# Social Return on Investment Report

## Re-Connect Project

Down to Earth
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January 2022

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# Executive summary

Down to Earth Project is a Not-for-Profit Social Enterprise working with members of the community for the past 15 years to deliver relationship centred and meaningful, outdoor experiences to vulnerable and disadvantaged young people and adults. Having worked for the last ten years with local National Health Service (NHS) Trust Swansea Bay University Health Board (formerly Abertawe Bro Morgannwg University Health Board), delivering programmes, and Swansea University, developing a long-term clinical research programme, Down to Earth have a robust evidence base and reliable track record as to the health benefits of its programmes and approach to health and education. Bringing together two Welsh Government public health bodies, NHS Wales and Natural Resources Wales, Down to Earth created a project that aims to encourage and evidence the benefit of sharing resources and best practice across health care departments for the benefit of patients with long term chronic health conditions. The aim of this study is to evaluate the impact of Down to Earth's Re-Connect Project using the Social Return on Investment (SROI) methodology. The project ran for 18 months from July 2018 until December 2019.

## Re-Connect Project

The Re-Connect project was conceived to develop a new, patient-led, inter-departmental approach to the NHS using Natural Resources Wales woodlands for delivering clinically valid health care programmes. Over the course of 18 months of programme delivery, participants reported a decrease in feelings of anxiety and depression, an increase in community connection and physical activity. Post monitoring of NHS staff supporting patients on programmes reported that these improvements led to better health outcomes and patient motivation, in addition to having a personal impact on staff. Volunteers attended monthly sessions, coming together to learn land and woodland management skills and engage in a community project with community members with shared interests.

## Social Return on Investment

Social Return on Investment (SROI) is a framework for measuring and valuing change and impact in ways that relate to and are of significance for the people or organisations that experience or contribute to this impact (Nichols et al., 2012). This method of analysis provides an assessment of whether value is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them (Jones et al., 2016). There have been a number of SROI analyses conducted for physical activity projects, mental health and social inclusion interventions, and volunteering conservation activities, with the health benefits of interaction with nature, well documented. However, the author struggled to find a similar project that addressed these factors collectively, nor had a SROI analysis been conducted on this type of comprehensive intervention. There is little research that has examined the health, educational and wider benefits to the community of projects when delivered at the community level by a community organisation.

## Methods and process of research

This SROI study follows the six stage SROI process (Nichols et al., 2012). The first three stages of the process involved the identification, involvement and engagement of the project stakeholders to determine well-defined outcomes, measurable indicators and impact to create a Theory of Change.

Once the scope of the analysis had been determined and key stakeholders had been identified, stakeholders were engaged to determine long-term impact (s) of the project and change enacted to

achieve that impact. To determine these changes that had occurred because of the project and the importance/value of these changes to stakeholder groups, questionnaires were created from programme sessional feedback and clinical monitoring data. Questionnaires were completed online by participants and NHS staff; during sessions with volunteers; and in team discussions with DTE staff to ascertain what the personal key benefits of the project were and what change had occurred as a result. These responses were put through a thematic analysis and follow up interviews with a sample of the respondents were conducted (discussed in detail in 1.7 and 1.8) to determine the creation of well-defined outcomes (see section 2: Outcomes and evidence).

A smaller sample of participants, NHS staff/Referral Agency Workers and Volunteers were engaged to assign value and ranked importance of the outcomes.

Eight stakeholder groups were identified for whom 22 outcomes were allocated based on stakeholder feedback and responses.

- Data for this study was gathered from baseline and end of programme monitoring from 70 participants, feedback from these participants and 37 supporting staff on Re-Connect. Post programme data was gathered from six members of NHS staff representing 48 previous participants and 14 previous participants completing online questionnaires.
- Sessional and small group discussion feedback and questionnaires for volunteers provided data for long term impact and the creation and of outcomes.
- NHS staff (6 out of 8) completed an online questionnaire reflecting personal impact with a smaller sample contacted via telephone or virtually to define the outcomes and convey personal value of the changes that occurred.
- Sessional feedback and telephone/virtual interviews with NHS staff and Ward/Departmental Managers enabled the creation and valuation of outcomes for Swansea Bay university Health Board.
- Communication and site visits with NRW informed data gathered towards outcomes.
- Conversation, observations and team training feedback of DTE staff informed the creation of well-defined outcomes for DTE.
- Self-reporting from participants and responses from NHS staff/Referral Agency Workers provided data for the Local Community outcome reflecting the number of previous participants that had engaged in community volunteering since the re-Connect project.
- Outcomes for local government were based on financial costs and savings associated with participants and volunteers moving into work or higher education.

Once outcomes were identified, stakeholders identified what they had to put into the programme to experience the change (outcome), time, skills, financial contribution and location/venue for the programmes. Outputs and how the change would be measured were discussed with each stakeholder group, with feedback taken on board by the DTE team and NRW. There was general consensus amongst stakeholder groups on how outcomes would be measured and what the outputs would be, however, the final decision on how data would be collated to reflect this was decided by DTE. A collection of sources of evidence to estimate the impact of outcomes was conducted. For each outcome, a number of different valuations was presented. Stakeholders were first asked to determine what outcomes were most important and held the greatest value through ranking. From this process, appropriate financial proxies were assigned to outcomes in conjunction with rationale

for monetary valuation. Values assigned reflect those outcomes that were determined to be of greatest value to stakeholders and ranked accordingly. This is explored further in 1.9 SROI methodology.

Next, to establish the impact to stakeholders of the project, feedback from stakeholders enabled the calculation of how much change happened as a result of this project (deadweight), what other organisations/support networks may have contributed to this change (attribution), what other activities or interventions may have missed out by this project running (displacement) and how long this change was expected to last/had lasted (duration and drop-off). In the SROI methodology, this is stage 4. An engagement table of stakeholder participation in the SROI process is included in 1.9 SROI methodology.

Once these five adjustments have been included in the valuation of the outcomes, the Social Return on Investment can be calculated. Putting the calculation through a sensitivity analysis by testing assumptions in order to assess for areas of sensitivity in the model enabled the development of a band of value to account for assumptions made during the process of analysis, calculation and evaluation.

Finally, the reporting of findings of the SROI analysis are collated and explained in this report for the Re-Connect project. These findings have been disseminated to the management of DTE, Re-Connect Project Management and the wider team at DTE. Results will be shared with other stakeholders when the findings have been assured.

The results of this SROI analysis will inform development and funding of future projects and how DTE involves stakeholders in the development of said programmes. The specific finding revealed from this forecast analysis is the importance of engaging stakeholders during the initial delivery, if not planning stages, of a project. This will enable DTE to demonstrate need for certain projects and provide evidence as to the efficacy of the approach, resulting in further participants and organisations being impacted by DTE projects and programmes. The learning from this forecast analysis is being utilised by DTE in a pilot project on Stakeholder Involvement and Community Engagement in Green Hospital Infrastructure and Outdoor Healthcare.

The objective of this research was an assessment of costs to develop and deliver the Re-Connect project and accurately value the changes experienced by various stakeholders. In addition to funding from NRW and DTE, Swansea Bay University Health Board and the cost of staff time in hospital, patients time and volunteers time are costed.

## Overall SROI results

The social return is expressed as a ratio of present value divided by value of inputs. The analysis calculated the duration of the impacts up to three years. The total financial value of the inputs for the Re-Connect Project was £ 161,788.00 and the total present value was £1,478,480.06. This results in a SROI ratio of £9. 14 of social value created for every £1 of investment. To account for assumptions made in the calculation process, the sensitivity analysis resulted in a band of value between £8.24 to £15.08.

## Sensitivity analysis

The role of the programme in improving the mental and physical health for NHS patients with long-term, chronic illnesses was difficult to conduct as a valuation due in part to the lack of well-established financial proxies. Overall, multiple changes to the key assumptions of measuring impact inclusive of rates for duration and attribution, did not reduce the ratio of social return below £1:£1. These calculations show that even when significant changes are made to the analysis, the results still show clear evidence of social value being created up to 3 years after the participation in a Re-Connect patient programme or regular volunteering sessions.

## Conclusions

This SROI forecast analysis found that through the Re-Connect Project, Down to Earth has achieved the innovative development and successful delivery of a healthcare and education programme that not only brings significant benefits to patients with long term health conditions and regular volunteers, but to the NHS staff that support them. There are wider benefits to the local NHS Health Trust, SBUHB, in the form of less demand for mental health and rehabilitation services and increasing patient engagement in their health outcomes. Additionally, the local community and government benefit indirectly from increased community engagement, participants returning to employment or higher education. The impact on stakeholders of these outcomes is significant and valued to the extent that DTE have seen increased demand for this calibre of integrated and interwoven intervention based on clinically researched results.

The SROI provides a financial measure of this value: that for every £1 spent on DTE programmes, such as Re-Connect, there is social value of £9.14 created over a maximum calculated duration of three years. The methods applied and results derived from this research create a base of knowledge and process to establish an evaluation framework for future social value reporting through this forecast SROI. This forecast analysis template can then be applied to other DTE funded projects and eventually to the organisation as a whole. The development of this research corresponds with numerous SROI studies relating to methodology, results and reporting and would suggest that outcomes similar in nature to those represented in this report can be forecast for other DTE projects developed and the evaluation of those implemented.

# 1. Scope and stakeholders

## 1.1 Introduction

Down to Earth Project is a Not-for-Profit Social Enterprise working with members of the community for the past 17 years to deliver relationship centred and meaningful, outdoor experiences to vulnerable and disadvantaged young people and adults. During this time, Down to Earth (DTE) has worked with thousands of people and established a comprehensive clinical research programme. Through the results of this clinical research, it has been shown that DTE programmes are as effective as medication in reducing clinical anxiety and depression in participants. Building on this and through feedback from NHS staff, patients and patient support networks attending programmes, DTE have seen the positive impact upon the recovery and rehabilitation of those working with and experiencing chronic long-term illnesses.

It is this quantative data and qualitative feedback that led to the development of a funded partnership project with Natural Resources Wales (NRW), whom DTE have a long association and working partnership with. The Re-Connect project was conceived to develop a new, patient-led, inter-departmental approach to the National Health Service (NHS) using NRW woodlands for delivering clinically valid health care programmes. The aim of this project was to assess the benefits to the NHS of working together through a peer mentoring scheme using the outdoors. Down to Earth aimed to highlight how this project could work towards reducing the waiting lists for mental health services in the NHS and challenge the separation of departments within the NHS regardless of patients' shared underlying issues. Re-Connect addressed resilience in people & eco-systems. Improving mental health & wellbeing in participants, improves their ability to cope with long-term illness. Through the sustainable management of Welsh woodlands, woodlands that are more resilient to climate change impacts are created.

## 1.2 Background to Down to Earth Project

Down to Earth has delivered programmes in the communities of South Wales since it was founded in 2005 on Gower in the City and County of Swansea. Since their inception, DTE have been collaborating with different community groups and service providers to provide educational programmes and experiences in the outdoors to the most disadvantaged members of the community. This is achieved through innovative and inclusive approaches such as creating remarkable buildings with natural materials, award-winning learning & well-being programmes and also through adventure activities. This unique approach and way of working helps participants to transform not only their own lives, but also numerous community centres, education centres and two stunning venues on the Gower peninsula, Swansea. DTE believe that all members of the community can thrive given a supportive and genuinely relationship centred approach which is based on meaningful and practical activities.

The people DTE work with build cutting edge training venues which then become the venues for future participants. Groups are taught the skills needed to work together, merge traditional and sustainable construction and also create sustainable food growing areas and remarkable outdoor learning spaces. By merging innovation in health care delivery with innovation in education delivery DTE works with people to deliver community-wide change.

Over the last ten years, DTE have developed their clinical research programme, working in partnership with Swansea University and Swansea Bay University Health Board (SBUHB). During this time, they have developed clinical research measures that enable the voices of marginalised

communities to be heard, that are not solely language based and are based upon universal themes of well-being.

## 1.3 Social Return on Investment Analysis

The SROI was undertaken in house to analyse the Re-Connect Programme and reflect the true value of a DTE project. Additionally, DTE will use the learning in this report to quantify and provide evidence to funders and investors the extra-financial value their programmes and approach are creating. It provides an opportunity for the organisation to assess how their approach to education and healthcare is impacting participants, how much change is occurring, learn from the report and adapt practice if and as needed. Key to the on-going commitment to Best Practice and Participatory Action Research, throughout DTE's planning, programme delivery, and monitoring, they engage in an iterative cycle of research, action and reflection. The SROI is a process that will enable the organisation to comprehensively forecast the change made by their programmes. It will be instrumental to provide evidence of the efficacy of the approach and help to communicate this impact to existing and potential funders and those they work with.

## 1.4 Activities under Analysis

The Re-Connect project ran for 18 months, July 2018 to December 2019, and was part funded by NRW. The Re-Connect programmes ran for 7 & 8 weeks and were based primarily in local woodlands on Gower, South Wales. Re-Connect has delivered programmes for eight volunteer groups during the period of September 2018 to December 2019. A total of 70 participants with chronic illnesses engaged with the project, attending at least two weekly outdoor sessions over an 8-week period. Participants for these groups came from an array of departments within the SBUHB, as is shown below in table 1.

| Swansea Bay University Health Board Department | Description of the service |
|---|---|
| Early Intervention in Psychosis community team | Community based service which identifies people at risk of becoming psychotic and attempts to intervene before symptoms become too severe |
| Brain Injury Service | This service provides ongoing support for people who have suffered acquired or traumatic brain injuries |
| Gwelfor Ward | A residential, low security forensic mental health unit in Cefn Coed Hospital |
| Taith Newydd | A residential, specialist low secure unit aimed at supporting adults with mental health problems and complex needs. |
| Cefn Yr Afon | Rehabilitation and Recovery Unit- an adult mental health service providing a rehabilitation service in the community for persons of age 18 and over. |
| Stroke Ward at Singleton Hospital and Stroke Recovery Group | Recovery and support group in partnership with Stroke Association Swansea Neath Port Talbot |
| Parkinson's Treatment Centre and Support Group | Recovery and support group in partnership with Parkinson's UK Swansea District |
| Cwm Seren House- Hywel Dda University Health Board | A psychiatric unit specialising in adults with mental health needs and learning disabilities |

Table 1: SBUHB departments working with DTE and Re-Connect

In addition to the 70 participants that DTE worked with, staff facilitated monthly volunteering sessions based at two separate sites where volunteers learned and practiced their land and woodland management skills. Those in attendance were both former programme participants, referral agency staff, and members of the general public. Whilst a number of people in the

community engage with the volunteer programmes, there are a core group of volunteers, numbering 30, attending regularly in all weathers. See feedback below from a selection of stakeholders.

- ***Gave me greater confidence and ability to talk to others who were struggling with their disability too.*** – Re-Connect participant
- ***I come from a building background but this project with their old ways of using nature's natural ways and materials was brilliant and the dedicated staff were totally amazing.*** - Re-Connect participant
- ***Very positive experience gained from trying something new and challenging with fellow suffers of a debilitating condition.*** - Re-Connect participant
- ***This is the best of the best, whoever runs and sponsors this project, thank you.***
  - Re-Connect participant
- ***An excellent vocational rehabilitation programme, we hope to be able to return in the future under Covid restrictions. Staff are excellent, supportive, knowledgeable, experienced and educative particularly in developing practical skills. Excellent practical interventions to build on service users' self-confidence, social skills, connecting with the outdoor environment and future interests.*** - NHS staff member
- ***It was the most physical activity I'd seen come from our patients, they participated when usually they would shy away or not engage. Being part of the project for our patients gave them a sense of camaraderie with fellow patients and other people taking part in the project.*** -NHS staff member
- ***It has made me more confident, given me a purpose and I've made new friends.*** -Regular Volunteer

Re-Connect worked with 37 members of NHS staff during the 15 months of programme delivery, who supported participants activities and engagement and transported them to and from the sites. These staff worked for local NHS Health Trust, Swansea Bay University Health Board. Due to the nature of life-limiting conditions and chronic illnesses experienced by the participants, there was a need for a high staff to patient ratio. In addition, staff support was not able to be consistent to certain NHS staff due to other work-related responsibilities. This accounts for the high number of staff engaging with the project; there were 37 different members of NHS staff engaging with the project with 32 staff members attending for a minimum of two sessions.

In total, 6 DTE staff members worked part time on the project facilitating sessions, recruiting and booking in groups, and monitoring and reporting on the project. For the purposes of the SROI analysis, this has been represented as 3 full time positions. However, all staff members who facilitated programmes for this project were involved in observations and interviews and wider staff training discussions around impact on stakeholders of DTE's approach and projects.

The local community and government have been identified as indirect stakeholders. Stakeholders and their inputs are discussed further in 1.8: Stakeholder identification and engagement.

Through this project, DTE have developed and delivered academic research programmes centred on meaningful outdoor activity which brings together patients within different health care departments to share the benefits of outdoor based programmes. These programmes have brought about positive change to the participants in the form of reduced anxiety, depression, and accreditation, but also benefitting the wider environment by the improvement of woodlands on Gower (reduced invasive species, improved sustainable management of the woodland).

## 1.5 Identifying the need and strategic context

### 1.5.1 Living with chronic illness and long-term conditions

A report by the London School of Economics and Political Science in 2012, found that mental illness often increases the scale of physical illness and that the extra physical healthcare caused by mental illness costs the NHS at least £10 billion in 2012. Roughly half of all mental illness consists of anxiety conditions and if untreated, these conditions are frequently lifelong. In Wales, 1 in 3 adults report having a long-term, or chronic, health condition (Welsh NHS Confederation, 2018). Long-term conditions place significant pressure on the NHS and other public services in Wales (Roberts and Watt, 2016) and are the greatest pressure facing the future of the NHS (Roberts et al., 2012). The effective management of chronic conditions is not solely about health and is dependent upon strong partnerships with patients, carers and other service providers such as social services and the voluntary sector (NHS Wales, 2007). Living with chronic conditions impacts all areas of life and can have a particularly profound effect on the social life and independence of individuals and their support networks.

Year on year demand for funding for healthcare in the healthcare budget is increasing (Royal Pharmaceutical Society Wales, 2016) and accounts for 50% of the Welsh national budget, £8 billion per annum in 2019/2020 (Welsh NHS Confederation, 2018). A sustainable system of public services and funding needs to be established which moves away from a model focused on treatment services to one investing more in preventative and early intervention services that impact on the wider determinants of health and wellbeing. (NHS Wales, 2018). This will entail engaging patients in their healthcare, rehab and recovery. The concept of self-management provides the opportunity to make a significant reduction in the pressure on NHS Wales services by helping people to manage their condition through education programmes that support them to look after their own health and well-being. Individuals with long-term conditions who are more highly activated are more likely to engage in positive health behaviours and to manage their health conditions more effectively (Hibbard and Gilbert, 2014). The benefits of patients engaging in their recovery and rehabilitation is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012) and is highly relevant to the outcomes of people with mental health disorders, including depression, post-traumatic stress disorder, bipolar disorder, anxiety and schizophrenia (Cabassa et al, 2013).

### 1.5.2 The benefits to health of increased physical activity outdoors

Increasing regular physical activity helps improve your overall health, fitness, and quality of life (Penedo et al., 2005). For NHS patients living with chronic and long-term illnesses, increasing physical activity is key to improving long-term health outcomes (Von Korff et al, 1997). Pertaining to chronic health conditions such as Stroke and Parkinson's, increased physical activity can improve physical function and decrease the risk of falls or injury from a fall (U.S. Department of Health and Human Services, 2018).

