

Evaluating social innovations and their contribution to social value: the benefits of a 'blended value' approach

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Abstract

Social innovation is viewed as a solution to developing new services that address complex needs and create 'social value' but what constitutes social value and how to measure it is contested. Drawing on an a case study of a social prescribing pilot, this paper provides an example of how social value can be evaluated to support decisions by commissioners of socially innovative interventions. It argues that social value presents an epistemological, and methodological challenge for commissioners seeking to embed it in decision making and recommends evaluating social innovations through a 'blended value' lens.

Key words

Social innovation; Social value; Blended value; Social prescribing

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Introduction

Social innovation, which addresses complex social problems and unmet needs through novel activities and services that maximise 'social value' (Phills et al, 2008; Mulgan et al, 2007), is increasingly seen by public policy makers as a solution to developing and testing new services (Mulgan et al, 2007). Its rise to prominence is closely linked to the austerity measures enacted by western governments following the 2008 global economic downturn and the predominance of neoliberal ideas and norms in western democracies which have led public bodies to seek market based approaches to service delivery that will reduce public sector costs and responsibilities (Eikenberry, 2009; Evans et al, 2005). However, the attention paid to social innovation also signifies a step-change in policy thinking which gives greater consideration to the wider social, economic and environmental benefits that accrue from public and social investment. This has historically been referred to as the 'triple bottom line' (Norman and MacDonald, 2004; Hubbard, 2009) and is increasingly identified in policy discourses as 'social value'.

Despite its rise to prominence within policy discourses, the efficacy of different social innovations and policy makers' understanding of the scale and nature of the social value they create remains limited (Mulgan et al, 2007; Sinclair and Baglioni, 2014) and research and evaluation in the field lacks a conclusive definition and theoretical framework (Graddy-Reed and Feldman, 2015). This paper contributes by considering what social value is and how it should be evaluated in the context of socially innovative services that have been funded by public sector bodies. Its central argument is that social value presents an epistemological and methodological challenge for commissioners, with the concept of 'blended value' posited as offering a more holistic lens through which social value can be understood. Empirical support for this argument is provided through a case study of a socially innovative public service pilot, social prescribing, which was evaluated with the explicit intention of demonstrating its social value and provides an in-depth insight into the

epistemological and methodological complexities of demonstrating social value when a wide array of social and economic benefits are evident for a number of different stakeholders.

The paper begins by discussing the concepts of social innovation and social value and their position within mainstream policy making, focussing on some of the dominant narratives around how social value should be operationalised for commissioning purposes. It then presents empirical analysis of the social prescribing case study, discussing how the evidence contributes to an understanding of what social value is, in particular how it is operationalised and measured within public service commissioning.

Social innovation and its relationship to social value

Social innovation has been described as:

"A novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals." (Phillis et al, 2008, p 36)

And:

"Innovative activities and services that are motivated by the goal of meeting a social need and that are predominantly developed and diffused through organisations whose primary purposes are social." (Mulgan et al, 2007, p 8)

Social innovations are typically developed in response to perceived market and government failures and it is argued that when markets (Phillis et al, 2008), governments (Le Grand, 1991; Wolf, 1979) and even traditional voluntary action (Salamon, 1987) fail social innovation is able to meet needs that would not be met through other means and create value that would not otherwise be created (Phillis et al, 2008). Social innovations therefore tend to be created, adopted and diffused in a particular social and political context (Phillis et al, 2008) or triggered as a response to a stimulus that could be internal to those involved or as a result of external pressures (Neumeier, 2012).

The notion of additional 'social' value creation over private value creation is at the core of most conceptions of social innovation. Social value can be described as the benefits created for society through efforts to address social needs and problems (Phillis et al, 2008): these benefits could be societal, economic or environmental and may accrue to disadvantaged groups in society or society as a whole but, crucially, they should go beyond the private gain and profit maximisation that motivates traditional market activity (ibid; Mulgan et al, 2007). Despite the absence of defining frameworks (Graddy-Reed and Feldman, 2015) most authors agree that social innovation occurs and its value takes effect beyond traditional market boundaries and as such is distinct from traditional business innovation. For example, Howaldt and Schwarz (2010) argue that social innovation does not occur in the medium of technical artefact but in social practice, while Neumeier (2012) emphasises the importance of sustainable social benefits arising from social innovation and Moulaert et al (2005) highlight the satisfaction of (social) needs that are not currently satisfied. This distinction between societal and private benefit is important as it provides a clear rationale for policy interventions that promote the development of social innovation and the creation of social value through publicly funded interventions (Borgaza and Bodini, 2014).

