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Abstract

Social enterprises are being promoted as responsive and innovative way to deliver public services. As part of this promotion, these organizations are being required to demonstrate the social and economic value they generate. Social return on investment (SROI) is a performance measurement tool currently being encouraged to capture this impact. This paper draws on survey and interview data to analyse how SROI is used and understood in health and social care settings. It indicates that despite being accepted as an internationally recognized measurement tool for social enterprise, SROI is underused and undervalued due to practical and ideological barriers.

Introduction

Trends in public management draw attention to the decline and fragmentation of established bureaucracies in the face of an increasingly complex and plural system involving the public, private and third sector (e.g. Osborne, 2006). This is no more so than in health and social care where recent reform efforts have

sought to diversify provision in order to stimulate competition and choice (Allen, 2009). One notable supply side reform has been the introduction of social enterprise. In recent years, English health and social care policy has encouraged NHS professionals and community groups to set up their own social enterprises. It has done so based on the belief that such organizational forms have the potential to deliver greater responsiveness, efficiency and cost effectiveness (Department of Health, 2006, 2010).

The rise of social enterprise is based on their apparent achievement of a double or even triple 'bottom line' in combining environmental and social aims with trading viability through innovative approaches to service delivery (Dart, 2004; Fazzi, 2012; Harding, 2004; Teasdale, 2012). As with the third sector more broadly, such organizations are increasingly required to have formal standards and measures of performance in place. They are being called upon to assess the outcomes of their activity in order to demonstrate their social, economic and environmental value (Bull, 2007; Office of the Third Sector (OTS), 2009; Ryan and Lyne, 2008). This need to generate evidence on outcomes is by no means straightforward, as social enterprises may face difficulties in 'unravelling performance' (Paton, 2003:5). It is often argued that emphasis on outcomes and evidence-based performance misses out key aspects of third sector activity and functioning. Evidently, there tends to be a lack of understanding about the business models they use (Department of Trade and Industry, 2002; Haugh, 2005).

A range of performance measurement tools have been introduced and utilized by social enterprises. A technique widely advocated is Social Return on Investment (SROI), which is designed to understand, manage and report on the social, environmental and economic value created by an organization (New Economics Foundation (NEF), 2004). In the UK, policy makers have actively encouraged social enterprises to measure their social value using SROI (Nicholls, 2007). In health and social care, the Department of

Health encouraged SROI in England as a way for social enterprises to understand and share their value (Department of Health, 2010). It also established the Social Enterprise Investment Fund (SEIF) to support social enterprise entry into the NHS market and made SROI a feature of its funding to encourage social returns. The SEIF, which began in 2007, provides financial and business support to new and existing social enterprises in health and social care.

Social return on investment has emerged as a preferred technique for measuring impact and outcomes. As a result, the promotion of SROI is now extending beyond the US and UK as a global product. There have been notable recent publications of SROI in Chinese and French (SROI Network, 2011) and SROI membership organizations, such as the SROI Network, have members from across the globe. Whilst this technique is presented as a crucial development in capturing third sector outcomes, there is limited empirical evidence on its use by social enterprises. Furthermore, the relatively scarce literature that does exist suggests a number of practical and implementation issues with its use (Darby and Jenkins, 2006¹¹. Darby, L. and Jenkins, H. 2006; Peattie, K. and Morley, A. 2008.

The following paper analyses the use of performance measurement tools in social enterprise organizations delivering health and social care services. Based on its ever increasing relevance and apparent popularity as a measurement technique, the paper pays particular attention to SROI. It draws on interview and survey data collected from organizations who received funding from the Social Enterprise Investment Fund (SEIF) to understand how measurement tools are utilized and understood by organizations and those who fund social enterprises; issues that appear to have been largely neglected from research to date. In doing so, the paper provides an important contribution to debates about the benefits and potential barriers of SROI for social enterprises and the commissioners of services. It contributes and responds to calls for research which can help to

find improved ways to capture and report on the value of social enterprises (Peattie and Morley, 2008).

