Creating Wellbeing and Measuring its Value

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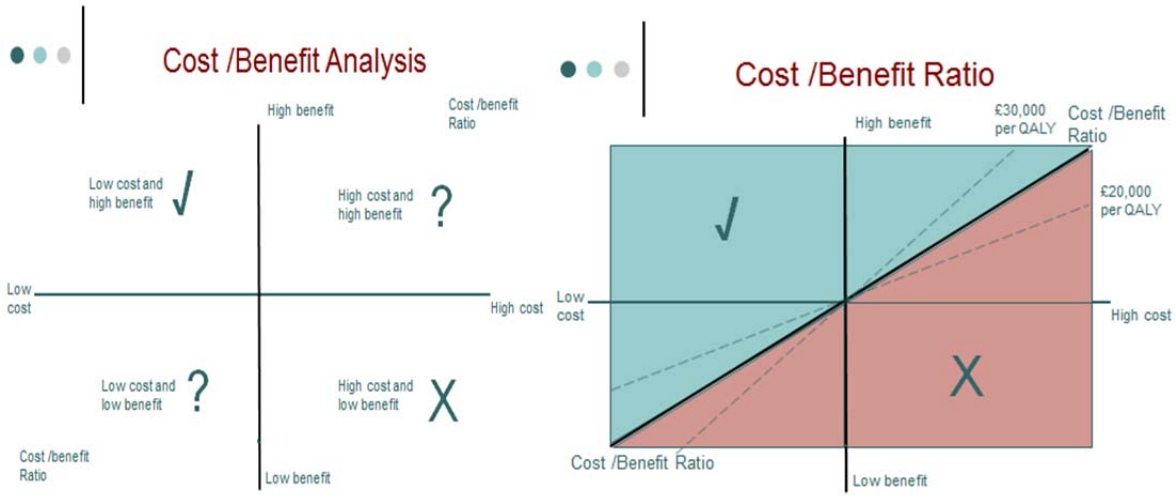
This introduction to the application of Social Return on Investment to health and wellbeing was originally developed to assist the Royal Borough of Greenwich and their partners in the NHS and Community Organisations to develop their approach to this issue at workshops. I have now updated this to share some ideas at the Sodexo Institute Brussels Dialogue on Quality of Life and the Workshop on Implementing and Leading Positive Deviance at Oxford. I set out some of the ideas that have guided my work for the UK Department of Health in developing tools for evaluating health and wellbeing programmes such as the Health Trainer Service, Smoking Cessation services, Obesity, diet and activity programmes, Alcohol harm reduction, Bowel Cancer survey response and Breast Feeding continuation and my work for an EU Integration Fund programme to develop Social Capital amongst new migrant women and a project to provide "through the gate" mentoring for ex-offenders. This is an emerging field in which our understanding – or at least mine – is limited so it is important to stress that I know there is much that I don't know and hope to learn from colleagues.

The context for the Greenwich workshops was: the Health and Social Care Act of 2012 which gave Local Authorities responsibility for local population health improvement and introduced Health and Wellbeing boards and the Public Services Act of 2012, which requires Local Authorities to consider the impact of services in terms of their social value to wellbeing. In addition a number of measures, including the Care Act of 2014, have underlined the importance of Local Authority Social Care services working in closer harmony with NHS and local Community Organizations. At a time of public sector austerity, such initiatives must demonstrate that they represent good value for money.

The relevance of applying techniques for measuring health and wellbeing programmes in terms of the Social Return on Investment (SROI) achieved has been underlined by Cabinet Office support for the publication of the New Economic Foundation guidelines in 2009 and the 2013 guide to the application of SROI to Wellbeing. See http://www.neweconomics.org/publications/entry/a-guide-to-social-return-on-investment and http://www.neweconomics.org/publications/by/well-being

The dimensions of autonomy and positive deviance brought by the Brussels and Oxford dialogues offer exciting opportunities to address wellbeing improvement in fresh and exciting ways.