There are large numbers of studies with significant and growing evidence of the benefits to health of being outdoors (Twohig-Bennett et al., 2019) (Hartig and Kahn, 2016). Physical exercise in the outdoors boosts self-esteem and mood, which can be particularly beneficial to those with pre-existing mental health conditions (Barton et al., 2012). With evidence suggesting that physical activity outdoors is more psychologically beneficial than in other locations (Thompson et al., 2014), the physical and mental health benefits of green spaces (Balfour and Allen, 2014) research reveals that spending as little as 3 hours in nature per week can have similar health benefits as those associated with living in an area of low vs high deprivation (White et al., 2019). Further studies are showing that the type of green space you spend time in can enhance those health benefits (Park et al., 2010). Improved access to woodland increases activity levels and perceived quality of life (Ward

et al. 2014) and that increased biodiversity in natural areas biodiversity promotes better mental health and well-being (Marselle et al., 2019).

### 1.5.3 Ecotherapy

Nature-based solutions for health, such as ecotherapy, are preventative and low-cost treatments that can reduce public sector expenditure and citizens' costs (Institute for European Environmental Policy, 2016). Ecotherapy is the ability of interaction with nature to enhance healing and growth (Sommers and Vivian, 2020) and has been proven to enhance recovery from mental and physical illness (Chaudhury and Banerjee, 2020). Ecotherapy projects that focus on conservation of natural areas, such as woodlands, offer opportunity for social integration through a chance to give back (Burls, 2007). Low levels of social inclusion are linked to adverse health impacts, specifically mental health (van Bergen et al., 2019). This natural approach to healthcare allows people to develop skills and positive social relationships; it builds strength and resilience for individuals; sustainable, connected communities; and promotes purpose and participation enabling people to build self-esteem and confidence levels (Vardakoulias, 2013). Increasing one's positive sense of self-esteem is central to recovery for patients (Shepherd et al. 2008). Critical to developing sustainable communities is the need to increase social inclusion of members. Social inclusion is about active participation in the community, not simply access to public services. A study of the Ecominds programme, a programme of nature-based interventions, resulted in an average saving per participant of £7082, via reduced costs to the National Health Service, benefits reductions and increased tax contributions (Vardakoulias, 2013).

### 1.5.4 Community volunteering

A further step to community integration and inclusion is through volunteering (Ramsey, 2012). Volunteering can not only improve the health and well-being of those participating, it can improve employability rates and encourages engagement in other community projects (Molsher and Townsend, 2015). The health benefits for volunteers are on par with NHS patients. A 2018 volunteer survey conducted for Wildlife Trusts found that through volunteering outdoors, volunteers greatly improved their understanding of the environment and the need to conserve it, more than doubled their physical activity and 83% reported improvements in their mental well-being. Feedback from volunteers at DTE revealed similar findings:

- *Volunteering has helped my mental health and confidence beyond words.*
- *It has made me more confident, given me a purpose and I've made new friends.*
- *Knowing that water is treated on site, that energy is produced on site, and that organic pork and fruit and vegetables are produced on site shows how possible living sustainably is*
- *It (volunteering with DTE) has made me more aware of the whole issue of sustainability and the diversity involved and affecting climate change.*
- *Volunteering is exceptionally rewarding and engages me on a level that nothing else does.*
- *What I enjoy most about volunteering here is the feeling of having achieved something, being with nice people and knowing that it helps others.*
- *Anyone who is able should volunteer as it is good to give something of yourself to benefit others and you get educated at the same time. It gives you a sense of well-being.*

### 1.5.5 Public Health Wales NHS Trust and staff well-being

In 2019, Welsh Government published, *A Healthier Wales*, the long-term future vision of a 'whole system approach to health and social care'. This 'community-based approach' sees more services provided closer to home and outside of hospital and clinical environments. It is intended to take pressure off hospitals, reduce the time people have to wait to be treated, and the time they spend in hospital when they have to go there (Welsh Government, 2019). This builds on close relationships

across public services in Wales and the impact on health and wellbeing throughout life. Emphasis is placed on preventing illness, supporting people to manage their own health and wellbeing, enabling people to live independently for as long as they can and incorporating community methodologies; the key priorities to ensure sustainable health and care services. (Welsh NHS Confederation, 2018).

Inclusive in this policy, is the health and well-being of the NHS Wales workforce. NHS Wales are Wales's largest employer with employee wages accounting for 75% of its total annual costs (NHS Wales, 2020). A recent study commissioned by Public Health Wales found that amongst NHS nursing staff,

- 36.8% have trouble feeling relaxed
- 62.1% say they suffer with work related stress
- Less than 30% reported feeling that their NHS Trust takes positive action to improve staff health and wellbeing

Sickness absence rates in the NHS are higher than in the rest of the economy equivalent to 1.4 million full time days in 2019 (Gray et al, 2020.). The percentage of days lost due to anxiety, stress, depression and other psychiatric illnesses has risen steadily over the past seven years among nursing and health visitor staff (Copeland, 2019). *Anxiety/stress* was the second reason for NHS workforce sickness absence, accounting for 25% of all sickness absence (Welsh NHS Confederation, 2017). During the current Covid-19 global pandemic, it has been reported to be three times higher than yearly increasing levels. The absence rates are not solely from Covid-19 illness and isolation but from reported mental ailments such as anxiety, stress and PTSD from treating patients during the pandemic (Campbell, 2020). The return on investment in workplace mental health interventions is £4.20 for every £1 spent (Health Education England, 2019).

**1.5.6 Well-being of Future Generations Act: the 'sustainable development principle' and Well-being Duty**

The Well-being of Future Generations (Wales) 2015 Act is about improving the social, economic, environmental and cultural well-being of Wales. Its vision is "a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood." (Well-being of Future Generations (Wales) Act, 2015). It obligates public bodies to think more about the long-term in terms of planning, funding and delivery of services, work better with people and communities and each other, and look to prevent problems by taking a more joined-up approach to delivering services. The Act also puts in place a 'sustainable development principle' which means that public services in Wales must think about future generations when planning and carrying out work. It also includes a Well-being Duty which places a duty on public bodies to set well-being objectives and take all reasonable steps to achieve those objectives.

For Public Health Wales NHS Trust, this entails development and delivery of a strategy of long-term thinking, prevention and early intervention, integration of well-being objectives across partner organisations, collaboration throughout the NHS and involvement of all stakeholders. Supporting the development of a sustainable health and care system will deliver well-being objectives for the NHS, its workforce and people of Wales (Public Health Wales, 2018).

Natural Resources Wales is another public body of Welsh Government whose role is to sustainably manage the natural resources of Wales. In accordance with the Well-being of Future Generations Act, NRW published their Well-Being Objectives in 2017 (Natural Resources Wales, 2017). These objectives focus after these natural resources and what they provide for us: to help reduce the risk to people and properties of flooding and pollution; to look after special places for well-being, wildlife and timber; and to work with others.

### 1.5.7 Re-Connect project: sustainable approach to healthcare and well-being

The evidence demonstrates the need for a new and innovative approach to healthcare for patients living with chronic illness. Through Re-Connect project, DTE have developed a new, patient-led, inter-departmental approach to the NHS using NRW woodlands for delivering clinically valid health care programmes. This project focused on and demonstrated the benefits to the NHS of working together through the outdoors to deliver health and well-being objectives. The successful delivery and positive outcomes achieved by this project worked towards reducing the waiting lists for mental health services in the NHS and challenge the separation of departments within the NHS regardless of patients' shared underlying issues. These clinically researched programmes centred on meaningful outdoor activity which brings together patients within different health care departments to share the benefits of outdoor based programmes. These programmes were developed to deliver positive change to the participants in the form of reduced anxiety, depression, full/part qualifications, and to benefit the wider environment by the improvement of NRW woodlands on Gower (reduced invasive species, improved sustainable management of the woodland). Re-Connect not only facilitates partnership working throughout an NHS Trust, saving resources and promoting best practice; additionally, it brings together two Welsh Government public bodies to work together to meet their Well-Being Objectives and to deliver sustainable solutions for the benefit of individuals, the community and the natural environment.

## 1.6 Stakeholder Case Studies

The following case studies focus on two of the stakeholder groups: patients living with chronic long-term illness and NHS staff supporting patients on DTE programmes with Re-Connect.

### Case Study: Sara Norman Thomas, Re-Connect Project participant and Mentor

In March 2017, Sara suffered a stroke that changed her life, leaving her with muscle weakness and post stroke fatigue. The most severe impact for Sara, though, was her loss of self-confidence, loss of self-respect and loss of feeling in control of her life and her future. When Sara came to Down to Earth and completed the baseline monitoring Patient Health Questionnaire, she scored above the threshold for clinical anxiety and depression.

The impact of the stroke, taking away her independence, losing her businesses and jobs, impacting how she could care for her children and financially support a household, was “devastating” and “life changing” for Sara.

Although having tried different rehabilitation support groups previously, Sara felt excluded due to lack of mobility and they did little to build her self-confidence and feelings of self-reliance. Sara said she had “no hope” and “felt so sad and angry”.

#### Down to Earth Re-Connect Project

In May 2019, through her volunteer work with the Stroke Association, Sara was offered the opportunity to join an 8-week programme with Down to Earth.

*"When I was asked to go to dte, it was definitely out of my comfort zone. That first day, I drove to the site and actually had a panic attack on the way. When I left that first day, I couldn't wait to go back the next week. I felt so happy, so lifted and had been made to feel that I was quite important again. It really boosted my spirits. Down to Earth was the first place I'd been after my stroke where I felt safe and valued and seen for who I am, not the trauma that I'd been through."-Sara*

Sara returned as a Mentor in November 2019 for her third and final programme with this funded project; having spent 24 weeks in total engaging and helping others to engage in practical outdoor activities, team building, and peer support. Her natural rapport with people was invaluable in bringing the group together, her optimism and excitement for the project irresistibly contagious.

**Looking to the future**

Since involvement with the project, Sara has continued to enjoy improved well-being and quality of life. In February 2020, Sara was featured on BBC Wales News, talking about her experience as a stroke survivor, highlighting the work of Down to Earth and the impact that attending a programme has had on her. The link below will take you to a clip shown nationally on the evening news:
https://downtoearthproject.org.uk/blog/2020/06/09/bbc-wales-features-down-to-earth/
In September 2020, Sara achieved her dream of returning to work, part time as a Personal Assistant.

*"It's all down to everyone at Down to Earth that I have the confidence to go out and find employment again. I am so chuffed! This has had a huge impact on my wellbeing, bringing out the old me once again. I feel completely safe, valued and cared for while at Down to Earth." -Sara*

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### 1.6.2 Case Study: Mal Edwards, Occupational Therapy Technician; Cefn Coed Hospital: Gwelfor Ward High Dependency, Low Security Forensic Mental Ward SBUHB

*"I see first-hand what being outside and in natural environments does for our patients. If when I come here, I destress, you can imagine what is does for the people we bring here, stuck in a clinical environment all day."-Mal, Referral Agency Worker*

Mal has been joining Down to Earth Project, supporting groups he brings to site since 2014. During that time, he has been able to assess the impact of our programmes on his patients in addition to discussing the benefits he has received through our programmes. Most recently, Mal joined us for two intakes of our Re-Connect Project in partnership with Natural Resources Wales. This project developed and delivered clinically researched programmes centred on meaningful outdoor activity which brings together patients within different health care departments to share the benefits of

outdoor based programmes. We collected data about the impact of our programmes on Referral Agency Workers as a pilot monitoring project during these programmes.

Bringing a group to our site in Murton and giving people a chance to discover what we are about as a company, is important, Mal comments. Only after a few sessions together on site, getting to know each other, assessing ability with tools and energy levels, do groups go into the woodland together.

*"What I really enjoy is using the old tools and traditional methods and seeing the patients get a chance to learn that. There's a reason why things have been done this way for so many years. You are using your hands, you are doing something meaningful, it puts you in a zone where you are focused, you are present. That's good for our patients and it's good for me seeing that and working with them."*

Mal was able to update us on the progress of two past participants from the hospital where he works, who progressed on to become Volunteer Mentors for a Stroke Recovery Group.

*"They are both doing great. After so long on the ward, they have both moved on. K went from the Volunteer Mentor programme to getting a part time job in the community. L gained the confidence to move on to a (transition) house in the community. First time in 20 years, he wasn't living on the ward."*

Mal commented that he was sure the confidence that both had received from being Volunteer Mentors on the programme, helped them expand their horizons and want to engage more in their communities.

*"If it was my choice, I would reduce all the medication they're on. It stops them being able to engage with and feel the world around them, engaging, progressing, moving on. Get them outside as a group, get them talking together and walking and working together, you see immediate and lasting benefits."*

## 1.7 Theory of change

For each stakeholder, chains of change are illustrated in the theory of change. A theory of change is a description of why a particular way of working will be effective, showing how change happens in the short, medium and long term to achieve the intended impact (National Council Voluntary Organisations, 2020). It is this journey of change that communicates the process from stakeholder inputs, using quantifiable indicators to calculate outputs to measurable outcomes and intended impact. These chains of change inform the creation of the Value Map (attached separately), used to calculate the SROI of the project.

The Theory of Change was developed through engagement with stakeholders to develop well-defined outcomes, to assess material change, determine outputs to quantify how much change had occurred and the valuation of these outcomes.

Engaging with stakeholders was done through online questionnaires, virtual meetings, telephone interviews and group discussions. There were a number of different outcomes identified, with some being unique to a particular respondent; however, for the most part there was a similarity in which outcomes stakeholders felt had the most relevant impact.

**Stakeholder: participants with long-term/chronic illness**

People with long-term chronic illness experience change in different ways, at different stages in their rehabilitation and to varying degrees. In addition to intended outcomes, as measured with the clinical monitoring and feedback sessions, participants were invited to contribute their feedback in an on-line questionnaire as to what change they experienced through participation in the Re-Connect Project. Fourteen participants responded to the questionnaire out of 20. Concurrently, the NHS staff supporting participants were asked to complete a questionnaire to assess long term impact on their patients of the programme and contribute to the determination and relevance of outcomes achieved. Of the 70 participants engaged in the project, post programme data was given for 48 participants. Once the responses had been thematically analysed, the benefits that participants identified with greatest frequency were collated into a short list of 9 outcomes. Online participant questionnaires were anonymous, however, 5 participants got in touch with DTE to let the facilitators know that they had completed the surveying. This then enabled a follow up telephone conversation or on-line meeting to discuss the short list of outcomes and the value that they felt they had for them. Finally, how the change needed to achieve the outcome would be measured was decided for the outcomes in the form of a quantifiable indicator by the Lead Researcher of the clinical monitoring programme at DTE, and author of this forecast analysis; the Managing Director of DTE and DTE's clinical research partner at Swansea University, Professor Jason Davies.

The outcomes were almost completely positive with one exception. A representative of the stakeholder group of regular volunteers stated that engaging with DTE volunteer programmes monthly was preventing them engaging in other volunteer activities scheduled for the same day. Dates of Volunteering Saturdays were amended to reflect this feedback and resolve this negative outcome. As it was commented by one out of the sample of 14 surveyed, it was not included in the analysis.

**Stakeholder: NHS staff**

The outcomes for NHS staff were determined from qualitative feedback from those support staff that accompanied the groups and post-programme on-line questionnaires. The commonalities in their responses and feedback developed well-defined outcomes with on-line follow up conversations as to the value of achieving this change. The key aim of the project, the main intended impact, was to build resilience in individuals, local communities and the environment through the development and delivery of clinically researched programmes of meaningful outdoor activity. However, it had been observed and discussed with NHS staff on other funded programmes, the benefit that NHS staff experienced through attending the programmes to support participants. NHS staff said how much they looked forward to the weekly sessions and the "lift" it gave them knowing that they would be away from a clinical environment and emersed in the outdoors.

It was decided in the commencement of this analysis, that NHS staff would be included as stakeholders who experience a direct benefit. Out of the eight groups that were worked with during the Re-Connect project, 6 departments responded to an online, anonymous questionnaire. From the responses, three common themes emerged: reduced work-related stress levels, improvement in personal mental health, and working outdoors with participants gave staff increased confidence in accessing different activities for rehab and recovery outdoors, helping them build a rapport with participants in a relaxed environment. Three NHS staff that worked consistently with their groups (not a weekly change of support staff), were contacted to discuss the responses of the questionnaire. Each of the three staff said that these three outcomes were how they personally

benefitted from participation. In addition, two of the three staff spoken to said that they benefitted from seeing their patients thrive, build confidence, engage in physical activity and improve their mobility. They also noted that the programmes gave structure and focus to the week for their patients. It was determined that there was not a way to measure the benefit that NHS staff received from seeing patients thrive and therefore, this was not included as a well-defined outcome.

**Stakeholder: Regular volunteers**

Regular volunteers were asked to complete a questionnaire during one of the monthly volunteering sessions. Out of the 30 volunteers who attend on a regular basis, 14 completed the questionnaire. Informal interviews and a group discussion during the lunch break and post session enabled the researcher to find out what the volunteers felt was the reason that they attended volunteer sessions regularly; what brought them back each month. Volunteers had individual reasons for getting and staying involved, such as learning more about practical sustainability. By far, the long-term impact of attending regularly was that being involved had a positive impact on their health and gave them a chance to meet new people and visit with friends they'd made. The two other outcomes identified that every volunteer agreed with were: being involved in a project where they could learn new skills and ways of working and that supporting something they believed in, made them feel good about themselves. It was determined that the long-term outcome, the main change for volunteers, was being involved in a community project and the opportunity to socialise with a group of like-minded people. Therefore, the financial proxy for this outcome was assigned a higher value than the other two outcomes. Four volunteers were contacted separately to contribute data to the duration of these outcomes, what other factors could have contributed to the change, what activities/projects they would be involved with if not for this project.

**Stakeholder: Down to Earth**

Down to Earth staff have team training twice a year and this presents an opportunity for staff and management to explore core reasons and motivations for being an employee with DTE, what the benefits of programmes are for participants, staff, the organisation, and wider community. These are not incidental sessions; DTE regularly review the impact of programmes and how they can be improved to increase positive benefit for all involved. In August 2020, DTE staff returned from three months of furlough and embarked on two weeks of training where topics were explored, such as the impact of the pandemic on themselves, participants and the work they do. The majority of DTE staff have been with the company for at least five years and this presents strong evidence that staff get personal benefit from being employed with DTE beyond wages alone. During one of the training sessions, DTE staff discussed what their main motivation was, what they felt the personal benefit to them was of working for the organisation. On another day of the training, staff explored what the key outcomes were for DTE of participatory action research, on the ground programme evaluation, post programme evaluation sessions, clinical research and the SROI forecast analysis.

