



University of the
West of England

For All Healthy Living Centre Healthy Connections Project

Weston-super-Mare

Final Evaluation Report & Social Return on Investment (SROI) Analysis

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Group
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QUOTES

“Mental health is very misunderstood. You don’t think it’s going to happen to you. You can see someone one day and talk to them – no problems – and a couple of days later they’re in hospital. Nobody knows when it’s going to hit you – it can happen to anyone.”

“I wanted somebody to help me. To pull me back up. I felt like I was drowning. Like I was going deeper and deeper, as if something was pulling me down. I felt that there is help out there, I know there’s help out there. I’ve got to go for it.”

“What you get out of it you can’t put a price on. How it can make you feel. Because if it makes you feel better, makes you feel more relaxed, good about yourself, you can’t put a price on it.”

“Healthy Connections is an important service for supporting those with mental health needs who fall between agencies and for those who should be in Positive Step or secondary mental health services but won’t go. It’s a moving forward service. Local therapy for local people.”

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EXECUTIVE SUMMARY

Aim

The aim of this research was to evaluate the impact of the Big Lottery funded For All Healthy Living Company's (FAHLC) Healthy Connections project on its participants, and demonstrate the social value that the project is creating using the method of Social Return on Investment (SROI). The evaluation focusses on the first 15 months of operation of the Healthy Connections project (Aug 2013-Nov 2014) and includes all those who registered with the project and received an intervention during this time ($n=79$).

Healthy Connections

The Healthy Connections Project is aimed at improving the mental health and wellbeing, and social support and resilience of people with mild to moderate mental health needs in South Ward, Weston-super-Mare.

Healthy Connections is a service targeted at local people experiencing low level anxiety, depression or isolation. It offers participants an introductory session and up to six 1:1 sessions after this with a Wellbeing Worker who uses a solution focussed approach to support participants to explore their situation, identify future action to improve their situation and develop an action plan to achieve health and wellbeing goals. The support provided also includes referral and introduction to other elements of the FAHLCs' Wellbeing Project when appropriate, and to other local agencies for specialist support.

All adults with mild to moderate mental health needs living in South Ward, Weston-super-Mare are eligible for the project. Given that common mental health problems affect up to 15% of the population at any one time based on a population size of 10,400 in Weston-super-Mare it can be estimated that around 1,000 adults might benefit from Healthy Connections at any time.

Importance of mental health and wellbeing

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health¹.

It is estimated that mental health problems impose a total economic and social cost of over £105bn a year². The economy loses more than £30bn a year from sickness absence and unemployment caused by mental ill health, while treating mental health problems cost the NHS and social care over £21bn a year. But the majority of the financial burden of mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Despite a wealth of published evidence about effective interventions to promote mental wellbeing and prevent and treat mental illness both anxiety and depression often go undiagnosed and many individuals do not seek treatment. Certain groups are known to have particular difficulty in accessing mental health services, especially those in low income groups and those with other health and social problems. This is particularly relevant to Healthy Connections which is based in South Ward, Weston-super-Mare, and an area of large inequalities and social deprivation.

¹ Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all

² Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

Social isolation and mental health wellbeing

Social circumstances and environmental factors play an important role in determining mental health and wellbeing. The Healthy Connections Project is aimed not only at improving mental health but also reducing social isolation, thus improving the resilience of individuals and the local community.

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures. There is strong evidence that social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services³.

Social support is important for increasing resilience and promoting recovery from physical and mental ill health. However, in the most deprived communities such as South Ward many report severe lack of support, meaning that those who are at greatest risk can be the least resilient to the detrimental health effects of social and economic disadvantage.

There is good evidence that interventions that seek to improve wellbeing at individual and community levels, can help to increase resilience to the wider impacts of the social determinants of health and risky behaviours. For the individual, mitigating loneliness will improve quality of life. Changes may also impact on health and social care service use, limiting dependence on more costly intensive services. Supporting social engagement and reducing social isolation also provides benefits to the wider community by enabling a possible 'harnessing' of potential contribution to the community through, for example volunteering and caring responsibilities¹¹.

What is Social Return on Investment?

Social Return on Investment (SROI) is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is created by measuring social, environmental and economic outcomes and uses monetary values to represent them. SROI is one approach to economic evaluation of which there are many. SROI captures value often left out of more traditional methods of economic evaluation such as cost benefit analysis.

Social Value

Whilst there is no single accepted definition of social value it is clear from the definition of SROI above and the way in which it is described in other key documents that it refers to measures of impacts of programmes, organisations and interventions that include wider social, economic and environmental benefits.

Interest in social value has been raised by The Public Services (Social Value) Act⁴ which came into force on 31 January 2013. The Act requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area. The act defines social value as "the benefit to the community from a commissioning/procurement process over and above the direct purchasing of goods, services and

³ Social Care Institute for Excellence. Preventing loneliness and social isolation: interventions and outcomes <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf>

⁴ <https://www.gov.uk/government/publications/social-value-act-information-and-resources/social-value-act-information-and-resources>

outcomes". Being able to demonstrate the social value of a project may therefore support business cases and applications for funding.

Method

Quantitative and qualitative data have been used to inform this SROI. Measures of mental health and wellbeing collected from participants as part of the project's outcome monitoring were analysed together with qualitative data collected through project monitoring and research interviews with participants and key stakeholders. Eight interviews were undertaken with project participants (all in person) and fourteen with staff from FAHLC partner agencies (mixture of in person and telephone interviews).

Project Participants

The main beneficiaries of Healthy Connections are the clients who engage with the project and receive an intervention. During the first 15 months of operation of Healthy Connections (Aug 2013-Nov 2014), the project received 94 referrals (self-referral and referral from partner agencies), of whom 79 attended one or more intervention sessions with the Wellbeing Worker. Many had complex needs.

Average age of the participants was 45 years; the majority (78.5%) were female and white British (87.3%). Very few (12.7%) were in any kind of paid employment; 31.6% were unemployed and 21.5% described themselves as long term sick or disabled. Half (50.6%) reported having childcare responsibilities. Almost two thirds (63.3%) of participants said they had at least one long term condition or disability. Most reported more than one condition. Commonly reported conditions included mental health conditions such as depression and anxiety (18.9%) and also common lifestyle related conditions such as diabetes and cardiovascular disease (16.5%) as well as mobility issues (12.6%).

Findings

SROI analysis found that the net SROI ratio which takes account of the amount invested is 1:2.73. This means that the SROI analysis estimates that for every £1 spent on Healthy Connections there is £2.73 of social value created.

The total value of the impact for the 79 participants who received an intervention in the first 15 months of the Healthy Connections project is £109,009.55. Whilst project participants are the greatest beneficiaries of the value created (67%) there is also substantial benefit to local NHS services (10%), the Local Authority (10%) and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (10%) as well as FAHLC (3%).

The table below provides a summary of all the outcomes included in the SROI analysis and the way in which they were valued.

Social Return on Investment – outcomes included and their values

Outcome	n (%)	Financial Proxy	Value per participant
Number of participants reporting improved mental well-being.	74 (94%)	A course of CBT to build psychological resilience and self-esteem	£930
Number of participants reporting reduced symptoms of anxiety	65 (82%)	Cost of counselling	£240
Number of participants who report improved social wellbeing and improved relationships with partner and other family members	47 (60%)	Cost of social club membership and attendance at activities	£50
Number of participants reporting reduced GP attendance	40 (50%)	Cost of GP appointment – average. Calculated as 1 fewer appointments per participant per year.	£42
Number of participants reporting they feel more positive and can manage day to day life better	40 (50%)	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course	£480
Number of participants reporting improved physical activity	24 (30%)	Cost of gym membership/local activity session. Calculated as 1 session per fortnight per participant.	£124.40
Number of participants reporting volunteer engagement	15 (19%)	Economic value of volunteer time. Calculated as 1 hour per week for 6 months	£335.92
Number of participants referred to other counselling/ listening services	10 (13%)	Preparation for counselling	£240
Number of participants engaging with tenancy support team.	8 (10%)	Cost of sessions with housing worker. Calculated as 4 sessions per participant.	£60
Number of participants who report registering for a course and/or achieving new qualification	6 (8%)	Cost of part time course at Weston College	£300
Number of participants reporting retention of employment	3 (4%)	Workplace mental wellbeing intervention	£83
Prevention of referral to secondary mental health services	3 (5%)	Cost of secondary mental health care outreach service for 6 months	£3,832
Number of participants reporting return to work	2 (3%)	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work)	£8,632

Outcome	n (%)	Financial Proxy	Value per participant
Number of participants who give significant credit to the work they did with Healthy Connections in supporting them to retain custody of their child.	2 (3%)	Cost of child in care. Calculated as cost for 3 months.	£8,400

Analysis of quantitative outcome data collected by the project provides clear evidence of significant and lasting benefit to those who receive an intervention from the Wellbeing Worker in terms of improved feelings of individual wellbeing and reduced signs of anxiety, as well as improved social wellbeing and reduced social isolation. There is also evidence that these improvements, and the changes made as a result of the signposting and practical advice and tools given to participants, results in a reduction in GP appointments; increased physical activity levels; and more appropriate use of other support services.

"I now see light at the end of the tunnel, which I didn't before I came to Healthy Connection. Healthy Connections has really helped me a lot and I know it could help other people."
Project participant

Longer term outcomes captured qualitatively include significant life changes such as gaining or maintaining employment in paid or voluntary work; gaining new educational qualifications; improvements in housing situation; improvements in relationships and in a few cases maintaining custody of a child.

Stakeholders interviewed identified a number of positive things about the project; in particular that it is local and well integrated with other services in the area; and that the Wellbeing Worker's proactive approach means that those referring are confident that even difficult clients will be followed up and well supported rather than getting lost in the system or falling through service gaps.

Participants themselves felt they benefited particularly from the quick access (there is no waiting list); the flexibility of the project and the way in which the support provided is tailored by the Wellbeing Worker to individual needs. It was clear from all the interviews conducted that the personal attributes of the Wellbeing Worker were highly valued and key to the success of the project.

"You didn't give up on me when I didn't attend some of the earlier appointments and that was fantastic. It made a real difference and I stuck with it. Thank you." Project participant

Some concerns were also raised about the project including the under representation of men amongst project participants; the short term funding for the project and uncertainty about its long term sustainability; and possible overlap and confusion about the difference between Healthy Connections and other local services, particularly Positive Step, North Somerset's main NHS service for anxiety and depression and also with the role of North Somerset's Health Trainers. However, there was little evidence that contact with Healthy Connections was displacing contact with other services. In fact interview findings suggested the opposite; that support from Healthy Connections helps clients to get ready for and use other support services more appropriately.

Strengths and Limitations

A key strength of this SROI is the excellent methods for collecting baseline and follow-up data from project participants established by the Wellbeing Worker. This meant that there was paired data for many of the project participants that could be incorporated in to the evaluation, and also useful qualitative data to support it.

There are also some limitations. Although data completeness was good the number of participants with follow-up data was small, particularly at 3 month follow-up so there is some uncertainty in the results of quantitative analyses. There will be some benefits that are important to stakeholders but which cannot be monetised. It is also likely that some of the wider impacts of Healthy Connections on FAHLC and the local community have not been captured in the analysis.

Conclusion and Recommendations

In this SROI report we have monetised the benefits of the Healthy Connections project to its participants and other agencies working with the community in South Ward, Weston-super-Mare. The report demonstrates a significant social return for the investment made, and the feedback from participants and stakeholders clearly illustrate the programme's positive impact to participants' mental wellbeing and wider measures of social wellbeing and reduced isolation. These findings fit with theories of change for interventions that seek to improve mental wellbeing at an individual level and reduce social isolation by increasing connections within the community.

A key concern for Healthy Connections is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing Healthy Connections might have on the local community and other local services. It is likely that those who have benefitted from the service and those who might benefit from it in the future will simply slip back through the gaps in services.

This report provides a tool for working with local mental health and public health commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.

It also highlights ways in which improvements could be made to the project to maximise benefit to individuals and other local projects and services in FAHLC and more widely in South Ward. For example since is also FAHLC a provider of Primary Care services there is opportunity for Healthy Connections to work more closely with the FAHLC GP Practice to target their registered patients, working with the Practice and perhaps also Positive Step to take referrals and work with clients to identify solutions that enable them to help themselves, and also to access other support services more appropriately.

Recommendations are:

- Use this report as a tool to demonstrate the value of Healthy Connections and for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.
- Explore opportunities for undertaking a whole system evaluation and SROI of FAHLC to provide insight in to the ways in which it benefits the local community and promotes health and wellbeing in South Ward.

- Identify ways for FAHLC to promote mental wellbeing to men in South Ward, and access to appropriate mental health and wellbeing services including Healthy Connections, Primary Care and Positive Step.
- Identify ways for Healthy Connections to work more closely with other local services, particularly the FAHLC GP Practice and Positive Step, to take referrals and work with clients to identify solutions that enable them to help themselves where appropriate, and also to access other support services more appropriately.
- Review data collection methods used by Healthy Connections in light of the outcomes captured by this SROI and identify ways to capture all relevant outcomes to project and future funders whilst ensuring that burden of paperwork is minimised for participants and project staff.

1. INTRODUCTION

1.1 Aim

The aim of this research was to evaluate the impact of the For All Healthy Living Company's (FAHLC) Healthy Connections project on its participants, and demonstrate the social value that project is creating using the method of Social Return on Investment (SROI). The Healthy Connections Project is aimed at improving the mental health and resilience of people with mild to moderate mental health needs, such as stress, depression and anxiety in South Ward, Weston-super-Mare.

The evaluation focusses on the first 15 months of operation of the Healthy Connections project (Aug 2013-Nov 2014) and includes all those who registered with the project and received an intervention during this time ($n=79$).

The objectives for this analysis were:

- To produce an Impact Map and SROI Report.
- To identify suitable indicators that would enable the measurement of outcomes and social impact of Healthy Connections.
- To produce a working document that can be used to demonstrate the social value of investing in Healthy Connections.
- To use this initial report as a base for identifying the changes necessary to sustain and improve the social value of Healthy Connections and associated activities at FAHLC.

1.2 Purpose

There is a particular need for an evaluation and analysis of the Healthy Connections project to provide evidence to support bids for future funding for the project beyond March 2015. A key audience for the findings of the SROI analysis will be potential future funders. This includes local commissioners (CCG and Local Authority) as well as national funding agencies.

FAHLC is very interested in the concept of SROI and how it could be used to demonstrate the value of other services and projects it offers. This evaluation will therefore also provide a useful test of the methods on a discrete project which is characteristic of the overall work of the agency and that Healthy Connections is appropriate for this to inform potential future wider SROI analysis.

1.3 Big Lottery Healthier Way to Live Programme

Healthy Connections is part of the Big Lottery funded Healthier Way to Live Programme (HWTL); a programme that seeks to improve the well-being of people in poor health, experiencing isolation and living in socially disadvantaged neighbourhoods in the south west of England. Eight local projects deliver a broad base of linked social, non-medical alternatives to positive health promotion that include lunch clubs, community kitchens, weight management groups, community allotments, befriending groups, collective arts and creative activities. The projects share an emphasis on bottom-up community involvement and informal social networks. For individual participants the focus is on positive physical, social and mental states, as opposed to the absence of pain, discomfort and incapacity.

The HWTL Programme is being funded by the Big Lottery fund and the funding for this SROI evaluation and the evaluation of other HWTL projects has also been provided by the Big Lottery fund. The University of the West of England, Bristol (UWE) has been commissioned by the Westbank CHC and the HWTL consortium to undertake these evaluations as a means of obtaining a clearer picture that will help them to make more intelligent investment / funding decisions in the future.