Social innovation, social value and public sector policy

Social innovations and the social value they have the potential to create resonate particularly strongly with the neo-liberal ideologies that dominate contemporary policy and politics. Since 2010 the UK and other western governments have implemented large scale public sector funding cuts and substantial programmes of welfare reform and public service transformation (Taylor-Gooby, 2012). Central to this is the stated intention to eliminate budget deficits and promote of market based approaches to service delivery that will reduce public sector costs and responsibilities (Eikenberry, 2009; Evans et al, 2005). Alongside these developments has been the emergence of a position in mainstream policymaking, sometimes referred to as public value governance, through which policy makers are encouraged to address effectively what the public most cares about and peruse what is good for the public through policy interventions (Moore, 1995 and 2013; Bryson et al, 2014). Although public sector funding cuts and marketisation have been extensively contested (Eikenberry, 2009; Taylor-Gooby, 2012), they are a reality and commissioners are drawn to social innovation because of its perceived ability to deliver a triumvirate of policy objectives in the form of competitively outsourced (i.e. cheaper) service provision, upstream savings to the public purse, and wider societal benefits (social value).

In the UK, the drive to source market-based solutions for complex social problems in combination with wider social value benefits is encapsulated in the Public Services (Social Value) Act 2012. The Act requires that public authorities: i) have due regard to the economic, social and environmental well-being impacts of procuring public services, and; ii) must consider whether to consult on this issue at the pre-procurement stage. It applies to contracts across most parts of the public sector and was developed with the explicit aim of facilitating the growth of social enterprises, charities and cooperatives, and to have a positive impact in the areas where public services are commissioned. A note published alongside the Act clarifies that commissioners should "consider how what is to be procured may improve the social, environmental and economic well-being of the relevant area, and how they might secure any such improvement and consider the need to consult".

The Act was initially heralded as important development in enabling more socially innovative organisations to engage in public service delivery. However, it does not make explicit reference to the commissioning and procurement steps that should be followed nor is it prescriptive about how social value should be interpreted in methodological or epistemological terms (Harlock, 2014; Teasdale et al, 2012). This lack of clarity raises some fundamental questions for commissioners about how social value should be measured. For example, should it be evidenced through quantitative indicators of economic or behavioural change; or should assessments be based on interpretive qualitative insights from different stakeholders in a service? In addition, should commissioners consider only the intended benefits of interventions, or include unintended or additional benefits, when considering social value?

This uncertainty around social value is reflected in practice, where few policy led approaches to stimulating and measuring social value have been developed. Those that do exist, such as the social impact bond (SIB) funding mechanism (Fox et al, 2011) and the social return on investment (SROI) measurement framework (Millar and Hall, 2012; Nicholls et al, 2009), have been criticised for their emphasis on positivistic 'mechanical' economic

models of cause and effect. These approaches tend to treat interventions in isolation, and attribute outcomes to them whilst failing to recognise the complexity and contexts of the social problems public services seek to address (McHugh et al, 2013). As a result, they tend to produce narrow or oversimplified understandings of social value with limited emphasis on the more intangible and unexpected benefits or the actual processes that contribute to social value (Arvidson et al, 2013; Harlock, 2014).

In contrast to the positivistic approach to social value advocated by the SIB and SROI models, the 'blended value' approach to understanding social value provides a basis for capturing a broader series of benefits arising from a socially innovative service. Blended value was coined by Emerson (2003) and later developed by Nicholls (2009). It recognises that all organisations generate a combination of financial, economic and social outputs and outcomes and that these are intrinsically linked and should not be analysed in opposition through a zero-sum equation (Emerson, 2003; Nicholls, 2009). Using a blended value lens social value can be conceived as occurring on a spectrum that extends from quantitative understandings of financial or economic value at one pole to qualitative measures of social change on the other (Emerson, 2003). As such it provides an analytic methodology through which more effective operational responses to social problems can be designed (Nicholls, 2009). As a loose epistemological framework it enables a social innovation such as social prescribing to be evaluated according to the different types of social value that accrue to different stakeholders. These stakeholder level distinctions are particularly important in the case of social innovation as Philis et al (2008) argue that innovation can only be considered truly social if it creates greater benefits to the public or society (particularly those facing disadvantage) as a whole (social value) than to investors and ordinary consumers (private value). Similarly, Neumeier (2012) suggests that the benefits arising from social innovation may well be manifested in changes in attitudes, behaviours or perceptions, in contrast to tangible economic benefits or technical improvements.