It is from these training sessions that the two well-defined outcomes were developed for this analysis pertaining to DTE as a stakeholder. 14 members of DTE delivery, office and management staff participated in the training sessions. The well-defined outcome that staff agreed upon was the main reason/benefit to staff working for the company and staying employed for a longer period of time than they had in previous employment; the satisfaction and improved personal well-being that comes from seeing the benefit of our work with participants. DTE staff collectively agreed that the key outcome of the amount of clinical research, forecast social value analysis and on-going, in-house programme evaluation of funded projects DTE is engaged with, is that it enables the company to recruit increasing numbers of participants. This in turn provides evidence that the innovative approach of the company to healthcare and well-being is producing results in the community and to provide further evidence as to the efficacy of this DTE approach. It is these two outcomes that were identified as material for DTE as a stakeholder in the Re-connect Project. Staff also discussed how

these outcomes would be measured. A number of indicators were discussed with the agreed indicators coming from the Managing Director of the company. It was these indicators that have been included in the Theory of Change. The valuation of these outcomes was determined in the training sessions with staff participation. The increased value to the company of reaching a wider audience of participants and sharing our work was determined to be the amount needed for each participant to attend a similar funded programme. The benefit of staying with the company for a long period of time, with the amount of training and personal specialised skills base diversity amongst the DTE team (inclusive of higher education teaching qualifications), it was determined that a minimum of 10 years' experience with the company was equivalent to the salary of a secondary school teacher on an M5 Main Pay Range. This figure currently stands at £35, 406.00 annual income (NASWUT, 2021). As this could not be evidenced as a proxy based on staff conclusions alone, an approximate and similar financial proxy was sought that had been used in a previously published and assured SROI report.

**Stakeholder: Swansea Bay University Health Board**

The outcomes for Swansea Bay University Health Board were derived from informal discussions and phone interviews with NHS staff and Ward/Departmental Managers. Staff discussed with the researcher and project facilitation staff not only how they and their patients benefitted from participation in the Re-Connect project but what the implications of this type of programme are upon the wider health board. A number of comments were shared regarding this, such as less time spent in hospital for recovery and reduced need for clinical intervention as part of the rehabilitation process. It was determined, though that there was not a way of obtaining this information in the middle of a pandemic due to pressures on the NHS. What could be measured was the self-reporting of patients that without this project, they would have sought support for mental health issues. Additionally, two departmental managers noted that the whole programme worked to build confidence in patients as to what they can achieve and were encouraged to engage in activities through peer support and person-centred facilitation. These two aspects had prompted patients to try new things and actively engage in the rehabilitation, as it wasn't viewed or experienced by patients as rehabilitation (as opposed to a session in a clinical environment). Patients who had participated in one programme were regularly asking NHS staff supporting their recovery when another DTE project would be running. The fact that patients were enjoying themselves, were asking to participate in activities where previously they had not had this motivation and were engaging with other activities as a result of attendance to programmes with Re-Connect, demonstrated to practitioners that patients were actively engaging in their rehabilitation and experiencing improved mood and motivation as a result. This provides additional reasoning for the outcome for Down to Earth, increase in recruited participants. It also affirms what participants self-reported was a positive impact of the project, increased mobility. Through these conversations and feedback from NHS staff and Departmental Managers of groups engaged with the project, the two outcomes and associated indicators were chosen to reflect what measurable outputs for the Health Board as a result of this project were.

**Stakeholder: Local Community and Government**

The outcomes and indicators assigned to these stakeholders as indirect beneficiaries were derived from self-reporting by participants and NHS staff.

Post programme data that completed by NHS staff regarding the progress of previous participants on the project, showed that out of the 48 participants that were reported on, 16 had progressed on to other volunteering opportunities in the community after participation with DTE.

The outcomes and indicators for government were economical savings and cost benefit resulting from previously unemployed persons moving to employed persons. The outcomes are based on the

extra earning and taxation contribution made by someone who is employed. The reduction of welfare payment for adults younger than the State Pension age who are having difficulty finding work because of their long-term medical condition or a disability is the indicator for the outcome relating to savings made by the government in not having to pay this benefit as a basic income-replacement paid in lieu of wages.

A full description of the theory of change is displayed in Appendix B.

### 1.7.1 Attribution

Attribution takes account of external factors, or the contribution of others, which may have played a part in the changes that are identified. DTE clinical monitoring data, participant, NHS staff, and Volunteer testimonies and sessional feedback suggest that without access to these funded programmes, the participants, volunteers and NHS staff would be unlikely to have reported the improvements in health and well-being that they did. These programmes have been developed based upon clinically researched data that provides robust evidence for the efficacy of DTE's approach to healthcare and education. Attribution is difficult to calculate, however, in calculating this Down to Earth has used conservative estimates to avoid over-claiming and sourced precedents for the percentages calculated.

Informal discussions and group sessions occurred during each session of the programmes of the Re-Connect Project. Through these conversations, project facilitators aim to learn more about the individual, their life, their interests, what they have been involved with/doing over the past week. It is through these individual and group discussions that the researcher and DTE staff were able to ascertain what other influences and external factors could have been influential in the changes made to stakeholders. DTE staff record any observations and comments made in a sessional evaluation at the end of the day. Additionally, at the end of the project, project staff meet to perform a project evaluation which collectively with monitoring results and post programme participant and Referral Agency support staff feedback, inform the final reporting on the project to the funder(s) and DTE Board of Directors. This information informed the generation of attribution rates and how much of the outcome was caused by the contribution of other organisations or people.

Organisations and support networks were identified and considered that could contribute to achieving outcomes for stakeholders are displayed below in table 2.

| Organisations and support networks | Description of |
|---|---|
| **Actif Woods Wales:** | Coed Lleol (Small Woods Wales) runs woodland health and wellbeing activity groups in Swansea as part of Actif Woods Wales programme. These programmes have been running since 2010 and are currently funded by the Healthy and Active Fund, a partnership initiative between Welsh Government, Sport Wales and Public Health Wales and Natural Resources Wales |
| **Surfability:** | Provides surfing lessons and experiences for people with additional needs due to disability, illness, injury or learning difficulties. |
| **Penllegarre Valley Woods:** | Woodland volunteers meet up on a weekly basis on Tuesdays and Thursdays from 9am – 2pm to carry out much needed restoration and maintenance activities. |
| **Wildlife Trust of South and West Wales** | Volunteering opportunities weekly at a variety of locations |
| **NHS support** | On-going clinical support for treatment, recovery and rehabilitation of patients. |
| **Family and friends** | On-going support, encouragement, and care provided by friends and family in a person's recovery and rehabilitation |

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| **Support groups** | Social groups in the community that provide support, advice and social engagement opportunities for persons with a specific condition, illness or injury. |

Table 2: Organisations and support networks included in attribution rates

## 1.8 Stakeholder identification and engagement

Down to Earth have established strong working partnerships over the last 15 years with a wide array of stakeholder groups. DTE have been working with the local NHS Trust, Swansea Bay University Health Board, for the last ten years on social prescribing. It is this partnership and the robust evidence base of the efficacy of DTE's approach, collated through delivery of aforementioned programmes, that led to the development of this project. Re-Connect was developed for the benefit of SBUHB patients living with chronic and long-term conditions, the local community and natural environment. Identifying the stakeholders enabled DTE to focus their monitoring activities and actively engage stakeholders in the collection of data relating to the SROI analysis and the creation of the Theory of Change.

The people, organisations and service providers and the quantity of those DTE worked with, displayed below in table 3, were considered to impact or be impacted by the work of Re-Connect and so were consulted to the extent possible on the change experienced as a result of the project; considering restrictions imposed by Coronavirus. The local community of Swansea and the government are identified as indirect stakeholders.

Identification of potential stakeholders were determined upon at the inception of this SROI analysis by the Company and Project Management team. The SROI process was commenced in June 2020 after meetings between the Company Director of Down to Earth and the author, a DTE employee of 10 years, responsible for the research and monitoring programme at DTE. As stated above, Re-Connect Project was chosen for analysis as it was a pilot project developed and delivered to determine the impacts of an innovative approach to healthcare, rehabilitation and recovery utilising the outdoors.

| Stakeholder | Type of beneficiary | Change experienced | Quantity of general population and data collection | Included/excluded in analysis |
|---|---|---|---|---|
| **Natural Resources Wales** | direct | Increase in biodiversity in local woodlands through decrease in invasive species present, clearing of woodland floor and thinning of the canopy. Increase in general public utilising local woodlands for health, well-being and recreation resulting in an increased awareness of the benefits of local woodlands and understanding of the importance of sustainably managing local woodlands in Wales for biodiversity and public access. | Conversations, online communication and site visits with at least two members of NRW staff | included: major funder |
| **Down to Earth Project** | direct | Increase in referral numbers on similar programmes providing additional evidence for efficacy of DTE approach | 3 full time staff out of 14 full time employed staff<br><br>Observations and conversations; wider team training | included: match funder and organisation developing and delivering Re-Connect project |

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| | | | sessions exploring ethos of DTE with 14 participating | |
| **Patients with chronic illness or Well-being Limiting Health Condition** | direct | Through being engaged in physical activity outdoors, participants experience a decrease in feelings and symptoms of anxiety and depression (Beyer et al., 2016) which builds resilience in living with a long term, chronic illness (Vardakoulias, 2013)<br><br>Participants experience an increase in feelings of self-confidence and self-reliance which will help participants living with a long term, chronic condition or illness recognize and manage dependence (Moore, 2021).<br><br>An increase in connection to the community felt by participant is experienced resulting in a sense of belonging and contribution through engaging in the project (Jacubek et al., 2019)<br><br>"Participants learn new work-relevant woodland skills and<br>training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009).<br><br>Participants experience an improvement in their physical health and increased mobility after engaging with the programme which has improved motivation and activation in their rehabilitation and healthcare. This leads not only to better healthcare outcomes (Hibbard and Greene, 2013) but which also results in decreased need for clinical time for rehabilitation and recovery (Hibbard and Gilbert, 2014).<br><br>Participants increase their regular physical activity which helps participants improve overall health, fitness, and quality of life (Penedo et al., 2005) and for NHS patients living with chronic and long-term illnesses is key to improving long-term health outcomes (Von Korff et al, 1997).<br><br>Participants experience increased sense of identity and purpose through returning to work with potential to improve financial security (NHS, 2021)<br><br>Participants experience greater social and community engagement and may experience increased earning potential as a result of engaging in higher education and gaining a degree or qualification (U.K. Dept of Education, 2019). | 70 patients engaged out of 70<br><br>48 out of 70 post-programme monitoring from Referral Agency Workers/NHS support staff<br><br>14 out of 22 post programme survey respondents<br><br>5 of 5 engaged in creation of Theory of Change<br><br>6 out of 6 NHS support staff (questionnaires and feedback), online/telephone conversations<br><br>3 out of 3 Department or Ward Managers | included: directly benefit from programmes |
| **NHS staff** | direct | Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to help manage stress (Calogiuri et al., 2014).<br><br>Staff experience improved personal mental health and well-being at work.<br><br>Staff benefit from developing more positive working relationships with service users in a non-clinical, | 37 NHS staff engaged in programmes<br><br>6 post programmes survey out of 6 contacted | included: directly benefit from supporting patients on programmes |

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|---|---|---|---|---|
| | | informal setting with knowledge gained in practical interventions to build on service users' self-confidence, social skills, connecting with the outdoor environment and future interests. | 3 follow up telephone/virtual interviews with Ward/Department Managers<br><br>Sessional feedback from staff | |
| **Regular volunteers** | direct | Volunteers regularly attend volunteer days outdoors which act as a social activity. leading to increased social contacts/networks and results in reduced social isolation and feelings of belonging to a community group. This socialisation and feeling of belonging to a community group, "hugely strengthens community resilience" (Patel et al, 2017; Blood, 2017).<br><br>Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment.<br><br>Volunteers gain new practical outdoor work related skills and Increased knowledge about sustainability and the environment through participating in a DTE Volunteer programme | 30 volunteers out of 30 long term volunteers<br><br>14 out of 30 survey respondents and group discussion | included: directly benefit from attending volunteer programme |
| **Swansea Bay University Health Board** | indirect | A reduction in number of patients experiencing poor mental health and wellbeing through engaging in a DTE programme outdoors could lead to reduced numbers seeking NHS treatment for mental health (consultancy appointments and prescriptions) and result in a reduced in cost to NHS.<br><br>Through attending a rehabilitation and recovery programme in the outdoors, participants demonstrate an increased engagement in their healthcare and willingness to try a different approach. The benefits of patients engaging in their recovery and rehabilitation (patient activation) is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012). | Feedback and survey results from NHS support staff (6 out of 6) and Telephone/virtual interviews with Ward/Department Mangers (3 out of 3) | Included: directly benefit from reduction in those seeking mental health support, patients actively engaging in their rehabilitation and recovery and from benefits to NHS staff attending programme. This final outcome was not included as there was no way to accurately measure this. |
| **Community** | indirect | There is an increase in the number of people engaging in community volunteering projects which is a benefit to the wider community (Ramsey, 2012). | Self-reporting from programme participants about other projects they had engaged with post programme; | included: indirectly benefit in increase in number engaging in community volunteering and increased |

| | | | | |
|---|---|---|---|---|
| | | | Reporting via survey from NHS staff as to number of service users who have engaged or are currently engaged in community volunteering 16 volunteers out of 48 total. | community engagement |
| **Government** | indirect | Increase earning power of the individual with associated increased spending for the economy and contribution of taxes to the exchequer<br>Reduction in Employment Support Allowance costs for the government. | no direct data collection | included: indirectly benefit from reduction in welfare payments, increase in employment tax contributions and earning power increased earning potential resulting from higher education and correlated increase in earnings and tax contributions. |

Table 3: Re-Connect Project Stakeholder Identification

The purpose of the stakeholder engagement was to identify any changes that each stakeholder experienced as a result of the project. The methodology implemented has been derived from the six steps of SROI, SROI principles (both sourced from Social Impact UK) and extensive research by the author on the necessary components of an SROI analysis. Stakeholders were engaged during programme delivery and post-programme to determine what impacts, short and longer term they had experienced. This is explored in detail in section 1.7 for the Theory of Change.

**Participant engagement**

Sessional feedback from participants during programme delivery with programme facilitators and clinical monitoring during delivery informed the creation of post programme questionnaires (see Appendix A). Out of 70 participants, 62 participants, completed two measures for research monitoring, baseline and end of project monitoring. In addition, 47 out of the 62 participants completing monitoring provided written or verbal quantitative feedback on their immediate experience of the project on feedback slips or in group discussions. Out of 22 past participants contacted online and by telephone, 14 participants completed an anonymous, online survey 6-12 months after programme completion to determine the efficacy of the programmes in achieving stated aims, the impact on their health and well-being and the longevity of any impact.

NHS staff (or Referral Agency Workers) were asked to report on the progress of their participants 12 months after programme completion. Of the total number of participants engaged in the programme, post programme data was collected for 48. Results from these responses were synthesized with data collected during project delivery and put through thematic analysis. Five past participants were contacted and interviewed individually as to what they felt were the most impactful changes experienced in addition to the intended outcomes. Participants were asked to determine which of the outcomes applied to them and how important these changes had been/were (rating the outcomes). These participants were asked as to the duration of the change experienced, what changes had come from this project alone, what other factors may have influenced the change, and what other activities may they have engaged with had this programme not been offered.

Responses from these five participants enabled the assigning of financial proxies, with financial value reflecting how the outcomes were rated. Of the six identified outcomes, intended and unintended, with the exception of two participants moving on to higher education, the outcomes were rated by participants according to importance of impact to their lives of the change. The rating of outcomes for participants is displayed in table 4 below. Financial proxies were assigned to reflect the ranking of the outcomes in terms of impact of the change that had occurred.

| **Valuation rating of participant outcomes** |
|---|
| **1. Relief from feelings of anxiety and depression (intended outcome): £18,338.00** |
| **This was by far the biggest reason for attending in the first instance and the benefit of this change impacted other areas of their lives, inclusive of engagement in other activities, community volunteering, family relationships.** |
| **2. Increase in self-confidence (unintended): £6540.00** |
| **Results from both participants and NHS staff reported this change as a "springboard" to additional changes in trying new things, returning to past interests, getting involved in the community initiatives and activities, seeking employment, volunteering or training opportunities.** |
| **3. Increase in regular physical activity outdoors (intended): £4179.00** |
| **Participants and NHS staff responded that having the opportunity to do non-traditional activities to get the heart rate going and break a sweat, in the natural environment found them doing more exercise than they were previously used to. The benefit of this was feeling a sense of achievement; being tired from physical activity, not fatigued; calmer behaviour on residential wards and as one participant put it,** ***"Just getting outside and working like I used to, doing something practical and useful, made me look forward to each week in the woods. I didn't miss one session, even when I was feeling ill and fatigued in the morning, I knew working in the woods would make me feel better again."*** |
| **4. Feeling part of the community (intended): £3753.00** |
| **Although many participants had support at home or on the ward from family and friends, in addition to clinical staff and support services, participants gave feedback during initial sessions that they felt lonely and that they did not feel like they belonged anymore/nobody understood what they were going through with their illness/condition. Being part of a community project, with peers who have experienced similar circumstances, performing meaningful work that has a purpose, enables people to contribute and feel valued. One participant responded when asked about the value of being invovled in the project responded:** *"Absolutely loved the experience. Taught me a lot about myself. Wish I could go more often. It gives you confidence when working with people who also have brain injuries. When you are isolated with a brain injury you feel you will never be able to take part again."* |
| **5. Increase in mobility (unintended): £2847.00** |
| **This outcome come mainly from post monitoring feedback from participants, but from *sessional* feedback from the NHS staff that supported them. As DTE have worked with different healthcare providers in the past, some of the NHS staff have past experience as to the benefits and impact that DTE programmes can have for patients with long term/chronic illnesses. Whilst participants did not rate this impact as high in value as the other outcomes, this was one of the main benefits identified by NHS staff and Ward/Departmental Managers as it meant that Patient activation was occurring. Patient Activation results in improved motivation towards self-care behaviours and teaches participants to actively identify challenges and solve problems associated with their illness. For one participant impacted by a stroke, improved mobility gave him more confidence:** ***"I feel that doing a down to earth programme has helped me towards being who I used to be, before doing this I felt I was always on the outside looking in but with the groups I was getting more involved making more of an input. It has helped me with mobility. I would never attempt walking in the woods before but doing the programme has made me*** |

| |
|---|
| ***a bit more sure-footed, i.e., more aware of my surroundings and my abilities. It made me feel part of a team and not just me it has boosted my confidence no end."*** |
| **6. Learning new skills/traditional skills (intended): £150.00** |
| **For many of the participants, learning new skills or relearning past skills with a modified technique to accommodate needs, was something that was appreciated and important to them but that it was a means to more impactful change, hence the lowest rating of the participant outcomes. When asked what skills had been gained during participation, it is shown how the practical skills led to the soft skills enhancement and lead to satisfaction and happiness.**<br>***"Practical skills involved in woodland management, reinforcement of social skills needed for effective teamwork, increased confidence derived from overcoming the challenge of the physical demands one was faced with undertaking the activities experienced during the programme. The pleasure of making some simple wooden Christmas decoration which also delighted my grandchildren."*** |

Table 4: Ranking of outcomes for valuation by participants with long-term/chronic illness

**NHS staff/Referral Agency Workers**

NHS support staff/Referral Agency Workers were asked to fill in an online survey about how they personally benefitted from the programmes. Telephone/virtual interviews with three staff determined what the outcomes were for NHS staff and how they were valued is reflected in the financial proxies. Improvement in mental health was by far the highest-ranking outcome, followed by attending weekly to support participants gave them respite from stress at work, and the importance of working with participants in a non-clinical setting to aid rehabilitation and relationship building between staff and patients.

