Manchester Sport and Leisure Trust

Telling the story of our actions
Using Social Return on Investment

December 2013 *Full Report*

BAKER TILLY

Manchester Sport and Leisure Trust

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Manchester Sport and Leisure Trust Limited

Chairman's Foreword

Not only is Manchester the birthplace of the industrial revolution and an economic powerhouse of the north, but hosting the Commonwealth Games in 2002 provided a legacy of one of the most unique collections of elite and community sporting facilities in the world.

With a primary objective of *'making sport and leisure facilities available for all, through a range of affordable and accessible activities at free or subsidised rates',* over the past five years, Manchester Sport and Leisure Trust have developed programs that are both innovative and exciting which tackle the broader issues of improving people's health (both physical and mental), reducing obesity, providing alternatives to crime and anti-social behaviour, facilitating social inclusion and helping young people back into employment.

In recent years, Manchester, like many local authorities, has had to undertake reviews on local government spending that jeopardise the provision of everyday public services, such as leisure and sports centres. These reviews have presented and continue to present additional challenges to our business. However, during any difficult times, additional opportunities will always be available if you're progressive and pro-active, ensuring that our primary objective can continue to be achieved, despite such pressures.

This is one of the key reasons we decided to implement the research model for measuring our Social Return on Investment (SROI). Despite the challenging economic landscape, we have seen significant socially focused achievements, alongside our financial improvements as a result of hard work, partnership working and having the vision, flexibility and ability to move away from traditional models of working.

For the Trust, SROI provides external validation of our work and another way to evaluate our overall performance and worth, contributing to our decision-making and strategy development.

SROI is also about value, rather than just money, and helps measure change in ways that are relevant to our business. It is much more than just a number. It is a story about change; it helps tell the story of our actions against social, environmental and economic outcomes and uses monetary values to represent them.

And what a story!

Over £37m of considerable gains per annum identified as a result of just a few of the selected activities delivered by the Trust and its partners. For this exercise, we focused on the following five areas, accounting for up to 10% of our users;

1. Cardiac Rehabilitation and Management of Chronic Obstructive Pulmonary Disease (COPD)
2. Neurological and Stroke Rehabilitation
3. Disability Activities
4. Women Only Activities
5. Health & Fitness Offer (focussing on one of our community facilities contributing 1 of 9 pools and 1 of 11 gyms)

The report provides insight into the social impact of improving fitness and social inclusion for local Mancunians, and is a fascinating read that is testament to our passion and commitment and justifies our 'raison d'être'.

So what now?

The findings have helped us further cement and gain a better understanding of the importance of our role and our primary objectives in Manchester, especially within our local communities, and we will embrace the challenges the future brings with our usual drive and vigour.

The knowledge gained from this study has better equipped us with a greater understanding of our social impact alongside our existing financial analysis framework.

Over recent years we have also reinvested into sport in Manchester – and this will remain, continuing the cycle of positively impacting on peoples' lives, health and well-being, alongside our culture, professionalism, commitment and strategic direction.

And to strengthen and enhance our work, we recognise that we have far greater impact when we work closely with our partners, as demonstrated during this project with valuable contributions from Manchester City Council, our managing agent and Trust staff.

I and our Senior Management Team look forward to sharing the findings and results with key stakeholders and using this knowledge to positively focus our resource and efforts.

Alan Benzie
Chairman

Manchester Sport and Leisure Trust

Introductory Comments from Jim Clifford

Manchester Sport and Leisure Trust is now one of many Third Sector organisations that are seeking to show the social impact of its work. Against a traditional tendency to emphasise the good in what is being achieved for beneficiaries (be they individuals or communities), we are all increasingly asking "what effect did it have?" and "how did you do that?" All too rarely do even the best of organisations get the chance to stop and ask those questions, yet when they do it becomes a time of revelation. This was certainly the case for the MSLT team as they were able to link the reactions from various regular and not-so-regular participants in their activities with the often life-changing effects that those bring to them every day.

In examining in detail five programme areas within MSLT we discovered that the gains for participants and their families went significantly beyond the general benefits in combatting obesity, and maintaining general health. We found advantages in socialisation and social development, in family welfare (for example for families with disabled children and young people), in the development of support networks (such as the mutual support for COPD sufferers), and development of self-esteem and self-confidence.

This study evaluates at over £37.1m the gains from some, but not all, of Manchester Sport and Leisure Trust's activities. We recognise that wider gains arise, over and above those evaluated. Nevertheless, its contribution to health, equality of access, and rehabilitation care, is considerable. Of these gains, some £9.2m are realised as cashable benefits by the public authorities. In these times of pressure to delivery efficiency in public spending, MSLT is, as we have seen with others of the community sector leisure groups, delivering value for money.

Social Impact Measurement is increasingly being recognised not as a fascinating, but optional extra, or even a new idea, but as a key part of the mainstream: in public commissioning, which must now be outcomes-based, and as a foundation for the emerging social investment sector. SROI is a methodology within that field which addresses two key aspects of impact: clarifying and quantifying the economic, social and environmental effects – the change achieved – and developing the theory of change, linking the change achieved, or outcome, back to the activity that achieved that

The research methodology used in this project, and indeed the majority of similar projects we are undertaking, is Action Research, also known as Action Science. In a process which allows the research to reflect the stories that it can tell about its work, the organisation is supported by the researcher in learning about what it achieves and for whom. In this context, it gathers quality information, from those that best understand it, building in relevant, validated third party data, and giving the organisation the knowledge to be able to embed it in its performance monitoring systems: all in one go. It works, and delivers results cost-effectively.

SROI can become a process-driven exercise in which the answer emerges as a function of the process. It can also suffer from the use of financial proxies that have a poor correlation with the outcomes they attempt to measure, or are based on over-enthusiastic assumptions, and a lack of robustness in linking outcomes to the activities in which they originate. This is not the case here. As is increasingly the case for SROI studies of this type, the evaluations have been developed with real thought, care and prudence, and are soundly based on validated underlying data, with conservative assumptions where such are necessary.

Jim Clifford OBE
Head of Social Impact Services, Baker Tilly

Jim Clifford is Head of Non-profit Advisory Services, and Chairs the Public Sector Group at Baker Tilly. He has authored a number of high profile social impact and cost studies including the social impact protocol for Sector Skills Councils, published in 2010, the study of PACT's domestic adoption and fostering services, referenced in the Narey Report on Adoption, Alana House Women's Community Centre, the PRTC National Carer's Centre Network, and comparative study of costs of special schools for NASS, Following from the PACT study he led the development of the Sector's response: "It's All About Me", the first voluntary sector-originated Social Impact Bond, and has since been appointed its first Chair. He is also technical chair of the GECES subgroup advising the European Commission on the development of social impact measurement under emerging EU policy for social enterprise. He is a Visiting Fellow at Cass Business School's Centre for Charity Effectiveness where he is undertaking research into evaluative protocols for transactional decision making (linking Social Impact with conventional valuation and brand valuation). He is a non-executive director of the Centre for Public Scrutiny**.** He was awarded an OBE in 2013 for services to social investment.

Contents

Definitions of Terms

The following definitions apply throughout this document, unless the context requires, otherwise:

Term	Definition
ASB	Anti-Social Behaviour
CMO	Chief Medical Officer
CSJ	Centre for Social Justice
COPD	Chronic Obstructive Pulmonary Disease
GP	General Practitioner
GVA	Gross Value Added
MCC	Manchester City Council
MSLT	Manchester Sport and Leisure Trust
NEET	Not in Education, Employment or Training
NHS	National Health Service
ONS	Office for National Statistics
SROI	Social Return on Investment
UK	United Kingdom
NCFFC	North City Family & Fitness Centre
PARS	Physical Activity Referral Scheme

1. Executive Summary and Key Findings

Background to this report

Background to Manchester Sport and Leisure Trust

1.1 Manchester Sport and Leisure Trust is a company limited by guarantee with charitable status. The Trust was formed in 1997 firstly to manage the Manchester Aquatics Centre and then 10 community leisure centres throughout Manchester. In 2008 the world-class facilities at Sportcity along with North City Family & Fitness Centre (in 2009) transferred into the Trust - increasing their portfolio to 18 unique sports facilities.

1.2 MSLT has an annual turnover of circa £12m. Of this figure, approximately £5.5m comes from Manchester City Council (MCC) as a service payment and the balance is earned income. The Trust pays Serco to operate two contracts covering the eight facilities which it operates as managing agent. The Trust directly employs 78 staff (split between full and part-time contracts) as well as 2 apprentices and a number of casual (non-contract) staff such as coaches and instructors. In addition to this Serco employs 262 full and part time contracted staff plus casual employees and apprentices.

The importance of promoting fitness

1.3 The importance of physical activity is increasingly being stressed by Local Government, UK Government bodies and other agencies. Generally across England, participation in exercise is relatively low. The NHS highlights that 61% of men and 72% of women fail to meet the recommendation for physical activity[A].

1.4 The Department of Health estimated the NHS costs due to the population's physical inactivity to be between £1billion and £1.8billion per annum (only from chronic diseases, not taking into account obesity itself). The cost of lost productivity has been calculated at approx. £5.5billion due to sickness absence and £1billion from premature death of people of working age[B].

1.5 The prevalence of clinical obesity in Manchester is such that it is estimated that 14,000 children are obese along with 90,000 adults. These figures are expected to continue rising[C].

1.6 In addition to the economic impacts (in terms of cost savings or increased productivity) of participation in exercise, the Cabinet Office's 2002 report[D] highlights the wider benefits of sport, including:

- Personal satisfaction and better social life;
- Improved overall health (both physical and mental);
- Improved educational outcomes;
- Crime reduction;
- Social inclusion; and
- Enhancing the environment.

[A] Statistics on obesity, physical activity and diet: England 2012, The NHS Information Centre, Lifestyle Statistics, 23 Feb 2012, Page 7
[B] http://www.sepho.org.uk/topics/physActivity.aspx
[C] Manchester's Healthy Weight Strategy 2010-2013 - Ahston, Gillespie and Dawson Feb 2010
[D] 'Game Plan: A strategy for delivering Government's sport and physical activity objectives', Cabinet Office, 2002, p.44

1.7 None of the above studies considers the effect of obesity or chronic diseases risk on wider family members, notably the effect on children and the elderly when the prime carer is obese, or is distracted from their prime carer role by having to fulfil a similar one for another person. This then affects education and development for the children, as well as potentially encouraging lifestyles that tend towards obesity in the next generation.

1.8 The above evidence from research in the field of health and fitness highlights the importance of MSLT's work in promoting participation in order to achieve a preventative or remedial effect to reduce the cost borne by health and social care agencies and the wider economic impact from being overweight or obese.

Scope of this report

1.9 This study presents an evaluation using Social Return on Investment methodology (see section 3 for further detail on methodologies used) of the following areas of MSLT's work:

- Management of Chronic obstructive pulmonary disease (COPD) and Cardiac care through special physical activities;
- Neurological and Stroke Rehabilitation;
- Women-only facilities;
- Working with disabled individuals; and
- Physical activity for wider population from selected services[E].

1.10 In terms of the total population accessing MSLT services, this evaluation covers up to approximately 10% of the total individuals who access MSLT facilities in a 12 month period. This has been estimated using footfall across facilities as provided by MSLT's membership data.

1.11 The study uses four key measures to evaluate the gains achieved by these specific projects:

- Reduction in direct health and social care costs;
- Reduced cost access to facilities compared to commercial alternatives;
- Reduced costs associated with mental health problems and
- Increase in employment.

[E] Gym, classes and social swimming access at the North City Family & Fitness Centre

Results of the evaluations

1.12 In this exercise, rather than risk an overly complicated analysis that may be viewed as spuriously accurate, a smaller number of key assumptions have been identified. We have worked with project representatives for each area of work to develop a prudent result at a high level. It has been considered important to present a more defensible, prudent analysis than one which is overly complicated and risks overstatement.

1.13 Detailed models and commentary thereon are included as Appendix B to this report. The table below shows an analysis of the annual gains achieved by the evaluated areas of work, through the key measures listed above at 1.11:

	Evaluated gains
Management of COPD and Cardiac care	£ 2,751,305
Neurological and Stroke Rehabilitation	£ 1,834,476
Activities for disabled people	£ 1,755,966
Women-only activities	£ 958,284
Physical activity for wider population from selected services	£ 29,893,162
Total	£ 37,193,193

1.14 The table above shows total benefits from the projects included in this evaluation to be at least £37 million per annum. This is a similar figure to that calculated in evaluations carried out with North Lanarkshire Leisure (£41 million) and Edinburgh Leisure (£32.5 million). It is important to note however that the assessed services and membership numbers are not the same across the three organisations and this information is provided only to place MSLT's study in context.

1.15 Of these benefits we have also evaluated them in relation to expenditure saved over a 12 month period relating to narrow and wider cashable savings alongside some local area economic value created, see section 5.5. From the services evaluated it would be expected that were they to be removed, within a timeframe of 6 to 18 months after closure the following additional costs would be borne out:

Assessed Service	Value lost
Management of COPD and Cardiac care	£511,762
Neurological and Stroke Rehabilitation	£490,108
Provision of Services for those with Disabilities	£314,809
Provision of women-only services	£149,842
Wider Health and fitness services	£7,778,397
Total assessed Narrow Social Impact	**£9,244,918**

1.16 This evaluation does not extend to the benefits resulting from specifically funded areas of work, other than those identified above. In particular it excludes the value of improvements in the well-being of the wider community that may be achieved by certain projects. One example would be greater community involvement by individuals who have benefitted from an increased quality of life and are able to participate more.

1.17 The benefits shown above take reasonable account of the key areas of deduction required in SROI evaluations (three standard areas plus risk, which is also needed). The three standard ones are:

- Deadweight - gains that would have happened anyway;
- Alternative attribution - where part of the gain is more reasonably attributable to a partner or third party; and
- Displacement - where the gain is tempered by a lesser dis-benefit.

1.18 These results are to be set in the context of total annual funding of £5.5 million per annum, albeit this funding covers a wider area of activity than just those projects evaluated.

1.19 On this basis, the impact of the benefits evaluated for the areas of work shown above exceeds MSLT's total annual funding by at least £31.6m per annum.

1.20 It should be noted that this report only includes the benefits evaluated from the projects shown in this study, which MSLT estimates represent around 10% of its users. Hence, if all the areas of MSLT's work were evaluated the total impact would be likely to increase.

1.21 In common with most SROI evaluations, it is not practicable or cost-effective to evaluate every aspect of the effect of the projects. This relates often to the wider well-being and less proximate benefits from MSLT's work. Hence the results shown above may not reflect full evaluations of benefits including:

- Long term impacts on subsequent generations due to lifestyle change among the current one;
- The value of friendships made during participation in certain activities;
- The wider impact on communities of improved well-being due to certain project outcomes including reductions in Anti-Social Behaviour rates;
- The promotion of participation in competitive sport, including the development of professional athletes;
- Improved water safety and, potentially, lifesaving skills derived from social swimming; and
- Improved educational outcomes and social cohesion through participation in sport.

1.22 This report does not constitute an evaluation of the entirety of MSLT's work. Other notable areas of work that are not accounted for in the evaluations shown above include; the hiring of football pitches, tennis and swimming lessons, team sports provisions, racket sports, martial arts, athletics and gymnastics.

1.23 Where specific evidence exists, the SROI Project Team have sought to evaluate these benefits as noted in the report (e.g. personal satisfaction leading to an increase in economic activity). However, a number of these outcomes which could be considered as attributable to MSLT were perceived to be either too remote or subject to too many uncertainties to be evaluated reliably, and as such have not been included.

1.24 As this evaluation does not seek to measure the value of the further outcomes and areas of work listed above, the value of these would be incremental to the result shown above. Hence, the evaluation of £37,488,663 shown in this study is lower than the full value of the outcomes potentially generated by MSLT.

Conclusions from the evaluations

1.25 In the words of New Philanthropy Capital in their 2010 positioning statement on SROI, it is an "incredibly useful tool." This is apparent here, illustrated as a significant financial value, based on sound and researched third party data.

1.26 The total of £37.1 million is shared between 5 groups of activities that have been evaluated; Cardiac and COPD maintenance was evaluated at a gain of £2.7 million, Stroke and Neurological rehab at £1.8 million, activities for disabled people at £1.8 million, women-only activities at £1 million and the wider gain from swim and gym facilities of £29 million.

1.27 The total of £37.1 million per annum of economic and social gain for MSLT is set against around £5.5 million of funding from Manchester Council. This provides a fascinating insight into the wider social impact of improving fitness and social inclusion, and draws the reader into wanting to know how it is done: what is MSLT doing that it achieves so much?

1.28 That enquiry not only tells us more about their activities, but also highlights that this is only a partial evaluation of the wider gains from their work. These wider gains (New Philanthropy Capital describe several of these as "social well-being") are nonetheless of significant social value, and should not be disregarded for their lacking financial measures at this juncture.

1.29 The methodology around SROI can become a process-driven exercise in which the answer emerges as a function of the process. It can also suffer from the use of financial proxies that have a poor correlation with the outcomes they attempt to measure, or are based on over-enthusiastic assumptions, and a lack of robustness in linking outcomes to the activities in which they originate. This is not the case here. The evaluations have been developed with real thought, care and prudence, and are soundly based on validated underlying data, with conservative assumptions where such are necessary. It fairly represents the very valuable contribution of MSLT to the communities in Manchester it serves, and, indeed, to the wider economy in the fields evaluated.

1.30 Assessing the narrow cashable savings enabled by MSLT's work shows the short term impact that their work has on local communities and services. **This is a vital piece of understanding for MSLT and their partners and at an evaluated figure of over £9.2 million demonstrates the savings they help to deliver.**

2. Introduction

2.0 Manchester Sport and Leisure Trust is a company limited by guarantee with charitable status. The Trust was formed in 1997 firstly to manage the Manchester Aquatics Centre and then 10 community leisure centres throughout Manchester. In 2008 the world-class facilities at Sportcity along with North City Family & Fitness Centre (in 2009) transferred into the Trust - increasing their portfolio to 18 unique sports facilities.

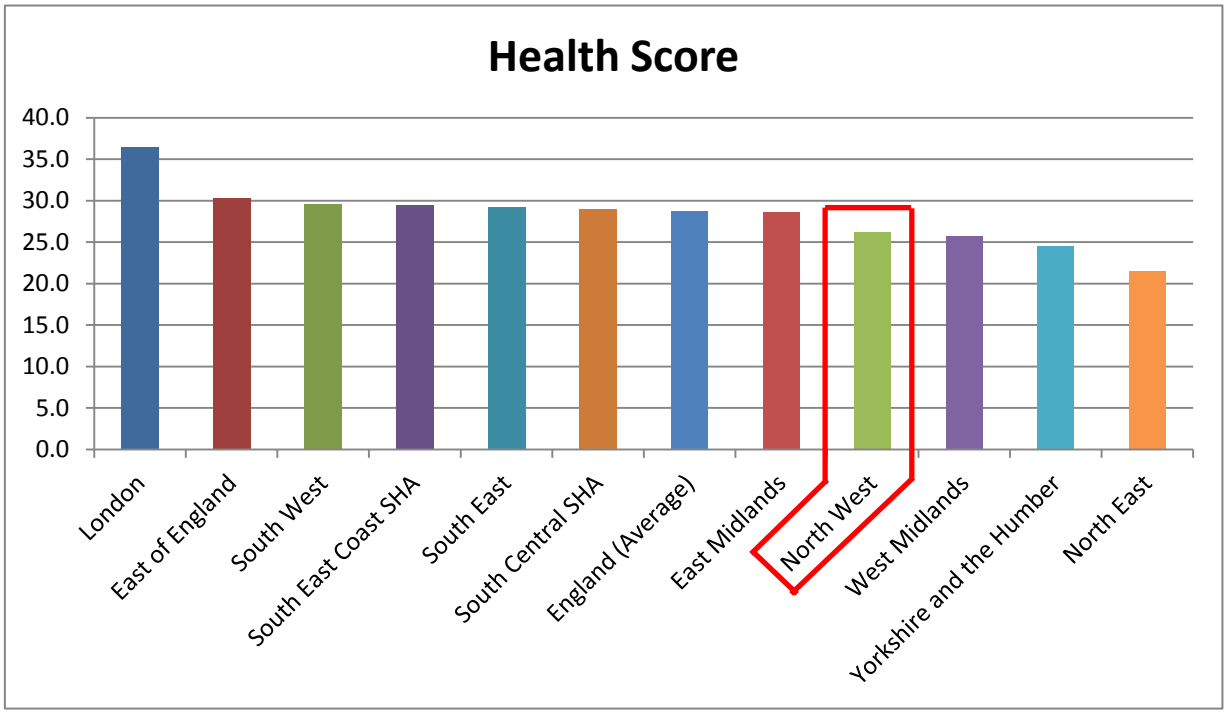
2.1 MSLT has an annual turnover of circa £12m. Of this figure, approximately £5.5m comes from Manchester City Council (MCC) as a service payment and the balance is earned income. The Trust pays Serco to operate two contracts covering the eight* facilities which it operates as managing agent. The Trust directly employs 78 staff (split between full and part-time contracts) as well as 2 apprentices and a number of casual (non-contract) staff such as coaches and instructors. In addition to this Serco employs 262 full and part time contracted staff plus casual employees and apprentices.