Social Enterprise in Health and Social Care

Social enterprise encompasses a large range of organizational types and forms. A review by Teasdale (2012) describes how the social enterprise discourse has been used to describe voluntary organizations delivering public services, democratically controlled organizations blending social and economic goals, profit-orientated businesses with a social conscience and community enterprises addressing social problems. Although this wide variety has rendered conceptualization problematic (Simmons, 2008), the defining characteristics of social enterprises rest on the primacy of social aims, the centrality of trading and the degree of democratic control and ownership (Peattie and Morley, 2008).

Since the late 1990s, the concept of social enterprise has achieved policy recognition in many countries and enthusiasm for social enterprise in England can be dated to the election of a New Labour government in 1997 (Teasdale, 2012). Over the next decade the purported benefits of social enterprise expanded dramatically and were linked to a wide range of government agendas (OTS, 2009). A variety of initiatives introduced to boost the sector included the introduction of a Social Enterprise Unit by the Department of Trade and Industry in 2002 who developed a definition of social enterprise as – ‘business[es] with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximize profit for shareholders and owners’ (DTI, 2002). The Office of the Third Sector was established in 2006 resulting in the development of a Social Enterprise Action Plan (OTS, 2006).

In health and social care, social enterprise has resonated with supply side reform of service delivery to stimulate competition and choice (Allen, 2009; Heins et al., 2010). Through its combination of social goals and business practices, it has been argued that social enterprise can encourage greater efficiency, as well as an entrepreneurial approach to promote innovation and improve quality (Department of Health, 2010; National Audit Office, 2011). In England, a variety of policy initiatives have sought to encourage NHS staff to set up social enterprises as a means of 'unleashing public sector entrepreneurship' (Department of Health, 2006: 173), including NHS employees in England being given a 'Right to Request' to set up social enterprises to deliver primary and community services (Department of Health, 2009b, 2011).

The Department of Health also established the Social Enterprise Investment Fund (SEIF), which through the provision of funding and business support, aimed to build much needed capacity and skills within the social enterprise sector, enabling organizations to adapt to new financial and political environments of public sector contracting and business development (see Alcock et al., forthcoming; Department of Health, 2009a; Millar et al., 2010). One of the SEIF goals was to encourage social enterprises to measure and communicate their social return. To achieve this, some SEIF investees (12%) were provided with additional funding and training (through the SROI Network) to engage in SROI (Alcock et al., forthcoming).

This enthusiasm for social enterprise and social investment appears to have continued with the coalition government, who have promised to support social enterprises to deliver public services in the era of the Big Society (Daly, 2011). There is increasing interest in promoting social business and measuring the social impact of these organizations. Initiatives include Big Society Capital, a £600 million fund to promote the growth of the social investment market (Cabinet Office, 2011). There has also been

increasing interest in Social Impact Bonds as a form of outcomes-based contracting, where public sector commissioners draw on private investment to pay for significant improvement in social outcomes associated with particular interventions (see www.socialfinance.org.uk).

SROI and Performance Measurement

As social enterprises come under increasing pressure to measure their performance and value (Peattie and Morley, 2008), SROI has been encouraged as a means to capture this value. In the UK, it has been promoted as a way to enable the social enterprise sector to better understand the wider impacts of service delivery and quantify that value in monetary terms. Developed by the Roberts Enterprise Development Fund in the US (Roberts Enterprise Development Fund (REDF), 2000) and tested by the New Economics Foundation in the UK (NEF, 2004), SROI is based upon the principles of accountancy and cost-benefit analysis that assign monetary values to social and environmental returns to demonstrate wider value creation (Rotheroe and Richards, 2007). This measures the value of social benefits created by an organization in relation to the relative cost of achieving those benefits (Emerson and Twersky, 1996). The result is a ratio of monetized social value. For example, a ratio of 3:1 indicates that an investment of £1 delivers £3 of social value.

$$\text{SROI} = \frac{\text{Net Present Value of Benefits}}{\text{Net Present Value of Investments}}$$

Social return on investment uses elements of cost-benefit analysis (CBA) as costs and benefits are quantified and compared to evaluate the desirability of a given intervention expressed in monetary units (Layard and Glaister, 1994). Healthcare settings are familiar with such cost benefit approaches and the recent pursuit of explicit priority setting has been accompanied by the development of decision support tools and methodologies

