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Carers Support Centre, Bristol and South Gloucestershire

Summary Social Impact Evaluation of the Carers Health Project

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Contents

List of Abbreviations

Term	Definition
A&E	Accident and Emergency Department
CCG	Clinical Commissioning Group
CSC	Carers Support Centre, Bristol and South Gloucestershire
GP	General Practitioner
GVA	Gross Value Added
JSA	Job Seekers Allowance
LA	Local Authority
NHS	National Health Service
ONS	Office for National Statistics
SROI	Social Return on Investment
UK	United Kingdom

1. Social Impact Measurement

Background to this report

1.1 This report presents the evaluated social impact related to the outcomes reached by a number of projects delivered by Carers Support Centre, Bristol and South Gloucestershire (CSC).

1.2 The report also explains the academic underpinning for social impact measurement to provide the justification for evaluating the value created and costs saved. The report then goes on to set out the evaluation of three areas considered by this study.

1.3 The review has been carried out at a high level to provide feedback on specific elements of the work of CSC's Carers Health Project. It is therefore an introduction to the benefits and opportunities of measuring wider social impact of CSC's work in general.

1.4 Many Voluntary and Community Sector Organisations are experts in the fields within which they operate; they understand the intricacies of the work they carry out and to a variable degree are aware of the range of impacts that result. Historically, however, measuring and valuing these impacts has been overlooked in favour of reporting the practical work the activities carried out; this misses out a vital opportunity, helping others to understand the value inherent in the work being done.

1.5 Social Impact Measurement provides the tools needed to enable this process. It unpicks and understands the story of those affected by an organisation's intervention, whether directly or indirectly, in the short-term or into the future. It looks from various perspectives: those of the individual, their family, their community (real or virtual) and the State. It then understands how the intervention or project creates or furthers that effect, and assesses how others help to deliver that change (or "outcome").

1.6 The outcomes (the change achieved in the lives of the beneficiary, individuals or communities) are examined from the perspectives of those beneficiaries, their communities, or the State agencies that support them. Those outcomes take into account of both:

a Primary Outcomes

- direct, proximate, arising on a short to medium timetable, in the hands of the immediate beneficiary, for example the benefits arising from supporting carers such as reduced likelihood of a breakdown in the caring situation;

b Secondary Outcomes

- arising in the medium to long term, or indirectly as a result of the good start given by the primary outcome, or indirectly into the lives of those around the primary beneficiary, for example reduced likelihood of a breakdown in the caring situation resulting in decreased utilisation of social services.

1.7 These outcomes and the change made are then evaluated, selecting appropriate financial proxies for them (e.g., increases in productivity, reduced need for State, health or domestic support, etc.). They are also, based on evidence appropriately gathered, traced back to the activities and outputs that caused, or supported, their creation. Combining the two elements we can evaluate the effect (the impact) of the work from the chosen projects and the chosen perspective.

1.8 Where more than one proxy for those outcomes is relevant, we can calculate each and then make an assessment as to which is more appropriate, choosing a blended answer when that is necessary.

1.9 Social Return on Investment (SROI), as a method of social impact measurement, is, whilst a relatively new (twenty-year old) presentation of this form of evaluation, not a radical, new stream of thought. It is a version of economic cost-benefit analysis (which itself goes back to the 1700's and perhaps before) set in the context of modern non-profit operation. This is a well-founded and widely recognised methodology, originating in the philanthropy community, but becoming of increasing use in the wider not-for-profit arena.

Social Return on Investment ("SROI")

1.10 The SROI methodology has been developed in order to help organisations to "[measure and quantify] the benefits they are generating" (per Lawlor, Neizert & Nicholls writing in the SROI guide, 2008[i]). This approach was piloted in the UK through the Measuring What Matters programme during 2002 and has evolved since then as further work has been done to develop the framework around it.

1.11 It is increasingly being seen as an "incredibly useful tool"[ii] by a number of organisations and key commentators within the Third and Public sectors in the push to measure and evaluate social impact. In the 2013 E3M report on measuring Social Impact in Social Enterprise[iii] it is recognised as a leading protocol in the field of monetised social impact evaluation, and a key tool in the measurement of commissioned public services. The E3M report observed that there are five key aspects to developing social impact measurement that meets stakeholder needs, which are:

- "A clearly enunciated story, with its theory of change, but with presentation adapted to the story it is trying to tell
- A clarity of beneficiary perspective: who and how it looks from their viewpoint
- Evidence of outcomes or causal link between outputs and outcomes with an intention to collect outcome data over time
- Demonstration of that change over time, from the identified beneficiaries' perspectives
- Linking learning based on analysis back to organisational learning"
- These are also reflected in the draft standards for social impact measurement being proposed by the European Commission GECES.[iv]

This report and the research process that supports it, adhere to those principles and to those in the European Commission report.

1.12 There are three 'bottom line' aspects of social return:

Economic: the financial and other effects on the economy, either macro or micro;

Social: the effects on individuals' or communities' lives that affect their relationships with each other; and

Environmental: the effects on the physical environment, both short and long term.

1.13 For this study the primary focus has been on economic and social benefits, rather than environmental benefits, as any environmental benefits generated would appear to be too far removed from the intended purpose of the original services provided and appear to be too difficult to measure reliably.

1.14 The benefits of using SROI include:

Accountability: organisations are able to give both the numbers and the story that supports them;

Planning: SROI provides a change management tool to assist in the direction of resources towards the most effective services and to assess the viability of potential additional services;

Cost and time effectiveness: the measures can produce an analysis of the most cost and time effective activities; and

Simplicity: impacts can be reduced to a simple comparison of the cost of funding CSC and the benefits that flow from their core activities to facilitate analysis and give a clear indicator of types and ranges of success.

1.15 SROI takes total measurable outcomes, discounted to present value where the benefits occur in the future or are recurring over a period of time, and deducts:

Deadweight: Outcomes that would have occurred regardless of the intervention;

Alternative attribution: Outcomes that arise as a result of intervention by others; and

Displacement: Outcomes that are negated or compromised by disadvantages arising elsewhere either in terms of social, economic or environmental damage.

In taking those measurable outcomes it allows for *drop-off*, that is the reduction over time of the depth of the effect of the intervention

1.16 A review of academic work and practical examples of SROI in use by the non-profit sector suggests that the measures fall into three patterns, which have been used in this work:

- *Economic benefit created:* where there is an impact on earning capacity or productivity;
- *Costs saved or not wasted:* where the intervention results in a saving, either in the cost of another intervention or in a consequential cost (e.g. introducing prevention to save on the cost of a cure). This may be seen in either removing the need for or increasing the effectiveness of an alternative intervention; and
- *Alternative or cheaper sourcing:* where one intervention directly replaces another more expensive one.

