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Evaluation of the British Red Cross Community Connectors Programme

Final Report, Social Return on Investment: May 2019

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1. Background

A Social Return on Investment (SROI) was undertaken to evaluate the economic impact of the Community Connectors programme. This type of analysis is particularly suited to interventions that include a wide range of benefits (Nicholls, Lawlor, Neitzert, & Goodspeed, 2009). The different benefits and costs included are decided by stakeholders and local experts, rather than the evaluators. This approach promotes relevance of findings and encourages a collaborative focus. The SROI approach has been successfully used to evaluate wellbeing interventions. For example, a community befriending programme (Arvidson, Battye, & Salisbury, 2014). It is widely used and recognised by decision makers; for example, the Cabinet Office has issued guidance on how to use SROI. A key advantage of the SROI for evaluating the Community Connectors project is that it enables the economics model to develop over time, and be shaped by unanticipated cost and benefits. This enables any changes to the programme or its costs/benefits to be incorporated. This is important because of the innovative and developing nature of the Community Connectors programme.

The SROI sought to address the following objectives:

- Provide robust evidence to inform the British Red Cross decision making with regard to wider rollout and support advocacy

- Understand the costs of service delivery and make judgments about its value for money including reductions in the use of other services that might occur as a consequence of the support provided to service users

2. Summary of Findings

The Inputs taken into account (costs for delivering the project) are British Red Cross central organisational costs for the set-up and coordination of the project, British Red Cross project delivery costs and the time donated by volunteers for their training and participation in the Community Connector service. The outcomes (benefits) that are taken into account are improved wellbeing of volunteer, improved wellbeing of service-users and reduced missed health appointments.

Table 1 (below) shows the ultimate findings from these calculations in terms of total inputs, outcomes, net present value and Social Return on Investment ratio. This demonstrates an economic return to society in general of £1.48 for each pound invested in the project. The second table (table 2) shows these inputs and outcomes broken down into quarterly time periods.

Table 1: Present Values (these are values 'in the present' with 3.5% discount per annum accounted for*)

* "Discounting recognises that people generally prefer to receive money today rather than tomorrow because there is a risk (e.g., that the money will not be paid) or because there is an opportunity cost (e.g, potential gains from investing the money elsewhere). This is known as the 'time value of money'."

<div align="right">(Nicholls et al, 2009, p.67)</div>

*The value of 3.5% is recommended as the basic rate for the public sector in the HM Treasury's Green Book (H M Treasury, 2003).

Inputs	Outcomes	Net Present Value	SROI Ratio
£3,174,170.73	£4,692,192.31	£1,518,021.59	£1.48

Table 2: Breakdown of inputs and outcomes per quarter (£)

	2016				2017				2018					
Inputs	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	**Total**	**Present Value**
Project delivery costs	0.00	0.00	0.00	0.00	3,344.90	198,639.22	267,878.02	284,760.18	282,704.66	340,591.67	467,452.86	484,181.03	2,329,552.54	2,143,759.99
Central organisation costs	24,013.71	95,217.18	74,141.703	72,951.48	80,964.56	77,277.71	106,380.18	170,088.75	46,790.20	47,781.45	75,703.42	53,343.89	924,654.29	873,530.93
Volunteer time for training						1,161	5,418	8,256	5,676	2,967	5,031	1,161	29,670.00	28,707.60
Volunteer time for activities	0.00	0.00	0.00	0.00	0.00	62.5	8,848.33	3,664.16	16,500.83	39,786.17	61,626.67	9,605.83	140,094.50	128,172.21
Outcomes	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Total	Present Value
Volunteer wellbeing	0.00	0.00	0.00	0.00	0.00	23,688.00	110,544.00	168,448.00	115,808.00	60,536.00	102,648.00	23,688.00	605,360.00	560,757.72
Service-user wellbeing	0.00	0.00	0.00	0.00	0.00	89,536.98	486,296.30	617,378.00	660,472.24	776,823.01	1138,051.24	722,253.27	4,490,811.05	4,125,605.71
Reduced health service DNAs	0.00	0.00	0.00	0.00	0.00	0.00	270.00	870.00	1,200.00	1,410.00	1,350.00	1,260.00	6,360.00	5,828.88

The following figures show the outcomes as they were experienced per quarter of a year and the total outcomes.

Figure 1: Time series of outcomes
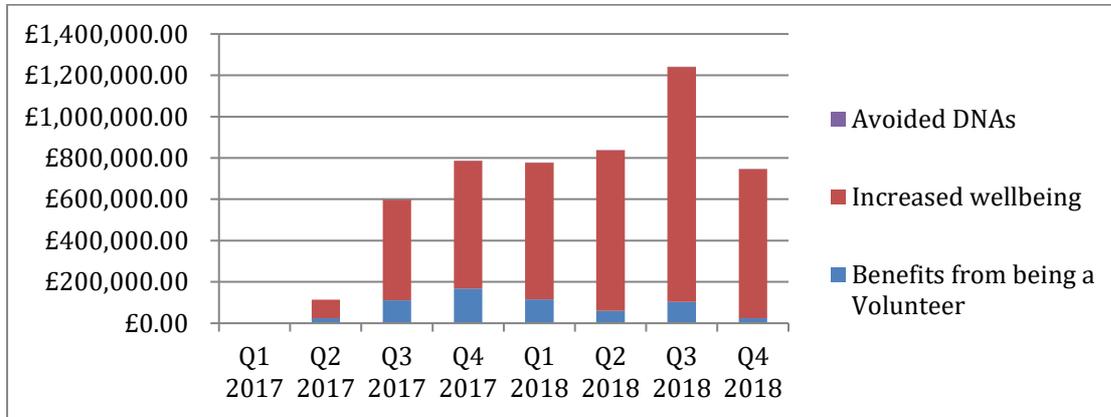
Figure 2: Total financial value of included Outcomes
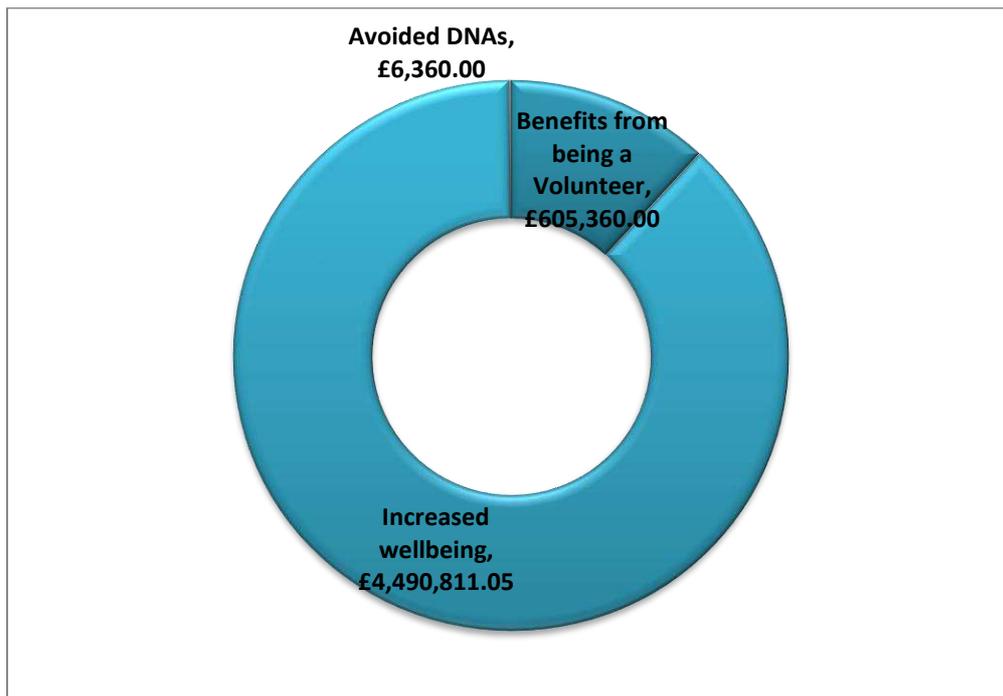
The following figures show the inputs (investments) for the project, including the central organisational costs incurred to set-up and coordinate delivery of the service. These are shown per quarter of a year (from Q1 2016 to Q4 2018) and in total, for the duration of the project.

Figure 3: Time series of inputs

Investment by Quarter

Legend:
- Time given by Volunteers *
- Central Organisational Costs
- Project delivery costs

Y-axis: £ (0 to 800000)

X-axis: Q1 2016, Q2 2016, Q3 2016, Q4 2016, Q1 2017, Q2 2017, Q3 2017, Q4 2017, Q1 2018, Q2 2018, Q3 2018, Q4 2018
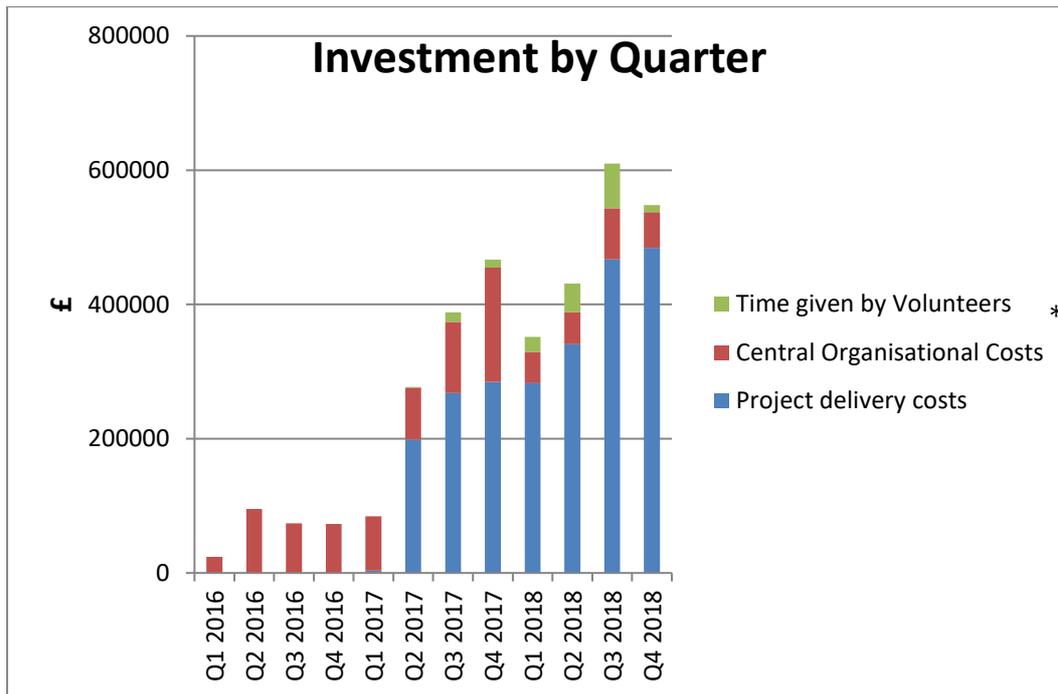
Figure 4: Total Inputs

