Social Return on Investment of

BME Health Forum's Multilingual Emotional Wellbeing Support service in RBKC

BME healthforum

Envoy Partnership

Contents

Executive Summary 3

1. Background to the service 6

2. Evaluation approach 8

3. Findings: Stakeholder outcomes 10

4. Findings: SROI estimate 17

5. Efficacy of the model 21

Conclusions 26

Appendix 28

Executive Summary

NHS England's Long Term Plan (January 2019) promises increased funding for mental health services worth an additional £2.3 billion a year by 2023/24. The Long Term Plan states that 'new and integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses'; and that 'a new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use'. The Long Term Plan will also develop new services for people who have the most complex needs and will '**proactive(ly) work to address racial disparities'**. There is an additionally higher level of need and complexity for those who reside in England but do not yet fully speak or understand English health information and advice; yet these are supposed to be **universal for all**.

Black, Asian and Minority Ethnic (BAME) groups have less access to health services in general and the disadvantaged socio-economic position of many BAME groups explains a considerable part of these inequalities, but does not offer a sufficient explanation; English language barriers to health information, and in addition discrimination, are likely to play a role[1]. The inequalities in West London boroughs are often stark.

NHS England stated in **Developing the Long Term Plan** (2018) that by working with statutory ***and voluntary sector partners***, positive progress was made in tackling health inequalities in some areas, but that more needs to be done to systematically address inequalities that are evident between groups of people with different characteristics. In direct relation to this, the **Multilingual Emotional Wellbeing Support (MEWS) service supports BAME people who are resident in Kensington & Chelsea[2] - including those who do not fully speak or understand English** - **and are experiencing emotional and mental wellbeing difficulties, but are not mental health service users.**

The MEWS model therefore works proactively to address racial health inequalities, as desired by NHS England's Long Term Plan. Around **185-195 RBKC service users** were reached per year, in the three years 2016-2018 (**total 569**). BAME clients (from the providers' target group) are provided with bilingual one-to-one sessions by one of their approved VCS support workers, who speaks the client's language or mother tongue. The bilingual support workers are relatable through shared language and culture, and provide a listening ear to help clients open up and discuss their mental health or emotional wellbeing crisis – which can involve issues that are stigmatised or taboo within certain BAME groups. Support workers are highly knowledgeable about local networks of available support, and are trained in wellbeing support. They use this knowledge to offer guidance, and help service users access relevant therapies or further support with other statutory or VCS partners. The support workers focus on producing and following-up on an action plan with the service user, to best resolve their crisis, improve their self-care skills, and health information knowledge. The sessions can be conducted at the VCS organisation or during home visits to the client.

[1] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/access-to-health-care-minority-ethnic-groups-briefing-kings-fund-february-2006.pdf

[2] And also Westminster and Hammersmith & Fulham under a separate stream that is non-RBKC funded, but funded by local Clinical Commissioning Groups

The service is managed by **BME Health Forum**, a partnership and infrastructure organisation for the local voluntary and community sector (VCS); and is funded mainly by Royal Borough of Kensington & Chelsea (RBKC). There is further partnership involvement from West London Clinical Commissioning Group (CCG) and the NHS Foundation Trust for Central and North West London (CNWL's Improving Access to Psychological Therapies/IAPT).

The MEWS service also aims to support organisations working with BAME clients by recognising the role these organisations have in maintaining the mental wellbeing of their clients, and by offering training and resources to volunteers and staff members. The need for this service has been established through a number of surveys and consultations with BAME organisations.

This report presents evaluation findings on the MEWS service **in RBKC specifically**. The evaluation was conducted by **Envoy Partnership**, drawing on a Social Return on Investment (SROI)[3] approach. This draws on both qualitative and quantitative research to identify the outcomes and net benefits created for key stakeholders of the service. We also explore the process efficacy through which a significant difference is made to them by the model. Our analysis shows a range of health and wellbeing problems amongst BAME service users.

We estimate the **MEWS service generated c.£175,000 attributable social value in 2018 in RBKC**, approximately **£3.20 of attributable social value for every £1 invested.** Almost 90% of this value is generated for service users in terms of the worth of improved aspects of their subjective health and wellbeing.

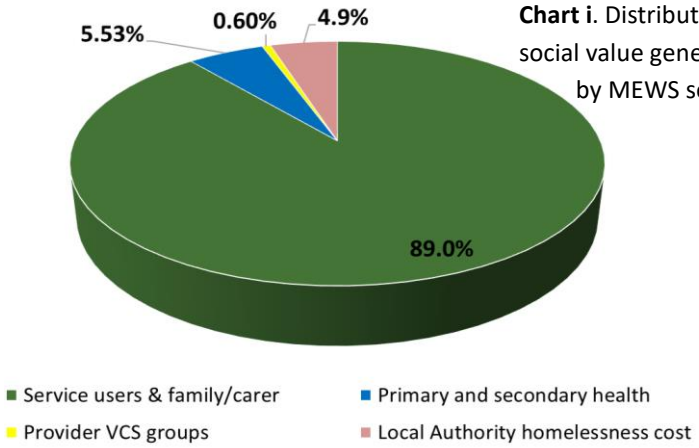


Chart i. Distribution of social value generated by MEWS service

Through the MEWS service, **100% of service users reported an improvement in health status**, from **an average starting point of 44 out of 100, improving significantly to a score of 70**. There has been some reduction in use of secondary care, GPs, and reduced risk of service user homelessness or eviction. Furthermore, client scores improved in a range of mental and emotional health indicators (see Chart ii),

Chart ii. Multilingual Emotional Wellbeing Service, change in client wellbeing scores 2017-18 (n=184)[1]

[3] *A guide to Social Return on Investment*, (2012), Cabinet Office. For more details, see http://www.socialvalueuk.org/resources/sroi-guide/

drawing on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS); including loneliness, self-worth, stress and anxiety, resilience, and feeling in control of their situation.

The MEWS service model overall works well for its service users. This report presents some of the evidence that at an aggregate level the service contributes directly to helping improve people's emotional and mental wellbeing, their overall health, and can reduce their level of isolation. Support workers manage their caseloads relatively well and with resource constraints in mind, as in reality, funding and resources are limited given the high level and broad scope of diverse needs.

The model works well not only because of the **crucial element of bilingual support and knowledge,** but also because the provider organisations involved have deeper connections, trust, and roots with their target communities through shared language or culture. **Statutory health and care services may not be able to provide this highly needed role and relationship**, but do generally recognise the value of working in tandem with the MEWS model as part of a joined-up, systems-wide approach to provision. The two sectors aim to complement each other, and share the viewpoint that better outcomes and experiences, as well as reduced health inequalities, are possible when people actively shape their own support and care.

Through offering one-to-one and sometimes home-based visits to a broader range of non-English speaking BAME residents, the MEWS model can support alignment with NHS England's Long Term Plan to provide 'timely, **universal** mental health care **for everyone',** including within community-based (adult) mental health crisis settings. Furthermore the MEWS model is aligned with the Long Term Plan's aim for mental health 'services to be resourced to offer intensive home treatment as an alternative to an acute inpatient admission'.

In terms of funding received and number of residents reached, this is summarised below in Table A.

Table A. Number of service users reached across RBKC in past three years (2016-2018)

Year	RBKC funding	BMEHF reserves	RBKC clients reached
2018	£45,000	£0	185
2017	£45,000	£9,131	197
2016	£45,000	£8,300	187

It is worth noting that the MEWS model is also provided in Westminster City Council (WCC) and London Borough of Hammersmith & Fulham (LBHF) using other *non-RBKC* funding. When factoring in service users and small additional funding from local Clinical Commissioning Groups covering Westminster and Hammersmith & Fulham (in addition to RBKC), the total SROI ratio for the three boroughs can range from c.£4 to £5 per £1 invested over the three years.[4]

[4] See Appendix 2; note that CCG funding include Central London, West London, and Hammersmith & Fulham in different years.

1. Background to the service

BAME groups face inequities in access to health care compared to the majority population. They have less access to services in general and the services they have access to are on average of a lower quality. The disadvantaged socio-economic position of many BAME groups explains a considerable part of these inequalities but does not offer a sufficient explanation; English language barriers, and in addition discrimination, is likely to play a role too[5].

