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Making a Difference

Social Return on Investment Evaluation



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Making a Difference

Social Return on Investment Evaluation

Report for Tees Valley Rural Community Council

July 2015



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Glossary

ASC	Adult Social Care
CA	Community Agent
CAB	Citizens Advice Bureau
CAP	Community Agent Project
CCG	Clinical Commissioning Group
DNA	Did not attend
DWP	Department of Work and Pensions
FAC	Fair Access to Care
GP	General Practitioner
HES	Hospital Episode Statistics
LA	Local Authority
LTC	Long term condition
NPV	Net Present Value
OT	Occupational Therapist
RCBC	Redcar & Cleveland Borough Council
RCVDA	Redcar & Cleveland Voluntary Development Agency
SROI	Social Return on Investment
STHFT	South Tees Hospitals Foundation Trust
TPV	Total Present Value
TVRCC	Tees Valley Rural Community Council
VODG	Voluntary Organisations Disability Group

1. Introduction

This evaluation report focuses on two key questions – 1) Has the Community Agents Project made a difference to people engaged with the project and 2) Has the project created any social value?

This is the final report evaluating the impact of the Community Agents Project which was designed as a demonstration project to explore the feasibility of bringing together the health and social care sectors to work with voluntary sector services to better meet the non-health needs of the elderly and vulnerable adults in the Redcar & Cleveland area.

Community Agents was funded as a 22 month project (June 2013-March 2015, which included a 4-month lead in) and has been fully operational since 30th September 2013. The project has since been extended to March 2016. This report will focus on the period September 2013-March 2015.

The primary aim of this project was to demonstrate the capacity of a partnership of voluntary sector agencies and the statutory sector to support vulnerable adults living in the borough of Redcar & Cleveland. The project operated in 3 areas (i) Greater Eston – Eston, Normanby, South Bank, Grangetown (ii) coastal areas – Redcar, Marske and (iii) East Cleveland – Saltburn, Guisborough, Lingdale, Loftus, Brotton, Liverton Mines, Skinningrove, Easington.

The key objectives of the Community Agents Project were:

- To help older and vulnerable people **live independently** and safely in their own homes
- To help older and vulnerable people **return home from hospital** as quickly as possible
- To **reduce admissions** to hospitals and residential care homes
- To **reduce social isolation** and loneliness
- To **improve the financial status** of older and vulnerable people by supporting appropriate access to benefits
- To engineer a **more appropriate use of health and social care services**
- To **encourage cost savings** in health and social care
- To **increase community capacity**.

The Centre for Health & Social Evaluation (CHASE) at Teesside University was commissioned to evaluate the work of the project and it was agreed that this should be done using a Social Return on Investment (SROI) form of analysis. This SROI evaluation has been prepared by CHASE with support from the Tees Valley Rural Community Council and other key stakeholders of the Community Agents Project.

In order to provide a robust SROI analysis, the SROI Framework as developed by the SROI Network¹ has been utilised. The evaluation team have followed the key principles for producing an SROI analysis. These include:

- Involving stakeholders
- Focusing on what changes
- Valuing the things that matter
- Emphasising 'materiality' – including only things that are material
- Avoiding over-claiming
- Being transparent
- Verifying results.

It is acknowledged that there is always an element of subjectivity within any SROI analysis. However, the research team have used conservative estimates as a way of avoiding over-claiming and have clearly shown how and where such assumptions have been made to ensure transparency.

The structure of the report following this introduction is as follows: Section 2 provides a short section describing the work of the lead organisation and Section 3 the context in which the Community Agents project was embedded. A review of the monitoring data is provided in Section 4. Following this a fuller description of the Community Agents Project is given in Section 5. Sections 6 through to 11 follow the SROI process and include information about the scope and stakeholders, programme inputs, outcomes and evidence, programme impact, social return on investment and verification. A discussion section is included (Section 11), providing the opportunity to highlight other key findings and finally conclusions are drawn from the findings (Section 12).

¹ <http://socialvalueuk.org/>

2. About Tees Valley Rural Community Council (TVRCC)

This Section provides information about the lead agency responsible for managing the Community Agents Project

TVRCC is one of 38 Rural Community Councils operating to support rural communities in England. TVRCC operates across the whole of the Tees Valley area – Darlington, Stockton-on-Tees, Hartlepool, Middlesbrough and Redcar & Cleveland.

TVRCC is involved in a wide range of projects. These include:

- Tees Valley and Vale of Mowbray Leadership Programme
- Village Halls Advice Service
- Transport Brokerage
- Information, Advice and Support for Rural Groups
- Community Car Scheme
- Consultations.

TVRCC initially worked alongside South Tees NHS Foundation Trust (SFHFT) who were exploring a new concept of “Community Fixer” and were actively seeking engagement with local VCS organisations to support this development. This was in order to reduce bed days in hospital and prevent bed blocking by patients unable to return home because there was a lack of services available to offer non-medical support and practical help for those people. TVRCC were interested in developing a project based on the “Village Agent” model in rural communities. Working together the Community Agent model was developed. Additional discussions between TVRCC and Redcar & Cleveland Borough Council (RCBC) Council Adult Social Care highlighted that the local authority were also looking at ways to support people to stay in their own homes for longer. The Community Agent model was tweaked in order to meet the needs of health and social care and TVRCC were contracted as the delivery partner.

STHT secured funding for the initial Community Agent proposal through non-recurrent funding made available from the PCT in 2012-2013.

Redcar & Cleveland Borough Council (RCBC) were also looking at ways to support people to stay in their own homes for longer, and to reduce bed days in hospital and bed blocking by elderly patients unable to return home because there was a lack of services available to offer non-medical support and practical help for those people.

The Community Agents model was derived from the Community Fixers and Village Agents model² approach in order to address issues for health and social care and as a result, money made available from both SFHFT and RCBC to jointly fund this project, which would be managed overall by TVRCC. Community Agents was thus designed, developed and implemented using a co-production model. Additional stakeholders have been identified as the project has progressed and an ethic of co-production continues to underpin its development, implementation and impacts.

All agencies have continued to work together closely on the governance and operation of the project. This was achieved through the setting up of both Governance (strategic) and Operational (implementation) Groups and these groups have continued to meet regularly throughout the lifetime of the project.

Although not unheard of, it is rare for Health and Adult Social Care to work together in this way. STHFT were already exploring ways of working in partnership with VCSE organisations to address some of the challenges of the increasing pressures on acute and community hospitals, in particular supporting timely discharge from hospital. Concurrently, TVRCC were looking at the development a Village Agents type project, exploring how such a model could help reduce the strain on adult social care. It was recognised that pivotal to any success was the involvement of the voluntary and community sectors, and TVRCC already had positive relationships within the voluntary sector that could be utilised and further developed. While both Health and Adult Social Care have different sets of aims and objectives, it was realised that they dovetailed well, and money was made available from each of them to fund the Community Agents project.

² Gloucester Village Agents Project - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/186841/gloucs-village-agents.pdf and Somerset Village Agents Project - <http://somerstrcc.org.uk/somerset-village-agents-project>

3. The Context

This Section provides the rationale as to how the Community Agents project emerged, who it was aimed at and why it was needed.

It has been well demonstrated that the population in England is ageing (Windle, Francis and Coomber, 2011). In fact, in 2011 there were 8,729,667 people aged over 65 years of age in England (ONS, 2011). It is estimated that by the year 2020 there will be 10,603,004 people over 65 years old (ONS, 2012). Older people are very important to society because they contribute to services and support community groups (Hatamian, Pearmain and Golden, 2012). However, as people grow older, they are more likely to require care and support in order to sustain their wellbeing (CRC, 2008). It is also more likely that older people will experience loneliness and social isolation, particularly if they live in a rural area (Scharf and Bartlam, 2006; Clifton, 2009). However, research has shown that elderly people living in rural areas have generally better support than people living in urban areas (Giarchi, 2006). Nevertheless, older people who experience social isolation and exclusion often suffer in terms of their wellbeing (Allen, 2008). In fact, social isolation has been linked with poor physical and mental health which leads to increased need of support (Manthorpe et al., 2008). It has been demonstrated that older people want to have control over their lives and be able to contribute to society and that, with some support, they can retain their independence and stay healthy and active for longer (Audit Commission, 2004). For this reason it is vital that statutory, health and voluntary sector services are able to support and enable older people to remain independent and socially active for longer.

Public services for older people often fail to provide support at an early stage. Social Services have been criticised as providing a narrow range of services to vulnerable older people who have reached crisis point (Audit Commission, 2004). It has been argued that a shift is necessary in the way services for the elderly operate; instead of providing support at crisis point, independence and wellbeing should be promoted and an early intervention approach should be taken (Beresford, 2010). Since the austerity measures following the financial turmoil post 2007, financial cuts and loss of funding have had a major impact on provision (Dilnot, 2012).

New eligibility criteria were developed for social care services; the Fair Access to Care Services (FACS) criteria were introduced by the government in 2003 in order to provide a common framework for determining eligibility for public support (Department of Health, 2003). They were recently reviewed, as it was felt that more emphasis was needed on prevention and early intervention (Department of Health, 2010). According to these guidelines there are four categories of need for support: critical, substantial, moderate and low (Fernandez and Snell, 2012). Eligibility for Social Services support varies amongst local

authorities; some provide support for people with critical and substantial needs whereas others provide support to people with critical needs only.

Table 1: Fair Access to Care (FACs) Criteria

<ul style="list-style-type: none"> • Critical - serious risks to someone's independence, which are likely to occur within 72 hours.
<ul style="list-style-type: none"> • Substantial - significant risks to someone's independence, which are likely to occur between 72 hours and six weeks.
<ul style="list-style-type: none"> • Moderate - some risks to someone's independence, which are likely to occur between six weeks and six months.
<ul style="list-style-type: none"> • Low - one or two risks to someone's independence, which are likely to occur after six months.

(DOH 2010)

In addition, the Department of Health has emphasised the importance of early intervention and prevention (Department of health, 2010). According to the Department of Health (2010) it is essential to utilise resources in the voluntary sector in order to relieve the pressures on social care and to ensure that people's needs are addressed as early as possible.

The voluntary sector has been found to provide useful levels of health and social support: 62% of all the services in the voluntary sector are health and social care services (Third Sector Research Centre, 2009). A number of case studies have been produced showing that the services provided by charities can address social and health needs and prevent the need for public support (VODG, 2010).

Despite the fact that there are resources in the voluntary sector that could be utilised in order to prevent a statutory response for vulnerable people's needs, communication issues between the public sector and the voluntary sector have been identified (Paxton, Pearce, Unwin and Molyneaux, 2005). It has proved difficult for example for the public sector to refer straight into the voluntary sector (Holder, 2013). In addition, taking into account funding issues, the provision from the voluntary sector constantly changes (Barings Foundation, 2013). As a result, it is challenging for individuals in need of support to find the most appropriate services for them. For these reasons, it is of a great importance for people with knowledge of the voluntary sector to act as a signposting service.

Some local authorities have created signposting services where vulnerable and elderly people can receive advice, guidance and information around services available to them. Gloucestershire have their own Village Agents programme. It was piloted for two years (2006-08) and it has been running ever since. The Village Agents service provides information and advice on relevant services that can support older people in rural areas and their needs (Wilson, Crow and Willis, 2008). The Village Agents programme was very successful in terms of the support that elderly and vulnerable people received and also

found to be cost-effective with regards to the long term savings for social care (Wilson, Crow and Willis, 2008).

In addition, one local authority in Essex funded a pilot programme Village Agents in 2009-10. The project is now re-funded and re-named as Community Agents in Essex. Other local authorities have piloted similar projects that are increasingly proving cost-effective.

Following initial discussions STFT and TVRCC began to explore a range of models and work out how they could develop something that would be achieve the outcomes they were looking at. By incorporating a number of different approaches the Community Agent Project was developed as a demonstration project to test its ability to promote co-production, meet the needs of both health and social care and also of elderly and vulnerable people across the whole of the Redcar & Cleveland area. The matched funding from RCBC meant that the geographical scope, which included some of the more urban areas within the borough, and the length of the project was expanded.

4. About the Community Agents Project

This Section provides information about the Community Agents Project, its design, how it has been implemented and what we have learned so far.

The Community Agents Project is an innovative approach to meeting the social needs of the elderly and vulnerable population in the area. Local community health and adult social care professionals had identified that the elderly population were continually requesting services no longer on offer, and this was impacting on their quality of life and often resulting in crisis intervention, hospitalisation and/or increased care needs. There was, however, little in terms of an evidence base to either indicate levels of local need or to support the effectiveness of such a model. From the beginning there was an acceptance that this was a “risky venture”, a pilot to test a model that was untried in this setting.

Although the Redcar Community Agents model (Figure 1) is developed from ideas embedded in the Community Fixer and Village Agents model, it was adapted to suit the specific nature of the area covered. It has the aim of demonstrating and developing the capacity of both the statutory and voluntary sectors to support vulnerable people living in the Borough of Redcar & Cleveland.

Close working relationships established during initial discussions and lead-in time between Health (acute and community), Local Authority (adult social care and public health) and the TVRCC have been the mainstay of the project to date. Original aims and objectives were agreed and a consensus was achieved, indicating that there were common aims and objectives across all the partners. The project aimed to deliver cost savings where possible, but the core aim was to deliver better support to elderly and vulnerable adults.

The Community Agents Project was primarily designed as a signposting service but also to solve practical challenges experienced by people in the community and those being discharged from hospital. It was established to build relationships across the sectors, to provide up-to-date information and link clients to existing services and activities in order to better meet the needs of these clients.

Community Agents are predominantly providing advice and support to the elderly and vulnerable people across the borough, many of them in need of general support not currently provided under the Fair Access to Care Service (FACS) criteria. It is noted that the eligibility criteria have changed with the implementation of the Care Act 2014, but this evaluation pre-dates the Care Act.

At the start of the project, given Government spending cuts and their impact on local authority spending and reductions in grants to the voluntary sector, existing relationships

between the statutory and voluntary sector and the Community Agents very quickly began to act as the link between the two sectors, linking clients with services and also providing some practical support themselves.

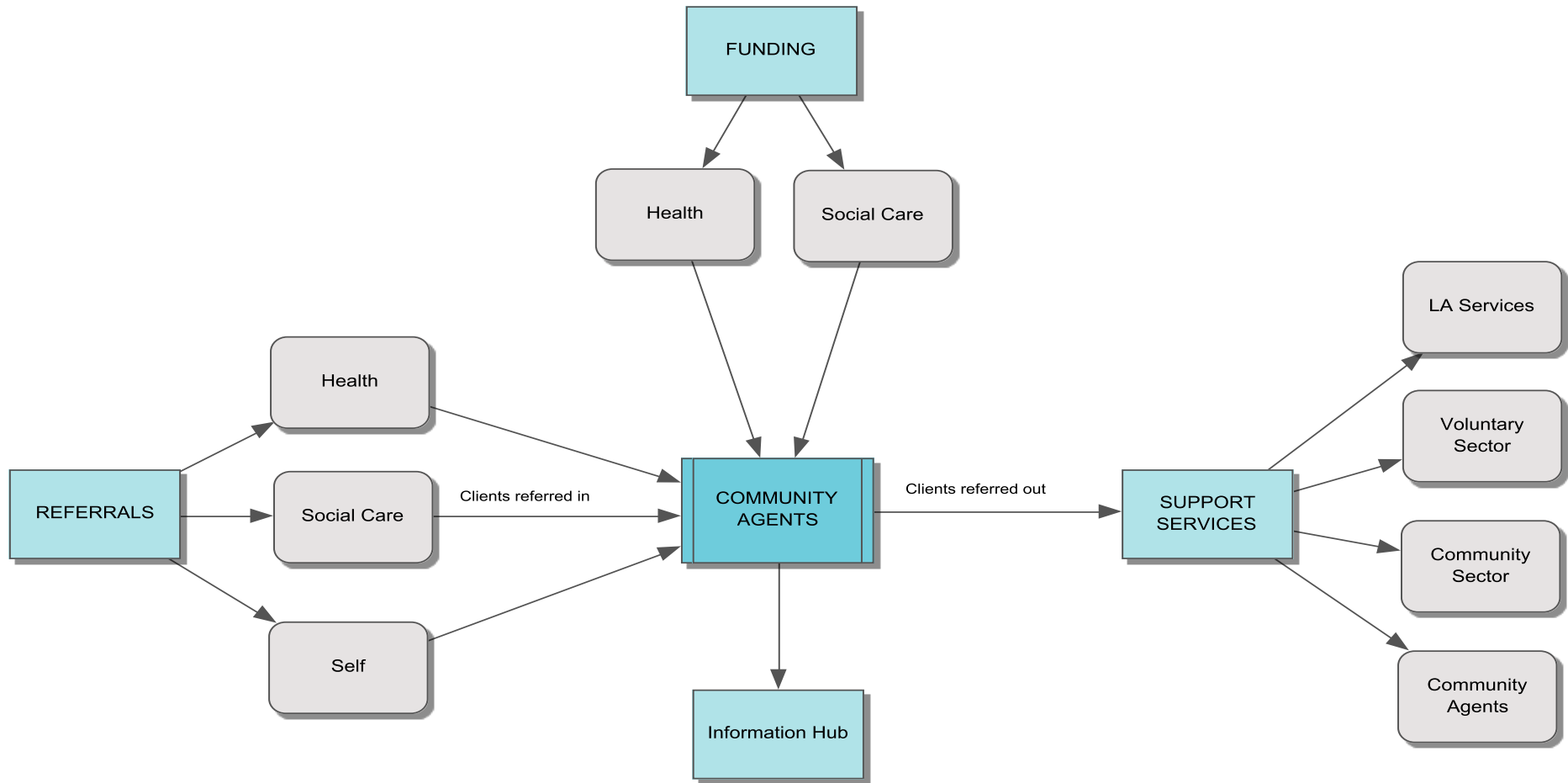
Initially, one community agent was placed in each of the three areas. The idea behind this was for each of them to establish networks with relevant services and agencies within each of the localities. Due to staff changes in July 2014, the two remaining Community Agents began to cover all three areas.

Over the length of this project they have continued to develop positive relationships with key agencies and raise awareness of the project within the local area. They have continued to meet the social needs of the majority of clients by linking them effectively to available services and activities.

The Community Agents are now recognised as a first point of contact for any person presenting with low level social needs across the area. Such interventions include shopping, cleaning, gardening, form filling, accessing social activities. They are often described as “a conduit” across the sectors; they are bridging that gap in services that arose as a result of changes to the FACS criteria, and they continually track existing services and activities. Referrals into the service are primarily from adult social care, self-referrals are continuing to increase and referrals from some teams of community health professionals continue, although they are lower than originally anticipated.

Community Agents assess the needs of clients referred into the service, discuss options and then refer to relevant activities or services. Community Agents also offer some practical support themselves although this tends to be one-off, or emergency support rather than ongoing. They have also been trained in completing financial assessment forms and also help clients with other forms as appropriate.

Figure 1: Community Agent Model



5. Analysis of Monitoring Data

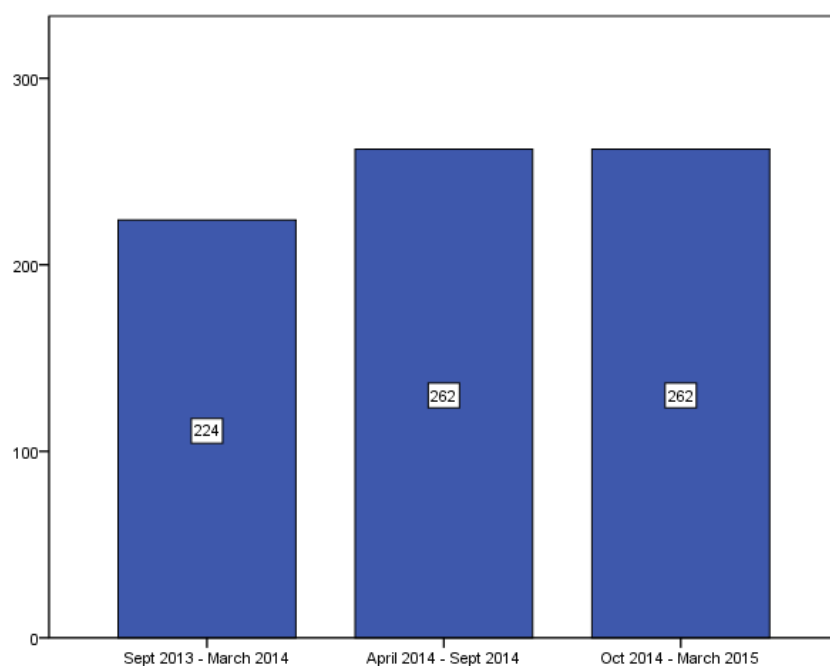
This section provides an analysis of the monitoring data collected throughout the lifetime of the project.

