"It's a reason to get up in the morning, and it's better than any drug." client

THE SOCIAL IMPACT OF THE ARFON SOCIAL PRESCRIPTION MODEL SOCIAL RETURN ON INVESTMENT (SROI)

An update on the results looking at 18 months of data from June 2016-December 2017.

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MANTELL GWYNEDD
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1. Introduction

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. In June 2017 we presented a full Social Return on Investment Evaluation and Forecast report on the first 12 months. Further data is now available as well as some case studies with individuals who have benefited from the project, and therefore this report provides some updated results, looking at any key changes based on further data.

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. The Social Return on Investment Principles can be seen below to remind us. 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.

Social Return on Investment Principles[1]

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

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

included in the account in order that stakeholders can make reasonable decisions

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 result of £4.90:1 indicates that for each £1 of value invested, £4.90 of value is created. This is a higher SROI than was reported in June 2017. The key changes that explains this increased value is that the investment (input) per individual has been reduced due to having start-up costs at the beginning of the project. Also, more referrals are now being made to the service seen as the project has been established, with 240 referrals at the time of preparing this report.

There is a growing need for an alternative to support the growing pressures 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 is 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.

2.0 Stakeholder Engagement

In the last report, although a limited amount of stakeholder engagement was done, questions were asked more around what they hope to change as they received support from the service. Data was available for a small sample of clients and the findings were backed up with secondary research from other social prescribing models. Further qualitative interviews were possible in October 2017 that provided an insight in to the impact of the project on clients and other stakeholders.

An interview was held with five clients about what had changed for them as a result of this project. Although they all had different referral routes and different reasons for needing the support, the changes identified could all be linked. This qualitative data helped to install confidence in our Chain of Change identified in the last report, and that the right questions are being asked to understand the distance travelled.

Questions were also asked around Deadweight (what could have happened anyway), attribution (who else contributed) and duration to ensure that the rates given are accurate and that we aren't over claiming.

Case study

A referral was initially made from the GP for a lady with an early diagnosis of Alzheimer's, but during the initial assessment, support was also offered to her husband who was also he carer.

He explained the loneliness he felt at the time of diagnosis when he suddenly needed to know about a new world which he had very little knowledge of. Through the Community Link Officer's support, he's been in touch with Carers Outreach, Alzheimer's Society and attended many events that helped to grow his understanding about the condition. He felt the reassurance of knowing that help is available, and that others are also on the same journey.

Through the support also, he's recognised that he is allowed respite every few weeks and shouldn't feel guilty about that as it benefits everybody. This support and allowing himself time has helped to improve his mental health.

This was an example of how the project not only benefited the wife but the whole family.

3.0 Project Inputs

We have now included the financial input for the whole 18 months in the value map. Some inputs are financial, whereas others are not – yet where possible inputs are monetised.

A financial input of £55,773 was provided for the 9-month pilot by the Intermediate Care Fund 2016-17 which was 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 GP 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 table below, as seen in the full report, has been updated to include the project inputs for the whole 18 month period. Given the need for health and social 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 1) 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.

Table 1 – 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 (59 referrals X £31). Therefore, total of £1,829	

	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).	PSSRU Health and Social Care Costs page 145 [2]
		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 (29 referrals X (£38/6)). Therefore, total of £184	PSSRU Health and Social Care Costs page 168

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

Adult, health and wellbeing Services, Social Services	Initial referral – estimated 10 minutes each.	£55 per hour of individual-related work (54 referrals X (£55/6)). Therefore, total of £495	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 (20 referrals X (£40/6)). Therefore, total of £133	PSSRU Health and Social Care Costs page 159

Table 2 – 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 – managed funding received through the Intermediate Care Fund and Arfon Cluster for 18 months.	£95,773	Strategic management, time, expertise	£399 per individual
Totals	£98,974		£412 per individual referred.

It is worth noting here that the cost per individual from the funding has been reduced from £634 in June 2017 to £399. Fundamentally, the reason for this is that the amount of financial input was reduced as it didn't include any start up costs. Also, as is natural with any new service, it takes time for referrals to come through the system. Now, 18 months after beginning the project, 240 referrals has been made to the service.

4.0 Outputs

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. When this report was prepared there were 240 referrals made to this project. From this number, 69% of clients had experienced positive outcomes, which means 166 clients had experienced positive changes in their lives.

It's worth looking again at the referral table to understand the breakdown of how clients are referred in to the project.

Table 3

Source of Referral	Number of Individuals Referred	Percentage of referrals
GP	59	24%
Mental Health Team	29	12%
Adult, health and well-being Services, Social Services	54	22%
Occupational Therapists	20	8%
Self-referral (GP also)	62	26%
Support Workers	4	2%
Physiotherapists	6	3%
Community nurse	1	1%
Others	5	2%

Compared to the results in June 2017, there is an increased number of self-referrals. Having discussed this with the staff, most of these self-referrals have been given the card by the GP, therefore this figure has been included together with the GP referrals in the value map.

It's worth noting also that as many direct referrals are made by Social Services as by the GP which recognises the need for this project across all Health and Social Care services.

Case study

After suffering from a breakdown and severe depression, this lady was referred to the project by her GP. Having moved to a new area and dealing with many changes in her life, she needed some support and guidance.

The Community Link Officer gave her some practical support first of all in the house with unpacking so she could get settled. She explained how she immediately started to feel better because of the help that was available,

"My spirits starting coming up, and also it was nice having company."

She was given an information pack with all the support available to her which included support for the home from Gofal a Thrwsio (Care and Repair) and Nest to support with energy efficiency.

