

AGE UK LEWISHAM AND SOUTHWARK

S.A.I.L. Connections

Pilot Evaluation using an adapted Social Return
on Investment Methodology

July 2016 – February 2018

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Introduction and Background

Age UK Lewisham and Southwark exists to improve the lives of older people. The challenges faced and support required by our older population is unique to each person. However, there are a number of physical, mental and social factors commonly associated with ageing. There is also a direct interaction between social variants including: isolation, financial instability and quality of housing and a person's physical and mental health as they grow older¹. The most successful support and interventions will therefore be those which holistically address needs across a variety of areas. Reflecting this, recent research and policy focuses on the importance of considering both the clinical and non-clinical needs of a person in combination to maximise efficiency in Health and Social Care services.² The Health and Social Care systems are under significant pressure, through both diminishing resources and increasing demand. The impact of this can be seen in services across primary care including within general practice³.

Social prescribing has been demonstrated as an effective mechanism for enabling Health professionals, including GPs, to utilise community-based resources to bridge this growing gap between need and service availability. It also naturally supports the consideration of non-clinical needs and social barriers. While there are a number of definitions of social prescribing the basic principle is that there is a wide range of support available in the community for vulnerable adults. This support can have great value in improving and protecting vulnerable people's health and wellbeing and by extension decrease pressure on statutory services, whether through decreased hospital admissions, reduction in crime and antisocial behaviour or fewer calls to emergency or primary care services. Social prescribing describes the mechanisms via which Healthcare professionals can efficiently access and use these services, generally achieved through use of a 'link worker' from the voluntary sector who can be referred vulnerable adults and support them to access community-based support.

This paper serves as an evaluation of Lewisham Safe and Independent Living (SAIL) Connections. Funded through the Better Care Fund in Lewisham and delivered in close collaboration with Lewisham Council and the Lewisham Clinical Commissioning Group (CCG), SAIL Connections is a social prescribing scheme that also operates as a first contact tool, enabling self-referral, early intervention and prevention through use of community-based services across multiple sectors. The SAIL project runs in various other areas in the country (separately and with no association to Lewisham SAIL Connections) including Southwark, Lambeth and Dorset, where the idea for SAIL first began. Dorset SAIL has been shown to deliver effectively through a Social Return on Investment (SROI) assessment⁴ and this evaluation intends to demonstrate similar findings for

¹ Marmot M, Allen J, Goldblatt P et al (2010) : Fair society, healthy lives: strategic review of health inequalities in England. 2010 Marmot Review Team.

² Taking prevention measures seriously is a key message of the NHS Five Year Forward View, which includes using social prescribing as an intervention tool and utilising CCGs to push more funding into community services for non-clinical issues

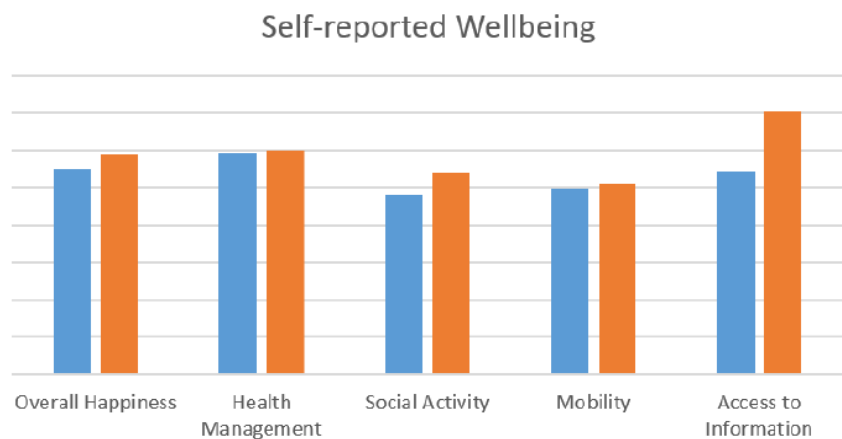
³ Davies, Nicola (2011) : Promoting Healthy Ageing: the importance of lifestyle. Nursing Standard 2011 p43-49

⁴ Findings show that for every £1 invested in SAIL a further £3.15 may be saved in further referral costs. See: Harflett N & Bown H (2014) *The economic value of older people's community based preventative services*. Bristol: National Development Team for Inclusion.

SAIL Connections with regards to efficiency, cost-effectiveness and benefits to older people in the borough of Lewisham.

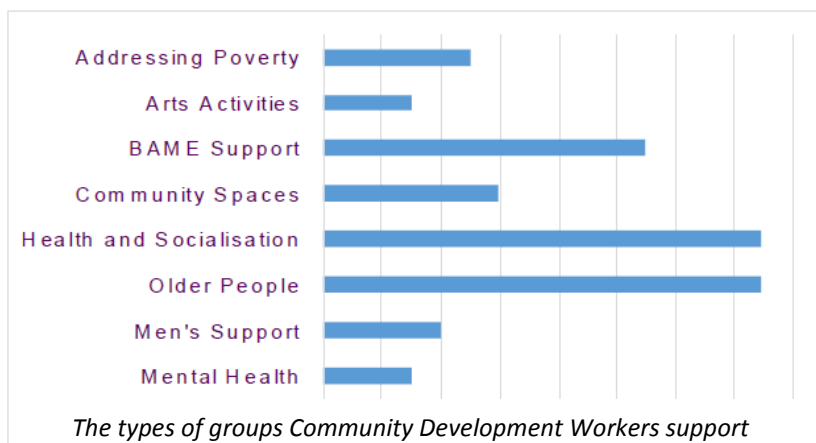
Social Prescribing in Lewisham

There are several existing social prescribing schemes utilised across the country and within Lewisham itself which demonstrate the value of social prescribing. Community Connections is a consortium social prescribing project led by Age UK Lewisham and Southwark in Lewisham since 2013. Community Connections aims to improve integration between services across Health and Social Care and the community sector as well as supporting decreased isolation and improved mental wellbeing for vulnerable adults in Lewisham. This is achieved through the combination of Community Development Work and one-to-one Community Facilitation for vulnerable individuals⁵.



Wellbeing Measures before and after Community Facilitator Intervention

The model has been demonstrated to be highly effective. In 2017-2018, Community Connections Development Workers supported 39 groups through development plans and made 517 development visits to those and other groups around the borough. Meanwhile, Community Facilitators supported 804 vulnerable adults through person-centred planning and work. The team supported an additional 201 vulnerable adults through advice provided to the London



Borough of Lewisham Social Care team. 72% of those supported reported an improvement in their overall wellbeing after Community Connections' involvement.⁶

Part of the success of the Community Connections model is down to its

⁵ Age UK Lewisham and Southwark: Community Connections 2017-2018 Impact Report. Available at: <https://www.ageuk.org.uk/lewishamandsouthwark/services/community-connections/>

⁶ Age UK Lewisham and Southwark Report and Financial Statement. Available at: <https://www.ageuk.org.uk/lewishamandsouthwark/about-us/>

consortium-based approach. It embraces the range of effective mechanisms for social prescribing by drawing on strengths from each of the 6 Partner organisations (Age UK Lewisham and Southwark, Rushey Green Time Bank, Voluntary Services Lewisham, Lewisham Disability Coalition, Carers Lewisham and Voluntary Action Lewisham.) Taking time-banking for example: time-banking works on a system of volunteers ‘depositing’ their time in the Bank to help others and being able to ‘withdraw’ time from others when they themselves are in need of assistance. This approach has been placed as a tool within the ‘whole system’ approach to community integrated care as set out by the NHS Five Year View and GP Forward View plans.⁷ Timebanks have been found to attract socially isolated groups including older people⁸ and have been shown to provide relief from stress and anxiety as well as improve overall health.⁹ Further indicative of their success of alleviating pressure on statutory services is the Department of Health’s exploration into establishing Timebanks within GP surgeries.¹⁰

Social prescribing schemes are beginning to be recognised as vital tools not only in Lewisham but across the country. They have the capacity to assist statutory services as they look to ‘do more with less’ in the face of a growing, aging population and restricted funding. And the end user benefits as well not just from the destination at which they arrive – finding their place within a new social group, for example – but also through the journey of streamlined processes and increased access to a wide range of services, which might be thought of as an advantage only for the referrer. On the contrary, this can also contribute to a service user’s improved wellbeing and is something on which SAIL Connections focuses.

Older people’s needs in Lewisham

Lewisham sits at a population of around 303,400, making it the 13th largest borough in London and the 5th largest inner London borough. Around 28,200 people, or 9.3%, are over the age of 65.¹¹ In 2011, about 3500 people (1.2%), were over the age of 85.¹² Lewisham is ethnically diverse, with 47.4% of the population coming from BAME groups – the 11th highest out of the 32 London boroughs. It is also a borough with a high level of economic deprivation; Lewisham ranks as the 48th most deprived of all 326 local authorities in the country, placing it in the 20% most deprived areas in England. The elevated level of deprivation in Lewisham, when compared with the rest of the country, is even greater when looking at the older population. Indeed, the English Indices of Deprivation put Lewisham in the top 20 local authorities with income deprivation affecting older people – a proportion of 25.7% experience this form of deprivation.¹³

⁷ Timebanking UK (2017) *Timebanking: A Prospectus*

⁸ Seyfang, G., & Smith, K. (2002) *The time of our lives: Using time banking for neighbourhood renewal and community capacity building*. London: New Economics Foundation

⁹ Timebanking UK (2017) *Calculating the social value of person to person Timebanking*

¹⁰ National Endowment for Science, Technology and the Arts (NESTA) (2013) *More than medicine: New service for people powered health*. London: NESTA Innovation Unit.

¹¹ GLA Population Estimates, <http://londondatastore-upload.s3.amazonaws.com/instant-atlas/borough-profiles/atlas.html> (Accessed 11th April 2018)

¹² ONS Census 2011, accessed through Nomis

¹³ The English Indices of Deprivation 2015

This statistic alone could be deemed evidence that there is a need for support amongst the older population in Lewisham. But further consideration can be given when looking at Health and Social Care use in the borough. For example, Lewisham's hospital admission and readmission rates for older people are higher than the national average and about 15% of people 65+ access Social Care services.¹⁴ When factoring in general issues which can affect all older people in the country, such as isolation, long-term illness and frailty, the need for a specialist intervention becomes clear.

An older people specific social prescribing model will therefore compliment and expand existing work in Lewisham. SAIL Connections has the advantage that it can also operate as a first contact scheme supporting early intervention and empowering older people to self-refer and remain more independent and so less reliant on professional services.



What is SAIL Connections?