1.4 The For all Healthy Living Company

The For All Healthy Living Company (FAHLC) is a social enterprise which works to sustain and develop the wellbeing of people in South Ward, Weston-super-Mare.

FAHLC runs a Healthy Living Centre, manages a GP practice and is commissioned or grant aided to run other services and projects in South Ward. Through partnership with other agencies FAHLC also provide on-site access to a wide range of services including a library, a Children's Centre, a church and social care team.

Through the delivery of these services and projects, and the promotion of healthy life styles and choices FAHLC aims to tackle the high levels of health inequality experienced in the area; the GP practice has the highest level of deprivation of any practice in the South West of England.

1.5 Weston-super-Mare South Ward

South Ward in Weston-super-Mare, which includes the areas of Bournville, Coronation, Oldmixon, and the Potteries has a population of approximately 10,400 people. South Ward includes some of the most deprived areas in North Somerset, and indeed nationally; South Ward encompasses areas which are classed within the most deprived 1% in England.

A recent Health Needs and Assets Assessment⁵ undertaken by North Somerset Council describes some of the key features of the South Ward area. When viewed through the lens of the deficit model there are many needs within the area including child poverty and poor child health, low aspirations and/or expectations in young people, high prevalence of alcohol and substance misuse, poor mental health, high unemployment, high smoking prevalence, poor cardiac health and high premature mortality. High levels of social housing and unemployment have contributed to a negative perception of the area by outsiders and to a certain extent local statutory agencies and efforts to tackle such a range of needs can seem daunting.

Changing the lens and viewing the area through a strengths-based approach reveals many assets in the community. For instance there are already a number of health promoting assets in the area including community focused schools, a vibrant Healthy Living Centre, a library, a youth centre, football grounds and a number of other green spaces including allotments, to name but a few. There are also local residents committed and connected to the area who are passionate about the ward's people and places.

⁵ Van de Venter, E. Weston-super-Mare South Ward Health Needs and Assets Assessment 2014.

[http://www.n-somerset.gov.uk/community/partnerships/Documents/JSNA/Health%20and%20wellbeing/south%20ward%20health%20needs%20and%20assets%20assessment%20chapter%20\(pdf\).pdf](http://www.n-somerset.gov.uk/community/partnerships/Documents/JSNA/Health%20and%20wellbeing/south%20ward%20health%20needs%20and%20assets%20assessment%20chapter%20(pdf).pdf)

1.6 FAHLC Wellbeing Project

FAHLC received Big Lottery funding to provide a suite of activities as part of a Wellbeing Project. The Wellbeing Project is part of the HWTL portfolio of projects led by Westbank in Devon.

The Wellbeing Project activities cover many aspects of wellbeing including mental health, diet, physical activity and community connections.

They include:

- **Healthy Connections:** solution focussed, time limited 1:1 intervention for people experiencing low level anxiety, depression or isolation
- **Wellbeing group:** weekly group for more isolated people providing mutual contact and support.
- **Volunteering:** support to introduce and support people from the project to existing volunteering opportunities in the centre including; café work, allotment group, 'welcomers'.
- **Physical activity:** supporting and developing existing activity groups; walking, swimming, local gym and developing new activities for people with weight management issues and diabetes.
- **Café time:** working with local people to increase information and experience of healthy eating options in the FAHLC café.

1.7 Healthy Connections

As described above Healthy Connections is one of the FAHLC Wellbeing Project activities funded by the Big Lottery. The focus of this evaluation and social return on investment (SROI) analysis is on this project.

Healthy Connections is a service targeted at local people experiencing low level anxiety, depression or isolation. It offers participants an introductory session and up to six 1:1 sessions after this with a Wellbeing Worker who uses a solution focussed approach to support participants to explore their situation, identify future action to improve their situation and develop an action plan to achieve health and wellbeing goals. The support provided also includes referral and introduction to other elements of the Wellbeing Project when appropriate, and to other local agencies for specialist support.

Healthy Connections have also begun piloting group sessions for 8 weeks. These sessions aim to offer participants an opportunity for social connection to share experiences and for peer support.

Healthy Connections has been identified as of particular interest for SROI for a number of reasons.

- There is an opportunity for ongoing funding of the Healthy Connections project through local joint commissioning (CCG and Local Authority) through the new Better Care Fund (a new national single pooled budget to support health and social care services to work more closely together in local areas). Evidence of the impact of the project is needed to support any commissioning proposal and it was felt that an SROI analysis would help with this.

- FAHLC is very interested in the concept of SROI and how it could be used to demonstrate the value of the services and projects it offers. It was felt useful to test out the method on a discrete project which is characteristic of the overall work of the agency and that Healthy Connections is appropriate for this.

Table 1: Healthy Connections – service model

Eligibility criteria:	Adults (18 years +) living in South Ward who are experiencing low to moderate mental health difficulties (depression, low mood, anxiety) or isolation.
Referral route:	Initially referral from Primary Care and local partner agencies Now open to self-referral
Intervention:	Tailored and flexible solutions focussed approach which provides service users with emotional and practical support to set and work towards health and wellbeing goals, and access other local services.
Outcomes:	Improved health and wellbeing. Referral to other local services.
Data collected:	Baseline Final session Three month follow-up

The annual budget for Healthy Connections is £39,055. This includes funding for a full-time Wellbeing Worker, general overheads and running expenses for the project and some funding for training for FAHLC staff and volunteers and project participants.

2. LITERATURE REVIEW

The aim of the Healthy Connections project is to provide project participants experiencing low level anxiety, depression or isolation with support in 1:1 sessions with a Wellbeing Worker to improve their situation and develop an action plan to achieve health and wellbeing goals. A solution focussed approach is used.

A literature review was undertaken to provide context and supporting evidence to this method of intervention. The literature review considered the epidemiology of mental health and illness, particularly mild to moderate mental ill health, the national policy context, and the evidence for community based and public health interventions to improve mental wellbeing.

Some background to solution focussed therapy is provided, but a review of psychological therapies is not included.

2.1 What do we mean by mental health and wellbeing?

The World Health Organisation⁶ defines mental health as

“a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

The concept of well-being thus comprises two main elements, feeling good and functioning well.

The Foresight Mental Capital and Wellbeing Project⁷ defines mental wellbeing as

“a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.”

The Foresight Report links mental well-being to mental capital, which it defines as

“This encompasses a person’s cognitive and emotional resources. It includes their cognitive ability, how flexible and efficient they are at learning, and their “emotional intelligence”, such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high personal quality of life.”

⁶ World Health Organisation (WHO). Mental health: a state of well-being.

http://www.who.int/features/factfiles/mental_health/en/

⁷ Foresight Mental Capital and Wellbeing Project (2008). Final Project report. The Government Office for Science, London.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292450/mental-capital-wellbeing-report.pdf

2.2 What do we mean by mental illness?

There is no agreed definition for mental illness; it is usually defined through medical diagnosis. One definition provided by the World Health Organisation⁸ is

“the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions.”

Mental illnesses can be grouped into those deemed to be common and those that are severe and enduring.

Common mental health problems include a range of conditions relating to low mood and anxiety, which can affect people’s ability to work, study or maintain relationships. Common mental health problems affect up to 15% of the population at any one time⁹. They include depression, generalised anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), mixed anxiety and depressive disorder, and medically unexplained symptoms.

Severe and enduring mental health conditions include psychosis (schizophrenia, schizoaffective and delusional disorders and psychosis with substance abuse); bipolar disorder; eating disorders; emotional dysregulation disorders, and conduct disorders. It is estimated that around 5 people in every 100 will be affected by one of these conditions in their lifetime.

A person diagnosed with a mental health problem can be affected to different degrees at different times.

- A mild mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life.
- A moderate mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.
- A severe mental health problem is when a person has many symptoms that can make their daily life extremely difficult.

There is a complex relationship between mental illness, mental health and mental wellbeing. For some, mental illness can be seen on a continuum with mental wellbeing, as we all experience periods of better or worse mental health. For others mental illness and mental wellbeing should be viewed separately as you can suffer from mental illness but have good levels of mental wellbeing. Societal responses, such as stigma, labelling and exclusion, have an important bearing on the experience of mental illness.

⁸ World Health Organisation (WHO). The ICD-10 Classification of Mental and Behavioural Disorders <http://www.who.int/classifications/icd/en/bluebook.pdf>

⁹ National Institute of Health and Care Excellence (NICE). Common mental health disorders: Identification and pathways to care. NICE guidelines [CG123] Published date: May 2011 <https://www.nice.org.uk/guidance/cg123/ifp/chapter/common-mental-health-problems>

2.3 Determinants of mental health and wellbeing

There are known risk factors and protective factors for mental health and wellbeing; these include individual attributes, the social circumstances in which persons find themselves and the environment in which they live, and are often complex and inter-related¹⁰.

Certain groups in society may be particularly susceptible to experiencing mental health problems, including those who are unemployed, have a low income and are living with debt. People with chronic health conditions and some minority groups are known to be at particularly high risk. Some groups also experience greater barriers in accessing help and support.

Table 2: Determinants of mental health and wellbeing

<i>Level</i>	<i>Adverse factors</i>		<i>Protective factors</i>
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
	Loneliness, bereavement	↔	Social support of family & friends
Social circumstances	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Education achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to services	↔	Equality of access to services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social inequalities	↔	Social equality

Adapted from WHO¹¹

¹⁰ World Health Organisation (WHO) 2012. Risks To Mental Health: An Overview Of Vulnerabilities And Risk Factors http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

¹¹ WHO and the Calouste Gulbenkian Foundation. Social determinants of mental health. http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health

2.4 Social isolation

The table above shows that whilst individual attributes can determine mental health and wellbeing social circumstances and environmental factors also play an important role. The Healthy Connections Project is aimed not only at improving mental health but also reducing social isolation, thus improving the resilience of individuals and the local community.

There is strong evidence that social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services¹².

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures. It can be created or imposed through marginalisation or discrimination by families or communities or through deteriorating mental health or mental capacity. Lack of social networks and support and chronic loneliness can cause long-term damage to physical and mental health.

Social support is particularly important in increasing resilience and promoting recovery from illness. However, in the most deprived communities many report severe lack of support, making people who are at greater risk less resilient to the detrimental health effects of social and economic disadvantage.

There is good evidence that interventions that seek to improve wellbeing at individual and community levels, can help to increase resilience to the wider impacts of the social determinants of health and risky behaviours. For the individual, mitigating loneliness will improve quality of life. Changes may also impact on health and social care service use, limiting dependence on more costly intensive services. Supporting social engagement and reducing social isolation also provides benefits to the wider community by enabling a possible 'harnessing' of potential contribution to the community through, for example volunteering and caring responsibilities¹¹.

2.5 Impact of mental illness

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health¹³.

It is estimated that mental health problems impose a total economic and social cost of over £105bn a year¹⁴. The economy loses more than £30bn a year from sickness absence and unemployment caused by mental ill health, while treating mental health problems cost the NHS and social care over £21bn a year. But the majority of the financial burden of mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Mental health problems can lead to poor physical health; suicide and self-harm; alcohol misuse, smoking and obesity, all leading to a reduction in life expectancy, as well as unemployment; crime; stigma, discrimination and social exclusion. Among people under 65, nearly half of all ill health is

¹² Social Care Institute for Excellence. Preventing loneliness and social isolation: interventions and outcomes <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf>

¹³ Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all

¹⁴ Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

mental illness. Research suggests that the degree of disability imposed by depression is 50% higher than that for angina, asthma, arthritis or diabetes¹⁵.

There are thus strong health and economic arguments for investment in services which prevent and treat mental health problems.

2.6 National Policy Context

Historically mental health has been far less well recognised by health services than physical health, and physical and mental health treatments have been viewed and delivered as separate health services. As a result investment in health services and research for mental health has been much lower, and there have been lower treatment rates for mental health conditions than physical health conditions. This means that people with poor mental health are more likely to have poor physical health that goes untreated or treated too late and vice versa¹⁶.

More recently there have been calls for mental health to be valued equally with physical health or “Parity of Esteem”¹⁷. This was enshrined in law by the Health and Social Care Act 2012¹⁸.

Parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by¹⁹:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

In addition to this increased focus on mental health services and treatment in health policy it has been recognised that public health has an important role to play in protecting and promoting mental wellbeing.

In 2011 the Department of Health published No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages²⁰ which sets out shared objectives to improve people's mental health and wellbeing and improve services for people with mental health problems.

No Health without Mental Health outlined 6 key objectives:

- More people will have good mental health
- More people with mental health problems will recover

¹⁵ Moussavi, S et al. 2007. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet* Volume 370, No. 9590, p851–858, 8 September 2007 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61415-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61415-9/fulltext)

¹⁶ Royal College of Psychiatrists 2013. Whole-person care: from rhetoric to reality Achieving parity between mental and physical health <https://www.rcpsych.ac.uk/pdf/Parity%20of%20esteem%20sum.pdf>

¹⁷ NHS England. Valuing mental health equally with physical health or “Parity of Esteem” <http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/>

¹⁸ Health and Social Care Act 2012 <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

¹⁹ Royal College of Psychiatrists . Parity of esteem. <https://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx>

²⁰ Department of Health 2011. The mental health strategy for England. <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

These objectives show the change of national policy focus to include prevention as well as treatment and it is now well acknowledged that the greatest opportunities to reduce the levels of mental ill health in the population in the long term lie in mental health promotion, as well as mental illness prevention and early intervention.

2.7 Local Policy Context

Mental health and wellbeing is acknowledged as a priority in North Somerset and at the time of writing (January 2015) North Somerset Council are consulting on a draft Public Mental Health Strategy²¹ which describes how North Somerset Council, North Somerset Clinical Commissioning Group, Avon and Wiltshire Mental Health Partnership and other key partners will work together to develop positive mental health and wellbeing for the population of North Somerset. This strategy provides most relevant local context to the Healthy Connections Project although there are other local strategies and policies relating to mental health services.

The overall vision for this strategy is:

“To support individuals, families and communities within North Somerset to achieve their optimum mental wellbeing enabling them to feel good and function well in their daily lives”.

A key objective is to promote early identification of mental health problems and improve access to early support. In South Ward Healthy Connections is key to achieving this goal and there are clear opportunities for FAHLC to work together with Public Mental Health Strategy Group members to identify ways of developing the project in-line with strategy objectives.

2.8 Access to mental health services

Considering mental health problems affect about one in four people, of 1000 people at risk 250 will experience a mental health problem. Of these the vast majority (about 230) will seek advice from their GP and about 130 are subsequently diagnosed as having a mental health problem. Only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital²².

Many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. In fact there is evidence that currently there is a very significant overall treatment gap in mental healthcare in England, with about 75% of people with mental illness receiving no treatment at all²³. NHS England aims to ensure that at least 15% of those with anxiety or depression have access to a

²¹ North Somerset Council 2014. Draft Public Mental Health Strategy for consultation. <http://consult.n-somerset.gov.uk/consult.ti/publicmentalhealth2014/consultationHome>

²² Joint Commissioning Panel for Mental Health. Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services [http://base-uk.org/sites/base-uk.org/files/\[user-raw\]/11-06/practical-mental-health-commissioning.pdf](http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/practical-mental-health-commissioning.pdf)

²³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf

clinically proven talking therapy services by 2015²⁴; this means that even when these targets are reached 85% will not have access to these services.

Certain groups are known to have particular difficulty in accessing mental health services, especially those in low income groups and those with other health and social problems. The complexity of these patients needs mean that they are unlikely to be well supported by local Improving Access to Psychological Therapies (IAPT) services, which are mainly set up to deal with relatively straightforward cases of anxiety and depression, while at the same time the severity of their mental health conditions is generally insufficient to meet the clinical thresholds for treatment which are set by specialist or secondary mental health services.