**Regular Volunteers**

Regular Volunteers provided sessional feedback in group discussions and completed a questionnaire on what the impact of involvement had been for them individually. Of the 30 people who regularly attend, 14 completed the questionnaire. The results were discussed in smaller groups to enable the creation of a shortlist of outcomes, which were then ranked in importance and impact by 5 of the volunteers. These volunteers were later contacted to discuss their responses and to ascertain the duration of the change experienced, what changes had come from involvement with DTE and not other organisations, what other factors may have influenced the change, and what other activities may they have engaged with had this programme not been offered.

1. Attending, working outdoors and being with old friends/meeting new people:

*"Knowing that I have this to look forward to each month helps me to look forward and also getting to know new people."*

2. Improvement to physical and mental health and well-being through increase physical exercise outdoors:

*"Volunteering has helped my mental health and confidence beyond words. The feeling of having achieved something, being with nice people and knowing that it helps others."*

3. Learning new skills:

*"I love learning new skills, e.g., building stuff. There is nothing I don't enjoy (maybe the weather)."*

**DTE staff**

DTE staff participated in training sessions to explore the impacts of working at DTE on employees and the impact of research, analysis and project/programme evaluation on DTE as a company. It is from these sessions that the DTE outcome, indicator and value were created. There were 14 members of DTE staff involved in these sessions.

**Natural Resources Wales**
NRW were consulted in on-line communication, virtual meetings and previous site visits to the woodland venue to determine how they believed funding this project benefited their organisation, what measurable outcomes were and if they were relevant. In addition to the two outcomes used, a third was suggested: Work towards achieving Well-Being Objectives in accordance with Well-Being of Future Generations (Wales) Act. However, this was not included in the analysis as it was deemed to be tautological.

**Swansea Bay University Health Board**
Sessional feedback and post programme feedback through telephone/virtual interviews with NHS staff from six different departments in the health board and three Ward/Departmental Managers, established what the relevant impact to SBUHB was of the RE-Connect Project. Access to information regarding patient waiting lists, staff absenteeism and other discussed outcomes is not in the public domain and obtaining access through communication and requests for information was restricted as a result of time and resource pressure for the NHS during the pandemic. Outcomes for this stakeholder group were determined from clinical monitoring results, feedback from participants and NHS staff.

Indirect stakeholders (local community/government) were not consulted about material change occurring as a result of this project. Quantifiable economic indicators were assigned for local government. Well-defined outcomes for the Health Board were developed with feedback from both the NHS staff supporting participants on programmes and Departmental management feedback as to the benefits to their service of having staff and patients engage with the Re-Connect Project.

Financial proxies were decided upon with stakeholder involvement, as detailed above, to assign an economic valuation to outcomes to ascertain how much social value would be created if the project met its intended aims and objectives; the impact that this project had on individuals; the wider community; ways of working within the NHS; and the natural environment.

To ensure that data collection was open to unintended results that were not anticipated, some open-ended questions in interviews and on questionnaires were included. See figure below for some examples.

| Examples of open-ended questions from questionnaires and interviews | Stakeholder and method of data collection |
|---|---|
| *What skills do you feel you acquired skills through participating in a Down to Earth programme? For example:*<br>*• Practical skills: increased mobility and learning to pace yourself during activity*<br>*• Soft skills: increased confidence, teamwork, peer support, self-reliance* | Participants with chronic illness and/or well-being limited condition-questionnaire |
| *How would you value the impact of participant's experience of our programmes on your own work experience? For example, being able to access woodlands weekly with participants, supporting and getting involved in practical sustainable woodland management tasks, etc.* | NHS staff/Referral Agency Workers-questionnaire |
| *What do you feel is the benefit to NRW and local woodlands of this project?* | Natural Resources Wales-interview |

Figure 1: Example of open-ended questions for stakeholders

To ascertain the duration of benefit to participants, post programme questionnaires were issued via and completed online by 14 project participants out of a total population of 22 participants that were contacted to complete the questionnaires. Resulting from their mental ill-health and some

with learning difficulties, certain participants in residential care, generally needed support from Referral Agency Workers to complete the post programme monitoring and therefore were not asked to self-complete the post programme monitoring questionnaires. NHS staff/Referral Agency Workers contacted the participants for their responses, recorded them and then submitted responses. Out of the 70 participants engaged in the project. We received post monitoring information from 69% of attendees (48).

DTE staff participated in training sessions to explore the impacts of working at DTE on employees and the impact of research, analysis and project/programme evaluation on DTE as a company. It is from these sessions that the DTE outcomes, inputs and value were created with the participation of 14 DTE staff members.

Table 5 below summarises the extent to which stakeholders were involved in the SROI process and determines the social value of the ReConnect project.

| Stakeholder group | Stage of the SROI | No. engaged | **Total population** | Method of engagement |
|---|---|---|---|---|
| **Participants with chronic illness** | Theory of Change<br>• Outcomes | 62 | 70 | Online questionnaire completed by participants or referral agency assistance in completing questionnaire on behalf of participants. |
| | Inputs and outputs | 5 | 5 | Post programme virtual/phone semi-structured interview |
| | Valuation of outcomes | 5 | 5 | Post programme virtual/phone semi-structured interview |
| | Duration, attribution, deadweight data | 5 | 5 | Post programme virtual/phone semi-structured interview |
| **NHS staff** | Theory of Change<br>• Outcomes | 6 | 12 | Online questionnaire, feedback from NHS staff |
| | • Outputs<br>• Inputs | 3 | 3 | Post programme virtual/phone semi-structured interview |
| | Valuation | 3 | 3 | Post programme virtual/phone semi-structured interview |
| | Duration, attribution, deadweight data | 0 | 0 | |
| **Volunteers** | Theory of Change<br>• Outcomes<br>• Outputs<br>• Inputs | 14 | 30 | Questionnaire and group discussion |

| | | | | |
|---|---|---|---|---|
| | Valuation | 14 | 30 | Questionnaire and group discussion |
| | Duration, attribution, deadweight data | 4 | 5 | Post programme virtual/phone interview |
| **Down to Earth staff** | Theory of Change<br>• Outcomes<br>• Outputs<br>• Inputs | 14 | 14 | Training group session activity, discussion and feedback |
| | Valuation | 14 | 14 | Training group session activity, discussion and feedback |
| | Duration, attribution, deadweight data | 3 | 3 | Targeted meeting with project management |
| **Natural Resources Wales** | Outcomes, outputs, inputs | 2 | 2 | On-site visits, virtual/telephone communication |
| **Swansea Bay University Health Board** | Outcomes, outputs, inputs | 6 | 37 | Clinical research monitoring (DTE internal); sessional feedback; online conversations, virtual/telephone interviews with NHS staff and Ward/Departmental managers |
| | Valuation | 3 | 3 | Online conversations, virtual/telephone interviews with NHS staff and Ward/Departmental managers |
| **Local Community** | Outcomes, outputs, inputs | 48 | 62 | Online questionnaire completed by participants or referral agency assistance in completing questionnaire on behalf of participants. |
| **Local Government** | Outcomes and outputs | 2 | 2 | Self-reporting from participants or via Referral Agency/support Staff |

Table 5: Stakeholder involvement in SROI process for forecast analysis

## 1.9 SROI methodology

By surveying stakeholders during the period of activity and post, SROI can quantify and ultimately monetise impacts so they can be compared to the costs of producing them. This doesn't mean that

SROI can generate an "actual" value of changes, but by using monetisation of value from a range of sources it is able to provide an evaluation framework through a forecast SROI that changes the way value is accounted for – one that considers economic, social and environmental impacts (Jones et al., 2016).

Social Return on Investment is a measurement tool that helps organisations understand and quantify values that are not reflected in the financial reporting of performance. By valuing the social, economic and environmental value that results from an organisation's activities, an SROI can identify how effectively a company uses its capital and resources to create value for the community. It can improve programme management through better planning and evaluation and allow better communication regarding the value of the organisation's work (both internally and to external stakeholders). An SROI analysis produces a narrative of how an organisation creates and destroys value while making change in the world, and a ratio that states how much social value (in £) is created for every £1 of investment (Nichols et al., 2012).

There are two types of SROI reports: evaluative and forecast. This report is a forecast SROI report for the Re-Connect project with the period of analysis from July 2018 to December 2019. Weekly delivery of programmes occurred from September 2018 to December 2019. The study and analysis for this report started in June 2020 as an analysis of this project. While it is useful and necessary to determine whether the project met its targets and quantifies said impact for funders and internal reporting, DTE determined that this method of capturing change did not accurately reflect the holistic benefit experienced by stakeholders. DTE aimed to ascertain what change was occurring that wasn't captured through the clinical research and monitoring programme and how much change was occurring to capture a reasonable representation of all the material changes caused by an activity.

The organisation decided that by instigating an SROI analysis and engaging stakeholders in examining what outcomes have taken place, which are relevant, and which need to be measured beyond intended outcomes, it could be possible to forecast the change that will occur.

Post-project data was collected between June and October 2020. Monitoring of intended outcomes took place during project delivery.

### 1.9.1 Seven Principles of SROI

SROI is based on seven principles which are intended to guide organisations and individuals from all sectors on best practice in measuring social value The Principles provide the basis for collecting data that support decisions to increase the value being created for stakeholders and hold the organisations to account for their impact (Social Value International, 2018).

1. **Involve stakeholders**
2. **Understand what changes**
3. **Value the things that matter**
4. **Only include what is material**
5. **Do not over-claim**
6. **Be transparent**
7. **Verify the result**

### 1.9.2 Six steps of SROI

The six steps to conducting an SROI and a brief description of how each is accomplished are displayed on the following page in table 5.

| SROI step | Description |
|---|---|
| 1. Establishing scope and identifying key stakeholders | Clear boundaries about what the SROI will cover, and who will be involved are determined in this first step. |
| 2. Mapping outcomes | Through engaging with stakeholders, a theory of change, which shows the relationship between inputs, outputs and outcomes is developed. |
| 3. Evidencing outcomes and giving them a value | This step first involves finding data to show whether outcomes have happened. Then outcomes are monetised with input coming from stakeholders as to the value to them of the change – this means putting a financial value on the outcomes, or financial proxy, including those that don't have a price attached to them. |
| 4. Establishing impact | Having collected evidence on outcomes and monetised them, those aspects of change that would not have happened anyway (deadweight) or are not as a result of other factors (attribution) are isolated. |
| 5. Calculating the SROI | This step involves adding up all the benefits, subtracting any negatives and comparing them to the investment. |
| 6. Reporting, using and embedding | This important last step involves compiling a report of the results, sharing findings and recommendations with stakeholders, and embedding good outcomes processes within your organisation. |

Table 6: Six steps of SROI (Social Value UK, 2018)

# 2. Outcomes and evidence

This section details the relationships between inputs, outputs and outcomes for each stakeholder group. The numbers of stakeholders 'achieving' the outcomes are calculated and financial proxies are assigned to each outcome. This assignment of financial proxies enables a monetary value for impact to be calculated. This is explored in the Section 1.8 as part of the process of stakeholder engagement.

## 2.1 Inputs and Outputs

The input of stakeholders gives an overview of the total investment in an activity or intervention. The investment, in SROI, refers to the financial value of the inputs. Inputs are the resources and contributions of the stakeholders in order to deliver the activity or intervention. These can be financial and non-financial. The numbers achieving the outcomes need to be determined as this quantifies the numbers who have experienced the different impacts. Outputs are the direct, quantifiable product derived from the activity or intervention.

| Direct Stakeholder | Inputs | Outputs |
|---|---|---|
| **Down to Earth Project** | Staff time, specialist knowledge, administration of the project, resources (vehicle, equipment, welfare amenities, Agored accreditation, venue, clinical research monitoring and evaluation). Match funding: £50,104.00 | • 70 participants recruited and engaging in similar programme |

| | | |
|---|---|---|
| **Natural Resources Wales** | Part funding of the project (£48,000) and the time and specialist knowledge of a member of the Conservation and Land Management Team. | • Amount of invasive species cleared, trees thinned, and brambles cut back<br>• 107 people accessing local woodlands for health, well-being and recreation |
| **NHS patients with chronic illness and/or well-being limiting condition** | time and practical woodland management tasks | • 62 participants with relief from anxiety and depression doing practical activities outdoors<br>• 40 participants reporting increase in self-confidence and self-reliance<br>• 44 participants reporting increase in community connection<br>• 48 participants with improved practical skills<br>• 13 participants reporting increased mobility/improvements in physical health<br>• 48 participants with increased physical activity<br>• 3 participants moving to employment<br>• 2 participants moving to higher education |
| **NHS staff** | time, administration, transport of participants to and from project. | • 5 staff on programme reporting reduced work-related stress<br>• 6 staff reporting an improvement in personal mental health<br>• 6 staff reporting increased confidence in accessing different activities for rehab and recovery outdoors with staff benefitting from developing more positive working relationships with service users in a non-clinical, informal setting |
| **Volunteers** | time and skill | • 30 volunteers regularly attending voluntary organisation working outdoors<br>• 14 volunteers gaining physical exercise and improvements in mental well-being from working outdoors<br>• 14 volunteers acquiring new skills and knowledge |
| **Swansea Bay University Health Board** | money for staff wages | • 70 patients with improved mental health<br>• 70 patients actively engaging in their rehabilitation |

Table 7: Stakeholder inputs and outputs

## 2.2 Outcomes

Outcomes are the (long term) changes created for the stakeholders related to the activities or intervention in the scope of the analysis. Table 6 below lists a sample of the well-defined outcomes for each stakeholder group, quantifiable indicators of change and evidenced outcomes for Re-Connect. Significant and relevant well-defined outcomes were derived from the changes identified

by stakeholders and DTE. A full list is available in Appendix F. Unintended outcomes of the project are discussed following the table.

| Stakeholder | Indicator | Evidenced Outcome |
|---|---|---|
| **Natural Resources Wales** | Physical measurement of area worked by volunteers established through NRW communication and on-site visits.<br>-being and recreation. | Increase in biodiversity in local woodlands through decrease in invasive species present, clearing of woodland floor and thinning of the canopy. |
| **Down to Earth** | Average increase in PAX numbers based on year-on-year increase in PAX numbers on funded programmes over four year period (175) | Organisation benefits from increased recruitment of participants to similar healthcare and well-being programmes in the outdoors and provides further evidence as to the efficacy of this approach which will lead to further growth. |
| **Patients with long-term or chronic illness and/or Well-being Limited Condition** | Achievement of accredited unit in Sustainable Woodland Management or Taster Woodwork (n=48)<br><br>Post programme survey for PAX; participants asked to name practical and soft skills gained through attending providing qualitative evidence of practical skills gained for context of results.<br><br>Post programme survey for Support NHS staff about impact of programmes on participant pertaining to benefits to participants of the programmes providing qualitative evidence of practical skills gained for context of results. | Participants learn new work-relevant woodland skills and<br>training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009). |
| **Regular volunteers** | In session survey and informal discussion group feedback about what impact engagement has on wellbeing. Every participant surveyed/spoken with mentioned physical and mental health benefits and exercise. Each participant noted that being outdoors made them “feel better”, “feel more calm”, “feel | Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment. |

| | | |
|---|---|---|
| | happy" and/or "feel at one with nature". | |
| **NHS staff** | Post programme survey for Support NHS staff about impact of programmes on reduced work related stress levels as a result of attending the programme to support patients. *Being part of a Down to Earth programme supporting participants helped to increase my resilience and ability to deal with my work-related stress levels. Rate on a five-point scale: strongly disagree to strongly agree*. Answers for agree and strongly agree included. | 1. Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to efficiently manage stress and induce restoration (Calogiuri et al., 2014). |
| **SBUHB** | Participants engaging with at least two 4/5 hour sessions as marked on attendance register; virtual/telephone interviews with 3 NHS staff and Ward/Departmental managers | Through attending a rehabilitation and recovery programme in the outdoors, participants demonstrate an increased engagement in their healthcare and willingness to try a different approach. The benefits of patients engaging in their recovery and rehabilitation (patient activation) is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012). |
| **Local community** | Post programme monitoring from Referral Agencies about those previous participants that had engaged in volunteering in the community. | There is an increase in the number of people engaging in community volunteering projects which is a benefit to the wider community (Ramsey, 2012). |
| **Government** | Number of participants and volunteers gaining employment, self-reporting. | Reduction in Employment Support Allowance costs for the government. |

Table 8: Sample of stakeholder Indicators and outcomes and evidencing

It was not the specific aim of the Re-Connect programmes to get participants back to employment or enter into Higher Education, however, after the programmes ended, and through data gathered in post-monitoring, it was discovered that three persons had moved into part-time employment (see Case Study 2: Referral Agency Worker-Mal Edwards) and two participants had been accepted to university, where they are thriving. As these outcomes have such an impact upon participants' lives and as the Re-Connect programmes and Down to Earth were instrumental in the achievement of these outcomes, as testified by participants and Referral Agency Workers, they were included in the SROI. In addition, DTE has been credited through other funded projects, with helping get participants get back into employment, higher education and training, and volunteering. These are not outcomes that we have previously tracked through post monitoring. Yet, through this process of analysis for

the SROI report, recognition of these achievements is poignant and data on these outcomes will be collected for DTE henceforth.

**2.2.1 Unintended outcomes reported by stakeholders include:**

- Participants and volunteers: Gaining employment
- Participants: moving to higher education, socialising and making new friends; not feeling socially isolated because of illness, increased mobility
- Referral Agency Workers of residential care: The programmes gave structure to the week for many participants, something to look forward to, and in addition, helped them focus, which impacted positively on their behaviour throughout the week.

## 2.3 Analysis of investment

The financial investment for this project to develop and deliver programmes comes from two sources: Natural Resources Wales and Down to Earth Project. NRW contributed approximately half of the funding; additionally, the programmes were delivered mainly in local NRW woodlands. DTE match funded the project through the contribution of specialist staff time and knowledge to engage stakeholders in the programmes, capital resources such as tools, transport, equipment, Personal Protective Equipment for participants, and welfare facilities. Time and partnership working to develop, achieve part funding in grant form and recruit for the programmes was invested by DTE staff over the course of 24 months (see table 2.1).

Both participants and volunteers contributed their time to the project, which could not have occurred without this investment. The time of NHS staff to liaise with DTE, transport and support participants on the projects was very much valued but not essential, as three of the eight groups did not have NHS staff support and attended the project with their own transport.

Investment in the project from Swansea Bay University Health Board came in the form of payment of wages for the NHS staff and enabling said staff to have the time to accompany patients to support the project.

The total financial amount invested in Re-Connect (inclusive of staff wages and resources), and with volunteer and participant time given the financial proxy of the national living wage in Wales (£8.72 over 23 years old) of £40 for a day's work (4 hours and 7 sessions) is £161,788. 00.

## 2.4 Duration of outcomes

SROI calculations recognise that outcomes can continue after an activity has ended. Skills acquired by a stakeholder through an activity can be usefully applied after the activity has stopped. Therefore, an estimation of the duration of an outcome is necessary. Durations are estimated in terms of years in SROI calculations. A drop-off percentage is estimated for each outcome that lasts greater than one year; recognising that whilst an outcome may continue beyond one year, it may deteriorate as time progresses. Duration and drop off can be difficult to assess because it can vary for individuals and for different stakeholder groups.