- Time given by Volunteers*, £169,764.50
- Central Organisational Costs, £924,654.29
- Project delivery costs, £2,329,552.54
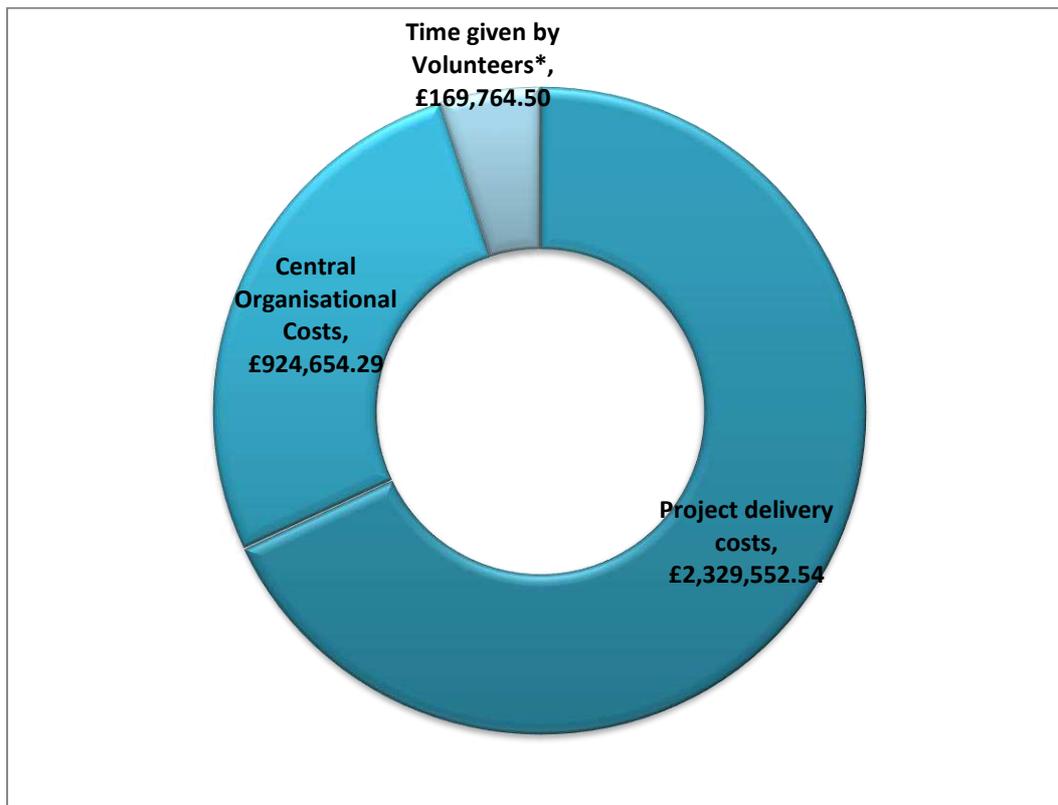
*Time given by volunteers represents an estimate of the value of this time for volunteers (rather than actual financial input) and is calculated at the same hourly rate as project support workers (i.e. £10/hour). Hours of input are derived from project records for face-to-face and phone contacts and survey data estimating time required for induction and training.

3. Methodology

The SROI study involved six stages that were performed in a combined parallel, sequential and recurrent order so that evidence was built up iteratively. The other qualitative and quantitative work streams of the larger multi-disciplinary evaluation ran in parallel so that findings and questions were shared throughout the investigation ensuring all appropriate evidence was included to inform this analysis.

6-Stages:
1. The identification of key stakeholders
2. Mapping of the full range of inputs, outputs & outcomes
3. Identification and measurement of key outcome indicators
4. Assessment of attribution, sustainability and displacement of other services
5. Valuing outcomes
6. Calculating the ratio of attributable benefits to costs plus sensitivity analysis

For the major outcomes in this study (benefits of volunteering and improvements in subjective wellbeing), a valuation technique derived from HACT's Social Value Bank and Wellbeing Valuation methods was employed. Whilst this methodology is compatible with SROI methodology, it does not rely on the extensive stakeholder engagement and bottom-up valuation techniques often relied upon for SROI studies. Therefore, much of the stakeholder investigation described in this study can be viewed as providing additional rigour, by confirming these values, refining impact claims, exploring other potential outcomes and investigating the potential for unanticipated or negative outcomes. This additional value of conducting a well targeted SROI study alongside Social Value methodology is indicated in the following quotes:

> "Value Insight and the Value Calculator act as a low overhead mechanism for calculating social returns. They do not include all aspects of what is conventionally included within SROI, for example, the tools include some short before and after surveys but otherwise involve no engagement with the stakeholder.
> This less resource intensive approach to measuring and modelling social value is made possible as a result of the robust metrics set in the Social Value Bank, which sit at the heart of the tools. (p.2)…
> A well-targeted SROI could add understanding of the experience of a specific stakeholder group or provide insight around the delivery of a specific project. (p.4)"
>
> (HACT/SROI Network, 2015)

For details of how these techniques map onto SROI principles, please see the "SROI and HACT's Social Value Bank Linkages Paper" (2015). The following report describes the SROI study in accordance with the seven Social Value International Assurance Standards (2017) for SROI, which are based on the technical guidance found in The Guide to SROI, Supplementary Guidance on Stakeholder Involvement, Materiality & Understanding Change (http://www.socialvalueuk.org/resources/sroi-guide/) and also included in Cabinet Office guidance:

1) Involve stakeholders: Inform what gets measured and how this is measured and valued by involving stakeholders

2) Understand what changes: Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended

3) Value the things that matter: Use financial proxies in order that the value of the outcomes can be recognised. Many outcomes are not traded in markets and as a result, their value is not recognised

4) Only include what is material: Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact

5) Do not overclaim: Only claim the value that organisations are responsible for creating

6) Be transparent: Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders

7) Verify the result: Ensure appropriate independent assurance

(Cabinet Office, 2009)

The following describes the SROI study in terms of these 7 SROI assurance standards.

a. The involvement of key stakeholders

i. Scope of the SROI analysis

The identification of the main stakeholder groups was fairly straightforward. This began with discussions with the project delivery team and was refined over time as service-level and qualitative data became available. The following diagram (figure 5) demonstrates a simplified picture of the area of interest for the SROI analysis.

Figure 5: Area of interest for the SROI analysis
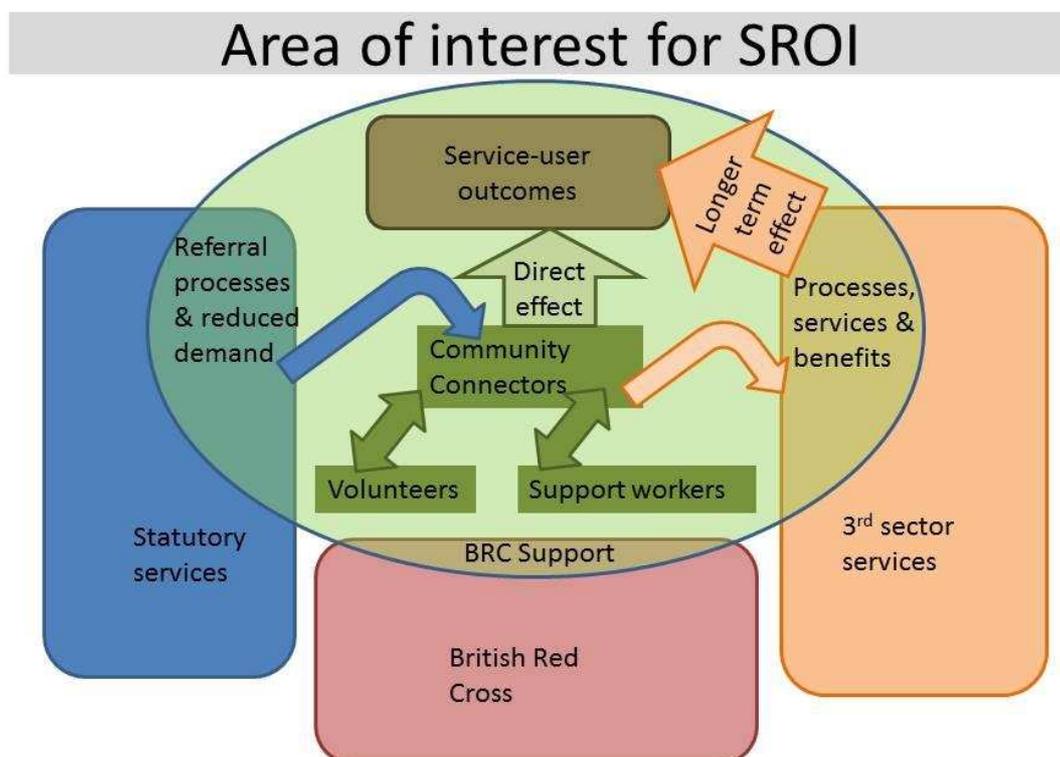
Referral into the service was mostly from statutory health (22%) and local authority (18.8%) services. The people that were referring into the service from these organisations were considered key stakeholders. Likewise, service users were signposted (or referred onwards) to 3rd sector organisations or community groups and the people managing these signposts were also considered key stakeholders. The extent of involvement of these stakeholders was limited to the areas of contact with the Community Connector services; that is, the immediate effects of the referral or signposting processes and procedures. In reality, the referral routes were less clear-cut, as referrals into the service also came from 3rd sector organisations (17.5%) and the British Red Cross (7.4%) and the most common single source of referrals was self-referral (32.1%). Service users were also signposted (referred on to) statutory services and the British Red Cross. However, despite these more complicated user pathways, the main stakeholder groups remained the same.

A limitation of evaluating these types of national, individualised and local context specific signposting services is the large number of subgroups of stakeholders involved. Practical resource issues and the length of time allowed for the evaluation means that it is not possible to represent the entirety of subgroups involved. For instance 3rd sector organisations were subdivided into over 20 types of groups for the purposes of the quantitative analysis, and local authority services were subdivided into 11 categories, which represented a large number of different organisations.

However, our investigations confirmed that whilst the Community Connector service performs a fairly distinctive connecting function, generally this has little overall effect on these partner organisations, which would refer onwards to, or receive signposted individuals from, other sources if it were not for the Community Connectors. Whilst there was some weak evidence for changes to these organisations, which will be discussed later, there was not compelling evidence for changes beyond the admission and referral process, which would indicate the requirement for a sample of stakeholders from a representative variety of types of organisations.

This report describes an evaluative SROI analysis. There were 2 key time periods for the analysis: firstly, there was a set up and coordination period, which commenced in the second quarter of 2016 and continued until the completion of the project at the end of the final quarter of 2018. Secondly, the project delivery began at the beginning of the 2nd quarter of 2017 (1st May 2017). However, some expenditure from the project delivery budget began in the first quarter of 2017.

ii. Identification and involvement of stakeholders

Stakeholder groups were identified initially through the development of the project logic model and discussions with the project delivery team. We followed up these stakeholder groups and asked them if they could identify any other stakeholders. Two rounds of surveys (including closed and open questions), a workshop, discussions with stakeholder representatives, evidence from routinely collected data (e.g. referral and signposted organisations) and qualitative findings from other work streams were used to establish the importance of specific stakeholder groups, including the exploration of evidence for materially different outcomes.

We had contact details for all of the Community Connectors (45 at the time of sending the main survey). Contact details for voluntary representatives from referral and signposting organisations were sought through the British Red Cross, by consulting with Community Connectors, resulting in a total of 37 contacts. Service users requested to respond to a survey (175) were contacted through the British Red Cross.