Analysis of data from survey data from a major Economic and Social Research Council (ESRC) funded study of emotional support found that despite much lower levels of subjective well-being and higher rates of serious mental health difficulties in those on low incomes, those in the poorest households are no more likely than those in the most affluent households to have been in receipt of talk-based support. They are, by contrast, almost twice as likely to have been prescribed drugs in the face of emotional difficulties²⁵.

This data suggests that whilst those living in South Ward are likely to be at greater risk of mental health problems than those living in more affluent areas, they are also more likely to experience difficulties in accessing support such as talking therapies. There is thus great potential for them to benefit from a targeted project such as Healthy Connections.

2.9 Interventions to promote mental wellbeing and prevent mental illness

There is a wealth of published evidence about effective interventions to promote mental wellbeing and prevent and treat mental illness. However, only a minority of people with a mental disorder currently receive any treatment. This section highlights evidence that provides context to the development of a theory of change and impact map for the Healthy Connections project.

Public Mental Health

Public mental health interventions promote mental health and wellbeing and reduce the impact of mental disorder and poor wellbeing and can reduce health and social inequalities; help achieve parity of mental health with physical health; and deliver large economic savings and benefits.

Good evidence exists for a range of public mental health interventions. Of most relevance to the Healthy Connections project are early interventions which seek to improve outcomes and reduce associated inequalities²⁶.

Stepped care

A key feature of mental health services is the stepped care model. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or

²⁴ NHS England. Valuing mental health equally with physical health or “Parity of Esteem” <http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/>

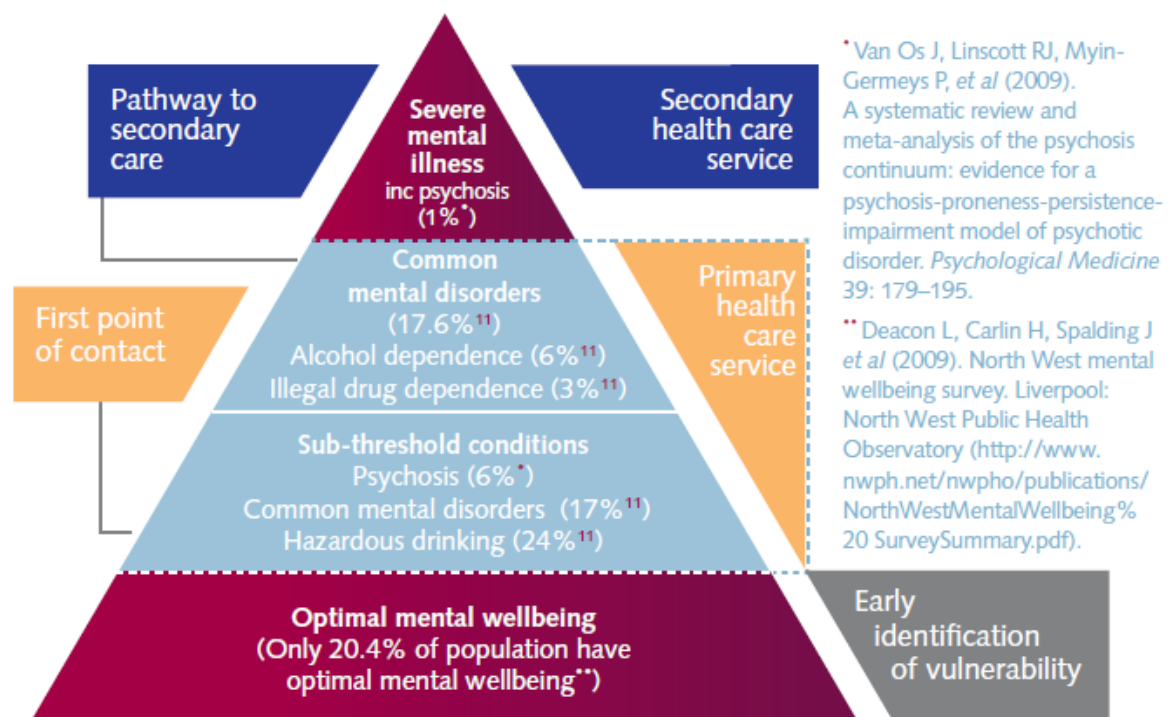
²⁵ Anderson S, Brownlie J. Build it and they will come? Understanding public views of ‘emotions talk’ and the talking therapies. *British Journal of Guidance & Counselling* 2011 , vol: 39 , (1) , pp: 53-66

²⁶ Joint Commissioning Panel for Mental Health. Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services [http://base-uk.org/sites/base-uk.org/files/\[user-raw\]/11-06/practical-mental-health-commissioning.pdf](http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/practical-mental-health-commissioning.pdf)

down the pathway according to changing needs and in response to treatment²⁷. This means that the majority of people will be supported in the community often with help from their GP.

The most common method of treatment for common mental health disorders in primary care is psychotropic medication, despite the strong evidence of effectiveness for psychological therapy and the fact that these treatments are generally preferred by patients. This is due to the limited availability of psychological interventions.

Figure 1: Stepped Care Model



Interventions for mild to moderate common mental health disorders

The National Institute for Health and Care Excellence (NICE) recommends the following for treatment and referral advice for sub-threshold symptoms and mild to moderate common mental health disorders (Step 2).

²⁷ Commissioning stepped care for people with common mental health disorders. National Institute of Health and Care Excellence (NICE). Commissioning stepped care for people with common mental health disorders. NICE commissioning guides [CMG41] Published date: November 2011 <http://www.nice.org.uk/guidance/cm41/chapter/3-a-stepped-care-approach-to-commissioning-high-quality-integrated-care-for-people-with-common>

For people with persistent sub-threshold depressive symptoms or mild to moderate depression, offer or refer for one or more of the following low-intensity interventions:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- a structured group physical activity programme
- a group-based peer support (self-help) programme (for those who also have a chronic physical health problem)

For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help
- psychoeducational groups

For people with mild to moderate panic disorder, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help

The Improving Access to Psychological Therapies (IAPT) programme was designed to support NHS commissioners and service providers in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for stepped care for people suffering from depression and anxiety disorders, and this tends to be the main focus when commissioning local services; however other approaches and more targeted services also exist.

Cognitive Behaviour Therapy

As seen in the NICE Guidance above individual and group based self-help approaches are a key focus for low level interventions for common mental health problems, most often based on the principles of cognitive behavioural therapy (CBT)

Cognitive Behaviour Therapy, or CBT, is a talking therapy. It has been proved to help treat a wide range of emotional and physical health conditions in adults, young people and children. CBT looks at how we think about a situation and how this affects the way we act. Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of distress or symptoms in the past, it looks for ways to improve current state of mind²⁸.

Solution Focussed Brief Therapy

The Healthy Connections project uses a solution focussed approach for supporting its clients. Solution Focussed Brief Therapy (SFBT) is an approach to psychotherapy based on solution-building rather than problem-solving²⁹. It is a strengths-based intervention that is founded in the belief that clients have the knowledge and solutions to solve their problems. Two important aims of SFBT are

²⁸Royal College of Psychiatrists. Cognitive Behavioural Therapy.

<http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/cognitivebehaviouraltherapy.aspx>

²⁹Iveson, C. Solution-focused brief therapy. *Advances in PAsyPcThi* (a2tr0i0c2 T)r, evaotml. e8n, pt .(2104092), vol. 8, pp. 149–157 <http://apt.rcpsych.org/content/8/2/149.full.pdf>

that the clients' lives should become better, and they should become more confident about finding solutions on their own.³⁰

SFBT evolved as a form of brief therapy and has often been recommended because it can achieve results with less time and cost than other approaches. SBFT is a relatively new therapy, developed in America in the 1980s by Steve de Shazer and Insoo Kim Berg³¹. It uses a number of specific techniques, as described in a recent systematic review and meta-analysis³²:

1. Therapist's use of the "miracle question"
2. Use of scaling questions
3. A consulting break and giving the client a set of compliments
4. Assignment of homework tasks
5. Looking for strengths or solutions
6. Goal setting
7. Looking for exceptions to the problem

However, there is considerable variability in the techniques and well as the outcomes measured.

Because the approach is still relatively new, research evidence of its effectiveness is still growing. Evidence consists of a broad range of descriptive, quantitative and qualitative research, as well as clinical observations. The studies relate to a wide variety of topics including serious mental health problems, drug and alcohol use, criminal behaviour and domestic violence.

A number of systematic reviews and meta-analyses examining the effectiveness of solution focussed therapy have been published^{23,33}; results from these reviews have been used to highlight evidence supporting the use of this approach in the Healthy Connections project and development of a theory of change and impact map.

There appears to be some good evidence for the use of a solution focussed approach to supporting people with depression. A recent systematic qualitative review³⁴ of controlled outcome studies concluded that the strongest evidence of effectiveness came in the treatment of depression in adults; four separate studies found SFBT to be comparable to well-established alternative treatments. This review also found that SFBT may be briefer and therefore less costly than alternative approaches. These findings are supported by those of a recent meta-analysis which concluded that SFBT appears to be effective with internalising behaviour problems such as depression, anxiety, self-concept, and self-esteem³⁵.

³⁰Wehr, T. The Phenomenology of Exception Times: Qualitative Differences between Problem-Focussed and Solution-Focussed Interventions. *Appl. Cognit. Psychol.* 24: 467–480 (2010). <http://onlinelibrary.wiley.com/doi/10.1002/acp.1562/abstract>

³¹De Shazer S. (1985) *Keys to Solution in Brief Therapy*. ONorton, NewYork.

³²Kim, JS. Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. *Research on Social Work Practice* 2008 18: 107

³³Wallace J. Gingerich and Lance T. Peterson. Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Research on Social Work Practice* 2013 23: 266

³⁴Wallace J. Gingerich and Lance T. Peterson. Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Research on Social Work Practice* 2013 23: 266

³⁵Kim, JS. Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. *Research on Social Work Practice* 2008 18: 107

3. SOCIAL RETURN ON INVESTMENT

3.1 What is Social Return on Investment?

Social Return on Investment (SROI) is one approach to economic evaluation of which there are many. SROI captures value often left out of more traditional methods of economic evaluation such as cost benefit analysis. SROI can help to improve services in a range of ways³⁶.

SROI is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them. It is thus a method of measuring social value. This enables a ratio of benefits to costs to be calculated. For example, a ratio of 3:1 indicates that an investment of £1 delivers £3 of social value. SROI is about value, rather than money. Money is simply a common unit and as such is a useful and widely accepted way of conveying value.

It can help to:

- understand the social, environmental and economic value created by your work;
- maximise the positive change you create and identify and manage any negative outcomes arising from your work;
- reconsider which organisations or people you should be working with, or improve the way you engage with your stakeholders;
- find ways to collect more useful, better quality information.

There are seven principles of SROI that underpin how it should be used:

1. **Involve stakeholders.** Stakeholders should inform what gets measured and how this is measured and valued.
2. **Understand what changes.** Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.
3. **Value the things that matter.** Use financial proxies in order that the value of the outcomes can be recognised.
4. **Only include what is material.** Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact.
5. **Do not over claim.** Organisations should only claim the value that they are responsible for creating.
6. **Be transparent.** Demonstrate the basis on which the analysis may be considered accurate and honest and show that it will be reported to and discussed with stakeholders.
7. **Verify the result.** Ensure appropriate independent verification of the account.

³⁶ The SROI Network. The SROI Guide. <http://www.thesroinetwork.org/sroi-analysis/the-sroi-guide>

The six stages of SROI analysis

Carrying out an SROI analysis involves six stages:

1. Establishing scope and identifying key stakeholders.
2. Mapping outcomes through engagement with stakeholders to develop an impact map (also called a theory of change or logic model) which shows the relationship between inputs, outputs and outcomes.
3. Evidencing outcomes and giving them a value. This stage involves finding data to show whether outcomes have happened and then giving them a monetary value.
4. Establishing impact. Identifying those aspects of change that would have happened anyway or are a result of other factors to ensure that taken out of the analysis.
5. Calculating the SROI. This stage involves adding up all the benefits, subtracting any negatives and comparing the result with the investment. This is also where the sensitivity of the results can be tested.
6. Reporting, using and embedding. This vital last step involves verification of the report, sharing findings with stakeholders and responding to them, and embedding good outcomes processes.

3.2 Stage 1: Establishing Scope and Identifying Key Stakeholders.

Scope

The purpose of this SROI analysis is to evaluate the Healthy Connections project run by the For All Healthy Living Company, South Ward, Weston-super-Mare. The analysis focusses on the first 15 months of operation of the Healthy Connections project and includes outcomes for all those participants who registered with the project and received an intervention during this time (Aug 2013-Nov 2014).

Key stakeholders

Stakeholders are people or organisations that experience change (positive and negative) as a result of an intervention. They are best placed to describe the change. The purpose of stakeholder involvement is to help identify the most important outcomes to the project and to set out an understanding of those outcomes that has been informed by stakeholders.

A list of stakeholders who experience change or affect the Healthy Connections project was prepared by the Wellbeing Worker together with the evaluation lead. A table outlining this initial list and reasons for inclusion in qualitative interviews included in Appendix 1.

In total fourteen interviews were undertaken with staff from FAHLC and other partner agencies (mixture of in person and telephone interviews).

The list of stakeholders interviewed included:

- Project participants
- Healthy Connections Wellbeing Worker
- FAHLC Centre Manager
- FAHLC Activities Co-ordinator
- FAHLC GP Practice Manager
- FAHLC Health Trainer
- FAHLC Librarian
- FAHLC Volunteer Co-ordinator
- FAHLC Receptionist

- Positive Steps – Step 2 Low Intensity Service Manager
- Family Support Worker – Bournville School
- Children’s Centre worker
- Troubled Families Worker
- Alliance Housing Support Worker
- Clinical Psychologist

Initial stakeholder mapping noted that family and friends of project participants might benefit from the project as improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities. Project participants were invited to bring a partner, family member or friend with them to the interview but none took up this offer.

Project Participants

The main beneficiaries of Healthy Connections are the clients who engage with the project and receive an intervention. All adults with mild to moderate mental health needs living in South Ward, Weston-super-Mare are eligible for the project. Based on a population size of 10,400 in Weston-super-Mare it can be estimated that around 1,000 adults are affected by a common mental health problem at any time, and thus might benefit from Healthy Connections.

Data collected by the project provides insight in to the demographics of the project participants. During the first 15 months of operation of Healthy Connections (Aug 2013-Nov 2014), the project received 94 referrals (self-referral and referral from partner agencies), of whom 79 attended one or more intervention sessions with the Wellbeing Worker. The data presented in Table 3 are for these 79 participants. Limited information is available about those who did not engage. All were female.

Many participants reported being in touch with other services as well as Healthy Connections. This is demonstrated in data about referral route collected by the Wellbeing Worker.

Table 3: Source of referral

Referral route	<i>n</i>	%
Self-referral/recommended by friend	22	27.8%
GP/Primary Care	25	31.6%
Other partner agency	31	39.2%
Missing	1	1.3%

Referring agencies included the local housing association Alliance Housing; Family Support Workers in local schools; social care staff and other workers based in FAHLC.

Average age of the participants was 45 years (SD 14.5); the majority (78.5%) were female and white British (87.3%). Very few (12.7%) were in any kind of paid employment; 31.6% were unemployed and 21.5% described themselves as long term sick or disabled. Half (50.6%) reported having childcare responsibilities.

Almost two thirds (63.3%) of participants said they had at least one long term condition or disability. Most reported more than one condition. Commonly reported conditions included mental health conditions such as depression and anxiety (18.9%) and also common lifestyle related conditions such as diabetes and cardiovascular disease (16.5%) as well as mobility issues (12.6%). The project believes that there is very significant under reporting of mental health conditions because of the

way in which the questions is worded; respondents tended view the question as relating to their physical rather than mental health.