(Williams, 2011). In addition to CBA, this includes Health Technology Assessment (HTAs) and cost-effectiveness analysis (CEA) used to evaluate the efficacy, safety, ethics and costs of an intervention to help bodies make resource allocation decisions (Drummond et al., 1997; Gold et al., 1996; Williams, 2011). However, the key difference between CBA and SROI is that SROI has its focus on the third sector and explicitly attempts to involve stakeholders at every stage (Arvidson et al., 2010) through assessing how much stakeholders value the service (New Philanthropy Capital, 2010). New Philanthropy Capital. 2010. The SROI process can vary from the social value generated by an entire organization, or focus on just one specific aspect of the organization's work. Social return on investment can be evaluative, conducted retrospectively and based on actual outcomes that have already taken place; or a forecast, which predicts how much social value will be created if the activities meet their intended outcomes (Department of Health, 2010). Department of Health. 2010.

There have been a number of success stories documented in relation to SROI (e.g. Flockhart, 2005; Ryan and Lynne, 2008). Of particular note, in 2009 the Department of Health commissioned an action research project on 'the value of social enterprise in health and social care' (Department of Health, 2010). Five social enterprises delivering primary and community care services were supported to undertake SROI analysis. Whilst the research demonstrated the financial returns created by each organization, it also identified a number of additional benefits of SROI, including that it could be used to involve stakeholders in more meaningful ways. This report also argued that SROI analysis helped social enterprises work with commissioners in making sure that their value was identified, managed and paid for.

These findings support the claims made about SROI that it can provide not only an opportunity for social enterprises to demonstrate their effectiveness but also create a competitive

advantage by enabling commissioners to make more informed decisions when tendering for public sector service contracts (Ryan and Lynne, 2008). It can also enable stronger relationships between investors and the organizations they support (Social Ventures Australia (SVA) Consulting, 2012). Social return on investment can also be useful internally as an instrument for organizational learning by enabling staff to analyse and improve their services (Arvidson 2009); New Philanthropy Capital 2010). Social return on investment has therefore been argued to enable organizations to learn what is and isn't working and use this to improve their strategy, as well as strengthen management and monitoring systems (SVA Consulting, 2012).

Despite this apparent success, literature in this area draws attention to the limited uptake of measurement tools, including SROI, by social enterprises (Nicholls, 2007; Peatte and Morley, 2008). Sheridan (2011) analysed data from the State of Social Enterprise Survey 2009 and found a limited uptake of impact measurement tools in the social enterprise sector, with SROI coming off worst, being used by only 1% of health and social care organizations. This study also found that measuring social and/or environmental impact was only done by 65% of health and social care organizations. Of those that did measure their impact, most used internal tools/systems (17%) or social audit (11%).

A number of practical issues have been put forward to explain why social enterprises are not using SROI and other measurement tools. This includes the difficulty of attributing a financial figure to 'soft' outcomes such as confidence or self-esteem (Sheridan, 2011) that involve subjective value judgments (Lingane and Olsen, 2004; Thomas, 2004). Furthermore, these tools make assumptions that conflict with the way organizations are run. For example, SROI requires an organization to have a good evidence base and financial proxies; however, this data is often unreliable, resulting in poor quality SROI reports (New Philanthropy Capital, 2010). Furthermore, SROI requires some idea of 'what would have

happened anyway' and this counterfactual data is rarely available resulting in considerable calculation errors (New Philanthropy Capital, 2010). New Philanthropy Capital. 2010.

Further practical and implementation problems draw attention to the time and resource inputs associated with measurement tools. Social enterprises may see measurement as a burden, rather than a source of competitive advantage or a useful activity (Social Enterprise Partnership UK, 2003). SROI in particular can be costly, requiring significant amounts of time and specialist skills (Gair, 2009; New Philanthropy Capital, 2010). Here, organizational size matters as only those organizations with sufficient resources are likely to take up performance measurement (Zimmerman and Stevens, 2006). Furthermore, Lingane and Olsen (2004) suggest organizations are unlikely to spend valuable time and resources on impact assessment unless it is seen as important to their investors. Conversely, studies suggest that evaluation reports may not even be used by funders as a basis for decision making (Arvidson, 2009). Funders may not find social value being expressed in financial terms very compelling (New Philanthropy Capital, 2010). Such findings resonate with the application of cost effective tools and techniques in healthcare. Whilst the international evidence confirms the use of HTA and economic evaluation among national organizations, a disjuncture remains as local decision makers operating with fixed healthcare budgets and established practices lack the requisite resources and expertise to make such priority setting decisions (Williams et al., 2008).

