acvo
aberdeen's 3rd sector interface

Exploring the Social Impact of the ACVO TSI Supported Social Transport Project

31st July 2016

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STUDY OVERVIEW

The ACVO TSI Supported Social Transport Project (STP): Exploring its Social Impact

[1. What is the STP?]

- **Funded by the Reshaping Care for Older People Aberdeen Partnership Change Fund**
- **Resulted in the delivery of 2 services:**
  1. **An organisation focused group transport service**
     - Ended 31st March 2016 (a Change Fund requirement)
  2. **An individual focused flexible transport service (FTS)**
     - Funded until 16th December 2016

[2. What does the STP do?]

- **It helps Aberdeen City residents (aged 55 years and over who can't use regular public transport) to improve and maintain their quality of life**
- **It does this by helping them access health and social care in the city**
- **It provides a door-to-door, more accessible service, charged at a maximum return fare of £3.00 to the person travelling and no additional cost for a carer who travels with them**

[3. What is "Social Impact"?]

- **In this work "social impact" has been defined* as:**
  "the future consequences of a current or proposed action on individuals, groups, organisations or social systems" (adapted from Becker, 2001, p. 312 and Vanclay, 2003, p. 8)
- **It is an idea that can help us to:**
  - decide which course of action to take
  - plan and monitor a chosen course of action
- **An action may not always have 'good' social impact!**

[4. What did we do in the study?]

- **We sent questionnaires to people working in Primary Care (Practice Managers, GPs and Nursing Staff)**
- **We worked closely with the Falls Service at City Hospital**
- **We interviewed people (aged 55 years and over) living in Torry who were identified by the Torry GP Practice as "housebound"**
- **We looked at who was travelling – in terms of age and gender – where they were leaving from and where they were going to**

[5. What did we find from the study?]

- **The STP has the potential to have significant social impact in each different setting, for example, in terms of the capacity, form of delivery and cost of health and social care services, as well as (and most importantly) on people's health and wellbeing**
- **"Social impact" looks different to different groups of people in different settings, e.g., in Primary Care, in the Falls Service, in a local area**
- **The way that the STP has been operated and accessed *may* need to change in order for that significant social impact to be realised**
- **The evidence we collect and how we collect it needs careful consideration if we are properly to understand and demonstrate the continued social impact of the STP**

References:
Becker, H. A. (2001) Social Impact Assessment, *European Journal of Operational Research*, 128(2), 311-321
Vanclay, F. (2003) International Principles for Social Impact Assessment, *Impact Assessment and Project Appraisal*, 21(1), 5-12

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KEY MESSAGES

MS SUPPORT

- "Not a stressful journey anymore."
- "It's good to know you are guaranteed a lift."

PULMONARY REHAB

- "It takes the stress and anxiety out of the journey; you can attend classes feeling positive."

ALTENS COMMUNITY CENTRE

- "I would go hungry without transport to the shops."
- "It's the only outing we get. We appreciate it."

FERRYHILL COMMUNITY CENTRE

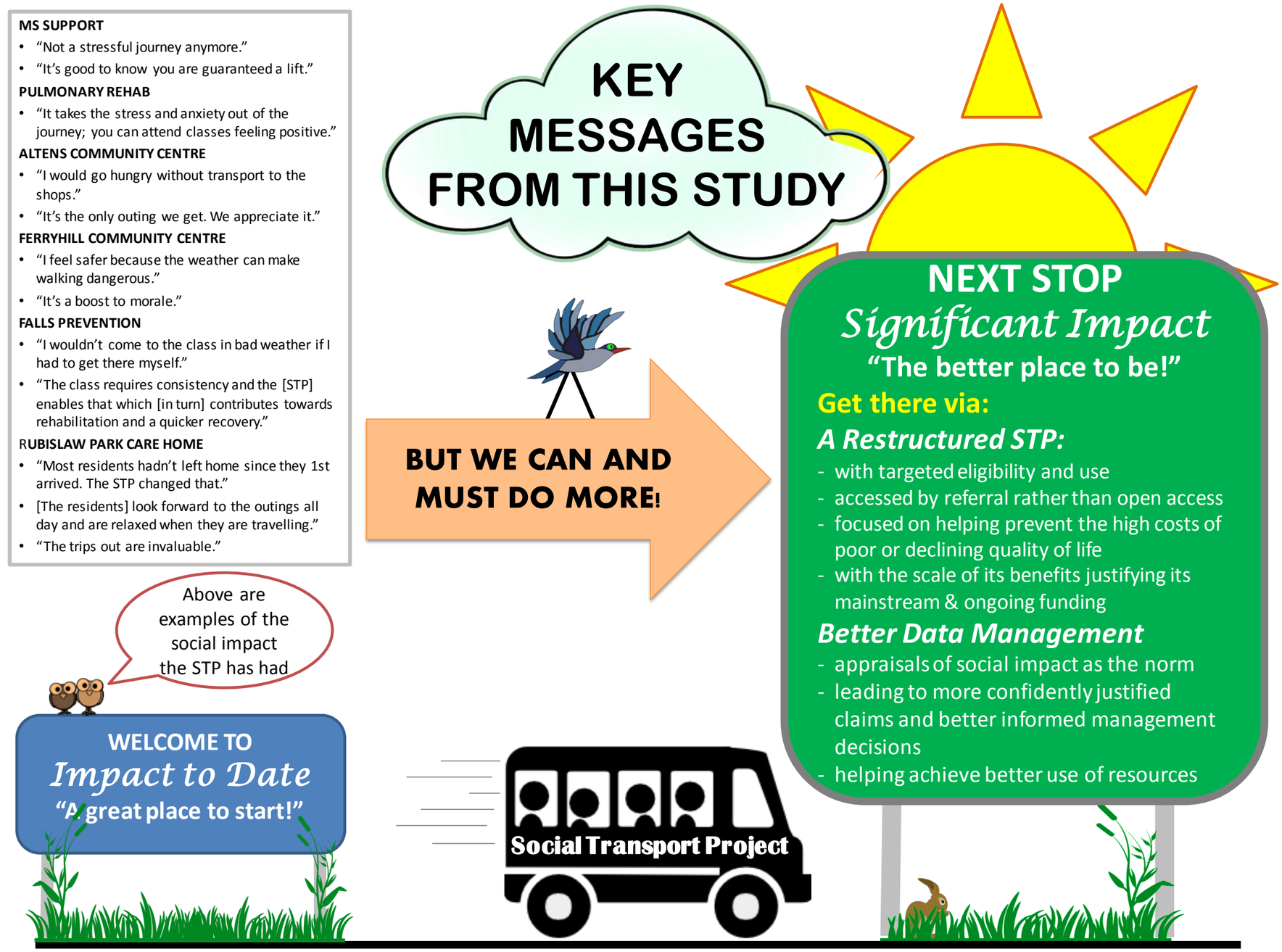
- "I feel safer because the weather can make walking dangerous."
- "It's a boost to morale."

FALLS PREVENTION

- "I wouldn't come to the class in bad weather if I had to get there myself."
- "The class requires consistency and the [STP] enables that which [in turn] contributes towards rehabilitation and a quicker recovery."

RUBISLAW PARK CARE HOME

- "Most residents hadn't left home since they 1st arrived. The STP changed that."
- [The residents] look forward to the outings all day and are relaxed when they are travelling."
- "The trips out are invaluable."



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EXECUTIVE SUMMARY

1.0 Introduction

This is a report about research to explore the social impact of the ACVO TSI supported social transport project (STP). This Executive Summary comprises 4 sections: section 2.0 explicitly states the principal findings of the research; section 3.0 then provides the background to those findings by offering a brief overview both of the STP and of the nature of and need for this study of its social impact, and finally; sections 4.0 and 5.0 present the recommendations (for Integration and for the ACVO Board respectively) and opportunities for further work arising out of the research.

2.0 The Principal Findings of this Research

This work has found that the STP has undoubtedly effected constructive social impact for the 623 people that have so far registered to use the service. It has done this by providing person-centred, door-to-door, nil or low cost[1] travel for individuals and groups to access health and social care services and to take part in activities conducive to improving or maintaining their quality of life. However, the analysis suggests that – with changes to the way the STP is operated and accessed, as well as to the types of data collected about it – the STP has the potential to effect *significantly more* constructive impact throughout the health and social care ecosystem. In other words, constructive impact not just for those stakeholder groups comprising people that do, have, should or could use health and social care, but for those stakeholder groups – i.e., people and organisations – that provide such services. Indeed, in financial terms, the scale of the potential benefits – identified through this research – is such that there is already a strong argument for the mainstream and ongoing funding of social transport for this purpose. Further work on the social impact of the STP will ultimately strengthen that argument.

[1] To the person travelling.

3.0 Overview of this Study and of the STP

ACVO conducted this research for 2 reasons:

- firstly, to establish if and how the concept of social impact could provide the basis for a more holistic and socially just appraisal of an intervention. In other words, an appraisal that – in addition to the more conventional operating and headline financial data – also considers the wider social and economic implications, including those relating to people's objective and subjective wellbeing, i.e., their "quality of life"[2], and;
- secondly, to explore and understand the realised and potential social impact of the STP with a view to ensuring that it does not fall foul of the inverse care law which states that: "… the availability of good medical care tends to vary inversely with the need for it in the population served" (Hart, 1971).

Consequently, this report considers, among other things: the meaning, use and value of the concept of social impact; the nature, scope and scale of evidence needed to demonstrate the social impact of an intervention (i.e., the STP); and the means by which that evidence has, could and should be collected.

This is all set within the context of the integration of health and social care in Aberdeen city (hereafter "Integration") and in relation to decision-making about the form, fit, function, funding and future of interventions, in this case of social transport, in that context.

Research of this nature displays a good fit with the work of the 3rd sector – of which the TSIs are an integral and essential part – for 3 key reasons:

- firstly, by its very nature, the sector is in daily close contact with (and acts as a conduit for) wider society with regards to a very broad range of quality of life issues;
- secondly, as generalists rather than specialists, the sector is less hampered by the problems of "silos", (Scottish Government, 2011) and;

[2] For a brief overview of the concept of quality of life see, e.g., de Groot and Steg (2006, pp. 463-465).

- finally, by it's very existence, the sector is constituted of a significant number of people who value and demonstrate flexibility, responsiveness and empathy, and are proactive about building a better society, particularly for those individuals and groups in greatest need.

Services provided by the 3rd sector are considered to be a means to an end; that end being to improve or maintain an individual's quality of life. Consequently, there is no place for the notion of "Serviceland" (Tomlinson, 2008) in the sector because services are expected to be person-centred and, hence, to effect constructive impact in an individual's life in a multitude of ways meaningful to that individual. Because of this – and because it is inherently dynamic, innovative and reflexive – the 3rd sector can make a significant contribution in the context of partnership working, sometimes in surprising ways.

Funded from an award to ACVO by the Reshaping Care for Older People Aberdeen Partnership Change Fund, the STP originally comprised 2 strands: (1) an organisation focused group travel service (which ended 31st March 2015 – a Change Fund requirement), and; (2) an individual focussed flexible transport service (FTS) called *THInC – Transport in the City*, due to its relationship with the HTAP partners' existing transport to health and social care information centre (THInC). At the time of writing the 2 vehicle FTS was ongoing and had funding in place to allow it to operate until **16th December 2016**.

The STP was established with the *explicit aim* of helping Aberdeen city residents – aged 55 years and over and unable to use conventional public transport – to access health and social care provided by the public, private and 3rd sectors. The *implicit aim* of the STP was, therefore, to help those same residents improve or maintain their quality of life. An appraisal of the social impact of the STP was considered necessary in order to more fully understand its role and value, with a view to informing decisions about its form, fit, function, funding and future.

In this work, social impact was defined as:

> the future consequences – of a current or proposed intervention – on individuals, organisations and social systems. Whereby, "consequences" regards changes to,

e.g., people's quality of life. (Adapted from Becker, 2001, p. 312 and Vanclay, 2003, p. 8)

In accordance with this definition, evidence to support claims and arguments about the social impact of the STP was collected using 4 mechanisms: (1) a citywide survey of primary care clinical staff and GP practice managers; (2) telephone interviews with patients registered with Torry GP Practice and identified by the practice as "housebound"; (3) a collaborative diagramming exercise exploring the relationship between the STP and the delivery of the Falls Service based at City Hospital in Aberdeen, and; (4) operating data from "Trapeze", the transport and travel management software for the THInC – Transport in the City FTS.

Through analysis and critical review of the resultant dataset, and through a critical review of public sector, 3rd sector and scholarly literature, the recommendations arising out of this study are as follows.

4.0 Recommendations in Relation to Integration

4.1 Partnership Building

Social impact is a concept that has the potential to make a significant, constructive contribution to the decision-making process, particularly within the context of Integration. It is well suited to the tasks of: (a) prospective evaluation, i.e., helping to chose between possible courses of action, and; (b) the planning and progress monitoring of a chosen course of action. Conversely, by its very definition and because of issues with acquiring the necessary data, using it for retrospective evaluation, although not impossible or without value, can be problematic and, in any event, may be akin to closing the stable door after the horse as bolted. However, it must be used carefully and consistently by ACVO and throughout the Aberdeen City Health and Social Care Partnership (ACH&SCP) ACH&SCP. Doing so will contribute to establishing the clarity and unity of understanding, purpose and action essential to achieving, among other things, high levels of stakeholder engagement, creating a strong sense of community and building effective teams (CIPD, 2016, p. 5). Indeed, this argument applies to a range of concepts and practices – e.g., "social justice" and

"community" – and will be integral to the success of Integration. It is recommended, therefore, that:

a. ACVO builds on the foundations laid down in this exploratory study and continues to develop a capability in relation to social research more generally and appraisals of social impact specifically, particularly where such work enables the net value to society of an intervention to be established;

b. because of the value they can add to the decision-making process, there should be a presumption in favour of performing appraisals of the social impact of interventions.

It is essential to recognise that the high quality social research (including that related to appraisals of social impact) needed to effect the recommendations set out in this report, is challenging and, at the very least, depends on: (a) being able to identify the stakeholder groups and individual points of contact within those groups; (b) developing an adequate understanding of the work, working and living contexts of those stakeholders relevant to the task at hand; (c) having adequate time and opportunity to develop and maintain effective personal and working relationships, and; (d) receiving timely responses to questions. (Note that the work of ACVO's Partnership Manager has been essential in helping to meet some of these conditions.) It is also recommended, therefore, in collaboration with the ACH&SCP and its partners, that:

c. ACVO implements appropriate arrangements – e.g., maximises opportunities for co-located working – with and within the ACH&SCP and its partners. This should be done with a view to supporting the development of effective working relationships and information flows, particularly where teams have been temporarily convened with regards to a specific intervention or action;

d. ACVO, also in collaboration with the ACH&SCP and its partners, continues to work to disseminate any learning, from its research and social impact activities, across the entire health and social care ecosystem;

e. ACVO continues to contribute to the goal of bringing about greater transparency, clarity and accessibility – in the context of social research

generally and social impact specifically – with respect to understanding who does what within the health and social care ecosystem.

