients had experienced no change. Looking at the sample of data, **5%** of clients experienced no change, this represents 12 individuals. Consideration should be given as to why these individuals do not experience any change, and if inappropriate referrals are being made to the project. In the previous report, these clients were identified as follows:

- a) Clients who need support to make changes in their lives that will help to introduce positive and sustainable changes which could include reducing loneliness and even entering training or employment.
  
- b) Crisis clients – those referred who need immediate support, but because of their situation may not experience positive changes; however, the service could prevent things from deteriorating and needing statutory support. This has been highlighted in the report, some may not have experienced

significant change, and some social value and positive change has been created to improve clients' mental well-being.

- c) Negative outcomes – some negative outcomes were identified this year, 5% of clients felt increased levels of anxiety and stress. For some reason, the project has not benefited them. A contributing factor may be people have been dealing with the pressures of the cost-of-living crisis since 2021 and throughout 2023 and now 2024. Consideration should be given to why this is the case, and what change can the project make to reduce this number.

## Value

The difference between using SROI to other frameworks is that it places a monetary value on outcomes. By using monetisation, it allows us to not only give the story of what is changed in people's lives, but also it allows us to put a value on these changes so we can compare costs and outcomes. This is not about putting a price on everything, but it allows us to demonstrate what impact the service has on other stakeholders and the possible savings an intervention can create. It also goes beyond measuring and allows organisations to manage their activities to ensure the best possible impact is created for those that matter to them the most, the individuals. The table below shows the average weighting given to the outcomes, demonstrating that positive changes in their loneliness and isolation were the most valuable to the individuals. The outcomes were weighted out of 10.

<b>Outcome</b>	<b>Value (out of 10)</b>
<b>Improved mental health</b>	8.0
<b>Reduced loneliness and isolation</b>	8.5
<b>Improved physical health</b>	6.5

## Causality

When assessing the social value created through a project or service, one of the considerations is how much of the change is actually caused by our activities.

The main considerations are:

- Counterfactual – could this have happened without this intervention?
- Attribution – who else has helped?

The questions were asked during this initial qualitative and quantitative data collection and consideration is given to any changes annually based on services available or a change in service.

<b>Outcome</b>	<b>Counterfactual</b>	<b>Attribution</b>
<b>Improved mental health</b>	30%	60%
<b>Reduced loneliness and isolation</b>	30%	60%
<b>Improved physical health</b>	30%	60%

For all three outcomes, a counterfactual rate of 30% was included. Many of the clients have mentioned that the changes they experienced may have not happened without the support given by the Community Link Officer. An attribution level of 60% is included in the SROI calculations, in line with previous years reporting and to ensure we are not overclaiming the social value created by the project. Much of the change happens within the community organisations that they are referred to and therefore it is appropriate to attribute the value to those support groups.

## CASE STUDY 'E'

An 86-year-old individual, referred to as E, was directed to the Community Link Officer by their GP surgery due to a need for assistance with utility companies, physical health, cancer support, and feelings of isolation. The Community Link Officer arranged a home visit to assess the situation and discuss available help and options.

During the visit, which lasted 3.5 hours, E expressed difficulties in contacting family, friends, or emergency services, as their phone had been non-functional for several months. Despite efforts from two neighbors to resolve the issue, they had been unsuccessful. After extensive troubleshooting with the phone company, including various tests and attempts, the phone was finally restored to working order after approximately 2.5 hours.

Following this resolution, further discussions were held regarding E's needs. A referral was initiated to Gofal Mon for a lifeline service, and another was made to Care and Repair for assistance with handles, falls prevention, and necessary repairs and maintenance in the home. Support was also provided to complete a form for renewing E's driving license, along with referrals to Age Cymru for information on the Blue Badge scheme and attendance allowance. Additionally, E was referred to receive training on using a basic mobile phone for emergency situations and to Macmillan for further support and guidance.