The impact of sport and exercise

Evaluating the economic damage from physical inactivity

2.2 The importance of physical activity is increasingly being stressed by Local and UK Government bodies and other agencies, including, the "Change4Life" campaign. The North West is one of the poorer areas for public health, consistently scoring below the national average.

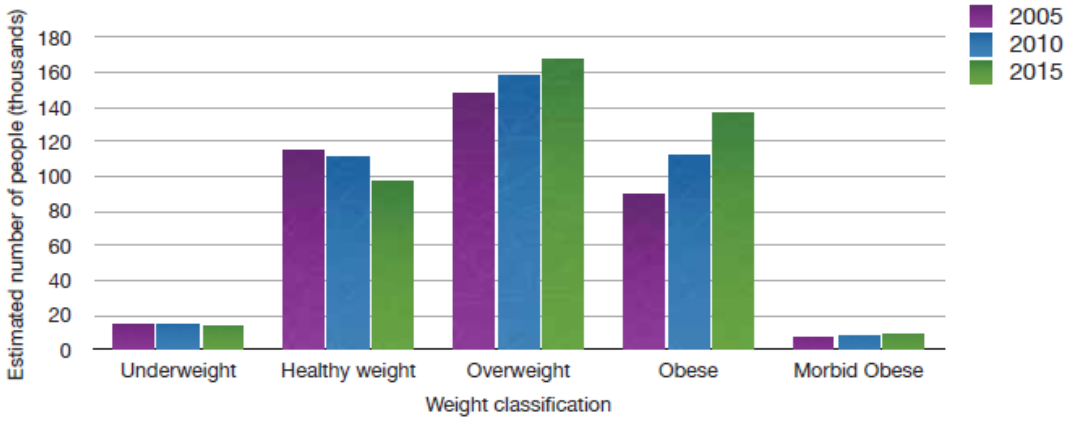
2.3 The charts below which are extracted from "Public Health Profiles, 2012" [F] starkly illustrate the issues that the North West has to deal with regarding the increasing levels of poor health in comparison to other areas.



[F] Public Health Profiles 2012 - www.apho.org.uk (accessed Feb 13th 2013)

2.4 Predictions of the continued rise in obesity level for Manchester illustrate that unless changes are made the figures show no sign of declining:

Graph 1. Projection of weight classification among adults in Manchester, based on the Foresight predictions (2006-2015)



Source: Greater Manchester Public Health Network (2009)

2.5 The UK Chief Medical Officer's ("CMO's") 2009 Annual Report[G] suggests that the direct costs of inactivity equate to £5m per annum per Primary Care Trust, and estimates the total annual cost to the NHS of inactivity and obesity combined at some £5bn to £6bn across the UK. Indeed, the Foresight report concludes that the cost (including a proportion of the costs of treating obesity-related diseases) amounts to some £7.5bn[H] per annum. The CMO's report also highlights that 61% of men and 71% of women aged over 16 years fail to meet the minimum recommendation for physical activity (2009, p.22).

2.6 The British Heart Foundation published a document in February 2010 – Costs of Physical Inactivity factsheet - which noted the following statistics for the UK:

- The economic costs to the UK of sickness absence and workless-ness associated with working age ill health are over £100 billion per year – greater than the current annual budget for the entire NHS, and;
- The chronic diseases associated with physical inactivity contribute to sickness absence significantly: in 1998, there were over 18 million days of medically certified sickness absence attributable to obesity in the UK.

2.7 According to a report by the Health and Social Care Information Centre[I], one in five individuals are obese. In August 2011 the Lancet (www.lancet.com) published a range of papers outlining some of the issues and highlighting the concerns of "The Future Challenge of Obesity". This set part of the scene and played a significant role in advance of a UN High Level Meeting on Non-communicable Diseases in New York in September 2011 and in further national and international policy programmes. These papers make reference to a wide range of studies throughout the world – the broad summary from these papers is that without action obesity-related diseases will result in an increasingly high cost for the UK through the next decades. The Lancet advocates research and action to mitigate this issue both for the UK and globally. Amongst other statistics highlighted by that study is the view is that, if the UK trends for 1993 to 2008 continue, the prevalence of obesity will rise from 26% to 35-48% by 2030 (depending on the sex of the person) and that the costs (undefined as to whether this is cost to the

[G] '2009 Annual Report of the Chief Medical Officer', Department of Health, 2009, p.22
[H] 'Foresight – Tackling Obesities: Future Choices – Project Report', 2nd Ed., Government Office for Science, 2007, p.40
[I] Statistics on obesity, physical activity and diet: England 2012, The NHS Information Centre, Lifestyle Statistics, 23 Feb 2012, Page 7

State or in terms of productivity and such wider costs) will increase by £2billion per year. A range of options are clearly available to seek to minimise future growth of "costs" relating to obesity and related avoidable illness which may include policy interventions to promote healthier dietary intake and increased physical activity.

The benefits of physical activity in reducing obesity

2.8 This summary of work defining the damage caused to the economy by physical inactivity shows that the benefits of exercising include reduced costs to the NHS and increased productivity. A number of studies[JK] have concluded that, aside from higher sickness absence, being overweight is likely to lead to reduced productivity when in the workplace.

2.9 One of the Lancet set of papers was "Minimum amount of physical activity for reduced mortality and extended life expectancy" which in broad summary supports the assertion that "a small amount of leisure time physical activity reduces total mortality, mortality from cardiovascular disease and mortality from cancer". This further supports the link between higher levels of physical activity and lower cost of healthcare and that these lower costs can be over a long period of time and potentially extend the lifetime of participants.

2.10 The UK Government's current recommendation is that adults should take 30 minutes of moderate exercise at least five times a week. However, it has been found that there is a strong link between socioeconomic status and participation rates for physical activity: for example, the rate of walking as a leisure time activity among men of social class I is some 38% higher than men of social class V[L] Figures from 2001 showed that Manchester had 18% of the population classified as being in social class V[M].

2.11 The Cabinet Office's 2002 report[N] highlights the wider benefits of sport, including:

- Personal satisfaction and better social life;
- Improved health (both physical and mental)
- Improved educational outcomes;
- Crime reduction;
- Social inclusion; and
- Enhancing the environment.

2.12 None of the above studies considers the effect of obesity on wider family members, notably the effect on children and the elderly when the prime carer is obese, or is distracted from their prime carer role by having to fulfil a similar one for another person. This then affects education and development for the children, as well as potentially encouraging lifestyles that tend towards obesity in the next generation.

[J] Health and economic burden of the projected obesity trends in the USA and the UK - Wang et al, Lancet 2011
[K] Gallup Healthways Well-Being index - 2011
[L] 'At Least Five A Week – evidence on the impact of physical activity and its relationship to health, a report from the Chief Medical Officer', Department of Health, 2004, P.13
[M] http://www.visionofbritain.org.uk/unit/10033007/cube/SOC_GEN - accessed 19th July 2013
[N] 'Game Plan: A strategy for delivering Government's sport and physical activity objectives', Cabinet Office, 2002, p.44

Economic damage from mental health problems

2.13 Mental health is an increasing problem within the UK: one in four people will experience a mental health problem at some stage. A survey in 2009 of 18,500 people in the North West of England found that, across the region as whole, the proportion of respondents with low, moderate and high mental well-being was 16.8%, 20.4% and 62.8% respectively, measured using a seven-item Warwick-Edinburgh Mental Well-being Scale[O].

2.14 The impact of mental illness in the UK was estimated to result in costs in the region of £105 billion[P] in 2010. Mental illness places an enormous stress on individuals, families and the wider local community. This cost can be broken down into 3 separate parts:

- The human costs, including negative impact on quality of life, estimated at £53.6 billion per annum;
- Direct health and social care costs of £21.3 billion per annum; and
- Economic damage due to lost output of £30.3 billion per annum.

2.15 These problems are also projected to increase given the current economic downturn, which exposes people to 'known risk factors for mental health problems' such as unemployment, limited opportunities for work, poverty, income disruption, stressful work environments, debt and financial strain[Q].

The benefit of physical activity in reducing mental health problems

2.16 A link has been established between those suffering from mental health problems and inactivity, where it was noted in a study carried out by Landers and Petruzzello that in 81% of cases physical activity was related to anxiety reduction following exercise[R], and was found to be at least as effective as other therapies including medication in some cases.

2.17 Using exercise as a method of mental health treatment also results in further benefits accruing on the individual, such as reduced obesity, incidents of cardiovascular and other obesity related diseases, increased self-esteem and more restful sleep.

MSLT's role in promoting physical activity

2.18 MSLT works to promote exercise and sport in its local communities through the provision of reduced cost access to high quality facilities (in comparison to privately owned operators), combined with a number of programmes aimed at improving participation rates.

2.19 We understand from MSLT that the membership scheme has around 191,000 members. Around 2.44 million visits[S] to all MSLT facilities are made each year.

[O] http://www.nwph.info/nwpho/NorthWestMentalWell-beingSurvey.pdf (Accessed February 2013)
[P] The economic and social costs of mental health problems 2009/10, Centre for Mental Health 2010
[Q] Supporting Continued Investment in Mental Health Improvement in Scotland in an Economic Downturn', NHS Health Scotland, 2011, P. 5
[R] Petruzzello, S.J., Landers, D.M., Hatfield, B.D., Kubitz, K.A., & Salazar, W. (1991). A meta-analysis on the anxiety-reducing effects of acute and chronic exercise. *Sports Medicine, 11(3),* 143–182
[S] Source: Manchester Sport and Leisure Trust management information

Scope and purpose of this report

2.20 Baker Tilly has been engaged by MSLT to support it in investigating the social impact of activities relating to five programmes. These programmes, which are considered to be representative of the spread and depth of MSLT's activities, are:

- Chronic obstructive pulmonary disease (COPD) maintenance and cardiac rehabilitation at Sportcity Health & Fitness Centre[T]
- Neurological and stroke rehabilitation at Moss Side Leisure Centre;
- Activities for disabled people across the portfolio;
- Women-only activities across the portfolio;
- Wider health and fitness through the provision of gym, classes and social swimming facilities at NCFFC.

2.21 A SROI Project Team was established by MSLT to take part in the SROI evaluation. The SROI Project Team comprised representatives of each project, drawn from MSLT, Managing Agent (Serco) and Manchester City Council, led by MSLT's Community Engagement and Partnership Manager. The SROI Project Team were supported by researchers from Baker Tilly who applied an Action Research methodology for gathering information on the projects incorporated within the scope of this evaluation and for testing data assumptions. Action research has been used as it:

- Enables the research to stay close to the data;
- Enables the theory – that is the answer to the research – to emerge from the data as it is gathered;
- Promotes a cyclical revisiting of the data through the research process which promotes internal validity and triangulation of the results: that is the data gathered and the conclusions drawn are better tested;
- Through encouraging the organisation itself to learn from the process of the research, staff are better able to embed the results and benefit from them in developing future strategy: the work can be more useful.

2.22 Through the process of Action Research, the SROI Project Team and Baker Tilly have produced:

- An overview of social impact and other methodologies used in this work;
- An analysis of the activities and outcomes of the above programmes/areas;
- An overview of how those outcomes may be measured using financial proxies;
- An overview of the results of the evaluation; and
- A detailed presentation of the models and assumptions used in the evaluation.

[T] Cardiac rehabilitation is also offered by MSLT at Abraham Moss, Broadway, Moss Side & Withington Leisure Centres

Reliance on work by MSLT

2.23 During the course of our work with MSLT, we have relied on information and explanations provided by them and the SROI Project Team including:

- The nature, outcomes and beneficiaries of their activities; and
- The assumptions used in evaluating the impact of their services.

2.24 Where possible, assumptions from the SROI Project Team have been validated based on independent data or data extracted from MSLT's management information systems. Nevertheless, MSLT is responsible for making the assumptions used in this report, and has confirmed that they are, to the best of their knowledge and belief, accurate and reasonable.

Aim of this report

2.25 The aim of this report is to evaluate the benefits generated by the selected services set out above, and, where possible, to provide guidance on the use of these models and results to measure the social impact of MSLT's remaining activities.

2.26 The following sections of this report cover:

- Section 3: An overview of the concepts and methodologies used in this study;
- Section 4: an overview of the evaluated activities and projects and their associated outcomes and beneficiaries;
- Section 5: an overview of the evaluation and modelling approach used to evaluate the economic and social impact of the activities and projects included in this study; and
- Section 6: summary of findings and conclusions.

2.27 A detailed analysis of the evaluation models used and the assumptions and inputs to them is included as Appendix B to this report, with a sensitivity analysis included at Appendix C.

3. Concepts and Methodologies Used

Social Return on Investment ("SROI")

3.1 The SROI methodology has been developed in order to help organisations to "[measure and quantify] the benefits they are generating" (per Lawlor, Neizert & Nicholls writing in the SROI guide, 2008[U]). This approach was piloted in the UK through the Measuring What Matters programme during 2002 and has evolved since then as further work has been done to develop the framework around it.

3.2 It is increasingly being seen as an "incredibly useful tool"[V] by a number of organisations and key commentators within the Third and Public sectors in the push to measure and evaluate social impact. In the recent E3M report on measuring Social Impact in Social Enterprise[W] it is recognised as a leading protocol in the field of monetised social impact evaluation, and a key tool in the measurement of commissioned public services. That report observed that there are five key aspects to developing social impact measurement that meets stakeholder needs, which are:

- "A clearly enunciated story, with its theory of change, but with presentation adapted to the story it is trying to tell
- A clarity of beneficiary perspective: who, how and how it looks from their viewpoint
- Evidence of outcomes or causal link between outputs and outcomes with an intention to collect outcome data over time
- Demonstration of that change over time, from the identified beneficiaries' perspectives
- Linking learning based on analysis back to organisational learning"

This report and the research process that supports it, adhere to those principles.

3.3 There are three 'bottom line' aspects of social return:

- *Economic:* the financial and other effects on the economy, either macro or micro;
- *Social:* the effects on individuals' or communities' lives that affect their relationships with each other; and
- *Environmental:* the effects on the physical environment, both short and long term.

3.4 For this study the primary focus has been on economic and social benefits, rather than environmental benefits, as any environmental benefits generated would appear, for many of the evaluated areas of work, to be too far removed from the intended purpose of the original services provided and appear to be too difficult to measure reliably. Where environmental benefits arise from the work of MSLT that can be reliably measured, these are included. Where environmental gains are either too remote from the intended purpose of the work or cannot be measured reliably, the nature of the benefit has been noted, and recorded as an unmeasured additional benefit.

3.5 The benefits of using SROI include:

- *Accountability:* organisations are able to give both the numbers and the story that supports them;

[U] Lawlor, E., Neitzer, E. & Nicholls, J.. 2008. Measuring Value: a guide to social return on investment. London. New Economics Foundation
[V] Copps, J. and Heady, L. 2010. *Social Return on Investment: Position Paper, April 2010.* London. NPC. From www.philanthropycapital.org
[W] Clifford, J, Markey, K., and N Malpani. (2013) Measuring Social Impact in Social Enterprise: The state of thought and practice in the UK. London. E3M

- *Planning:* SROI provides a change management tool to assist in the direction of resources towards the most effective services and to assess the viability of potential additional services;
- *Cost and time effectiveness:* the measures produce an analysis of the most cost and time effective activities; and
- *Simplicity:* impacts can be reduced to a simple comparison of the cost of funding MSLT and the benefits that flow from their core activities to facilitate analysis and give a clear indicator of types and ranges of success.

3.6 SROI takes total measurable outcomes, discounted to present value where the benefits occur in the future or are recurring over a period of time, and deducts:

- *Deadweight:* Outcomes that would have occurred regardless of the intervention;
- *Alternative attribution:* Outcomes that arise as a result of intervention by others; and
- *Displacement:* Outcomes that are negated or compromised by disadvantages arising elsewhere either in terms of social, economic or environmental damage.

3.7 A review of academic work and practical examples of SROI in use by the non-profit sector suggests that the measures fall into three patterns, which have been used in this work:

- *Economic benefit created:* where there is an impact on earning capacity or productivity;
- *Costs saved or not wasted:* where the intervention results in a saving, either in the cost of another intervention or in a consequential cost (e.g. introducing prevention to save on the cost of a cure). This may be seen in either removing the need for or increasing the effectiveness of an alternative intervention; and
- *Alternative or cheaper sourcing:* where one intervention directly replaces another more expensive one.

3.8 In identifying these benefits, a key underlying requirement is to consider not only the positive contribution that MSLT makes, but also the economic damage that is avoided by having it in place. Much of our report involves the quantification of the damage to stakeholders that would result based on these implications. By avoiding this damage, MSLT contributes to the economy just as meaningfully as where the effect is an incremental benefit.

The case for political support for SROI

3.9 Further support for SROI's adoption by the third sector has been seen in the recent report 'Outcome-Based Government', published by the Centre for Social Justice ("CSJ")[X]. This report considers the need to link funding of interventions with the expected outcomes (and their associated value). CSJ suggests that funding should be focused on those interventions that are likely to achieve the highest value outcome: "Improving life outcomes should be the ultimate goal of a government's social policy: if policy makers can better identify failing initiatives, and shift spending toward programmes that effectively deliver sustainable, long-term outcomes, the social and financial returns to society and the public sector will be very great indeed."

[X] Brien, S., 2011, Outcome-Based Government, London, Centre for Social Justice

3.10 CSJ strongly advocates a shift towards evidence-based government, in which funding decisions are based on clear, high quality evidence of impact value, with SROI cited as a "more rigorous approach to performance management while attempting to capture the social and environmental impacts of public spending."

3.11 The rationale for adopting SROI may be applied equally strongly to local communities, who may rightly expect organisations such as MSLT to demonstrate that their support is delivering real value to their community and society as a whole.

Addressing issues concerning the use of SROI

3.12 Overall, it is felt that SROI is a vital tool to provide non-profit sector bodies such as MSLT with a means to evaluate its wider contribution to Society. However, there are several issues to consider when applying this, that are worthy of mention:

- SROI, as it is typically presented, tends to ignore the risks associated with the benefits generated. In the course of our work with MSLT, the project representatives were encouraged to consider the achievable benefit created, and to build in reductions to assumptions to account for risks, where necessary;

- A robust SROI analysis must consider the proximity of the benefit created to the actions of the organisation that is seeking to claim ownership of that benefit. The project representatives were encouraged to focus only on outcomes that are directly attributable to their activities and, where necessary, obtained evidence of the link between the outcome and MSLT's activities;

- SROI is typically presented as a ratio of the value of the benefits achieved per pound spent to achieve those benefits. This may be useful internally to each organisation as a measure of performance relative to prior periods. However, the use of this ratio to compare organisations is inherently flawed due to sector and organisation-specific factors that reduce the level of comparability between organisations. Hence, the results of this report are not presented in the form of a ratio;

- There is a danger that organisations seeking to evaluate their impact using SROI may create calculations that are extremely granular to the extent that they become open to accusations of 'spurious accuracy'. In this exercise, a smaller number of key assumptions have been identified by the project representatives during discussions facilitated by Baker Tilly to develop a prudent result at a high level. It is considered important to present a more defensible, prudent analysis than one which is overly complicated and risks overstatement; and

- SROI does not take account of the interrelationship of social impact and brand value. By creating greater social impact, the recognition and perceived quality of an organisation's brand is likely to improve, thus increasing the value of that brand. In turn an entity with a stronger brand may use that to enhance the social impact of its project work. .

Research methodologies

3.13 We have worked with an SROI Project Team, comprising three MSLT staff, two Manchester City Council staff and one Managing Agent (Serco) Staff member, to carry out an Action Research process (see Appendix A). In this, a meeting with the SROI Project Team was held to determine the key services that the relevant MSLT projects provide, the outcomes of these services and the beneficiaries. Three further meetings were held, interspersed with the SROI Project Team testing out the conclusions from each interview by practical application in their work, then reporting the results back to the next meeting.

3.14 A list of SROI Project Team members is shown at Appendix E. The group met on four occasions during October 2012 to January 2013 with phone calls interspersed between these meetings to discuss progress and review emerging evidence from internal and external consultation. Members of the group were encouraged to discuss emerging findings with colleagues in order to confirm their views on the manner in which the areas of work under review achieve a change in outcomes for beneficiaries (known as the theory of change) and the extent of the change achieved. For certain projects, the group co-ordinated further work to gather feedback on the success of projects from beneficiaries and external stakeholders as evidence to form a basis for certain key assumptions used in this study.

3.15 Based on this research, the SROI Project Team was involved in co-developing potential means of evaluating the impact of these services by substituting financial measures (proxies) for the outcomes described. Data and assumptions provided by staff at MSLT have been relied upon in our analysis; Baker Tilly have acted to facilitate MSLT's understanding of the methodologies used to evaluate the impact but Baker Tilly are not responsible for the assumptions used in the evaluations shown in this report.

4. Overview of Evaluated Activities

Understanding the services

4.1 For the purposes of this report, and in common with other similar evaluations, it was not set out to evaluate the impact of all services provided by MSLT. Rather, focus has been on selected key projects and outcomes that MSLT believe to be representative of a cross section of their activities to deliver projects that improve quality of life for the communities that they serve.

4.2 This evaluation therefore does not extend to specific funded projects or core programmes/facilities other than those listed earlier in this report. In particular, it excludes:

- Hire of team-sport's pitches;
- Racket sports provision;
- Martial arts;
- Swimming lessons;
- Athletics; and
- Gymnastics.