4.2 Alignment

Allied to the preceding recommendations, it is recommended that proposals for interventions are developed and evidenced, with due consideration being paid to:

a. why a specific intervention is needed and is the preferred course of action;
b. how that intervention sits within the context of and contributes to the fitness-for-purpose of the wider health and social care ecosystem;
c. how that intervention aligns with the guiding principles of ABCD (in relation to *all* stakeholder groups) as well as the 3 Horizons Model of Transformative Change;
d. how it contributes (including in terms of its social impact) to the Strategic Priorities set out in the ACH&SCP Strategic Plan (2016), and;
e. most importantly, how it helps improve or maintain the quality of life of Aberdeen's citizens.

4.3 Prioritisation

In relation to the design and delivery of surveys (and indeed any data gathering mechanism) – it is important to try to develop as full an understanding as possible of the context in which that mechanism will operate. It is therefore recommended that:

a. adequate time be spent in dialogue with potential participants before any research design and delivery decisions are taken. While timescale will likely pose a problem in this regard, quality should be prioritised over quantity of data;

b. due consideration be given to undertaking smaller, more focussed, more collaborative research exercises, rather than more complex, larger scale, catch-all ones.

4.4 Evidence Based Management

In respect of the possible tensions arising with regards the relative worth of 'objective' and 'subjective' data – and given the values promoted in the Strategic Plan (ACH&SCP, 2016) – it is recommended that ACVO, in collaboration with the ACH&SCP and its partners, works to develop a form of guidance for all stakeholder groups on how to deal with the tension between – e.g., economic and value driven considerations – in decision-making in practice.

4.5 Targeted Support and Developing Options for Delivery

As discussed in section 2.0, the STP has undoubtedly effected constructive social impact for the people who have benefitted from its services. However, it was found to have the potential to do and to demonstrate *considerably* more and – because of its further potential to effect financial savings over and above its own cost – to be a very strong candidate for receiving mainstream and ongoing funding. This could be achieved, it has been argued in this report, through the STP helping:

a. reduce the number of avoidable home visits by (primary care) clinical staff, freeing up time for other tasks;
b. support innovation in the delivery of primary care, e.g., enabling the provision of ad-hoc community based, multi-agency clinics;
c. improve or maintain attendance at – e.g., the Falls Service and its associated exercise classes – thereby helping reduce the incidence of falls in the city and the downstream social and economic costs of an individual incurring a fall;
d. tackle health inequalities – arising from inequalities in access to health and social care services – and the associated social and economic costs of poor or declining health, and;
e. improve the quality of life of "housebound" individuals by enabling them to achieve reasonable goals such as meeting friends, attending clubs, going shopping and seeing their home city of Aberdeen for the 1st time in 2 years.

Building the evidence and arguments required to support this claim likely requires a change both to the way that the STP is currently operated and accessed, and to the sources and types of data that are collected in relation to its services and

impact. It is recommended that a further phase of work be undertaken during the remainder of 2016 which – with a view to maintaining continuity of service beyond the current 'end' date of **16th December 2016**:

a. collaboratively develops a set of alternative approaches to operating and accessing the STP (including the associated eligibility criteria) so that those people with the greatest need to travel are those that are both eligible and get to use it as a matter of priority. This is consistent with the intention to tackle health inequalities and to help bring about a more just society;

b. prospectively evaluates those approaches – including through an evaluation of their likely social impact – with a view to identifying either a unique or blended preferred approach, and;

c. seeks funding for the implementation of that preferred approach.

4.6 Holistic Approach to Service Delivery

Transport related issues should not be solely a matter for patients to raise since that runs the risk that: (a) only the most capable are heard and have the chance of being appropriately supported, and; (b) that health inequalities will, consequently, persist. It is recommended that consideration is paid to how – in the context of the health and social care ecosystem – information about people's transport related issues and needs (in the broadest sense) is most appropriately collected and used.

5.0 For the ACVO Board

The concept and practices of social impact – when properly, carefully and consistently used – are relevant and, hence, valuable in and within the context of ACVO's activities and, by extension, throughout the 3rd Sector as a whole. Those concepts and practices offer significant potential in terms of supporting effective decision-making by ACVO, its members, partners and affiliates. It is recommended that they be adopted, developed and promoted by ACVO for that purpose.

To ensure that ACVO is appropriately equipped to support its members and affiliates in this regard, and to continue to champion their needs in the context of Integration, as well as at higher levels of governance, the following are also recommended:

a. through performing a gap analysis, ACVO develops a better appreciation of the resources needed to support its research, evaluation, planning and monitoring capabilities. Some of those resources will be freely accessible or could be made available through emerging partnerships with, e.g., Aberdeen's universities. Some – particularly those associated with high quality research practice – including software for: accessing existing research, analysing texts and doing statistical analyses, will have an associated cost.

b. ACVO prepare a framework protocol for the conduct of high quality social research (including that relating to appraisals of social impact) incorporating the learning arising out of this exploratory study. That protocol should also set out ACVOs approach to the topic of research ethics, including the requirements and process for ethics review to secure approval.

6.0. Next Steps and Closing Remarks

Work to ensure that interventions (in this case the STP) are developed, planned, implemented and monitored – using high quality decision-making data – is essential to the fitness-for-purpose of the health and social care ecosystem and, thus, the quality of life of Aberdeen's citizens. The STP has most definitely had constructive social impact but has the potential to do *considerably more*. However, it is imperative that the necessary mechanisms are in place to collect evidence to more confidently support that claim. A further phase of work to cement ACVOs understanding of and approach to appraisals of social impact is necessary and worthwhile. It will help to ensure (through high quality evidence and argument) that interventions, in this case the STP, are not cast aside – on the grounds of their headline cost alone – as being "a nice to have" rather than a necessity. Failure in this regard would leave those people – who, in the context of the STP, are genuinely in need of social transport and who may harbour a modest ambition either to go shopping, to meet friends, to attend clubs or to see

their home city for the first time in 2 years – with a quality of life that is inconsistent both with the aims of Integration and the Government's ambitions for life in 21st century Scotland.

Dr Rob Craig
ACVO TSI, July 2016

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ACKNOWLEDGEMENTS

ACVO TSI has been proud to be a part of the Change Fund process and to play a key role in exploring, developing and enhancing the 3rd sector's contribution to people's quality of life within the context of health and social care integration here in Aberdeen.

We would like to offer our sincere thanks to all of those people – too numerous to name individually – that participated in this research and that gave freely of their time, and of their life and work experience, to contribute to and to support this work.

Joyce Duncan – CEO, Jane Russell – Partnership Manager and
Rob Craig – Research and Social Impact Consultant
ACVO TSI, July 2016

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ACRONYMS, ABBREVIATIONS AND SYMBOLS

ABCD	Asset Based Community Development
ACH&SCP	Aberdeen City Health and Social Care Partnership
ACHCV	Aberdeen Community Health and Care Village
ACVO TSI	Aberdeen Council for Voluntary Organisations 3rd Sector Interface
ARI	Aberdeen Royal Infirmary
CAARS	Community Adult Assessment and Rehabilitation Service
CIPD	Chartered Institute of Personnel and Development
DACB	[Buchan] Dial-a-Community Bus
DN	District Nurse
ff.	following pages
FTS	Flexible Transport Service
GP	General Practitioner
H	Horizon (as in H1, H2 and H3)
HTAP	Health and Transport Action Plan
SPSS	Statistical Package for the Social Sciences
IDEF	Integrated Definition for Function Modelling
IFF	International Futures Forum
ISD	Information Services Directorate (of the NHS)
K	thousand
NHS	National Health Service
p.	page
PDSM	Practice Development and Support Managers
PM	Practice Managers
pp.	pages
SIA	Social Impact Assessment
STP	Social Transport Project
THInC	Transport to Health and Social Care Information Centre
TSI(S)	Third Sector Interface(s)
%	percent, percentage

1.0 PURPOSE AND SCOPE OF THIS REPORT

1.1 This is a report about research to explore the social impact of the ACVO TSI[3] supported social transport project (STP). The work started on 1st October 2015 with around 80 days of funded resource and ended, with this report, on 31st July 2016.

1.2 ACVO conducted this research, in relation to the STP and its operating context, to establish if and how the concept of social impact could provide the basis for a more holistic and more socially just appraisal of an intervention. In other words, an appraisal that – in addition to the more conventional operating and headline financial data – also considers the wider social and economic implications, including those relating to people's objective and subjective wellbeing, i.e., their quality of life[4] (for a brief overview see, e.g., de Groot and Steg, 2006, pp. 463-465).

1.3 Consequently, this report considers, among other things: the meaning, use and value of the concept of social impact; the nature, scope and scale of evidence needed to demonstrate the social impact (in this case) of the STP, and; the means by which that evidence has, could and should be collected and used.

1.4 This is all set within the context of the integration of health and social care provision in Aberdeen city (hereafter "Integration") and in relation to decision-making about the form, fit, function, funding and future of the STP (or indeed any intervention) in that context.

1.5 Research of this nature displays a good fit with the work of the 3rd sector generally – of which the TSIs are an integral and essential part – for 3 key reasons:

- firstly, by its very nature, the sector is in daily close contact with wider society with regards to a very broad range of quality of life issues;

[3] Aberdeen Council for Voluntary Organisations - Aberdeen's 3rd Sector Interface, see: www.acvo.org.uk

[4] Which de Groot and Steg (2006 citing Delhey et al., 2003 and Poortinga et al., 2006 respectively) consider to be applicable at the level of the individual and of society and to comprise 22 indicators, one of which is health.

- secondly, as generalists rather than specialists, the sector is less hampered by the problems of "silos" (Scottish Government, 2011), and;
- finally, by it's very existence, the sector is constituted of a significant number of people who value and demonstrate flexibility, responsiveness and empathy, and are proactive about building a better society, particularly for those people in greatest need.

1.6 Services provided by the 3rd sector are considered to be a means to an end; that end being to improve or maintain an individual's quality of life. Consequently, there is no place for the notion of "Serviceland" (Tomlinson, 2008) in the sector because services are expected to be person-centred and, hence, to effect constructive impact in an individual's life in a multitude of ways meaningful to that individual. Because of this – and because it is inherently dynamic, innovative and reflexive –, the 3rd sector can make a significant contribution in the context of partnership working, sometimes in surprising ways.

1.7 Returning now to the present work, this report is structured as follows: section 2.0 provides a brief overview of the history and operation of the STP; section 3.0 discusses the nature of the concept of social impact and defines its use in this work; section 4.0 places this study in its wider context and sets out its aim and objectives; section 5.0 explores the approach to collecting primary and secondary data; section 6.0 presents a critical review of the resultant social impact dataset and the findings arising from this work; section 7.0 summarises the report before presenting its conclusions, and finally; section 8.0 presents recommendations – including suggestions for further work – in relation to appraisals of social impact and to the operation of the STP.

2.0 AN OVERVIEW OF THE SOCIAL TRANSPORT PROJECT (STP)

2.1 In 2012 – to address a systemic, transport related[5], issue with delivering quality of life related projects across the city, and in collaboration with a range of statutory and non-statutory partners, Table 2.1 – ACVO TSI

[5] Primarily a scarcity of transport suitable for those people with, e.g., specific physical or emotional needs.

secured around £450K from the Reshaping Care for Older People Aberdeen Partnership Change Fund.

Project Leads	• ACVO TSI • Robert Gordon University – Aberdeen Business School • NESTRANS[6] • Scottish Care
Aberdeen Social and Community Transport Group	• Aberdeen City Council Public Transport Unit • Buchan Dial-a-Community Bus • British Red Cross • Royal Voluntary Service • Co-wheels Car Club Aberdeen

Table 2.1: Aberdeen Partnership Change Fund – Proposal Partners

2.2 Subsequent to this award – and ACVO commissioned research, by Robert Gordon University in 2014, on developing a social transport infrastructure to support Change Fund projects – ACVO issued a call for proposals for the funding of transport to support 'services' which help improve or maintain the quality of life of Aberdeen's residents.

2.3 Of 34 proposals received 13 were approved, see Table 2.2. Those 13 constituted the 1st of 2 strands comprising the STP, namely, *organisation focused*[7] *group transport*. This provided for individuals to travel as part of a group – to attend a place on a day and at a time, *all* specified by an organisation – to take part in that organisation's activities.

2.4 This strand was operated collaboratively. Thus, ACVO arranged and paid for a vehicle to be available in accordance with the activity schedules agreed with each organisation, and; each organisation sent the details of those wishing to travel direct to the relevant transport provider, who then provided a door-to-door[8] return service without charge to those travelling.

2.5 The service started in late 2014 with an *explicit* end date of 31st March 2016 (a Change Fund requirement). In November 2015, ACVO began assisting each organisation with their efforts to assure continuity of transport for their respective participants beyond the March deadline.

[6] North East Scotland Regional Transport Partnership, see: www.nestrans.org.uk
[7] But nonetheless person-centred!
[8] From and to their place of residence.

ORGANISATION
1. Aberdeen City Council Social Care and Wellbeing – Men's Group
2. Altens community Centre – ASDA run
3. Altens community Centre – Tuesday Club
4. Altens Tuesday Club – Pensioner's Bingo Group
5. Balnagask Community Centre
6. Ferryhill Community Centre – Thursday Fitness Class
7. MS Society at the Stuart Resource Centre
8. NHS City Hospital Falls Prevention Group
9. NHS City Hospital Falls Triage Clinic
10. NHS City Hospital Pulmonary Rehab Group
11. NHS Forest Grove Carer's Exercise and Information Group
12. NHS Heart Failure Clinic
13. NHS Wound Clinic at the Health Village

Table 2.2: The 13 Organisations Securing Group Transport Support

2.6 In parallel with the group transport activity, ACVO funded a single vehicle, flexible transport service (FTS)[9] – jointly operated by Buchan Dial-a-Community Bus (DACB) and the HTAP[10] partnership. This constituted the 2nd of the 2 strands comprising the overall STP, namely, an *individual focused FTS*.

2.7 This strand *continues*, successfully, to provide for individuals to travel independently (or with a carer) – to attend a place on a day and at a time, all of *their* own choosing – in order to access 'services' aimed at improving or maintaining their quality of life. Door-to-door, wheelchair accessible, direct to destination transport is provided by drivers, chosen in part on the basis of their people skills, and trained in adult protection and, dementia and falls awareness[11]. Journeys are charged to the person travelling at a maximum return fare of £3.00, there being no additional charge if a carer travels with someone.

[9] "Flexible Transport Service (FTS) is an emerging term which covers [a service] provided for passengers … which [is] flexible in terms of route, vehicle allocation, vehicle operator, type of payment and passenger category." (Mulley and Nelson, 2006, p. 40)

[10] See: www.nhsgrampian.org/grampianfoi/files/NHSG_Nestrans_HTAP_2014.pdf (HTAP - Health and Transport Action Plan covers the notional Grampian Region of Aberdeen city, Aberdeenshire and Moray).

[11] In other words it is also very much a person-centred service.