1.17 In identifying these benefits, a key underlying requirement is to consider not only the positive contribution that CSC makes, but also the economic damage that is avoided by having it in place. Much of our report involves the quantification of the damage to stakeholders that would result based on these implications. By avoiding this damage, CSC contributes to the economy just as meaningfully as where the effect is an incremental benefit.

Working with Carers Support Centre

1.18 This study was carried out at a high level in order to illustrate the potential benefits of CSC's Carers Health Project. This has been done to a reduced scope as against a usual Baker Tilly academic Social Impact Evaluation, reflecting the high-level approach taken to the research. This reduced scope details that work has been carried out over a shorter time frame leading to less exploration around additional areas of benefit. It therefore tends to understate and under-recognise the full extent of the secondary impact of the intervention. **As such it is to be expected that final values would increase were a full evaluation to be carried out.**

1.19 Interviews and workshops were carried out with a range of participants with various involvements, namely:

i Carers who have been supported by CSC;

ii CSC Staff providing support within GP's surgeries;

iii CSC Staff providing support within a hospital setting; and

iv CSC Staff involved with developing protocols for improving the carer pathways at GP's surgeries

1.20 Prior to the first interviews preliminary research was undertaken based on existing work that Baker Tilly have done and other available data to determine the likely areas of impact related to the proposed areas of study; namely elements of the Carers Health projects. This included the earlier report on carers centres undertaken by the Baker Tilly team in 2011.[v] At the interviews these were discussed with the individuals around each project area and the scope was narrowed to CSC support to carers in a hospital setting, support to carers in GP Practices and improving protocols within GP Practices. Taking a series of workshops enabled those involved to engage with colleagues in challenging each other's views, and then to return to the workplace to reflect, before returning to the group to refine the ideas further.

1.21 At the subsequent workshops the draft Outcomes Maps and Evaluative models were continually refined to the point where the project teams felt they represented fairly the work of each project. Full details of the evaluation models used have been included within appendix B.

1.22 The staff chosen by CSC to take part in the research are listed below:

- Emma Ryan - Health and Policy Team Manager CSC
- Ann Tolaini - GP Carer Liaison Team Manager CSC
- Dale Cranshaw - GP Carer Liaison Worker CSC
- Mary Bennett - GP Carer Liaison Worker CSC
- Emma Bull - Hospital Carer Liaison Worker CSC
- Jamie De Carvalho - Hospital Carer Liaison Worker CSC
- Patricia Barnes - Carer supported by GP Carer Liaison Worker
- Heather Wheeler - Carer supported by Hospital Carer Liaison Worker

2. Background to the project

2.0 Around one in eight adults[A] in the UK can be classified as a carer; this totals approximately 6.5 million people caring for at least one person. Working together they save the economy an average of £119 billion[B] per year and for those in receipt of Carers Allowance (currently at £59.75 for a minimum of 35 hours work), they receive approximately £1.71 per hour in financial recognition.

2.1 As well as contributing significantly to the UK economy, approximately 625,000[C] carers receive a below minimum wage amount and suffer mental and physical ill health as a consequence of their caring activities.

2.2 CSC recognises the contribution made by these carers and provides them with advice, information and support to help ease some of the pressures faced. This evaluation has sought to understand and evaluate the contribution that this support makes through three elements of CSC Carers Health Project:

- Support in a hospital setting;
- Support in a GP setting; and
- Improving protocols and practices within GP surgeries.

Support in a hospital setting

2.3 Many carers do not identify themselves as carers and as such do not seek out or receive any form of support. The first opportunity they may have to be recognised as a carer is when accompanying a cared-for individual on a ward in which a representative from CSC is based.

2.4 Three part time Hospital Carer Liaison Workers are based within three hospitals covering Bristol and South Gloucestershire. Whilst based on a ward CSC Hospital Carer Liaison Workers seek to identify and offer support to carers whilst also training and aiding hospital staff to recognise the value of carers and how they might best support them. CSC staff attend multi-disciplinary meetings with ward staff and can identify carers and additional levels of required support through these meetings. Through these meetings staff also have the opportunity to identify other support services that carers may benefit from.

2.5 Carers can face many barriers when interacting with hospital staff during the cared-for's stay. For example, staff may not recognise a carer as an expert partner in the cared-for person's care. This can lead to them inappropriately failing to share information that impacts upon the carer, for example discharge arrangements or not listening to the carer about issues such as the cared-for's preferences for care or their medical history. This leaves the carer isolated in being unable to understand the current actions being taken by the hospital and can also lead to them being unprepared to adequately care for the individual upon discharge.

2.6 CSC staff will also act as a vital independent link between carers, the cared for and hospital staff. Relationships can be strained as a result of the emotional and mental strain that all parties are under; CSC staff who understand hospital pathways and also the needs of carers can help mediate potential conflicts and maintain a healthy relationship between both parties.

2.7 In situations surrounding the discharge of a cared-for individual CSC staff work with the carer to understand the situation at home, recognising the available facilities and support available to the carer. Using this information CSC staff can help to quicken or slow down the discharge process so that the cared-for individual is only discharged when medically appropriate and crucially into an environment

[A] Facts about Carers 2012, Carers UK, December 2012
[B] Facts about Carers 2012, Carers UK, December 2012
[C] Facts about Carers 2012, Carers UK, December 2012