Ideological issues draw attention to how performance measurement tools may clash with the values and culture of social enterprises. Some tools, such as social audit and benchmarking, originated in the private sector and were adapted to public and non-profit contexts. They were originally designed to focus on large business models, where rationalization, resource maximization, market growth and financial measures are highly sought-after (Garengo et al., 2005). However, social enterprises

may lack the resources and may adopt different business ideologies, ethics and organizational structures (Ridley Duff et al., 2011). The diversity of social enterprises in terms of their activities and strategies also mean that universal or standardised measurement tools are not appropriate (Hart and Houghton, 2007). As Paton (2003) suggests, the relevance of 'mainstream' management ideas and their adaptation to social enterprises demonstrates that performance measures may not be the universal solution as promised.

Methods

Our study of performance measurement formed a key part of a national evaluation of the Social Enterprise Investment Fund¹ (SEIF) (see Lyon et al., 2010; Millar et al., 2010). The purpose of this evaluation was to assess the effectiveness of SEIF activities in enabling the start up and growth of social enterprises in English health and social care (see Alcock et al., forthcoming; Hall et al., forthcoming).

The research employed mixed methods carrying out a survey and in-depth case studies with a selection of social enterprises which had applied to the SEIF. These delivered across a range of different service areas to respond to gaps and demands within the health and social care system. Most targeted vulnerable and excluded groups and aimed to provide a responsive and innovative service in meeting individual and community needs. Our survey research indicated that SEIF applicants were categorized into four key areas; health and wellbeing (62%), healthcare (20%), social care (19%), and social exclusion (16%) (Hall and Millar, 2011). These social enterprises are therefore not representative of all English health and social care services and only include those that have received state support through the SEIF.

The survey was undertaken with all successful (n = 285) SEIF applicants who had received their investment decision between the start of the SEIF on 1 August 2007 and 31 March 2010 (see Hall and Millar, 2011). A high response rate of 60% (n = 172) was obtained. Non-respondents primarily included those organizations that had closed down or where email addresses had changed. For the purpose of this paper, we draw upon responses to a series of survey questions on impact measurement, which were asked to (and answered by) all survey respondents. Using a mixture of closed and open questions we asked if participants measure their social impact, how they measure impact and the value of measuring impact. The survey was administered online, with telephone backup.

The case study research carried out in-depth qualitative interviews with a total of 16 social enterprises within four case study sites. Three of these sites were defined by geographic locality (using Primary Care Trust (PCT) boundaries), while the fourth focused thematically on 'Right to Request' organizations. The three sites defined by locality were selected to obtain a diversity of contexts based around the number of SEIF applications, the type and amount of SEIF investment made and type/size of social enterprise organizations within each locality. The sample was purposive in its aim and included a diverse range of successful (n = 13) and unsuccessful applicants (n = 3) to the SEIF ranging from large social enterprises delivering mainstream healthcare services, to small local organizations delivering wellbeing services. Two (15%) of the successful organizations received SEIF funded SROI training (representative of the 12% who received SROI support overall). A total of 30 qualitative interviews were carried out with representatives from the selected social enterprises. A further 12 qualitative interviews were carried out with health and social care commissioners and social enterprise support agencies. Our interviews included questions on impact measurement and the extent to which impact measurement tools, including SROI, were

taken into account when allocating funding and public service contracts.

Quantitative data from the survey were analysed in SPSS using descriptive statistics and cross-tabulations. Qualitative data from the interviews (and open survey questions) were coded focusing on the use of SROI, how it was used and the strengths and limitations of the technique. Based on the iterative nature of qualitative research, analysis also looked to code wider interpretations of measurement activity including understandings and conceptions of measurement and measurement tools. This analysis of the transcribed interview text was assisted by NVivo software (Miles and Huberman, 1994). Quantitative survey data were used to explore the use of performance measurement tools across all SEIF investees, whilst the qualitative data were used to provide insight and depth into the reasons why certain tools were (or were not) utilized. Here, triangulation benefitted the research in obtaining multiple viewpoints allowing for greater accuracy by collecting different kinds of data bearing on the same phenomenon (Denzin, 1978). As with other public management research (e.g. Boyne et al., 2005; Kitchener et al., 2000), the use of multiple measures allowed us to uncover some unique variance which otherwise may have been neglected by single methods.