The remainder of this paper aims to demonstrate the epistemological and methodological challenges of evaluating social value and how a blended value approach can be applied to develop a broader understanding of the benefits of socially innovative public services. It does this through a case study of social prescribing, a publicly funded social innovation pilot which was evaluated with the express intent of identifying the different types of social value created.

Case Study: The social value of social prescribing

This section provides the main empirical content of the paper, drawing extensively on quantitative and qualitative data collected and analysed for an evaluation of a social prescribing service, a social innovation pilot in community level health services. It begins with an introduction to social prescribing and the specific pilot being evaluated before presenting key insights and analysis from the evaluation, focussing on the operationalisation and measurement of social value within the commissioning process.

An introduction to social prescribing

Social prescribing is a catch-all term for non-medical services and referral pathways developed with the aim of preventing worsening health for people with long term health conditions and reducing the number and intensity of costly interventions in urgent or

specialist care. In recent years a number of locality based social prescribing services have been developed by health and social care commissioners to provide a mechanism for General Practitioners (GPs) and other primary care services to link patients with sources of social, therapeutic and practical support provided by voluntary and community sector organisations in their locality. These social prescribing services have been developed in a policy environment which places greater emphasis on integrated preventative interventions for people from marginalised and disadvantaged groups (HM Government, 2010) alongside a pressure to reduce public sector budgets and implement market based approaches to delivery. The Department of Health (HM Government, 2006) has advocated social prescriptions for almost ten years whilst more recently NHS England (2014) has promoted non-clinical interventions from the voluntary and community sector as a way of making general practice more sustainable.

The pilot on which this paper is based was one of the largest examples of social prescribing in the UK to date. It was funded by an NHS Clinical Commissioning Group (CCG) using £1 million of non-recurrent monies that had not been committed for mainstream services. Local health commissioners had historically used non-recurrent funds to provide ad hoc grant funding for local voluntary and community organisations for small or short-term projects. The development of the social prescribing pilot was viewed as an opportunity to take a more sustainable and strategic approach to commissioning services that supported primary care objectives. As an NHS stakeholder explained:

"(the local NHS CCG) were considering ways to make the voluntary sector more sustainable...and around this time we were involved in discussions...about funding a pilot project with the VCS as key players in supporting the NHS to address issues related to patients with long-term conditions"

The pilot covered an entire local authority area, supporting more than 1,000 people with health conditions to access community level services over an 18 month period. A local voluntary sector organisation was commissioned to deliver the pilot, employing 'Advisors' whose role was to provide a link between the service and practitioners in primary and social care. The pilot also funded an additional 24 voluntary and community sector organisations through 'pump-priming' grants to deliver 31 separate 'micro-commissioned' services to complement existing local provision. Advisors received referrals from GPs of eligible patients and carers and assessed their support needs before referring them on to appropriate pump-primed or wider voluntary and statutory provision. The assessment took place during a home visit where the Advisor would talk through the patient's needs and discuss the options available to them through social prescribing. Advisors also formed part of Inter-disciplinary Case Management Teams, attending meetings when social prescribing patients were being discussed where they fed back on the types of services accessed.

The pilot can be considered an example of social innovation on a number of levels. First, at a programme level and similar to many examples of social innovation, the social prescribing pilot was developed as a response to a specific market failure (Philis et al, 2008): the myriad of information asymmetry and imperfect information that exists between people with long term conditions, health practitioners and commissioners, and providers (or potential providers) of community level services. Prior to the development of the pilot none of the parties had the requisite information for patients' needs to be met effectively. Second, and

also at a programme level, the service delivery model was innovative compared to other social prescribing models in its provision of pump-priming grants, and in the way that micro service commissioning decisions related to these grants were devolved to a local voluntary organisation. Finally, and at community level, it was an example of 'grassroots innovation' in which networks of people and organisations organise themselves to generate novel solutions to social problems from the bottom-up (Seyfang and Smith, 2007). They differ from top-down approaches because they involve people and communities developing solutions for the betterment of the local area (ibid) in ways that build capacity and resilience (Kirwin et al, 2013). Pump-primed examples from the pilot include local neighbourhood groups developing peer-led sensory arts and crafts sessions for people suffering from social isolation and mental health problems, and peer advocacy support to enable women from BME communities to access health services and social care packages.

