The social value of improving the primary care response to domestic violence and abuse: A mixed methods Social Return on Investment analysis of the IRIS programme

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Acronyms

AE	Advocate Educator
DHR	Domestic Homicide Review
DVA	Domestic violence and abuse
GP	General Practitioner
IRIS	Identification and referral to improve safety
MARAC	Multi-agency Risk Assessment Conferences
ROI	Return on investment
SROI	Social return on investment

Executive summary

Evaluation Overview

A one-year longitudinal mixed methods service evaluation of the social value and impact of the IRIS programme was conducted in five varied UK sites.

The evaluation consisted of a scoping review, qualitative interviews, document analysis, meeting observations, follow up survey, a return on investment (ROI) analysis and a social return on investment (SRoI) analysis.

Findings: IRIS Social Value and Impact Framework

The evaluation identified the following qualities as important in assessment of the social contributions of the IRIS programme:

Guiding Values

These are broad principles against which the nature and importance of changes brought about by IRIS are judged.

Optimism – Promoting a sense of hope and optimism about addressing DVA.

Visibility – Raising the visibility of DVA as an issue in the primary care system, and helping identify service users who otherwise would be missed by traditional routes into services.

Alignment – Improving alignment between the values and priorities of organisations working towards reducing DVA, including those in service provision, health services and IRISi.

Social Impacts

These are the measurable social impacts against which the success of the work is assessed by stakeholders.

Connectedness – Providing a new form of connection for service provision and information sharing between service providers, service users and healthcare professionals.

Professional role – Increasing the confidence and ability of healthcare staff to engage with and help patients who are experiencing DVA on an ongoing basis.

Service user outcomes – Increasing referrals into services which leads to social outcomes for patients including improved feelings of safety and availability of support, de-escalation of violence, and reduced medicalisation of social issues.

Compatibility with existing infrastructure – Flexibility and compatibility with local systems for outcomes and social impact to be realised.

Credibility – Legitimacy of the service among local stakeholders, and contribution of service to overall credibility of DVA activity

Return on Investment

On average per site the IRIS Programme cost £97,926 and covered a target population of just over 230 thousand women.

On average, the monetary benefits of the IRIS Programmed amounted to £1,644,945.25 per site, implying a ROI ratio of £16.79 per pound invested. In other words, for each pound invested on the IRIS Programme a monetary return of £16.79 is expected.

When considering public spending only, the benefits of the IRIS Programme amounted to £118,981 and it yielded a 21% return on investment of public spending.

Social Return on Investment

The Social Return on Investment analysis aimed to monetise the social impacts explored in depth in the Framework analysis. We were able to quantify for all but one measure of social impact. Only 'Compatibility with the existing infrastructure' could not be included in the analysis.

The total net social benefit of the IRIS Programme was estimated to be £1,049,215. This resulted in a SROI ratio of £10.71 : £1, meaning that for each pound invested in the IRIS Programme, a social return of £10.71 was obtained.

Implications for policy and practice

- For policy makers:
    - Combining financial and social return on investment analyses with qualitative participant narratives provides a persuasive account of the social value that can be attributed to a service.
- For commissioners:
    - There is a compelling case for investing in the IRIS programme in terms of the potential financial and social return on investment.
    - The success of the IRIS programme is assessed by a complex range of values and social impacts that go beyond financial return on investment. This complexity should be considered in commissioning decisions.
- For practitioners:
    - Understanding the social values that drive the programme directs attention to the activities that can improve the readiness of the service landscape, thereby maximising the social return on investment. In this case these were activities that increase professional engagement in the programme and increase service capacity to receive referrals.

Limitations

- An important limitation of the ROI and SROI analysis is its sensitivity to the number of referrals.
- This evaluation has focused on social values and impact of the IRIS Programme across early adopters of the social franchise model. It did not evaluate the quality of services provided as it was beyond the scope of this research.

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Background

Return on investment (ROI) calculations are commonly used to guide investments of public funds, underpinned by a view that services should be at least cost-effective and preferably cost-saving (National Institute for Health and Clinical Excellence, 2013). There is increasing emphasis on examining the *social* return on investment (SROI) of public-funded services. This approach enables decision-makers to examine and quantify if a service delivers valuable social impacts, in addition to understanding the solely financial returns.

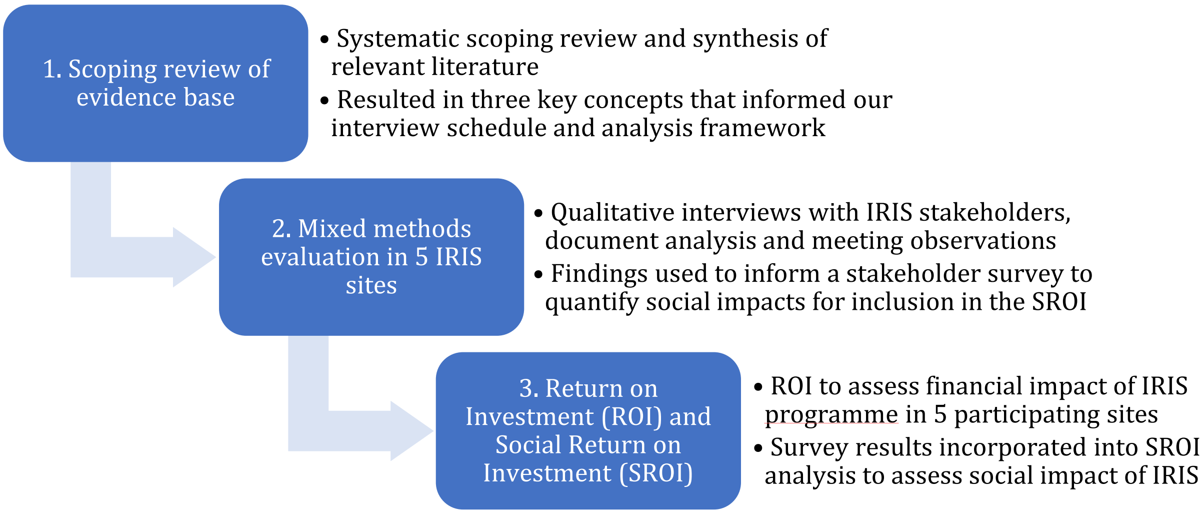
SROI analyses in the UK in relation to domestic violence and abuse (DVA) to date have focused on the impact achieved through survivor interventions (NEF Consultancy, 2013, Baraki and Lupton-Paez, 2021) and perpetrator programmes (Ariss et al., 2017). They have demonstrated that both activities deliver social value. Examining a different area of the system response to DVA, this evaluation investigates the value of investing in primary care health services as part of a pathway for identifying and supporting patients affected by abuse.

This report details the findings from a longitudinal mixed methods service evaluation of the social value and impact of the Identification and Referral to Improve Safety (IRIS) primary care domestic violence and abuse training and support programme. IRIS is a collaboration between primary care and third sector organisations specializing in DVA. Core areas of the programme include ongoing training, education and consultancy for the clinical team and administrative staff, care pathways for primary health care practitioners and an enhanced referral pathway to specialist DVA services.

The IRIS programme has previously been demonstrated to be clinically effective under research conditions (Feder et al., 2011) and in real-world implementation (Sohal et al., 2020), as well as cost-effective (Barbosa et al., 2018). While there has been examination of the positive social impact of the programme from the perspective of service users (Malpass et al., 2014, Dowrick et al., 2020) the broader social value of the programme on the local health system and beyond has not been investigated. Given the wealth of existing research into service user perspectives on the positive impact of DVA advocacy in general (Rivas et al., 2019, Stanley and Humphreys, 2015), and the impact of the IRIS programme specifically (Malpass et al., 2014, Dowrick et al., 2020, Roy et al., 2021), we chose not to duplicate this work in our primary data collection.

Adopting a mixed methods approach over the course of a year (December 2020 – December 2021), we set out to identify the social impact of the IRIS Programme. We did this through the following steps (Figure 1):

Figure 1: Process overview



Step 1: We undertook a scoping literature review to understand existing research on the social value of public health initiatives. We used the findings of this review to inform the qualitative component of this evaluation (Chapter 2).

Step 2: We undertook qualitative research with stakeholders involved in the delivery and commissioning of IRIS to develop a ‘value framework’ for how they interpret the success of their work (Chapter 3).

Five UK sites were selected for data collection due to their being early adopters of the social franchise approach to replicating the IRIS model[1], and represented varied provider

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[1] IRISi has been using a social franchise approach to replicate and launch IRIS in new sites since early 2020.
This was possible as they were recipients of a grant from the Health Foundation (through their SARTSL programme) and consultancy and support from social franchising experts Spring Impact.
The Health Foundation commissioned an independent evaluation, conducted by Cordis Bright, focussing on whether social franchising is a suitable means of replicating and scaling good interventions in an NHS context.

types at different stages of the commissioning and delivery model at the point of evaluation initiation. The sites include: Greenwich (service provider: Her Centre), Middlesbrough (service provider: My Sister's Place), Gwent (service provider: Llamau), Swansea Bay (service provider: Calan DVS) and Swale (service provider: SATEDA).

We interviewed key stakeholders in each IRIS site, reviewed core policy documents from their area, observed steering group meetings and conducted follow up surveys with participants. From these data we developed and refined a social value framework. This framework was then used to as the basis for a SROI analysis of the IRIS programme.

