

Forecast Social Return on Investment Analysis on the Co-location of Advice Workers with Consensual Access to Individual Medical Records in Medical Practices

Primary Author: Karen Carrick

Contributory Authors: Kate Burton
Paige Barclay



Executive Summary

The report provides a forecast of the social return from the investment in co-locating advice workers in medical practices and allowing advisors consensual access to the medical records of individuals.

The benefits¹ measured are those that are made possible by the investment of NHS Lothian, Edinburgh Health and Social Care Partnership and Dundee City Council. These benefits have been identified following consultation with those who were most directly affected.

The analysis was undertaken during 2016 by the Improvement Service with support from NHS Lothian, Dundee City Council and Granton Information Centre.

Social Return on Investment (SROI) provides a principled approach that can be used to measure and account for a broad concept of value. It enables the social and economic benefits a service or activity delivers to be calculated and monetised. It is a stakeholder-informed process and consultation is an integral part of the methodology.

The analysis identified those who derive benefits from the co-location of advice workers in medical centres with access to individual medical records and values some of the changes they experience.

As a result of having contact with advice workers in medical practices who have access to medical records, patients/clients experience improved health and wellbeing, feel less stigmatised, and report increased feelings of self-worth. Individuals, particularly those who may be experiencing social and/or economic disadvantage have improved and earlier access to services. They also report increased self-motivation and confidence, resulting in an increased ability to use other services

Medical practice staff are able to make better use of their time and to focus on medical interventions. They develop a better understanding of welfare benefits and money advice issues and report increased job satisfaction.

For medical practices as a unit, the co-location of advice workers results in the improved delivery of cost-effective services.

Advisors state that they have improved productivity and there is a verifiable reduction in the number of appeals and ongoing work. As well as saving time, advisors are able to get a better understanding of the needs of their client and have greater job satisfaction.

Funders value the opportunity that co-locating advisors in medical centres offered, as it improves their ability to target resources at priority groups. There is recognition that a reduction in health costs will result from the improvements to health and wellbeing reported by clients/patients as a consequence of easier and earlier access to advice services.

It was found that every £1 invested would generate around £39 of social and economic benefits. By applying a sensitivity analysis, or varying any assumptions made in the calculation, the value of such benefits derived ranges from £27 to £50.

¹ In the context of this report, 'benefits' refer to the social, economic, and environmental outcomes of the activity

Contents

Executive summary	1
1. Introduction	4
1.1 Background	4
1.2 Subjects of analysis	5
1.3 Policy Context	5
1.4 Social Return on Investment	6
1.5 Purpose of the analysis	7
2. Scope and stakeholders	8
2.1 Scope	8
2.2 Stakeholder identification and consultation	8
3. The theory of change from the perspective of the different stakeholders	9
3.1 Service users- clients and patients	9
3.2 Practice Staff	11
3.3 Medical Practice	12
3.4 Advisors	12
3.5 Funders	13
4. Inputs and outputs	15
4.1 Investment (inputs)	15
4.2 Outputs	15
4.3 Quantities	15
5. Outcomes and valuation	17
5.1 Outcomes evidence	18
5.2 Valuation	17
6. Social return calculation and sensitivity analysis	19
6.1 Duration and drop off	19
6.2 Reductions in value to avoid over-claiming	19
6.2.1 Deadweight	19
6.2.2 Attribution	19
6.2.3 Displacement	20
6.3 Calculation of social return	20
6.4 Sensitivity analysis	19
6.5 Materiality Considerations	20
7. Conclusions and Recommendations	23
Appendices	
1. Audit trail and impact map information	24
1.1 Stakeholders identified who were included or excluded	24
1.2 Engagement methods for 'included' stakeholders	24
1.3 Outcomes identified but not measured	24

1.4 Financial proxies	26
1.5 Deductions to avoid over-claiming	27
1.6 Calculation	29
2. The principles of SROI	31

1. Introduction

This analysis describes and quantifies the potential social return from investing in co-locating advice workers in medical practices and allowing advisors consensual access to the medical records of individuals.

The analysis has been prepared by the Improvement Service and NHS Lothian. To provide direction and support, a Reference Group was established which included representatives from the Scottish Government, Granton Information Centre, Dundee City Council and NHS Scottish Public Health Network.

The period considered in the analysis is a duration of one year, from April 2015 until March 2016.

1.1 Background

Advice services have been identified as being used most frequently by the poorest individuals in communities². At a time when local authority budgets are reducing and demand for services is rising³, new methods of providing and sustaining critical services that reduce inequalities need to be considered. Co-locating advice workers in medical practices and allowing advisors consensual⁴ access to the medical records of individuals is an example of such an approach. The multiple benefits of delivering advice services in this way are identified, measured and valued in this analysis.

The Scottish Government, NHS and Local Government are committed to reducing health inequalities and improving health. NHS Health Scotland⁵ state that health inequalities are unfair and avoidable differences in health across social groups and between different population groups. The health inequalities that exist between affluent and deprived areas because of poverty and deprivation have a major impact on health and life expectancy. Personal factors between groups of people based on gender, disability and ethnicity also contribute to health inequalities. Evidence suggests that the UK Government's Welfare Reform programme is likely to have a negative impact on some working age people, including those with disabilities, individuals with long term health conditions (including mental health) and also lone parents and women⁶. Many of the individuals likely to be affected are already members of those groups that are most likely to experience health inequalities.

One measure to tackle health inequalities and mitigate the impact of welfare reform is the co-location of advisors in GP practices. Across Scotland, there has been a gradual increase in the number of advisors being co-located in GP practices in response to the impact of socio-economic issues on people's health, with particular developments in Edinburgh and Dundee. This approach is included in the Scottish Government's NHS Outcome Focused Plan⁷ to mitigate the impact of welfare reform on health and health services and to reduce health inequalities.