2.8 Commencing in March 2015, the individual focused FTS (hereafter just "FTS") quickly evolved into its present form. Thus, DACB take responsibility for the vehicles and drivers, and the HTAP partners take responsibility for the travel booking and vehicle scheduling capability, provided through their existing Transport to Health and Social Care Information Centre (THInC). This relationships means, therefore, that the FTS has been promoted as *THInC - Transport in the City*[12].

2.9 In mid-February 2016 the FTS was bolstered by a 2nd vehicle entering service, mainly to support the South Locality[13] but still available citywide at 'off-peak' periods[14]. At the time of writing, the 2 vehicle THInC - Transport in the City FTS was ongoing and funded until **16th December 2016**.

2.10 In summary, the STP originally comprised 2 strands[15]: (1) an organisation focused group transport service, and; (2) an individual focused FTS called THInC - Transport in the City. These services had both explicit and implicit aims. In short, their *explicit aim* was to help Aberdeen city residents, aged 55 years and over[16] and unable to use conventional public transport, to access health and social care provided by the public, private and 3rd sectors. Their *implicit aim* was, therefore, to help those same residents improve or maintain their quality of life.

2.11 There is an important observation to make here about the foregoing paragraph. Firstly, in its current form, the *explicit aim* of the STP is couched in terms relating to the movement of people. Arguably, this represents what the International Futures Forum's (IFF) development of the *3 Horizons Model of Transformative Change* would consider to be "H1" type thinking, i.e., the siloed thinking that is typical of the "… dominant system at present … [the system which loses] strategic fit and therefore dominance over time" (IFF, 2016).

[12] This service is overseen by but *typically* operates without the day-to-day involvement of ACVO TSI.
[13] The Aberdeen City Health and Social Care Partnership's Integration test locality.
[14] In other words, spare capacity on the South Locality vehicle, in so far as is possible, will not go to waste.
[15] At the time of writing only the 2nd strand, i.e., the individual focused FTS, continues to operate.
[16] This criterion is thought to have stemmed from the funding source: "Reshaping Care for Older People."

2.12 As an aside, the IFF model comprises 2 further horizons relevant to this discussion, namely: Horizon 2 (H2) – representing innovations that benefit from opportunities arising due to social change, and; Horizon 3 (H3) – which accords with underlying patterns in society and which eventually becomes the dominant system (*ibid.*). H2 can be delineated further in terms of "sustaining innovations" (H2-) those which act to maintain the dominance of the current (H1) system, and "disruptive innovations" (H2+) those which hasten progress towards H3 (*ibid*.).

2.13 With this in mind, the position taken in this work is that the explicit aim of the STP (in its role as an enabling capability, e.g., in respect of accessing health and social care) *should* be cross-cutting and, hence, more strategic and *should* align with (if not directly reflect) the Strategic Priorities set out by the Aberdeen City Health and Social Care Partnership (ACH&SCP) in their Strategic Plan (2016, pp. 10-12). Taking this approach would immediately shift the emphasis – of appraisal, planning and monitoring for this and, indeed, any other intervention – away from the intervention itself (e.g., the STP and the physical movement of people) and towards what ultimately matters, i.e., the quality of life of Aberdeen's citizens.

2.14 This alternative stance would seem to accord more closely with H2+ type thinking and, in a broader context than just the STP, offers at least 2 potential benefits. Firstly, it would mean that the priorities set out in the ACH&SCP Strategic Plan would be directly linked to, *explicitly* reflected in and provide a common purpose for the day-to-day actions of every stakeholder in the health and social care ecosystem[17]. Secondly, it provides a degree of commonality across a range of decision-making contexts. So, for example, requests for financial support from the Integrated Care Fund would have to clearly demonstrate the contribution of a proposed course of action to the common purpose and, hence, in turn to the Strategic Priorities.

[17] For an explanation of the use of this term, see the discussion in section 5.2.

2.15 This study follows the above line of argument and considers the social impact of the STP in terms both of the quality of life of Aberdeen's residents, and of the fitness-for-purpose of the health and social care ecosystem itself. This position is developed further through discussion of the *concept* of social impact and it is to that discussion that attention is now turned.

3.0 THE CONCEPT OF SOCIAL IMPACT AND ITS PLACE IN THIS WORK

3.1 Defining the term "social impact" and placing it in the present context is important because it has a direct bearing on the value of this work and on how that value is realised. For example, it aids decisions on what the aim and objectives of the work should be and how the claim, that the aim and objectives have been met, is substantiated. This, in turn, informs decisions about the nature, scope and scale of the data needed to support such a claim, as well as the means by which that data is collected, analysed and used. Thus, for the purposes of this work, social impact is defined as:

> the future consequences – of a current or proposed intervention – on individuals, organisations and social systems. Whereby, "consequences" regards changes to, e.g., people's quality of life.
>
> (Adapted from Becker 2001, p. 312 and Vanclay 2003, p. 8)

3.2 There is an important point to make here about the definition and use of a term such as "social impact"[18]. This is that it represents a *concept* that can mean different things to different people in different contexts. To use it without defining it and placing it in context risks it being misused, popularised and eventually to lose meaning *and* value (McNiff, 2013, p. 6).

3.3 Consequently, as a matter of the quality of the output, outcomes and impact of ACVO's work, it is important that concepts and their definitions (which may relate to practices too) are used carefully and consistently; indeed, this stance should be adopted throughout the ACH&SCP. That is not to suggest that such concepts and definitions should be exempt from

[18] This is relevant to the definition and use of many other such terms e.g. social exclusion and inequality.

ongoing critical review and, as necessary, revision. Rather it is to suggest that their considered and consistent use is integral to establishing the clarity and unity of understanding, purpose and action essential to achieving, high levels of stakeholder engagement, creating a strong sense of community and building effective teams (CIPD, 2016, p. 5).

3.4 Allied to the foregoing point, it is also a matter of quality that stakeholders in the health and social care ecosystem have *ready access* to the resources required to develop a considered appreciation – not only of concepts, definitions and practices – but of a particular issue and its potential resolutions. Those resources include, e.g., corporate knowledge bases and research output, secondary data, policy and strategy documents, and the skills and tools, time and support required to extract maximum value from those resources.

3.5 Moving the discussion forward, and in view of the points made in paras 3.1 to 3.3, it is important to be clear that this study is *not* intended to be and, therefore, is not identified as a Social Impact Assessment (SIA) which, according to Vanclay (2003, p. 6):

> "… includes the processes of analysing, monitoring and managing the intended and unintended social consequences, both positive and negative, of planned interventions (policies, programmes, plans, projects) and any social change processes invoked by those interventions. [An SIA's] primary purpose is to bring about a more sustainable and equitable biophysical and human environment."

3.6 While the *present work* broadly conforms with the spirit of this definition – which is endorsed by the International Association for Impact Assessment[19] (IAIA) – this research is approached in a less prescriptive, more open-minded, more collaborative and more person-centred way.

3.7 Further, this work is also *not* intended to be an assessment of social value; a term which Polonsky and Grau (2008, p. 130) define as:

[19] See www.iaia.org

> "… the total social impact [an organisation] has on all its stakeholders and thus needs to have a broader scope than might traditionally be considered in performance evaluation. Our definition is adapted from Dillenburg, Greene, and Erekson (2003), which suggests that [an organisation's] total social impact includes [its] interaction with key stakeholders: consumers, employees, owners and investors, suppliers, competitors, communities, and the environment."

3.8 In other words, "social value" – in the light of the above definition at least – is the net effect of all social impacts (for every stakeholder group) that a particular activity may lead or actually leads to. While, within the context of health and social care provision as a form of ecosystem, an appraisal of the social value of an intervention should be the ultimate goal, it requires a level of resource far exceeding that available for the present work.

3.9 Consequently, the present work should be viewed (and is referred to) as an *exploratory* study of the social impact of the STP. It is on this basis that the aim and objectives of the work have been established. These are set in their wider context and discussed further in the following section.

4.0 STUDY CONTEXT, AIM AND OBJECTIVES

4.1 Context

4.1.1 This exploratory study of the social impact of the STP is taking place against the backdrop of Integration in Aberdeen city. The requirement to integrate health and social care has been driven by the accession of the Public Bodies (Joint Working) (Scotland) Act 2014 which mandates:

- nationally agreed health and social care outcomes for which NHS Boards and Local Authorities will be held to account;
- the formation of health and social care partnerships incorporating the 3rd and private sectors in service planning and delivery, and;
- the associated integration of health and social care budgets.

(Scottish Government, 2014)

4.1.2 Since the STP was established to support access to health and social care and, since it was to operate within the context of Integration, the interrelationship between the STP and Integration is an important element of the present work. In this regard, there are 2 aspects that merit particular consideration: (1) the shift towards Asset Based Community Development (ABCD Institute, 2016), and; (2) the use of the "3 Horizons Model" (already discussed) to help secure and sustain cultural, organisational and operational change.

4.1.3 Finally, because this study was resource limited to around 80 days it was necessary to limit its scope. Consequently, it has focused on primary care as a principal point of access to the health and social care ecosystem.

4.2 Aim and Objectives

4.2.1 The *aim* of this work has been to explore the social impact of the STP – within the context of Integration, ABCD and the 3 Horizons Model of Transformative Change – with a particular focus on primary care. This was all with a view to further developing ACVO's capability to support decisions about the form, fit, function, funding and future of interventions (in this case the STP), as they relate to the design, delivery and efficacy of health and social care and, hence, to people's quality of life. This aim breaks down into the following principal *objectives*:

a. to explore the 'meaning' and use of the concept of social impact;
b. to explore how the social impact of the STP has, could and should be appraised in a variety of personal and organisational contexts;
c. to identify and comment on the nature, scope and scale of any social impacts that the STP has had, could or should have, and;
d. to provide recommendations regarding the role, value and use of the concept of social impact in the context of ACVO's work for and on behalf of the 3rd sector, particularly in relation to Integration.

4.2.2 Evidence relating to the aim and objectives was generated through a review of public sector, 3rd sector and scholarly literature, and through the

collection and analysis of data using the methodology presented as Appendix A.

5.0 ASSERTIONS INTEGRAL TO THE METHODOLOGY

5.1 Four assertions were integral to the methodology, namely that:

a. health and social care provision constitutes a form of ecosystem (see e.g., Figure 5.1) of which Aberdeen city's population is an integral part:

> "… as in all ecosystems [health and social care] is both a system and systemic. As a system, [it] is a complex whole made up of elements that work together as parts of an interconnecting network. As systemic, any change or changes made in any part of the system will affect not only that part, but rather all the rest of the system."
>
> (Kirschner, 2015)

Consequently, the quality of life of the population is inextricably linked to and, therefore, dependent on the fitness-for-purpose of every other part of the health and social care ecosystem. Thus, in the process of forming a considered appreciation of a problem and its resolution say (including for example decisions about funding) it is essential that the perspective of every *stakeholder group* is considered and *not just* that of those stakeholder groups comprising people who do, have, should or could use health and social care[20].

b. allied to point (a), each stakeholder group is a form of community in its own right. Thus, the guiding principles of ABCD (Appendix B) are equally applicable in working say with communities of practice (e.g. primary care staff) as they are with, say, communities of place (e.g. residents of Torry);

[20] This is also consistent with the position stated earlier that an appraisal of social value - i.e., net social impact – is the standard to aim for.

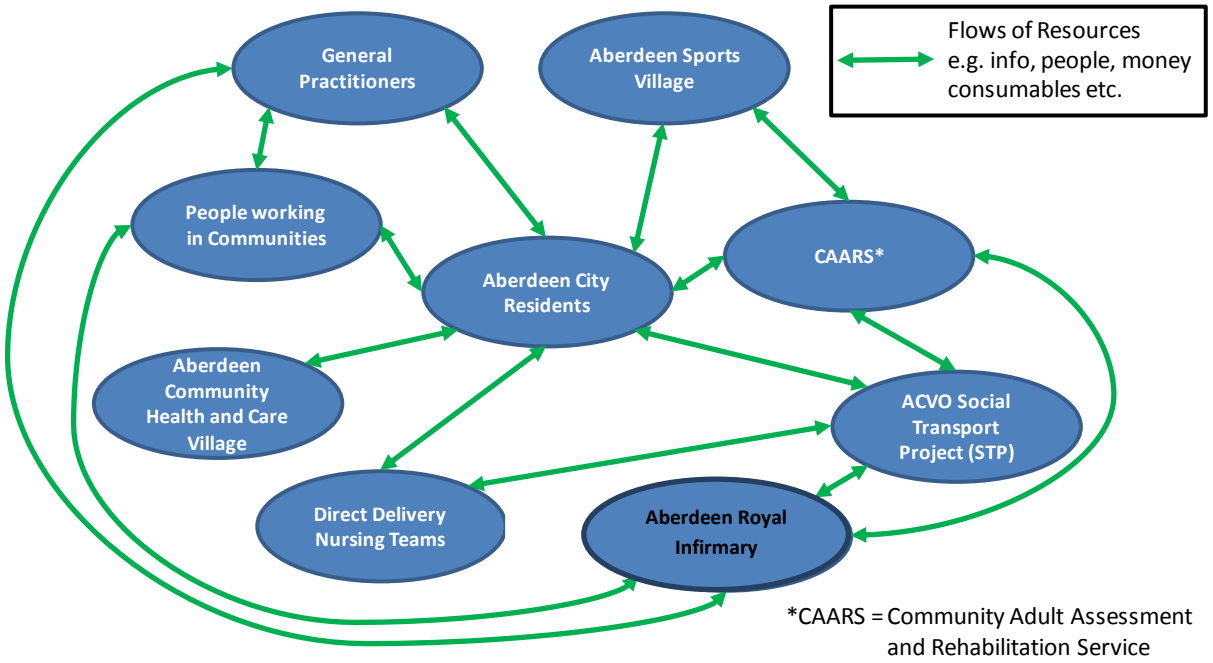

Figure 5.1: A Subsection of the Ecosystem Encountered in this Work
(Note the presence of the ACVO STP – which is integral to the flow of certain resources – as an integral part of the ecosystem.)

c. provision of the STP is motivated, among other things, by a desire to tackle health inequalities and, hence, bring about a more just society. In this case, that is to say that those people who have the greatest need, for transport to help them access health and social care, are those that are both eligible and actually get to use such transport as a matter of priority;

d. in respect of the value of different forms of data to the decision-making process, there is an influential and hence important interplay between the 'subjective' and the 'objective' (as discussed further in the next section).

5.2 The Relative Importance of 'Subjective' and 'Objective' Data

5.2.1 Figure 5.2 is an initial attempt to express a possible source of tension in respect of the influence which work, such as the present study, might have over a state of affairs.

5.2.2 On the one-side sits 'subjective' data – e.g., that based on people's attitudes, beliefs and opinions – which in this study is held to be: (1) as valid as any other in decision-making, and; (2) from a humanitarian

perspective, to have influence over people's motivations, e.g., the motivation derived from having a constructive impact on people's lives as a consequence of performing a particular action.