Step 3: Using the value framework as a starting point, we conducted economic analyses to estimate the (financial and social) return on investment of IRIS (Chapter 4).

Step 4: We brought the findings of the first three steps together to make recommendations for policy and practice based on our evaluation of the social value of investing in the IRIS programme (Chapter 5).

Scoping Review

Key points

The scoping review of the evidence base involved systematically reviewing 1534 papers for relevance, resulting in 20 included papers. The findings from these papers were synthesised to inform and underpin the mixed methods evaluation framework approach.

We identified and outlined the following findings from the synthesis:

‘Social impact’ – papers described multiple ways of measuring the difference that programmes, policies and services can make to target populations.

‘Social value’ - papers drew attention to how localised and contextual assumptions were important in assessments of the relative importance of a given change. They also highlighted the breadth of actors, factors and contexts (individual, family, community, local/national economy, and environment) that can experience change.

‘Processes of valuing’ – papers affirmed that it is important to hear a range of voices in different parts of the system, and to attend to the multiple ways in which valuing gets done.

There is a diverse literature exploring social value in the context of commissioning community-based services for public benefit. We undertook a scoping review to determine the key learning from this literature that would inform this evaluation. Our objective was to situate our approach to the evaluation within the existing literature and to inform the development of our interview schedule and framework for analysis.

Scoping reviews are useful for iteratively and systematically mapping the literature on a topic and identifying key concepts, theories, sources of evidence and gaps in the research. Scoping studies ‘aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available’ (Arksey and O'Malley, 2005).

In particular, a scoping study tends to address broader topics where many different study designs might be applicable, as well as focusing on patterns in the literature rather than very specific research questions or analyses of research quality. For this evaluation project, performing a scoping review enabled us to do two activities (Arksey and O'Malley, 2005):

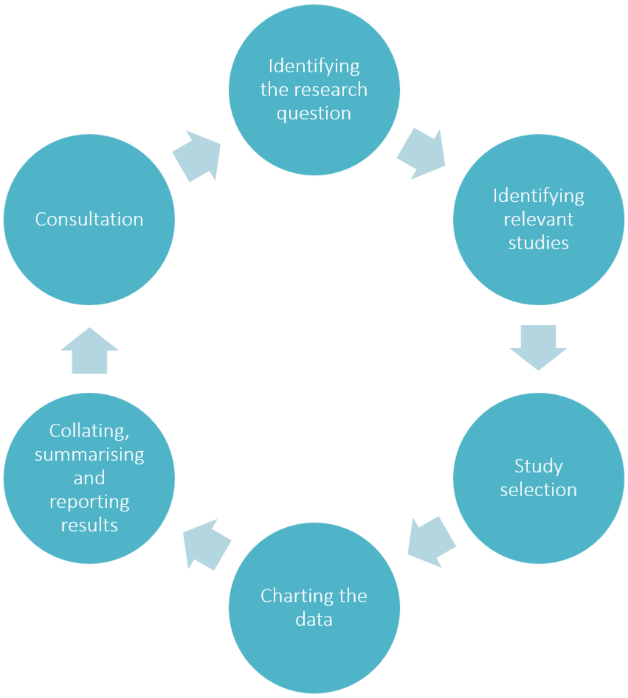
- Examine the extent, range and nature of available research on social value and social impact in relation to services aiming to improve health or social outcomes in the community
- Summarize and disseminate research findings across a body of heterogeneous research evidence
- Inform the framework we will use to guide the qualitative data collection and analysis in the following sections.

The aim of this scoping review was to identify key research and theoretical learnings that could inform our approach to evaluating the social value of the IRIS service.

Methods

This scoping review followed the methods outlined by Arksey & O'Malley (2005), outlined below as six iterative steps (figure 1).

Figure 1 – Scoping review methodology



Identifying the research question

- *How is social impact and social value in the context of public sector investment constructed and interpreted in the literature?*
- *How might debates on these topics relate to addressing the issue of domestic violence and abuse (DVA) in community health-care settings?*

Our research questions were broad to encompass both how social value and impact are defined and utilised in the literature, particularly in relation to health care and DVA support settings.

Identifying relevant studies

We undertook a broad scan of the academic and grey literature across a range of different fields (e.g. organisation and management studies, sociology, anthropology, health services research, development, policy studies). This included the use of two literature databases, PubMed and QMUL Library Global search engine in December 2020. We adapted the SPIDER tool (Cooke et al., 2012) to guide selection of our search terms: Sample, Phenomenon of Interest, Design, Evaluation, Research type.

Key word search terms:

("Social impact" OR "social value") AND (theor* OR evaluat* OR Interven* OR program* OR service* OR practice*) AND (community OR "public sector" OR "public health" OR "health service" OR "domestic abuse" OR "domestic violence" OR DVA) AND (UK OR England OR wales OR Scotland OR Ireland)

Due to the language limitations of the research team, we restricted the results to those written in the English language.

Study selection

The searches resulted in 1534 results across the two search engines, which were then sorted in ascending order by 'relevance'. The first 150 records from each search engine were screened by MH and AD for inclusion in the review. This resulted in 22 papers being included in the first instance. Upon detailed reading a further two were excluded, bringing the total to 20 papers included. In this process, we identified the highly cited, most relevant and influential papers from within these fields.

Charting the data

Key information and methodological information were extracted from the selected papers into a shared Excel spreadsheet. We charted the data from these studies according to:

- Author, title, publication year
- Type of paper (empirical/ theoretical)
- Study aim
- Methodology and context/ setting
- Key concepts
- Theoretical and empirical insights/ key findings
- Potential for conflict of interests

The key concepts in the evidence base were mapped in a systematic way to inform the evaluation project.

Collating, summarising and reporting the results

Following the charting exercise, MH and AD re-read the mapped studies and worked discursively to draw out and summarise key patterns and concepts from the included studies. This paper reports on the findings from this process.

Consultation

The concept mapping process from stages 1 to 5 were discussed with the wider evaluation team, encompassing those with expertise in undertaking social impact evaluations, and those with expertise in programmes addressing DVA.

The scoping review forms the basis of the background to the evaluation report, and shaped our methodological approach and interpretations.

Scoping Review Findings

Included studies

We included 20 papers in the mapping exercise, including a mix of reviews (7 papers), empirical studies (8 papers), service reports (2 papers), and opinion/ reflective pieces (4 papers). Papers were published between 1999 and 2020. All but two of the papers (which did not report funding) identified funding sources as governmental or public research funds, such as local health authorities. Of the empirical papers, the majority were undertaken in the UK setting, with others including Africa and Australia. Whilst papers focussed on a broad array of public health related programmes and concerns, none of the papers assessed social value specifically related to a programme to address DVA, signifying an important gap in the literature for our evaluation.

Table 1 – Characteristics of included papers

Lead Author	Year	Title	Paper type
Altinay	(2016)	Social value creation through tourism enterprise	Empirical
Ashton	(2020)	The social value of investing in public health across the life course: a systematic scoping review	Review
Bauer	(2019)	Valuing recovery-oriented practice at the interface between mental health services and communities: The role of organisational characteristics and environments	Empirical
Dayson	(2020)	A Comparative Analysis of Social Impact Bond and Conventional Financing Approaches to Health Service Commissioning in England: The Case of Social Prescribing	Empirical
Ey	(2018)	“Soft, airy fairy stuff”? Re-evaluating ‘social impacts’ in gendered processes of natural resource extraction	Empirical
Garnett	(2018)	Social enterprises and public health improvement in England: a qualitative case study	Empirical
Mortimer	(2018)	Sustainability in quality improvement: redefining value	Review
Smith and Richardson	(2005)	Can we estimate the ‘social’ value of a QALY? Four core issues to resolve	Review
Wells	(2007)	An equity-focussed social impact assessment of the Lower Hunter Regional Strategy	Public health report
Barnes	(2005)	The social impact of land contamination: reflections on the development of a community advocacy and counselling service following the Weston village incident	Review/ reflections on a service

Morgan	(2015)	Calculating Social Value: a critical analysis of how social value is constructed, understood and utilised within public sector value for money decision making	Review
Luyten and Beutels	(2016)	The social value of vaccination programmes: beyond cost effectiveness	Review/comment
Beckett	(2018)	Embracing complexity and uncertainty to create impact: exploring the processes and transformative potential of co-produced research through development of a social impact model	Opinion paper
NICE Citizen's Council	(2014)	What Are the Societal Values That Need to Be Considered When Making Decisions about Trade-Offs between Equity and Efficiency?	Meeting summary
NICE Citizen's Council	(2011)	How Should NICE Assess Future Costs and Health Benefits?	Meeting summary
Danziger	(1999)	The social impact of HIV testing: a comparative analysis of Britain and Sweden	Empirical
De St Croix	(2019)	Feeding young people to the social investment machine: The financialisation of public services	Empirical
White	(2018)	A Cook's tour: Towards a framework for measuring the social impact of social purpose organisations	Empirical
Reidpath	(2005)	'He hath the French pox': stigma, social value and social exclusion	Theoretical
Shah	(2013)	NICE's social value judgments about equity in health and health care	Policy Review

Key concepts

Our mapping and analysis revealed three interconnected themes in the literature, which we have characterised as: 'social impact', 'social value', and 'processes of valuing'.