Referrals in

A total of 748 referrals were received from across the borough of Redcar and Cleveland for the period September 2013 to March 2015.

Figure 2 shows the pattern of referrals for each six month period over the first eighteen months of operation. Whilst there was an increase in the numbers referred in the second six month period compared to the first, after that the number of referrals appears to have levelled off.

Figure 2: Referrals over time

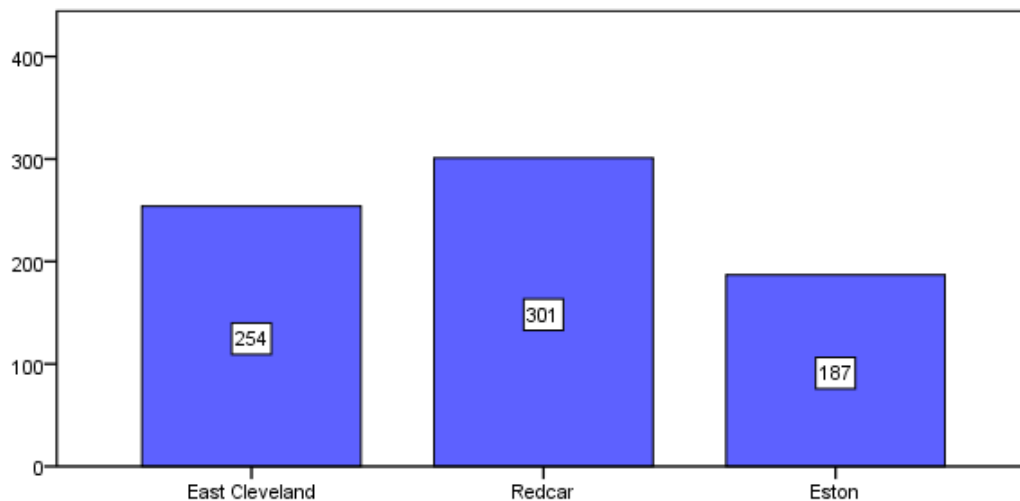


Referrals by area

Overall, Eston has received the lowest number of referrals amounting to a quarter (25%) of the total referrals for the borough. The proportion of referrals made by Redcar (40%) and East Cleveland (34%) continues to be similar [average age of service users are similar – differs from the last report]. These statistics continue to demonstrate that residents in the Eston catchment area do not engage as well with services as those in other areas; however, the percentage of referrals from this area had increased slightly (2%) since September 2014.

There is a view within the project that this increase is due to a reorganisation within the locality teams.

Figure 3: Referrals by area



NB: 6 missing values

As the project has continued, whilst the total number of referrals has increased, there has been a reduction in the proportion of repeat referrals that are being made. Currently, repeat referrals account for only 7% of the total number of referrals being made, down from 16% at September 2014. East Cleveland continues to have the highest proportion of repeat referrals (12%) compared to both Redcar (4%) and Eston (6%), but all of these areas are reporting lower levels than previously.

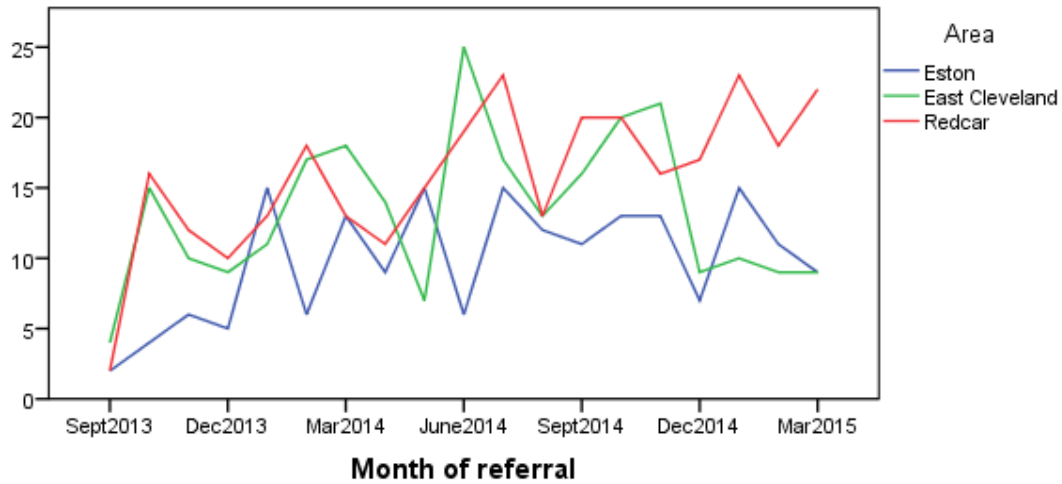
Referrals over time and area

The number of referrals that are made from East Cleveland and Redcar follow a very similar pattern through the lifetime of the project, with an increased number of referrals being made during the summer months (May-July 2014). Originally it had been anticipated that referral rates were likely to increase substantially over the winter periods. However, this was not the case. There was a large drop in referrals made for East Cleveland during the Christmas period for both 2013 and 2014. The main reason for this would appear to be the holiday period, as the other areas also had a reduction in referrals over the same period although not such a marked one. However, while referrals began to increase again following the Christmas break in both Eston and Redcar, the number of referrals made in East Cleveland has remained low.

Whilst the number of referrals that have been made in the Eston area has been consistently lower than in the other areas, the pattern of referrals has been similar. However, there was a reduction in referrals during the summer months of 2014 while the other two areas

received their greatest number of referrals. No specific cause could be attributed to this decrease by commentators within the project.

Figure 4: Referrals over time and area



The fact that in July 2014 one community agent (Eston area) resigned and the remaining two began to work across the three areas (as opposed to working in a designated area) appears to have had no significant impact on the number of referrals made or the service provided by the Community Agents.

Referrals by age and gender

Of all of those referred into the service 61% were female and 38% were male; in seven instances (1%), gender information was not captured on the database. The higher proportion of female service users is unsurprising, given that women live longer and are known to be more likely to engage with support services. However, elderly males are considered the most isolated group who will often be reluctant to seek help and engage with services. The proportion of male service users has increased slightly since Sept 2014 – from 36% to 38% by March 2015.

Figure 5: Gender Breakdown

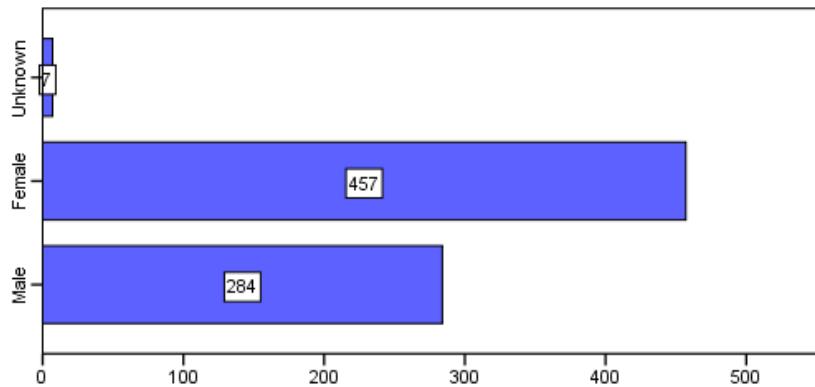
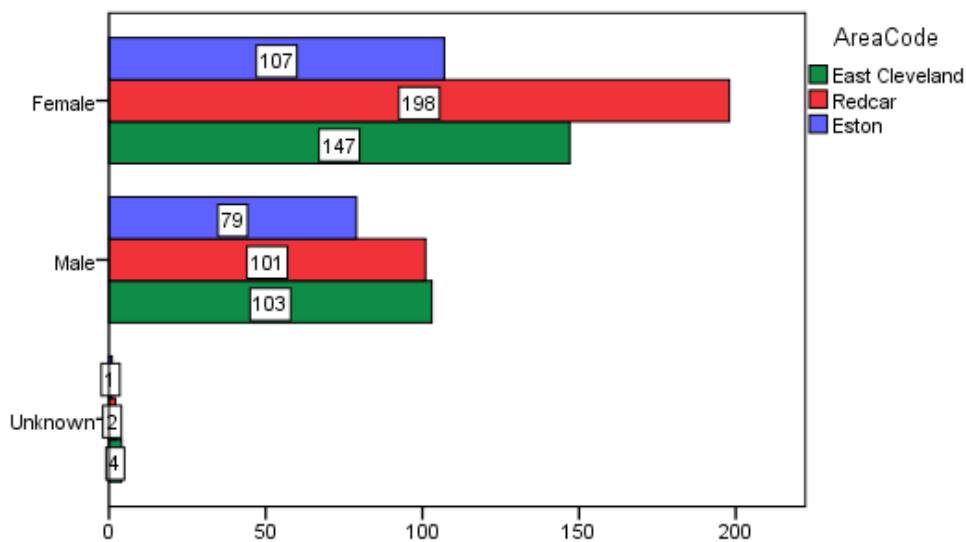


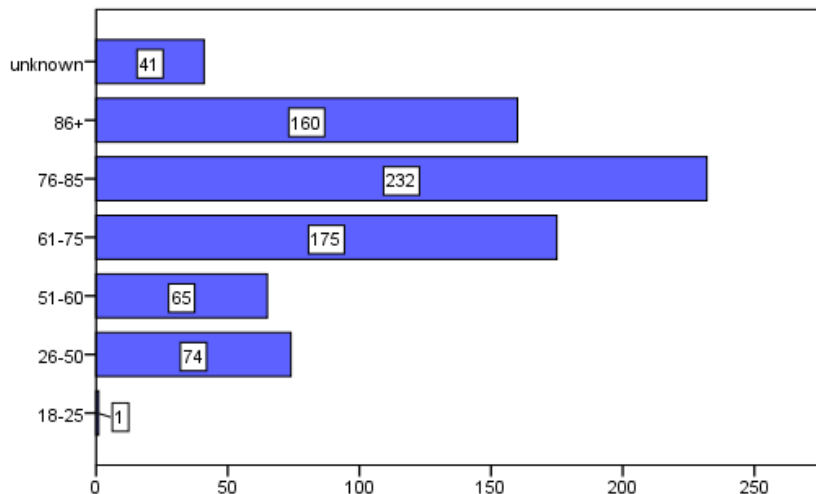
Figure 6: Breakdown of gender by area



A further breakdown of gender and area highlights that a similar proportion of males in Eston (42%) in East Cleveland (41%) have been referred to the Community Agents project compared to 34% in Redcar and Eston.

Service users are aged between 19 years and 100 years, with the most prominent age range of service user being 73 years. The average age is slightly higher for female service users (74 years) compared to males (71 years).

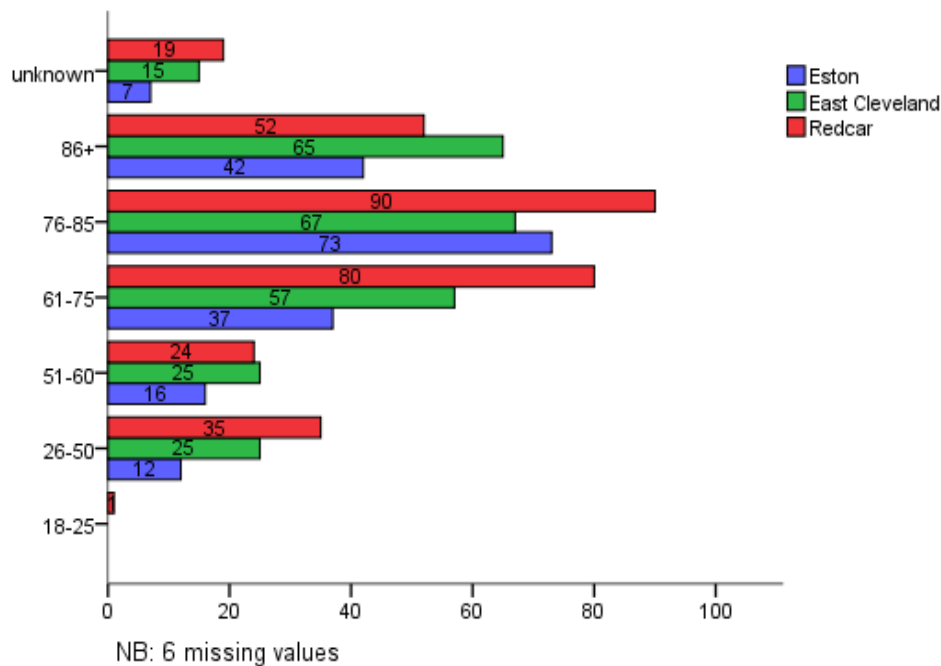
Figure 7: Breakdown by Age



Service users are most likely to be referred into the scheme when they are over 61 years of age, with almost a third (31%) of total referrals being made for service users aged between 76 and 85 years. Almost a quarter of referrals (23%) relate to service users aged between 61 and 75 years. A smaller proportion of referrals have been made for the over 86 age group to March 2015 (21%) than was reported to September 2014 (24%). Furthermore, the number of referrals has continued to increase for those below the age of 60 years, accounting for 19% of total referrals to March 2015.

The increase in the number of clients referred who are under 60 years has highlighted the lack of services available within the voluntary sector for vulnerable people within this younger age group, and this growing evidence of need reiterates recommendations in previous reports (Watson, Shucksmith 2014) that this should be explored further by commissioners of services.

Figure 8: Referrals by age and area

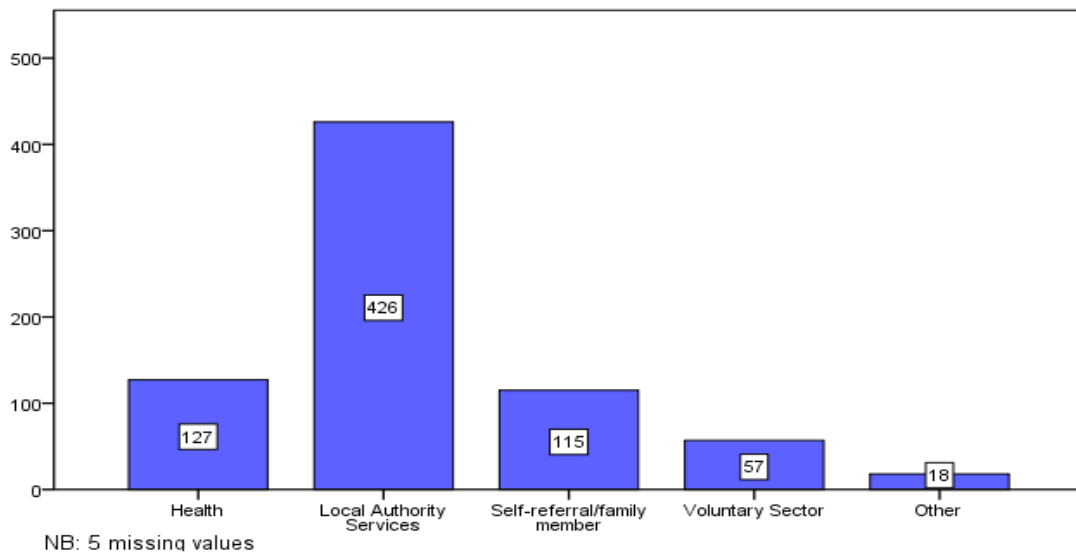


When broken down by area, the pattern remains very similar with females and service users over 61 years accounting for a greater proportion of the referrals in each of the three areas. Requests for services and support for people under 60 years are higher in the Redcar area.

Referrals by sector

Referral data clearly demonstrates that the greatest proportion of referrals are made from the social care sector, with referrals originating from Local Authority services accounting for 57% of referrals to March 2015. Referrals made by health professionals and self-referrals (including those made by family members) are made at a similar level, 17% and 15% respectively.

Figure 9: Referrals by Sector



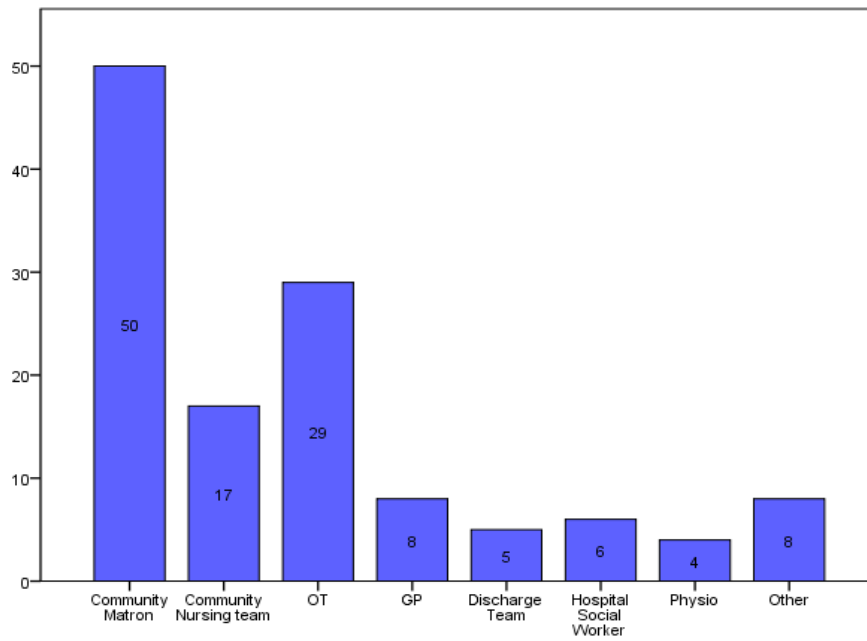
When looking at the referral data for each area, it is clear that Local Authority services in Redcar continue to make the greatest proportion of referrals to Community Agents. The proportion of Local Authority referrals was greater in Redcar (42%) than in East Cleveland (31%) and Eston (26%). The greatest proportion of referrals made by health professionals was observed in East Cleveland (52%), compared to Redcar (30%) and Eston (17%) (proportions based on the total number of referrals made per sector). One reason for this is likely to be the pre-existing relationships between the community agent and health professionals in that area.

The number of referrals that are made by voluntary sector organisations has begun to increase (currently 8% of the total number of referrals made).

Self-referrals have continued to increase steadily throughout the lifetime of the project. This is likely to be due to raised awareness and word of mouth. It is also acknowledged that a proportion of the self-referrals are made as a result of health and/or social care staff providing information about the Community Agents service to their patients/clients.

A breakdown of the health referrals clearly shows that Community Matrons and OTs have embraced the Community Agent Project as a way of addressing the more social needs of their clients. The breakdown of figures also clearly highlights the lack of engagement from the acute hospital and GP services.

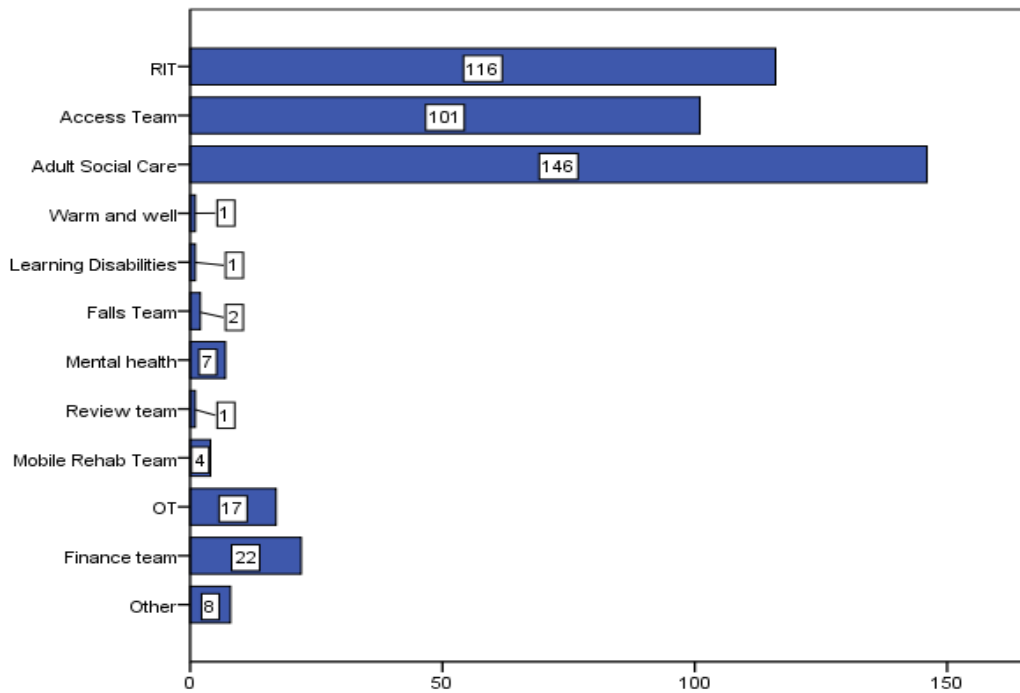
Figure 10: Breakdown of referrals from health professionals



More work is needed to re-establish relationships with the acute hospital staff and also to maintain existing relationships with other community health staff.

