Economic Evidence for the Community and Voluntary Health Sector in Scotland – What are the questions we still need answered?

A report of a roundtable discussion and background information

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The opinions expressed in this publication are those of the participants in this discussion and do not necessarily reflect those of NHS Health Scotland.

Lizanne Conway
NHS Health Scotland
June 2010

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1.1 Background

Participants at the NHS Health Scotland Conference, 'Healthier Lives, Wealthier Communities?'[1], called for more support to help demystify economic evidence as applied to the community and voluntary health sector. As one delegate commented, the 2009 conference was a 'good start to a complex subject', but not an end in itself.

Indeed, as this report will demonstrate, the conference was neither the start nor intended end point of activity to help better inform the sector's awareness and understanding of economic evidence in relation to health improvement. From the appropriate use of economic evidence initially appearing within the recommendations made to Scottish Government by the Community-Led: Supporting and Developing Healthy Communities Task Group in 2006, and the consequent scoping paper, roundtable discussion, action research and action plan produced by NHS Health Scotland and the Community Health Exchange in 2008 (Appendix 1), to the still ongoing Scottish Government's Social Return on Investment Project[2], economic tools to help measure the impact of organisations are becoming increasingly talked about and practiced across the Third Sector in Scotland.

However, despite this increase in awareness and opportunity to deepen understanding of economic evidence, feedback from the 'Healthier Lives, Wealthier Communities?' conference, suggested that sometimes the most fundamental questions about economic evidence are still not fully understood within and out with the sector.

As a result, a small working group made up of staff from NHS Health Scotland, the Community Health Exchange (CHEX), the University of Glasgow's Department of Public Health and Health Policy, Community Food and Health (Scotland) and Voluntary Health Scotland (VHS), organised a roundtable discussion on 20 April 2010 with the purpose of collecting the questions, which invited representatives from the community and voluntary health sector wanted to ask about economic evidence. This report describes the process of arriving at these questions, which will shortly be answered in the form of a briefing paper for

[1] To find out more about this conference and related case studies and activity, please visit http://www.healthscotland.com/topics/settings/community-voluntary.aspx#economicEvidence

[2] For more information, visit: http://www.sroiproject.org.uk/

the sector. For those who would like to know more about what preceded this roundtable discussion, appendix 1 of this paper gives some background information about past activities, which have helped shape and inform progress made to date on this complex agenda.

1.2 Planned Outcomes

The working group identified the following outcomes for the roundtable discussion.

To have:

- Increased understanding of the challenges and promoters experienced when compiling and using economic evidence
- Increased understanding of the problems affecting the compilation of economic evidence
- Identified and generally agreed key questions to be addressed in the planned economic evidence briefing paper.
- Given an opportunity to strengthen the voice of the community and voluntary health sector in Scotland on the theme of economic evidence

At the beginning of the event, these outcomes were shared with the roundtable's 13 participants, of which a full list is contained in Annexe 1. Feedback from the evaluation at the end of the day indicated that most of the discussion's planned outcomes were all or partly met for participants. For more information about the roundtable's evaluation, please see Annexe 2.

1.3 Part one – Where are we at now?

During the first half of the event, some valuable insights were shared between participants to kick start the roundtable discussion, even although amusingly there was no roundtable in sight! The purpose of this session was to get a sense of where participants were currently at with collecting and using economic evidence within their own organisations. It should be noted that participants were all invited to this event due to a previous connection to economic evidence activity or learning, such as having been a case study[3] or having attended the 'Healthier Lives, Wealthier Communities?' conference. Participants, for the most part, were therefore not coming 'cold' to the topic.

[3] In addition to the three NHS Health Scotland case studies, Community Food and Health (Scotland) has also produced two case studies highlighting the economic value of community food and health activity: http://www.communityfoodandhealth.org.uk/plugins/publications/

To maximise discussion, participants were randomly divided into three small groups – aptly named pounds, shillings and pence. It was immediately clear from the group discussions that all participants had a strong interest in collecting and using economic evidence, though most participants modestly likened their experience as having only 'dipped their toe in the water'.

Despite most participants having some experience of economic evidence activity already, the majority were still trying to unpack what economic evidence means in relation to their organisation - what it is, what it is not, and what can it help them achieve. Some questioned if it was another form of evaluation or an evaluation tool. Some asked would it be of real value, especially when funders so far do not seem to be requesting it. All participants wanted to be more able to effectively communicate to funders and commissioners the impact of their organisation's work using economic evidence alongside other evidence, particularly existing qualitative methods. They therefore all valued the idea of the planned briefing paper and were enthusiastic to contribute to setting the questions.

In each small group, an experienced community health practitioner in economic evidence methods kicked off the discussion by sharing their story so far. The following paragraphs describe some of the key discussions, which took place in the pounds, shillings and pence groups.

All groups were asked to loosely consider these questions to guide their facilitated discussion:

Are you already collecting economic evidence?
If so, how are you going about this? Have you had support?
How are you using the information collected, or how are you planning to use it? Have your funders been involved?
If you are not already doing so, would you like to collect and use economic evidence?
What would help you do this?
What barriers have you experienced along the way?

1.4 Small Group - Pounds

Julie Fox, Manager of the Annexe Healthy Living Centre for the west of Glasgow, shared her developed understanding and more recent practical experience of collecting economic evidence from a Social Return on Investment (SROI) perspective. Julie had only recently completed a 6 week training course on SROI funded by Community Planning Glasgow, and is now undertaking an SROI for her organisation. Her interest in the area pre-dates this training though as Julie was involved in the early phase of Health Scotland's activity on economic evidence following the launch of the Community-Led Task Group's recommendations in 2006.

Julie considers SROI to be one approach, but not the only approach. However, as SROI was a funded course, it so far is the most attractive option for her organisation to pursue. Organisational time and capacity to undertake an SROI were noted by Julie as considerations, but having an established outcome focused evaluation system in place, made undertaking the SROI process far less complex. She believes that if full cost recovery is to be achieved by the voluntary sector, then time and resource needs to be prioritised for economic evidence collection and funders should be made more aware of this.

SROI has highlighted the weaknesses in the organisation's own internal systems, and what can be improved, and has been an opportunity as a manager to actually speak with project users or stakeholders in a way that pressures of work seldom allow. All in all, SROI for the Annexe has been a positive experience to date.

All members of this group were involved (actively or in the past) with SROI due to funding and training availability. No other method of economic evidence collection was being used, and no other methods were known to them – however, they would welcome more information on the range of alternative methods available. One delegate had attended the Scottish Government funded training on SROI, and another delegate, like Julie, had undertaken separate local training which was funded by their funding organisation. In all instances, the demand for the training had been greater than places would allow.

While the participant from Evaluation Support Scotland reported only receiving 6 formal approaches for support for SROI from organisations across Scotland to date, informally organisations seem to be saying to them that they are scared not to be on board with SROI since Government is giving it such a big push as the 'gold standard'. Added to this, the group felt that SROI was the only method which they could afford to do internally by themselves. Indeed, as they were still not clear what other methods would involve, they were concerned that alternatives might be more costly and require external expert input, which would be unaffordable from existing budgets.

In relation to support, this small group had accessed the Scottish Government training and considered the Cabinet Office publication to be the most comprehensive guide to SROI – for some group members, the endorsement of the Cabinet Office represented a publication they would trust. Some of the group, in addition to accessing Scottish Government support, had accessed local training, but all said ongoing local and national peer support would be crucial to ongoing success – they were not sure if this was on offer. Sheila Drury from Fourth Sector had personally been a source of support to some of the group and this tailored expertise was valued.

In terms of how the group members planned to use the material generated by the SROI process, some expressed concern about the subjective nature of the material due to financial proxies, and how some organisations could skew findings and questioned how could this be prevented, or independently checked. Without appropriate training for funders either, one group member voiced that there could also be a temptation for funders to look only at the end figure rather than all the evidence underpinning how that figure had been arrived at by an organisation.

For the most part, group members were already benefiting from the SROI process, rather than the end point. Like Julie Fox's experience, the group recognised how SROI was also helping them to improve information collection and undertake outcome focused evaluation processes. They felt that if their SROI process had been undertaken by independent consultants, this learning perhaps would not have taken place, and the positive changes to practice not applied as a result. In this sense, they saw SROI as not really an end in itself, but a valuable learning process for organisations to take forward.

Some practical applications of the SROI process to date included one group member using it to highlight the value of community gardens from a quantitative perspective to complement existing qualitative evidence.

No one had experienced funders requesting economic evidence as yet. The Big Lottery's Funders Forum, which Evaluation Support Scotland is supporting, was reported as only beginning to get fully outcome focused, which is the first step before moving towards understanding economic evidence. The group agreed that it was useful to get a head start before funders began to request economic evidence, but would want them to actually provide practical and financial support for economic evidence collection if and when they do begin to request it at a future point.

1.5 Small Group - Shillings

Group 2 enjoyed a very useful input from Ed Garrett, the Manager of the Mearns and Coastal Healthy Living Network in Aberdeenshire. This healthy living organisation has been using SROI for 1 to 2 years. Ed emphasised that once systems are in place, it is a relatively straight forward method to maintain, analyse and present data. He stressed that it was especially important to use a bank of appropriate financial proxies, and time should be taken to clearly establish what these should be and how they should be evidenced.

