Appendix 4: Social Return on Investment for the Macmillan Social Prescribing service

This appendix discusses the detailed method for the Social Return on Investment (SROI) work in this evaluation of the Macmillan Social Prescribing (MSP) service, funded by Macmillan Cancer Support and delivered by the Bromley by Bow Centre.

Contents

A4.1 Outline of Approach

There is an emerging body of cost-benefit studies regarding social prescribing (Polley, et al 2017), with various different emphases in assigning outcomes and values. This cost-benefit analysis is a Social Return on Investment, following the method outlined in 'A Guide to Social Return On Investment', particularly its seven principles of an SROI study (The SROI Network, 2012). Its SROI self-assessment tool was used to check progress against these seven principles (see Box 1).

Box 1: Principles for an SROI (The SROI Network, 2012)

The conduct of each analysis is based on seven principles:
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.

In designing an SROI specifically for this social prescribing service, this work has particularly been informed by initial preparation work by Kimberlee (2019) and the methodology of a recent SROI on the British Red Cross (2019) Community Connectors programme.

This SROI was created as a companion to 'Macmillan Social Prescribing – A Summary Evaluation Report' and is intended to be read in conjunction with this work. This appendix is accompanied by a full account of the assumptions and calculations involved in creating this SROI in the spreadsheet 'SROI calculations'.

A4.2 Establishing scope and identifying outcomes

Scope of this SROI assessment

The purpose of this work was to 'assess whether MSP provides a return on investment for different stakeholders.' It is performed within the context of the evaluation of Phase 2 (July 2017 – April 2019) of the MSP service. This SROI assessment follows the same time scale, database, range of activities and differentiation between Level 1, 2 and 3 support as the wider evaluation (for more details of activities, process mechanisms and impacts, see Sections 2, 3 and 4 of the main evaluation report).

The audience for the wider evaluation was threefold: for the MSP team, for similar teams setting up a similar service, and for commissioners and funders in the wider healthcare

setting seeking to understand the value and position of a cancer-specific social prescribing service. This SROI is of particular relevance to this third audience of decision makers and service designers, as it aims to explicate and assign monetary value to the impacts of the service.

There were several important inputs in creating the theoretical and evidential framework for this SROI: MSP's Theory of Change, providing an account of the mechanisms of change and tested in the evaluation of Phase 1 of the service (Frontline, 2017); the recommendations from this initial evaluation, incorporating suggestions of design and data capture; and themes from both evaluations supplying a framing for the impacts discussed.

Finally, the approach of this assessment was specifically designed to acknowledge two factors of the service design deemed important by the MSP team:

- The difference in support received by clients at different levels of the service
- A focus on the value experienced by clients of the MSP service, with a consideration of how this value extended through the wider healthcare and voluntary sectors

Stakeholder involvement

Only impacts related to the work done with clients were used in this SROI, although all stakeholders were consulted to some extent (see Table A4.1 for a summary of stakeholder involvement). MSP clients were comprehensively involved throughout this assessment: in total 30% of all clients in Phase 2 (n=1104) had a self-appraisal of MSP's impact incorporated into this SROI (via the MyCAW assessment).

Table A4.1: Stakeholder involvement

Stakeholder and how they affect or are affected by the activity	**What we think happens to them, positive and negative**	**Included/ excluded?**	**Method of involvement**	**How many?**
Clients of the MSP service	Problem alleviation Wellbeing	Self appraisal of relevant outcomes and change in outcomes Consulted about outcomes and attribution overall	MyCAW Focus groups	326 - prioritisation 105 - change 17
Referral partners – primary and secondary care	Better use of service – leading to more timely and effective interventions	Phase 1 Consulted about outcomes and attribution overall	Survey Interviews	18 3
Commissioners	Understanding of MSP service mechanisms and needs/interests of clients living with and beyond cancer	Consulted about outcomes and attribution overall	Interviews	2

Service providers	Change in demand Potential in change in clientele For most popular services, shaping delivery of service	Consulted about outcomes and attribution overall	Interviews	2

Stakeholders were asked about their perspective of the impact of MSP. Questions specifically related to establishing outcomes for clients within the surveys, focus groups and interviews are listed below. A discussion on how this evidence was incorporated into establishing the outcomes can be found in Section A4.3.

Table A4.2: Questions relating to establishing outcomes for clients

Healthcare professional survey	Do you think the MSP service brings benefits to the wellbeing of your patients? Please explain To what extent does the MSP service allow for more appropriate use of community and voluntary services? Please provide any examples
Client focus group	**WHAT DIFFERENCE** (if any) did the support provided by Macmillan Social Prescribing Service make to you/your life? What services were you referred onto? Were there issues that MSP weren't able to solve? We are interested to know if the Macmillan Social Prescribing service has had an impact on how you use other health services **1. New (unscheduled) GP practice appointments** *As a result of the MSP Service….* I've booked more GP appointments I've booked the same number of GP appointments I've booked fewer GP appointments **2. Going to Accident and Emergency** *As a result of the MSP Service….* I've gone to accident and emergency more I've gone to accident and emergency the same amount/this is unchanged I've gone to accident and emergency less **3. Contacting my cancer nurse** *As a result of the MSP Service….* I've contacted my Cancer Nurse more I've contacted my Cancer Nurse the same amount (unchanged) I've contacted my Cancer Nurse less
Stakeholder interviews	How do you know the service is valuable? What do you perceive to be the benefits of the MSP service to the individual clients? Do you wish to see the MSP service continue? Why?