A further breakdown of local authority referrals shows that Adult Social Care are the main referrers and that the Access Team, RIT and social work teams are the predominant users of the service.

Figure 11: Breakdown of referrals from the Local Authority

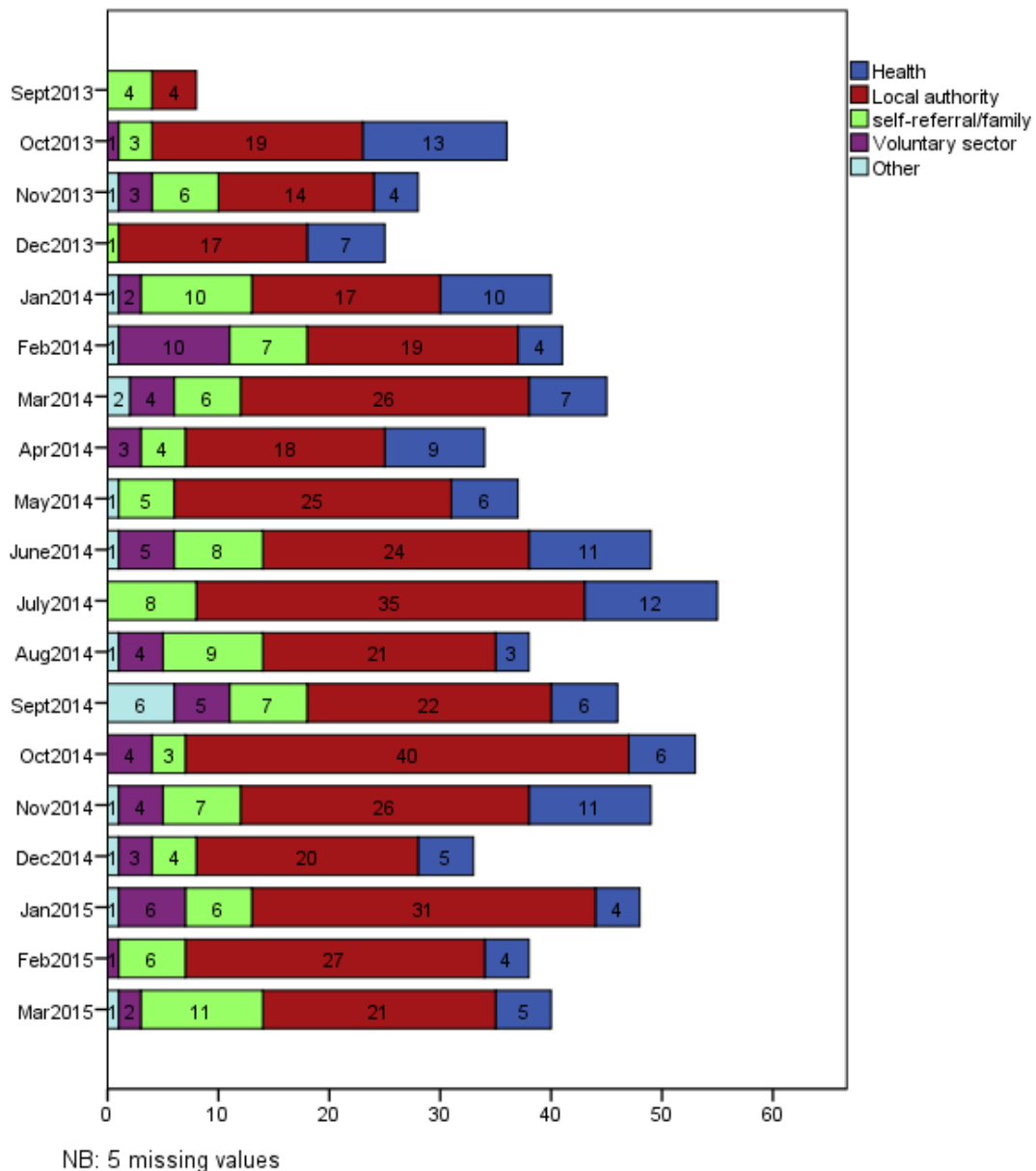


Monthly breakdown of referrals to Community Agents

The graph below shows the number of referrals made each month across the duration of the scheme. There were two peaks in the total number of referrals made during June/July 2014 and October/November 2014.

The graph shows that Local Authority services are consistently the main source of referrals but that there are increasing numbers of self-referrals that have surpassed Health professionals' referrals in recent months.

Figure 12: Monthly breakdown of referrals



Referral rates have continued to rise overall, but with dips in referral rates corresponding to public holidays, e.g. Easter and Christmas. The 'other' category includes a range of services that have referred service users on occasion. These include:

- Neighbourhood team
- Highways inspector
- Coast and Country Housing
- Tees Valley Housing
- Town/Parish Councillor
- Member of the public
- Social Housing association
- Antisocial behaviour team.

The number of referrals from the health sector has begun to reduce from January 2015. It would appear that due to some major staff changes, existing links are proving difficult to maintain, and this is an issue which needs to be addressed to ensure there is no further decline in the number of referrals from health.

Referrals to relevant service providers

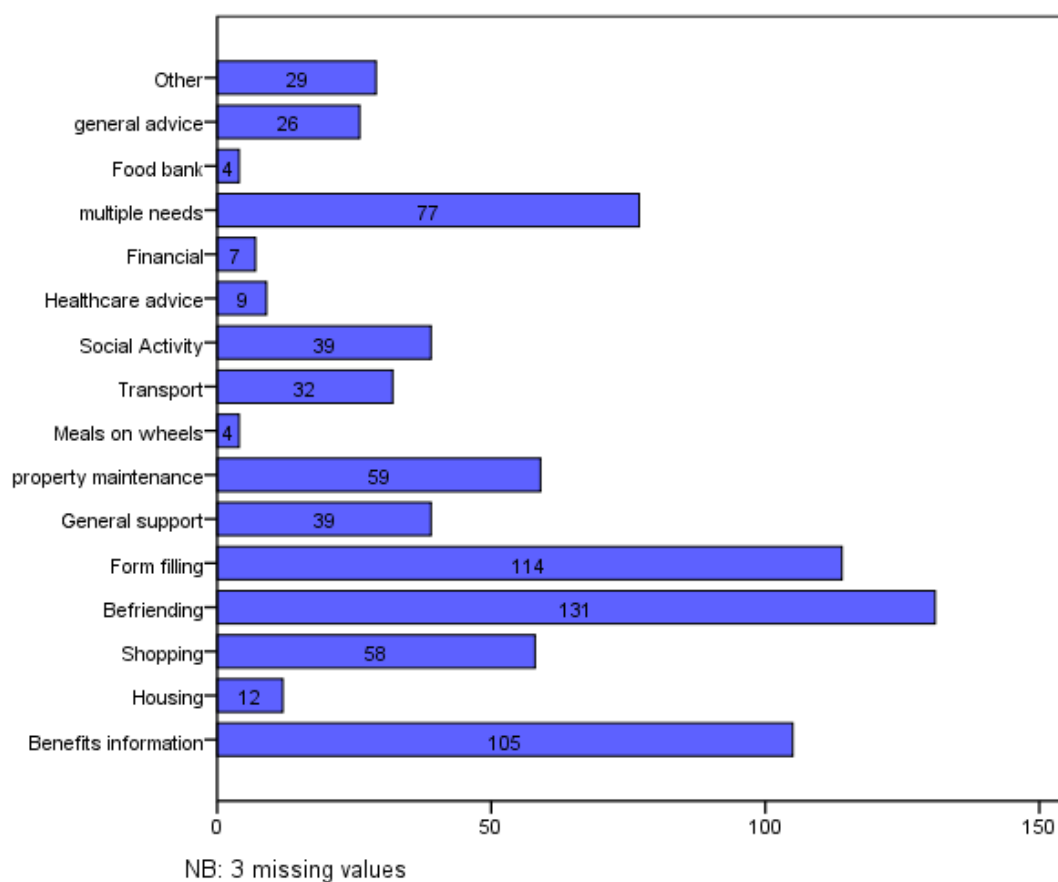
Needs being met

The most popular services that are being provided are befriending, benefits advice and help with completing forms. The befriending service accounts for 17% of the total number of referrals made, with form filling (15%) and benefits information (14%) accounting for similar proportions.

The Community Agent team are dealing with an increasing range of needs that are being presented to them. Property maintenance, including gardening, decorating and other domestic services accounts for 8% of the total number of referrals that were made into the service. Access to other services such as 'meals on wheels' and support to access food banks has also increased. Service users are increasingly likely to be referred to Community Agents for general advice and support relating to financial, legal and health/care needs.

Help with shopping currently accounts for 7% of total referrals to March 2015; in some cases the community agent has delivered shopping items to the service user, assisted with bill paying and referred to other organisations who are able to provide ongoing support of this nature. Requests for assistance with transport (3%) and information about availability of social activities (5%) continue to provide service users with the means of 'getting out of the house' whether to attend medical appointments, visit relatives in hospital or to reduce their social isolation. These are the key needs regularly addressed by the Community Agent Project.

Figure 13: Breakdown of needs being met

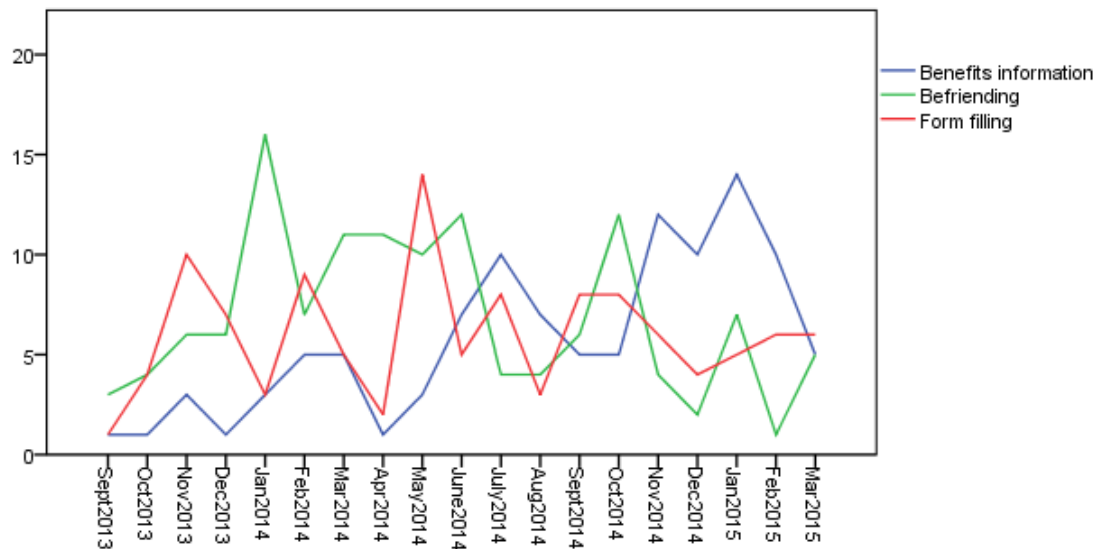


The most recent data that has been collected has enabled the separation of referrals where multiple needs were being addressed. Consequently, it appears that the results quoted above are lower than those shown in the previous reports. However, the results presented here relate solely to referrals where a single need was identified at the outset.

A total of 77 referrals, 10% of the total, relate to multiple needs that were identified after contact has been made with the client. Of the 77 referrals for multiple needs, a total of 57 were for requests for a combination of befriending/social activity/transport. These referrals focus on addressing the social isolation of the service users. The remaining 20 referrals reporting multiple needs, related to the need to access multiple services and information.

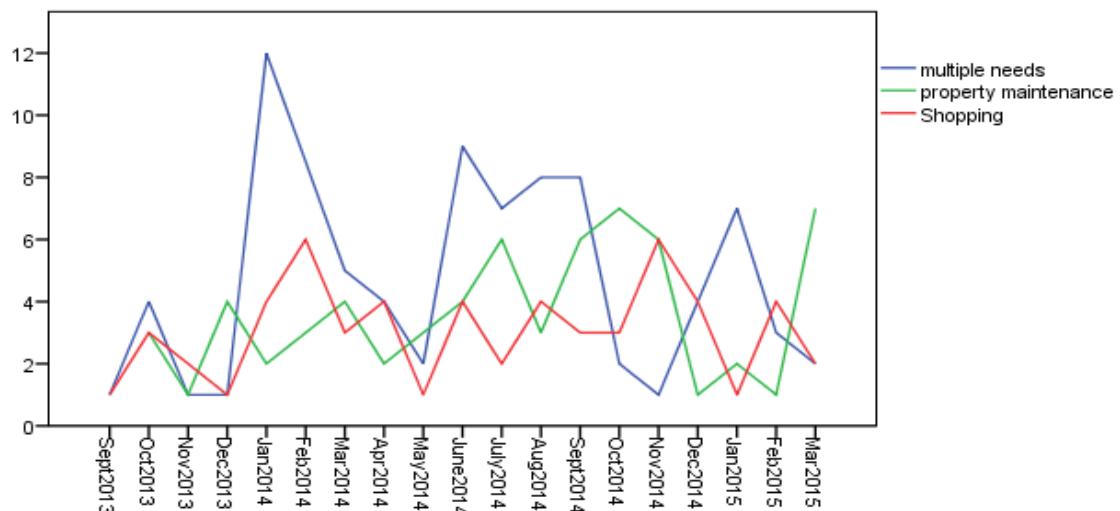
The following graph shows the pattern for key needs that are identified at the initial referral. The need to provide up to date and relevant benefits information has increased throughout the duration of the scheme, with increasing number of referrals observed where there were drops in befriending requests and for help completing forms. There was a marked increase in need for befriending services following the Christmas period for 2013 and 2014. This period is known to increase the sense of loneliness amongst elderly people.

Figure 14: Breakdown of needs being met by month - top 3 needs



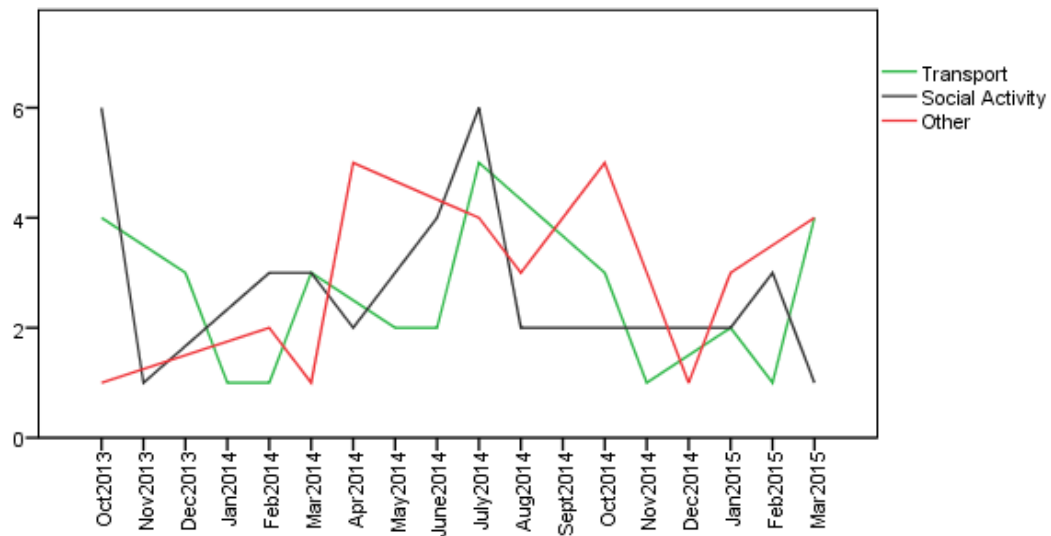
The graph below shows the referral pattern for service users presenting with multiple needs. It is unsurprising that these referrals follow a similar pattern to that shown above for befriending services, since befriending accounts for a large proportion of the multiple needs reported. Similar patterns are also observed for home based helping services such as property maintenance and shopping assistance. Services of this nature are no longer included in social care service provision. However, this project has clearly shown that the demand for such services remains and that they are an important factor if people are to remain independent for longer.

Figure 15: Breakdown of needs met by month (Part 2)



Furthermore, requests for transport and the provision of social activities received a similar rate of referrals to the service: the pattern of referrals for these two related needs is very similar too.

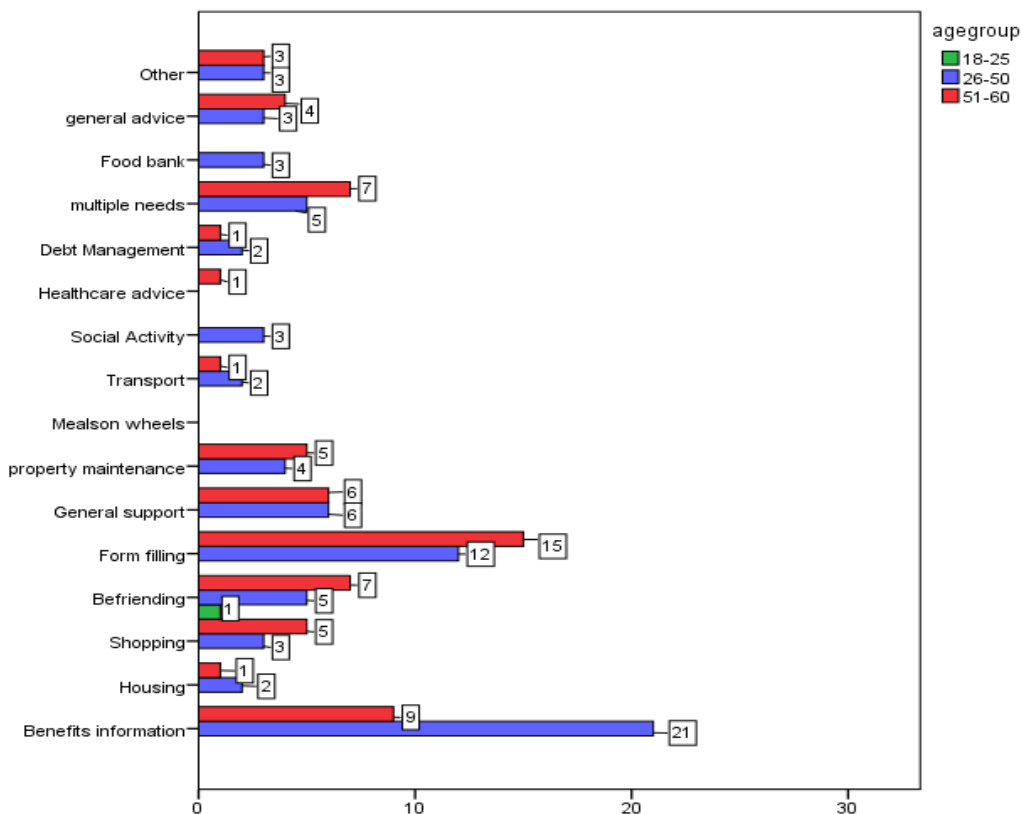
Figure 16: Breakdown of needs met by month (Part 3)



Graphical representation of the remaining needs have not been included here as there were relatively few referrals made for them overall and so no pattern can be identified.

Further analysis shows that those clients being referred who are under 60 years are also presenting with a range of needs.