As mentioned, SAIL Connections is a social prescribing project hosted by Age UK Lewisham and Southwark in Partnership with a range of services across sectors which support older people and help maintain independence and prevent deterioration of health.

SAIL Connections is a first contact scheme facilitating holistic assessment and easier access to services for older people. Through a single checklist it provides a simple mechanism for any professional or non-professional person to refer an older person (60+) to a wide range of services that are known to support maintained independence and keep older people safe in the community. The core aim of the project includes: improved health and wellbeing in older people; prevention of falls and malnutrition in older people; improved mental resilience and decreasing social isolation; improved fire safety, security and financial inclusion of older people.

¹⁴ *Frail Older People in Lewisham: Local demography, health and social care use and literature use, August 2013*

The Lewisham S.A.I.L. Connections Checklist

		Tel 020 7358 4077 Fax 020 7378 9217 Email sailconnections@ageuklands.org.uk Stones End Centre 11 Scovell Road London SE1 1QQ	
Name: <input type="text"/>		DOB: <input type="text"/>	
Address: <input type="text"/>		Postcode: <input type="text"/>	
Rented (Council) <input type="checkbox"/> Rented (Private) <input type="checkbox"/> Housing Association <input type="checkbox"/> Owned <input type="checkbox"/>		Ethnicity: <input type="text"/>	
Telephone: <input type="text"/>		GP Surgery: <input type="text"/>	
Please tick the services you would like and return checklist to: sailconnections@ageuklands.org.uk			
HEALTH AND WELLBEING			
Would you like a pendant alarm to keep you safe and secure? Linkline Telecare Service			<input type="checkbox"/>
Would you like to talk to someone about Telecare equipment e.g. sensors that could help you stay independent in your home for longer? Linkline Telecare Service			<input type="checkbox"/>
Have you had a fall or a near miss in the last year that has NOT been investigated or treated? Lewisham Falls Services			<input type="checkbox"/>
Do you have dementia, or do you care for someone with dementia and would like to speak to someone about support available? MindCare			<input type="checkbox"/>
Are you blind, partially sighted, or do you have a specific visual impairment? BlindAid			<input type="checkbox"/>
Have you lost weight recently without meaning to or are you eating less than usual and have NOT been referred to a dietician? Lewisham Primary Care Dietetics Service			<input type="checkbox"/>
Do you smoke? If so would you like to stop? Stop Smoking Service			<input type="checkbox"/>
Has your drinking or drug use increased slowly over the years, would you like to talk to someone? Do you use alcohol or drugs to unwind/relax? - would you like to talk to someone? Lewisham Drug and Alcohol Teams			<input type="checkbox"/>
Do you care for someone, or does someone care for you on an unpaid basis due to frailty, disability, addiction, physical or mental illness? Would you like to talk to someone about support available for carers? Carers Lewisham			<input type="checkbox"/>
 Would you like to talk to someone about social activities including: volunteering, befriending, social groups, exercise classes, lunch clubs, help with using the Internet? Community Connections			<input type="checkbox"/>
LIVING CONDITIONS			
Is your home cold? Would you like in-home advice about keeping warm, saving energy and funding available for heating and insulation? Warm Homes Healthy People Project			<input type="checkbox"/>
Do you have any difficulties using the bath/toilet/kitchen facilities? Do you have difficulties getting in and out of your home, or using stairs? If yes, please specify your area of difficulty. Lewisham Council Occupational Therapy			<input type="checkbox"/>
Do you have an odd job around the home that you need help with? Lewisham Handyperson			<input type="checkbox"/>
Are you worried about the condition/repair/maintenance of your home? Advice Lewisham			<input type="checkbox"/>
SAFETY, SECURITY AND INCOME			
Would you like advice from your Local Police Team regarding crime prevention, home security, or a recent incident of crime or anti-social behaviour in your area? Police			<input type="checkbox"/>
Have you ever been concerned about services or goods you have bought from someone who knocked at your door? Crime Enforcement and Regulation Service			<input type="checkbox"/>
Have you sent money to anyone who contacted you by phone or mail saying you had won money or a gift unexpectedly, and that money or gift never materialised? Crime Enforcement and Regulation Service			<input type="checkbox"/>
Do you have a working smoke alarm? Would you like a free Home Fire Safety Visit? London Fire Brigade			<input type="checkbox"/>
Would you need help leaving your home in the event of an emergency? London Fire Brigade			<input type="checkbox"/>
Are you having trouble paying your bills or would you like someone to help check that you are receiving all the income that you are entitled to? Advice Lewisham			<input type="checkbox"/>
Visited by: <input type="text"/>		From: <input type="text"/>	
Date: <input type="text"/>		Telephone/Email: <input type="text"/>	
IMPORTANT: This must be read to the client: "In signing this form you are consenting to this information being shared with partner organisations in accordance with the Data Protection Act 1988". Please tick here if completing by phone to demonstrate you have discussed this with the client. <input type="checkbox"/>			
Signed (client/representative): <input type="text"/>			

Version 1 created September 2016

Working closely with Healthcare professionals and in particular GP practices, SAIL Connections operates as a social prescribing project, enabling Health professionals to easily refer to services across multiple sectors. The Project Coordinator provides a link between referrers, older people and services provided. Additional link workers within the Partnership provide further expertise

and person-centred support to those most vulnerable including dementia-specialised Support Workers and Community Facilitators, specifically focusing on social isolation and building community connectedness.

Older people are known to be a vulnerable group specifically affected by many of the social challenges which can be supported in this way. SAIL aims to bring that support to Lewisham, concentrating on the wellbeing of older people but in doing so providing a benefit for all in the borough by reducing pressures on already stretched statutory services. The project also intends to streamline referral pathways by acting as a single point of access for referrers and those being referred, increasing efficiency and reducing duplication.

The idea for this form of social prescribing and the SAIL project itself came originally from Dorset Fire and Rescue Service. In 2008, after a large spike in fire deaths amongst older people whom were known to Care services, the DFRS recognised the need for a link between public sector services as a way to share information about their vulnerable clients.¹⁵ The SAIL model was then established in Southwark by Age UK Lewisham and Southwark in 2013 before forming in neighbouring Lewisham in 2016. As SAIL Southwark has developed it has become increasingly effective as a social prescribing tool supporting older people across the borough. There are now SAIL Care Navigators linked specifically with GP practices to maximise the value of the service in decreasing pressure of general practice, as well as the continued use of the checklist. In the year 2017-2018 SAIL Southwark received 2257 checklists for older people and generated 2292 onward referrals to the Partnership.

SAIL's objective is to capture a wide range of aspects known to affect older people's ability to remain safe and independent at home, solving problems where possible and preventing them from developing into issues for the NHS or Social Care.

The SAIL Connections Partnership

The Lewisham SAIL checklist is split into three areas in which support is offered: **Health & Wellbeing, Living Conditions** and **Safety, Security & Income**. Within each of these sections, SAIL targets specific matters which are likely to affect or apply to older people. The actual support for these areas is delivered by SAIL's Partner organisations. All share the same established pathway to accept SAIL referrals and all accept the SAIL form in place of their traditional referral forms.

Below is a brief summary of the Partners and how they support the older population in Lewisham:

Health & Wellbeing

¹⁵ Local Government Association. Available at: <https://www.local.gov.uk/dorset-fire-and-rescue-launches-safe-and-independent-living-initiative>

- **Blenheim Drug and Alcohol Teams:** A charity delivering a recovery-based model encompassing support work and medication to assist those at risk of alcohol or substance misuse.
- **BlindAid:** A charity which supports people with visual impairments, working to alleviate social isolation and keep people safe at home.
- **Carers Lewisham:** An organisation which supports anyone in the borough that cares for someone else on an unpaid basis.
- **Community Connections:** A consortium project led by Age UK Lewisham and Southwark, which assists vulnerable adults in the borough to access social activities and can signpost on for further support. They also work to develop and support community groups and facilities in Lewisham.
- **Lewisham Community Falls Team:** A multidisciplinary team of occupational therapists, physiotherapists, therapy assistants and postural stability specialists assisting older people who have fallen or who are at risk of falls.
- **Lewisham Primary Care Dietetics Service:** A Community team of Dieticians that assist people who are going through unexplained weight loss or are at risk of malnutrition.
- **Linkline:** providing and monitor Telecare equipment, including pendant alarms, falls detectors, property exit sensors and more.
- **MindCare:** Specialists in providing support for people with dementia. This can involve signposting and giving advice or more involved short-term case work. MindCare is a project delivered by Bromley and Lewisham Mind.
- **Stop Smoking Service:** An NHS Service that helps people to stop smoking through a combination of support work and medication across a 12-week programme.

Living Conditions

- **Advice Lewisham:** Specially trained advisors from a consortium of voluntary sector providers can offer information and advice regarding large home maintenance issues and help to liaise if the Council or a Housing Association is involved.
- **Handyperson Service:** The initial Partner (Lewisham Handyperson Service) unfortunately had to close during the pilot. The Project Coordinator now works with the older person to identify the most suitable alternative. There are two voluntary sector handyperson services operating in the borough, providing support with odd jobs that help older people stay safe at home such as changing light-bulbs, putting up curtains or moving furniture. The Age UK London's Business Directory is also sometimes used to support older people in finding paid tradesman if appropriate.
- **Lewisham Council Occupational Therapy:** The Occupational Therapy team assess people in their homes and can provide equipment and/or adaptations to help them remain safe and independent, e.g. grab rails or stair lifts.
- **Warm Homes Healthy People Project:** Run by the organisation Groundwork, Warm Homes have 'Green Doctors' that visit people in their homes and can advise about

switching providers, saving money/energy and securing funding for people in cold homes.

Safety, Security & Income

- **Advice Lewisham:** As well as general benefits reviews, Advisors can also support people to apply for benefits by filling out forms, liaising with DWP, and completing benefit checks. Further casework can also involve appeals.
- **Crime, Enforcement and Regulation Service:** The CER Team has duties in a wide range of areas; Crime Reduction, Licensing, Trading Standards and Public Health and Nuisance. For SAIL, they offer their support for people who have experienced or who are at risk of financial scamming.
- **London Fire Brigade:** The Fire Brigade can perform home visits to assess people's homes for any fire safety risks or hazards. They can also test smoke alarms and provide free alarms if necessary and register if an individual would require help leaving their home in the event of an emergency.
- **Police:** Safer Neighbourhood Teams can visit people who are recent victims of crime or those concerned about home security or their living situation. This can be for peace of mind or advice/escalation of an existing issue.