² http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-84_The_social_impact_of_the_2016-17_local_government_budget.pdf

³ <http://www.audit-scotland.gov.uk/report/an-overview-of-local-government-in-scotland-2016>

⁴ Consensual, in this context, refers to permissions to share access being given by both GPs and patients

⁵ NHS Health Scotland (2015) Health Inequalities: What are they? How do we reduce them? Edinburgh: NHS Health Scotland

⁶ UCL Institute of Health Equity (2012) The Impact of the Economic Downturn and Policy Changes on Health in London, London: University College London

⁷ <http://www.gov.scot/Topics/People/fairerscotland/HealthWelfareReform/NHSOutFocPlan>

1.2 Subjects of the analysis

This analysis has measured the social and economic benefits of providing patients with direct access to advice workers attached to medical practices. It has specifically considered the support provided by those advice workers, where informed consent has been granted, who have access to the medical records of individual patients.

The study has taken place in the practices listed below, each of which support different socio-economic groups and have a distinct operating and management structure.

- **Taybank Medical Practice (Dundee):** 1 advisor is employed by the Local Authority to provide support on an outreach basis in an area of moderate deprivation.
- **Access Centre (Edinburgh):** 1 advisor is employed by Granton Information Centre (third sector organisation) through Health and Social Care Partnership funding to support homeless people.
- **Mill Lane Medical Practice (Edinburgh):** 1 advisor is employed by Granton Information Centre through Health and Social Care Partnership funding. The locus is considered to be an area of high deprivation.

In each practice, medical staff are able to make direct referrals to advisors.

Service users/patients at each location are able to access the following services which are delivered by advice workers:

- individualised welfare rights advice, casework and representation
- debt management
- representation at appeal tribunals
- employability support
- housing advice
- casework and representation

As well as supporting individuals, advice staff provide training and briefings for practice staff on relevant topics such as welfare reform and financial inclusion.

1.3 Policy Context

The social and economic benefits of providing advice in medical practices for both individuals and the wider community are well established.

The Low Commission and Advice Services Alliance commissioned research into the role of advice services in health outcomes⁸. This found that advisors working directly with the NHS produced real benefits for patient health which resulted in: lower stress and anxiety, better sleeping patterns, more effective use of medication, smoking cessation, and improved diet and levels of physical activity.

In addition, this approach addresses health inequalities and the social determinants of health, as highlighted in the Marmot Review 2010. The report states that co-locating advice services within health settings is most effective as it targets the most vulnerable within settings they trust, and where their specific health needs are understood. In addition, they found that welfare advice provision in primary care can reduce, by an estimated 15%, the time GPs spend on benefits issues, and also leads to fewer repeat appointments and prescriptions. A review⁹ of welfare rights advice in primary care concluded that:

⁸ Consilium (2015) The Role of Advice Services in Health Outcomes, Advice Services Alliance and The Low Commission
⁹ LHIN (2013) Welfare Benefits Advice through General Practices; A Business Case, London: London Health Inequalities Network

- It is an effective way of mitigating the impact of welfare reform on health and health services
- It improves people's health by increasing their income through benefit take-up, welfare rights and representation
- GP's and other health workers value the service and see it as having a positive impact on their work
- GP's and other health workers believe that the service leads to an improvement in the health of some patients, reducing anxiety and depression in particular
- Issues raised by clients are more complex than those traditionally seen in welfare rights agencies

Even when there are a number of advice services across a city or town, evidence demonstrates that there are particular advantages to the advice worker being co-located in a GP practice or health centre¹⁰. The reasons for this are because medical practices are:

- more accessible and convenient to people because they are provided in local and familiar surroundings
- more accessible for people who have difficulty in attending more 'centralised' services due to age, poor health, poverty, lack of transport or psychological barriers
- more likely to be used if recommended by a GP or health professional

1.4 Social Return on Investment

Social Return on Investment (SROI) provides a principled approach that can be used to measure and account for a broad concept of value.

SROI measures social, environmental and economic change from the perspective of those who experience or contribute to it. Through the use of financial proxies, it is possible to identify and apply a monetary value to represent each change that is measured. The resultant financial value is then adjusted to take account of other influential factors. In this way, the overall impact of an activity can be calculated and the value generated compared to the investment in the activities. This enables a ratio of cost to benefits to be calculated. For example, a ratio of 1:3 indicates that an investment of £1 in the activities has delivered £3 of social value¹¹.

Whilst an SROI analysis will provide a headline cost to benefits ratio, it will also deliver a detailed narrative that explains how change is created and evaluates its impact through the evidence that is gathered. A SROI analysis is based on clear principles and progresses through set stages. SROI is much more than just a number. It is a story about change, on which to base decisions, and that story is told through case studies, qualitative, quantitative and financial information. The principles of the SROI approach are set out in Appendix 2.

There are two types of SROI analyses: a forecast SROI predicts the impact of a project or activity, and an evaluative SROI measures the changes that a project or activity has delivered. This report is a forecast SROI analysis.

¹⁰ Greasley, P. and Small, N. (2002) Welfare Advice in Primary Care, Nuffield Portfolio Programme Report No 17, Bradford: University of Bradford

¹¹ In SROI, 'social' is taken as a shorthand for social, economic and environmental value

1.5 Purpose of the analysis

Research supporting the multiple benefits of co-locating advice workers in health centres has been outlined in section 1.3. This analysis seeks to add to the findings by examining two areas that have not been fully considered: the benefits from a stakeholder perspective and the social return on investment.

At a local level, the analysis has produced social value maps which will enable funders and service providers to identify the outcomes that are achieved by using this model of service delivery, as well as the benefits derived by individual stakeholders. The maps can also be used as a template for establishing a framework that uses an outcomes-based approach to commissioning, monitoring and evaluation.

Strategically, it is hoped that this analysis will be used to inform the development of the Scottish Government's Advice Strategy and Scotland's new Social Security powers, and the review of NHS Scotland's Welfare Reform and Health Outcome Focussed Plan.