Throughout the development of this SROI, the MSP steering group, and particularly several stakeholders within the group, acted as a 'critical friend' to test the broader ideas behind the approach.

Stakeholders were also asked about topics that would inform the discounting decisions of Section A4.5. Questions around establishing the position of the service, the potential for unmet need (and on the other hand displacement) and attribution of outcomes are displayed in Table A4.3. As seen below, these were often framed by more general conversations about alternative services and professional behaviours.

Table A4.3: Questions relating to displacement and attribution

Healthcare professional survey	If the MSP service were to stop please rate the following: • I would try to find some of the support myself by finding appropriate organisations • I would steer away from opening up holistic conversations if I couldn't refer to appropriate organisations • I believe it would affect the ability of my patients to address social determinants of health • I believe it would affect the ability of my patients to engage with their health • I don't think it would make much difference
Client focus group	What else (outside of MSP) has helped you? How does the MSP service fit alongside (or differ from) any other support you are receiving from your Cancer Nurse? What would have happened if the support from Macmillan Social Prescribing was not available to you? Who would you have spoken to? Where would you go? Has your GP or Practice Nurse referred you for any other similar support?
Stakeholder interviews	How does the MSP service complement (or otherwise) other support out there, both clinical and non-clinical? Prior to referring to the MSP service were patients' non-clinical needs being met? How? What type of patient do you refer and why? Where MSP clients have gone on to access support and achieve positive outcomes from this, how important do you think the linking role of MSP is to achieve these outcomes? Where MSP clients have improved their mental wellbeing whilst engaging with the service, in your experience how much do you think can be attributed to MSP? What would you do if the service didn't exist? What would happen without the MSP service? Where else would you refer them if MSP didn't exist?

Due to time constraints, stakeholder interviews and focus groups were not followed by a more comprehensive survey about attribution of the impacts. Stakeholder involvement could also have been used to establish valuations for outcomes which were missing proxies (as discussed in Section A4.4), but this was not pursued for the same reason. In future, these are areas of work that could yield further insights.

A4.3 Mapping outcomes

Costings

The impact that we are measuring is that delivered by MSP to clients through their intervention. The final SROI figure is deliberately not a measure of the overall benefit that has accrued to clients after accessing MSP (such as clients maintaining their job, improving their fitness levels, reducing their isolation), as this would include the contributions of other organisations – and therefore we would also need to include their costs within this SROI.

Therefore the only costs that we are considering within this SROI are the running costs of MSP over a 22-month period (Phase 2, or July 2017-April 2019) of their service.

Funding to the service in total is £188,000. Once we have removed the cost of micro-commissioning dance and yoga groups and evaluation costs, this falls to £166,288 per year and £304,751 for 22 months.

Creation of three impact maps

This SROI focuses firmly on the impacts experienced by clients of the MSP service. These may also have wider societal and organisational benefits, as they affect clients' perception of and interaction with the healthcare and voluntary sector. However, they are primarily based on an individual's experience.

Drawn from the Theory of Change of the service, change happens through: connection to oneself, appreciation, awareness and action, leading to improved wellbeing and problem alleviation. For this SROI, this change was expressed through three impact maps:

- Impact map 1 - Direct benefits attained through the work within the sessions (as attested to in the 'connection to yourself' and 'appreciation' mechanisms)
- Impact map 2 - The benefit of linking clients to other services, which would not otherwise have happened (as attested to in the 'awareness' and 'action' mechanisms)
- Impact map 3 - The overall impact of clients taking action and the MSP supporting this action, leading to relief from depression and anxiety (as attested to in the overall impacts of the service on wellbeing and problem alleviation – Section 4)

Population of impact maps

The areas of impact within these maps were established through using the MyCAW and referral/signposting data, generated from client-identified concerns. This data had been categorised into common themes, which linked to the previous evaluation and were developed further in this evaluation, and supported by analysis of case notes to provide more textual detail. The themes were:

- Advice, including financial support
- Emotional wellbeing
- Physical concern and treatment options
- Physical activity
- Work and learning
- Socialising
- Talking, relationships and support groups

- Practical support and other

Actions of the client and social prescriber were then matched to each of these themes. For example, actions for ‘advice, including financial support’ included: referrals/signposting to benefits, debt, housing, immigration or any other advice; grants completed by the social prescriber; referrals/signposting to a food bank and other food-related organisations; and information and support given for blue badge applications.

The actions developed into the indicators for each of the outcomes (see Figure A4.1).