Methodology

Remit

SAIL Connections was commissioned for an 18-month pilot in Lewisham based on the success of the SAIL model in Southwark. The project is designed to provide quick and easy access to a range of services that support safe and independent living for older people. The project includes a single checklist which is completed by anyone but particularly intended for use by Healthcare professionals including GPs. It therefore acts as a social prescribing pathway for accessing community resources but also a first contact scheme promoting early action and prevention and facilitating self-referral.

The 18-month pilot has been accessible for anyone over 60 living in Lewisham. Evaluation is intended to explore the success of the model, its benefit for a range of stakeholders and the financial benefits for the Health and Social Care system. This will give insight for future development and an opportunity to reflect on the parameters of the project and how to most effectively fit this resource into the framework of support for older people across Lewisham.

External Validation

Professor Catherine Needham from the University of Birmingham has been an external evaluation Partner on the project, involved in oversight of evaluation design, data gathering and analysis.

The Approach – a partial Social Return on Investment analysis

In order to evaluate the impact of the SAIL Connections model we have chosen to adapt methodology for Social Return on Investment analysis. The Social Return on Investment (SROI) framework for evaluation is a well-established methodology designed to provide an indication of impact in financial terms. This is achieved through in-depth calculations of probable outcomes with and without an intervention. The use of proxy measures is important in monetizing outcomes which may not have clear, quantifiable financial results. Proxies make it possible to provide quantitative and financial information for qualitative or otherwise intangible impacts.

While SROI therefore provides a powerful tool for both commissioning and service providers in determining the most impactful use of resources, it relies on assumptions and probability-based calculations. The extent to which evaluation by this method is meaningful is therefore highly affected by the strength of these assumptions and the rationale behind the calculations.

The financial benefits of SAIL Connections as a project largely come from its preventative impact. So, while the model lends itself well to elements of monetized evaluation, there are many aspects which cannot be captured in this way or for which concrete measurements cannot be attained. For this reason, the SROI framework is laid down as the base for evaluation

but also more qualitative methodologies and case studies will be utilised to demonstrate aspects of the project.

It is also important to note that the scale of this evaluation is limited by the data available and were a more comprehensive SROI analysis of the project to be completed this would require significantly increased resources including access to NHS and Health and Social Care data. Where this process has been undertaken, for example the Rotherham social prescribing pilot, strong evidence for the success of social prescribing and preventative community-based schemes has been provided¹⁶.

Structure of Analysis

The evaluation follows this structure:

1. Analysis of the SAIL Connections projects model and mapping of its impact. This includes working with stakeholders to establish a range of perceptions of the project and determine what change it brings about. To achieve this, the evaluation has:
 - Facilitated a structured activity with the SAIL Connections Partners exploring how SAIL Connections supports their services and fits with their values and which aspects of the mode they believe most fundamental to its success
 - Gained feedback from a sample of referrers on the value and most important features of the SAIL Connections project to them as stakeholders
 - Gained feedback from a sample of older people who have used the SAIL Connections on the outcomes achieved for them and user experience of the service
2. Analysis of the project outputs and activity throughout the 18-month pilot process. This involves both qualitative and quantitative evaluation, including use of case studies where appropriate.
3. Monetized analysis of outcomes to give an indication of financial savings through the model. This was achieved using indicators and proxies according to SROI process. As the project is unable to be comprehensively evaluated in this way, a sample of outcomes are used to give an indication of the financial efficiency of the project.

¹⁶ Dayson C, Bashir N, (2014): The social and economic impact of the Rotherham Social Prescribing Pilot

The SAIL model is designed to support two separate beneficiary groups:

1. Older people, for whom SAIL Connections aims to:
 - Improve health and wellbeing
 - Reduce poverty and isolation
 - Support older people to remain safe and independent in the community
2. Professionals working across sectors, for whom SAIL Connections aims to:
 - Facilitate holistic working
 - Reduce pressure on services by saving time
 - Decrease duplication
 - Provide a simple pathway for cross sector referrals

An activity was conducted with the SAIL Connections Partnership in which Partners were asked to list the aspects of SAIL Connections they felt were important to capture for evaluation, as well as how the project fit with their values and work. Thematic analysis of Partner responses identified the following:

Coded Partner Responses	Frequency
Community Improvement	2
Managing diminished resources	2
Improves Wellbeing and social inclusion for older people	2
Integrated with whole system plan	3
Holistic Approach	4
Preventative	4
Older Person Focused	6
Independence and self management of health for older people	8
Partnership Working	9
Efficiency - of time and simplicity of process	15
Improves Access to service	15

The most consistently highlighted benefits of the project were that it **improves efficiency**, making it very quick to make multiple referrals, and **improves access** to services. The SAIL checklist achieves this through its simplicity and by gathering multiple services onto a single form. It also enables referrals from any source to any Partner, meaning Partner projects can receive referrals through new pathways. For example, Healthcare services can now receive referrals from the community and likewise there is capacity for an increase in referrals to Police, fire prevention and community services from Healthcare professionals.

Additional benefits of the SAIL Connections model highlighted by Partners include:

- Identifying and supporting those who are ‘hard to reach’ or likely to slip through the gaps in services
- Meaning older people do not ‘go around in circles’ when seeking support, which can be a causal factor in relapse or deterioration in health
- A flexible and person-centred approach

This feedback also highlighted the projects use in cutting down on not just duplicate referrals but inappropriate submissions too. As one key stakeholder writes:

‘Prior to SAIL referrers were not always aware of the support services available and did not have the time to check eligibility or service information. This resulted in inappropriate referrals, multiple referrals and delays in people receiving appropriate support.’

Though no explicit downsides of the project or its delivery were highlighted in this feedback, the heavy bias toward improving access and efficiency in comparison to other potential benefits could be argued as indicative of negatives. For example, as a social prescribing project, SAIL’s focus is facilitating better use of the community on a large scale to improve wellbeing. However, only a fraction of Partners recognized this as an important-to-capture attribute. Equally, as a project entirely for older people, the idea that the project might not be seen by everyone as older person focused is another shortcoming. Indeed, if one of the main benefits seen by Partners is the improvement of access to services, particularly if that includes the new avenues for Health Partners to receive referrals and the increased rate at which they can receive them as result of increased efficiency, that wholly counteracts SAIL’s aim to relieve pressure on statutory services.

All of these points suggest the need to look at how SAIL is publicized and how it is perceived. In doing so, areas for improvement in the overall delivery of the project might be discovered.

Referrer feedback:

A sample of frequent referrers were also asked about their experience using SAIL Connections and for feedback on the process. Referrers were overall positive about the project, with the main benefits again established as ease of use and efficiency. Coding the referrer responses in the same manner as Partners above reveals in fact that almost every key piece of feedback relates to efficiency.

Coded Referrer Responses	Frequency
Independence and self management of health for older people	1
Older People focused	1
Improves Access to service	4
Efficiency - of time and simplicity of process	15

Referrers mirrored each others feedback when remarking on how the tick box system makes the form *‘easy to understand’* and that the checklist acts as *‘a one stop shop for service users to get advice and support.’*

One health colleague pointed out that the accessibility of the checklist itself helps cement older people's independence and can save referrers even more time by letting the service users fill it in themselves where appropriate:

'I like that older people themselves can fill it in and know the range of services that are available to them.'

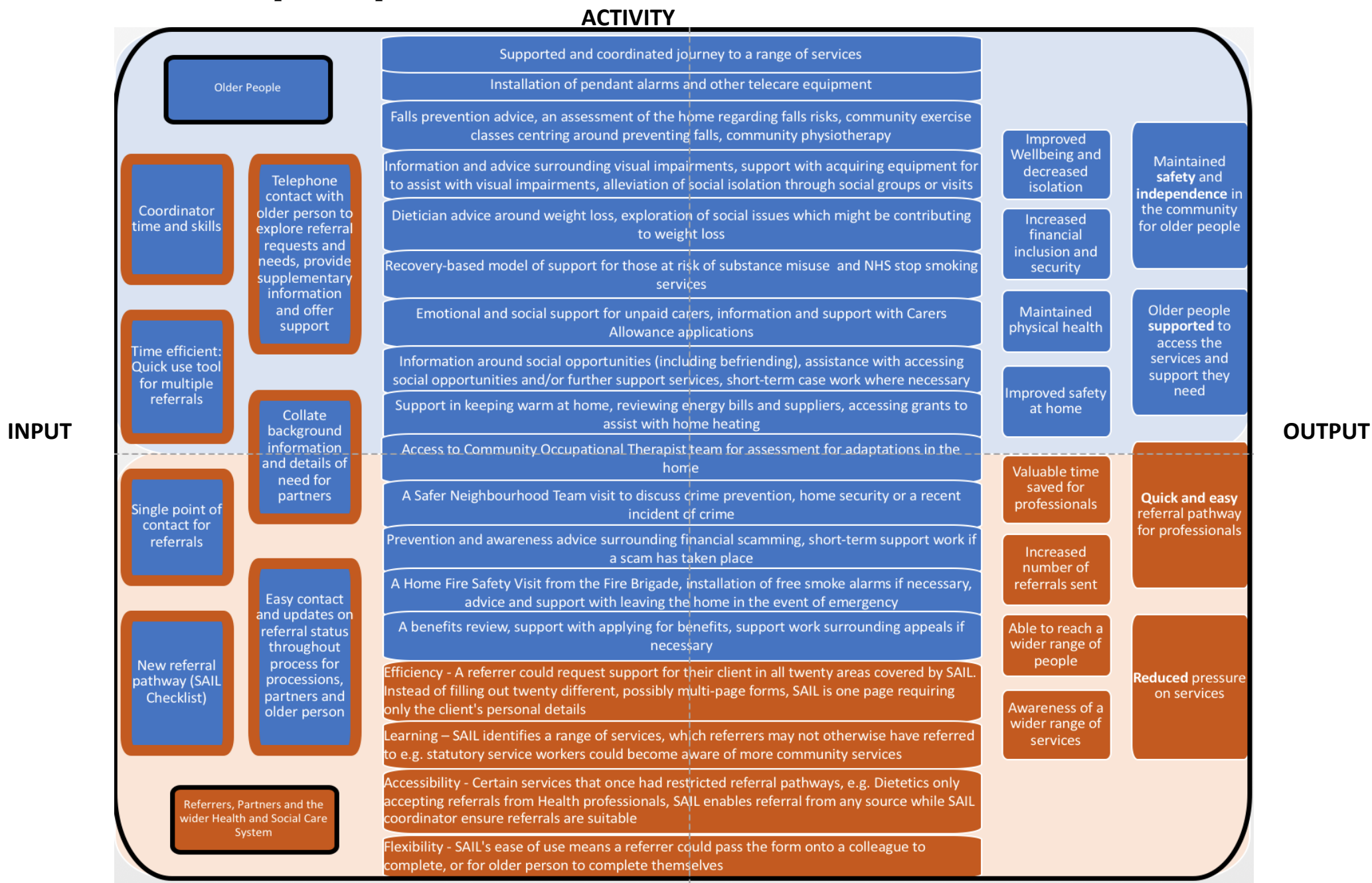
Looking at criticisms, the same ideas brought up from the Partner feedback apply here, i.e. an overemphasis on efficiency that could indicate too narrow a focus when promoting the project and a need to explain its purpose and other benefits fully. However, other points were made by this group of referrers which highlight further opportunities for learning.