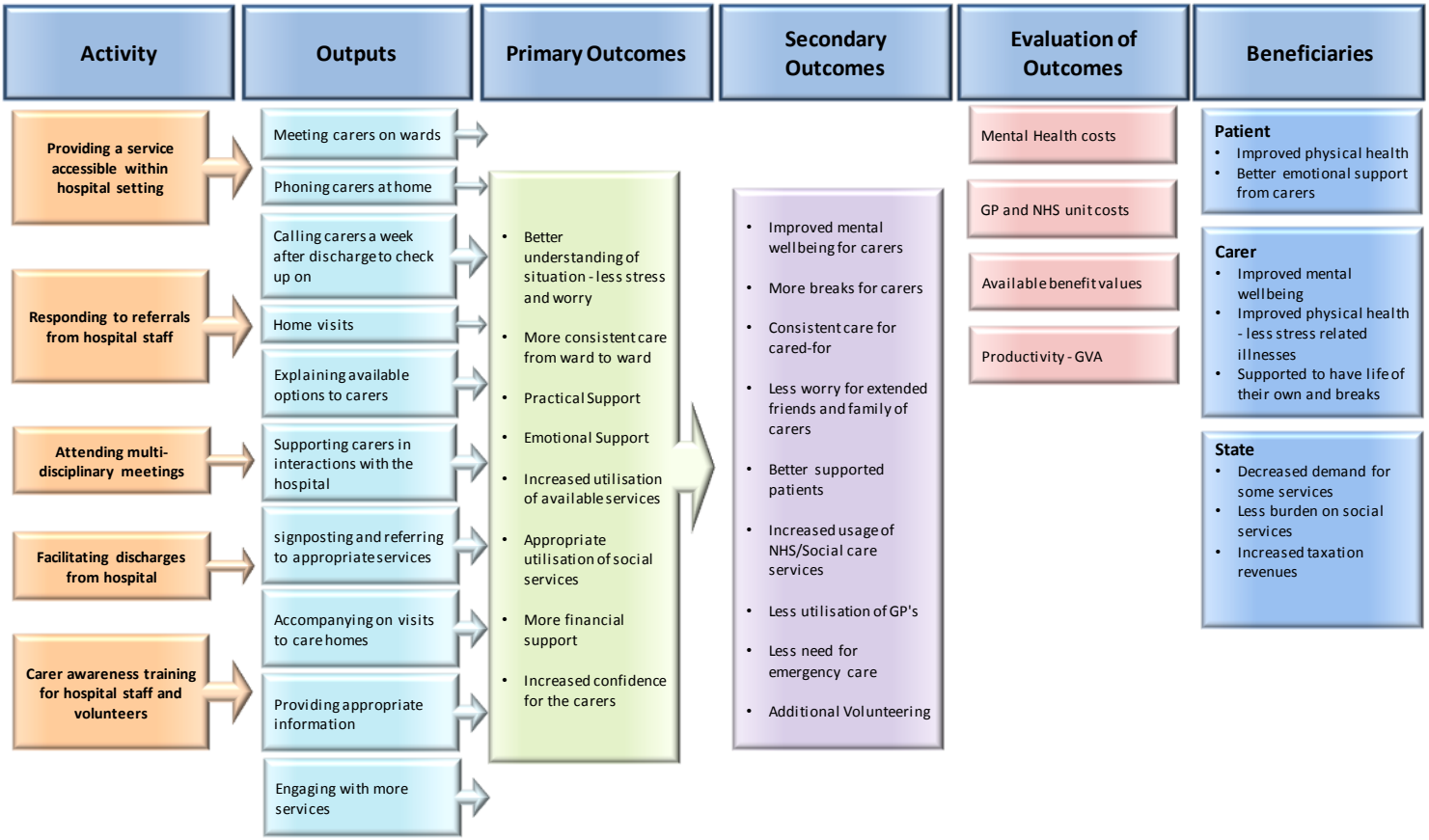
where they and the carer can be adequately supported. The carer may feel they are unable to continue in their caring role and would receive support to make this sometimes difficult decision. The experience of staff and carers has shown this to aid in reducing future emergency visits and on average reducing the number of days cared-for individuals take up a hospital bed.

2.8 After discharge CSC staff will contact carers to assess how they are managing with the transition back to the home environment. This can be an important time as carers re-adapt to providing care for a significant period of time, there may also be changes to the condition and needs of the cared-for which necessitate a change in approach.

2.9 Offering support along these documented avenues eases pressure on carers. Experiences of staff and carers within CSC has shown that for many it can feel an isolated existence, their lives are consumed by providing care for the cared-for and their individuality can be lost in providing significant levels of care. This can have a knock on effect to close friends and family who may be unable to offer support but recognise the stress the carer is facing; this illustrates how stress can permeate out through relationships and the wide reaching impact providing care can have.

2.10 A full range of the activities, outputs and outcomes are included below in the Hospital Carer Liaison Team Outcome Map:

Hospital Carer Liaison Team



Support in a GP setting

2.11 Three part time GP Carer Liaison Workers are based within GP Practices where they support carers through Carers Surgeries and work with staff to develop pathways and procedures for identifying and supporting carers in the Practice.

2.12 Once identified, carers are able to benefit from a number of services which have been signposted by CSC staff. Experiences and national research have shown that by supporting carers in primary care they are in turn able to provide more effective care to the individuals that they care for.

2.13 As within the hospital setting there is a range of information and support available to carers via the GP Practice. However many individuals do not recognise themselves as carers and as such are not exposed to any level of support. Within GP Practices, CSC staff run Carers Surgeries to identify carers and to provide advice and support during a 30 minute appointment.

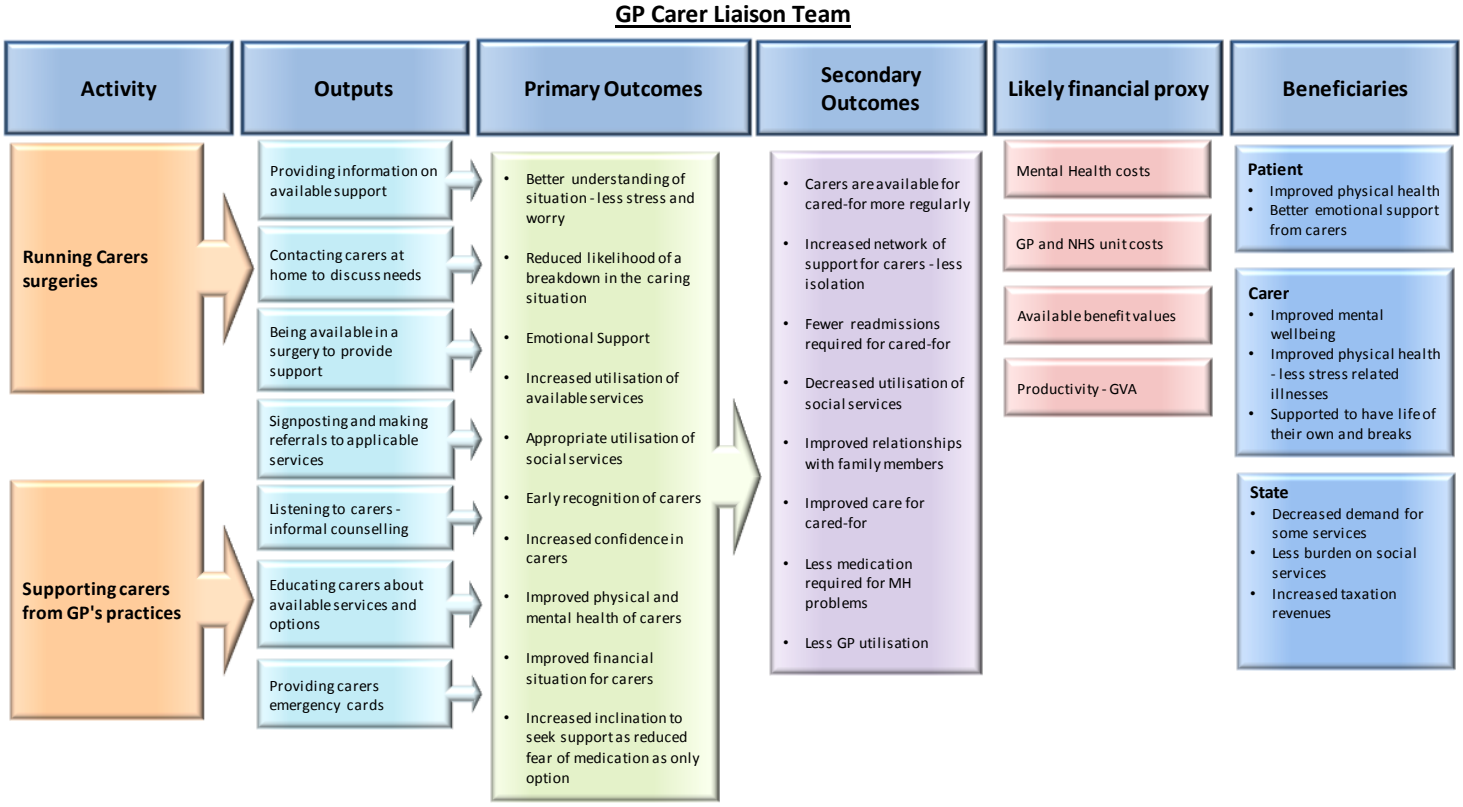
2.14 Carers can be referred to Carers Surgeries or, when appropriate, directly to CSC staff who can then arrange telephone calls or home visits as appropriate. For many carers who may only interact with health professionals through the cared-for individual, they do not have the opportunity to be identified and supported without this outreach service.

