THE SOCIAL IMPACT OF THE ARFON SOCIAL PRESCRIPTION MODEL SOCIAL RETURN ON INVESTMENT (SROI) EVALUATION AND FORECAST REPORT

"Can you imagine what it's like not to speak to anybody for a whole month" (individual)

Social Value Cymru

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Contents

Executive Summary

Mantell Gwynedd is running an 18-month proof of concept project using a social prescribing model, which offers an alternative for individuals with social and emotional needs. This report considers the first 12-months of data, but further interviews and analysis will be made between now and December 2017 to get a better understanding of the impact created by this service. The project was analysed using the Social Return on Investment (SROI) framework to understand the total value created for individuals who were referred to the service as someone who perhaps was dependent on statutory service but needed alternative support to medicine. Where possible, existing data has been used to calculate the value of the social prescribing service, and in other circumstances careful estimations and modelling of the potential impacts has been included to provide a conservative appraisal of the programme. The results demonstrate that significant value is created through the activities of Mantell Gwynedd.

The result of £3.42:1 indicates that for each £1 of value invested, £3.42 of value is created.

There is a growing need for an alternative to support the growing pressure on statutory services. There are vast amounts of services available locally, and the Social Prescription model offers the missing link to ensure that those who are most isolated in communities are able to access these services and reduce the pressure on statutory services.

Outcomes experienced by clients include **improved mental and physical health, and reduced loneliness and isolation**. For many, this service provided them with the reassurance that there was support available for them within their community, and by having the time to communicate their concerns with the Community Link Officer they had an increased awareness of services available and was able to feel satisfaction that they had something to look forward to.

Acknowledgements

This report would not be possible without involving key stakeholders who help us to understand what changes and establish the impact. This was a pilot project, so time was limited to see any big change, but for those that received support from the service, their involvement was key and we're extremely grateful to them for feeding back on their experiences and their willingness to help us understand what happens. A huge thank you to Rhian who is clearly passionate about the work, and in many cases, had gone above and beyond to help the individuals. Also, a big thank you to all staff at Mantell Gwynedd for their involvement.

Diolch yn fawr / Thank you

Eleri Lloyd

1.0 Introduction

Mantell Gwynedd have been running a pilot social prescription model in Arfon, an area within Gwynedd for 12 months with funding in place for a further 6-months up to December 2017. This report will analyse the findings from this pilot using the Social Return on Investment (SROI) framework to complete an evaluation report up to June 2017 but will forecast the anticipated impact created by this service to individuals.

The pilot is funded by Betsi Cadwaladr University Health Board (BCUHB), and managed in partnership by Mantell Gwynedd and BCUHB. Initial funding was given through the Intermediate Care Fund for 9-months including start-up costs, and then a further 9-months funding was directly given through the Arfon GP cluster. The project works closely with GPs and clinical staff to explore alternative ways of helping individuals within the community, particularly those who are visiting health care professionals more often than average with non-clinical needs. Through the Community Link Officer at Mantell Gwynedd, the role of social prescription is then to use knowledge of the activities and services offered by the local third sector to identify opportunities for people to engage in activities that create positive impacts in the lives of people and reduce their demand on statutory services such as the NHS and Social Services.

Through engaging with the individuals and gathering data, appropriate estimations have been made based on secondary evidence to arrive at an assessment of the value likely to be created by Mantell Gwynedd.

The purpose of this report is not just to demonstrate the forecasted value of the activities of the Arfon Social prescription model, but also to provide the information by which improvements to service delivery are made possible. The measurement of social value should

always be part of the ability to manage, and make even more impacts in the lives of individuals and other important stakeholders.

1.1 Background & Context

Key Organisation(s)

Mantell Gwynedd operates as a charity (Charity Number 1068851) and company limited by guarantee (Company Number 3420271), and as the County Voluntary Council for Gwynedd their role is to promote and support the multiple needs of the third sector in Gwynedd, as stated by the organisation;

'promote any charitable purpose for the benefit of residents in Gwynedd and especially through assisting and supporting charitable purposes and the work of voluntary organisations in the area'.[1]

Project Outline

Community Link (social prescription model) was established as a pilot in June 2016. It will allow primary care services to be able to refer individuals with social, emotional and practical needs to a range of locally based services.

Social prescription is a new model that is developing in different areas of the UK with a focus on offering alternative solutions to individuals emotional and social needs. One of the most recognised models is seen in Rotherham and the report prepared by Sheffield Hallam University[2] on this model describes social prescribing as,

[1] Mantell Gwynedd www.mantellgwynedd.com
[2] Dayson, D. Bashir, N. Pearson, S. (2013). From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot. Summary Report. Sheffield Hallam University.

"Solutions for improving the health and well-being of people from marginalised and disadvantaged groups that place greater emphasis on preventative interventions have become increasingly common in public policy. Social prescribing commissions services that will prevent worsening health for people with existing LTCs [Long-term conditions] and reduce costly interventions in specialist care." (p.1)

The aim of the project is to reduce demand on statutory services by providing a long-term solution for individuals that has a positive impact on their lives. The Community Link Officer works closely with local GPs and clinical staff to try and embed this service into part of their services to individuals, offering an alternative to medical treatment. However, as the project developed referrals were also received by Social Services and the Community Mental Health team (Health and Social Care Unit, Gwynedd Council) as well as others. A full list can be seen in table 6 later on in this report.

When a referral is made, the individual will have an initial meeting with the Community Link Officer, to identify their needs, allowing them to be central to the discussion of looking at solutions to their needs. Meetings with the Officer will be restricted to no more than 5 sessions and referrals will be made to other third sector organisations where appropriate. By having the support at the beginning to assist people to become more involved in various activities, the Community Link Officer is able to "hold their hand" to take those first steps that can start to integrate them in to the community and reduce dependency on services.

The service is available to anyone who is 18+ who have social or emotional needs and perhaps feel isolated within a community. Many of those referred are living with various mental and physical health conditions which has created barriers for them previously.

By January 2017 there were 24 referrals made to the service mainly from GPs but with some referrals coming from Social Services, Occupational Therapists and others with a target of 50 referrals by the end of March 2017. By the end of June 2017, 120 referrals have been made to the service which exceeded the target, and goes some way to demonstrate the demand from statutory services to offer an alternative to some individuals / patients. The needs of the individuals varied with some needing more intense support and others requiring a subsequent referral or signposting only. For each other referral, an action plan is created in partnership with the Officer, helping to focus the search for alternative options available. Some examples of available services include;

- Education Programs for Patients – health and wellbeing
- Mind
- Carers Outreach
- Citizens Advice
- Employability support – such as OPUS project
- Walking groups
- Prime Cymru
- Specialist groups such as Action for Hearing, Stroke Association, Alzheimer's
- Red Cross
- Age Cymru Gwynedd & Môn
- Canllaw – housing improvements
- Shelter
- Ffrindia' Befriending scheme
- RVS

- Lunch clubs
- Men's Sheds
- Housing Associations
- Local training opportunities such as Art or language courses
- Volunteering Opportunities
- Community Transport

In some cases, the Community Link Officer will attend the first meetings with the individual or will arrange transport that might have been a barrier to engagement previously. Attending the first session or walking in to a new venue can be a barrier for many individuals, and therefore taking those first steps with them can be important to achieve a positive change.

This service is currently being piloted in the Arfon area which include the city of Bangor, Caernarfon area and down to Dyffryn Nantlle. If this project proves to be successful in reducing demand on services, then this service could be rolled out to be available throughout Gwynedd.

As part of this project, it was emphasised that continuous monitoring should be conducted using the Social Return on Investment (SROI) framework with Social Value Cymru being commissioned to do the work and an evaluation and forecast report being available in June 2017 and a full evaluation will be available at the end of December 2017.

Identifying the need

There is an increasing pressure on statutory services with public funds being restricted, and this creates the need to consider alternative ways of offering services to be seen as a priority. The social prescribing model has already been adopted in some areas such as Bristol and

Rotherham. In their paper 'Developing a Social Prescribing approach for Bristol'[3], the authors discuss how a response was needed to deal with the 'crisis' on services,

"GP surgeries are facing an increase in number of presentees. In reality GPs are not necessarily equipped to handle all the social and psychological burdens that individuals present with. The traditional GP model of service delivery is changing." (p.11)

These are challenges that is being recognised in Wales also, and plans and strategies are already being developed as well as the new legislation in response to the predicted changes in population. The Office for National Statistics predicts that the number of the population that is over 65 will increase 44% over the next 25 years, [4] which brings its own challenges for Health and Social Care providers.