Health inequalities are especially an issue in London, where 37.6% of the population comes from a BAME background, versus only 13.6% of the UK population. The population of the borough of Hammersmith & Fulham is slightly less diverse, with 31.2% of the population identifies as Black, Asian, Arabic and other minority ethnic groups[6]. Likewise, the Royal Borough of Kensington & Chelsea (RBKC) has a lower than average minority ethnic population, with 33.2%. Westminster on the other hand has, with 40.4%, a higher than average ethnic minority population. In terms of resident population, the RBKC is smallest with 157,711 residents, followed by Hammersmith & Fulham with 179,410 and Westminster with 242,299 residents[7]. When we look at mortality under 75, split by deprivation level, we can see a similar trend for all boroughs: the most deprived are more likely to be than the average to pass away before 75, whilst the most privileged are less likely to pass away young. This trend applies to both men and women. Many ethnic groups in these areas are deprived and it is therefore highly likely that they are overrepresented among the most deprived groups mentioned before.

The inequalities in these three West London boroughs is stark. This is shown among others by the inequality in life expectancy. Although the average life expectancy for men and women in the RBKC is higher than the average, there is a life expectancy gap of 13.8 years for men and 7.5 years for women of the most deprived backgrounds[8]. The same trends are visible for Westminster with a life expectancy gap of 12.5 years for men, and 7.5 years for women, whilst both averages are higher than the national[9]. The gaps are lower in Hammersmith & Fulham, namely 6.4 years for men and 3.4 years for women. However, the average life expectancies are only slightly higher than the average value for England.[10]

Mental health issues are also prevalent amongst BAME communities, and there is therefore substantial demand for support services. Yet at the same time poor mental health is sometimes stigmatised, which results in not everyone seeking the help they need[11]. Research among Hammersmith & Fulham, RBKC and Westminster residents showed that half of the BAME residents had lower than average wellbeing and they were also more likely to have felt anxiety[12]. **Furthermore, long term mental health conditions have also shown to be among the highest country wide in the West London CCG area**[13].

[5] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/access-to-health-care-minority-ethnic-groups-briefing-kings-fund-february-2006.pdf
[6] 2016 data https://fingertips.phe.org.uk
[7] 2015 data https://fingertips.phe.org.uk
[8] Local Authority Health Profile 2018 - RBKC
[9] Local Authority Health Profile 2018 - Westminster
[10] Local Authority Health Profile 2018 – Hammersmith & Fulham
[11] The roads to wellbeing - 2017
[12] https://www.jsna.info/sites/default/files/Public%20Health%20Annual%20Report%20WCC%26RBKC%202016-17.pdf
[13] https://www.westlondonccg.nhs.uk/media/45263/NHS%20West%20London%20CCG%20Annual%20Report%20and%20Accounts%202017-18.pdf

It is in this ongoing context, that the Royal Borough of Kensington & Chelsea (RBKC) has supported a service to support multilingual emotional wellbeing, through a local partner managing organisation and their selected service provider VCS organisations. This service has evolved over several years, with small additional support from several clinical commissioning groups (varying between Central London, West London or Hammersmith & Fulham in different years). The service targets key groups and aims to reflect changing demographics in the boroughs in which it operates.

Multilingual Emotional Wellbeing Support (MEWS)

In the three years 2016-2018, the MEWS service supported **569 BAME people** who live in Kensington & Chelsea, including residents who did not yet fully speak or understand English health information, and experienced emotional and mental difficulties, but who were not mental health service users. (There is also a separate strand of MEWS that is *non-RBKC* funded, which covers residents in Westminster and Hammersmith & Fulham). This report focuses on RBKC specifically in its main analysis.

The service also aims to support organisations working with BAME clients by recognising the role these organisations have in maintaining the mental wellbeing of their clients, and by offering training and resources to volunteers and staff members to make the project more sustainable.

The need for this service has been established through a number of surveys and consultations with BAME organisations. The main issues identified are:

- Support for mental wellbeing is one of the prevalent needs amongst BAME communities, (alongside diabetes and heart disease).
- People who do not speak English are vulnerable to feelings of isolation and need culturally appropriate support in their own language, and encouragement to develop bilingual skills levels.
- Support during a time of crisis can prevent deterioration of mental health.
- Early referrals to mental health services can prevent deterioration of mental health.
- BAME volunteers need support and training to improve their skills and employability, and to be able to contribute fully towards the organisations with which they volunteer.
- Voluntary organisations provide a lot of emotional support towards their communities which sometimes goes unnoticed by the statutory sector and need support to be able to demonstrate this.

2. Evaluation approach

Research principles

Static reporting frameworks, no matter how sophisticated, often risk providing only narrow evidence on which to base decisions, rather than demonstrating the dynamic flows of value arising from different functions and outcomes, over the short and long term. We have drawn on the Social return on investment (SROI) approach, which is unique in its ability to translate the measurement of social values into economic language. It is a stakeholder-informed cost-benefit analysis that uses a broader understanding of value-for-money. It can assign values to social, as well as economic outcomes.

The methodology followed in this report draws on the UK Cabinet Office's *Guide to Social Return on Investment*.[14] SROI proceeds via six distinct stages, as defined in the guide. It is a *mixed methodology* approach, relying on both *qualitative* research (particularly in stage 2 below) and *quantitative* research (particularly in stages 3 and 4 below):[15]

1. Establishing scope and identifying key stakeholders
2. Mapping of outcomes
3. Evidencing outcomes and giving them a value
4. Establishing impact
5. Calculating the SROI
6. Reporting, using and embedding

The Envoy research team conducted the research between June and October 2018. The research was underpinned by the **Seven Principles** of SROI as set out in the Cabinet Office SROI Guide, and shown in the box on the right.

The Seven Principles of SROI

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

This approach to evaluating the service was underpinned by a core understanding of the inputs and activities involved, and the outputs and outcomes that arise.

Once identified and tested, it is easier to identify appropriate indicators that demonstrate the magnitude of change in outcomes. Measurement focuses on the ultimate benefit or change experienced by stakeholders, as well as the outputs - the quantifications of activities e.g. the number of service users.

Establishing impact

In SROI terminology, 'Impact' is a measure of the difference made by the project or organisation being evaluated. It recognises that there is likely to be a difference between the change observed, and the change for which the project or organisation can claim credit. Such considerations are important to ensure that the analysis does not over-estimate value created.

[14] *A guide to Social Return on Investment*, (2012), Cabinet Office. For more details, see http://www.socialvalueuk.org/resources/sroi-guide/
[15] *Ibid.,* pages 9-10

Four key areas include the following:

- Deadweight (the probability that some outcomes are likely to have happened anyway);
- Attribution (the extent to which outcomes arise because of the service, rather than because of the contribution of other people or organisations);
- Displacement (whether any value is 'displaced' elsewhere, or a drawback is created for another stakeholder);
- Drop Off (the extent to which outcomes are sustained over time e.g. if lasting beyond a year – however not required in our analysis).

Research

Envoy conducted a mixed-method approach, drawing on both qualitative data (focus groups, and one-to-one phone interviews for service users who felt their personal needs were too sensitive to share in a group) and analysis of quantitative data (project wellbeing surveys, service usage data).
The primary research samples are summarised in Table 1 below.

Table 1. Summary of primary research samples and tasks

Stakeholder group	Research task	Number of participants
Service users	One-to-one phone interviews	**5**
	Focus groups x3 (FAWA, Midaye, Iranian Association)	**25**
	Health and wellbeing status surveys	**184**
Provider VCS organisations	One-to-one phone interviews	**5**
Wider statutory stakeholders - West London CCG x2 - North West London Collaboration of CCGs	One-to-one phone interviews x2 Face-to-face interview x1	**3**

Regarding primary data, a significant part of the project survey questions were based on the short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) which use a 5-point frequency scale (e.g. 'All of the time' to 'Not at all'), on pre- vs post-service comparison format i.e. baseline reading plus follow-up.

Secondary data

We have drawn on publicly available national statistics, health and social care unit costs, and reports, from health and NHS resources, government departments, wellbeing measurement research, and diabetes and social care research. A full list of references and sources is available.

3. Findings: Stakeholder outcomes

Theory of change

In an (SROI) analysis, qualitative research from stakeholder engagement should inform the creation of a *Theory of Change*. The Theory of Change is the foundation for identifying which stakeholder outcomes should be measured and valued. It presents stakeholders, activities, and outcomes that arise from the Multilingual Emotional Wellbeing Support (MEWS) service model. It can be useful for helping to understand the different conditions that exist, and for helping to understand where potential enablers and barriers might occur. It aligns with HM Treasury Magenta Book guidance on logic mapping.[16]

Figure 1 shows the Theory of Change for the MEWS service. It summarises the outcomes for material stakeholders arising from core activities of the model. It shows how input activities lead to outcomes for the material stakeholder groups, and how intermediate outcomes lead to the final long-term outcomes which should be valued.

We have presented a theory of change for the service, and indicating which material stakeholders are involved. Not all of the health and wellbeing outcomes are applicable for all of the service users, but are observed at an aggregate level. The left-hand side of the Theory of Change maps the main input activities and provision activities. The financial input to the RBKC component of MEWS is not presented, simply to make clear the process in Figure 1 – this averaged at around £55,000-£60,000 per year between RBKC funding, a small part of CCG funding where it is available, and BMEHF funding.