The findings from this analysis may also assist local authorities, funders and providers of advice service to consider how they can improve the way advice services in Scotland are delivered to ensure a prevention, rather than crisis, intervention which takes into account the holistic needs of individuals and families. Taking services into communities in this way improves accessibility for individuals, supports organisational integration and promotes client-centred approaches to service design and delivery.

2. Scope and stakeholders

2.1 Scope

This is a forecast of the social return from investing in co-locating advice workers in medical practices and allowing advisors consensual access to individual medical records. The predictions it contains are based on a one year period from April 2015 to March 2016.

2.2 Stakeholder identification and consultation

All those who were likely to experience change as a result of the project (the stakeholders), were identified, the nature of any changes that might be experienced considered and how such changes might be measured explored. This resulted in a list of those organisations or individuals whom it was believed would be significantly affected (the 'included' stakeholders). Details about the rationale for including these stakeholders are provided in Appendix 1.1.

A list of those whom it was thought would not experience significant change, and hence who were not considered appropriate to contact for further discussion, was also identified (the 'excluded' stakeholders). More details on this group and the reason for not considering them further in relation to the analysis can be found in Appendix 1.1.

A consultation plan was established for each of the identified stakeholders using methodologies that best suited their individual needs. Consultation was carried out by the Improvement Service and staff from Dundee City Council and Granton Information Centre. Appendix 1.2 sets out the engagement methods used for each stakeholder.

Stakeholders were consulted initially to confirm possible outcomes that had been identified by the Reference Group¹². They continued to be consulted, in a variety of ways, at all stages of the process.

¹² The Reference Group includes representatives from the Improvement Service, NHS Lothian, Scottish Government, Granton Information Centre, Dundee City Council, and NHS Scottish Public Health Improvement Service

3. Theory of change from the perspective of stakeholders

By engaging with stakeholders this analysis has identified, from the perspective of each, the changes that have taken place as a result of supporting, providing or using advice services that are co-located in medical centres. Within each stakeholder grouping, not all individuals experienced the same change and this is reflected in the quantities used to calculate the return on investment. The quantities used are drawn from survey results and questionnaire responses and are considered in section 4.3.

The outcomes reported by stakeholders are described in the following sections and are illustrated by quotes and case studies.

3.1 Clients/Patients (referred to as patients¹³)

As a result of having contact with advice workers in medical practices who have access to medical records, patients experience **improved health and wellbeing**. By being supported to start to address their socioeconomic problems, patients start to regain control over their lives and many experience a reduction in the level of stress-related illnesses. Individuals have more time to focus on other aspects of their life as they are no longer consumed with worry about debts, welfare benefits, housing or other such difficulties. They also begin to develop a more optimistic outlook towards the future.

“My quality of life has improved.”

“This service has changed my life tremendously. It turned my life around and allowed me to get out of the house.”

“I feel less stressed out.”

“I’m still a bit worried about life, but I’m feeling better.”

“I feel more positive about the future.”

Patients with access to advice workers in medical practices **feel less stigmatised**, and report **increased feelings of self-worth**. The trusting relationship patients have with their GP and other staff members in the medical practice helps to facilitate positive engagement with the co-located advisors. While there may be some initial suspicion, direct referral to the advisors by someone they respect helps to ease concerns about stigmatisation. This translates into improved cooperation between the advisors and patients, particularly as a non-judgemental approach is adopted by advisors. As a result of this mode of referral, some individuals who previously would not have considered applying for the welfare benefits they are entitled to because of the associated stigmatisation now feel comfortable doing so.

“I felt I could trust the advisor because I was referred by my GP.”

¹³ Health services refer to service users as patients and advice services as service users. For ease of reference users of the service are referred to as patients.

“I found this service invaluable. I wasn’t claiming benefits I should be claiming. I was brought up to feel that being on benefits is wrong - there is a stigma attached to it. The advisor was not judgemental and understood what I needed.”

“I was very paranoid when I first accessed the service, and I was worried about sharing my personal information. But, because I trusted my doctor, I trusted the advisor.”

John’s¹⁴ Story

John is 39 and has been homeless for the past 2 years, having lost his tenancy due to rent arrears. He has a very long history of mental health difficulties and substance misuse. His past history also includes head injury, epilepsy, personality disorder, depression and Chronic Obstructive Pulmonary Disease. His medication includes methadone treatment, antiepileptics, an antidepressant and inhalers.

On 3rd Feb he was found to be fit for work following his Work Capability Assessment for Employment and Support Allowance (ESA). He attended the medical practice on 17th March distressed, agitated and fearing welfare sanctions, as he felt unable to comply with the criteria for Job Seeker’s Allowance. He expressed feelings of hopelessness and suicidal thoughts. The GP he saw was concerned enough to give him a list of crisis contact numbers and start him on an antipsychotic medication for agitation. He was booked in to see the advisor the following week.

The adviser accessed his medical records and was able to request a Mandatory Reconsideration within two days¹⁵. Supplementary medical evidence - including details of the range of his physical and mental health problems, as well as hospital letters printed directly from his medical records - were included.

Following a successful Mandatory Reconsideration, John received ESA and his mental health improved significantly. He did not require any crisis or emergency services. Within several months he was supported to start to resolve his financial problems and to acquire his own tenancy, allowing him to move out of homelessness accommodation.

The co-location of welfare benefit and money advisors in medical practices also results in patients having **improved access to services**. They no longer have to visit several different locations for assistance in addressing multiple issues - the prospect of which often prevents individuals from seeking help in the first place or in sustaining support when it is provided. This is a particularly important benefit for those with mobility issues, as well as those experiencing mental health difficulties. Being directly referred to advisors by staff in the medical practice allows patients to access help quickly and at an earlier stage before a crisis point is reached.

¹⁴ Pseudonym

¹⁵ Process of appealing a decision in relation to social security benefits: <https://www.gov.uk/social-security-child-support-tribunal/before-you-appeal>.

"It's good having a local service - a lot of people with health problems can't get into the town centre to access other services."

"I only accessed the service because my GP referred me. It broke down a lot of barriers."

"If this service wasn't available and easy to access, I would still be totally lost."