Ed stressed that organisations should not attempt to use SROI to evaluate all of their activities. Instead a few activities should be selected and prioritised. In his experience, using SROI in this way has helped his organisation evaluate and articulate its overall social impact.

To conclude, Ed emphasised the need to get 'buy-in' from key stakeholders (service users, management, funders, and certain local partners), and for them to get active in the process. Like in the previous small group, he emphasised the benefits from having received support from the Scottish Government programme for implementing SROI and recommended that local networks should be established for practice exchange and support to individual practitioners.

General group discussion then followed around a number of topics including the:

- tension and demands for one organisation to produce evaluations for 9 different funders on a quarterly basis
- high expectations from funders on small to medium sized organisations to produce evaluations
- move from grants to business models
- use of outcome focussed planning in demonstrating impact
- need for dedicated time and capacity building to support compiling and using economic evidence
- example of calculating a unit cost in reference to a specific health improvement activity in Dundee
- application of economic evidence in comparison with evidence from other health interventions

The key points from the discussion were usefully recorded by the group into two categories: 'concerns' and 'benefits'.

1.5.1 Economic Evidence Concerns

- monetary value could be valued higher than social value
- limited available resources to help with implementation – what will happen when the Scottish Government support programme finishes?
- application of economic evidence in comparison with other evidence from other health interventions – so risk of not comparing like with like
- community and voluntary sector already undertaking extensive evaluation of their work – how could the gathering of economic evidence dovetail into and complement existing evaluations?
- limited opportunities for training and capacity building
- culture of different jargon and communication emerging in relation to economic evidence – how does everyone keep up?
- will funders be ready to receive economic evidence from community and voluntary health sector organisations – how will they interpret it and apply it in their decision-making together with other forms of evidence?

1.5.2 Economic Evidence Benefits

- it can bring a tangible dimension to evaluation that will appeal to decision-makers, especially politicians
- it is not just about monetary value – it is about social value too; the trick is to show the added monetary value from the social value
- SROI and other models fit in well with outcome focussed planning and demonstrating impact within Single Outcome Agreements
- the qualitative and quantitative evidence tells you something new which can be used in the implementation of work programmes and used to redefine and redirect
- it provides a strong evidence base to enable an organisation to talk with confidence to partners, the wider community, and decision-makers etc.
- despite perceived difficulties in compiling and using economic evidence within the Third Sector, provision of evidence has come a long way over the last 2-3 years.
- benefit in having a standardised economic evidence framework for all partners (Third Sector and Public Sector). It would need to be widely accepted, flexible, and simple to use and embrace several models.
- if done well, economic evidence will help show impact on stated outcomes

1.6 Small Group- Pence

Ian Shankland kick started the discussion with a short account of the work he had been involved in at Lanarkshire Community Food and Health Partnership. This included how information had been gathered 'simply' and how information had been used internally to ensure resources are targeted most appropriately.

Ian discussed how he has shared this information with funders even though he never has been asked to provide this type of information or has had any feedback about it. He did note that this was not just an issue for economic evidence, but was a wider issue for all evaluation material in general.

The group's main discussion points were as follows:

1.6.1 Health outcomes: the group discussed the need to evidence health outcomes as well as provide economic evidence. Although data gathered can often be used for multiple purposes, this is not always straight forward and dependent on systems which are in place. Demonstrating health outcomes is a priority when considering requests for reporting.

1.6.2 What is the point? As groups are not currently being asked to report with economic evidence, the investment of capacity and resources to gather/analyse/present economic evidence was questioned. This was, however, counterbalanced with the view that funders may ask for this information in the future and being ahead of the curve was to the sector's advantage. In addition, like the other groups, this group recognised that collecting economic evidence was useful for internal use. There were also queries around SROI - what is the future for the support provided for SROI? Is the intention that this will lead to all funders requesting SROI information? Why are no other sectors undertaking SROI work?

1.6.3 Proportionality: it was felt that in some respects the community and voluntary sector are already ahead of game in terms of evaluation as well as economic evidence. Expectations for evaluation and carrying out evaluation needs to be in proportion to the capacity of small organisations as well as the amount of funding they receive. It was reflected that community and voluntary organisations do not exist to evaluate – working with and within communities is always the sector's priority.

1.6.4 Co-ordination of economic evidence: a central place for economic evidence to be stored was strongly suggested by this group so that organisations can learn from the work of others and so that organisations were not continually 'reinventing the wheel'. There was mention of the Scottish Government SROI portal, which will contain a database of SROI reports. However, the group felt there would be more value in having a collection of results/reports from a range

of different approaches for economic evidence, not just SROI. Participants also thought there would be value in having an identified co-ordinator who would not only work to share information and learning, but would also have the expertise to provide support and to mentor groups who are working with economic evidence.

1.6.5 Case studies: case studies were felt to be a very valuable way of sharing experiences and learn from the work of other organisations. Examples of how economic evidence is gathered would be useful for others, as well as sharing successes and challenges.

1.6.7 What do we mean by economic evidence? There were queries around the difference between 'hard' economic evidence and 'socio economic' evidence, which organisations might be gathering. The issue of valuing time was considered and the different ways that this could be done. However, it was recognised that there is no 'one size fits all approach' and that the way time could be valued would be very dependent on the circumstances of individual organisations. One organisation had recorded benefit in kind and another in this group had valued time based on minimum wage. There was discussion around the most robust way to value time and the opportunities/challenges for this to happen within the sector.

1.6.8 Resources/capacity: One participant in this group had been on the Scottish Government SROI training, which had been very useful and had increased the skills and confidence of their organisation to start working with SROI (for certain aspects of their work, not all). More training and guidance would be welcomed for all economic evidence activity.

1.6.9 Accessibility: there was a lot of discussion around language and how this is not consistent. Not only was it highlighted that funders/commissioners and community and voluntary organisations need to be speaking the same language, but it was also highlighted that different funders all need to be speaking the same language. The role of the Scottish Funders Forum in this was queried. In addition to this, there was a similar concern shared by the other groups about the different ways that different funders could interpret economic evidence and compare organisations, even though not like for like.

1.6.10 Politics: there was recognition of current political drivers, namely the Scottish Government's overall national objective of 'sustainable economic growth'. The group felt that this was influencing the work which is currently happening around SROI. What would happen if political will and motivations were to change, would this influence the current drive from Scottish Government to collect and use economic evidence to help measure impact in the Third Sector?

1.6.11 Wider evaluation issues: As promoted by the Scottish Government**,** the value of good quality qualitative evidence to support and complement any

economic evidence was stressed by the Pence Group. Members were concerned that if the sector was to focus on numbers alone it would not fully convey the wider added value of community and voluntary health sector organisations

1.7 Part two - What do we still want to know?

The second part of the roundtable discussion focused on the questions, which the group felt still remained unanswered about collecting and using economic evidence. The working group has since started to cluster the questions so that the briefing paper, which will shortly follow, will answer as many of these questions as possible. The expertise of Dr Liz Fenwick, a health economist and also a working group member, will guide the responses to each of the briefing paper's identified questions to ensure accuracy and clarity.

To ensure we share back to participants all the questions that were generated during the large group discussion, we have for the purposes of this report divided them into three categories for easier reading:

1.7.1 **What** - the theory and the evidence

- What do we mean by economic evidence? How can we bust the jargon?
- Does it differ from economic evaluation?
- What can economic evidence help us achieve? What can it not do?
- What are the different methods of collecting economic evidence?
- How can we differentiate between these methods or models, particularly the Scottish Government endorsed SROI method? What is the evidence behind each of them?
- Internationally and across the UK more generally, is there promotion and uptake of economic evidence – if so, what good practice exists?

1.7.2 **How –** doing it in practice

- Before attempting to collect economic evidence, what mechanisms, systems and processes first need to be in place within your organisation (for example, outcome focused evaluation processes)?
- How do you decide which model to select based on our own organisation's needs, scale, resources, interests and skills? (Flow diagram)
- What resource, skills, time, training is required to undertake the collection and analysis of economic evidence? What support is available?
- Can different approaches be used together?

- How do these models relate to other frameworks and priorities (for example, outcomes approaches, Health Impact Assessment, Equality Impact Assessment)
- What sort of economic evidence could be used within funding bids and tenders?
- How can we use economic evidence to complement other forms of evidence?
- How can you compare the outcomes from difference economic evaluations – is it like comparing apples and pears?

1.7.3 Why – the drivers behind it

- If funders are not looking for economic evidence, is there really any point dedicating time and resource for this purpose?
- Would organisations lose out of they chose not to demonstrate their impact using economic evidence?
- What are the expectations of Scottish Government's different Directorates around economic evidence and the Third Sector? How will they use / take forward / advocate the impact of economic evidence generated by Scotland's Third Sector over the coming years? Will other sectors be expected to produce similar evidence of impact?
- What work is being undertaken to ensure funders and commissioner, particularly within Community Planning Partnerships are 'on the page' with economic evidence?
- Why is SROI the gold standard? Is it always the best option, and if not, what else?