Many project participants therefore have quite complex health needs. These findings fit with those of the Health Needs and Assets Assessment³⁷ undertaken by North Somerset Council, and the practice population described by a stakeholder from the FAHLC GP Practice in interview.

“Our Practice population is different to any other in North Somerset ... They’ve got lots of medical problems, lots of co-morbidities and a huge amount of depression or low mood. They don’t make old bones here. They just don’t.” Stakeholder

All data available from project participants has been included in quantitative data analysis. In total eight interviews were undertaken with project participants (all in person) to gather qualitative data.

³⁷ Van de Venter, E. Weston-super-Mare South Ward Health Needs and Assets Assessment 2014.
[http://www.n-somerset.gov.uk/community/partnerships/Documents/JSNA/Health%20and%20wellbeing/south%20ward%20health%20needs%20and%20assets%20assessment%20chapter%20\(pdf\).pdf](http://www.n-somerset.gov.uk/community/partnerships/Documents/JSNA/Health%20and%20wellbeing/south%20ward%20health%20needs%20and%20assets%20assessment%20chapter%20(pdf).pdf)

Table 4: Project participants – demographics (n=79)

	<i>n</i>	%
Sex		
Female	62	78.5%
Male	16	20.3%
Missing	1	1.3%
Age group		
<26 years	6	7.6%
26-64 years	62	78.5%
65 years +	7	8.9%
Missing	4	5.1%
Ethnicity		
White British	69	87.3%
Other	<6	<5%
Missing	7	8.9%
Employment status		
Carer	13	16.5%
Employed/self-employed	10	12.7%
Retired	8	10.1%
Unemployed	25	31.6%
Long-term illness or disability benefits	17	21.5%
Missing	6	7.6%
Any long-term illness, health problem or disability?		
No	21	26.6%
Yes	50	63.3%
Missing	8	10.1%
Child carer status		
No	33	41.8%
Yes	40	50.6%
Missing	6	7.6%
Adult carer status		
No	67	84.8%
Yes	6	7.6%
Missing	6	7.6%
Smoker		
No	20	25.3%
Yes	28	35.4%
Missing	31	39.2%

3.3 Stage 2: Mapping inputs and outcomes

SROI is an outcomes-based measurement tool. The aim of this stage is to map outcomes to develop an impact map (also called a theory of change or logic model) which shows the relationship between inputs, outputs and outcomes. Sections of the impact map are included throughout this chapter however the report is best understood when read together with the full impact map – Appendix 2.

Mapping inputs

The investment, in SROI, refers to the financial value of the inputs. Inputs are what stakeholders are contributing in order to make the activity possible and are used up in the course of the activity – money or time, for example.

The annual budget for Healthy Connections is £39,055 (£48,820 for 15 months). This includes funding for a full-time Wellbeing Worker, general overheads and running expenses for the project and some funding for training for FAHLC staff and volunteers and project participants. No other costs were identified in input mapping.

Table 5: Healthy Connections annual budget

Item	Cost (£)
Staffing	24,000
NI and pensions	5,280
Rent	2,075
General running expenses	500
Producing information	500
Training for staff and volunteers	700
Training for participants	800
Travel for staff and volunteers	450
Consultancy & advice	300
Organisation overheads - line management	3,425
Organisation overheads - accommodation	625
Other - Care Costs, Translation and Interpreting	400
Total annual budget	39,055

Mapping outputs - data collection methods

Quantitative and qualitative data have been used to inform this SROI. The Healthy Connections Project Wellbeing Worker has established excellent methods for collecting baseline and follow-up data from project participants. The data recorded is outlined below. Stakeholder engagement was undertaken using qualitative interviews with individuals. Project specific questions appropriate for each of the stakeholder groups were developed for this process as outlined in Appendix 3 and 4.

- Registration Form Data
 - Gender
 - Age
 - Race/Ethnicity
 - Postcode
 - Source of Referrals
 - Employment Status
 - Carer status (child/adult)
 - Illness and Disability
 - Tobacco use
- Wellbeing Questionnaire Data – baseline, final session, 3 month follow-up
 - Mental Ill-health: Depression
 - Mental Ill health: Anxiety
 - Overall Life Satisfaction
 - Personal Mental Wellbeing
 - Social wellbeing
 - Physical activity
- Client Aims and Potential Solutions
- Exit Questionnaire

Impact Map 1: Inputs and Outputs

Stakeholders	Intended/unintended changes	Inputs		Outputs
Who do we have an effect on? Who has an effect on us?	What do you think will change for them?	What do they invest?	What is the value of the inputs in currency (£)	Summary of activity in numbers
Big Lottery funders	Intended project outcomes achieved	Funding	48820	
FAHLC project staff including Wellbeing Worker and centre manager	Time, commitment, skills and experience	Time - cost included in funding above	0	1 full-time Wellbeing Worker. Line management from centre manager. Supervision from Clinical Psychologist.
Project participants - South Ward residents with low mood/anxiety/depression	Improved mental wellbeing (depression, anxiety, life satisfaction, personal mental wellbeing, social wellbeing.	Time	0	94 referrals, of which 79 attended one or more intervention sessions with the Wellbeing Worker.
	Reduced social isolation			
	Improved confidence			
	Signposting and access to other services			
	Reduction in GP appointments and improved use of Primary Care resources			
	Confidence developed to take up and maintain employment and volunteering opportunities			
	Increased sense of independence and ability to do things alone rather than seeking support from services.			
Increased physical activity levels and participation in local sport and activity groups.				
Family and friends of project participants	Improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities.	Time and support to participants	0	Family and friends of 94 referrals, of which 79 attended one or more intervention sessions with the Wellbeing Worker.
Staff from FAHLC local partner organisations	Referral route to and from project for extra support for their clients.	Time, commitment, skills and experience	0	Referral to Healthy Connections: GP/Primary Care – 25, other partner agency - 31

Total

£48,820

3.4 Stage 3: Evidencing outcomes and giving them a value

This stage involves finding data to show whether outcomes have happened and then giving them a monetary value. As discussed above, the Wellbeing Worker has established excellent methods for collecting baseline and follow-up data from project participants. This enabled quantitative data analysis to be undertaken. Qualitative data captured by the Wellbeing Worker and through interviews with project participants and stakeholders tell the stories of change experienced by project participants and enable outcomes to be explored further and to be valued.

Details of qualitative interview schedules and tools used to collect quantitative data are included in the appendix.

Qualitative data analysis – stories of change

The following data and quotes from Healthy Connections participants and stakeholders give a sense of the reasons why clients seek help from the project, and provide useful indicators for the impact the support they receive from the Wellbeing Worker has on them and thus the project outcomes.

The Wellbeing Worker keeps a record of all issues raised by the client as areas they would like to work with when they first meet. Most clients come with more than one issue. Many participants come to the project with complex needs. Domestic violence and childhood trauma have featured in a significant number of cases.

The table below shows the ten most frequently raised issues. This shows that whilst depression, anxiety and low mood are commonly reported issues, clients come with many other problems. Whilst some are beyond the remit of the project they must be acknowledged in discussions with the Wellbeing Worker who often signposts to and liaises with other services on behalf of the client.

Table 6: Issues worked with

Issue	n	%
Depression	51	63.0%
Anxiety/panic attacks	34	42.0%
Physical health	29	35.8%
Social isolation	26	32.1%
Low mood	17	21.0%
Confidence building	14	17.3%
Parenting	12	14.8%
Relationship difficulties	11	13.6%
Child custody/ child protection	11	13.6%
Bereavement	8	9.9%

“It’s been such hard work being on my own with health problems ... I wasn’t getting out and about and it was starting to get me down. Because of my illnesses I couldn’t keep doing everything every day. I had to do a little bit every day and have a rest. It was taking so long I couldn’t see an end to it. I wanted to get back focussed on the balance, being able to go out and see people and do things outside and still try and get everything sorted out in the flat. I felt doing that would help get me back focussed on myself.” Project participant

"I had a set of circumstances at home which changed my whole life dramatically ... Everything went spiralling out of control. I'm on my own. I don't have any extended family or anything like that. I just have nobody. I wasn't doing very well so I asked for a bit of help and support. I don't often do that. But I had to do that and she recommended different agencies and I came to Healthy Connections." Project participant

"I needed all the support I could get at the time. Not only for my daughter but for my mental state of mind. To move me on. I think I was hoping to change my life and to turn my life around from my feelings. Feeling no hope and despair. To get my mind and my confidence and back. I was feeling lost and empty and you know suicidal at times." Project participant

Many participants reported being in touch with other services as well as Healthy Connections. Stakeholders who refer to the project highlighted the added benefit Healthy Connections can bring to participants, and the way in which working with Healthy Connections can give participants the confidence and motivation to engage effectively with other services.

"Healthy Connections offers fabulous support ... Parents often get pushed down the list because of the focus on their children ... Caring can be exhausting both mentally and physically ... The Wellbeing Worker can focus on parents rather than children. We are good at meeting the child's needs but families need looking after too." Stakeholder, partner agency

"I personally find referral to Healthy Connections helpful. [The Wellbeing Worker] will deal with things quickly. It's helpful when someone is in immediate need of help. It's a useful starting point. Helps motivate them. Opens them up to more self-help and use of other services." Stakeholder, partner agency

"I saw a client yesterday who had been through Healthy Connections who I'd tried to connect with before. They'd sort of approached me but hadn't followed through on anything. She's now had 5 sessions [with the Wellbeing Worker] and has finally got to the stage where she's happy to come to me. She actually feels confident that she can follow a plan through with me now whereas in the past that just wasn't going to happen. She just wasn't at that stage." Stakeholder, partner agency

Stakeholders also reported referring clients who may not meet the threshold for other services, or who they see as "falling through the gaps".

"Healthy Connections is an important service for supporting those with mental health needs who fall between agencies and for those who should be in Positive Step or secondary mental health services but won't go. It's a moving forward service. Local therapy for local people." Stakeholder, partner agency

Many participants reported positive outcomes that fit with these themes.

"I've never had this kind of support which is why I enjoyed it so much. It was more focussed on me rather than the work I was doing. It was more about getting out there and putting more uses to myself rather than filling me up with medication. More about what I can do to get out there and achieve things." Project participant

The exit questionnaire used by the Wellbeing Worker also includes space for clients to provide qualitative feedback on:

- If they had a specific goal they wanted to achieve and if they achieved it?
- What they will you do in the future to continue support their health and wellbeing?
- Other comments about Healthy Connections and/ or Healthy Living Centre?

These comments also help to understand the outcomes experienced by participants.

"I am more positive about myself and my wellbeing; I have started to do more for myself. For the first time in ages I want to go out and meet people and socialise more." Project participant

"I can go out now. I couldn't even walk up the road before. I can go for a walk now and go shopping. I had to have people to do that for me before. It's a very big change."
Project participant

Participant feedback the length of the Healthy Connections intervention was generally positive. Some of those interviewed went on to participate in a pilot group follow-up. This part of the project has not been explored in depth as part of this project, but all those who attended commented on benefits they experienced from attending.

"I think 6 sessions was about right otherwise you become too dependent on something like that. Right from the start to the finish you feel that you've opened up enough to move on to something else. The group was at just the right time for me."
Project participant

The list below provides a summary of the positive outcomes experienced by individual participants identified from qualitative data:

- Improved mental wellbeing: anxiety, life satisfaction, personal mental wellbeing, social wellbeing.
- Reduction in GP appointments and improved use of Primary Care resources
- Reduction in medication use – antidepressants and other medications
- Suicide prevention
- Support and confidence development to access other services and sessions
- Getting home sorted, tackling hoarding behaviours
- Reduced social isolation
- Confidence developed to take up and maintain employment and volunteering opportunities
- Improved relationships with partner and other family members
- Ability to cope better with past and situations
- Use of relaxation techniques and mindfulness
- Assertiveness
- Getting ready for other services
- Support filling in forms

- Life balance
- Increased sense of independence and ability to do things alone rather than seeking support from services.
- Increased physical activity levels and participation in local sport and activity groups.
- Increased confidence, resilience and improved parenting skills contributing to retaining custody of a child

As discussed above initial stakeholder mapping noted that family and friends of project participants might benefit from the project as improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities. Project participants were invited to bring a partner, family member or friend with them to the interview however none took up this offer and there was little mention of benefits to others during the interviews therefore identifying and valuing outcomes for this group is very difficult.

Quantitative data analysis

Quantitative data provides supporting evidence for the stories above and enables estimates to be made of how many project participants experience the outcomes described. The results show improvements in all aspects of wellbeing measured, but not depression score. This is discussed further below.

Mental Ill-health: Depression

Depression is assessed by the Healthy Connections project using the shortened seven item version of the Centre for Epidemiological Studies Depression Scale (CES-D7)³⁸. The Center for Epidemiologic Studies-Depression (CES-D) scale is one of the commonly used depression measurement tools originally developed for use in the general population and asks seven questions about how the respondent has felt during the past week.

Possible scoring range is 7-35. No formal threshold for identifying depressive symptoms has been established with this particular set of questions from the CES-D, but based on other similar questionnaires we would suggest a threshold of about 19 for identifying individuals with significant depressive symptoms.

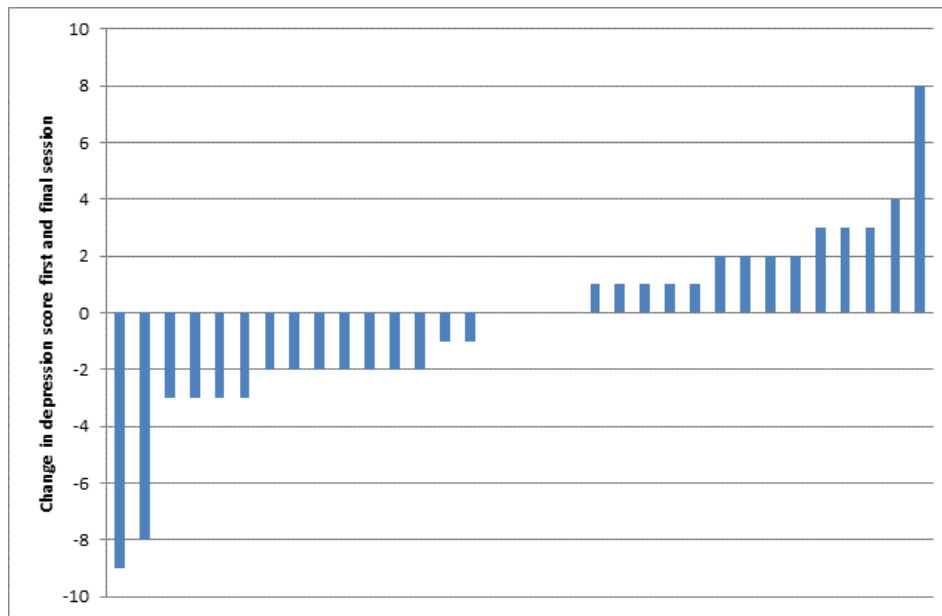
Scores for 70 participants were available at baseline; 63 (90%) had a score of 19 or more (mean score 21.8, SD 2.9) indicating that they had significant depressive symptoms.

Matched scores for the first and final session were available for 33 participants. A paired T test indicates no statistically significant difference ($p > 0.05$) between these mean scores (baseline mean 21.5, SD 3.1; final session mean 21.8, SD 2.6).

These findings are perhaps surprising given that results show improvements in all other aspects of wellbeing measured. It should be noted that definitions for mental illness and mental wellbeing are different, and the scales used in this evaluation each measure a different aspect of mental health and wellbeing. Indeed it is quite possible for someone to be diagnosed with a mental illness but have good levels of mental wellbeing.