4.3 The MSLT SROI Project Team has also noted that this study does not seek to evaluate certain externally funded projects, including; swimming lessons, tennis lessons, school holiday activities, local providers and NGB programmes.

4.4 Further details on activities offered by MSLT but excluded from this study can be found at www.manchestersportandleisure.org

4.5 For each of the evaluated areas of work, discussions were held with MSLT around:

- The nature of the service(s) provided;
- The identification of the direct and indirect beneficiaries;
- The nature of the benefits derived from the service;
- Where relevant, the identification of other agencies or companies that could provide a similar service; and
- The likely cost of providing equivalent services through alternative sources.

4.6 This discussion was developed to consider how financial measures can be substituted into the place of service outcomes, so that they can be measured. The results of this discussion are shown below for each project.

4.7 For the purposes of mapping outcomes in this study, we have defined 'primary' and 'secondary' outcomes. These represent:

- **Primary outcomes:** the outcomes that directly and immediately result from the intervention in question. For example, supporting an individual to gain employment achieves an immediate saving in some welfare benefits; and

- **Secondary outcomes:** the long term results that flow from primary outcomes. For example, the individual who is now in employment will be economically productive in the longer term, and that outcome will have an effect for others around them: their families, work colleagues and communities.

4.8 This study does not include those secondary outcomes further removed from the activity, as to do so would be to lose proximity to the intervention that is being measured. Using the example of an individual supported in gaining employment, it is likely that if they are in work for the long term, this may influence the behaviour of their children in seeking work rather than perpetuating a cycle of reliance on welfare benefits. Whilst undoubtedly valuable, such outcomes are not sufficiently proximate to the original intervention for a meaningful evaluation to be carried out. This is consistent with the seven principles of SROI evaluation (shown in the Cabinet Office guide) *"do not over-claim"*[Y], as well as with good research practice.

Overview of evaluated projects – MSLT

COPD and Cardiac Care

4.9 MSLT runs separate COPD maintenance and Cardiac rehab sessions at Sportcity, but for the purposes of this report we have grouped the activities together when evaluating their outcomes. This has been done as the limitations present in sufferers, the nature of the sessions and supervising teams are all similar.

4.10 MSLT have approximately 67 individuals who regularly attend the COPD session over the course of a year as well as around 50 individuals on the Cardiac program at the Sportcity site (other cardiac programmes run at a number of other facilities but the focus of this report is just one facility). COPD Users initially complete a 12 week exercise and education course with the ARAS team based out of the North Manchester General Hospital. This course is carried out within the hospital or a community setting and the subsequent referral is directly onto MSLT. For Cardiac users the referral can be from either hospital, GP or other healthcare professional at which point they complete a 12 week PARS service before transitioning onto MSLT indefinitely.

4.11 The nature of the individuals who enter the program is that many suffer symptoms at the severe end of the scale. For example, a large number of individuals on the COPD programs have oxygen tanks with them on referral and struggle to carry out everyday activities.

4.12 Where previously individuals may not have been able to walk to the shops unaided, following MSLT programmes, they are increasingly able to assert their independence. They are able to no longer require having oxygen to hand and can complete many of the tasks that they would have taken for granted before the COPD. However, it is noted that the nature of COPD means a full recovery is not possible.

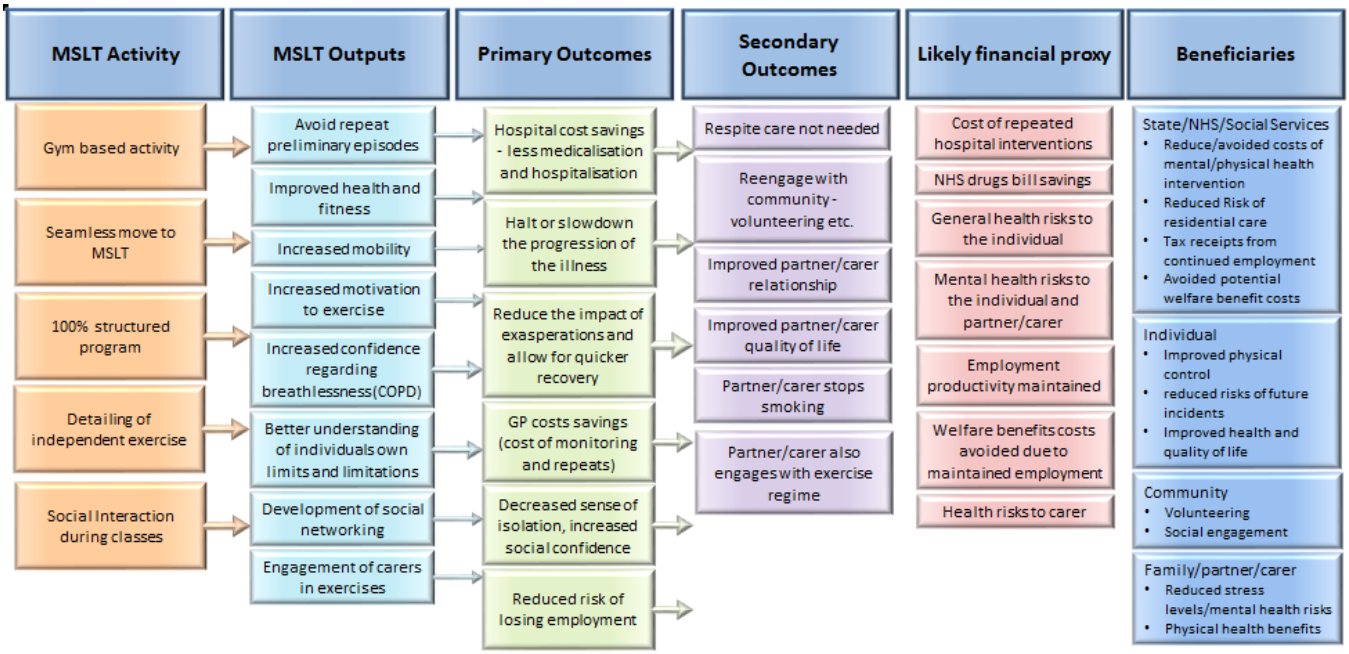
4.13 The sessions are run with the aim of increasing the general level of fitness of participants and instilling confidence in them that they can complete basic tasks that many had thought were beyond them. The sessions are run in the "universal setting" MSLT have available to them and care is taken by staff to normalise the activities as much as possible.

[Y] Cabinet Office, Office of the Third Sector. April 2009. A guide to Social Return on Investment. London. Society Media

4.14 As well as benefitting directly from the exercise and activities undertaken, individuals on both the COPD and Cardiac session have noted that, by the therapy being offered in regular gyms and leisure centres, it enables them to feel less ostracised or hidden away as a result of their condition.

4.15 Supporting this benefit to an individual's mental health, the sessions are run in a very relaxed atmosphere, supervisors develop friendships with the individuals with whom they are working and people seize upon the opportunity to socialise with other people suffering from the same affliction. It is the quality with which the activities are delivered that conveys value, as much as the activities themselves.

4.16 It is this combination of factors that come together to aid an individual's physical and mental well-being which increases the impact on the individuals and their communities.



Neurological and Stroke Rehabilitation Sessions

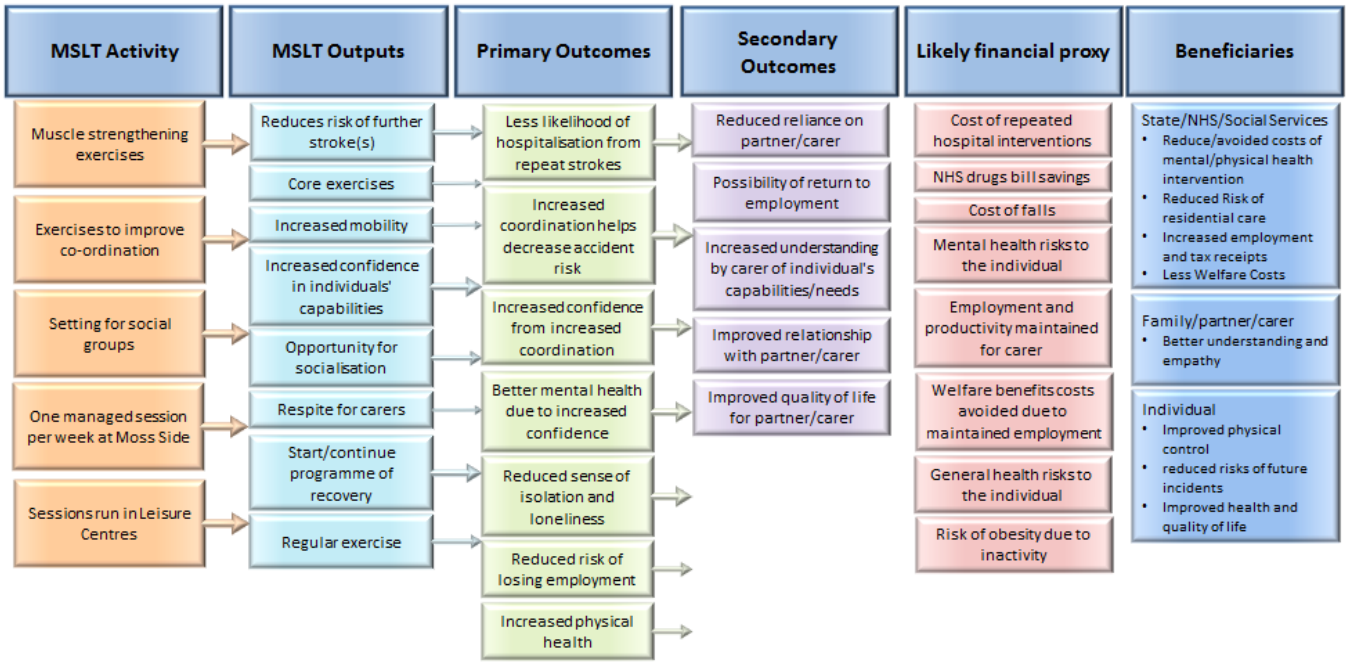
4.17 As with the Cardiac and COPD sessions individuals are directly referred onto the neurological and stroke sessions following their initial rehabilitation session with local NHS services. This usually takes the form of a 12 week course in partnership with Central Manchester University Hospital NHS Foundation Trust (CMUHT) and Serco and is continued after this through weekly sessions with a MSLT at Moss Side Leisure Centre.

4.18 People who have suffered a stroke or another neurological episode can have issues with mobility and coordination and it is these aspects on which MSLT's work focusses. The intervention enables participants to work together on exercises and activities that reflect everyday tasks individuals will come across. Typical examples include climbing stairs or carrying shopping.

4.19 People attend these sessions with a carer or a physiotherapist and MSLT engage with these people as part of the rehabilitation progress. This helps develop the relationship between carer and individual, both benefitting in mental health terms. It also helps carers to understand the needs and capabilities of the people they are caring for, better enabling a more effective level of support.

4.20 This program also aids greatly in enabling the individual to understand their own limits and limitations. The fear of falling or of not being able to complete a task is often a significant barrier to the individual being able to complete them, so developing their confidence is key.

4.21 As with the cardiac and COPD sessions, the activities are carried out in a local setting away from Hospitals which benefits the individuals reintegrating into local communities. They receive their rehabilitative care in their communities, and so can be expected to find it easier to translate the lessons and techniques learned better into their daily lives. One of the most important aspects to the individuals attending the session are the friendships that develop. These sessions had a core of users who often arrange transport and attend the sessions together and socialise outside them. The benefits to mental health for people recovering from a traumatic event cannot be underestimated.



Activities for disabled people

4.22 In partnership with MCC, MSLT operates a range of different activities for those with mental or physical disabilities. Some of these are exclusively for disabled individuals and others are mixed sessions where disabled individuals are welcome:

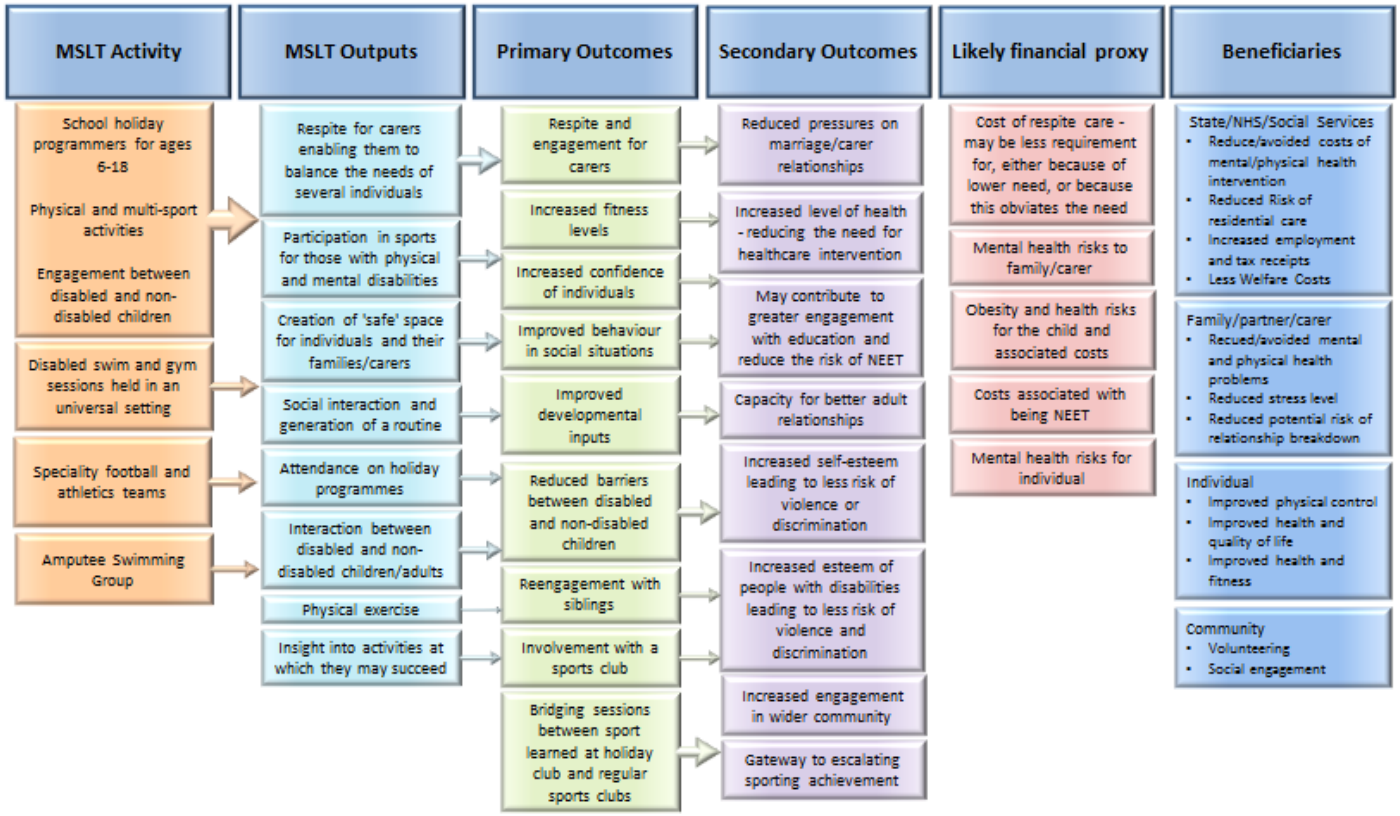
- Holiday camp activities;
- Junior athletics;
- Junior football;
- Adult athletics;
- Adult football;
- Amputee swimming (MANFIT); and
- Supervised swim and gym sessions

4.23 The key to MSLT's success in their activities for disabled people is the company-wide ethos of inclusion and acceptance and their strong partnership with MCC. One of the major hurdles faced by people with disabilities is the public's misconceptions about the extent and effect of their disabilities, and their being uncomfortable in the company of disabled people. By being able to offer a wide range of services in an "universal setting" with staff who are both understanding and accepting, this models

appropriate behaviours for the wider public, and enables individuals to feel included within a community setting. In turn this has great benefits for their mental health.

4.24 The activity about which the members of the SROI Project Team were most enthusiastic was the holiday multisport-activity camps. These offer a range of services that MSLT believe are crucial to children with disabilities and their families. The courses offer a range of benefits:

- They provide the opportunity for respite for parents: the camps can be attended by both able and disabled children and parents/guardian are able to leave them in an environment where they are supervised by knowledgeable and caring staff;
- It provides interaction between able-bodied and disabled children as well as between children with different disabilities. This helps break down the barriers and prejudice many disabled children and their families face. It also benefits able bodied children who are able to better understand the needs and qualities of their disabled counterparts;
- As siblings are able to attend the course together it can help foster their relationships through engaging in activities together and not having to compete for attention; and
- It offers an opportunity for physical activity from which many children (both able-bodied and disabled) benefit. Disabled children face a far greater risk of obesity than able bodied children due to the lack of provision of available services, together with, in some cases, a greater difficulty in achieving effective exercise.



Women-only activities

4.25 MSLT offers and hosts, often in partnership with MCC, a number of differing programmes of Women-only activities. These are designed to cater for women who would prefer to be able to exercise in surroundings which are exclusively for women. This can be because of religious or cultural reasons, as a result of past experience leading to personal trauma, or simply a matter of personal preference.

4.26 These sessions are supervised or led by women and where possible are facilitated in an environment that allows for complete exclusion of men, where possible. There a number of sites that are able to offer closed-off pools, changing areas and female only gym space, which are one of a number of enabling factors which contribute to making these sessions accessible to the greatest possible number of women.

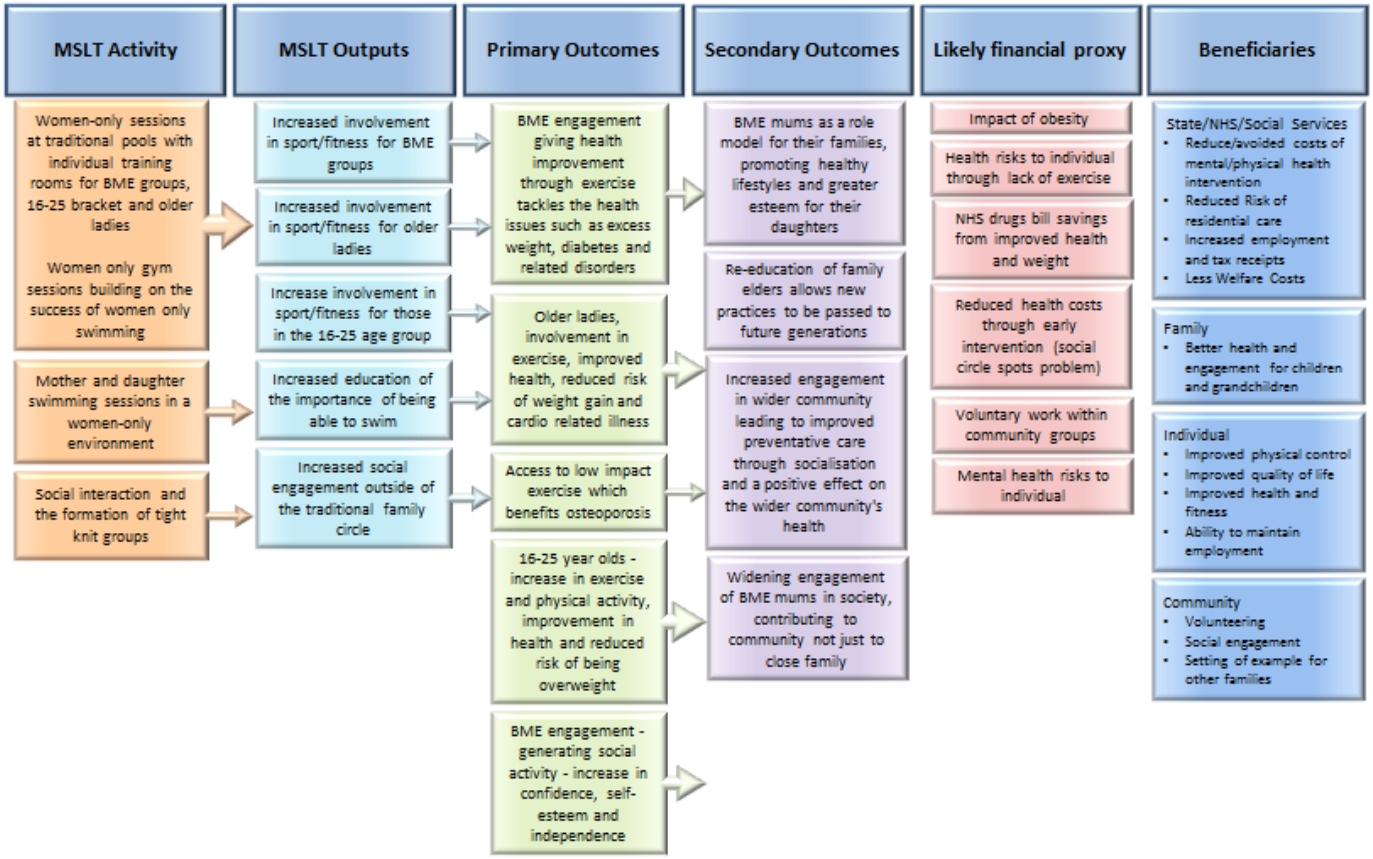
4.27 Men are 30% more likely to take regular exercise than women[z] and one of the causes to this is the lack of facilities where women feel able to exercise freely. The research group highlighted that women from a BME background frequently expressed the view that they did not feel able to exercise as they could not access any women-only sessions.