For instance, there were mixed views with regards to improved access to services. While one referrer explained that they *'would definitely consider referring on to a wider range of services since the introduction of SAIL,'* another wrote that SAIL is *'not really making a difference to the number of services I am referring my client to.'* Though making referrers aware of more services isn't a primary aim of SAIL, it is important to consider the viewpoints of the individuals that are indeed making the referrals. This is especially true when looking at Partner feedback, which so greatly stresses the benefit of improved access.

Further to the above, when looking at actual referral numbers – which will be examined in more depth later in this paper – there are a high number of SAIL referrals which are only for one Partner or two Partners, out of a possible twenty. This, combined with the fact that no referrer in the questioned group mentioned the holistic approach of the project, implies that SAIL is not being used as an assessment tool. The strong focus on efficiency from both Partners and Referrers compounds this idea and, along with some referrers saying they are not referring to new services, suggests the SAIL form is being used as a quicker substitute for other organisations' longer referral forms as opposed to a separate referral form in its own right.

This is not necessarily a negative, it may be worth looking at SAIL overall and examining if there are better ways to promote the project as a form of holistic assessment or if it would be helpful for all parties to change its aims and further facilitate efficiency and ease of use.

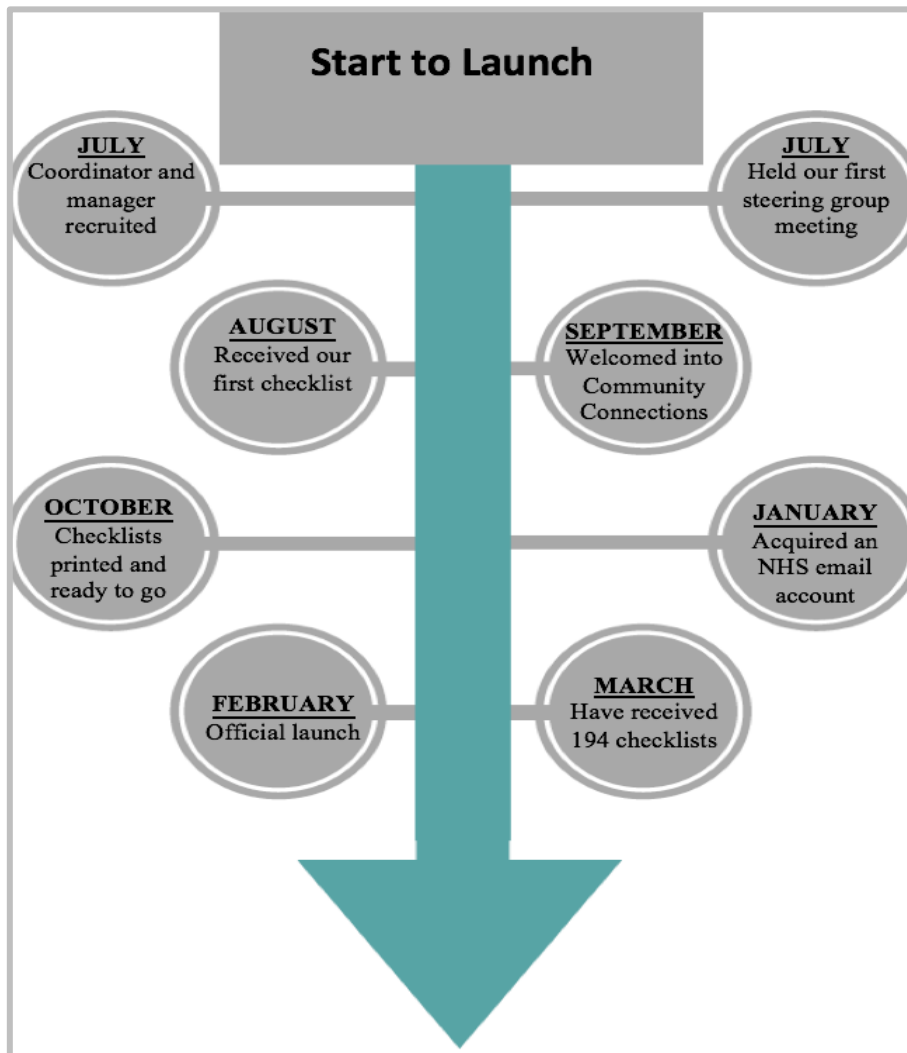
SAIL Connections Impact Map:



Project Development:

Over the 18-month pilot period SAIL Connections has received **1063** SAIL checklists and supported **926** older people.

The Project Manager and Coordinator were recruited and the Partnership established in July 2016. After project development and an initial soft launch to test the process the project was officially launched in February 2017 as outlined below.



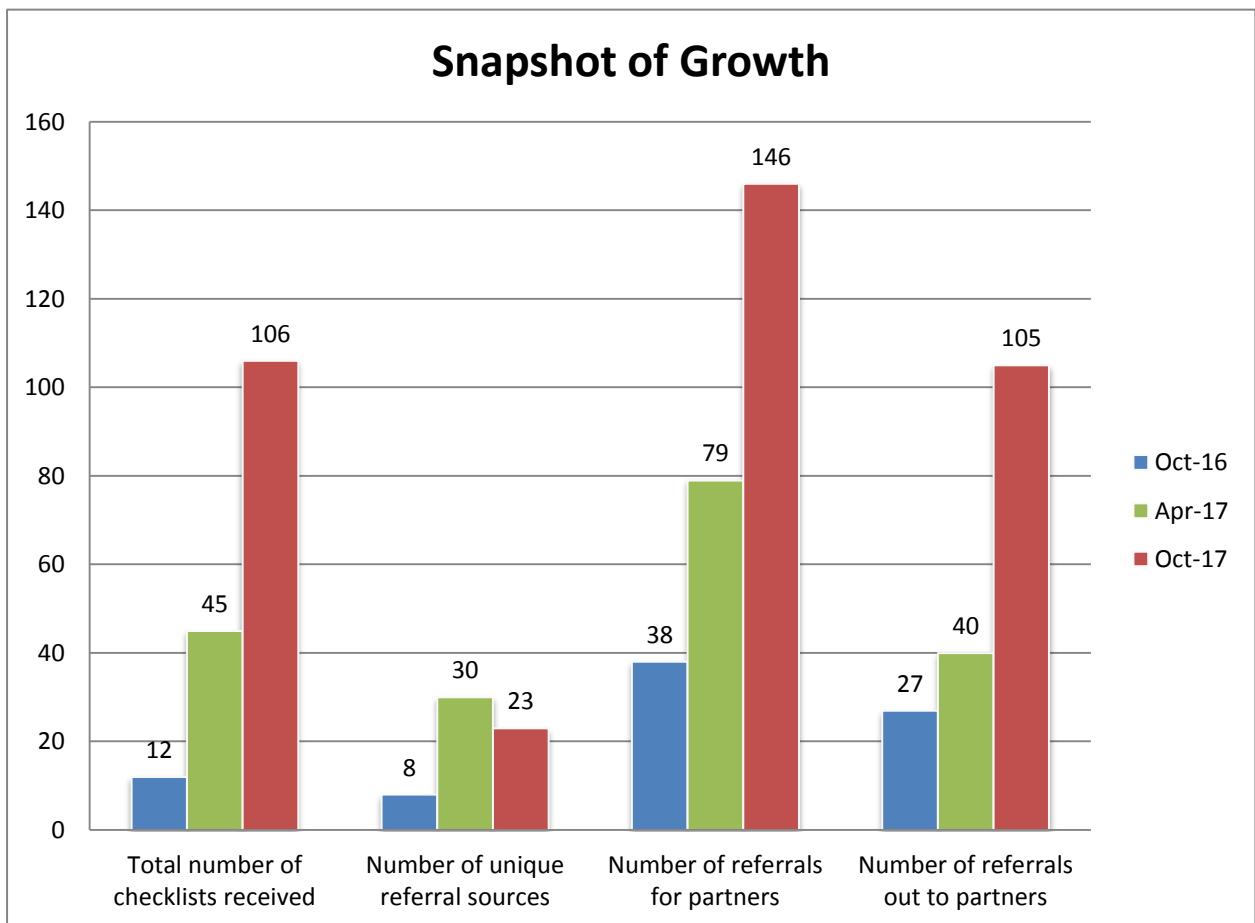
Throughout the pilot the project has continued to grow both in numbers of checklists received and the variety of sources from which these checklists are received.

The Partnership itself has also continued to develop over time. Referrals to additional services have also been incorporated as they come available to older people in Lewisham. In some cases, the Project Coordinator will also refer to services not within the Partnership if this is the most effective way to support the older person's needs.

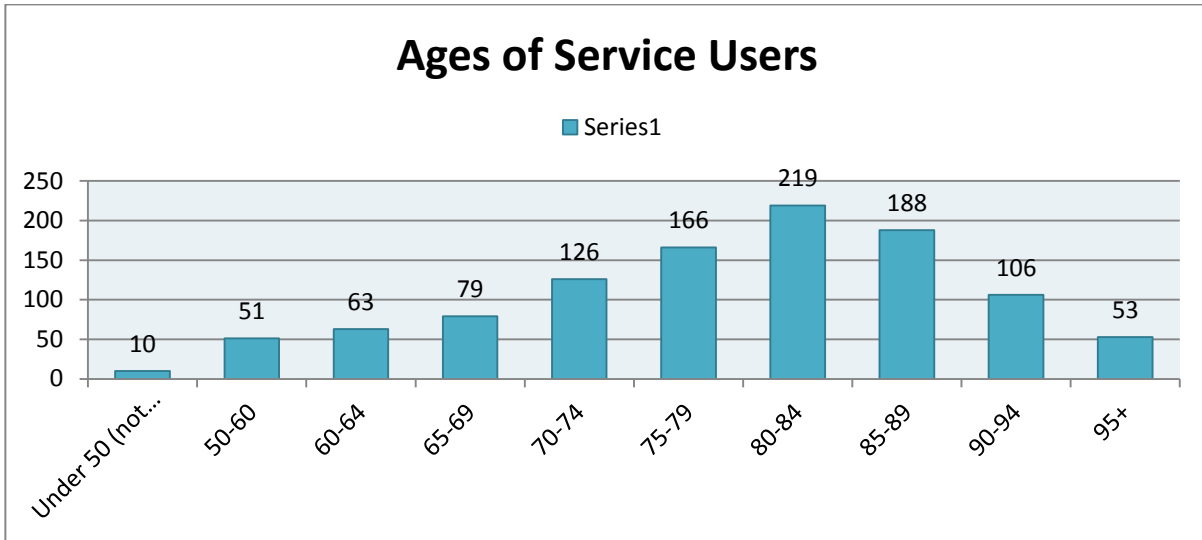
Some key developments to the Partnership during the pilot phase include:

- The introduction of the **Lewisham Community Falls Service** (launched in June 2017) providing exercise classes, physiotherapy and advice for older people around falls prevention.
- Referrals to **South East London Community Energy**, supporting home owners and private renting older people in gaining grants to ensure a warm home during the winter. This has been particularly important given the large number of older home owners in Lewisham.
- Adapting to the unfortunate closure of the **Lewisham Handyperson Service** in July 2017. In this case the project Coordinator has worked with service users on a case-by-case basis to find an alternative that best suits them. This could be a voluntary sector organisation or Age UK London’s Business Directory of vetted, trusted private businesses.