Social prescribing has been promoted by commissioners for its purported potential to create significant social value, including: better social and clinical outcomes for people with health conditions and their carers; more cost efficient and effective use of NHS and social care resources; and a wider, more diverse and responsive local provider base. However, this position is based on commissioner's normative perceptions of social prescribing, rather than robust evidence, as there is limited good quality research or evaluation to inform the commissioning of social prescribing services, and most of the available evidence tends to describe small scale pilots with insufficient detail to judge success or value for money (Booth and Wilson, 2015).

Operationalising and measuring the social value of social prescribing

The normative social value 'proposition' described above provided the rationale for commissioning the social prescribing pilot on which this paper is based. However, service commissioners recognised the need for robust evidence if the pilot was to become embedded in mainstream provision in the longer term.

"We want something robust to say this has stopped 200 people going into hospital".

As such, the pilot was independently evaluated with the express intention of identifying the range of social value created, utilising the principles of the blended value approach, with a focus on the following social and economic benefits:

- changes in the use of urgent and emergency hospital resources by patients referred to the pilot
- changes in the well-being of patients referred to the services
- any wider unintended changes for key stakeholders in the service

Despite commissioner's interest in three broad areas of social value, and although their investment in social prescribing didn't displace funding for core NHS providers, they were quite clear that one measure - the reduction in the use of urgent and emergency hospital resources - would be given primacy in decisions regarding the re-commissioning or mainstreaming of the service.

"From a commissioners point of view we're (still) interested in the big picture, which is, if we spend x on a project designed to reduce acute admissions, have we saved x on acute admissions".

As such, social value was operationalised through an evaluation methodology that provided them with sufficient evidence about the project's social value to make decisions about whether or not to extend their funding beyond the pilot period. Commissioners were kept up to date about the progress of the evaluation through an annual event where key progress measures were reviewed.

The study utilised a mix of quantitative and qualitative data from a range of sources: hospital episodes data on a sample of social prescribing patients' use of hospital care were used to evidence resource impacts; a pre/post well-being questionnaire completed by social prescribing patients was used in conjunction with a series of qualitative interviews with patients and their carers (n=17) to understand well-being benefits; and qualitative interviews with commissioners (n=7) and providers (n=20) involved with the pilot provided evidence of wider benefits. Participation in the interviews was on the basis on informed consent, with ethical approval provided by the University Ethics Committee in addition to local NHS Research Governance approval to undertake a 'service evaluation'.

The mixed-method multi-stakeholder approach enabled the evaluation to be framed within the blended value approach advocated by Emerson (2003) and Nicholls (2009) and produce a linked analysis of social and economic benefits rather than considering each separately or in opposition. Information about each method is provided in the following sections, with an overview of their contribution to the evidence about social value provided in table 1. Analysis of the types of social value is presented in the sections that follow.

<INSERT TABLE 1 AROUND HERE>

Changes in the use of hospital resources

For a cohort of 108 patients referred to the social prescribing service data was obtained from the NHS Data Management and Integration Centre (DMIC) on the number of inpatient stays, Accident and Emergency attendances, and outpatient appointments for the 12 month periods immediately prior to and following their first contact with the pilot. The sample included 42 patients who opted to take-up a social prescribing intervention with a pump-primed provider and 66 patients who did not. These two groups of patients were compared to provide an indication of the effect of taking-up a 'social prescription'.

The change in the number of hospital episodes for patients referred to social prescribing are presented in table 2. Data is presented for all patients referred to the social prescribing pilot alongside data for patients referred to pump-primed services and patients who did not take-up a pump-primed service for comparative purposes. A related samples Wilcoxon Signed Rank Test score is provided as an indication of statistical significance: the data violated the assumption of normality required for a dependent t-test but the distribution of the differences between the two time points was symmetrically shaped, enabling a series of Wilcoxon tests to be performed.