Social impact

Our key finding 'social impact' encapsulates how the literature considered various ways of observing and measuring change or the difference that activities make. Our review included papers that outline, develop methodology for and critically engage with, methods for determining the social impact of services, programmes and policies. For instance, Wells (2007) used an equity lens to engage with a social impact assessment process, and considered whether certain interventionist actions actually increased vulnerability for some sectors of the population. Another paper highlighted the challenges of life course approaches and measuring ‘well-becoming’ - considering how to measure impact on the future - as opposed to ‘well-being’ which focusses on the present (Ashton et al., 2020). Methods for observing and measuring change included the development of analytic frameworks (White, 2018), models, measures and diverse forms and uses of data: case studies, policy analyses, and numerical and qualitative data.

Social value

Morgan (2015) conceptualises social value as the assumptions about the nature and importance of the change that is measured as ‘impact’, whether financialised or not. Social values are generated by the ‘interlocking of value creation processes at three levels: at an individual stakeholder level; at the meso-level and at the macro-level’ (Altinay et al., 2016). Social values can be focussed on the individual, family, community, local/national economy, and environmental, and are context specific. For example, Bauer’s research (2019) suggested ‘interconnectedness’ between people and services was a key social value for younger and smaller health care organisations to react to the needs of their population through achieving a ‘critical mass for social change’, whilst remaining true to their social values of ‘innovation’ and ‘autonomy’ from larger more static organisations such as the NHS.

Of key relevance to our work in domestic abuse, we found that this theme included the consideration of ‘soft’ factors that are often not included in conceptualisations of social value, e.g. ‘feelings of safety’ or ‘justice’. For example, Ey (2018) used their empirical research to illustrate the gendered nature of ‘soft’ measures such as qualitative data and values such as emotions, in contrast to ‘harder’ financial and quantifiable outcomes such as ‘dust and noise’ in land development projects (Ey, 2018).

Processes of valuing

Our third finding concerned the processes through which ideas, thoughts and meaning of social value are determined. These processes are often embedded in the social practices of institutions, e.g. Smith and Richardson (2005) outlined that NICE has a particular way of establishing health-related quality adjusted life years (QALYs).

We found that the best practice for valuing processes includes multiple voices and engages in a democratic process of debate and trade-off of different values and how they are measured. This skilled work allows for how different people, of different ages and from different backgrounds, might conceptualise the value of interventions differently (NICE Citizens Council, 2014, NICE Citizens Council, 2011). The process of co-production of these social values also acknowledges different forms of knowledge (Beckett et al., 2018) and may reduce the likelihood of epistemic injustice in defining social value (Fricker, 2007).

The processes for valuing are inseparable from the resultant outcome of the intervention: the impact of an intervention is both the social outcome, and the values that underpin the intervention (Danziger, 1999). Furthermore, the process of valuing shapes and is shaped by the policy and social context within which actors navigate services, and has outcomes for service users that may go beyond the scope and intentions of the intervention. For example, De St Croix (2019) draws on assemblage theory to outline how the 'social investment machine' of the national citizenship scheme (re)produces young adults' futures and promotes an agenda of 'neoliberal aspiration, personal responsibility and individualised notions of social mobility'.

Conclusion

We were unable to identify any papers that specifically evaluated the social value of interventions which aimed to address DVA in community settings. Whilst this limited our ability to fulfil the second objective of this scoping review, this provides important justification for the undertaking of our evaluation on the social value of the IRIS programme in 5 UK locations, which forms part two of this project.

Papers examining 'social impact' described multiple ways of measuring the difference that programmes, policies and services can make to target populations. They also highlighted that impact is not necessarily immediately visible - making imagined future impact important – and that it rarely distributed equally across populations. Studies of 'social value' developed this perspective, drawing attention to the localised and contextual assumptions inherent in assessments of the relative importance of resultant change. They also highlighted the breadth of actors, factors and contexts (individual, family, community, local/national economy, and environment) that can experience change, whether intended or not. Building from these points, the literature on ‘processes of valuing’ affirmed that it is important to hear a range of voices in different parts of the system, and to attend to the multiple ways in which valuing gets done.

These findings informed the next stages of the evaluation in a number of ways. First, they sensitised us to the importance of including multiple voices with differing perspectives on the value of IRIS in the development of our social value framework, both within teams and across geographical settings. Second, they encouraged us to explore multiple ‘valuing practices’ done by stakeholders, paying close attention to the ‘soft’ values as well as the ‘hard’, quantifiable values. Following the literature, we were careful to develop our interview schedule to discuss values that were not immediately visible or usually acknowledged by participants, as well as future imaginaries. Lastly, it sensitised us to an important caveat in this work: that understandings of value are locally negotiated and context-specific, albeit within wider systems of valuing. We return to these considerations in the report discussion.

Developing a social value framework for IRIS: qualitative findings

Key points

Over 12 months we collected and analysed qualitative data in the form of documents, interviews (18), observations of steering group meetings (5), survey responses (17).

Our analysis developed insights about the *guiding values* and *social impacts* of IRIS. Guiding values were significant to all involved in the delivery and commissioning of the IRIS programme, but are not immediately quantifiable. Social impacts were specific ways of observing and measuring the change or difference that IRIS related activities make.

We identified three guiding values which informed assessment of IRIS: contributing to optimism about addressing DVA; improving visibility of DVA in the primary care system; improving connectedness between institutions with a DVA agenda.

We identified five direct social impacts that were used to judge the success of IRIS: impact of professional response to DVA; impact on service user outcomes; improving interactions between patients, GPs and local DVA support services; compatibility of the programme with local infrastructure; and credibility of the work among local stakeholders.

Qualitative Data collection

Data collection occurred longitudinally over the course of a 12 month period (December 2020 – December 2021). We utilised a mixed method, multi-phased approach to service evaluation. This included:

- Analysis of existing policy documents in each site discussing DVA/IRIS, to understand how social value is described (e.g. commissioning guidance, DVA strategy)
- Online interviews with (n=18) IRIS stakeholders to understand what the value of IRIS is for different people involved in planning and delivering the service

(stakeholders included: Advocate Educators, Clinical Leads, heads of service, programme managers, commissioners). Interviews lasted between 20 minutes to an hour and were audio recorded and transcribed.

- Observation of a steering group meeting at each site to understand how value was discussed and measured over time among wider stakeholder groups.
- Follow-up anonymous online survey with previous participating stakeholders (n=16) developed using Microsoft Forms to further refine our social value framework. This included Likert scale and open-ended questions and took around ten minutes to complete. This had a 62% response rate.

Ethical considerations

This study was classified as a service evaluation according to guidance from the Queen Mary University of London Research Ethics Committee and the University of Bristol Research Ethics Committee, therefore formal ethics approval was not required. Informed consent was provided by each participation prior to interview commencement. Transcripts and notes were stored on a secure, password protected shared folder and all direct quotes have been pseudo-anonymised.

Research Setting

This evaluation focused on five locations, selected because they were early adopters of the social franchise approach to replicating the IRIS model. They were therefore in the early stages of their journey with the IRIS programme. Additionally, service providers in these locations (figure 2) began the implementation of IRIS at different times, thus we captured views on the programme from different stages of programme roll out. Figure 2 provides a brief overview of these sites. To protect participant confidentiality, qualitative data collected and presented in this report has not been directly attributed to each site.

Figure 2 – Site profiles

Evaluation Sites

Greenwich - Her Centre is a small local women-focused and led charity based in Greenwich, working with over 1000 women a year. Their aim is to engage, enable and empower women to move away from abuse and move forward with their lives. Greenwich experiences the third highest levels of DVA amongst London boroughs, and in 2017 3,387 DVA offences were recorded by the police. Areas where DVA is highest in the borough consist of some of the most deprived areas in the country. Approximately 23,076 women living in Greenwich have been the victim of DVA in their lifetime. Her Centre were an early adopter of the social franchise approach to the programme, commencing IRIS in September 2020.
www.hercentre.org

Middlesbrough - My Sister's Place was established in 2002, and is an independent specialist service for women who have experienced or are experiencing domestic violence. It aims to promote individual freedom and quality of life, to explore and share innovative ways to address domestic violence, to campaign change in policy and practice, and to work with the wider community towards zero tolerance of domestic abuse. Cleveland police force experiences the second highest level of DVA incidents in England, and Middlesbrough is their area of highest need. There were 4,921 recorded DVA incidents in Middlesbrough in the year to 2017. My Sister's Place launched their IRIS programme in January 2021.
www.mysistersplace.org.uk

Gwent – Llamau is a registered charity aiming to reduce homelessness amongst vulnerable women and children in Wales. As part of this, they recognize that one of the biggest causes of homelessness amongst women is DVA. They are committed to supporting women and children experiencing DVA and "breaking the cycle of abuse" for future generations. One in three women in Wales will experience DVA and in South Wales reports of DVA incidents occur every 15 minutes. A 2020 survey showed that 89% of service users disclosed DVA to their GP, but none were supported to make contact with DVA services. Llamau joined the IRIS programme in March 2021.
www.llamau.org.uk