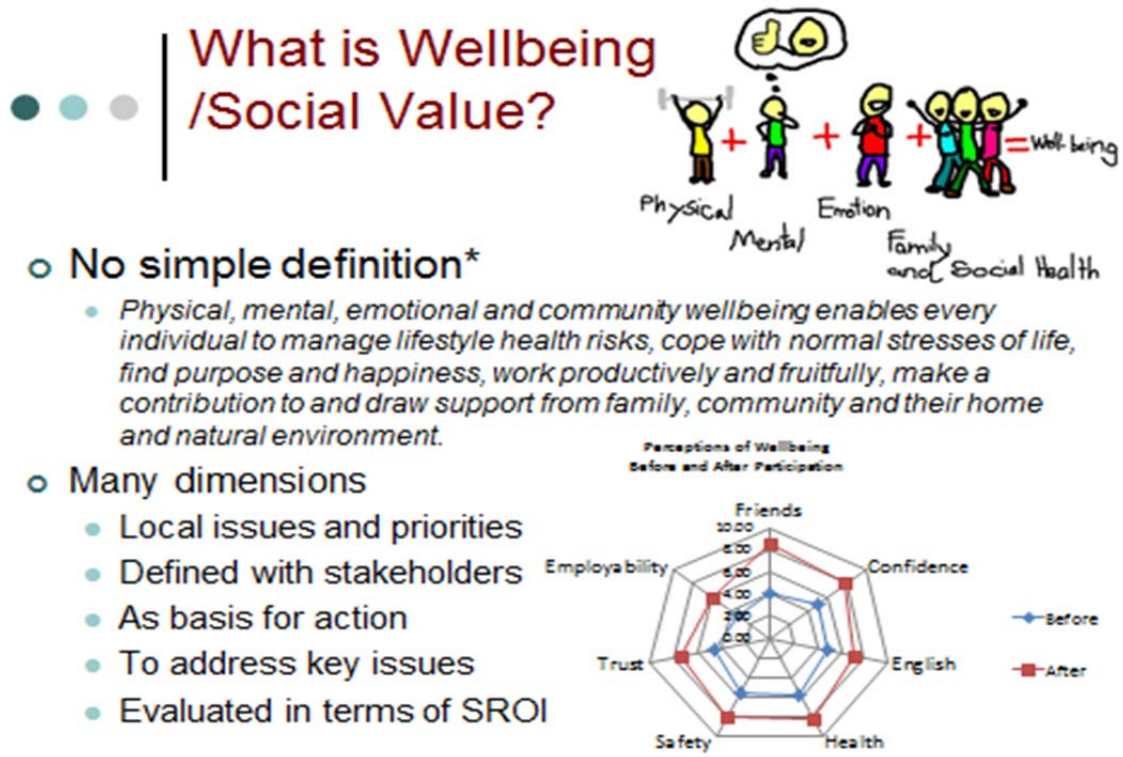
When considering the cost and benefits of any project it is obvious that if high benefits can be achieved at low cost it will be a worthwhile investment, while if costs are high and benefits low, it is likely to be a poor investment. But in most cases both costs and benefits are intermediate – so the question is how much is it worth spending to achieve each incremental unit of benefit? This is the cost/benefit ratio which is the criteria for deciding whether a project should be funded or not.

Cost benefit ratios are developed by considering the level of return available from alternative programmes to achieve similar outcomes and /or the value that members of the public or employers attribute to comparable outcomes. In the case of investment to improve health, the National Institute for Health and Care Excellence, expenditure of £20,000 or up to £30,000 is considered reasonable for each Quality Adjusted Life Year (QALY) achieved, based on studies of willingness to pay to reduce health risks and an estimate that it costs the NHS about £25,000 for each additional QALY it generates (though this figure has recently been challenged). For employers a cost benefit ratio for improving employee wellbeing may be derived from the unit cost of alternative measures, the reduction in costs of recruitment and/or improvement in productivity.

Value for money is always important. Both the public and private sector seek to achieve the best use of resources. To ensure this cost/benefit analysis can be applied at different levels:

a) Cost Offset – is used to examine actions which have a direct effect on reducing other costs, e.g. systems to inform people of their appointments may reduce the cost non-attendance.
b) Cost effectiveness –compares different ways of achieving the same outcomes, e.g. different smoking cessation services can be compared in terms of cost per quitter.
c) Cost consequences – is used to evaluate initiatives that have multiple outcomes, e.g. a project may describe and measure: health, mental wellbeing and social outcomes.
d) Cost-utility – compares actions with different, but comparable outcomes using a common scale, e.g. QALYs are used to compare different health outcomes in comparable terms.
e) Cost-benefit – can be applied when outcomes can be translated into economic values, e.g. by applying assumptions about the value of different outcomes such as lifetime earnings.
f) Social Return on Investment – is a form of cost benefit analysis comparing total social costs and benefits, e.g. examining cost/benefit to society, employers and individuals.

Cost benefit analysis is based on how much the funder is prepared to pay for each unit of benefit.