3.2 Practice Staff

The co-location of advice workers in medical practices who are able to access medical records allows practice staff to **make better use of their time and to focus on medical interventions**. Instead of attempting to deal with issues patients may have with benefits, rights or debt, practice staff can confidently refer them to skilled advisors. This allows a significant portion of time that may previously have been spent discussing non-medical problems with patients to be spent more appropriately on addressing health needs.

"Before this service was introduced, 50% of my workload was taken up by the socioeconomic problems of patients."

GP

"Patients don't talk to me about their money problems anymore. If they mention any issues, I can refer them to the money advisor for an appointment. This gives me more time to address their medical problems."

GP

"I don't have to spend time looking for information on welfare rights and money advice, and can just refer patients to the advisors."

Community Psychiatric Nurse

Working alongside advice workers has also resulted in practice staff developing a **better understanding of welfare benefits and money advice issues**. When practice staff require information about these areas, they can easily contact the advisors co-located in the practice. If there are developments in policy and practice that may impact on health services, advisors can share information that is relevant. This saves the practice staff time that would otherwise be spent researching such issues and allows them to focus more on health related activities. This approach also engenders the development of a better personal understanding by medical staff of the socioeconomic problems faced by their patients.

"I now understand the welfare system better myself, and I can easily contact the money advisor if I have any questions."

GP

"I'm able to use the advisor's knowledge and expertise, and so can pass on the correct information to patients."

Practice Mental Health Nurse

Practice staff also reported **increased job satisfaction** as they are able to perform their role more effectively. Staff are able to better use their expertise, focus their attention on dealing with patients' medical difficulties, and refer patients who may need non-medical support to advisors who have the requisite skills and knowledge. The ability to directly refer patients with minimal effort makes practice staff feel more confident and less stressed.

"I can do my work a lot more effectively and efficiently now."

Practice Nurse

"I'm now less stressed at work and can do my job better."

Phlebotomist

3.3 Medical Practice

For medical practices as a unit, the co-location of advice workers results in the **improved delivery of cost-effective services**. The benefits experienced by medical centre staff enable them to work more efficiently in their roles, therefore making the practice itself more efficient and effective.

"Practice staff can now spend more time working effectively in their roles: GPs have more time to address patients' medical issues, and receptionists can easily book appointments for patients to see the welfare and money advisors."

Practice Manager

3.4 Advisors

The advisors co-located in medical practices report **improved productivity and a reduction in appeals and ongoing work**, as a result of their ability to access patients' medical records and get advice and assistance from medical staff in complex cases.. As well as saving time, advisors are able to get a better understanding of the needs of their client.

"Having access to patients' medical records reduces the time I have to spend on their cases. I can also easily contact medical practice staff for assistance and clarification, if necessary, which results in fewer appeals."

"I can now provide a better and quicker service for patients."

The advisors co-located in medical centres also experience **increased job satisfaction**. This is partly because of their increased confidence in the quality of the service they are able to offer individuals seeking advice, due to the efficiencies gained from having direct access to medical records and the improved understanding they have of the needs of the individuals they are supporting. A further contributory factor reported is the productive working relationships they have with practice staff.

“I feel a sense of satisfaction knowing that the service I’m providing to patients has improved.”

Managers emphasised that appointing advisors with the key skills and right approach was essential to the success of this approach to service delivery. This was endorsed by the funders.

3.3 Funders

Funders valued the opportunity that co-locating advisors in medical centres offered to **improve their ability to target resources at priority groups**. It was recognised that the method of service delivery offered a way of reaching out to, and engaging with those most likely to experience health inequalities in a setting in which they felt safe and secure, and where they could be supported by professional staff in whom they had trust and confidence.

“The approach has been so successful I am now thinking about other ways of using ‘trusted’ locations, such as schools as a way of engaging directly with individuals”

“Trust is transferred from the medical staff to the advisors”

“To be successful, services should be delivered where the user can access them most easily”

Funders confirmed the benefits of delivering services in this way, as have already been identified by other stakeholders.

“GP’s want to focus on health issues but can’t get near the patient to talk about them because the patient is more concerned about other issues such as welfare benefits or debt”

“To get the best possible advice patients need to speak to the person who understands the situation best and can ask the right questions. For a health matter it is a member of the medical staff whilst for assistance with welfare benefits it is an advisor. As well as improving the quality of the service working this way is much more cost effective”

The ability to reduce the number of interventions at crisis points is a priority for funders and will result in considerable savings. The effects of stress and worry on mental health are well documented and the cost to the NHS is significant¹⁶. Both patients and advisors reported that their advice was sought and given at an earlier stage as a result of the accessibility of advice services. This ability to access advice at an earlier stage in safe surroundings significantly improves the health and wellbeing benefits for patients, which will result in **reduced costs of mental health care as a result of earlier interventions**.

¹⁶ <http://news.gov.scot/news/investment-in-mental-health>

“A more holistic approach towards providing health services is required where all agencies work together to achieve common objectives”

Health should be considered in the widest possible sense. It is not just about medical interventions and treating your wallet is part of providing high quality health care”

4. Inputs and outputs

4.1 Investment (inputs)

The money invested by the stakeholders below was used to meet staffing and associated costs.

Stakeholder	Description	Amount (£)
Health and Social Care Partnership (Edinburgh)	Staff and associated costs at Mill Lane medical practice	9,743.00
Health and Social Care Partnership (Edinburgh)	Staff and associated costs at the Access Point medical practice	28,320.00
Dundee City Council	Staff and associated costs at Taybank medical practice	11,020.00
Total inputs for April 15 to March 16		£49,083.00

4.2 Outputs

The outputs describe, in numerical terms, the activities that took place as a result of the inputs. It is these activities which will result in the changes (or outcomes) for each of the identified stakeholders. The outputs reported below are the sum of all three medical practices.