Figure 17: Breakdown of needs for Under 60's



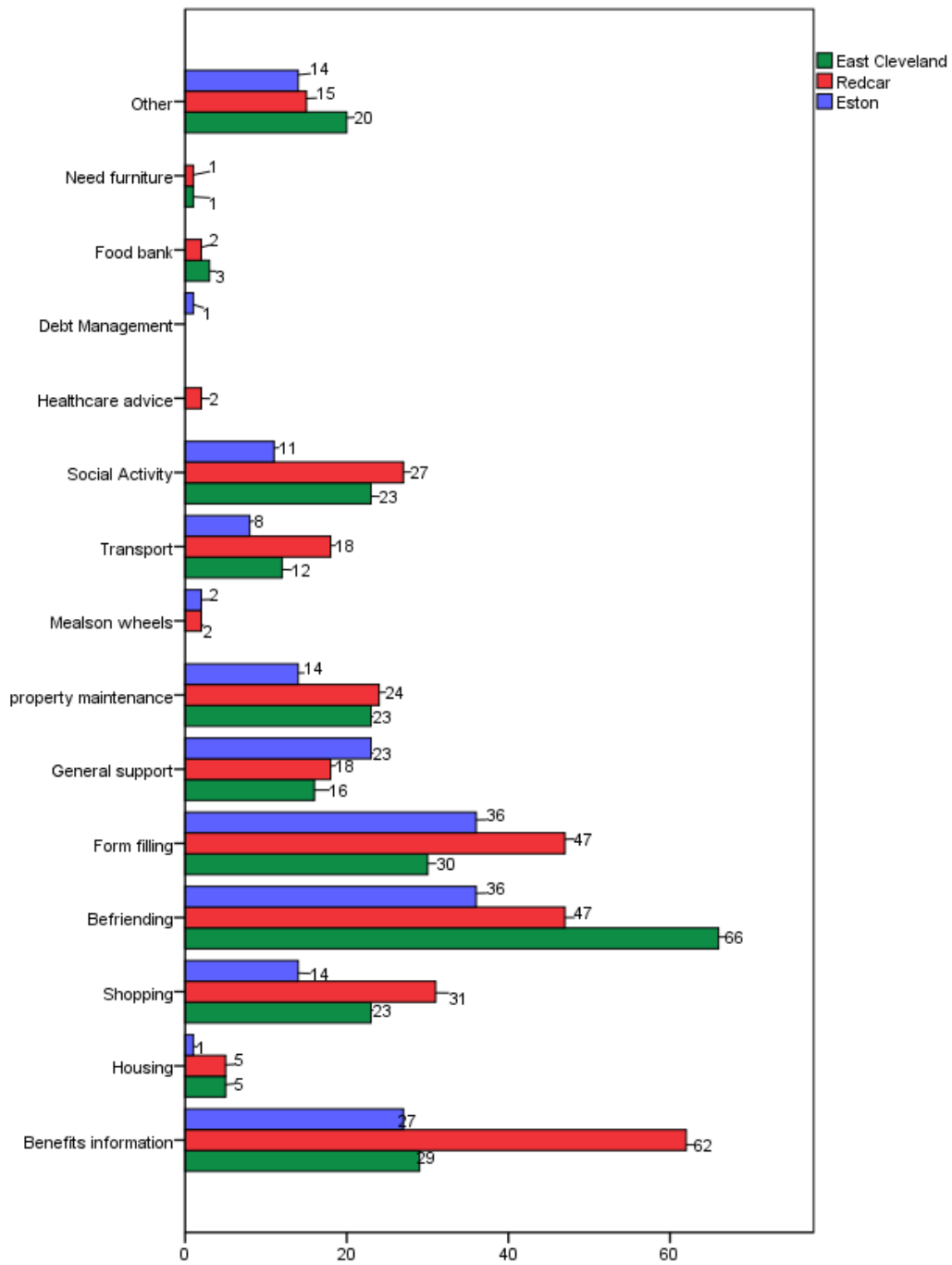
However, Figure 16 clearly illustrates that provision of benefits information, form filling and general support are the primary needs for this particular age group.

Breakdown of needs being met by area

Similar levels of referrals are observed for many of the needs being met across the three different areas. The greatest differences can be observed below and relate to requests for the befriending service, with East Cleveland continuing to initiate the highest rate of referrals (45% of all befriending referrals) Similarly, Redcar have produced the most referrals relating to need for benefits information (52% of all benefits information referrals) and form filling (41% of all form filling referrals).

It is likely that the number of referrals for support with financial assessment forms is likely to reduce over the next year as systems are due to be put in place within the local authority, resulting in direct referrals from social care staff to the Welfare Rights Unit.

Figure 18: Breakdown of needs met by area



NB: 9 missing values

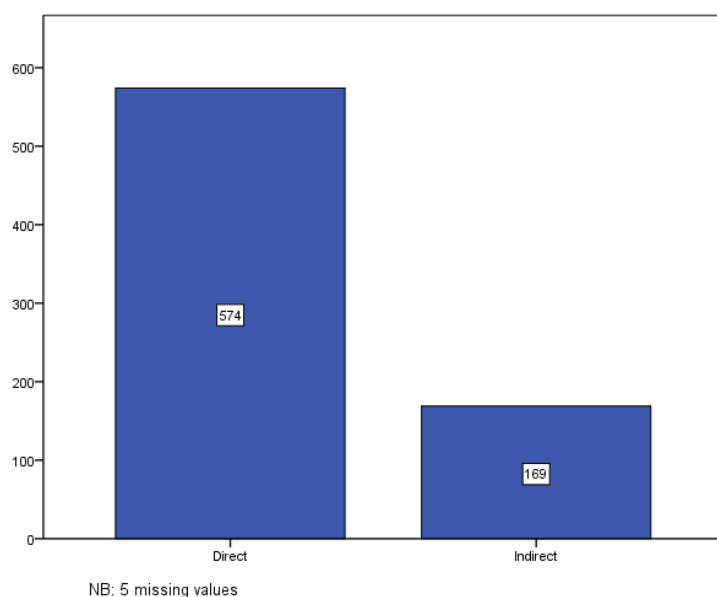
Some clients presented with more than one need

Community Agents

Direct or indirect referrals

Community Agents continue to respond to service user referrals in two ways – either making direct contact with the client or by providing information to the referring agent who would pass on this information back to the service user (indirect contact). The majority of referrals (77%) continue to involve direct contact between Community Agents and the client.

Figure 19: Community Agent contact

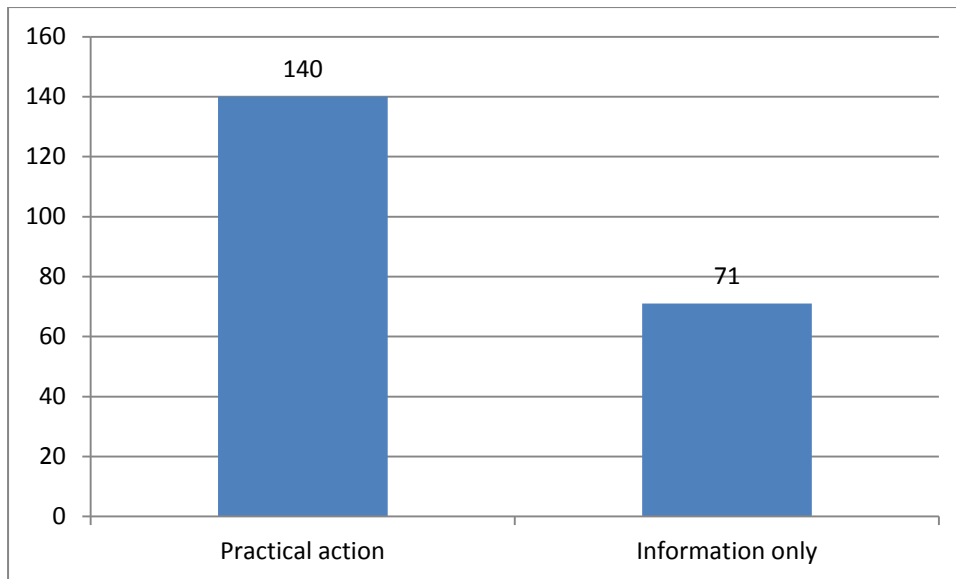


For each of the three areas, indirect contact accounted for between a quarter and a third of referrals. The main method of Community Agents engaging with service users was either by telephone or home visit. This was consistent across all three areas.

Community Agents have increasingly become service providers themselves (not the original intention) as the project has developed. More generally they address more immediate need when no-one else is available or able to provide the support needed. The majority of this support involved practical help, transport to an activity or appointment, delivering food parcels, writing letters or completing financial assessments.

Community Agents also liaise closely with family members when the need arises.

Figure 20 : Breakdown of actions taken by Community Agents

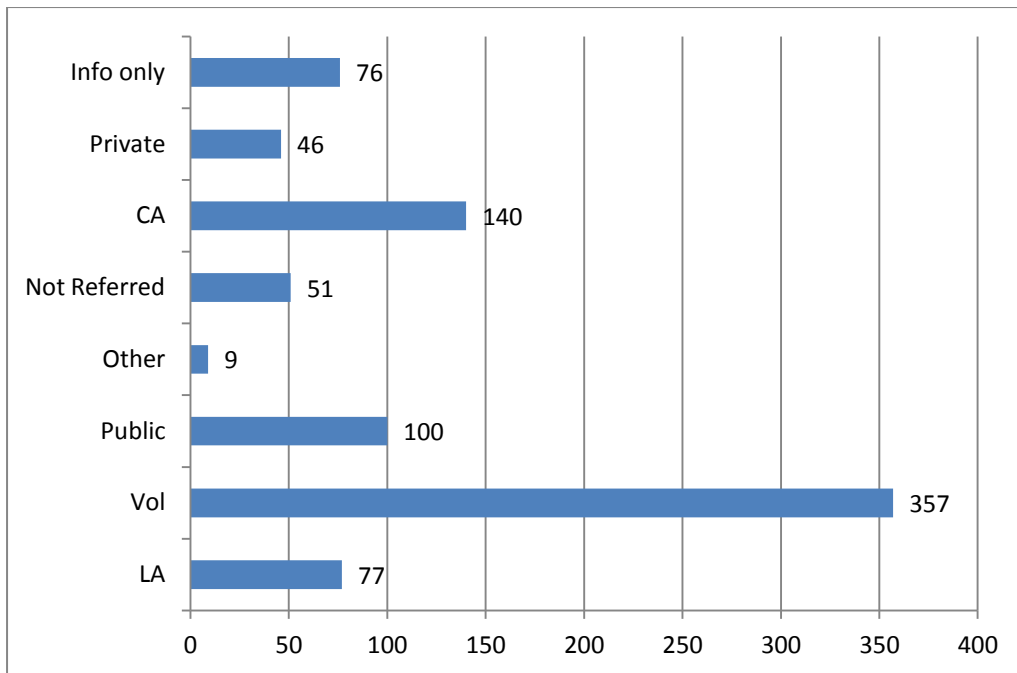


Other action by the Community Agents is the provision of information, often to health and social care professionals which they, in turn, pass on to the patients/clients. However, as awareness of the project has risen, requests for information also come from family members or service users themselves.

Service Providers

Once the Community Agents have assessed the needs of those people referred to them, they then either provide the service themselves or identify relevant service and pass the referral on to them. The majority of these referrals are to the voluntary sector. Public sector services include Welfare Rights and housing, while the private sector referrals include requests to private care companies and social housing providers. There are also clients who require referrals to multiple agencies in order to meet a series of needs not provided by one single organisation.

Figure 21: Breakdown of where referrals were directed to by sector



NB: Some clients were referred to more than one organisation

To date the Community Agents have referred clients to over 70 organisations to access services. A list of agencies that Community Agents have referred people to for services can be found in Appendix 2.

In total 357 referrals have been made to the voluntary sector, 77 to wider local authority services and 100 to the public sector.

The time Community Agents spent on each referral varies from 10 minutes for providing information to 415 minutes to deal with more complex needs requiring multiple agency involvement. This is an average of 49 minutes per referral. Using time 3 time bands (under 1 hour, 1-3 hours and 3+ hours), further analysis clearly highlights the complexity of some referrals and the time needed to deal with these.

Figure 22: Time spent

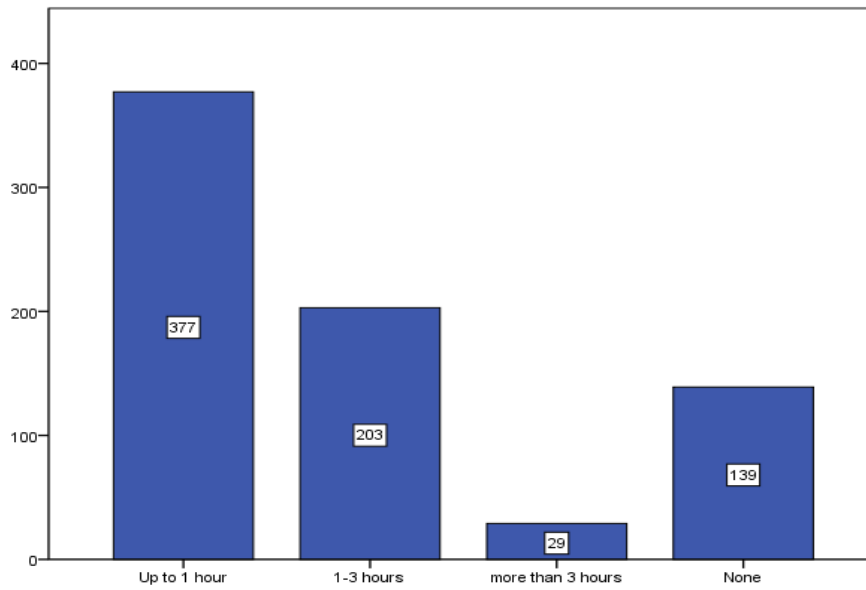


Figure 21 clearly shows that just over 50% of clients require less than one hour of Community Agent input prior to a referrals being made. However, 31% of referrals are more complex and require large amounts of time. This tends to involve sourcing services for a range of needs and multiple referrals to agencies to provide support.

6. Scope and Stakeholders

This Section examines scope and boundaries for the SROI study and the Theory of Change for the Community Agent Project and identifies the key stakeholders involved in the project.

Scope of analysis

As this project was developed and designed as a demonstration project, it was essential that any evaluation would include impact. It was decided that the most effective way to achieve this would be to understand the social impact of the project across the stakeholder groups in order to support future funding applications if the project was shown to be a success.

Initially the project was to be operational within the more rural areas of the Borough but the funding bodies required fuller coverage of the whole of Redcar & Cleveland. This also allows the evaluation team to produce the evaluative SROI analysis which portrays the total value created by the project.

TVRCC intend to use this SROI report to:

- Understand the difference the project has had on the lives of service users
- To be able to show the impacts of the project to project partners, potential funding bodies and other stakeholders involved
- To explore the process, understand the effect changes throughout the lifetime of the project have had and why, in order to identify possible improvements to any future roll out
- To be able to show potential funding bodies the benefits of the project and the possible social return on their investment if the project is sustained.

Materiality

The SROI framework is clear that only outcomes that are material (relevant) to the stakeholders and to the project itself should be included when calculating SROI. It is also made clear that outcomes must be both relevant and significant to be included. This final report builds on earlier reports whereby the Governance and Operational Groups have established which outcomes should be included while agreeing the key performance indicators (KPI) for the project. Therefore, every attempt has been made to ensure that the information and evidence used in this report is both significant and relevant and will provide an accurate assessment of the project.

Stakeholder Groups

This project includes a range of stakeholders, most of whom are deemed as relevant so need to be included in the SROI analysis. Table 1 shows the stakeholders identified as part of this project and shows the reasons for inclusion or exclusion.

Table 2: Inclusion of Stakeholder Groups in the SROI Analysis

Stakeholder	Included	Reason
Community health professionals	Yes	It was expected that people referring clients into the project would also see some benefits
Adult social care professionals	Yes	It was expected that people referring clients into the project would also see some benefits
Other Local Authority teams	No	Do not achieve any material outcomes themselves – more generally are service providers
Clients referred into the project	Yes	The main beneficiaries of the project
Family members of clients referred into the project	No	Limited resources for the evaluation meant it was not possible to gather the evidence from this group
Voluntary Sector agencies providing services	Yes	The voluntary sector agencies were a major partner in the project
TVRCC	No	TVRCC were project managers and did benefit in terms of workforce development but these are not included in the SROI calculation as this was not directly linked to project activities
Wider NHS	Yes	Reduced bed days, reductions in re-admittance, reduce bed-blocking. To support the CCG and wider strategic priorities to reduce pressures on acute beds, ameliorate winter pressures

The main stakeholder groups included in the analysis are:

- **Community health professionals** – Community Matrons, Occupational Therapists (OT), District Nurses, Discharge Team, GP
- **Adult social care** – Social workers, Rehabilitation & Independence team (RIT), Access team, substance misuse service
- **Elderly and vulnerable adults in need of social support** - Clients referred to the Community Agents for low level support
- **Voluntary sector agencies** – while the voluntary sector role in the project is primarily as a service provider, some have benefitted from additional volunteers, training and expansion as a result of funding secured to enable them to meet the needs of the additional referrals from the Community Agents.

- **NHS** – Able to discharge people more quickly from hospital and reducing issue of bed-blocking thus releasing beds for new patients more quickly.

Key reasons for excluding some stakeholder groups include:

- **Other local authority departments** – On reflection, the wider local authority departments e.g. Benefits Advice, local councillors, highways department, financial assessment teams did not appear to benefit directly from their involvement. Some simply referred people into the Community Agents while others provided a service for clients.
- **Family members** – While it is likely that some family members did benefit from the Community Agents support, it was not possible to make contact with this group to gather evidence to support this view given the limited resources available
- **TVRCC** – While it is clear the TVRCC have achieved a range of benefits from being part of and managing this project e.g. learning, staff development, networking and involvement in new opportunities, they have been excluded from the SROI analysis as the main purpose is to understand the impact of the project on others.

Theory of Change

In order to identify planned and expected changes emerging from the Community Agents project a Theory of Change model was developed. This clearly shows the reasoning behind the project and the context to which it relates, plus the benefits and changes that were anticipated as a result of the establishment of the Community Agents scheme for beneficiaries and stakeholders.

Community Health

From the early stages of design and development it was expected that the healthcare system would benefit from the scheme, through enabling earlier discharge from hospital and better engagement with health professionals which would, for example, reduce non-attendance (DNA) at GPs' surgeries and hospitals. Unexpected outcomes achieved have included improved engagement with health planning and medication compliance, but also time saved. Health professionals can simply refer to Community Agents who will source the services needed and work directly with the client to put the services in place, as opposed to community health professionals themselves trying to identify suitable services to meet non-medical needs.

The key driver for the local NHS Trust to jointly fund this project was to test if this model would reduce the number of bed days of people having to remain in hospital when medically they are fit to return home but are unable to do so because they have non-medical needs preventing this. Initially, interest in this outcome arose from the Acute Trust, but it was agreed that - to ensure Community Agents had a manageable caseload as it set up

- this would be postponed until later in the project. In the meantime, however, the South Tees Hospitals Foundations Trust provided funding for an alternative 'Home from Hospital' Scheme that further developed work with discharge teams and key wards in the acute hospital. As a result, Community Agents restricted this element of the work to people leaving the community hospitals in the Redcar & Cleveland area.

As a result, for the purposes of the SROI we have focused on bed days saved with the community health professionals as opposed to the wider NHS, primarily as the role of community hospitals was changing due to the transformation programme at South Tees 2014-15.

Adult social care

From the early stages of the project it was expected that the project could help reduce the numbers of elderly people going into residential care by helping them to remain independent in their own homes for longer. In addition to these, a number of unexpected outcomes have also been achieved. These are:

- Time saved having a single point of contact to deal with low-level need
- Improved staff morale as a consequence of having diminished levels of frustration at not being able to help and support clients with more social needs because the Community Agents are able to help address those needs
- Time saved as social work staff do not need to source relevant services for clients not meeting the FACs criteria.

Elderly and vulnerable adults

Improving access to services and better meeting the social needs of elderly and vulnerable adults were, from the very beginning, the main aim of this project and they have continued to be the key focus throughout. Improving the quality of life for individuals in this group was seen as pivotal in achieving many of the objectives. This group of people were always intended to be the key beneficiaries of this project. From the outset, the anticipated changes as a result of this project were – for vulnerable people:

- Reduced isolation
- Retaining independence
- Improved financial status
- Improved health and wellbeing.