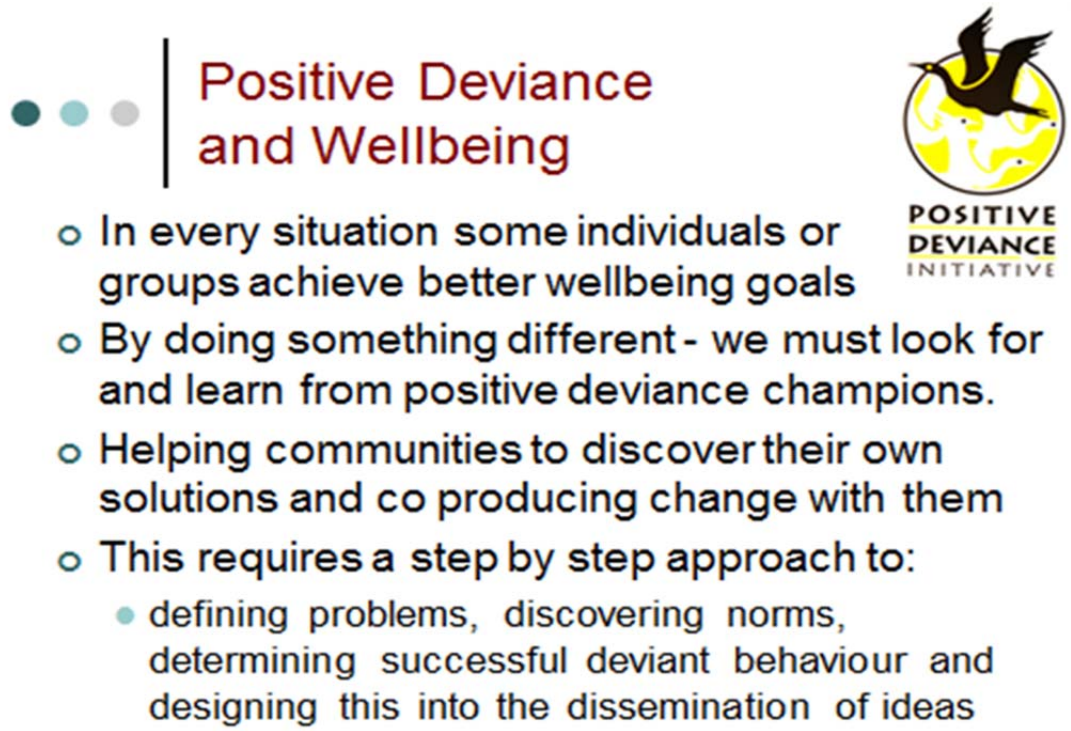


While there are many references to wellbeing, ranging from the World Health Organization Constitution to UK Legislation, there is no simple answer to the question: "What is wellbeing?" see the discussion provided by the National Wellbeing Institute Australia http://nwia.idwellness.org/2011/02/28/definitions-of-wellbeing-quality-of-life-and-wellness

It may be better to ask: " How do certain individuals and communities achieve wellbeing improvement?" To answer this we need to ask those involved:" What makes life better for you?" One approach is to develop a "Radar" chart, as shown above from the Portsmouth Gateway Project, to describe different factors that are seen as affecting people's wellbeing, their perception of current life chances and steps which improve their wellbeing, see Croydon Councils guidelines for creating social value: https://www.croydon.gov.uk/sites/default/files/articles/downloads/socialvalue.pdf and Liverpool Clinical Commissioning Group Social Value Strategy and Action Plan http://www.liverpoolccg.nhs.uk/Library/About_us/Publications/Social_Value_Strategy_LCCG_2014.pdf

The combination of factors that people address to improve wellbeing outcomes in a specific case can be seen in the Seven Pathways to Reduce Reoffending see http://prisonlinks.co.uk/the-7-pathways-to-reduce-reoffending/ .These are: 1 accommodation and home support, 2 education, training and employment, 3 physical and mental health care, 4 drugs and alcohol desistence support, 5 help with financial, debt and benefits issues, 6 support for relationships with families and children, 7 help in addressing attitudes, thinking and behavioural problems.

The Mentoring Solutions Initiative, provides an example of a project to address these seven issues by engaging ex-offenders as mentors and guides for a "through the gate" service. This also illustrates the importance of approaching wellbeing from the perspective and understanding of those involved, see http://www.building-leadership-for-health.org.uk/co-producing-community-integration/co-producing-a-path-from-prison/



This introduction to positive deviance taken from and introduction by Lars Thuesen expresses the simple ideas that underlie the approach to managing change for improved wellbeing, as a process of co production in which the leaders of behaviour change are not those who advise others on change but those who have achieved change and purpose in their lives.

This approach is evident in the development of Health Trainer Services and Health Champions where those leading change are most often drawn from the communities they support. Equally the Mentoring Solutions "through the gate" support service succeeded because the mentors were themselves ex-offenders – and for the most part, ex-addicts who shared their experience.