Stakeholder	Relevant outputs
Patients/Clients	<ul style="list-style-type: none">807 patients/clients accessed advice in their medical practice
Medical Practice Staff	<ul style="list-style-type: none">10.23 FTE members of staff are employed in supporting patients and making referrals
Medical Practices Advisors	<ul style="list-style-type: none">There are 3 medical practices in which advice staff are co-located
Advisors	<ul style="list-style-type: none">There are 3 advisors who are employed on a PT basis – 1 FTE

4.3 Quantities

It is important to clarify the number of individuals in each stakeholder group who will actually experience the outcome that has been identified. In many cases, not all of the stakeholders involved will experience change, or indeed may do so to varying degrees. For example whilst over 800 individuals have been able to access advice, not all will experience improved health and wellbeing or feel less stigmatised.

This is a forecast analysis and, for some of the outcomes predicted, total cost savings have been applied. When this occurs, quantities have been based on research or stakeholder information.

Patients/Clients

The chart below details the numbers of the cohort who have experienced the reported outcomes. The findings have been scaled up based on the responses received from the sample surveyed.

Number reporting improved access	746
Number reporting earlier access to service*	403
Number reporting improved health and wellbeing	616
Increased self-worth through feeling less stigmatised	766

*outcome for funders

The total number of patients/ clients is 807. Although it had been intended to conduct surveys with 50 patients/clients, this was not possible and 35 responses were received. The reasons for this are considered further in section 6.5 on materiality. At a 95% confidence level with a sample size of 35 out of a population of 807, the margin of error is c14+/-.

Practice Staff

A total of 20 staff were interviewed and the outcomes reported are detailed below. It should be noted that several members of staff were engaged on a part time basis. At a 95% confidence level with a sample size of 20 out of a population of 23, the margin of error is >3+/-.

In both cases it is assumed that 75% of respondents selected a particular answer.

Number reporting a better understanding of welfare benefits and money advice	6
Number reporting better use of time and focus on medically related interventions	18
Number reporting increased job satisfaction	16

Advisors

All three advisors interviewed reported achieving all outcomes recorded.

5. Outcomes and valuation

Detailed results from the stakeholder engagement and information collection are represented in the impact map information in Appendix 1.

5.1 Outcomes evidence

The changes (or outcomes) which were identified, following consultation with each stakeholder, are detailed below along with information on how the outcome was measured (indicators). All of the outcomes reported were positive. The outcomes which were identified in the course of the analysis but could not be measured, and the reasons for this, are listed in Appendix 1.3.

Stakeholder	Outcome	Outcome Indicator	Source
Clients/Patients	Improved health and wellbeing	Number of users reporting improved health and wellbeing	Stakeholder Contact/Patient records
Clients/Patients	Increased self-worth through feeling less stigmatised	Number of users reporting feeling less stigmatised and more socially included	Stakeholder Contact/Patient records
Clients/Patients	Improved access to services	Increased number of users / Reduction in Did Not Attend levels	Stakeholder Contact/Attendance records
Practice staff	Staff can make better use of time and focus on medically related interventions	Amount of time spent by staff providing medically related advice that was not previously available	Stakeholder Contact
Practice staff	Better understanding of benefits and money advice	Reported level of skills	Stakeholder Contact/Numbers attending information sessions
Practice staff	Increased job satisfaction	Stakeholder valuation	Stakeholder Contact/Attendance records
Practice	Improved delivery of cost effective services	Cost savings based on reduction in 'Did Not Attend' figures	Stakeholder Contact/Budget reports

Advisors	Improved staff productivity as a result of reduction in appeals/ ongoing work through ability to access medical information	Amount of time freed for other tasks	Stakeholder Contact/ reduced number of mandatory reconsiderations
Advisors	Increased job satisfaction	Single salary Increment	Stakeholder Contact/Attendance records
Funders: HSCP/LA ¹⁷	Reduced costs of mental health care as a result of earlier intervention	Cost savings	Research and Financial Reports
Funders: HSCP/LA	Reduced costs of publicity/promotion as improved ability to target resources at priority groups	Cost savings	Attendance records and patient profile

5.2 Valuation

Financial proxies have been identified, which allow a monetary value to be placed on the changes experienced by individual stakeholders. In each case, stakeholders have been consulted on the appropriateness of these measures and given the opportunity to make suggestions on potential financial proxies. These were taken into account in the final selection. In identifying the value given to a financial proxy, attempts have been made to link the financial amount to the level of importance placed on the change by individual stakeholders.

Further information on how each outcome is valued is provided in Appendix 1.4.

¹⁷ Health and Social Care Partnership and local authority

6. Social return calculation and sensitivity analysis

6.1 Duration and drop off

Before the SROI calculation can be finalised, the period of time the changes produced by the activity will last must be considered. This is so that their future value can be assessed. The question to be answered is *'if the activity stopped tomorrow, how much of the value would still be there?'*

To predict the length of time changes will be sustained, stakeholder opinion and independent research are both taken into account. There will be variations in the length of time that benefits last according to the nature of the change and the characteristics of individual stakeholders. If significant assumptions have been required about the likely duration of changes then these will be tested in the sensitivity analysis.

In the absence of relevant research or stakeholder views that would suggest the time period the benefits are likely to last, the duration of all outcomes has been set at one year. It is likely that client outcomes will endure for a longer period but, at this stage, in the absence of robust evidence to support this hypothesis, a conservative approach has been adopted.

Outcomes lasting several years cannot be expected to maintain the same level of value for each of these years. This is dealt with by assuming that the value will reduce or 'drop off' each year. As none of the outcomes are predicted to last for longer than one year, neither duration nor drop-off are considered further.

6.2 Reductions in value to avoid overclaiming

As well as considering how long the changes a service or activity delivers will last, it is necessary to take account of other factors that may be influential. The recorded change might have happened regardless of the service, something else may have made a contribution to it, or the service may have displaced changes taking place elsewhere. In considering the extent to which each of these factors have played a part in the total impact, a realistic approach should be adopted. The aim is to be pragmatic about the benefits actually provided by the ability to access advisors in medical practices and to recognise that the value created is affected by other events. The SROI methodology does this by taking all these factors into account when calculating the actual impact a project or activity delivers.