1.8 Conclusions

After questions were generated and recorded, the event came to a conclusion. If time had not been an issue, lots more discussion between participants could have continued based on the energy in the room. For the working group, this highlighted just how much interest as well as concern there is about this topic. All participants were offered the opportunity to continue to be involved in the process of commenting on the briefing paper as it develops via email from NHS Health Scotland. Since the event, the working group has begun the process of further refining and answering questions for the purposes of the briefing paper, which will hopefully be available by late summer.

While not an exact list, in summary, the awaited briefing paper will address the following types of key questions and issues as identified as a result of this roundtable discussion event:

- National/international methods shown to be of value in general and to the sector in particular?
- What do we mean by economic evidence?
- How to reconcile one single/standardised approach versus different appropriate options for different organisations?
- Strengths and weaknesses of each model?
- Which model suits which situations?
- What resources/skills are required for each model?
- Flowchart to determine appropriate model for each situation/organisation
- What can you expect to show funders following collection of economic evidence?
- What is specific to economic evidence rather than simply evidence?
- What are funders used to seeing?
- How can SROI fit into what funders are used to seeing?
- What is the theory behind different models?
- Why SROI?
- How is SROI used internationally? Nationally?
- What are the implications of not taking an SROI approach?
- What are the implications of providing/not providing economic evidence?
- How does provision of economic evidence fit with other health impact assessment already undertaken?
- What is the gold standard approach?

For more information about the developing briefing paper, please contact Lizanne Conway (Lizanne.conway@nhs.net) in the first instance.

Annexe 1: Participants on 20 April, 2010.

	Name	Surname	Job Title	Organisation	E-mail
Ms	Julie	Fox	Manager	The Annexe Healthy Living Centre	julie.fox@theannexehlc.org.uk
Ms	Lyndsay	Macadam	Development/Capacity Building Officer	CVS Fife	lyndsay.macadam@cvsfife.org
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Ms	Sheila	Duffy	Chief Executive	Ash Scotland	Sduffy@ashscotland.org.uk
Ms	Beverley	Black	Manager	Dundee Healthy Living Initiative	beverley.black@nhs.net
Mr	Ian	Shankland	Manager	Lanarkshire Community Food and Health Partnership	ian.shankland@btopenworld.com
Mr	Ed	Garret	Project Manager	Mearns and Coastal Healthy Living Network	mhln@care4free.net
Ms	Amanda	McGonigal	Volunteer Management Committee Member	Westquarter and Redding Community Health Project	(c/o) Johnl.burt@falkirk.gov.uk
Ms	Sylvia	Bradely	Volunteer Management Committee Member	Westquarter and Redding Community Health Project	(c/o) Johnl.burt@falkirk.gov.uk
Mr	Iain	Stewart	Chief Executive	Edinburgh Community Food Initiative	istewart@ecfi.org.uk
Ms	Jessica	Lindhof		Paths For All Partnership	jessica.lindohf@pathsforall.org.uk
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Dr	Liz	Fenwick	Health Economist	University of Glasgow	e.fenwick@clinmed.gla.ac.uk

Annexe 2: Evaluation Feedback (From eleven returned forms)

1. Please indicate if you think the following outcomes were achieved from the Discussion

Expected Outcomes	Yes	Partly	No
Increased understanding of economic evidence being compiled and used by community and voluntary health improvement organisations	4	7	1
Increased understanding of problems affecting compilation of evidence	9	2	1
Identification and general agreement of questions to be addressed in Briefing	11	-	-
Provided me with an opportunity to become more involved either locally or nationally in strengthening the sector's voice	6	6	-

One participant commented that although we used the term economic evidence in our first question we didn't really talk about any alternatives to SROI.

2. What was the most useful part of the Discussion and why?

- exploratory discussion in the morning – gave me a good picture of use of SROI in voluntary health and other people's experiences.
- Small group discussions – more opportunity for in depth discussions and sharing of ideas
- Small groups – experience in group
- Hearing about how other projects are working
- Getting a better handle on place of SROI in wider landscape
- Questions identification session with whole group
- Learning about what Economic Evidence is and making it a bit clearer!
- All useful
- Learning from people who have used SROI
- Group discussions interesting and useful to hear different experiences and points of view
- Good to hear other opinions and difficulties. Went beyond SROI which is very welcome.
- Workshop/ discussion session. Discussion with peers on a common, topical issue. This exposed some significant issues to be addressed.

3. What was the least useful part of the Discussion and why?

- Large group work on questions – only a few people contributed (I was one!), small groups might have encouraged more contribution
- Nothing
- Summing up of small group work as it didn't reflect the discussion
- All useful
- It was all useful

4. Please describe any key learning points you have taken from the Discussion

- SROI is being marketed and people are buying it. There is a disconnect between outcomes, evaluation, economic evidence, quality and impact tools.
- The future importance of economic Evidence.
- How far has the "top down" approach gone
- Clearer understanding of lack of joining up in Government departments and with regional (CPP) structures
- Improving knowledge about economic evidence why we use it.
- Interesting to see that "we" are not the only one hesitant about SROI – value of dialogue with peers. Greater understanding of key issues.

5. If relevant, please describe one new action that you will take away from the Discussion and implement within your organisation or agency?

- look at our own advice/guidance on Economic Evidence – this was a very useful meeting.
- I will wait to see the outcome for the organisations that have used SROI.
- Learn more about SROI
- Will continue to feed back on briefing paper
- Look at the range of Evidence – Evaluation / SROI etc required and develop our flowchart for organisation
- Has helped me to go and finish my SROI analysis! When the briefing is ready I'll certainly available to my members.
- Stay engaged with this process. Think wider than SROI!

6. Any other comments?

- Good Session
- Well worth having, thanks
- Excellent location, good food. Really pleased that the event happened as a result of feedback from September 09 event – makes it worth filling out these forms! – Think you should produce 2 briefings one for voluntary groups, but one for funders / public sector commissioners.
- Good session very good to air issues around evaluation 7 SROI / economic evidence
- Thank you for organising the event and I (Paths for All) would like to stay involved in the process.

Annexe 3: Further Information

Scottish Government Social Return on Investment Project Website, which includes case studies, a proxy database and useful information about how to undertake SROI: http://www.sroiproject.org.uk/

Existing activity undertaken on economic evidence for community and voluntary sector health organisations by NHS Health Scotland and partners, including three economic evidence case studies and an overview of the 2009 national conference on this theme: http://www.healthscotland.com/topics/settings/community-voluntary.aspx#economicEvidence

Community Food and Health (Scotland) has also commissioned two case studies to help highlight the economic value of community food and health activity: http://www.communityfoodandhealth.org.uk/plugins/publications/ The first is an economic evaluation of Happy Jack, and was commissioned by Community Food and Health (Scotland) in partnership with Edinburgh Community Food and the City of Edinburgh Council. The second report is an evaluation of the Food Train (Dumfries and Galloway) in terms of its economic value.

"What makes a Good Report for Funders – Guidance from the Scotland Funders' Forum". The Funders' Forum has recently issued a checklist that seeks to make reporting more effective and less burdensome for all parties. It's brief, practical and helpful and can be accessed via the Community Health Exchange website: http://www.chex.org.uk/news-index/news-index/235/

***A glass half-full* aims to show how an asset approach can improve community health and well-being. It was commissioned by the Improvement and Development Agency's Healthy Communities Programme in England, which aims to help local government improve the health of local communities. While not immediately about economic evidence, it is a useful complimentary approach: http://www.idea.gov.uk/idk/aio/18410498**

***Measuring What Matters* – A conference report of the Community Development Alliance Scotland in conjunction with the International Association for Community Development and the Scottish Community Development Centre, Dundee City Council and Carnegie UK: http://www.communitydevelopmentalliancescotland.org/documents/seminars/MWM%20Conference%20Final%20Report.pdf**

Wider reading

Making the most of it: Economic evaluation in the social welfare field. Sefton T, Byford S, McDaid D, Hills J, Knapp M. Joseph Rowntree Foundation, 2002. Practical introduction to the main types of economic evaluation with illustrative examples from the social welfare field. Discusses the particular challenges that need to be overcome in applying economic evaluation in this area.
http://www.jrf.org.uk/publications/making-most-it-economic-evaluation-social-welfare-field

Because it's worth it: A practical guide to conducting economic evaluations in the social welfare field. Byford S, McDaid D, Sefton T. Institute of Psychiatry/Joseph Rowntree Foundation, 2003. A practical, but not exhaustive, guide to economic evaluation in the social welfare field. Explains and illustrates the uses of the main types of economic evaluation, with examples from the social welfare field.
http://www.jrf.org.uk/publications/because-its-worth-it-practical-guide-conducting-economic-evaluations-social-welfare-fie

Economic Appraisal of Public health interventions. Published by the NHS Health Development Agency (2005) with a good reference list.
http://www.fcrss.ca/kte_docs/Economic_appraisal_of_public_health_interventions%5B2%5D.pdf

Methods for the economic evaluation of health care programmes, 3rd ed, M E Drummond, M J Sculpher, G W Torrance GW, O'Brien B, Stoddart GL. Oxford University Press, 2005. This is a detailed text most relevant for those designing or interpreting an economic evaluation in detail.