Swansea Bay - Calan DVS was formed in 2012 and is one of the largest DVA charities in Wales. Their mission is to build resilient and safe communities free from DVA, aiming to relive the distress, suffering and poverty experienced by families affected by DVA. They also aim to educate the public about this issue and raise the profile of preventative methods. In South Wales there were a total of 33,000 DVA incidents reported to the police in 2017/18. In the Western Bay area, 3,177 incidents of DVA were recorded in the year to 2016, and there were two domestic homicides. Calan DVS successfully launched their IRIS programme in February 2020.
www.calandvs.org.uk

Swale - Support & Action To End Domestic Abuse (SATEDA), is a registered charity, established in 2009. SATEDA are based in Swale, Kent and provide access to support and assistance, advocate for victims and survivors and support their recovery as they rebuild their lives. Medway and Swale have some of the highest incidence rates of DVA in Kent. 26,149 incidents of domestic abuse were recorded in Kent and Medway by the police in 2017. In the same year, they found 38% of all violent crime was categorised as domestic abuse and domestic abuse made up 15% of all crime. SATEDA secured funding and successfully launched IRIS in September 2021.
www.sateda.org

Stakeholder characteristics

In line with those working in this field and the gendered nature of DVA, our interview and survey sample was mostly female (n=16), with an age range of 25-59 years. We interviewed stakeholders from a range of professional roles, including advocate educators[2] (n=5), commissioners (n=5), clinical leads[3] (n=5), and heads of service (n=3). In terms of years of experience, stakeholders varied, with 5 having worked in the field of DVA for less than a year, and 13 having more experience. Some had worked in this area for more than a decade. Stakeholders self-identified as being from a range of ethnic backgrounds, with 4 from minoritised ethnic groups in the UK.

Analysis

We applied a framework analysis methodology to interpret this data (Gale et al., 2013). We developed an analytical coding framework based on preliminary readings of the data, using the findings from the scoping review to sensitise us to representations of social value and social impact. We inputted this into a Microsoft Excel matrix, with codes in the columns and data from interviews, documents, observations and free text survey responses entered as individual cases in the rows. The framework was refined during wider team discussions and adapted iteratively.

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[2] The advocate educator provides training to the practice teams and acts as an ongoing consultant as well as being the person who patients are referred to by clinicians for expert advocacy and ongoing support.

[3] Clinical leads for each site promote the IRIS project, recruit practices, deliver in-house training at the practices, and act as a source of advice, guidance and support for clinical colleagues on the subject of DVA.

Findings

Table 2: Summary of guiding values and social impact relevant to IRIS

Guiding social values		
Optimism	Promoting a sense of hope about addressing DVA	*In the last three years [pre-IRIS] there have been [a total of] 34 referrals… When IRIS got up and running we already had 34 in less than a year*
Visibility	Raising the visibility of DVA as in issue in the primary care system, helping to identify service users who would otherwise be missed	*I find it particularly worthwhile reaching those clients we have never spoken to before*
Alignment	Improving alignment between the values and priorities of organisations working towards addressing DVA at a system level	*I noticed everything was very siloed… We're now thinking how the services align so there is a 'DA offer' not a 'service offer'*
Social impact		
Professional role	Increasing the confidence and ability of healthcare staff to engage with and help patients who are affected by DVA	*It goes from nothing, no conversations about abuse, to something*
Service user outcomes	Increasing referrals into services, leading to social outcomes for patients including: improved feelings of safety and availability of support, de-escalation of abuse, and reduced medicalisation of social issues	*If they go and access support via a GP and have a response fairly quickly then that is life-changing and life-saving*
Connectedness	Introduction of new forms of connection for service provision and information sharing between service providers, service users and healthcare professionals	*IRIS is that vital bridge between client and service and that bridge is in a safe space in primary care*
Compatibility with existing infrastructure	Possibilities for flexibly integrating the programme within existing local systems	*We are implementing this at one of the most challenging times that any of us have experienced*
Credibility	Legitimacy of the service among local stakeholders, and contribution of service to overall credibility of DVA activity	*IRIS is a ready-made model with an evidence base. That's rare in primary care*

1. Guiding social values

Guiding values were important outcomes identified by stakeholders that IRIS as a programme was expected to contribute to, but which were challenging to quantify. They were often expressed in terms feelings about the worth of IRIS, rather than 'hard' outcomes.

1.1 Optimism

A strong current running through discussions of the value of IRIS was that it offered a sense of hope. This built from a feeling that opportunities to intervene in DVA had previously been missed, with IRIS offering a vision of optimism for different outcomes in the future. This was particularly relevant when reflecting on instances where women had been killed by their partners.

> *I think we're all wanting, really wanting this to work, particularly when you end up with domestic homicides where, you know, I'm not suggesting that if the GP [general practitioner] had done x, y and z then the domestic homicide wouldn't have happened, but, certainly there were opportunities that were missed for the GP to at least ask the question and possibly intervene in whatever way they could. (Site 3)*

IRIS offered a pathway for re-invigorating efforts to address existing challenges within the system.

> *At one point 50% of crime here was related to DVA. Not just physical but also mental health, lack of aspiration and generational violence. This calls for a more specialist attempt. (Site 1)*

The rapidly visible results of IRIS were often used as evidence of the potential for IRIS to make a positive contribution locally.

> *In the last 3 years there have been 34 referrals. It is a place that is deprived, a lot of health issues, a lot of substance misuse issues, two homicides there within last couple of years, yet 34 referrals in three years. When IRIS got up and running we already had 34 in less than a year. (Site 5)*

Whilst specific outcomes were seen as important in different parts of the system, such as improving safety and reducing the incidence of domestic homicide (and by association Domestic Homicide Reviews), most stakeholders described a shared feeling that IRIS represents a route towards positive outcomes. The investment and work of IRIS was, by this rationale, worthwhile.

1.2 Visibility of DVA

Another important guiding value used by stakeholders to assess IRIS was how the programme contributes to the visibility of DVA. This manifested in a number of ways across the sites. First, IRIS made DVA and the needs of those affected by abuse more visible within primary care systems, raising it as a priority for primary care teams.

> *We don't think of it enough, it's not in our thought process, me personally I don't think I'm addressing it enough. (Site 3)*

Second, IRIS was perceived as creating opportunities to identify women who may otherwise not access support.

> *Despite our presence locally - and I always feel we are a well-known organisation, it is always interesting that IRIS reaches out to clients we have not had contact with before. I find it particularly worthwhile reaching those clients we have never spoken to before. There was a particular case, which was immediately assessed as 'High Risk' and referred into MARAC, there was no other professional involved but the GP - there is now an appropriate multi-agency response for that client and her family. (*Site 4)

This idea that IRIS helped to identify women who would have otherwise *'slipped through the net'* was echoed across all the IRIS sites involved in this evaluation. These were characterized generally as women whose experiences of abuse were at comparatively lower risk of escalation - as measured by the DASH DVA risk indicator checklist - and therefore unlikely to be identified by services that primarily deal in high-risk cases (for instance, the police). The wider range of people a GP might have contact with meant that more patients could become visible as needing DVA support. This included patients who may have been living with abuse for many years:

> *I have received referrals for patients who were not known to specialist DA services especially those who have been in 10+, 15+ years abusive relationships. (Site 2)*

There was also reflection that primary care offered a different and important avenue for making DVA visible to patients themselves.

> *The most moving thing was when I received a referral for an 80-year-old client. It was so emotional while we were speaking to her. She didn't know there was anyone like us who existed. She'd suffered abuse from her husband, coercive control, and didn't know what it was. She hadn't been able to understand experiences. She asked me 'do other women suffer this?' (Site 4)*

1.3 Alignment between different efforts to address DVA at a system level

The third value that guides reflection on the contribution of IRIS is the degree to which it facilitates alignment between the different institutions, systems and people that are connected through the work of responding to DVA. At an organisational level this involved alignment of priorities within different public service providers:

> *I noticed everything was very siloed – all in different departments, working separately. All crisis and emergency rather than prevention and early intervention. Now we're thinking about how the services align so there is a 'DA [domestic abuse] offer' not a 'service offer' (Site 4)*

IRIS also represented alignment between national legal responsibilities with regard to DVA and local practices.

> *When the Care Act came in 2016, then we all started to think, "well what are we doing about this category called domestic abuse?" because it already had a whole strategy in community partnerships, already a whole team of people collecting data and providing services, "how do we link in to that?" (Site 3)*

Some stakeholders, however, expressed caution about mission creep and the expectation that IRIS could address issues of communication between all services.

> *One of the issues we've had come up is between GPs, MARAC [multi agency risk assessment conferences] and health information, with information not going in either direction. People think IRIS is the way to resolve that situation. This isn't IRIS – it can support this but that is not the purpose of the service. We don't want to go*

> *off on a tangent. IRIS is here to do what IRIS is here to do – a GP referral service. It is not here to resolve every concern between health and specialist DVA support. (Site 4)*

2. Social impact

Social impacts were the specific outcomes that were considered important in each site. While there were local and contextual variations, the broad categories described in the following section were conceptual tools for assessing the contribution IRIS was making across all sites.

2.1 Professional role

A core social impact that stakeholders expected of IRIS is that it would improve the knowledge and confidence of primary care staff in relation to DVA, which can in turn increase their engagement in conversations about DVA with patients.