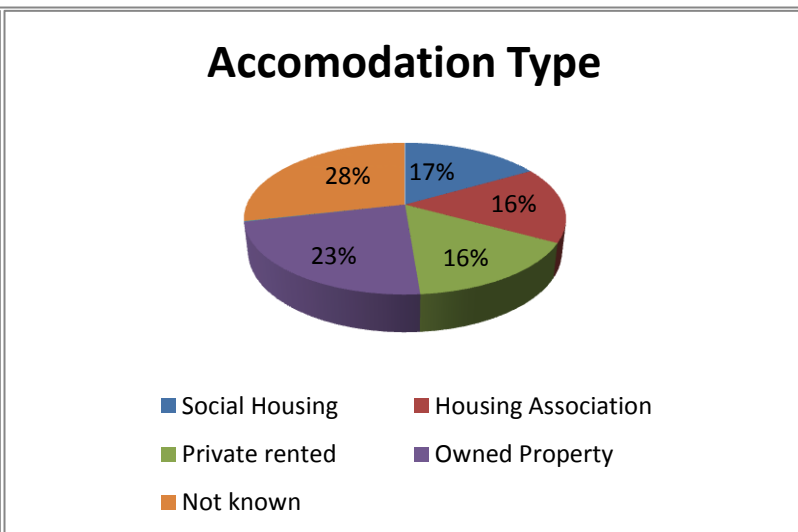
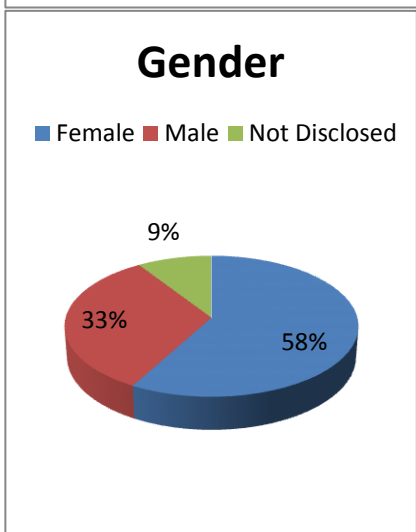
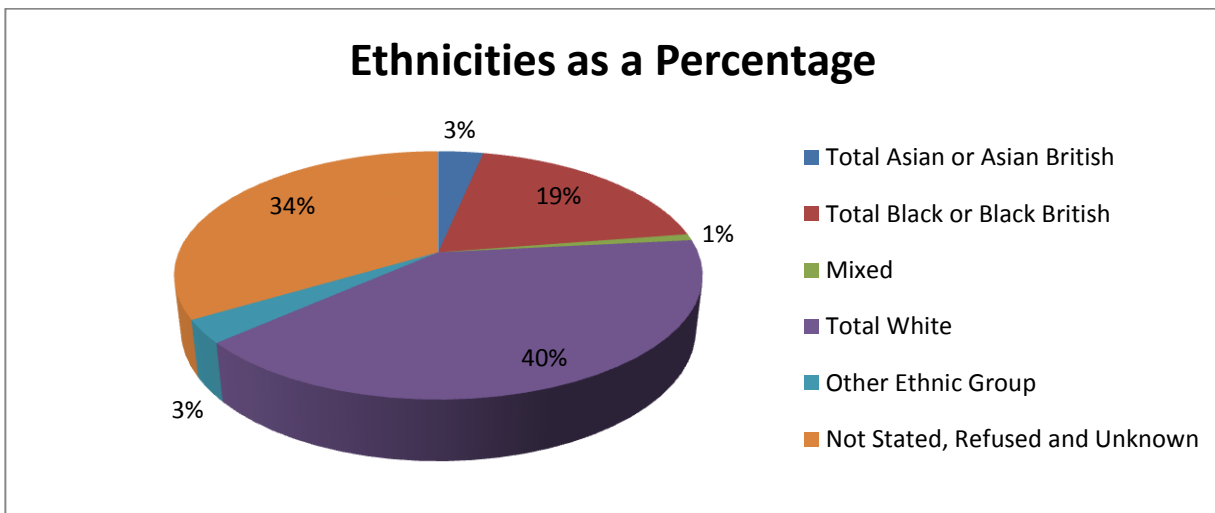
The chart below shows a snapshot of the continual growth in numbers of older people supported throughout the pilot. The number of checklists received and referrals to the Partners has grown consistently throughout. Variation in the number of services requested and made also demonstrated the role played by the Project Coordinator in screening referrals, removing duplication and ensuring that older people are referred to the services most relevant to them.



Demographics:

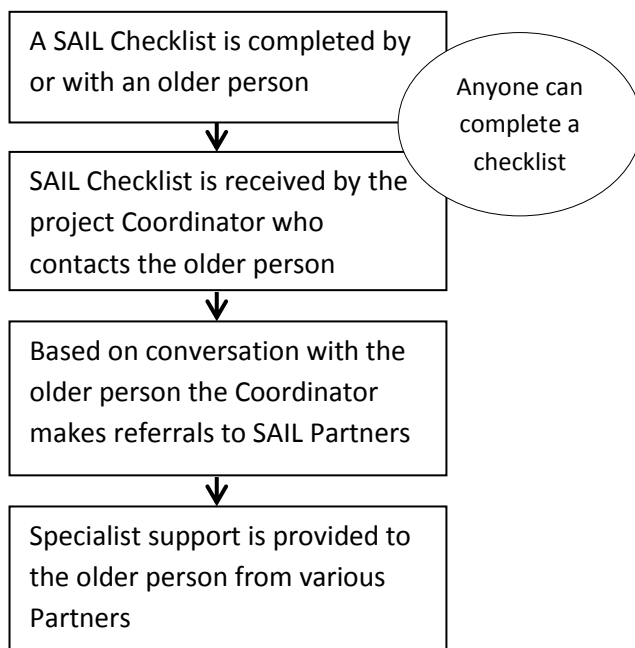


Over 94% of the referrals received were for people over 60 with the majority falling between 75 and 90 years older. However, 5% of referrals were for older people between 50 and 60. This group was still supported through the project.



Impact Analysis

As defined in the impact map, the outputs and outcomes of SAIL Connections can be separated into those benefiting older people and those benefiting professionals working with older people. Some aspects of the project impact however are hard to capture and this evaluation therefore uses a combination of quantitative analysis, case studies and where possible estimates the financial viability of the model using SROI methodology.



SAIL Connections generates referrals to a Partnership of services designed to support older people to maintain safety and independence. The pathway is summarized to the left.

SAIL Connections aims to increase accessibility of services and provide new pathways and ways to reach support. It is therefore likely SAIL Connections has facilitated an increased number of referrals to Partners and that these referrals may have occurred earlier in the older persons journey as a result of SAIL Connections, however the extent of increase cannot be calculated. Similarly, SAIL Connections

intends to smooth the journey older people experience in gaining support. Case studies demonstrate how the project achieves this but without a comparison group it is not possible to quantify the extent of the impact. Furthermore, SAIL Connections is a preventative project and therefore a successful outcome may be maintained health or a slower onset of symptoms.

Outputs and outcomes for Older People

Over the 18-month pilot SAIL Connections made **1185** referrals to the services within the Partnership. In each case this included a conversation with the Project Coordinator to build trust and understanding with the older person before making the onward referral(s). This conversation benefits the older person, providing them with a single point of contact and space to discuss their choices and the support they are looking for. The contact with the SAIL Coordinator is also critical to Partners gaining information required for their service and in screening referrals made according to Partner guidelines.

The Coordinator made **626** changes to the checklists received based on the choices and needs of the older people referred and the specialist understanding of Partners' service criteria. As well as preventing duplicate referrals the Coordinator is able to identify additional referrals expanding the services offered to the older person.

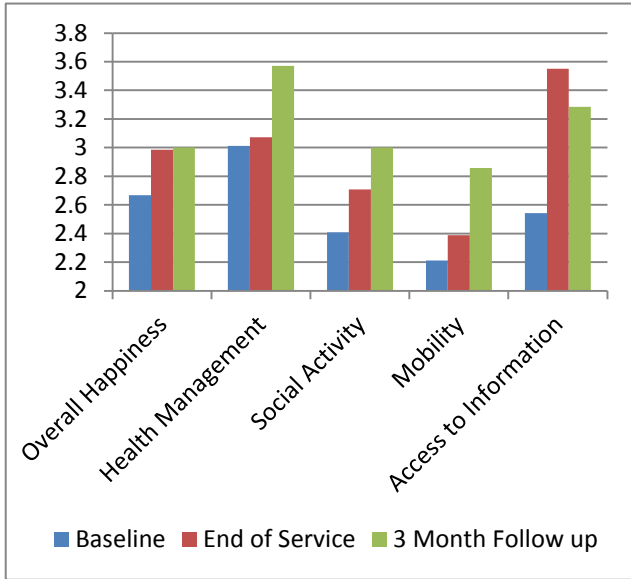
Referrals to Partners:

Every question on the checklist received at least one referral with the most frequently made referrals being made to Community Connections and Advice Lewisham. The chart below shows the full breakdown of onward referrals made by the SAIL Coordinator to the SAIL Connections Partners.



The outcome of each of these referrals contributes to the older person remaining safe and independent at home in different way, however the full benefit comes from the combined value of multiple services made available.