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Appendix 1: Background Activity Papers

As was highlighted in the report's introduction, this roundtable discussion has been informed by a range of processes and prior activities, including work that took place in 2008 by NHS Health Scotland in partnership with CHEX in response to the recommendations of the Community-Led Task Group. The following two papers give some useful background to this earlier thinking, which has helped shape where we are today with this agenda.

The first document is a scoping paper, which includes a comprehensive review of the literature at the time of production. This paper was later used to inform a roundtable discussion, which we held on this topic in March 2008.

Paper 2 details what was discussed at this 2008 Roundtable. In addition, Health Scotland afterwards commissioned further action research into this area together with the production of an action plan. This was undertaken by the consultant Duncan Wallace in summer 2008. A copy of this work can be accessed via: http://www.healthscotland.com/uploads/documents/9062-Communityled%20health%20action%20plan%20and%20research%20findings%20October%202008.pdf

It was this action plan, which led to the commissioning of the three case studies and the organisation of the 2009 conference, 'Healthier lives, Wealthier communities?'.

Paper 1: Community-Led Health – value for money?

A scoping paper, February 2008

Authors: Dr Emma Halliday, (formerly) NHS Health Scotland and Janet Muir, CHEX

Introduction and background

Context of the Healthy Communities Task Group recommendations

The publication of 'Healthy Communities: A Shared Challenge'[4], set out twelve interconnected recommendations that provide a framework to take forward the Government's ongoing commitment to involving communities actively in health improvement.

They do this by proposing the development of more robust evidence to show what actions are most effective and the outcomes that can be achieved as a result of sustained investment in community-led health. They also recommend the actions that need to be taken to strengthen the capacity and capability of communities to shape the agenda of local planning partnerships and to be involved in delivering their own solutions for lasting and meaningful health improvement for all.

Building the evidence base

The first two recommendations are focused on building an evidence base for community led health. These recommendations are primarily concerned with improving the ability of funders and projects to measure the impact of community-led approaches and achieve a better balance between accountability, meeting targets and gathering robust data for a 'good enough' evidence informed approach. Within this context, economic information is understood to be an important piece of this evidence 'jigsaw'.

It is also useful to understand the broader context to this work. The new government in Scotland has championed an outcome-focussed approach to national and local public services. This is important as it provides further opportunity to support a greater focus on outcomes and evaluation for health improvement.[5] This makes it important for community led approaches to be able

[4] By the Community-led: Supporting and Developing Healthy Communities Task Group (December 2006)

[5] Emma Halliday NHS Health Scotland and Steven Marwick, *Evaluation and monitoring in community led health. What are the challenges and how do we solve them? A practical briefing and guidance paper.* Health Scotland website.

to demonstrate the value that its outcomes contribute to health improvement priorities in Scotland.

What is meant by community led heath?

Before embarking on the rest of this paper, an understanding of a community led approach to health improvement is set out.

Box 1: Except from J Dailly and A Barr (2008) *Understanding a Community Led Approach to Health Improvement*:

To understand a community-led approach to health it is important to understand the wider concept of community-led development. Community-led development is an approach to social change that is based on the premise that changing situations of disadvantage and social injustice cannot be achieved by top-down solutions alone. Because of the complexity of the factors that contribute to and perpetuate inequality and disadvantage, including institutional discrimination and the sense of alienation experienced by disadvantaged groups and individuals, change also requires community-led action, whereby those who are affected by social injustice bring their collective experience to bear in defining the issues they face; identifying what needs to change; identifying solutions and acting for and influencing change.

A community-led approach to health then is an application of this approach in the context of health improvement and addressing health inequalities.

A community-led approach to health is not a new concept; it has (explicitly or implicitly) informed the work of community health initiatives in the UK for many years. Internationally, it is the approach to health improvement and addressing inequality that is advocated by the World Health Organisation and is the approach that underpins international policy and practice frameworks for health promotion like the Ottawa Charter (WHO, 1986)[6]

Typical characteristics of a community-led approach to health

- The identification of needs, priorities and the agenda for change is led by those experiencing disadvantage and agreed with others
- A community rather than an individual level focus
- A targeted and inclusive approach – engaging with the most disadvantaged
- An empowerment approach to change – involving people in the process of their own development and supporting and enhancing the ability of participants to exercise influence over their individual, group or community circumstances

[6] World Health Organisation (1986), Ottawa Charter, WHO, Ottawa

- A partnership/collaborative approach to change – involving communities and agencies in developing new approaches to address community needs and issues, and supporting the capacity of service agencies to work in this way

Most importantly, community led health is concerned with the 'community as the focus of, and mechanism for, change rather than community as a setting for health practice'. This makes it fundamentally different from the provision of community-based health services and also different from the participation of communities in pre-determined health initiatives (Dailly and Barr 2008).

A logic model that sets out links between common inputs, activities/ processes, shorter and longer term outcomes for community led approaches to health improvement (prepared for the wider work on the *Healthy Communities Task Group recommendations)* is included in the supplementary papers. The wider detail and explanation of the logical links of this model is provided for reference in the supplementary papers (see J Dailly and A Barr (2008) *Understanding a Community Led Approach to Health Improvement*: pp11-30). It identifies the outcomes that community led health realistically has capacity to influence and provides some clarity around how these outcomes sit within a model of health improvement/inequalities.

Aims of this programme of work

The broad purpose of this programme of work is to improve the capacity of community led organisations/projects and funders/commissioners to measure the economic value of community led health outcomes and its contribution to health improvement priorities. It is anticipated that this would be achieved through the development and implementation of practical economic models or evaluation tools for funders and organisations undertaking or funding community led approaches to health improvement. In the longer term, it is hoped that by gaining a better understanding of the economic value of community led approaches, then this will contribute to more sustained investment in community led approaches.

As a starting point and to achieve greater clarity on what future work would be most appropriate and useful, the Scottish Government agreed that NHS Health Scotland and CHEX should convene a meeting in March 2008 with stakeholders from the UK who have expertise or an interest in this area, with a view to funding further work in this field.

Known issues and challenges

We already know that traditional methods of economic evaluation face challenges in their application to community led health (Shiell and Hawe,1996)

Additionally, while much is known about the economic value of discrete aspects of health improvement policy and practice e.g. individual clinical or behavioural interventions (Drummond et al, 2007), there is still much more to learn about the value of a wider range of approaches to health improvement, including the impact of complex & multi-faceted population level and community led approaches.

Some of these challenges include:

Evaluation of public health interventions has often dwelled on the potential of health promotion to reduce future health care costs through the avoidance of disease (Hale, 2000). McDaid and colleagues argue that in mental health promotion and suicide prevention, an economist's focus on a single outcome, e.g. rate of suicide or the number of life years saved, may be seen to be too reductionist as it does not capture the complexity of synergistic approaches to mental health promotion (McDaid et al, 2007 quoted in Mackenzie et al (2007)

For community led health, this is also an issue. Measuring the narrow benefits misses the 'added value' or outcomes particular relevant to this approach. Community-led health initiatives often deliver crucial 'outcomes along the way' to health improvement such as increased empowerment, social networks or awareness.[7] See also the example of the walking school bus in box 2.

Community-led health initiatives and those who fund such approaches also need to be clearer about the underpinning logic of this approach and articulate the processes and activities that happen through their project: what outcomes should result and how these relate to health priorities.[8]

Relevant information for economic analysis e.g. costs is not routinely collected by projects/interventions or is not available in the published literature. Moreover, the evidence base within the voluntary and community sector is either unpublished or not easily accessible because it has been produced for reporting to funders or for internal use.

[7] Emma Halliday NHS Health Scotland and Steven Marwick, *Evaluation and monitoring in community led health. What are the challenges and how do we solve them? A practical briefing and guidance paper.* Health Scotland Website
[8] Ibidem.

- Health economists have noted a potential conflict with the purpose of economic evaluation, which is often driven by questions of efficiency and how to make best use of limited resources. In this context, the more equitable programme may not be the programme that is the most effective or cost saving (Hale, 2000). However, an intervention that promotes health may also result in widening inequalities.

- The individualist basis of economics may be out of step with community development approaches, which often have the community, not the individual, as the focus (Shiell and Hawe, 1996).

- It is also important that any future work is practical and of benefit to funders and projects/organisations. Many organisations have four or more main funders with different monitoring and evaluation requirements. Multiple funders and multiple monitoring processes can lead to administration and reporting processes that are perceived to be burdensome, or to get in the way of delivering a service.[9]

- In addition, Rush et al (2004) points out that even where evidence exists, economic evidence is rarely if ever definitive, results require interpretation and value-judgments always remain. Work is required to build capacity and translate the results of economic evaluations into practical policy recommendations and to develop expertise in how to use this type of evidence.

Health economists have attempted to address the methodological issues. Manuals and research to support work in this field include (but not exhaustive):

- M Drummond, H Weatherly, K Claxton et al (2007) *Assessing the Challenges of Applying Standard Methods of Economic Evaluation to Public Health Interventions. Final report*. Public Health Research Consortium.

- J Hale, D Cohen, A Ludbrook, C Phillips, M Duffy and N Parry-Langdon on behalf of the UK Health Promotion and Health Economics Forum (DATE?) *Moving from evaluation into economic evaluation: a health economics manual for programmes to improve health and well-being*

- T Sefton, S Byford, D McDaid, J Hills and M Knapp (2002) *Making the most of it*, Joseph Rowntree Foundation.