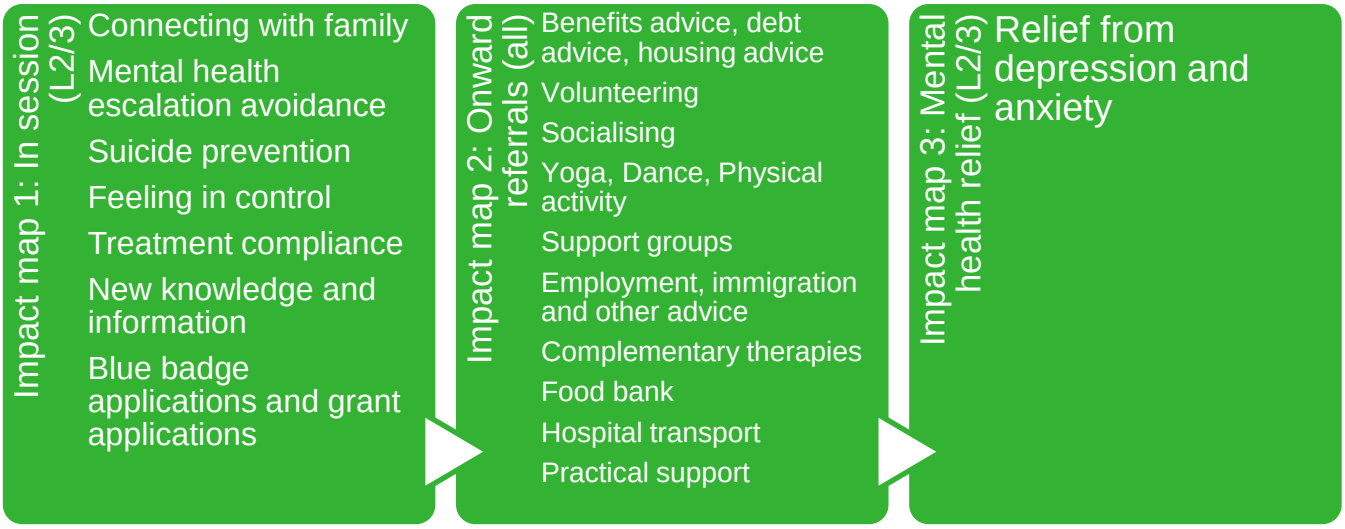

Figure A4.1: Three maps of impact

Testing against stakeholder responses

Stakeholders had been asked an open question about the difference MSP had made. Client focus group feedback on this question was used in understanding the creation of impact, particularly within the discussions in Section 3 of the main evaluation report. Once the impact maps had been populated, the interview data and Phase 1 healthcare professional survey were then used to test the maps. Stakeholder interviews emphasised: the importance of the work done in Impact map 1, particularly creating a space and time to be “supporting quality of life, empowerment, confidence, learning techniques and ways to manage symptoms”; the importance of allowing clients to “connect” with support (Impact map 2); and in contrast to clients, other stakeholders seemed to emphasise combating “isolation”.

A4.4 Evidencing outcomes and giving them a value

Data collection process for evidence

Once the impact maps had been populated, evidence of these outcomes being attained was needed. Appendix 1 outlines the data collection process for all of the evidence considered in this evaluation, including the measures, questions and rate of return within the routine monitoring tools.

Evidencing outcomes from data sources

Where possible, two independent sources of evidence were used for each outcome. These are referred to in the spreadsheet as primary and secondary sources of evidence.

The evidence base largely rested on four sources of evidence: close reading of case notes, referrals data for all clients, MyCAW problem data, and paired wellbeing data.

Table A4.4: Method of evidencing outcomes

Data source	Sample	Method
Close reading of case notes	for Level 2/3 clients a sample of 147, or 39% - where this was used, the instances were scaled up to all 377 Level 2/3 clients	Case notes covered multiple sessions with the client. The case notes were read systematically for a bank of key issues (codes) and recorded in blocks of 10 clients. The case notes were only counted towards an outcome if some action was taken on this issue (either within the session or reported in subsequent sessions). After every batch of 40 case notes, the codes were reviewed. Finally, the total number of relevant case notes for each code was summed up. An 'illustrative example' of each outcome was also chosen from the groups of coded case notes. Searches of the case note data bank were also performed using Nvivo, particularly to establish prevalence of key words within case notes
Referral and signposting data	all clients	The referral and signposting data was part of the MSP client spreadsheet. Each referral/signposting organisation was assigned a category dependent on the type of concern it aimed to address for clients. They were also categorised in terms of the type of organisation they represented. A pivot table in Microsoft Excel then aggregated the total number of referrals/signposts per organisation and per concern.
MyCAW problem data	for Level 2/3 clients a sample of 326 – percentages of this sample were used, which were seen to be representative of all Level 2/3 clients.	The MyCAW problem data was analysed firstly through theming each of the concerns raised by clients. The prevalence of each theme and the amount of change in concern before and after MSP was then aggregated through the use of pivot tables and paired datasets.
Paired wellbeing data – from MyCAW and ONS4 questions	For Level 2/3 clients a sample of 105 and 40 respectively - where this was used, the instances were scaled up to all 377 Level 2/3 clients	Wellbeing data was paired for each client and the difference before and after MSP calculated. When aggregating these differences, a measure of net change was used [net change = number of clients with a positive change – number of clients with a negative change], to acknowledge that MSP clients' wellbeing could decrease as well as increase and therefore include potentially negative impacts within the SROI. This data was also tested for significance using a paired two-tailed t-test for means.

Further data was used in Test 2 of the sensitivity analysis (Section A4.7) when new parameters for knowledge shared and increased autonomy were introduced, using the client surveys, presented in Sections 3.2 and 3.4 of the evaluation report.

Thresholds for outcome measures

Impact map 1

Case notes were only counted towards an outcome if a concern was discussed and some action was then taken on this issue (either within the session or reported in subsequent sessions).

After scaling up to all Level 2/3 clients, outcomes were discounted with the assumption that 35% of action is successful in the longer-term (using the finding that 35% of signposts/referrals are enacted, in Section 3.4 of the report).

Financial value of grants awarded (taken directly from the database) and suicide prevention (calculated from the 'safety netting' portion of the database and validated through case notes) were the exceptions to this method, due to having more direct evidence.

Impact map 2

With the exception of one housing outcome and the financial value of benefit advice, outcomes are measured through referrals or signposts made to a relevant organisation. In Section 3.4 of the evaluation, it was established that 35% of signposts/referrals are enacted, so referral figures were multiplied by 35% to include this assumption.

Impact map 3

There were a variety of ways 'relief from depression and anxiety' could be measured, before being scaled to Level 2/3 clients, as shown in Table A4.5.