The inputs and activities then build from left to right into the intermediate and final outcomes, which we define below:

- **Intermediate outcomes** are those that can happen during the sessions or in the first few weeks after all sessions are complete.
- **Final (Long-term) outcomes** are those that are expected to arise or be maintainted a few months after the sessions are completed.

Key aspects of how change arises

In the majority of cases, service users hear about the MEWS service through the following channels:

- Word of mouth, friends, or acquaintances in their community
- Newsletters and promotion by the Provider
- Internal recommendation/internal referral by a Provider already dealing with a service user i.e. via another service of the respective Provider
- Provider website
- Referral from partner health agency

We would argue that a wide range of potential referral pathways can provide more opportunity to tackle the complexity and variation of people's needs. This means however, that it is difficult to

[16] The Magenta Book: Guidance for Evaluation, HM Treasury (2011) see logic model in Chapter 5

ascertain which referral pathways are the most effective, or whether a more structured model of referral adds or detracts from the efficacy of the model.

A first session is arranged by the Provider for the service user with their BMEHF-trained support worker. In this first session the support worker is focused on listening to the service user's needs and situation, taking time to understand the different strands or layers of issues that are contributing to poor emotional or mental wellbeing. This varies depending on each individual, and problems can be diverse and multi-faceted. For example an individual's needs can include one or a combination of the following, each compounded by lack of sufficient English language skills:

- High anxiety or extreme stress
- Depression
- Family/home-life problems, including problem behaviours with children, including coping with ADHD and special needs
- Loneliness and social isolation
- Lack of adequate guidance or support to manage a mental health problem
- Housing-related problems and/or risk of eviction/homelessness
- Poor knowledge of local administrative processes and how to interact with statutory services
- Poor knowledge of certain health and wellbeing conditions, or social and cultural taboos about discussing such conditions
- Being too physically inactive or sedentary
- Mobility challenges, or at risk of being housebound
- Domestic abuse (minority of cases)
- Post-traumatic stress disorder often in cases of people who have sought refuge in the UK from civil war or political persecution or repression

The first session provides an opportunity for needs assessment and goal-setting for the service users' first steps, actions, and follow-up sessions. Actions supported by the session worker can include:

- A forward referral to an appropriate statutory service if judged to be a requirement or urgent, and providing practical support in going through the respective process from start to finish;
- Recommended attendance or taster session on a new activity offered by the Provider or an appropriate local VCS/community-based provider e.g. English course, yoga, complementary therapy, group meetings or a women's-only/men's only club;
- Accessing the correct prioritisation pathway with statutory services e.g. in one case a pregnant woman who was previously at risk of being homeless;
- Support with applications e.g. for housing support or income support or attendance allowance;
- Informal bilingual counselling;
- Bilingual advocacy support and negotiation support e.g. with statutory officers;
- Participating in carefully selected outdoor-based activities or events, including escorting for service users with mobility challenges/ability to get out of their home;
- Home visits by the support worker for those who are isolated or frail and elderly and housebound;
- Being signposted to new sources of information and online advice.

The first session provides the foundation for the service user to feel confident in the process, and also confident that they can open up to the support worker in a confidential setting, where required in their language or mother tongue. The **bilingual provision of support** is an important differentiator that many service users have iterated is of great value compared to other non-bilingual services. Being able to communicate with someone in their first language or who understands their cultural context, is a highly significant catalyst for building trust, confidence, openness, and stabilising of their mental and emotional condition; which are important steps to feeling respected and listened to, become more motivated, and gain more resilience in their personal journey.

Follow-up sessions (on average roughly three to four, sometimes more depending on the severity of the case) provide an opportunity to track progress and build the relationship with the support worker, which is key for improving the service user's health care and self-care knowledge; positive experience of the support process; resilience to tackle their day-to-day challenges; and integration into community life as much as possible. The pre-cursors to such longer-term outcomes are explored in the following sections and the Theory of Change in **Figure 1**.

Stakeholder outcomes

RBKC service users

"For me the service was a lifeline…I was sofa surfing, and **risked being homeless**, and my support worker here literally **saved my life**, put me on the right priority list, I didn't even know this was an option. **I'm pregnant so thank God I can come here and receive this support**" ***Midaye client***

"Without this service, I would be very **sad, and confused and depressed, I would be lonely and have to deal with my problems by myself.** I can speak to [my support worker] in my language, and now can go to classes and access other [activities]. It gave me help with translating [and understanding] letters [from housing provider and schools]. **My son has ADHD** and it all was getting too stressful, but now I got guidance and **can talk to each other better**" ***Al Hasaniyah client***

Service users tend to experience a range of impacts, including short-term intermediate outcomes as stepping stones to longer term benefits. Generally, **intermediate outcomes** occur during the sessions and the accompanying activities or actions that they are undertaking. These are building blocks for achieving longer-term change.

For many, intermediate outcomes are reflected by an improvement to their practical understanding of English language and the British system, especially in local service provision and the processes of interacting with statutory authorities (sometimes this can be as simple as understanding the administrative and legal value of official letters and paperwork). Their bilingual skills improve for all of their other interactions and the practical day-to-day.

Depending on the type of need, intermediate steps can include improvements to social interaction skills; uptake of physical activity and changes to lifestyle; improvements to skills in parenting and family management; and gaining an initial understanding of how to better manage their specific health condition or situation.

In the longer-term, when service users continue their actions or behaviours beyond their initial sessions, more significant outcomes are achieved. These **long-term outcomes** can include improved integration and cohesion between their diverse communities and British culture, reduced levels of loneliness, isolation, anxiety, stress, and improvements to physical and mental health and wellbeing. Often these are accompanied by improved social and family relationships, increased resilience and self-worth, and better self-care practices about their own health and wellbeing, resulting from the knowledge and experiences gained during the support they have received.

It is of significance that **service users report reducing their need for GP appointments, from six visits per year, to four visits per year on average.**

"What we gain from bilingual support is **feeling healthier, and more mobile, so having a better lifestyle can reduce our impact on local health services**, it helped us to gain information we can understand about emotional and physical health, how to manage it and get support – like **screenings for diabetes, breast cancer, prostrate cancer, blood tests – it made us more aware, have more courage**, and be more open to discuss, to ask what options there are and go for it – so it's **really empowering**" ***FAWA workshop***

There is a clear sense of improved empowerment for many service users, through the support and knowledge gained. This is reflected in their improved resilience and improved confidence to replicate the 'navigation and negotiation' processes of dealing with statutory services and local community organisations. And overall, as service users have become more empowered, they often gain an improved sense of being treated equally and fairly as other people in the local system. This can help reduce a sense of inequality in terms of access to health and wellbeing support, and develops a greater sense of inclusion and community integration.

"This service makes a huge difference, being referred to English language for health, exercise class, learning and knowledge increases – life starts to change, we saw an **emotional improvement**, support to get the right housing benefit, correct pension credit…the worker is always kind and helping…now I feel like being young again! Before, felt isolated, alone, low confidence….even grieving when I lost my son, I needed this service to understand funeral arrangements, how to make complaint to hospital…also it helped me understand **information on NHS Choices website, and how to make appointments for my health issues or get letter for dentist**….and now we have **less arguments and stress at home because we know how to do things to access health support…We get better sleep, and better self-care skills…this service helped us to feel valued, respected, listened to - because I felt with my language to be accepted and have my identity back, belong to both cultures**"

Iranian Association workshop

Impact on statutory services

Local services that work in partnership with MEWS include RBKC (who fund the service), West London Clinical Commissioning Group, and Central and North West London NHS Foundation Trust, in particular for Improving Access to Psychological Therapies (IAPT). The key rationale for working with bilingual emotional wellbeing support provision can be summarised in three motivating factors:

- Health care and social care services want to draw on bilingual VCS providers as existing community assets, to **improve reach to BAME residents** who would otherwise not be able, knowledgeable, or confident enough to access statutory care services they actually require (or may need translation support for); So on balance, there would be some increase in *appropriate* access.

- The service contributes in a small way to a **preventive approach to stop escalation** of problematic conditions or wellbeing deterioration, so that there is reduced **inappropriate or avoidable usage of health services** e.g. GPs, secondary care - however, the preventive outcomes may yet take several years to evidence without long-term tracking of service users' specific conditions.
- The outcomes reflect improvements in the service user's **self-care skills,** and improvements to their ability to access **healthier lifestyle opportunities** related to this.

Partly, these motivating factors are borne out by service users reporting they have reduced their need for **GP appointments, from an average of six per year, reducing to four** (as described previously).