4.28 This lack of access, especially for the older generation, can perpetuate the problem down the generations as it is generally the older women in the family who set an example for younger ones. By accessing exercise and promoting the benefits they are able to make changes which will benefit future generations of families.

4.29 The SROI Project Team found that, once introduced to exercise through the conduit of women-only classes, many women felt the benefits to such an extent that they were able to attend more sessions and utilise open sessions. This enabled them to develop wider social engagement, and to attend family swimming and similar activities.

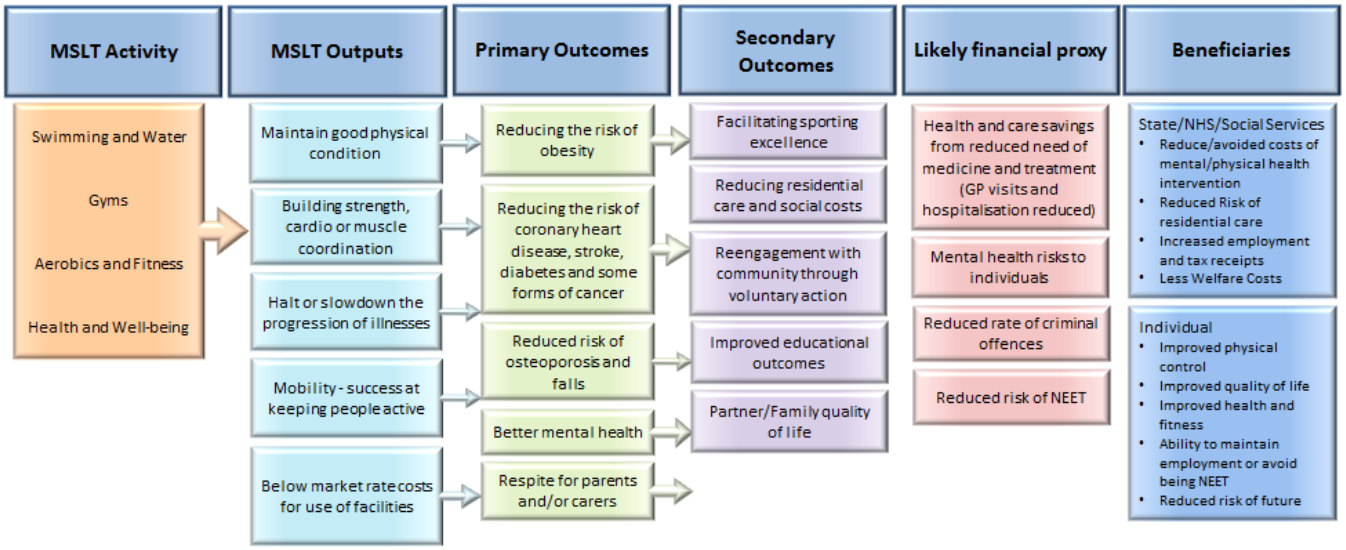
4.30 This increase in confidence is one of the many mental health benefits that exercise can have on the women who participate. It was also found that once one or two women from a community or family started at a session they were very likely to bring others along in future, strengthening social ties between individuals. The lack of confidence was a key factor causing 16-25 year olds to avoid using mainstream gyms or pools. By offering, with partners, a safe, women only environment MSLT were able to provide a setting where these women felt comfortable to exercise and were able to do so.

[z] 'Statistics on obesity, physical activity and diet: England', The Health and Social information Centre, 2012, Page 30



Wider health and fitness – swim and gym

4.31 Alongside the more specialist activities mentioned, MSLT offer a full range of typical swim and gym facilities to the general public. These are offered at a substantial discount to the prices of other available private providers and are a valuable resource in keeping the population of Manchester fit and healthy. By offering access at much lower price points across the various facilities it reduces the barrier to entry that some individuals will face. This may be caused by a lack of disposable income or an internal decision based on the value of membership versus the cost.



Summary maps of outcomes

4.32 The charts included above show the theory of change for each of the MSLT offerings. They were compiled following the action research sessions with the SROI Project Team. Larger versions of the diagrams can be found in Appendix B.

4.33 Detailed descriptions of the approaches used to evaluate the above outcomes are discussed in section 5.

Outcomes measurement approaches identified

4.34 Given the primary and secondary outcomes shown above, we have evaluated four key outcomes of MSLT's activities, several of which are common to a number of projects included in this study:

- Improved mental health;
- Improved physical health;
- Reduced costs to access provision; and
- Increased employment.

4.35 A detailed overview of the application of these approaches is shown in section 5.

5. Summary of Evaluation Approaches

5.1 This section provides an overview of the outcomes of the projects to be evaluated. In conjunction with the project representatives, it was considered how these outcomes may be measured using the three key evaluation approaches:

- ***Economic benefit created:*** where there is an impact on earning capacity or productivity;
- ***Costs saved or not wasted:*** where the intervention results in a saving, either in the cost of another intervention or in a consequential cost (e.g. introducing prevention to save on the cost of a cure). This may be seen in either removing the need for or increasing the effectiveness of an alternative intervention; and
- ***Alternative or cheaper sourcing:*** where one intervention directly replaces another more expensive one.

5.2 As is noted in section 4, it is clear that the outcomes generated fall into four broad categories, subject to minor variations in the nature of project-specific assumptions. These categories are:

- Improved mental health;
- Improved physical health;
- Reduced cost to access provision; and
- Increased employment.

5.3 The tables below matches the broad outcome categories described above to the three evaluation approaches and describes, in general terms, the approach that has been taken in evaluating these outcomes for the purposes of this study:

Outcome	Model(s) used	Approach
Improved mental health	Costs saved	Mental health cost savings have been assessed by taking an average of the total cost to the UK of mental health problems and the total affected UK population. This gives a very broad figure for the associated costs of £10,403 per individual case. For the different activities that have been evaluated different figures have been used with reference to the prevalence, and in some cases, cost of mental health problems. There is a higher risk of mental health problems for those who have COPD[AA] but in the absence of other data the general cost of mental health problems have been used in conjunction with this figure. Carers have an especially high prevalence of mental health problems[BB] and this has again been used in accordance with the general costs of mental health problems in arriving at the attributable cost savings. People who have had heart attacks are also at a greater risk of mental health problems so a specific incidence has been used[CC] along with the general cost of problems. People who are recovering from a stroke are highly susceptible to mental health problems and a specific measure has been used.[DD] For disabled adults[EE] and children[FF] separate incident rates have been used to calculate the cost of mental health problems and for children a specific cost per incident has been found which represents the specific risk and harm mental health problems can cause children.[GG] Whilst looking at the women-only services, separate figures have been used for the prevalence of mental health problems amongst BME women as these are markedly higher[HH]. Deadweight is accounted-for by removing from the models those beneficiaries that would be likely to remain free of mental health problems in any case. A deduction for alternative attribution is included in order to account for the role of other parties in promoting better mental health, including the local NHS, family, employers and friends. MSLT believes that it makes a significant contribution to achieving this gain, due to its role in providing understanding, social settings and a gateway to better mental health through exercise. MSLT does not believe that its work gives rise to damage elsewhere, hence no adjustment for displacement is needed.

[AA] Boutin-Forzano S, Moreau D, et al. Int J Tuberc Lung Dis 2007;11:695–702
[BB] NHS Information Centre Social Care Team (2010), 'Survey of Carers in Households 2009/10', London, NHS Information Centre
[CC] Frasure-Smith N, Lesperance F, Juneau M, Talajic M, Bourassa MG. Gender, depression and one-year prognosis after myocardial infarction. Psychosomatic Medicine 1999;61(1):26-37
[DD] Poynter, B., Shuman, M., Diaz-Granados, N., Kapral, M., Grace, S. L., P.H.D., & Stewart, Donna F,M.D., F.R.C.P.C. (2009). Sex differences in the prevalence of post-stroke depression: A systematic review. Psychosomatics, 50(6), 563-9
[EE] "Equality and Inequalities in Health and Social Care: A Statistical Overview" Report, DHSSPSNI, 2004, Page 1
[FF] Taken from, The Mental health of Children and Adolescents with learning disabilities in Britain, Emerson and Hatton, January 2007
[GG] Average of means found in, Surhcke M, Pillas D & Selai C (2008) Economic aspects of mental health in children and adults in: Social cohesion for
mental well-being amongst adolescents. World Health Organisation Regional Office for Europe
[HH] The Fundamental Facts, Mental Health Foundation, Page 28

Improved physical health	• Economic gain
	• Costs saved
		• An assessment has been made of the number of regular users based on the size of the membership base and the number of non-member visits. Detail on the approach to this is included in Appendix B. This working includes an assumed deduction of 20% to 40% to remove members who would access alternative provision in any case. This is broadly consistent with the level of deduction used in other similar studies[II]. This adjustment is included to account for deadweight (i.e. those beneficiaries who would remain active in any case), and is consistent with research that shows around 65% of the population of the UK is overweight or obese[JJ].
		• The total number of users is apportioned into age bandings in line with the demographic trend observed in the membership base. In the absence of empirical data, it is assumed that non-members fall into a similar age profile to members.
		• For those beneficiaries that would not otherwise remain active, annual physical health gains are applied by age group as follows:
		  ◦ Under 16: £250 p.a.
		  ◦ 16 to 29: £450 p.a.
		  ◦ 30 to 39: £450 p.a.
		  ◦ 40 to 49: £500 p.a.
		  ◦ 50 to 59: £750 p.a.
		  ◦ Over 60s: £750 p.a.
		• It is assumed that costs associated with being overweight or obese increase with age due to age-related factors and the likelihood that other conditions would exist that may be complicated by being overweight among older people than younger people.
		• For the Cardiac, Stroke and Neurological rehabilitation sessions that have been evaluated work has been done to calculate the costs saved as a result of decreasing the likelihood of recurrent episodes. Figures have been obtained detailing the likely chance of a repeat heart attack[KK] or stroke[LL] and then this has been compared to the actual number per MSLT records that have occurred during the evaluated time period.
		• The recorded costs of treatment[MMNN] have then been taken as an attributable gain. Where for COPD there are no specific 'attacks' as such, the costs of treatment[OO] have been taken and the research group has arrived at an assumption of the alleviation-of-symptoms that their work allows the individuals.

[II] Clifford, C., McCallum, S. and Theobald, C. (2010), 'North Lanarkshire Leisure – Social Impact Evaluation', Coatbridge, North Lanarkshire Leisure

[JJ] '2009 Annual Report of the Chief Medical Officer', Department of Health, 2009, p.22

[KK] Heart Disease and Stroke Statistics, Internet. American Heart Association. (Accessed January 22nd 2012).

[LL] Long-term risk of recurrent stroke after a first-ever stroke. The Oxfordshire Community Stroke Project, Burn J, Dennis M, Bamford J, Sandercock P, Wade D, Warlow C, 1994

[MM] Mant J, Wade DT, Winner S (2004) Health care needs assessment: stroke. In: Stevens A, Raftery J, Mant J et al., editors, Health care needs assessment: the epidemiologically based needs assessment reviews, First series, 2nd edition. Oxford: Radcliffe Medical Press, p141–244

[NN] Coronary Heart Diseases Statistics 2012 Edition, British Heart Foundation, 2012

[OO] COPD Costing report, NICE, February 2011

		▸ One of the key benefits of exercise and MSLT sessions for older users and those recovering from a stroke or other neurological disorder is the increase in co-ordination it affords. This has a direct effect on the likelihood of an individual suffering a fall. Percentages for stroke victims[PP] and the elderly[QQ] have been obtained and the research group have made an assumption of the benefit the MSLT work decreases this likelihood. ▸ A general cost per fall has been taken with reference to the cost of over 65 falls[RR] and the UK population over 65. This has also been used by the research group in arriving at costs saved for the stroke sufferers in the absence of other data. ▸ As individuals exercise more and become healthier they are likely to take fewer sick days. In order to evaluate this gain an average number of sick days avoided per person was taken[SS]. An assumption was then made as to the numbers of users who were economically active and this was used in conjunction with the Greater Manchester GVA[TT] to calculate an attributable gain for MSLT.
Reduced cost to access provision	▸ Alternative commercial cost	▸ Where a realistic commercial alternative for a service exists (notably for membership fees), a review of prices in the Manchester area has been carried out to determine the typical cost of a comparable service at commercial providers. ▸ This commercial cost is then compared to the cost at MSLT and the saving recognised as a gain to the beneficiaries that would otherwise pay the higher rate. ▸ For those members who would access alternatives (i.e. those for whom no net fitness or productivity gains were recognised in this study), a saving is derived based on a commercial annual membership cost of £450 per annum compared to the cost of MSLT membership of £300 per annum (i.e. a saving of £150 per annum per beneficiary). ▸ For respite care of disabled children figures were taken for other local services at £10 per hour and compared with the MSLT cost of £5.4 per hour to give a saving of £4.6 per hour. ▸ Given that these beneficiaries would access alternative provision, there is no requirement to adjust for deadweight, as all achieve a saving of broadly this magnitude. ▸ No other agency is active in delivering this saving compared to other facilities; hence no adjustment for alternative attribution is required. ▸ MSLT does not believe that this saving gives rise to damage elsewhere; hence no adjustment for deadweight is needed.

[PP] The incidence and consequences of falls in stroke patients during inpatient rehabilitation: Factors associated with high risk. Teasell, McRae, Foley and Bhardwaj 2002
[QQ] Falls in the Elderley, KE Anderson, 2007
[RR] Falls in the Elderly, KE Anderson, 2007
[SS] Leisure time physical activity and sickness absenteeism; a prospective study, Ludovic G. P. M. van Amelsvoort1, Mark G. Spigt2, Gerard M. H. Swaen1,3 and IJmert Kant, May 2006
[TT] Local Gross Value added (GVA) 2011, Greater Manchester South and comparators, Nigel Waddington, December 2012

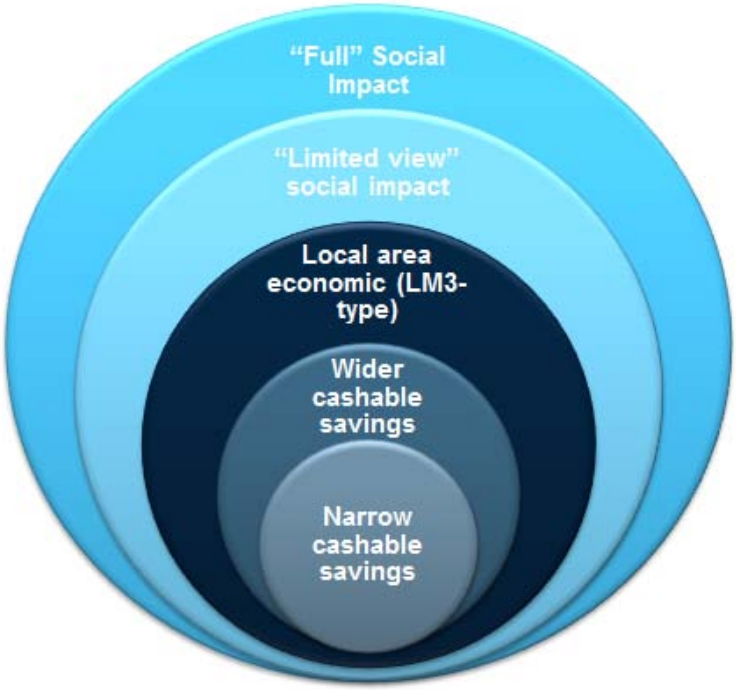
Increase in employment	▸ Economic gain ▸ Wastage avoided	▸ The rehabilitation sessions that MSLT run have an effect in enabling individuals to regain employment by alleviating their symptoms to give them the ability to re-enter work or by reducing their need for care to such an extent that a partner or other informal carer is able to take on formal employment. ▸ By questioning the individuals on the programme where possible, or by making reasonable assumptions based on the SROI Project Team's knowledge of the individuals, the number of people who have re-entered employment has been calculated. Using the Greater Manchester GVA allows an attributable gain for employment to be calculated. ▸ Young people regularly attend the women-only programme. Statistical research across the wider population suggests that 16.2% of young people are currently NEET at age 16 to 24, with a rate among 16 year olds of 6.3%[UU]. ▸ The SROI Project Team has obtained case study evidence which suggests that some participants have been re-motivated or re-engaged with their education as a result of socialising with their peers and benefiting from a structured activity (as opposed to becoming bored and disengaged from society in their spare time). ▸ MSLT has assumed that 16% of this group would be at risk of being NEET at age 16 to 24, in line with the UK average. For prudence, MSLT has assumed that 10% of the at-risk group would experience a positive change as a result of the project. In the absence of empirical data on the number of participants that would have become NEET in the absence of the intervention, the SROI Project Team believes this to be a prudent assumption. ▸ The value of damage avoided by this project is derived from the Prince's Trust[VV], which shows lost productivity and welfare benefit costs of £16,320 for each year in which a young person is NEET with a subsequent lifetime wage penalty of 10% compared to peers who went on to further education, training or employment post-16. The Prince's Trust study estimates the present value of this wage penalty at £45k. The combined present value of this penalty, lost productivity and welfare benefit costs (assuming a four year NEET period in line with the Prince's Trust study findings) amounts to £150k per beneficiary.

5.4 A detailed analysis of the individual models used to evaluate each of the projects listed in section 4, together with a detailed description of the assumptions and sources used is provided at Appendix B.

[UU] Department for Education (2011) 'Statistical Release – NEET statistics – Quarterly Brief August 2011', London, Department for Education
[VV] McNally, S, & Telhaj, S. (2010) ' The cost of Exclusion: counting the cost of youth disadvantage in the UK', Prince's Trust, London

Breadth of impact

5.5 In evaluating the social impact of the selected services the value being saved or created can be viewed in terms of how narrow these are to selected services. Some impacts will be very narrow and likely to confer cashable savings for organisation over the next year or so. Others will be far less tangible and may not come to fruition for a number of years.



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5.6 The above diagram illustrates the ripple like effect of the assed social impact, spreading out from narrow more direct savings in the centre out to the full scope of a social impact.

5.7 In applying these principles the impacts for MSLT's assessed services were broken down to understand what there narrow cashable savings were likely to be. This figure allows MSLT and partner agencies to understand the likely direct impact on state funding in the shorter term of a withdrawal of the selected services.

5.8 Whilst these are included as narrow cashable savings, it is likely that the impact would still be affected by a lead in time, were services to be withdrawn tomorrow the consequent increase in costs would not be immediately felt as illustrated below:

5.9 Having analysed the models and extracted those impacts that were assessed as being narrow range (within given selected State services) and over a 12 month period the following impacts were assessed. Within COPD and Cardiac rehabilitation the models were adapted to remove increases in employment and reduced costs of COPD care as these were both assessed as being services where there is a longer lead time for cost savings. For example, it takes a significant period of COPD rehabilitation before conditions can be mitigated to a demonstrable extent. However, in the short term direct costs can be saved

COPD and Cardiac Rehabilitation	Impact
Benefit of a reduction in mental health problems (COPD)	£47,140
Benefit of a reduction in mental health problems for carers (COPD)	£49,160
Reduction in direct healthcare costs (COPD)	£87,547
Decreased likelihood of future cardiac arrests	£253,536
Benefit of a reduction in mental health problems (Cardiac)	£37,692
Benefit of a reduction in mental health problems for carers (Cardiac)	£36,687
Total assessed Narrow Social Impact	**£511,762**

5.10 When assessing Neurological and Stroke rehabilitation the gains attributable to increases in employment have been removed as these were assessed as occurring over a greater than 12 month period. Other models have been adapted over a shorter timescale.

Neurological and Stroke Rehabilitation	Impact
Benefit of reducing the number of falls	£4,947
Avoided societal costs of future strokes	£351,199
Avoided societal costs of mental health problems post stroke	£92,873
Benefit of a reduction in mental health problems for carers	£41,089
Total assessed Narrow Social Impact	**£490,108**

5.11 The provision of services for those with disabilities' gains have been reduced by removing longer term health gains as a result of increased physical activity due to the length of time over which these gains would be attributable.

Provision of services for those with disabilities	Impact
Decrease in need for respite care	£96,158
Economic benefit of a reduction in the number of mental health problems for adult users	£27,441
Economic benefit of a reduction in the number of mental health problems for child-users	£122,627
Economic benefit of a reduction in the number of mental health problems for siblings	£37,470
Economic benefit of a reduction in the number of mental health problems for guardians	£31,113
Total assessed Narrow Social Impact	**£318,809**

5.12 For women only services, only mental health savings were assessed as occurring over a short enough time-frame to be included within this focus.

Provision of women-only services	Impact
Reduction in mental health problems for non BME women	£104,811
Reduction in mental health problems for BME women	£45,031
Total assessed Narrow Social Impact	**£149,842**

5.13 For the wider health and fitness population all models were recognised as being attributable to a narrower impact, but it was recognised that the impact would be reduced. The attributable gains for health and fitness to the various age groups were therefore reduced to 10% of their original levels.