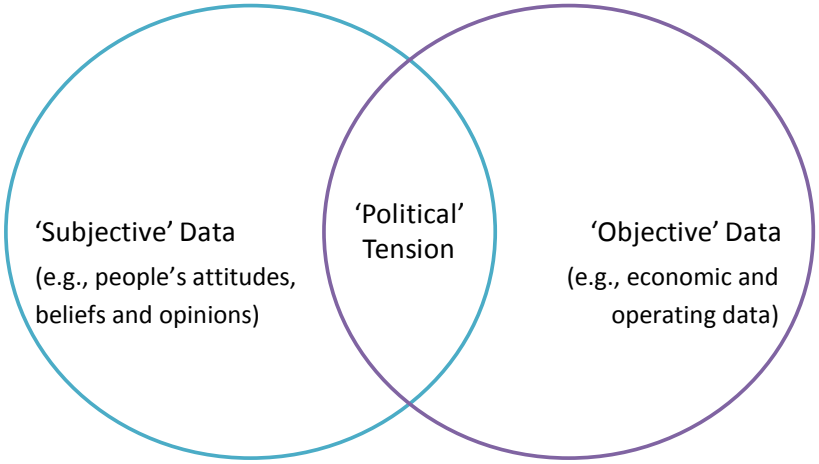

Figure 5.2: The Relative Influence of 'Subjective' and 'Objective' Data

5.2.3 On the other side sits 'objective' data – e.g., operating and economic data – which is also held in this study to be valid in decision-making but which, it is asserted, can often be too readily favoured over and to the detriment of the 'subjective'. This leads to a 'political' tension – which ACVO and the ACH&SCP will have to confront – best illustrated by example.

5.2.4 Thus, if economic considerations hold sway over decisions about the delivery of health and social care services – of which the STP is considered here to be an integral part – then, other than the kinds of humanitarian value identified above, to what extent can spending scarce resources on building 'subjective' evidence be justified? To collect such evidence only for it to carry no weight in the decision-making process could (i.e., depending on how it is done) be an unjustifiable waste of public money. This issue is important to note, however, its resolution sits outside the scope of the present work.

6.0 DISCUSSION OF THE STUDY DATASET AND FINDINGS

6.1 This section critically reviews the social impact dataset (created using the methodology presented as Appendix A) including issues relating to the collection, processing and analysis of its constituent data and the

associated findings. The discussion covers each of the 4 component parts of the dataset, namely: (1) a citywide survey of primary care clinical staff and GP practice managers; (2) telephone interviews with patients registered with Torry GP Practice and identified by the practice as "housebound"; (3) a collaborative diagramming exercise exploring the relationship between the STP and the delivery of the Falls Service based at City Hospital in Aberdeen, and; (4) operating data from "Trapeze", the transport and travel management software for the THInC - Transport in the City FTS.

6.2 Survey of Primary Care Clinical Staff and GP Practice Managers

6.2.1 The survey of primary care staff comprised two Aberdeen *citywide* questionnaires: one sent by email to all GP practice managers (PM); the other nominally emailed as a Survey Monkey[21] link to all primary care clinical staff, i.e., GPs, district nurses, community nurses, practice attached nurses and practice employed nurses.

6.2.2 Both questionnaires were developed, with reference to the good practice set out in de Vaus (2002), in collaboration with the South Cluster: Practice Development and Support Manager – Susan Harrold; GP Clinical Lead – Alasdair Jamieson, and; Nurse Manager (part-time) – Helen Mitchell. Input was also provided by Nursing Services Manager – Linda Press and others. It is important to note that the demands on these people's time meant that this process was largely undertaken at arms length (via email). This compounded the problems of complexity and timescale typically encountered in questionnaire design and delivery.

6.2.3 The *PMs' questionnaire* was exploratory in nature; its purpose primarily being to begin teasing out issues of concern, from the perspective of GP practice administrators, regarding the *potential* role of the STP in the context of primary care. This questionnaire was sponsored and distributed by Susan Harrold on 8th February 2016 and an email reminder sent on 25th February 2016. By the 10th March 2016, 11 out of a total of 30 practices

[21] See: www.surveymonkey.co.uk

(37%) had responded[22]. Between then and the 31st March 2016, ACVO agreed – based on concerns about the financial year end demands on practice staff time – that no further reminders should be sent. After this date, attempts were made to encourage others to reply and this secured a further 3 responses, taking the total to 14 out of 30 practices (47%). While this response rate may be considered 'typical' in say other research contexts, in which response is notionally voluntary (Baruch and Holtom, 2008, p. 1152 *ff*. and citing Demaio, 1980), in the present context – where the emphasis is on gathering relevant, quality, timely data to support effective organisational decision-making – it needs to be considerably better. Consequently, the future approach to acquiring such data will need full and careful further consideration if it is to be and remain fit-for-purpose.

6.2.4 Figure 6.1 shows the citywide response rate to the PM's questionnaire along with the percentage of practices in each cluster that responded. This work was done prior to the introduction of "localities" within the city and is therefore presented by GP cluster. The apparent division between the 'North' and 'South' of the city is noteworthy, with the latter seemingly more responsive. The possible reasons for this should be explored with the practice development and support managers (PDSMs) in the first instance.

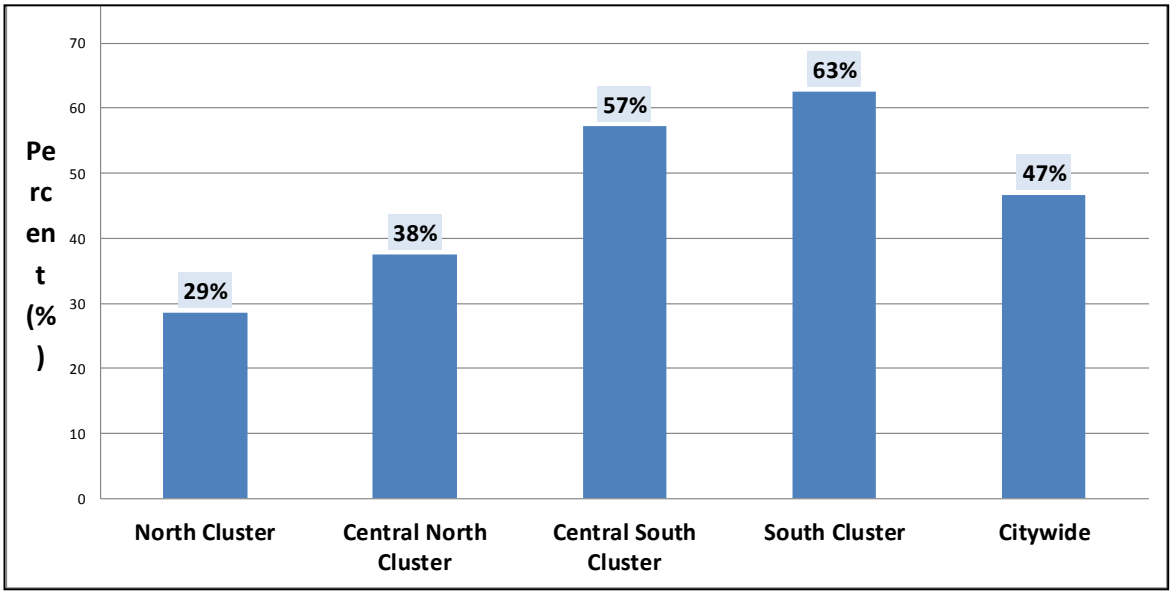

Figure 6.1: Responses to the PMs' Questionnaire by Cluster and Citywide

[22] One PM had responded by 11.04am on the 9th February!

6.2.5 The analysis of the PMs verbatim responses to each question has identified the following themes:

a. issues to do with transport, are typically identified indirectly, mainly by patients or their carers raising them at the time of booking appointments. These can manifest themselves as requests for “time consuming” home visits that may turn out to be “inappropriate”. In some instances, the medical professional attending may notify the administrative staff of this problem. Questions about patients’ ability to attend do not seem to be routinely asked. It could be worth doing so periodically, particularly with ‘at risk’ patients, i.e., those that are experiencing or more likely to experience ‘transport related problems’ irrespective of the cause of those problems. At present, there is a reliance on the patient ‘speaking up’. Since some may be reluctant to do so, this may be contributing to the general perception that, from the point of view of the practice, the scale of patients’ issues with transport is “not significant”. However, from the perspective of the patient (i.e., in the context of person-centred health and social care) their individual transport issues may be very significant;

b. social transport is considered to offer a range of realised and potential opportunities and benefits with: firstly, the *realised* benefits including: “… supporting attendance at [related services particularly] the Pulmonary Rehabilitation clinics …”, and; secondly, the *potential* benefits being to enable people to attend appointments at short notice – e.g., “on the day”, tackle problems of social isolation (an issue considered to be “very detrimental to health”), and; combine the transport of people with that of medicines from pharmacies to people’s homes;

c. and finally, there appears to be a lack of clarity and consistency of understanding about THInC and THInC - Transport in the City with some practices “not aware” of either service. This issue could be addressed, initially through collaboratively reviewing the approach taken to promoting these services.

6.2.6 The *clinical staff questionnaire* was more comprehensive than the PMs’ questionnaire and encompassed the topics shown in Figure 6.2. The core

themes of this topic set, which were identified as being of particular importance by primary care clinical and administrative staff, relate to the *potential* for the STP to help increase the capacity and reach of primary care. Thus, for example, questions were asked regarding the *potential* for the STP to help reduce the number of avoidable home visits, and release GP and nurse time for other tasks.

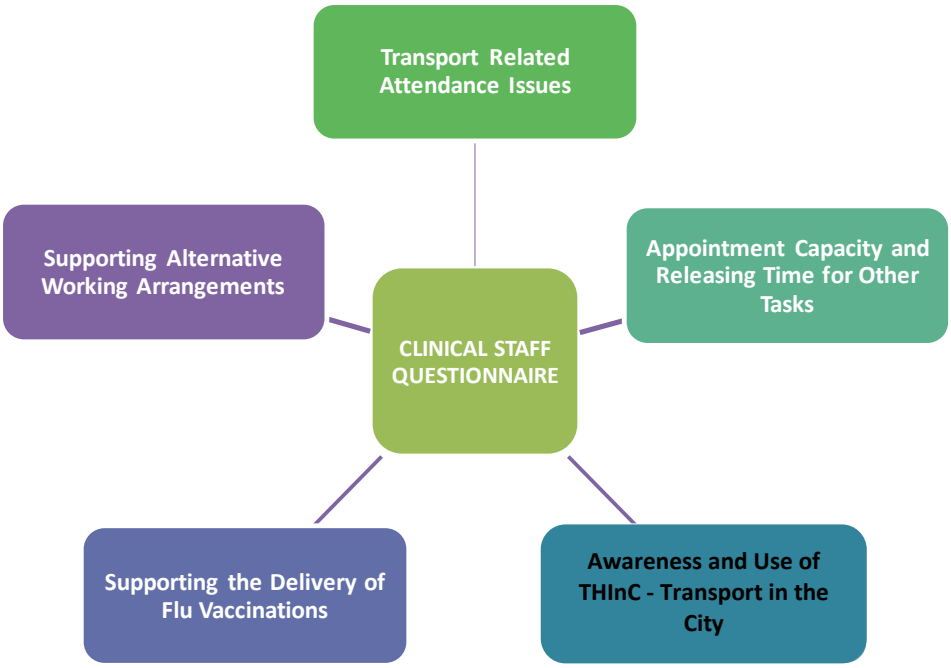

Figure 6.2: Topic Set for the Clinical Staff Questionnaire

6.2.7 The detail and complexity of this questionnaire meant it took longer to finalise; it was eventually distributed in 2 tranches. The first tranche was sponsored by Helen Mitchell and was emailed – nominally to all district, community and practice *attached* nurses in the city, i.e., those people employed directly by the NHS – on the 18th March 2016. The second tranche was sponsored by Alasdair Jamieson and was emailed nominally to all GPs and practice *employed* nurses in the city – i.e., those people employed by the practices – although the date of distribution is not known.

6.2.8 A total of 38 responses were received; 32 via the NHS employed tranche and 6 via the practice employed tranche. It has not been possible to establish the response rate for the NHS employed tranche because the survey was distributed using existing lists which may have prompted a

team rather than an individual response to the questions. This issue could have been avoided by including a question aimed at identifying who answered for whom. For the practice employed tranche, the absence of responses from the practice employed *nurses* may just be due to them not having received the questionnaire; it has not been possible to confirm this either way. For the GPs, *assuming* a citywide headcount of 248 based on NHS Information Services Directorate (ISD) Scotland data (2016a), the response rate was around 2% which is exceptionally low.

6.2.9 Notwithstanding the foregoing, of the 38 responses received 31 (81%) were provided by nurses, 6 (16%) were provided by GPs and 1 (3%) was unidentified. These responses show the following:

a. the NHS Employed staff were either more willing and/or more able than the practice employed staff to respond to this survey;

b. of the 31 nurses responding, 30 (97%) said "I always have to travel to see my patients". Those people that see patients at a practice, clinic or drop-in at some point comprised 6 GPs and 1 nurse (7 total). The following 3 comments were made about this question:

   i. "as a team we often visit patients who are not housebound and are able to get out to hairdresser, lunch and hospital appointments etc.";

   ii. "we have a high % of frail elderly in this area who would be able to attend the practice for treatment but cannot go on public transport and find it too expensive for taxis";

   iii. "as a District Nurse [DN] I always need to travel to see my patient. However transport can prevent patients attending the practice (and therefore practice nurse) and require a DN to visit";

   This suggests that there *are* people receiving home visits that do not necessarily need them and that those people – and those that currently are unable to attend because of a transport issue – could perhaps attend if transport more suited to their needs was available.

c. 3 out of the 7 (43%) who see patients at a practice, clinic or drop-in at some point, said they *would* get to hear about patients' *transport related struggles for attending appointments* and regarded it to be a "Small" to "Moderate" problem for their patients. The following comment was also made:

i. “difficult to say, [the Patient is] possibly more likely to inform reception staff of this issue than GP”;

d. 6 out of the 7 (86%) who see patients at a practice, clinic or drop-in at some point, said they would *not* necessarily get to hear about patients *failing to attend or cancelling because of a transport issue*. The 1 person who said they would get to hear about it regarded it as a “Moderate” problem (in terms of scale) for their patients. The following 3 comments were made about this question:

   i. “again hard to say more likely that reception staff would know this. In case of a specific clinic (e.g., diabetes) I would be more likely to be informed”;

   ii. “[a Patient] might feed this back but probably not”;

   iii. “probably but not necessarily”;

   These and the comment in paragraph 6.2.9c above suggest that, at present anyway, practice administrative staff are more likely to hear about patients’ transport issues. However, that is not to suggest that it should be that way in future. Nor is it to suggest that – in view of the earlier contention that transport, health and social care are interconnected – issues with transport should be a matter solely for the patient to advise and resolve;

e. all 37 responses (100%) indicated there were patients to whom people currently make planned (home) visits but who, in their clinical judgment, would be able to attend if those patients had transport more suited to their needs. The following 7 comments were made:

   i. “however due to poor motivation, or lack of ability to organise themselves some patients in this area will not engage with heath services unless we go to them!”;

   ii. “there is a large number of our patients who would be able to attend the practice or clinic if they had transport”;

   iii. “patients often classed as housebound because they don’t have transport to get out”;

   iv. “if this service was to be widely advertised at a practice and local level it would help as we do encounter resistance on this issue from some patients and especially relatives who often feel on grounds of age alone that patients should be seen at home. There are realistically very few patients who are truly housebound”;

   v. “although relatively small number”;

   vi. “several patients prefer for the nurse to visit them at home but as a general rule DNs [District Nurses] only visit the housebound/very ill patients + not those who 'prefer' a home visit”;

vii. "very few could attend a practice although our patients are mainly terminal and their health condition can change on a daily basis making it difficult to arrange transport in advance";