As the project has progressed it has become clear that support from Community Agents to achieve these changes has also resulted in additional benefits. These include |:

- Increased confidence
- Becoming much less anxious and worried about general things

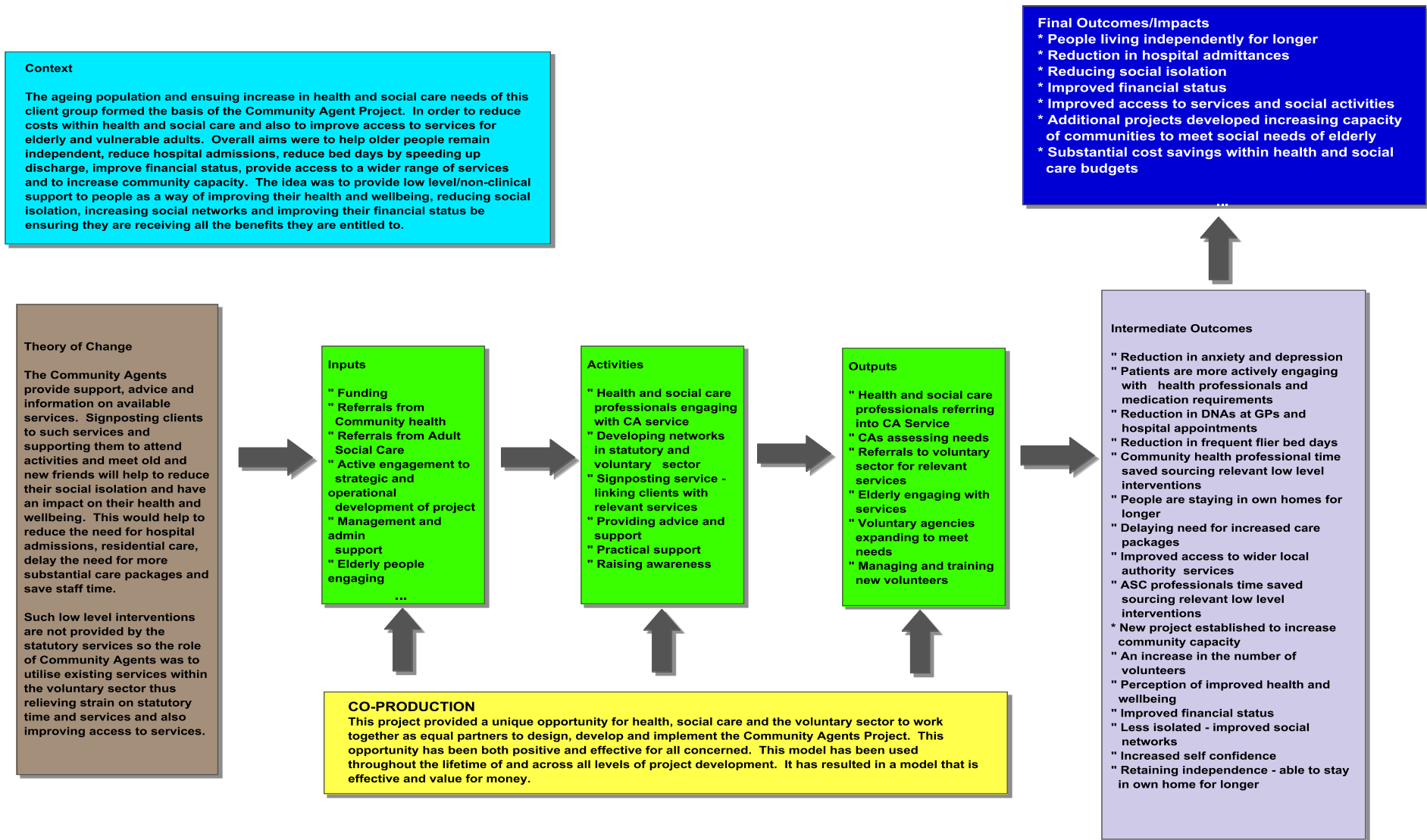
- Expanding social networks
- Improved perceptions of their own health.

Voluntary Sector

It was recognised during the planning phase that the involvement of the voluntary sector in providing services for the elderly and vulnerable clients was the critical factor for any success achieved by this project. While Community Agents were able to provide some practical help, they were not equipped or resourced to provide activities or services. Initially it was believed that the main benefit for the voluntary sector would be the expansion of their client numbers, improved networking and raised awareness of their organisation and services. However, their capacity to provide some services was identified as a major issue early in the project. Therefore funding was secured to increase the numbers of volunteers in order to better meet the needs of Community Agent referrals. As a result some agencies have increased their volunteer numbers.

Figure 23 shows the theory of change developed as part of this project.

Figure 23: Theory of Change



Stakeholder engagement

The Theory of Change model was developed based on early interviews with key stakeholders. Using a logic model approach it was possible to clarify aims and objectives, agree activities and outcomes and longer term expectations.

Using a standard logic model format, qualitative interviews were carried out with key stakeholders from Health, the Local Authority and service delivery as a way of clarifying aims and objectives, activities and outcomes.

Interviews with people involved within each of the stakeholder groups have continued throughout the lifetime of the project. Beneficiaries of the services were interviewed later in the process in order to better capture the impacts their involvement with Community Agents has had on their lives.

Throughout this evaluation the Theory of Change illustrated above has been tested during the interview process, and information and evidence has been collated from each of the stakeholder groups on an ongoing basis. In addition to the qualitative interviews undertaken, the evaluation team has maintained regular contact with the Community Agents themselves, TVRCC and other stakeholders as a way of testing out findings and verifying evidence gathered.

Findings have been regularly fed back into both the Governance and Operational Groups, thus informing project development.

Stakeholder engagement with the project

Throughout this project key stakeholders have adopted a co-production model of engagement. This model proved to be very successful, particularly in the first year of the project. Each stakeholder group was actively involved in the design, development and implementation of the project at both strategic and operational levels. Some major staff changes within the STHFT have resulted in reduced some stakeholder involvement at strategic level, but more importantly it has meant a loss of system intelligence from the NHS. Community health professionals continue to play an active role at operational level.

Stakeholder engagement with the evaluation

Given the resources available for this evaluation, the capacity to carry out interviews across the stakeholder population was limited. In total 41 interviews were carried out across the stakeholder groups. Using a purposive sampling frame it was possible to involve individuals involved in the project at different levels and in different roles. This included staff referring clients into the project and services/organisations providing support to those clients. A breakdown of roles for those who participated in interviews is as follows:

Table 3: Breakdown of Interviews

Stakeholder role	Involvement in project	Number of interviews
Strategic Management – health and social care	Design, development and implementation	8
Health Professionals	Refer in	6
Adult social care	Refer in	9
Voluntary sector services	Service providers	6
Wider statutory sector services eg DWP	Service providers	2
Clients/Service users	Beneficiaries	10
Project Management	Managers and staff	3

Regular group sessions with the Community Agents themselves, were also carried out throughout the implementation of the project. These sessions served to improve information flow, support the monitoring process, and provide the opportunity to check and verify findings.

Systems were developed from the onset of the project to monitor referrals etc. As the project developed, the monitoring also began to include outcomes and case studies each month, which have also been utilised as part of this evaluation.

7. Project Inputs

This section describes the inputs of all of the stakeholders to the Community Agents Project

We will now examine the inputs for each of the main stakeholder groups.

South Tees Hospitals NHS Foundation Trust

The STHFT provided £84,763 to support the design and implementation of the Community Agents Project across the lifetime of the project (May 2013-March 2015).

As part of a jointly funded project staff have also provided in-kind support to the project to attend regular meetings and time to support project staff and offer training. A conservative estimate of the value of staff time spent working/supporting this project is £5,5500. These figures are derived from interview data and PSSRU costings. This is calculated on the basis of a minimum of twenty meetings lasting two hours for five members of staff at an average cost of £25.00 per hour plus one training event valued at £500. In addition, during the lead in period, senior NHS staff were involved in the early development of the project. We estimate that two members of staff provided a minimum of three days work at £500 per day totalling a further £3,000. An extra five days at £500 per day has also been included to cover in-kind contribution of staff supporting the project management, recruitment, publicity events etc. Total in-kind input for STHFT is calculated at £11,000.

Adult social care – Redcar & Cleveland Borough Council

RCBC were joint funders and also provided £84,763 to support the design and implementation of the project for the same period. Funding was secured from the public health budget to support this project.

Staff also provided in-kind support to the project for attending regular meetings and also management support to TVRCC when needed. A conservative estimate of the value of staff time spent on the Community Agents project is £6,000. This figure is calculated on the basis of a minimum of twenty meetings lasting two hours for six members of staff at an average of £25.00 per hour. In addition the value of a further five days at £500 per day to cover in-kind contribution when staff have supported the project management, involvement in recruitment, attending publicity events etc. Total in-kind contribution for RCBC is calculated at £8,500.

Voluntary Sector

Voluntary and community sector organisations had no financial input to the project. However, as a result of referrals made to Community Agents, many experienced an increase in workload which was not funded through the project. For the purposes of the SROI, we

calculate that agencies/organisations were required to carry out an assessment of the client referred to them by Community Agents prior to them receiving any service. Using the number of referrals made to the voluntary sector (according to monitoring data this figure is 357³) and an assumption that assessments were carried out by voluntary sector staff for a minimum of 60% of referrals made at a minimum of one hour at a cost of £15.00 per hour including travel costs, the value of in-kind support to the project from voluntary sector agencies is estimated as £3,210 across the lifetime of the project. It is possible that additional costs such as advertising, recruitment and DBS checks but there is no available evidence on these costs so they have not been included as an input at this time.

No monetary value has been attached to the provision of services or activities as these costs are currently covered within the core funding of these agencies/organisations.

TVRCC

It is also acknowledged that TVRCC have provided an in-kind contribution in terms of management and support time for the project. While management costs were included in the funding proposal, there is clear evidence to suggest that TVRCC have added considerable value to the project by contributing a substantial amount of time not covered within the budget. However, given the difficulties in accurately estimating the amount of time provided, no monetary value has been placed on this in-kind contribution and it is not included in the SROI.

Overall Input

For SROI purposes, the total inputs to the Community Agents Project have been valued at £192,191. This includes direct funding and in-kind contributions from stakeholders.

Table 4: Breakdown of inputs 2013-2015

Stakeholder	Financial Contribution	In-kind Contribution	Total
STHFT	£84,763	£11,000	£95,763
RCBC	£84,763	£8,500	£93,263
Voluntary Sector	Nil	£3,165	£ 3,210
Total			£192,236

³ This figure includes some clients being referred to more than one agency for support due to more complex needs

8. Outcomes and Evidence

This section will describe the projected outcomes of the Community Agents Project, the indicators agreed for measuring that those outcomes have been achieved, the numbers attached to each outcome, the period of time attached to the outcomes and the financial proxies used to measure them.

Outcomes

The model adopted for the Community Agents project has continued to develop and evolve. There have also been some staff changes in terms of project staffing, governance and operational membership. However, the project has continued to adapt to these changes and move forward. The co-production model has also continued, although the staff changes, particularly within the health sector have impacted on this slightly, although health professionals do continue to engage with the project, albeit to a lesser extent.

The primary aims of the Community Agents project are:

- To help older and vulnerable **people live independently** and safely in their own homes
- To help older and vulnerable **people return home from hospital** as quickly as possible
- To **reduce admissions** to hospitals and residential homes
- To **reduce social isolation** and loneliness
- To **improve financial status** by supporting appropriate access to benefits
- To engineer a **more appropriate use of health and social care services**
- To **encourage cost savings** in health and social care
- To **increase community capacity**.

It is accepted that these are very broad aims. However, the project team have worked steadily toward achieving these aims.

Overall, the evidence gathered in the stakeholder interviews supports the view that the work of the Community Agents has resulted in a range of positive outcomes for both service users and the statutory services, which are unable to provide the low level support to the clients that is often needed.

However, the Community Agents project made no real headway in speeding up discharge from hospital. While it is clear that Community Agents have supported clients after they have been discharged from hospital, there is no evidence suggesting they had any role to play in instigating speedier discharge. It seems fair to say that the funding of a Home from Hospital Scheme from JCUH goes some way in explaining lack of progress in this area.

It would also appear that the voluntary sector has benefited in terms of some increase in the numbers of volunteers, with some expanding their service to support clients referred by Community Agents. However, they have also suffered some more negative outcomes as they often struggled with their capacity to meet the additional demands of the clients referred into the agency by Community Agents.

Stakeholder interviews identified a range of outcomes achieved as a result of the Community Agents Project. These are shown in the table below.

Table 5: Stakeholder Reflections on Outputs and Outcomes

Stakeholder	Outputs/Activities	Outcomes
NHS/Community Health Professionals	<ul style="list-style-type: none"> • Funding Partner • Project development • Refer in for low level interventions 	<ul style="list-style-type: none"> • Reduction in anxiety and depression • Patients are more actively engaging with health professionals and medication requirements • Reduction in DNAs at GPs and hospital appointments • Reduction in frequent flier bed days • Community health professional time saved sourcing relevant low level interventions
Adult social care	<ul style="list-style-type: none"> • Funding Partner • Project Development • Refer in for low level interventions 	<ul style="list-style-type: none"> • People are staying in own homes for longer • Delaying need for increased care packages • Improved access to wider local authority services • Adult Social Care (ASC) professionals time saved sourcing relevant low level interventions
Voluntary Sector	<ul style="list-style-type: none"> • Service providers • Training, supporting and managing volunteers 	<ul style="list-style-type: none"> • New project established to increase community capacity • An increase in the number of volunteers
Elderly and vulnerable people	<ul style="list-style-type: none"> • Actively engaging with Community Agents • Actively engaging with service providers 	<ul style="list-style-type: none"> • Perception of improved health and wellbeing • Improved financial status • Less isolated – improved social networks • Increased self confidence • Retaining independence – able to stay in own home for longer

Many of the outcomes reported throughout the interview process as achieved were expected as a result of the project and included in the Theory of Change. However, a number of previously unexpected positive outcomes were also found.

While most of the changes made as a result of the project resulted in positive changes, a small number of negative outcomes were also identified.

Unintended Outcomes

Stakeholder interviews confirmed that the majority of outcomes achieved to date were intended and included in the Theory of Change. However, the project has brought about some unexpected outcomes.

Community Health Professionals

- Patients engaging more positively with health and medication regimes
- The actual time saved on trying to find low level, non-clinical support for patients

Redcar & Cleveland Council

- The actual time saved on trying to find low level, practical support for clients
- Better utilisation of existing local authority services

Voluntary Sector

- Difficulties in meeting demand

Elderly and vulnerable people

- Increase in self confidence
- Less stressed

We will now examine in further detail the outcomes achieved as a result of the Community Agent Project for each stakeholder group.

Outcomes for each stakeholder group

Community Health Professionals

Outcome 1: Reduction in anxiety and depression

Community health professionals reported a range of changes that had begun to have an impact on their caseload planning.

Overall they reported Community Agents bringing about positive changes for their patients. To date 127 referrals have been made to the Community Agents from health professionals working directly with patients living in their own homes. Referring personnel include community matrons, community nursing teams, OTs, physiotherapists, hospital discharge and social work staff.

Having someone come to my home once a week for a coffee and a chat makes all the difference to me. I really look forward to it, I feel better in myself and I want to look after myself better.

Service User

However, it is acknowledged that use of the Community Agent project by health professionals is dependent on individuals knowing about and using the service. Gaining full team 'buy in' to the approach has proved very difficult to achieve to date. There is evidence gathered from interviews to indicate that the number of people within community health

teams who know about and use the service is increasing, although referrals are not consistent across time. More work needs to be done to further increase the number of health professionals using the service and to also promote more consistent use.

I didn't know which way to turn until she [Community Agent] turned up at my door. What a difference. It's like a light has come on for me.

Service User

Community health professionals made it clear that many of their patients would not have been able to stay in their own homes without Community Agent input. They recognised that many of their elderly patients suffered from depression and some were becoming

anxious as their conditions worsened. Patients living with long term conditions requiring regular healthcare in the home are often prone to anxiety and depression primarily due to the fact that they are housebound, lonely, with no family or friends.

Health professionals began to see a real difference in the attitude of patients as they were supported by the Community Agents, often becoming more socially active as a result.

It was like they, some of them, had got a second wind, instead of just sitting around. They wanted to be out doing different things and were much happier in themselves.

Community Matron

When you are 90 years old, you are not bothered about whether you are on the best treatment for diabetes, you just want to know that you can manage and stay in your own home. A lot of things you need to be able to do that is where the Community Agents Service comes into its own.

Community Matron

There is a lot of literature to support the negative impact of social isolation on general health and wellbeing (Nicholson 2012, Bernard 2013) and community health professionals recognise that the reduction of social isolation for some of their patients is having a positive effect on health and wellbeing.

The evidence suggests that one of the key reasons for patients becoming anxious and depressed is their worry that they may not be able to stay in their own homes. As their health deteriorates and they are less able to retain their independence in terms of keeping themselves safe, and their homes and gardens in the way they like, the concern about leaving their home grows.

Community Matrons identified anxiety and depression as an important factor in addressing health needs and reported that anxiety and/or depression was an issue for approximately 80% of their patients and that input from the Community Agents has made a difference in the majority of cases referred. To date community matrons and community nursing staff have referred 50 patients to the Community Agents. The evidence supports the view that Community Agents have been successful in making changes that have impacted on vulnerable patients' anxiety and/or depression in many of these cases.

I was at the end of my tether, no-one seemed to be able to help me. I was thinking about ending it all. The Community Agent turned up at my door, made some call, arranged for food parcels and helped me over the worst time of my life.

Service User

However, reducing anxiety and depression was not limited to health referrals. One of the more severe cases highlighted the impact of Community Agent input on a person who was suffering extreme physical and mental health problems who was

contemplating suicide. While we have not attempted to put a value on this as it presented as an outlier, it does illustrate the wide spectrum of impacts resulting from the Community Agents project.

Some clients referred in from various sectors were identified as suffering from various levels of anxiety or depression. This was reflected in the number of referrals made by Community Agents to MIND and the MIND Reablement Team.

Outcome 2: Patients are more actively engaging with health professionals and medication requirements

Community Matrons and Occupational Therapists, particularly, reported that because patients were often feeling happier in themselves due to improvement in social networks and activities, they were also beginning to more actively engage with their

Having someone come to my home once a week for a coffee and a chat makes all the difference to me. I really look forward to it, I feel better in myself and I want to look after myself better.

Service User

healthcare and take their medication properly. Ultimately this has meant that patients are feeling better in themselves. As a result some visits were shorter and some patients have

We generally discharge patients at the point of referral to Community Agents. Up to now I have only had one person who has been seen by community agents come back to me and that was with a health issue.

Occupational Therapist

been discharged once Community Agents are involved. Previously, even though their medical/clinical needs were met, they could not be discharged as they remained a cause for concern due to non-medical issues.

There is thus anecdotal evidence that some cost savings result from Community Agent input. The evidence suggests that some community health professionals are able to discharge patients sooner and as a result take new patients onto their caseload.

Many of our patients are referred by GPs as people who are bouncing in and out of hospital and having a lot of contacts with the GP practices. Once the plans are fully in place we are certainly seeing a reduction in calls to us and the GPs are not re-referring to us, indicating they are also having less contact.

Community Matron

Community Matrons confirm that their patients are becoming more

settled within their care packages, which are now increasingly including services sourced through the Community Agents which is in turn, resulting in fewer GP visits.

Outcome 3: Reduction in DNAs at GP and hospital appointments

It's so much easier with Community Agents because we can say 'refer to them' instead of having to think about and find all the different agencies or voluntary services. It definitely saves us a lot of time because now we don't have to find the appropriate services.

Social Worker

...

Community health professionals report that the activities resulting from Community Agent input have also meant that patients are arriving for hospital and GP appointments when expected, reducing the DNA rates. Difficulties in attending health appointments and also having someone with you to support you

had been identified as a problem for some clients. Changes to the North East Ambulance Service (NEAS) criteria for transport meant that some of those who originally could access this transport were no longer eligible. Given the numbers involved here it is not possible to confirm this outcome using NHS statistics, but community health professionals continue to reiterate that this is indeed one outcome achieved as a consequence of the Community Agents project.