In response to the new legislation in Wales, a Population Needs assessment[5] has been conducted that allows a detailed assessment of needs by local area. Public Service Boards are established to ensure that all services work together to respond to these needs locally and create a better future in Wales[6]. The data available demonstrates that 27% of people in Gwynedd are economically inactive, with this rate higher in Bangor at 37%. Fuel Poverty in Gwynedd is 21% of households compared to the average of 14% in Wales. The Suicide rate in Gwynedd is 14.7 per 100,000 which is higher than the Wales average of Wales at 12.2. These figures allow organisations to identify the social, physical and emotional needs are in their local areas to plan their services accordingly.

[3] Gray, C. (2013). Developing a Social Prescribing approach for Bristol. Bristol Health and Wellbeing Board.
[4] Welsh Government – National Population projections (2015). http://gov.wales/statistics-and-research/national-population-projections/?lang=en
[5] Gwynedd and Anglesey Well-being consultations (2016). https://gwyneddandmonwell-being.org/
[6] Welsh Government (2016) http://gov.wales/topics/improvingservices/public-services-boards/?lang=en

On the 23rd May 2017, Vaughan Gething, The Cabinet Secretary for Health, Well-being and Sport introduced agenda item 8 in the Plenary in the Senedd which was a debate on Social Prescribing. He discussed the growing evidence of people attending GP for social issues and referred to the King's Fund[7] definition of Social Prescribing as,

"'a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.'"[8]

This debate clearly demonstrated the need for such early intervention schemes and it was also stressed that there is a need for such service for younger people as well as for the elderly. Dai Lloyd AM, himself a GP also gave a personal definition of social prescribing,

"That's what my understanding is, basically, of social prescribing—that GPs and nurses in the community can refer people to projects that tackle their illness, looking at the bigger picture of their health in its entirety, referring people, therefore, to the voluntary sector, most often, such as arts activities, volunteering, gardening, cooking, healthy eating advice and a wide range of sporting activities, such as walking."[9]

An increasing need to support those with mental health issues is recognised and the Welsh Government has prepared a 'Together for Mental Health Delivery Plan 2016-2019'[10] as a response to this need. A number of the actions in this Plan is a response to the Social Service and Well-being (Wales) Act 2014[11] which transforms the way Social Services are delivered. This also is a response to the Well-being of Future Generations (Wales) Act 2015[12] which aims to;

[7] https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing
[8] Welsh Government (2017) http://senedd.assembly.wales/ieListDocuments.aspx?MId=4292
[9] Welsh Government (2017) http://senedd.assembly.wales/ieListDocuments.aspx?MId=4292
[10] Welsh Government (2016). http://gov.wales/docs/dhss/publications/161010deliveryen.pdf
[11] Welsh Government (2016) http://gov.wales/topics/health/socialcare/act/?lang=en
[12] Welsh Government (2016) http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en

- Think more about the long-term
- Work better with people and communities and each other
- Look to prevent problems and take a more joined-up approach.

Social Prescription, although not a recent concept, is a way to respond to these new pieces of legislation to consider doing things differently and offering alternative ways to create long-term solutions.

One of the fundamental principles of the Social Service and Well-being (Wales) Act 2014 is prevention and early intervention. Social Prescribing allows primary care providers to refer individuals to services within the community that can help improve emotional and physical needs without having to rely on statutory services. By identifying early on those with needs, prevention from deterioration to more serious health needs can be addressed. These changes can take months, possibly even years to realise, which is important when analysing a pilot project in operation for only 12-18 months. The report on the Rotherham Social Prescribing Model[13] noted that changes were identified after 18-24 months. These outcomes included;

- Improved health and quality of life
- Increased patient satisfaction
- Fewer primary care consultations
- Reductions in the number of hospital admissions
- A decrease in the use of wider hospital resources.

One of the emotional needs most cited by GPs and in research as a reason for using health services when there is no clinical need is the loneliness of the patient. Although an emotional

[13] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

state, loneliness has been identified as having high risks of causing many physical and mental illnesses. Table 1 identifies some of those risks and how this can have implications in later life taking from the Ffrindia' befriending SROI report[14].

Table 1 – Risk Factors and Implications of Loneliness in Later Life

Personal risk factors		Wider societal risk factors
Poor health or sensory loss		Lack of public transport
Reduced mobility		Inappropriate physical environment (i.e. lack of public toilets, non-dementia aware environments)
Bereavement		Unsuitable housing
Retirement		Fear of crime
Becoming a carer		Technological changes
Potential implications of chronic loneliness		
Physical health	Exceeds impact on mortality of factors such as obesity – similar effects as smoking 15 cigarettes a day (Holt-Lunstad, 2010)	
	Increases the risk of high blood pressure (Hawkley *et al.* 2010)	
	Increased risk of disability (Lund *et al.* 2010)	
Mental health	Greater chance of cognitive decline (James *et al.* 2011)	
	64% increased likelihood of developing clinical dementia (Holwerda *et al.* 2012)	
	Increased chance of depression (Cacioppo *et al.* 2006; Green *et al.* 1992)	
	Increased likelihood of suicide in later life (O'Connell *et al.* 2004)	
Maintaining independence	Increased number of visits to GP, higher use of medication, greater incidence of falls & increased factors for long term care (Cohen, 2006)	
	Early entry into residential/nursing care (Russell *et al.* 1997)	
	Increased use of accident & emergency services (independent on chronic illness) (Geller, Janson, McGovern & Valdini, 1999)	
Adapted from Campaign to End Loneliness, 2016		

[14] Richards, A. (2016). Ffrindia' Social Return on Investment Report – The Value of Friendship.

This analysis will consider how the social prescribing model can respond to the needs of the new legislation in Wales, the needs of local residents based on the Population Needs Assessment and if it can reduce some of the pressure on statutory services, but most importantly create a positive change in the lives of Arfon residents.

2.0 Social Return on Investment (SROI) Framework

By explicitly asking those stakeholders with the greatest experience of an activity, SROI can quantify and ultimately monetise impacts so they can be compared to the costs of producing them. This does not mean that SROI can generate an 'actual' value of changes, but by monetising the value of stakeholders' outcomes from a range of sources it is able to provide an evaluation of projects that changes the way value is accounted for – one that takes into account economic, social and environmental impacts. Social Value UK (2014)[15] states;

'SROI seeks to include the values of people that are often excluded from markets in the same terms as used in markets, that is money, in order to give people a voice in resource allocation decisions'

Based on seven principles, SROI explicitly uses the experiences of those that have, or will experience changes in their lives as the basis for evaluative or forecasted analysis respectively.

Social Return on Investment Principles[16]

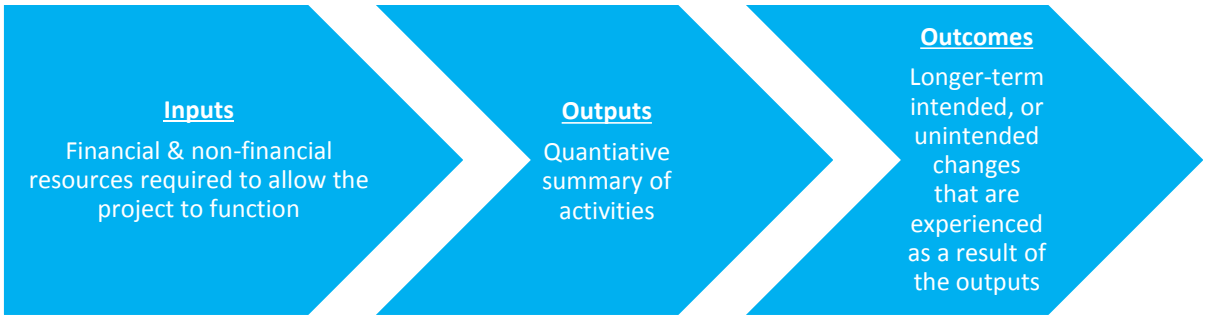
1. Involve stakeholders Understand the way in which the organisation creates change through a dialogue with stakeholders
2. Understand what changes Acknowledge and articulate all the values, objectives and stakeholders of the organisation before agreeing which aspects of the organisation are to be included in the scope; and determine what must be included in the account in order that stakeholders can make reasonable decisions

[15] Social Value UK (2014). www.socialvalueuk.org
[16] Social Value UK (2016). http://www.socialvalueuk.org/why-social-value/the-principles-of-social-value/

3. Value the things that matter Use monetisations of value in order to include the values of those excluded from markets in the same terms as used in markets
4. Only include what is material Articulate clearly how activities create change and evaluate this through the evidence gathered
5. Do not over-claim Make comparisons of performance and impact using appropriate benchmarks, targets and external standards.
6. Be transparent Demonstrate the basis on which the findings may be considered accurate and honest; and show that they will be reported to and discussed with stakeholders
7. Verify the result Ensure appropriate independent verification of the account