These serve to underline the observation made at the end of paragraph 6.2.9b above, about the prevalence of avoidable home visits and the role of suitable transport in helping people attend;

f. 35 people (29 nurses and 6 doctors) *estimated* the number of planned (home) visits they could save each month on average and the saving in *travel time* per visit. Aggregated over a year and converted to potential financial savings – on the very conservative basis of *hourly pay* to the individual (the only readily accessible data) rather than the more appropriate, hourly cost to the NHS or the Practice – those results are shown in Table 6.1:

RESPONDENT GROUP	ESTIMATED AVERAGE TOTAL TIME SAVED PER ANNUM	POTENTIAL FINANCIAL SAVINGS (CONSERVATIVE ESTIMATES)
Nurses	36 hours per nurse	Assuming an hourly *pay rate* of £12.00 for a District Nurse (DN) and a *Grampian wide* DN headcount of 358 (ISD, 2016b). **This equates to approx. £155,000 per annum.**
GPs	25 hours per doctor	Assuming an hourly *pay rate* for a GP of £25.00 and a *Aberdeen citywide* total GP headcount in 2015 of 248 (ISD, 2016a). **This also equates to approx. £155,000 per annum.**

Table 6.1: Estimated Travel Time Saved by Reducing the Number of Avoidable Home Visits

These figures (in light of the findings presented in paragraph 6.2.9e above) suggest that the number of avoidable home visits is potentially very significant. For example, in financial terms, the scale of this problem seems such that the savings made in clinical staff time alone underpin the case for the mainstream funding of the STP on an ongoing basis;

g. when asked about the number of patients whose annual flu vaccination would normally have been administered during a home visit, but who ended up attending a practice, clinic, drop-in or other treatment provider instead, the GPs said 30 patients and the nurses said 514 patients fell into this category. It is important to note that, while this adds further weight to the argument about avoidable home visits, the similarity between this and the preceding question risks the problem of double accounting. This is something that requires due consideration in future work;

h. people were asked if there were any other treatments (excluding the flu vaccination) that were administered on either a 3-monthly, 6-monthly or annual basis. Those treatments are listed in Table 6.2, the value of which information comes from them being other areas in which social transport may help to: (1) also avoid unnecessary home visits, and; (2) support the delivery of ad-hoc community based, multi-agency or other such clinics;

FREQUENCY	DETAILS
3-monthly	Vitamin B12, Zoladex Injections, Hydroxocobalamin Injections, Catheter Changes, Ca Prostate Injections, Bloods, Venepuncture, Continence Assessment, Decapityl, Management of Long-term Conditions
6-monthly	Denosumab, Doppler, CDM reviews, Diabetic Reviews, Bloods
Annually	Bloods, CDM Reviews, Continence Reassessments, ACP/KIS, Shingles Vaccine, Anticipatory Care Plan, Medication Reviews

Table 6.2: Other Periodic Planned Treatments

i. 22 out of 30 people (73%) said that they had previously heard of THInC - Transport in the City. Of those 22, 4 (18%) said they had contacted the service on behalf of patients or their carers; 9 (41%) said they had given the contact details for the service to patients or their carers; 4 (18%) had done both, and; 5 (22%) said they had had nothing to do with the service. The following 5 comments were also made:

i. “used it x2, but it is difficult to get appointments booked”;

ii. “neither patient could be accommodated as not enough notice. Call handler explained we usually have to give 2 weeks notice. Patient had tried prior to this and was unable to get transport booked”;

iii. “patients have refused to contact this number and have been quite upset at "having to pay" for treatment”;

iv. “have been unable to help most of the time”;

v. “have heard about it but unsure re contact details etc.”;

These raise a question about how, with limited capacity, the service can best meet the prevailing need for travel which in turn ties into the questions of eligibility, social justice and health inequality. Thus, is it sufficient for eligibility to be decided on an individual’s age and self-reported ability to use conventional transport alone? Further, does THInC - Transport in the City effect the greatest constructive social impact by being an open access service – i.e., without any prioritisation of who gets to benefit from it – or would some other approach, such as a referral based service, be more effective? These questions need to be addressed to ensure that the STP (and indeed any intervention) does not fall foul of the inverse care law which states that: ”the availability of good quality healthcare tends to vary inversely with the need for it in the population served”. (Hart, 1971)

j. of the 30 people who answered the question, 7 people (23%) said that concerns about transport were preventing them from moving forward with their ideas or plans for alternative ways of delivering primary care; and 12 people (40%) said they were not currently considering alternative ways of delivering primary care. The remainder (37%) said that transport was not preventing them from moving forward with their plans. The following comments were also made;

i. “management of urinary catheters. However this work is often unpredictable and unplanned”;

ii. “this would be an excellent idea”;

iii. “leg ulcer care - other areas have set up 'foot/leg clinics' where it is a social event with refreshments provided and a nurse to re-dress leg ulcers at the same time - usually weekly or bi-weekly”;

iv. “it is being considered in other areas but not in our geographical area”;

v. “transport likely not available on ad-hoc basis and short notice for some procedures. Our service users can have chaotic lifestyles so not always engaged with health advice or requests to attend. Unfortunately the GPs default position is to ask District Nurse to visit which is not always appropriate, especially for bloods etc. Patient may not be in when nurse visits and have been sometimes in pub or betting shop!”;

vi. “improvement in education and self-empowerment is difficult to adequately do within home attendance”;

vii. “not enough availability for patients to book transport”;

viii. “no point in setting up foot/leg centres as transport is always the issue. Most DN visits are for housebound patients therefore most transport is not suitable i.e. need an arm to help them or are in a wheelchair”;

ix. “setting up injection clinics especially for 3 or 6 monthly injections. Its only 2-4 times a year they need input”;

x. “trying to set up a clinic 2 days at week at Airyhall for patients we visit at home but are not strictly housebound. Sometimes we visit because the treatment room at their practice cannot accommodate their visit i.e. catheter change, leg bag change, long visit for washing and dressing legs. Sometimes visits for blood tests and injections that the patient has difficulty getting to their practice for but could come to Airyhall as there [are] parking spaces [and] no stairs. A lot of these patients manage to attend hospital appointments as they get patient transport but are then 'housebound' for the purposes of our visits”;

These suggest that there may be opportunities for transport to support innovation in the delivery of primary care. The 2nd point in paragraph 6.2.9k below also supports this observation. Further, while a significant proportion of people may not *currently* be considering alternative ways of delivering care, their position *may* change if transport driven innovation is shown to be feasible and sustainable;

k. The final question asked for general feedback about the survey and received the following comments:

i. “no issues”;

ii. “I believe that if we offered a drop in clinic for older people needing home visits, where transport is provided and patients receive refreshments whilst at clinic and where able to socialise with other similar people, our caseload would decrease and the volume of anxious calls we receive on a daily basis would be reduced and it usually is because of loneliness”;

iii. “difficult to think of exactly how many patients could travel to a clinic and we do not have a current record of the numbers of those who attended the practice for their flu instead of us so numbers are estimates”;

iv. “would need to have known before embarking on this that you needed details of number of visits as this all takes time to find out. certainly more than 10 minutes! I just answered yes for the 3, 6 monthly and annual visits but you were maybe looking for exact numbers?”;

v. "time constrained as always so not absolutely accurate."

The final 3 points above suggest that, in relation to the design and delivery of surveys, it is important to try to develop as full an understanding as possible of the context in which a survey will be received. This requires more time to be spent in dialogue with potential participants before any design and delivery decisions are taken. Timescale will always pose a problem in this regard, but quality of response should be prioritised over quantity of data. Thus, it may be better to undertake smaller, more focussed, more collaborative research exercises, than more complex, larger scale, catch-all ones.

6.3 Interviews with Patients

6.3.1 ACVO and Community Renewal[23] developed a collaborative task to explore the lived experiences – under the general theme of "getting out and about" – of patients, aged over 55, registered with Torry GP Practice. While Torry was selected partly out of expediency (appropriate working relationships already existed in that area) it is also within the South Locality, i.e., the Integration test site; nominally, the intended focus of this social impact work.

6.3.2 Torry GPs wrote to 53 patients – in the target age group and identified as being "housebound" – asking for those people who did not want to take part in a short telephone interview to notify the practice. Two self-exclusions resulted in a list of 51 potential participants of which 11 (22%) had been successfully contacted at the time of writing. Those 11 people comprised 9 women and 2 men, aged in the range 58 to 92 years.

6.3.3 Five questions were asked during each interview, their purpose being to better understand people's lived experiences of getting out and about, their restrictions (if any) on doing so, and the impact this has on their lives. In this joint exercise, it was agreed that ACVO would consider people's

[23] A National charity engaged in community development work with the Danestone and Torry GP Practices in Aberdeen; see: www.communityrenewal.org.uk

responses to identify particular *themes*, and Community Renewal would consider needs at an individual level with a view to taking action locally.

6.3.4 The analysis of the verbatim responses shows the following:

a. difficulties walking, breathing, climbing steps and hills, and back pain as well as a lack of (suitable) transport impact people's ability to get out and about. These issues would seem to be interconnected, i.e., suitable transport could – in the context considered here – help mitigate the impact of breathing and walking difficulties say. Further, depending on the nature of those difficulties, any improvement in people's quality of life brought about by the provision of appropriate transport, may indirectly help improve their specific physical difficulties;

b. most people feel they would like to but are unable (or at least less able) to get out in the fresh air, to go shopping, meet friends or attend groups. One individual had "…not been in town for 2 years". These would seem to be very modest ambitions and social norms which people should reasonably and rightly expect to be able to participate in;

c. everyone had some sort of support in place. This variously included: spouses, sons and daughters, friends and paid carers as well as support in the form of doctor and nurse visits;

d. (social) transport was quoted as being something that could help people get out and about more although 2 people said they were happy with the way things were. One person felt that low level housing would help;

e. 7 out of the 11 (64%) said they had never used or did not know about 'Dial-a-Bus' type services in their area. Strong locality specific identities (i.e., brand) and ongoing promotion – through a variety mechanisms – could be key to raising and maintaining awareness of such services.

6.3.5 These interviews with patients have proved useful in terms of identifying the specific issues that individual people face in their day-to-day lives in Torry. Ethically speaking (see, e.g., Oliver, 1992) , action should now be taken with a view to addressing those issues for those individuals. Self-evidently, the STP has a role to play in this regard and it is essential that

that is taken into consideration in the planning of future social impact work. It is important to ensure that in that next phase of work, consideration continues to be paid to the broader subject of good (ethical) research practice so that, for example, it is not just the most able that are the ones who can choose either to be heard or to be excluded from such work.

6.4 THInC - Transport in the City Operating Data Analysis

6.4.1 A range of operating data, for the THInC - Transport in the City FTS, has been (and continues to be) collected via the travel booking and vehicle scheduling capability provided by the HTAP Partners. That capability – a key component of which (other than its staff) is the "Trapeze"[24] software – has enabled geographic, demographic and operations data to be compiled into reports relevant to both the 'proper' operation of the FTS and, hence, also to this study. Agreement was reached for these reports to be provided monthly. At the time of writing, ACVO had received (and has therefore analysed) data for the period May 2015 to January 2016 (inclusive).

6.4.2 Figures 6.3 and 6.4 breakdown the THInC - Transport in the City client base by age and gender. Figure 6.3 shows the wide variation in the ages of people using the service, including some people of very advanced years, with the majority of those travelling comprising people in the 70 to 79 and 80 to 89 years age groups. In other words, the service is definitely attracting people in the requisite age group, i.e., 55 years and over.

6.4.3 That said, it also seems to be attracting, admittedly in very small numbers and typically as one-offs, people aged less than 55 years. (A note of caution is required here on the grounds that around 30% of people have not provided their age). While this may not be endorsed by the eligibility criteria for the service, this is not necessarily a problem provided that: (1) the vehicle would otherwise be sitting idle; (2) use of the service by 'younger' people does not infringe any licencing, insurance, funding or other such criteria, and; (3) that those 'younger' clients are in need and do not have any alternative travel options.

[24] See: www.trapezegroup.co.uk

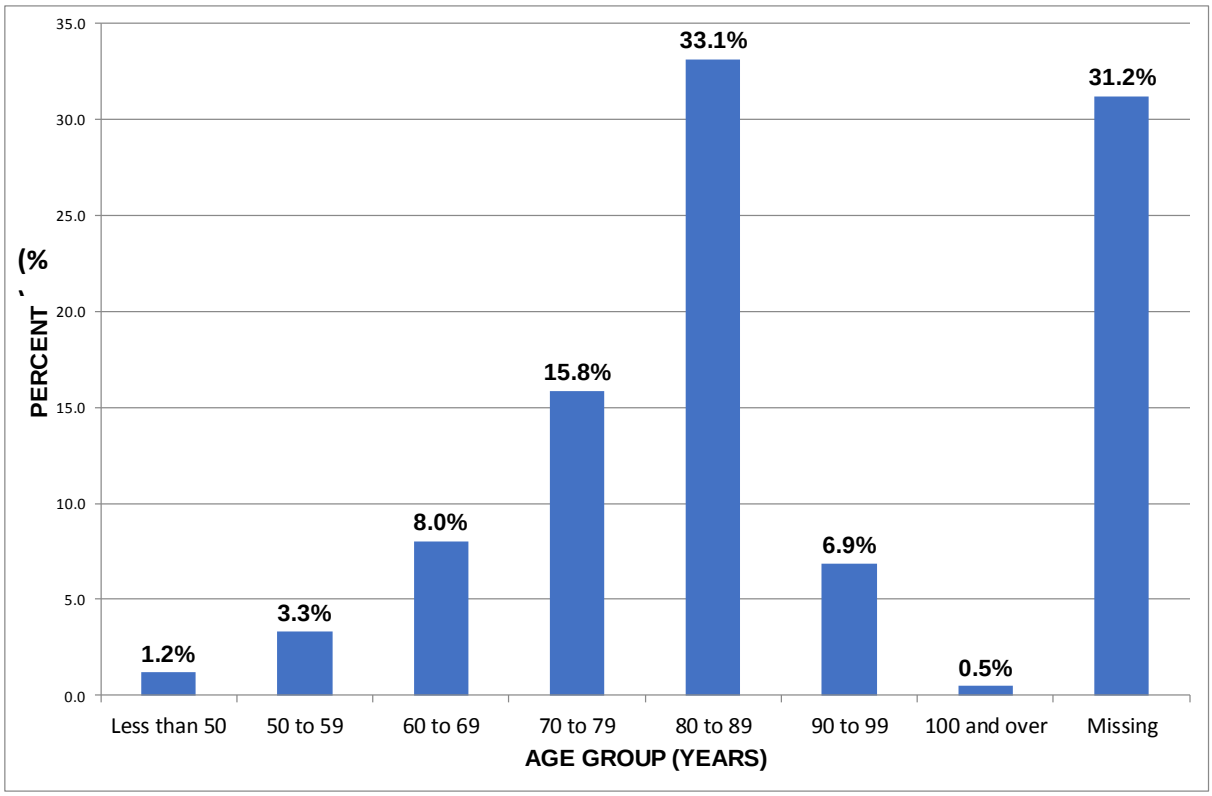

Figure 6.3: THInC – Transport in the City,
Analysis of Client Base (to January 2016) by Age Group

6.4.4 The question of "need" is crucially important in relation to the role of the STP and its ability to effect constructive social impact. It was asserted elsewhere in this document that provision of the STP has been motivated, among other things, by a desire to bring about a more just society; which aligns with the Scottish Government's ambition to tackle "… the significant inequalities in Scottish society" (Scottish Government, 2016a and b). In this case, that is to say that those people who have the greatest need for (social) transport to help them access health and social care are those that are both eligible and actually get to use it as a matter of priority. While, for example, in relation to the work of the Falls Service (as discussed in section 6.5 below) the issue of who is and is not eligible to use the STP *may* be more self-evident, when it comes to the THInC - Transport in the City FTS it is less so. Further work is therefore required in order to be able to demonstrate that the FTS is delivering as much constructive social impact as possible. This in turn requires a review of: (a) the sources and types of information collected about the circumstances of people who have

or might use the FTS, and; (b) the way in which the service is operated and accessed[25]. This work seems to be essential to the task of ensuring that the greatest value is derived from the STP and that, in turn, the already strong arguments about sustaining and even expanding the service are strengthened.