2.15 Once identified carers can benefit in a number of ways, for example from flexible appointment times with GPs for themselves, enabling them to manage their own care around that of the cared-for individual. This allows them the opportunity to care for themselves; many carers may neglect their own needs due to the care they provide. Offering alternative avenues and a flexibility of care can enable them to attend to their own needs before issues have the opportunity to escalate into a more serious condition.

2.16 An issue that some carers have highlighted within the research carried out is the stigma around treatment for mental health. The strain of caring for another individual can often result in diagnosable mental health problems, many carers however do not wish to highlight the pressures they face to their GP for fear of being prescribed medication with no attempt being made to tackle the underlying causes. By having CSC staff available to offer informal counselling and support some carers may feel a significant element of mental strain lifted and others feel comfortable speaking to their GP and requesting a non-medicated form of treatment. The service provided can improve mental wellbeing and help to save treatment costs whilst still providing much needed support.

2.17 Carer's emergency cards are available through CSC staff in GP Practices; these operate by identifying an individual as a carer. Should the carer then be subject themselves to a medical emergency it ensures that the needs of the cared-for can also be met. As well as providing a necessary service should the situation arise, it has the added benefit of removing a worry from the mind of the carer.

2.18 A full range of the activities, outputs and outcomes are included below in the GP Carer Liaison Team Outcome Map:



Improving protocols and procedures within GP's Practices

2.19 In addition to working within Practices to directly support carers, the three GP Carer Liaison Workers support GPs and associated staff develop procedural change in order that they may better support carers.

2.20 CSC Carers Health Project have introduced a range of procedures to help promote the needs of carers; working with staff on reception at Practices to enable them to help identify carers, running surgeries for identified carers at each practice, signposting available support and promoting local initiatives funded by CCG's.

2.21 Carers often accompany the cared-for individual to their annual flu jab and as a result flu injection clinics are a good place to identify and signpost carers for information and advice. Carers themselves are also entitled to free flu vaccinations in their own right.

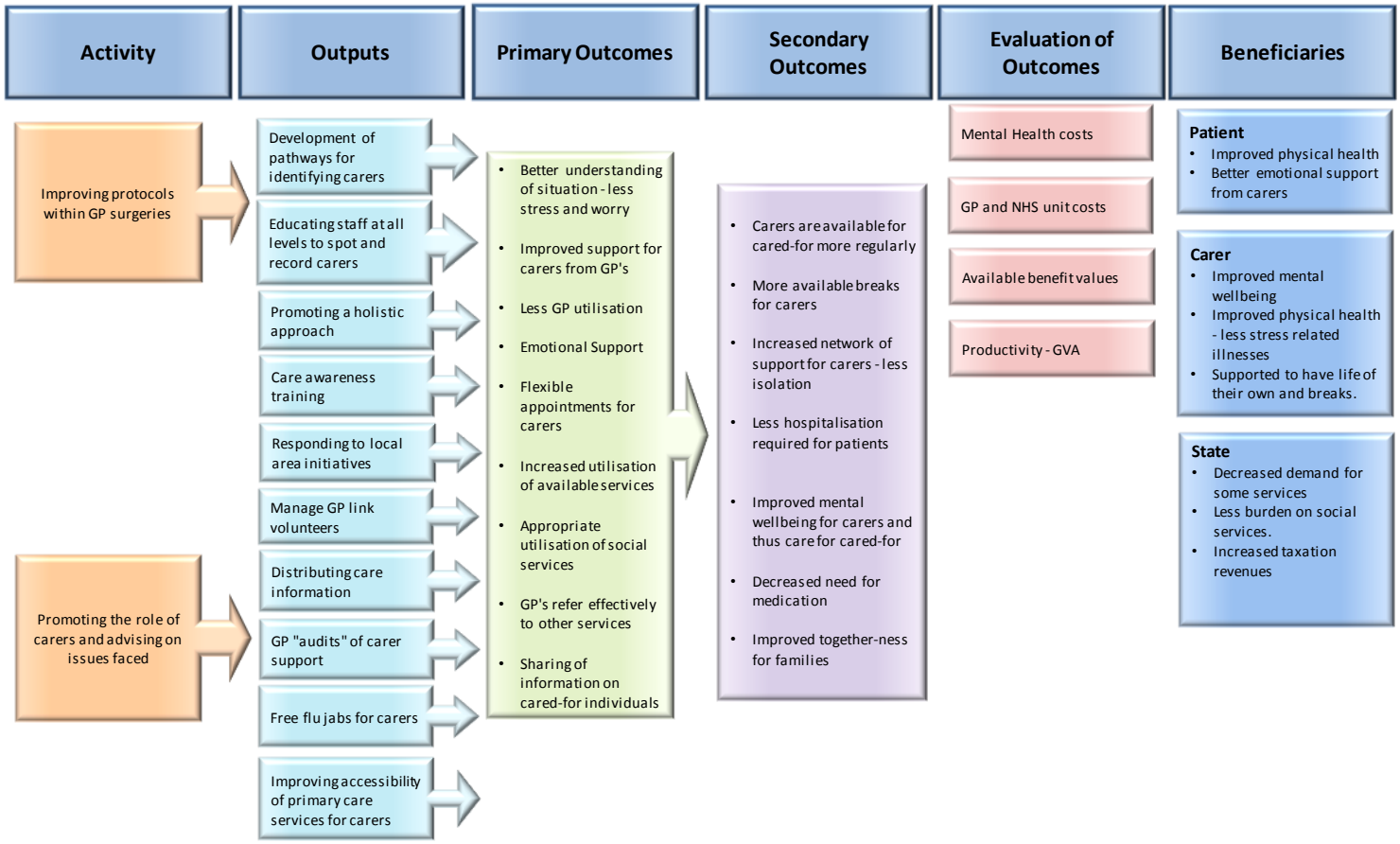
2.22 The experience of staff has shown that the formal identification of carers is one of the most easily overcome hurdles in providing increasing levels of support. CSC staff act as champions for carers and help other healthcare professionals to recognise the contribution that they make.