The Portsmouth Gateway Project, which helped new migrant women, from non-EU countries to develop social capital through mutual support was designed as a co production, ensuring that the women participants led the definition of needs and solutions. This was enabled by offering participants not only training but also a choice of opportunities to participate in community activities such as advice and information services, support for those with health and benefits problems help for others in learning English and so forth. It was remarkable how the opportunity to participate in community projects was welcomed by participants as giving purpose and meaning to their lives, see http://www.building-leadership-for-health.org.uk/co-producing-community-integration/ .

In addressing such issues a step by step development process is required see the Engagement Spectrum of the Action Learning Team of the Office of the Deputy PM (2004) which relates to Arnstein's ladder of participation see http://www.vcn.bc.ca/citizens-handbook/arnsteinsladder.html

The Government's "Big Society" initiative also showed that participation in community projects generates a sense of purpose and wellbeing see https://www.gov.uk/government/topics/community-and-society

Social impact matrix for a wellbeing project

Objectives › Stakeholders ∨	Improved Health and Wellbeing	Reduced inequality	Improved social capital	Reduce long term costs
1. Local Authorities	Improved wellbeing health gain	Disadvantaged and Hard to reach %	Membership of community groups	Reduced social care and other service costs
2. NHS	Improved health status health gain	Reduce health inequity %	Better use of NHS services more participation	Reduced NHS costs from associated conditions
3. Other Government	Improved health and wellbeing	Reduced health and wellbeing inequity	Improved employment	Tax, benefit, excise and VAT impacts
4. Clients	Improved personal health and wellbeing	Access for disadvantaged and hard to reach	Better family life More opportunities to participate and community support	Employment income Less expenditure on addictive products and informal care
5. Community	Better access to health and care	Wider participation	Increased volunteering	Opportunities for cost sharing
6. Employers	Reduced sickness and absenteeism	Less long term sickness	Improved staff relations	Less costs of replacing staff better productivity

One way of summarising the perception of the value of a project by different stakeholders is to draw up a Social Impact Matrix. This clarifies the main benefits as perceived by each stakeholder and helps to identify intermediate and long term outcomes that can be measured and valued.

In practice, though it may be possible to draw up a social impact matrix based on preconceptions, the importance of such a chart lies in its stimulus to learning from participants, through discussion and refinement. This helps to develop a common understanding of what each party can contribute to and achieve from the project and how outcomes may be assessed and valued in a way that reflects all participants' perspectives.

This is an important way of identifying the complementary objectives of Local Authorities, the NHS, Employers and Community organizations, it is a basis for joint planning and evaluation. Identifying and engaging stakeholders and understanding their perspectives, provides a basis for working together to design the process to support the improvement in wellbeing.

I first applied this approach to social impact analysis in assessing the Value for Money of Health Trainer Services for the Department of Health, I found it so useful that I have used it on every similar evaluation, see http://www.building-leadership-for-health.org.uk/evaluating-behaviour-change/health-trainers-health-economics-behavioural-economics-new-media/

Note that in all evaluation models for the Department of Health or EU I have included the estimation of employer investment and benefits. Sadly this is seldom actually applied in practice.

Autonomy and self-efficacy can be seen as two sides of a coin. On the one side the ability to exercise choice and control, depends upon the opportunities presented, the resources available and the support provided. On the other side belief in one's ability to undertake a task or achieve a life goal is essential if opportunities are to be grasped. Often people face both lack of opportunity to make choices and exercise control and low belief in their ability to do so effectively. Ex-offender, people facing behavioural health issues such as obesity, smoking and other addictions all face issues of low self-esteem and low levels of community support.

Autonomy has been measured as an indicator of Inequality (though I prefer the term inequity), see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85544/summary-measuring-equality.pdf

The New General Self-efficacy Scale by Chen, Gully and Eden (2001) uses 8 questions with answers scaled on 5 points from strongly agree to strongly disagree the questions are:

1. I will be able to achieve most of the goals that I have set for myself.
2. When facing difficult tasks, I am certain that I will accomplish them.
3. In general, I think that I can obtain outcomes that are important to me.
4. I believe I can succeed at most any endeavour to which I set my mind.
5. I will be able to successfully overcome many challenges.
6. I am confident that I can perform effectively on many different tasks.
7. Compared to other people, I can do most tasks very well.
8. Even when things are tough, I can perform quite well.

This scale was used in the evaluation of Health Trainer Services referred to earlier. It is a relatively good predictor of improved feelings of wellbeing, persistence in health behaviour change and mental wellbeing.

What is social capital? Is it part of wellbeing?