Table A4.5: Potential outcome thresholds to establish 'relief from depression and anxiety'

Evidence base	Measures within this		Considerations
Using ONS4 anxiety measure: people moving out of 'poor' anxiety score	Number of people moving from 'poor' to 'fair' or higher Number of people moving from 'poor' to 'good' or 'very good' – net	10% - Net 4 out of 40 (9 positive change, 5 negative change) 13% - Net 5 out of 40 (7 positive change, 2 negative change)	Smaller sample size – 'noisy' reading
Using MyCAW wellbeing measure – substantial change in measure, out of "serious" categories	Movement from 'serious' to 'not at all serious' (5/6 – 0-2) Number of people changing their wellbeing by 3 points or more (necessitating move out of 'serious' category) Number of people changing their wellbeing by	7% - 7 out of 105 **14% - Net 15 out of 105 (16 positive change, 1 negative change)** 27% - Net 28 out of 105 (35 positive change, 7	

	2 points or more *Reference - number of people improving in wellbeing*	negative change) *50% - Net 52 out of 105 (62 positive change, 10 negative change)*	
Stress reduction: concerns decreased substantially using the MyCAW measure (measure of anxiety)	**Problems** Number of identified concerns that decreased by 3 points or more Number of identified concerns that decreased by 4 points or more **People** Both problem 1 and 2 decreased : by 1 or more by 2 or more by 3 or more by 4 or more At least one of problem 1/2 decreased by 4 or more	26% - Net 62 out of 237 (66 positive change, 4 negative change) 17% - 41 out of 237 problems 43% - Net 45 out of 105 (46 positive change, 1 negative change) 30% - 32 out of 105 13% - 14 out of 105 8% - 8 out of 105 27% (28 out of 105)	A less direct measure of wellbeing
Referrals/signposts as a proxy for receiving help	368 referrals and signposts to different wellbeing services	To counselling services: 128 To bereavement services: 12 To mindfulness courses, meet-ups or tools: 36 To psychology workshops: 192	Need further assumptions that an outcome has been successful

The MyCAW wellbeing measure was chosen due to its sample size and its direct measure of the outcome. ‘Relief from depression and anxiety’ being a large change in wellbeing, it was decided that a high threshold would be set: in total the change demanded was a difference in 3 points on the 7-point scale, necessitating a move out of ‘serious’ concern to ‘fair’ or ‘little’ concern. The three other methods were then employed as supporting evidence and within the sensitivity analysis.

Wellbeing valuation

Assigning values for these impacts followed the wellbeing valuation methodology of SROI calculation (HACT, 2014; Cabinet office, 2009; HM Treasury, 2013) – for consistency, where possible using the HACT (2014) database and method.

Wellbeing valuation is a two-step process of using regression techniques to examine the impact of a specific event on life satisfaction and then comparing this change to a comparable change in income (Fujiwara, 2014):

"Wellbeing Valuation judges the success of a project by how it affects people's wellbeing. Rather than asking people about how much something has improved their life, which can introduce psychological complexities and extensive data collection, Wellbeing Valuation analyses existing datasets of national surveys which instead reveal effects on wellbeing... Analysis can isolate the impact of a specific aspect of life on wellbeing. We can then value this by finding from the data the equivalent amount of money needed to increase someone's wellbeing by the same amount." (HACT, 2014:10)

Proponents of the method claim that valuations are based on actual experiences rather than counterfactual estimates and that the set of valuations are "methodologically consistent and robust" (HACT, 2014:11)

Choice of value

The creation of valuation was primarily through use of the HACT valuation calculator, where possible. As per the guidance, consistent measures were taken to avoid double counting – particularly around wellbeing-related valuations.

Reliance on this method, without using stakeholder surveying to establish our own values, led to several gaps in suitable proxies for the outcomes identified. These gaps were most prominent in impact map 2, linking to hospital transport, practical support, wider advice and complementary therapies. Proxies in impact map 1 for treatment compliance, access to knowledge and information, feeling in control and mental health escalation avoidance were either missing or underestimated. In general, outcomes involving contact with NHS services were not present. For this reason, proxies from other sources were also considered, although suitable proxies are still missing for 9 indicators (see Table A4.6). Furthermore, it is clear that more work is needed within the wider literature on the methodology of valuing the bridging and linking role of social prescribing services.

Table A4.6: Outcomes with values other than HACT

Impact map 1 – direct intervention within session	Mental health escalation avoidance (strategies/intervention within session)	Increased autonomy and control Global Value Exchange (2019)
	Suicide prevention	Value of delayed suicide for a year Knapp et al (2011)
	Building confidence and control of the future	Increased autonomy and control Global Value Exchange (2019)
	Built knowledge and skills – the impact of information widening options	Time gained by NHS administration staff due to increased knowledge of local

		services available. NEF Consulting (2018)
	Blue badge application	Road value of a blue badge, Kimberlee (2019).
	Treatment compliance	No suitable proxy
Impact map 2 – linking to support	Food bank	Value of malnutrition avoided by using foodbanks. NEF Consulting (2018)
	Support groups	Annual estimated health service savings for support groups. McDaid and La Park (2017)
	Benefits advice	Value of benefits received by clients – taken directly from database of the service
	Other food related referrals	No suitable proxy
	Immigration advice	No suitable proxy
	Other advice	No suitable proxy
	Employment advice and training	No suitable proxy
	Adult learning courses	No suitable proxy
	Complementary therapies	No suitable proxy
	Hospital transport	No suitable proxy
	Practical home support	No suitable proxy

A4.5 Establishing impact

Discounting decisions

Discounting decisions were made on the basis of the most conservative assumption available for that value:

- Deadweight: 81% of services wouldn't have been contacted otherwise (Section 3.2 of report).
- Attribution: dependent on each impact map (10% - 100%) (see ensuing discussion)
- Displacement: no evidence for this. In fact, as 20% of referrals are to services that MSP has significantly shaped, the opposite effect seems to be true (see ensuing discussion)
- Drop off: 100% - all values calculated for a one-year period.