<INSERT TABLE 2 AROUND HERE>

The data demonstrates a reduction in the number of each type of hospital episode following referral to social prescribing:

- **Inpatient admissions:** there was an overall reduction of 21 per cent (0.30 per patient; $p>0.05$) in the number of admissions in the 12 month period following referral: patients referred to pump-primed services displayed a greater reduction (0.36 per patient; $p>0.05$) than those who did not take take-up a service (0.26 per patient; $p>0.05$) - a difference of 0.10 admissions per patient.
- **Accident and Emergency attendances:** there was an overall reduction of 20 per cent (0.39 per patient; $p>0.05$) in the number of attendances in the 12 month period following referral: patients referred to a pump-primed service displayed a greater reduction (0.52 per patient; $p>0.05$) than those who did not take take-up a service (0.30 per patient; $p>0.05$) - a difference of 0.22 attendances per patient.
- **Outpatient appointments:** there was an overall reduction of 21 per cent (0.36 per patient; $p>0.05$) in the number of appointments in the 12 month period following referral: patients referred to a pump-primed service displayed a greater reduction (0.55 per patient; $p>0.05$) than those who did not take take-up a service (0.24 per patient; $p>0.05$) - a difference of 0.31 appointments per patient.

Despite these changes the results of the Wilcoxon Signed Rank Test indicate that the reductions observed cannot be considered statistically significant at 95 per cent confidence interval ($p>0.05$ in all three cases). This is likely to be due to the relatively small size of the sample ($n=108$) and the scale of the reductions identified. As such, the evaluation did not provide clear evidence that commissioners' primary social value target - to reduce use of urgent and emergency hospital resources - was being met within the timescales of the pilot.

Changes in patient well-being

A cohort of 280 social prescribing patients completed an eight-item five-point scale well-being questionnaire at two points in time: at referral on their first contact with the pilot, and then four months later once they had engaged with pump-primed social prescribing services and were, in theory, expected to 'move on' to broader voluntary sector provision. The eight items covered by the questionnaire were developed to be indicative of an individual's ability to manage their long term condition more independently: feeling positive; lifestyle; looking after yourself; managing symptoms; work, volunteering and social groups; money; where you live; family and friends. Patients responded to a narrative description of each item with a score of between one and five (low to high) to describe how they felt 'today'.

The mean baseline and follow-up scores for each measure on the well-being questionnaire are presented in table 3. The change in the mean score and the proportion making positive progress between the baseline and follow-up measurements is also presented. Overall, 83 per cent of patients made progress on at least one outcome measure and each separate outcome measure demonstrated progress. In addition, the outcome measures with the lowest baseline scores exhibited the greatest amount of change: the mean score for 'work, volunteering and social groups' improved by 0.71 (2.52 to 3.23), with 49 per cent of patients

demonstrating progress; similarly the mean score for 'feeling positive' improved by 0.43 with 35 per cent of patients demonstrating progress.

<INSERT TABLE 3 AROUND HERE>

Analysis of outcome change for low-scoring patients provides an insight into the effectiveness of social prescribing at addressing patient's well-being in the areas where they exhibited most need. Tables 4-5 provide an overview of outcome change for patients who provided low-scores (two or less) in the baseline questionnaire. The mean baseline and follow-up scores for low-scoring patients for each measure is presented in table 4. The change in the mean score and the proportion making positive progress between the baseline and follow-up measurements is also presented. The proportion of patients providing a low score at baseline and follow-up stages is presented in table 5 along with a figure for the percentage point change and a McNemar test score to provide an indication of statistical significance.

<INSERT TABLES 4-5 AROUND HERE>

This demonstrates that compared to the full sample of patients, a greater degree of positive progress was exhibited against each outcome measure by low scoring patients and a higher proportion of low-scoring patients made positive progress. Similarly, for each outcome measure fewer patients provided a low score in the follow-up questionnaire than the baseline and the difference was statistically significant for seven of the eight measures. The only measure for which the change was not statistically significant was 'managing symptoms'.

The survey evidence indicates that social prescribing was effective at helping patients achieve an immediate boost in their well-being, something which was corroborated by the findings from qualitative interviews, which identified well-being as one of the most important and widely identified benefits of the Pilot. Service providers were particularly effusive about the wide ranging well-being benefits they felt beneficiaries experienced and some specific examples of these benefits were identified through the interviews with patients and carers. Improvements in mental well-being were particularly evident: Mrs A welcomed the opportunity to meet people and interact by attending a sensory arts group, and saw it as a "lifeline" in her battle with anxiety and depression:

"If it wasn't for the group, I might not be here now because I'd been that down and depressed....just getting out of the house has helped me with the fear, anxiety...talking to people lifts your mood and forget about problems at home".

Similarly, Mrs B felt that attending a variety of groups and activities funded through the Pilot had "got her out of her depression" and Mrs C reflected that the activity she attended "makes us feel worthy instead of worthless...feeling less depressed".