Improved Wellbeing and Decreased Isolation



273 older people were referred to Community Connections through the SAIL Connections project. Each received a home visit during which a Community Facilitator developed a person-centered plan with the older person based on their interests and wishes. Around 40% of the referrals made by Community Connections are to social groups and activities, and a further 10% for transport related benefits or support. However, Community Connections makes a wide array of additional community-based support available to older people,

forming a critical part of SAIL Connections’ social prescribing value. Community Connections use a bespoke wellbeing survey to monitor the impact of their approach. A self reported measure of overall happiness, health management, social activity, mobility and access to information all increase after the Community Connections intervention, and the three month follow up demonstrates lasting benefit and continued improvements in health management, social activity and mobility.¹⁷

As well as referrals to Community Connections **30 referrals were made to BlindAid**, who provide befriending and additional support for people living with significant visual impairment or blindness. One referral to BlindAid stands out as a clear example of how SAIL Connections works and conveys its benefits:

Grace is a 76 year old lady who lives in a Housing Association property and is partially sighted. She was referred to SAIL Connections after meeting some of the Southwark Team at AUKLS’s Healthy Living Centre. After speaking with a Coordinator she was referred to BlindAid, as well as Occupational Therapy, Linkline and the Fire Brigade. Grace was paired with a home visitor from BlindAid who now regularly visits Grace, saying it feels like their ‘visiting a friend.’ But as well as that, the visitor was also able to assist her with her OT needs, measuring her bath and supporting her with some forms. SAIL Connections was able to facilitate both of these referrals happening at the same time, and without this Grace’s adaptations may not have been provided as quickly or the process might not have gone as smoothly. These sorts of stories show the complete way that early intervention and prevention can happen through the project, beyond the original referral to SAIL Connections.

¹⁷ Mobility in this context does not necessarily directly link to physical health but to the ability to get out of the home through use of transport benefits or support of volunteers.

SAIL Connections also made **25 referrals to MindCare**, who provide specialist support for people with a dementia diagnosis. A significant part of this includes supporting people with dementia to remain socially active and engaged, which is known to be important in slowing the progression of dementia.¹⁸

The outcomes for these Partners is not limited to improved mental wellbeing and decreased isolation, but these outputs, as well as others such as the work of **Carers Lewisham** and **Advice Lewisham** also contribute significantly toward improved wellbeing and decreased isolation.

Improved Financial Inclusion and Security

Advice Lewisham supported 188 older people who were struggling financially.

This included giving advice on bills payments, completing benefits checks and supporting applications for disability benefits such as Attendance Allowance as well as other benefit applications. As managing personal finances becomes an increasingly digital affair, many application processes require computer literacy which translates to older people facing additional challenges in accessing the money to which they are entitled. Through benefit applications for some of those referred to Advice Lewisham older people **gained £206,348.30**.

An additional **41 referrals to Advice Lewisham** were made specifically for support around home maintenance or issues relating to tenancy.

In addition, SAIL Connections made **47 referrals to Groundwork London's Warm Homes Healthy People** project. Groundwork London have a team of Green Doctors who visit people at home to look for the most economic ways to keep their home the temperature they want. This is vitally important in keeping the older person safe and free from illness in the winter months. One of the ways in which this is achieved is through supporting older people to check and switch their energy provider. Groundwork helped those they support save £500,000 last year in London, at an average of £200 per household.

Finally, SAIL Connections made **61 referrals to Carers Lewisham**, who provide a range of emotional and practical support for carers including supporting them to apply for Carers Allowance and ensuring they are receiving any additional financial support they are entitled to.

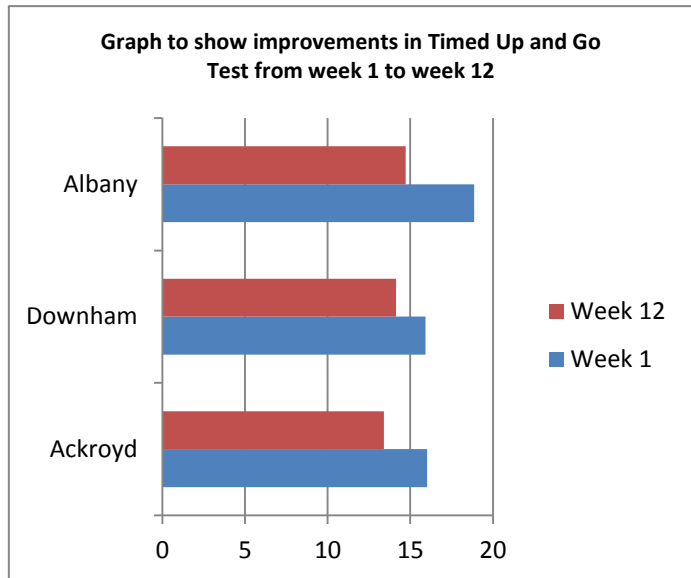
Maintained and Improved Physical Health

72 older people were referred to Lewisham Community Falls Service. Stable and Steady classes are run by Qualified Postural Stability Instructors who have been trained in Falls Management Exercise (FaME). FaME is a tailored and progressive Falls Management programme which has robust evidence in both primary and secondary falls prevention. It has also been shown to increase physical habitual activity in older people.

¹⁸ Many studies have been produced which demonstrate the link between social engagement and the slowing of advancing cognitive impairment. For example, see: Hughes, T., Flatt, J., Fu, B., Chang, C., & Ganguli, M. (2013). *Engagement in social activities and progression from mild to severe cognitive impairment: The MYHAT study*. *International Psychogeriatrics*, 25(4)

The Public Health England Falls and Fractures Consensus Statement 2017 recommends FaME as a cost-effective evidence-based programme to reduce falls.

An initial data sample from classes, to the right, indicates a significant improvement in the TUAG test (Time up and Go) amongst the participants in these classes. Given this improvement at week 12, greater improvements would be anticipated by week 25 which would significantly reduce risk of falls.



Community Dieticians supported 41 older people who were experiencing increased frailty as a result of weight loss and malnutrition. Through a combination of dietary changes and advice dieticians are able to support older people to regain and maintain a healthy weight.¹⁹

Stop Smoking and Blenheim’s Drug and Alcohol support provide person-oriented support for people in tackling addiction and dependency also contributing significantly to improved physical health.

Finally, there is an interaction between physical health, mental wellbeing and wider socio-economic factors meaning the outcomes of each of Partners’ work will likely contribute to improved or maintained physical health.

Improved Safety at Home

SAIL Connections referred 119 older people to the Council’s Occupational Therapy Team, resulting in a wide range of adaptations and aids being made available in the home for older people. This includes the installation of grab rails and shower seats as well as assessments for larger scale adjustments to ensure the older person is safe and independent in their own home.

Similarly, **56 referrals to Lewisham Linkline for pendant alarms** and **25 for other Telecare support** provide older people with technological aids ensuring they maintain a sense of safety at home and are always able to raise an alert and gain support. This equipment, especially the pendant alarm, is mainly geared towards to those who have falls in their home and would struggle to get back up. This is a significant avenue of assistance when considering

¹⁹ The link between malnutrition and frailty is well documented. For an overall review and insight into how they might be diagnosed and treated together, see: Laur C. V., McNicholl T., Valaitis R., and Keller H. H., (2017) *Malnutrition or frailty? Overlap and evidence gaps in the diagnosis and treatment of frailty and malnutrition*. Appl. Physiol. Nutr. Metab. 42: 449–458

that 'long lies' – a fall that result in the person being on the floor for an extended period of time – has been shown to lead to serious injury, admission to hospital and need for changes to living arrangements or introduction of long term care. Falls of any type can be the start of a debilitating cycle that sees an older person restrict their activities out of fear falling again, limiting independence and losing physicality which in itself can lead to further falls. Effective Telecare use can act as 'peace of mind' for users as well as an intervention tool.²⁰

SAIL Connections made **137 referrals to the London Fire Brigade**. These referrals involve either a Home Fire Safety Check, which can result in installing smoke alarms, other fire-resistant equipment if appropriate and providing specialist information and guidance, or assessments and advice around fire safety for older people who would not be able to leave their property unaided in the event of an emergency. This, combined with **16 referrals to the Police and 8 to the Crime Enforcement and Regulation Service**, has preventative value for older people and also provides emotional reassurance and a sense of safety to vulnerable older people.

Outputs and outcomes for Professionals

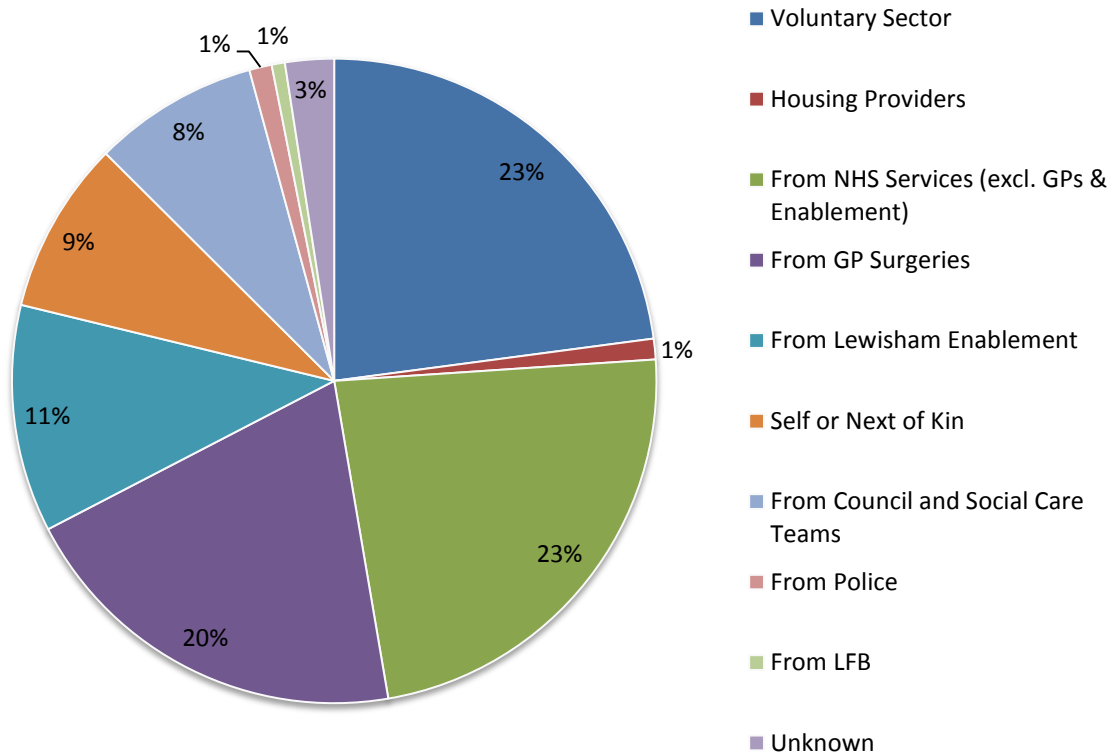
One of SAIL Connections' aims is to enable GPs to quickly and easily make referrals to services across sectors and in the community. **20% of checklists were received from GP practices**. SAIL Connections enables GPs to refer to a wider range of services and provides a quick method for community referrals.