6.2.1 Deadweight

A reduction for deadweight reflects the fact that a proportion of an outcome might have happened without any intervention. For example, patients may well have gained access to advice in some other way. The detailed assumptions about deadweight are contained in Appendix 1.5.

6.2.2 Attribution

Attribution takes account of external factors, including the contribution of others that may have played a part in the changes that are identified. For instance, it is likely that other factors, such as participation in support groups or medication may have contributed to the cost savings reported as a result of the improved mental health of patients. The detailed assumptions about attribution are contained in Appendix 1.5.

6.2.3 Displacement

Displacement applies when one outcome is achieved but at the expense of another outcome, or another stakeholder is adversely affected. In the analysis this is not considered to have occurred.

6.3 Calculation of social return

Appendix 1.6 details the values for each outcome that a stakeholder experiences and takes into account deductions to avoid over-claiming. These individual values have been added together then compared with the investment in the service provided at section 4.1 above.

The results show a social return on investment of around £39 for every £1 invested based on the assumptions set out above.

6.4 Sensitivity analysis

In calculating the social return on investment, it has been necessary to make certain assumptions which may include the use of data which is either not subject to universal agreement or which cannot be adequately evidenced. To assess how much influence this has had on the final value that has been calculated, a sensitivity analysis is carried out and the results recorded. By doing this the value of the benefits can be expressed within defined limits. The base level for testing is £38.62.

The most significant assumptions that were made were tested in the sensitivity analysis as detailed below:

Factor	Variation	Result
Attribution	Increase by 10%	£27.32
Attribution	Decrease by 10%	£49.76
Deadweight	Increase by 10%	£33.49
Deadweight	Decrease by 10%	£43.69
High value financial proxies (>£500)	Reduce by 10%	£34.85
High value financial proxies (>£500)	Reduce by 20%	£31.09
Quantities of patients/clients	Decrease by 15%	£34.30

It can be seen that varying the level of attribution has the most significant impact on the investment ratio. Attribution considers the contribution made by others to the changes recorded. There is limited research available that can be used to support the research findings and, in line with adopting a conservative approach, the level of attribution has been set highly.

As many stakeholders reported that the outcomes identified would not have happened if the activity had not taken place, it is suggested that levels of deadweight are either non-existent or very low. Varying the levels of deadweight does not impact greatly on the result.

The financial proxies used in relation to wellbeing and social inclusion/reduced stigma are derived from work published by HACT and the London School of Economics. These have been incorporated as a new evaluation approach in the Government's Green Book. The numbers reporting achievement of the outcomes are based on stakeholder surveys and scaling up the results.

For the reasons outlined above there can be a degree of confidence that between £27 and £50 of social and economic benefits are likely to be created for every £1 that is invested.

6.5 Materiality Considerations

At every stage of the SROI process judgements have to be made about how to interpret and convey information. Sometimes the rationale behind the decision is obvious and fully evidenced. However, on other occasions additional explanation or information may be required. SROI demands total clarity and complete transparency about the approach that is taken so that there is no possibility of confusion or misinterpretation. Applying a concept of materiality means that explanations must be offered for information that can be interpreted in different ways, and which can exert influence on the decisions others might take.

The concept can be of particular importance when ensuring that outcomes for stakeholders are relevant, are not perceived as being duplicated, and that the different values individual stakeholders may ascribe to the changes they experience are understood.

In assessing issues that are material SROI requires that various factors are taken into account. Stakeholder views are of paramount importance: from the outset, and throughout the preparation of this analysis, stakeholders were invited to comment on the interpretation of data and the inclusion of information. Engagement took various forms including e-mail requests for comment, telephone interviews and one to one meetings.

Financial proxies for patients/clients

To determine the financial proxies to be used to monetise the outcomes for patients/clients, in line with SROI principles, stakeholder consultation took place. The direct approach had limited success, as individuals were reluctant to engage in this aspect of the analysis. To provide a more robust and consistent measure, reference was made to the Housing Associations' Charitable Trust Wellbeing Valuation approach¹⁸ and Value Calculator.

The Wellbeing evaluation approach is included in HM Treasury's Green Book¹⁹ and *"measures the success of a social intervention by how much it increases people's wellbeing. To do this, the results of large national surveys are analysed to isolate the effect of a particular factor on a person's wellbeing. Analysis then reveals the equivalent amount of money needed to increase someone's wellbeing by the same amount"*²⁰.

The Value Calculator provides average values for several outcomes related to advice and the evidence that is needed to support their application. The content of the surveys used in stakeholder engagement and the corresponding changes reported by stakeholders were used to select the most appropriate outcome and value.

Sample sizes

The number of patients/clients who participated in the analysis, by completing a survey or taking part in an interview, was lower than anticipated. This resulted, in part, from individuals

¹⁸ <http://www.hact.org.uk/measuring-social-impact-community-investment-guide-using-wellbeing-valuation-approach>

¹⁹ <https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-government>

²⁰ Ibid 15

being reluctant to talk about financial problems or personal circumstances. Advisors were able to help individuals overcome any initial reluctance to an extent but, given the nature of the client/advisor relationship, there were limits to the extent they were able to exert influence.

It is acknowledged that the sample size used for scaling up the findings is small. However, there can be confidence that the group are representative of patients/clients, and there is strong evidence of this in the consistency of the responses that were received. Nevertheless, it is acknowledged that this is a weakness and, as such, it has been tested in the sensitivity analysis. It was found that reducing the number of patients/clients by 15% (the margin of error) did not have a significant impact on the cost to value ratio.

Unexpected outcomes

During the study, some outcomes were identified which were not included in the final impact map. Potential outcomes were identified through a combination of discussion with the Reference Group and engagement with a sample of stakeholders. The potential outcomes identified formed the basis of structured questionnaires/surveys designed to quantify the benefits, which were distributed to the wider sample of stakeholders.