- Social capital is the framework of values and norms that fosters bonds within community groups, bridges between groups and links with formal and informal organisations
- Behaviour change depends on and builds social capital
  - By recognising and influencing existing group norms
  - By forming social groups to support behaviour change persistence
  - By providing links to social support from community and services
- Social capital is essential to wellbeing and equity
  - Most care (70%) is from community resources
  - Most behaviour is determined by community norms

* Rosalyn Harper (2002) "The Measurement of Social Capital in the UK" National Statistics

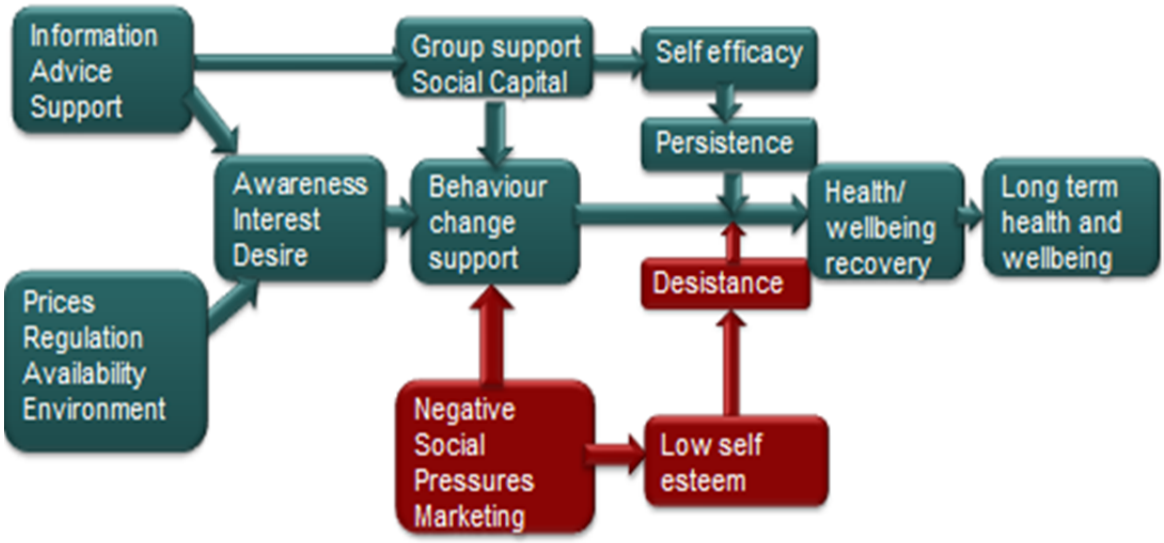
Social capital is a measure of how we interact through and are integrated by overlapping communities or networks of neighbourhood, interest, culture and activity see http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html . It is a major determinant of Quality of Life as expressed in Life Satisfaction measured at national level by the British Household Survey and internationally by the OECD Better Life Index, see http://www.oecdbetterlifeindex.org/topics/life-satisfaction/

Social capital can have both positive and negative connotations for society. Wide ranging and balanced social capital (bonding, bridging and linking) provides opportunities for mutual support and civil participation. But a network that defines itself only by strong bonds within the group but does not form bridges to other groups or links with what may be seen as "external" social organisations will limit its members' perspectives and life chances (particularly if they end up in Syria).

Social capital is also a major determinant of behaviour, as we are influenced by the accepted normal behaviour or "norms" of those we define as our peer group and from whom we take most of the clues for our behaviour. For example, smoking is sometimes a defining group norm of "assertive young women." To address such behaviour we have to understand existing group norms as symbols of identity. The most powerful way of influencing behaviour and helping people to persist in behaviour change is to create social groups, whether through group activity or by on-line engagement through social media, that support positive behaviour norms, such as not smoking, eating healthily and exercising but also civil participation and volunteering.

Social capital is also relevant to the way people interact at work, it is part of the support that colleagues offer one another and can be a major source of wellbeing and support, particularly for people who may feel pressure or stress in their job. For similar reasons social group support from people with a shared experience is particularly important for ex-offenders and ex-servicemen. Social capital within the work place may be reinforced by engagement with the wider community.

The Process of Behaviour Change: How, where and when do we change



A process map helps to identify how change is planned to occur and the stages at which intermediate or long term benefits may be expected as well as potential unintended consequences which may result in dis-benefits unless measures are taken to avoid such outcomes.

A description of the process also provides a basis for the evaluation of how and when benefits will be achieved for all stakeholders, how behaviour will be sustained by group meetings, telephone or on-line social apps that share and support group encouragement and how intermediate outcomes will be measured. This can be compared with the expected outcome if no intervention were made or if an alternative process was adopted. It is important to stress that any evaluation requires a comparison between action and inaction or an alternative approach, see for example, the NAVCA report on Measuring Social Value at http://www.navca.org.uk/localvs/lcp/research .