Health and fitness for wider population	Impact
Health benefits	£1,414,594
Reduction in sickness absence	£2,693,453
Savings on membership fees	£416,198
Reduction in mental health problems	£2,531,983
Reduction in numbers of falls	£722,169
Total assessed Narrow Social Impact	**£7,778,397**

5.14 Combining these impacts together shows that the total of MSLT's assessed narrow cashable savings to the local community is over £9 million.

Summary Impacts	Impact
COPD and Cardiac Rehabilitation	£511,762
Neurological and Stroke Rehabilitation	£490,108
Provision of Services for those with Disabilities	£314,809
Provision of women-only services	£149,842
Wider health and fitness services	£7,778,397
Total assessed Narrow Social Impact	**£9,244,918**

Avoidance of double-counting

5.15 The projects selected for analysis are felt to be sufficiently distinct as to avoid the risk of double counting of benefits.

5.16 Where numbers of participants have been derived from MSLT's management information systems, care has been taken by MSLT staff to avoid double counting beneficiaries, notably in relation to the following projects:

- Membership and general access visits;
- Social swimming visits; and
- Rehabilitation session visits.

6. Conclusion

Results of this evaluation

6.1 Based on the results of our discussions with MSLT, as summarised in section 5, and on the results of the evaluation models (Appendix B), the evaluated benefits of the selected MSLT activities may be summarised:

	Evaluated gains
COPD and Cardiac care	£ 2,751,305
Neurological and Stroke Rehabilitation	£ 1,834,476
Activities for disabled people	£ 1,755,966
Women-only activities	£ 958,284
Physical activity, gym and swim facilities	£ 29,893,162
Total	**£ 37,193,193**

6.2 The table above shows total benefits from the projects included in this evaluation to be at least **£37.1 million per annum**.

6.3 These results are to be set in the context of total annual funding of £5.5m per annum, albeit this funding covers a wider area of activity than just those projects evaluated.

6.4 On this basis, the impact of the benefits evaluated for the areas of work shown above **exceeds MSLT's total annual funding by at least £31.6m per annum**.

6.5 It should be noted that this report only includes the benefits evaluated from the projects shown in this study, and therefore if all the areas of MSLT's work were evaluated the total assessed impact would be likely to increase.

Other outcomes not evaluated

6.6 In common with most SROI evaluations, it is not practicable or cost-effective to evaluate every aspect of the effect of the projects. This relates often to the wider well-being and less proximate benefits from MSLT's work. Hence the projects shown above may not reflect full evaluations of benefits including:

- Long term impacts on subsequent generations due to lifestyle change among the current one;
- The value of friendships made during participation in certain activities;
- The wider impact on communities of improved well-being due to certain project outcomes including reductions in Anti-Social Behaviour rates;
- The promotion of participation in competitive sport, including the development of professional athletes;
- Improved water safety and, potentially, lifesaving skills derived from social swimming; and
- Improved educational outcomes and social cohesion through participation in sport.

6.7 This report does constitute an evaluation of the entirety of MSLT's work. MSLT estimates that the projects covered by this study account for up to 10% of its patronage.

6.8 Where specific evidence exists, it has been sought to evaluate these benefits as noted in the report. However, it is difficult to evaluate reliably in financial terms the value of increased well-being of certain beneficiary groups, including people that live in communities that have experienced a reduction in crime and/or an increase in employment rates as a result of MSLT's work.

6.9 As this evaluation does not seek to measure the value of the further benefits listed at paragraph 6.6, the value of these outcomes would be incremental to the value shown above. Hence the evaluations shown above are expected to be lower than the full value of the outcomes potentially generated by MSLT.

Sensitivity Analysis

6.10 Various assumptions have been made in the course of preparing this analysis and the detailed tables of calculations in Appendix B. Some relate to estimates made by the MSLT SROI Project Team in coming to the views of outcomes, and some relate to the interpretation of information arising from other research work and statistical analysis referenced in this work.

6.11 In order to assess the extent to which these assumptions are material, potentially key assumptions have been identified. Each has been subject to variation within what appears to be a reasonable range, and the effect on the total valued outcomes under the study has been recast. The resulting analysis is shown at Appendix C.

6.12 The conclusion from this analysis is that even if certain key assumptions are subjected to a material change, the overall conclusion from this study (i.e. that the social return generated by the evaluated projects is significantly greater than their cost) would not change.

Appendices

A. Notes on Action Research

Action Research, or Action Science as some, including Gummerson[KK], prefer to call it, is a recognised and respected research approach originating in the social sciences arena, which involves the researcher and the researched jointly learning in and investigating the research area. Whilst primarily a qualitative methodology, it can be constructed in such a way as to gather and test data with levels of validity that would constitute scientific research (as opposed to casual enquiry) whilst retaining the proximity to that data that best comes from working with those who are involved with it.

The researcher works with the researched jointly to investigate an issue of common interest. Together they gather data, test and validate it, and draw interpretations and conclusions out.

Action research is hence an iterative research methodology that is intended to bridge the gap between theoretical research and the practical realities of the real world. As Gustavsen puts it:

"The point is to understand the world as it is by confronting it directly; by trying to grasp the phenomena as they really are.[LL]"

Reason and Bradbury (2001) define Action Research as *"a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview... It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities."* (2001, p.1)

In simplistic terms, Action Research is collectively learning from experience by sharing that experience with others and taking action to bring about change by building on that experience.

In our work with Manchester Sport and Leisure Trust, it has been vital that an understanding was gained, not just of how their activities could *theoretically* be benefiting the local area, but of how they create benefit in practice. Theoretical research on SROI methodologies gives us a view on where the benefits may lie, but only through an iterative process of discussing, developing and refining our understanding can a true picture be obtained of where the benefits of Manchester Sport and Leisure Trust's activities actually lie.

The process of conducting Action Research may be summarised using the diagram shown overleaf:

[KK] Gummerson, E. 2000, Qualitative Methods in Management Research. 2nd Ed. Thousand Oaks, Ca. Sage Publications
[LL] 'New Forms of Knowledge Production and the Role of Action Research', Bjorn Gustavsen, Action Research 2003; volume 1 at p.153

The diagram shows an iterative five stage approach to Action Research. The way in which our approach fits with this model is described as follows:

1. **Observation:** from our initial discussions with Manchester Sport and Leisure Trust, it is clear that a lack of understanding of its Social Impact may weaken its position when negotiating with funders or demonstrating the value it returns to the community it serves, thus damaging its ability to continue some aspects of its work. However, it is also clear that by improving awareness of the extent of its impact on the community, MSLT can further improve its brand recognition, and therefore, potentially, the breadth of its user base;
2. **Reflection:** by using Social Impact measurement tools such as SROI, it is believed that it is possible to begin to increase the understanding of the benefits Manchester Sport and Leisure Trust generates among key stakeholders;
3. **Data gathering:** the services that MSLT provides were discussed with a team of project representatives, and the outcomes these projects produce and key beneficiaries were identified. A range of possible methods of evaluating these services were discussed using the three models described at Section 3.7 of this report to cover the concept of value from the perspective of all key stakeholders;
4. **Test claims and conclude:** many of the assumptions used in the evaluation models (Appendix B) are based on data gathered by MSLT management information systems. Copies of the supporting records for such data were obtained. Where an assumption was required, MSLT were encouraged to be prudent in order to avoid overstating benefits. In some cases, assumptions have been informed by data from external sources combined with the use of judgement. Copies or records of any research were obtained. MSLT undertook internal consultations and some informal discussions with external stakeholders in order to validate and test key assumptions or to provide evidence to support the theory of change suggested by the working group;
5. **Monitor improvements:** it is hoped that this work will result in improved awareness of MSLT's activities among stakeholders (including funders), and therefore address the risks identified at stage 1 of the process.

Having reached a stage where an improvement is expected, the iterative nature of Action Research allows for further studies to be carried out in future building on the work presented in this report, including on-going measurement of benefits and the use of similar methodologies to assess proposed future projects.

Clearly, wherever data already exist to quantify a benefit, they are to be used. However, in the absence of observed data, Action Research allows us to gain an accurate perspective on the real benefits that are generated. In some cases it will be impossible to observe the impact, as to do so would require a comparison between a world in which Manchester Sport and Leisure Trust exist and one in which they do not, all other factors being equal. Clearly such comparison will never be possible, and so reliance must be placed on the common-sense and judgment of Manchester Sport and Leisure Trust, based on their real-world experience.

Where data may be, but is not currently, observed, our work allows us to refine the list of useful data that may be gathered in future as a basis for refining the measurement of the economic benefit that is generated. This project may therefore act as a platform for identifying further Action Research projects that will develop detailed measurement tools.

Any outline of a research methodology would be incomplete without looking at broader criticisms of it in management science circles. Criticisms of action research are several, but most emanate from proponents of statistical sampling and questionnaire-based research methodologies. In brief, these tend to surround the following areas, each of which is shown with a brief response related both to theory and to this research in particular.

How can you assert validity when all the data is of internal origin?

Bypassing the theoretical debates about the validity of different data sources and the extent to which all are, to some degree, partly objective and partly partisan, the key point here is that the data is not all of internal origin.

Many of the measurement criteria within the financial proxies are:

- from publicly available data sources, often validated Government data;
- from appropriately structured pilot studies;
- from research appropriately undertaken by the subjects' own SROI Project Team; or
- separately sense-checked or reviewed by the SROI Project Team.

It is not true research because the researcher influences, and is involved in the outcome….?

It is true that the researcher is involved in the sense that "the action researcher… may help clients make more sense of their practical knowledge and experience…"[ww]

This is consistent with the second of the seven principles of SROI: Measurement with people.

If the researcher facilitates the better collection and interpretation of data from the researched and leaves them with an understanding and knowledge to enable them to embed that in future action, then this active involvement must be seen as a virtue and not a weakness. It improves the understanding of data gathered and at the same time, seeks to embed the results in the organisations (the final stage of the SROI process).

[ww] Gill, J. And Johnson, P. 2002. Research Methods for Managers. 3rd Ed. London, Sage. p.92.

Berg[XX] summarises the strengths of action research in these fields as follows:

- "a highly rigorous, yet reflective or interpretative, approach to empirical research;
- the active engagement of individuals…in the research enterprise;
- the integration of some practical outcomes related to the actual lives of participants in this research project;
- a spiralling of steps…"

It has been found, in this study and other similar ones, that Action Research provides an ideal foundation approach for developing a Social Impact Evaluation and embedding it in the organisation.

[XX] Berg, B. 2009. Qualitative Research Methods for the Social Sciences. 7th Ed. Upper Saddle River, NJ. Pearson. .248.

B. Detailed Evaluation Models Used

Summary of evaluations

The table below shows a summary of the detailed evaluation models presented in this Appendix:

Model	Evaluated Gains (£'000)
COPD and Cardiac Rehab	
Societal costs of COPD	88
COPD Mental Health problems	137
COPD Mental Health problems for carers	143
Increase in employment rate (Cardiac)	607
Increase in employment rate (Cardiac) - Carers	164
Decrease in Cardiac recurrences	1,398
Cardiac Mental Health problems	109
Cardiac Mental Health problems for carers	106
Total gains due to COPD and Cardiac rehab	**2,751**
Neurological and Stroke Rehab	
Increase in employment rate	167
Increase in employment rate for carers	73
Attributable gain from a reduction in number of falls	23
Attributable gain from a reduction in number of stroke re-occurrences	1,018
Attributable gain from a reduction in mental health problems post-stroke	434
Attributable gain from a reduction in mental health problems (carers)	119
Total gains due to Neurological and Stroke rehab	**1,834**
Services for those with disabilities	
Attributable savings from cheaper respite care	96
Attributable gain from a reduction in mental health problems amongst adults	128
Attributable gain from a reduction in mental health problems amongst children	1,056
Attributable gain from a reduction in mental health problems amongst siblings	323
Attributable gain from a reduction in mental health problems amongst guardians	90
Attributable gain from an increase in activity levels amongst adults	16
Attributable gain from a reduction in the numbers of inactive children	47
Total gains due to services for those with disabilities	**1,756**
Women-only services	
Attributable gain from a reduction in inactivity amongst non-BME women	136
Attributable gain from a reduction in inactivity amongst BME women	121
Attributable gain from a reduction in mental health problems amongst non BME women	489
Attributable gain from a reduction in mental health problems amongst BME women	210
Attributable gain from a reduction in the level of future NEET's	2
Total gains due to women-only services	**958**
Swim and Gym services	
Attributable gain from health benefits to regular users	14,146
Attributable gain from a reduction in sick days	2,693
Attributable saving from lower cost memberships	499
Attributable gain from a reduction in mental health problems	11,833
Attributable gain from a reduction in the number of falls amongst over 60's	722
Total gains due to swim and gym services	**29,893**
Total gains due from all services	**37,193**

COPD and Cardiac Rehabilitation

Societal Costs of COPD

MSLT has approximately 67 individuals who regularly attend COPD rehab session over the course of a year. These rehab sessions aim to build on an individual's fitness to improve their resistance to further complications. This in turn helps cut down on the NHS costs of further admittances to hospital, the use of drugs, GP visits and many other associated costs, the calculations to this are represented below:

Avoided societal costs of COPD	Assumptions	Calculation	Benefits (£)
Number of individuals on program	67		
Unit costs of COPD			
	£		
Cost for the NHS treatment	800,000,000		
Total national cost		£ 800,000,000	
Number of diagnosed COPD cases in UK	900,000		
Therefore, average cost per COPD case		889	
Increase in costs associated with severe COPD		8,889	
Reduction on the cost	30%	2,667	
Present value			**178,667**
Deadweight	1%		-1,787
Alternative attribution	50%		-89,333
Total attributable gain			**87,547**

Key assumptions:

- **Number of people on program**: Taken from information provided by the SROI Project Team of those on COPD programs
- **Total National cost of COPD**: Taken from a report; COPD Costing report, NICE, February 2011. This includes the direct NHS costs of treating COPD in patients and also the lost days of productivity due to increased sick leave etc.
- **Diagnosed cases in UK**: Taken from a report detailing the number of COPD related diagnoses in the UK, (http://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease/Pages/Introduction.aspx) accessed Jan 2013
- **Average cost per case**: Taken as a calculation of the above numbers
-

- **Increase in costs of severe COPD**: As the individuals that MSLT work with can be classified as on the severe end of the COPD spectrum with many requiring supplemental oxygen it is appropriate to uplift the costs to reflect the greater economic burden they carry. Figure taken from http://www.dh.gov.uk/health/2012/05/nhs-companion-copd/ (Accessed January 2013)

- **Reduction of symptoms**: From the research group an assumption of the benefit to the symptoms and subsequent care that the work the MSLT services provide to those suffering from COPD.

- **Deadweight**: Due to the nature of COPD problems individuals do not recover on their own and they are not 'curable'. The work done helps to alleviate symptoms and increase the sufferer's quality of life. The researchers felt it was prudent to set it at 1%.

- **Alternative Attribution**: This represents the work that follow up sessions with the NHS does to alleviate their symptoms and other sources of help such as support from carers and family.

COPD resultant Mental Health problems for individuals

Due to the nature of COPD as a debilitating illness the direct impact that it has on an individual is great and as a result of this many individuals also suffer from mental health problems. The illness can cause individuals to have to rely on others in order to complete even simple activities. This feeling of helplessness can manifest itself in depression or other mental health issues that impact the individual and those around them:

Economic benefit of reduction in mental health problems (COPD)	Assumptions	Calculation	Benefits (£)
Number of regular users	67		
Risk of mental health problems amongst COPD sufferers	20%		
Expected problems amongst population		13	
Amount alleviated through regular exercise/activities with MSLT	50%		
Cases avoided		7	
Cost per incident	£ 10,403		
Value of mental health problems avoided			**69,700**
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	
Present value of gain from mental health problems			**195,274**
Alternative Attribution	30%		- 58,582
Attributable gain from mental health problems avoided			**136,692**

COPD resultant Mental Health problems for carers

Having to provide informal care for an individual can place a heavy burden on an individual as they have to sacrifice a large proportion of their time to provide support. This places strain on an individual's mental health and carers are at a very high risk of suffering from depression or other mental illnesses[YY]. By alleviating the symptoms or reducing the support that an individual needs MSLT are also alleviating some of the pressures on the carer which has a marked effect on their own mental health:

Mental health problems (COPD) for carers	Assumptions	Calculation	Benefits (£)
Number of regular users (assumed 1 carer each)	67		
Risk of mental health problems amongst carers	73%		
Expected problems amongst population		49	
Cost per incident	£ 10,403		
Value of mental health problems avoided			**508,811**
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	
Present value of gain from mental health problems			**1,425,503**
Deadweight	60%		-855,302
Alternative Attribution	30%		-427,651
Attributable gain from mental health problems avoided			**142,550**

Key assumptions:

- **Number of regular users**: Taken from figures the SROI Project Team have provided of the number of regular users of COPD sessions.
- **Risk of mental health problems amongst COPD sufferers**: Taken from a report; Boutin-Forzano S, Moreau D, et al. Int J Tuberc Lung Dis 2007;11:695–702**.**
- **Risk of mental health problems amongst carers**: Taken from the report, NHS Information Centre Social Care Team (2010), 'Survey of Carers in Households 2009/10', London, NHS Information Centre.
- **Expected problems amongst population**: This calculation uses the above two assumptions to calculate the expected mental health issues amongst the MSLT users.

[YY] Clifford, J., Mason, S and Theobald, C (2011) Princess Royal Trust for Carers: Social Impact Evaluation using Social Return on Investment. London, Princess Royal Trust for Carers.

- **Amount alleviated through regular exercise and social interaction**: This is a figure provided by the SROI Project Team of the assumed benefit the sessions have on regular users. This is based upon trainers/supervisors experience with the individuals taking part and by their questioning of individuals.

- **Cases avoided**: Calculation based on the above figures.

- **Cost per incident**: Figure taken from a calculation found in the 'wider population' study.

- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and thus avoids mental health problems and has been agreed upon by the MSLT SROI Project Team. This figure represents the fact that once an individual has started on this course they recognise the benefits and are likely to continue attending, alleviation of symptoms requires continual work.

- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of figures in later years.

- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.

- **Deadweight**: This figure represents that a significant proportion of carers would have started working again regardless of any intervention from MSLT.

- **Alternative Attribution**: This assumption represents the other organisations that endeavour to reduce mental health problems by enabling exercise and social interaction.

Evaluation of the gains from an increase in individuals being able to participate in employment as a result of Cardiac Rehabilitation

The individuals who participate on the cardiac rehab sessions tend to be of working age and the work that MSLT does with them enables them to build the fitness and strength needed to re-enter the workplace. In order to successfully recover from a heart attack an individual needs to change their lifestyle and incorporate health and fitness. Without this they are far more likely to suffer a repeat occurrence. By enabling individuals to re-enter employment this has the dual effect of increasing the productivity of an individual and of reducing the welfare support that an individual needs to receive:

Increase in employment rate (Cardiac)	Assumptions	Calculation	Benefits (£)
Number of individuals	50		
Rate of employability on MSLT program	50%		
Extra employable people		25	
Unit Cost			
	£		
Greater Manchester GVA	18,113		
Reduction experienced by those with disabilities	-9.50%		
		£	
Average Unit Impact value		16,392	
Annual welfare benefits saved		£ 10,496	
Lifespan of the impact	5		
Discount rate	3.50%		
Annuity factor		4.52	
Gain from employment increase			**3,035,071**
Deadweight	10%		-303,507
Alternative attribution	70%		-2,124,549
Attributable gain from employment increase			**607,014**

Evaluation of the gains from an increase in carers being able to participate in employment as a result of Cardiac Rehabilitation

As individuals are able to regain employment so too are their carers free to re-enter or increase their employed hours. As with mental health issues this has an important impact on society:

Increase in carer employment rate (Cardiac)	Assumptions	Calculation	Benefits (£)
Extra employed people from programme	25		
Assuming these people have at least 1 carer	1		
Extra employable people		25	
Unit Cost			
Greater Manchester GVA	£ 18,113		
% of working time previously spent caring for individual	50%		
Reduction in the amount of care time needed	80%		
Additional GVA "freed" by individual entering employment		£ 7,245	
Lifespan of the impact	5		
Discount rate	3.50%		
Annuity factor		4.52	
Gain from employment increase			**817,811**
Deadweight	10%		-81,781
Alternative attribution	70%		-572,468
Attributable gain from employment increase			**163,562**

Key assumptions:

- **Number of individuals using services**: From data provided by MSLT, number of individuals of working age taking part in MSLT cardiac rehab at Sportcity only.
- **Rate of employment on MSLT Cardiac courses**: Assumption put to SROI Project Team to estimate the number of individuals who are in employment on the Cardiac courses.
- **Extra employable people**: Calculation based on the above numbers.

- **Extra employment attributable to MSLT**: Calculation based upon above numbers.

- **Percentage of working time previously spent caring for an individual**: This is an assumption agreed upon by the SROI Project Team of the average time spent by a carer which could have been spent working.

- **Reduction in the amount of care time needed**: This is an assumption of the reduction in care time that individuals now need as a result of MSLT intervention.

- **Greater Manchester GVA**: This is the average value added by each employed person in the Greater Manchester area, as taken from; Local Gross Value added (GVA) 2011, Greater Manchester South and comparators, Nigel Waddington, December 2012.