> *With the training, regardless of what has been triaged, GPs will be able to pick it up. It goes from nothing, no conversations about abuse, to something.*
> *(Site 3)*

The importance of primary care staff being skilled in recognising abuse is often attributed to them occupying a unique position within the community. Face-to-face appointments offer a local, private space for consultations (the COVID-19 pandemic has impacted the availability of in-person consultations), and the longevity of primary roles means clinicians may have multiple opportunities to engage in the issue of DVA with patients. Staff also may see several different members of the same family.

> *Mum, daughter and son all presented with health conditions to GP, all connected with DV [domestic violence]. The son was angry, the daughter had tummy pains and the mum was anxious. They had a professionally curious GP who considered the family situation. The woman said "nobody has ever asked us about domestic abuse before". Who else in the community would have picked that up? Who else would have contact with all three family members? GPs are in a unique position to know everyone. (Site 4)*

However, a challenge in achieving this impact was in getting practitioners to recognise their unique role and their ability to contribute as a health care professional.

> *I remember an elderly couple where the GP made a referral to social services. The GP wasn't happy about DVA, felt it wasn't a health issue, "this is a social problem", not for her to get involved in. This is deep rooted within people, "it is something else, not my problem" (Site 5)*

IRIS was understood by stakeholders as enabling primary care staff to recognise their role within DVA, as practitioners who can act as a gateway for specialist DVA support, and to feel confident in having a conversation about abuse with patients:

> *It's about giving them skills to have confident conversations with women, because they may feel like they don't want go there. (Site 3)*

In turn, this was perceived to positively impact on the quality of medical encounters regarding DVA, particularly around clinicians noticing cues which could lead to a conversation about abuse:

> *They might sometimes get complaints from families about not finding solutions to health problems. Talking about DVA offers other avenues to travel down with medical problems. (Site 3)*

> *A doctor I work with who questioned the value of IRIS referred a patient who was suffering from a same sex partner who was controlling the patient. The doctor had received IRIS training and she said she looked at this patient in a different way and realised what was happening. She said before IRIS training she would not have taken on board what was going on with the patient (Site 2)*

> *The first time I felt that I had picked up on DVA due to the training I had received from IRIS - and would never have spotted it before IRIS. It happened to be a case*

> *completely unknown to DVA services and to the GP and was very high risk for domestic homicide - being told I had probably saved her life was amazing! (Site 2)*

IRIS was also imagined as a possible way to improve GPs engagement in DVA with patients across time. GPs were identified as services which women affected by abuse might keep links with the longest, so it was considered important for them to understand the long-term course of abuse.

> *With GPs it is increasing their understanding of trauma and DA [domestic abuse]. Services who receive a disclosure, they expect a response, they expect a woman to leave and she often won't. But a person will continue with their GP. A lot of victims go in and out of services, with GP always sort of connected. It's about how to have that relationship and support victims across time (Site 4)*

> *So training gives support to gain confidence for a consultation and learn how to approach it. Because GPs feel frustrated at people staying in that situation but teaching shows you need to have patience that all her gains will come at a slower pace. (Site 3)*

2.2 Service user outcomes

While the initial focus of the IRIS programme is general practice teams, there was an expected social impact relating to improved outcomes for survivors of DVA. This was initially visible in the uptake of the service by patients via GP referrals.

> *After we had provided one particular practice Clinical 1& 2 training, it generated 11 referrals the first week from that practice and two a week after that for 4 weeks. so that is 19 women who are now aware of the support available to them and are now known to specialist DA agencies. (Site 2)*

> *Since the start of the Programme we have successfully supported over 100 women and as a result, over 60 children, the future generation. From that number, we have managed to find temporary, safe, accommodation with support, for 4 high risk women and their families, thus quite possibly saving their lives. (Site 5)*

The outcomes considered particularly important by individuals were locally negotiated in each IRIS site, and included reducing escalation of abuse, improving feelings of safety, onward referral for further support, and identifying and addressing unmet needs. Ultimately, it was challenging to put a *'price on a life':*

> *How can you put a price on a life, and multiple lives, even if you have one victim or survivors, the ripple effect the wider implications of that go far beyond that household. And waiting lists for DVA organizations are just growing by the day, and if they go and access support via a GP and have a response fairly quickly then that is life changing and lifesaving, if you miss that chance it might never come back around. (Site 2)*

There was also a perceived value in improving the quality of healthcare support provided by identifying alternative avenues to medicalisation of patient issues.

> *We have [a high] level of DVA […], high deprivation, and we see a lot of complex patients. If doctors could realise that the underlying reason for consulting was DA, they would get a much higher quality of care and get sorted sooner without extra harm from all the extra treatments they receive. (Site 4)*

> *We know the health problems the women have. We work with women day in day out, all the women have some sort of health issue. (Site 5)*

While there was pride in supporting women to leave abusive relationships, an important guiding principle is that support will be available to women regardless of their current relationship with the perpetrator:

> *The value is in ensuring her safety even if she wants to stay. The way we work with women is - whether they are in the relationship, planning to leave, already left – support is always there. The aim is for them to know what is available out there and build their confidence in case they want to access it. (Site 3)*

A further impact identified for service users was educating them about how to recognise an abusive relationship:

> *What is important is their determination not to return to the situation and a recognition of what an abusive relationship is. (Site 3)*

2.3 Connectedness

IRIS was expected to positively impact on connectedness primarily between clinicians, patient and DVA support services around the issue of DVA, which is observable through referrals.

> *It's helpful, it feels like there is another connection that helps us keep the client engaged and find out if there is anything going on, and GP surgeries that's probably the last service people with disengage from, particularly if they have children. (Site 3)*

Whereas the broader value of alignment related to how well different policy objectives and services aligned around DVA, connectedness was often imagined as a bridge between GP, patient and AE. The services available from the Advocate Educator were felt to enable GPs to meet patients' needs in a different way:

> *We know that there are multiple contacts [in primary care] which are failed contacts... if you look properly at a group of people and their needs and what is out there to support them, in the case of the bridge of the AE and the clinician (Site 2)*

> *IRIS is that vital bridge between client and service and that bridge is in a safe space in Primary Care (Site 5)*

Connectedness was also perceived as important between the local agencies with responsibilities towards DVA, manifest through improved information sharing and perceived ease in interactions.

> *A police officer was asked to attend a practice at the same time as the AE – they commented "this is the first time I have been involved with trying to help a victim of DV through a GP practice and these links are crucial" (Site 5)*

There was an implicit assumption among some stakeholders that improving these connections would lead to a reduction in use of healthcare services, as women received support for abuse. However, the tangible impact of connection on reduced use of health care services was challenging to materialise:

> *Going to be a long time till they see a reduction in people visiting [primary care] and a reduction in medication. (Site 5)*

It was also considered important among clinical stakeholders in particular that connections between GPs and Advocate Educators were maintained, usually through lines of communication about referral outcomes. Feedback was important for embedding new behaviour around DVA in clinicians.

> *Feedback after the patient / client has been seen is crucial. As clinicians in primary care feedback is scarce. This makes us feel our efforts are a waste of time. If we want IRIS to become embedded in primary care permanently and effectively that closure of the feedback loop to the clinician showing all the interaction and services the client has been offered and / or used is very powerful. It simply means that clinicians will ask the DVA question more often and find more clients and more lives will be saved and improved (Site 5)*

2.4 Compatibility with existing health and DVA infrastructure

An indirect impact of IRIS was understood to be its compatibility with local services, structures and policies. The IRIS programme had to be able to effectively integrate within local infrastructure for the other impacts to be sustainably delivered. Stakeholders reflected on the challenges and successes of delivering this integration.

One important aspect of integration was ensuring that the IRIS service complemented and improved upon (as opposed to reproducing or diluting) the existing DVA offer in the community – a goal that the IRIS service strived towards. This involved assessments of the added value of the IRIS training approach, revisiting current training offers and ensuring a coherent pathway between DVA providers.

A more difficult aspect of compatibility was making the IRIS training a priority for general practices. There was a clear rationale connecting training with existing clinical responsibilities towards safeguarding:

> *All surgeries have been contacted about the training highlighting that it meets their safeguarding requirements as an angle to generate interest (Site 3)*

However, securing time for the training among the other priorities of general practice proved a consistent struggle. There was often a perceived incompatibility between the length of training and the availability of general practice teams.

> *Many of the GPs have not engaged due to the length of the training, and because we cannot reduce this we are struggling to get engagement (Site 3)*

While a universal challenge across IRIS sites, there were different responses by different teams. Some sites sought to shorten training to make it more accessible; some suggested further investment from commissioners for locums who could release staff for training; some offered multiple training sessions so that whole practice teams would not be taken away from work; and others pushed back against pressure to reduce training length:

> *The length of training is always a bugbear with clinicians, but I think this reflects their difficulties in taking the subject of DVA seriously and I think rather than shortening the training we need GPs to realise that it is worth their "precious" time. (Site 2)*

Even in instances where IRIS was considered fully compatible with local infrastructure, keeping the service in place was a challenge given uncertain sustainability of funding.

> *In my opinion the only barrier to maintaining the programme is the lack of sustainable funding. The funding only being secured for 1 year at a time is not beneficial to the service and risks losing very experienced AE's and clinical leads which in turn means all the hard work that has been put in has potentially been lost (Site 5)*

This evaluation was conducted at a time of unprecedented disruption due to the COVID-19 pandemic, which resulted in additional obstacles in ensuring an effective fit between the newly established IRIS service and existing local resources.