The change process should involve client stakeholders in achieving better outcomes and provider stakeholders in adapting services and support to better achieve the agreed process for achieving wellbeing goals. This approach is called co production treating people as participants in the process and experts in their own needs and values rather than the targets for professional intervention. It should also help to identify potential unintended consequences as seen by all stakeholders.

A practical application of co production principals is shown by the EU funded Gateway Portsmouth project note that the participants developed their own online platform to support their activity.

Other useful guidance on the evaluation of social values in health can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215895/dh_122354.pdf
http://www.thesroinetwork.org/publications/doc_details/224-guide-to-commissioning-for-maximum-value
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/building-social-value.pdf

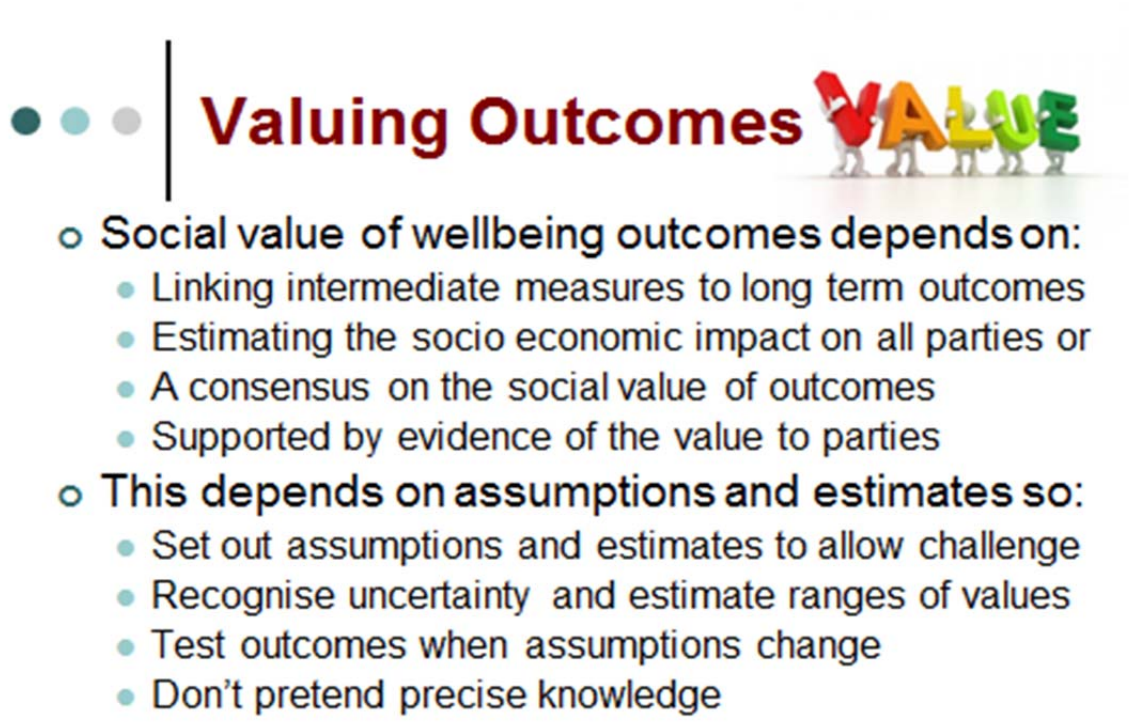
Measuring Social Value/ Wellbeing Improvement

- Outcomes are often measured as short term changes
  - E.g. Group participation, Behaviour change, Mental Wellbeing (WEMWBS scale), Awareness and Attitude change, Self Efficacy or Autonomy (Generalized Self-Efficacy Scale),
- These are used to predict long term outcomes such as:
  - Physical and Mental Health (QALYs e.g. EuroQol 5D)
  - Social Capital Measures (Bonding, Bridging and Linking (ONS))
  - Environmental Impact, Carbon footprint
  - Employability, Employment, Lifetime earnings
- At national level these indicators may relate to ratings of
  - Perceptions of personal: wellbeing, satisfaction with relationships, perceived health, employment, locality, finance, the economy, education, governance and the natural environment.

A false distinction is sometimes made between qualitative description and quantitative measures, both are necessary components of SROI. The aim of SROI is to identify, measure and value the most important and relevant inputs and outcomes for all participants. These must first be described, in most cases the outcomes that can be detected are short term changes in attitudes, knowledge and behaviour, measured by attitudinal surveys or behaviour measures. These intermediate measures can be used to predict long term outcomes.