Added benefits for statutory services include outcomes from engaging with bilingual session workers who help improve responsiveness and cultural sensitivity amongst health and care professionals. For example, GP staff have been taken on visits with interpreters to engage with BAME service user groups. GPs and GP receptionists can have as much of an impact on service user experience, by having a major role to play in improving access and managing training for staff, especially on issues such as cultural sensitivity, interpretation support, and managing perceptions of some BAME groups that they are being discriminated or blocked by staff or GPs.

"In terms of impact on clients, they start off feeling lost and alone, then the [bilingual support service] **helps make a difference emotionally, and gets them in the right frame of mind to engage with services**, whether that is accessing benefit payments, better peace of mind, reducing depression or dependence on medication; and often they **re-use this knowledge** in other contexts, and maintain relationship with the worker".

(IAPT, CNWL)

"Top strengths (of MEWS) – is **the range of cultures and languages of BAME groups that are reached, but we find difficult to engage with**, difficult to build trust and give them a secure environment…it helps us increase reach to residents that we otherwise wouldn't, and so commissioning decisions are informed by the outcomes and results from that. The [MEWS] service enables us to get key messages out in that way – especially for specific [health] campaigns, **this maximises [our] effectiveness**"

(West London CCG)

According to health services, based on the cases presented in the model, quite a number of service users would have lost their home, or were at risk of eviction, or of having to go to court and suffer visits from bailiffs, but were instead enabled by their support workers to negotiate and resolve their problems with the respective stakeholders.

Additionally, some complex cases may slip through the gaps between health and social care, as borne out in the case of an Arabic lady struggling with housing support, and emotional depression and anxiety. Some of her needs came in under social care and some needs under health care, but she was struggling to get support approved from either. As her situation deteriorated and risk level escalated, a session worker helped to advocate and liaise for her to eventually access the respective sources of health and social care. Many cases like this have been reported, showing a lack of integration and communication between health and social care that is further exacerbated without bilingual support – for both the service users and the professionals.

Other forms of multilingual support are perceived by health services to be only available in pockets, at very small scale, and often without bilingual support. This is a continuing challenge in the provision of

health information and health knowledge, which should be universal. In addition, the target groups are often unaware of how and where to access courses that support English language skills for health.

Within the MEWS service, we observe that it has become the role of the MEWS workers to 'hold the space' for all sides involved, as someone who is broadly autonomous yet neutral, with good relationship management skills to create bilingual dialogue, whilst maintaining respect to the client's needs and confidences.

Outcomes for VCS providers

The providers involved in MEWS already have a track record of provision for their target service users. They are organisations who draw on various areas of funding and cross-sector working in order to provide a person-centric, holistic, and joined-up approach as much as possible. They are already embedded in the local VCS-statutory ecosystem, and their workers have deep knowledge of other available specialist services and community-based support – often more so than statutory providers.

However, we observe that the MEWS model, training and supervision, has in its manifestation, created additional capacity for the BAME VCS sector to provide better forms of emotional support, and take more ownership over best practice.

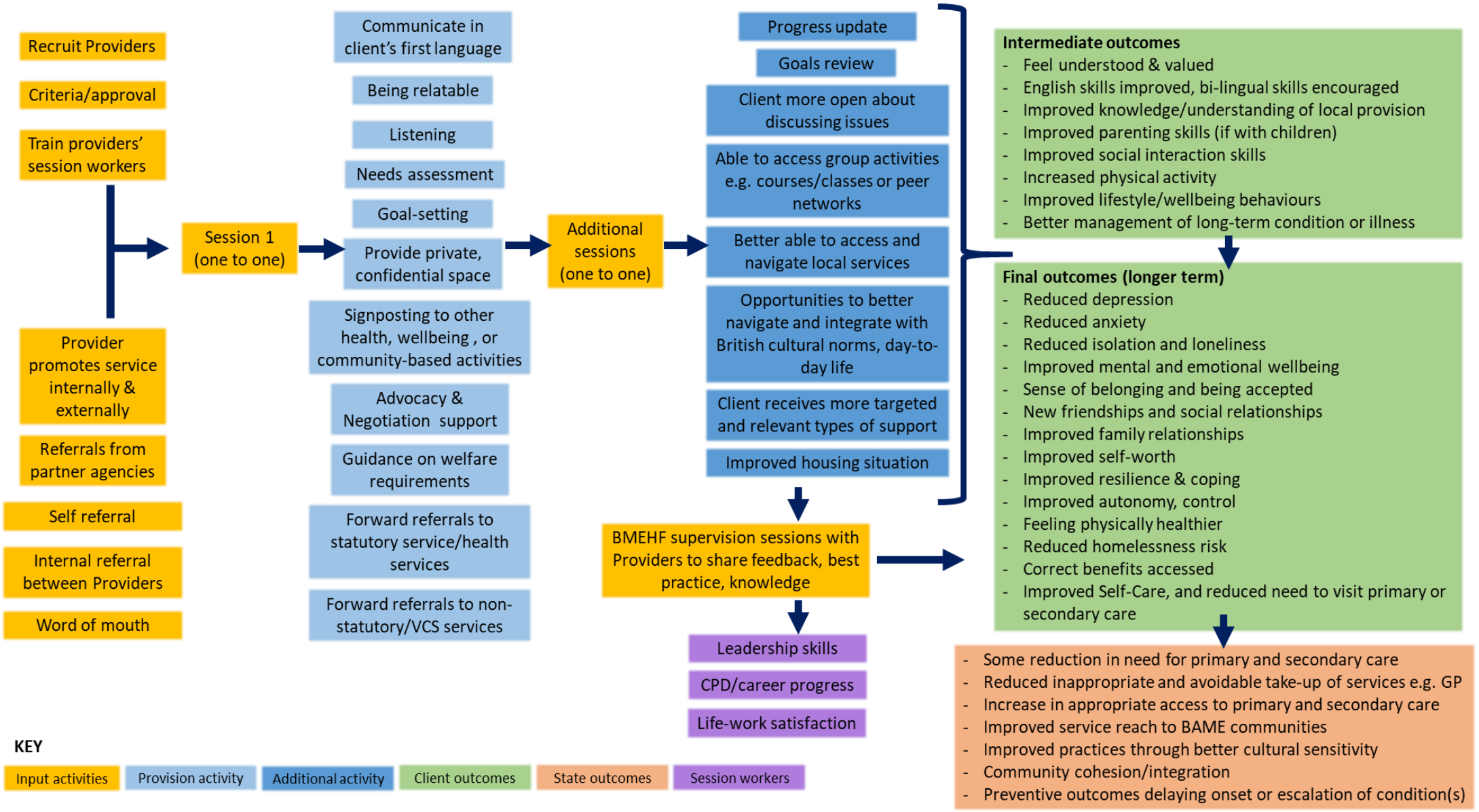
As part of the MEWS model, the selected VCS providers experience organisational outcomes in addition, in particular:

- **Knowledge-sharing** and improvements to their support worker practices, particularly through **supervision sessions that are co-facilitated by an IAPT worker**;
- Improving their ability to help service users overcome systemic barriers to accessing community-based mental health support;
- **Training** and professional development of support workers, often enhancing leadership skills and progression to longer-term careers;
- Cross-referrals in a small number of cases;
- **Closer relationships** to their service users, communities, and other BAME organisations;
- Positive growth in how the VCS providers view mental health at an individual level, in society, and at a systemic level when working with statutory partners.

Training provided by BMEHF focuses on small groups of support workers/volunteers, involving skills development in goal setting, problem solving, supporting of different cultures, and setting important boundaries to help others. In general it is well received by all participants, with goal setting and problem solving with people with different values as being especially helpful.

Areas for improvement included minor issues such as one trainee could have been more sensitive to some of the other trainees having some degree of existing knowledge; and the efficacy of role play and feedback tasks between facilitators and trainees.