2.23 Without CSC GP Carer Liaison Workers supporting behind-the-scenes at GP Practices many Practices spend significant energies in understanding the needs of individuals who they see on a regular basis without recognising that they may be or may have a carer. Having the knowledge of the carer relationship can empower GP's to better meet the needs of the carer and cared-for individuals.

2.24 Once identified the pathways available to carers open up and they have access to a greater range of support. By supporting this role CSC Carers Health Project greatly aids in contributing to the significant impact carers have on the people they care for and the wider state.

2.25 A full range of the activities, outputs and outcomes are included below in the GP Policies work Outcome Map:

GP Carers Liaison Team Policies Work



3. Results of the evaluation

Modelling the impacts

3.0 In assessing the impact of the services provided by CSC's Carers Health Team a selection of models was decided upon that capture some of the outcomes for each intervention. Whilst the three assessed areas are disparate in how they offer support to carers, the outcomes that they are seeking to achieve are closely linked.

3.1 The models have been drawn together from the experiences offered in the interviews and workshops facilitated with CSC. Through a combination of these experiences and publicly available data from the NHS and Government sources the models represent an accurate representation of the social value CSC creates.

3.2 The outcomes that have been evaluated are:

- Improved mental wellbeing for the carer, cared-for and also wider friends and family;
- Improved physical wellbeing for the carer;
- Health service costs avoided; and
- Increased productivity of the carer.

3.3 From these separate outcomes the results have been further split down to illustrate the gains to the individual and the wider state and those resulting from physical versus mental wellbeing improvements.

3.4 Further details on the models evaluated below can be found in appendix B. These have been based around data provided by CSC and evaluate the value over an annual basis for 340 carers, caring for 527 individuals and with an extended friends or family network of 1,972.

Alternative attribution, displacement and deadweight

3.5 When modelling the social value, deductions are taken from the gross value evaluated. These deductions represent a range of factors that must be taken into account in order to accurately reflect the net value created. In this case the displacement cost of excess bed days resulting from CSC staff supporting a delay in discharge to ensure that homes and carers are available was modelled as the only recognised area of displacement. This recognised that, in this case, the intervention by CSC resulted in increased costs for the NHS.

3.6 Deductions were also made for deadweight which represents the acknowledgement that certain positive outcomes would have occurred regardless of the support offered. This recognised that of the people supported by CSC a percentage would perhaps have gained no benefit from the support offered.

3.7 The final and most sizeable deduction made was recognising the part that other partners make in supporting carers and the cared-for. Whilst the support from CSC is seen as a catalyst and significant factor in the positive outcomes achieved, a deduction of 45% of the value created was made as a result of varying levels of support provided by the following organisations and individuals:

- Friends, family, gyms and fitness centres, local churches, social clubs, work, social workers, other local charities, GP's and their staff, community matrons, practice nurses, occupational therapists, physios, district nurses, podiatrists, hospitals, healthcare assistants, fire/police services, counsellors, palliative care nurses, mental health workers, hospices, care homes, national charities, volunteers, and the citizen advice bureau.

3.8 These organisations do not all engage with carers or the cared-for but are a selection of those mentioned that the research team had come across during their experiences.

Improved mental wellbeing

3.9 Improved mental wellbeing represents the alleviation of stress and other burdens relating to both mental and physical health. Experiences drawn out from the interviews and workshops clearly identified the mental pressure acting as a carer placed on the individual. By providing support some individuals were able to avoid medication or reduce the level received, others felt that whilst they were not able to reduce the treatment they were receiving, it substantially aided in preventing mental health problems deteriorating further.

3.10 These gains are felt by a range of different individuals in the carer's proximity. The carer themselves benefits substantially; moreover, in supporting the carer the cared-for also benefits from a reduced impact on their mental health burden. For many it can be a difficult situation having a friend or family member care for them and when the care results in significant levels of stress this negatively affects the mental wellbeing of the cared-for. In supporting the carer these benefits then "flow" out to the cared-for.

3.11 Other friends and family members are also susceptible to additional stress as a result of the negative mental wellbeing faced by carers. In the same way that the cared-for benefits from an improvement in the carer's mental wellbeing, so to, do friends and family. Knowing that the carer is supported and able to provide care with an improvement in their own mental wellbeing enables friends and family members to worry less about them and reduces negative impacts on their own mental wellbeing.

3.12 Proxies have been used from published data on the costs for mental health based upon the direct cost of treatment, human costs and output losses. For these areas of data the models reflect the conditions faced by the individuals concerned. For example a prudent assumption has been made that cared-for individuals are less likely to be in employment so output losses have been removed from calculating the value of improving the cared-for's mental wellbeing.

Improved physical wellbeing

3.13 In the same way that mental wellbeing is affected as a result of caring, so too is physical wellbeing. Carers have over a 23% increased likelihood of suffering a stroke or form of coronary heart disease[vi] and this has been used as a proxy to indicate the physical pressures placed on carers. By comparing the expected occurrences of stroke or coronary heart disease amongst a population against those which CSC are aware of, a measure can be taken of the effectiveness of the intervention in terms of the physical wellbeing of carers.

3.14 Physical wellbeing of the cared-for individual has not been evaluated due to the complexities and wide range of afflictions that could cause an individual to need care, it has been considered prudent to evaluate only those outcomes which could reliably be measured.

Health service costs avoided

3.15 As a result of the support provided the contact with health services can reduce or in certain situations increase. For example support may lead to a quicker discharge from hospital; thereby reducing bed days of the cared-for's stay. Support may also, in some cases, lead to a slightly slower discharge in order to put community services in place, and this results in an increase of bed days of that hospital stay. We would however, expect the latter scenario to reduce overall bed days in the longer term by avoiding readmission. Using data provided in the Department of Health reference costs and the experiences and data collected by CSC enables the costs saved to be accurately measured.

3.16 The costs avoided have been looked at across a range of services:

- Costs of a non-elective inpatient stay;
- Cost per excess bed day;
- Cost of attendance to A&E;
- Visit to a walk in centre; and
- Visit to a GP.

3.17 For each of these services, data provided by CSC has been evaluated to arrive at a cost saving figure as a result of the overall net decrease in services found to be utilised.