[9] Emma Halliday NHS Health Scotland and Steven Marwick, *Evaluation and monitoring in community led health. What are the challenges and how do we solve them? A practical briefing and guidance paper.* Health Scotland website.

Measuring capabilities

Current work is underway as part of the Gowell project[10] to explore the relevant of a *capabilities approach* in measuring and valuing the outcomes of public health interventions. These works aims to build on work on the capability approach by Anand and colleagues in order to refine the survey instrument proposed by Anand et al and validate its use for public health evaluations. For further information, slides from a presentation at the Glasgow Centre for Population Health in August 2007 are available.[11]

Scoping of economic research relevant to for community led health

In Autumn 2007, a short scoping exercise was undertaken of work in this field to measure economic value and impact. The next section of the paper does not recommend any particular approach nor is a definitive list but provides examples of related work with links to further information. Findings of this exercise are also supported by an earlier scoping exercise prepared by CHEX.[12]

Professor Alan Shiell, and colleagues have undertaken extensive work in the field of economic evaluation and community development (see for example: Rush et al, 2004; Shiell and Hawe, 1996; Shiell and McIntosh; Shiell 2007). The example of the Walking School Bus serves to illustrate some of the challenges described above.

Box 2: Walking school bus: Except adapted from Shiell (2007) *In search of social value,* Int J Public Health 52 1–2

The WSB involves a group of eight children walking to school with two adult supervisors. The alleged benefits potentially included a range of outcomes including less traffic congestion and air pollution; more opportunities to meet friends and neighbours, and to make new friends; increased sense of community and self confidence; reduced travel and time costs for parents who are not 'driving' the bus. Potential health benefits were listed as fewer road accidents and increased physical activity leading perhaps to improved cardiovascular fitness, reduced risks of osteoporosis, depression and diabetes, and possibly even obesity. However, an economic evaluation uncovered at close to $1 million Australian per disability-adjusted life-year gained, the WSB was remarkably poor value for money and not cost-effective. Yet in the calculations of cost-effectiveness, the only potential health benefit to be included was reduced risk of obesity. On closer (cont/)

[10] http://www.gowellonline.com/

[11] Economic Evaluations of Public Health Interventions: A Role for the Capabilities Approach? Presentation made as part of the Glasgow Centre of Population Health seminar series (August 2007) http://www.gcph.co.uk/seminar/otherevents.htm

[12] Cost/Benefit Analysis of community-led approaches to health improvement and tackling health inequalities – a discussion paper (July 2006)

analysis, it was clear that further health benefits were ignored and the evaluation had significantly underestimated multiple and multiplier effects. Examples include: organisers of the WSB program gain administrative and managerial skills that can be generalised to other tasks; the paired bus 'drivers' discuss with each other issues of common concern, such as the corner store that sells cigarettes to pupils, and begin to plan action to stop this; health and social benefits are enjoyed by older children who are now allowed to walk or cycle to school unescorted, etc

National Evaluation of Healthy Living Centres (HLC)

The national evaluation of the HLC programme undertook rigorous analysis of the costs of a small number of case studies, and modelled the potential impact of their activities. This required a full costing of each local centre, including additional input such as volunteer time and resources from partner organisations, compared with the numbers using the services and the likely impact on health (Hills et al, 2007).

Box 3: Economic analysis of HLCs (Adapted from Hills et al)

The evaluation showed that the overall costs of the HLC initiative are very low, with the annual budget from all sources for all HLCs in England being equivalent to just six months of the budget for one PCT.

Compared with those for other interventions seeking to promote physical activity. Both case studies of BLF-funded HLCs suggest that they represent good value for money, and that the national programme on Walking for Health in particular appears to have also generated many additional benefits and helped encourage a very large number of people across the country to walk more.

The low cost of HLCs depends crucially on their level of engagement and frequency of contact with target populations. In individual case studies cost per contact varies between £5 and £500. Crude national data suggest costs per contact may vary between £200 and £2000.

Case studies of both national and local HLCs suggest that they can remain very cost effective, even when contact rates are varied substantially, and are favourable

The low cost of delivering HLC schemes means that only a small number of adverse events need to be avoided to cover much of the delivery costs, implying that some schemes have the potential to be cost saving.

Volunteers are contributing substantial extra resources and benefits to HLCs. If volunteers were replaced with staff of statutory organisations or if programmes were mainstreamed costs might rise substantially. Another challenge if schemes are (cont/) mainstreamed might be to maintain enthusiasm of volunteers and others to continue to participate and run activities. (cont/)

Engagement rates in many schemes are much lower than projected in applications for funding, but many schemes are still only halfway through their life expectancy and have experienced delays in implementation. Assessment of individual engagement data for each HLC is required before any judgement can be made about the value for money of any single HLC scheme.

Related to these issues, McDaid and Needle (2007) argue that economic evaluations should make better use of qualitative methods or realistic approaches 'to understand more about why interventions have differing success rates in different contexts.

See also findings from research undertaken by the NI HLC programme[13]

NICE: Community engagement consultation

NICE has recently published public health guidance on community engagement and community development approaches to health improvement[14]. It should be noted that while the researchers recognized community engagement and community development to be two complementary but different terms (see also comments below), researchers found that it was not possible to make recommendations that distinguished between the two approaches.

The consultation included work on economic evaluation. In one paper and after an extensive literature search, the researchers found only a handful of studies (eight) that met the relevant criteria for inclusion. While the findings suggested that community engagement as part of a multifaceted approach to health promotion may have positive effects and could possibly be cost-effective, the authors were unable to draw robust conclusions about the cost-effectiveness of community engagement *per se*.

The rapid review of the economic evidence for community engagement and community development approaches in interventions or initiatives seeking to address wider determinants of health identified twenty studies (on 12 interventions) reporting funding or cost information and some measure of benefits and / or identification of barriers to engagement were included. [15]

[13] The HLC Support programme also found that in Scotland, an average cost of working with local people who use the services amounts to £1 per person per week or £52 per year. Comparative figures, which help contextualise this include local authority leisure and community services – around £4 per touch, GP appointment – £18, niche health service for vulnerable/at risk group – in excess of £100. (Comparative figures taken from FMR Research, October 2006). *Information taken from economic evidence prepared by the Belfast Healthy Living Centre Network*

[14] http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11929

[15] http://www.nice.org.uk/nicemedia/pdf/RapidReviewCostEffectivnessSocialDeterminants.pdf

Some concern was noted by the researchers about the limited relevance of applying economic evaluation models to community engagement given that the 'principle of community engagement is entwined with the building blocks of a democratic society' (Carr-Hill and Street, 2007). This view is supported by Alan Shiell[16] who makes the distinction between community engagement (an essential element of a democratic society - thus it should stand outside of economic evaluation) and community development (an approach to promoting health and other outcomes) and suggests of the latter that its merits should be evaluated alongside alternative means of achieving the same outcomes.

The recommendation on the following page is made in relation to economic evaluation in the final published guidance (Feb. 2008)

Recommendation 4: economic evaluation

- wherever appropriate, include economic evaluation as an integral part of funded evaluation studies
- use before and after study designs with comparators
- identify and describe the community engagement approach under investigation (including its underpinning value system)
- where possible, use validated intermediate and long outcomes to measure the direct impact of the approach used
- consider the appropriate follow-up period needed before outcomes are measured (public health outcomes often require long follow-up periods)
- take careful account of the costs and other resources used
- consider the wider benefits of involving local communities (including changes in employment prospects, income and health).

NICE (Feb. 2008), *Community engagement to improve health. Public health guidance 9.*
http://www.nice.org.uk/nicemedia/pdf/PH009Guidancev2.pdf

[16] Unpublished correspondence

Mental health promotion: building an economic case

Recent work by Friedli and Parsonage (2007) was undertaken on 'making a case' for mental health promotion commissioned by NIAMH. It draws on economic analysis to 'develop the case for greater investment in mental health promotion, defined as both the prevention of mental illness and the promotion of positive mental health'.[17]

Demonstrating levels of complementary investment

In addition, economic evaluation has also been used to demonstrate the level of additional investment that the community and voluntary sector can generate over and above initial investments in projects/services.

For example, the evaluation of Scotland's suicide prevention strategy (Choose Life) considered the amount of additional complementary investment (both monetary and in-kind) generated for *Choose Life*, where information was available. This demonstrated that in additional to government funding, the majority of areas were successful in raising funds from a variety of sources, including public sector organisations, national charities and the national lottery. In total more than £1.6 million had been identified (Platt et al, 2006). Analysis suggests that resources went beyond those invested by the Scottish Executive and that a partnership approach between government, local authorities and other stakeholders helped generate a synergy by which additional resources are committed to community initiatives (Ibidem).

[17] http://www.niamh.co.uk/info.php?content=infopublications&submenu=Publications

Further models and approaches

Social accounting model

A further relevant approach is the use of social accounting and audit. The following excerpt is taken from a briefing sheet on SAA that provides a framework for social, environmental and economic (SEE) reporting.