Measuring the Impact of Social Enterprise Organizations

The following sections present our findings from both survey and interview data of how SROI was utilized by respondents, presenting both the advantages of the tool along with the internal and external barriers to its use.

Capturing heterogeneity: The preference for customized tools and techniques

Performance measurement within social enterprises was an accepted feature of organizational life. Our survey found that 59% of social enterprises already measured their social impact and a

further 33% were planning to do so. Collecting evidence and measuring impact was an extremely important process both internally to improve working practices and externally to attract funding. This was evidenced by a large health and wellbeing social enterprise who were using impact data to market their services:

Our marketing is being able to evidence why people should buy what we're offering, so actually collecting that evidence is extremely important to us, and making sure that the impact is needed by local authorities and by individuals.

Whilst the principle of performance measurement was accepted, our findings identified a variety of different interpretations and uses of measurement tools (see Table 1). There was no 'one size fits all' approach to measuring performance and value. Instead, performance measurement tools and techniques were frequently tailored to the particular contextual features and dynamics of each social enterprise. Social enterprises often developed customized tools, and our survey found that two-fifths of survey respondents (40%) used their own internal tools and techniques to measure performance. This included methods that encouraged 'bottom up' engagement with users through user feedback, case studies and user forums. A qualitative user-based approach was often considered the most appropriate way to capture activity, as described by an organization delivering services to tackle social exclusion:

I think it's about getting it from the people themselves who are using the facility rather than just doing stats and data. I think that proves nothing really.

Customized tools included different metric-based techniques to capture the impact of organizational interventions. These were often based on established scales, including the

Table 1 : The use of measurement tools by SEIF investees (survey respondents only)

| Measure of social impact | % of survey respondents |
|------------------------------|-------------------------|
| Internal tools/systems | 40 |
| SROI | 30 |
| Other | 4 |
| Not yet selected a tool | 33 |
| Do not measure social impact | 8 |

Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) used to capture the effectiveness of a small counseling intervention, and the General Practice Assessment Questionnaire to gather outcomes on a nursing and support service. Measurement tools were often chosen on the basis that they are contextually appropriate to organizational values, goals and working practices, as explained by a large health and wellbeing social enterprise:

The evaluative tool will be used wherever we're working ... we've got to have a tool which allows [staff] to use their normal processes to gather data.

Alongside these customized tools, approaches to measurement were frequently led by the requirements of funders. For those funded by Local Authorities or the NHS, measuring impact was often shaped by commissioner targets, often referred to as Key Performance Indicators (KPIs). Performance measurement tended to involve monthly reports to the funding body that built on defined outputs, for example the number of reduced hospital admissions as a result of the social enterprise intervention. This included a social enterprise delivering healthcare to socially excluded groups that had designed their performance measurement around commissioner funding and contractual requirements:

We have to deliver targets to the board so we have to report back on our quality agenda to make sure that we're on track, that we're performing against our five-year contract to demonstrate that ... we're spending the money appropriately.

Customized tools were therefore favored by both our survey and case study respondents; however, our survey found that nearly a third (30%) of social enterprise organizations were using SROI, either on its own or in addition to customized tools. Despite SROI being encouraged by the Department of Health and 12% of SEIF investees being supported to use it, our research found a diverse range of interpretations of its use. Whilst there was some support for the tool, most social enterprises found that it presented them with a number of challenges.

SROI: A square peg in a round hole?

Our interviews identified some organizations that supported the use of SROI as their preferred measurement tool. This perspective was in recognition that undertaking an SROI brought value as an instrument for organizational learning. The potential benefits associated with SROI were based on enabling organizations to reflect on their own performance, and find opportunities to improve services for staff and users. One health and wellbeing social enterprise described the way in which SROI enabled them to realize their value and integrate this into their ongoing learning and development:

I think that [SROI] made us really recognise the value, but more importantly it's good to do it because it can demonstrate the kind of difference it's making.