³⁸ Center for Epidemiologic Studies Depression Scale Revised. (CESD-R) <http://cesd-r.com/>

Figure 2: Individual changes in depression score between first and final session (n=33)



When explored further the data shows that participants' change in depression score varied widely; around half reported a reduced score between the start and end of the intervention (indicating less depressive symptoms) whilst the other half reported a higher score. (A few reported no change at all).

There are many possible explanations for these findings. Recovery from depression takes time and it may be that these measures were taken too soon to measure change. Results at 3 month follow-up suggest a very small decrease in average depression score (baseline mean 22.0, SD 2.1; 3 month mean 21.4, SD 2.2). However, scores were only available for a matched sample of 17 participants; this sample is too small to draw any robust statistical conclusions.

Given the number of participants who did report a reduction in depressive symptoms, and other positive findings in this section it would be inappropriate to interpret this lack of significant positive change as a failing of the Healthy Connections Project to have any impact on depression.

Mental Ill health: Anxiety

The Healthy Connections wellbeing questionnaire asks two questions related to anxiety:

- “Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?”
- “Over the last 2 weeks, how often have you been bothered by worrying too much about different things?”

These have five point options ranging from not at all (score 1) to nearly every day (score 5).

At baseline, of 70 respondents, the scores were:

- Mean 3.1 (SD 1.0) for nervousness and anxiety
- Mean 3.4 (SD 1.0) for worrying too much

A paired T test indicates that both these scores fell between the first and last sessions and that these differences are statistically significant difference ($p < 0.05$).

For nervousness and anxiety, matched scores for the first and final session were available for 33 respondents. They show a fall in the mean score from 3.2 (SD 0.9) to 2.2 (SD 0.9). For worry, comparison of the matched sample showed a fall in the mean score from 3.5 (SD 0.9) to 2.8 (SD 1.0). Score fell for 27 of the 33 respondents (81.8%).

These analyses were repeated for the 17 participants with data available at 3 month follow-up. Although the sample size is too small to make confident use of a paired T test, analysis suggests a positive change remained.

Overall Life Satisfaction

Overall life satisfaction was assessed using a widely used questionnaire with a 10 point rating: (0 very low, and 10 very high): *All things considered, how satisfied are you with your life as a whole nowadays?*

At baseline 71 respondents reported a mean score of 4.1 (SD 2.1). The mean score in a general adult population study is 7.2³⁹. Comparison of a matched sample of 34 respondents showed a rise in the mean score from 4.4 (SD 1.8) to 7.4 (SD 1.4) by the time of the final session. Use of a paired T test indicates this is a significant positive change ($p < 0.05$). Data for 17 participants was available at 3 months follow-up. For this small sample the positive benefit remains; difference ($p > 0.05$) (baseline mean 4.1, SD 1.8; 6 month mean 6.2, SD 1.8).

Personal Mental Wellbeing

The Wellbeing questionnaire uses a Big Lottery 2008 adapted version of the Short Warwick Edinburgh Mental Wellbeing Scale⁴⁰. The score range is 10-50. The Warwick-Edinburgh Mental Wellbeing scale was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. WEMWBS is sensitive to the changes which occur in the context of a variety of wellbeing promotion initiatives from those which encourage physical activity and healthy eating, complementary and alternative medicine and parenting support. It was not designed as a screening instrument to detect mental illness.

Of the 69 respondents at baseline the mean score was 26.3 (SD 5.4). Comparison of a matched sample of 32 respondents showed a rise in the mean score from 26.1 (SD 5.5) to 33.7 (SD 5.2) ($p < 0.05$), a difference that remained statistically significant at 3 month follow-up although with the small sample available ($n=17$) this should be interpreted with caution.

³⁹ North West Public Health Observatory. North West Mental Wellbeing Survey - Profiles of wellbeing. <http://www.nwph.net/nwpho/Publications/forms/AllItems.html>

⁴⁰ NHS Health Scotland. Measuring mental wellbeing. <http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx>

Social Wellbeing

The Healthy Connections wellbeing questionnaire has a series of questions concerned with social wellbeing and social capital. Respondents are asked to rate on a scale of 1-5 how much they agree with a set of statements (1= strongly disagree, 5= strongly agree).

Data were available for 70 participants at baseline. Mean scores are shown below.

Table 7: Mean social wellbeing score at baseline

Question	Mean	SD
1. There are people in my life who really care about me	4.1	0.9
2. I regularly meet socially with friends and relatives	2.9	1.2
3. I find it difficult to meet with people who share my hobbies or interests	3.3	1.0
4. People in my local area help one another	3.1	1.1
5. Overall, how satisfied or dissatisfied are you with your neighbourhood as a place to live?	3.3	1.3

Matched scores for the first and final session were available for 33 participants. Significant changes from baseline were found for 2 of the questions; Q2 (change in mean score from 2.9 (SD 1.1) to 3.6 (SD 1.0)) and Q5 (change in mean score from 3.2 (SD 1.6) to 3.7 (SD 1.0)) suggesting that the project may help participants to find more time and feel more confident in meeting socially with friends and relatives and feel more satisfied with their neighbourhood as a place to live. It is not clear whether these two outcomes are linked.

Physical activity

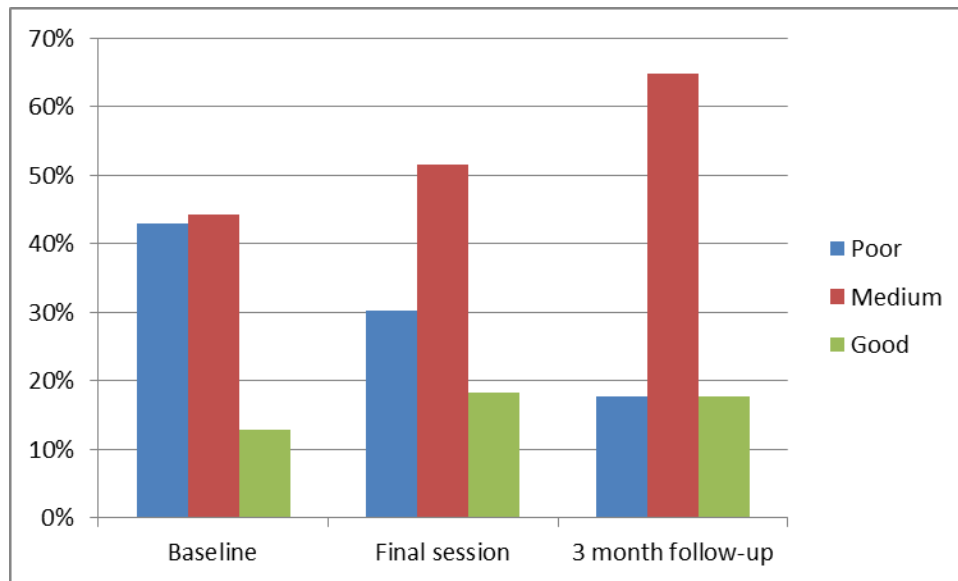
The Wellbeing questionnaire asks participants to rate their physical activity levels as poor, moderate or good.

At baseline 70 individuals gave the following response to the question *“How would you rate your physical activity level?”*

- Poor: 38.0% ($n=30$)
- Moderate 39.2% ($n=31$)
- Good 11.4% ($n=9$)

Matched scores for the first and final session were available for 33 participants for baseline and final session and 17 for baseline and 3 month follow up. The chart below shows changes in the proportion of reporting poor, moderate and good activity levels at each of these times.

Figure 3: Change in physical activity levels (n=70 baseline, n=33 final session, n= 3 month follow-up)



The chart shows that whilst the proportion of participants who rated their physical activity levels as good remained relatively low throughout the project, the number who reported their levels as “medium” increased over time. Whether this is due to changes in activity levels or simply more positive reporting is unclear.

Exit Questionnaire

Healthy Connections uses an Exit Questionnaire to help record client perceptions of change, project satisfaction and goals at the final session. Data was available for 33 participants.

The questionnaire asks some further questions about changes noticed in addition to those described above. Respondents are asked to rate on a 10 point scale whether:

- I feel less stressed
- I feel more positive about myself
- I manage my day to day life better
- I have visited my GP less often

These correspond well to the outcome measures described above and add further validation to the self-report measures, give evidence of attribution and record unanticipated changes and processes.

Figure 4: change in feelings of stress at end of intervention (n=33)

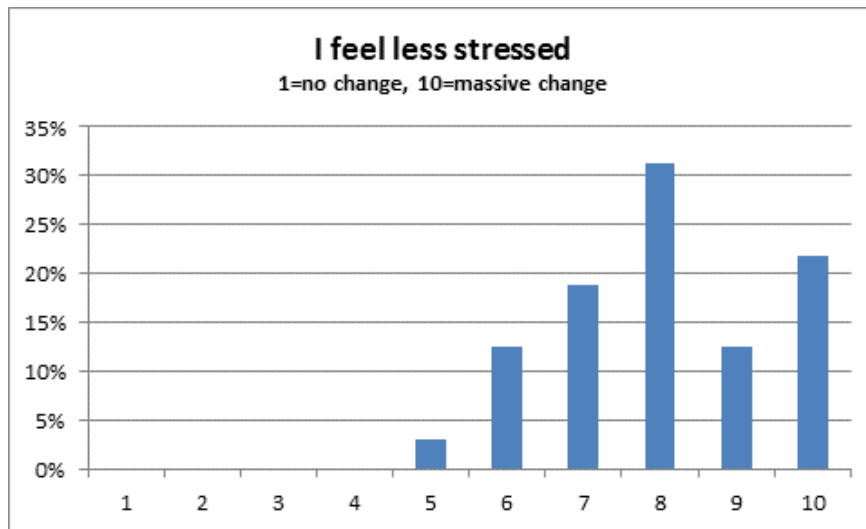


Figure 5: change in positive feelings at end of intervention (n=33)

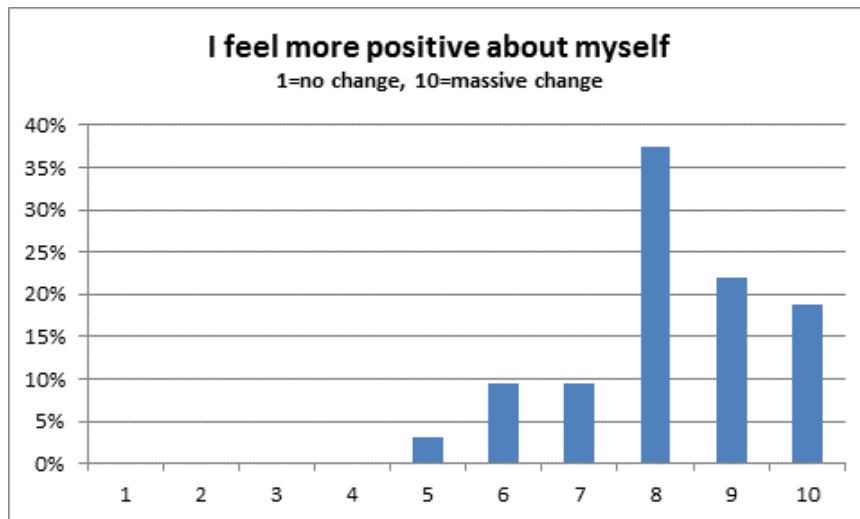


Figure 6: change in day to day life management at end of intervention (n=33)

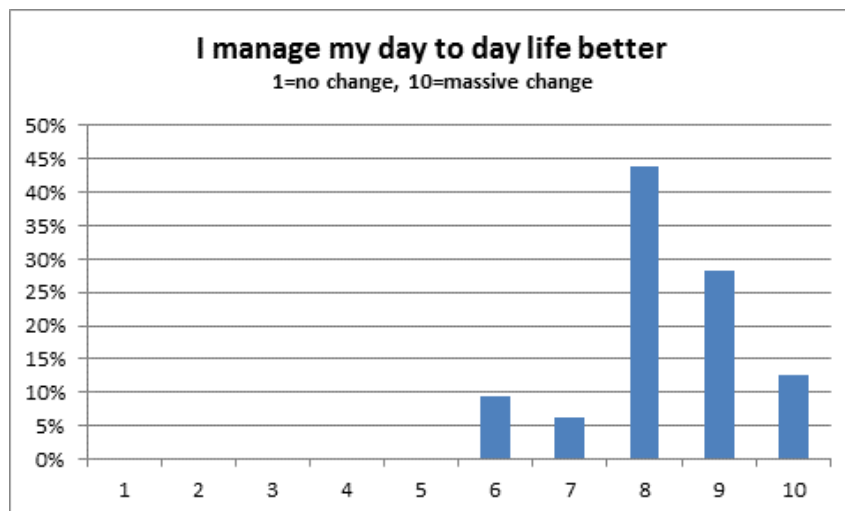
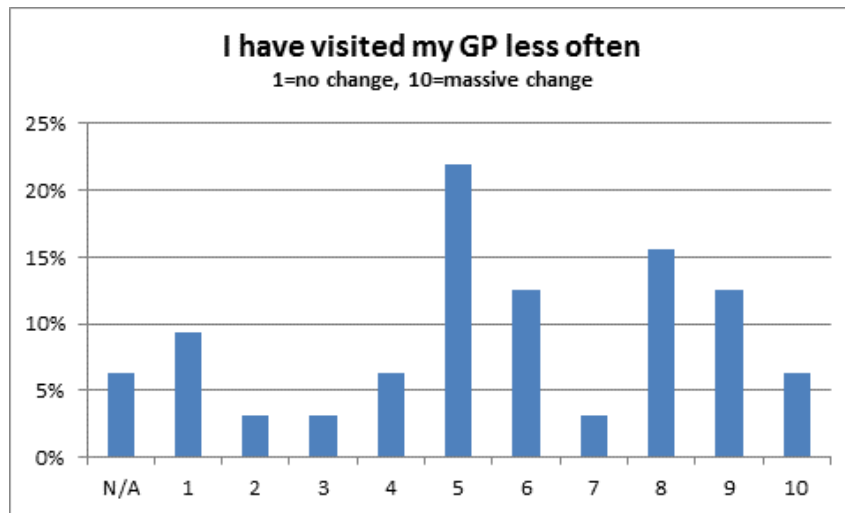


Figure 7: Change in GP visit frequency at end of intervention (n=33)



The data show positive trends in most of the outcomes measured although a change in frequency of GP visits is less clear. 16 (50.0%) scored 6 or more for this question.

Longer term outcomes

Because of the short term nature of the Healthy Connections intervention it is not always possible to know what happens to participants in the longer term, or indeed how much is attributable to the project. However, analysis of qualitative data collected at each session and discussion with the Wellbeing Worker identified some stories of further change.

The Wellbeing Worker was aware of:

- 3 people who obtained paid employment in the time she worked with them, and 2 others who sustained jobs in difficult circumstances.
- 9 people who tried out a new voluntary role for the first time and at least another 6 who sustained existing voluntary roles for the period they were accessing Health Connections.
- 10 referrals to Positive Step and another 10 people supported and encouraged to make use of other counselling/ listening services (such as Cruse) in the area.
- 8 formal referrals to Support Alliance for assessment for support services, where housing related need had been identified. Most of these have related to maintaining independent living in the home.
- 2 people who went on to achieve vocational qualifications (one in fitness instruction and one in childcare) as a direct result of exploring their goals in Healthy Connections, and 4 others who went on to do non-vocational courses .
- 2 individuals who give significant credit to the work they did with Healthy Connections in supporting them to retain custody of their child.