We carried out two rounds of Surveys. The contacts and respondents for the first survey are detailed in the following table (table 3):

Table 3: First Survey contacts and responses

Stakeholder group	Number contacted	Responses to survey
BRC management	2	-
Independent living managers	4	1
Community Connectors	6	4
Volunteers	1	-
COOP funders	3	1
3rd sector external organisation (CRUSE only)	2	-
TOTAL	**18**	**6 (33%)**

This first survey was conducted in the early stages of the evaluation, prior to access to referral and signposting data, and therefore included a number of questions to attempt to identify the range of partner organisations (see appendices).

A workshop was held with a range of stakeholders to refine and test early theories about the programme (table 4). Specifically, we explored types of services signposted to and referral routes, possible reasons for referral back into British Red Cross services, deadweight, inputs, involvement of volunteers, repeat referrals, outcomes (for service users, volunteers, 3rd sector organisations, family and friends).

Table 4: Workshop attendees

Stakeholder group	Number of attendees
BRC national management	2
BRC locality management	1
Community Connectors	2
COOP funders	1
Referring/signposted organisations	2
TOTAL	**8**

The second round of surveys were designed specifically for three different groups of respondents: referrers and signposted organisations, Community Connectors and service users. The contact and responses are detailed in the table below (table 5). The service user response rate was very low (6%), and numbers of surveys distributed was high (175) these responses skew the overall response rate. Therefore, a sub-total is provided.

Table 5: Second survey contacts and responses

Stakeholder group	Number of surveys sent	Responses to surveys	Response rate
Community Connectors	45	14	31%
3rd sector external organisation	18		
Local Authority services	7	8	22%

Health services	12		
Sub Total	**82**	**22**	**27%**
Service users	175	10	6%
Total	**257**	**32**	**13%**

The questions included in these 3 surveys are included in the appendices. Open questions were used to explore new areas of interest and closed questions were used, specifically to quantify elements of the delivery model that had been established. In addition to exploring potential benefits, we also sought to expose any negative aspects of the service. For instance, service users and partner organisations were asked "Were there any unexpected or negative consequences as a result of contact with the Community Connector service?" Partner organisations were also asked questions such as "Has engagement with the Community Connectors service required additional resources from your organisation (e.g. staff time)?"

The key stakeholder groups that could be considered not to be well represented in the development of the model are volunteers, support workers and service users. The rationale (where appropriate) and impact of this lack of involvement is discussed below.

It was not considered necessary to focus specific SROI evaluation resources on exploring experiences of volunteers as information gathered from the qualitative evaluation work-stream and from other stakeholders did not indicate that their experiences would be qualitatively different from those described in the large amount of literature about these groups (for instance issues to consider when conducting an SROI analysis of volunteering in 3rd sector organisations (Arvidson et al, 2010)) and included in the economic valuing methodology applied in this study (e.g. Fujiwara et al, 2013). For instance, established benefits include enhanced self-esteem, personal development, occupational experience, improved health and education and learning (e.g. See Chinman and Wandersman, 1999). These potential benefits were supported by those Community Connectors working closely with volunteers, and no additional or unexpected benefits were identified.

Support workers were not specifically targeted for involvement in the SROI analysis. They were included later on in the development of the service, as part of a 2-stage 'boost' plan, and their views can be assumed to be largely represented by those of the Community Connectors. As paid employees of the project they can be assumed to have neutral costs and benefits as they are inputting their time, which is being financially reimbursed at the accepted market rate for this work. There are many other similar roles available with other charity organisations, which it can be assumed that they would otherwise be engaged with. Therefore we can assume 100% deadweight. There were some suggestions that the quality of training available and the reputation of the British Red Cross might be an added advantage of being involved in the service. However, there was not enough good quality evidence to support these claims and differentiation from the quality of opportunities in other organisations was considered to require extensive exploration (beyond the scope of this study) for potentially only small marginal differences in value.

Despite attempts to engage with a large number of service users (175 postal surveys sent), response rates were very poor. To some extent this lack of engagement was compensated for through exploring the current literature in relation to similar types of services.

For instance; feasibility of main outcome measures, as demonstrated by the successful use of WEMWBS in evaluation of befriending & community connecting schemes (e.g. Evaluation Support Scotland, 2017) and SROI analysis using SWEMWBS (e.g. Action for Wellbeing, 2018), We also identified types of outcomes for further exploration, for instance the balance between reduced service use and health and wellbeing benefits recognised in similar 'social prescribing' projects such as the following, reported in an SROI report (Kensington and Chelsea Social Council, 2018):

- Reduced physical pain and discomfort
- Reduced depression and severe anxiety
- Reduced levels of loneliness and social isolation
- Improved self-confidence/self-worth
- Improved sense of health equality i.e. feeling valued the same as other people by care services
- Maintained independence and dignity, especially when enabled to access income support
- Reduced avoidable need for entering primary and secondary care

<div align="right">(Kensington and Chelsea Social Council, 2018, p.4)</div>

In contrast to the majority of SROI analyses, we also had extensive findings available from the qualitative work stream of the evaluation. We also had the benefit of routinely collected data; detailing the goals set and attained and types of services that service users were signposted onwards to. An exercise conducted early on in the evaluation process involved mapping service-user goals against the outcome measures being administered by the project.

The valuation technique for service-users outcomes used for this SROI study is focused on global values of subjective wellbeing, rather than estimating the minutiae of the broad range of intermediate benefits and attained goals. The wide range of organisations and social groups that users were connected with and the often vague and potentially overlapping concepts described in the recording of attained goals (e.g. 'Increased satisfaction with home environment') would create an overly complex picture with outcomes that would be difficult to measure accurately. Decreasing loneliness and social isolation was a key aim of the project. However, whilst the UCLA measure was available to assess changes in loneliness, this did not measure related concepts such as social isolation, and might only be one possible factor in a collection of responses to complex interventions that contribute to improved wellbeing.
Measures of subjective wellbeing (e.g. SWEMWBS) can therefore be viewed as the ultimate outcome for service-users. For this reason, the lack of extensive engagement with a large number of service users is not considered to be particularly detrimental to this study.

iii. Summary of stakeholder engagement
As described above, this SROI analysis was combined with qualitative and quantitative work streams as part of a larger multidisciplinary evaluation. This gave the added value of a combined and coordinated approach to gathering evidence. The SROI investigation therefore informed and was informed by interviews and analysis of routinely collected data as well as quantitative data collected specifically for this element of the evaluation. We also used current literature and expert opinion to help to build, refine and test the SROI model in an iterative fashion. Ongoing communication with the project delivery team and the review of an interim report and drafts of the final SROI report has ensured an ongoing process of verification. The following table (table 6) summarises the stakeholder engagement undertaken for this analysis.

Table 6: Summary of stakeholders and method of engagement

Stakeholder	Brief description	Number and method engaged reporting outcomes, identifying value and calculating impact claim or rationale for exclusion
Red Cross management	Provide time to oversee delivery of the Community Connector service and provide centralised supporting actions/functions.	Ongoing contact (phone, email and face-to-face meetings)with key members of the project delivery team.
Community Connectors	Front line operational people delivering service including building referral routes, managing volunteers, supporting service users and sourcing community activities.	25 - by telephone interview 7- 1st SROI survey 14- 2nd SROI survey
Volunteers	Support Community Connectors and engage with service users.	9- by telephone interview
Service users	People referred into and supported through Community Connector services and intended beneficiaries of the services.	26- interviews (24 telephone and 2 face to face) 10- SROI survey 142- Service-user satisfaction survey 5787- Routinely collected data (e.g. referral routes) 820- Matched, pre-post UCLA (loneliness) questionnaires 36- Matched, pre-post SWEMWBS (wellbeing) questionnaires
Third sector community organisations	Organisations delivering the community activities services are signposted into. Also refer people into the service for support.	3- SROI survey 1-Focus group
Health services	A main source of referrals into the programme, and potential beneficiary through reduced demand for their service.	3- SROI survey
Friends and family	Potential beneficiary by relieving them of providing additional support through a formal or informal caring role.	0 Friends and family are potentially recipients of benefits from the project. However, information obtained from service-users did not indicate significant potential benefits for this group.
Coop funders	Funding and overseeing the programme.	2- Focus group
Local authority services	A main source of referrals into the programme, and potential beneficiary through reduced demand for their service.	2- SROI survey
Coop staff and pioneers	Local promotion of Community Connector services and sharing information about other local services. Supporting Community Connector events.	0 Involvement was established through discussions with Community Connectors. Inputs were variable and not considered generally important for delivery of the project.

iv. Stakeholder involvement in establishing the levels of attribution, drop off, deadweight and displacement of outcomes

Throughout the identification and involvement of stakeholders for the study, the evaluators continually asked questions related to the levels of attribution, drop off, deadweight and displacement of outcomes. From the outset, where possible, stakeholders were specifically chosen for their ability to respond to these questions. Examples of some survey questions are provided in table 7, below (surveys are available in full in the appendices).

Table 7: Questions to establish impact claims

Stakeholder	Attribution	Drop-off	Deadweight	Displacement
Partner organisations	To what extent are programme activities likely to be contributing to observed outcomes?		To what extent would similar outcomes be expected anyway?	To what extent are the benefits claimed by the project participants at the expense of others outside the project.
			If you could not refer into the Community Connector programme, to what extent could you refer into other services that would have the same (or similar) outcomes?	
	How much credit for outcomes can be claimed by BRC?		If there are alternative services, what are these?	
			If you did not receive referrals/signpostings from the Community Connector programme, to what extent would other services do this?	
Community Connectors	Is there anything about the BRC brand or approach that is important or unique?		In your area are there services that are similar to Community Connectors?	
	If there are any aspects of the Community Connectors services that are unique compared to other available services (i.e. they could not be provided by others), what are these unique aspects?		If there are services in your area that carry out similar activities to the Community Connectors programme, what are these services?	
			If the Community Connector service was not available how much of the outcomes could be achieved by other locally available services?	
Service-users	If you have mentioned any benefits that resulted from the Community Connector (CC) service; how much would you say these benefits were due to the CC service?	How long do you expect these benefits to last?	What would have happened if the service did not exist? For instance, if you had not been in contact with the Red Cross Community Connector service, are there other places you could have gone to receive similar help or support?	

In addition to stakeholder engagement to elicit opinions about the drop off for benefits, we also carried out some empirical work to establish the sustainability of key outcomes, such as improved loneliness and wellbeing. This was conducted by repeating measures approximately 3

months after receiving services from the project. Some of these relevant findings are discussed later, and further detail is available in the companion reports.

b. Understanding the change (mapping, measuring and valuing the full range of inputs, outputs and outcomes)

The following table (table 8) demonstrates the initial logic model for the service, including activities, outputs, and expected short-term and longer-term outcomes and impacts. These assumptions were refined and tested throughout the study, using a wide range of methodologies; including analysis of routinely collected data, findings from the qualitative and quantitative work streams, stakeholder focus group, surveys and ongoing discussions with service management.