This perspective was from an unsuccessful SEIF applicant who had received funding from their local healthcare commissioner to undertake SROI. The same organization had also successfully used SROI to support applications for funding:

We did SROI on one strand [service], and we noticed such a difference, particularly in terms of the investment of £1 and the return would be £8.60 ... So having that to support us with documents that we were putting forward for [funding].

However, the majority of social enterprises interviewed (including those who received support from the SEIF for SROI training) were critical of SROI. The grounds for this criticism centered on three areas: the conflicting assumptions between SROI practices and social enterprise values; the practical problems of SROI; and the value of SROI to commissioners (and a wider external audience).

Conflicting assumptions

Using financial proxies to measure the outcomes of social enterprise activities was for some interviewees considered inappropriate. This was due to the diverse nature of the groups they serve and the dynamic contexts in which they are situated (Hart and Houghton, 2007). Their main impacts are often focused around 'soft' outcomes, for example improving a person's well-being or confidence. These are intangible impacts that many of our interviewees felt could not be measured in financial terms. This was especially the case for 'well being' services, the principles of which were based on a user centered approach to encourage happiness and confidence building. Using financial proxies to measure these social activities was considered inappropriate, as evidenced by a social care social enterprise that had used SROI:

I think it was just this formula ... you needed to then find a cost of what you were doing within an equivalent service, so the NHS. And there wasn't an equivalent cost. It's such a broad area, you know? I suppose it was just that, sort of, vagueness of [SROI] I didn't like.

Finding financial proxies was therefore a significant barrier to undertaking an SROI analysis, and organizational contexts were

such that they were unable to obtain or develop the necessary robust financial comparative data. For those organizations that were only just starting up or had not yet begun trading, undertaking a SROI (even a forecast SROI) was considered especially problematic as it required them to generate performance data that speculated on the benefits of a service not yet in existence. The above respondent who had received a SEIF investment to set up a new social enterprise and was required to undertake SROI, commented that it was 'very hard to do an assessment of something that's not happening'.

Practical constraints

Interviewees also highlighted the practical implementation issues associated with SROI, including the significant time and cost resources it required. This was a particular challenge for small organizations with limited capacity, especially those run mainly by volunteers. For example, a small health and wellbeing social enterprise felt that it was not possible to undertake expensive and time consuming impact measurement (although may consider SROI in the future):

I think up to now we've mainly been running the project with volunteers rather than paid staff and so what we're able to do is not an awful lot ... Most of the time is involved in providing the service. To be able to look at some of these other things is perhaps a luxury.

The cost and time required for an SROI could also not be justified by other organizations, both large social care providers and small well being services:

I think was it Jamie Oliver's Fifteen, I think they spent something like £45,000 on their social return on investment and we were like, £45,000? We can do a lot of good with that.

It costs money to implement, it costs time and money to keep going, it requires a good deal of thinking about ... The problem with SROI is that measuring it makes you feel good but doesn't actually bring about an improved return.

These findings suggested that the resources associated with SROI could be better used on service developments. As a result, the priority was more about developing cheaper and more applicable internal measurement tools, as had been done by a small health and wellbeing social enterprise:

Our knowledge of the SROI tool is that it's a complex, time-consuming and expensive thing to use ... when we just did the initial work on our evaluative framework we looked at a number of existing tools, and certainly SROI as it was then was just not going to deliver what we needed it to deliver.

Alongside cost and capacity issues, capability problems were evident as organizations reported that they did not feel they could undertake an SROI due to its complexity. Some particularly struggled with its methodological processes, as evidenced by one respondent who had received SROI training through the SEIF:

I mean, [SROI] is a really complex thing, isn't it? [During SROI training] they might as well have been speaking Swahili at one point It was just the methodology. It was incredibly complex.

Overall, despite the Department of Health goal to encourage the use of SROI, our research found that SROI proved relatively unsuccessful due to these methodological and practical challenges.