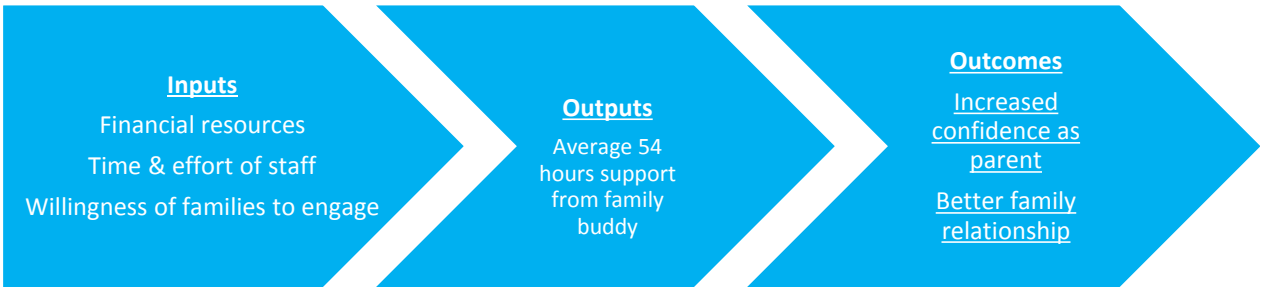
The guiding principles ensure that *how* value is accounted for remains paramount. To ensure a consistent approach is used, chains of change are constructed for each material stakeholder explaining the cause and effect relationships that ultimately create measurable outcomes. These chains of change create the overall Value Map (attached separately as appendix 6), and these stories of change are equally as important as the final result of analysis. In fact, SROI is best thought of as a story of change with both quantitative and qualitative evidence attached to it. Figure 2 summarises the different elements for each chain of change included within the SROI analysis (before the impact of outcomes is calculated).

Figure 2 – Outline of the Chain of Change



SROI is an outcomes-measurement approach, and only when outcomes are measured is it possible to understand if meaningful changes are happening for stakeholders. To illustrate this idea, figure 3 displays a brief chain of change for a family early intervention project to assist with developing resilience and parenting skills - only by measuring the final outcome, is it possible to understand the impact of the early intervention and preventative programme.

Figure 3 - Example Chain of Change –



As will be discussed at the point of analysis, SROI also incorporates accepted accounting principles such as deadweight and attribution to measure the final impact of activities that are a result of each particular activity or intervention. Importantly, SROI can capture positive and negative changes, and where appropriate these can also be projected forwards to reflect the longer-term nature of some impacts. Any projected impacts are appropriately discounted using the Treasury's discount rate (currently 3.5%). The formula used to calculate the final SROI is;

SROI = Net present value of benefits

Value of inputs

So, a result of £4:1 indicates that for each £1 invested, £4 of social value is created

Overall, SROI is able to create an understanding of the value of activities relative to the costs of creating them. It is not intended to be a reflection of market values, rather it is a means to provide a voice to those material stakeholders and outcomes that have been traditionally marginalised or ignored. Only by measuring impacts are organisations able to not only demonstrate their impacts, but also importantly improve them. This thereby strengthens accountability to those to which they are responsible, which in the third sector is fundamentally the key beneficiaries of services.

3.0 Stakeholder Engagement & Scope of the Analysis

Including stakeholders is the fundamental requirement of SROI. Without the involvement of key stakeholders, there is no validity in the results – only through active engagement can we understand actual or forecasted changes in their lives. Only then can SROI value those that matter most.

To understand what is important for an analysis, the concept of materiality is employed. This concept is also used in conventional accounting, and means that SROI focuses on the most important stakeholders, and their most important outcomes, based on the concepts of relevance and significance (see figure 4). The former identifies if an outcome is important to stakeholders, and the latter identifies the relative value of changes. Initially, for the evaluation of Arfon Social Prescription Model, a range of stakeholders were identified as either having an affecting, or being effected by the project – table 2 highlights each stakeholder, identifying if they were considered material or not for inclusion within the SROI analysis.

Figure 4 – Materiality Principle

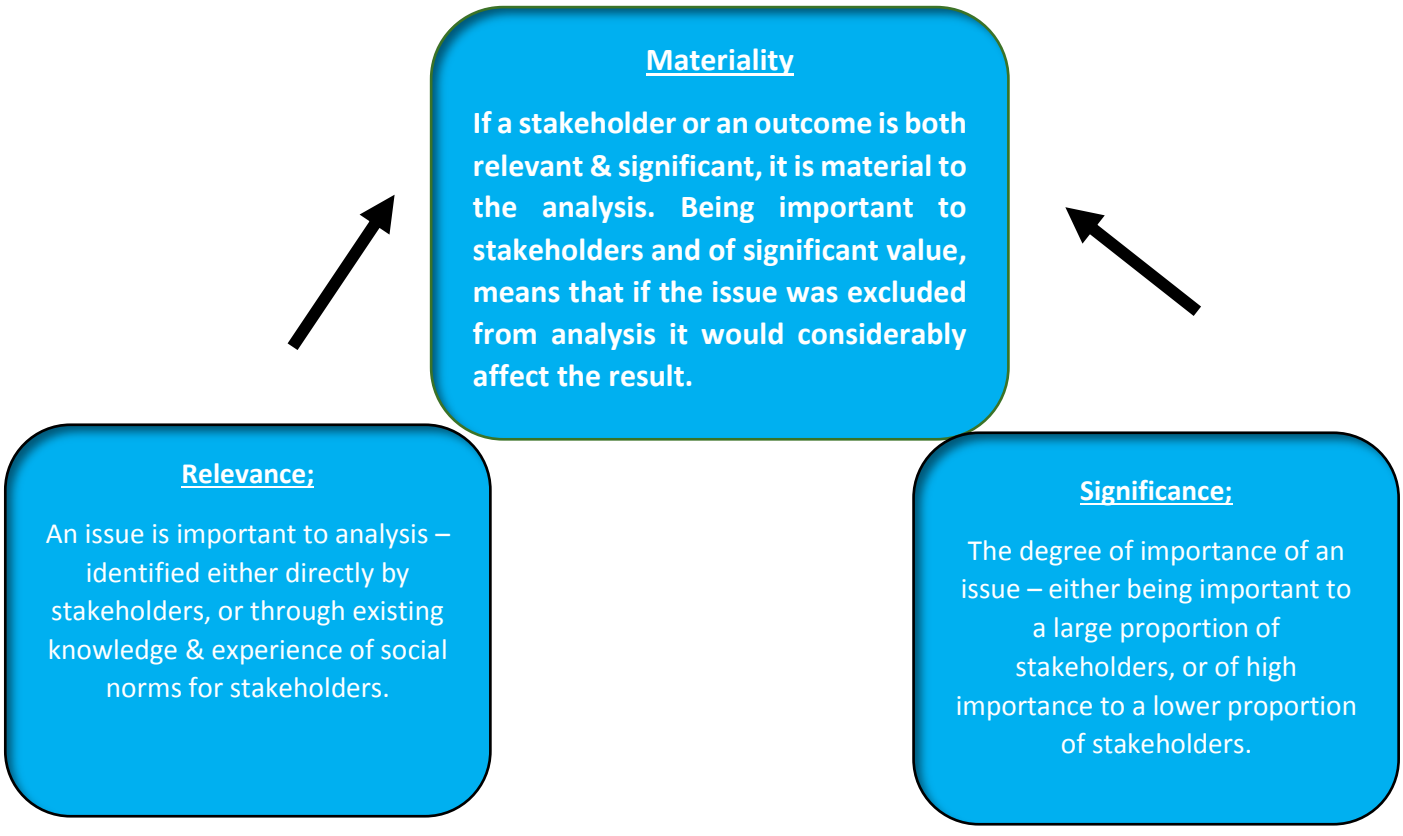


Table 2 – Stakeholder List & Materiality

Stakeholder	Material stakeholder?	Explanation
Individuals	Yes	As key beneficiaries of the service these are the most important stakeholders and some changes experienced will be both relevant and significant.
Family members	No	Although the changes to the individuals potentially have an impact on other family members, unfortunately we were not able to engage with them for this analysis.
Mantell Gwynedd	Yes	The involvement of Mantell Gwynedd is essential for the creation of any changes. Therefore, financial resources and the inputs from key members of staff must be included. However, changes experienced by the organisation are not included as they are not relevant to the project.
NHS – GP surgeries	Yes	As a key referral agent, partnership working with them is essential towards the success of the service. Any impact and changes for the individuals is likely to have an impact on their demand of such services also.
Social services	No	As a key referral agent, partnership working with them is essential towards the success of the service. Any impact and changes for the individuals is likely to have an impact on their demand. However, for this short-term pilot, not enough data is available to identify the value to them but will be considered in the longer term.

Other Third Sector Organisations	No	Although the changes to them will be relevant as without them this service wouldn't be possible, their changes will not be significant. However, they are recognised in the attribution of outcomes, and future evaluation could include them to see what impact the project has on their referral rates.

