June 2021 – Approach to Social Impact for Societal Growth

Smart Social has considered carefully how individuals, groups and societies grow positively and how social impact methods can be deployed to assist through a public health approach. This document explains our approach, theory of change and how we measure/prove positive impact. It takes the view that all parts of society (businesses, public organisations, communities) should work together.

1. THE RELEVANCE OF INDIVIDUAL AND SOCIETAL BEHAVIOURAL CHANGE

Although not itself new, "The New Public Health" model promoted by The World Health Organisation and UN social development goals, has received increasing support globally as an important development strategy to improve public policy and the overall quality of life. In this sense, public health is defined broadly, to include all social determinants such as crime and violence prevention, unemployment, poor health/mental health, exclusion and other societal problems that reflect the overall functioning of both individual community members and the collective communities, whole countries. In this sense, the public health model serves as a blueprint for social change – the public health model is an organising framework for the application of evidence-based practices across the prevention/earlier intervention continuum as a means to address many important problems of human development. With its focus on promotion of positive behaviours/lifestyle, the public health model recognises that most of the burning societal ills of our time have many diverse causes or determinants. It recommends earlier intervention dealing with root causes, so sustained prevention of longer lasting crises is achieved. This approach considers causal risk factors that fall across multiple domains. While no problem behaviour is guaranteed with the presence of a specific risk factor, as the number of risk factors increases, so too does the probability of the problem behaviour. Improved public growth thus requires coordination, advocacy, and policy across all of these domains (individual, family, education, community, media, business, faith-based, justice) for sustainable impacts to occur, for societies to grow.

Although social prevention efforts must still target the individual, more sustainable and significant behavioural change will occur when at least two or more risk factors are targeted at any one time (i.e. an integrated approach to change). Despite decades of evidence, behavioural change itself remains an elusive topic for real understanding. This is because of the obvious significant variability operating across individuals and places. These social development approaches require significant partnerships of time and money throughout the community to reduce the number of risk factors acting as behavioral determinants on individuals, while increasing protective factors that build both individual self-efficacy and community collective efficacy for positive change efforts. Such coordinated public health approaches to social development are consistent with the United Nation's goal of promoting good health and wellbeing, prosperous communities, inclusion (see UN SDGs).

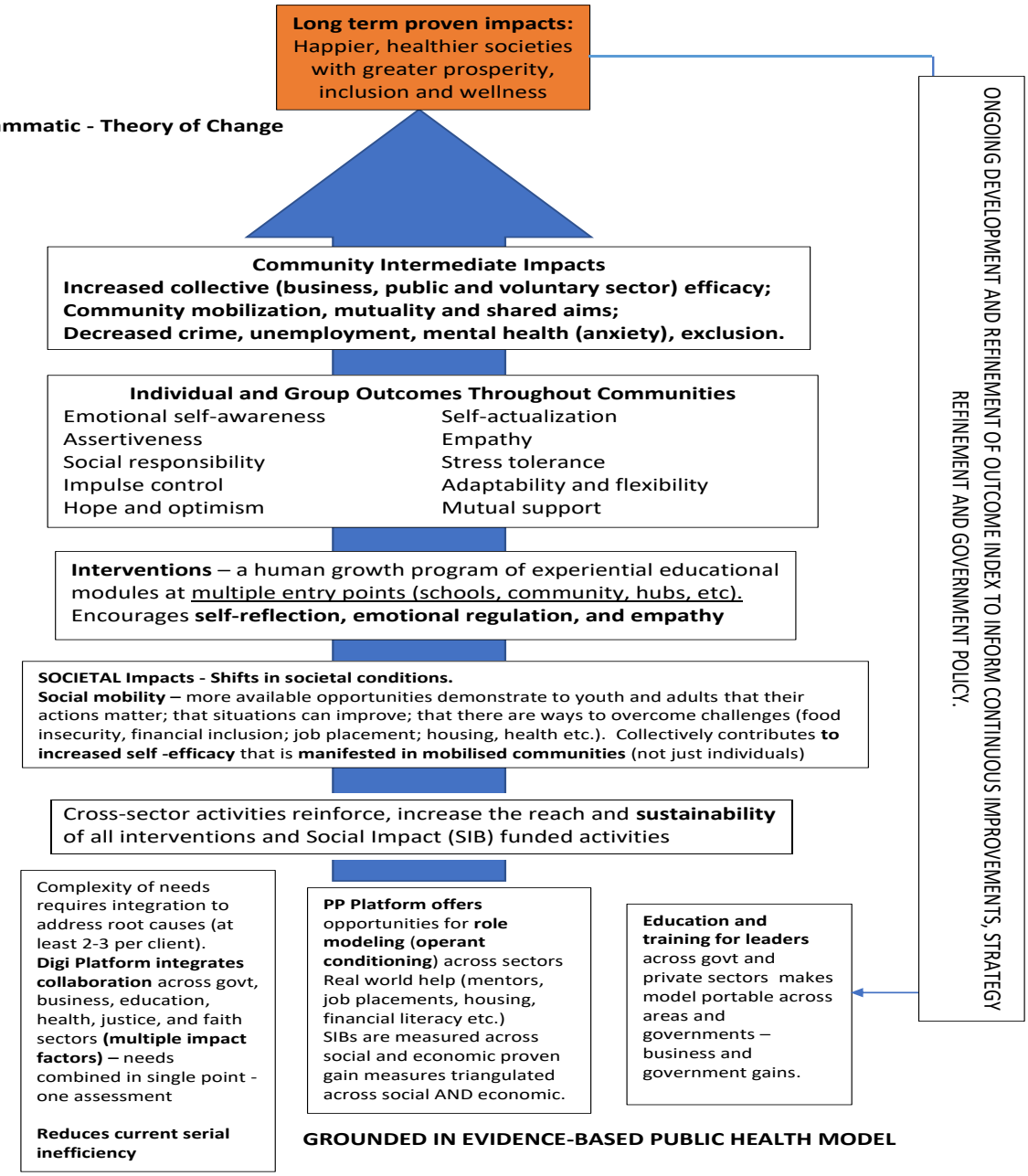
1.1 A Theory of Change (TOC): What is needed?