For example, in evaluating smoking cessation we may record the number of people who tell the researchers they have quit or we may measure the Carbon Monoxide level in their breath. But in predicting long term health outcomes we must be aware that people often provide the answer that they hope will please the researcher, moreover their behaviour may rebound in the short or long term. Studies suggest that only one person in seven who reports that they have quit smoking will persist in not smoking in a year's time, while about one in four CO tested quitters will persist. Over the following ten years about one in ten quitters will resume smoking. To estimate the impact on health outcomes we also need to consider the degree to which they are likely to recover health. This depends upon age – we find that up to the age of 35 smokers recover most of their health but beyond the age of about 50 smokers only recover half of the health risks they have imposed on their bodies. The final step in this case is to link the reduction in health risk over the lifetime of those who do succeed in quitting to their long term health outcomes. This draws on studies such as the Institute of Health Metrics and Evaluation Global Burden of Disease study which estimate the long term impact of smoking (and other behaviour) on health outcomes for the UK. To see this rather complex link used in a practical evaluation tool view the Smoking Cessation VfM Tool and Guide at: http://www.building-leadership-for-health.org.uk/evaluating-behaviour-change/introduction-smoking-weight-diet-and-activity/

While some wellbeing issues are less complex than this, it is nearly always necessary to consider the link between intermediate measures and longer term outcomes.



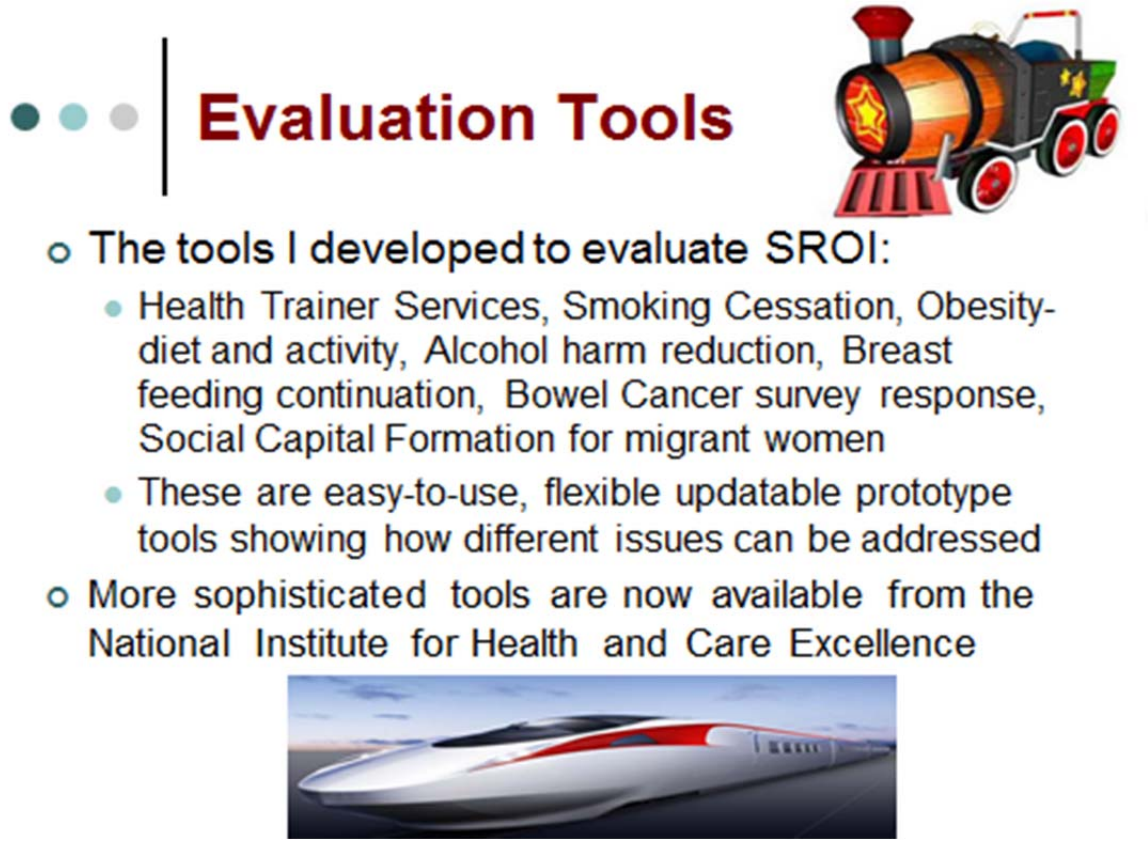
As described on the previous page it is essential to link intermediate measures to long term outcomes as a basis for valuing outcomes. This may be based on an estimate of the full cost to society of the long term outcome over the life of the people who change, discounted to current values by applying the social time preference rate (3 ½ %) . In the case of smoking this includes: impact on NHS, Social care and other Local Authority costs, Government taxes, duties, pensions and benefit payments, costs to employers arising from lower productivity and absenteeism and costs to individuals and families from expenditure on cigarettes, informal care and reduced income. Alternatively outcome values may be based on consensus supported by evidence.