Making a judgement on outcomes

When deciding on which outcomes to include in an SROI there are a number of factors to consider including the project objectives as well as the views of stakeholders. It is also important to consider whether the outcomes identified in the data should be considered as separate or intermediate outcomes in a chain of events – this is what is meant by the theory of change

This can be understood better by considering the story of one of the participants interviewed for the project.

Table 8: example chain of events

Reason for accessing Healthy Connections	Immediate outcomes experienced during 1-1 sessions	Outcomes measured through data tools	Longer term impact
<p>Low mood</p> <p>Waiting to be contacted by Positive Step</p>	<p>Feeling of being listened to and understood</p> <p>Practical skills for managing day to day life</p> <p>Support form filling and contacting other services for support</p>	<p>Depression</p> <p>Anxiety</p> <p>Overall Life Satisfaction</p> <p>Mental wellbeing</p> <p>Social wellbeing</p> <p>Physical activity</p> <p>Stress</p> <p>Positivity</p> <p>Self-management</p> <p>GP use</p>	<p>Getting out more and trying new things</p> <p>Cleaning up flat</p> <p>Joining local walking group</p> <p>Increased physical activity through walking more</p> <p>Improved sense of wellbeing</p>

A key decision to make is what outcome in the chain should be valued. This has been done by making a judgement about what is important and what is measurable. Every effort has been made to ensure that the decision process is transparent with explanations provided as to why outcomes have been included and why not.

Putting a value on the outcome

The purpose of valuation is to reveal the value of outcomes and show how important they are relative to the value of other outcomes. All value is, in the end, subjective. In SROI we use financial proxies to estimate the social value of non-traded goods to different stakeholders. By estimating this value through the use of financial proxies, and combining these valuations, we arrive at an estimate of the total social value created by an intervention.

This step therefore involves identifying appropriate financial values for the outcomes experienced by project participants as a result of the project. Values are thus a way of presenting the relative importance to a stakeholder of the changes they experience.

For some outcomes identifying a value is relatively easy as there are clear, measurable cost savings often with nationally recognised indicators e.g. the savings from reduced GP appointments. SROI also gives values to things that are harder to value so are routinely left out of traditional economic appraisal. There are several techniques available. For this SROI methods used with stakeholders focussed mainly on stated preference and contingent valuation. This approach assesses people’s

willingness to pay, or accept compensation, for a hypothetical thing. Stakeholders were asked in interviews:

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important to you?

This method had limitations, particularly since many of the project participants had low incomes and thus limited ability to pay. When identifying proxies it is important to remember that we are not interested in whether money actually changes hands. It also doesn't matter whether or not the stakeholders in question could afford to buy something – they can still place a value on it. This was discussed in interviews.

“In terms of putting monetary value on it it’s very difficult to say how much would these guys would pay because they wouldn’t. They just wouldn’t pay for it. Is it as important as other things they’re doing? Probably more so. It’s probably more important than their Sky subscription because that’s getting them out of the house when the other one is keeping them in. But if there was a charge. I know these people. I know the area. They don’t want to spend money.” Stakeholder

Project participants identified a range of different values for the one-to-one and group sessions they took part in. What came across from many of them was the different way in which these two interventions made them feel. Many reported feeling pampered in the group sessions:

“For something like the group, with people coming and talking, beauty therapists. £25-£50 for that – you wouldn’t pay less than that.”
Project participant

“At Carlton centre we were paying £2.50 for half an hour aromatherapy.”
Project participant

“It’s difficult to put money on it. I really don’t think you can put a price on it. Not a money price. I could perhaps compare it to what I do. Like swimming. When I’m swimming I empty my mind. Senior swim £2.90, adult swim £4.60.”
Project participant

Many equated the one-to-one sessions as similar to counselling.

“Normal counselling session is £25-£30. That’s what the value would be.”
Project participant

Many found it hard to value the outcomes they experienced.

“What you get out of it you can’t put a price on. How it can make you feel. Because if it makes you feel better, makes you feel more relaxed, good about yourself, you can’t put a price on it.”

Project participant

Negative outcomes

SROI should also take account of the cost of negative outcomes. A few potentially negative consequences of the project were identified. These focussed particularly on the short term funding for the project; and the impact of investing so much time and effort in developing a project, raising expectations about availability of a new service and then losing it when the funding goes might have on the community. Interviews with stakeholders also highlighted some possible overlap and confusion about the difference between services, particularly Positive Step, North Somerset’s main NHS service for anxiety and depression, and also with the role of North Somerset’s Health Trainers. It is difficult to put a value on these concerns. Potential impact is discussed in the section on displacement.

No individual level negative outcomes were identified for project participants or their friends and family. This is interesting as often in projects of this nature participants report problems that ‘surface’ as a consequence of engagement that can’t be addressed by the project. It is therefore of some concern that no such adverse consequences were identified. This may be because none occurred, or may be because of limitations in the interview questions used.

Outcomes and proxy values

The final set of outcomes and financial proxies presented have been identified through data analysis, stakeholder interviews, discussion with the Wellbeing Worker and colleagues in the SROI team at the University of the West of England, and review of published SROI reports.

Table 9: Outcomes included in SROI

How would the stakeholder describe the changes?	How would you measure it?	Where did you get the information from?
Reduced symptoms of anxiety	Number of participants reporting reduced symptoms of anxiety	Scaling question - anxiety recorded at baseline and follow-up
Reduced GP attendance	Number of participants reporting reduced GP attendance	Exit questionnaire
Improved social wellbeing	Number of participants who report improved social wellbeing and improved relationships with partner and other family members	Scaling question - social wellbeing recorded at baseline and follow-up. Participant and stakeholder interview
Improved physical activity	Number of participants reporting improved physical activity	Exit questionnaire
Improved mental well-being.	Number of participants reporting improved mental well-being.	Scaling question - mental wellbeing recorded at baseline and follow-up
Volunteer engagement	Number of participants reporting volunteer engagement	Participant and stakeholder interview
Return to work	Number of participants reporting return to work	Participant and stakeholder interview

How would the stakeholder describe the changes?	How would you measure it?	Where did you get the information from?
Retention of employment	Number of participants reporting retention of employment	Participant and stakeholder interview
Improved confidence and sense of independence and ability to do things alone rather than seeking support from services.	Number of participants reporting they feel more positive and can manage day to day life better	Participant interview, exit questionnaire
Referral to other counselling/ listening services	Number of participants referred to other counselling/ listening services	Participant and stakeholder interview
Referral to housing support team for tenancy support	Number of participants referred to housing support team	Participant and stakeholder interview
Engagement in further education	Number of participants who report registering for a course and/or achieving new qualification	Participant and stakeholder interview
Retaining custody of a child	Number of participants who give significant credit to the work they did with Healthy Connections in supporting them to retain custody of their child.	Participant and stakeholder interview

Table 10: Outcomes and proxy values

Outcome	Proxy	Evidence Source for Proxy	Value per unit £
Reduced symptoms of anxiety	Cost of counselling	Cost of local counselling service – initial 6 week course. http://www.wellspringsomerset.btck.co.uk/AccessToServices	£40/session for 6 weeks £240
Reduced GP attendance	Cost of GP appointment – average	Cost of GP appointment http://www.pssru.ac.uk/uc/uc.htm	£42/GP appointment
Improved social wellbeing	Cost of social club membership and attendance at activities	Cost of social club membership and attendance at activities https://www.facebook.com/pages/49-Social-Club-WsM/145176858857668	£50/year
Improved physical activity	Cost of gym membership/local activity	Group Fitness Classes/Cycle Workout at local leisure centre http://www.leisurecentre.com/hutton-moor-leisure-centre/PriceList	£ 4.90/week
Improved mental well-being.	A course of CBT to build psychological resilience and self-esteem	A course of CBT to build psychological resilience and self-esteem costs. A course of CBT may last for 10 sessions at £93 per session http://www.pssru.ac.uk/uc/uc.htm	£930

Outcome	Proxy	Evidence Source for Proxy	Value per unit £
Volunteer engagement	Economic value of volunteer time	Estimated from average hourly wage in England (ONS 2013) http://www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/2013-provisional-results/stb-ashe-statistical-bulletin-2013.html http://www.volunteering.org.uk/component/gpb/is-there-any-way-of-measuring-the-economic-value-of-the-work-our-volunteers-are-doing	£12.92/hour
Return to work	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work)	This valuation is the overall fiscal benefit to the government of a workless claimant on Employment and Support Allowance/Incapacity Benefit entering work. It is comprised of savings made by the Department of Work and Pensions in benefits payments, and savings made by NHS in improved health of the individual.	£8,632 per claimant per year.
Retention of employment	Workplace mental wellbeing intervention	Multi-component intervention to promote wellbeing in the workplace Cost is estimated at £83 per employee per year. http://www.pssru.ac.uk/project-pages/unit-costs/2014/	£83/person
Improved confidence and sense of independence and ability to do things alone rather than seeking support from services.	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course	Managing Yourself and Personal Effectiveness Training Course http://www.revolutionlearning.net/managing-yourself-personal-effectiveness-training-course/	£480
Referral to other counselling/ listening services	Preparation for counselling?	Cost of local counselling service – initial 6 week course. http://www.wellspringsomerset.btck.co.uk/AccessToServices	£40/session for 6 weeks £240
Housing difficulties prevented due to engagement with tenancy support	Cost of sessions with housing worker	Cost of intervention estimated from average salary of housing officer for a year. http://www.prospects.ac.uk/housing_manager_officer_salary.htm £15/hour for 4 sessions	£60
Engagement in further education	Cost of part time course at Weston College	Examples taken from sport and fitness http://www.weston.ac.uk/	£300/course
Retaining custody of a child	Cost of child in care	Local authority foster care for children	£700 per child per week

Outcome	Proxy	Evidence Source for Proxy	Value per unit £
Prevention of referral to secondary mental health services	Cost of secondary mental health care	Assertive outreach teams provide intensive support for people with severe mental illness who are 'difficult to engage' in more traditional services http://www.pssru.ac.uk/project-pages/unit-costs/2014/	£7,664 average cost per case

3.5 Stage 4: Establishing impact

Establishing impact involves identifying those aspects of change that would have happened anyway or are a result of other factors to ensure that this is taken out of the analysis. This is important as it reduces the risk of over claiming and means that the results are more credible.

There are some key concepts within this stage:

Deadweight

Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage. Since implementation of Healthy Connections was not planned as a controlled study there is no direct comparison group available to estimate deadweight from. Deadweight was explored in interviews with participants and stakeholders through questions about what would have happened without Healthy Connections. Findings from these interviews suggested that very little would have changed for the project participants without Healthy Connections.

"I couldn't imagine what it would be like without [Healthy Connections.] It helped with rebuilding my confidence. Being able to talk to, you know. I was really lacking in confidence and self-worth but talking to [the Wellbeing Worker] she made me feel human, that there is more to life than sitting in on my own." Project participant

[The Wellbeing Worker] talked to me about doing things for myself and I did. I wouldn't have done that without Healthy Connections because I never thought I was good at anything – I thought I'm useless. But she said give it a go ... and that's what I did. Project participant

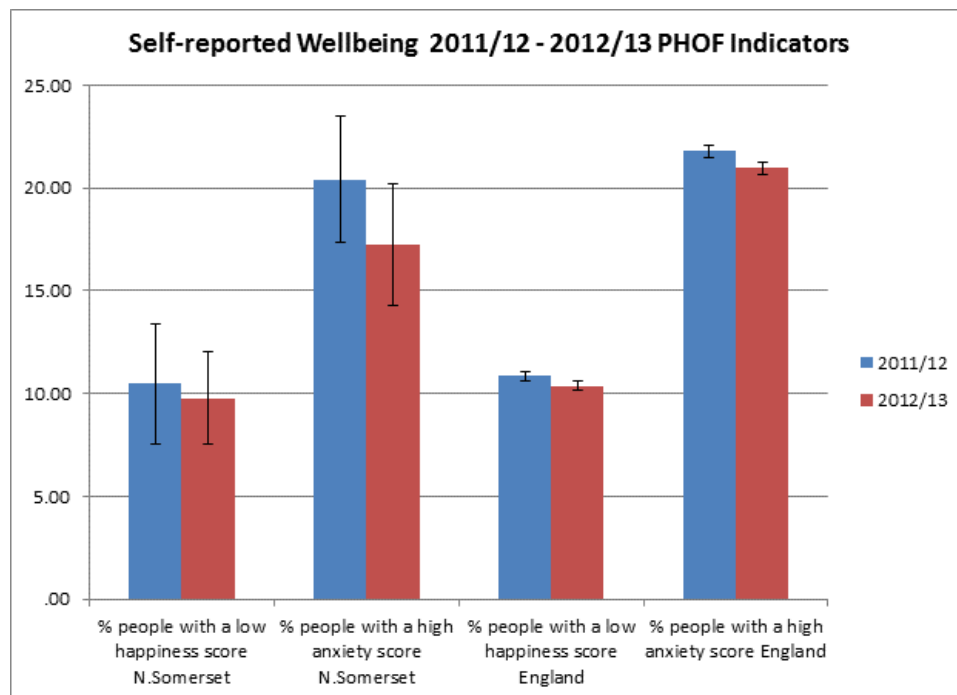
It was clear from conversations with participants and other stakeholders that many participants were in touch with services other than the Healthy Connections project. This was for a number of different issues. Most reported frequent contact with their GP for physical health problems. Discussions with stakeholders highlighted the benefits they saw for their services, with many feeling that the Healthy Connections project helped them to engage with other services. This would suggest that the changes seen in participants are unlikely to have happened anyway.

An alternative way to calculate deadweight is to look at population level data. The Public Health Outcomes Framework⁴¹ includes some measures of population wellbeing captured by the Office for National Statistics (ONS) Annual Population Survey. Data about two aspects of wellbeing (low happiness, high anxiety) is available for each Local Authority in England for two time periods; 2011/12 and 2012/13. This data suggests that overall there may have been some small positive changes at a population level; however in North Somerset these changes do not appear to be statistically significant.

Wellbeing data for 2013/14 is not yet published at Local Authority level, however national data analysis indicates that over this three-year period, there have been small but significant improvements in average all personal well-being ratings. The greatest gain has been in reduced anxiety levels.

⁴¹ Public Health England Public Health Outcomes Framework <http://www.phoutcomes.info/>

Figure 8: Self-reported wellbeing scores in England and North Somerset 2011/12- 2012/13



Source: Public Health Outcomes Framework

These population level changes (survey questions completed by an average of 750 respondents in North Somerset and 12,000 in England) indicate that some improvements in wellbeing for Healthy Connections participants may have happened without the project. However qualitative data suggests that other more practical changes such as accessing other services, taking up volunteering opportunities and developing confidence to move on would not have happened. It would therefore seem reasonable to apply a deadweight value of 10% which is a similar value to that used in other similar SROI evaluations.

Displacement

Displacement is another component of impact and is an assessment of how much of the outcome displaced other outcomes. For example, has the increased involvement in community groups and volunteering observed in Healthy Connections participants meant that they have stopped volunteering somewhere else or doing other things with a social value? Interviews with stakeholders and participants revealed very limited evidence of displacement. Many participants said that without Healthy Connections they would still be “stuck at home on the sofa”. A clear benefit of Healthy Connections identified by participants was the Wellbeing Worker’s flexibility in booking appointment times. This meant there was no evidence that participants missed out on other activities or took time away from work, volunteering or caring responsibilities to attend.

The evaluation did highlight some possible overlap between services, particularly Positive Step, North Somerset’s main NHS service for anxiety and depression. Discussion with stakeholders identified some confusion about the difference between Healthy Connections and Positive Step. However, participants themselves seemed clearer on the differences and also why they felt that Healthy Connections was more appropriate for them than Positive Step which they felt had too much emphasis on group work, and also on looking back at the past and problem solving rather than finding solutions for the future. There was little evidence that contact with Healthy Connections was displacing contact with Positive Step. Displacement for this project has thus been calculated at 5%.