Increased productivity of carers

3.18 The final model evaluated represents the ability of a carer to maintain or re-enter employment as a result of additional support in the caring process. This additional employment has a significant impact on local economies by increasing overall productivity and the associated boon for the economy.

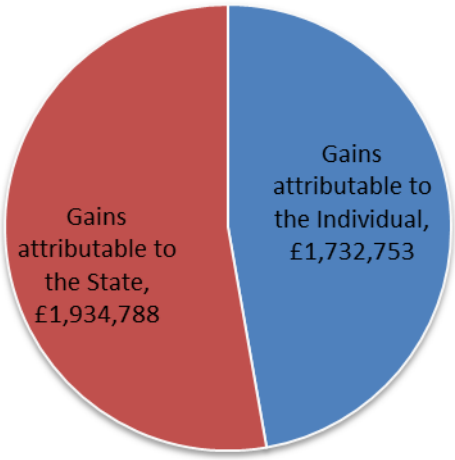
3.19 Data captured and provided by CSC gives an indication of the level of employment supported and the resulting impacts.

Summary results

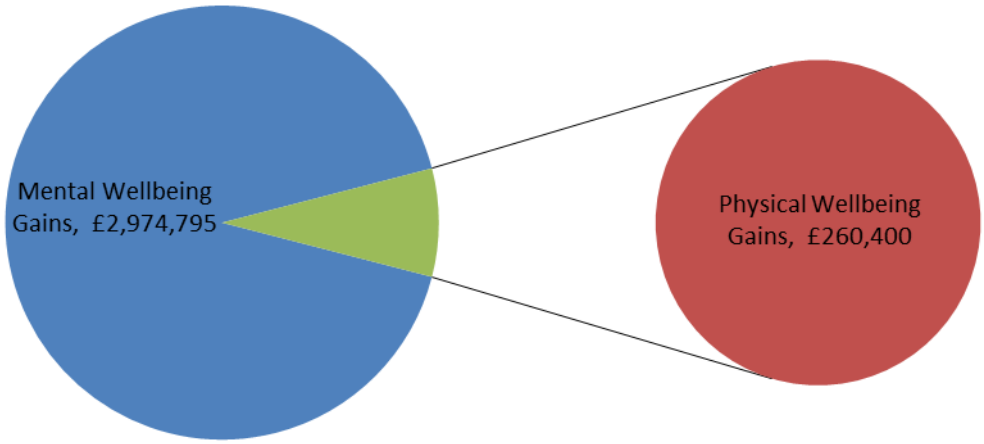
3.20 The summary results of the evaluated outcomes are provided below. These have been prudently evaluated at all stages, for more details the full range of models are included in appendix B:

Outcomes Evaluated	Evaluated Social Impact
Mental Wellbeing of Carer	£ 455,644
Physical Wellbeing of Carer	£ 260,400
Mental Wellbeing of Cared-for	£ 658,893
Health service costs avoided	£ 238,810
Mental wellbeing of friends and family	£ 1,860,258
Increased productivity of Carer	£ 193,536
Total:	**£ 3,667,541**

3.21 Analysing these results further can help to provide further insight into how the work of CSC provides social value. Splitting out each of the models into gains for the individual or the states shows the significant contribution made. Gains for the individual represent those areas where the direct beneficiary is considered to be the individual, for example the increase in mental wellbeing experienced by an individual. Gains for the state represent value and cost savings attributable to state run services. For example a reduction in treatment costs or an increase in productivity within the economy:



3.22 The largest gains resulting from the support provided by CSC's Carers Health Team are those resulting from the improved mental wellbeing experienced by carers, the cared-for and wider friends and family. When compared alongside the physical wellbeing benefits evaluated it provides a stark illustration of the importance of supporting individuals' mental wellbeing:



3.23 These evaluated impacts are only a selection of the total impacts that CSC are likely to have amongst the carers and other individuals that they work with. For CSC's Carers Health Team to have an evaluated impact of over £3.6 million demonstrates the value of the work provided and the importance of it to carers in the local area.

4. Appendices

Appendix A

Social Return on Investment ("SROI")

The case for political support for SROI

4.0 Further support for SROI's adoption by the third sector has been seen in the recent report 'Outcome-Based Government', published by the Centre for Social Justice ("CSJ")[vii]. This report considers the need to link funding of interventions with the expected outcomes (and their associated value). CSJ suggests that funding should be focused on those interventions that are likely to achieve the highest value outcome: "Improving life outcomes should be the ultimate goal of a government's social policy: if policy makers can better identify failing initiatives, and shift spending toward programmes that effectively deliver sustainable, long-term outcomes, the social and financial returns to society and the public sector will be very great indeed."

4.1 CSJ strongly advocates a shift towards evidence-based government, in which funding decisions are based on clear, high quality evidence of impact value, with SROI cited as a "more rigorous approach to performance management while attempting to capture the social and environmental impacts of public spending."

4.2 The rationale for adopting SROI may be applied equally strongly to local communities, who may rightly expect organisations such as CSC to demonstrate that their support is delivering real value to their community and society as a whole.

Addressing issues concerning the use of SROI

4.3 Overall, it is felt that SROI is a vital tool to provide non-profit sector bodies such as CSC with a means to evaluate its wider contribution to Society. However, there are several issues to consider when applying this, that are worthy of mention:

- SROI, as it is typically presented, tends to ignore the risks associated with the benefits generated. In the course of our work with CSC, the project representatives were encouraged to consider the achievable benefit created, and to build in reductions to assumptions to account for risks, where necessary;

- A robust SROI analysis must consider the proximity of the benefit created to the actions of the organisation that is seeking to claim ownership of that benefit. The project representatives were encouraged to focus only on outcomes that are directly attributable to their activities and, where necessary, obtained evidence of the link between the outcome and CSC's activities;

- SROI is typically presented as a ratio of the value of the benefits achieved per pound spent to achieve those benefits. This may be useful internally to each organisation as a measure of performance relative to prior periods. However, the use of this ratio to compare organisations is inherently flawed due to sector and organisation-specific factors that reduce the level of comparability between organisations. Hence, the results of this report are not presented in the form of a ratio;

- There is a danger that organisations seeking to evaluate their impact using SROI may create calculations that are extremely granular to the extent that they become open to accusations of

'spurious accuracy'. In this exercise, a smaller number of key assumptions have been identified by the project representatives during discussions facilitated by Baker Tilly to develop a prudent result at a high level. It is considered important to present a more defensible, prudent analysis than one which is overly complicated and risks overstatement; and

- SROI does not take account of the interrelationship of social impact and brand value. By creating greater social impact, the recognition and perceived quality of an organisation's brand is likely to improve, thus increasing the value of that brand. In turn an entity with a stronger brand may use that to enhance the social impact of its project work.