Figure 1. Theory of Change for BMHEHF Multilingual Emotional Wellbeing Support

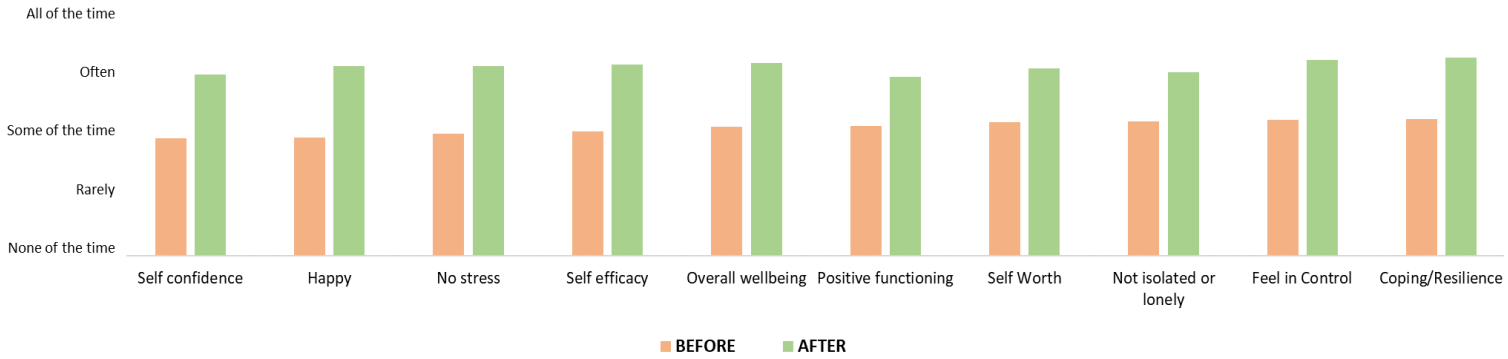


4. Findings: SROI estimate

Measuring health and wellbeing outcomes

For measuring subjective wellbeing for **RBKC service users**, we have analysed the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) scores recorded by service users. These have been collected at two points; pre-service provision, and then again at the end of the service provision. Therefore we are able to compare to pre vs post change at an aggregate level, presented in **Chart 2**. For the outcome regarding reductions in depression, we have used the change reported by service users for the WEMWBS indicator for self-efficacy ('Feeling good about myself') as a proxy measure.

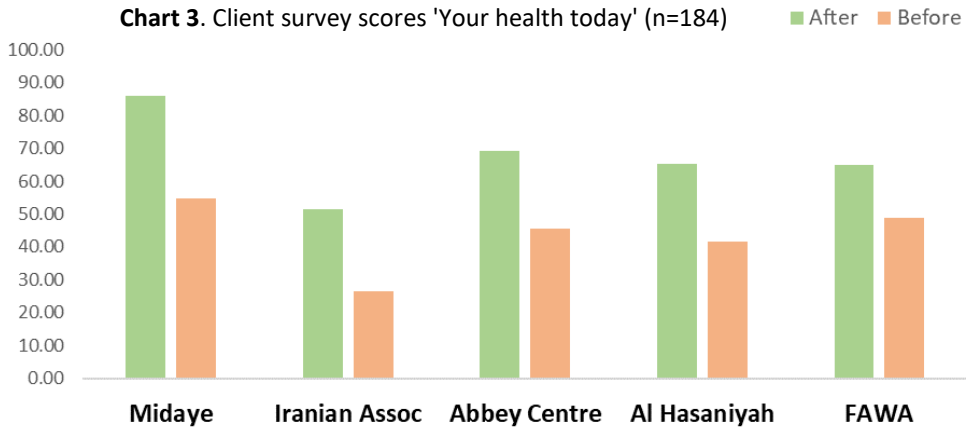
Chart 2. Multilingual Emotional Wellbeing Service, change in client wellbeing scores 2017-18 (n=184)[17]



For the outcome regarding improved physical health, we have drawn on the change reported by service users regarding their health status. **100% of service users reported an improvement in health status**, from **an average starting point of 44 from 100, improving significantly to a score of 70 post-service**. The starting points and magnitude of change differs for each provider, as illustrated in Chart 3, however there are significant improvements for each of their service user groups. We have not been able to analyse the drivers and factors as to these differences, and suggest that this may require further research and analysis.

However, it does also suggest that it is highly important to have services which have deep capabilities to tailor their approach to cultural and language needs of respective BAME clients.

Chart 3. Client survey scores 'Your health today' (n=184)



In addition to reflect our observations from interviews and workshops with service users, providers, and health service partners, we have conservatively assumed:

- Approximately 15% of service users experienced the wellbeing benefit of sustaining or gaining their housing i.e. were at risk of homelessness, arrears, eviction, or losing housing support

[17] Based on Warwick-Edinburgh Mental Wellbeing Scale indicators

- Approximately one in four service users required support to access correct benefits e.g. Personal Independence Payment (previously Disability Support Allowance), or Employment Support Allowance.
- Approximately one in twenty service users go on to take up a volunteering opportunity.

For measuring material outcomes to **health services**, we have drawn on the change reported by service users regarding frequency of visits to their GP to measure direct reduction in GP appointments for a non-medical need. According to service user survey responses **GP visits reduced from around six per year to four per year as a result of accessing the MEWS service.**

In addition, we have drawn on survey data regarding reduced likelihood of future use of GP and health services as a proxy measure for reduced inappropriate or avoidable take up of primary and secondary care for those whose health status scores have improved.

For measuring outcomes for the five **RBKC provider organisations**, we have taken a conservative estimate of c.7.5 session workers benefiting from improved leadership and employability skills, and c.5 of these gaining job-progression and a resulting wage improvement. We have not been able to produce an estimate for the Provider organisations' improved organisational development and reputation within their communities, although these are important material outcomes in addition to our SROI estimate.

Valuing outcomes

To value the range of stakeholder outcomes, we drew on verified proxy values and unit cost values, pro-rated to the amount of change experienced by the respective stakeholder. Changes in outcomes are illustrated in the previous section. **A full list of financial values are listed in the Appendix**.

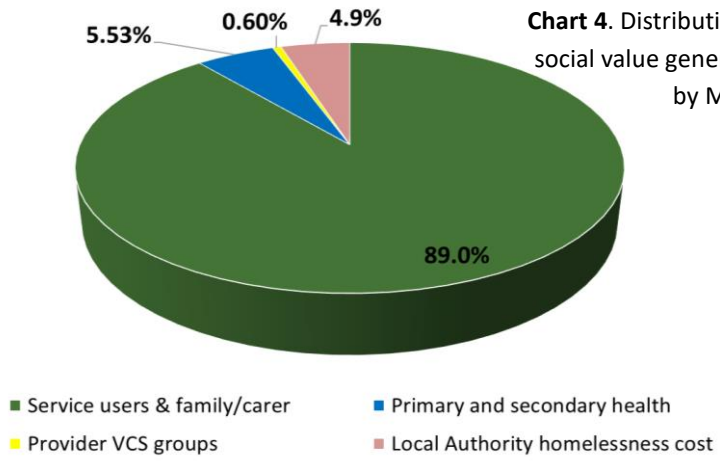


Chart 4. Distribution of social value generated by MEWS

The distribution of total value is generated almost in entirety (c.90%, see **Chart 4** and **Table 2**) for the c.185-195 annual service users reached per year, reflecting the key purpose of the service. Much smaller proportions of value are generated for statutory services. We estimate **c.£702,000** of health and wellbeing value is generated in RBKC by the model overall, including partners and other contributing factors and support services that clients are linked-up to. After these adjustments, the **attributable value to MEWS alone is estimated to be c.£175,000 in 2018.** This represents an attributable Social Return on Investment (SROI) of **c.£3.20 social and economic value per £1 invested.** Based on c.570 RBKC service users **over the past three years, we estimate the total attributable social value created to be c.£550,000 creating c. £3 of social and economic value per £1 invested**.

(If factoring in separate *non-RBKC* funded ***Westminster and LBHF service users*** who use a similar strand of MEWS, the SROI could range between £4 to £5 per £1 invested in total, across all three boroughs; 170 clients in total, see Appendix).

Table 2. Monetised valuation of material stakeholder outcomes (Annualised, values may change due to rounding)

Stakeholder group	Outcome	Present value of outcomes across whole project (incl. partners, other contributing factors)	Present value of outcomes attributable to MEWS service only
Service users	Improved self-worth	£12,400	£4,100
	Improved positive functioning	£8,500	£2,800
	Reduced loneliness	£38,000	£12,500
	Feeling more in control of problems	£9,800	£3,200
	Reduced stress and anxiety	£12,800	£4,200
	Improved self-confidence	£11,800	£3,900
	Improved resilience/coping	£16,800	£5,500
	Reduced depression	£30,800	£10,200
	Improved physical health status	£265,500	£87,600
	Wellbeing benefit of sustained housing	£137,000	£29,00
	Accessing correct benefit payment	£80,200	£20,100
	Take up volunteering	£3,800	£1,000
Health services	Direct reduction x2 GP appointments for non-medical need (@£17 per appointment*)	£3,500	£900
	Future reduction: x1 inappropriate, avoidable GP visit (@£17 per appointment* plus anti-depressant medication x2 months)	£2,500	£600
	Future reduction: inappropriate, avoidable visits to community-based secondary care (@£824 per community-based mental health support**)	£29,000	£7,300
Family member/Carer	Wellbeing - Peace of mind	£5,300	£1,800
Provider organisations	Improved leadership skills (support worker)	£2,100	£500
	Improved employability (support worker)	£1,000	£250
	Job progression (support worker)	£1,200	£300
Local Authority	Additional cost of homelessness support	£30,300	£8,500
TOTALS		**c.£702,300**	**c.£175,250**

* Based on WLCCG My Care, My Way business case data (2016) on c.£60 hourly cost of GP appointments, and c.3.5 appointments per hour.