Box 4: Social Audit Network, *Social Accounting and Audit: a framework for social, environmental and economic (SEE) reporting*

"Social accounting and audit allows a social enterprise to build on its existing monitoring, documentation and reporting systems to develop a process whereby it can account fully for its social, environmental and economic impacts, report on its performance and draw up an action plan to improve on that performance. Through the social accounting and audit process it can understand its impact on the surrounding community and on its beneficiaries and build accountability by engaging with its key stakeholders…Social Accounting and Audit provides the process for social enterprises and other organisations to measure how well they are achieving their overall objectives and living up to their values. It accurately describes what a social enterprise is achieving and allows it to demonstrate to others what it is and what it does. It assesses social or community enterprises in a holistic way." [18]

There are understood to be six underpinning principles for social accounting, these are

1 Social accounting should engage with and reflect the opinions of a wide variety of people (key stakeholders) affected by (and able to affect) the organisation (*multi-perspective*).

2 Social accounting should cover all the activities of the social enterprise or organisation (*comprehensive*).

3 The organisation should be able to compare its performance over time and also against similar organisations (*comparative*).

4 It should be undertaken regularly rather than be a one-off exercise and become embedded in the running of the social enterprise or organisation (*regular).*

5 The Social Accounts should be checked (audited) by an independent social audit panel, chaired by an approved Social Auditor (*verified*).

6 The findings of the audited Social Accounts should be widely circulated and discussed (*disclosed*).

[18] Social Audit Network, Information Sheet: Social Accounting and Audit: a framework for social, environmental and economic (SEE) reporting

Social Return on Investment (National Economics Foundation)
The NEF Guide on *Measuring real value* describes the process of Social Return on Investment (SROI) analysis, which is a 'process of understanding, measuring and reporting on the social, environmental and economic value that is being created by an organization.'[19] SROI can be used by those who create social value, procure social value, invest in the creation of social value, and develop policy.

Key elements of the SROI process involve:

- Talking to stakeholders to identify what social value means to them
- Understanding how that value is created through a set of activities
- Finding appropriate indicators,
- Putting financial proxies on those indicators that do not lend themselves to monetisation
- Comparing the financial value of the social change created to the financial cost of producing these changes[20]

Some benefits of this process identified are improved accountability, better information for future decision making - when used for planning - and cost and time effectiveness - by focusing on critical impacts.

Social enterprises and health improvement

Social enterprises are businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders or owners' (Department of Trade and Industry, 2002 quoted in conference report '*Fit for Purpose'*)

Social enterprises are active in the communities where poverty, deprivation and ill health are most noticeable and are perceived to directly impact on areas of life that help to improve the health at different levels (individuals, families and communities).

For further information, see report of conference held in Glasgow in autumn 2007 that provides a record of the event and key recommendations/outcomes: *'Fit for Purpose – Social Enterprise and Health Improvement'*[21]

[19] New Economics Foundation, MEASURING REAL VALUE: a DIY guide to Social Return on Investment
[20] Ibid.
[21] http://www.phru.net/Lists/Announcements/DispForm.aspx?ID=38

Summary

This paper does not attempt to provide a definitive landscape of economic evaluation for community led health. However, it does suggest that much work is currently underway, that demonstrating the economic value is feasible, and there are a number of different models/approaches that could be used. It is also recognises the need for multi-disciplinary approaches to be used and for evaluation to 'build in an assessment of the costs and resources required to implement interventions in different settings, cultures and contexts, and to obtain qualitative information on the success and obstacles to implementation' (Zechmeister et al, 2008)

In conclusion, the following questions should be addressed in considering a forward approach:

- What constitutes 'good enough' economic evaluative evidence for funders, policy makers and projects?
- How do we think stakeholder groups would use this evidence?
- What current models and approach(s) to demonstrating the economic value are most appropriate and where is further research required?
- What capacities are required (in addition to addressing the methodological difficulties) to support our ability to build an economic case for community led health?

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Nice consultation on community engagement

A full list of papers produced for the NICE consultation on community engagement guidance is available at http://www.nice.org.uk/page.aspx?o=CommunityEngagement

Final guidance available at Feb. 2008:

NICE (Feb. 2008), *Community engagement to improve health. Public health guidance 9.* http://www.nice.org.uk/nicemedia/pdf/PH009Guidancev2.pdf

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Paper 2:
Community led health: value for money? Demonstrating the economic value of community led health

A report of a round table discussion on March 11, 2008 and suggestions for future work

Prepared by NHS Health Scotland and CHEX, April 2008.

This work was commissioned by the Public Health and Wellbeing Directorate, Health Improvement Strategy Division of the Scottish Government.

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Introduction

Who is this report for?

This paper is for people with a role in commissioning, funding or evaluating community-led health projects and programmes. In particular those involved in community led initiatives for health improvement, Community Health Partnerships, Community Planning Partnerships, or Scottish Government programmes.

The report primarily draws on conclusions of a round table discussion held on the economic value of community led health in March 2008. The event was attended by 18 delegates, predominantly from Scotland but also England and Northern Ireland. Participants included a mix of policy makers, evaluators, community project representatives and national intermediaries[22] (see appendix 1). The

[22] Delegates involved with the UK Health Promotion and Health Economics Forum, Community Development Exchange in England and Sainsbury Centre for Mental Health were invited (but were unable to attend on this date)

report is also informed by an earlier scoping exercise undertaken on the economic value of community led health[23].

Background

Community led health is concerned with the 'community as the focus of, and mechanism for, change rather than community as a setting for health practice'. This makes it fundamentally different from the provision of community-based health services and also different from the participation of communities in pre-determined health initiatives (Dailly and Barr 2008). Typical characteristics of a community-led approach to health include:

- The identification of needs, priorities and the agenda for change is led by those experiencing disadvantage and agreed with others
- A community rather than an individual level focus
- A targeted and inclusive approach – engaging with the most disadvantaged
- An empowerment approach to change – involving people in the process of their own development and supporting and enhancing the ability of participants to exercise influence over their individual, group or community circumstances
- A partnership/collaborative approach to change – involving communities and agencies in developing new approaches to address community needs and issues, and supporting the capacity of service agencies to work in this way (Dailly and Barr 2008).

The publication of '***Healthy Communities: A Shared Challenge***'[24] by the Community-Led: Supporting and Developing Healthy Communities Task Group in December 2006 set out twelve interconnected recommendations that provided a framework to take forward the Government's ongoing commitment to involving communities actively in health improvement. The four key themes of these recommendations centred on evidence and evaluation; planning and partnerships; capacity building; and sustainability. Subsequently, the (then) Scottish Executive convened an Implementation Steering Group to discuss next steps and implementation plans.

Work to address the recommendations of the Task Group was agreed by the Implementation Steering Group in July 2007. Work on recommendations one and two were progressed by NHS Health Scotland, Scottish Community Development

[23] Health Scotland website
[24] Community-led: Supporting and Developing Healthy Communities Task Group (December 2006) available at http://www.healthscotland.com/documents/1403.aspx

Centre (LEAP[25] Support Unit) and Evaluation Support Scotland[26]. These two recommendations focussed on the need to develop robust evidence that show what outcomes can be achieved by community-led health improvement activity and its contribution to national health improvement priorities in Scotland.

Integral to this work was to consider how best community led organisations/projects and funders/commissioners can be supported to measure and report on the 'economic value' of community led health improvement outcomes. As part of the Task Group's recommendations, scoping 'the use of cost benefit analysis in assessing the impact of community led activity' was defined as an area for action.

The idea of a 'roundtable discussion' with colleagues from across the UK to progress this work was approved by the Implementation Steering Group. The outcomes from this discussion would help shape the development of a future plan of work on the economic value of community led health.

Purpose of the report

The report sets out expectations for this work (as defined by those attending the 11 March round table discussion), and key challenges and issues associated with demonstrating economic value of community-led health.

The report concludes with some suggestions to help inform a plan for the next phase of this work, derived from discussions held at the round table meeting.

Expectations for demonstrating the economic value

The broad purpose of this work is to improve the capacity of community led organisations/projects and funders/commissioners to measure the economic value of community led health outcomes and its contribution to health improvement priorities. It is anticipated that this would be achieved through the development and implementation of practical economic models or evaluation tools for funders and organisations undertaking or funding community led approaches to health improvement. In the longer term, it is hoped that by gaining a better understanding of the economic value of community led approaches, then this will contribute to more sustained investment in community led approaches.

[25] The LEAP framework ('Learning evaluation and planning') is a toolkit designed to support a partnership approach to achieving change and improvement in the quality of community life. See http://leap.scdc.org.uk/leap-framework
[26] http://www.evaluationsupportscotland.org.uk/

Participants at the 11th March 2008 event broadly shared these anticipated outcomes and discussed their expectations for this work.

Thinking in the longer term, one participant from the Scottish Government expressed that the ultimate outcome for this work was 'improved health and reduced inequalities in health across Scotland'.

The remainder of outcomes expressed were framed in terms of expectations related to work on the economic value of community led approaches. Timescales for achieving these outcomes were not defined during the sessions.

Participants highlighted there would be a better understanding of the benefits of demonstrating economic value among all groups represented at the round table discussion. This related as well to an improved understanding of the community and voluntary sector - there was a need for clarification of the contribution of community and voluntary sector to health improvement both by funders and within sector itself.