External challenges to SROI

In addition to the 'internal' complexities of undertaking an SROI, most of our interview respondents felt that SROI was not a useful tool in helping them to secure new contracts. Overall, respondents felt that there was a lack of understanding of SROI amongst commissioner audiences. This was also echoed by some of the commissioners we interviewed, including a primary care commissioner:

Whether there is a level of awareness amongst commissioners ... Given the level of seniority of the group I was addressing recently, my impression is that there isn't universal understanding of SROI. I am sure there are individual commissioners who do.

Of particular note, SROI was not widely understood or encouraged by commissioners because funding decisions were frequently based on internally developed Key Performance Indicators (KPIs). This was indicated by a primary care commissioner of a social enterprise delivering fitness programs:

The data we want is based on their KPIs. We want to know how many people are in the organisation, sickness levels ... weight loss etc.

Within the current commissioning climate of imminent cuts to funding and competition from different providers, there was also an acceptance that demonstrating social value, including through SROI, was going to be important. In the context of social enterprises facing increased competition, including from private providers, the need to demonstrate evidence about impact became ever more pressing. There was, however, some concern that continued faith in SROI as the preferred technique within policy was underestimating the difficulties of using it, as expressed by a social enterprise support agency:

[The Government] definitely wants to put some sort of requirement in place where you've got to measure your

social impact, but they just need to decide what form it takes.

Interpreting measurement tools and SROI

The findings presented above illustrate that capturing the performance of social enterprise organizations is important, yet complex and open to a variety of different interpretations. There exist a range of different tools and methods that inform how social enterprises measure their impact, including SROI. In England, SROI has been promoted by the Department of Health, including through the SEIF, as a way for social enterprises to record and communicate their social return. Our research has shown that despite the SEIF funding SROI training for some of its investees, some social enterprises are not utilizing it as the policy intended. Our survey identified a relatively high use of SROI among SEIF investees overall (at 30%), especially compared with the findings of previous surveys on social enterprises (e.g. Sheridan, 2011). However those that had used SROI found it a challenging, complex and time consuming process with minimal resulting benefits.

The practical difficulties we identified with SROI appear to support previous work (e.g. Lingane and Olsen, 2004) showing how organizations are unlikely to spend valuable time and resources on impact assessment unless it is of significant value. Rather than providing a useful management tool, SROI was in many respects interpreted as irrelevant, a burden, or as something that got in the way of delivery (Social Enterprise Partnership UK, 2003). On this basis, most felt that internal and customized tools and techniques developed by the organizations themselves were deemed more relevant and responsive (Thomas, 2004) and better suited to day-to-day delivery in the ways they could be integrated into activities, organizational goals and available resources (Bull, 2007; Burns et al., 2008). This reflects the diversity of social enterprise organizations, especially within health and social care, in terms of

their structure, objectives and outcomes (Hart and Houghton, 2007). There is no one definitive or standardized way of measuring them and they instead require a wide range of tools and methods to define impact in a meaningful way (Hart and Haughton, 2007).

The assumptions on which SROI is based appear to further highlight how performance measurement is often too 'generalist' in its approach. In this case, SROI was limited in capturing the distinctiveness of each organization (Paton, 2003), especially when attempting to measure 'soft' outcomes. Social return on investment techniques were found to conflict with social enterprise values and assumptions, which may reflect the continuing challenges of transferring methods originating in the private sector and from different contexts (here SROI originated from the US) into public and non-profit contexts. These organizations were not built on the business and financial principles underpinning SROI (Bull, 2007; Paton,) but on different epistemological assumptions; those emphasizing qualitative experience and tacit knowledge that may be unexpressed and immeasurable. This presents a further critique to the assumptions underpinning SROI that social enterprise organizations can be seen as systems of rational causality, with inputs leading to outputs, which can be 'objectively' assessed (Ridley Duff et al., 2011). Here, such notions of 'blended' value based on a single monetary scale were in tension with interpretive images of organizations which could not be easily monetised or made commensurable (Westall, 2009).