** Calculated from Personal and Social Services Research Unit cost database, 2015, based on mental health care cluster contacts, community care contacts, and one outpatient incidence; Over a six-month treatment period.

Valuation of subjective health and wellbeing outcomes

Subjective wellbeing outcomes are valued using research from the Centre for Mental Health[18] suggesting that 0.352 proportion of a full Quality Adjusted Life Year comprises of mental and emotional health (therefore the remaining part suggests being comprised of physical health). The breakdown of sub-components of wellbeing (e.g. self-worth, resilience, depression, control, positive functioning) combines research and guidance from the New Economics Foundation[19] (which aligns with the ONS wellbeing measures, and previously the Government Office for Science's Mental Capital and Wellbeing research, 2008); as well as New Economy Manchester[20] for local community budgets. We have used a lower QALY threshold of £20,000 (as an alternative to £30,000 for some interventions) to reflect the less

[18] MVH Group (1995), *The Measurement and Valuation of Health: Final Report on the Modelling of Valuation Tariffs,* Centre for Health Economics, University of York

[19] nef (2008) *National Accounts of Wellbeing*, London

[20] New Economy Manchester (2012) *Social Value: Understanding the wider value of public policy interventions,* Manchester

physically terminal and critically life-limiting nature of the service, as well as to align with observations by the British Medical Association[21]. Key aspects of this approach have been used for recent SROI evaluations this past year (2018) for Westminster City Council (Community Champions) and West London Clinical Commissioning Group (My Care, My Way, Self-Care social prescribing services).

Benefit period

We have taken a one-year benefit period for service users and the directly related secondary care outcomes i.e. reduced avoidable need for future mental health support (excluding a proportion referred to services such as IAPT), based on responses from interviews and workshops responses. The benefit period for primary care health services and providers was deemed to be one year also. The benefit of reduced homelessness and sustained housing is assumed to be two years minimum. However, it would be reasonable to also use a two-year benefit period for some of the health and wellbeing outcomes related to prevention of avoidable admission to secondary care, as the learning is usually sustained beyond a year for many service users i.e. outcomes for feeling in control, resilience, isolation and positive functioning that can result from taking the knowledge and drawing on it when navigating other services. **In this case, the SROI could potentially be in the region of £4 to £4.50.**

Impact considerations: attribution, deadweight, displacement, benefit drop-off

From qualitative research, we estimate approximately two-thirds of the RBKC service users' and directly related secondary care outcomes can be **attributed** solely to the MEWS service providers and BMEHF, and 50% of health service outcomes, benefits and housing, and provider outcomes can be attributed, given other partner groups and complementary activities or support services involved in the model. To account for **deadweight**, we have assumed a 25% probability, given that some service users may have benefitted similarly through other channels in a borough where community provision is relatively decent compared to others. We have also used a 33%-50% range in **drop-off** of outcome and attribution 'strength', for any relevant outcomes. We have used 11% **displacement rate** for health service outcomes, as suggested by the Additionality Guidance document (2014) of Homes & Communities Agency.

Other considerations

Our model assumes that any new housing benefits secured for the relevant service users are paid straight to registered social landlords, so are not valued as extra income – although we have valued the wellbeing outcome of sustaining a home or avoiding homelessness/eviction. The risk of homelessness and eviction appeared to be relatively high amongst the service users we interviewed; lack of bi-lingual support and poor knowledge of how to access and navigate housing services was felt by the relevant service users to be a key driver to levels of poor emotional and mental health.

We would suggest further research would be needed to estimate the potential value to statutory health services and policymakers of improved service reach to BAME groups and reducing health inequalities; and additional research to estimate the value of any improved organisational development or working practices amongst the participating VCS groups.

[21] British Medical Association (2017*) Exploring the cost effectiveness of early intervention and prevention*, London

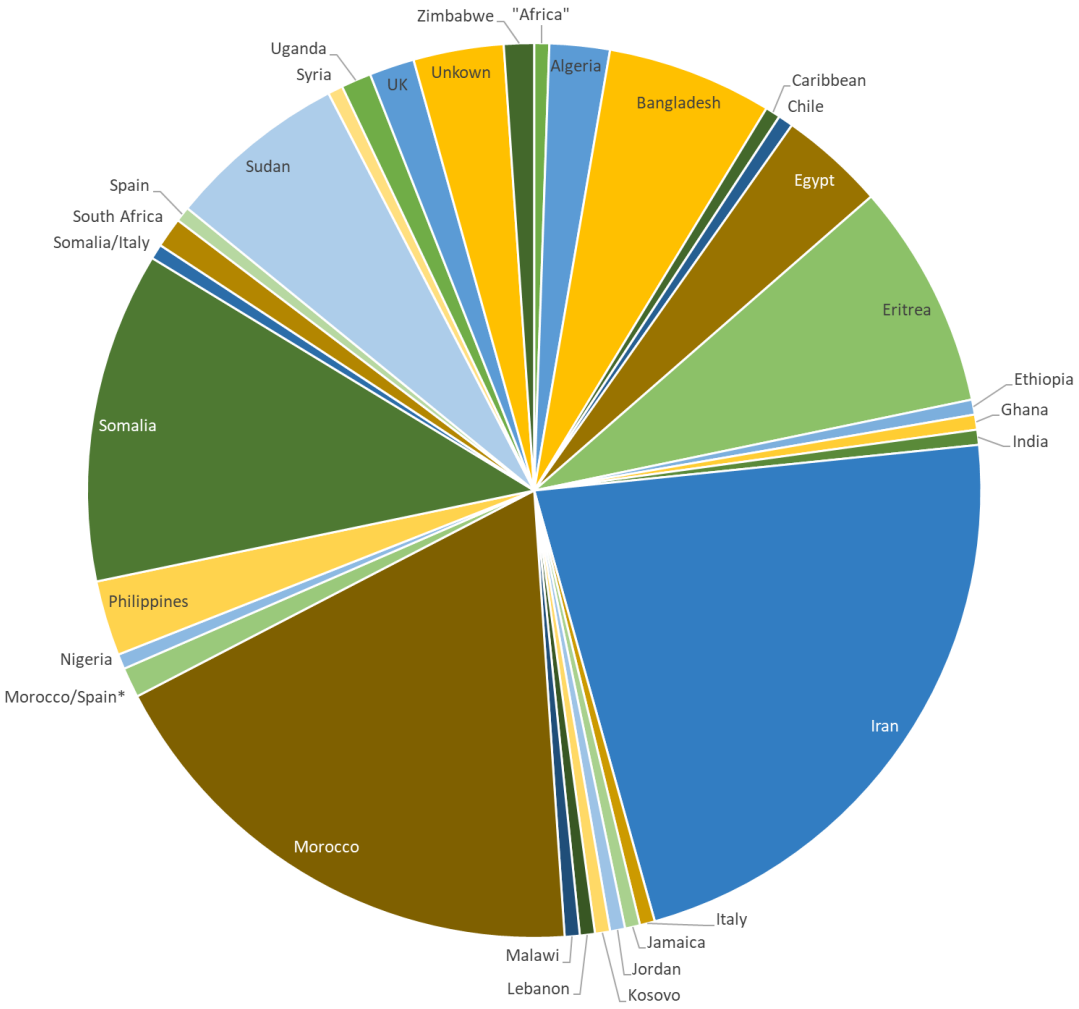
5. Efficacy of the model

This section describes the general characteristics of service users reached, and the objectives and efficacy of the MEWS service model overall, including challenges and opportunities.