The key inputs for the service derive from project set-up, coordination and running costs resulting from activities of the Community Connectors, support workers and volunteers. Activities that are important for the effectiveness of the service include raising the profile of the service to encourage appropriate referrals into the service and exploring and making links with local community services and groups. These are necessary to support the flow of service users from organisations where their needs are identified, but unable to easily be met, through the Community Connector service to local services that can address their specific needs. As discussed earlier, the key stakeholder groups considered in relation to inputs, outputs and outcomes were:

- Volunteers
- British Red Cross organisation
- British Red Cross Community Connector project
- Service users
- Referring organisations*
- Signposted organisation*
- Family and friends

*Referring organisations and signposted organisations include the wide range of health services, local authority services and 3rd sector organisations and community groups that formed part of the service user pathways.

Whilst volunteers provided inputs and outputs, and also received benefits from volunteering, the British Red Cross (whole organisation and Community Connector implementation team) provided inputs and outputs, but without any intrinsic outcomes. Service users were the main stakeholder group for experiencing outcomes, but had no inputs or outputs attributable. Referring organisations, signposted organisations, and friends and family were stakeholder groups that were on the fringes of the scope of this evaluation. However, we made explorations into the relative importance of these groups for the SROI analysis. Largely these findings are inconclusive, but they contribute to our understanding and lay foundations for any future work in this area.

Table 8: Initial Logic Model

Actions	Outputs	Outcomes		Impact	
		Short term		**Long term**	
Partnership	• Partnerships established	• Good working relationship	• Increase access to services		
Workforce: • **Project staff** **Community connectors** • **Volunteers**	• Recruited, trained and are based in local communities • Capacity to deliver services	• Knowledge and understanding of existing infrastructure & pre-existing relationships • Good relationship and trust with clients	• Engaging with local community members		
Service delivery within local communities	• Supports plans developed	• Clients receives emotional support to help build their confidence and independence	• Clients are motivated to engage with workers to set personal goal	• Clients have increased confidence	Improved wellbeing
	• Workers connecting community members to existing services, resources e.g. social networks, community engagement groups etc.	• Clients receive adequate information support on the available community services/activities, resources and events.	• Clients helping to set own target goals • Clients co-creating their support plans	• Increased social connected ness	
	• Workers creating relevant links for clients	• Links created are sustained by clients	• Clients feeling empowered	• Decreased social isolation and loneliness	
	• Establishing social Networks	• Social networks are functional	• Clients using local resources • Clients interacting well with local community groups	• Independe nce	

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i. Volunteers

Within the volunteer supported delivery model another key activity is the identification, induction, training and support of volunteers. Volunteers not only assist the Community Connectors in the delivery of services, but also can be considered as a group with their own specific needs and they also derive benefits from involvement in the service. The effort expended on supporting volunteers can be understood to detract from front line service provision by Community Connectors. However, to an extent this effort is repaid by the labour provided by volunteers. Further discussion of this balance is provided later in the report.

The volunteers provide substantial input for the service, by providing their time for training and delivering services. Salamon et al. (2011) highlight the difficulties of placing a monetary value on volunteering as "there is no market-determined price that can stand automatically as the value of volunteer work. The most recommended and used substitute for the price of volunteer work is based on a revealed preference technique (e.g. Fujiwara et al, 2013) is the wage of a paid worker doing a similar job that the volunteer does for free" (p.4). The costs of this volunteer time are born by the volunteers and in this model are costed at the same rate (£10.00 per hour) as the service support workers. Time provided by volunteers (total 16,977 hours) was calculated by adding together the routinely collected activity records for time providing face-to-face and telephone contact with service-users (total 14,010 hours) with the results of Community Connector survey data (n=13), in which Community Connectors reported an average 12.9 hours induction for each volunteer (total 2,967 hours).

As well as providing inputs to the service, volunteers can also be understood to benefit from the act of volunteering. Indeed, the qualitative investigation (details in companion report) highlighted the psycho/social needs of volunteers that were met through the act of volunteering for the project. Using the wellbeing valuation approach, a person needs to be actively volunteering at least once a month for at least 2 months to qualify for the full annual value of £3,249 (which takes into account the possibility of overestimating for some people and underestimating for others). Deadweight is derived from the HCA 'Additionality Guide' (Dancer, 2014) and calculated using the Social Value, Value Calculator (V4_0-2); proportionately at the standard rates for direct wellbeing benefits and health benefits (Dancer, 2014), which have different deadweight values attributed to them. The total value of £3,249 is made up of £892 health benefits and £2,357 direct wellbeing benefits (Trotter et al, 2015).

The Value calculator is a spreadsheet that applies deadweight at rates derived from the additionality guide. Wellbeing values are compound values: made up from different types of outcomes, which have different deadweight values and these are calculated proportionally. Using this approach we can assume that 19% of the benefit would have happened without the intervention (i.e. only including 81% of the total value). Drop-off for the benefits gained from volunteering is calculated at 100% for periods over 1 year (i.e. no benefit is assumed after 1 year).

> "To avoid overcounting, in the current version of the approach we do not permit impact to be counted as extending past a year even if you collect data that indicates that the beneficiary continues to be in the improved state. This is because of the increasing level of deadweight that would occur over time (the proportion of people in your intervention who would have achieved the same outcome without your activity at some point over the coming years)." (Trotter, 2014).

ii. British Red Cross organisation

The British Red Cross wider organisational involvement in the project was related to the set-up and coordination of the service and the associated funding required for this. Lengthy discussions with the project management and organisational financial management identified the inputs that should be allocated to the delivery of the project.

In order to calculate the operations-focused central cost, we separated out the central costs to identify UK operational costs and the policy and communications work. From the policy and communications budgets we removed any policy and advocacy costs, costs related to the core brand campaign and fundraising costs. The remaining costs were then added to the UK operations central costs to get the total central costs. In terms of a percentage of this to allocate to the project, activities were split according to the number of Community Connector schemes compared to the number of schemes running in parallel for other projects. As the Community Connector project accounted for the majority of activity during the allocated time period, 90% of these costs were attributed to the project.

Whilst the project did not start delivering services until Q2 2017, central organisational costs involved in the set-up and coordination of the project were being incurred from Q2 2016 until Q4 2018. This resulted in a 1-year period of inputs without any corresponding outcomes.

iii. British Red Cross Community Connector Project

The project began incurring some costs from Q1 in 2017, and these inputs continued until the end of Q4 2018. Inputs increased greatly in the second quarter of 2017, when the service began delivery. Running costs for the project increased over time, and included 2 'boost' plans, which were introduced to provide increased resources targeted at schemes where this could make the most difference to the numbers of service users engaged with. All of the costs incurred by the project for delivery of the service are regarded as legitimate inputs. The breakdown of running costs taken into account is listed below.

- Fleet costs
- Staff costs
- Training costs
- Costs for premises and facilities
- Travel, accommodation and subsistence expenses
- Hospitality and catering
- Fundraising and marketing
- Grants and other payments to partners
- Recruitment costs
- Equipment, materials, software and stationery
- Telecommunications
- Bank charges and financial gains and losses
- Other miscellaneous costs
- Postage and shipping
- Professional fees and insurance
- Recharges and financial corrections
- Consumables
- VAT costs

iv. Referring organisations

No inputs or outcomes were included for the SROI model regarding referring services. However, it is clear that these organisations provided outputs that were important for the operation of the Community Connector service; notably referring service users into the Community Connector project.

There were a number of considerations that were explored to understand whether inputs or outputs could be related to these outputs. For instance, organisations referring into the service also might benefit from improved organisational efficiency, by handing over the task of searching for and supporting social based activities for their service users. Whilst some of these referring services did report organisational time saved by referring into the Community Connector service, this was not true across the board and was variable and difficult to quantify, without further targeted research. Survey responses (n=6) reported time savings from 0 (n=3) to 60 minutes (n=1) and 30-60 minutes (n=2) per person referred. Whilst this could be estimated as a saving of 25 minutes per person, the numbers of responses are very small and not generalizable. Therefore, in order to ensure a conservative estimate of benefits, these have not been included in the SROI model. Rationales for time savings included "able to connect patient with a service that will help and support them investigate community services and therefore also saves my time as a clinician", and "Referring to community connectors saves us a lot of time with regards to local groups/activities. Although we are aware of many social groups and activities, exploring and arranging this with the patients takes a lot of time so it is highly beneficial for us to refer to community connectors". The personal support for service users was also valued by one respondent "They provide support for people to access services we have identified for a client e.g. accompanying them to an event or appointment".

Referring organisations acknowledged that it takes time to refer people into the Community Connector service, although responses to the survey indicate that this might ultimately be time saving: "yes it takes time to process the referral but making the referral means the patient gets a good service and making a referral takes less time than doing the research etc yourself".

When considering deadweight for benefits for referring organisations, using responses to the following question "If you could not refer into the Community Connector programme, to what extent could you refer into other services that would have the same (or similar) outcomes?" we estimated this (mean of all responses) at about 37.5% (225/6). The following table (table 9) shows survey responses to the deadweight question.

Table 9: "If you could not refer into the Community Connector programme, to what extent could you refer into other services that would have the same (or similar) outcomes?"

Actual question asked: If you could not refer into the Community Connector programme, to what extent could you refer into other services that would have the same (or similar) outcomes? (0%=there are no other services that you could refer to <-> 100%=there would be no problem finding alternative services to refer into)?

Label (answer choice)	Value	Responses received	Total
None	0	1	0
About 25%	25	3	75
About 50%	50	0	-
About 75%	75	2	150

Label (answer choice)	Value	Responses received	Total
All	100	0	
Total		**6**	**225**
Mean			**37.5%**

As described above, the mean average of time saved from survey responses was 25 minutes. From this small sample about 16 minutes are being saved by referring organisations (25 minutes, minus 37.5% deadweight).

v. Signposted organisations

A similar investigation was undertaken to explore any inputs, outputs and outcomes for signposted organisations. Indeed some of these organisations were involved in both referring and receiving signposted service users. No inputs or outcomes were included for the SROI model regarding signposted organisations. However, it is clear that these organisations provided outputs that were important for the operation of the Community Connector service; notably receiving service users from the Community Connector project.

Specific survey questions included "What are the main areas of value for your organisation in receiving clients from the Community Connector programme?" and "What are the main costs for your organisation in receiving clients from the Community Connector programme?" One of the respondents reported that each new signpost allows them to access £400 additional revenue, and another replied that the identification of each client saves approximately 75 minutes of outreach work. In terms of inputs, one of the respondents stated that it takes an additional 5 minutes to process each new signposted service user.

To explore deadweight, we asked "If you did not receive referrals/signpostings from the Community Connector programme, to what extent would other services direct clients to you?" (table 10).

Table 10: "If you did not receive referrals/signpostings from the Community Connector programme, to what extent would other services direct clients to you?"

Actual question asked: *If you did not receive referrals/signpostings from the Community Connector programme, to what extent would other services direct clients to you (0%=there are no other services that would do this <-> 100%=we would have the same number and type of referrals/signposts)?*

Label (answer choice)	Value	Responses received	Total
None (if not CC then no other services)	0	1	0
About 25%	25	0	-
About 50%	50	1	50
About 75%	75	1	75
All (would be the same)	100	1	100
Total			**225**
Mean			**56.25%**

Again, the responses indicated the huge variety of the experiences of stakeholders from signposted organisations. One of the respondents stated that if it were not for the Community Connector service, then no other services would refer clients to them. On the other hand, 1 of the respondents stated that they would still have the same number of clients directed to them if the Community Connector service were not in existence. Whilst there are only a small number of responses (4) and these represent a wide variety of experiences, the average deadweight is (100, 75, 50, 0=) 56.25%.