The target was set for referrals to the project as 50 over the 9-month initial pilot period. By 17th March 2017, there had been 58 referrals and by the end of June 2017 there were 120 referrals made. Although the project originally was only meant to take referrals from GPs, referrals were made also by the Mental Health team and Social Services, all identifying a need for this service. A table of all referral sources and percentages is shown in table 6 on page 26.

Usually with an SROI analysis, involving stakeholders right from the beginning is essential to influence any paperwork and monitoring processes to understand what possible changes there will be. As time was limited, monitoring systems were developed using secondary research on the impact of other similar projects. Members of Mantell Gwynedd visited the Rotherham Social Prescribing Pilot, and identified their eight measurements which included Feeling Positive, Lifestyle, Looking after yourself, Managing Symptoms, Work, Volunteering and other activities, Money, Where you live and Family and friends. The paperwork created for this pilot had similar measures considering finance and housing, mental and physical health, self-esteem, loneliness and employment and skills. The paperwork can be seen in Appendix 1.

An initial review was conducted after 2-3-month period, which is a short amount of time to identify many significant change, but this was due to the timescale of the project itself. It was

also possible for the officer to ask individuals where they hope to be in few months' time to forecast of any changes.

Having identified the material stakeholders for analysis, table 3 highlights the size of the populations, the sample size engaged with and the method of engagement.

An initial conversation was had with the Community Link Officer and the Project Manger to understand the scope and the potential list of stakeholders. As well as monitoring through the paperwork, two interviews were also held with individuals who had been referred early on to see if there were changes already happening. Further interviews will be held before December 2017 to see the change in those that have been referred to the project at least 12 months before to see the amount of change.

Unlike quantitative methods, qualitative interviewing does not have a statistical method for identifying the relevant number of interviews that must be conducted. Rather, it is important to conduct sufficient number until a point of saturation is reached – this is the stage at which no new information is being revealed

Table 3 – Stakeholder Engagement

Stakeholder	Population size	Method of engagement
Individuals	120	2 x face to face interviews Analysed a sample of data following second review.
Mantell Gwynedd	1	Regular meetings with Community Link Officer and Project Manager
NHS	1	Direct contact with NHS departments was not possible for this analysis. However, a discussion was conducted with one of the referral GPs. The

		information collected from those directly involved in the service and data from Mantell Gwynedd provided sufficient information to arrive at reasonable estimations of impact.

4.0 Project Inputs

This section of the report describes the necessary inputs from multiple stakeholders. Some inputs are financial, whereas others are not – yet where possible inputs are monetised.

Individuals / Patients

This service is free to those that receive it but some non-financial inputs are also necessary to ensure any changes. Their willingness to work 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. A high number of the individuals / patients had likely been isolated for some time and therefore this might take a lot of time and effort for them to make, but is required to ensure any benefits.

Mantell Gwynedd

The financial input is managed by Mantell Gwynedd. A financial input of £55,773 was provided for the 9-month pilot by the Intermediate Care Fund 2016-17 which is managed by the North Wales Social Care and Well-being Services Improvement Collaborative. This paid for the salary of a full-time Community Link Officer, administration support, management and resources. This also included the start-up costs of recruiting and marketing the service. Following this 9-month pilot the ICF fund was no longer able to support the programme, and therefore the Arfon Cluster team gave a financial input of £40,000 to continue the programme for a further 9-month period which will support the project until the end of December 2017.

The skills of the Community Link Officer to work with individuals in an empathetic manner and being able to identify their needs and match that with locally available options within the

community and the third sector is essential to the success of the project. The ability to establish a good partnership and work closely with the GP surgeries and Social Services is also important to ensure the success of this project.

Initial meetings will be done by the Community Link Officer, and the number of sessions with individuals will vary from 1 up to 5 sessions depending on their needs. This session on its own was identified as a sort of therapy by some of the individuals, recognising the Officer as someone non-judgmental who wanted to help. Matching the needs of the individuals to the services available and sometimes accompanying them to the first sessions is also an important input.

National Health Service

This project was funded by the Intermediate Care Fund initially, managed by the North Wales Social Care and Well-being Services Improvement Collaborative which includes Betsi Cadwaladr University Health Board. Then a further 9-month funded has been given directly by the Arfon cluster group. However, this funding is already included as an input under Mantell Gwynedd, and does not therefore need to be included again. In addition to necessary funding, a good working relationship between GPs and other clinical staff and the Community Link Officer, along with their willingness to refer individuals is essential towards the success of this project.

However, given the need for health care professionals 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 4) for example, based on the opportunity cost of not providing services directly to other individuals, the cost of a typical GP appointment of £31 is employed for referrals from this source.

Total monetised inputs

The total inputs for the project over the 12-month pilot period have been calculated as £71,694 created by both financial and non-financial inputs from the range of stakeholders above. This information is displayed in table 5, and is compared to the costs per individual.

Table 4 – Value of time taken for referrals

Referral agent	Task	Value	Source
General Practitioner	Initial referral – estimated 10 minutes each.	£31 per GP appointment – used to represent 1 appointment missed per referral made (58 referrals X £31). Therefore, total of £1,798	PSSRU Health and Social Care Costs page 145
	GP Cluster meeting with Community Link Officer – estimated to last 30 minutes with 6 GPs in attendance	£31 per GP appointment – used to represent the value of each 10 minutes of the meeting per GP in attendance (30 minutes X 6 GPs X £31).	

		Therefore, total of £558	
Mental Health Team	Initial referral – estimated 10 minutes each.	£38 per hour per team member of the community mental health team for adults with mental health problems (17 referrals X (£38/6)). Therefore, total of £102	PSSRU Health and Social Care Costs page 168
Adult, health and well-being Services, Social Services	Initial referral – estimated 10 minutes each.	£55 per hour of individual-related work (26 referrals X (£55/6)). Therefore, total of £283	PSSRU Health and Social Care Costs page 156
Occupational Therapists	Initial referral – estimated 10 minutes each.	£40 per hour of local authority operated occupational therapists (6 referrals X (£40/6)). Therefore, total of £40	PSSRU Health and Social Care Costs page 159
Support Workers	Initial referral – estimated 10 minutes each.	£52 per hour for family support worker used (4 referrals X (£52/6)).	PSSRU Health and Social Care Costs page 161

		Therefore, total of £34.50	

Table 5 – Total Monetised Inputs for Social Prescribing

Stakeholder	Financial input	Non-financial input	Cost per individual
Individuals / Patients	N/A	Willingness to take part and take action identified with the Community Link Officer	N/A
Mantell Gwynedd – manage funding by the Intermediate Care Fund and Arfon Cluster for 12 months.	£69,106	Strategic management, time, expertise	£634 per individual
NHS	(£69,106 funding but included above)	£2,815.50 of value for the time taken to refer people to Community Link	£23.46
Totals	£71,922		

5.0 Outputs, Outcomes & Evidence

The immediate outputs for the Social Prescription, Community Link project, is the number of referrals made to the project and how many hours of support each person received from the Community Link Officer. In this 12-month pilot period there were 120 referrals made to the project who were all contacted. Table 6 below shows a breakdown of how individuals where referred to the project. A small percentage do not meet the Community Link Officer on a face to face basis, as the information given to them via phone seemed to be sufficient. This is relevant to about 5% of individuals, however, they are still logged has having a service and a review will still happen to see if there are any positive outcomes.

Table 6 – Source of referral

Source of Referral	Number of Individual Referred	Percentage of referrals
GP	58	49%
Mental Health Team	17	14%
Adult, health and well-being Services, Social Services	26	22%
Occupational Therapists	6	5%
Self-referral	9	7%
Support Workers	4	3%

Individuals can have between 1-5 sessions with the Community Link Officer, depending on their needs. The average number of sessions was 3 meeting, so usually 3 hours contact time per individual. Time would also be spent gathering information on the individual's behalf, arranging

appointments and making enquiries. The total average hours provided to support each individual is therefore 5 hours.

Following the contact with the Community Link Officer, an action plan will be jointly made, where individuals can start getting involved in various activities depending on their needs. Two examples are given below;

Case study 1 – A gentleman facing financial and housing difficulties as a result of losing a partner and facing health challenges himself. He was put in touch with the Gwynedd Council Homeless Officer and was able to sort out a deposit on a new home. Also, visited the Job Centre and was explained the process of applying for ESA as a result of his physical disabilities. He was also put in touch to an Asperger's Support group as well as Cruise should he need more support dealing with his grief.

Case study 2 – A 60-year-old gentlemen wanted to socialise more and get involved in the community through volunteering. He was put in touch with the Volunteering Centre and discussed various options. He was also given information on Age Cymru, Lunch Clubs, Men's Sheds and other courses and social groups in the area.