6.4.5 Figure 6.4 shows a significant disparity, in terms of their use of the STP, between women and men. This requires further investigation since it has a bearing on the discussion of the role of the STP in tackling issues of health inequality and social injustice. The prevalence of "Missing" data – in the records of age and gender – also has a bearing in that regard and therefore also requires further investigation.

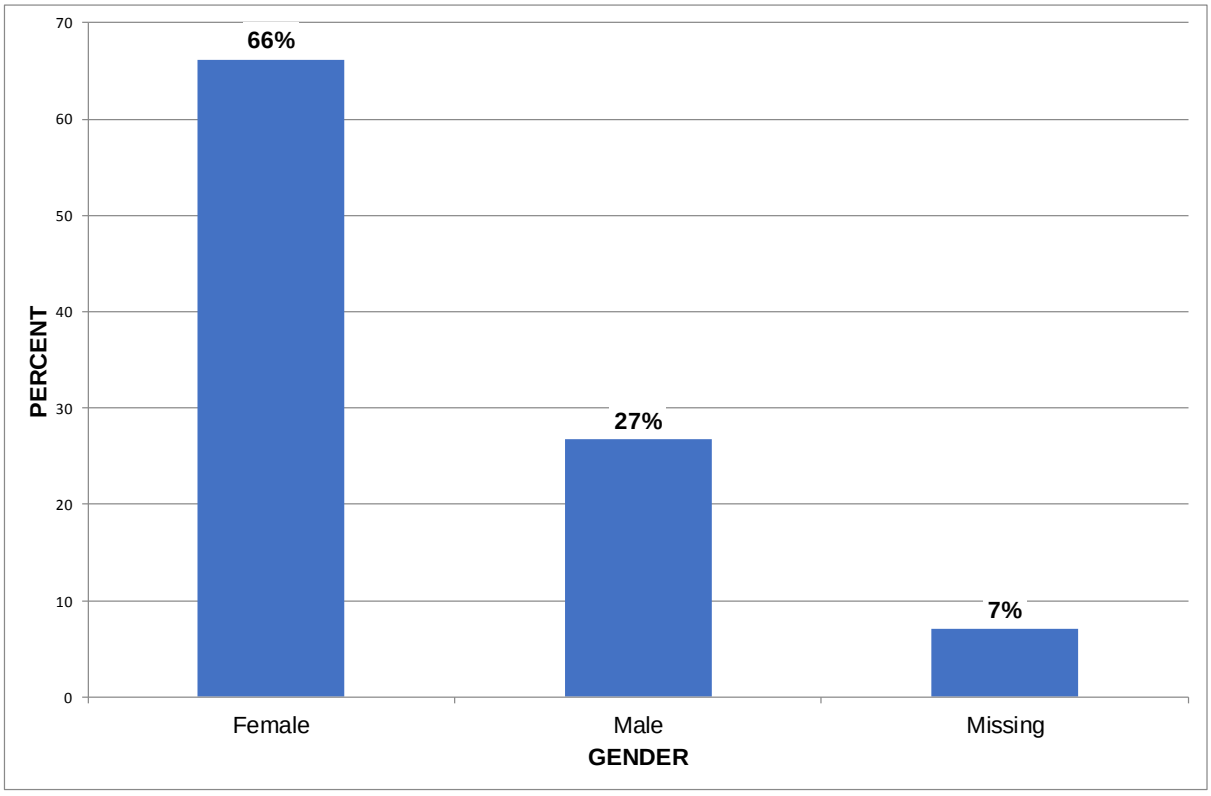

Figure 6.4: THInC – Transport in the City
Analysis of Client Base (to January 2016) by Gender

6.4.6 Figure 6.5 presents the point of origin, by locality, for outbound and return journeys. This shows that – from May 2015 to January 2016 inclusive –

[25] For example, and as already suggested, a referral service might be preferable to an open access service. This is because, e.g., the latter runs the risk that it is, relatively speaking, only the most able – in terms of being organised and confident enough to phone and book – that get to use the FTS.

the majority of outbound and return journeys originated in the Central and South Localities. It also shows, that the North and West localities currently seem to make relatively limited use of the STP. This should be investigated further, e.g., is there an underlying reason for this disparity of use such as a lack of awareness of the STP?

6.4.7 It is important to note that Figure 6.5 is based on the relatively recently introduced localities based division of the city. This maps onto the previous cluster arrangement (see, e.g., Figure 6.1 on p. 15) as follows:

- North Cluster = Aberdeen North Locality
- Central North Cluster = Aberdeen Central Locality
- Central South Cluster = Aberdeen West Locality
- South Cluster = Aberdeen South Locality

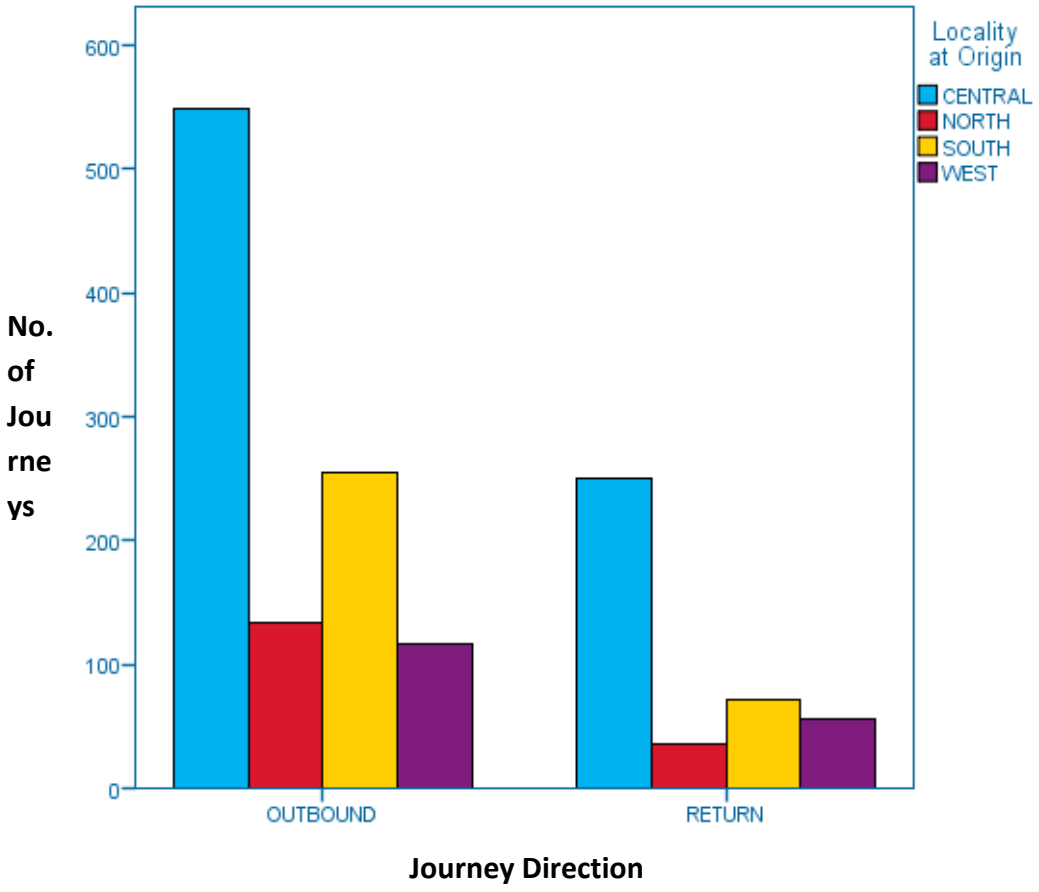

Figure 6.5: Locality of Origin of Outbound and Return Journeys In the Period May 2015 to January 2016

6.4.8 In relation to the use of the service – in terms of clients and their destinations – the analysis shows the following: (a) that 17 out of 339 (5%) of the total number of clients that used the STP in the period considered here, accounted for almost 30% of its total usage, and; (b) the top 5 destinations (in alphabetical order) namely, Aberdeen Community Health and Care Village (ACHCV), Aberdeen Royal Infirmary (ARI), City Hospital, Foresterhill Health Centre and Woodend Hospital accounted for 522 out of 1796 (25%) of journeys in the period with the top destination being ARI. These observations raise questions of equity with regards the use of the STP – e.g., are the benefits which the STP confers being fairly distributed among Aberdeen's population? This is an important question that ties into observations about the way the service is operated and accessed, and requires further consideration.

6.5 Collaborative Diagramming with the Falls Service at City Hospital

6.5.1 Two 'organisations' were identified in Figure 2.2 on page 3 – the Falls Prevention Group and Falls Triage Clinic (hereafter "the Falls Service") – as recipients of support through the STP in the form of organisation focused group transport.

6.5.2 A collaborative diagramming exercise – to explore the social impact of this strand of the STP in the context of the work of the Falls Service – was undertaken in collaboration with the Falls Lead, Rosie Cooper.

6.5.3 This exercise took a systems thinking approach and drew on a technique known as Integration Definition for Function Modelling Method Zero (IDEF0). This is a diagramming "… method designed to model the decisions, actions, and activities of an organization or system …" (IDEF, 2016). In simple terms, IDEF0 provides a means of helping:

a. breakdown a complex system into its principal functions and sub-functions;
b. analyze the inputs, outputs, resources and controls necessary to the 'proper' operation of those functions and sub-functions;

c. understand how "…decisions, actions and activities…" (*ibid.*) constitute and influence that system;
d. determine if and how the system might be improved.

6.5.4 In this work, the "system" was the Falls Service, and the IDEF0 method was used to: (1) understand how that system works; (2) understand how the STP does or could fit into that system; (3) understand the contribution of the STP to the overall social impact of that system, and; (4) identify the data that is either available now or needs collecting to evidence that social impact.

6.5.5 While a number of perspectives could have been taken into account in this exercise – such as those of clinical staff both within and outwith the Falls Service, patients and administrators – the decision was taken to focus, at this stage, on the process of delivering the service itself.

6.5.6 That process has been taken to be encompassed by the principal purpose of the Falls Service, expressed (with the consent of Rosie Cooper) as:

> "… working with people – who are at risk from falling for the 1st time or falling again – in order to reduce their risk from falling and thus help improve and maintain their quality of life".

6.5.7 In this context, risk is defined as the product of the likelihood of falling and the consequence of falling. Therefore an individual's risk from falling can be lowered by lowering either their likelihood and/or consequence of falling.

6.5.8 This diagramming exercise has helped to identify 4 areas – in which the STP either does or could support the purpose of the Falls Service and therefore effect constructive social impact – as follows: (1) individual or group attendance at the preventative, 'upstream' Stable and Able classes; (2) patient attendance at the Triage Clinic; (3) patient attendance relating to onward referral from the Falls Service, and; (4) individual or group patient attendance at the 'downstream' Strength and Balance classes.

6.5.9 It is important to remember that the 4 areas identified in paragraph 6.5.8 are based on a particular perspective, i.e., that of the process of delivering the Falls Service. Those 4 areas, therefore, are part of a bigger picture of social impact comprising, among others, the perspectives of staff and patients. Those other perspectives should be considered in future work.

6.5.10 From this process related perspective, the STP helps to effect constructive social impact as an integral part of the Falls Service. This is consistent with the contention that health and social care is an ecosystem and that transport is integral to its good functioning. This role is summarised in Figure 6.6 overleaf. This figure is a first attempt to identify the chain of causality of the social impact of the STP in relation to the Falls Service. Thus, to evidence the social impact of the STP, it is necessary to evidence each of the stages shown in the figure. At the time of writing, this task was a work in progress which will be reported at a later date to be decided.