In order to explore displacement, we also asked respondents "How often do people coming from the Community Connector programme deprive other people of your services? For instance, if a person takes a place at a community activity is this at the expense of another person, who cannot now get a place?" All 4 of the respondents stated that this happens 0% of the time, so for this small sample we can assume 0% displacement.

The small number of responses and the large variety of different community groups and organisations, as well as statutory services and large charities that service users are signposted towards indicates that further investigation might be required in this area. The large range of different service delivery models and funding arrangements as well as relative scarcity or abundance of service users for these signposted services mean that it is beyond the scope of this evaluation to explore the broader social costs and benefits resulting from service users being signposted to other services.

vi. Family and friends

No inputs, outputs or outcomes were calculated for family and friends. Some changes in reliance on family and friends were reported to be largely based around practical support (such as help with shopping and social company), and could therefore be considered an economic outcome. Apart from these practical benefits, broader wellbeing outcomes are possible. However, whilst it is possible that there were wellbeing outcomes for family and friends, there was little evidence for this other than benefits from short-term social contact for service users, which might have provided some additional support and alleviated some pressure from family and friends. Effects on family and friends were not measured within the project, and (despite asking specific questions about this in the service user survey) it was difficult to establish any good evidence for these effects. Changes in reliance were mostly based on short-term practical support from the programme, which was not associated with the main aims of the service; so it was assumed that any benefits are unlikely to last beyond the contact time. Therefore, whilst no specific inputs, outputs or outcomes for family and friends were established, this could be an area of influence that a Community Connector service might want to focus on and set up measurement for in the future.

vii. Service users

Service users had no inputs or outputs. We concentrated efforts on exploring outcomes for service users. The Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant et al., 2007) was used as the key measure for service user outcomes (subjective global wellbeing). Although one of the main aims of the project was to address loneliness and social isolation, these are generally considered to be aspects of wellbeing (e.g. Michaelson et al, 2012), which can be measured using the SWEMWBS tool (e.g. Davidson et al, 2015). Therefore, if we only valued changes in loneliness scores, we would be only measuring a part of the potential benefits for service users. A further incentive for using changes in the SWEMWBS score as the key outcome is the availability of robust valuation methodology (e.g. Fujiwara, 2014).

Unfortunately, there are currently no credible or accurate techniques available for measuring changes in loneliness. This area of knowledge is in the very early stages of development and we would not be comfortable in using loneliness as an outcome in this study. Recent attempts (e.g. Social Finance Ltd, 2015) tend to employ a binary (lonely or not lonely) approach, which is rather simplistic and not sensitive to degrees of change. Often studies conflate correlation with causation (e.g. loneliness causing dementia, whereas it is probably more likely that cognitive impairment makes people feel lonelier), and rely on linkages between loneliness and characteristics that are not amenable to change through these types of interventions (e.g. class, gender, renting your home or living in a deprived area).

We used the wellbeing valuation approach (summary in appendices) to place a monetary value on changes in the SWEMWBS questionnaire using only matched pre-post responses (adjusted for inflation at 3.58%, 2017 rate) (see table 11). A pre-post comparison is the preferred method for establishing change, when a control group is not available. This approach groups scores (7-35) into 12 categories and applies a monetary value to the pre-score category and a monetary value to the post-score category (Trotter and Adams, 2017). The value of change is calculated as the difference between these. As the pre-post method is expected to produce an overestimate of benefits we applied the recommended 27% deadweight (Fujiwara et al, 2017).

Table 11: values for changes in SWEMWBS scores

Category	Overall SWEMWBS score	Full model value	2017 annual inflation at 3.58%
1	7 to 14	£0.00	£0.00
2	15-16	£9,639.00	£9,984.08
3	17-18	£12,255.00	£12,693.73
4	19-20	£17,561.00	£18,189.68
5	21-22	£21,049.00	£21,802.55
6	23-24	£22,944.00	£23,765.40
7	25-26	£24,225.00	£25,092.26
8	27-28	£24,877.00	£25,767.60
9	29-30	£25,480.00	£26,392.18
10	31-32	£25,856.00	£26,781.64
11	33-34	£26,175.00	£27,112.07
12	35	£26,793.00	£27,752.19

The following table and bar chart (table 12, figure 6) show the frequencies for baseline and end of service value categories. It clearly indicates that there were generally reductions in the lower value categories and increases in the higher value categories. From these findings, we calculated a mean change in value of £5584.93 per completed pre-post measure for each service user.

Table 12: Changes in SWEMWBS value categories

SWEMWBS Category	Baseline		End of Service		Change
	Frequency	Percentage	Frequency	Percentage	Frequency
1	13	19.4	3	4.5	-10
2	9	13.4	3	4.5	-6
3	6	9.0	8	11.9	2
4	14	20.9	4	6.0	-10
5	4	6.0	11	16.4	7

6	10	14.9	9	13.4	-1
7	6	9.0	15	22.4	9
8	2	3.0	8	11.9	6
9	3	4.5	3	4.5	0
10	0	0	2	3.0	2
11	0	0	0	0	0
12	0	0	1	1.5	1
Total	67	100.0	67	100.0	

Figure 6: Bar Chart for Changes in SWEMWBS value categories (n=67)
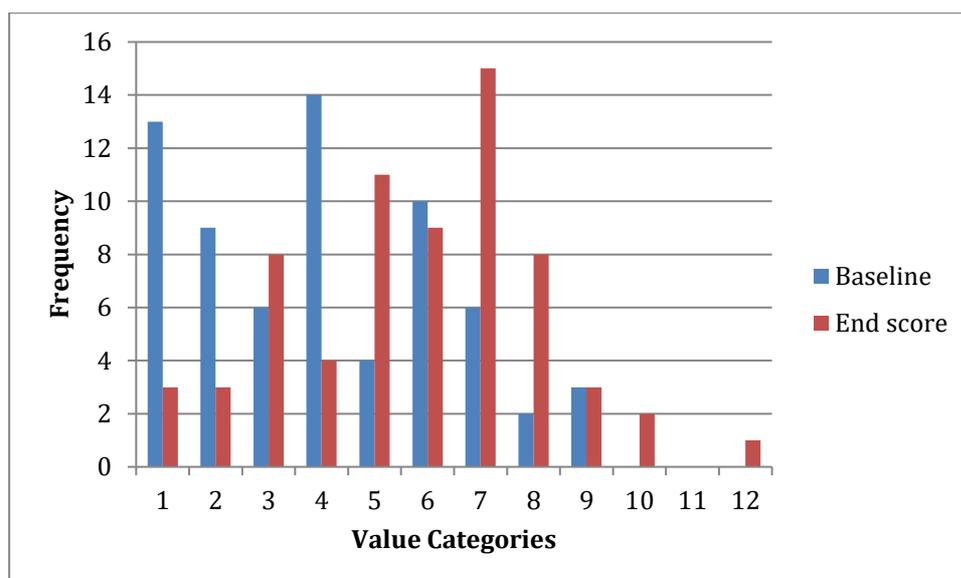
A 3-month follow up collection of SWEMWBS data (n=34) indicated that there was fairly rapid drop-off for benefits of 41.2% per quarter (see table 13 below). If this decline is projected further, responses would expect to revert back to baseline values at 7.3 months post-intervention. Therefore, to ensure a conservative estimate of benefits we applied a 50% drop off (or a reversion to pre-intervention measurements at 2-quarters following the intervention).

Table 13: Sustainability of changes in SWEMWBS scores

Calculating drop-off for SWEMWBS								
Base, n=67	End, n=67	3-month follow up n=34	3-month difference	1-month difference	Base-End difference	Months to revert back to base value	% decline per quarter	
18.9	22.3	20.9	1.4	0.467	3.4	7.29	41.176	
End mean	1 month	2 month	3 month	4 month	5 month	6 month	7 month	8 month
22.30	21.83	21.37	20.90	20.43	19.97	19.50	19.03	18.57

The SWEMWBS analysis demonstrated a value for improved wellbeing equivalent to £5584.93 for everyone that completed both questionnaires. An important limitation of the accuracy of the SROI ratio is the small number of completed pre-post SWEMWBS questionnaires completed (n=67), as these are the key benefits for service users. We have addressed this limitation by extrapolating these benefits to a wider representative population of service users. We excluded service users that had less than 2 contacts with the service as these would not be able to complete a pre and post intervention questionnaire and would therefore not be representative of those that did complete 2 questionnaires. We made efforts to exclude repeat contacts to avoid double counting. However, with the available data it was not possible to identify all of these individuals. Therefore, we excluded all self-referrals as conversations with members of the service delivery team indicated that it was fair to assume that a number of these were repeat service users; referring themselves back into the service. This assumption is supported by the exponential increase in self-referrals; indicating a feedback loop in the self-referral process. Therefore the total number of service users assumed to have positive changes in wellbeing was reduced from 5787 (total referrals) to 2203 (2136+67). It should be noted that this is a conservative estimate as it is not expected that all self-referrals would be repeat contacts, however this was considered the best available estimate as other approaches run the risk of overcounting benefits.

There are some differences in the characteristics of service users that completed the SWEMWBS measures and those that did not, which are presented in greater detail in the companion report. Notable differences were regarding gender and ethnicity. In the wellbeing sample, three quarters of the service users were female (75.4%) compared to 64.9% in the overall sample. Almost 90% of the wellbeing sample was White British (88.3%) whereas in the main sample the proportion was smaller at 76.7%. The 2 sample groups were similar regarding living arrangements and age. Despite some differences between the wellbeing subsample and the wider sample, where there are differences in the specific demographics, these were not related to changes in loneliness. Therefore, we can be quite confident about the generalisability of the wellbeing data to the wider population of service users.

viii. Additional inputs, outputs and outcomes

Whilst investigating the potential effects of the Community Connector service, we explored leads that were indicated through the quantitative analysis of routinely collected data and qualitative investigations. Responses to surveys indicated that Community Connectors were accompanying service users to health care appointments and therefore preventing non-attendance (Did Not Attend=DNA). It was also possible to explore these activities in the routinely collected data. In the routine data it was assumed that each Community Connector visit recorded as a 'hospital/health appointment' (n=212) prevented an appointment being missed. We can consider this to be a conservative estimate as these events equate to about 5.7 prevented DNAs per scheme (37 schemes). However, when Community Connectors were specifically asked, "If the Community Connector service has helped someone to attend a health care appointment that they would otherwise have missed, how often has this happened?" the average of responses to the survey estimated prevented DNAs at over 13 per scheme (see table 14). This assumption is supported by the recognition in the companion report that activity recording was incomplete.

Table 14: Prevented DNAs reported by Community Connectors

Respondent	1	2	3	4	5	6	7	8	9	10	11	12	13	Total	Mean	Range
DNAs prevented	-	15	10	45	20	7	4	20	0	2	10	12	-	145	13.2	0-45

		(10-20)												

It is common to base the cost of DNAs at the full cost for that appointment, assuming that the time was not used for other activities and the appointment could not be filled by another patient. For instance, recent news from NHS England placed the cost of each missed GP appointment at an average of £30 (NHSE, 2019). The £30 value per appointment was used for this evaluation.