Appendix B

Detailed Evaluation Models Used

All models have evaluated gains and costs savings over a 12 month period unless otherwise specified

Mental Wellbeing of Carer

Providing support to carers through CSC's Carers Health Project offers considerable mental wellbeing benefits. The carers and support workers all emphasised the impact having people available to counsel, offer advice and listen made to their lives. Carers often felt isolated with few available options for support until they contacted CSC. Improving the mental wellbeing enables carers to reduce treatment costs of mental-health problems on the NHS, maintain employment and provide a higher level of care to the individuals they are caring for.

Mental Wellbeing of Carer

Individuals			340
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ 3,021,920,000		
Human costs	£ 53,600,000,000		
UK Population	63,200,000		
UK Population affected	16%		10,112,000
Cost per incident		£	7,706
Determined value to the individual of the support provided			
	34.0%	£	2,620
Social Value of increased mental health wellbeing		£	890,800
Deadweight	7%	-£	62,356
Alternative Attribution	45%	-£	372,800
Value to the person		£	313,423
Value to the state		£	142,221
Social value attributable to CSC		**£**	**455,644**

Key assumptions:

- **Unit Costs of mental health problems** - In order to assign a value to positive mental health wellbeing the cost of poor mental health has been used as a proxy. This represents that as poor mental health is a drain on society then conversely positive mental health can contribute to society through avoiding these costs and generating additional contributions. Figures taken from "The economic and social costs of mental health problems 2009/10", Centre for Mental Health 2010. From these figures those for output losses have been altered to reflect that from the research carried out by the project team an average of 17% of carers supported were in

employment for an average of 22 hours per week. The base line has then been altered to reflect these conditions.

- **UK Population** - Figures taken from the 2011 census data being the latest available

- **UK Population affected** - By using research from Weich, S., McManus, S, 2002, 'Common Mental Disorders', in Sproston, K., Nazroo, J., (ed) Ethnic Minority Psychiatric Illness Rates in the Community (Empiric), National Centre for Social Research, TSO. The SROI project team agreed upon a rate of 16% for typical mental health problems amongst the population, this is lower that the figure used in the 2011 study as no age range has been applied; it is considered that the occurrence rate in under 18's would be less than that of the 18-65 group.

- **Cost per incident** - Calculation based upon the above figures.

- **Determined value to the individual of the support provided** - Based upon the project teams' experiences, researched data[viiiix] and testimonies of the participants it was felt that using the average cost of a mental health problem at 34% was reasonable in reflecting the impact that the scheme had on the individual's positive mental wellbeing. This was lower than the 40% used in the 2011 PRTC study but reflects the personal experiences of the research group and other individuals that were questioned.

- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains in mental wellbeing without CSC's intervention it was not impossible and some others would obtain the same benefits from other organisations.

- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in maintaining positive wellbeing. CSC are the primary factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources.

- **Value to the Person** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the individual concerned.

- **Value to the State** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the state.

- **Social Value attributable to CSC** - Sum of the above.

Physical Wellbeing of Carer

Providing support to Carers convey considerable physical health benefits. Research has shown that carers under strain are over 20% more likely to suffer from a cardiac arrest or stroke compared to carers under less strain. Using this as a proxy the benefit to carers of being support by CSC and removing this strain has been modelled by using expected occurrences versus those occurring within the sample population.

Physical Wellbeing of Carer - risk of stroke

Number of individuals				340
Risk of stroke for carers with no strain		11.06%		
Risk of stroke for carers with strain		13.62%		
Actual recorded cases in the population		1		
Strokes avoided due to intervention				8
Unit cost of stroke episodes				
Direct Cost of NHS treatment	£ 2,800,000,000			
Cost of informal care	£ 2,400,000,000			
Loss of productivity	£ 1,800,000,000			
Total national cost		£ 7,000,000,000		
Stroke cases per annum in UK	110,000			
Average cost per case		£ 63,636		
Present value of avoided stroke episodes			**£**	**509,091**
Deadweight			7% -£	35,636
Alternative attribution			45% -£	213,055
Total attributable gain from avoidance of stroke			**£**	**260,400**

Key Assumptions:

- **Number of individuals -** Carers supported over an annual period.
- **Risk of stroke for carers -** Researched figures taken from an applicable report[x].
- **Actual cases in population -** From data gathered by the project team, how many carers that CSC was supporting had suffered from a stroke or cardiac arrest.
- **Strokes avoided due to intervention -** Calculation based on the support individuals receiving from CSC removing them from the "with strain" category, resulting in a decreased likelihood of stroke. This was then applied to the total population and rounded down.
- **Unit Costs of stroke episodes -** Taken from research[xi] and NICE guidelines[xii].
- **Present value of avoided stroke episodes -** Calculation based on above figures.

- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains in physical wellbeing without CSC's intervention it was not impossible and some others would obtain the same benefits from other organisations.

- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in maintaining positive wellbeing. CSC are the primary factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources.

- **Social Value attributable to CSC** - Sum of the above.

Mental Wellbeing of Cared-for

Providing support to carers through CSC's Carers Health Project offers considerable mental wellbeing benefits to the carer but also to the cared for. As carers are supported not only are they able to provide better support to the cared-for individual, the strain for the cared-for of seeing a friend or family member under strain whilst caring for them can also be alleviated, helping to strengthen the relationship and reduce the likelihood of a breakdown in the relationship.

Mental Wellbeing of Cared-for

Individuals			527
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ -		
Human costs	£ 53,600,000,000		
UK Population	63,200,000		
UK Population affected	16%		10,112,000
Cost per incident		£	7,407
Determined value to the individual of the support provided			
	33.0%	£	2,444
Social Value of increased mental health wellbeing		£	1,288,159
Deadweight	7%	-£	90,171
Alternative Attribution	45%	-£	539,094
Value to the person		£	471,518
Value to the state		£	187,375
Social value attributable to EH		**£**	**658,893**

Key assumptions:

- **Individuals** - From the CSC database, being the average number of individuals cared-for by each carer and apportioned to the 340 individuals in this study.
- **Unit Costs of mental health problems** - In order to assign a value to positive mental health wellbeing the cost of poor mental health has been used as a proxy. This represents that as poor mental health is a drain on society then conversely positive mental health can contribute to society through avoiding these costs and generating additional contributions. Figures taken from "The economic and social costs of mental health problems 2009/10", Centre for Mental Health 2010. From these figures those for output losses have been removed to reflect that from the research carried out by the project team it was unlikely that the cared-for individual would be in employment.
- **UK Population** - Figures taken from the 2011 census data being the latest available
- **UK Population affected** - By using research from Weich, S., McManus, S, 2002, 'Common Mental Disorders', in Sproston, K., Nazroo, J., (ed) Ethnic Minority Psychiatric Illness Rates in the Community (Empiric), National

Centre for Social Research, TSO. The SROI project team agreed upon a rate of 16% for typical mental health problems amongst the population.