A further benefit linked to beneficiaries' well-being was a reduction in social isolation and loneliness. Service providers highlighted the importance of linking people with limited mobility and social contact with the wider community and this was also evident in the interviews with beneficiaries. For example, when she was referred Mrs C didn't expect to get anything out of Social Prescribing but has since realised that she now does not feel as

isolated and was *"just looking at four walls without the service"* and noted *"while you're here you don't think about your health conditions, you just get on with it"*. Similarly, Mrs F, who received re-abling and befriending support through the pilot, valued the additional high quality social contact it provided.

"It's someone coming to talk to me and with me and they acknowledge me...because you can sit and stare at space and people take no notice whatsoever...I feel like I belong to a society".

Increased independence was also identified by service providers and beneficiaries as an important benefit of Social Prescribing. In particular, those with limited mobility were able to become more independent as a result of improvements in their physical health. For example, Mr B had suffered a severe stroke three years ago, which affected his mobility and his speech, and was told his health may never improve. After being referred to social prescribing Mr B started going to a gym once a week, and participated in activities at the community centre on other days, including creative writing. Since receiving support through social prescribing Mr B had become more independent and positive.

"I was on my own, I was totally on my own...each day I'm getting better and better...before I could hardly walk...I'm feeling very positive, each day I get up and I just can't believe how much I've come on".

Similarly, Mrs G was referred to an exercise class and her mobility improved significantly. As a result she had *"regained some independence"*, and felt better physically and emotionally because she had *"something to look forward to"*. Without social prescribing, Mrs G believed she would withdraw within herself and become isolated again.

Wider social value benefits

In order to gain a broader perspective on the social value created by the social prescribing pilot the qualitative interviews explored how the social prescribing pilot had contributed to additional or unintended social or economic benefits from different stakeholder perspectives. Through these interviews it became clear that there was one important stakeholder group in receipt of benefits through the pilot who had not been considered by commissioners through their original conception of social value: the local voluntary and community sector, both organisations in receipt of pump-priming grants and the wider body of groups and organisations within the locality.

For many of the 24 voluntary and community sector organisations in receipt of pump-priming grants the pilot was the first time they had been in receipt of statutory health funding. As such, for the first time these organisations were able to demonstrate to commissioners their ability to contribute to local strategic health and well-being targets and outcomes. As one VCS provider explained *"previously, advocacy work (now being funded through social prescribing) was unpaid (unfunded)"* and the pump-priming grant had enabled them to expand the service and receive referrals from health professionals that had not been possible prior to the pilot. These organisations were also able to add considerable value to the social prescribing pilot by cross-referring patients to other services they provided or that were provided by partner organisations.

"(The organisation) also provides other services (that can be accessed)...a welfare advisor, who can provide benefit checks and other information for patients. We also have relationships with other organisations...so can take shortcuts in finding help for patients."

A further, unexpected benefit for a number of voluntary and community organisations, and by extension the local people they supported, was the ability to use social prescribing to attract additional income from other sources. Three voluntary and community organisations in receipt of pump-priming grants were able to secure additional grant funding as a result of their social prescribing work: one provider received £180,000 from the Big Lottery Fund (BLF), one received £10,000 from NHS England and another received £10,000 from Awards for All (BLF small grants fund). In addition, 11 pump-primed providers reported that social prescribing patients had accessed additional services through self-funding or by using their Direct Payments or Personal Budgets: the value of this additional income was at least £10,000 over the course of the pilot.

Beyond those voluntary and community organisations in receipt of pump-priming grants there were a number of examples of beneficiaries becoming involved in independent social and community action since accessing services pump-primed through the pilot. This includes patients becoming volunteers within the organisations they were referred to, establishing new peer and interest groups based on the principles of self-help and mutual aid, and accessing services in the wider voluntary and community sector that were not directly part of the social prescribing pilot. For these individuals social prescribing provided a necessary first step in their involvement in and engagement with wider voluntary and community activity.

Case study epilogue: onward commissioning of the social prescribing pilot

It is important to conclude discussion of the social prescribing case study with a note on what happened with the service upon conclusion of the pilot. In short, it was re-commissioned for a further three years with the same level of resource as part of the local health and social care integration programme. Although the evaluation was not able to evidence significant reductions in urgent and emergency hospital attendances commissioners viewed the findings as demonstrating a positive indication of effectiveness. Importantly, they were also swayed by the breadth of evidence available on the wider social value benefits of social prescribing; in particular the narrative qualitative accounts provided by patients and GPs on the wider impacts of the pilot.