- **Reduction experienced by those with disabilities**: This reduction reflects the fact that employed disabled people on average receive less pay than able-bodied equivalents; Disability in the United Kingdon, Papworth Trust, Jan 2010, Page 3.

- **Annual welfare benefits saved**: This is an assumption based upon the fact that if individuals are in employment they are not in receipt of certain benefits. Figures based on JSA and Housing Benefit at £150 per week, which is the low end of the spectrum per www.dwp.gov.uk.

- **Average Unit Impact value**: Calculation of the above figures.

- **Lifespan of the impact**: This is an assumption that is based on the length of time that an individual will maintain employment. Supporting information taken from Employer Perspectives on the Recruitment, Retention and Advancement of Low Pay, Low Status Employees, Institute for Employment Studies, July 2003, Page 23.

- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.

- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.

- **Alternative Attribution**: This figure represents the other bodies and organisation that enable those who are on Cardiac programs to maintain work.

- **Deadweight**: This figure represents that some individuals could be expected to have continued/found employment without MSLT's intervention. This is unlikely due to the severity of the symptoms but has been set prudently.

Decrease in recurrent cardiac arrests

As individuals' health and fitness improve and they successfully adopt a healthier lifestyle the likelihood of having a repeat occurrence dramatically reduces. A heart attack is very costly in terms of direct NHS costs and the subsequent informal care the individual require, by avoiding these MSLT can help contribute to large savings for society:

Decrease in future cardiac problems	Assumptions	Calculation	Benefits (£)
Number of users	50		
Likelihood of repeat heart attack for Men	21%		
Likelihood of repeat heart attack for Women	33%		
Average		27%	
Expected Cases		14	
Actual Cases	-		
Cases Avoided		14	
Unit Cost			
	£		
Direct Health Care Costs of CHD	1,799,459,000		
	£		
Productivity loss due to Mortality	2,228,423,000		
	£		
Production loss due to Morbidity	920,518,000		
	£		
Informal Care Costs	1,725,225,000		
		£	
Total Costs		6,673,625,000	
Heart attacks per year	103,000		
		£	
Cost per attack		64,792	
Lifespan of the impact	6		
Discount rate	3.50%		
Annuity factor		5.33	
Present value of gain from avoiding repeat heart attacks			**4,660,877**
			-
Alternative attribution	70%		3,262,614
Total attributable gain			**1,398,263**

Key assumptions:

- **Number of users**: Taken from the data provided by MSLT.
- **Likelihood of repeat heart attacks**: Taken from Heart Disease and Stroke Statistics, Internet. American Heart Association. (Accessed January 22nd 2013). An average between men and women has then been used. Although this figure is taken from an American study it is assumed that the link between future subsequent attacks is likely to be consistent and is a measure of the weakness present in the heart following an attack.
- **Expected Cases**: Calculation based on the above numbers.
- **Actual Cases**: Taken from information provided by MSLT as to the number of regular attendees who have suffered a repeat heart attack whilst also attending sessions.
- **Cases Avoided**: Calculation based on above numbers.
- **Direct healthcare costs, mortality, morbidity and informal care costs**: Taken from Coronary Heart Diseases Statistics 2012 Edition, British Heart Foundation, 2012 as a cumulative figure for the listed costs.
- **Heart attacks per year**: Taken from Coronary Heart Diseases Statistics 2012 Edition, British Heart Foundation, 2012 as an average number per annum.
- **Cost per attack**: Calculation taken from above numbers.
- **Lifespan of the impact**: Taken from the same source as the chance of a repeat attack as this percentage was based on a 6 year period from the first attack.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 6 years at the above discount rate.
- **Alternative Attribution**: This figure represents the other bodies and organisations that enable those who have had a heart attack to minimise their chances of a repeat attack.

Mental Health benefits to cardiac rehab individuals and carers

As noted above with relation to the COPD rehab sessions individuals on the cardiac sessions face similar burdens as do their carers. As a result of this separate models have been created:

Reduction in mental health problems (Cardiac)	Assumptions	Calculation	Benefits (£)
Number of regular users	50		
Risk of mental health problems amongst Cardiac sufferers	30%		
Expected problems amongst population		15	
Amount alleviated through regular MSLT activities	50%		
Cases avoided		8	
Cost per incident	£ 10,403		
Value of mental health problems avoided			**78,023**
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	
Present value of gain from mental health problems			**218,591**
Alternative Attribution	50%		- 109,295
Attributable gain from mental health problems avoided			**109,295**

Reduction in mental health problems (cardiac) for carers	Assumptions	Calculation	Benefits (£)
Number of regular users (assumed 1 carer each)	50		
Risk of mental health problems amongst carers	73%		
Expected problems amongst population		37	
Cost per incident	£ 10,403		
Value of mental health problems avoided			**379,710**
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	
Present value of gain from mental health problems			**1,063,808**
Deadweight	60%		- 638,285
Alternative Attribution	30%		- 319,142
Attributable gain from mental health problems avoided			**106,381**

Key assumptions:

- **Number of regular users**: Taken from figures the SROI Project Team have provided of the number of regular users of cardiac sessions.
- **Risk of mental health problems amongst people who have had a heart attack**: Taken from a report; Frasure-Smith N, Lesperance F, Juneau M, Talajic M, Bourassa MG. Gender, depression and one-year prognosis after myocardial infarction. Psychosomatic Medicine 1999;61(1):26-37.
- **Risk of mental health problems amongst carers**: Taken from a report, NHS Information Centre Social Care Team (2010), 'Survey of Carers in Households 2009/10', London, NHS Information Centre.
- **Expected problems amongst population**: This calculation uses the above two assumptions to calculate the expected mental health issues amongst the MSLT users.
- **Amount alleviated through regular exercise and social interaction**: This is a figure provided by the SROI Project Team of the assumed benefit the cardiac sessions have on regular users. This is based upon trainers/supervisors experience of working with the individuals on the sessions.
- **Cases avoided**: Calculation based on the above figures.
- **Cost per incident**: Figure taken from calculation done as part of wider population study.
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and thus avoid mental health problems as a result in taking part in the MSLT sessions.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Deadweight**: This figure represents that a significant proportion of carers may have been likely to re-enter work without any intervention from MSLT.
- **Alternative Attribution**: This assumption represents the other organisations that endeavour to reduce mental health problems by enabling exercise and social interaction.

Neurological and Stroke Rehabilitation

Increase in employment of individuals and their carers

Using a similar methodology to that applied for Cardiac and COPD rehab, the table below shows an evaluation of the gain resulting from increased employment of individuals and their carers:

Increase in employment rate	Assumptions	Calculation	Benefits (£)
Number of individuals	56		
Rate of employability on MSLT program	5%		
Extra employable people		2.8	
Unit Cost			
	£		
Greater Manchester GVA	18,113		
Reduction experienced by those with disabilities	-9.50%		
		£	
Average Unit Impact value		16,392	
Annual welfare benefits saved		£ 10,496	
Lifespan of the impact	5		
Discount rate	3.50%		
Annuity factor		4.52	
Gain from employment increase			**339,928**
Deadweight	1%		-3,399
Alternative attribution	50%	-169,964	
Attributable gain from employment increase			**166,565**

Increase in carer employment rate (Cardiac)	Assumptions	Calculation	Benefits (£)
People on programme	56		
Assuming these people have at least 1 carer	1		
Affected people		56	
Unit Cost			
	£		
Greater Manchester GVA	18,113		
% of working time previously spent caring for individual	80%		
Reduction in the amount of care time needed	20%		
Additional GVA "freed" by individual entering p/t employment		£ 2,898	
Lifespan of the impact	5		
Discount rate	3.50%		
Annuity factor		4.52	
Gain from employment increase			**732,759**
Deadweight	20%		-146,552
Alternative attribution	70%		-512,931
Attributable gain from employment increase			**73,276**

Key assumptions:

- **Number of individuals using services**: From data provided by MSLT, number of individuals of working age taking part in MSLT offerings.
- **National employment rate of people with disabilities**: As taken from Office for National Statistics Labour Force Survey, Jan - March 2009.
- **Expected employed people**: Calculation based upon the above figures.
- **Employed users at MSLT**: Numbers provided by MSLT.
- **Extra employment attributable to MSLT**: Calculation based upon above numbers.
- **Greater Manchester GVA**: This is the average value added by each employed person in the Greater Manchester area, as taken from; Local Gross Value added (GVA) 2011, Greater Manchester South and comparators, Nigel Waddington, December 2012.

- **Percentage of working time previously spent caring for an individual**: This is an assumption agreed upon by the research group of the average time spent by a carer which could have been spent working.

- **Reduction in the amount of care time needed**: This is an assumption of the reduction in care time that individuals now need as a result of MSLT intervention.

- **Reduction experienced by those with disabilities**: This reduction reflects the fact that employed disabled people on average receive less pay than able-bodied equivalents; Disability in the United Kingdon, Papworth Trust, Jan 2010, Page 3.

- **Annual welfare benefits saved**: This is an assumption based upon the fact that if individuals are in employment they are not in receipt of certain benefits. Figures based on JSA and Housing Benefit at £150 per week, which is the low end of the spectrum per www.dwp.gov.uk.

- **Average Unit Impact value**: Calculation of the above figures.

- **Lifespan of the impact**: This is an assumption that is based on the length of time that an individual will maintain employment. Supporting information taken from; Employer Perspectives on the Recruitment, Retention and Advancement of Low Pay, Low Status Employees, Institute for Employment Studies, July 2003, Page 23.

- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.

- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.

- **Alternative Attribution**: This figure represents the other bodies and organisations that enable those who have had a stroke or other neurological problem to re-enter work.

Evaluation of the gains from a reduced number of falls

One of the results of having a stroke or other neurological disorder is a loss of coordination. This often leads to serious falls which in turn lead to increased care needs. The work that MSLT does as part of the rehab session work with individuals is fundamental in allowing neurological pathways to be reopened and maintained. This coupled with an increased range of movement which results from specifically tailored exercises causes the population to experience less falls:

Economic benefit of reduced number of falls	Assumptions	Calculation	Benefits (£)
Total users	56		
General risk of fall amongst stroke victims	54%		
Expected Incidents		30	
% avoided due to MSLT intervention	70%		
Total incidents avoided by MSLT		21	
Unit cost of falls			
Cost per fall for strokes	£ 592.80		
Increase in costs associated owing to stroke victim	20%		
Cost per stroke victim fall		£ 711.36	
Lifespan of effect of fall	5		
Discount Rate	3.50%		
Annuity Factor		4.52	
Projected cost of fall		£ 3,212	
Value of falls avoided			**67,988**
Alternative Attribution	66%		- 44,872
Adjusted value of avoided falls			**23,116**

Key assumptions:

- **Number of individuals:** Those recovering from a stroke and/or with mobility/balance issues.
- **Risk of falls in stroke victims**: Taken from a report, 'The incidence and consequences of falls in stroke patients during inpatient rehabilitation: Factors associated with high risk.' Teasell, McRae, Foley and Bhardwaj 2002.
- **Costs of falls**: Taken as a base from that calculated in the wider population and then altered by the research group to a level that they feel represents the changing circumstances faced. This cost covers the NHS costs of fall and the resultant injuries and hip fractures.

- **Length that fall effects individual**: This is an assumption arrived at by MSLT recognising that once an individual has fallen this will have a longer term effect to their health. Affecting their mobility, confidence and the extent to which friends, family and the NHS must care for them.

- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.

- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.

- **Alternative attribution**: Figure taken as MSLT members who are enabled to exercise or increase mobility by other sources.

Evaluation of the gains from a reduced number stroke recurrences

Once an individual has suffered from a stroke or neurological disorder the odds of them having suffering a repeat are greatly increased. Through the work that individuals do with MSLT this has shown to be extremely successful in cutting the likelihood of another stroke:

Avoided societal costs of future strokes	Assumptions	Calculation	Benefits (£)
Number of individuals	56		
Average rate of stroke recurrence	30%		
Actual recorded cases in the considered population	0		
Strokes avoided due to MSLT intervention		16.8	
Unit cost of stroke episodes			
Direct Cost of NHS treatment	£ 2,800,000,000		
Cost of informal care	£ 2,400,000,000		
Loss of productivity	£ 1,800,000,000		
Total national cost		£ 7,000,000,000	
Stroke cases per annum in UK	110,000		
		£	
Average cost per case		63,636	
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	
Present value of avoided stroke episodes			**2,995,205**
			-
Alternative attribution	66%		1,976,835
Total attributable gain from avoidance of stroke			**1,018,370**

Key assumptions:

- **Number of individuals**: Number of individuals on MSLT's stroke program at moss Side Leisure Centre only.
- **Average rate of stroke recurrence**: Taken from a report, Long-term risk of recurrent stroke after a first-ever stroke. The Oxfordshire Community Stroke Project, Burn J, Dennis M, Bamford J, Sandercock P, Wade D, Warlow C, 1994.
- **Actual recorded cases in the considered population**: From MSLT information - those who have had a recurrence whilst also taking part in MSLT sessions.
- **Strokes avoided due to MSLT intervention**: Calculation based on above two numbers.
- **Total national cost**: Calculated from a range of figures taken from a report; Mant J, Wade DT, Winner S (2004) Health care needs assessment: stroke. In: Stevens A, Raftery J, Mant J et al., editors, Health care needs assessment: the epidemiologically based needs assessment reviews, First series, 2nd edition. Oxford: Radcliffe Medical Press, p141–244.
- **Stroke cases per annum in UK**: Figure taken from, NICE cost impact and commissioning assessment: quality standard for stroke, NICE, June 2010, Page 2.
- **Average cost per case**: Calculation based on the above figures.
- **Lifespan of the impact**: Estimate to be put to the research group of the length of time that the work being done can guard against a further stroke.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Alternative attribution**: Figure taken as MSLT members who are enabled to continue exercise and healthier living by other organisations.

Evaluation of the gains from a reduction in Mental Health problems for individuals and carers

The sessions that MSLT run are set up in a way that engages both the individual and their carer in the session. This helps allow both people to understand their limitations and abilities and engages them in the rehabilitation process. What is also of great importance is the ability for people to meet others who have suffered similar afflictions; the sessions are run in an informal manner which has aided in friendships being made between many of the attendees. Being able to engage socially as well as physically in the session has had a great effect in improving the mental health of both individuals and carers:

Avoided societal costs of mental health problems post stroke	Assumptions	Calculation	Benefits (£)
Expected cases of MH problems post-stroke	33%		
Expected cases in MSLT population	18.48		
	£		
Cost per person	10,403		
Known Cases of mental health problems in MSLT population	0		
Avoided cases		18.48	
Lifespan of the impact	5		
Discount rate	3.50%		
Annuity factor		4.52	
Present value of gain			**868,007**
Alternative attribution	50%		-434,004
Total attributable gain of avoiding mental health problems			**434,004**

Benefit of reduction in mental health problem for carers	Assumptions	Calculation	Benefits (£)
Number of regular users (assumed 1 carer each)	56		
Risk of mental health problems amongst carers	73%		
Expected problems amongst population		41	
	£		
Cost per incident	10,403		
Value of mental health problems avoided			**425,275**
Lifespan of the impact	3		
Discount rate	3.50%		
Annuity factor		2.80	

Present value of gain from mental health problems		**1,191,465**
Deadweight	60%	-714,879
Alternative Attribution	30%	-357,440
Attributable gain from mental health problems avoided		**119,147**

Key assumptions:

- **Expected cases of depression post-stroke**: Taken from a report; Poynter, B., Shuman, M., Diaz-Granados, N., Kapral, M., Grace, S. L., P.H.D., & Stewart, Donna F,M.D., F.R.C.P.C. (2009). Sex differences in the prevalence of post-stroke depression: A systematic review. Psychosomatics, 50(6), 563-9.
- **Risk of mental health problems amongst carers**: Taken from a report, NHS Information Centre Social Care Team (2010), 'Survey of Carers in Households 2009/10', London, NHS Information Centre.
- **Expected cases in MSLT population**: Calculation based upon the MSLT population and the above percentage.
- **Cost per person of depression**: Taken from the Wider Population calculations as a UK average of the cost of mental health costs.
- **Cases of depression in MSLT population**: From the information provided by the SROI Project Team.
- **Avoided cases**: Calculation performed upon the above numbers.
- **Lifespan of the impact**: Estimate to be put to the research group of the length of time that the work being done can guard against future mental health problems.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Deadweight**: This figure represents that a significant proportion of carers may have been likely to re-enter work without any intervention from MSLT.
- **Alternative attribution**: Figure taken from agreement by SROI Project team of MSLT members of those others who enable individuals to combat the risk of depression.

Services for those with disabilities

MSLT, often in conjunction with strategic partners such as MCC, provides a number of different activities for children and adults with disabilities. These can range from activity courses during the holidays to a specialist swimming sessions for amputees. One of the key features of these activities is that they are all held in the universal setting of MSLT premises. All of the activities are held in the normal MSLT facilities around normal opening times, for individuals who have mainly experienced having to attend specialist centres this has a big impact on their self-esteem. By having all the staff from receptionists to coaches comfortable and able to interact and help these individuals it helps to break down the barriers between the disabled and able-bodied.

Evaluation of the gains from the provision of services cheaper than typical respite care

For a lot families there are few options available to them if they need respite care; all of the MSLT offerings are very cheap in comparison to other forms of respite care for disabled children. This allows the families to save money which they can utilise in other ways:

Decrease in need for respite care of disabled users	Assumptions	Calculation	Benefits (£)
Number of users utilising respite care	67		
Average monthly hours spent at MSLT activities	6		
Average cost of respite care in Manchester region	£ 10.00		
Average hourly cost of MSLT session	£ 5.40		
Savings made per month		27.6	
Total attributable savings per year			96,158

Key assumptions:

- **Number of users utilising respite care**: Taken from SROI Project Team data - number of children utilising MSLT services who would/do use respite care.
- **Average monthly hours spent at MSLT activities**: From the data provided this is the average hours spent per month at MSLT activities.
- **Average cost of respite care in Manchester region**: From information provided by SROI Project Team regarding alternative provisions for respite care in the Manchester area.
- **Average hourly cost of MSLT session**: Taken from the data provided as an average.
- **Savings made per month**: Calculation based on the above numbers.

Evaluation of the mental health gains for children, their siblings, guardians and adult users

A running theme through all of MSLT's work is that inclusion is a key aim of their provisions. By fostering an atmosphere where all users can feel part of a community this goes some way to offset the disillusionment many disabled users feel in day-to-day life. For services aimed at children an area that is often overlooked is how able-bodied children cope with the increased attention and needs their disabled siblings naturally receive. This can often lead to resentment and a breakdown in their relationship. By offering activities where both siblings can attend it helps to foster an improved relationship between them. This improved relationship has the added bonus of easing some of the stresses felt by their parents or guardians. Having activities where it's possible to have both children attending thus cutting down on the logistical issues many parents are faced with also helps cut down on stress as does the comfort of knowing that children are being cared for and occupied in sessions managed by professional, caring staff.

Benefit of reduction in mental health problems for adult users	Assumptions	Calculation	Benefits (£)
Number of regular users	42		
Risk of mental health problems amongst disabled population	52%		
Expected problems amongst population		22	
Amount alleviated through exercise and social interaction	50%		
Cases avoided		11	
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ 30,300,000,000		
Human costs	£ 53,600,000,000		
UK Population	£ 63,200,000		
UK Population affected		10,112,000	
	Low	Average	High
Cost Ranges	£ 5,202	£ 10,403	£ 15,605
Cost per incident to be used		£ 10,403	
Lifespan of the impact of being able to exercise	5		
Discount rate	3.50%		
Annuity factor		4.52	
Value of mental health problems avoided			**512,937**
Alternative Attribution	75%	-	384,703
Attributable gain from reduction in Mental Health problems			**128,234**

Benefit of reduction in mental health problems for child users	Assumptions	Calculation	Benefits (£)
Number of regular child users	67		
Risk of mental health problems amongst disabled children	36%		
Expected problems amongst population		24	
Amount alleviated through exercise and social interaction	60%		
Cases avoided		14	
Unit cost of mental health problems			
Cost per incident	£ 35,080		
Lifespan of the impact of being able to exercise	10		
Discount rate	3.50%		
Annuity factor		8.32	
Value of mental health problems avoided			**4,222,156**
Alternative Attribution	75%		- 3,166,617
Attributable gain from reduction in Mental Health problems			**1,055,539**

Economic benefit of reduction in mental health problems for siblings of child users	Assumptions	Calculation	Benefits (£)
Number of regular child users	67		
Assumed average number of siblings	1		
Risk of mental health problems amongst children	10%		
Expected problems amongst population		7	
Amount alleviated through improvements in sibling	33%		
Cases avoided		2	
Unit cost of mental health problems			
Cost per incident	£ 35,080		
Lifespan of the impact of being able to exercise	10		
Discount rate	3.50%		
Annuity factor		8.32	
Value of mental health problems avoided			**645,052**
Alternative Attribution	50%		- 322,526
Attributable gain from reduction in Mental Health problems			**322,526**

Benefit of reduction in mental health problems for guardians of users		Assumptions		Calculation		Benefits (£)
Number of regular child users	67					
Assumed average number of guardian	1.75					
Risk of mental health problems amongst general population		16%				
Expected problems amongst population			19			
Amount alleviated through improvements in dependent user		33%				
Cases avoided			6			
Unit cost of mental health problems						
		£				
Cost per incident	10,403					
Lifespan of the impact of being able to exercise		3				
Discount rate		3.50%				
Annuity factor				2.80		
Value of mental health problems avoided						**180,434**
Alternative Attribution		50%				-90,217
Attributable gain from reduction in Mental Health problems						**90,217**

Key assumptions:

- **Number of regular users**: Taken from figures the SROI Project Team have provided of the number of regular users of disabled sessions.
- **Risk of mental health problems amongst disabled population**: Taken from a report; "Equality and Inequalities in Health and Social Care: A Statistical Overview" Report, DHSSPSNI, 2004, Page 1.
- **Risk of mental health problems amongst disabled children**: Taken from a report; "Equality and Inequalities in Health and Social Care: A Statistical Overview" Report, DHSSPSNI, 2004, Page 1.
- **Risk of mental health problems amongst general population**: Taken from a report "The Mental health of Children and Adolescents with learning disabilities in Britain, Emerson and Hatton, January 2007.
- **Expected problems amongst population**: This calculation uses the above two assumptions to calculate the expected mental health issues amongst the MSLT users.
- **Amount alleviated through regular exercise and social interaction**: This is a figure provided by the SROI Project Team of the assumed benefit the sessions have on regular users. This is based upon trainers/supervisors experience of talking and getting to know the participants.
- **Cases avoided**: Calculation based on above numbers.
- **Assorted mental health costs**: These costs have been taken from a report, the economic and social costs of mental health problems 2009/10, Centre for Mental Health 2010 which details out the cost to the UK of mental health problems.