The duration of different outcomes varied across the stakeholder groups. For participants with a chronic illness, improvements in physical and mental health and well-being were reported to last between two months to one year post programme participation.

Outcomes associated with socialisation and improvement in social networks for participants was judged to be a benefit that endured beyond the initial period of engagement. Interviews and survey responses from participants and NHS staff on behalf of participants indicated that friendships were made at DTE which were expected to last beyond the year. However, without further analysis of the duration new social networks and relationships lasted beyond initial engagement, the duration for social networks and relationships with participants has been reduced to impact within the first year post engagement. The exception to this is the duration of the value of going on/returning to higher education, where duration is 3 years for the degree duration, and the duration of value for volunteers attending regular volunteering sessions; DTE monitoring shows that 30 regular volunteers have been with the project for three years or more. The duration for this outcome has been reduced to three, though, to account for any drop offs from the wider volunteer database.

Volunteers were similarly questioned during volunteer sessions to ascertain duration and drop off regarding social networks and skills acquisition. There is precedence for a level of duration of three years for volunteers established through the North York Moors National Park Authority's *SROI: Measuring Health and Well-being Impact* (Lindsay and MacMurray, 2018) and through *ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project* (Marden, 2013).

## 2.5 Outcomes valuation

Not all outcomes achieved by an activity, project or intervention are economic. Social and environmental outcomes can, therefore, not be included in a traditional cost-benefit analysis, and these outcomes may not be included in the success/failure of the endeavour. SROI requires placing a financial value on the changes that activities and projects bring about. Assigning a monetary value to social impacts is challenging as these impacts do not have a market price. What is being calculated is the monetary value that corresponds to the impact of the outcome for individuals (Simsa et al., 2015) SROI calculations look to identify financial proxies to estimate the value of outcomes. An example of the financial proxies employed in this analysis are displayed below in table 7 with a complete list in Appendix E. The financial proxies for this forecast analysis have been sourced from a number of assured SROI reports and Social Value databases, suggesting they are accepted as appropriate measures. Stakeholders provided feedback on valuation of outcomes through ranking which outcomes had the greatest impact on them and how they would value this change. Stakeholder engagement in the SROI process is discussed further in 3.5 Stakeholder involvement in SROI process.

| Stakeholder | Outcome | Financial Proxy | Source |
|---|---|---|---|
| **Participants with long-term/chronic illness** | Through being engaged in physical activity outdoors, participants experience a decrease in feelings and symptoms of anxiety and depression (Beyer et al., 2016) which builds resilience in living with a long term, chronic illness (Vardakoulias, 2013) | £18,338.00<br><br>HACT v4 Outcome 28: Relief from anxiety and depression.<br>Based on DTE clinical research results, with an average decrease across the project of 53% in depression and anxiety, the costs associated with HACT v4 Outcome 28: *Relief from anxiety and depression in adults,* has been reduced by 50% to avoid overclaiming and in recognition that 46% of those not receiving mental health support reported they would have sought | Housing Associations Charitable Trust, 2014. Version 4; (Trotter et al., 2014). |

| | | | |
|---|---|---|---|
| | | mental health support if they had not had this project. (Outcome original proxy: £36.766.00) | |
| NRW | Increase in general public utilising local woodlands for health, well-being and recreation resulting in an increased awareness of the benefits of local woodlands and understanding of the importance of sustainably managing local woodlands in Wales for biodiversity and public access. | £148.00<br>Cost associated with an adult continued education course in leisure category. Increased awareness in community reflects same outcome associated with lifelong learning. | Fujiwara, 2012. Valuing the impact of Adult Learning, Adult lifelong learning: improvement in health |

Table 9: Example of outcomes and valuations employed for each stakeholder

# 3. Impact

## 3.1 Deadweight

A reduction for deadweight reflects the fact that a proportion of an outcome might have happened without any activity or intervention.

A complete list of deadweight ascribed to each indicator and the rationale behind its incorporation is listed in Appendix D. Included with the rationale is a description of the other areas or groups against which deadweight is estimated.

During the practical sessions, participants, staff and volunteers, discussed with DTE staff on an informal basis if they were aware of other local groups or services available that could offer the same opportunities and similar well-being results. This is part of the DTE approach in person-centred programmes. The relaxed nature of the sessions, the informal atmosphere, natural environment, and involvement of other group members experiencing the similar issues, regularly prompt participants, supporting staff and volunteers to be open and disclose personal information that in another setting, they may be hesitant to. Based on these answers in addition to research to explore different options and organisations, a judgement was made.

What was taken into consideration was the unique nature of DTE programmes, the clinical research to evidence results, and the availability of a similar calibre of resourced programmes. Participants remarked that they had tried some form of support previously but struggled to engage. Other participants noted that whilst still attending some form of rehabilitation or support group, the diversity of the activities, the inclusive and adaptable practice, the multi-layered learning and support and the environment made the difference to enjoyment and engagement.

All health outcomes for participants with long-term illnesses have been assigned a deadweight of 30%, recognising that health objectives may have occurred without any intervention. Social and educational outcomes have been set between 10% to 50% to reflect the unique nature of the project and the level of additional support that would be needed outside of this project to achieve the outcomes.

Volunteer deadweight and attribution rates were set at 27% with the rationale that 27% of all adults in Wales volunteer on a regular basis (Welsh Government, 2020), therefore the outcome could be achieved through engagement in other community projects.

For NHS staff, deadweight was set at 13% for any health improvements. This is based on research that showed access to Cognitive Behavioural Therapy (CBT), the most recognised form of support for mental health for NHS staff, in the workplace with or without relaxation therapy for periods of follow-up from 1 month to 6 months showed a 13% decrease in relative risk of stress compared to no intervention (Ruotsalainen et al., 2015). CBT was conservatively assumed to lead to a reduced risk of stress of 13% relative to no intervention (Public Health England, 2017).

***I feel that doing a down to earth programme has helped me towards being who I used to be, before doing this I felt I was always on the outside looking in but with the groups I was getting more involved making more of an input. It has helped me with mobility. I would never have attempted walking in the woods before but doing the programme has made me a bit more sure footed, i.e., more aware of my surroundings and my abilities. It made me feel part of a team and not just me it has boosted my confidence no end.*** **-Re-Connect participant**

## 3.2 Attribution

Attribution takes account of external factors, or the contribution of others, which may have played a part in the changes that are identified. Down to Earth think that without access to these funded programmes, the participants, volunteers and NHS staff would be unlikely to have reported the improvements in health and well-being that they did. Attribution is difficult to calculate, however, in calculating this Down to Earth has used conservative estimates to avoid over-claiming and sourced precedents for the percentages calculated. A description of the other organisations to which outcomes may have been attributed is included in section 1.7.1 Attribution, table 2: Organisations included in attribution rates and discussed further in the rationale.

Participants attending programmes often have a complex set of healthcare needs that require a range of support organisations and individuals. Every aspect of this support network may be influential in the change and positive benefits experienced. 70% of the participants were being supported regularly through a service specifically focused on their health conditions. Therefore, with regards to improved health conditions, a higher rate of attribution (30%) was given to participants and volunteers than to those outcomes associated with learning and socialisation (10-25%). The exception being for those outcomes associated with higher education and employment. These were allocated a higher attribution rate acknowledging the various factors and levels of support needed to take that next big step, such as family, friends, clinical support. See following feedback from an Early Intervention Psychosis Service Manager for SBUHB.

*In our practice, we have found that our service users have wanted to participate in work, educational or social activities, but have lacked the confidence or motivation to do so. We were looking for a service that could provide a "stepping stone" in helping these young people work towards their goals without overwhelming them and putting them in intense situations which may contribute to a further decline in confidence, mental health and functioning. Staff participate in activities alongside the service users, which has helped us to develop a therapeutic relationship in a non-clinical setting. The activities were educational and through these activities the service users have also obtained accreditations, which has given them a confidence boost too.*

*Two service users are now in full time education, the programme helped to encourage a healthier day time routine e.g., get up in the morning and participate in activities, being active and socialising / having fun. From this they improved in general and went to enrol in university - something they thought they would never be able to do.*

For NHS staff, the attribution rates for health outcomes and work-related stress were set at 46% in recognition of the support services offered to NHS staff for work related stress and personal mental health. Observed experience in Cardiff suggested that significant positive impacts on mental health were seen in 46% of those who received CBT (Ruotsalainen et al., 2015).

Volunteer and Community outcome attribution rates were set at 27%, recognising that 27% of all adults in Wales volunteer and this outcome may be achieved without this project.

A complete list of attribution rates ascribed to each indicator and the rationale behind its incorporation is listed in Appendix E. Included with the rationale is a description of the other areas or groups against which attribution is estimated.

## 3.3 Displacement

Displacement applies when one outcome is achieved, but at the expense of another, or another stakeholder is adversely affected. In relation to the Re-Connect programmes, sources of displacement could have arisen as a result of NHS staff being diverted from other interventions. However, it is difficult to calculate the effect of this. There is no comparable service of this kind in the geographical region, using the woodlands and peer support to improve health and well-being, to enhance rehabilitation and improve recovery times in those with chronic health conditions, and to accredit practical skills and teach environmental awareness and engagement. As a result, DTE is confident that they have not displaced other courses or stakeholders through the delivery of these programmes, unless stated below.

**Regular volunteers:** A displacement rate of 27% was included for all outcomes relating to volunteering. A Welsh Government survey in 2020 found that 27% of all people in Wales volunteer at least once a month. If volunteers had not been going to DTE, they may have sought volunteering in other community projects.

## 3.4 Drop off

Drop off rates for all outcomes that last longer than a year, include a 25% drop off rate or greater recognising that benefits gained in the first year of a project may lessen over the remaining period of impact duration. The exception is the outcome for DTE staff which states that employees remain in their place of employment for a minimum of 2 years and report high levels of job satisfaction. Therefore a 25% drop-off rate has not been included.

# 4. Social return calculation

## 4.1 Calculating the SROI

The financial impact of the Re-Connect project, its development and delivery of intervention is calculated using the formula displayed below in figure 2.

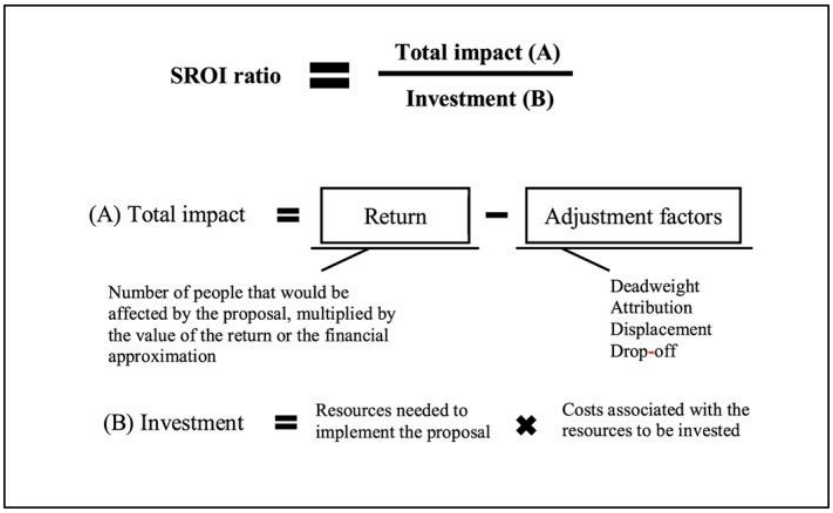


Figure 2: SROI calculation (Merino et al, 2020)

- A = £ 1, 207,660.10
- B = Investment = £161,788.00
- Total Present Value = £1,478,480.06
- Net Present Value (minus the investment) = £1,316,764.04

Year of delivery (period of activity): A = £1,207, 660.10

Investment (money, time, resources): B = £161,788.00

Social Return (value per amount invested): £1: £7.46

As is shown in table 9 below, the return of an outcome can last a number of years and can be achieved during the period of activity or after. Of the 22 outcomes 10 had a duration of two or three years and were applicable to both the period of activity and after. A drop off rate for each of these outcomes was assigned, varying between 25%-27%, for each year after year one. This details what is displayed in table 8. It explains why the calculation of the return for the period of activity divided by the initial investment returns a social value ratio for the period of activity at £1: £7.46. When the duration of the impact of the outcomes is included within the equation,

- Total Present Value = £1,478,480.06

Investment = £161,788.00

Social Return (value per amount invested): £1: £9.14

| | | | | | | |
|---|---|---|---|---|---|---|
| **Present value of each year** | 1,207,660.10 | 167,594.32 | 100,156.21 | 3,069.42 | 0.00 | 0.00 |
| **Total Present Value (PV)** | | | | | | 1,478,480.06 |
| **Net Present Value (PV minus the investment)** | | | | | | 1,316,692.06 |
| **Social Return (Value per amount invested)** | | | | | | 9.14 |

Table 10: Annual return of outcomes annually (duration); inclusive of 25% annual drop off rate

*For full calculation of the input and outcome valuations and rate of return over three years, please see separate Down to Earth Re-Connect Value Map Jan 21, attached with this report.

## 4.2 Sensitivity analysis

It is important that the SROI calculations are tested by understanding how the judgements made throughout the analysis affect the final result. The aim of such an analysis is to test which assumptions have the greatest effect on your model (Social Value U.K., 2016). By testing the sensitivity of changes to the key assumptions of each of these outcomes was investigated whether and to what extent the total ratio is affected.

Outcomes across the range of stakeholders were subjected to the sensitivity analysis in the acknowledgement that some outcomes would have occurred anyway. Assumptions made as to how and to what degree these outcomes were achieved were put through a sensitivity analysis with results shown in table 10.

| Scenario | Sensitivity test | Outcome test | New value | Baseline social return ratio | New social return ratio | Difference |
|---|---|---|---|---|---|---|
| 1 | Increase duration of outcomes for all participants and volunteers | All outcomes of one year are increased by one-year | +1 yr. duration | £9.14 | £15.08 | +£6.94 |
| 2 | Decrease duration of outcomes for all participants and volunteers | All outcomes are decreased to one-year | -1 yr. duration | £9.14 | £9.00 | -£0.14 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | All outcomes with an attribution estimate of 20% of higher | -5% attribution | £9.14 | £9.56 | +£0.42 |
| 3 | Change attribution estimations for all participants and volunteers | All outcomes with an attribution estimate of 15% or lower | +5% attribution | £9.14 | £9.14 | No change |
| 4 | Increase deadweight estimations all participants and volunteers | All positive outcomes are increased by 10% | +10% deadweight | £9.14 | £8.24 | -£0.90 |
| 5 | Increase drop-off estimates for all stakeholder groups | All outcomes in the SROI | +5% drop-off | £9.14 | £9.12 | -£0.08 |
| 6 | Increase duration of outcomes for other direct and indirect beneficiaries | All outcomes with more than one-year duration | +1 yr. duration | £9.14 | £10.65 | +£1.51 |

Table 11: Sensitivity analysis

The sensitivity analysis resulted in a band of value between £8.24 to £15.08. In all scenarios tested the SROI ratio remains above 1:1, indicating that social value that is forecast to be created is likely to be greater than the investment that is forecast to be made in the project (Australian Government, 2014).

# 5. Audit trail

## 5.1 Stakeholders not included

During the initial meeting at the beginning of the SROI analysis, in a roundtable discussion with the company Director, Project Management and Programme Facilitators (2), twelve direct and indirect beneficiaries were identified. Of these twelve, eight were include in this analysis, highlighted in bold.

- **Participants with chronic illness**
- **Regular volunteers**
- **Swansea Bay University Health Board**

- **Natural Resources Wales**
- Local environment
- **Local community**
- **Local government**
- **NHS staff supporting participants**
- Family members of participants
- Friends of participants
- Employers
- **Down to Earth Project**

The reasons given for excluding other stakeholders of the Re-Connect Project were the inability to measure the change that occurred due to lack of access to stakeholder groups (family members of participants, friends of participants, employers) or the ability to measure the change occurring (local environment).

## 5.2 Outcomes not included

A number of outcomes were identified but not included in the analysis. See table 11 below.

| Stakeholder | Outcome |
|---|---|
| NRW | Work towards achieving Well-Being Objectives in accordance with Well-Being of Future Generations (Wales) Act. |
| Patients | Increase in feelings of teamwork |
| | Increase in feelings of self-worth |
| NHS staff | Benefit to staff of watching patients thrive |
| SBUHB | Reduction in waiting list for mental health services |
| | Improved health outcomes associated with loneliness and social exclusion including depression, cardiovascular disease, quality of life, general health, biological markers of health, cognitive function and mortality (Courtin and Knapp, 2015) reduce need for clinical intervention by NHS. |
| Down to Earth | Staff earn an income, positive engagement with participants, improved wellbeing because of nature of work and in outdoor environment, remain employed for long period of time and have stated the enhanced benefit of being employed by DTE. |

Table 12: Outcomes not included in SROI analysis

The reason why the NRW outcome was not used was because it was tautological and part of NRW's remit. The two outcomes for patients were not included as only a certain percentage of the respondents chose this as an outcome, whilst other outcomes were deemed to be of greater importance amongst the stakeholders. As there was no data base or way of obtaining the information needed for these outcomes from NHS Wales, these outcomes were not included. Finally, an outcome identified for Down to Earth related to the enjoyment and well-being that staff experienced from the nature of their work, the environment and being long term employees believing in their work. However, although it was felt to be an outcome that was unique to the organisation and feedback sessions and interviews had been held with DTE employees, there is not a way to evidence this. It was therefore deemed tautological and not used. There may be potential for using the Patients outcomes for future SROI reporting.

## 5.3 Financial proxies not included

There were a number of financial proxies researched but not included. For example, a valuation of volunteer hours was based on the living wage for age 23+ as used in the Wildlife Trusts SROI by Bagnal et al, 2018, not based on Fujiwara et al., 2013 as originally intended.

# 6. Recommendations

This forecast analysis underlined the importance of identifying and engaging stakeholders to determine the true valuation of the project, not the economic impact alone. Down to Earth Project cost their activities and programmes at a higher rate than other organisations who may offer one or two similar activities. The higher rate reflects the specialist knowledge of staff, robust evidence bases for success of the DTE approach, diversity of activities and programmes, and quality of teaching and resources. Whilst there was quantative data in the form of attendance rates, clinical monitoring and accreditation achievements and qualitative data in the form of feedback from service users, there is a lack of evidence as to what the extra-financial benefits of participation in a programme are for stakeholders. Engaging stakeholders during project planning and development will enable Down to Earth to forecast change that may occur and target funding and resources accordingly.

Results from this process to establish an assessment framework through a forecast SROI will and has informed evaluation of a social housing project currently being delivered by DTE and Coastal housing in South Wales. Learning from this forecast SROI has already been applied to this project with stakeholders currently involved in the development of the Theory of Change. Future reporting on this new project will include knowledge obtained through this forecast analysis to progress Down to Earth's SROI reporting to an evaluative analysis. This reporting is and will include greater stakeholder engagement, including other stakeholders from those we are providing an intervention for, asking for negatives and engaging stakeholders in valuation of outcomes.

Additionally, DTE are currently contracted to deliver a three-year project to build green hospital infrastructure. Presently in the consultation and planning stage of the project, knowledge and experience gained from the development of this forecast SROI is informing how DTE is engaging with stakeholders in the project for the development of an evaluative analysis of the project.