Outcome 4: Reduction in 'frequent flier' bed days

Community health professionals report many of their clients who suffer from acute long term conditions do require hospitalisation on a regular basis. However, other patients who have more manageable long term conditions are beginning to cope better as a result of their receiving support with the more social and practical elements of their lives. When people are feeling less lonely it appears to reduce their liability to end up as a short term admission to hospital.

However, given the relatively small numbers involved, this reduction is currently not showing on the hospital episode statistics, although Community Matrons and other community health staff confirm this to be the case.

I had a lady with COPD who was dropping in and out of hospital all the time but was quickly turned around and sent home. She had family but they were busy working. There often wasn't much wrong with her to warrant admission. She struggled to get out of the house and the Community Agents arranged for her to go to a luncheon club and that led to other bits and pieces. She hasn't been admitted since and it got to a point where she didn't need us going in any more. She is managing. She still has the condition but she is following her plan. This is happening more and more often.

Community Matron

...

While one of the original objectives for the project was to speed up discharge from hospital care, thus saving bed days and reducing bed blocking, there is no evidence to suggest that this has been achieved to date. Early efforts in the project to engage with acute trust staff

were not fruitful so, while some bed days were saved, it was more in terms of re-admittances than speedier discharge.

Outcome 5: Time saved sourcing relevant low level interventions

Community health professionals are very clear that having the Community Agents as a single referrals point has saved them large amounts of time per patient. They acknowledge that many of their clients have social needs that need to be addressed as well as their more medical/clinical needs and that failure to address these needs does impact on their health.

In the past, they have had to try and find relevant services and this can take a lot of time. Given that the majority of patients are classified as socially isolated, time spent on finding support for their social needs has been substantial.

I have to set goals for my patients and one might be to improve socialisation. I would have to look at how to do that. Before the Community Agents I had to ring all the volunteer services myself and it could take hours. Now the Community Agents take care of that and they often find a lot more than I ever had time to do.

Occupational Therapist

In total 127 referrals have been made from health professionals. According to interview participants they were likely to spend between 30 minutes to 2 hours trying to source services to meet social needs for their clients depending on the complexity of needs. If we assume an average of 1 hour per client, this equates to a minimum of 127 hours of time

saved for health professionals alone as a result of the Community Agents project

Redcar & Cleveland Council

Outcome 1: People are staying in their own homes for longer

One of the primary aims of the Community Agents project was to help people retain their independence in their own homes for longer, thus reducing the numbers accessing residential care services.

Redcar & Cleveland Council Adult Social Care Service were very clear that the increasing number of the people going into residential care was

There are some things I can do myself and others that I can't. It's just really nice to know there are people out there who can help me. I like my home and want to stay here as long as I can. It's important to me.

Service User

due to the fact they found it difficult to manage in their own homes and had been unable to access the general support that they needed to help them do this. The ability to cope and manage daily tasks such as shopping, cleaning, and generally looking after themselves is very important if elderly people are to stay at home.

It's about acknowledging that the lower level needs, even under FACs, if they are not addressed, become higher level needs and you end up in a crisis situation. It's the nature of the beast at the minute, we just don't have the money to offer the hours to provide support for those low level needs.

Social Worker

Social workers report that elderly people want to stay in their own homes and are more likely to need placing into residential care at a time of crisis. Social workers also reported that support with more social needs can delay such crises and held a view that some of their clients would in fact have required some form of residential care without the support of

the Community Agents. The statistics within social care do not show a general reduction in people accessing residential care.

It's not just about delaying moving into residential care, it's also about not having to increase the care packages that we need to provide.

Social Worker

However, it is not possible to link such a reduction directly to Community Agent support, as there are a number of other key factors such as costs, reductions in residential care places and available funding for residential care that also must be acknowledged as contributing to this.

Outcome 2: Delaying the need for more complex care packages

It's not just about keeping people in their own homes for longer. There are a lot of people who we would have expected to require more complex care packages at home that haven't. These can be very expensive so the project is helping us in that way too.

Social Worker

Social workers were very clear that many of their clients would have needed more extensive care packages without Community Agent input; thus input from the Community Agents has reduced the strain on the social care budget. There is clear evidence to support the view that as people's perception of their own

health improves and their social networks are either re-established or newly developed, their outlook becomes more positive and this maintains the status quo for longer periods of time.

Outcome 2: Improved access to wider council services

From the outset of the project it had been recognised that people were not accessing wider council services. It was felt that much of this was due to lack of awareness. The Community Agents serve to raise awareness of those services with the wider client population.

It's about knowing what's out there and if you work outside of the Council we don't always know what they can offer. The Community Agents took the time to find out and have increased the usage of some of those services.

Community Matron

I had never heard of Warm and Well until the Community Agent got me in touch with them. They were great.

Service User

Community Agents continue to refer clients to Warm & Well, Welfare Rights, and the Housing Department. There is a view that while clients had not accessed these services before, some of them might have been referred to these services by others.

However, stakeholders confirm that the majority would not have accessed these services without the Community Agents. Monitoring data shows that 62 clients were referred to existing services within the local authority.

The evidence clearly supports the view that - through these referrals - the Community Agents have opened up options within the statutory sector which were not previously being used effectively.

Outcome 3: Time saved sourcing relevant low level interventions

Adult social care teams have been shown to be the main referrers to the Community Agents. Throughout the lifetime of the project they have referred 426 (64%) clients for low level support and interventions. Prior to Community Agents, a huge problem for the adult social care teams had been the fact that increasingly they were unable to provide the support people were requesting and they found this to be both upsetting and frustrating.

It's so much easier with Community Agents because we can say 'refer to them' instead of having to think about and find all the different agencies or voluntary services. It definitely saves us a lot of time because now we don't have to find the appropriate services.

Social Worker

For many, the ability to refer on to the Community Agents has been seen as a really positive step. Rather than telling clients they were unable to do anything, staff were previously using vast amounts of time trying to source relevant services. Community Agents now take on this role. In total, the social work teams have referred a total of 426 clients to the Community Agents. Social workers report that without Community Agent involvement they would have had to try and source relevant services themselves which would take anything between 15 minutes and 2 hours. Again if we take an average of one hour per client, over 426 hours have been saved enabling them to focus on statutory services. It is also noted that many clients referred by the social work have a range of needs which requires the Community Agents to make multiple referrals to different elements of support.

Voluntary Sector

Outcome 1: Increasing Capacity within local communities

Getting volunteers is becoming increasingly difficult and there are never enough to meet the demand but the new project has meant we have an opportunity to increase the numbers of volunteers. It also means that as the Community Agent project continues we have further evidence to support future applications.

Voluntary Sector Manager

Early findings from the Community Agent project evaluation provided evidence of need to build capacity within local communities. While a number of voluntary and community sector agencies were operational across the Borough, it became clear that some were having difficulties in meeting the needs of people referred to them by the Community

Agents due to a lack of volunteers. An application to the Clinical Commissioning Group (CCG) for £34,000 to recruit and train additional volunteers in the area was successful. Based on the evidence of need provided from the preliminary findings of the Community Agent evaluation, a separate project was established to recruit additional volunteers. The Redcar & Cleveland Voluntary Development Agency (RCVDA) are the lead on this project but have worked closely with TVRCC and other voluntary agencies to increase the number of volunteers.

TVRCC are also supporting a Volunteer Driver Scheme aimed at providing volunteer drivers to transport people to hospital appointments, social activities, visiting family. Community Agents clearly identified a gap in service and an existing project was expanded to fill this gap in services.

The Volunteer Driver Scheme is part of a wider Transport Brokerage Project. People often couldn't get out of their homes because of a lack of transport and this was a real gap that needed to be filled.

TVRCC

Outcome 2: An increase in the numbers of volunteers

We have had to change how we work with clients so we can meet the demand. We can offer a telephone buddy service until we can match people up with a befriender. We are increasing our volunteer base and we are also expanding geographically as a result of the Community Agents Project. This means extra volunteers and people to manage them.

Voluntary Sector

Using evidence from the Community Agents Project highlighting the need for additional volunteers to provide services for Community Agent clients, funding was secured from the CCG for the Vital Health Volunteers Project. This project has had some success in increasing the number of volunteers for some of the voluntary sector projects. In addition to this, Community Agents have also had

the opportunity to promote volunteering within local communities and have also signposted eight potential volunteers to organisations. Stakeholders from the voluntary sector confirm that, although most would welcome even more

We have had occasions where people have asked for information about volunteering and have passed their details on to some of the voluntary sector groups to follow up.

Community Agent

volunteers, numbers are increasing, although not at a fast enough pace to fully meet the needs of clients referred to them. Some organisations have also expanded their services to meet the geographical needs of the Community Agents, and as a result have increased numbers of staff involved in co-ordinating, training and managing volunteers as well as increasing the numbers of clients they are servicing.

Negative Outcome: Increased pressure on the voluntary sector

Stakeholders from the voluntary sector report feeling under pressure to meet the additional needs referred by Community Agents. The voluntary sector is currently going through some major changes due to the austerity measures and major reductions in their core funding and the shift from grants to contracts for service delivery.

There has been a financial implication for us . . . This organisation has picked up the cost of the volunteer training, recruitment, visiting clients. Referrals didn't come with any financial support so everything that comes through the door from Community Agents has to be financially supported by this organisation.

Voluntary organisation manager

They are currently trying to provide additional assessments and services for Community Agent clients without any additional funding to do so. Some of the agencies feel that supporting increasing numbers is a positive thing; others see it as adding pressures on staff and stretching already limited resources.

However, regardless of these difficulties, the voluntary sector agencies have continued to provide services to a large proportion of clients referred to them by the Community Agents. While acknowledging the negative impact, the fact that this has not been an issue for the whole of the voluntary sector and that many agencies have adapted to provide services for Community Agent clients, so no negative values will be included in the SROI.

Elderly and vulnerable adults

Outcome 1: Perception of improved health and wellbeing

The views of health and social care professionals that the general health and wellbeing of patients is improving as a result of the Community Agents input is fully supported by the elderly and vulnerable adults involved. Interviews with this stakeholder group clearly highlighted that their perceptions of their own health and wellbeing had improved

dramatically. Managing long term conditions has been made easier and people are feeling

I just feel so much better in myself, much happier. I still have my health problems but they seem easier to manage.

Service Users

The Community Agents have been my light at the end of the tunnel. I really didn't know where to turn. I knew I needed help but couldn't find it. The day she knocked on my door changed everything for me. I still have a way to go yet but at least I feel that I am going to get there now.

Service User

much less anxious and desperate. Also, just knowing that there is someone there who they can reach out to for help should they need it, are all factors that this have led to this stakeholder group feeling better. As a consequence of this

people are engaging better with services and community health and social care staff and are much more amenable to accepting help and trying new things. Community Matrons and other community nursing staff reiterated this in terms of patients engaging with their healthcare and medications.

Outcome 2: Improved financial status

I got attendance allowance first, then an increase in my pension credits. I've never had so much money. What this means is that when I do need to pay for some care I won't have to worry about it because the money will be there and that is such a relief.

Service User

It is readily accepted that many elderly and vulnerable people do not claim all of the benefits to which they are entitled. According to Age UK⁴, up to £5.5bn of means tested benefits go unclaimed by older people every year and even though approximately 4 million older

people are entitled to pension credit, 1 in 3 of those eligible are not claiming it. Reasons for this vary and much effort has been made to ensure that this changes.

⁴ Age UK. Benefits and Entitlements. Accessed 30/10/14 <http://www.ageuk.org.uk/money-matters/claiming-benefits/?gclid=Clzg6NuZ18ECFYrjwgod1IIAvA>

Community Agents have directly supported 114 clients in the completion of statement of resources forms which has resulted in clients successfully reducing their care costs or not having to pay any costs towards their care. In most cases clients had found it difficult to complete these forms properly and as a result calculations were not accurate.

We do home visits and, although we don't follow up to see the results of the visit. We only visit if there is a strong likelihood of success, in other words that the client meets the criteria. I would say that over 90% of our visits are successful in gaining additional benefit.

DWP

Community Agents made 80 referrals to the Department of Work & Pensions (DWP) alone for clients to receive benefits advice. This was predominantly related to Attendance Allowance and Pension Credits. A further 47 referrals for benefits advice have also been made to the Welfare Rights Team and CAB. The DWP offers a home visiting service which has proved very useful bearing in mind the client group. DWP only carry out visits when they are sure that claimants are not claiming their full entitlement.

My care costs were reduced which meant I had more money to play with. I had been really worried about how I was going to keep paying them.

Service user

Elderly and vulnerable clients also reported substantial increases in their finances due to either additional benefits or subsidised or free care and equipment. In some cases clients found it difficult to cover care costs e.g. day

centre use, personal care packages. Also some had been told they were not eligible for subsidised care. Community Agents have been involved in a number of resubmissions which have resulted in people no longer having to pay for their care. Community Agents were provided with training so they were able to complete financial assessment forms which were generally used to assess if payment is needed from individuals for the package of care they are receiving.

Improved financial status also has an effect on "peace of mind". Many service users told us that having increased their income meant they are feeling less pressured and worried about paying their way. This in turn helps them feel better.

I need someone to go with me when I go to the hospital, so getting a taxi isn't any use. I often used to cancel my appointments. Now I have the extra money I feel I can ask my neighbour to take me and pay her. That way I am not on my own and I don't feel cheeky asking her.

Service User

Outcome 3: Less isolated – improved social networks

Social isolation is the pre-eminent need referred to Community Agents. While some clients present with specific health and social care needs there is also a large element of the vulnerable and elderly population who are simply lonely. Many of them have outlived or lost contact with friends, are housebound, have family living at a distance and often lack the confidence or ability to go out and make new friends.

I am housebound so don't get out much. Although I have lived in this area for almost 30 years, I haven't really go any friends who visit. My family live all over the place so since my husband died, I spend a lot of time on my own. Just knowing that someone is coming to see me once a week for a chat and a coffee makes all the difference and I really look forward to it.

Service User

There is clear research evidence that links the effects of loneliness to older people's health. The link between loneliness and depression is also well evidenced. As a result lonely and isolated people use more healthcare resources and are more likely to need long term care and are more likely to have a poorer quality of life, be at a greater risk of dementia and are also at greater risk of dying prematurely.

Both health and social care professionals are now adopting a more holistic approach to care, and are regularly identifying that clients are lonely and isolated. As a result, they are

I look forward to her coming so much; it has made such a difference to me, she's only young and she's like my granddaughter who lives in Australia.

Service User

referring them to Community Agents, which they see as one way of preventing the more extreme effects of loneliness and isolation on clients' health and wellbeing. Through the lifetime of this project 131 people have been referred for befriending services

with a further 39 people referred on for social activities, equalling 23% of all referrals.

The number of clients/patients referred with multiple needs is also increasing. To date, 77 people have been referred requiring multiple services. Of these 57 are also identified as being socially isolated and in need of befriending or improving their social networks through engaging with community activities.

Being old and lonely is really hard . . . you get to a point where you just don't want to do anything. You feel useless and that all you can do is sit at home watching TV. I didn't know what was out there or how to get it. Now I go to different activities, meet up with some old and new friends and what a difference that has made to me.

Service User

Service users involved in this evaluation are very clear that loneliness and not being able to get out of the house severely impacts on how they are feeling. Many of the people referred to the Community Agents are now regularly seeing a befriender. For some this involves regular

I recently went to a Vintage Cream Tea at Redcar Golf Club with the volunteer car driver. It was good to get out and have a ride in the car. I really enjoyed the sing-a-long and am looking forward to going to another one soon.

Service User

visits by the befriender to the home, for others it is enabling engagement in activities such as shopping, events, groups. Some clients are also engaging more with community events and groups, which in turn results in an increasing their social networks and links them with other activities.

The fact that there is scope to transport clients to activities and events through the volunteer driver scheme is also an important factor.

Outcome 4: Increased self-confidence

The fact that elderly people are coping with long term conditions, feeling lonely, sad, depressed, having little interaction with other people and are often less mobile all has an impact on their confidence. Many of the

service users involved in this evaluation had begun to accept the status quo, feeling that there was no-one out there to help them make some changes to their lives. By becoming involved with befrienders and improving their access to local activities or hobbies such as

Just knowing that there is someone out there who you can call if you need to stop you just giving up. I know that the Community Agents will either help me or know someone who can so I don't worry about sounding silly or worry about them thinking I'm a nuisance.

Service User

knitting clubs, elderly people are reporting feeling more confident to continue attending without support or to attend new things. For many attending social activities, re-establishing contacts with old friend who they had lost touch with was an unexpected bonus which often served to open the door to additional activities and sustain engagement for longer periods of time.

Outcome 5: Retaining independence – able to stay in own home for longer

Social work teams were very clear, that for elderly and vulnerable people to stay in their own homes safely, there are a number of things that need to be in place. Many of these have been covered earlier in this section of the report. However, in addition to improving health and wellbeing and reducing anxiety and isolation, there is also a need for service professionals to be able to offer more practical support such as home maintenance, gardening, access to regular meals and even shopping.

I am waiting for my walk-in shower to be installed. I have fell twice in the last year and was admitted to hospital for a few days the first time and needed hospital treatment the last time. The Community Agents have helped me get all the approvals and fill the forms in so I can get out of the bath safely.

Service User

While lack of such practical support would not be a major cause for people moving into residential care, it is regarded as a serious contributory factor. If people are not able to manage and maintain their property or access equipment they need, their houses are more likely to become unsafe, people will suffer more falls

and generally begin to feel unhappier in themselves.

There have been a number of instances whereby homes have become unsafe due to elderly people developing hoarding tendencies, or the upkeep of properties has generally been poor, with damp, leaking pipes etc, creating conditions which have often resulted in falls.

Community Agents have actively supported clients in removing clutter to enable tradesmen access to rooms to repair central heating which, in turn, means the property can be heated so clients are not living in the cold. Feeling comfortable and safe in their own homes is very important and relevant in them staying in their home homes for longer. Patient/client safety is a prime concern for both health and social care staff.

I call the Community Agent my community angel. She helped me clear a room so that the repair man could get in and fix my heating. It had been so cold in the house because the heating hadn't worked for so long but now its fixed and I can keep warm.

Service User

Outcome Indicators

In order to ensure this SROI evaluation is as accurate as possible we have agreed indicators for each of the outcomes with the stakeholder groups as a way of measuring the quality and depth to which these outcomes have been achieved.

Table 6: Outcome Indicators

Stakeholder	Outcomes	Indicators	Source
Community Health Professionals	Outcome 1: A reduction in anxiety and depression	<ul style="list-style-type: none"> Reporting of improved health and wellbeing Numbers reporting feeling less anxious and depressed 	<ul style="list-style-type: none"> Baseline data Monitoring and feedback data Interviews with stakeholders
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements	<ul style="list-style-type: none"> Decrease in community health staff time as a result of CA involvement – earlier discharge from community caseloads 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring and feedback data
	Outcome 3: Reduction in DNAs at GP and hospital appointments	<ul style="list-style-type: none"> People now attending hospital, GP appointments using the volunteer car scheme or other transport to appointments sourced by Community Agents (CA) 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring and feedback data
	Outcome 4: Reduction in frequent flier bed days	<ul style="list-style-type: none"> Number of bed days saved 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders NHS HES stats Feedback data
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions	<ul style="list-style-type: none"> Amount of time saved per client referred 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring data
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	<ul style="list-style-type: none"> Numbers of people staying in their own home for longer 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring data
	Outcome 2: Delaying need for increased care packages	<ul style="list-style-type: none"> Elderly maintaining current levels of care without need for more complex packages being put into place 	<ul style="list-style-type: none"> Baseline and endline interviews with health and social care professionals
	Outcome 3: Improved access to wider local authority services	<ul style="list-style-type: none"> Numbers of people using wider LA services 	<ul style="list-style-type: none"> Monitoring data Interviews with CAs Endline interviews with LA staff
	Outcome 4: ASC time saved sourcing relevant low level interventions	<ul style="list-style-type: none"> Amount of time saved per client referred 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring data

Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	<ul style="list-style-type: none"> Number of new projects 	<ul style="list-style-type: none"> Minutes of meetings Endline interviews Project documents
	Outcome 2: An increase in the numbers of volunteer	<ul style="list-style-type: none"> Number of additional volunteers 	<ul style="list-style-type: none"> Baseline and endline interviews with stakeholders Monitoring data
Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	<ul style="list-style-type: none"> Numbers of people engaging with services and social activities and improved financial status 	<ul style="list-style-type: none"> Baseline and endline interviews with service users Monitoring and feedback data
	Outcome 2: Improved financial status	<ul style="list-style-type: none"> Numbers of people now in receipt of benefits that had been previously unclaimed 	<ul style="list-style-type: none"> Baseline and endline interviews with service users Monitoring and feedback data
	Outcome 3: Less isolated – improved social networks	<ul style="list-style-type: none"> Numbers attending social and physical activities on a regular basis Numbers regularly seeing a befriender 	<ul style="list-style-type: none"> Baseline and endline interviews with service users Monitoring and feedback data
	Outcome 4: Increased self-confidence	<ul style="list-style-type: none"> Clients reporting improved social networks has led to further activity 	<ul style="list-style-type: none"> Baseline and endline interviews with service users Monitoring and feedback data
	Outcome 5: Retaining independence – able to stay in own home for longer	<ul style="list-style-type: none"> Numbers receiving practical support to maintain their homes 	<ul style="list-style-type: none"> Baseline and endline interviews with service users Monitoring and feedback data

Every effort has been made to avoid double counting. The next section will now focus on the numbers of people who have achieved these outcomes and for how long they are likely to continue to feel those benefits.