The following tables summarise the inputs, activities, outputs and outcomes for the project.

Table 15: Inputs by stakeholders

Stakeholder	Activities/Identified inputs	Output	Total input/cost and source
Red Cross Management and administration	Local management of Community Connectors and services. National programme management and other central costs such as communications and marketing to support operational delivery.	> Set up and coordination of project > Recruitment of key staff members	£924,654.29 identified from BRC financial accounts
Community Connectors	Operational costs of establishing services and operation from 01/05/2017 to 31/12/2018. This includes recruitment of Community Connectors and volunteers, salaries and supporting costs such as equipment, vehicles and expenses to support operation.	> 37 services operating across the UK > 44 Community Connectors recruited and trained > 5,320 people accepted for support (90% of referrals)	£2,329,552.54 identified from BRC financial accounts
Volunteers	Deliver support to those referred into the services. Time to undertake training required.	> 390 volunteers recruited, 230 trained > 14,010 hours of support to people > 16% of people supported had interactions with volunteers.	£140,094.50 for service delivery and £29,670 for training and induction Using £10.00 per hour for volunteer time (equivalent to support worker hourly rate)
Health services	No evidence was found to suggest consistent inputs	> Support for 212 service-users to attend health appointments	£30.00 each average cost for a missed GP appointment (NHS England News, 2019).
Local Authorities	No evidence was found to suggest consistent inputs or outcomes for local authorities		
Third sector/community organisations	No evidence was found to suggest consistent inputs or outcomes for 3rd sector organisations		

Friends and family	No evidence was found to suggest consistent inputs or outcomes for family or friends		

Table 16: Outcomes and their values

Stakeholder	Identified outcome(s)	Indicator/source	Impact Claim	Valuation
People supported	Increased wellbeing	Short Warwick Edinburgh Mental Wellbeing Scale score	Deadweight: 27% Drop-off: 50% (per quarter) Displacement: 0%	£4,490,811.05 Using Wellbeing Valuation Approach to value changes on SWEMWBS scale (unknown location and age, inflated for 2017 rate at 3.58%) n=67 extrapolated to larger selected sample (n=2203)
Health Services	Avoided missed health appointments	People supported to attend health appointments. Identified in operational data.	The impact for this outcome is related to a single, recorded one-off event. Deadweight, drop-off and displacement are not applicable.	£6,360.00 212 prevented missed appointments valued at £30.00 each
Volunteers	Improved wellbeing	Trained volunteers identified in operational data. Benefits supported by Community Connector surveys and Volunteer interviews	Deadweight: 19% Drop-off: 100% annually Displacement: 0%	£605,360.00 Valued using the Wellbeing Valuation Approach (Value Calculator V4_0-2) based on 230 trained volunteers and a value of £2,632 per volunteer (accounting for deadweight, unknown location)

c. Sensitivity Analysis

As deadweight and attribution are included in the valuation methodology, we have not explored changes in these values for the sensitivity analysis. However, we have calculated:

- Service user outcomes being sustained for a longer time period
- Running costs only (excluding set-up and coordination costs)
- Only including service-user wellbeing outcomes
- Attaining a neutral SROI ratio
- No estimates for prevented non-attendance at health appointments
- Reductions in outcomes required for a neutral SROI ratio
- No outcomes for volunteers
- Variability of outcomes within 95% confidence intervals

i. Sustaining service user wellbeing benefits

The drop off for service user wellbeing benefits might be amenable to improvement. Therefore, we calculated the SROI ratio assuming a 1-year duration of outcomes rather than 6-months. The result of this longer duration of benefits are shown in table 17 below:

Table 17: SROI ratio with longer duration of service user outcomes

Total Present Value (PV) of outcomes	£8,817,798.02
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£5,643,627.29
Social Return £ per £	£2.78

ii. Running costs only (no central organisational costs)

We calculated the SROI ratio if central organisational costs were not calculated as required project inputs (£2.04). This might represent a situation which might be achieved in the longer-term when the service was able to produce the same outcomes from only the financial **investment required for day to day running costs. As shown in the table below, this scenario** produced a SROI ratio of £2.04.

Table 18: SROI ratio with no central organisational costs

Total Present Value (PV) of outcomes	£4,692,192.31
Present Value of investments	£2,300,639.80
Net Present Value (NPV)	£2,391,552.51
Social Return £ per £	£2.04

iii. Only including service-user wellbeing outcomes

The following table shows the SROI ratio when outcomes for volunteers and health services are removed; only service-user wellbeing outcomes. This demonstrates that the project would still show a positive SROI ratio (£1.30) if only these outcomes were taken into account.

Total Present Value (PV) of outcomes	£4,125,605.71
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£951,434.98
Social Return £ per £	£1.30

iv. Attaining neutral SROI ratio £1

As the changes in SWEMWBS scores (indicating improved wellbeing) were the outcomes that had the greatest effect on the SROI ratio, we calculated what reductions would need to be made to create a neutral SROI ratio. In this scenario SWEMWBS present values need to total £2,607,584.12 rather than £4,125,605.71; a reduction of 63%.

v. Removing health service outcomes

Removing the outcomes calculated for reduced DNAs at health service appointments still retains a positive SROI ratio (£1.48), as shown below (table 19). The change is so small that this does not change the value of the SROI ratio when compared to the full model.

Table 19: SROI ratio with no DNA outcomes

Total Present Value (PV) of outcomes	£4,686,363.43
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£1,512,192.70
Social Return £ per £	£1.48

vi. Removing outcomes for volunteers

Removing the outcomes calculated for benefits for volunteers also still retains a positive SROI ratio, as shown below (table 20). In fact, the SROI ratio (£1.30) is the same as the analysis above (iii), which only accounts for service-user wellbeing as an outcome.

Table 20: SROI ratio with no outcomes for volunteers

Total Present Value (PV) of outcomes	£4,131,434.59
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£957,263.86
Social Return £ per £	£1.30

vii. Variability of outcomes within 95% confidence intervals

We calculated the upper and lower 95% confidence intervals for the mean wellbeing values for service users, which were £3,487.19 and £7,682.67 (i.e. we can be 95% certain that if we provided the service again under the same conditions that people would have an improvement resulting in values between these figures). If we use these values to calculate the SROI ratio, the following results are achieved (tables 21 and 22):

Table 21: Lower 95% confidence interval for SWEMWBS values (£3,487.19)

Total Present Value (PV) of outcomes	£3,189,555.57
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£15,384.84
Social Return £ per £	£1.00

Table 22: Upper 95% confidence interval for SWEMWBS values (£7,682.67)

Total Present Value (PV) of outcomes	£6,194,829.06
Present Value of investments	£3,174,170.73
Net Present Value (NPV)	£3,020,658.33
Social Return £ per £	£1.95

This demonstrates that despite the small numbers of matched pairs of pre-post SWEMWBS measures completed, we can be fairly confident that, if it were implemented again, the project would return an SROI ratio of between £1 and £1.95.

4. Discussion and recommendations

a. Volunteers

As mentioned earlier in the report, the time spent recruiting, training, inducting and supporting volunteers was treated as resource-neutral (i.e. the time invested by Community Connectors for this activity was repaid through the volunteers providing their time to offer services). Recruiting, training and supporting volunteers was reported to require a lot of resources and to reduce the time that Community Connectors had for directly providing services. However, in responses to the survey, there was a large amount of variability (table 23).

Table 23: SROI survey response from Community Connectors

n=13	No. of Volunteers	Total time to support (hrs.)/ week	Hours per volunteer (Total time/No. of volunteers)	No. of volunteers per year	Time taken for each induction	Induction time per CC per year
Total	88.5	93	-	66	167	690
Mean	6.8	7.2	1.1	5.1	12.9	53.1
Range	3-14	2-30	0.35-2.5	2-12	4-35	10-120

From table 1 above, you can see that the average time required to support each volunteer was 1.1 hours/week. However, the range was 21 minutes to 2 hours 30 mins. Time required for induction of volunteers was 53.1 hours per year (1.02 hours/week). The average time required for support and induction of volunteers is therefore 2.12 hours per week. Perhaps more important is the range of values. For instance, each induction was reported to take from 4 hours to 35 hours, indicating that the experience for each volunteer is extremely variable. Whilst noting that this information is derived from opinion and recollection of Community Connectors and therefore has limited reliability, we can compare this time used to support volunteers to the productivity of volunteers using recorded contact times (table 24).

Table 24: Volunteer productivity

	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
Cumulative volunteers	0	9	51	115	159	182	221	230
Total time (hours) for face to face and phone contacts	0	6.25	885	366	1650	3979	6163	961
Mean time (hours) per volunteer each quarter	0	0.69	17.35	3.19	10.38	21.86	27.89	4.18

Again, the results are highly variable, depending on the time period. It would be fair to ignore the low productivity at the start of the project, when there were few volunteers engaged.

However, the range per quarter is from 3.19 hours (0.25 hours per week) to 27.89 hours (2.15 hours per week) per volunteer, and the mean for the duration of the project is 10.69 hours (0.82 hours per week).

Using these figures, there is only one quarter (Q3, 2018) where the inputs and outputs for volunteers break even (2.12 hours Community Connector time for support and induction of each volunteer and 2.15 hours of contact time per volunteer). On average, it takes an additional 1.3 hours per week to support volunteers than is returned by face to face contact between volunteers and service users. It is important to note that this does not include time that volunteers are engaging in other meaningful activity. However, whilst there might be questions surrounding the benefits to BRC (at an organisational level) of engaging volunteers, it is well-established that volunteers gain a wide range of benefits from regular volunteering. The total net present value attributed to volunteer's benefits from involvement in the project is £560,757.72.

> "Participants have been found to derive benefits from volunteering through a number of different ways, including enhanced self-esteem (Omoto and Snyder, 1992); personal development (Schmitz and Schomaker, 1994); occupational experience (Hackl et al., 2007; Knoke and Adams, 1987); improved health (Oman et al., 1999; Adelman 1994; Wilson and Musick, 2000); and education and learning (Knoke, 1988; Moore and Allen, 1996). See Chinman and Wandersman (1999) for a full review of the literature."

> (in Fujiwara, Oroyemi & McKinnon, 2013; pp 7-8)

b. Referrals

In responses to the SROI survey, all Community connectors identified unique aspects of the service, including:

- the 12-week duration
- referral for non-specific interventions
- bespoke and locally designed interventions
- flexible and adaptive support
- Focus on loneliness and isolation
- providing accompanied visits
- transport and easy access to other BRC services (over 10% of all signposts)

The service has greater value (reduced deadweight) in localities where there are little or no other comparable services to refer into. Out of 6 survey respondents from external organisations; 2 thought that about 75% of the time there were other services that could be used, 3 respondents thought this to be true only 25% of the time and 1 respondent said that they had no other alternatives. One service user reported that they were helped to be taken out of their local area where there were no opportunities for social contact. **Recommendation: consider avoiding overlap with existing local services and focus on areas most deprived of opportunities.**

c. Self-referrals

At the end of the project, self-referral was the main route of referral into the service, an increase from 17% described in the interim report (August 2018) to 43% in the final quarter of 2018. Self-referrals account for 48% of all referrals that result in a contact (i.e. recorded activity) with the project. Interestingly, only 46% of these self-referrals resulted in a contact in the last quarter of

2018; which indicates concerns either about the appropriateness of these referrals or completeness of data recording. The time-series analysis included in the SROI (see figures 7 and 8 below) and evidence from qualitative investigation (see additional report) suggests that the service might be acting as a "revolving door" for some service users who are referring themselves back in at the end of service. The increasing number of self-referrals might also be due to the service becoming established and known within local communities (e.g. word of mouth recommendations).