In terms of building capacity, participants thought that both commissioners and projects would be better able to report on and understand the impact of community led health and organizations and would be supported with the means to develop experience in this area. Related to this, there would be better knowledge around economic evaluation tools that were relevant and applicable to the Scottish context / communities.

An expectation for an agreed planning and evaluation framework to be in place was identified by one set of participants. This would inform and support decision making about the value and contribution of community-led health. One group identified that economic evaluation would be built into reporting from the outset of planning. For example when stakeholders come together in the implementation of the *National Standards for Community Engagement.*

Finally, one participant suggested that a culture of innovation would need to be in place to allow new ideas to develop.

Expectations from four different perspectives (policy, commissioning, project and evaluation)

At the round table discussion, different perspectives were invited on the relevance of demonstrating the economic impact of community led health for their organisation and the issues that are around in relation to showing the economic impact.

Roddy Duncan from the **Public Health and Wellbeing Directorate, Health Improvement Strategy Division, Scottish Government** set out the context to

this work including the purpose of the Scottish Government "To focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth" and its 5 strategic objectives (wealthier & fairer, healthier, safer & stronger, smarter and greener).

The *Better Health, Better Care action plan* (published in December 2007) sets out strategy for health services for the next 5 years and sets reducing health inequalities as the top priority in health. It recognises the contribution of the voluntary and community-led sector and commits to improving the relationship between NHS and third sector.

Roddy drew attention to the challenge of finding ways of evaluating impact, effectiveness and cost-benefit in a way that places minimal demand on front-line organisations, but can deliver enough information for funders to make informed decisions on. It needed to be recognised that community-led health is not only about delivering services, but has much wider social, community and health benefits which should be taken account of when assessing its impact.

From a commissioning perspective, **Hamish Battye (South East Glasgow Community Health & Care Partnership)** described working in a CHCP that is in a high area of deprivation and has poor record of health. The area also benefits from a vibrant third sector that includes a range of organisations. A key challenge faced by the CHCP is that with a potentially declining resource base, as resources are distributed more equitably in future, it becomes increasingly more difficult to retain and develop third sector activity. Projects have been encouraged to take a more integrated approach to their work, in order to reduce overheads and running costs so that resources could be freed-up for frontline activity. He also pointed to the reality of decisions that are taken within a political context – decision makers including local councillors need also to be persuaded that investment in organisations / projects is beneficial to improving health and tackling inequalities. How we demonstrate that in a meaningful way was a challenge.

Ed Garrett (Mearns and Coastal Healthy Living Network - MCHLN) spoke about a competitive funding environment for projects. In this context, his organisation was increasingly expected to demonstrate that for each pound invested, then this would produce a certain amount of health benefit. However, demonstrating the economic impact was also construed to have internal benefits: Projects are able to see how effective they are in reaching their goals and if the level of costs allocated to services are appropriate.

The MCHLN currently uses social accounting in order to evidence their social impact. Combined with an approach such as Social Return on Investment, social accounting can form part of a jigsaw of evidence, including economic impact, in which there is no attempt to try and reduce all values to economic measures. There is adaptability in the approach according to the organisation / context and it is stakeholder led.

Finally, **David McDaid (London School of Economics)** provided the evaluation perspective and emphasised the importance of this work given that projects are working in a context of 'Money Talks' and that the case for investment must be made across different sectors if an initiative demonstrates outcomes for multiple partners. He suggested some pointers for taking forward work:

- Integrating economic impact into capacity building programmes and training that can be used as part of routine monitoring
- Aim to achieve standardization of reporting for community led health
- Need for a central body to support community led health and commissioners with data/support/models on economic impact
- Run short courses to raise awareness and knowledge of economic value
- Engage and interact with university sector

Issues and challenges

It is well documented that traditional methods of economic evaluation face challenges in their application to community led health (Shiell and Hawe,1996). These challenges are described in the research literature and were also borne out by participants at the round table discussion in March.

Evaluation of public health interventions has often dwelled on the potential of health promotion to **reduce future health care costs** through the avoidance of disease (Hale, 2000) but can mean that benefits are too narrowly defined and may mean the impact of the initiative is missed.

For community led health, this is also an issue (see appendix two). Community-led health initiatives often deliver crucial **'outcomes along the way'** to health improvement such as increased empowerment, social networks or awareness.[27] Feedback from the round table pointed to the danger of making it 'all too simplistic and narrow' given rich tapestry of the sector and that purely scientific model of evaluation / measuring benefits and outcomes may drive out some of

[27] Emma Halliday NHS Health Scotland and Steven Marwick, *Evaluation and monitoring in community led health. What are the challenges and how do we solve them? A practical briefing and guidance paper.* Health Scotland Website

the less tangible benefits. Funders needed to value intermediate social outcomes and recognise that health outcome may not be seen till longer term.

Making the case from loss of investment. At the round table, an evaluator suggested that it is inaccurate to assume an automatic cost saving if there is not investment or if a service is not funded. The illustration was provided of a *HLC that provides 'wrap around care' for children and training opportunities for parents. Although this service does not directly impact on health outcomes, there are important investments gained from the opportunity for parents to gain new skills and go to work, thereby providing a contribution to the economy, increasing income and learning new skills.* This investment would be lost if the service were no longer provided.

Community-led health initiatives and those who fund such approaches also need to be clearer about the **underpinning logic** of this approach and articulate the processes and activities that happen through their project: what outcomes should result and how these relate to health priorities.

Relevant **information for economic analysis** (e.g. costs, volunteer time) is not routinely collected by projects/interventions or is not available in the published literature. Moreover, the evidence base within the voluntary and community sector is either unpublished or not easily accessible because it has been produced for reporting to funders or for internal use.

Health economists have noted a potential conflict with the **purpose of economic evaluation**, which is often driven by questions of efficiency and how to make best use of limited resources. In this context, the more equitable programme may not be the programme that is the most effective or cost saving (Hale, 2000). The individualist basis of economics may be out of step with community development approaches, which often have the community, not the individual, as the focus (Shiell and Hawe, 1996).

Some participants at the round table discussion urged that the purpose of economic evaluation should not be **misused**, e.g. as a way of rationalising resources or to look for the cheap and low cost investment in community led health.

Many organisations have four or more main funders with different monitoring and evaluation requirements. **Multiple funders and multiple monitoring processes** can lead to administration and reporting processes that are perceived to be burdensome, or to get in the way of delivering a service.[28] It is also important that any future work is practical and of benefit to funders and

[28] Emma Halliday NHS Health Scotland and Steven Marwick, *Evaluation and monitoring in community led health. What are the challenges and how do we solve them? A practical briefing and guidance paper. Health Scotland Website.*

projects/organisations. However, round table participants noted a tension between the expectations of funders and what is realistic to expect projects to achieve and report on.

The need for **adequate resource** for meaningful evaluation was discussed at the round table sessions. This related to capacity and resources (time, skills, access to data and funding) and the accessibility of such data for non-economists. The tension for this sector in being expected to generate evidence of economic impact (when this is not seen to be a requirement of statutory sector services) was raised.

Work is required to **build capacity and translate** the results of economic evaluations into practical policy recommendations and to develop expertise in how to use this type of evidence. Rush et al (2004) points out that even where evidence exists, economic evidence is rarely if ever definitive, results require interpretation and value-judgments always remain. Participants at the round table questioned whether even if all this evidence and information is collected and analysed, then would it realistically impact on funding and resourcing decisions?

Options for next phase of this work

Participants at the round table discussion agreed that work to demonstrate the economic value was important and feasible and suggested various ideas for taking this forward.

Establish national level group in order to drive forward work and link together key people/organisations (policy makers, universities, national intermediaries, commissioners/funders and project representatives). This should also involve those not represented at the March 11th event, e.g. Funders Forum. This group could feed into a loose network of interested organisations/people.

Undertake **rapid stock take** and build on work to date by conducting detailed mapping economic evaluation for community-led health (including unpublished evidence) that seeks to learn:

- how economic evaluation conducted and how used (case studies)
- tools available (within health and also in other sectors such as regeneration
- gaps/strengths
- current capacity / skills

Build **common language**, e.g. common frame of reference with shared language that makes sense across sectors or guidelines on benefit of economic impact for various audiences including initiatives, planners and politicians. Develop a

shared understanding among commissioners and projects, e.g. run series of workshops or events to expose **challenges and benefits** of the process. Existing programmes could be used as a vehicle for this

Build capacity of projects and commissioners through a multi-level approach

- Developing resources by building on existing models and approaches, e.g. integrating economic dimensions to capacity building for outcome focused planning, integrating economic dimension to LEAP, use social auditing etc
- Run training sessions for commissioners and projects / practice development support through national intermediaries
- Create opportunities to improve links between projects, national intermediaries and academics. E.g. create 'economic advisors for national intermediaries'

National support and information point - Explore the potential for national/external organization/agency that could provide bank of information and function to share and disseminate information on economic impact.

Build evidence and draw on examples: Collate case studies based on existing work and test out models integrating different types of data, including economic information. Qualitative case studies of community led health undertaken by Evaluation Support Scotland may provide building blocks for this work[29].

Consider external factors: None withstanding, it was also important to understand and address the broader contextual challenges that might impact on success of work to demonstrate the economic impact:

This included:

- A potential tension between commissioning for outcomes by statutory organisations and community driven priorities that might be different from these national or local statutory priorities.