The importance of segmenting stakeholders to identify if they experience different outcomes based on characteristics such as age, gender, health conditions, location etc. However, due to this being a short-term pilot as well as only having a small sample size, for now all will be grouped together. Future social impact analysis should consider analysing outcomes for different groups to assist in decisions about possible variation of needs for different individuals.

A Chain of Change for the individual can be seen in Appendix 2 which shows the story of what can happen for individuals, and Table 7 below summarises all the stakeholders, their outputs

and looks at all possible outcomes considered after engagement with all stakeholders. Consideration is given to what will be included and excluded and can then be seen in the Chain of Change.

Table 7 – Stakeholder Outcomes

Stakeholder	Outputs	Outcomes	Included / Excluded
Individuals	Referral made from the GP or social services. Initial contact with Community Link Officer with an average of 3 hours contact time.	Reassurance of being less alone in their situation	Excluded – individuals can feel this sense of reassurance from their first contact with the Community Link Officer. However, this isn't a key outcome and might only last while in contact with the officer. This is included in the Chain of Change.
		Satisfaction from knowing they have something to look forward to	Excluded- This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Improved financial situation	Excluded – Many of the individuals received support in sorting out their finances, which was having a negative impact on their health. This is an important outcome but leads to the outcome of improved mental health. In the data collected many noted Debt concerned as 'not applicable' and therefore although it was relevant for some, it wasn't for many others.
		Improved housing	Excluded-This was relevant to many but not significant, but also leads to the ultimate outcome of improved mental and physical health.
		Improved mental health	Included – this is a key outcome experienced by some individuals and is both significant and relevant.
		Increased social interaction	Excluded - This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Increased skills due to training and volunteering	Excluded – although this was relevant for some it was not significant.

		Increased confidence to try new things	Excluded - This is an intermediate outcome that leads to all the ultimate outcomes of this project. Many individuals explained how having something to look forward to lead to them feeling much happier and more hopeful about the future.
		Reduced loneliness / isolation	Included – this is a key outcome experienced by some individuals and is both significant and relevant.
		Improved Physical health	Included – although many of the individuals are living with long – term physical conditions, the support given by the Community Link Officer to introduce some changes had a positive impact, and helped ensure more physical movement.
NHS	Reduced demand on services	**Reduced demand on GP appointments**	Included – although it is early to identify changes, some data was available as well as using data from other social prescribing models to forecast the results.
		Reduced demand on appointment with Nurse	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
		Reduced demand on Emergency hospital visits	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
		Reduced demand on Out-patient hospital appointments	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.
Social Services	Reduced demand on services	Reduced number of visits by Social Worker.	Excluded - Although some data available, not enough yet to include in the impact map so will focus on the outcomes for the individuals currently.

Outcomes and Indicators

Material outcomes for each stakeholder

This is an 18-month 'proof of concept' project and is a short period of time to start seeing any significant change, and this report considers the first 12-months of data, but through asking the stakeholders what has already changed, and what they think will change for them we are able to forecast also based on secondary research. However, positive change could already be identified within the first months by asking individuals to score against the measures, baseline data was collected and then reviewed some months afterwards. A copy of the paperwork can be seen in Appendix 1.

5.1 Individuals

Outcome 1 – Reduced loneliness and isolation

One of the main objectives of the project is to support individuals who have social and emotional needs and to reduce demand on statutory services. Loneliness and isolation can have impact on many individuals of any age, gender or other social economic factors. Questions were asked to the individuals about their level of social interaction, about feeling part of the community and about time spent with others. In the second review questions was asked more specifically about what activities they are now part of, any new groups they might be involved with and how often.

In the Arfon pilot project, there were various reasons why people found themselves feeling lonely and isolated which included caring duties, physical and mental health conditions, or living in rural areas with limited transport opportunities.

One individual explained how his disabilities has restricted him from going out from his home over the years and how he became very isolated,

"Can you imagine what it's like not to speak to anybody for a whole month"

When looking at a sample of individuals during the analysis, for those that had already experienced positive change, there was a movement of 20%. As they would continue to take action and hopefully continue to attend new groups and make new contact, this is likely to continue and improve to a higher percentage of change.

As discussed above, time can be seen as something that was important here. Due to the pressures on statutory services, time is very limited which can lead to feelings of isolation and loneliness. Having time with the Community Link Officer and then time to spend with community groups and activities, individuals were able to feel less isolated and lonely. The difference between social prescribing and attending a GP surgery is discussed in the NHS report based on developing a Social prescribing approach in Bristol[17]. In the report, one of the GPs discussed how the social prescribing model allows individuals the time to discuss their problems more explicitly and the officer is able to get "under the skin and find out what makes people tick, what their stresses are in life and what resources already exist to help." (p.25 Developing a Social Prescribing approach for Bristol.)

Reduced loneliness and isolation is also an outcome identified by the Rotherham Social prescribing model[18]. For many, they didn't realise this was a problem until they started to see the positive changes, but is seen by many as the first step to change and knowing what is available

[17] Gray, C. (2013). Developing a Social Prescribing approach for Bristol. Bristol Health and Wellbeing Board.
[18] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

for them across all sectors, which also includes welfare benefits, which was also identified in the Arfon project.

Outcome 2 – Improved mental health

Questions were asked to individuals about their situation around financial worries, housing, stress and anxiety and feeling part of the community. These are all indicators that can be evidence about their state of mental health, but questions around health were also asked or discussed specifically.

One individual expressed feeling much less anxious about things, and also feeling generally happier as he now has things to look forward to. He also expressed the feeling of reassurance at having somebody to talk to who has the time. When dealing with statutory services he always feels rushed and doesn't have time to express his needs.

"People don't realise how valuable it is."

Another individual also explained that immediate outcome of reassurance and satisfaction that there are opportunities available for him.

"It's a push to start me on the ladder in the right directions."

This individual had not currently started any activities as arrangements were still being made, but he expressed the difference in having somebody to explain to him what is available and felt hopeful.

Improvement in well-being and especially mental well-being was also identified in the Social and Economic impact report of the Rotherham Social prescribing model[19]. Similar to the Arfon project, individuals identified these opportunities as a starting point towards positive changes.

[19] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

"Since being referred to Social Prescribing individuals' and carers' mental health has improved, they have become more independent, less isolated, more physically active, and have begun engaging with and participating in their local community." (p.36.)

Outcome 3 – Improved Physical Health

Many of the individuals referred to this project are living with various acute and chronic health conditions. This include 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. As discussed in the introduction, loneliness can also have a negative impact on a person's physical health being linked to high blood pressure and obesity.

Some of the information and the activities introduced by the Community Link Officer can lead to improvements in physical health. One lady suffers from arthritis and has very challenging and stressful situation at home. The Community Link Officer was able to give her information on ways to manage the pain and how to eat healthier. She was also able to introduce her to a local social group where she could go and have a conversation with others and socialise, which has had a positive impact on her mental and physical health.

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 reducing their visits to the GP.

The Rotherham Social Prescribing Model[20] used 'lifestyle' and 'Looking after yourself' as two of the measures when measuring change. Increased independence was recognised as an outcome for this model, which can also be identified here due to the improvements allowing them to have better access to services and engaging more with the community due to their improvements in physical health.

For most, it is very early days to recognise any vast improvements following the change, however, when asked about the future, some were very positive that they would see a big change, with one individual hoping to see a 50% improvement in a years' time in confidence to try new things and that leading to improvements in health.

Possible negative impacts

As seen in the Chain of Change in Appendix 2, for individuals who do not follow the path to successful change, for some there will be no change or possible negative outcomes. Considering the possible negative outcomes is important to allow the organisation to manage these in the future.

Dependency

Many of the individuals were dependant on statutory services such as the GP in the past, and for some this was due to needing to communicate and have time with others. Ensuring individuals do not become dependent on the Community Link Officer is important, however, this is managed currently by ensuring that individuals are aware of the short-term contact with them but that leading to a long-term plan by integrating into current services available within the community.

[20] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

During the review meetings, the Community Link Officer has a conversation with the individuals to understand what has changed, if any, and further plans for the future. A small percentage of them expressed that they would like further support during these meetings. The officer said that 10% will go back 'on the books' as they need a few more action points to continue their journey to better health. This shows the importance of maintaining contact as some individuals will need that extra support, and also incidents will happen in their day to day life which means that they will need support from time to time. Some individuals expressed the reassurance they felt from knowing they could just pick up the phone to the officer if needed.

Increased feeling of loneliness due to the project not working for them

As with many projects, this will not work for everybody. However, by raising somebody's expectation and that leading to no change, there is a possibility of somebody feeling worse due to having tried something and not being successful. This can lead to increased feelings of loneliness due to hopes being raised of social interaction possibilities, but then disappointment when this did not realise. Care must be taken therefore potentially in the selection of individuals, and also in the management of expectations. Due to some not having any change in the second review, and other not been available for a second review a judgment of 5% is taken here of those having a second review.