Quality of outcomes

Using the responses provided in all the stakeholder interviews, the monitoring data collected by the project and ongoing input from the Community Agents and other service providers, we have examined each of the outcomes in detail and attached the numbers of those people reporting benefits from these outcomes. In some cases, this is the actual

numerical value recorded; however, in some cases these are conservative averages based on the interview responses.

Table 7: Outcomes

Stakeholder	Outcomes	Quantity
Community Health Professionals	Outcome 1: A reduction in anxiety and depression	45
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements	45
	Outcome 3: Reduction in DNAs at GP and hospital appointments	50
	Outcome 4: Reduction in frequent flier bed days	25
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions	127
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	10
	Outcome 2: Delaying need for increased care packages	45
	Outcome 3: Improved access to wider local authority services	77
	Outcome 4: ASC time saved sourcing relevant low level interventions	426
Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	1
	Outcome 2: An increase in the numbers of volunteer	35
Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	122
	Outcome 2: Improved financial status	62
	Outcome 3: Less isolated – improved social networks	85
	Outcome 4: Increased self-confidence	60
	Outcome 5: Retaining independence – able to stay in own home for longer	118

Duration of Outcomes

Assessing the duration of outcomes for a project of this nature is difficult. There is potential for a short one-off contact with a Community Agent resulting in a longer term outcome e.g. improved financial status. On the other hand, ongoing contact with a Community Agent may result in a solution that has a much shorter term outcome e.g. arranging for someone to walk a client’s dog.

In order to assess the duration of outcomes more accurately, information from the stakeholder interviews and additional discussions with the Operational Group to corroborate these findings has been used.

For the purposes of this study we believe that while various outcomes are likely to last for different durations, we have assessed duration as being for a maximum of three years. Linking outcomes to project actions is much more difficult after that time period. This is thus a conservative estimate to avoid over claiming.

Table 8: Length of time outcomes are likely to last

Stakeholder	Outcomes	Duration (years)	Assumptions
Community Health Professionals	Outcome 1: A reduction in anxiety and depression	3	As confidence grows patients are more likely to continue accessing services and activities without CA input
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements	3	As above
	Outcome 3: Reduction in DNAs at GP and hospital appointments	2	Given that many will have LTC they are more likely to need additional input from these teams as time progresses
	Outcome 4: Reduction in frequent flier bed days	3	As confidence grows patients are more likely to continue accessing services and activities without CA input
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions	3	CA’s will continue to fill this gap thus saving professional time at least until end of year 3
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	2	Based on people staying at home for at least one year longer for each year of the project

	Outcome 2: Delaying need for increased care packages	2	Reducing isolation and improved perceptions of own health will impact on care needed for a while but LTCs do deteriorate over time
	Outcome 3: Improved access to wider local authority services	3	CAs will be continuing to direct clients to wider services at least until the end of year 3
	Outcome 4: ASC time saved sourcing relevant low level interventions	3	CAs will continue to fill this gap, thus saving professional time at least until end of year 3
Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	1	One project established, one organisation expanding to meet needs but very reliant on available funding at times of deep austerity measures
	Outcome 2: An increase in the numbers of volunteer	3	While there is some turnover of volunteers, many are retired and continue to provide services over long periods of time
Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	3	Based on age and possible health deterioration over a longer period of time
	Outcome 2: Improved financial status	3	Once received additional benefits likely to continue but after 3 years the likelihood of others picking this up increases
	Outcome 3: Less isolated – improved social networks	3	Improving social networks extend beyond the lifetime of project as relationships continue to develop over time thus reducing feelings of isolation and loneliness
	Outcome 4: Increased self-confidence	3	Continued engagement is likely to have a longer lasting effect
	Outcome 5: Retaining independence – able to stay in own home for longer	3	As long term conditions (LTC) progress people are more likely to have more complex care needs so will require residential/nursing care regardless of CA inputs

Financial Proxies

Financial proxies have been used to determine the value to be attached to each of the outcomes. Where possible, the actual financial costs will be included e.g. hourly rates, costs of activities etc. For those outcomes without a clear market value, a range of sources has been used. Service users found it very difficult to place actual values on some of the outcomes. For most, “feeling better, more confident, less isolated” were priceless. For those outcomes that the elderly stakeholder group were unable to place an actual value on we have used a number of sources which offer accepted values. Table 7 below shows the financial proxies and the values given. The sources can be found on the full Impact Map in the appendices.

Table 9: Financial Proxies

Stakeholder	Outcomes	Financial Proxy	Value
Community Health Professionals	Outcome 1: A reduction in anxiety and depression	Average cost of service provision for adults suffering from depression and/or anxiety	£830.00
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements	Cost of number of visits saved at average hourly rate	£25.00
	Outcome 3: Reduction DNA at GPs, hospital	Average cost of DNA to GPs and hospitals	118.76
	Outcome 4: Reduction in frequent flier bed days	Bed days saved	611.00
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions	Average hourly rate of staff for hours saved	£25.00
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	Costs of a one year stay in residential care - £553 pw	£28,756 pa
	Outcome 2: Delaying need for increased care packages	Cost of moderate care packages for older people - £148 pw	£6.660 pa
	Outcome 3: Improved access to wider local authority services	Staff time – on the basis of an average of 3 hours per client	£60.00
	Outcome 4: ASC time saved sourcing relevant low level interventions	Average hourly rate of staff for hours saved	£20.00

Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	Funding secured	£34,000
	Outcome 2: An increase in the numbers of volunteer	Average value of volunteering	£7,490.00
Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	Value placed on just feeling better in themselves	£5,000.00
	Outcome 2: Improved financial status	Average increase in benefits over a one year period	£2,593.44
	Outcome 3: Less isolated – improved social networks	Value of regular attendance at social activities/events	£1,850.00
	Outcome 4: Increased self-confidence	Value of increased confidence to health and wellbeing	£995.00
	Outcome 5: Retaining independence – able to stay in own home for longer	Average cost of paying for practical services making it possible to stay in home for longer	£85.00

9. Programme Impact

This section examines the overall impact of the project and acknowledges other elements that may also have influenced the outcomes

A key objective of the evaluation was to show the full impact of this project. Using the SROI framework, we have identified the key stakeholders, gathered evidence of impact and verified the findings. However, the Community Agents Project does not operate effectively as a stand-alone project and is often dependent on others to provide services. Alongside this, the elderly and vulnerable clients are also likely to be receiving some support from other agencies and services.

In order to ensure that the SROI evaluation is accurate (avoiding over claiming), it is necessary to also look at the effects of attribution, displacement, deadweight and drop-off and incorporate them into the final calculation. These terms are defined below.

IMPACT

Attribution – the part of the outcome that can be attributed to the project activities

Displacement – what similar existing activities/services/outcomes were replaced by the Community Agent Project

Deadweight – how much of the outcome would have happened anyway

Drop-off – to what extent the benefits of the outcomes will reduce over time.

Attribution

Attribution is a key factor for an accurate measure of impact of the Community Agent project. Many of the outcomes are due to more than one service working with or supporting clients. However, the role of the Community Agents is pivotal in getting those services in place. The principle of the Community Agent project is to either provide or identify services for the elderly and vulnerable clients that are not covered within statutory provision. Without Community Agent input, their assessment and signposting, many of those clients may not have been identified to the voluntary sector.

There is a need to recognise the influence of other people/services on the outcomes achieved in accurately assessing social value. Therefore we have estimated the percentage of the outcome that can be attributed to others and provide the rationale for these estimates in Table 7 below. This will be subtracted from the final values.

Table 10: Attribution

Stakeholder	Outcomes	Attribution %	Rationale
Community Health Professionals	Outcome 1: Reduction in anxiety and depression	50%	On the basis that continued healthcare and ongoing relationships with health staff also equally contribute towards the outcomes bearing in mind the impact of not addressing social needs on wider health and wellbeing.
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements		
	Outcome 3: Reduction DNA at GPs, hospital		
	Outcome 4: Reduction in frequent flier bed days		
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions		
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	30%	On the basis of ASC staff carrying out assessments, identifying social needs and making those referrals to Community Agents, the age of the clients
	Outcome 2: Delaying need for increased care packages		
	Outcome 3: Improved access to wider local authority services		
	Outcome 4: ASC time saved sourcing relevant low level interventions		

Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	0%	This funding would not have been secured without the CA evidence to support the need although others did input to the funding process.
	Outcome 2: An increase in the numbers of volunteer	40%	The CAs and the new project are increasing the numbers of volunteers but are not the only source of new volunteers.

Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	30%	Based on the fact that there are potentially 2 groups of elderly people within this stakeholder group. 1) those entitled to ASC services but requiring services not provided under FACs and 2) those people not currently entitled to ASC services needing low level support to help them remain independent. We estimate that across the 2 groups only 30% are likely to be able to source and access these services without the aid of the Community Agents
	Outcome 2: Improved financial status		
	Outcome 3: Less isolated – improved social networks		
	Outcome 4: Increased self-confidence		
	Outcome 5: Retaining independence – able to stay in own home for longer		

Displacement

Displacement refers to what activities, services etc were displaced by the arrival of Community Agents. No evidence was found of displacement. Community Agent input focuses on supporting people in need of low level services and interventions which are not currently covered within statutory provision. No project that is doing similar work operates in Redcar & Cleveland. The project was designed to address an identified gap in services at a time when no funding was available to provide such support.

Deadweight

Examining the deadweight is generally acknowledging the amount of each of the outcomes that would have happened anyway without Community Agent input. The issue of deadweight was examined with each stakeholder group in terms of what could have been achieved without Community Agents. Table 8 shows the deadweight attached to the outcomes for each stakeholder group and the rationale for those percentages.

Table 11: Deadweight

Stakeholder	Outcomes	Deadweight	Rationale
Community Health Professionals	Outcome 1: Reduction in anxiety and depression	50%	On the basis of continuing health needs and ongoing contact and given the number of referrals it is possible that the health sector staff could go on to identify services for a proportion of those patients.
	Outcome 2: Patients are more actively engaging with health professionals and medication requirements		
	Outcome 3: Reduction DNA at GPs, hospital		
	Outcome 4: Reduction in frequent flier bed days		
	Outcome 5: Community health professionals time saved sourcing relevant low level interventions		
Redcar & Cleveland Council	Outcome 1: People are staying in their own homes for longer	25%	On the basis that given the numbers and that social needs cannot be provided for under the FACs criteria that ASC would be unlikely to have the time to source effective services for more than 25% of their clients
	Outcome 2: Delaying need for increased care packages		
	Outcome 3: Improved access to wider local authority services		
	Outcome 4: ASC time saved sourcing relevant low level interventions		
Voluntary Sector	Outcome 1: New project established to increase capacity within local communities	0%	This funding would not have been secured without the findings from the early part of the CA project to support it in proving the need to increase capacity.
	Outcome 2: An increase in the numbers of volunteer	40%	New volunteers are coming in as a result of the new project but this is not the only source.
Elderly and vulnerable adults	Outcome 1: Improved health and wellbeing	30%	Based on the fact that there are potentially 2 groups of elderly people within this stakeholder group. 1) those entitled to ASC services but requiring services not provided under FACs and 2) those people not currently entitled to ASC services needing low level support to help them remain independent. We estimate that across the 2 groups only 20% are likely to be able to source and access these services without the aid of the Community Agents
	Outcome 2: Improved financial status		
	Outcome 3: Less isolated – improved social networks		
	Outcome 4: Increased self-confidence		
	Outcome 5: Retaining independence – able to stay in own home for longer		

Drop-off

Drop-off explores how the benefits derived from each outcome are likely to reduce over time. It is important to include any reductions when calculating the values to ensure a better degree of accuracy.

The Community Agent project was designed and developed as a 2-year project and it seems fair to assume that anything beyond that time could mean a reduction in the effects of the outcomes. Unlike attribution, displacement and deadweight which are calculated on the basis of stakeholder groups, calculating the drop-off deducts from the individual outcomes each year.

For the purposes of this SROI we have worked on the basis of zero drop-off during the lifetime of the project, given ongoing contact and the increase in referrals over time. We also believe that it is unlikely that service users would still be feeling the benefits of Community Agents after five years, so the drop-off rate for year three is estimated at 33%.

Impact

The impact of the Community Agents Project has been assessed by calculating the quantity of each the outcomes multiplied by the value of the financial proxies used and then minus the attribution and deadweight.

Table 12 shows the impact for the first year of the project.

Table 12: Year 1 Impact

Stakeholder	Outcomes	Quantity	Value Proxy	Attribution	Deadweight	Impact
South Tees Hospitals Foundation Trust	Reduction in anxiety and depression	45	£830	50%	50%	£9,337.50
	Patients are more actively engaging with health professionals and medication requirements	45	£25	50%	50%	£281.25
	Reduction in DNAs at GPs and hospital appointments	50	£118.76	50%	50%	£1,484.50
	Reduction in frequent flier bed days	25	£611.00	50%	50%	£3,818.75
	Community health professional time saved sourcing relevant low level interventions	127	£25.00	30%	50%	£1,111.25
Redcar & Cleveland Borough Council	People are staying in own homes for longer	10	£28,756.00	30%	40%	£120,775.20
	Delaying need for increased care packages	45	£6,660.00	30%	40%	£125,874.00
	Improved access to wider local authority services	77	£60.00	30%	25%	£1,512.00
	ASC professionals time saved sourcing relevant low level interventions	426	£20.00	30%	25%	£4,473.00
Voluntary Sector	New project established to increase community capacity	1	£34,000.00	0%	0%	£34,000.00
	An increase in the number of volunteers	25	£7,490	40%	40%	££67,473.00
Service Beneficiaries	Perception of improved health and wellbeing	122	£5,000	30%	30%	£298,900.00
	Improved financial status	62	£2,593.44	30%	30%	£78,788.71
	Increased self confidence	85	£1,850.00	30%	30%	£77,052.50
	Less isolated – improved social networks Increased self confidence	60	£995.00	30%	30%	£29,253.00
	Retaining independence – able to stay in own home for longer	118	£85.00	30%	30%	£4,914.70

10. Social Return on Investment

In this section we will show how the SROI value for the Community Agent project is generated

This SROI evaluation has closely followed the SROI framework. Seeing this process through, the final calculation must also include an adjustment to the values that indicates the present day value of the benefits (PV) that are expected into the future. In line with SROI requirements, a 3.5% discount is applied to values projected for more than a one year period. This 3.5% discount is recommended in the Government Green Book as an acceptable discount.

Working through the SROI process we can see that the total of impact values of the Community Agent project is £1,673,278.38. The Total Present Value for the project including the 3.5% discount is £1,610,988.93. As a result the Net Present Value (NPV) is £1,418,797.93 which is the total extra value created by the Community Agent project.

The equation used to calculate the SROI is:

$$\text{SROI} = \frac{\text{Net Present Value}}{\text{Total Inputs}}$$

These figures give us an SROI ratio of the net present value divided by total investments = **£7.38 per £1 invested**. This means that for every £1 of investment in the Community Agent project, **£7.38** social value has been created.

11. Discussion

The Community Agent Project has continued to evolve throughout the period under study, and has successfully forged a place for its services within the wider community. The co-production model on which it was designed and developed has continued, albeit not to the same extent as at the start, but it seems fair to say that as the project progressed, a lesser degree of input from the originating agencies was needed. However, although less intensive, positive partnerships have remained intact throughout the lifetime of the project. There has been a wide range of staffing changes both within stakeholder engagement and the project itself and the project team have managed to work through these changes and move forward.

There is little doubt that the Community Agents have filled a gap both in terms of knowledge and understanding of the voluntary sector. They have adopted the role of “link person” or bridge between the statutory and voluntary services. In doing so they are successfully ensuring that elderly and/or vulnerable people are able to access a range of services that otherwise it is very likely that they would have missed out on. At the same time they have continued to develop their networks within both sectors as well as establishing good relationships with a wide range of smaller community organisations across the Borough. The Community Agents appear to have created a niche for themselves that complements health and social care services and at the same time provides an additional level of care to clients that was largely inaccessible before.

There is also little doubt that the role of Community Agents has impacted on the way both health and social care professionals carry out their own roles. By dealing with requests for low-level, non-clinical interventions this has meant that health and social care professionals are no longer required to source such interventions and that this in itself is saving them a lot of time. It also means they are less concerned about patients/clients at discharge, as the Community Agents will be around and they are trusted to refer back if this is needed. There is also some evidence to support the view that health and social care professionals are much happier, as they had been increasingly frustrated by the fact that they were unable to provide support for their elderly and vulnerable clients. The relationships between the Community Agents and health and social care professionals have developed over time and remain positive. The numbers of people referring patients/clients to Community Agents for services continues to increase; however, there does not appear to be a whole-team approach to referring across either Health or Social Care and referrals are predominantly through individuals within teams.

Community Agents are approached to deal with a diverse range of social and low level needs, all of which are likely to have impact on health and wellbeing and clients’ ability to maintain independence. Reducing social isolation was a core aim of the project and Community Agents have ensured positive outcomes for clients in this area. Support with

finances and accessing both social and medical activities have all served to improve clients' perception of their own health and wellbeing, increased their income, led to many of them becoming more socially active, having increased self-confidence and generally feeling well supported, thus reducing levels of depression and anxiety.

While the voluntary sector has struggled to provide some services and as a result there is a waiting list, this is predominantly for befriending services. Some voluntary sector agencies have developed their volunteer base to meet the needs of Community Agent referrals and the Vital Health Volunteer Project was developed to further address any shortages. Relationships between the voluntary sector and Community Agents have generally been largely positive and, as a result of Community Agent input, it is fair to say that some organisations have increased their capacity to meet those additional needs.

The evidence supports the view that the ability to address the social needs of these clients has resulted in some of them remaining independent in their own homes for longer. Both health and social care professionals were able to provide examples of clients that they had expected to become in need of full time residential care sooner rather than later, and they have no doubt that this has been delayed by the support provided through the Community Agent project. Similarly there is also a view that Community Agent input has also delayed the need for more complex care plans for some clients.

Health professionals also reported some very positive changes in the way some clients were engaging with health professionals and taking their medication more effectively as a result of their feeling better about themselves, feeling more in control and being able to get out more. This was an unanticipated outcome.

While many of those referred to the scheme do have a long term condition or continuing health needs, the results of which often bring about depression, anxiety, social isolation, for many these health needs will continue. However, Community Agents are impacting on promoting a more positive approach to dealing with such conditions by increasing clients' social networks, reducing their worries and concerns (particularly finance related ones) and improving access to practical services to ensure they are able to feel safe and secure in their own homes and also that their homes are well maintained.

While this project was originally designed as a signposting service, Community Agents are also providing services. The majority of these services are supporting by form-filling, helping clients respond to letters etc, and they are increasingly providing such practical support to clients. The role of the Community Agents appears to have developed over time and they are increasingly called upon to deal with complex needs requiring a wide range of services. A number of these are illustrated in the case studies in Appendix 3.