She explained how she felt much better now and how her confidence had grown and as a result has been able to find part time employment. All these positive changes has resulted in her medication being reduced, and when we asked what she thought could have happened without this support, she expressed that she feared that things would have continued to deteriorate and she felt she would have had to go back to hospital.

This case study showed how some practical and emotional support had helped to take those first steps to positive change and how that continued as she gained employment and became more sociable.

5.0 Outcomes

Since the report in June 2017, further qualitative and quantitative research has been conducted which provides further confidence in the results presented.

The monitoring paperwork is used to capture all the changes identified. For 26% of clients, no change was experienced, with a small percentage being re-referred back in to the project at a later date. In future, it is recommended that we track these clients better in order to understand why it didn't work for them. The reasons for this could include that they weren't ready to engage with the Officer or to take on some of the activities recommended, or that some physical or mental health conditions at the time meant that they were not able to adopt any changes yet. One example was given from the Community Link Officer of a client who shortly after the referral was made was hospitalised for some time.

The majority of the changes identified can still be categorised under the same three outcomes as identified in June 2017, which are;

Outcome 1 – Reduced loneliness and isolation

Outcome 2 – Improved mental health

Outcome 3 – Improved Physical Health

Some reported improvement in debt management, housing situation, training and employment, however, these don't appear to be either significant or relevant to many clients, but are factors that can contribute to the reduced isolation and improved physical and mental health. It is still worth monitoring all of these as the changes identified by some are significant with one client reporting an 80 % improvement in employment.

The percentage of clients experiencing each of the three outcomes above was slightly higher with the distance travelled (amount of change) also slightly higher. In June 2017 we reported that 63% of clients had reported that their loneliness had been reduced, looking at further data and a bigger sample now this is slightly higher at 69.5%. The distance travelled has increased by 4%, again based on more data.

One client during the qualitative research explained how she was isolated due to a chronic illness, and how this service had allowed her to find solutions in the community. She now goes to a group on a weekly basis and had just been on a trip which clearly had a positive impact on her,

"It's a reason to get up in the morning, and it's better than any drug."

Reduced Demand on Services

All outcomes to the NHS and Social Services relate to the potential for cost reallocation related to avoiding 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 an impact on services, and evidence from this analysis and from other previous studies was used to make conservative estimates.

In June 2017, we looked at a sample of 30 clients to see how the service had an impact on the number of GP visits. We have now looked at a sample of 60 clients over the 18 month period, and 75% are recognised as having a positive change, reducing the use of GP visits. This reduction gives an average of 11.7 appointment less per client, which is slightly less than in

June. As reported in June, some clients increased their use of the GP, but this shouldn't be seen as a negative as it could be clients that needed to go previously but weren't going and were referred from elsewhere.

Table 4

Sample of 60 individuals			
Positive change	45	75%	11.7 less appointments per individual receiving positive change
Negative change (more use of services but not necessarily negative)	8	13%	13.4 more appointments per individual
No change	7	12%	

We still haven't got sufficient data to be able to report any changes in the use of other health and social care services such as Social Services. This is something that we should monitor more closely in order to understand the impact this service has on social care.

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, i.e. the individuals.

The same values have been used here as used in the June 2017 report. The valuations for the outcomes identified to the individuals were taken from HACT'S Social Value Calculator (version 3)[3] that identifies a range of well-being valuations. The Value game again wasn't an option for us here due to time restrictions, however, in the longer term in order to comply with the Principle number 1 of Involving stakeholders, we should use this method to value our outcomes.

7.0 Impact

In order to assess the overall value of the outcomes of the Arfon Social Prescribing Model we need to establish how much is specifically as 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.

The only change in the percentage given here is that the drop-off rate was increased slightly to 60%. This means the contribution of the service has reduced every year. Although the clients still felt that the changes should be credited to this service, the involvement of others

[3] HACT well-being valuations. Available at http://www.hact.org.uk/value-calculator

will become much more noticeable over time so to be more confident that we didn't over-claim this was increased slightly.

During the qualitative research, clients where asked about What would have happened anyway (deadweight)? What is the contribution of others (attribution)? This is also a question asked during the review in the normal monitoring process. Again, the answers given provided us with further confidence that the rate we are included in the impact map is correct. In the qualitative research they said that a 100% was down to this project, however, with the principle of over-claiming we must attribute a high percentage to the services available in the community because without them, these outcomes wouldn't continue to increase.

8.0 SROI results

This section 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 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 leads 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.

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	£484,962
Investment value	£98,972
Net present value (present value minus investment)	£385,990
Social Return on Investment	£4.90:1

The result of £4.90:1 indicates that for each £1 of value invested in Community Link, Arfon Social Prescribing Model, a total of £4.90 of value is created.

9.0 Conclusion

Further qualitative and quantitative research results are available, which allows further understanding of the social value of the project and more scope to manage the impact moving forwards.

This results has demonstrated that Community Link, Arfon Social Prescription Model pilot will create over £480,000 of value and for each £1 invested, £4.90 of value is created;

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

During the interviews with clients and looking at the data from the monitoring, it is apparent that the story of every client is very different, but the problem of loneliness and isolation can be seen as an underlying problem in each case, and the results identified by those who experienced positive changes are all linked.

Some of the key words heard were time, listening and understanding. Time, as was identified previously, is something that health and social care staff isn't able to offer clients because of the pressures on statutory services, and therefore listening and understanding can be challenging. By having a third party that can go and listen and spend some time to find the route of the problem, then a solution can start to be identified.

The positive changes wouldn't be possible without all the services already available in our communities provided by third sector organisations, community groups and other agencies. Their contribution is vital and therefore a fair rate of attribution is given to represent this. However, having an umbrella organisation that has a broad knowledge of the variety of services available can coordinate this effectively with the needs of the client at the heart of the decisions.