An information pack was provided, which included details on bereavement support, resources from the Eryri Cooperative, and a list of activities available in the village.

Feedback from E expressed gratitude: "I was amazed that Rhian was able to resolve the phone issue; I had been trying for months. She is very professional and helpful. In just one visit, she addressed years of ongoing problems. I am a very satisfied customer."

## SROI results

This section of the report presents the overall results of the SROI analysis of the social prescribing model service provided by Mantell Gwynedd. Underpinning these results are the eight SROI principles that have carefully been applied to each area of this analysis. The results demonstrate the positive contribution that the Community Link Social Prescribing project makes through the dedication of staff to create a positive change in the lives of those with social, emotional, and practical needs.

By giving individuals, the time to explain their needs, and to reduce possible restrictions they have experienced in the past to access local-based services, the Community Link Officer can guide them through what is available and assist them with taking the first steps to change. This has led to positive changes in their lives in the short time that we did this analysis, but we forecast that this will continue to improve over time.

The results in Table 4 indicate a positive return for individuals who were referred to the Community Link Officer and experienced positive outcomes based on current data.

**Table 4 - Present Value Created per Individual Involved**

<b>Stakeholder</b>	<b>Average value for each individual involved</b>
<b>Individuals</b>	£1,836.89

The overall results in Table 5 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

## Table 5 – SROI Headline Results

Total value created	£
Total present value	£222,264.70
Investment value	£64,455.54
Net present value (present value minus investment)	£155,793.16
Social Return on Investment	<b><u>£3.34</u></b>

The result of 3.34:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, an estimate of £3.34 of value is created.

It's worth noting that this report covers 12 months of service. Previous reports have covered longer reporting times due to changing reporting needs and therefore the SROI reflects the time period.

## Conclusion and Recommendations

Next year, the Arfon Community Link project will celebrate 10 years of service to the local community. What this report demonstrates is that the need for the support continues with the number of referrals being consistent over the years.

Following some extensive research in the early years, an impact management framework was developed within Mantell Gwynedd to measure and manage the social value. This will always be refined and developed as the nature of the service will change as the needs within communities' change.

Loneliness and isolation continue to be the key motivation for referrals. For various reasons many reports feeling alone in their situation and therefore by having the initial time with the Community Link Officer to get to the root cause of concern they are able to identify some possible actions together. For many, this immediately offers reassurance that support is available within the community. However, as they start to engage with service and activities it is then they start to socialise, improve confidence and feel less isolated.

Some of those referred are very anxious at the point of referral and some have reported feeling let down by services previously and sceptical of the service. However, 80% of the clients said they felt less anxious following the support. Some were facing some crisis at the time of referral, many with housing and financial concerns, and by having an action plan that covers all of their needs, the stress and anxiety levels starts to ease, or avoids further decline.

Social Prescribing continues to be high on the agenda in Wales as it aligns with our legislative framework in Wales to ensure a person-centred approach to manage well-being and focuses on what matters to them as individuals. Again, the report shows a positive return on investment and that is due to the dedication and skills of the Community Link Officer to be sure that the voice of the individual is heard and that actions are taken to create change.

## Recommendations for 2025-2026:

- 1) **Managing impact** – Some recommendations will be made to the Mantell Gwynedd Social Value working group to continue to measure and manage the impact of this service. The process of measuring baseline and follow up data on the outcomes is now well-established and therefore further data analysis of the various segments can be refined to look at demonstrating the impact for various sub-groups. This will allow for improved decision making as to the support package for the clients. The Mantell Gwynedd stakeholder engagement plan also states that another in-depth analysis is needed to ensure that all measures continue to be correct and therefore the full social value survey will need to be shared with some work on understanding the change in use of services.
- 2) **Capacity** – The need continues to be within Arfon as demonstrated, but also increasingly referrals are made from other parts of Gwynedd. By having more social prescribers, the social impact can be greater and is reduces the current gaps in service within Dwyfor and Meirionnydd.