As noted, long term impacts on physical and mental health outcomes may be ascribe a value based on the NICE recommendation that the social value of a Quality Adjusted Life Year (QALY) can be valued at £20,000 or in some cases up to £30,000. Both these methods of valuing health outcomes are demonstrated in the evaluation tools I developed for the Department of Health.

The tool to evaluate social capital creation for migrant women by enabling training and volunteering and reducing barriers to friendship by English Language Classes uses values derived from current studies. These include values from a study of the lifetime impact on household incomes of basic training, produced by the Dept. for Business Innovation and Skills and values taken from a report by Fujiwara, Oreyemi and McKinnon 2013 "Well Being and Civil Society: Estimating the value of volunteering using subjective wellbeing data" published by the Dept. of Work and Pensions and Cabinet Office, at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221227/WP112.pdf

Estimates of the social value of a range of social outcomes are available from Housing Associations Charitable Trust (HACT) Guides and Measures of social value at http://www.hact.org.uk/social-value-publications

In all cases it was important to state the assumptions and estimates used and to show a range of values reflecting the high and low estimates that would arise from using different assumptions.



The tools that I developed for the UK Department of Health with the National Centre for Social Marketing were designed to illustrate how a range of different behaviour change interventions to promote better health and wellbeing could be evaluated. The ready reckoner type tools are designed to be used by local teams with basic training in the content and application of the tools. They were developed with the guidance of an expert panel drawn from NICE, Health England, the NSMC, the Department of Health and Directors of Public Health. They were developed at low cost based on evidence supplied by NICE as prototypes to illustrate the principles of evaluation.

As such they are flexible and can be updated as better evidence emerges, indeed I have updated the main instruments twice to reflect new data. Approximately 350 NHS and Local Authority staff have been trained to use these instrument and I hear that they have been very influential in helping to improve and sometimes save services of this nature. They are available from http://www.building-leadership-for-health.org.uk/evaluating-behaviour-change/

Since the original prototypes were developed NICE has commissioned more sophisticated evaluation tools for some aspects of health and provides training for users. These tools are available from:

- http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-return-on-investment-tool
- http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Physical-activity-return-on-investment-tool
- http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Alcohol-return-on-investment-tool

Such tools bring clarity to the assumptions on which they are based and the experience of those who have participated in the process. They bring a common understanding of wellbeing and its impac

Where next?

- What does wellbeing mean for participants?
  - Consult participants – role models (e.g. positive deviants)
  - How can participants achieve this - (e.g. autonomy/self efficacy)
- What processes support this
  - Process mapping – (e.g. intended and unintended outcomes)
  - Support persistence – (e.g. support groups and social apps)
- How can improved wellbeing be measured and valued
  - Qualitative feedback – (e.g. user and employer response)
  - Quantitative measures and values – (e.g. evaluation tools)

Drawing on what we have learnt so far about identifying, supporting and assessing wellbeing the lessons seem to be:

1. Wellbeing means different things in different situations, thus we have to start by asking all the parties involved in achieving and supporting improved wellbeing, what it means for them. This will require consultation which can be aided by identifying those positive deviants who have achieved better wellbeing outcomes by their own exceptional behaviour. A Radar chart and Social Impact Matrix are ways of setting out the elements of wellbeing.
2. Wellbeing improvement can be supported by a step by step process of increasing autonomy and self-efficacy, mapping the intended outcomes for all and being mindful of possible unintended consequences. Action to promote mutual support in groups and communities, for example by developing social media apps that support and encourage positive behaviour are important ways of mobilising social capital for wellbeing improvement.
3. It is important to measure and value wellbeing improvement by both qualitative feedback from participants and quantitative measures and values, demonstrated by evaluation tools.

Practical steps towards the application of this approach in different contexts might include:

a. Engaging different participants in defining what wellbeing improvement might mean for them: e.g. people working in isolated groups such as oil rig workers, people coping with complex personal development issues such as ex-offenders, military personnel etc.
b. Mapping a range of wellbeing development pathways: e.g. fitness, sports, diet and health at work, family support and contact, child care and advice, providing opportunities for social contribution through work, volunteering in the local and global community.
c. Developing generic support apps using social media and ways of measuring and valuing wellbeing improvement applying qualitative and quantitative evaluation tools.

Theories of wellbeing, positive deviance, social capital and autonomy can lead to action.