The results of the SROI analysis will be utilised by DTE in future funding bids and participant recruitment to reflect an accurate valuation of the work that DTE perform and the specialisation of its approach.

# 7. References


1. Bagnall, A.M., Freeman, C., Southby, K., Brymer, E., 2018. Social Return on Investment analysis of the health and wellbeing impacts of Wildlife Trust programmes, Centre for Health Promotion Research, School of Health and Community Studies, Leeds Beckett University, Carnegie School of Sport, Leeds Beckett University Social Return on Investment. Available at: https://www.wildlifetrusts.org/sites/default/files/2019-09/SROI%20Report%20FINAL%20-%20DIGITAL.pdf.
2. Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. Psychological Review, 84(2), 191–215. Available at: https://psycnet.apa.org/record/1977-25733-001
3. Barton, J., Griffin, M., Pretty J., 2012. Exercise-, nature- and socially interactive-based initiatives improve mood and self-esteem in the clinical population. *Perspect Public Health*, March 2012, 132, 2, pp. 89-96.
4. Bates, B. and Yentumi-Orofori, R., 2013. Veteran's Contact Point Social Return on Investment SROI Report. Available at: https://www.socialvalueuk.org/app/uploads/2016/03/vcp_sroi_final_draft_complete.pdf .
5. Binder, M., 2015. Volunteering and Life Satisfaction: a closer look at the hypothesis that volunteering more strongly benefits the unhappy, Applied Economics Letters, 22, 11, pp 874 – 885.
6. Blood, I., 2017. The anatomy of resilience: Toolkit, *Imogen Blood and Associates and Housing and Support Partnership*, Social Care Wales, Welsh Government. Available at: https://socialcare.wales/cms_assets/file-uploads/SCW-Digital-English-AoR-Toolkitv02.pdf.
7. Bowler, D.E., Buyung-Ali, L.M., Knight, T.M., 2010. A systematic review of evidence for the added benefits to health of exposure to natural environments. BMC Public Health 10, 456.
8. Burls, A., 2007. People and green spaces. Journal of Public Mental Health 6, 3, pp. 24–39.
9. Cabassa, L.J., Gomes, A.P., Meyreles, Q., Capitelli, L., Younge, R., Dragatsi, D., Alvarez, J., Nicasio, A., Druss, B., Lewis-Fernández, R., 2013. Primary health care experiences of Hispanics with serious mental illness: a mixed-methods study, *Administration and Policy in Mental Health*, October 26, 2013.
10. Cacioppo, J. T. and Cacioppo, S., 2014. Social Relationships and Health: The Toxic Effects of Perceived Social Isolation. *Social and personality psychology compass*, *8*, 2, pp. 58–72.
11. Calogiuri, G., Evensen, K., Weydahl, A., Andersson, K., Patil, G., Ihlebæk, C., Raanaas, R., 2016. Green exercise as a workplace intervention to reduce job stress. Results from a pilot study. Work. 53. 99-111. Available at: https://www.researchgate.net/publication/283854558_Green_exercise_as_a_workplace_intervention_to_reduce_job_stress_Results_from_a_pilot_study
12. Calm City Mind, 2020. Cost of stress reduction, mindfulness course in nature. Available at: https://www.calmcitymind.com/.
13. Cambell, D., 2020. NHS hospital staff illness or absence up to three times usual level, the guardian. 3.12.20. Accessed: https://www.theguardian.com/uk-news/2020/dec/30/nhs-hospital-staff-illness-or-absence-up-to-three-times-usual-level.
14. Chaudhury, P., Banerjee, D., 2020. Recovering With Nature: A Review of Ecotherapy and Implications for the COVID-19 Pandemic. Front Public Health, Dec 10, 2020.
15. Courtin, E. and Knapp, M., 2015. Social isolation, loneliness and health in old age: a scoping review. Health and Social care in the community, V 25, 3, pp.799-812. Date of Issue on-line May 2017. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12311 .

16. Department for Health & Social Services, 2007. Designed to Improve Health and the Management of Chronic Conditions in Wales: An integrated model and framework, Welsh Assembly Government. Available at: http://www.wales.nhs.uk/documents/chronic_conditions_english.pdf .
17. Envoy Partnership, 2018. Self-Care Social Prescribing Kensington & Chelsea Social Council and NHS West London Clinical Commissioning Group Social Return on Investment, January 2018. Available at: https://www.kcsc.org.uk/sites/kcsc.org.uk/civi_files/files/civicrm/persist/contribute/files/Self%20Care/7641_SROI-Report_DIGITAL_AW.pdf.
18. Field, J., 2009. Good for your soul? Adult learning and mental well-being, International journal of Lifelong Education V 28; I 2; pp 175-191, 27.3.2009. Available at: Good for your soul? Adult learning and mental well-being: International Journal of Lifelong Education: Vol 28, No 2 (tandfonline.com).
19. Fujiwara, D. 2012. Valuing the Impact of Adult Learning: An analysis of the effect of adult learning on different domains in life, National Institute for Adult Continuing Education. Available at: https://www.voced.edu.au/content/ngv:52639.
20. Fujiwara, D., Oroyemi, P., and McKinnon, E., 2013. Wellbeing and civil society: Estimating the value of volunteering using subjective wellbeing data, Department for Work and Pensions and the Cabinet Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/221227/WP112.pdf .
21. Godwin, K.M., Wasserman, J., Ostwald, S.K., 2011. Cost associated with stroke: outpatient rehabilitative services and medication. Top Stroke Rehabilitation, 2011 Oct. Available at: https://pubmed.ncbi.nlm.nih.gov/22120036/.
22. Gray, B.J., Bright, D., Bolton, S. and Davies, A.R., 2020. Towards a healthy and sustainable workforce for the future. The current health and wellbeing of the nursing and midwifery workforce in Wales. Cardiff: Public Health Wales NHS Trust. Available at: https://phw.nhs.wales/publications/publications1/towards-a-healthy-and-sustainable-workforce-for-the-future1/.
23. HACT and Fujiwara, D., 2018. Community investment values from the Social Value Bank, Source: www.socialvaluebank.org, License: Creative Commons Attribution-Non-Commercial-No Derivatives license (http://creativecommons.org/licenses/by-nc-nd/4.0/deed.en_GB).
24. Hartig, T. and Kahn, P. H., 2016. Living in cities, naturally. Science, 352, pp. 938–940.
25. Health Education England, 2019. NHS Staff and Learner's Mental Wellbeing Commission. Available at: https://www.hee.nhs.uk/our-work/mental-wellbeing-report .
26. Hibbard, J. and Gilburt, H., 2014. Supporting people to manage their health: An introduction to patient activation, The King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf .
27. Jones, M., Pitt, H., Oxford, L., Orme, J., Gray, S, Salmon, D., Means, R., Weitkamp, E., Kimberlee, R., and Powell, J., 2016. Food for Life: A Social Return on Investment Analysis of the Locally Commissioned Programme. Full Report. UWE Bristol.
28. Kempton et al., 2020. Quality Adjusted Life Years (QALYs) in Social Return on Investment (SROI). Available at: https://envoypartnership.com/blog/2020/06/10/quality-adjusted-life-years-qalys-in-social-return-on-investment-sroi/ .
29. Linsley, P. and McMurray, R., 2018. North York Moors National Parks Authority: Measuring Health and Well-being Impact, The York Management School, York. Available at:

https://www.northyorkmoors.org.uk/about-us/how-the-authority-works/health-and-well-being/Social-Return-on-Investment-Final-report-2018.pdf.

30. London School of Economics and Political Science, 2012. How mental illness loses out in the NHS: a report by The Centre for Economic Performance's Mental Health Policy Group. Available at: https://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf .
31. Marden, R. 2013. ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, Family Action network, R.N. Insight. Available at: https://www.family-action.org.uk/content/uploads/2014/07/ESCAPE-SROI-Assured-Report.pdf.
32. Marselle M.R., Martens D., Dallimer M., Irvine K.N., 2019. Review of the Mental Health and Well-being Benefits of Biodiversity. In: Marselle M., Stadler J., Korn H., Irvine K., Bonn A., eds. Biodiversity and Health in the Face of Climate Change, Springer. Available at: https://link.springer.com/chapter/10.1007/978-3-030-02318-8_9.
33. Merino, María & Jiménez, Margarita & Manito, Nicolas & Casariego, Emilio & Ivanova, Yoana & Gonzalez-Dominguez, Almudena & Saturnino, Maite & Hidalgo-Vega, Alvaro & Blanch, Carles, 2020. The social return on investment of a new approach to heart failure in the Spanish National Health System. *ESC Heart Failure*. Available at: https://www.researchgate.net/publication/338481104_The_social_return_on_investment_of_a_new_approach_to_heart_failure_in_the_Spanish_National_Health_System .
34. Molsher, R. and Townsend, M., 2015. Improving Wellbeing and Environmental Stewardship Through Volunteering in Nature. Ecohealth, March 2016, 13(1), pp. 151-5.
35. National Health Service Wales, 2020. NHS Wales-About Us. NHS Wales website. https://www.wales.nhs.uk/nhswalesaboutus#:~:text=The%20NHS%20in%20Wales%20employs,of%20its%20total%20annual%20cost.
36. National Health Service, 2021. Returning to work after mental health issues. Available at: Returning to work after mental health issues – NHS (www.nhs.uk)
37. Natural Resources Wales, 2017. Managing today's natural resources for tomorrow's generations Well-being Statement 2017/18. Available at: https://naturalresources.wales/about-us/what-we-do/how-we-work/our-well-being-statement/?lang=en.
38. Nicholls, J., Lawlor, E., Neitzert, E. and Goodspeed, T., 2012. A guide to Social Return on Investment, Cupitt, S (ed), *Social Value UK*, January 2012. Available at: http://www.socialvaluelab.org.uk/wp-content/uploads/2016/09/SROI-a-guide-to-social-return-on-investment.pdf.
39. Off Centre and University of Bristol, 2012. Off Centre Social Return on Investment: Summary Report. Available at: http://static1.1.sqspcdn.com/static/f/579533/20632434/1350309467913/Off+Centre+SROI+Report+Final.pdf?token=b0e4eioC2Ajcpc6cZsqxGGHAPW8%3D.
40. Paine, A., McKay, S. and Moro, D., 2013. Volunteering and employability, *Voluntary Sector Review*, 4 3, pp. 355-376.
41. Park, B.J., Tsunetsugu, Y., Kasetani, T., Kagawa, T., & Miyazaki, Y. (2010). The physiological effects of Shinrin-yoku (taking in the forest atmosphere or forest bathing): Evidence from field experiments in 24 forests across Japan. Environmental Health and Preventative Medicine, 15, 18–26.
42. Patel S.S., Rogers M.B., Amlöt R., Rubin G.J., 2017. What Do We Mean by 'Community Resilience'? A Systematic Literature Review of How It Is Defined in the Literature. *Public Library of Science Currents*. 2017 Feb 1, 9. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29188132.

43. Penedo, F. and Dahn, J., 2005. Exercise and well-being: a review of mental and physical health benefits associated with physical activity, Current Opinion in Psychiatry, March 2005, V 18, I 2, pp 189-193.
44. Pompei, F. and Selezneva, E., 2019. Unemployment and education mismatch in the EU before and after the financial crisis, Journal of Policy Modelling, pp. 1-26.
45. Public Health England, 2017. Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health. Prepared by: David McDaid, A-La Park and Martin Knapp, *Personal Social Services Research Unit, London School of Economics and Political Science*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640714/Commissioning_effective_mental_health_prevention_report.pdf .
46. Public Health Wales, 2018. Our Well-being Statement. Available at: http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20-%20Our%20Well-being%20Statement%20-%202018.pdf .
47. Ramsey, N., 2012. Understanding how volunteering creates stronger communities – A literature review, Institute for Volunteering Research, July 2012. Available at: https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/u/n/d/understanding-how-volunteering-creates-stronger-communities.pdf.
48. Roberts, A., Marshall, L. and Charlesworth, A., 2012. The funding pressures facing the NHS from 2010/11 to 2021/22 – A decade of austerity? Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/research/a-decade-of-austerity-the-funding-pressures-facing-the-nhs-from-2010-11-to-2021-22 .
49. Roberts, A. and Watt, T. 2016. The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31, The Health Foundation. Available at: http://www.health.org.uk/sites/health/files/PathToSustainability_0.pdf.
50. Royal Pharmaceutical Society of Wales, 2016. Improving Care for People with Long Term Conditions, Policy document. Available at: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/LTC%20-%20Wales.pdf.
51. Ruotsalainen, J.H., Verbeek, J.H., Mariné, A., Serra, C., 2014. Preventing occupational stress in healthcare workers. Cochrane Database System Review, 13, 11. Available at: https://pubmed.ncbi.nlm.nih.gov/25391582/ .
52. Ryvicker, M., Peng, T.R., Feldman, P.H., 2012. Patient activation and disparate health care outcomes in a racially diverse sample of chronically ill older adults, Journal of Health Care for the Poor and Underserved, V 23, 4, pp. 1577–89.
53. Shaheen, F., 2011. Degrees of value How universities benefit society, New Economics Foundation, Universities U.K., University Partnership Programme. June 2011. Available at: https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2011/degrees-of-value.pdf.
54. Shepherd, G., Boardman, J., and Slade, M., 2008. Making Recovery a Reality, London: Sainsbury Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/publications/making-recovery-reality.
55. Silverman, M.N., and Deuster, P.A., 2014. Biological mechanisms underlying the role of physical fitness in health and resilience, Interface focus, V 4,5.
56. Simsa, R., Herndler, M. and Totter, M., 2015. Meta-Analysis of SROI Studies – Indicators and Proxies, TSI Working Paper Series No. 6. Seventh Framework Programme (grant agreement 613034), European Union. Brussels: Third Sector Impact. Available at:

https://thirdsectorimpact.eu/site/assets/uploads/documentations/tsi-working-paper-no-6-meta-analysis-of-sroi-studies-indicators-and-proxies/TSI_WP6_SROI_Impact1.pdf .

57. Social Value U.K., 2016. SROI Guide: Stage 5: Calculating the SROI. Available at: https://www.socialvalueuk.org/app/uploads/2016/03/sroi_guide-stage5.pdf .
58. Summers, J.K. and Vivian, D.N., 2018. Ecotherapy – A Forgotten Ecosystem Service: A Review. Front Psychol. Aug 3, 2018, 9, p. 1389.
59. Thompson, C. W., Aspinall, P., Roe, J., 2014. Access to Green Space in Disadvantaged Urban Communities: Evidence of salutogenic effects based on biomarker and self-report measures of wellbeing, Procedia – Social and Behavioral Sciences, 153, pp. 10 – 22. Available at: https://core.ac.uk/download/pdf/82002938.pdf .
60. Trotter, L., Vine, J. and Fujiwara, D., 2015. The health impacts of housing associations' community investment activities. HACT. May 2015 London. http://www.hact.org.uk/sites/default/files/uploads/Archives/2015/6/HACT%20Investment%20Activities%20report%202015.pdf.
61. U.K. Department of Education, 2019. Graduates continue to benefit with higher earnings, 25.8.2019. Available at: Graduates continue to benefit with higher earnings – GOV.UK (www.gov.uk).
62. U.S. Department of Health and Human Services, 2018. Physical Activity Guidelines for Americans, 2nd edition. *Washington, DC: U.S. Department of Health and Human Services*, 2018. Available at: https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf#page=81.
63. van Bergen, A.P.L., R L M Wolf, J.R.L.M., Badou, M., de Wilde-Schutten, K., Ijzelenberg, W., Schreurs, Bouwine Carlier, H., Hoff, S.J.M. and van Hemert, A.M., 2019.The association between social exclusion or inclusion and health in EU and OECD countries: a systematic review, *European Journal of Public Health*, 29, 3, June 2019, pp. 575–582.
64. Vardakoulias, O., 2013. The Economic Benefits of Ecominds: A Case Study Approach. *NEF Consulting*. Available at https://www.mind.org.uk/media/338566/The-Economic-Benefits-of-Ecominds-report.pdf .
65. Von Korff, M., Gruman, J., Schaefer, J., Curry, S.J., Wagner, E.H., 1997. Collaborative Management of Chronic Illness, MPH, Annals of Internal Medicene, PerspectivesDecember 15, 1997. Available at: https://www.acpjournals.org/doi/abs/10.7326/0003-4819-127-12-199712150-00008.
66. Ward Thompson, C., Peter Aspinall, P., Jenny Roe, J., 2014. Access to Green Space in Disadvantaged Urban Communities: Evidence of salutogenic effects based on biomarker and self-report measures of wellbeing, Procedia – Social and Behavioral Sciences, 153, pp. 10 – 22.
67. Welsh Government, 2015. The Well-Being of Future Generations (Wales) Act 2015. Available at: https://www.futuregenerations.wales/wp-content/uploads/2017/02/150623-guide-to-the-fg-act-en.pdf.
68. Welsh Government, 2019. A Healthier Wales: our Plan for Health and Social Care, https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf.
69. Welsh Government, 2020. Volunteering (National Survey for Wales): April 2019 to March 2020. Key findings, 10.12.20. Available at: https://gov.wales/volunteering-national-survey-wales-april-2019-march-2020-html .

70. Welsh NHS Confederation, 2017. Mental health practice in Wales: A briefing for Ams, July 2017. Available at: https://www.nhsconfed.org/-/media/Confederation/Files/Wales-Confed/WNHSC-Briefing-MH-Briefing.pdf.
71. Welsh NHS Confederation, 2018. The Future of Funding the Welsh NHS, The Welsh NHS Confederation, December 2018. Available at: https://www.nhsconfed.org/-/media/Confederation/Files/Wales-Confed/The-Future-Funding-of-Welsh-NHS.pdf .
72. White, M.P., Alcock, I., Grellier, J. et al. Spending at least 120 minutes a week in nature is associated with good health and wellbeing. Sci Rep 9, p. 7730.
73. Wild things Environmental Education, 2020. Cost of 2-day course in environmental education. Available at: Environmental Education; https://wild-things.org.uk/our-events/environmental-education-in-social-care-eesc-training-course/ .

## Appendix A: Participant, NHS staff, and volunteer questionnaires

# Re-Connect: Participant Post Programme Monitoring

Determining the long-term impact of our work on Down to Earth participants.

*Please rate the statements from 1 (disagree) to 5(agree).
All responses are anonymous.

1. Attending a programme with Down to Earth Project has helped with my recovery or rehabilitation.

1 2 3 4 5

2. I have an improved knowledge in Sustainable Woodland Management and techniques from involvement in a programme with Down to Earth Project.

1 2 3 4 5

3. I have an improved connection to my community through participating in a community project with Down to Earth and feel more capable and confident to get involved with a community project in the future.

1 2 3 4 5

4. Attending a programme with Down to Earth Project had a positive impact on my mental health.

1 2 3 4 5

5. I would recommend participating in a programme with Down to Earth to others living with long term or chronic illness.

1 2 3 4 5

6. What skills do you feel you acquired skills through participating in a Down to Earth programme?

- Practical skills: increased mobility and learning to pace yourself during activity
- Soft skills: increased confidence, teamwork, peer support, self-reliance

7. If you had not accessed this project, do you feel you would have looked for clinical treatment for mental health support?