Service user characteristics

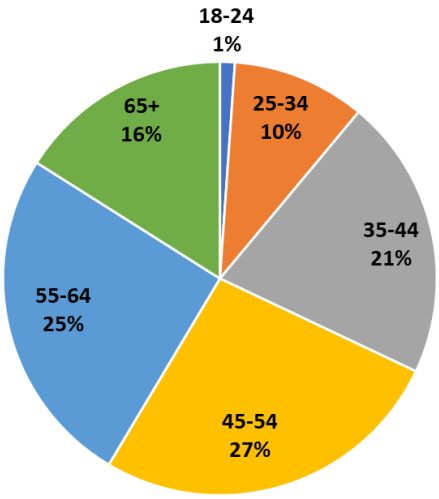
In terms of ethnic groups, using survey data, we have presented the approximate representation of RBKC clients by ethnic origin in **Chart 5**. At least 30 countries are represented amongst the latest year's service users, from across Africa, the Middle East, Europe, the Caribbean and South America. The most represented groups comprising 78.5% of all clients are from Iran, Morocco (including mixed Moroccan-Spanish*), Somalia, Eritrea, Bangladesh, Sudan, and Egypt; countries which are also characterised mainly by clients of Muslim faith. South East Asian groups appear under-represented in RBKC e.g. Vietnam, Chinese, however, these groups may have their own language-specific networks and community groups. We note there was more provision for BMEHF multilingual support for Chinese speaking groups in *Westminster* (through other prior funding), and perhaps expanding the approach taken there to raise awareness in RBKC would improve uptake.

Chart 5. MEWS service users by ethnic origin (n=184)



In terms of female-male proportions, service users are characterised as being predominantly **female (83%)**. We suggest there is scope to expand and tailor services to reach more men, who as a group have historically been harder for health services to reach and engage with.

Chart 6. MEWS service users by age range (n=184)



In terms of age representation, **over half of service users fall into the age groups 45-54 and 55-64**. **Over two-thirds are aged 45 or older**. The youngest service user was aged 20, and the eldest was aged 77.

Service objectives and delivery model

The objectives of the service include:

- Training bilingual volunteers to provide emotional support to clients, make appropriate referrals, and write case notes.
- Providing emotional support for clients who are going through a difficult time in their lives because of a change in circumstances e.g. separation or family breakdown, bereavement, illness or disability, becoming a parent or carer, loss of employment, moving home.
- Making appropriate referrals for befriending and mentoring schemes to clients that require such a service and to offer a befriender to clients who are not suitable for any of the available befriending schemes.
- Making appropriate referrals to other services including mental health services e.g. NHS Improving Access to Psychological Therapies (IAPT) to clients that need them.
- Supporting BAME organisations in their work with vulnerable clients and enable them to demonstrate the mental wellbeing work they do.

Delivery Model

The model of provision can be summarised as follows:

- The BME Health Forum has recruited five organisations that work with BAME clients in, Kensington & Chelsea to deliver the project. The project supports a minimum of 180 clients and each client will receive on average four one-to-one sessions.
- Staff and volunteers have been trained to conduct needs assessments, provide emotional support, referrals and advocacy.
- One-to-one sessions are provided in a safe space for clients to communicate, using a person-centred, non-judgemental approach, and can be goal orientated, depending on the needs of the client.
- Group Support Supervision Sessions for all project staff and volunteers take place monthly, with 2 hours per session.

Strengths of the model

The MEWS service model overall works well for its service users. There is evidence that at an aggregate level it contributes directly to helping improve people's state of emotional and mental wellbeing and can reduce their level of isolation. Support workers manage their caseloads relatively well and with resource constraints in mind, as in reality, funding and resources are limited given the high level and broad scope of diverse needs. One key observation is that the project is not necessarily provided in exactly the same way by each provider, and that it is a strength (and potentially a challenge) that each provider can tailor their approach appropriately to their target groups.

The model works not only because of the **crucial element of bilingual support for BAME residents who do not speak or understand English sufficiently,** and knowledge that is offered, but also because the

provider organisations involved have deeper connections, trust, and roots with their target communities through shared language and culture. **Statutory health and care services may not be able to provide this highly needed role and relationship**, but do generally recognise the value in working in tandem with the MEWS model as part of a joined-up, systems-wide approach to provision. The two sectors aim to complement each other.

The role of an organisation such as BMEHF in managing and co-ordinating the model, as well as in-depth training of workers, is also of importance. They are a respected infrastructure BAME-focused VCS organisation, and their role as the managing contractor enables some accountability to RBKC and to the VCS organisations, and to some extent clinical commissioning partners. Both statutory and VCS sectors are able to negotiate their needs and objectives through BMEHF as the responsible conduit, with some degree of flex. In addition, BMEHF has also provided very good practice in ensuring provision of specialist training to the Provider organisations' support workers (feedback overall has been good); as well as in bringing all organisations together in a regular framework, for supervision sessions and knowledge-sharing. For example, there is strong partnership working with Central and North West London NHS IAPT (Improving Access to Psychological Therapies), which means that workers and volunteers get supervision from an IAPT counsellor.

Demand and Capacity

In terms of demand and capacity, there is some flex for support workers to decide where more or less sessions may be needed, as is proportionate for the complexity and severity of their client's case. This means they do not have to be constrained by having to provide an obligatory number of sessions that run for a required fixed time period. Demand has been better-managed where:

i) the Providers and referring organisations have communicative, working relationships and informal feedback loops between each other, and;
ii) the Provider organisations can offer additional sign-posting, other sources of support and counselling, or appropriate complementary activities, outside of the MEWS service

Challenges for the model

In terms of challenges, the bilingual nature of provision means the service is reliant on the existence of language-specific organisation in the local area. In one case, a French-African oriented Provider has also expanded their MEWS offer to wider non-French speaking African/African-Caribbean, and Spanish-speaking service users, as in the latter, one of their key colleagues is a Spanish-speaker. However, if this is not embedded more fully into the remit and capabilities of the organisation, the Spanish-speaking element would arguably not be sustainable for the neighbourhood's Spanish and Latin-American communities.

We also observe that there will be a time lag between raising awareness of the service and breaking down stigma or taboo issues for some ethnic groups e.g. mental health not being talked about openly. This can slow down progress at an individual level if it is hard for them to be more open and feel at liberty to discuss their situation with others, or motivate themselves to attend appointments, or make

new friends and relationships, given their feelings about their issues. This may also be a reason why some cross-cultural integration can be slower amongst some groups than others i.e. not all groups mix with other cultures at the same pace or as openly to the same degree – although we appreciate there may be deeper underlying issues around this which requires further research.

Linked to this is the way in which men can also be harder to engage with. Women (83%) are more represented than men in the service user population – and in the case of Midaye, Al Hasaniyah and the Abbey Centre this is because they have chosen to provide a service specialising for vulnerable women - however in our interviews and engagement, men were quite well represented in the other Provider organisations (FAWA and Iranian Association), indicating there is opportunity to reach more BAME men through the model.

Furthermore, Social Housing providers are perceived to be working in silos, rather than joining up with Health, Care and VCS partnerships; there may potentially be some duplicating of provision in some areas, and conflict of interest in others.

Universal Credit is also an upcoming challenge for a number of clients, in terms of English language barriers, poor online capability (some clients will not even have internet connectivity), and the potential of the UC system to create unstable sources of support from one quarter to the next.[22]

RBKC providers in the MEWS model are described below:

Abbey Community Association Ltd (ACAL) at The Abbey Centre

ACAL's mission is to bring together local people and organisations to address community needs in south Westminster. The Abbey Community Association is a charity established in 1948, which supports the communities of south Westminster to improve their quality of life. Their focus is on households with priority needs living in the wards of Churchill, Tachbrook, Vincent Square, Warwick and St James. The south of Westminster is characterised by households living in concentrated areas of acute deprivation in close proximity to some of the wealthiest households in the UK. This diversity presents unique challenges for local communities, expressed in perceptions of low community cohesion and access to affordable food, services and housing. ACAL work in partnership with organisations that share their passion for social justice, and to promote improved health and wellbeing for local vulnerable residents and families; and to increase inter-community and generational understanding and connections.

Al-Hasaniya

Al-Hasaniya serves the needs of Moroccan and Arabic-speaking women and their families in London – primarily Kensington and Chelsea residents, but with some pan-London projects – providing support for health, welfare, education and cultural activities. With over 30 years of experience, Al-Hasaniya Moroccan Women's Centre seeks to encourage and help clients to access mainstream services and promote positive citizenship and greater understanding among communities. The organisation also tries to support access to other service that can assist.

[22] As illustrated in a range of BBC reports: https://www.bbc.co.uk/news/uk-46355306 and https://www.bbc.co.uk/news/uk-england-merseyside-46235842

French African Welfare Association

The French African Welfare Association (FAWA) was set up to relieve poverty and ill health, and to promote the social status of people of African origin, in particular migrants, refugees and asylum seekers from French speaking African countries. In the context of West London and the bilingual emotional wellbeing support service, FAWA expanded their remit support non-French African residents, particularly including Spanish-speaking and Latin American communities. In order to achieve the above aims and objectives, FAWA delivers the following services for and on behalf of its service-users: The provision of information, advice and advocacy, translation and interpreting services, drop-in service, outreach in the community, running peer support services for people living or affected by HIV, referrals services, counselling and emotional support, organising works to bring people together, and networking with other partners that provide services to clients.