However, the checklist is **also** designed to be accessible to any professional as well as to members of the general public. **8%** of the total number of checklists completed via **self-referrals or referrals by Next of Kin**. SAIL Connections also provides a simple way for voluntary sector organisations and housing providers to refer. **24% of referrals are received from the voluntary sector or housing providers**. It is often difficult for small voluntary sector groups to know what referrals are suitable or to stay up to date with the services available for older people, and SAIL Connections therefore increases the probability that older people will be referred from these sources.

34% of checklists are received from the Lewisham Enablement Service and other NHS teams, including the Older People's Assessment and Liaison Service at University Hospital Lewisham. Through these pathways SAIL Connections is helping bridge the gap between community-based services and hospital care.

²⁰ Johnston K., Grimmer-Somers K., Sutherland M., *Perspectives on use of personal alarms by older fallers*. Int J Gen Med. 2010;3:231–237

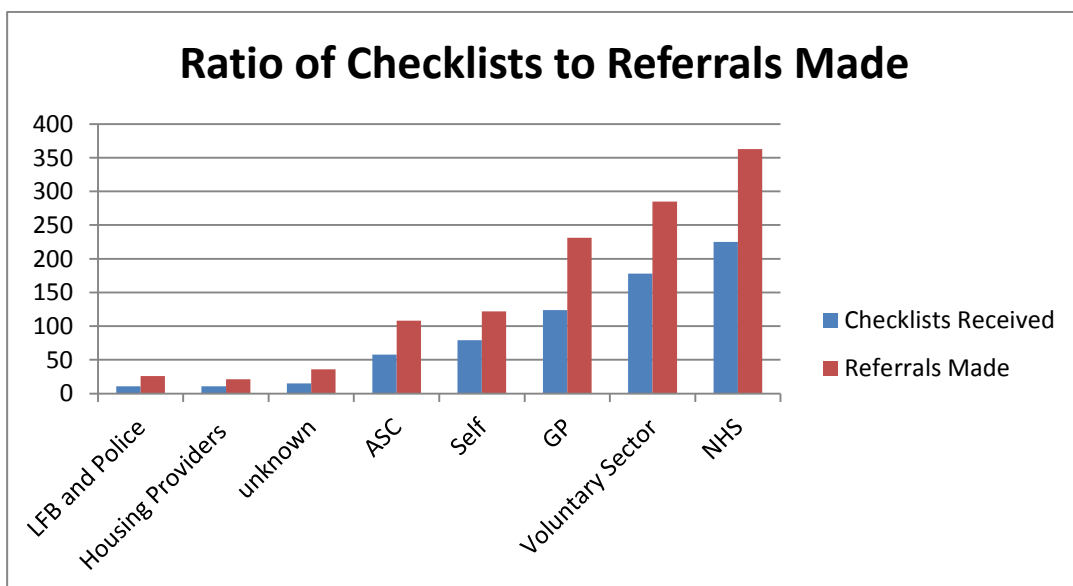
Who Refers to SAIL Connections



Time Saving Tool for Professionals

SAIL Connections provides a single checklist which enables professionals to make up to 20 referrals at a time. The average number of referrals per checklist is 1.9 with some small fluctuation depending on the referrer category shown below. The greatest number of referrals generated by a single SAIL checklist was 10 referrals.

Ratio of Checklists to Referrals Made



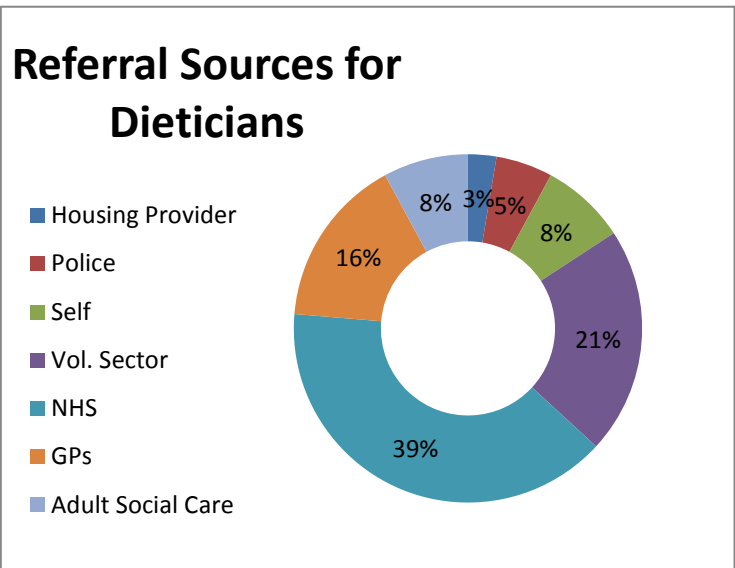
A number of SAIL Checklists are completed and sent to only one or two Partners. This still has time saving benefits for professionals, as unlike most conventional referral forms SAIL Connections checklist does not require referrers to give any additional details. The project Coordinator will work directly with the older person to find out more information about the referrals that are required. This means the checklist can be completed by a wider number of people.

- **SAIL Connections received 94 checklists from Next of Kin or via self-referral.** The Coordinator screening is essential to making this a possibility, as not all of the SAIL Partners would have received self-referrals prior to SAIL Connections being established.
- **Around 30% of referrals received from GP practices have been completed by reception staff,** demonstrating that SAIL Connections makes it possible for older people to be supported without making a GP appointment.
- **Around 25% of the checklists completed by the voluntary sector were completed by volunteers rather than paid staff members.** This empowers volunteers to become more involved in supporting service users as well as removing pressure from frontline staff.

This is possible because of the role the Coordinator takes in ensuring referrals are being directed to the most suitable service and gaining additional information for the Partners. The SAIL Coordinator made **626 changes** to checklists received through SAIL Connections during the 18 month pilot.

Able to reach a wider range of people

SAIL Connections helps identify people who are not otherwise ‘known to service’ by creating new referral pathways. Prior to SAIL Connections the **Community Dieticians** and the **Lewisham Adult Therapy Teams** (which provided support to people vulnerable to falls before the Lewisham Community Falls Service) received all their referrals from Health and Social Care Pathways.



63% of referrals made to the Community Dieticians through SAIL Connections were due to checklists sent by GPs, NHS or Adult Social Care. However, the remaining **37% of referrals or referrals to Community Dieticians were received through novel pathways created by SAIL Connections.** This includes 8% as self or next of kin referral and 21% via the voluntary sector.

Similarly, while the Lewisham Community Falls Service was not in place at the start of the pilot the Lewisham Adult Therapy Teams, which include physiotherapists supporting people at risk of

falls, were previously accessed via Health and Social Care only. **33% of SAIL Connections referrals to the Community Falls Service originated in voluntary sector referrals. 4% were self-referrals.**

SAIL Connections also increases awareness and referrals to services less well known to professionals, including voluntary sector Partners, the local Police Safer Neighbourhood Teams and the London Fire Brigade's Home Fire Safety Check service.

A More Holistic Approach

The SAIL Coordinator provides a single point of contact for Partners who have received referrals as well as for referrers. Both parties utilize this to ensure they are supporting the older person in the most appropriate way and to remain up to date with their situation. The Coordinator is able to pace the rate at which referrals are sent and take time to empower the older person to make choices.

Another benefit of the Coordinator's conversation with the older person is the other avenues of questioning that can open up; questions that might not be asked without the Coordinator call. It has already been mentioned above that the Coordinator will try to support the older person to find alternative services outside of the SAIL Partnership should it not fit their needs.

But crucially, this can extend further than a search for other options. When complex cases arise that go beyond the scope of how SAIL or other services can assist, the Coordinator can advise getting in contact with Adult Social Care where appropriate. With consent, they can also act as the referrer to Social Care and explain the situation if the older person feels they cannot do this. This also applies to raising Safeguarding alerts. The Coordinator still acts as the single point of contact for the older person and Social Care and, this can also act as vital intervention and prevention before a situation worsens.

The Impact of SAIL Connections

The SAIL Connections process and level of support varies depending on the older person's situation and the Project Coordinator and Partners work together to provide the most meaningful support in each case. The impact of the project can best be seen in the stories of those who have received support. These case studies were selected to give an idea of the wide range of situations in which SAIL can be used.

Alice's Story:

*Alice was referred in by the Enablement team after a stay at hospital. They identified that she wasn't getting all the money she was entitled to and were able to use SAIL as pathway to **Advice Lewisham**. The Coordinator got in touch and referred her for a benefits check. One of Age UK Lewisham and Southwark's advisors visited her in her home and helped her with applying for attendance allowance. Alice now receives an **extra £4321.20** a year.*

Sally's Story:

*We first spoke to Sally after the Royal National Institute for Blind People (RNIB) called Age UK Lewisham and Southwark for some advice. Sally was struggling with a few bits and pieces she was struggling with as a result of her visual impairment – small things such as going through her post or looking through some documents. The project Coordinator had a chat with Sally. One Partner, **BlindAid**, was already supporting her but she just needed a bit more help. We referred Sally to **Community Connections**, who were able to find her a befriender to visit weekly. The RNIB also stayed in touch with Sally and now knew about our SAIL Connections project. A year later RNIB referred to us again as Sally had had a fall. We referred her to the **Community Falls Team** for support in regaining her strength and balance, as well as to **Advice Lewisham** for some assistance in filling in forms.*

John's Story shows how SAIL helps people get support without needing a GP appointment:

*John was in a bad place after undergoing a major back operation which had left him in chronic pain and meant he could no longer work. He was referred into SAIL by a Receptionist at his GP surgery. He was referred in for support in a few areas but ended up just getting assistance from **Groundwork London Warm Homes Healthy People** after a chat with a Coordinator. This was the most **important to John** at the time but the Coordinator was concerned there might be a few areas John would need help with in the future. We made sure John knew to get in touch if he wanted any other support. Over the next few months John ended up **self-referring** into SAIL a couple of times. We referred him for a **Home Fire Safety Check** and to **occupational therapy**, to get some rails for outside his property. The SAIL Coordinator has been a point of contact for John throughout his journey, not just through referrals made but through the advice and reassurance we are able to provide for John at any time.*

Charlotte's Story

*Charlotte and her husband were referred in to SAIL as a pair by their **local Police Safer Neighbourhood Team**. They had been victims of repeated burglaries, but after a visit from the police a referral to SAIL opened the door to a range of support. Charlotte's husband was very unwell and both were struggling to cope. Age UK Lewisham and Southwark's **Help at Home** team were able to provide domestic cleaning for Charlotte, lessening the load for her as she cared for her husband. We also referred to the **London Fire Brigade**, **Lewisham Adult Social Care** and the **Community Dieticians** for Charlotte's husband. This was a process carried out over a period of months, throughout which the SAIL Coordinator acted as the single point of contact to make things easier for Charlotte and the professionals involved. Tragically, Charlotte recently called to let us know her husband had passed away. The Coordinator arranged a priority referral to **Community Connections** who were able to gain Charlotte bereavement support and **Advice Lewisham** who are working with her to ensure she is receiving all the income she is entitled to.*

Monetization of impact

It is not possible to create a full Social Return on Investment analysis for SAIL Connections at this scale, and so a sample of outcomes have been chosen and potential financial savings estimated. SAIL is a preventative project and so many of the most significant outcomes are hard to quantify and their value cannot easily be measured. These figures have been adjusted for inflation where necessary.