Yes No

8. Is there anything else you would like to tell us about your participant experience at Down to Earth?

Link to online form:

https://forms.office.com/Pages/ResponsePage.aspx?id=Psuc4Z_ZEEWgvhNsY4XtoNiILrtBVtpLn7GK_49jgTRUNkZDME5DWE80UTlJTUlFQVNNWDg2WUNaRy4u

# Down to Earth Project: Post programme feedback

Referral Agency Feedback NRW Re-Connect Project: determining the impact of our programmes on Referral Agency Workers.

Please rate from 1-5, with 5 being the highest.
All answers are anonymous.

1. Supporting participants on a programme with Down to Earth had a positive impact on my personal health and well-being.

1 2 3 4 5

2. Being part of a Down to Earth programme supporting participants helped to increase my resilience and ability to deal with my work-related stress levels.

1 2 3 4 5

3. Through attending a Down to Earth programme with participants, I feel I have gained practical skills and have more confidence in accessing the outdoors for recovery and rehabilitation of patients.

1 2 3 4 5

4. How would you value the impact of participant's experience of our programmes on your own work experience? For example, being able to access woodlands weekly with participants, supporting and getting involved in practical sustainable woodland management tasks, etc.

5. Is there anything else you would like to share with us from your personal experience of being a part of a Down to Earth programme?

Link to online form:

https://forms.office.com/Pages/ResponsePage.aspx?id=Psuc4Z_ZEEWgvhNsY4XtoNiILrtBVtpLn7GK_49jgTRUQlJZQ1ROQ0lGRFRWRjEzQjc4WDVJRFdWSy4u

# NRW Re-Connect Volunteer Feedback

We would like to hear about your experience volunteering with Down to Earth Project. We value all feedback that you can provide for us. Any other comments you'd care to make would be appreciated.

1). How has volunteering with us had an impact on your well-being?

2). Would you recommend volunteering with Down to Earth to friends and family? Why or why not?

3). Has being involved in this project enabled you to gain knowledge about how sustainable development at a local level has a positive impact concerning climate change? How?

4). Do you feel work you do as a volunteer is engaging and rewarding?

5). What do you enjoy the most about volunteering with Down to Earth Project? What do you enjoy the least?

6). If given the opportunity, would you volunteer with Down to Earth Project more than once a month?

**Thank you for taking the time to complete this for us.**

# Appendix B: Theory of Change: Re-Connect Project

## Impact: **Building resilience in individuals, our communities and local environment through the development and delivery of clinically researched programmes of meaningful outdoor activity.**

## Natural Resources Wales:

**Inputs**: funding and woodland location
**Activities:** Part funding of woodland-based health care programme
**Outputs:**

1. Reduction in invasive species cover
2. Improved access to local woodlands

**Outcomes:**

1. Increase in biodiversity in local woodlands
2. Increase in general public utilising local woodlands and become more invested in their care and management

## Patients with long-term, chronic illness:

**Inputs:** time
**Activities:**

- Participants engage in a community project with others who have shared experience of chronic illness.
- Participants attend programmes working outdoors doing practical activities in which they gain accreditation.

**Outputs:**

1. Accreditation of practical skills in Sustainable Woodland Management
2. Reduction in anxiety and depression amongst participants through attending an outdoor based programme
3. Improved connection to the community
4. Increased mobility/improvements in physical health
5. Increase in self-confidence and self-reliance
6. Increased physical activity outdoors
7. Return to higher education, training or employment

**Outcomes:**

1. Participants reporting improvement in well-being through decrease in feelings of anxiety and depression, leading to increased resilience in dealing with long-term illness, less need for clinical intervention and reduction in prescribed medication
2. Increase in feelings of self-confidence and self-reliance leading to increased independence, improved social networks and community connection.
3. Improvement in community engagement and in sense of belonging
4. Improvements in physical functioning and mobility leads to improved motivation and physical health and results in improved self-care behaviours.
5. Increase in regular physical activity helps improve your overall health, fitness, and quality of life (National Center for Chronic Disease Prevention and Health Promotion, 2020) and confers resilience potentially adverse behavioural and metabolic consequences of stressful events and preventing many chronic diseases (Silverman and Deuster, 2014).
6. Increased earnings for participants
7. Increased earning potential, social and community engagement for participants

## NHS staff

**Inputs:** time

**Activities:** NHS workers support participants weekly in outdoor environment to help with recovery and rehabilitation.

**Outputs:**

1. NHS staff on programme reporting reduced work-related stress
2. NHS staff reporting an improvement in personal mental health
3. NHS staff reporting increased confidence in accessing different activities for rehab and recovery outdoors

**Outcomes:**

1. Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to help manage stress (Calogiuri et al., 2014).
2. Staff experience improved personal mental health and well-being at work.
3. Staff benefit from developing more positive working relationships with service users in a non-clinical, informal setting with knowledge gained in practical interventions to build on service users' self-confidence, social skills, connecting with the outdoor environment and future interests.

## Regular volunteers

**Inputs:** time and skill

**Activities:** Volunteers attend sessions and work together on different land and woodland management tasks

**Outputs:**

1. Regular attendance at voluntary or local organisation working outdoors
2. Volunteers acquiring new skills and knowledge
3. Volunteers gaining physical exercise and improvements in mental well-being from working outdoors

**Outcomes:**

1. Increased social contacts and networks; reduced social isolation for volunteers
2. Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment.
3. Volunteers gain new practical outdoor work-related skills and increased knowledge about sustainability and the environment through participating in a DTE Volunteer programme

## Down to Earth Project

**Inputs:** staff time, staff knowledge, company resources, administration support

**Activities:** DTE develops and delivers healthcare programmes using NRW woodlands to improve health, wellbeing and resilience of participants, NHS staff, volunteers and local woodlands.

**Outputs:**

1. Increase in participants recruited and engaging in similar programme

**Outcomes:**

1. Benefit from innovative approach of company to healthcare and well-being and provide further evidence as to the efficacy of this approach

## SBUHB

**Inputs:** money for staff wages

**Outputs:**

1. Patients with improved mental health
2. Increase in patients actively engaging in their rehabilitation

**Outcomes:**

1. Reduction in number of patients needing NHS treatment for mental health (consultancy appointments) resulting in reduction in cost to NHS; reduction in mental health prescriptions also results in reduction in cost to NHS.
2. Improved recovery rates and Patient Activation rates resulting in increased resilience to present and future health conditions

## Local Community:

**Outputs:** Number of people volunteering for community projects increases
**Outcomes:** Benefit to community of engaging more people in volunteering and community projects (Ramsey, 2012).

## Government:

**Outputs:**

1. Number of people gaining employment increases
2. Number of people no longer claiming income support allowance increases

**Outcomes:**

1. Reduced reliance on state benefits and welfare benefits paid to unemployed
2. Reduction in Employment Support Allowance

# Appendix C: Valuation of Outcomes for stakeholders

| Stakeholder | Outcomes | Financial proxy | Source |
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| **NRW** | Increase in biodiversity in local woodlands. | £112.35<br>Costs associated with:<br>• 300 sq meters brash and bramble cleared and left to decay<br>• 300 sq metres rhododendron clearance<br>• 150 sq metres tree thinning | Natura 2000 in Wales: Costings for Terrestrial Actions, 2015, NRW |
| | Increase in general public utilising local woodlands for health, well-being and recreation resulting in an increased awareness of the benefits of local woodlands and understanding of the importance of sustainably managing local woodlands in Wales for biodiversity and public access. | £148.00<br>Cost associated with an adult continued education course in leisure category. Increased awareness in community reflects same outcome associated with lifelong learning. | Fujiwara, 2012. Valuing the impact of Adult Learning, Adult lifelong learning: improvement in health |
| **DTE** | Demonstrate the validity of dte approach through continual referrals and increase in funding for similar projects. | £460.00<br>Costs associated with pricing per participant to attend 4.5-hour session over 8 weeks with DTE. In addition, reflecting the amount of funding that would need to be secured for each participant to run a similar project | Down to Earth: www.downttoearthproject.org.uk |
| **Patients with chronic, long-term condition** | 1. Through being engaged in physical activity outdoors, participants experience a decrease in feelings and symptoms of anxiety and depression (Beyer et al., 2016) which builds resilience in living with a long term, chronic illness (Vardakoulias, 2013) | £18,338.00<br><br>HACT v4 Outcome 28: Relief from anxiety and depression.<br>Based on DTE clinical research results, with an average decrease across the project of 53% in depression and anxiety, the costs associated with HACT v4 Outcome 28: *Relief from anxiety and depression in adults,* has been reduced by 50% to avoid overclaiming and in recognition that 46% of | Housing Associations Charitable Trust and Fujiwara, v4, 2018. |

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| | | those not receiving mental health support reported they would have sought mental health support if they had not had this project. (Outcome original proxy: £36.766.00) | |
| | 2. Participants experience an increase in feelings of self-confidence and self-reliance which will help participants living with a long term, chronic condition or illness recognize and manage dependence (Moore, 2021). | £6540.00<br>HACT v 4 Outcome 27: Confidence (high) Adult. Costs associated with this outcome but as there was no measurement of how much confidence was gained during the project, costs associated have been reduced by 50% to assign a value to a general increase in confidence as reported at the end of the programmes and at least 6 months post programme. | Housing Associations Charitable Trust and Fujiwara, v4, 2018 |
| | 3. An increase in connection to the community felt by participant is experienced resulting in a sense of belonging and contribution through engaging in the project (Jacubek et al., 2019) | £3,753.00<br>HACT v4 Outcome 24: Feeling belonging to neighbourhood | Housing Associations Charitable Trust and Fujiwara, v4, 2018 |
| | 4. "Participants learn new work-relevant woodland skills and training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009)" | £150.00<br>Costs associated with 2-day course in traditional skills | Linsley & McMurray, 2018. |
| | 5. Participants experience an improvement in their physical health and increased mobility after engaging with the programme which has improved motivation and activation in their rehabilitation and healthcare. This leads not only to better healthcare outcomes (Hibbard and Greene, | £2847.00<br>Costs associated with yearly costs for stroke rehabilitation services 1-year period after discharge from inpatient rehabilitation. This figure is divided by 6 to represent the time spent on the programme. | Godwin et al. 2007. Cost associated with stroke: outpatient rehabilitative services and medication. |

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| | 2013) but which also results in decreased need for clinical time for rehabilitation and recovery (Hibbard and Gilbert, 2014). | | |
| | 6. Participants increase their regular physical activity which helps participants improve overall health, fitness, and quality of life (Penedo et al., 2005) and for NHS patients living with chronic and long-term illnesses is key to improving long-term health outcomes (Von Korff et al, 1997). | £4179.00<br>HACT Outcome 58: Frequent moderate exercise; Participation in exercise that raises your heart rate and results in breaking into a sweat at least once a week for at least two months | Housing Associations Charitable Trust and Fujiwara, v4, 2018 |
| | 7. Participants experience increased sense of identity and purpose through returning to work with potential to improve financial security (NHS, 2021) | £1229.00<br>Outcome 5: Part-time employment Moving from unemployment to part time employment | Housing Associations Charitable Trust and Fujiwara, v4, 2018 |
| | 8. Participants experience greater social and community engagement and may experience increased earning potential as a result of engaging in higher education and gaining a degree or qualification (U.K. Dept of Education, 2019). | £12,100.00<br>Difference in average annual wages for those that<br>do not got to university (£17,800) and those that do<br>(£29,900). | Shaheen, 2011. |
| **Volunteers** | 1. Regular attendance at voluntary or local organisation working outdoors resulting in improved social contact, feeling belonging to a community group and reduced social isolation | £1773.00<br>HACT v4 Outcome 7: Regular attendance at voluntary or local organisation duration 3 years | Housing Associations Charitable Trust and Fujiwara, v4, 2018 |
| | 2.<br>Volunteers gain new practical outdoor work related skills and Increased knowledge about sustainability and the environment | £150.00 Costs associated with 2-day course in traditional skills | Linsley & McMurray, 2018. |

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| | through participating in a DTE Volunteer programme | | |
| | 3. Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment. | £150.00<br>Average value of outdoor fitness class in Swansea 5 hour session £10 based on attending 15 sessions/year to be considered long-term volunteer. | SOFIT; www.fatsoma.com/e/9n8tbmku/swansea-outdoor-fitness |
| **NHS Staff** | 1. Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to help manage stress (Calogiuri et al., 2014). | £225.00<br>Based on costs of stress reduction mindfulness course in nature | Calm City Mind, https://www.calmcitymind.com/ |
| | 2. Staff experience improved personal mental health and well-being at work. | £1794.00<br>Costs associated with poor mental health for staff in the NHS; using lowest estimate: £1,794-£2,174 per employee per year 1,794.00 | Health Education England, 2019. NHS Staff and Learner's Mental Wellbeing Commission |
| | 3. Staff benefit from developing more positive working relationships with service users in a non-clinical, informal setting with knowledge gained in practical interventions to build on service users' self-confidence, social skills, connecting with the outdoor environment and future interests. | £150.00<br>Costs associated with 2-day course in Environmental Education in Social Care based in Scotland, | Wild Things Environmental Education; https://wild-things.org.uk/our-events/environmental-education-in-social-care-eesc-training-course/ |
| **SBUHB** | 1. Reduction in number of patients on NHS mental health waiting lists (consultancy appointments) and reduction in amount of NHS resources needed (costs for prescriptions and appointments (Ozbay et al., 2007). | £2940.00<br>Savings associated with financial costs of mental health on NHS: % of QALY assigned to moderate mental and emotional well-being estimated at 0.098 of a QALY. | Kempton et al., 2020. Quality Adjusted Life Years (QALYs) in Social Return on Investment (SROI). Envoy Partnership, 2018. |
| **SBUHB** | Improved recovery rates and adoption of self-care behaviours. The benefits of patients engaging in their recovery and | £1165.00<br>Costs associated with self-care calculation physical exercise/mental well-being/social isolation | Self-Care Social Prescribing Kensington & Chelsea Social Council and |

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| | rehabilitation is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al 2012). | | NHS West London Clinical Commissioning Group<br>Social Return on Investment January 2018 |
| **Local Community** | Benefit to community of engaging more people in volunteering and community projects (Ramsey, 2012). | £13,500.00<br>Value assigned to frequent volunteering and cost reaped by community in increased number of people volunteering for local projects | Fujiwara et al., 2013. Wellbeing and civil society Estimating the value of volunteering using subjective wellbeing data |
| **Government** | Reduced reliance on state benefits and welfare benefits paid to unemployed | £3540.00 per annum<br>Estimate developed by NEF of housing & council tax assistance £70pw | Bates and Yentumi-Orofori, 2013. Veteran's Contact Point SROI |
| | Reduction in Employment Support Allowance | £3851.00 pa<br>Job Seekers Allowance paid to unemployed at £74.35 per week aged over 25 | Bates and Yentumi-Orofori, 2013. Veteran's Contact Point SROI |

# Appendix D: Deadweight % for indicators of outcomes with a financial proxy

| Deadweight: What would have happened if the intervention never took place? | | | |
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| **Beneficiary** | **Indicator** | **Value** | **Rationale** |
| **NRW** | Amount of woodland sustainably managed | 0% | Costs associated with Natura 2000 in Wales: Costings for Terrestrial Actions, 2015, NRW and based on 300 sq meters brash and bramble cleared and left to decay= £1800/ha; 300 sq metres rhododendron clearance= £3883/ha; 150 sq metres tree thinning= £490/ha. 1000 sq. meters=1 hectare. This work would have eventually been achieved by NRW workers but not in the seasonal way performed by the volunteers, as stated by NRW correspondence. Therefore, 100% of this outcome was achieved by our project alone. |
| | Increase in people accessing local woodlands for health, well-being and recreation | 10% | Cost associated with an adult continued education course in leisure category. Increased awareness in the community reflects the same outcome associated with lifelong learning. *Adult lifelong learning: improvement in health: Fujiwara, 2012. Valuing the impact of Adult Learning.* There may have been opportunity to access woodlands of their own will, however, mobility and access issues/concerns had previously prevented participants from accessing woodlands as testified by participants and RA workers Therefore engagement with the project is responsible for the majority of people feeling they can access the woodlands safely and confidently. |
| **Patients with chronic, long term health condition** | Participants report a relief and decrease in feelings of depression and anxiety | 30% | Approximately 60% of the participants were already receiving medication for chronic mental health issues with 43% of post programme survey responders noting that had they not accessed this project; they would have sought alternative support for their mental health. The average is 51.5%. However, there was a reported decrease in feelings of depression and anxiety over a 2-month period with duration lasting on average for 6 months minimum leading to more regularly accessing the outdoors for health and well-being, further increasing well-being. This project claims at least 70% of this outcome would not have been achievable in the duration with continuing benefits on feelings of anxiety and depression for participants. |
| | Participants reporting increase in feelings of self-confidence and self-reliance | 20% | As the unique approach is focused around increasing self confidence levels in participants through experiencing and learning in the outdoors, with the purpose of this specific project centred around recovery and rehabilitation for chronic illness using the woodlands, a high percentage for this outcome is claimed. There are no similar projects of this nature for this beneficiary base in the region and the multi-faceted approach to building self-confidence, as |

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| | | | evidenced through testimony and post monitoring, could not have been achieved without this project. |
| | Participants reporting increase in community connection | 25% | Participants could have engaged in another community project that could have given a sense of belonging. Yet the project was designed to bring together people with similar chronic conditions to experience peer support, learn and experience a feeling of belonging to a group and community project. Many participants stated how important this was to them, to just be accepted for themselves, without a focus on their condition and coming together with others in similar situations to do meaningful work outdoors, gave them a strong sense of community belonging. Connection to community monitoring scores had increased for all groups by an average of 20%. |
| **Patients with chronic, long term health condition** | Participants with increased physical activity | 30% | If participants were not working on this rehab and recovery, there is a chance that they may receive rehab in a clinical environment or join another group for physical activity. However, as stated before, these participants were chosen specifically because of the hesitancy to engage in other rehab programmes. |
| | Participants with improved practical woodland management skills | 10% | The skills gained through this project are unique in their cultivation. Additionally, the learning through doing approach employed by DTE utilises traditional and sustainable tools and techniques to achieve conservation objectives. There is not another service that provided this learning in the area. |
| | Participants moving to higher education | 50% | As used in: *Degrees of value: How universities benefit society, NEF and Universities UK, Shaheen,2011*. In *Outcome: Higher Aspirations*. Two participants working with us have gone on to university, with their Key Worker stating that the project was a direct influence in the gaining of confidence to make this decision. Therefore, the deadweight is set at 40% to not overclaim, take into account the variety of other influences in this person's life, whilst at the same time recognizing the impact of the project on their well-being, confidence, and social engagement. |
| | Participants moving to employment | 50% | Participants may have improved their health, well-being and confidence to decide to return to work through other organisations and then secured employment. However, all 3 participants stated that attendance on the project had a direct impact on their decision to begin looking for employment. |
| **Volunteers** | Volunteers regularly attending volunteering days | 27% | Based on a Welsh Government national survey that says 27% of people in Wales volunteered at least once a month in 2019/20. (WG, 2020). This outcome could have been achieved without this project. |
| | Volunteers gaining physical exercise and improvements in mental well-being from working outdoors | 27% | Regular volunteers attend DTE not solely for the environmental volunteering and outdoor practical work, feedback suggests that they attend due to the shared beliefs of DTE and engaging in a project that "makes them feel good" and "valued". Based on a Welsh Government national survey that says 27% of people in Wales volunteered at least once a month in |