Both questionnaires and surveys included open-ended questions and it was through the answers given that it was possible to identify unanticipated outcomes. As there is some uncertainty about the number (or quantity) of the stakeholder cohort who are likely to experience these outcomes, they have not been valued and included in the calculation.

It is likely that one of these outcomes, which relates to patients/clients, would have increased materially the investment to value ratio and hence is described below.

An unexpected outcome of co-locating advice workers in health centres is that patients experience **increased self-motivation and confidence to use other services**. As a result of the positive experience of engaging with advice workers in medical centres, some patients feel more confident about the prospect of seeking out further help in the future. They also develop greater understanding of their rights and have increased self-awareness of their own situation and the range of services available to them.

“I didn’t understand the welfare system at all, and this service helped a lot.”

“I now know where to go when I need help.”

7. Conclusion and Recommendations

The purpose of this analysis was to consider the benefits of co-locating advisors in medical centres who had direct access to medical records and, by monetising the various costs and benefits, the social return on investment was calculated.

All the outcomes identified, measured and valued have resulted from stakeholder engagement, and represent the benefits they actually experience. The analysis provides compelling evidence of the multiple benefits this approach delivers for funders, providers and service users. Using a different model for service delivery has resulted in significant impacts.

For an investment of c£49,000, funders receive benefits that are valued at c£92,000. The financial value of the impact of this investment on patients/clients is significantly more and equates to c£1,844,000. This represents a return of c£37.00 for every £1 invested.

However, investment is not justified solely on the 'best value' or the economic advantages that it delivers in the short term. The nature of the outcomes experienced by patients/clients will result in earlier intervention and reduced inequalities, which research shows reduces health costs and lowers demand for welfare benefits in the long term²¹.

Promoting health and wellbeing, which this approach achieves, enhances resilience, employment, and contributes to other social outcomes.

Recommendations

The findings from this analysis should be widely disseminated and consideration should be given to replicating this approach to service delivery on a Scotland-wide basis, whilst taking account of local needs and priorities.

This approach should be given due consideration by the Scottish Government in both the new Social Security powers and the Review of Advice Services in Scotland.

The Improvement Service and Scottish Public Health Network should facilitate support to advice services, NHS and Health and Social Care Partnerships to implement this approach as part of a local prevention strategy.

Stakeholder-informed approaches to identifying outcomes should play a key part in planning services and allocating resources.

The main benefits experienced by patients/clients are health-related and this should be reflected in the way that resources are allocated.

²¹ http://www.euro.who.int/_data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

Appendix 1: Audit trail and value map information

1.1 Stakeholders identified who were included or excluded

The Reference Group identified and considered potential stakeholders and outcomes.

Stakeholder	Included/ excluded	Rationale
Family and friends of patients/clients	Excluded	After initial consultation unable to identify sufficient potential beneficiaries to identify likely outcomes
Patients/clients	Included	Key stakeholders and likely to experience significant outcomes
Practice Team - GP, manager, nurses (1 from each group)	Included	Key stakeholders and likely to experience significant outcomes
Advisors	Included	Key stakeholders and likely to experience significant outcomes
Funders	Included	Key stakeholders and likely to experience significant outcomes

1.2 Engagement methods for 'included' stakeholders

Stakeholder	Method	Number	Medium
Patients/ Clients	Structured Questionnaire	8	One to one interviews
Patients/Clients	Short Survey	27	Paper survey
Practice Team - GP, manager, nurses (1 from each group)	Structured Questionnaire	20	One to one interviews
Advisors (All)	Structured Questionnaire	3	One to one interviews
Funders	Structured Questionnaire	3	One to one interviews

1.3 Outcomes identified but not measured

The reasons why it has not been possible to measure and value all outcomes have already been explained in section 6.5 on materiality. This section also considers, in detail, one of the outcomes which was not taken through to valuation but is likely to have impacted on the social return on investment ratio.

A further outcome that was identified, but which would not have had such a significant impact because it is experienced by fewer individuals, is considered below.

Practice Staff

An unexpected outcome of co-locating advice workers in medical practices is that practice staff experience **improved relationships with their patients**. Patients are less anxious and

stressed, as they are receiving assistance to address many of the issues about which they are worrying. As a consequence, practice staff can build better relationships with patients, making communication and agreement on solutions to medical issues easier. Overall, this contributes to a more pleasant and cooperative working environment.

“Once money problems are solved, we are able to build a better relationship with patients.”
Practice Nurse

“Patients problems are being solved, and so they don’t come to us with as much challenging behaviour anymore.”
Community Psychiatric Nurse

“Patients are less emotional and much calmer.”
Medical Secretary

No negative outcomes were identified in the analysis (a negative outcome is one which has an adverse effect on stakeholders).

1.4 Financial proxies

All of the outcomes that were included had a financial proxy assigned to them.

Stakeholder	Outcome	Financial Proxy	Value £	Source
Clients/Patients	Improved health and wellbeing	Housing Associations' Charitable Trust Social Value Calculator; average of outcomes Financial Inclusion: relief from being overly burdened by debt	£9,428.00	http://www.globalvaluechange.org/
Clients/Patients	Increased self-worth through feeling less stigmatised	Housing Associations' Charitable Trust Social Value Calculator Social Value Calculator; Member of Social Group	£1,850.00	http://www.globalvaluechange.org/
Clients/Patients	Improved access to services	Cost of travel based on average return journey prices by public transport in Dundee and Edinburgh	£3.40	https://lothianbuses.co.uk/tickets/ticket-options
Practice staff	Staff can make better use of time and focus on medically related interventions	Average hourly rate: £47.00 (GP) and £16.08 (Nurse)	£39.58	http://content.digital.nhs.uk/catalogue/PUB21763/nhs-staff-earn-jun-16.pdf
Practice staff	Better understanding of benefits and money advice	Basic training course	£300.00	http://www.cpag.org.uk/content/fees-and-booking-information
Practice staff	Increased job satisfaction	Stakeholder view	£50.00	Token of appreciation