5.2 Health and Social Care

Reduced Demand on Services

All outcomes to the NHS and Social Services relate to the potential for cost reallocation related to avoided demand on services. The main objective of the project is to reduce demand on statutory services by supporting those who regularly use services but who could use other

services or take part in other activities to better manage their social, physical and emotional needs. The material outcomes for the individuals will therefore have impact on services, and evidence from this analysis and from other previous studies was used to make conservative estimates.

A theme that emerges through this analysis is time. The individuals' needs time to engage with people due to their emotional needs. Feeling isolated and lonely for various reasons, many engaged with services as they need to communicate with someone and need reassurance from others. However, due to increased pressure on services, time is something that is limited for GPs and Social Workers, they are therefore unable to give them the time to carefully identify the core of the individuals' issues. By having more time to engage, the Community Link Officer is able to gain an understanding of their needs and to find suitable solutions which reduces demand on the health and social care services.

One individual had a medical condition that means he needs to attend appointment on a monthly basis that will not change. However, due to him feeling lonely and isolated he used to also call the surgery on a regular basis. Since receiving support from this project, this has now stopped, and so dramatic was the change that the surgery staff decided to make enquiries about his welfare as it was so unusual for him not to call. This has relieved some time for the staff, but also is an indicator of the positive changes in his life.

However, although some changes have been identified, more time is required to see more significant change, so a forecast is provided based on a small sample data, but also by using current data available from other social prescribing models.

The Rotherham Social Prescribing Model[21] focused more on reduced hospital admissions rather than GP visits, looking at inpatients, outpatients and A&E attendees. There was an overall reduction of 21% after 12 months of being referred to the social prescription service. We analysed the baseline data for individuals and saw that individuals visited the GP on average 22 times a year. We looked at a sample of 30 individuals to see how often they used the GP surgery at the start of the service and after a few months following intervention from the Community Link Officer. The table below summarises the results.

Sample of 30 individuals			
Positive change	20	66%	12.6 less appointments per individual receiving positive change
Negative change (more use of services but not necessarily negative at all)	5	17%	18.6 more appointment per individual
No change	5	17%	

For those that had positive change (66%), they now use the GP on average 12.6 less appointments per year based on the change they had identified. This means that 998 appointments less are potentially being used due to this preventative service. However, 17% were now using the services more often, and this was an average of 18.6 more appointment per individual. Further research is needed to understand the reasons for this, but based on communication with the Community Link Officer for many this was a positive thing as they needed to go to the GP more

[21] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

often for medical reasons. A further 17% had not experienced any change in their use of service, again this might be for reasons that attending the GP is necessary.

For Social Services, insufficient data is available for this yet, but from the baseline data available, most individuals were not currently receiving many services but were identified as those at risk of needing services from a social worker. This will be something to review when the project has been running for 18-24 months to identify any change.

6.0 Valuing Outcomes

The difference of 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's changed in people's lives, but also allows us to put a value on these changes so we can compare costs and outcomes. This isn't about putting a price on everything, but it allows us to demonstrate what impact the service has on other stakeholders and 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.

Impacts of Arfon Social Prescribing pilot

SROI analyses uses accepted accounting principles to calculate the overall impact of activities. Taking into account any deadweight, attribution, displacement and drop-off factors, means that SROI analyses will avoid over-claiming value that is not a result of the activities. The boxes below outline each of the impact factors.

Deadweight

This asks the likelihood an outcome could have occurred without an activity taking place. So, for example if it is believed that there was a 10% chance that someone could have found work without a training programme, the value of that outcome is reduced by 10%.

Attribution

Considers what proportion of an outcome is created by other organisations/individuals, so can therefore not be legitimately claimed by the SROI analysis. For example, if external agencies also support someone receiving training, that organisation is responsible for creating some of the value, not just the training organisation.

Displacement

This asks if an outcome displaced similar outcomes elsewhere. This is not always a necessary impact measure, yet must be considered. For example, if a project reduces criminal activity in one area, which results in increases in other locations, there is a need to consider the displaced outcomes.

Drop-off

Outcomes projected for more than one year must consider the drop-off rate. This is the rate at which the value attributable to the focus of the SROI analysis reduces. For example, an individual who gains employment training may in the first year of employment attribute all of the value to the training organisation, but as they progress in their career less value belongs to the initial initiative owing to their new experiences.

Stakeholder 1 –Individuals

The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 3)[22] that identifies a range of well-being valuations. However, the data from the initial assessment and second review provided a distance travelled on how much change had been experienced, therefore a proportion of the wellbeing valuations were used accordingly.

The valuation for Reduced Isolation / Loneliness was taken from the outcome 'Talks to neighbours regularly' as a well-being valuation. There were other valuations on Global Value Exchange[23] that was much higher than this, such as the wellbeing valuation for Loneliness (change in) for older people values at £15,666 (http://www.globalvaluexchange.org/valuations/8279e41d9e5e0bd8499f2cd8). We also considered taking the value from the Ffrindia' SROI report[24] on loneliness that was taken from using the Value Game with the individuals that were befriended, which was a value of £5,580. Following the principle of not over-claiming, the lower value from HACT is used.

The value for Improved mental health (HACT Code HEA1602 Relief from depression / anxiety) and Improved physical health (HACT Code HEA1603 - Good overall health) also uses well-being valuation. It should be noted that the value here is much higher than for Reduced Loneliness.

When having more time to identify changes, individuals should be asked to rank their outcomes in order of importance, as currently the values might not represent this.

Due to this being a short-term pilot, using already existing well-being valuations allowed us to establish the Social Return on Investment for this project. However, in the longer term, the

[22] HACT well-being valuations. Available at http://www.hact.org.uk/value-calculator
[23] Global Value Exchange www.globalvaluexchange.org
[24] Richards, A. (2016). Ffrindia' Social Return on Investment Report – The Value of Friendship.

value game will be used with individuals to ensure that stakeholders are involved at each stage and to ensure that stakeholders are involved at each stage (Principle1).

It can also be noted here that due to the high value given to Improved mental health, a higher attribution is given to ensure a more realistic figure.

Stakeholder 2 – Health and Social Care

To put a value on the reduced potential demand on the NHS, the published Unit Costs Health and Social Care 2016, by PSSRU[25] was used. Individuals were asked if there were any changes in their use of health and social care services. An average GP visit will cost £31 and will last on average 9.22 minutes. By taking a sample of the individuals and analysing the data given in the initial meeting and at the second review an estimation of potential savings to the NHS was made. Based on 66% of individuals receiving some form of positive outcomes in that they use services less often a judgment was used to say there would be 998 less appointment taken up per year as a result of this services which is an average of 12.6 less appointments for those individuals that have had a positive change in their lives as a result of the social prescribing model. However, we have also included that some individuals used the services more often, and based on the sample of 17% in this category, this gave a total of 379 appointments that needs to be deducted from above. Table 8 shows how some of the individuals' outcome valuations have been calculated.

[25]Curtis, L. Burns, A. (2016) Unit Costs of Health and Social Care 2016. PSSRU.

Table 8 – Examples of Outcome Valuations

Outcome	Identified value	Value of average distance travelled	Quantity of stakeholders experiencing outcome
Individual; Reduced loneliness and isolation	Used HACT Code ENV1410, talking to neighbours regularly valued at £4,511 for unknown area. Took 20% of this value based on the distance travelled, therefore £902.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1 point – which equals 20% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 63% had experienced change here, so 76 individuals.
Individual; Improved mental health	Used HACT Code HEA 1602, Relief from depression / anxiety valued at £36,760 for unknown area. Took 25% of this value based on the distance travelled, therefore £9,190.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1.25 – which equals 24% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 66% had experienced change here, so 79 individuals.
Individual; Improved physical health	Used HACT Code HEA1603, Good overall health valued at £20,141 for unknown area. Took 20% of this value based on the distance travelled, therefore £4.028.	Taking the lowest point for our questionnaire scale asking individuals to rate against measures (very poor =0%, poor= 25%, ok = 50%, good = 75%, very good = 100%) The average movement was 1 point – which equals 20% Although based on low sample size the results were in line with tone of interview comments – this was cited as an extremely significant change.	From the data in second review, 53% had experienced change here, so 64 individuals.
NHS; Reduced potential demand on service	£31 per GP appointment from PSSRU Health and Social Care Costs.	From the baseline data, there was an average of 22 GP appointment by individuals per year. Based on a sample of individuals that had baseline data and a review, there were 66% of individuals receiving a positive change in reducing their need to use GP service.	Considered 66% of individuals that had positive change and reducing appointments by 12.6 appointments each.