Outcome	Measure	Assumption and adjustments	Financial proxy	Calculation	Value
Improved Wellbeing	Community Connections (CC) Wellbeing Measure	Assuming that the average 16% increase in wellbeing experienced by CC clients is experienced by 5% of referrals	The value of 'feeling in control of life' for an older person (50+) in London: £15,734 ²¹	(16% x 15734) = 2517.44 £2,517.44 x 5% of CC referrals (237 x 0.05)	£29,831.66
Decreased Falls	Lewisham Falls Team TUAG Measure	Taking an average improvement on TUAG test as 17% after Lewisham Falls Team intervention and assuming every older person referred experienced this level of improvement ²²	Estimated cost as a result of an older person falling in London: £5,553.50 ²³	(17% x 5553.5) = 944.35 £944.35 x number of Falls Team referrals (72)	£67,993.20
Improved Financial security	Income Gains for Older people	This figure is the level of income gained by clients as a result of referrals to Advice Lewisham. It is not a speculative figure and so no adjustments need to be made.	Annual Gain	Total income Gain = £206,348.3	£206,348.30
Fire Safety	Number of Home Fire Safety Checks (HFSC) Complete	Assuming 5% of referrals for a HFSC each prevented a single fire	Average cost of response to a fire in London: £4,976.08 ²⁴	5% of HFSC referrals (137 x 0.05) x 4976.08	£34,024.50
Decreased Crime	Number of referrals to	Assuming 5% of referrals to an SNT prevented one burglary	Cost of burglary in a dwelling: £4784.41 ²⁵	5% of SNT referrals (16 x 0.05) x 4784.41	£3,827.53

²¹ HACT and Daniel Fujiwara, *Community Investment Values from the Social Value Bank* (www.socialvaluebank.org)

²² Figures taken from graph on page x

²³ *The Falls Prevention Economic Model* (2016) England: Chartered Society of Physiotherapy

²⁴ *The economic costs of fire: estimates for 2008, Fire research report 3/2011*. (2011) London: Department for Communities and Local Government

	Safer Neighbourhood Team				
Decreased calls to 999	Number of referrals to Pendant Alarms	Assuming that each pendant alarm resulted in 1 prevented 999 call.	Cost of a call to 999 call out = approx. £190 ²⁶	Number of pendant alarm referrals (56) x 190	£10,640
GP Time Saving	Referrals per checklists completed by GP	Estimating it takes 5 minutes to complete a single referral form. Assuming that the GP would have completed the additional referral forms were SAIL not available.	GP Time: 5 minutes GP time = 1 referral = 20 <i>9.22 minute consultation costs</i> 37 ²⁷	GPs completed 124 SAIL checklists and generated 231. This saved 107 referrals being made by GPs. 75 x 20 = 1498	£1,498
	Number of referrals from checklists completed by GP reception staff instead of GP		5 minutes GP time – 5 minutes Band 2 time = 20-1.92 = 18.08 ²⁸	69 x 18.08 = 1247.52	£1,247.52
Statutory time saving (NHS, Adult social Care, police and LFB)	Checklists sent by statutory services	Estimating it takes 5 minutes to complete a single referral form. A large range of professionals have been grouped in this category. The estimated costs for a Band 5 NHS professional have been used as a proxy for all statutory referrals.	5 minutes band 5 or equiv. statutory staff time = 2.75 <i>1 Hour costs</i> 33 ²⁹	203 x 2.75 = 558.25	£558.25

²⁵ *Revisions made to the multipliers and unit costs of crime used in the Integrated Offender Management Value for Money Toolkit*, (Sept 2011). Please note that this is a paper with revised figures for HOOR 30/05 (2005)

²⁶ National Audit Office, *NHS Ambulance Services (HC 972)* (2017)

²⁷ Curtis L., Burns A., *Unit Costs of Health and Social Care 2017* (2017)

²⁸ Ibid.

²⁹ Ibid.

	Number of referrals to dieticians and falls which were not made by H&SC	These referrals would previously have been made by Health and Social Care professionals. It is therefore assumed that had SAIL not been in place the referrals would still have been made but via an alternative pathway.	5 minutes of band 5 statutory salary cost – 5 minutes vol sector time = $2.75 \times 1.2 = 1.55$	$1.55 \times 40 = 62$	£62
Time saving in voluntary sector	Number of referrals from checklists completed by volunteers	£25,000 has been used as an example voluntary sector salary with 15% M&O.	Estimated costs of 5 minute of voluntary sector staff time is £1.20.	$285 \times 1.20 = 342$	£342
	Number of referrals per checklist made by voluntary sector	£25,000 has been used as an example voluntary sector salary with 15% M&O.	Estimated costs of 5 minute of voluntary sector staff time is £1.20	$161 \times 1.20 =$	£193.30
Self referral, next of Kin Referral	Number of referrals made from referrals made by NOK or self referral	Some Partners would not have accepted self or next of kin referral prior to SAIL, however many do. SAIL makes it simpler for people to self referrer so may also have increased the number of referrals.	Estimated cost of 5 minutes for voluntary sector staff time	$122 \times 1.20 = 146.4$	£146.40

Using the figures above, the total value of savings as a result of SAIL Connections is **£356,154.41**.

Given an initial investment of **£72,534** the social return on investment is estimated at **£1** invested, the return is **£4.91**.

There are many necessary assumptions to the estimated Social Return on Investment analysis. A more accurate and in depth SROI analysis is not possible without access to additional data and resources. This is likely to be an underestimate of the financial savings brought about through SAIL Connections. It has not been possible to account for the preventative impact of the project and of making timely referrals to services which support people to remain safe and independent. Hospital admissions for older people are within the NHS greatest costs and effective preventative projects therefore result in huge cost savings.

Among outcomes not considered in monetization exercise:

- Improved physical health, other than decreased risk of falls
- Decreased number of hospital admissions – via improved health and wellbeing, better self-management, earlier identification or timely emergency support
- Decreased number of GP appointments, by providing an alternative point of contact for older people seeking support
- Decreased pressure Adult Social Care, by providing an alternative point of contact for older people seeking support
- Savings brought about as older people are able to remain at home longer
- Savings brought about by better managed dementia care, and slowed rate of decline in health
- Savings achieved by supporting carers to continue to provide un-paid care for loved ones

Conclusions and next steps

As this paper has demonstrated, the pilot phase of SAIL Connections has proven to be a success. SROI analysis shows that the original investment of **£72,534** from the Better Care Fund has produced an estimated saving of **£356,154.41**. For every **£1** invested, the return is **£4.91**.

Success can be measured through SAIL Connections' other achievements too. It has grown at a level passing expectations. Though it has been an 18-month pilot, the project was not accepting referrals until its 'public' launch in February 2017. This means SAIL Connections has received 1063 checklists in a year. These checklists have come from a growing number of unique sources as well as many that continue their repeated use of the tool; evidence of its utility. And perhaps the most candid and overt evidence of SAIL's positive reception is the number of referrals received; a number which has grown every quarter since launch.

SAIL Connections' positives can be conveyed through the feedback received from its key stakeholders and case studies. It is hard to capture the full nature of the service offered in quantitative measurements and so feedback from older people, case studies and stakeholders remains essential to fully understand the impact of the model. Referrers and Partners alike have praised it for its efficiency and accessibility, both for themselves and older people. The SAIL Connections project pushes older people needs first and tries to build around them, empowering older people by helping them make informed choices and making itself accessible in the first place. The Coordinator acts as single point of contact to help reduce any confusion or duplication and works with service users to tailor the support they receive to their needs; or rather what they feel is most important. As well as service users themselves, referrers have an easy-to-use tool and new pathways to services while Partners have a new source of clients, some of whom may not have been able to get support from their service without SAIL.

There are still points for improvement and learning. As discussed in the Referrer and Partner Feedback sections of this paper, there is a heavy emphasis by both parties on the efficiency of SAIL which outweighs all other potential positives. Partners felt improved access to services was also important, but Referrers – those actually making referrals to these services – did not agree. There is also evidence of SAIL not being used as a holistic assessment tool due to the high number of referrals for only one or two Partners, reinforced by Referrers feeding back that SAIL's efficiency was the most important to capture feature for evaluation. Though neither of these points are necessarily negative they highlight the need to reexamine the direction to take SAIL in the future, whether it be reiterating SAIL's other benefits and pushing it as its own referral form as opposed to an alternative; looking even further into stripping it down and making it an efficient tool first; or, as it is now, somewhere in between.

Moving forward the project has the potential to grow further, even outside the 60+ age group. The 50-60 year-old demographic has been identified as group which may benefit from the type of support SAIL offers. The project and its stakeholders may want to investigate the possibility of expanding its remit in the future, lowering the minimum age to reflect the needs of those in

the borough. This will come with its own challenges and considerations, including capacity for the coordination of the project and the Partnership overall. Especially important to consider would be the number of referrals to any statutory Partners which, while they have been shown to be manageable so far, could add to their pressures and go against the idea of aiding statutory services, an idea on which projects like SAIL are built.

To conclude, this SROI evaluation is the first of its kind for a SAIL project in London and were the others in other boroughs to conduct a similar analysis, it is likely they would find similarly high levels of return. SAIL is an effective tool and conveys the benefits of the Better Care Fund with regards to integration of Health and Social Services; SAIL and indeed social prescribing on the whole should be considered seriously when examining ways to both alleviate pressure on statutory services and improve individual health and wellbeing.