> *Stresses in system and pandemic might make recruiting practices slower than normal. (Site 1)*

> *We are implementing this at one of the most challenging times that any of us have experienced. We have to give ourselves a bit of a break too if we have to take a foot off pedal. There are bigger public health things at the moment, commissioners and funders will understand. Staff are really tired at this point. (Site 4)*

2.5 Credibility

A final social impact of the programme related to its credibility among stakeholders and how the broader IRIS brand contributes to the perceived quality of service. In this respect, the impact of the programme extends outside of a given site, in that this impact relates to both the national IRISi team and to the wider research environment that the IRIS programme is part of.

For some stakeholders, one of the benefits of the IRIS programme was that it had been developed over a number of years through collaboration with research institutions. This meant that it had both greater legitimacy as an evidence-based approach and came as a 'pre-packaged' model that could be easily implemented:

> *IRIS is a ready-made model with an evidence base. This is rare in primary care. That's helpful, and also the operational stuff, information from other areas, advice about how to deliver in practice, being able to have the costing toolkit. (Site 2)*

> *Commissioners do get excited about innovation and evidence-based things. (Site 4)*

The evidence base of IRIS also helped to distinguish why the IRIS approach – which embeds a direct referral pathway to specialist support alongside delivering training – yielded better results than previous or existing training-only programmes.

> *The research explained the difference between the IRIS training and 'normal training' and how IRIS worked better than the others in terms of referrals (Site 2)*

The practical experience of the national network of IRIS sites was also valued as a source of support to overcome start-up challenges:

> *They link to the rest of the country, so when our clinical lead wasn't sure about an element of the programme, the national [IRISi] team said "we'll put you in touch with another clinical lead in a different area of the country where they've already been through this process" so it's really helpful to have that link into the knowledge and experience, potentially nationally. (Site 3)*

The IRIS 'brand' was also perceived by stakeholders from smaller providers to increase credibility of local services in some areas.

> *That's the kind of thing that's good about this model. It feels like a respected well-known brand behind us and because we have been accepted and welcomed by IRIS[i] as an organisation that's good enough to deliver this on their behalf, it makes us more credible (Site 1)*

The social franchise approach for delivering the programme was perceived to have strengths and limitations. On one hand it was perceived positively as stimulating different approaches to commissioning:

> *The social enterprise type approach, it's the first time a cluster have commissioned something through the third sector. That coming bottom up has made the organization do different things around commissioning. (Site 2)*

On the other hand, some stakeholders felt that being part of a franchise was less relevant given the strength of their own service offer.

> *Social franchising is difficult to apply with strong existing local models. Big things have something to offer, but bottom line this should be coming from local services and people who use these services. It has become too removed, too theoretical. (Site 3)*

There was recognition that there should be a balance between local expertise and the expertise of the wider IRIS network, which connected to the balance of funding between local services and the IRIS social franchise fee.

Conclusion

In this chapter we have outlined the findings resulting from the document analysis, qualitative interviews, meeting observations and free text survey responses. Our mixed method framework analysis identified a number of core guiding values and social impacts that were considered important across the sites for measuring progress related to the IRIS programme.

The three guiding values - whilst providing important insights into the additional perceived value of IRIS - are difficult to measure or quantify with readily available routinely collected or research-generated data. This is a key challenge that researchers and stakeholders face when attempting to fully comprehend the social value of a complex, community-based health intervention in numerical analyses. This further justifies the need for a mixed-methods evaluation approach.

The social impacts we have illustrated here are more suited to an economic assessment of social value. Assessment of progress against these values was different in each site relative to their local context. However, despite being contextual and locally situated, four out of five of these impacts were found to be quantifiable and were therefore used to underpin a social return on investment analysis, which we examine in the next chapter.

The IRIS Return on Investment (ROI): Quantitative findings

Key points

In this section of the evaluation we conducted three analyses:

A Return on Investment (ROI) analysis for IRIS, showing the efficiency of investment in purely monetary terms. For every pound invested in the IRIS Programme, a return of more than £16 was achieved, ROI: £16.79 : £1 [95%CI 15.97; 17.61].

A Return on Investment analysis examining the impact of IRIS on public spending. For every pound of taxpayers' money invested in the IRIS Programme, one pound and 21 pence of public spending is avoided as a result, ROI: £1.21 : £1 or 21% [95% CI 1.15; 1.27].

A Social Return on Investment (SRoI) analysis, quantifying the results of the qualitative study in the previous chapter to determine the wider social impact of IRIS. For every pound invested in the IRIS Programme, on average, there was a £10.71 social return, ROI: £10.71 : £1 [95% CI 10.20; 11.22].

Return on investment (ROI) is a performance measure used to evaluate the efficiency of an investment in monetary terms. It only takes into consideration monetary costs and monetary benefits, and thus, is considered useful as a comparative measure between investments. While ROI is commonly used by private companies to ascertain how effective their different investments are, more and more ROI is used by governmental entities as a measure of value for money. Programmes funded by public money have also been incentivised to estimate their return on investment (ROI). This is the case of the IRIS Programme.

The formula for ROI is:

$$ROI = (Net\ Programme\ Benefits)/(Programme\ Costs)$$

While ROI is a useful measure, it does not take into account the passage of time. That is no discount is used, although it is understood that the benefit of the Programme may happen after the investment. Effectively, this means that ROI can miss opportunity costs of investing elsewhere. ROI is usually expressed as a ratio £ : £ or as percentage (%).

IRIS Programme Costs

The cost of the IRIS Programme (investment) was based on the financial models for each early adopter of the Social Franchise Model. There was some variation in budgets across all 5 sites, but this was mainly due to the size of the population covered by the Programme across sites. Furthermore, due to funding and commissioning cycles, sites included in the study began implementation of the programme at different times during the study period. Due to the relatively delayed start of Site 1 compared to the other sites, we did not consider data for this site in the ROI analysis, as the benefits cannot be estimated. Thus, for consistency, the costs were also disregarded.

The investment value for the IRIS Programme across all other social franchise sites included in this evaluation is presented on the table below. The table also includes the 95% confidence intervals[4] around the programme cost/investment.

Table 3: Average cost of the IRIS Programme for the first year (in 2020/21 prices) and average population size

Average Cost / Investment	**95% Confidence Interval: Lower bound**	**95% Confidence Interval: Upper bound**	**Average target population size**
£97,926	£97,687	£98,166	230,093

The cost of the IRIS Programme includes the direct costs, such as the initial IRISi fee, the cost of Train the Trainers course (T4T), and indirect costs, such as salary costs and cost of equipment.

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[4] The 95% confidence interval is defined as a range of values within a distribution that one can be 95% confident contains the true mean of the studied sample or population.

The initial IRISi fee is only charged once when the service is first commissioned, therefore, the average cost/investment in the IRIS Programme is smaller from Year 2 onwards. For the scope of this analysis, the initial fee was included in the cost, as it was decided to report actual return on investment/social return on investment. For subsequent years, it is expected that the returns will be higher, as costs are lower.

Net benefits of the IRIS Programme

The benefits of the IRIS Programme are measured in terms of prevention of future costs, i.e. by identifying and referring victims of domestic violence and abuse, the IRIS Programme prevents further abuse and aggravation in the severity of abuse.

SafeLives (2018) has estimated that the length of abuse is on average 3 years, this means that while the IRIS Programme may interrupt the cycle of abuse for certain victims, it more likely has an impact on the repeat nature of abuse, its severity and escalation.

A recent Refuge report (2021), which considered the outcomes for 6500 women supported by specialist-DVA services, estimated that 59% of these women felt safer, more confident, and no longer sought public services for reasons related to the abuse. This is similar to the results of modelling of effects from the IRIS in implemented settings (Barbosa et al., 2018) which estimated around 5% interruption of abuse and 60% reduction in terms of impact of abuse[5], totalling a 65% reduction in abuse.

For the purposes of estimating the benefits of the IRIS Programme for the social franchise early adopter sites, the average between both values will used, or 62%. The 59% figure from Refuge will be considered the lower bound of the confidence interval and the 65% figure from the IRIS modelling will be considered the upper bound of the confidence interval.

The cost of Domestic Violence and Abuse (DVA)

The cost of DVA has been previously estimated by Walby (European Institute for Gender et al., 2015, Walby, 2004, Walby, 2009) and more recently by the Home Office (Oliver et

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[5] These figures were obtained from the Markov Model built to assess the cost-effectiveness of the IRIS Programme in implemented settings. They take into account data from 6 sites across England and Wales and the calculation of steady states, which estimated a 5% probability of transition from abuse identified to no abuse and a 60% probability of increase in quality of life for those in the abuse identified state after seeing an advocate.

al., 2019) The latter was used in this analysis and it updates the estimates from Walby, as well as improves the estimates by accounting for costs of mental health harms.

The methodology used in the Home Office report was described in detail in 'The Economic and Social Costs of Crime' (Heeks et al., 2018) and only considered direct costs, which can be completely attributed to the relevant crime type(s), in this case, DVA. The direct cost approach implies that cost of abuse for children in abusive households is disregarded, as this is an indirect cost. This is a conservative approach, so potentially the actual societal cost of abuse per victim is higher.

For the monetisation of mental health harms, the QALY method was used, in line with the recommendation from 'The Green Book: appraisal and evaluation in central government' (HM Treasury, 2018) and 'The Economic and Social Costs of Crime' (Heeks et al., 2018).