"It was interesting that when the lead from the CCG was initially putting together the evidence on case management...he seemed a little sceptical about social prescribing but the overwhelming positive feedback from the GPs involved in the presentation convinced him to put a lot more emphasis in about it. GPs also spoke up in favour of social prescribing following our presentation at the Commissioning Event, which I think helped as well."

Conclusion

This paper has used a local level case study of a social prescribing pilot to demonstrate how the concept of social value can be operationalised for evaluation purposes in the context of socially innovative services commissioned by public sector bodies. This concluding section reflects on the case study evidence presented to consider the implications for evaluators and commissioners interested in understanding the social value of social innovation, and presents an argument for wider utilisation of blended value approaches to overcome the epistemological and methodological challenges involved.

The social prescribing case study highlights the central role commissioners play in determining what constitutes social value in the services they develop and procure. This role is enshrined in law through the Public Services (Social Value) Act and is likely to grow in importance as more public services are outsourced to the voluntary and community sector. The case study also demonstrates how commissioner's conceptions of social value can tend towards narrow, positivistic quantitative measures of change (Arvidson et al, 2013; Harlock, 2014) with an emphasis on resource utilisation that might lead to 'cashable' savings in the longer term. This is understandable in the context of severe public sector budget cuts (Taylor-Gooby, 2012) and the predominance of neoliberal led ideologies that prioritise reducing public sector costs and responsibilities (Eikenberry, 2009; Evans et al, 2005). However, the literature on social innovation and social value discussed at the beginning of this paper emphasises that social value is a complex multi-stakeholder phenomena and evaluation of it ought to reflect a plurality of stakeholder perspectives. The principle of incorporating multi-stakeholder perspectives in an understanding social value is encapsulated by the blended value approach embedded in the evaluation of the social prescribing pilot and the benefits identified as accruing to local voluntary and community organisations are a clear example of how a multi-stakeholder approach can unearth evidence that would have not have been identified if a narrow definition of social value had been adhered to.

Applying a mixture of qualitative and quantitative methods, as appropriate, is a further feature of the blended value approach and the case study has demonstrated how holistic evaluation into the multi-stakeholder social value benefits of social innovation can be undertaken in this way. Although the Hospital Episodes Statistics did not provide statistically significant evidence of a reduction in urgent and emergency care use the qualitative interviews with social prescribing patients provided a range of examples of how people's health and mental health improved following a social prescribing intervention. Similarly, the well-being survey findings were corroborated by examples from the qualitative interviews and provided reassurance that genuine and important well-being improvements had occurred whilst the evidence about the benefits accruing to local voluntary and community organisations would not have been surfaced without the use of qualitative research. It was this broader blended value evidence base that convinced commissioners to continue funding the pilot rather than a single social value benefit for a narrowly defined stakeholder group.

In moving away from a zero-sum understanding of the social value of the social prescribing pilot based on evidence of an immediate reduction in urgent and emergency care use the commissioners demonstrated a step-change in their epistemological understanding and expectations of social value. Their incorporation of a broader range of blended value evidence into their social value 'equation' signified a realisation that socially innovative

projects can be positively or adversely affected by strengths or limitations in other parts of the support system that a particular target group needs for a positive outcome to occur (Pawson, 2002). Similarly, they recognised that direct attribution of an outcome to a specific intervention is not always possible when its effect could be due to other services or an improvement in the wider environment (such as the economy) (McHugh et al, 2013). In fact, Hall (2002) reminds us that the underlying causes of outcomes are rarely known to policy managers and Bovaird (2014) argues that over many years cause-and-effect analysis in policy development making has been inconsistently applied and poorly understood. In this context it is important for commissioners to utilise a range of evidence from a variety of sources when operationalising and measuring social value.

The social prescribing case study provides an example of the underlying dual purpose to the measurement and communication of social value: although demonstrating progress against a series of social value aims and objectives is important, particularly in the context of public service commissioning, social value evidence also serves as an important communicative and discursive device. Throughout the social prescribing pilot commissioners and service providers maintained a regular dialogue regarding progress towards agreed social value objectives. This process enabled the blended value evidence to be introduced and raised commissioners' awareness of the wider benefits of the services they had funded. The ongoing dialogue about social value created a situation in which commissioners were able to make an epistemological step-change in their understanding of what counts as 'valid' evidence and be convinced of the importance of including qualitative evidence in combination with quantitative evidence in their social value equation. By assigning equal weight to the different types of evidence collected commissioners developed a broader understanding of the social value created through the pilot that would not have been possible if the initial narrow definition of social value had been adhered to. Commissioners of socially innovative public services are therefore recommended to apply a blended value approach to social value evaluation if they are to develop a full and rounded understanding of the social and economic benefits of the interventions being delivered.