Practice	Improved delivery of cost effective services	Reduction in Did Not Attend levels	£120.00	http://www.healthscotland.com/uploads/documents/25015-DNA%20analysis%20in%20Scotland_Who%20is%20least%20likely%20to%20attend_1.pdf
Advisors	Improved staff productivity as a result of reduction in appeals/ ongoing work through ability to access medical information	Number of additional hours available to offer support	£18.00	https://nationalcareersservice.direct.gov.uk/job-profiles/welfare-rights-officer
Advisors	Increased job satisfaction	Marginal increase in pay	£1,080.00	Staffing records provided by Dundee City Council
Funders: HSCP/LA	Reduced costs of mental health care as a result of earlier intervention	% cost of spend on adult mental health	£167.00	http://www.isdscotland.org/Health-Topics/Quality-Indicators/Publications/2013-03-26/2013-03-26-MH-Toolkit-Report.pdf
Funders: HSCP/LA	Reduced costs of publicity/ promotion as improved ability to target resources at priority groups	Health promotion costs exemplified by a Smoking Cessation campaign aimed at pregnant women - pre-Birth	£600.00	http://www.gov.scot/Topics/Research/by-topic/children-and-young-people/EarlyYears2

1.5 Deductions to avoid over-claiming

Stakeholder	Outcome	Deadweight %	Displacement %	Attribution %
Clients/ Patients	Improved health and wellbeing	25% Availability of alternative ways to achieve outcome	0% <i>Displacement does not apply to any outcomes</i>	66% Multiple factors will have contributed to

			<i>identified</i>	outcome
Clients/ Patients	Increased self-worth through feeling less stigmatised	25% Availability of alternative ways to achieve outcome	0%	66% Multiple factors will have contributed to outcome
Clients/ Patients	Improved access to services	0% Stakeholder consultation	0%	0% Stakeholder consultation
Practice staff	Staff can make better use of time and focus on medically related interventions	0% Stakeholder consultation	0%	0% Stakeholder consultation
Practice staff	Better understanding of benefits and money advice	0% Stakeholder consultation	0%	0% Stakeholder consultation
Practice staff	Increased job satisfaction	0% Stakeholder consultation	0%	0% Stakeholder consultation
Practice	Improved delivery of cost effective services	0% Stakeholder consultation	0%	0% Stakeholder consultation
Advisors	Improved staff productivity as a result of reduction in appeals/ ongoing work through ability to access medical information	0% Stakeholder consultation	0%	0% Stakeholder consultation
Advisors	Increased job satisfaction	0% Stakeholder consultation	0%	0% Stakeholder consultation
Funders: HSCP/LA	Reduced costs of mental health care as a result of earlier intervention	25% Availability of alternative ways to achieve outcome	0%	50% Multiple factors will have contributed to outcome
Funders: HSCP/LA	Reduced costs of publicity/promotion as improved ability to target resources at priority groups	25% Availability of alternative ways to achieve outcome	0%	25% Other factors will have contributed to outcome

1.6 Calculation

The table below summarises the factors that have been taken into account in calculating the total impact.

Stakeholder	Outcome	Quantity	Value	Less Deadweight	Less Displacement	Less Attribution	Impact
Clients/Patients	Improved health and wellbeing	616	£9,428.00	25%	0%	66%	£1,480,950.24
Clients/Patients	Increased self-worth through feeling less stigmatised	766	£1,850.00	25%	0%	66%	£361,360.50
Clients/Patients	Improved access to services	746	£3.40	0%	0%	0%	£2,536.40
Practice staff	Staff can make better use of time and focus on medically related interventions	67.25	£39.58	0%	0%	0%	£2,661.76
Practice staff	Better understanding of benefits and money advice	2.56	£300.00	0%	0%	0%	£768.00
Practice staff	Increased job satisfaction	7.67	£50.00	0%	0%	0%	£383.50
Practice	Improved delivery of cost effective services	80	£120.00	0%	0%	0%	£9,600.00
Advisors	Improved staff productivity as a result of reduction in appeals/ ongoing work through ability to access medical information	418	£18.00	0%	0%	0%	£7,524.00
Advisors	Increased job satisfaction	4	£1,080.00	0%	0%	0%	£4,320.00
Funders: HSCP/LA	Reduced costs of mental health care as a result of earlier intervention	403	£167.00	25%	0%	50%	£25,237.88
Funders: HSCP/LA	Reduced costs of publicity/ promotion as improved ability to target resources at priority groups	200	£600.00	25%	0%	25%	£67,500.00

Totals

The SROI calculation is expressed as a ratio of return from investment. It is derived from dividing the monetised value of the sum of all the benefits by the total cost of the investment.

In this report the total value is c£1,895,000; the total investment figure in the same period to generate this value is c£49,000.00.

The SROI ratio is calculated by dividing the present value by the investment.

The social return from investing in the co-location of advice workers in medical practices with consensual access to individual medical records is predicted to be in the region of £39 for every £1 invested.

For more information contact:

Karen Carrick, Project Manager, Money Advice Outcomes, Improvement Service

Tel Mobile: 07771 958963 Office: 01506 283566

Email Karen.carrick@improvementservice.org.uk

Kate Burton, Public Health Practitioner (Welfare Reform) Scottish Public Health Network

Tel Mobile 07970744519 Office 0131 537 9290

Email kate.burton@nhslothian.scot.nhs.uk

Appendix 2: The Principles of SROI

Principle	Description
Involve stakeholders	Inform what gets measured and how this is measured and valued by involving stakeholders
Understand what changes	Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended or unintended
Value the things that matter	Use financial proxies in order that the value of the outcomes can be recognised. Many outcomes are not traded in markets and as a result their value is not recognised
Only include what is material	Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact
Do not over-claim	Only claim the value that organisations are responsible for creating
Be transparent	Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders
Verify the result	Ensure independent appropriate assurance

The SROI Network has published a comprehensive guide to SROI. This can be downloaded at www.sroinetwork.org.uk