Iranian Association

The Iranian Association (IA) was established as a registered charity in 1985 and was initially known as West London Iranian Association. The IA has been a resilient organisation and has always embraced organisational development; for example, the service delivery was transformed to benefit all the ethnic groups a decade ago. The association has been a pioneer in innovative service delivery that has included providing online and Learndirect courses in the early years of the 21st century, delivering embedded learning a long time before the implementation of the idea by the mainstream colleges, operating one of the first Life in the UK test centres and ESOL for Citizenship courses in Britain, delivering the NHS Health Trainer service for the first time in Hammersmith and Fulham, and providing a direction for the community in recording their oral history.

Midaye

Midaye is a grassroots user-led community organisation, deeply embedded in the ethnic minority communities in West London. The organisation is committed to the well-being and empowerment of its clients, and making a tangible difference in the lives of individuals, families and communities. Midaye works to build bridges that strengthen the integration to the wider society. Midaye empowers communities to find their voice; to access services and resources which they have a right to; obtaining culturally-intelligent solutions to their specific challenges; and to contribute positively to wider London society. Midaye stands for ‘Unity‘.

Conclusions

Drawing on a socio-economic return on investment approach, the Multi-lingual Emotional Wellbeing Support (MEWS) service is estimated to generate at least **£175,000** socio-economic impact, approximately **£3.20 of attributable social value for every £1 invested**. Around 90% of this value is generated for service users in terms of key components of their health and wellbeing. Based on c.570 service users who have accessed this service **over the past three years, we estimate the total attributable social value created to be c.£550,000-£600,000**, achieving just over c.£3 social value per £1 invested.

The MEWS service aligns well with achieving NHS England's new Long Term Plan (2019) to develop new services for people who have the most complex needs, and work with more VCS providers and reduce the need for acute care, whilst '**proactive(ly) work(ing) to address racial disparities'**. There is a higher level of need and complexity for those who reside in England but do not yet fully speak or understand English health information and advice; thus, the MEWS service contributes to truly making this support **universal for all**.

The **bilingual provision of support** is an important differentiator from conventional health provision and welfare advice, that many service users have credited as being of great value compared to other non-bilingual services. There is an additionally higher level of need and complexity for those who reside in England but do not yet fully speak or understand English health information and advice; yet these are supposed to be **universal for all**.

Health care and social care services have drawn on the bilingual VCS providers as existing community assets, to **improve reach to BAME residents** who would otherwise not be able, knowledgeable, or confident enough to access statutory care services they actually require (or may need translation support for); on balance there would be some increase in appropriate access. The MEWS service also contributes in a small way to a **preventive approach to stop escalation** of problematic conditions or wellbeing deterioration, so that there is reduced **inappropriate or avoidable usage of secondary care**. However, the preventive outcomes may yet take several years to evidence without long-term tracking of service users' specific conditions. The outcomes identified in our research reflect improvements in the service user's **self-care skills,** and improvements to their ability to access **healthier lifestyle opportunities** related to this.

The target service groups also have a significant proportion who were at risk of eviction or homelessness (there was at least one case of a pregnant lady at risk of homelessness as she did not know how to access the right support), in large part due to not fully understanding or having appropriate access to information about changes and reforms to the welfare system; combined with poor knowledge of the main processes of dealing with and navigating statutory and welfare services.

The MEWS service model has also benefited VCS groups in improving their organisational development and reputation; their capacity to provide effective mental health crisis support; and job progression and leadership skills for volunteers and key workers. In some cases, there has been a knock-on benefit from

the relationships they have built where the service user also takes up volunteering in their community, as part of their re-integration into the area.

There are some key limitations of the model, namely that reaching the right 'mix' of groups is reliant on people in a local area having the right bilingual or multilingual skills to volunteer or work with those target BAME clients in the shared language (so not all groups are necessarily reached, although this is inherent in the system overall). Furthermore, cross-cultural integration can be challenging if some cases are characterised by stigma, taboo, or are highly complex.

Additionally, for the time being in our analysis, a greater proportion of value is likely created for secondary care resources, versus primary care. However, further research into any related long-term conditions amongst service users would likely affect some of our findings in this regard e.g. diabetes, Parkinson's, dementia.

We suggest that other key opportunities for improving the model to further expand reach and achieve broader impacts, could include:

- Working more jointly and closely with Community Champions in the borough who focus on promoting Public Health to residents through their local community hubs;
- Refine and enable improved monitoring of statutory service use by clients e.g. change in usage of GP, A&E, mental health services; this should be jointly worked on by BMEHF and WLCCG;
- Improve opportunities for client feedback and wellbeing outcomes to be recorded on their personal care plans;
- Work with local businesses' HR and diversity managers to i) raise awareness and revenue for bilingual emotional wellbeing support for their staff, and ii) fund-raise for the MEWS services;
- Given that sustaining their housing and Universal Credit are key to many clients' underlying stability, it is likely that there will be an increase in demand for MEWS service to be well-versed in helping clients deal with these issues;
- Approaching one housing provider to work closer in partnership for cross-referrals and resource-sharing, as an exemplar for the catchment area's BAME residents and improve their bilingual abilities;
- Further 'language skills gap analysis' with key partners in the local area where certain groups are not provided for, but volunteers speaking those languages could be recruited or employed in the short-term/part-time to raise awareness in those communities e.g. Chinese, Vietnamese, South East Asian.

Appendix: 1. List of financial proxy values

Proxy values used within the SROI model are pro-rated to the amount of change in an outcome indicator i.e. the amount of change experienced is converted to a 0-100% scale, and applied to the related relevant value.

Stakeholder group	Outcome	Financial proxy value linked to outcome	Source
Service users	Improved self-worth	£352	See Section 4: Sub-proportions of Mental Wellbeing QALY; Mental wellbeing comprising 0.352 of a Full QALY (Centre for Mental Health, *The economic and social costs of mental illness*, 2003); combined with guidance from nef (National Accounts of Wellbeing, 2008) and New Economy Manchester, *Social Value: Understanding the wider value of public policy interventions* (2012)
	Improved positive functioning	£264	
	Reduced loneliness	£1,173	
	Feeling more in control of problems	£264	
	Reduced stress and anxiety	£352	
	Improved self-confidence	£352	
	Improved resilience/coping	£584	
	Reduced depression	£1,056	
	Improved physical health status	£12,960	See Section 4: 0.648 proportion of NICE £20,000 QALY (BMA 2017 guidance in addition)
	Wellbeing benefit of sustained housing (15% proportion of service users)	£7,388	HACT social value toolkit, 2014-2016
	Accessing correct benefit payment (25% proportion of service users)	£4,602	Weighted average of Disability Living Allowance (aka Personal Independence Payments) and Employment Support Payments for 'Support Group' tier (https://www.gov.uk/employment-support-allowance/what-youll-get)
	Take up volunteering (5% proportion of service users)	£1,180	HACT social value toolkit, 2014-2016
Health services	Direct reduction x2 GP appointments for non-medical need (@£17 per appointment)	£34.51	WLCCG average annual cost, including London weighting, NI and pension: 2017/2018
	Future reduction: x1 inappropriate, avoidable GP visit (@£17 per appointment* plus anti-depressant medication x2 months)	£52.96	WLCCG average annual cost, including London weighting, NI and pension: 2017/2018
	Future reduction: inappropriate, avoidable visits to community-based secondary care (@£824 per community-based mental health support)	£824	Personal & Social Services Research Unit (PSSRU) 2015; pro-rated six-month cost of mental health care cluster admissions, community contacts, 1 outpatient incidence
Family member/Carer	Wellbeing - Peace of mind (reduced stress and anxiety as proxy indicator)	£352	As above for service users
Provider organisations	Improved leadership skills (support worker)	£1,191	Assumed 0.125 proportion of degree holder wage differential; nef, *Degrees of Value,* (2011)
	Improved employability (support worker)	£585	http://www.sbskills.com/prices.html Accessed 20/07/2012 linked to inflation
	Job progression (support worker)	£2,381	Assumed 0.25 wage differential of degree holder as equivalent to salary gain (nef, *Degrees of Value,* (2011)
Local Authority	Additional cost of homelessness support (15% proportion of service users)	£3,360	0.4 proportion of DCLG 2012 estimate for Supporting People in Local Systems including spend data 2010/11 pro-rated to number of Household Units as at 31.03.11

Appendix: 2. Funding sources and number of service users reached across RBKC, WCC and LBHF.

Year	RBKC funding	CCGs funding	BMEHF reserves	RBKC clients reached	Westminster & LBHF clients
2018	£45,000	£13,400	£0	185	67
2017	£45,000	£9,869	£9,131	197	0
2016	£45,000	£10,500	£8,300	187	103