Attribution

The impact maps are attributed to MSP at 100% for Impact map 1 and 10% for Impact maps 2 and 3.

Impact map 1 - Direct benefits attained through the nature of the sessions

Evidence of attribution from stakeholders: There is no direct evidence of attribution for this impact map, although there is evidence which attributes the support experienced directly to MSP. When describing the benefits of MSP, stakeholder interviews stressed the characteristics of time, skilled professional listening and connection to emotions and needs. The majority of healthcare professionals agreed that MSP would "affect the ability of [their] patients to engage with their health". Focus group participants also described the "emotional

support" of MSP in terms which referenced benefits and behaviours relevant to this impact map and attributed this support to work done within the sessions.

Table A4.7: Engaging with health - results from healthcare professional survey (Phase 1)

I believe it would affect the ability of my patients to engage with their health	
Neither agree nor disagree	5
Agree	5
Strongly agree	3

Motivation from wider evidence:

Attribution was set at 100% as all effects counted within this impact map were documented actions within the sessions, a result of direct work from the client and social prescriber.

Impact map 2 - The benefit of linking clients to other services

Evidence of attribution from stakeholders: there is some evidence of the value stakeholders place on the connecting role leading to positive outcomes, but this evidence is limited.

The healthcare professional survey from Phase 1 largely agreed that they would continue to try to refer people to appropriate services without MSP, but thought that MSP made a difference to patients "addressing the social determinants of health".

Table A4.8: Addressing social determinants - results from healthcare professional survey (Phase 1)

I believe it would affect the ability of my patients to address the social determinants of health	
Neither agree nor disagree	5
Agree	3
Strongly agree	5

When asked directly in stakeholder interviews, four estimates of attribution ranged from 20%-80%. Surprisingly, three stakeholders all stated that MSP played the largest factor in gaining positive outcomes after accessing further support.

"For some clients its more important than others. It's about timing - if you're going through treatment you have access to medical staff. Sometimes near the end of treatment, that's when they need the support more. The harder to reach groups, SP becomes the main way they get support. Social prescribing can provide a bit a top up rather than the whole reason for positive outcomes." (Stakeholder)

Motivation from wider evidence:

Within the evaluation, the "connecting" role of MSP was stressed, both within stakeholder interviews and focus groups. Focus group participants characterised MSP as "someone to show you the way" and "the beginning of taking action for me" and were clear that signposting to service providers was an important step in addressing their concern.

The specific role of MSP in providing timely intervention (as in Friedli, et al 2007:45) also seems significant for two reasons:

- A point of transition is disorientating and habit forming – for example, opportunities for new physical exercise habits, large changes in circumstance, income and daily routine
- Acting promptly enables the avoidance of escalation – particularly for benefits and debt, access to advice, and mental health. N.B. a counter-argument to this is the role of regression to the mean – clients' concerns could naturally improve over time if unusually displaced.

Furthermore, there is evidence that the 'connecting role' is active in impacting services for clients and referral volume is linked to relationships built with services. The MSP service provides around 12% of Macmillan Welfare Benefits clients. The MSP service shapes and (more recently) funds two of the major physical activity services referred – dance and yoga. These three most popular services constitute 20% of all referrals.

This analysis has kept to a more conservative estimate of 10% in the absence of more comprehensive evidence (such as further stakeholder interviewing).

Impact map 3 - The overall impact of clients taking action and the MSP supporting this action, leading to relief from depression and anxiety

Evidence of attribution from stakeholders:

Four stakeholders who estimated attribution directly associated MSP's impact from 20%-80% - and three estimated it at the higher figure. Interestingly, all interpreted this differently: MSP indirectly influencing wellbeing through supporting physical activity and alleviating financial worries, and through providing individual support.

"This is one of the greatest strengths of the service. Again it is individual based, their ability to provide emotional support is so interlinked and is valued by clients." (Stakeholder)

Focus group reflections explicitly linked MSP to a changed mindset - "the start of feeling alive" and that it "made [the client] think differently" - although did not estimate a percentage of attribution.

Motivation from wider evidence:

Anxiety and depression is recognised as more common in cancer patients compared to the general population, although it presents differently for different people (Linden et al, 2012; Hinz et al, 2010; Simon and Wardle, 2008). The work that MSP does within the sessions has been directly linked to relief of anxiety:

- Connecting to the family (Edwards and Clarke, 2004)
- Accessing appropriate information (Hussen et al, 2010)
- Exploring the "interpretations and meaning individuals attach to events" and providing a space for open communication (Stark and House, 2000)

The strong evidence that problems have been consistently identified and alleviated through the MSP service is also indicative of the role that linking positive action to emotional support plays in relieving anxiety.

Despite stakeholder feedback suggesting potentially a higher figure, this attribution is set at 10%, largely due to the number of referrals and signposts MSP makes to services supporting emotional wellbeing and the recognition that relief from depression and anxiety is a complex change often prompted by a variety of factors and actors.

Displacement

Section 6 of the evaluation report considers in depth MSP's position in the healthcare and voluntary sectors. It is clear that this is a role that has developed throughout the lifetime of the service and that it performs a unique service, although elements of its role can be recognised in other services.