- The need for commitment and understanding of the contribution that the community and voluntary sector makes to improving health and reducing inequalities.

- For community and voluntary sector participation at community planning and other decision making structures to be strengthened.

[29] Currently unpublished.

- The importance of nationally-driven support and a supportive policy environment

- Building current focus on outcome focussed approaches and placing more emphasis on improving so that people think about value they are creating and the extent to which it is worth investment.

- Modest requirements for gathering information on economic impact as part of internal evaluation and ensuring realistic expectations and requirements of what can be achieved.

Conclusions and next steps

The round table re-emphasised the importance of getting better at demonstrating the economic value of community led health and provided many useful suggestions about progressing this pragmatically. One unsurprising outcome of these discussions was that there was not one solution alone and a programme of future work could potentially involve a mix of awareness raising, capacity building and training, as well as further research and evaluation.

As a next step and to ensure that the discussion will lead to a practical outcome for community-led organisations and commissioners, Health Scotland will further explore and seek agreement with partners, the ideas suggested during the roundtable discussion. These next steps will be communicated to all those who participated in the events and those more broadly who have a stake in understanding the value of community led health.

Appendix 1: List of attendees

Barbury Cooke	Community Development and Health Network, N. Ireland
Bill Gray	Community Food and Health (Scotland)
David McDaid	London School of Economics
Debbie Sigerson	Evidence for Action team, Health Scotland
Ed Garrett	Mearns and Coastal Healthy Living Network
Elis Lawlor	New Economics Foundation
Elspeth Gracey	CHEX
Emma Halliday	Policy evaluation and appraisal team, NHS Health Scotland
Hamish Battye	South East Glasgow Community Health & Care Partnership
Heather Apsley	Settings team: Community and Voluntary sector programme, NHS Health Scotland
Helen Tyrrell	Voluntary Health Scotland
Janet Muir	CHEX
John Boswell	Convener of the Scottish Forum for Public Health
Liz Fenwick	University of Glasgow
Lizanne Conway	Settings team: Community and Voluntary sector programme, NHS Health Scotland
Mike O'Donnell	Scottish Government
Roddy Duncan	Scottish Government
Tina Burgess	Health Promotion Department, NHS Eileanan Siar (Western Isles)

Appendix 2: Walking school bus

Professor Alan Shiell (University of Calgary) and colleagues have undertaken extensive work in the field of economic evaluation and community development (see for example: Rush et al, 2004; Shiell and Hawe,1996; Shiell and McIntosh; Shiell 2007). The example of the Walking School Bus serves to illustrate some of the challenges described in this report.

Walking school bus: Except adapted from Shiell (2007) *In search of social value,* Int J Public Health 52 1–2

The WSB involves a group of eight children walking to school with two adult supervisors.

The alleged benefits potentially included a range of outcomes including less traffic congestion and air pollution; more opportunities to meet friends and neighbours, and to make new friends; increased sense of community and self confidence; reduced travel and time costs for parents who are not 'driving' the bus. Potential health benefits were listed as fewer road accidents and increased physical activity leading perhaps to improved cardiovascular fitness, reduced risks of osteoporosis, depression and diabetes, and possibly even obesity. However, an economic evaluation uncovered at close to $1 million Australian per disability-adjusted life-year gained, the WSB was remarkably poor value for money and not cost-effective. Yet in the calculations of cost-effectiveness, the only potential health benefit to be included was reduced risk of obesity. On closer analysis, it was clear that further health benefits were ignored and the evaluation had significantly underestimated multiple and multiplier effects. Examples include: organisers of the WSB program gain administrative and managerial skills that can be generalised to other tasks; the paired bus 'drivers' discuss with each other issues of common concern, such as the corner store that sells cigarettes to pupils, and begin to plan action to stop this; health and social benefits are enjoyed by older children who are now allowed to walk or cycle to school unescorted, etc

Appendix 3a: Selected information and resources

This appendix provided links to further information about sources of information referred to during the March round table discussion and collated from an earlier scoping exercise.

Capabilities approach:
Current work is underway as part of the Gowell project (http://www.gowellonline.com/) to explore the relevancy of a *capabilities approach* in measuring and valuing the outcomes of public health interventions. For further information, slides from a presentation at the Glasgow Centre for Population Health in August 2007 are available: 'Economic Evaluations of Public Health Interventions: A Role for the Capabilities Approach?' Presentation made as part of the Glasgow Centre of Population Health seminar series (August 2007) http://www.gcph.co.uk/seminar/otherevents.htm

Economic evaluation manuals
J Hale, D Cohen, A Ludbrook, C Phillips, M Duffy and N Parry-Langdon on behalf of the UK Health Promotion and Health Economics Forum (revised 2007) Moving from evaluation into economic evaluation: a health economics manual for programmes to improve health and well-being
Contact Janine Hale@wales.gsi.gov.uk

T Sefton, S Byford, D McDaid, J Hills and M Knapp (2002) Making the most of it, Joseph Rowntree Foundation.
http://www.jrf.org.uk/bookshop/details.asp?pubID=443
(Free pdf available for download)

Healthy living centres evaluation
The national evaluation of the HLC programme undertook rigorous analysis of the costs of a small number of case studies, and modelled the potential impact of their activities. (See Hills et al, 2007 in references and http://www.biglotteryfund.org.uk/prog_hlc_england.htm

Mental health promotion: building an economic case
Recent work by Friedli and Parsonage (2007) was undertaken on 'making a case' for mental health promotion commissioned by NIAMH.
http://www.niamh.co.uk/info.php?content=infopublications&submenu=Publications

NICE Guidance
NICE Public Health Programme Guidance PH009 – Community Engagement to Improve Health: See summary in appendix 3b

Social enterprises and health improvement

Social enterprises are businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders or owners'. , see report of conference held in Glasgow in autumn 2007 that provides a record of the event and key recommendations/outcomes: *'Fit for Purpose'*
http://www.phru.net/Lists/Announcements/DispForm.aspx?ID=38

Social accounting model

Social accounting and audit allows a social enterprise to build on its existing monitoring, documentation and reporting systems to develop a process whereby it can account fully for its social, environmental and economic impacts, report on its performance and draw up an action plan to improve on that performance.
http://www.proveandimprove.org/new/tools/socialaccounting.php

Social Return on Investment - National Economics Foundation:

The NEF Guide on *Measuring real value* describes the process of Social Return on Investment (SROI) analysis, which is a 'process of understanding, measuring and reporting on the social, environmental and economic value that is being created by an organization
http://www.proveandimprove.org/new/tools/sroi.php

The 1st Annual SROI Exchange & Launch of the SROI UK Network will take place in Manchester on 30th May 2008. http://www.sroi-uk.org/

Appendix 3b: NICE Public Health Programme Guidance PH009 – Community Engagement to Improve Health

The guidance and supporting documents cane be found at: http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11929

Scottish Commentary to be published on www.healthscotland.com by the end of July 2008.

Two reviews of the economic evidence were included to inform the recommendations within the guidance. Study inclusion criteria: Intervention has engaged communities in planning, design, delivery or governance of initiatives, for health promotion or addressing the wider determinants of health.

1. 'Rapid review of the economic evidence for community engagement in health promotion.'

   8 studies, of economic evaluations of CE in health promotion met inclusion criteria:
   - No economic evaluation focusing on community engagement in planning (priority setting or resource allocation) was identified.
   - 5 studies from US, 1 Scotland, 1 England, 1 Australia – only one generalisable to UK
   - Interventions targeted: 1 HIV, 1 diabetes, 5 smoking, 1 heart health behaviours.
   - Complex interventions and no study designed to evaluate the impact or cost effectiveness of a specific community engagement component.
   - None got high quality score, but all reported positive effects of community engagement.

2. 'Rapid review of the economic evidence for community engagement and community development approaches in interventions and initiatives seeking to address the wider determinants of health'

   20 studies – of 12 interventions.

   None of original 60 studies identified addressed costs/health benefits relative to a comparator therefore studies were included reporting funding or cost info and some measures of benefits/barriers to engagement:

   - All but one of 20 studies had no control/comparators
   - No study reported cost per unit of health effect
   - None reported health impact of non-health projects e.g. housing on morbidity
   - Investment in interventions ranged from £45,000 to 2billion
   - Health outcome data was self-reported

- None undertook systematic measurement of possible harm/adverse events associated with engaging communities.

NICE developed four sets of recommendations for research.

Recommendation for Research 4: economic evaluation:

Research councils, national and local research commissioners and funders and research workers should gather evidence on the costs and benefits of community engagement approaches, in particular:

- wherever appropriate, include economic evaluation as an integral part of funded evaluation studies
- use before and after study designs with comparators
- identify and describe the community engagement approach under investigation (including its underpinning value system)
- where possible, use validated intermediate and long outcomes to measure the direct impact of the approach used
- consider the appropriate follow-up period needed before outcomes are measured (public health outcomes often require long follow-up periods)
- take careful account of the costs and other resources used
- consider the wider benefits of involving local communities (including changes in employment prospects, income and health).

Appendix 3b provided by Debbie Sigerson Mar08
(NHS Health Scotland).