The costs reported in the Home Office Report were inflated to 2020/21 prices for comparability with the IRIS Programme Costs. Table 4 presents cost per category per victim of DVA for the year 2020-21.

Table 4: Unit cost of domestic violence and abuse per victim for the Year 2020/21.

Component	**Cost in £ (2020/21)**
Physical and mental health harms	£26,147
Lost economic Output	£7,796
Health Services	£1,291
Specialist-DVA services	£398
Police	£694
Criminal Justice	£183
Civil Justice	£75
MARACs and Housing	£5
Prevention: Governmental Awareness Campaigns and Domestic Violence Disclosure Scheme (DVDS)	£5
Total	**£36,595**

Estimating the net benefit of the IRIS Programme

In order to estimate the benefit of the IRIS Programme, we considered the average number of referrals each site has received (72.5; CI 72.29; 72.71), multiplied by the unit cost of DVA (£36,595) and by the probability of reduction of abuse (62%, CI 59%;65%). Mathematically:

$$Net\ benefit = Average\ referrals \times unit\ cost \times probability\ of\ reduction\ of\ abuse$$

The average net benefit of the IRIS Programme, therefore, is estimated to be £1,644,934. Table 5 shows the decomposition of the net benefit of the IRIS Programme.

Table 5: Decomposition of the Net benefit of the IRIS programme by cost component

Component	**Net benefit**
Physical and mental health harms	£1,175,299
Lost economic Output	£350,413
Health Services	£58,039
Specialist-DVA services	£17,895
Police	£31,196
Criminal Justice	£8,222
Civil Justice	£3,386
MARACs and Housing	£ 242
Prevention: Governmental Awareness Campaigns and Domestic Violence Disclosure Scheme (DVDS)	£ 242
Total	**£ 1,644,934**

As the table shows, most of the benefit from the IRIS Programme is realised by preventing future physical and mental health harms. The programme also produces important benefits by incentivising women's financial independence, return to employment and productivity gains. In terms of use of public services, most of the benefits take place within the health services here considered widely, which includes primary, secondary and tertiary care, as well as ambulance services.

The 95% confidence interval for the net benefit of the IRIS Programme is [£1,560,857; £1,729,535].

Return on Investment Calculation

Having estimated both the costs and net benefits of the IRIS Programme, we can now estimate the ROI ratio according to the formula.

$$ROI = \ (Net\ Programme\ Benefits)/(Programme\ Costs)$$

$$ROI = \ (£\ 1{,}644{,}934\ )/£97{,}926 = 16.79\ or\ £16.79{:}\ £1$$

This means that for every pound invested in the IRIS Programme for the social franchise early adopter sites, a return of more than £16 was achieved. The 95% confidence interval for the ROI is [15.97; 17.61] or [£15.97: £1 ; £17.61: £1].

Sensitivity Analysis: ROI of the IRIS Programme in terms of public spending

While the traditional return on investment approach preferred by economists includes any relevant societal costs, cost prevented and benefits in a ROI, one could argue that an important metric is the ROI focusing on public funds alone because the Programme is funded with taxpayers' money.

A public spending ROI calculation would not include harms to physical and mental health and lost economic output. Excluding these costs, the net benefit of the IRIS Programme sums £118,981 (95% CI [£112,900; £125,101]).

Table 6: Decomposition of the Net benefit of the IRIS programme by cost component, excluding physical and mental health harms and lost economic output

Component	**Net benefit**
Health Services	£ 58,039
Specialist-DVA services	£ 17,895
Police	£ 31,196
Criminal Justice	£ 8,222
Civil Justice	£ 3,386
MARACs and Housing	£ 242
Prevention: Governmental Awareness Campaigns and Domestic Violence Disclosure Scheme (DVDS)	£ 242
Total	**£118,981**

Using the ROI formula, one can estimate the return on investment of public spending in the IRIS Programme:

$$ROI_{public\ spending} = (£118{,}981\ )/(£97{,}926\ ) = 1.21\ or\ £1.21{:}\ £1\ or\ 21\%$$

This means that for every pound of taxpayers' money invested in the IRIS Programme, one pound and 21 pence of public spending is avoided as a result. Alternatively, one could say that there is a 21% return on investment on public spending for funding the IRIS Programme (95% CI [15.6%; 27.4%]).

Social Return on Investment

A Social Return on Investment (SROI) is a methodology used to estimate the net social value created by organisations, which are not normally included in a traditional Return on Investment Analysis due to their inherent difficulty in translating into a monetary figure.

The approach to estimating the SROI for the IRIS Programme comprised three stages:

1) Identifying social impact of the IRIS Programme
2) Developing a social return framework including attribution and monetary benefits from the IRIS Programme
3) Estimating the Social Return on Investment (SROI)

While calculating the SROI is helpful as a tool for evaluating impact and identifying organizational strengths and weaknesses, the analysis presented in this report reflects the unique experiences of the early adopters the of the social franchise approach. Given the relatively small number of interviews and people responding to the survey, all results should be considered carefully.

Identifying the social impact of the IRIS Programme

The relevant measures of social impact were defined by the framework analysis described in detail in the qualitative part of this report. As previously mentioned, while the guiding values of the IRIS Programme were significant to all involved in the delivery and commissioning of the programme, they are not immediately quantifiable, therefore cannot be included in the SROI calculation.

For the five identified measures of social impact, we have sought to find a monetary figure that conveyed the benefit of the measure. Wherever possible, we relied on previously conducted Social Return on Investment Analyses or Economic Evaluations to obtain such values. Unfortunately, we were unable to find a monetary figure either in terms of benefits or opportunity costs for the impact measure ‘compatibility with the existing infrastructure'. While this measure should increase the net benefit of the IRIS Programme, it happens at system level, and thus, by not including it in the SROI calculation could be considered a conservative approach. Table 7 summarises the decisions made regarding inclusion and exclusion from the analysis.

Table 7: Measures considered for inclusion in the SROI

Category	**Measure**	**Included in SROI**	**Reason**
Guiding social values	Optimism	No	Not quantifiable
	Visibility	No	Not quantifiable
	Alignment	No	Not quantifiable
Social impact	Professional role	Yes	
	Service user outcomes	Yes	
	Connectedness	Yes	
	Compatibility with existing infrastructure	No	No monetary benefit or opportunity cost found
	Credibility	Yes	

Developing a social return framework: attribution and monetary benefits from the IRIS Programme

Attribution Calculation

In a SROI, attribution is defined as an assessment of how much of the social impact was caused by the contribution of the relevant organisations or its people. In this report, attribution was calculated using the responses to specific questions on the follow up anonymous online survey (n=16) developed using Microsoft Forms, which had a response rate of 62%.

For the measures included in this SROI, the following questions were asked:

- Thinking about the social impacts of IRIS, how much does 'Improving clinicians' professional response to DVA' contribute to the overall success of the programme?
- Thinking about the social impacts of IRIS, how much does 'Improving service users' outcomes' contribute to the overall success of the programme?
- Thinking about the social impacts of IRIS, how much does 'Improving connections between clinicians, patients and DVA services' contribute to the overall success of the programme?

- Thinking about the social impacts of IRIS, how much does 'Building the credibility of the IRIS programme with stakeholders, participants and commissioners' contribute to the overall success of the programme?

Answers used a Likert scale, where 1= very little and 10=a lot. Table 8 presents the average attribution for each of the included social impact measures, as well as the minimum and maximum value attributed by survey responders and the calculated 95% confidence interval.

Table 7: Attribution scores by social impact measure

Measure	**Average**	**Min**	**Max**	**95% Confidence Interval**	
Professional Role	**9.13**	7	10	8.55	9.70
Service User Outcomes	**9.19**	8	10	8.83	9.54
Connectedness	**9.38**	8	10	8.87	9.88
Credibility	**8.94**	7	9.75	8.42	9.45

Net Social Benefit

The other component necessary for the calculation of SROI is the attributable monetary value of each measure. For each of the social impact measures, we have looked at previous Social Return on Investment Analyses, which could be directly transferable to this analysis. Three SROI on DVA interventions or DVA-specialist services were found in the literature: 2 conducted the New Economics Foundation, NEF, on behalf of Refuge (NEF Consultancy, 2013, Baraki and Lupton-Paez, 2021); and one conducted by the University of Sheffield (Ariss et al., 2017).

From the DVA-specific SROIs we were able to obtain monetary benefits for ‘Professional role’ and ‘Service User Outcomes’. While the Sheffield SROI managed to obtain a value for Professional Role, it proxied it by comparing the work of an advocate to that of a Education Welfare Officer, since they also provide a streamlined pathway, but in their turn between education and social care, as opposed to health and DVA-specialist service. For the measure ‘Service User Outcomes’, we chose to use the Refuge SROI for outreach services, since the IRIS Programme focuses mainly on community-based support for women experiencing abuse.

No values could be found on the published SROI for 'Connectedness' and 'Credibility'. Thus, we needed to take an opportunity cost approach to estimate the net benefit. For 'Connectedness', the estimated value uses the cost of holding a MARAC meeting, since it is a forum that effectively connects multiple stakeholders concerned with DVA, including health, specialist services, the police and social care. Finally, 'Credibility' was estimated based on the amount of time saved by GPs in relationship to DVA patients, as measured in the IRIS original trial. This was used as a proxy for estimating the cost prevented by the intervention being evidence-based and providing a clear pathway for referrals. All benefits were estimated using 2020-21 prices.