Several relevant themes emerge:

- The proactive way MSP reaches its clients – 71% through outreach and secondary care referrals – an 'unusual' social prescribing client base.
- An emphasis on 'unmet need' without MSP – strong evidence for the conclusion that is fills a gap, albeit from a limited range of sources. Healthcare professionals believe that it would 'make a difference' if the service were not there (Table A.9).
- A confusion of alternative services and professional behaviours offered both by clients and healthcare professionals – no clear consensus of a different pathway of action. In the focus groups, clients discussed accessing other services, such as Maggie's and Macmillan, or Cancer Transitions workshops, and saw them as providing different services to MSP although also supporting their experience of cancer.
- The strong distinction that all stakeholders make between MSP and other healthcare provision.
- The ways that MSP influence the sectors in which it operates – through creating demand and fashioning services, through influencing healthcare professionals' behaviour and by seeking to work within the NHS strategies.

Table A4.9: Making a difference - results from healthcare professional survey (Phase 1)

I don't think it would make much difference	
Neither agree nor disagree	3
Disagree	4
Strongly disagree	6

Without clear evidence either way, displacement was not incorporated into this assessment.

A4.6 Calculating the SROI

Comparison against problem severity and problem conclusion

The table below plots valuation from the SROI against the problem prevalence and change in severity after the MSP service for a range of different categories, in an attempt to check

whether the values associated with each outcome seem balanced between themselves. This rule-of-thumb comparison suggests that:

- Work done in the third most popular problem area of 'support with physical concerns' is significantly under-estimated,
- Similarly, 'practical support' and 'return to work and learning' were not valued
- Whilst potentially 'emotional wellbeing' could be over-estimated.

This disjunction is a function of the valuations available in the wider literature.

Table A4.10: Problem severity and problem alleviation by category of concern

Category	Problem categories	out of 326	Raw value to clients (unweighted for attribution)	Percentage movement from serious concern	Weighted measure
Volunteering	7	2%	£33,948	41%	2.87
Relationships	12	4%	£37,660	23%	2.76
Advice	18	6%	£0	47%	8.46
Treatment options	24	7%	£0	36%	8.64
Learning	28	9%	£0	41%	11.48
Talking about cancer	29	9%	£114,774	23%	6.67
Housing	31	10%	£9,363	47%	14.57
Return to work	31	10%	£0	41%	12.71
Practical support and other	51	16%	£0	23%	11.73
Socialising	59	18%	£129,192	20%	11.8
Physical concern (inc fatigue, diet/nutrition, sex)	82	25%	£1,632	36%	29.52
Physical activity	83	25%	£322,214	25%	20.75
Finance	121	37%	£385,075	47%	56.87
Emotional wellbeing	136	42%	£2,048,009	45%	61.2

The weighted measure here is a multiplication of the number of people identifying these concerns 'problem categories' and the percentage improvement seen.

Value of SROI – final calculation

The values given were calculated in a range of years (between 2010-2018), and were not adjusted for inflation to reflect 2019 costs. This was due to insufficiency of information across all values. Similarly, Wellbeing Valuation documentation (HACT, 2014; HACT, 2017) does not apply discounting of 3.5% to establish the Present Value of an impact. Due to this precedent this calculation was not performed.

Table A4.11: Valuation of SROI

Impacts	Total impact for clients	Attribution of impact map	Total impact attributable to MSP

Impact of in-session support	£440,658	100%	£440,658
Impact of onward referral and signposting	£801,945	10%	£80,194
Impact of relief from depression and anxiety	£1,707,024	10%	£170,702
Total	£2,949,627		**£691,555**

Present Value: **£691,555**

Net Present Value (total of Present Value – inputs): **£386,803**

SROI (Present Value / inputs): **£2.27**

Relevance of value to stakeholders

The wellbeing valuation approach is primarily a measure of benefit to clients through improved wellbeing. However, there are good indications that this benefit is at least partially diverting costs from other stakeholders. The value to NHS services, for example, is displayed in the table below. Few of the relevant factors have direct cost valuations available: these were valuations which only measured potential costs averted by the NHS system, not the wider benefit of wellbeing to clients. Three outcomes had relevant proxies, highlighted in Table A4.12 below. Once incorporating attribution for MSP to the calculation (see also SROI calculation spreadsheet), the total value to NHS services attributable to MSP is: **£347,094.**

Table A4.12: Cost valuation for outcomes relevant to NHS

	Amount	**Number**	**Total**	**Relevance for NHS**	**Cost valuation available**
Impact map 1			**£342,617**		
Mental health escalation avoidance (strategies/ intervention within session)	1400	5	£7,000	Timely mental health support at an appropriate level.	No
Suicide prevention	66,797	5	£333,985	Costs averted due to delayed suicide	Yes – Costs averted by delayed suicide for a year Knapp et al (2011)
Treatment compliance		11	£0	Timely and informed medical support for more effective treatment	No
Knowledge and skills - info and widening options	51	32	£1,632	Timely and informed medical	Yes - Time gained by NHS administration staff due to increased

				support for more effective treatment	knowledge of local services available. NEF Consulting (2018)
Impact map 2			**£436,988**		
Yoga	3610	41	£148,010	Protective factors for disease recurrence	No
Dance	1831	24	£43,944	Protective factors for disease recurrence	No
Physical activity	1002	130	£130,260	Protective factors for disease recurrence	No
Support groups	1551	74	£114,774	Timely mental health support at an appropriate level	Yes - Annual estimated health service savings for support groups. McDaid and La Park (2017)
Complementary therapies					No
Hospital transport				Timely and informed medical support for more effective treatment	No
Impact map 3			**£1,707,024**		
Relief from depression/ anxiety	35563	48	£1,707,024	Timely mental health support at an appropriate level. Stress reduction aiding cancer recovery	No

A4.7 Summary of sensitivity analysis

A sensitivity analysis was performed to explore some of the assumptions behind the SROI calculation, to test its responsiveness to altering the general parameters of attribution and costings (tests 1, 5, 10) and its robustness under a higher level of specificity behind some of the assumptions (tests 2, 3) or a different methodology of valuation (4, 6, 9). Tests 7 and 8 aim to explore the amount of change in assumptions needed to create a neutral (£1) SROI ratio.