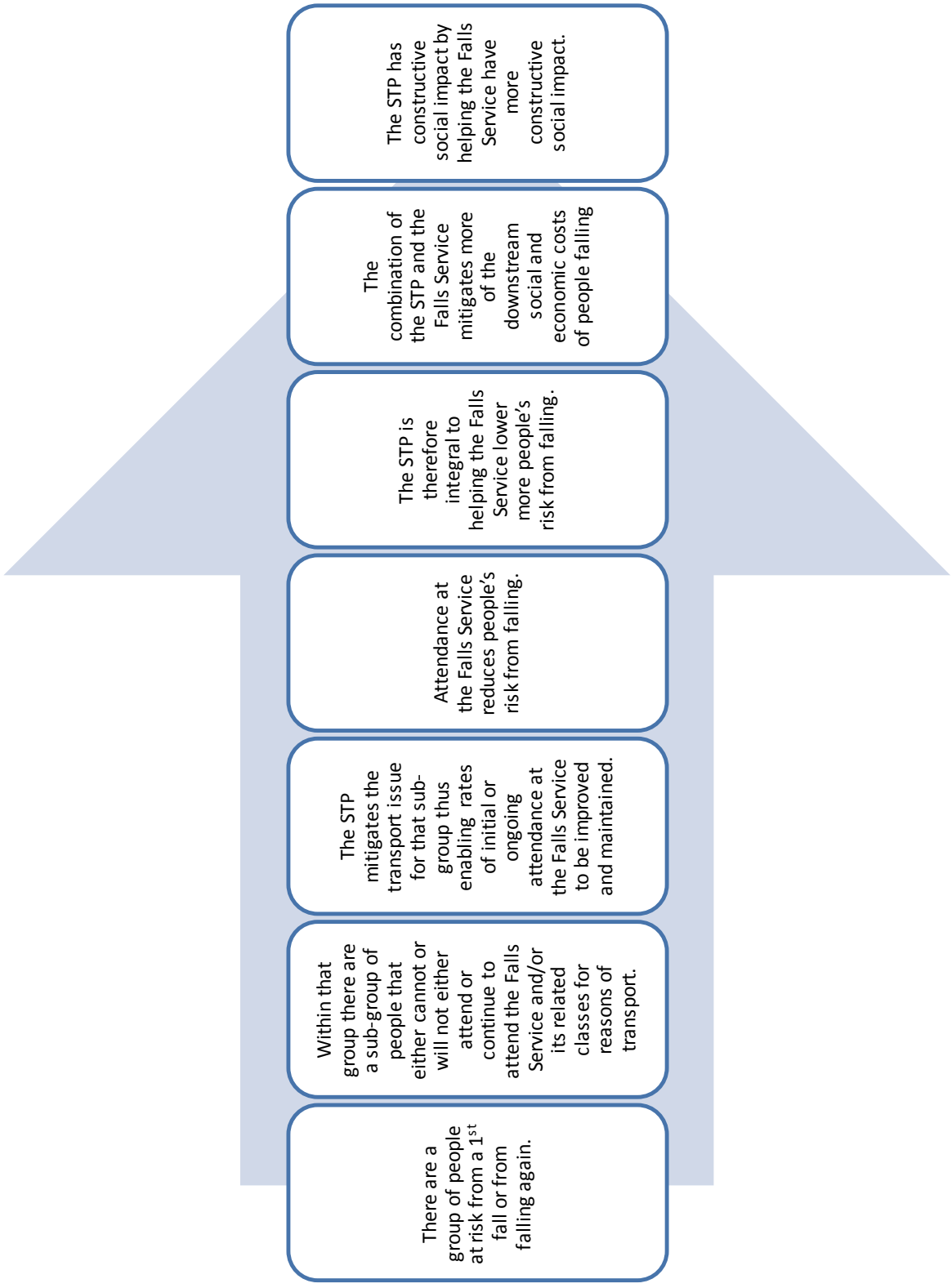

Figure 6.6: The Chain of Causality and Evidence of the Social Impact of the STP in the Context of Delivering the Falls Service

7.0 SUMMARY AND CONCLUSIONS

7.1 This study explored the social impact of the ACVO TSI supported social transport project (STP). There are 2 *principal conclusions* arising out of the work:

- firstly, the work has shown that by providing person-centred, door-to-door, nil or low cost[26] travel for individuals and groups – to access health and social care services and to take part in activities conducive to improving or maintaining their quality of life – the STP has undoubtedly effected constructive social impact for the 623 people that have so far registered to use the service. However, the analysis suggests that – with changes to the way the STP is operated and accessed, as well as to the types of data collected about it – the STP has the potential to effect *significantly more* constructive impact throughout the health and social care ecosystem. In other words, constructive impact not just for those stakeholder groups comprising people that do, have, should or could use health and social care, but for those stakeholder groups – i.e., people and organisations – that provide such services. Indeed, in financial terms, the scale of the potential benefits is such that there is a strong and growing argument for the mainstream and ongoing funding of social transport for this purpose.
- Secondly, the concept of social impact (and appraisals of the same) can, therefore, add significant value to decision-making in and within the context of ACVO's activities and, indeed, within the ACH&SCP. The evidence and arguments underpinning these conclusions, is summarised in the remainder of this section.

7.2 The STP – made possible by an award to ACVO from the Reshaping Care for Older People Aberdeen Partnership Change Fund – originally comprised 2 strands. The first strand, an organisation focused group transport service, commenced in late 2014 and ceased on the 31st March 2015 (a Change Fund requirement). This service provided for individuals to travel as part of a group – to attend a place on a day and at a time, *all*

[26] To the person travelling.

specified by an organisation – to take part in that organisation's quality of life related activities. The second strand, an individual focused flexible transport service (FTS) called "THInC Transport in the City" – due to its relationship with the HTAP partners' existing Transport to Health and Social Care Information Centre (THInC) – commenced in March 2015 and is currently funded until **16th December 2016**. This service *continues,* successfully*,* to provide for individuals to travel independently (or with a carer) – to attend a place on a day and at a time, all of *their own* choosing – in order to access health and social care services.

7.3 The typically considered and often expressed *explicit aim* of both services (i.e. the STP overall) has been to help Aberdeen city residents – aged 55 years and over who are unable to use conventional public transport – to access health and social care provided by the public, private and 3rd sectors. The *implicit aim* of the STP, therefore, has been to help those same residents improve or maintain their quality of life.

7.4 In its current form, the *explicit aim* of the STP is couched in terms relating to the movement of people. This study asserts that this represents Horizon 1 (H1) type thinking, i.e., the silo-like thinking that is typical of "… the dominant system at present" (IFF, 2016). Consequently, this work concludes that the *explicit aim* of the STP (in its role as a health and social care enabling capability) *should* be cross-cutting and, hence, more strategic and *should* align with (if not directly reflect) the Strategic Priorities set out by the Aberdeen City Health and Social Care Partnership (ACH&SCP) in their Strategic Plan (2016, pp. 10-12). Taking this approach would immediately shift the emphasis – of (social impact) appraisal, planning and monitoring, for this and, indeed, any other intervention – away from the intervention itself (e.g., the STP and the physical movement of people) and towards what ultimately matters, i.e., the quality of life of Aberdeen city's population.

7.5 This alternative stance would seem to accord more closely with H2+ type thinking (IFF, 2016) and, in a broader context than just the STP, offers at least 2 potential benefits. Firstly, it would mean that the priorities set out in

the ACH&SCP Strategic Plan would be directly linked to, explicitly reflected in and provide a common purpose for the day-to-day actions of every stakeholder in the health and social care ecosystem. Secondly, it provides a degree of commonality across a range of decision-making contexts. So, for example, requests for funding from the Integrated Care Fund would have to clearly demonstrate the contribution of a proposed course of action to the common purpose and, hence, in turn, to the Strategic Priorities.

7.6 This study followed the foregoing line of argument and considered the social impact of the STP not just in terms of the quality of life of the city's residents, but of the fitness-for-purpose of the health and social care ecosystem itself.

7.7 It was observed that the term "social impact" represents a concept that means different things to different people in different contexts. To use it without defining it and placing it in context risks it being misused, popularised and eventually to lose meaning and value (McNiff, 2013, p. 6).

7.8 This study concludes, therefore, that as a matter of the quality of the output, outcomes and impact of ACVO's work, it is important that concepts and their definitions which (may relate to practices too) are used carefully and consistently; indeed, it is further concluded that this stance should be adopted throughout the ACH&SCP.

7.9 In accordance with this position, in this work social impact was defined as:

> the future consequences – of a current or proposed intervention – on individuals, organisations and social systems. Whereby, "consequences", regards changes to, e.g., people's quality of life (Adapted from Becker, 2001, p. 312 and Vanclay, 2003, p. 8).

7.10 In order to derive value from this definition, it was necessary to place it in the context of this work. Thus, since the STP was established to support access to health and social care and since it was to operate within the context of the integration of health and social care in the city (hereafter just "Integration") the interrelationship between the STP and Integration was

considered to be an important element of the present work. In this regard, 2 aspects were identified as requiring particular consideration: (i) the shift towards Asset Based Community Development or ABCD (see: ABCD Institute, 2016), and; (ii) the use of the "3 Horizons Model" (discussed above) to help secure and sustain cultural, organisational and operational change.

7.11 Based on the foregoing, the aim of this study was to explore the social impact of the STP – within the context of Integration, ABCD and the 3 Horizons Model of Transformative Change – with a particular focus on primary care as an important point of access to the health and social care ecosystem. This was all with a view to further developing ACVO's capability to support decision-making about the form, fit, function, funding and future of interventions (in this case the STP) as they relate to the design, delivery and efficacy of health and social care and, hence, to people's quality of life. This aim was broken down into the following specific objectives:

a. to explore the 'meaning' and use of the concept of social impact;
b. to explore how the social impact of the STP has, could and should be appraised in a variety of personal and organisational contexts;
c. to identify and comment on the nature, scope and scale of any social impacts that the STP has had, could or should have, and;
d. to provide recommendations regarding the role, value and use of the concept of social impact in the context of ACVO's work, for and on behalf of the 3rd Sector, particularly in relation to Integration.

7.12 Evidence pertaining to the aim and objectives was generated through a review of public sector, 3rd sector and scholarly literature, and through the collection and analysis of primary and secondary data.

7.13 Primary data was collected through 2 mechanisms: (i) a citywide survey of primary care clinical staff and GP practice managers, and (ii) telephone interviews with patients (in the requisite age group) registered with the Torry GP Practice and identified by the practice as "housebound".

Secondary data was secured from 2 sources: (i) a collaborative diagramming exercise exploring the relationship between the STP and the delivery of the Falls Service based at City Hospital, and; (ii) operating data from “Trapeze”, the transport and travel management software for the THInC – Transport in the City service. The primary and secondary data collectively constitute the dataset for this exploratory study of social impact.

7.14 Four assertions were considered integral to the approach to constructing this dataset, namely that:

a. health and social care provision constitutes a form of ecosystem of which Aberdeen city’s population is an integral part. Consequently, the quality of life of that population is inextricably linked to and, therefore, dependent on the fitness-for-purpose of every other part of that ecosystem. Thus, in the process of forming a considered appreciation of a problem and its resolution say (including, for example, decisions about funding) it is essential that the perspective of every *stakeholder group* is considered, and *not just* that of those stakeholder groups comprising people who do, have, should or could use health and social care. This is consistent with the position stated earlier in this report that an appraisal of social value – i.e., of the net social impact of an intervention – is the standard to aim for;

b. allied to point (a), each stakeholder group is a form of community in its own right. Thus, the guiding principles of ABCD (Appendix B) are equally applicable to working with say communities of practice (e.g., primary care staff) as they are with, say, communities of place (e.g., residents of Torry);

c. provision of the STP is motivated, among other things, by a desire to bring about a more just society. In this case, that is to say that those people who have the greatest need for transport to help them access health and social care, are those that are both eligible and actually get to use such transport as a matter of priority, and;

d. there is an important and influential interplay between 'objective' data (e.g., economic and operating data) and 'subjective' data (e.g., that relating to people's attitudes, beliefs and opinions) that is a source of tension in respect of the influence, which work such as the present study, might have over a state of affairs. Thus, if economic considerations hold sway over decisions about the delivery of health and social care services – of which the STP is considered here to be an integral part – then, to what extent can spending scarce resources on building 'subjective' evidence be justified. To collect such evidence only for it to carry no weight in the decision-making process could (i.e. depending on how it is done) be an unjustifiable waste of public money. This issue is important to note, however, its resolution is a matter for further work.

7.15 From the analysis of the social impact dataset, the following has been concluded:

- while the response rate to the GP practice manager's questionnaire of 47% may be considered 'typical' in, say, other research contexts, in the present context – where the emphasis is on gathering relevant, timely data to support effective organisational decision-making – it needs to be considerably better. This observation is underlined by the response rate for GPs – in relation to the clinical staff questionnaire – of only 2%. Consequently, the future approach to acquiring such data – irrespective of the context – will need full and careful consideration if it is to be and to remain fit-for-purpose.
- There is a real and potentially significant issue relating to home visits. Thus, considerable clinical staff travel time is being expended on making home visits that are considered not strictly necessary. Opinion suggests that the provision of transport more suited to the needs of certain patients could form part of the solution to this problem; the STP is considered to be one form of such transport. Based on rough initial estimates – which assume a citywide headcount of 248 (ISD, 2016a) – the annual *saving* in GP travel time alone (which could then be made

available to support other tasks) amounts to over 5000 hours; equivalent to around £155,000 per annum. At this sort of scale – and bearing in mind that, in this study, the social impact of the STP has only been considered in terms of a relatively small subset of the health and social care ecosystem – the case for the mainstream and ongoing funding of the STP is strong and can become stronger;

- In respect of patients' transport related issues with attending, there seems to be a presumption in favour of the patient speaking up. Because of possible patient unwillingness to do so, this reliance may be contributing to the general perception that, from the perspective of GP practices, the scale of patients' problems with transport is "not significant".
- The STP, more specifically the individual focused FTS, has a limited capacity and denial of service (albeit infrequently) can adversely impact public perception of and opinion about the service. This issue ties into questions of eligibility, social justice and health inequality. Thus, is it sufficient for eligibility to be decided on an individual's age and their self-reported ability to use conventional public transport alone? Further, does the THInC – Transport in the City FTS effect the greatest constructive social impact by being an open access service – i.e., without any active prioritisation of who gets to benefit from it – or would some other approach, such as a referral based service, be more effective? These questions need to be addressed to ensure that the STP (and indeed any intervention) does not fall foul of the inverse care law which states that: "the availability of good quality healthcare tends to vary inversely with the need for it in the population served". (Hart, 1971)
- Opinion suggests that social transport, of which the STP is one form, has the potential to support innovation in the delivery of primary care, e.g., the provision of ad-hoc, community based, multi-agency or other such clinics. Further, while a proportion of survey participants said that they were *not* currently considering such innovation, their position may

be influenced by an actual lack of or lack of confidence in the necessary logistical arrangements of which transport may be one part.

- The interviews with patients suggest that some of the medical difficulties that prevent them from getting out and about more – e.g., walking, breathing and back pain – could be mitigated by the provision of appropriate transport. In the contexts of Integration and the norms of contemporary Scottish society, people's ambitions to get out in the fresh air, go shopping, meet friends, attend groups and see their home city for the 1st time in 2 years seem more than reasonable. This issue may be mitigated in part by greater efforts to raise the awareness of, as well as supporting people to use, existing social transport services where available (part of THInC's role). In addition to the points made elsewhere in this section, the case for extending the provision of such transport requires a better understanding of the nature, scope and scale of need within a geographical location. Among others, GP surgeries seem to be well placed to help develop that understanding.
- Analysis of the THInC – Transport in the City FTS operating data has the potential to add significant value to decision-making in respect of the planning, delivery and monitoring of that service, including understanding its social impact. In this work, the analysis shows that the FTS is being used by people in a wide range of age groups at or above the eligibility threshold of 55 years. This includes some people of very advanced years. While a small number of people under the requisite age are also using the FTS, this is not considered problematic provided: that the vehicle would otherwise be sitting idle, that use of the service by such 'younger' people does not infringe any legislative requirements, and that those 'younger' people are in need. In terms of the issue of social justice, and particularly health inequality, the analysis has also shown a disparity in the use of the FTS between men and women and between the origin of journeys by locality. Further, it has highlighted that, in the period considered (March 2015 to January 2016) 5% of its registered clientele used 30% of its capacity, 25% of all journeys were made to 5 destinations (in alphabetical order –

Aberdeen Community Health and Care Village, Aberdeen Royal Infirmary (ARI), City Hospital, Foresterhill Health Centre and Woodend Hospital) and the top destination was ARI.