7.0 Establishing Impact

In order to assess the overall value of the outcomes of Arfon Social Prescribing Model we need to establish how much is specifically a result of the project. SROI applies accepted accounting principles to discount the value accordingly, by asking; What would have happened anyway (deadweight)? What is the contribution of others (attribution)? Have the activities displaced value from elsewhere (displacement)? If an outcome is projected to last more than 1 year, what is the rate at which value created by a project reduces over future years (drop-off)? Applying these four measures creates an understanding of the total net value of the outcomes and helps to abide by the principle not to over-claim.

Deadweight

Deadweight allows us to consider what would happen if the service wasn't available. There is always a possibility that the individuals would have received the same outcomes through another activity or by having support elsewhere.

The Community Link Officer will refer individuals to services that are already available within the community, so there is a good possibility that individuals could have been signposted to these services elsewhere. However, individuals felt that the Community Link offered more than signposting, and was able to provide a personalised action plan and in some cases, help them with those first steps to receiving a service or taking part in an activity. One individual expressed how he had been referred to different places in the past, but didn't feel it offered a long-term solution like this project did.

Through the interviews with individuals and other stakeholders, and the results of the second review a reasonable estimate is given in table 9 below.

Table 9 – Deadweight value

Outcome	Deadweight	Justification
Reduced loneliness / isolation	30%	The services that the individuals are now or will be engaging with are already available within the community, so some deadweight percentage must be considered. However, barriers that had restricted them in the past meant it wasn't possible, so this project helped to break down those barriers to ensure positive change was created.
Improved mental health	30%	There is a chance that this outcome could have happened anyway through another activity or another organisation, so a 30% deadweight is given.
Improved physical health	30%	It is possible that other organisations could have given the same advice to have a similar impact, or family and friends could have helped. However, barriers that had restricted them in the past meant it wasn't possible, so this project helped to break down those barriers to ensure positive change was created.

Attribution

Attribution allows us to recognise the contribution of others towards achieving these outcomes. There is always a possibility that others will contribute towards any changes in people's lives such as family members or other organisations. Attribution allows us to see how much of the change happens because of the support by this project.

Individuals were asked specifically about how much of the changes were down to this project;

Question 24. Thinking about all of the things that have changed in your life since joining the scheme, how much of this is a result of Community Link (other people or organisations may also be important)? (question taken from individuals' second review)

This project will have very short contact time with the individual due to the nature of the service being to help them to engage with services already available within the community in order to reduce demand on statutory services. Without the organisations that provides these services,

these positive outcomes would not be possible, and therefore a proportionate percentage of the change should be attributed to them. However, it is this relationship between the project and the statutory services that allows these links to happen, and therefore a fair percentage of the change should be given to this project to represent the change that's been created.

"I get out of the house. I meet up with Maria RVS who is great. I have plans to go out for a meal with a group of people. I have information to help me to make my life easier. I have been talking to others re: the project and trying to get an interest in holding a group in Bethesda - lunch groups. There are a lot of people who would support this. Community Link helped a lot with my hearing, arthritis group to socialise. I want to thank you very much for your good work. It has opened doors for me. A lot of the changes are the result of Community Link." (Individual, feedback during second review)

An attribution of 70% is given to the Reduced Loneliness and Improved Physical health and a slightly higher rate of 80% is given to Improved Mental Health. The slightly higher rate is given to this outcome due to the high value that this outcome has due to a lack of another suitable value. This may appear as a high percentage to attribute to others, but again emphasis should be given that without the support of the Community Link Officer, this change may not have happened at all, but in order to not over-claim a higher attribution is given to acknowledge the contribution of all the third sector organisations within the Arfon area.

Displacement

We need to consider if the outcomes displace other outcomes elsewhere. For example, if we deal with criminal activity in one street, have we just moved the problem elsewhere. This model is currently new to the area and provides a link to all other services, and therefore does not displace any.

Duration & Drop-off

The aim of the project is to allow individuals to be better able to manage in the long-term and to ensure that they engage with services within the community as an alternative to medicine. By being more involved in the community and having more social interactions, there should be some long-term changes and benefits to the individual as well as a reduced demand on services. Over time many other factors will contribute towards maintaining these outcomes and therefore this analysis will only consider the value for 2 years. For the second year, a drop-off rate of 50% is given, as the impact created by the project will be reduced over time as the contribution of others will be more visible in maintaining or increasing the amount of change.

8.0 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 seven SROI principles which 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 are and to reduce possible restrictions they have experienced in the past to access local based services, the Community Link Officer is able to guide them through what is available and assist them with taking the first steps to change. This lead to positive changes in their lives in the short time that we did this analysis, but forecasting that this will continue to improve over time.

Table 10 displays the present value created for each of the included stakeholders who experience material changes. The present value calculations take account of the 3.5% discount rate as suggested by the Treasury's Green Book.

Table 10 - Total Present Value Created by Stakeholder

Stakeholder	Value created as a result of Community Link, Arfon Social Prescribing model	Proportion of total value created
Individuals / Individuals – Positive outcomes	£241,806	98%
Individuals – negative outcomes	-£4,347 (already deducted)	
NHS (Reduced GP visits)	£4,317	2%

Table 11 - Present Value Created per Individual Involved

Stakeholder	Average value for each individual involved
Individuals	£2,051

The above results in table 11 indicate a positive return for individuals who were referred to the Community Link Officer and experienced positive outcomes. This is based on current data but also forecasting results based on secondary research. The overall results in table 12 highlight the total value created, the total present value (discounted at 3.5%), the net present value, and ultimately the SROI ratio.

Table 12 – SROI Headline Results

Total value created	£
Total present value	£246,123
Investment value	£71,922
Net present value (present value minus investment)	£174,201
Social Return on Investment	£3.42:1

The result of £3.42:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £3.42 of value is created.

9.0 Sensitivity Analysis

The results demonstrate highly significant value created by the Arfon Social Prescribing model provided by Mantell Gwynedd, and is based on application of the principles of the SROI framework. Although there are inherent assumptions within this analysis, consistent application of the principle not to over-claim leads to the potential under-valuing of some material outcomes based on issues such as duration of impact.

Conducting sensitivity analysis is designed to assess any assumptions that were included in the analysis. Testing one variable at a time such as quantity, duration, deadweight or drop-off allows for any issues that have a significant impact on the result to be identified. If any issue is deemed to have a material impact, this assumption should be both carefully considered and managed going forward. To test the assumptions within this analysis, a range of issues were altered substantially to appreciate their impact. A summary of the results is presented in table 11.

Table 13 – Sensitivity Analysis Summary

Variable	Current assumption	Revised assumption	Revised SROI	Proportion of change
Individuals; reduced loneliness / isolation	Quantity; 76	Quantity; 35	3.27	4.4%
	Deadweight; 30%	Deadweight; 60%	3.30	3.5%
	Attribution; 70%	Attribution; 90%	3.23	5.5%
	Value; £902	Value; £400	3.26	4.7%
Individuals; Improved mental health	Quantity; 79	Quantity; 35	2.29	**33.0%**
	Deadweight; 30%	Deadweight; 70%	2.26	**33.9%**

	Drop-off; 50%	Drop-off; 80%	3.03	**11.4%**
	Value; £9,190	Value; £4,000	2.28	**33.3%**
NHS; Reduced demand on service (less GP appointments)	Quantity; 998	Quantity; 500	3.38	1.7%
	Attribution; 70%	Attribution; 90%	3.45	-0.8%

Although some of the sensitivity tests indicate changes to the result, owing to the scale of the amendments made and the verification of assumptions and data with stakeholders, the results still indicate that if a single variable were significantly altered, the overall results remain highly positive. The most significant impact of the sensitivity analysis is based on the change to the outcome for individuals on improved mental health. This could be because of the relatively high value given to this outcome compares to the outcome of reduced loneliness. Again, the sensitivity test uses a relatively large change, and although there is a great deal of confidence in the figure employed, it nevertheless indicates the importance for Mantell Gwynedd to carefully manage this issue in the future.

10.0 Conclusion

This report has demonstrated that Community Link, Arfon Social Prescription Model pilot will create over £246,000 of value and for each £1 invested, £3.42 of value is created;

What that means in practical terms is that people's lives have been positively changed.

Social Prescribing offers an alternative for professional staff working in Health and Social Care and offers a solution for individuals with social and emotional needs. The Arfon Social Prescribing Model works with individuals to create positive changes in the lives of people.

Time is limited for staff working in Primary Care with increasing pressure on services that will continue to be stretched based on the changing nature of the population. Time is something that the Community Link Officer can offer the individuals to understand what their needs are and to work together to find solutions locally. Any barriers which had previously restricted them from attending any local groups or taking part in activities are tackled head on.

This is a short-term project, but already there was a feeling of hope that things could change for the individuals. There is a vast amount of services available locally, but the Social Prescription model offers the missing link to ensure that those who are most isolated in communities are able to access these services and reduce the pressure on statutory services.