These findings show that the nature, extent and effectiveness of attempts to capture social value were largely not shaped by the SEIF and its application process but by internal organizational factors. The lack of ongoing use or understanding of SROI also draws attention to external contextual factors that shape the utilization of such techniques. Health and social care commissioners often refer to Key Performance Indicators (KPIs)

when evaluating service providers and making funding decisions. Such evaluation is frequently built into contracts and impact assessment is often a prerequisite for initial, continued or additional funding for social enterprise projects (Hart and Haughton, 2007). Although SROI has been promoted as a way for social enterprises to better negotiate new contracts for service delivery (Department of Health, 2010), in reality internal measurement systems and external performance targets are still favored by commissioners.

Evidently, commissioning bodies are still reluctant to risk what they perceive to be untried models. This being the case, not only does SROI face an uphill struggle for legitimacy but it may be a misplaced project. For this to change, it may be necessary to stipulate the use of specific social impact tools in public service contracts. This is something that has been advocated by some (e.g. Nicholls, 2007). However, by reviewing the use of SROI among SEIF organizations, we have shown that imposing the use of SROI on social enterprises is not always successful. Simply providing SROI training and financial support does not necessarily lead to successful implementation. Furthermore, if SROI is to be championed as the main tool for measuring social impact and a tool to support social enterprises negotiate with funders (e.g. Department of Health, 2010), there is a need for further training among funding bodies.

In practice, to reduce the gap between national policy and local interpretation with regards to measuring outcomes, a greater acceptance of value pluralism is required. Much more work needs to be done on practical issues such as understanding the appropriate governance models for different kinds of social enterprises. It also requires finance providers and funders to move beyond the current narrow focus on monetary value creation. Unfortunately this is likely to be difficult in the current climate of health and social care reform as economic pressures and the dominance of existing metrics mean funders have the potential to

become more prescriptive and directive (Holden, 2004; Westall, 2009). The use of metrics such as social impact bonds might well suggest a different way of capturing social value however in the current climate there is likely to be little room for looking at the difficult dimensions of value creation and ways of talking about these issues. The result of this may well lead to further tensions with the potential erosion of existing values and local meanings (Westall, 2009).

Even so, broader ideas of social value are needed that incorporate the co-production of knowledge between local contexts, social enterprises and those they serve (Brandsen and Pestoff, 2006; Knox and Worpole, 2007). Ways to bridge the divide might include measuring the social value of entire systems of social enterprise (Ridley Duff et al., 2011). The broad idea of 'Return on Investment' could have multiple numerators combining monetary, qualitative and narrative measures that may reflect more specific and direct returns to different stakeholders. Social value chains or social accounting might also provide alternative ways to look at value creation by third sector actors (Westall, 2009).

Conclusion

The use of measurement tools within social enterprise organizations is contextually bound. The heterogeneity of social enterprises means that they often struggle to fit with standardized performance measurement tools and techniques. SROI has been accepted as an internationally recognized measurement tool for social enterprise within UK policy and beyond and has been promoted by the Department of Health as a favored measurement tool. Despite the high aspirations associated with it, we have found some social enterprises and those that commission health and social care services are not utilizing the tool as anticipated. These findings support the ongoing debates that practical and ideological factors often act as a barrier to the

uptake of measurement tools by social enterprises (Peatte and Morley, 2008; Sheridan, 2011).

This study offers a significant contribution to the literature on the use of SROI by social enterprises and provides an important contribution to assessments of the validity, robustness, and appropriateness of performance measurement within social enterprises more generally. Evidently, it was conducted at a particular point in time, within the specific context of health and social care and with a group of organizations that applied to SEIF. In the UK, changes in the policy environment are likely to result in further expectations for social enterprises to use impact measurement tools, such as SROI, to demonstrate the 'added value' they create. If SROI or any other social impact measures are to be successful, more support is needed to recognize and enact their use.

Despite being UK oriented, these findings also have implications for the implementation of social investment strategies across public services, and for other welfare regimes in Europe and beyond where efforts to promote social enterprise are underway (Fazzi, 2012). They highlight the implicit value tensions and conflicts associated with multi-stakeholder governance models and show how much measurement literature and practice related to the third sector is currently dominated by the focus on monetizable outcomes at the expense of practitioner based measures and broader kinds of value. A more thorough understanding of value could better articulate the drivers and functioning of social enterprise activity. As such, policy and practice could be based on a more realistic understanding that any use and development of measurement systems needs to explicitly recognize the strategic objectives, context and influences of an organization.

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