The tests suggest that the SROI calculation has a good level of internal validity, without high sensitivity to changes across a range of assumptions. Within the range of tests, the SROI ranged from £0.82 to £3.35, with a median of £2.08. It is also consistent with a different

methodology of valuation. Detailed calculations can be seen in the spreadsheet attached with this appendix.

Table A4.13: Tests performed within sensitivity analysis. Here PV is used to represent the 'Present Value' of the impacts and NPV the 'Net Present Value'.

	Test	**Change**	**Valuation**
1	SROI based on Impact map 1	Consider only direct impact of MSP service	PV: £440,658 NPV: £135,906.67 SROI of £1.34
2	Impact map 1 – parameters for knowledge shared, autonomy and suicide prevention	Extending knowledge gained to all examples of imparting knowledge and improved wellbeing strategies – using survey data 83% - knowledge of local activities 89% - knowledge of where to go for non-medical issues 87% - knowledge of how to improve wellbeing 64% - L1 clients taking action Reducing assumptions of suicide prevention by 3 people	Autonomy and knowledge: PV: £1,020,420 NPV: £715,668.53 SROI of £3.35 Suicide prevention: PV: £602,053 NPV: £297,301.53 SROI of £1.98
3	Impact map 2 – Accounting for physical activity	Closer analysis of physical activity referrals/signposts to ensure avoidance of double-counting and correct valuation • Discounting clients with more than 3 referrals • Recoding walking with its own valuation	PV: £739,471.35 NPV: £434,720.02 SROI of £2.43
4	Impact map 3 - Different wellbeing thresholds	Recalculate using the range of different methods proposed in section A4.4 Lowest value: 7% (MyCAW wellbeing - number moving from 5/6 to 0/1/2) Highest value: 27% (one problem decreased by 4 or more points) Referrals/signposts: 140 directed to counselling services or bereavement services	Lowest value: £889,075. NPV: £305,008.63 SROI of £2.00 Highest value: £3,591,863. NPV: £575,287.43 SROI of £2.89 Referrals/signposts: £1,386,957. NPV: £354,796.83 SROI of £2.16
5	Impact maps 2 and 3 – Attribution	Adjusting attribution to 5% Adjusting attribution to 20%	Lowest value: £566,106 NPV: £261,355.10 SROI: £1.86 Highest value: £942,452, NPV: £637,700.40 SROI: £3.09

6	All impact maps – discounting	Adjusting discounting assumptions related to proportion of problems moved from “serious” to not serious	£683,356.07 NPV: £378,604.73 SROI: £2.24
7	All impact maps – difference in attribution needed to set SROI ratio to £1	Adjusting attribution assumptions for a neutral SROI ratio.	Impact map 1: 69% Impact map 2: 0% Impact map 3: 0%
8	All impact maps – number of financial proxies dismissed for SROI ratio to move to £1	Determining how many outcomes need to be included to create an SROI ratio of £1 Largest contribution first: Smallest contribution first:	Only one outcome - 91% of suicide prevention needed 0% of the largest outcome - suicide prevention is needed 69% of the second largest outcome - relief from depression and anxiety (i.e. attribution of 6.9% in total)
9	All impact maps – comparison to WEMWBS valuation	Calculation of overall wellbeing valuation based on change in MyCAW wellbeing scaled against WEMWBS Confidence intervals (CI) of 95% Incorporating this plus financial gains into the impact map (no wellbeing valuation proxies) (Caution to be used here as this is distribution is based on discrete data – seven datapoints and this valuation does not consider any impacts for L1 clients, 61% of the clients seen.)	£2,303,876.00 in total wellbeing gains for Level 2/3 clients Total SROI including purely financial proxies With suicide prevention: £2.18 Lower CI – £1.92 Upper CI - £2.44 Without suicide prevention: £1.08 Lower CI – £0.82 Upper CI – £1.34 PV ranges from £249,682.88 to £742,256.53 NPV ranges from negative £55,068.45 to positive £437,505.20.
10	All impact maps – re-calculating ratios compared to the total cost of service	SROIs of each test recalculated to include the total cost of the service (including micro-commissioning and evaluation costs) Median of re-run sensitivity analysis is outputted	Median SROI: £1.91 Associated NPV: £314,881.50

A4.8 Conclusion

Strengths and weaknesses of this SROI

Throughout this process, we reflected on our progress against the seven principles of SROI (see Table A4.14).