- The collaborative diagramming exercise with the Falls Service at City Hospital identified 4 ways in which the STP could support the work of that service and therefore effect constructive social change, namely: individual or group attendance at the 'upstream' Stable and Able classes; patient attendance at the Triage Clinic at City Hospital; patient attendance relating to onward referral from the Falls Service, and; individual or group patient attendance at the 'downstream' Strength and Balance classes. Work is ongoing to explore the chains of causality and evidence associated with the social impact of the STP in these areas and, hence, in respect of the work of the Falls Service overall. This will be reported at a later date, to be decided.
- Finally, in relation to the quality and conduct of social research (of which this social impact study is one form) it is important to develop as full an understanding as possible of an issue and of the context in which that issue is manifest.

8.0 RECOMMENDATIONS (INCLUDING FURTHER WORK)

8.1 In Relation to Integration

8.1.1 **Partnership Building:** It is essential to recognise that the high quality social research (including that related to appraisals of social impact) needed to effect the recommendations set out in this report, is challenging and, at the very least, depends on: (a) being able to identify the stakeholder groups and individual points of contact within those groups; (b) developing an adequate understanding of the work, working and living contexts of those stakeholders relevant to the task at hand; (c) having adequate time and opportunity to develop and maintain effective personal and working relationships, and; (d) receiving timely responses to questions. (Note that the work of ACVO's Partnership Manager has been

essential in helping to meet some of these conditions.) It is recommended that in collaboration with the ACH&SCP and its partners:

a. ACVO continues to contribute to the goal of bringing about greater transparency, clarity and accessibility – with respect to social research generally and social impact specifically – in the context of understanding who does what within the health and social care ecosystem;

b. ACVO implements appropriate arrangements – e.g., maximises opportunities for co-located working – with and within the ACH&SCP and its partners. This should be done with a view to supporting the development of effective working relationships and information flows, particularly where teams have been temporarily convened with regards to a specific intervention or action;

8.1.2 **Partnership Building:** Social impact is a concept that has the potential to make a significant, constructive contribution to the decision-making process, particularly within the context of Integration. It is well suited to the tasks of: (a) prospective evaluation, i.e., helping to chose between possible courses of action, and; (b) the planning and progress monitoring of a chosen course of action. Conversely, by its very definition and because of issues with acquiring the necessary data, using it for retrospective evaluation, although not impossible or without value, can be problematic and, in any event, may be akin to closing the stable door after the horse as bolted. Either way, it must be used carefully and consistently by ACVO and throughout the ACH&SCP. Doing so will contribute to establishing the clarity and unity of understanding, purpose and action essential to achieving, among other things, high levels of stakeholder engagement, creating a strong sense of community and building effective teams (CIPD, 2016, p. 5). Indeed, this argument applies to a range of concepts and practices – e.g., social justice, community and ABCD – and will be integral to the success of Integration. It is recommended, therefore, that:

a. ACVO builds on the foundations laid down in this exploratory study and continues to develop a capability in relation to social research more generally and appraisals of social impact specifically, particularly where such work enables the net value to society of an intervention to be established;

b. because of the value they can add to the decision-making process, there should be a presumption in favour of performing appraisals of the social impact of interventions;

c. ACVO, also in collaboration with the ACH&SCP and its partners, continues to work to disseminate any learning, from its research and social impact activities, across the entire health and social care ecosystem.

8.1.3 **Alignment:** Allied to the preceding recommendations, it is recommended that proposals for interventions are developed and evidenced, with due consideration being paid to:

a. why an intervention is needed and is the preferred course of action;
b. how that intervention sits within the context of and contributes to the fitness-for-purpose of the wider health and social care ecosystem;
c. how that intervention aligns with the guiding principles of ABCD (in relation to *all* stakeholder groups) as well as the 3 Horizons Model of Transformative Change;
d. how it contributes (including in terms of its social impact) to the Strategic Priorities set out in the ACH&SCP Strategic Plan (2016), and;
e. most importantly, how it contributes to improving or maintaining the quality of life of Aberdeen's citizens.

8.1.4 **Prioritisation:** in relation to the design and delivery of surveys (and indeed any data gathering mechanism) – it is important to try to develop as full an understanding as possible of the context in which that mechanism will operate. It is therefore recommended that:

a. adequate time be spent in dialogue with potential participants before any research design and delivery decisions are taken. While timescale

will likely pose a problem in this regard, quality should be prioritised over quantity of data;

b. due consideration be given to undertaking smaller, more focussed, more collaborative research exercises, rather than more complex, larger scale, catch-all ones.

8.1.5 **Evidence Based Management:** In respect of the possible tensions arising with regards the relative worth of 'objective' and 'subjective' data – and given the values promoted in the Strategic Plan (ACH&SCP, 2016) – it is recommended that ACVO, in collaboration with the ACH&SCP and its partners, works to develop a form of guidance for all stakeholder groups on how to deal with the tension between – e.g., economic and value driven considerations – in decision-making in practice.

8.1.6 **Targeted Support and Developing Options for Delivery:** The STP has undoubtedly effected constructive social impact for the people who have benefitted from its services. However, it was found to have the potential to do and to demonstrate *considerably* more and – because of its further potential to effect financial savings over and above its own cost – to be a very strong candidate for receiving mainstream and ongoing funding. This could be achieved, it was argued, through the STP helping:

a. reduce the number of avoidable home visits by (primary care) clinical staff, freeing up time for other tasks;

b. support innovation in the delivery of primary care, e.g., enabling the provision of ad-hoc community based, multi-agency clinics;

c. improve or maintain attendance at – e.g., the Falls Service and its associated exercise classes – thereby helping reduce the incidence of falls in the city and the downstream social and economic costs of an individual incurring a fall;

d. tackle health inequalities – arising from inequalities in access to health and social care services – and the associated social and economic costs of poor or declining health, and;

e. improve the quality of life of “housebound” individuals by enabling them to achieve reasonable goals such as meeting friends, attending clubs, going shopping and seeing their home city of Aberdeen for the 1st time in 2 years.

8.1.7 Building the evidence and arguments required to support this claim likely requires a change both to the way that the STP is currently operated and accessed, and to the sources and types of data that are collected in relation to its services and impact. It is recommended that a further phase of work be undertaken during the remainder of 2016 which – with a view to maintaining continuity of service beyond the current ‘end’ date of **16th December 2016**:

a. develops a set of alternative approaches to operating and accessing the STP (including the associated eligibility criteria) so that those people with the greatest need to travel are those that are both eligible and get to use the STP as a matter of priority. This is consistent with the intention to tackle health inequalities and to help bring about a more just society;

b. prospectively evaluates those approaches – including through an evaluation of their likely social impact – with a view to identifying either a unique or blended preferred approach, and;

c. seeks funding for the implementation of that preferred approach.

8.1.8 **Holistic Approach to Service Delivery:** transport related issues should not be solely a matter for patients to raise since that runs the risk that: (a) only the most capable are heard and have the chance of being appropriately supported, and; (b) that health inequalities will, consequently, persist. It is recommended that consideration is paid to how – in the context of the health and social care ecosystem – information about people’s transport issues and needs (in the broadest sense) is most appropriately collected and used.

8.2 For the ACVO Board

8.2.1 The concept and practices of social impact – when properly, carefully and consistently used – are relevant and, hence, valuable in and within the context of ACVO's activities and, by extension, throughout the 3rd Sector as a whole. Those concepts and practices offer significant potential in terms of supporting effective decision-making by ACVO, its members, partners and affiliates. It is recommended that they be adopted, developed and promoted by ACVO for that purpose.

8.2.2 To ensure that ACVO is appropriately equipped to support its members and affiliates in this regard, and to continue to champion their needs in the context of Integration, as well as at higher levels of governance, the following are also recommended:

a. through performing a gap analysis, ACVO develops a better appreciation of the resources needed to support its research, evaluation, planning and monitoring capabilities. Some of those resources will be freely accessible or could be made available through emerging partnerships with, e.g., Aberdeen's universities. Some – particularly those associated with high quality research practice – including software for: accessing existing research, analysing texts and doing statistical analyses, will have an associated cost.

b. ACVO should prepare a framework protocol for the conduct of high quality social research (including that relating to appraisals of social impact) incorporating the learning arising out of this exploratory study. That protocol should also set out ACVOs approach to the topic of research ethics, including the requirements and process for ethics review to secure approval.

9.0 NEXT STEPS AND CLOSING REMARKS

9.1 Work to ensure that interventions (in this case the STP) are developed, planned, implemented and monitored – using high quality decision-making data – is essential to the fitness-for-purpose of the health and social care

ecosystem and, most importantly, the quality of life of Aberdeen's citizens. The STP has most definitely had constructive social impact but has the potential to do considerably more. However, it is imperative that the necessary mechanisms are in place to collect evidence to more confidently support that claim. A further phase of work to cement ACVOs understanding of and approach to appraisals of social impact is necessary and worthwhile. It will help to ensure (through high quality evidence and argument) that interventions, in this case the STP, are not cast aside – on the grounds of their headline cost alone – as being "a nice to have" rather than a necessity. Failure in this regard would leave those people – who, in the context of the STP, are genuinely in need of social transport and who may harbour a modest ambition either to go shopping, to meet friends, to attend clubs or to see their home city for the first time in 2 years – with a quality of life that is inconsistent both with the aims of Integration and the Government's ambitions for life in 21st century Scotland.

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APPENDICES

Appendix A: Methodology for Data Collection and Analysis

The methodology comprised a case study strategy, centred on primary care, employing a collaborative, empirical, mixed methods approach to the collection and analysis of both 'objective' and 'subjective' data.

The purpose of this approach was two-fold: (1) to begin building an evidence base of the realised and potential social impact of the STP and; (2) to inform further development of ACVO's understanding of the theory and practice underpinning appraisals of social impact, commensurate with the aim and objectives of this work.

The methodology was *not* intended to provide for statistical precision or generalization to a wider population – but that does not exclude the possible value of statistical methods to and arising out of similar, future work. It *was* intended, however, that if any findings from this work could be used to provide direct and immediate benefit to the communities involved then, appropriately caveated, those findings should be used for that purpose.

Primary data was collected through 2 mechanisms: (1) a citywide survey of primary care clinical staff and GP practice managers, and; (2) telephone interviews with patients registered with Torry GP Practice and identified by the practice as "housebound". Secondary data was secured from 2 sources: (1) a collaborative diagramming exercise exploring the relationship between the STP and the delivery of the Falls Service based at City Hospital, and; (2) operating data from "Trapeze", the transport and travel management software for the THInC - Transport in the City FTS. Collectively, the primary and secondary data constitutes the social impact dataset for this work as summarised in Figure 5.1 overleaf.

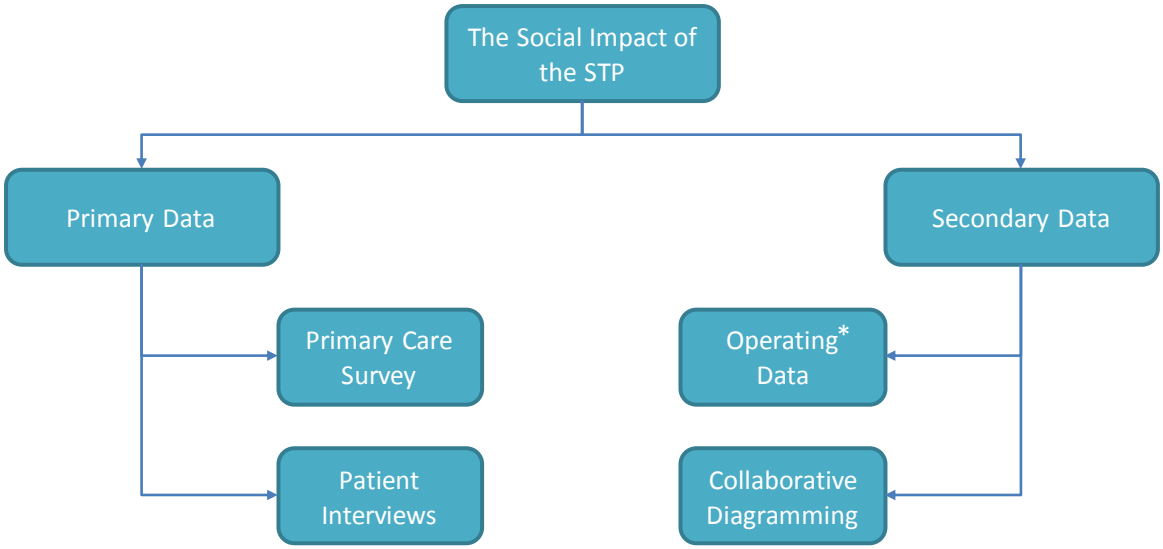

Figure A1: Structure of the STP Social Impact Dataset

(*THInC - Transport in the City operating data)

Appendix B: Guiding Principles for Asset Based Community Development

Most communities address social and economic problems with only a small amount of their total capacity. Much of the community capacity is not used and is needed! This is the challenge and opportunity of community engagement. Everyone in a community has something to offer. There is no one we don't need.

1. **Everyone Has Gifts** with rare exception; people can contribute and want to contribute. Gifts must be discovered.
2. **Relationships Build a Community** see them, make them, and utilize them. An intentional effort to build and nourish relationships is the core of ABCD and of all community building.
3. **Citizens at the Centre**, it is essential to engage the wider community as actors (citizens) not just as recipients of services (clients).
4. **Leaders Involve Others as Active Members of the Community**. Leaders from the wider community of voluntary associations, congregations, neighbourhoods, and local business, can engage others from their sector. This "following" is based on trust, influence, and relationship.
5. **People Care About Something** agencies and neighbourhood groups often complain about apathy. Apathy is a sign of bad listening. People in communities are motivated to act. The challenge is to discover what their motivation is.
6. **Motivation to Act** must be identified. People act on certain themes they feel strongly about, such as; concerns to address, dreams to realize, and personal talents to contribute. Every community is filled with invisible "motivation for action". Listen for it.
7. **Listening Conversation** – one-on-one dialogue or small group conversations are ways of discovering motivation and invite participation. Forms, surveys and asset maps can be useful to guide intentional listening and relationship building.
8. **Ask, Ask, Ask** – asking and inviting are key community-building actions. "Join us. We need you." This is the song of community.

9. **Asking Questions Rather Than Giving Answers Invites Stronger Participation.** People in communities are usually asked to follow outside expert's answers for their community problems. A more powerful way to engage people is to invite communities to address 'questions' and finding their own answer-- with agencies following up to help.
10. **A Citizen-Centred "Inside-Out" Organization is the Key to Community Engagement.** A "citizen-centred" organization is one where local people control the organization and set the organization's agenda.
11. **Institutions Have Reached Their Limits in Problem-Solving** all institutions such as government, non-profits, and businesses are stretched thin in their ability to solve community problems. They can not be successful without engaging the rest of the community in solutions.
12. **Institutions as Servants** p*eople* are better than programs in engaging the wider community. Leaders in institutions have an essential role in community-building as they lead by "stepping back," creating opportunities for citizenship, care, and real democracy.

(ABCD Institute, 2016)