This is a relatively low value. Different values are used in the sensitivity analysis to explore this further.

Attribution

Attribution is an assessment of how much of the outcome was caused by the contribution of other organisations or people. Attribution is calculated as a percentage (i.e. the proportion of the outcome that is attributable to your organisation). It shows the part of deadweight for which you have better information and where you can attribute outcome to other people or organisations. This stage is more about being aware that your activity may not be the only one contributing to the change observed than getting an exact calculation. Information was gathered from stakeholders about attribution in qualitative interviews.

This is difficult to judge. As described above many participants were receiving support from other services and agencies in addition to the Healthy Connection project. However, the reasons for this contact were different, and indeed many clients and other stakeholders described the lack of alternative services available to meet the specific needs met by Healthy Connections, and that the intervention supported them to access services more appropriately and effectively.

"I've had so many agencies and Healthy Connections has been part of that."

Project participant

In selecting outcomes and financial proxies to include in the SROI great efforts have been made to take into account what proportion of change it would be reasonable to assign to Healthy Connections alone. Given the efforts to take into account attribution within the proxies themselves, and reflecting on values for attribution used in similar SROI calculations it was felt that 25% attribution is a fair estimate.

Drop-off

Drop-off is used to account for the fact that the amount of outcome attributed to the project is likely to be less or, if the same, will be more likely to be influenced by other factors in future years. It is only calculated for outcomes that last more than one year. The HM Treasury Green Book⁴² recommends that costs and benefits occurring in the first 30 years of a programme, project or policy be discounted at an annual rate of 3.5%, and recommends a schedule of declining discount rates thereafter.

Since Healthy Connections provides only a short intervention in the lives of participants who often have quite complex and chaotic lives and are accessing a wide range of services for support it is difficult to judge how long the impact of Healthy Connections alone is likely to last. For most outcomes drop-off is likely to be much higher than 3.5% although this will vary between outcomes. This is discussed further in Stage 5.

⁴² The HM Treasury Green Book <https://www.gov.uk/government/publications/green-book-supplementary-guidance-discounting>

Calculating the impact

This stage involves adding up all the benefits, subtracting any negatives and comparing the result with the investment.

Impact for each outcome is calculated as follows:

- Financial proxy multiplied by the quantity of the outcome gives a total value.
- Deduct any percentages for deadweight or attribution.
 - Deadweight: 10%
 - Displacement: 5%
 - Attribution: 25%
- Repeat for each outcome (to arrive at the impact for each)
- Add up the total (to arrive at the overall impact of the outcomes included)

The total impact for the 79 participants who received an intervention in the first 15 months of the Healthy Connections project calculated from this analysis is £109,009.55. Full details of how this has been calculated are shown in the impact map below.

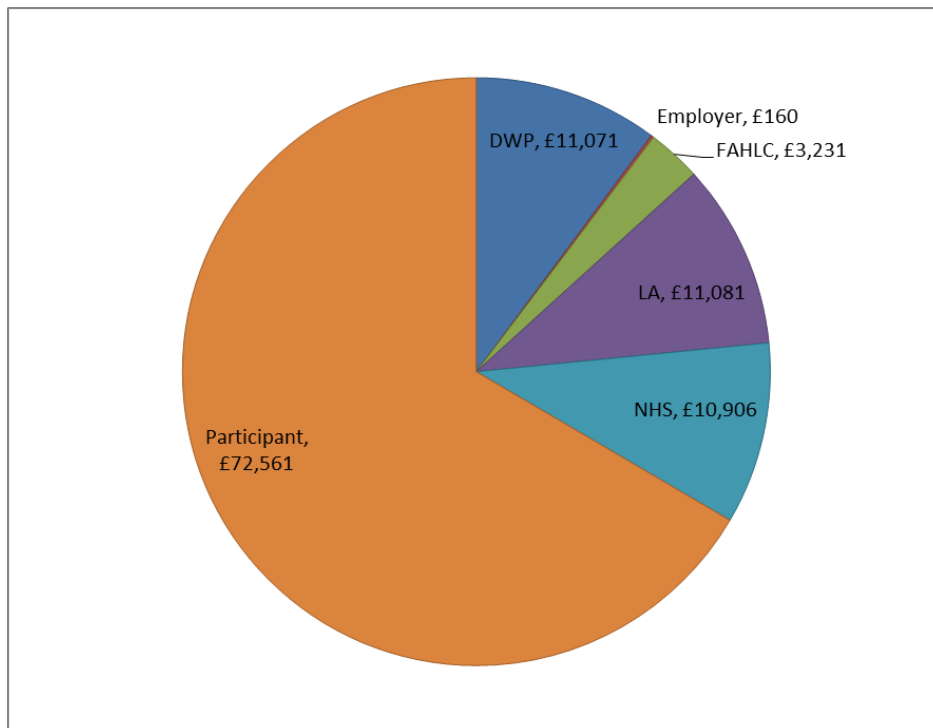
Impact Map 2: outcomes and values

Outcome	Quantity	<i>n</i>	Financial Proxy	Value per participant
Number of participants reporting reduced symptoms of anxiety	Reduction in 82% participants where data available	65	Cost of counselling	£240
Number of participants reporting reduced GP attendance	Reduction in 50% participants where data available	40	Cost of GP appointment – average. Calculated as 1 fewer appointments per participant per year.	£42
Number of participants who report improved social wellbeing and improved relationships with partner and other family members	Improvement in 60% participants where data available	47	Cost of social club membership and attendance at activities	£50
Number of participants reporting improved physical activity	Improvement in 30% participants where data available	24	Cost of gym membership/local activity session. Calculated as 1 session per fortnight per participant.	£124.40
Number of participants reporting improved mental well-being.	Improvement in 94% participants where data available	74	A course of CBT to build psychological resilience and self-esteem	£930
Number of participants reporting volunteer engagement	15 recorded by Wellbeing Worker	15	Economic value of volunteer time. Calculated as 1 hour per week for 6 months	£335.92

Outcome	Quantity	n	Financial Proxy	Value per participant
Number of participants reporting return to work	2 recorded by Wellbeing Worker	2	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work)	£8,632
Number of participants reporting retention of employment	3 recorded by Wellbeing Worker	3	Workplace mental wellbeing intervention	£83
Number of participants reporting they feel more positive and can manage day to day life better	Improvement in 50% participants where data available	40	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course	£480
Number of participants referred to other counselling/ listening services	10 recorded by Wellbeing Worker	10	Preparation for counselling	£240
Number of participants engaging with tenancy support team.	8 recorded by Wellbeing Worker	8	Cost of sessions with housing worker. Calculated as 4 sessions per participant.	£60
Number of participants who report registering for a course and/or achieving new qualification	6 recorded by Wellbeing Worker	6	Cost of part time course at Weston College	£300
Number of participants who give significant credit to the work they did with Healthy Connections in supporting them to retain custody of their child.	2 recorded by Wellbeing Worker	2	Cost of child in care. Calculated as cost for 3 months.	£8,400
Prevention of referral to secondary mental health services	Estimate 5% of participants based on prevalence of serious mental health conditions.	3	Cost of secondary mental health care outreach service for 6 months	£3,832

It's perhaps interesting to explore where this impact falls. The chart below that whilst project participants are the greatest beneficiaries of the value created (67%) there is also substantial benefit to local NHS services (10%), the Local Authority (10%) and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (10%) as well as FAHLC (3%).

Figure 9: Distribution of value of impact



3.6 Stage 5: Calculating the SROI.

The sections above present all the information required to calculate an SROI. This final section summarises the financial information recorded in the previous stages to provide the financial value of the investment and the financial value of the social costs and benefits.

Projecting in to the future

The value shown above is based on calculations from the outcome data available from the 79 participants who received an intervention in the first 15 months of the Healthy Connections project and includes information about outcomes for no longer than 12 months after the intervention began. SROI allows value of the change in future years to be projected and the value over all projected years totalled.

Analysis of outcome data recorded at 3 months post intervention suggested that for many participants positive changes remained. However numbers included in these analyses were small. It is possible that some of the impacts observed in participants will last in to the future and therefore continue to be of value to participants and the wider community. The concept of drop-off is discussed above. Since Healthy Connections provides only a short intervention it is difficult to judge how long the impact of Healthy Connections alone is likely to last and what proportion can be attributed to it in the longer term. Other SROI reports have used drop-off values in the range of 10% for wellbeing outcomes however this seems low. The SROI therefore caps the duration for all outcomes to a maximum of three years and estimates a drop off of up to 50% for many outcomes. These percentages are detailed on the impact map.

Net Present Value

Using these assumptions the Present Value of the Healthy Connections benefits can be calculated for the first 15 months of the project and subsequent years. Deducting the total input (£48,820.00) provides the Net Present Value (NPV).

Table 11: Net Present Value calculation (15 months)

	Year 1	Year 2	Year 3	
Input (15 months)				£48,820
Present value of each year	£109,009	£54,953	£28,019	
Present value of each year after discounting	£105,323	£51,299	£25,271	
Total Present Value (PV)				£181,894
Net Present Value (PV minus the investment)				£133,074

This calculation is perhaps a bit confusing because it is based on 15 months of data. Scaling down to just 12 months provides the following values.

Table 12: Net Present Value calculation (12 months)

	Year 1	Year 2	Year 3	
Input (12 months)				£39,055
Present value of each year	£87,207	£43,962	£22,415	
Present value of each year after discounting	£84,258	£41,039	£20,217	
Total Present Value (PV)				£145,515
Net Present Value (PV minus the investment)				£106,460

Social Return on Investment

Social return

The social return is expressed as a ratio of present value divided by value of inputs.

$$\text{SROI ratio} = \frac{\text{Present Value}}{\text{Value of inputs}}$$

For Healthy Connections the ratio is 1:3.73

This means that the analysis estimates that for every £1 invested in Healthy Connections there is £3.73 of social value created.

Net social return

It perhaps makes more sense to take account of the amount invested in this calculation. An alternative calculation is the net SROI ratio. This divides the net present value by the value of the investment.

$$\text{Net SROI ratio} = \frac{\text{Net Present Value}}{\text{Value of inputs}}$$

For Healthy Connections the ratio is 1:2.73

This means that the analysis estimates that for every £1 spent on Healthy Connections there is £2.73 of social value created.

Sensitivity analysis

The calculations above are based on a great number of assumptions. Sensitivity analysis allows these assumptions to be tested to assess the extent to which the SROI results would change if some of the assumptions made in the previous stages were changed. The aim of such an analysis is to test which assumptions have the greatest effect on the model.

The standard requirement is to check changes to:

- estimates of deadweight, attribution and drop-off;
- financial proxies;
- the quantity of the outcome; and
- the value of non-financial inputs

No non-financial inputs were included in the analyses. Sensitivity analyses based on changes to other assumptions were undertaken.

Changes to estimates of deadweight, attribution and drop-off

Repeating the analyses with changes to estimates of deadweight, attribution and drop-off indicates that substantial changes would have to be made to the assumptions in order for the ratio change from positive to negative.

Table 13: Sensitivity analyses - changes to estimates of deadweight, attribution and drop-off

Sensitivity Analysis	Social Return Ratio
Findings from analysis ¹	£3.73
Increasing deadweight to 50% ²	£2.07
Increasing displacement to 20% ³	£3.14
Increasing attribution to 50% ⁴	£2.48
Changing drop-off to 50% for all outcomes	£3.70
Changing drop-off to 10% for all outcomes	£5.66
1-4 above, drop-off 50%	£1.15
1-4 above, drop-off 10%	£1.77

Changes to financial proxies and quantity of outcome

The table below shows the estimated values associated with each of the outcomes identified. Halving the value of all the outcomes/number of participants experiencing them gave a social return ratio of £1.86.

Perhaps unsurprisingly the outcome valued highest in the analysis is improved mental wellbeing, accounting for around a third of the total value of the project. Other outcomes that have a relatively high value are improved confidence and sense of independence; return to work; retaining custody of a child; reduced symptoms of anxiety; prevention of referral to secondary mental health services.

Table 14: value of outcomes in SROI

Outcome	Impact
Improved mental well-being.	£35,305
Improved confidence and sense of independence	£9,850
Return to work	£8,856
Retaining custody of a child	£8,618
Reduced symptoms of anxiety	£8,003
Prevention of referral to secondary mental health services	£7,863
Volunteer engagement	£2,585
Improved physical activity	£1,532
Referral to other counselling/ listening services	£1,231
Improved social wellbeing	£1,206
Engagement in further education	£923
Reduced GP attendance	£862
Referral to housing support team	£246
Retention of employment	£128

Arguably all those outcomes related to improved mental wellbeing (improved confidence, reduced anxiety, improved social wellbeing) could be combined in to one outcome. Omitting all outcomes other than that for improved mental wellbeing reduces the social value ratio to £2.89. High value outcomes which are perhaps harder to link directly to Healthy Connections are return to work and

retaining custody of a child. Removing these from the analysis reduces the social value ratio to £2.98. If all the above are removed then the social value ratio reduces to £2.15.

These calculations show that even when significant changes are made to the analysis the results still show clear evidence of social value being created up to 3 years after the Healthy Connections intervention.

3.7 Stage 6: Reporting, using and embedding

This SROI report includes a large amount of qualitative, quantitative and financial information which will be useful to the Healthy Connections Wellbeing Worker and other staff at the For All Healthy Living Company, Big Lottery funders and other Big Lottery South West Wellbeing Programme as well as commissioners and service providers in Weston-super-Mare. The section below sets out conclusions and recommendations based on all the learning gained from undertaking this research and should be relevant to all stakeholders.

The final stage of Social Return on Investment will go beyond the publication of this report and involves sharing findings with stakeholders and responding to them. This will be planned and undertaken by UWE in partnership with FAHLC and West Bank.

4. CONCLUSION AND RECOMMENDATIONS

4.1 Summary of findings

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health. There are therefore clear financial and health benefits to investing in public mental health interventions and mental health services. This is particularly true in areas such as South Ward where risk factors for, and prevalence of mental illness is high, and local residents find it particularly difficult to access appropriate services.

This evaluation demonstrates that Healthy Connections is a valued project amongst the community and those working for the For All Healthy Living Centre and other agencies in South Ward, Weston-super-Mare. The SROI provides a financial measure of this value; that for every £1 spent on Healthy Connections there is £2.73 of social value created.

The total impact for the 79 participants who received an intervention in the first 15 months of the Healthy Connections project calculated from this analysis is £109,009.55. Whilst project participants are the greatest beneficiaries of Healthy Connections (77%) there is also substantial benefit to local NHS services (10%), the Local Authority (10%) and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (10%).

Analysis of quantitative outcome data collected by the project provides clear evidence of benefit to those who receive an intervention from the Wellbeing Worker in terms of improved feelings of wellbeing and reduced signs of anxiety. There is also evidence that these improvements, and the changes made as a result of the signposting and practical advice and tools given to participants, results in a reduction in GP appointments; increased physical activity levels; and more appropriate use of other support services.

"I now see light at the end of the tunnel, which I didn't before I came to Healthy Connection. Healthy Connections has really helped me a lot and I know it could help other people."
Project participant

Longer term outcomes captured qualitatively include significant life changes such as gaining or maintaining employment in paid or voluntary work; gaining new educational qualifications; improvements in housing situation; improvements in relationships and in a few cases maintaining custody of a child.

The evaluation provides further evidence to support the use of solution focussed approaches to help those with mild to moderate mental health needs. It also provides some insight in to how the clients experience an SFBT intervention. SFBT has often been recommended because it can achieve results with less time and cost than other approaches⁴³. Indeed when project participants were asked about the length of the intervention whilst many felt that the time went quickly, all felt that the number of sessions was about right. The economic implications of this for funders and policy makers are obvious, but brevity also benefits clients who can achieve their goals sooner and move on with their lives.