Table A4.14: Self reflections on progress against seven principles of SROI

Principle of SROI	Relevant methodological discussions
1. Involve stakeholders. Stakeholders should inform what gets measured and how this is measured and valued.	Stakeholder involvement section was strong in the development and population of the impact map: clients themselves set the outcomes, tested against organisational stakeholders, and weighted by clients' indication of importance. This aspect of the SROI could have been improved through more work to establish attribution and potentially to assign values to the outcomes with no suitable financial proxies.
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.	The Theory of Change and evaluation evidence formed the theoretical underpinning of this SROI. Impact maps based on mechanisms of change identified within wider evaluation Net movements (incorporating both positive and negative changes) have been recorded for Impact map 3. The potential for negative changes due to interventions in Impact maps 1 and 2 could have been explored further – within the case notes and client case studies, there were no recorded negative changes due to taking action, although clients did record difficulties in connecting to services and beginning this process in the first place.
3. Value the things that matter. Use financial proxies in order that the value of the outcomes can be recognised.	Most outcomes have financial proxies, largely within the Wellbeing Valuation accounting, although there are substantial gaps for NHS-related costs particularly.
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.	Two pieces of evidence were provided for each outcome, alongside an illustrative case study taken from case notes or focus group discussions.
5. Do not over claim. Organisations should only claim the value that they are responsible for creating.	Attribution discussions used specific evidence from the evaluation and wider literature. There was some attempt to validate attribution and displacement with stakeholders.
6. Be transparent. Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be	Full methodology and spreadsheet shared on BBBC website.

reported to and discussed with stakeholders.	
7. Verify the result. Ensure appropriate independent verification of the account.	The SROI was tested through the SROI self-assessment tool, use of the MSP steering group and an independent reviewer.

We also used the SROI self-assessment tool (Social Value UK, 2019) to identify the strengths and weaknesses of this report (see Figure A4.2).

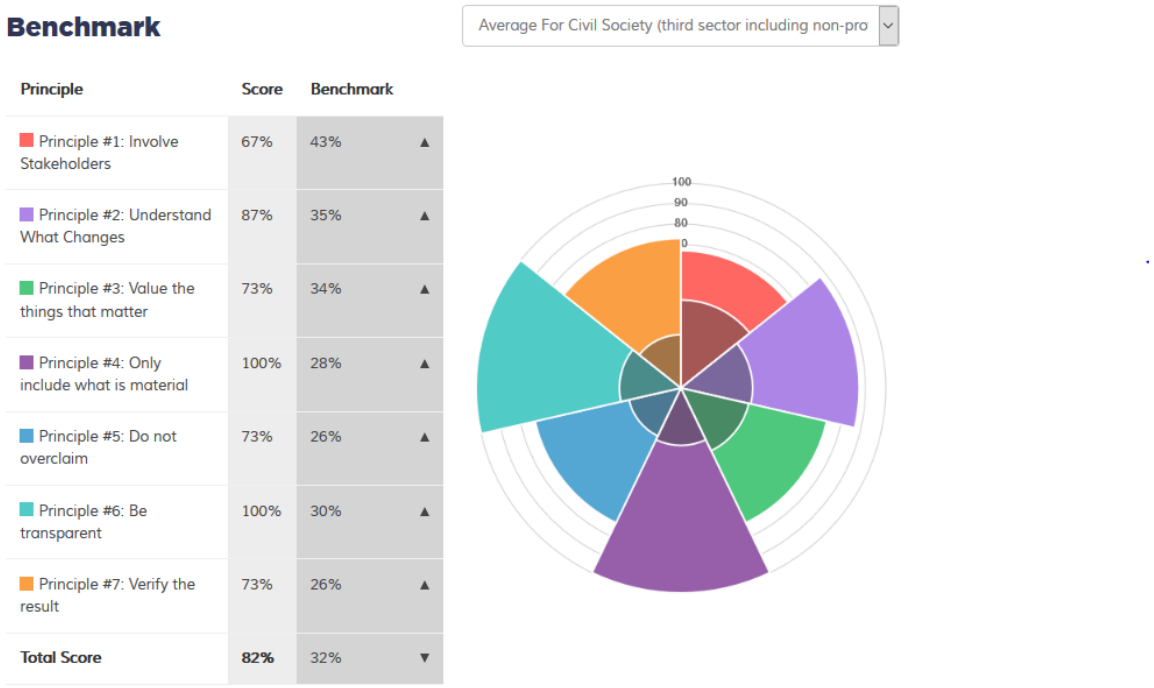

Figure A4.2: Self-assessment scores benchmarked against an average civil society assessment (Social Value UK, 2019)

Overall, this SROI is strong in its use of extensive client self-determined feedback (covering over a third of its clients), its adherence to the Theory of Change and therefore the internal logic of the service it represents, and the internal coherence of its financial proxies due to the extensive use of the Wellbeing Valuation methodology. Sensitivity analysis showed that it is a robust calculation. It could have benefitted from further stakeholder involvement in attribution. By choosing to follow the Wellbeing Valuation methodology, it also restricted the measurable outcomes and did not choose to develop valuations for those outcomes without suitable proxies. For this reason it is potentially underestimating several categories of impact.

Future use and embedding

This report will be shared with all relevant stakeholders through upload on the BBBC website and direct email. It informs Section 5 and Appendix 1 in the evaluation report of Phase 2 of the MSP service (Macmillan Social Prescribing – A Summary Evaluation Report) and is intended to be read as a companion to this work.

This SROI has also pointed towards the subtleties in establishing outcomes for social prescribing and the work and further tools needed for a comprehensive survey of this kind of work. It is hoped that the method employed in this report can galvanise a thorough stakeholder and outcomes mapping procedure for costs related to the linking role of social prescribing for clients and for costs prevented due to the range of relevant outcomes for the healthcare sector.

Future SROIs would also benefit in looking at the way that social prescribing services influence and work with the voluntary sector to provide relevant services for their clients.

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