The total net social benefit per woman of the IRIS Programme is £15,789. Table 9 breaks the net social benefit by social impact measure.

Table 9: Net monetary benefit estimates by social impact measure

Measure	**Benefit per woman (2020/21)**	**Type**	**Includes**	**Source**
Professional Role	**£5,112**	Net benefit	Value AE / Clinical lead and streamlined pathway between health and specialist service. Proxy based on value of Education Welfare Service, which offers streamlined relationships between schools and Social Care.	University of Sheffield SROI
Service User Outcomes	**£10,182**	Net benefit	Improvements in health, safety, social wellbeing and economic wellbeing	Refuge SROI analysis
Connectedness	**£231**	Opportunity Cost	Cost of holding a MARAC meeting including stakeholders from health, specialist services, police and social care	Manchester Unit Cost template (police)
Credibility	**£264**	Opportunity Cost	Opportunity cost of time of GPs when dealing with DVA patients (IRIS trial = 2.75 hours saved; £88 per hour)	PSSRU Unit Costs for Health and Social Care

Estimating the Social Return on Investment (SROI)

Similar to the ROI, the SROI is defined as $SROI = (Net\ Social\ Impact\ Benefits)/(Programme\ Costs)$.

However, the Net Social Benefits are a function of the average number of referrals in a year, the total social benefit per woman and the attribution expressed as a rate. Mathematically we have:

$$Net\ Social\ benefit = \sum_{Social\ impact}^{n=4} \left(Average\ referrals\ x\ net\ social\ benefit_{impact\ measure}\ x\ attribution\ rate_{impact\ measure} \right)$$

Table 10 presents the calculation of the net social benefit of the IRIS Programme.

Table 10: Net social benefit of the IRIS Programme: base case and 95% Confidence Interval

Base Case				
Social Impact Measure	Net value	Attribution rate	Number of Referrals	Net Benefit
Professional Role	£5,112	0.9125	72.5	£338,190.75
Service User Outcomes	£10,182	0.91875	72.5	£678,216.66
Connectedness	£231	0.9375	72.5	£15,700.78
Credibility	£264	0.89375	72.5	£17,106.38
TOTAL				**£1,049,215**
Confidence Interval Lower bound				
Social Impact Measure	Net value	Attribution rate	Number of Referrals	Net Benefit
Professional Role	£5,112	0.86	72.29	£315,977.91
Service User Outcomes	£10,182	0.88	72.29	£650,294.10
Connectedness	£231	0.89	72.29	£14,811.67
Credibility	£264	0.84	72.29	£16,072.92
TOTAL				**£997,157**
Confidence Interval Upper bound				
Social Impact Measure	Net value	Attribution rate	Number of Referrals	Net Benefit
Professional Role	£5,112	0.97	72.71	£360,526.95
Service User Outcomes	£10,182	0.95	72.71	£706,290.02
Connectedness	£231	0.99	72.71	£16,594.79
Credibility	£264	0.95	72.71	£18,145.54
TOTAL				**£1,101,557**

Table 11 presents the SROI ratios calculated using the estimate net social benefit and the cost of the programme.

Table 11: Social Return on Investment results

	Base Case	**95% Confidence Interval**	
Net Social Benefit	£1,049,215	£997,157	£1,101,557
Programme Cost	£97,926	£97,686	£98,165
SROI ratio	£10.71 : £1	£10.20 : £1	£11.22 : £1

These results imply that for every pound invested in the IRIS Programme, on average, there was a £10.71 social return. The confidence interval for the SROI is [10.20; 11.22] or £10.20: £1 ; £11.22: £1.

Discussion

Summary of findings

The social value of the IRIS programme

This study demonstrates that the value of IRIS extends far beyond increasing referrals to DVA services or improving service users' lives. At the macro level it can make DVA more visible in the primary care system, raising it as a priority for healthcare and shining a light on people affected by abuse who may otherwise be overlooked. It can improve alignment in values, priorities and responsibilities between organisations and localities working towards tackling DVA. As a programme, it can increase optimism and reinvigorate a sense of hope that DVA can be addressed for those working towards this goal.

At the local level, it can connect primary care professionals, service providers and service users, creating a new routes for addressing patient needs and information sharing. It can improve the knowledge and confidence of primary care staff around dealing with DVA, increasing ongoing engagement and the perceived quality of consultations around this issue. In terms of outcomes for patients, increased referrals combine with locally negotiated impacts such as improved feelings of safety, reduced escalation of violence, reduced medicalisation of social issues, and providing support at all stages of the relationship.

In order for these local impacts to be realised, IRIS must be flexible and compatible with local DVA systems, recognising and connecting with existing expertise. There were important differences between sites in the extent to which the IRIS programme was seen to achieve this, particularly around training uptake. For local providers and healthcare staff, IRIS has the potential to increase credibility through linkage to a national network of support run by IRISi, and its status as a programme underpinned by research with a clear and established evidence base. Similarly, IRISi was seen to benefit from connections with well-established local networks of DVA service provision.

The IRIS Social Return on Investment

When these social impacts are quantified, for every pound invested in the IRIS Programme, on average, there was a £10.71 social return. This evaluation has also demonstrated that IRIS is a good investment from a purely economic perspective, with a financial return on investment of £16.79 per pound invested. Even when narrowing the scope of the investment to public spending only, the IRIS Programme yields a return of 21%, which is larger than the 15% return earmarked by financial markets[6]. While the SROI and ROI are intrinsically different methods for assessing value for money, there is potentially some small overlap, if one considers that the benefits accrued in terms of 'improved outcomes for patients' may also be reflected in the avoided cost of DVA, particularly in terms of mental health harms.

Strengths and limitations

A key strength of this study is our approach - a mixed-method longitudinal service evaluation combining quantitative and qualitative insights. This interdisciplinary approach, underpinned by a scoping review, allowed us to triangulate our findings and strengthened our comprehension of the social value of the IRIS programme. It also highlighted the challenges of fully capturing the 'non-quantifiable' impacts of a complex community-based social intervention. The longitudinal nature of the study meant we were able to explore how stakeholders imagined and assessed the IRIS programme over time as it was implemented in their area.

There are, however, some clear limitations to this evaluation. First and foremost, only five IRIS sites were included, as these were the early adopters of the social franchise approach. While the number of interviews conducted and number of respondents to the follow-up survey are ample for a qualitative study, they are relatively small for a ROI and SROI analysis. Thus, while the methodology used throughout this research is robust, the Return on Investment (ROI) analysis and Social Return on Investment (SROI) analysis may be affected by small numbers.

An important limitation of the ROI and SROI analysis refers to its sensitivity to the number of referrals. There was great variation in the number of referrals received within

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[6] This translates to the fact that for banks and other financial institutions, an investment is considered poor performing or not good value for money if it does not yield a 15% return.

a year across the evaluated sites. While a larger number of referrals implies a higher return on investment and social return on investment figure, there are many factors influencing the number of referrals. This includes the challenges of implementing the programme, which we addressed qualitatively through the social impact 'Compatibility with existing infrastructure' but could not quantify. Furthermore, capacity to receive referrals is constrained by staffing at each site, with smaller staff numbers equating to lower referral capacity. Therefore, the results of this evaluation should not be used for between site comparisons.

This evaluation has focused on social values and impact of the IRIS Programme across early adopters of the social franchise model. It was beyond the scope of this research to assess the quality of services provided. The effectiveness of implementation and service delivery has been explored elsewhere (Lewis et al., 2019).

Implications for policy and practice

This evaluation has generated a number of lessons that can support stakeholders in the field of DVA and health services delivery.

For policy-makers, we have demonstrated the importance of conducting both financial and social return on investments when considering service developments. As well as generating a broad evidence-base to support commissioning decisions, clear narratives about the social value of a proposed or existing service are important for communicating investment decisions to diverse stakeholders. Aligning economic analyses with qualitative participant narratives provides a persuasive account of the social value attributed to a service. Specifically, we have contributed evidence about the value – both financial and social – of investing in pathways from primary care into DVA services.

For those involved in the practice of commissioning IRIS programmes in health care, we have provided insights into the social values that drive the programme and how they can be quantified. These can be taken into consideration in discussions about the value of starting or continuing investment in the IRIS service in the participating sites and other locations. Furthermore, examining the social values and social impacts that are locally important directs attention to activities with can in turn maximise a social return on investment. In the case of IRIS, this includes activities that would increase professional engagement in the programme and increase referral numbers.

For fellow researchers, this project has demonstrated a clear process through which actionable knowledge about difficult to quantify programme benefits can be generated to provide clear financial impetus for commissioning and funding practices. Similarly complex public health programmes in other contexts can draw on our methodological approach to inform their own evaluations of social impact.

Finally, for those involved in the delivery of the IRIS service we have ventured 'beyond the numbers' to more accurately capture the full social impact of their work and efforts in this important area. By drawing out findings such as the 'guiding values' we have gone some way to highlighting the complexity of fully recognising the multitude of values that arise through DVA service provision. In doing so we hope this report serves to convey the ongoing importance of the IRIS programme and shed light on the additional value-work that those involved in DVA interventions undertake.

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