⁴³ Maljanen T, Paltta P, Harkanen T, Virtala E, Lindfors O, Laaksonen M, Knekt P. The cost-effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy in the treatment of depressive and anxiety disorders during a one-year follow-up. The journal of mental health policy and economics 2012 , vol: 15 , (1) , pp: 13-23.

Stakeholders interviewed identified a number of positive things about the project; in particular that it is a local and well integrated with other services in the area; and that the Wellbeing Worker's proactive approach means that those referring are confident that even difficult clients will be followed up and well supported rather than getting lost in the system or falling through the gaps.

Participants themselves felt they benefited particularly from the quick access (there is no waiting list); the flexibility of the project and the way in which the support provided is tailored by the Wellbeing Worker to individual needs. It was clear from all the interviews conducted that the personal attributes of the Wellbeing Worker were highly valued and key to the success of the project.

"You didn't give up on me when I didn't attend some of the earlier appointments and that was fantastic. It made a real difference and I stuck with it. Thank you." Project participant

A few concerns were also raised about the project. The majority of Healthy Connections clients were female. There is a lot of evidence to suggest that men have a very different starting point when it comes to dealing with emotional difficulties than women⁴⁴. The gender imbalance in service access is not an issue unique to Healthy Connections or Weston-super-Mare. It is well known that women are more likely to report, consult for and be diagnosed with depression and anxiety and many studies have shown that men are less willing to use mental health services than women⁴⁵. It is possible that depression and anxiety are under-diagnosed in men; certainly we know that suicide is more common in men, as are all forms of substance abuse. One way that Healthy Connections might seek to improve the service it offers in the future could be to explore ways to promote access to men. However, it might be more appropriate for FAHLC to take a different approach to reaching men, developing services that target them specifically.

The evaluation highlighted some possible overlap and confusion about the difference between other local services, particularly Positive Step, North Somerset's main NHS service for anxiety and depression; and also with the role of North Somerset's Health Trainers. Participants themselves seemed clearer about the differences between these services than referring agencies, and also why they felt that Healthy Connections was the appropriate for them at that moment in time. Health Trainers is focussed on physical health and lifestyle choices such as healthy eating, weight loss and physical activity rather than mental wellbeing; many of those who had accessed the service before Healthy Connections reported not being ready to make the changes identified by the Health Trainer as changes that might benefit them. Healthy Connections helped them ready themselves for these changes. Project participants felt that Positive Step had too much emphasis on group work (although Positive Step staff reported that this is no longer the case), and also on looking back at the past and problem solving rather than finding solutions for the future which is the approach Healthy Connections uses. There was little evidence that contact with Healthy Connections was displacing contact with other services. In fact interview findings suggested the opposite; that support from Healthy Connections helps clients to get ready for and use other support services more appropriately.

⁴⁴ Anderson S, Brownlie J. Build it and they will come? Understanding public views of 'emotions talk' and the talking therapies. *British Journal of Guidance & Counselling* 2011 , vol: 39 , (1) , pp: 53-66

⁴⁵ Mackenzie C. S., Gekoski W. L. and Knox V. J. (2006) Age, gender and the underutilization of mental health services: the influence of help-seeking attitudes. *Ageing and Mental Health* 10, 574-82.

There were also concerns about the short term funding for the project; as is the case with so many grant funded projects there was real concern about the impact on the community of investing so much time and effort in developing a project, raising expectations about availability of a new service and then losing it when the funding goes.

4.2 Strengths and limitations

A key strength of this SROI is the excellent methods for collecting baseline and follow-up data from project participants established by the Wellbeing Worker. This meant that there was paired data for many of the project participants that could be incorporated in to the evaluation, and also useful qualitative data to support it.

Robust data collection is essential for service evaluation and SROI. However the need to capture outcome data must be balanced with the acceptability of completing large amounts of paperwork. Although project participants did not raise concerns about the data collection process for Healthy Connections the researcher did question whether all the tools used by the Wellbeing Worker were essential to the intervention and to the project evaluation. Discussions with the Wellbeing Worker about the evaluation findings included thoughts about how data collection could be “streamlined” to reduce the burden of paperwork on participants and the project. This has been incorporated in to the recommendations.

There are some limitations to this evaluation and SROI. Although the completeness of dataset was good the number of participants with follow-up data was small, particularly at 3 month follow-up so there is some uncertainty in the results of quantitative analyses.

It is likely that some of the wider impacts of Healthy Connections have not been captured in the analysis. Discussions with staff at FAHLC about findings from the project highlighted that the SROI has captured outcomes and value not previously considered and which could be captured better if data collection were redesigned. For example outcomes related to employment status.

There will be some benefits that are important to stakeholders but which cannot be monetised. For example many of the stakeholders interviewed highlighted the important work the Wellbeing Worker had done to promote Healthy Connections amongst other local agencies and the community which had also raised their awareness of other services and support offered by FAHLC. This may have increased the number of people in the local community benefitting from other FAHLC services but it is very difficult to value this without any outcome data.

“[The Wellbeing Worker] did some fantastic networking with everyone in the area. She’s contacted everyone. Gone out there to meet everyone. She’s pushed awareness of this project and this centre to Weston-super-Mare in an incredible way.” Stakeholder

Initial stakeholder mapping noted that family and friends of project participants might benefit from the project as improvement in mental health of participants is likely to have a significant impact on their relationships with others, and perhaps also on caring responsibilities. Project participants were invited to bring a partner, family member or friend with them to the interview but none took up this offer and little information about impact on family and friends was captured in interviews or other qualitative data.

The impact of this missing value is that the total social return of Healthy Connections might have been undervalued.

SROI should also take account of the cost of negative outcomes. Whilst a few potentially negative consequences of the project were identified no individual level negative outcomes were identified for project participants or their friends and family which could be included in the SROI analysis. This may be because none occurred, or may be because of limitations in the methods used. If this is the case then the SROI will have over-estimated value.

4.3 Recommendations

In this SROI report we have monetised the benefits of the Healthy Connections project to its participants and other agencies working with the community in South Ward, Weston-super-Mare. The report demonstrates a significant social return for the investment made, and the feedback from participants and stakeholders clearly illustrate the programme's positive impact to participants' wellbeing and how their lives have changed.

A key concern for Healthy Connections is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing Healthy Connections might have on the local community and other local services. It is likely that those who have benefitted from the service and those who might benefit from it in the future will simply slip back through the gaps in services.

This report provides a tool for working with local mental health and public health commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project. It also highlights ways in which improvements could be made to the project to maximise benefit to individuals and other local projects and services in FAHLC and more widely in South Ward.

The SROI only takes account of the benefits associated directly with Healthy Connections. When scoping the project FAHLCs' interest in the concept of SROI and how it could be used to demonstrate the value of other services and projects it offers was noted. It was clear from the data collected for this evaluation that the services and support offered by FAHLC are highly valued and the follow-on support and voluntary opportunities of great benefit to Healthy Connections clients.

"I think the Healthy Living Centre is the best thing that happened on the estate. There are so many people in this area who need help. I think what you are doing is brilliant."
Project participant

"FAHLC is a fantastic place. They've got everything you need under one roof." Stakeholder

Undertaking a whole system SROI of FAHLC could provide great insight in to the ways in which it benefits the local community and promotes health and wellbeing. We hope that this evaluation has provided a useful test of the methods and encouragement to explore their wider use.

The evaluation has highlighted the important role Healthy Connections has in meeting the needs of local people who often fall through gaps in existing service provision. This includes those with multiple health conditions, including mental health problems who, for various reasons, are difficult to manage in universal primary care services because of the complexity of their situation. These patients can be frequent users of health services such as the GP. With FAHLC a provider of GP services there is opportunity for Healthy Connections to target these patients further, working with the Practice and perhaps also Positive Step to take referrals and work with clients to identify

solutions that enable them to help themselves, and also to access other support services more appropriately.

Recommendations are:

- Use this report as a tool to demonstrate the value of Healthy Connections and for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.
- Explore opportunities for undertaking a whole system evaluation and SROI of FAHLC to provide insight in to the ways in which it benefits the local community and promotes health and wellbeing in South Ward.
- Identify ways for FAHLC to promote mental wellbeing to men in South Ward, and access to appropriate mental health and wellbeing services including Healthy Connections, Primary Care and Positive Step.
- Identify ways for Healthy Connections to work more closely with other local services, particularly the FAHLC GP Practice and Positive Step, to take referrals and work with clients to identify solutions that enable them to help themselves where appropriate, and also to access other support services more appropriately.
- Review data collection methods used by Healthy Connections in light of the outcomes captured by this SROI and identify ways to capture all relevant outcomes to project and future funders whilst ensuring that burden of paperwork is minimised for participants and project staff.

5. APPENDICES

5.1 Appendix 1 – Stakeholder List

STAKEHOLDER	REASON FOR INCLUSION
Project participants	Primary participants who are likely to be experiencing significant outcomes if intervention is successful
Family & friends of project participants	Improvement in mental health of participants could impact on families who may have previously had significant caring responsibilities
Members of the local community	Improvement in mental health of participants could have a wider impact on local people by improving overall sense of mental wellbeing in the community
FAHLC – staff and volunteers	Route for referral for those clients who staff and volunteers have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing, source of internal advice on mental health issues.
FAHLC based GPs and Health Professionals	Potential savings in health spending and reduction in workload and waiting times if participants' mental health improves.
Other GP practices in area	Potential savings in health spending and reduction in workload and waiting times if participants' mental health improves.
North Somerset Council –including Mental Health, High Impact Families, Social Care, Public Health, and Safeguarding Team	At population level service providing support to objectives to improve access to low level support and improve mental health and wellbeing. At individual level route for referral for those clients who staff have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing.
Alliance Homes / Living	Route for referral for those clients who staff have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing.
Local Mental Health Services including Positive Step and Primary Care Liaison Service	Potential savings in health spending and reduction in workload and waiting times if participants' mental health improves.
Local and voluntary services including Carlton Centre, Friend, Addaction, Second Step, Credit Union, WestonWorks Home Start, North	Route for referral for those clients who staff and volunteers have concerns about, route to recruitment of participants to other

STAKEHOLDER	REASON FOR INCLUSION
Somerset,Chapter1, Voluntary Action North Somerset (VANS), Age UK Somerset, St Loyes	projects/services, improved attendance of clients because of their improved mental wellbeing.
Police Community Support Officers & Victim Support	Improvement in mental health of participants could have a wider impact on local people by improving overall sense of mental wellbeing in the community
Local Schools – Bournville, Windwhistle, Oldmixon & Hans Price	Route for referral for those clients who staff have concerns about.
DWP/Job Centre Plus	Potential for reductions in benefit payments and increased state income from taxes where employment is increased

5.2 Appendix 2 – Impact Map



FAHLC SROI Impact
Map.xls

5.3 Appendix 3 - Participant interview questions

HEALTHY CONNECTIONS – PARTICIPANT INTERVIEW QUESTIONS

Thank you for agreeing to take part in this evaluation. The aim of this interview is for us to find out more about your experience of and the support you received from the Healthy Connections project and how things have changed for you since. The findings will form part of an evaluation report on the Healthy Connections project. Your views and those of all consulted as part of the evaluation will be used to inform the final evaluation report.

INTRODUCTIONS

Can you tell me a bit about yourself and your involvement with the Healthy Connections project?

- Name and background info – local resident? Registered with FAHLC Practice?
- Did you attend 1-1 sessions with the Wellbeing Worker?
- When did you start/finish attending sessions?
- How did you hear about the project?
- Why did you choose to attend? What did you expect?
- Were you already accessing other services at FAHLC?

BEFORE HEALTHY CONNECTIONS

Can you tell me a bit about how things were for you before accessing Healthy Connections?

- How were you feeling in general prior to joining the project?
- How was your mental wellbeing?
 - Existing / historical contact with mental health services / medication?
 - Suffering from depression / anxiety?
 - Sleep?
 - Isolated? Confidence?
- How was your physical health?
- Were you accessing any other health services?
 - GP
 - Mental health
- How was your lifestyle?
 - Diet, activity, smoking, alcohol, drug use
 - Relationship with family / community
 - Employment / Education
 - Receiving support from any other services / people?
 - Expectations of what the group was going to be like / what might change?

HOW DID YOU FIND HEALTHY CONNECTIONS?

- Practicalities – getting there, appointment times, frequency of appointments, length of contact
- Did you miss many sessions – why was this?
- What did you like / not like?

- Did you access any other services as a result of attending Healthy Connections?
- Did you give anything up to attend Healthy Connections?
- If there was anything you could have changed what would it be?
- Were you using any other services at the same time?
- Did the project match your expectations? How is it different to these?

WHAT CHANGED FOR YOU?

- Do you feel like anything has changed for you as a result of coming to Healthy Connections?
 - Changes to employment / educational status / volunteering? (More/Less)
 - Changes to Physical Health – exercise / diet / smoking / drinking
 - Changes to Mental Health – purpose / happiness / confidence / friendships
 - Changes to relationships with family / community / friends
 - Carrying out new activities? Join / Leave any new activities / groups?
 - Frequency of GP visits – more or less engagement with other services? Has the type of service changed?
- How important was this change?
- How would someone else know that this had happened and what would we show them? Could you measure it?
- Were all the changes positive?
- Were all the changes expected or was there anything that you didn't expect that changed?
- Which of these changes will make the biggest difference to you?
- How long do you think the change will last?

COULD ANYTHING ELSE ACCOUNT FOR THESE CHANGES?

- What other services/support were you accessing at the same time?
- Did anyone else contribute to the experience/change?

WHAT HAPPENED AFTER YOU LEFT THE GROUP?

- How did you feel about leaving the service?
- Did you move to any other group/service? How do they compare to Healthy Connections?

WHAT IS THIS SERVICE WORTH?

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important to you?
- Which other ways might you achieve the same changes?

5.4 Appendix 4 – Stakeholder Interview Questions

HEALTHY CONNECTIONS – STAKEHOLDER INTERVIEW QUESTIONS

Thank you for agreeing to take part in this evaluation. The aim of this interview is for us to find out more about your experience of and contact with the Healthy Connections project and what you think about the impact it's having. The findings will form part of an evaluation report on the Healthy Connections project. Your views and those of all consulted as part of the evaluation will be used to inform the final evaluation report.

INTRODUCTIONS

Can you tell me a bit about yourself and your involvement with the Healthy Connections project?

- Name:
- Organisation and role within the organisation
- How and when did you/your organisation get involved with Healthy Connections?
- Were you already working with other services at FAHLC?
- How do you work together with the project?

AIM OF HEALTHY CONNECTIONS

- What do you think are the aims of Healthy Connections?
- Who do you think it is targeted at?
- Do you think the aims and target groups are right to meet the needs of the local community?
- Do you refer/signpost people you work with to the project?

WHAT CHANGES?

- What impact do you think Healthy Connections has on its participants / the wider community?
 - What are the benefits?
 - What do you think are the most / least effective aspects of the programme?
 - What are the negative or unintended consequences?
- How important are these changes?
- How would someone else know that this had happened and what would we show them? Could you measure it?
- How long do you think the change will last?
- How do you think Healthy Connections compares with other similar projects/services?
- What would participants do if Healthy Connections weren't there?

COULD ANYTHING ELSE ACCOUNT FOR THESE CHANGES?

- What other services/support are you aware of participants accessing at the same time?
- Do you think anyone else contributes to the experience/change?

WHAT IS THIS SERVICE WORTH?

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important?
- Which other ways might you achieve the same changes?