- **UK Population**: Taken from the 2011 Census estimates.
- **Cost per incident**: Figure based on the above two assumptions.
- **Cost per incident (Children's mental health**: Taken from the average of means found in, Surhcke M, Pillas D & Selai C (2008) Economic aspects of mental health in children and adults in: Social cohesion for mental well-being amongst adolescents. World Health Organisation Regional Office for Europe.
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and thus avoid mental health problems. It was felt once someone was regularly exercising then 3 years represented an appropriate average for the length of time that benefits would continue as a result of continued exercise being maintained.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Alternative Attribution**: This assumption represents the other organisations that endeavour to reduce mental health problems by enabling exercise and social interaction in disabled groups.

Evaluation of the fitness gains from the provision of activities for disabled individuals

One of the core benefits of the activities are the health and fitness gains. All of the sessions are based around a sport or other physical activity. Disabled individuals are at a higher risk of inactivity due to the difficulty in finding activities which they can participate in and be supervised whilst doing so. Through a partnership approach with MCC, MSLT are able to offer these services which have an impact on the gains for both adult and child users:

Avoided societal costs of inactivity in adults	Assumptions	Calculation	Benefits (£)
Number of individuals	42		
	£		
Cost for the NHS treatment	1,800,000,000		
Loss of productivity (due to sickness absence and leave)	£ 5,500,000,000		
Adjustment for lower disability rates (See Section 1)	-		
	£		
Premature death	1,000,000,000		
Total cost to the UK of Obesity	£ 3,500,000,000		
		£	
Total national cost		11,800,000,000	
Physically active population:			
Men	39%		
Women	29%		
Men in UK	31,000,000		
Women in UK	32,200,000		
Total inactive people		41,772,000	
		£	
Cost per inactive person		282	
Lifespan of the impact of exercising regularly	5		
Discount rate	3.50%		
Annuity factor		4.52	
Present Value			**53,568**
Deadweight	10%	-	5,357
Alternative attribution	60%	-	32,141
Total gain			**16,071**

Avoided societal costs of inactivity in disabled children	Assumptions	Calculation	Benefits (£)
Number of individuals	67		
	£		
Cost for the NHS treatment	1,800,000,000		
Loss of productivity (due to sickness absence and leave)	£ 5,500,000,000		
Adjustment for lower disability rates (See Section 1)	-		
	£		
Premature death	1,000,000,000		
	£		
Total cost to the UK of Obesity	3,500,000,000		
		£	
Total national cost		11,800,000,000	
Physically active population:			
Men	39%		
Women	29%		
Men in UK	31,000,000		
Women in UK	32,200,000		
Total inactive people		41,772,000	
		£	
Cost per inactive person		282	
Lifespan of the impact of exercising regularly	10		
Discount rate	3.50%		
Annuity factor		8.32	
Present Value			**157,405**
Deadweight	10%	-	15,740
Alternative attribution	60%	-	94,443
Total gain			**47,221**

Key assumptions:

- **Number of individuals**: Taken from the SROI Project Team as the average number of regular users.
- **Total national cost**: Taken from two reports 'Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers', Department for Health, 2011, Page 14 and 'Economic costs of obesity and the case for intervention', McCormick B, Stone I, 2006, page 1. These give the total UK costs resulting from inactivity and obesity. This is taken as a good indicator of the costs that can be avoided through regular exercise.
- **Physically active population**: In order to calculate the cost per person of inactivity/obesity it's necessary to rule out from the UK population those who are classed as active. Using data from 'Statistics on obesity, physical activity and diet: England', The Health and Social information Centre, 2012, Page 30 and the 2011 census gives us an assumed number of inactive people in the UK.
- **Cost per inactive person**: Using the above two measures this gives us an assumption of the cost to the UK of each inactive/obese person.
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and avoid inactivity/obesity due to their being a regular exerciser in the present.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 or 10 years at the above discount rate. This figure changes to represent the longer lasting impact of children beginning to exercise regularly.
- **Deadweight**: This is the figure to be put forward to the research group of the number of individuals who would exercise anyway even if there was no MSLT offering.
- **Alternative attribution**: There are a wide range of organisation that offer support for disabled individuals, this percentage recognises the work that they do.

Evaluation of women-only services

MSLT hosts its own, and facilitates several women-only sessions through MCC's Active Lifestyles programme. These are run with the aim of enabling women who might otherwise not exercise to use the facilities at a time when they are able to feel comfortable doing so. They run sessions at pools and gyms and also offer specialist mother and daughter swimming sessions. For many women cultural or religious barriers stop them exercising in a mixed environment; for others it can be related to a lack of confidence or purely so as not to feel "on show". Having these session helps to confer physical and mental health benefits to the users. The attendance data has shown that there is a large number of BME women who attend, given the relatively high risk of both physical and mental health problems within the BME community this is very positive for the local communities.

Evaluation of the physical health gain from women-only services

As mentioned above the physical health gains from regular health are one of the more obvious attributable gains. In evaluating this we have split the population between BME women and non BME women. This is to take into account the differing prevalences of afflictions in each population:

Avoided societal costs of inactivity for non BME women	Assumptions	Calculation	Benefits (£)
Number of individuals	266		
Cost for the NHS treatment	£ 1,800,000,000		
Loss of productivity (due to sickness absence and leave)	£ 5,500,000,000		
Premature death	£ 1,000,000,000		
Total cost to the UK of Obesity	£ 3,500,000,000		
Total national cost		£ 11,800,000,000	
Physically active population:			
Men	39%		
Women	29%		
Men in UK	31,000,000		
Women in UK	32,200,000		
Total inactive people		41,772,000	
Cost per inactive person		£ 282	
Lifespan of the impact of exercising regularly	5		
Discount rate	3.50%		
Annuity factor		4.52	
Present Value			**339,267**
Deadweight	35%	-	118,743
Alternative attribution	25%	-	84,817
Total gain			**135,707**

Avoided societal costs of inactivity for BME women	Assumptions	Calculation	Benefits (£)
Number of individuals	100		
Cost for the NHS treatment	£ 1,800,000,000		
Loss of productivity (due to sickness absence and leave)	£ 5,500,000,000		
Premature death	£ 1,000,000,000		
Total cost to the UK of Obesity	£ 3,500,000,000		
Total national cost		£ 11,800,000,000	
Physically active population:			
Men	39%		
Women	29%		
Men in UK	31,000,000		
Women in UK	32,200,000		
Total inactive people		41,772,000	
Cost per inactive person		£ 282	
Lifespan of the impact of exercising regularly	5		
Discount rate	3.50%		
Annuity factor		4.52	
Present Value			**127,544**
Deadweight	5%	-	6,377
Alternative attribution	5%	-	319
Total gain			**120,848**

Key assumptions:

- **Number of individuals**: Taken from the SROI Project Team as the average number of regular users.
- **Total national cost**: Taken from two reports 'Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers', Department for Health, 2011, Page 14 and 'Economic costs of obesity and the case for intervention', McCormick B, Stone I, 2006, page 1. These give the total UK costs resulting from inactivity and obesity. This is taken as a good indicator of the costs that can be avoided through regular exercise.

- **Physically active population**: In order to calculate the cost per person of inactivity/obesity it's necessary to rule out from the UK population those who are classed as active. Using data from 'Statistics on obesity, physical activity and diet: England', The Health and Social information Centre, 2012, Page 30 and the 2011 census gives us an assumed number of inactive people in the UK.

- **Cost per inactive person**: Using the above two measures this gives us an assumption of the cost to the UK of each inactive/obese person.
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and avoid inactivity/obesity due to their being a regular exerciser in the present.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Deadweight**: This is the figure to be put forward to the SROI Project Team of the number of individuals who would exercise anyway even if there was no MSLT offering. This is assumed to be low given the minimal women-only provision currently offered elsewhere, especially for women from BME communities.
- **Alternative attribution**: This figure is assumed to be low as there are little efforts made to encourage BME women (who make up a large proportion of the women at MSLT sessions) to get exercise.

Evaluation of the mental health gain from women only services

As with the physical health gains we have split out the mental health gains to represent the different situations faced by the individuals based on whether they are from a BME background or otherwise:

Reduction in mental health problems amongst non BME users	Assumptions	Calculation	Benefits (£)
Number of regular users	266		
Risk of mental health problems amongst general population	16%		
Expected problems amongst population		43	
Amount alleviated through exercise and social interaction	35%		
Cases avoided		15	
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ 30,300,000,000		
Human costs	£ 53,600,000,000		
UK Population	63,200,000		
UK Population affected		10,112,000	
Cost per incident		£ 10,403	
Lifespan of the impact of being able to exercise	5		
Discount rate	3.50%		
Annuity factor		4.52	
Value of mental health problems avoided			**699,699**
Alternative Attribution	30%	-	209,910
Attributable gain from avoidance of mental health problems			**489,789**

Reduction in mental health problems amongst BME users	Assumptions	Calculation	Benefits (£)
Number of regular users	100		
Risk of mental health problems amongst BME population	26%		
Expected problems amongst population		26	
Amount alleviated through exercise and social interaction	35%		
Cases avoided		9	
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ 30,300,000,000		
Human costs	£ 53,600,000,000		
UK Population	63,200,000		
UK Population affected		16,179,200	
Cost per incident		£ 6,502	
Lifespan of the impact of being able to exercise	5		
Discount rate	3.50%		
Annuity factor		4.52	
Value of mental health problems avoided			**263,045**
Alternative Attribution	20%		- 52,609
Attributable gain from avoidance of mental health problems			**210,436**

Key assumptions:

- **Number of regular users**: Assumption from figures the SROI Project Team have provided of the number of regular BME users of women only sessions.
- **Risk of mental health problems amongst general population**: Taken from a report, 'Economic costs of obesity and the case for intervention', McCormick B, Stone I, 2006, page 1 as the percentage of people that experience mental health problems in the UK.
- **Expected problems amongst population**: This calculation uses the above two assumptions to calculate the expected mental health issues amongst the MSLT users.
- **Amount alleviated through regular exercise and social interaction**: This is a figure provided by the SROI Project Team of the assumed benefit the women only session have on regular users. This is based upon trainers/supervisors experience of talking and getting to know the participants.
- **Cases avoided**: Calculation based on above numbers.

- **Assorted mental health costs**: These costs have been taken from a report, the economic and social costs of mental health problems 2009/10, Centre for Mental Health 2010 which details out the cost to the UK of mental health problems.
- **UK Population**: Taken from the 2011 Census estimates.
- **Cost per incident**: Figure based on the above two assumptions.
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and thus avoid mental health problems.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Alternative Attribution**: This assumption represents the other organisations that endeavour to reduce mental health problems by enabling exercise and social interaction in women only groups.

Attributable gain from the reduced risk of becoming NEET

By encouraging women only sessions the SROI Project team have found that a number of 16-18 year olds attended the sessions as they enjoyed the privacy the sessions afforded them. Many young women do not enjoy exercise and as such are at risk from developing unhealthy lifestyles. Staff involved in these sessions have found that once engaged on the women-only sessions they have enjoyed the exercise and this has led to an interest in health and fitness which has prompted them to seek careers within this field

Benefit in the reduced risk of becoming a NEET	Assumptions	Calculation	Benefits (£)
Number of individuals	366		
Out of out of which, population participating in M&C	25%	92	
Risk of becoming NEET among children	16%		
People at risk of becoming NEET		15	
Percentage of incidents avoided due to MSLT	10%		
Therefore, total number of incidents avoided per annum		1	
Assumed annual productivity lost	£ 13,264		
Assumed annual Jobseekers Allowance	£ 2,696		
Annual economic damage during NEET period		£ 15,960	
Lifespan of the impact of being NEET	5		
Discount rate	3.50%		
Annuity factor		4.52	
Economic damage from NEET period		£ 105,496	
Present Value of long term wage penalty suffered		£ 45,000	
Benefit from reduced NEET's			**150,496**
Alternative attribution	99%		- 148,991
Total attributable benefit from reduced NEET's			**1,505**

Key assumptions:

- **Number of individuals**: Number of regular users of women only services both BME and non-BME.
- **Out of out of which, population participating in M&C**: Number of people attending Mother and Daughter sessions.
- **Risk of becoming NEET among children**: Taken from a report; Department for Education (2011) 'Statistical Release – NEET statistics – Quarterly Brief August 2011', London, Department for Education.
- **People at risk of becoming NEET**: Based on the above numbers, those who are at risk of becoming NEET.
- **Percentage of incidents avoided due to MSLT**: Assumption put by group of the number of children who avoid becoming a NEET due to the social and physical benefits experienced from taking part in MSLT offerings.
- **Annual economic damage during NEET period**: Costs taken from a report; McNally, S, & Telhaj, S. (2010) 'The cost of Exclusion: counting the cost of youth disadvantage in the UK', Prince's Trust, London which details the cost to society of an individual becoming NEET.
- **Lifespan of the impact of being NEET**: This is assumed at 5 years by the SROI Project Team.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Present Value of long term wage penalty suffered due to underachievement**: Individuals who have been a NEET at some point suffer from a 'wage penalty' throughout the rest of their employment as detailed in this report; McNally, S, & Telhaj, S. (2010) ' The cost of Exclusion: counting the cost of youth disadvantage in the UK', Prince's Trust, London.
- **Alternative attribution**: There are many other organisations who participate, be they schools, or government schemes to ensure that individuals do not become a NEET.

Wider gym and swim facilities

Alongside the more specialist services offered as detailed in the above sections MSLT also offer the traditional "swim and gym" facilities. There are a great many more wider access services offered but for the purposes of this evaluation, we have considered only the social swim, classes and gym offerings at NCCFC.

Evaluation of the fitness gains due to gym and swim facilities

The table below shows an evaluation of the impact on healthcare costs of participation among people that access the gym, classes or swim facilities regularly:

Calculation of beneficiary numbers	Assumptions	Calculation	Benefits (£)
Total Visits in the period	111,911		
Assumed % of regular visitors	25%		
Implied number of beneficiaries		27,978	
Number of members in age cohort 1 (under 16)	1,794		
Proportion that would access alternatives (%)	35%		
Number of members that would not access other facilities		1,166	
Number of members in age cohort 2 (17 -24)	571		
Proportion that would access alternatives (%)	50%		
Number of members that would not access other facilities		286	
Number of members in age cohort 3 (25-34)	563		
Proportion that would access alternatives (%)	50%		
Number of members that would not access other facilities		282	
Number of members in age cohort 4 (35-44)	967		
Proportion that would access alternatives (%)	50%		
Number of members that would not access other facilities		484	
Number of members in age cohort 5 (45 -59)	1,417		
Proportion that would access alternatives (%)	25%		
Number of members that would not access other facilities		1,063	
Number of members in age cohort 6 (over 60s)	3,710		
Proportion that would access alternatives (%)	20%		
Number of members that would not access other facilities		2,968	
Total members		9,022	
Numbers that would access alternative facilities		2,775	

Health benefits (all sites)	Assumption	Calculation	Benefits (£)
Number of members in age cohort 1 (under 16)	1,166		
Proportion of non-member users in this cohort	20%		
Total Users		6,729	
	£		
Annual Saving per Beneficiary	250		
Total Saving			**1,682,350**
Number of members in age cohort 2 (17 -24)	286		
Proportion of non-member users in this cohort	6%		
Total Users		2,056	
	£		
Annual Saving per Beneficiary	450		
Total Saving			**925,292**
Number of members in age cohort 3 (25-34)	282		
Proportion of non-member users in this cohort	6%		
Total Users		2,027	
	£		
Annual Saving per Beneficiary	450		
Total Saving			**912,328**
Number of members in age cohort 4 (35-44)	484		
Proportion of non-member users in this cohort	11%		
Total Users		3,482	
	£		
Annual Saving per Beneficiary	500		
Total Saving			**1,741,112**
Number of members in age cohort 5 (45 -59)	1,063		
Proportion of non-member users in this cohort	16%		
Total Users		5,457	
	£		
Annual Saving per Beneficiary	750		
Total Saving			**4,092,712**
Number of members in age cohort 6 (over 60s)	2,968		
Proportion of non-member users in this cohort	41%		
Total Users		14,473	
	£		
Annual Saving per Beneficiary	750		
Total Saving			**10,854,695**
Total saving (before benefit attributable to other agencies)			**20,208,489**
Total active users		34,225	
Benefit due to other agencies	30%		-6,062,547
Total benefits excl. deadweight and alternative attribution			**14,145,943**

Key assumptions:

- **Numbers of users by age cohort**: Taken from data provided by MSLT.
- **Proportion of users who would access other facilities**: This is an assumption the SROI Project Team decided was appropriate based upon the likelihood of an individual using an alternative facility if the MSLT facilities were not present.
- **Proportion of non-member users of facilities**: This is an assumption that non-member users will exhibit the same age split as members.
- **Annual saving per beneficiary**: These figures have been taken from a report on North Lanarkshire Leisure also carried out by Baker Tilly on a consistent basis with the report's findings. These figures were agreed by the action research group at MSLT. (Clifford, C., McCallum, S. and Theobald, C. (2010), 'North Lanarkshire Leisure – Social Impact Evaluation', Coatbridge, North Lanarkshire Leisure). It was felt that these were appropriate as they looked at the savings resulting from regular physical exercise at a number of Leisure Centres offering broadly comparable facilities to MSLT.
- **Benefit due to other agencies**: A deduction of 30% for alternative attribution is included in order to account for the role of other agencies (and indeed the participant's peer group) in promoting physical exercise, including the local NHS, government campaigns and Local Authority initiatives. MSLT believes that it makes a significant contribution to achieving this gain, due to its role in providing reduced cost access to high quality facilities with schemes in place to promote lifestyle change and long-term fitness.

Evaluation of the gain from a reduction in sick days

As individuals are healthier they typically take fewer sick days, this helps contribute greater productivity to society and has been evaluated here:

Economic benefit through a reduction in sickness absence		Assumptions	Calculation	Benefits (£)
Total Users	27,496			
Proportion of users that are economically active		60%		
Number of economically active beneficiaries			16,497	
Greater Manchester GVA	18,113		£	
Number of days sickness avoided per user per annum		4.7		
Economic damage of one day of sickness absence (£)			£ 50	
Annual saving to local economy from improved health				**3,847,791**
Benefit attributable to other bodies		30%		-1,154,337
Annual saving to local economy from reduced sickness				**2,693,453**

Key assumptions:

- **Total Users**: This is the figure used in section 1 with a deduction made for those under 16 so not of working age.
- **Proportion of users that are economically active**: This is an assumption agreed upon by the SROI Project Team of the percentage of users at MSLT who would be expected to be in employment.
- **Applicable GVA per annum**: This figure is taken from the Office of National Statistics and is the assigned value given to each productive individual in the UK.
- **Number of day's sickness avoided per annum**: Taken from a report; Leisure time physical activity and sickness absenteeism; a prospective study, Ludovic G. P. M. van Amelsvoort1, Mark G. Spigt2, Gerard M. H. Swaen1, 3 and IJmert Kant, May.
- **Benefit due to other agencies**: A deduction of 30% for alternative attribution is included in order to account for the role of other agencies (and indeed the participant's peer group) in promoting physical exercise, including the local NHS, government campaigns and Local Authority initiatives. MSLT believes that it makes a significant contribution to achieving this gain, due to its role in providing reduced cost access to high quality facilities with schemes in place to promote lifestyle change and long-term fitness.