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Tables and Figures

Table 1: Overview of social value methodology

	Type of Social Value Benefit		
	<i>Hospital Resources</i>	<i>Well-being</i>	<i>Wider/Unintended</i>
Hospital episodes data	x		
Well-being questionnaire		x	x
Qualitative interviews		x	x

Table 2: Change in number of hospital inpatient admissions

	All patients referred to Social Prescribing					
	Average (mean) number of episodes			% change	Wilcoxon Test Score (p value)	Base
	<i>12m before</i>	<i>12m after</i>	<i>Change</i>			
Non-elective inpatient admissions:						
All patients referred to Social Prescribing	1.46	1.17	-0.30	-20.5	0.229	108
Patients referred to pump primed services	1.45	1.10	-0.36	-24.8	0.155	42
Patients who did not take-up a pump primed service	1.47	1.21	-0.26	-17.5	0.607	66
A and E attendances:						
All patients referred to Social Prescribing	1.94	1.56	-0.39	-20.1	0.169	108
Patients referred to pump primed services	2.19	1.67	-0.52	-23.7	0.088	42
Patients who did not take-up a pump primed service	1.79	1.48	-0.30	-16.9	0.768	66
Outpatient appointments:						
All patients referred to Social Prescribing	1.70	1.34	-0.36	-21.2	0.079	108
Patients referred to pump primed services	1.90	1.36	-0.55	-28.9	0.203	42
Patients who did not take-up a pump primed service	1.58	1.33	-0.24	-15.4	0.229	66

Base: 108 patients referred to social prescribing pilot

Note that the figures presented will not always sum precisely due to rounding

Table 3: Change in well-being outcome measures

Outcome area	Mean baseline score	Mean follow-up score	Change in mean score	Positive progress made	
				<i>n</i>	<i>Per cent</i>
Feeling positive	3.21	3.63	0.43	97	35
Lifestyle	3.58	3.84	0.26	69	25
Looking after yourself	3.69	3.94	0.24	68	24
Managing symptoms	3.52	3.66	0.14	60	21
Work, volunteering and social groups	2.52	3.23	0.71	136	49
Money	4.13	4.43	0.31	59	21
Where you live	4.15	4.45	0.31	57	20
Family and friends	3.55	3.87	0.31	76	27

Base: 280 patients referred to pump primed social prescribing services

Note that the figures presented will not always sum precisely due to rounding

Table 4: Change in health and well-being outcome measures for low scoring respondents (mean)

	Base	Mean baseline score	Mean follow-up score	Change in mean score	Positive progress made	
					<i>n</i>	<i>Per cent</i>
Feeling positive	70	1.71	2.77	1.06	43	61
Lifestyle	45	1.67	2.69	1.02	29	64
Looking after yourself	35	1.66	2.74	1.09	21	60
Managing symptoms	44	1.68	2.70	1.02	25	57
Work, volunteering and social groups	119	1.55	2.70	1.15	64	54
Money	25	1.68	3.33	1.65	19	76
Where you live	18	1.56	3.41	1.86	14	78
Family and friends	35	1.66	2.94	1.29	24	69

Base: Patients referred to pump primed social prescribing services with low baseline scores (2 or less).
 Note that the figures presented will not always sum precisely due to rounding

Table 5: Change in health and well-being outcome measures: percentage of respondents recording low scores at the baseline and follow-up questionnaires

	Low scores: Baseline		Low scores: Follow-up		Change in low scores	McNemar
	<i>n</i>	<i>Per cent</i>	<i>N</i>	<i>Per cent</i>	<i>Percentage points</i>	<i>Sig</i>
Feeling positive	70	25	36	13	-12	p<0.001
Lifestyle	45	16	29	10	-6	p<0.01
Looking after yourself	35	13	20	7	-5	p<0.01
Managing symptoms	44	16	35	13	-3	p>0.05
Work, volunteering and social groups	119	43	68	24	-18	p<0.001
Money	25	9	7	3	-6	p<0.001
Where you live	18	6	4	1	-5	p<0.01
Family and friends	35	13	20	7	-5	p<0.01

Base: 280 patients referred to pump primed social prescribing services
 Note that the figures presented will not always sum precisely due to rounding