Figure 7: Time-series of all referrals into the service
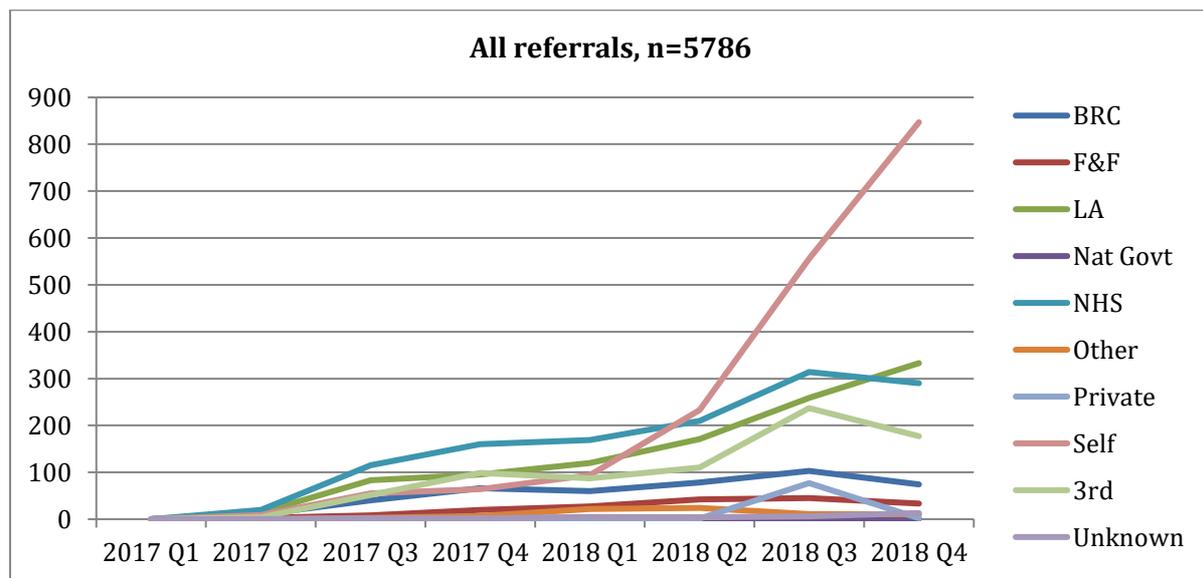
Figure 8: Time-series of all referrals into the service resulting in a contact
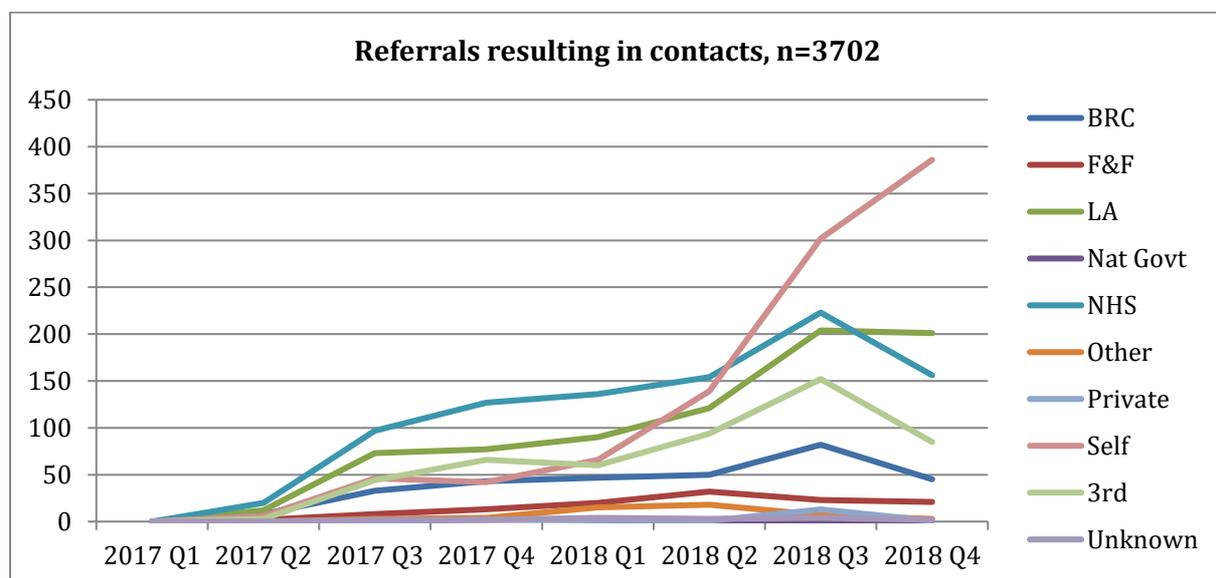
Recommendation: further guidance on the period of time between a service user finishing the service and being able to self-refer back in would be beneficial. Service users referring themselves back into the programme may be problematic if they are taking resource away from clients who have not yet experienced the service. Self-referral back into the programme also

suggests that the length of intervention is not meeting the needs of all clients. The BRC are working to better understand who these service users are. **Recommendation: The BRC may wish to undertake further analysis on how many service users have accessed the service previously and whether there are any trends to whether specific groups are more prone to this.**

d. Duration of the project

The SROI ratio could have been impacted by the relatively short (2-year) duration of the intervention. It is clear from the time-series analysis (see figures 7 and 8 above) that the programme had not yet achieved a stable state. For instance, when observing quarterly data, referrals were increasing up until the penultimate quarter of the project, and the ratios of referrals and signposting from various sectors and organisations were changing over the course of the project, for instance 'self-referrals' were increasing exponentially. In time, one would expect these features of the project to stabilise to some extent, and become more predictable.

For the purposes of understanding the SROI ratio that we might expect from the intervention; similar signposting interventions applying a limited definition of benefits (e.g. only mental health improvement) have demonstrated a modest but positive return on investment of £1.26 for every £1 invested over a five year period (McDaid, Park and Knapp, 2017). However, when (similar to this evaluation) wider benefits are included a higher ratio could be expected (between 2.0 and 3.0) (McDaid, et al, 2017). The Community Connector project compares well to this evidence from another similar study, as a positive SROI ratio was achieved over the 2-year duration of the service.

e. Referring and signposting organisations

This SROI study explored the effect of the Community Connector project on organisations that were referring into the service and receiving service users, signposted from the service. Whilst there was some weak evidence for costs and benefits for these organisations associated with contact with the service, the wide range of different services meant that further exploration of effects was beyond the scope of this study. Further exploration into outcomes for main referral and signposting route stakeholders, might be useful to uncover additional potential benefits.

f. Changes in health service use

There is no reliable evidence to suggest that social prescribing interventions reduce health service use. Whilst a recent study (Cames et al, 2017) demonstrated that there might be a small reduction in health service use following social prescribing interventions, this is likely to be a result of regression to the mean; as people are generally referred for social prescribing interventions when they have high consultation rates, which will decline over time without the additional intervention (Bickerdike et al, 2017). No evidence was found to suggest that this project would have a significant effect on longer term health service use.

5. Conclusions

The project under investigation comprised of the set-up coordination and delivery of the British Red Cross Community Connector service. Set-up began in the 1st quarter of 2016, the service began delivery in the 2nd quarter of 2017 and ran until the end of 2018. The study used a wide variety of investigative methods to explore the potential range of inputs, activities, outputs and outcomes for a number of stakeholders:

- Volunteers
- British Red Cross organisation
- British Red Cross Community Connector Project
- Service-users
- Referring organisations*
- Signposted organisation*
- Family and friends

[*Referring organisations and signposted organisations include the wide range of health services, local authority services and 3rd sector organisations and community groups that formed part of the service-user pathways]

Inputs that formed the SROI economic model were British Red Cross central organisational and delivery costs and the time given by volunteers to help deliver the service. Outcomes that formed the SROI economic model were improvements in wellbeing for service-users, improvements in health and wellbeing for volunteers and a small amount of value was calculated for helping service-users to attend health care appointments and therefore prevent the costs to health services for missed appointments.

The result of the analysis is a net present value of over £1.5M (from over £3.17M invested) and an SROI ratio of £1.48 return for every £1 invested. We are confident that the measurements and valuation methodology provide a robust estimation of the economic evaluation of the project. All relevant costs are included in the model from a detailed breakdown derived from operational data. We have been conservative in our estimation of benefits from the project and explored any potential negative or unintentional outcomes that might have affected this analysis.

Deadweight for benefits has been applied according to methodological guidance, and additional drop-off (50%), assuming a return to pre-intervention levels after 6-months, was included for the outcome with the highest overall value (improvement in wellbeing for service-users). This was a conservative estimate of additional data collection and analysis, exploring sustainability of SWEMWBS outcomes at 3-months post discharge from the service (n=34), which indicated a return to pre-intervention levels at a little over 7-months. This empirical analysis to estimate drop-off is a more rigorous approach than most SROI analyses, which tend to only measure pre-post intervention.

The sensitivity analysis explores a wide range of alternative scenarios. The main outcome (service-user wellbeing) would need to reduce by 63% to create a neutral SROI ratio. If service-user outcomes were sustained for 1-year, this would result in a significantly higher ratio of £2.78. We used statistical techniques to estimate the 95% confidence intervals for the value of the service-user outcomes. We are therefore 95% confident that if the service were run exactly the same again, there would be at the minimum a neutral return on investment (£1.00), and at the higher confidence interval there would be a return of £1.95.

We have been as transparent as possible in the description of our method and methodologies, in order that he results of this analysis can be replicated, and we have sought to iteratively verify

our approaches and findings with key stakeholders at various stages. This final report has been reviewed by members of the British Red Cross prior to wider circulation.

One important limitation of the study is the relatively small number of service-users that engaged with the evaluation. There was only one attempt to contact users with the SROI postal survey and no follow-up. There was also a small number of service-users that completed pre and post-intervention SWEMWBS questionnaires (n=67), and therefore the subsequent need to extrapolate these findings to a larger sample size. However, we sought to address this limitation using 4 approaches.

- Firstly, we analysed the characteristics of people that completed these measures compared to the wider sample of service-users and found no important differences and therefore concluded that the generalisability of the wellbeing data to the wider population of service-users is unlikely to be problematic.

- Secondly, we compared changes in wellbeing to changes in loneliness from a larger sample that completed these measures, and found (in line with other studies) that these had a statistically significant correlation. As stated in the companion report when exploring outcomes and the sustainability of these outcomes; "**Generally, the same service users who experienced an improvement in their wellbeing also had an improvement in their loneliness".** Whilst the sample was small (n=55), this correlation was statistically significant (Fishers Exact Test: p= .006). So it appears these two benefits go hand in hand" (p.77).