The outcomes wouldn't be possible without the contribution of third sector services that are already available within communities, so a fair amount of the value has been attributed to them. However, the services already existed so having the Social Prescription model ensures that the statutory services are made aware of what is available and can refer to one organisation instead of needing to refer to various service that time doesn't allow.

These outcomes of this project can show the contribution made here towards the National well-being goals as part of the new Well-being of Future Generations (Wales) Act 2015. By offering individuals an alternative we can contribute towards a more resilient Wales, a healthier Wales and also a more equal Wales where individuals / individuals are given the opportunities to engage more with their community and society.

11.0 Recommendations

1) This is an 18-month project, and so far, 12-months has gone by, and although small positive changes have been identified, **more time is required** to identify longer term impacts of the service. An average movement of 20%-25% was identified for all of the outcomes which is extremely positive, however, a further 18-24 months of data should be collected to ensure a clearer analysis of the social impact of this project. The positive impacts created for Health and Social Care services already, suggests further support in terms of funding should be provided in order to ensure that further potential reduce on demand on statutory services can have an impact.

2) The Community Link Officer originally offered individuals between 1-6 sessions with her to offer support and to take those first few steps to create the change identified in the action plan. This was quickly reduced to a maximum of 5 due to the high referral rate and to reduce the risk of dependency.

   As with many services, there isn't a standard number of sessions that will work for everybody as we all have different needs. For some, as seen here, one or two sessions was sufficient for them to identify what was available for them to start to identify change. However, for others they needed much more emotional support to take those first steps, for example to attend a group for the first time or to make arrangements on their behalf for example with transport or courses. As discussed in the report, care should be taken to manage dependency, and that this service is not seen as an alternative to regular visits to the GP, but a way to start managing their own long-term illnesses.

   As with the first recommendation, more time is needed to identify how much time the Community Link Officer should give individuals. By segmenting individuals based on age,

health needs, or other, the project could start to recognise if there are different needs in terms of number of sessions required which could then be managed.

3) Mantell Gwynedd is an umbrella organisation for the third sector in Gwynedd and is well placed to advise individuals on services available with no form of bias. Referrals are made to various organisations based on their services and expertise and the Community Link Officer continuously adds different services to the list of what's available as she hears of new groups. However, it is possible that these services can identify increased pressure on their services, without receiving any further funding support. As the project continues, it may be beneficial to ensure regular feedback is given from the organisation to ensure they have the resources to deal with increased referrals.

The Rotherham Social Prescribing model[26] commissions services to deliver the social prescribing model. They have 24 different organisations being commissioned that offers a menu of services and the grant allows them to have the right resources to deal with the increased referrals. This might be something to consider in the future. However, having a restricted number of services could restrict the service, and currently having the vast information of different services available allows the freedom of giving the individual the decision on what service will help them and lead to a positive impact in their lives.

4) Data collection – ensuring we have baseline data and having a mid-review and end review is essential for us to understand if there is any change, but also how much change, and are there differences in the needs of different individuals. It is therefore recommended that any continuation of this scheme, or indeed any other social prescribing, needs to invest the time and finances into ensuring suitable systems and processes are in place to

[26] Dayson, D. Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University.

measure social value, and also extend this to include other important stakeholders such as wider family members and unpaid carers. When such data is collected over a period of time, the potential to use resultant information to inform decision-making is possible. Ultimately, this means that value is not just being measured, but it is being managed to improve the impacts of the project.

It was also noted that during the review meetings, that 10% of individuals still felt they needed support, and therefore to understand what changes and to understand perhaps why there hasn't been any change, maintaining this relationship is crucial to develop the service.

12.0 Appendices

Appendix 1 – Project Paperwork

ADNABOD ANGHENION YR UNIGOLYN/IDENTIFYING INDIVIDUALS' NEEDS

Review 1; This form is intended to be used by new starters only

1. Enw / Name	
2. Dyddiad geni / Date of birth	
3. Cyfeiriad / Address	
4. Rhif Ffôn / Phone number	**Tŷ / House:** **Ffôn symudol / Mobile phone:**
5. E-bost / E-mail	
6. Ffordd gorau i gysylltu / Preferred method of contact	Ffôn / Phone Text E-bost / E-mail Post Facebook Arall / other
7. Gender	
8. Surgery	
9. Are you a carer?	Yes / No

10. Do you drive?	Yes / No

11. Pa gefnogaeth ydych chi yn dymuno ei gael gan Linc Cymunedol? Pa newid ydych chi'n gobeithio ei wneud? What support do you require from Community Link? What changes would you like to work towards?

13. A ydych yn derbyn unrhyw wasanaeth gan asiantaeth arall? Are you receiving support from any other organisation?				**Ydw/Nac Ydw** **Yes/No**
Mudiad/Organisation	**Enw Cyswllt/** **Contact Name**	**Cyfeiriad/Address**	**Rhif Ffôn/Phone**	**Math o gefnogaeth** **Type of support**

12. Are there any sorts of activities or things you would like to participate in?

15. Unrhyw sylwadau ychwanegol e.e. sefyllfa gymdeithasol/meddyginiaeth. Any other information e.g. social situation/medication

16. Thinking about what you might gain from involvement with Community Link, could you please rate your current situation for each of the below items (they may not all be relevant of course).

	Not applicable to me	1. Very concerned	2 A bit concerned	3 Neutral	4 Not concerned much	5 Not concerned at all
Concerns about debt						
	Not applicable to me	1 Very poor	2 Poor	3 Ok	4 Good	5 Very good
Physical health						
Stress, anxiety, depression or similar						
Time spent with other people socialising						
General confidence						
Feeling part of the local community						
Housing situation						
Employment situation						
Skills / education						
Other (please state)						
Other (please state)						
Other (please state)						

17. Thinking back over the last 12 months, how often have you used the following services?								
	Not used in the year	More than once a week	Once a week	About once every 2 weeks	About once a month	About once every 3 months	About once every 6 months	About once in 12 months
General practitioner								
Local nurse services								
Social Services								
Emergency hospital services								
Out-patient hospital services								
Carers Trust or similar								
Other								
Other								

Llofnod Cydlynydd/ Coordinators Signature		**Dyddiad/Date**	

ADNABOD ANGHENION YR UNIGOLYN/IDENTIFYING INDIVIDUALS' NEEDS

Review 2; (2-3 months after referral)

18. Pa brif newidiadau ydych chi wedi ei adnabod, os o gwbl, yn yr wythnosau /misoedd diwethaf? **What main changes have you experienced, if any, in the past few weeks / months?**

19. A ydych yn derbyn unrhyw wasanaeth gan asiantaeth arall? Are you receiving support from any other organisation?				**Ydw/Nac Ydw** **Yes/No**
Mudiad/Organisation	**Enw Cyswllt/** **Contact Name**	**Cyfeiriad/Address**	**Rhif Ffôn/Phone**	**Math o gefnogaeth** **Type of support**

20. Have you joined any *new* groups or started *new* activities (for example, joined the library, the choir, lunch club or started volunteering) since joining the project? And if so, how often do you undertake these activities?						
No		More than once a week	Once a week	Once every two weeks	Once a month	Less than once a month
Yes (please state below)						
1.						
2.						
3.						

4.						
5.						

21. As a result of the support from Community Link have you learnt about new services that are available to you within your community?	
No	
Yes (please state)	

22. Thinking about what you have experienced as a result of involvement with Community Link, could you please rate your current situation for each of the below items (they may not all be relevant of course).						
	Not applicable to me	2. Very concerned	2 A bit concerned	3 Neutral	4 Not concerned much	5 Not concerned at all
Concerns about debt						
	Not applicable to me	1 Very poor	2 Poor	3 Ok	4 Good	5 Very good
Physical health						
Stress, anxiety, depression or similar						
Time spent with other people socialising						
General confidence						
Feeling part of the local community						
Housing situation						
Employment situation						
Skills / education						
Other (please state)						
Other (please state)						

Other (please state)						

24. Thinking about all of the things that have changed in your life since joining the scheme, how much of this is a result of Community Link (other people or organisations may also be important)?	
All of the changes are the result of Community Link	
A **lot** of the changes are the result of Community Link	
About **half** of the changes are a result of Community Link	
A **little** of the changes are the result of Community Link	
None of the changes are the result of Community Link	

25. Have you experienced any negative changes as a result of being involved in the scheme?	
No	
Yes (please state below)	

23. Looking back over the last 6 weeks, how often have you used the following services?						
	Not used in the time	More than once a week	Once a week	About once every 2 weeks	About once a month	Once in 6 weeks
General practitioner						
Local nurse services						
Social Services						
Emergency hospital services						
Out-patient hospital services						
Carers Trust or similar						
Other						
Other						

Llofnod Cydlynydd/ Coordinators Signature	
Dyddiad/Date	

Appendix 2 Chain of Change – Individuals / individuals of Social Prescription Model