- A (personal performance [PP]) digital platform integrates data sharing, coordination of services, across all key public, voluntary and private sectors to reinforce behavioral change (with a combination of formal and informal educational strategies powered by behaviour change interventions) long enough for transformational change to take place.
- Individual level strategies reduce undesired motivations, attitudes, and behavior by influencing their behavior in each of the domains targeted across the sectors (family life, education, employment, housing, recreation). Formal and informal educational modules facilitate transformational change by:

- Practically demonstrating ways that individual choices can impact positive outcomes, even in overwhelming and challenging situations.
- Facilitating ways for the individual to connect to their unique talents and interests – frame this as within reach to work towards through positive choices; seeing past problem behaviors and associations (where relevant) as part of an "old identity" that can be changed.
- Offering tools for identifying and managing emotions, solving problems
- Providing formal and informal opportunities for role modelling and mentoring according to evidence-based operant conditioning principles

The diagram below describes the way individuals, groups and communities change. The diagram below brings together all sectors (business, public and non-profit partners) to coproduce positive change.

Diagrammatic - Theory of Change



2. THE RELEVANCE OF MEASURING CHANGE (proving impact)

There are many layers of the social safety net and reliable indicators that already exist. We will look at these and add to them to demonstrate the truly human commitment to proving impact in:

- Social Services
- Education
- Housing
- Unemployment
- Justice System
- Healthcare

Whilst we don't measure 'exclusion' in itself, it is the exclusion from a positive experience of the above that creates the social problem that a Public Health approach can help with.

The challenge is to add to the existing measures/indicators because we aspire to measure real human growth, real behaviour change. The hard metrics (objective and measurable) and softer data (interpreted and qualitative) are collected by all partners and aggregated through a performance governance arrangement to show the socio-economic gain.

2.1 Data sets

Below are the main measures collected. Measures are described as those which can be measured against a baseline and have an economic value (hard), and (softer) social-human measures that provide an indication of impact as people feel it or experience it. Both are important to assess to understand the true social impact. These outcome indicators represent those that are commonly accessed to measure social impact by governments globally. These outcomes will be a central part of the accreditation process for new partners referenced above. To these, additional human and social development outcomes will be identified and validated by partners as part of the continuous evaluation processes.

Social Services

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of:	Increase or reduction in:
Child taken into care	Child confidence/resilience
Children in need - management process	Isolation/loneliness
Residential/nursing care for older people	Mentor/support network
Reablement Service	Emotional intelligence
Home care package	Advice and guidance
Day care or day services	Positive influences (mentor/family)
Parenting Programme	
School-based emotional learning programmes	
Multi-systemic therapy	
Social worker (safeguarding) intervention	

Education

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of:	Increase or reduction in:
Persistent truancy	Mainstream education
Permanent exclusion from school	Family support
Alternative education/PRU	ACE/Trauma service
School-based emotional learning programme	Domestic threat
NVQ/C&G/BTEC and GCSE/A Qualification	PSHE programme benefit
Children's Centre/Hub	