- Thirdly, we excluded all service users that were assumed to not be representative of those that completed the pre-post measures (i.e. less than 2 contacts) and (a likely overestimation of those) who might have had repeat admissions to the service (i.e. self-referrals).

- Lastly, we conducted a statistical test to establish the extent of any expected variation and ensure that the values applied would hold true in 95% of investigations.

Another limitation of the study was that despite referring organisations and signposted services being intrinsically important for the delivery of the service (as the Community Connector service relied on these to complete the service-user pathways and achieve desired outcomes), no consistent inputs or outcomes could be identified for these stakeholders. Partially, this was due to detailed knowledge about the diverse nature of the impact of the project on these stakeholders being developed iteratively. Therefore, we would now be in a better position to investigate any potential inputs and outcomes. Another barrier to this investigation was the fact that the project involved a national service and also relied upon a multitude of small, local groups and services; making generalisation and efficient evidence-gathering particularly difficult. Service-user pathways also appeared to be uniquely designed around local services and the establishment of good relationships with individuals for referrals and signposting. Whilst evidence that was gathered pointed towards only small marginal benefits for these stakeholders, future evaluation or research work should focus on gaining a better understanding of the effects of the service on these stakeholder groups.

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7. Appendices

a. First stakeholder survey questions

- Which community organisations do you receive referrals/signposting from?
- Which Local Authority services do you receive referrals/signposting from?
- Which health services do you receive referrals/signposting from?
- Which types of community organisations do you signpost/refer people to?
- Which Local Authority services do you signpost/refer to?
- Which health services do you signpost/refer people to?
- On average how many hours a week do volunteers spend finding & recruiting service users?
- On average how many hours a week do volunteers spend in face to face contact with service users?
- On average how many hours a week do volunteers spend networking or identifying services/activities to refer people to?
- On average how many hours a week do volunteers spend on administrative work?
- What are the main benefits that service users can expect from involvement in Community Connectors?
- What are the main benefits of involvement for volunteers?

b. Service-user survey questions

1) Did the Community Connector put you in contact with other services or groups? If so what did they provide for you?

2) If you benefitted from contact with these other services or groups, what were these benefits?

3) If you benefited from contact with services or groups that the Community Connector put you in touch with, how long do you expect these benefits to last?

Less than 6 months
6-12 months
1-2 years
2-5 years
More than 5 years

4) If your reliance on friends or family has reduced as a result of contact with the Community Connector service, please state what has caused this.

5) If there were other benefits that you experienced as a result of contact with the Community Connector service, what were these?

[ ]

6) If there were other benefits that you experienced as a result of contact with the Community Connector service, how long do you expect these benefits to last?

Less than 6 months
6-12 months
1-2 years
2-5 years
More than 5 years

7) How much of any benefits you have described would you say are due to the Community Connector service?

None of them
A little of them
Some of them
Most of them
All of them

8) What would have happened if the service did not exist? Are there other places you could have gone to receive similar help or support?

Yes I could get the same service elsewhere
I could get almost as good service elsewhere
I could get a slightly worse service from elsewhere
I could get another service, but it would not be very good
I could not get a similar service anywhere else

9) If there were any unexpected or negative consequences as a result of contact with the Community Connector service, what were these?

c. Community Connector survey questions

1) In your area are there services that are similar to Community Connectors?

2) If there are services in your area that carry out similar activities to the Community Connectors programme, what are these services?

3) If there are any aspects of the Community Connectors services that are unique compared to other available services (i.e. they could not be provided by others), what are these unique aspects?

4) Is there anything about the BRC brand or approach that is important or unique?

5) If the Community Connector service was not available how much of the outcomes could be achieved by other locally available services?
None
About 25%
About 50%
About 75%
All

6) What activities do COOP staff members (e.g. shop/funeral service staff & Pioneers) contribute to the Community Connectors programme?

7) How many volunteer support workers do you usually manage?

8) On average, how much of your time per week (hours) is spent supporting existing Volunteer Support Workers?

9) On average, how many new volunteer support workers do you induct and train per year?

10) On average, how much of your time (hours) is needed to induct and train each new volunteer support worker?

11) What do you think are the main benefits experienced from being a volunteer support worker?
12) If you receive administrative support from your local BRC office (e.g. sending letters etc.), how much of your time does this save on average per week?

13) If the Community Connector service has helped someone to attend a health care appointment that they would otherwise have missed, how often has this happened?

14) If the Community Connector service has helped someone to find alternatives to local authority services, what have these been (e.g. mobility equipment assessment)?

15) If the Community Connector service has helped someone to find alternatives to local authority services, how often has this happened?

d. Referring and signposted organisations survey

Does your organisation (A) refer people into the Community Connector programme (a referrer) or (B) receive people from the community Connector programme that have been signposted or referred onwards (a Signpostee)? (A) If your organisation is a Referrer then answer questions 1 to 11. (B) If your organisation is a Signposted organisation then answer questions 12 to 23. (A+B) If your organisation is both, then please answer all questions.

1) What are the main areas of value for your organisation in being able to refer clients into the Community Connector programme? (e.g. does this save you time in identifying appropriate services for the client?)

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└─────────────┘
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2) If the benefit is in time-saving, how much time is this worth for your organisation per person, in terms of minutes saved?

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3) If the benefit is financial, how much is this worth for your organisation, in terms of pounds per person referred onwards?

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4) If there are other savings for your organisation, what are these?

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5) How much are these other savings worth, in pounds per person?

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6) What are the main costs for your organisation in referring clients into the Community Connector programme? (e.g. if you are an organisation that refers into the Community Connectors, does it take additional time in processing this referral?)

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7) How much time does this cost your organisation per person, in minutes?

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8) If there are other costs for your organisation, what are these?

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│             │
└─────────────┘
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9) How much are these other costs worth, in pounds per person that you refer?

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│             │
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10) If you could not refer into the Community Connector programme, to what extent could you refer into other services that would have the same (or similar) outcomes? (0%=there are no other services that you could refer to <-> 100%=there would be no problem finding alternative services to refer into)?

0%
25%
50%
75%
100%

11) If there are alternative services, what are these?

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│   │
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Signpostees
These questions are for people that receive clients from the Community Connector
Programme through referrals or signposting

12) What are the main areas of value for your organisation in receiving clients from the
Community Connector programme? (e.g. does this save you time in identifying new clients,
or allow you to access additional revenue?)

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13) If the benefit is in time-saving, how much time is this worth for your organisation per
person, in terms of minutes saved?

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14) If the benefit is financial, how much is this worth for your organisation, in terms of
pounds per person signposted?

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15) If there are other savings for your organisation, what are these?

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16) How much are these other savings worth, in pounds per person?

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17) What are the main costs for your organisation in receiving clients from the Community
Connector programme? (e.g. if you are an organisation that is signposted from Community
Connectors, does it take additional time in processing these clients or providing additional
services?)

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18) How much time does this cost your organisation per person, in minutes?

19) If there are other costs for your organisation, what are these?

20) How much are these other costs worth (in pounds), per person that you receive?

21) If you did not receive referrals/signpostings from the Community Connector programme, to what extent would other services direct clients to you (0%=there are no other services that would do this <-> 100%=we would have the same number and type of referrals/signposts)?

0%
25%
50%
75%
100%

22) If there are alternative services, what are these?

23) How often do people coming from the Community Connector programme deprive other people of your services? For instance, if a person takes a place at a community activity is this at the expense of another person, who cannot now get a place?

0% of the time
25% of the time
50% of the time
75% of the time
100% of the time

e. Overview of methodology used to value wellbeing

Extracted from:
Measuring the Social Impact of Community Investment:
A Guide to using the Wellbeing Valuation Approach
Lizzie Trotter
Jim Vine
Matt Leach
Daniel Fujiwara
Published March 2014
© HACT 2014

3.1 Overview of the approach

Wellbeing Valuation judges the success of a project by how it affects people's wellbeing. Rather than asking people about how much something has improved their life, which can introduce psychological complexities and extensive data collection, Wellbeing Valuation analyses existing datasets of national surveys which instead *reveal* effects on wellbeing in a robust way.

Analysis can isolate the impact of a specific aspect of life on wellbeing. We can then value this by finding from the data the equivalent amount of money needed to increase someone's wellbeing by the same amount.

Say that we are interested in the value of volunteering – that is the value that people gain in terms of enhanced life satisfaction through volunteering. We have data in our surveys and we use statistical analysis to identify and understand it in a two stage process:

• First, we look at data on life satisfaction and people's day to day activity to identify the impact that volunteering once a week has on self-reported life satisfaction (once you adjust to take account of all other factors that might impact on individuals' satisfaction levels). This might show, for example, that volunteering leads to a 3% increase in people's life satisfaction on average.

• Second, we then want to know the amount of money that would induce the same 3% increase in life satisfaction and this can also be estimated using the same type of statistical methods. Let us assume the analysis finds that £5,000 per year in extra income would also induce a 3% change in life satisfaction for the average person.

• We could then state that the uplift in life satisfaction caused by volunteering is worth on average around £5,000 per year. This is the Wellbeing Value for that activity. This is purely illustrative; please refer to the list of values for the actual value of this outcome.

3.2 Comparison with other approaches

The main advantages of Wellbeing Valuation over other sets of values that have been used in the past to measure social value is that these new values are methodologically consistent and robust. The consistency in the way that the values have been derived means that when examining values for different types of outcomes you are still comparing like with like.

The Wellbeing Valuation approach improves on other methods that rely on asking people how much they think their life would be better or worse in the absence or presence of a particular change (for example by asking them how much they would, in theory, be willing to pay for an outcome). By using data on self-reported wellbeing and life circumstances we have information on people's *actual experiences* and so the values are based on how they impact people's lives as they live them.

In light of all this, Wellbeing Valuation is one of the fastest-growing areas of social impact measurement in the UK. It is being used by a wide range of central government departments, including the Department for Business Innovation and Skills, the Department for Culture, Media and Sport, the Department for Work and Pensions, HM Treasury, the Cabinet Office and the Department for Communities and Local Government. It is also a firm part of OECD recommendations on wellbeing analysis in public policy.

Because the values are consistent with HM Treasury Green Book guidelines, the UK Government's core guide to policy evaluation, they are compatible with approaches to valuation used by central government departments, local authorities and other public sector bodies as well as the Office for National Statistics' National Wellbeing Programme.[12,13,14] The values can be used within any SROI or Cost-Benefit type analysis.

Values attributed to changes in SWEMWBS scores

Category	Overall SWEMWBS score	Full model value	2017 Inflation at 3.58%
1	7 to 14	£0.00	£0.00
2	15-16	£9,639.00	£9,984.08
3	17-18	£12,255.00	£12,693.73
4	19-20	£17,561.00	£18,189.68
5	21-22	£21,049.00	£21,802.55
6	23-24	£22,944.00	£23,765.40
7	25-26	£24,225.00	£25,092.26
8	27-28	£24,877.00	£25,767.60
9	29-30	£25,480.00	£26,392.18
10	31-32	£25,856.00	£26,781.64
11	33-34	£26,175.00	£27,112.07
12	35	£26,793.00	£27,752.19