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| | | | 2019/20. (WG, 2020). This outcome could have been achieved without this project. |
| | Volunteers acquiring new skills and knowledge | 27% | The skills developed are unique and knowledge is gained from the specialist team and volunteers who share interests. Feedback suggests that volunteers attend due to the shared beliefs of DTE and appreciate their ways of working. Therefore, people could volunteer for another community project; yet, without the aforementioned skills development and knowledge base. Based on a Welsh Government national survey that says 27% of people in Wales volunteered at least once a month in 2019/20. (WG, 2020). This outcome could have been achieved without this project. |
| **NHS Staff: Referral Agency Support Staff** | NHS staff on programme with reduced work-related stress | 13% | Based on research that showed access to Cognitive Behavioural Therapy (CBT), the most recognized form of support for mental health for NHS staff, in the workplace with or without relaxation therapy for periods of follow-up from 1 month to 6 months showed a 13% decrease in relative risk of stress compared to no intervention (Ruotsalainen et al., 2015). |
| | NHS staff on programme with improved personal mental health | 13% | Based on research that showed access to Cognitive Behavioural Therapy (CBT), the most recognized form of support for mental health for NHS staff, in the workplace with or without relaxation therapy for periods of follow-up from 1 month to 6 months showed a 13% decrease in relative risk of stress compared to no intervention (Ruotsalainen et al., 2015). |
| | NHS staff with increased confidence in accessing different activities for rehab and recovery outdoors with service users | 10% | There are no comparable programmes delivering rehab and recovery from chronic health conditions in natural settings and using practical activities outdoors. |
| **SBUHB** | Participants with improved mental health | 27% | Thresholds for the health and patient engagement rates have been set at 27%; based on The HACT social value bank stating that 27% of people experiencing a health improvement would have achieved it anyway (Bagnall et al., 2018). |
| | Participants actively engaging in their rehabilitation | 27% | Thresholds for the health and patient engagement rates have been set at 27%; based on The HACT social value bank stating that 27% of people experiencing a health improvement would have achieved it anyway (Bagnall et al., 2018). |
| **DTE** | Participants recruited and engaging in similar programme | 20% | It is the partnership working and person-centred approach to healthcare and education that has earned DTE its reputation as innovative in its field. Potential interested agencies and health and social care providers reach out to engage with programmes based on positive past experience or on the well-earned reputation. However, there is the knowledge that DTE runs a number of funded programmes and referrals for a similar programme can come from |

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| | | | another referral agency that is not involved in health or social care. |
| **Local Community** | People volunteering for community projects increases | 27% | Regular volunteers attend DTE not solely for the environmental volunteering and outdoor practical work, feedback suggests that they attend due to the shared beliefs of DTE and appreciate their ways of working. Therefore, 25% of people could volunteer for another community project; yet, without the aforementioned benefits. |
| **Government** | People gaining employment | 50% | Feedback from participants that engagement with Re-Connect project and DTE had a direct and significant role in returning to work. |
| | People no longer claiming income support allowance | 50% | Feedback from participants that engagement with Re-Connect project and DTE had a direct and significant role in returning to work. |

# Appendix E: Attribution % for indicators of outcomes with a financial proxy

| Attribution: How much of the outcome is due to the organisation/project? | | | |
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| **Beneficiary** | **Outcome** | **Value** | **Justification** |
| **NRW** | Increase in biodiversity in local woodlands. | 0% | As there is a rolling 5-year management agreement with NRW, this area is not actively managed by NRW staff. The project is 100% responsible for this outcome. |
| | Increase in general public utilising local woodlands for health, well-being and recreation resulting in an increased awareness of the benefits of local woodlands and understanding of the importance of sustainably managing local woodlands in Wales for biodiversity and public access. | 10% | There is another project in the area 'Actif Woods' that is funded and that engages the public to utilize and learn more about their local woodlands. This project does not have the experience in working with local health board patients as does dte, with a focus on rehabilitation and inclusion, nor does it accredit practical, sustainable skills. Mobility and access issues/concerns had previously prevented these participants from accessing woodlands, as testified by participants and RA workers. Therefore, engagement with the project is responsible for the majority of people feeling they can access the woodlands safely and confidently. |
| **Patients with chronic, long term health condition** | Through being engaged in physical activity outdoors, participants experience a decrease in feelings and symptoms of anxiety and depression (Beyer et al., 2016) which builds resilience in living with a long term, chronic illness (Vardakoulias, 2013) | 30% | This project is unique in that the organisation has over 8 years of clinical research in partnership with the local NHS Trust and Swansea University, behind them and has developed an inclusive set of measurement methods around anxiety and depression based on Short WEMHS. We are therefore able to monitor decreases in clinical anxiety and depression throughout the duration of the course. DTE research has shown that their approach is as effective as, if not more effective than, medication prescribed for these conditions. The unique approach coupled with over 10 years of experience in working with vulnerable participants from local health and social care organisations enable DTE to claim 30% of this outcome as there is no other project within the region that can offer the same service with the same success rate for this outcome. |
| | Participants experience an increase in feelings of self-confidence and self-reliance which will help participants living with a long term, chronic condition or illness recognize and manage dependence (Moore, 2021). | 20% | Both participants and referral agency workers have reported that confidence levels increased as a result of this project. 77% of the 34 participants that responded post programme reported an increase in self confidence levels, whilst also stating that this was one of the most important factors of the programme, the restoring of confidence in personal abilities while having a chronic condition. The financial proxy for this indicator was reduced by 50% to represent a general increase in confidence during and post programme. Therefore 80% of this outcome was achieved by this project. |
| | An increase in connection to the | 25% | As this project was uniquely designed to bring together those participants with similar needs and |

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| | community felt by the participant is experienced resulting in a feeling of belonging and contribution though engaging in the project (Jucabek et al., 2019) | | different chronic conditions in an outdoor environment to do meaningful community work, a high percentage of this increase in community connection and sense of belonging is attributable to this project, as attested by monitoring, qualitative comments and post programme surveys. |
| **Patients with chronic, long term health condition** | Participants experience an improvement in their physical health and increased mobility after engaging with the programme which has improved motivation and activation in their rehabilitation and healthcare. This leads not only to better healthcare outcomes (Hibbard and Greene, 2013) but which also results in decreased need for clinical time for rehabilitation and recovery (Hibbard and Gilbert, 2014). | 25% | Increasing mobility and improving physical health is a priority in rehabilitation for long term conditions as it increases independence, engages with self-care behaviours and gives greater resilience to illness and/or reducing recovery time. Participants gave feedback to the team and NHS staff that they are moving in ways that they hadn't before without realizing they were doing rehab. This has prompted many to continue volunteering, engage in new volunteering or join a health-related programme/support group. It is the combination of the approach to rehab of the programme that has given people the confidence and well-being to take greater control of their physical and mental health. |
| | Participants learn new work-relevant woodland skills and training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009). | 10% | |
| | Participants increase their regular physical activity which helps participants improve overall health, fitness, and quality of life (Penedo et al., 2005) and for NHS patients living with chronic and long-term illnesses is key to improving long-term health outcomes (Von Korff et al, 1997). | 25% | Physical activity in the outdoors that is meaningful and utilises traditional methods and materials appeals to participants in a way that conventional physical activity does not. Participants enjoy being outdoors and engaging in teamwork to accomplish a goal. This means that although they may be physically tired at the end of the session, it is not necessarily viewed as conventional physical activity and participants are more prone to engage in physical activity in ways they have not previously. Participants have commented that they feel a sense of satisfaction and accomplishment with their physical activity. Referral Agency workers have commented that they have never seen clients engage this well and be this active. |
| | Participants experience greater social and community engagement and may experience increased earning potential as a | 50% | The project was a key factor in deciding to apply for university as testified by both the individuals and their support workers; and evidenced through clinical research monitoring. Both had issues with confidence, motivation and mental health. Working with the project for a minimum of two 2-month |

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| | result of engaging in higher education and gaining a degree or qualification (U.K. Dept of Education, 2019). | | intakes, both individuals improved their mental health, increased their motivation, stamina and physical fitness and reengaged with their communities. As a result, 50% of this outcome has been attributed to the project. |
| | Participants experience increased sense of identity and purpose through returning to work with potential to improve financial security (NHS, 2021) | 50% | As evidenced from post programme surveys and interviews with Support workers and participants, these participants that moved into employment after a minimum of two 2-month intakes attributed the project to their securing PT employment. Therefore, a reasonable percentage has been claimed for this project. |
| **Volunteers** | Volunteers regularly attend volunteer days outdoors which act as a social activity. leading to increased social contacts/networks and results in reduced social isolation and feelings of belonging to a community group. This socialisation and feeling of belonging to a community group, "hugely strengthens community resilience" (Patel et al, 2017; Blood, 2017). | 27% | Down to Earth Project recognizes that some volunteers may already achieve these outcomes through volunteering for other organisations. |
| | Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment. | 27% | As above. |
| | Volunteers gain new practical outdoor work-related skills and Increased knowledge about sustainability and the environment through participating in a DTE Volunteer programme | 27% | As above. |
| **NHS Staff: Referral Agency Support Staff** | Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to help manage stress (Calogiuri et al., 2014). | 46% | This is the only nature-based project that these NHS workers are supporting patients on. As the project is delivered in woodlands and natural environments, and stress relief is directly linked to as an outcome to being in nature, staff reported that attending with patients once a week for 8 weeks reduced work related stress levels. |

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| | Staff experience improved personal mental health and well-being at work. | 46% | 50% NHS staff reported that they were either receiving support or taking medication for mental health issues. |
| | Staff benefit from developing more positive working relationships with service users in a non-clinical, informal setting with knowledge gained in practical interventions to build on service users self-confidence, social skills, connecting with the outdoor environment and future interests. | 10% | There is not another programme on which the support staff would gain this knowledge. However, they may access this information personally and have the confidence to put it into action. The likelihood is not strong, though as all respondents noted that they had increased their confidence and learned to use the natural environment to facilitate rehab and recovery through the project. Noted that 3 staff members have now been inspired to apply for funding for similar pilot programmes. |
| **SBUHB** | A reduction in number of patients experiencing poor mental health and well-being through engaging in a DTE programme outdoors could lead to reduced numbers seeking NHS treatment for mental health (consultancy appointments and prescriptions) and result in a reduced in cost to NHS. | 30% | HACT states that 27% of persons would have achieved health improvements regardless of type of intervention (Bagnall et al., 2018). |
| | Through attending a rehabilitation and recovery programme in the outdoors, participants demonstrate an increased engagement in their healthcare and willingness to try a different approach. The benefits of patients engaging in their recovery and rehabilitation (patient activation) is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012). | 30% | HACT states that 27% of persons would have achieved health improvements regardless of type of intervention (Bagnall et al., 2018). |

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| **DTE** | Organisation benefits from increased recruitment of participants to similar healthcare and well-being programmes in the outdoors and provides further evidence as to the efficacy of this approach which will lead to further growth. | 20% | Due to the innovative approach of the DTE programmes, ways of working and the unique nature of the organisation, referrals for future programmes are due completely to the hard work of the organisation. However, referrals could have come from another organisation and not directly as a result of this project. |
| **Local Community** | There is an increase in the number of people engaging in community volunteering projects which is a benefit to the wider community (Ramsey, 2012). | 27% | As a direct result of participation with DTE, participants engaged in other community projects outdoors. NHS staff supporting these patients said that their desire to return to DTE led them to explore additional options with environmental volunteering. For example, one support worker got his patients engaged in Penllergare Valley Woods volunteering after the programmes funding ceased. 27% is based on WG, 2020 survey that says 27% of all Welsh volunteer and therefore this outcome could have been reached by another community group that encourages volunteering progression. |
| **Government** | Increase earning power of the individual with associated increased spending for the economy and contribution of taxes to the exchequer | 20% | Employment gained could be attributable to a number of different factors. However, those that have returned to work have said that it is down to having participated in a DTE programme that gave them the skills and confidence to gain employment. |
| | Reduction in Employment Support Allowance costs for the government. | 20% | Employment gained could be attributable to a number of different factors. However, those that have returned to work have said that it is down to having participated in a DTE programme that gave them the skills and confidence to gain employment. |

# Appendix F: Full list of indicators and outcomes

| Stakeholder | Indicator | Evidenced Outcome |
|---|---|---|
| **Natural Resources Wales** | Physical measurement of area worked by volunteers established through NRW communication and on-site visits.<br>-being and recreation. | Increase in biodiversity in local woodlands through decrease in invasive species present, clearing of woodland floor and thinning of the canopy. |
| **Down to Earth** | Average increase in PAX numbers based on year-on-year increase in PAX numbers on funded programmes over four-year period (175) | Organisation benefits from increased recruitment of participants to similar healthcare and well-being programmes in the outdoors and provides further evidence as to the efficacy of this approach which will lead to further growth. |
| **Patients with long-term or chronic illness and/or Well-being Limited Condition** | Achievement of accredited unit in Sustainable Woodland Management or Taster Woodwork (n=48)<br><br>Post programme survey for PAX; participants asked to name practical and soft skills gained through attending providing qualitative evidence of practical skills gained for context of results.<br><br>Post programme survey for Support NHS staff about impact of programmes on participant pertaining to benefits to participants of the programmes providing qualitative evidence of practical skills gained for context of results. | Participants learn new work-relevant woodland skills and<br>training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009). |
| **Regular volunteers** | In session survey and informal discussion group feedback about what impact engagement has on wellbeing. Every participant surveyed/spoken with mentioned physical and mental health benefits and exercise. Each participant noted that being outdoors made them "feel better", "feel more calm", "feel | Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment. |

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| | happy" and/or "feel at one with nature". | |
| **NHS staff** | Post programme survey for Support NHS staff about impact of programmes on reduced work related stress levels as a result of attending the programme to support patients. *Being part of a Down to Earth programme supporting participants helped to increase my resilience and ability to deal with my work-related stress levels. Rate on a five point scale: strongly disagree to strongly agree*. Answers for agree and strongly agree included. | 1. Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to efficiently manage stress and induce restoration (Calogiuri et al., 2014). |
| **SBUHB** | Participants engaging with at least two 4/5 hour sessions as marked on attendance register; virtual/telephone interviews with 3 NHS staff and Ward/Departmental managers | Through attending a rehabilitation and recovery programme in the outdoors, participants demonstrate an increased engagement in their healthcare and willingness to try a different approach. The benefits of patients engaging in their recovery and rehabilitation (patient activation) is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012). |
| **Local community** | Post programme monitoring from Referral Agencies about those previous participants that had engaged in volunteering in the community. | There is an increase in the number of people engaging in community volunteering projects which is a benefit to the wider community (Ramsey, 2012). |
| **Government** | Number of participants and volunteers gaining employment, self-reporting. | Reduction in Employment Support Allowance costs for the government. |
| **Stakeholder** | Indicator | Evidenced Outcome |
| **Natural Resources Wales** | Physical measurement of area worked by volunteers established through NRW communication and on-site visits.<br>-being and recreation. | Increase in biodiversity in local woodlands through decrease in invasive species present, clearing of woodland floor and thinning of the canopy. |
| **Down to Earth** | Average increase in PAX numbers based on year-on-year increase in PAX numbers on funded programmes over four year period (175) | Organisation benefits from increased recruitment of participants to similar healthcare and well-being programmes in the outdoors and provides further evidence as to the efficacy of this approach which will lead to further growth. |

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| **Patients with long-term or chronic illness and/or Well-being Limited Condition** | Achievement of accredited unit in Sustainable Woodland Management or Taster Woodwork (n=48)<br><br>Post programme survey for PAX; participants asked to name practical and soft skills gained through attending providing qualitative evidence of practical skills gained for context of results.<br><br>Post programme survey for Support NHS staff about impact of programmes on participant pertaining to benefits to participants of the programmes providing qualitative evidence of practical skills gained for context of results. | Participants learn new work-relevant woodland skills and<br>training outdoors and gain accreditation having a positive direct influence on their well-being (Field, 2009). |
| **Regular volunteers** | In session survey and informal discussion group feedback about what impact engagement has on wellbeing. Every participant surveyed/spoken with mentioned physical and mental health benefits and exercise. Each participant noted that being outdoors made them "feel better", "feel more calm", "feel happy" and/or "feel at one with nature". | Volunteers experience an improvement to physical health and mental wellbeing from volunteering with the project and working in an outdoor environment. |
| **NHS staff** | Post programme survey for Support NHS staff about impact of programmes on reduced work-related stress levels as a result of attending the programme to support patients. *Being part of a Down to Earth programme supporting participants helped to increase my resilience and ability to deal with my work-related stress levels. Rate on a five point* | 1. Staff have opportunity to access green exercise in a natural woodland setting during the workday away from clinical environment to efficiently manage stress and induce restoration (Calogiuri et al., 2014). |

| | | |
|---|---|---|
| | *scale: strongly disagree to strongly agree*. Answers for agree and strongly agree included. | |
| **SBUHB** | Participants engaging with at least two 4/5 hour sessions as marked on attendance register; virtual/telephone interviews with 3 NHS staff and Ward/Departmental managers | Through attending a rehabilitation and recovery programme in the outdoors, participants demonstrate an increased engagement in their healthcare and willingness to try a different approach. The benefits of patients engaging in their recovery and rehabilitation (patient activation) is applicable across a range of different conditions and economic backgrounds, including disadvantaged and ethnically diverse groups (Ryvicker et al, 2012). |
| **Local community** | Post programme monitoring from Referral Agencies about those previous participants that had engaged in volunteering in the community. | There is an increase in the number of people engaging in community volunteering projects which is a benefit to the wider community (Ramsey, 2012). |
| **Government** | Number of participants and volunteers gaining employment, self-reporting. | Reduction in Employment Support Allowance costs for the government. |

## Appendix G: Statement of report assurance

SOCIAL VALUE INTERNATIONAL

# Statement of Report Assurance

Social Value International certifies that the report

## Social Return on Investment Report Re-Connect Project

satisfies the requirements of the assurance process.

The assurance process seeks to assess whether or not a report demonstrates a satisfactory understanding of, and is consistent with, the Principles of Social Value. Reports are independently reviewed by qualified assessors and must demonstrate compliance with the Social Value report assurance standard in order to be certified. The Social Value report assurance standard can be downloaded from the website socialvalueint.org.

Assurance here is against the Principles of Social Value only and does not include verification of stakeholder engagement, report data and calculations.

Awarded 01/12/2022

Signed

Mr Ben Carpenter
Chief Executive Officer
Social Value International

ASSURED REPORT
SOCIAL VALUE INTERNATIONAL

Social Value UK carries out the assurance service on behalf of Social Value International. Social Value International is the global network focused on social impact and social value. We are the global network for those with a professional interest in social impact and social value. We work with our members to increase the accounting, measuring and managing of social value from the perspective of those affected by an organisation's activities, through the standardised application of the Principles of Social Value. We believe in a world where a broader definition of value will change decision making and ultimately decrease inequality and environmental degradation.

Disclaimer: Social Value International will not be responsible for any actions that an organisation takes based upon a report that has been submitted for assurance. An assured report does not grant Accredited Practitioner status to the author/authors of the report unless it is part of a full application for Accredited Practitioner status.