Housing

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of:	Increase or reduction in:
Complex eviction/repossession	Feelings of security and safety
Homelessness	Ability to cope economically
Temporary accommodation	Community support from neighbours
Homelessness advice and support	Help to manage resources effectively
Rough sleepers	Financial management skills
Housing Benefit	
Social and affordable housing	
Supported housing	
Support costs for accommodation	

Unemployment

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of:	Increase or reduction in:
Job Seeker's Allowance - workless claimant	Work valorisation
Employment and Support Allowance	Feelings of self-worth and contribution
Not in Employment Education or Training	Financial education
Sickness absence - sick pay	Confidence
Troubled Families Programme	

Justice System

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of:	Increase or reduction in:
Anti-social behaviour	Restorative principles
Domestic violence	Emotional awareness/Trauma-informed
Offender, Prison and Probation (community)	Effect of crime on victim
Youth offender	Mentoring/coaching support
Court event	Wellbeing (mental and physical)
Violence against a person	Awareness of and de-escalation of risk triggers
Criminal proceedings	Pro-social motivation
Crime - (fiscal, economic and social values)	

Police officer usage Resettlement (post-custody) programme Juvenile Custody	

Healthcare

Measured Outcome (headline hard measure)	**Lead indicator (social-human measure)**
Reduction in/better use of: Alcohol misuse Drugs misuse Ambulance services A&E attendance (all scenarios) Hospital inpatients/day case Depression and/or anxiety disorders Mental health disorders Mental health community provision Care homes Counselling services GP/Dentist service and prescription	Increase or decrease in: Positive goals/ambition – lifestyle aims Wellbeing action (mental and physical) Coping with stress and pressure (resilience) Social network for support Skill-deficits action plan Problem-solving strategies (critical thinking) Emotional/Spiritual intelligence techniques Good nutrition/exercise

2.2 Data Management (quantitative and human measures)

Each project has its own set of data requirements. The data essentially tells us we are on track to achieving the desired outcomes. Most projects would have no more than 4 key measured outcomes and a similar number of lead indicators. Measured outcome data and lead indicator data should be collected monthly on all participants when a project is live. The data collected should seek to address the actual achievement or progress towards the achievement of outcomes or indicators. The source of data can be self-reported or triangulated through other parties which increases the data validity. All source information and disclosure showing achievement is an audit-trail and needs to be 'clean' and validated as it will be open to independent scrutiny.

Collection of data should be automated as far as possible and key support staff enter it in case notes that then flow into a data system which is reported on a given day each month and reviewed at the performance governance meeting where the 3 key partners (investor, delivery ant and outcome payer) sit. Data is often aggregated (combined across the whole client-cohort being worked on) to show the progress. Some outcomes/indicators will be weighted because they are critical to demonstrating the socio-economic and human progression – i.e. they are high-level outcomes because they show the core intent of the project and realise its benefits.

2.3 Socio-Economic Benefit

All projects are assessed on their outcomes and indicators. These tell us the benefit is being achieved and an economic index equivalent can be applied. Benefit is the productivity or improvement against a previous of comparable baseline. In other words, we show we are 20% (for example) better than the baseline of last year or compared to a similar area. It is harder to understand why Government and public sector commissioners do not do more social impact schemes that prevent and intervene earlier but instead end up paying four/five or ten times more when the person is in crisis, has reoffended, been out of work for years, is street homeless, excluded from school, traumatised, etc, which incidentally takes a lot longer to recover from …

There are many divisions in all societies, but the single biggest division is one of inequality/poverty (and its close friend 'poverty of hope'). There are communities with overused foodbanks, overrun public services and they are not coping. These were already disadvantaged communities and Covid-19 is impacting disproportionately on them. Recent discussions with a number of Government/public bodies reveals their health, social care and education resources are fully utilised in statutory (legally obliged) frontline, crisis services. They have nothing for earlier intervention or prevention for a communities' / families' needs. They can see the escalation of future need but cannot stop it (cannot level-up) and in time it spills over to be dealt with by justice agencies, social care and the NHS again and again, who are already overloaded and not the best agencies in the long term to deal with the issue. This is unfair, inefficient. People affected by violence, negative influences, mental health, trauma, gang affiliation, not in training/employment, struggling in troubled families are let down, often for the rest of their lives. These people/their families live in poverty, have a deeply ingrained poverty of hope trapped in a downward spiral. We need to transform.