The Community Agent project has managed to become a conduit for both health and social care. Community Agents offer an extensive knowledge of available services across all

sectors, have developed and maintained positive relationships and have shown their capability for meeting demands on services across the two years, but more importantly at peak times such as the winter periods. Referrals tended to increase following the Christmas period which is believed to be largely due to heightened feelings of loneliness following that period. Service provision was maintained even at peak times. Client satisfaction with the project continues to be high, and key referrers' satisfaction has also been consistently high throughout the period of operation.

The success of this project to date has increased the possibility of it being included as a service provider within the Better Care Fund planning, which has adopted a "Single Point of Contact" approach which is an extension of what the project has been doing. Additional funding to support the project until March 2016 has been secured through the local authority to ensure that the expertise, knowledge and experience gained through this project is not lost and can be integrated within the new structures.

12. Conclusions

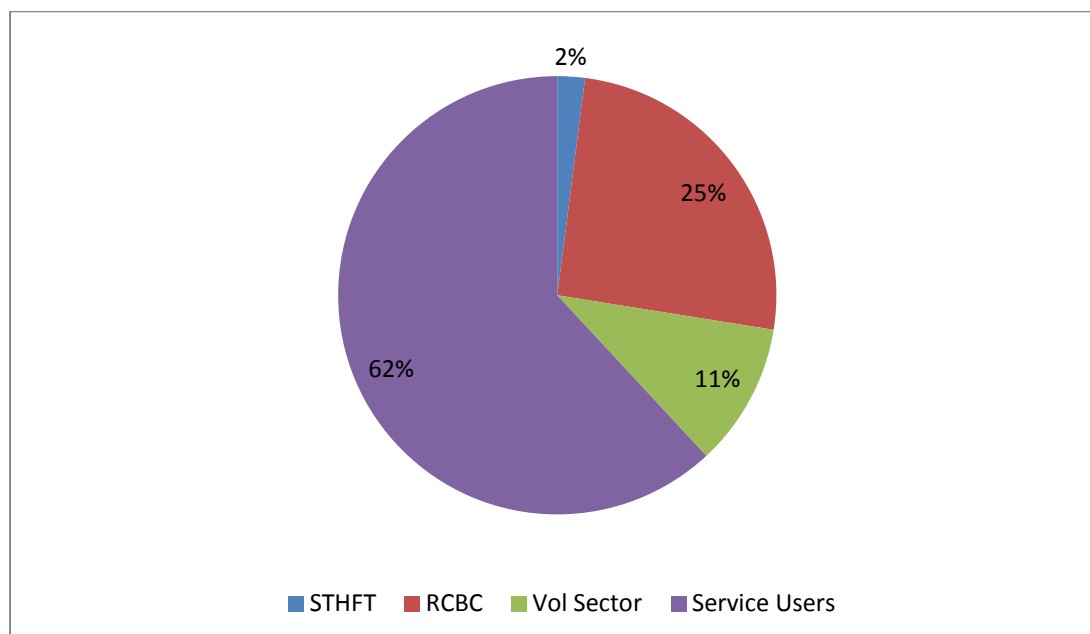
This section provides an analysis of the social value created by the Community Agents Project and presents conclusions from this evaluation

The social isolation of elderly and vulnerable people and the impact of that on their health and wellbeing is well documented elsewhere. TVRCC had begun by exploring this concept further with regard to rural communities. However, due to severe budget cuts, health and social care professionals also identified the need for a more widespread effort to sustain the independence of elderly and vulnerable people for longer and reduce hospital admissions and bed blocking by elderly people not being able to return home. They also pointed to the need to improve the general health and wellbeing of this client group by reducing social isolation, expanding social networks and increasing social activity.

This SROI evaluation shows that the Community Agents Project has created a significant social value of £7.38 for every pound invested into the project. This is based on a robust evaluation process using qualitative style interview techniques to ensure that any assumptions and estimates used are realistic and based on information provided by the key stakeholders.

The project has created a social value for each of the stakeholder groups involved. Figure 18 provides a breakdown of the social value created for each of the stakeholder groups.

Figure 24: Breakdown of social value created by stakeholder group



Stakeholders from the health sector would appear to accrue little actual value, although the qualitative interviews highlighted that community health staff were clearly benefiting from their involvement with Community Agents. However, many of those benefits were not

material so are not included in the overall social return on investment evaluation. One of the initial aims of the Community Agents project was to help speed up discharge from hospital by ensuring support was in place for low level needs which would otherwise have meant additional time in hospital. However, it was agreed that this aspect of the project would be delayed and in effect, was not ultimately a main focus of the Community Agents. If more work had been done to reach this aim, the social return on investment value for the health sector could be increased considerably. This is now being revisited and strategies put into place to revisit speeding up hospital discharges during 2015-16.

People using the services clearly gained the most value from project activities and outcomes, with 62% of social value accruing to this stakeholder group. This further highlights the effectiveness of the service in reaching, providing services and linking services to this group of people and its importance in improving their health and wellbeing generally.

Proxies agreed for saving residential care places and increased care packages are high and this does impact on the overall impact value achieved for this stakeholder group.

Given the positive response by both the health and social care sectors, it has now been agreed that the Community Agents Project be funded for a further year, in part by Redcar & Cleveland Public Health Department and by the Better Care Fund. This will ensure that the ground gained to date and the expertise and learning will not be lost, should a decision be made to include Community Agents as a service provider for social prescribing in the future.

The South Tees Better Care Fund is adopting a single point of contact concept for health and social care and given the success of the Community Agents to date, it has been recognised that they would be a valuable asset within this framework and already there have been discussions about their fit within the social prescribing element although these discussions are at an early stage at this time.

Overall the evidence supports the view that the Community Agents project has been successful in meeting many of its aims, has achieved some significant outcomes for stakeholders and particularly for service beneficiaries and can show that it has successfully created social value for all the stakeholders concerned, with an SROI of £7.38 for every £1 invested in the project.

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Appendices

1. Impact Map
2. List of Organisations
3. Case Studies

Appendix 1 – Impact Map

Stage 1		Stage 2			Stage 3								Stage 4					Calculating Social Return							
Stakeholders	Intended/unintended changes	Inputs		Outputs	The Outcomes (what changes)								Deadweight %	Displacement %	Attribution %	Drop off %	Impact								
Who do we have an affect on? Who has an effect on us?	What do you think will change for them?	What do they invest?	What is the value of the inputs in currency (only enter numbers)	Summary of activity in numbers	Description	Indicator	Source	Quantity	Duration	Outcomes start	Financial Proxy	Value in currency	Source	What would have happened without the activity?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Quantity times financial proxy, less deadweight, displacement and attribution	Discount rate	3.5%					
					How will the stakeholder describe the changes?	How would you measure it?	Where will you get the information from?	How much change was there?	How long does it last after end of activity? (Only enter numbers)	Does it start in period of activity (1) or in period after (2)	What proxy would you use to value the change?	What is the value of the change? (Only enter numbers)	Where did you get the information from?						Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	
Community Health Professionals	To reduce admissions into hospital To help people return home from hospital as quickly as possible To encourage cost savings Improve health and wellbeing Improved access to health appointments	Funding Partner In-kind contribution	£95,763	Funding Partner Project development Refer patients for low level support	reduction in anxiety and depression	Numbers reporting feeling less anxious and depressed	Monitoring and feedback data Baseline and endline interviews with health professionals	45	3	1	Average cost of service provision for adults suffering from depression and/or anxiety	£830	Health and Wellbeing Value Measures	50%	0%	50%	33%	9,337.50	9,337.50	9,337.50	6,256.13	4,191.60	0.00	0.00	
			£95,763		Patients are more actively engaging with health professionals and medication requirements	Decrease of community health stafftime as a result of CA involvement - earlier discharge of patients from community caseloads	Monitoring and feedback data Baseline and endline interviews with health professionals	45	3	1	Cost of number of visits saved and staff hourly rate	£25	Global Value Exchange Interviews with health professionals	50%	0%	50%	33%	281.25	281.25	281.25	188.44	126.25	0.00	0.00	
			£95,763		Reduction in GP visits, DNAs at GP and hospital appointments	People now attending hospital, GP appointments using the volunteer car scheme or other transport to appointments	Baseline and endline interviews with health professionals Monitoring and feedback data DNA stats	50	3	1	Average costs of GP and hospital outpatient consultations	£118.76	PSSRU 2014 Interviews with health staff, service providers and service users	50%	0%	50%	33%	1,484.50	1,484.50	994.62	666.39	0.00	0.00		
			£95,763		Reduction in frequent flier bed days	Number of bed days saved	Baseline and endline interviews with health professionals Monitoring and feedback data NHS HES stats	25	3	1	Bed days saved	£611.00	PSSRU 2014	50%	0%	50%	33%	3,818.75	3,818.75	2,558.56	1,714.24	0.00	0.00		
			£95,763		Community health professional time saved sourcing relevant low level interventions	Amount of time saved per client referred	Baseline and endline interviews with health professionals Monitoring data	127	3	1	Average hourly rate of staff saving an average of 1 hour per client	£25.00	PSSRU 2014 Interviews with health staff	50%	0%	30%	33%	1,111.25	1,111.25	744.54	498.84	0.00	0.00		
Redcar & Cleveland Council	To reduce numbers going into residential care To help people live independently and safely in their own homes for longer More appropriate use of wider LA services	Funding Partner In-kind contribution	£93,263	Funding partner Project Development Refer clients in for low level support Service provider	People are staying in their own homes for longer	Number of people staying in their own home for longer	Baseline and endline interviews with ASC staff Monitoring data	10	2	1	Costs of a one year stay in residential care - £553 pw	£28,756.00	PSSRU 2014 Interviews with health staff	40%	0%	30%	33%	120,775.20	120,775.20	120,775.20	80,919.38	0.00	0.00	0.00	
			£93,263		Delaying need for increased care packages	Elderly maintaining current levels of care without need for more complex packages being put into place	Baseline and endline interviews	45	2	1	Cost of submoderate care packages for older people - £154 pw	£6,660.00	PSSRU 2014 Interviews with staff	40%	0%	30%	33%	125,874.00	125,874.00	84,335.58	0.00	0.00	0.00		
			£93,263		Improved access to wider LA services	Number of people accessing wider LA services	Monitoring data Interviews with Cas Endline interviews with LA staff	77	3	1	Staff time – on the basis of an average of 3 hours per client	£60.00	Interviews with staff Monitoring data	25%	0%	30%	33%	2,425.50	2,425.50	1,625.09	1,088.81	0.00	0.00		
			£93,263		ASC time saved sourcing relevant low level interventions	Amount of time saved per client referred	Baseline and endline interviews with ASC staff Monitoring data	426	3	1	Average hourly rate of staff for hours saved	£20.00	PSSRU 2014 Interviews with staff	25%	0%	30%	33%	4,473.00	4,473.00	2,996.91	2,007.93	0.00	0.00		

Appendix 2 – List of Organisations

1. Accent Housing
2. Access Team
3. ACT Foundation
4. Action for the Blind
5. Adult Education
6. Age UK
7. British Red Cross
8. Brotton Lunch Club
9. Brotton Over 60s
10. Care and Repair
11. Caremark
12. Carers Together
13. Cat Protection League
14. Christians Against Poverty (CAP)
15. Citizens Advice Centre (CAB)
16. Coast & Country Housing
17. Coast & County Money Advisor
18. Community Gardening Service
19. Community Transport
20. Credit Union
21. DWP Home Visiting Service
22. Enable Care Group
23. Eston Grange Methodist Church
24. Foodbank
25. FRADE
26. Frozen Food Delivery Companies
27. Good Day Call Service
28. GP Practices
29. Guisborough Bridge Association
30. Handyman's Service
31. Helping Hands for You
32. Homecall
33. Hot Meal Providers
34. Independent Age
35. Ironing Service
36. Kemplah Lunch Club
37. Kidz Konnekt
38. Knit & Natter
39. Lakes Club Group
40. Lingdale Village Hall Group
41. MIND
42. MIND Reablement Team
43. NEAS – Hospital Transport
44. Occupational Therapists
45. Parkinsons Society
46. Physiotherapy Services
47. Police/Community Support Officers
48. R&C Welfare Rights Team
49. Redcar ROC
50. Refurbish
51. Royal British Legion
52. Royal Voluntary Service (RVS)
53. Salvation Army
54. Shelter
55. Silver Line
56. Skelton Library
57. St Emanuel Church
58. St Peter's Church Luncheon Club
59. STAMP
60. SWITCH
61. Take Heart Support Group
62. Tees Advocacy Service
63. Tees Valley Housing
64. Tees Valley Women's Centre
65. Teesside Society for the Blind
66. Transport Brokerage
67. U3A
68. VIP Group
69. Visually Impaired Group
70. Warm and Well

Appendix 3 – Short Case Studies

Case Study 1

Client: Douglas (not real name) **Age:** 62 **Gender:** Male

Background: Douglas contacted Homecall to say he needed help and asked them to get in touch with Social Care on his behalf. His details were given to Social Care and he was also visited by an Independent Living Advisor (ILA) from CaCH. Social care contacted him but he declined their assistance. ILA made referral to Community Agent Project (CAP.)

Their story: Douglas was first referred to the CAP in September 2013 by the Access Team as he was having difficulty doing his shopping due to a broken ankle. CA tried to contact him on many occasions and left voicemails but no contact was made so it was agreed with the Access Team not to continue and the case would be closed.

Douglas informed ILA that he is a registered alcoholic but is making effort to reduce his alcohol intake. He is estranged from his family and would like to get back in touch with them. He would like to move back to the area his daughter and grandchildren live and ILA asked if Community Agent (CA) would discuss that in more detail with him. ILA felt JT was becoming depressed and wondered if he could be told about befriending services. She had arranged for CaCH money advisor to visit because JT has an overpayment of benefit that he wants to query. No concerns about state of property.

CA called Douglas on 12/08 who said he has had numerous broken bones because of an osteoporosis diagnosis and has metal fitted in his hip and ankle bone which makes walking painful. He moved 18 months ago and since moving has not registered with a GP so he has been without GP prescribed pain relief and is managing his pain, poorly, with medication from the chemist. CA asked which GP Surgery he wanted to register with and he said his neighbours had recommended one. CA asked if he would like her to enquire about their registration procedure and he agreed to this.

He has also lost his bus pass (there is a small local bus service that he can use if has a bus pass but he can't afford to pay normal fares) and he can't get to the library to renew it as it is too far away.

He didn't declare a pension to DWP because he thought he didn't need to and has had 2 letters: one saying he has been overpaid benefit and it will be paid back from on-going benefit entitlement until December 2017 and another saying they are considering prosecuting him for non-declaration of income. He is very worried about the letters and had someone coming to see him on 18/08 but was unsure who that was. CA contacted CaCH and was informed that one of their Money Advisors was visiting him on 18/08 and will be supporting him with his benefit issues.

He is not interested in joining in activities but would like a befriender. He brought up a move back to be closer to his family (2 daughters and grandchildren) and said he was unsure if that would be a good idea or not so he doesn't want to pursue this.

CA rang chosen surgery to check on registration procedure: he needs to complete a form which is handed into practice and then a health check appointment is made. CA collected form and dropped it off for Douglas to complete and then took it back to the surgery. A health check appointment had to be made as part of the registration process and CA contacted Tees Valley Rural Community Council (TVRCC) Volunteer Transport Service to arrange for Douglas to be taken to and from the appointment on the 19/08. Also tried to get him to use transport to go to the library to renew bus pass on the same day but he said he didn't have £11 to pay for the renewal fee.

Case Study 2

Client: Paul (not real name) **Age:** 90 **Gender:** Male

Background: Social Worker informed the CA that Paul had been admitted to hospital after having several falls in the home which had left his legs very swollen. They had been dressed for some time at home but he was finally persuaded to be admitted to hospital for treatment as they were not improving. However, he was desperate to get home and although arrangements could be made for his care and health needs, he would also need help with shopping and could not go home unless his bed was downstairs

Their story: A joint visit with the social worker was carried out to Paul's home to see if it would be possible to get the bed downstairs as he had a stair lift and furniture would need to be moved / removed. As the bed was very old it could be lifted past the stair lift and the furniture in the living room could be moved outside into a covered shelter.

The Vicar at South Bank Baptist church was contacted to see if they had any volunteers who would be willing to help. He made enquiries on the Sunday and contacted the CA on the Monday (20/10) and arranged to meet at Paul's home on 21/10 when he and a volunteer moved all the furniture and the bed was brought downstairs.

RVS Home from Hospital service contacted for assistance with shopping and practical needs and their contact details passed on to the social worker to arrange support when he was discharged.

Outcome: Paul was discharged on 30/10 with a package of care and the necessary support for him to be cared for at home.

Case Study 3

Client: James (not his real name) **Age:** 85 **Gender:** Male

Background: James had a bad fall about a year ago and banged his head, but he is still quite independent although he can no longer drive his car. He doesn't have any family, but has a 92 year old sister who lives near Whitby and still tries to drives over on a weekly basis.

Their story: Since the fall, James has not driven his car which had been sat in his garage for a year and Sarah, contacted the project to see if we could help him to sell it. A home visit was arranged and he told me that he had advertised it, but the fact that it was automatic seemed to put people off. I went on line whilst there and got a quote for £4200 (dependant on inspection) from 'We buy any car .com', (WBAC) however the car was no longer taxed or insured and the battery was flat. James was happy for me to make some enquiries to see how I could get the car to the garage for inspection. Following conversations with the Police and my Insurance Co's, I was unable to find a solution to driving the car to the garage, however, WBAC got back to me with a contact number for a chap with a low loader - who agreed to transport car for £40 and also replace the battery for £40. I contacted Evan Halshaw (originally purchased from them) who stated they would beat the quote - once again dependant on inspection. James was unable to find his Log Book, so DVLA was contacted and a replacement ordered. His sister was contacted and I explained what I was doing, and she was happy for me to go ahead.

Transport was arranged for 7/05 and the battery replaced, the car was loaded onto the low-loader and we followed them in my car to Evan Halshaws.

Outcome: Initial offer of £4200 was decreased to £3200 when, on inspection, a total re-spray was required prior to sale. James was happy with this figure and a cheque was issued to him. On the journey home he thanked me and stated how pleased he was with the outcome saying "I would have been happy with £1000".

Case Study 4

Client: Joan (not real name) **Age:** 85 **Gender:** Female

Background: Joan lives on her own and does not have any family. She has difficulty walking due to inflamed legs and poorly maintained feet and is quite hard to understand.

Their Story: She was referred to us as her garden was overgrown with brambles and vegetation preventing her from getting to her bin, so she was beginning to stack rubbish up in her kitchen. An arrangement had been set up for the refuse men to collect the bin on collection day, but the overgrown garden was preventing them from getting to it. She also needed transport, as her SW had managed to get her to agree to attend an appointment with the podiatrist at the local clinic and organised a visit to see her GP immediately afterwards.

Outcome: Joan attended the Podiatrist and GP appointment transported by a volunteer driver, so helping with her mobility issues. The garden clearance was carried out on 20 April, and the majority of the vegetation was transported to the local tip that day. The SW was arranging for a wheelie bin to be delivered and contacted the refuse dept to inform them that the bin could now be collected.

Case Study 5

Client: Alice (not real name) **Age:** 94 **Gender:** Female

Background: Alice lives on her own but her son, who lives close by who, she stated, "gets called out when I wake up at 3 o'clock in the morning thinking I'm having a heart attack".


Their Story: Alice previously contacted the project in July, when she had received a letter from the Tax office saying she owed £1,286, and had been having sleepless nights because she was unable to pay this amount. I went to see her and, after a long wait on the phone to the Tax people, finally got through. The officer explained that it had been sent out in error, and although the mistake had been noted and another letter had been sent out with a new tax code, and she had been sent a rebate for a small amount of tax she shouldn't have paid, he was extremely sorry for the worry they had caused. Alice was very relieved and grateful. During this visit, I noted that she was only in receipt of her state pension and I felt that she should be entitled to attendance allowance and she was happy for me to refer her to the DWP Home Visiting Service.

She contacted me again this month as she had received another letter that she didn't understand. I visited her again and the letter was just for information but there was also a small form to complete regarding allowances, which we did together. Her son was at her home on this visit so I told him about support and advice he could get from Carers Together and he was happy for me to refer him to them

Outcome: Alice told me that the DWP had visited her and she showed me the letter she had received from them stating she was entitled to Attendance Allowance and is now getting the upper rate of £81 per week, which is really a big help and relief for her. She is also now a lot happier knowing that she has our number, should she be concerned about anything in the future.

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