- **Cost per incident** - Calculation based upon the above figures.
- **Determined value to the individual of the support provided** - Based upon the project team's experiences, researched data[xiiixiv] and testimonies of the participants it was felt that using the average cost of a mental health problem at 33% was reasonable in reflecting the impact that the scheme had on the individual's positive mental wellbeing.
- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains in mental wellbeing without CSC's intervention it was not an impossibility and some others would obtain the same benefits from other organisations.
- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in maintaining positive wellbeing. CSC are the primary factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources.
- **Value to the Person** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the individual concerned.
- **Value to the State** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the state.
- **Social Value attributable to CSC** - Sum of the above.

NHS costs avoided through the support from CSC

The intervention of CSC allows, in certain situations, for additional costs of NHS treatment to be avoided. For example supporting the discharge process effectively can allow for a smoother and or quicker transition and reduce the likelihood of emergency readmission. Reducing the physical and mental health burden on carers also reduces the contact time with GP's and other healthcare professional helping to reduce costs for the NHS.

Extra costs avoided by effective carer Support

NHS Unit costs		
Cost per day case	£	682
Cost per elective inpatient stay (excluding excess bed days)	£	3,215
Average costs of a non-elective inpatient stay (excluding excess bed days)	£	1,436
Average cost per excess bed day	£	264
Average cost of outpatient attendance	£	106
Average cost of A&E Attendance	£	108
Visit to a walk in centre	£	63
Visit to a GP	£	25

	Volume		Costs		Total Savings
Average costs of a non-elective inpatient stay	47	£	1,436	£	68,109
Average cost per excess bed day	1,476	£	264	£	389,558
Average cost of A&E Attendance	34	£	108	£	3,672
Visit to a walk in centre	34	£	63	£	2,142
Visit to a GP	136	£	25	£	3,400

Total social value saved		£	466,882
Deadweight	7%	-£	32,682
Alternative Attribution	45%	-£	195,390
Value attributable to CSC		**£**	**238,810**

Key assumptions:

- **NHS Unit costs** - Unit costs have been taken from the Department of Health reference costs 11/12 and the NHS "Choose Well" fact sheet. These have been used as applicable proxies for a reduction in the number of treatments required to be provided as a result of CSC's intervention.
- **Volumes of costs avoided** - These have been compiled by the project team and represent a prudent estimate of the interactions avoided for the assessed population on an annual basis.
- **Total social value saved** - Calculation using the above figures.
- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains without CSC's intervention it was not an impossibility and some others would obtain the same benefits from other organisations.
- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in supporting carers to reduce NHS interactions. CSC are the primary factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources.

Mental wellbeing of friends and family

Providing support to carers through CSC's Carers Health Project offers considerable mental wellbeing benefits to the carer, this can have a sizeable effect on friends and family of both the carer and cared-for. As carers are supported and their mental wellbeing improves so too does the stress and worry for friends and family who may feel powerless to assist in the caring relationship.

Mental Wellbeing of friends and family

Individuals	Multiplier:	**5.8**		1,972
Unit cost of mental health problems				
Health and social care		£ 21,300,000,000		
Output losses		£ 30,300,000,000		
Human costs		£ 53,600,000,000		
UK Population		63,200,000		
UK Population affected		16%		10,112,000
Cost per incident			£	10,403
Determined value to the individual of the support provided				
		30%	£	3,121
Social Value of increased mental health wellbeing			£	6,154,699
Deadweight		7%	-£	430,829
Alternative Attribution		68%	-£	3,863,613
Value to the person			£	947,812
Value to the state			£	912,446
Social value attributable to EH			**£**	**1,860,258**

Key assumptions:

- **Multiplier -** Evidence from the research group suggests that carers have, on average, 5.8 close friends and family who would experience an impact to their own mental wellbeing based upon the experiences of the carer supported by CSC.
- **Unit Costs of mental health problems** - In order to assign a value to positive mental health wellbeing the cost of poor mental health has been used as a proxy. This represents that as poor mental health is a drain on society then conversely positive mental health can contribute to society through avoiding these costs and generating additional contributions. Figures taken from "The economic and social costs of mental health problems 2009/10", Centre for Mental Health 2010
- **UK Population** - Figures taken from the 2011 census data being the latest available
- **UK Population affected** - By using research from Weich, S., McManus, S, 2002, 'Common Mental Disorders', in Sproston, K., Nazroo, J., (ed) Ethnic Minority Psychiatric Illness Rates in the Community (Empiric), National Centre for Social Research, TSO. The SROI project team agreed upon a rate of 16% for typical mental health problems amongst the population.

- **Cost per incident** - Calculation based upon the above figures.

- **Determined value to the individual of the support provided** - Based upon the project team's experiences, researched data[xvxvi] and testimonies of the participants it was felt that using the average cost of a mental health problem at 30% was reasonable in reflecting the impact that the scheme had on the individual's positive mental wellbeing.

- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains in mental wellbeing without CSC's intervention it was not an impossibility and some others would obtain the same benefits from other organisations.

- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in maintaining positive wellbeing. CSC are the primary factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources.

- **Value to the Person** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the individual concerned.

- **Value to the State** - An apportionment of the total social value after deadweight and alternative attribution based upon the original costs that can be assigned to the state.

- **Social Value attributable to CSC** - Sum of the above.

Increased productivity of carer

As carers are supported they are able to maintain employment or enter employment as a result of coping successfully with the caring relationship. Increased productivity helps stimulate the local economy and provides an increase to regional and national productivity.

Increased productivity of carer

% in employment		17%
Number in Employment		57.80
GVA for South West	£	19,093
Assumption on average hours worked		22
Productivity enabled	£	693,676
Deadweight	7% -£	48,557
Alternative Attribution	70% -£	451,583
Value attributable to CSC	**£**	**193,536**

Key assumptions:

- **Percentage in employment** - Assumption made by the research group based on experiences and available data.
- **GVA for South West -** Taken from the regional GVA figures for December 2012 as a measure for productivity in the local economy, it was felt that (pro-rata) the individuals would be at a higher level than the base GVA used but in the absence of concrete data this was used as a prudent value.
- **Assumption on average hours worked -** Group based assumption arrived at by the research group.
- **Deadweight** - A deduction for deadweight has been levied to represent that whilst the project team felt that it was very unlikely that the individuals would have experienced similar gains in mental wellbeing without CSC's intervention it was not an impossibility and some others would obtain the same benefits from other organisations.
- **Alternative Attribution** - Representing the role of the individual, friends, family and other factors in maintaining or creating employment. CSC are an important factor in that they offer support, target it specifically to individual people and provide the support framework but there is a recognisable contribution from other sources, not least the organisations providing employment.

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xv In Poor Health: The impact of caring on health, Carers UK, 2004

xvi Help Wanted?: Providing and Paying for