We need a new way forward, a new narrative. This should be by engaging/funding the unique, proven and specialist skills of the local voluntary/charitable sector supply chains to reduce needs and bring about better outcomes for all (the whole community), for the whole of society. Wrapping up such societal, community, family support and prevention services within a social impact product adds value and is the way to demonstrate a reduction in predictable future needs. Within such a product the voluntary sector partners would have a contract with volumes/costs and clear outcomes, and they would be encouraged to integrate and use their skills mutually/collectively to maximise impact and stem the rising tide of needs by working closely with communities and people, their families. A managed partnership of expert organisations is created coordinating all referrals and personalising the person's/whole family journey by picking across a menu of support options to suit and de-escalate their needs, helping them to change positively and contribute locally.

A social impact product is invested in commercially (by the commercial business sector), the risks sit with the investors. Upon delivery of outcomes the investors are repaid (from proven savings made) and usually such products roll for sustainability reasons for 5+ years to track long-lasting change. This is incentivised need reduction with investment continuity for measured long-term transformational gain. A social impact partnership product also allows for integrated payment of outcomes across government and other commercial donors (who for philanthropic social responsibility reasons will contribute). The outcomes benefit whole communities and relieves pressure on our public services. 90% of GDP (wealth) in the UK is in the hands of commercial business (not Government) so let's get them involved in the prevention solution through impact investment. The CBI certainly feels this is the root to levelling-up.

We are clear on what we are presenting here - this is a public health informed prevention model that has social and economic value – it's investing to save. The scheme follows lines to services preventing future use of public services and is based on central Government best practice for social impact investment structuring. This innovative way of thinking is an important way to manage/stem demand into statutory services which are currently overloaded. A social impact pilot scheme allows this to happen, is portable to other areas and fits squarely into societal growth strategies and utilises alternative investment and accurately captures improvement data/outcomes. The first job of Government must be to deal with inequality and the impact this has on people, their families, their communities (in fact, the whole of society).

3. THE RELEVANCE OF SOCIAL IMPACT AND A NEW INDEX (to track transformational gain)

Our intention is to establish a unique (that is academically acknowledged) and unconventional way to understand impact in the future - a new index of assessment/reference. The resulting process is designed to provide a holistic approach to the support, development and wellbeing of an individual, group or society. By its very nature this requires us to engage with a wide range of individuals and sector / subject matter experts, all of whom are qualified to have opinions, can propose theories and carry out research that will be ideally acknowledged and accepted by their peers and the subject audience.

Apart from academics - we also looking to include input from other groups of people – these being those who have what can be best described as "lived experience". There is much to be learned/coproduced from listening to those who have first-hand experience of a certain time period or situation and whilst they may lack the recognised academic credentials, they do have real-life experience.

Phase 1 – Selection and Scoring of the Indicators An advisory team of experts drawing from the psychological, education, criminal justice, and economic fields will identify a series of indicators representing the most validated and reliable measures at the time. Where necessary, new indicators and measures will be created if needed to fill in any gaps. However, in all cases selected indicators will represent only one dimension of a construct (e.g., hope, happiness) so that they can be later summed together to represent levels of said dimension. For example, higher scores of emotion management represent a greater capacity for emotion management.

Phase 2 – Validation Studies Outside the use of on-going research studies to assess the reliability and validity of developed measures; a large-scale study will be used to fully validate the developed Social Impact index. Following a power analysis to identify the sample size necessary to include for the validation study, a sampling framework of the postcode from UK residential registers will be used as the basis for a randomised administration of the new Index at three longitudinal points in time. Several analyses will be conducted to assess the overall reliability and validity of the Index, or whether or not it is measuring what it is intending to measure, including: Item analysis to determine the extent to which the overall index is related to the indicators it comprises – reliability of indicators (crosstabulations of inter-item correlations). Factor analysis – identify underlying factors, or the indicators that group together that can be used to enhance the overall interpretation of new Index's data, and/or suggest possible revision points. Predictive validity – measure the extent to which the Index is predictive of other logical constructs, such as economic security and employment. Longitudinal – measure changes in the Index based upon external variables over time.

Phase 3 – Dissemination of Completed Index. Additional studies will assess the ability of the Index to adequately reflect individual well being at cross-sectional points in time to be assigned emojis reflective of Index scores. This is a tech-enabled future way to gain real-time feedback.

Our work is UK-wide. Our approach is flexible to understanding the situation locally. Our TOC remains in place, but we know there are different starting points for different regions, but we still apply the concepts of human development, measured (impact) change, which has both economic and social benefit. Our TOC is still applied to working across business, people, and governments everywhere we go, but we inform this by the most pressing needs locally. If a particular region has a set of local issues, we start from this position and understand the local drivers and the TOC fits around this.

Contact: *lee@smartsocial.org.uk*