Attributable savings from low-cost MSLT membership

The MSLT membership and access prices are substantially beneath the private alternatives available which represents a saving for those members who attend:

Membership fee savings		Assumptions	Calculation	Benefits (£)
Number of members who would join other facilities	2,775			
Average cost of membership (£ per annum)		£ 180		
Average cost of alternative membership (£ per annum)		£ 360		
Annual saving per member that would join alternative (£)			£ 180	
Annual Membership saving				**499,437**

Key assumptions:

- Number of members who would join other facilities: This is the number taken from section 1 as a result of the assumptions arrived at by the SROI Project Team.
- Average cost of membership at MSLT: Taken from the data provided by MSLT.
- Average cost of alternative membership: Put to the SROI Project Team as a reasonable average of alternative gym prices in the Manchester area.

Attributable gain from a reduction in mental health problems

As also evaluated in the other sections, people who regularly exercise typically suffer from fewer mental health problems this is due to the physiological effect of exercise but is also contributed too by the social interaction and friendships that these sessions enable:

Economic benefit of reduction in mental health problems	Assumptions	Calculation	Benefits (£)
Number of regular users	34,225		
Risk of mental health problems amongst general population	16%		
Expected problems amongst population		5,476	
Amount alleviated through regular exercise	23%		
Cases avoided		1,259	
Unit cost of mental health problems			
Health and social care	£ 21,300,000,000		
Output losses	£ 30,300,000,000		
Human costs	£ 53,600,000,000		
UK Population	63,200,000		
UK Population affected		10,112,000	
Cost per incident		£ 10,403	
Lifespan of the impact of being able to exercise	5		
Discount rate	3.50%		
Annuity factor		4.52	
Present value of mental health problems avoided			**59,160,797**
Alternative Attribution	80%		- 47,328,638
Attributable gain of reduction in mental health problems			**11,832,159**

Key assumptions:

- **Number of regular users**: Taken from the MSLT provided data in section 1.
- **Risk of mental health problems among general population**: Taken from a published report and accepted as reasonable by the SROI Project Team. (Weich, S., McManus, S, 2002, 'Common Mental Disorders', in Sproston, K., Nazroo, J., (ed) Ethnic Minority Psychiatric Illness Rates in the Community (Empiric), National Centre for Social Research, TSO.
- **Amount alleviated by regular exercise**: This figure has been agreed upon by the action research group as the amount of regular exercisers who will not experience mental health problems that otherwise may have been expected to.
- **Unit costs of mental health problems**: Taken from a report detailing the costs of mental health afflictions. 'The economic and social costs of mental health problems 2009/10', Centre for Mental Health, 2010
- **Lifespan of the impact of an active lifestyle**: This is an assumption that is based on the length of time that an individual will maintain an active lifestyle and thus avoid mental health problems.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Alternative Attribution**: This assumption represents the other organisations that endeavour to reduce mental health problems by enabling exercise and social interaction.

Attributable gain from a reduction of the number of falls in over 60's

The MSLT data shows that significant portions of the membership are over 60. At this age individuals are at a far higher risk of suffering falls which may well lead to hospital stays and longer term impacts. By enabling regular exercise which aids both fitness and coordination MSLT are contributing to a decreased likelihood of falls:

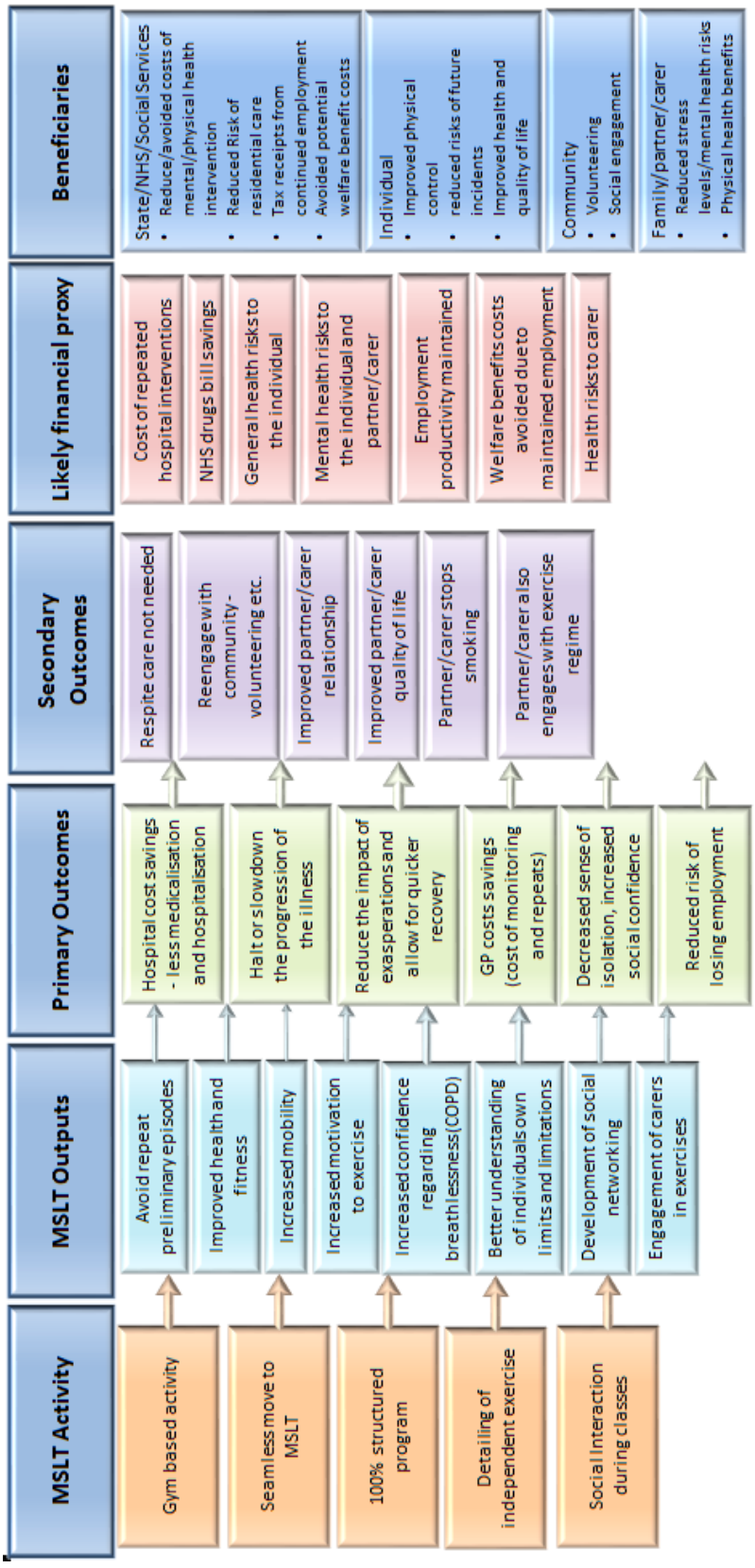
Economic benefit of reduced number of falls	Assumptions	Calculation	Benefits (£)
User of facilities at greatest risk >60	14,473		
General risk of fall amongst over 60's	33%		
Expected Incidents		4,776	
% avoided due to MSLT intervention	33%		
Total incidents avoided by MSLT		1,576	
Unit cost of falls			
Population in UK over 65	8,690,200		
Likelihood of fall	33%		
Number of falls		2,867,766	
Cost of fall in over 65's	£ 1,700,000,000		
Cost per Fall		£ 592.80	
Lifespan of effect of fall	1		
Discount Rate	3.50%		
Annuity Factor		0.97	
Projected cost of fall		£ 573	
Value of falls avoided			**902,712**
Alternative Attribution	20%	-	180,542
Adjusted value of avoided falls			**722,169**

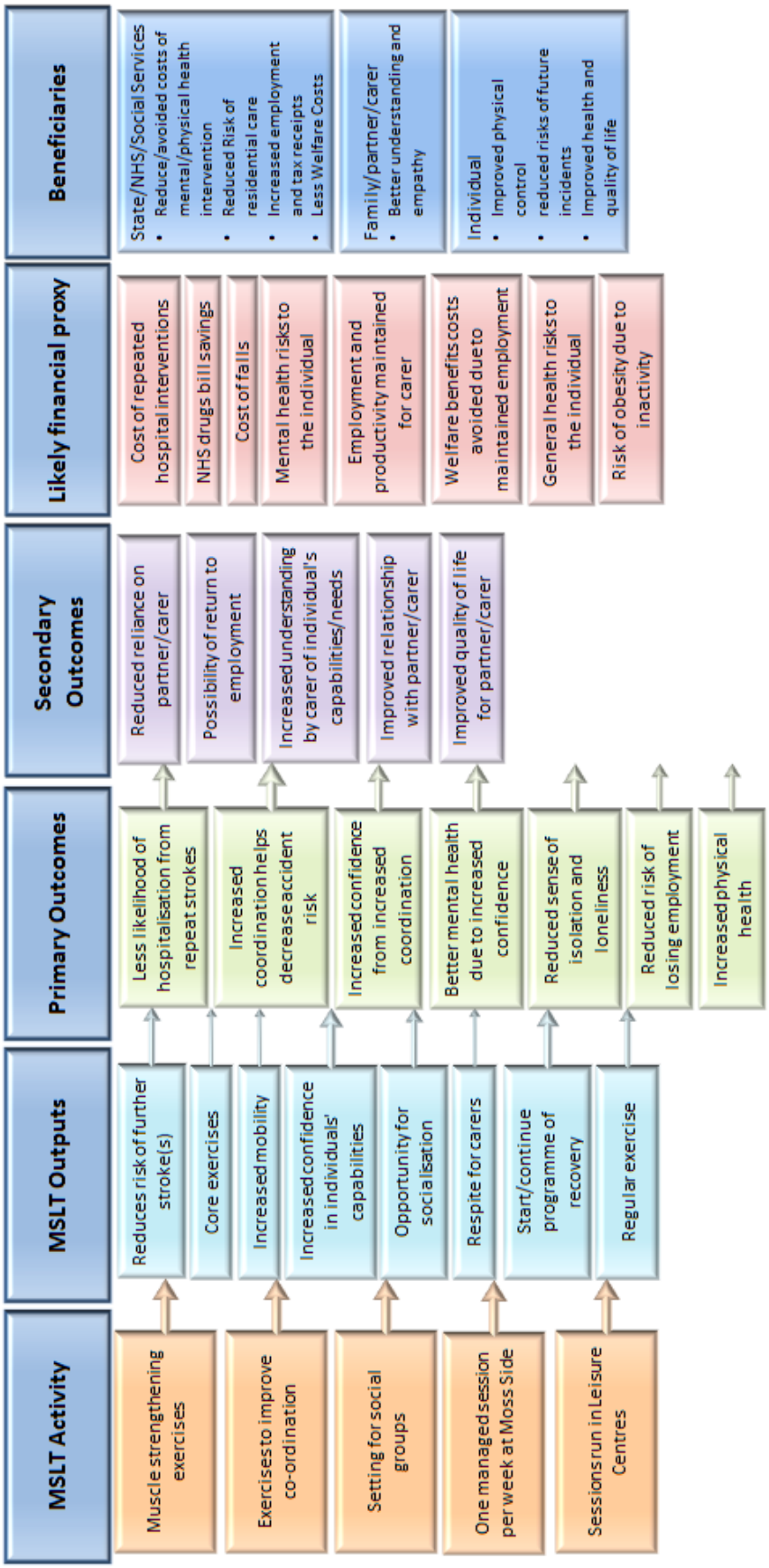
Key assumptions:

- **Users of facilities at greatest risk**: Taken from MSLT data provided in section 1.
- **Risk of falls in over 65's**: Taken from Department for Work and Pensions report published on their website. http://www.dwp.gov.uk/publications/specialist-guides/medical-conditions/a-z-of-medical-conditions/falls/ (accessed Jan 2012)
- **Costs of falls in over 65's**: Taken from report published detailing total cost; 'Falls in the Elderly', KE Anderson, 2007. This includes the NHS costs of treating falls related injuries and hip fractures in the over 65's.
- **Length that fall effects individual**: This is an assumption arrived at by MSLT recognising that once an individual has fallen this will have a longer term effect to their health, affecting their mobility, confidence and the extent to which friends, family and the NHS must care for them.
- **Discount Rate**: Figure taken as reasonable to account for the diminishing return of effects in later years.
- **Annuity Factor**: Taken from published financial information of the annuity factor over 5 years at the above discount rate.
- **Alternative attribution**: Figure taken as MSLT members over 65 who are enabled to exercise by other sources. This is thought to be fairly minimal and agreed by the SROI Project Team.

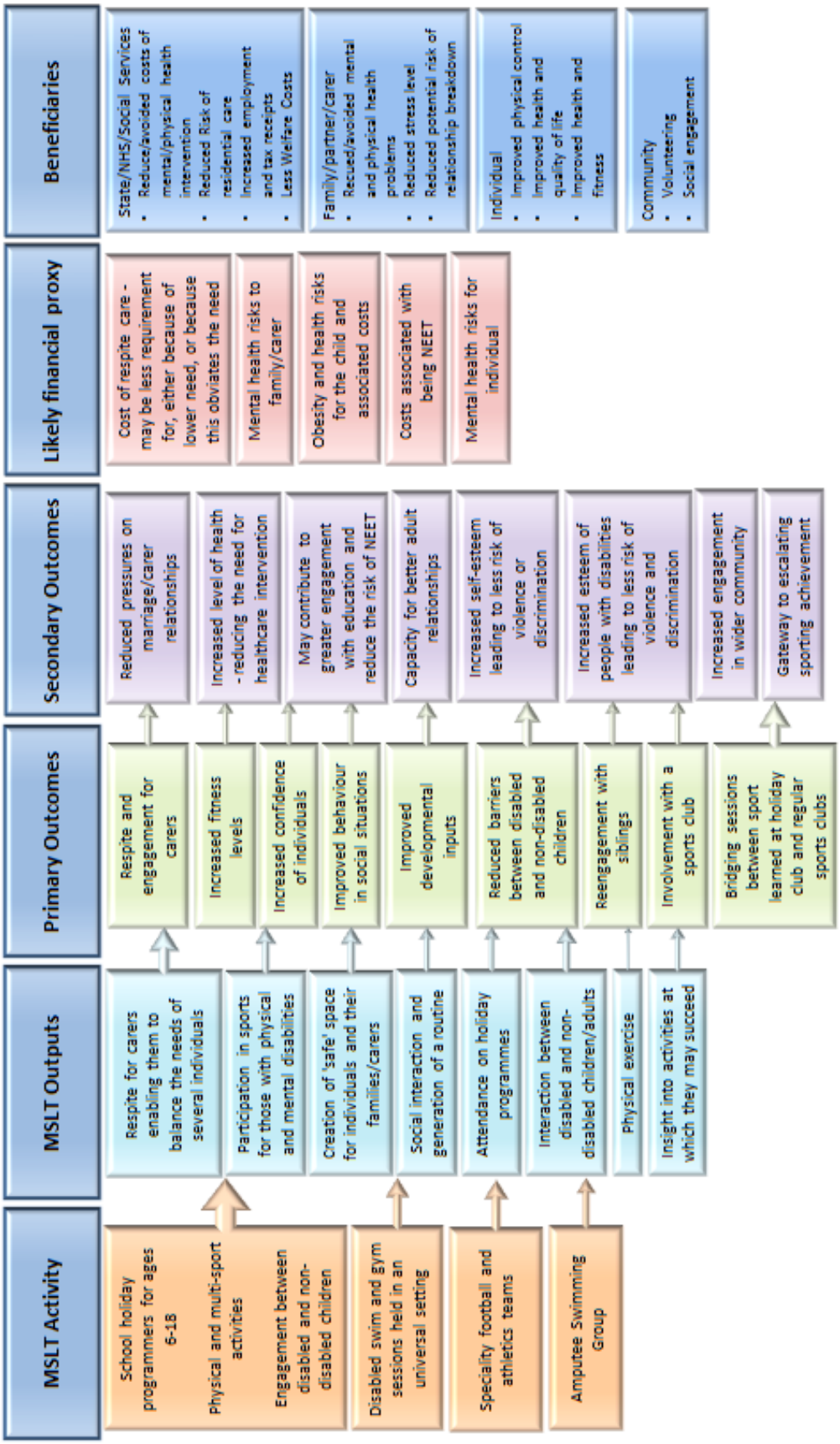
Outcome Maps

Cardiac and COPD

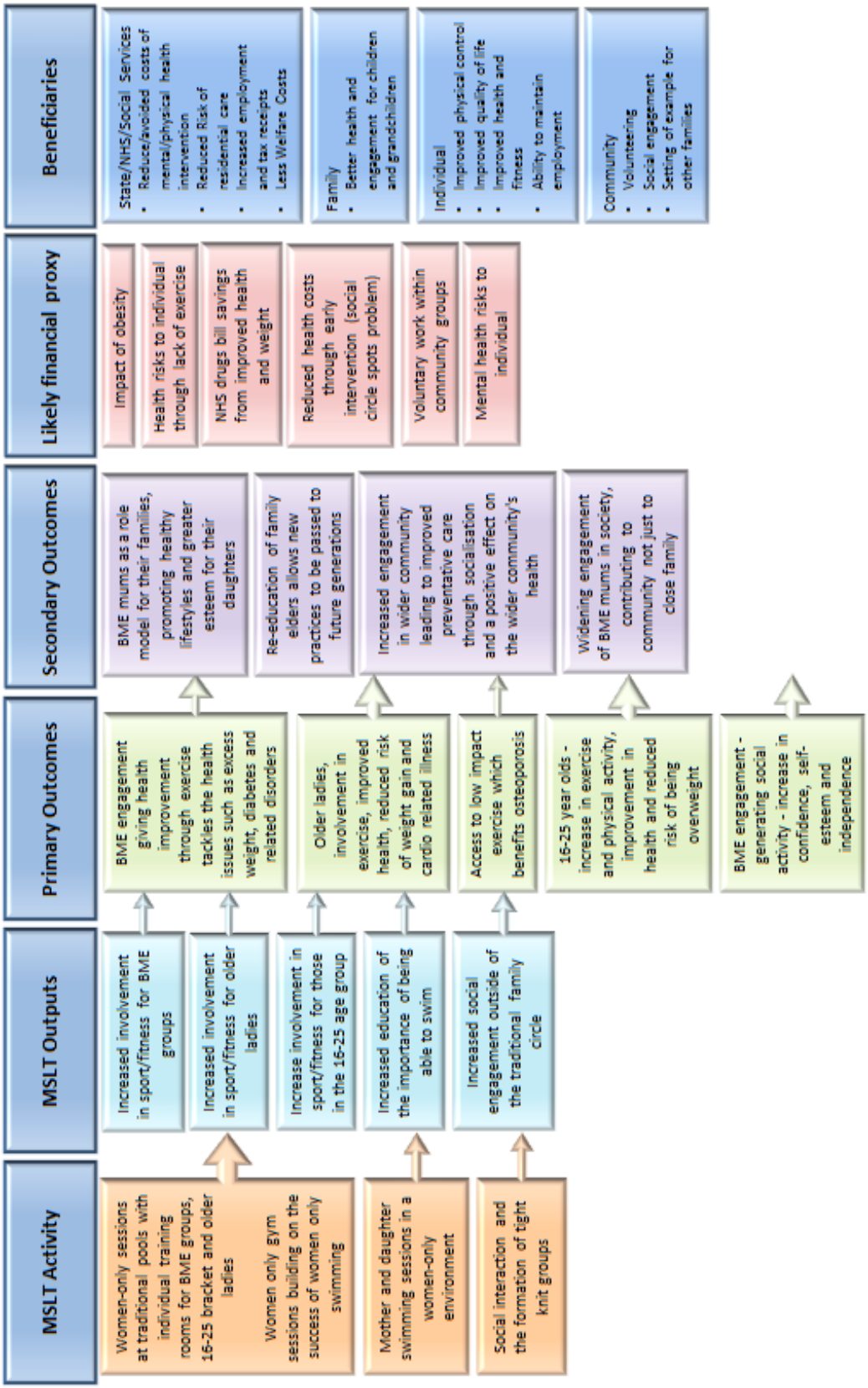



MSLT Activity
MSLT Outputs
Primary Outcomes
Secondary Outcomes
Likely financial proxy
Beneficiaries
Muscle strengthening exercises
Exercises to improve co-ordination
Setting for social groups
One managed session per week at Moss Side
Sessions run in Leisure Centres
Reduces risk of further stroke(s)
Core exercises
Increased mobility
Increased confidence in individuals' capabilities
Opportunity for socialisation
Respite for carers
Start/continue programme of recovery
Regular exercise
Less likelihood of hospitalisation from repeat strokes
Increased coordination helps decrease accident risk
Increased confidence from increased coordination
Better mental health due to increased confidence
Reduced sense of isolation and loneliness
Reduced risk of losing employment
Increased physical health
Reduced reliance on partner/carer
Possibility of return to employment
Increased understanding by carer of individual's capabilities/needs
Improved relationship with partner/carer
Improved quality of life for partner/carer
Cost of repeated hospital interventions
NHS drugs bill savings
Cost of falls
Mental health risks to the individual
Employment and productivity maintained for carer
Welfare benefits costs avoided due to maintained employment
General health risks to the individual
Risk of obesity due to inactivity
State/NHS/Social Services
Reduce/avoided costs of mental/physical health intervention
Reduced Risk of residential care
Increased employment and tax receipts
Less Welfare Costs
Family/partner/carer
Better understanding and empathy
Individual
Improved physical control
reduced risks of future incidents
Improved health and quality of life

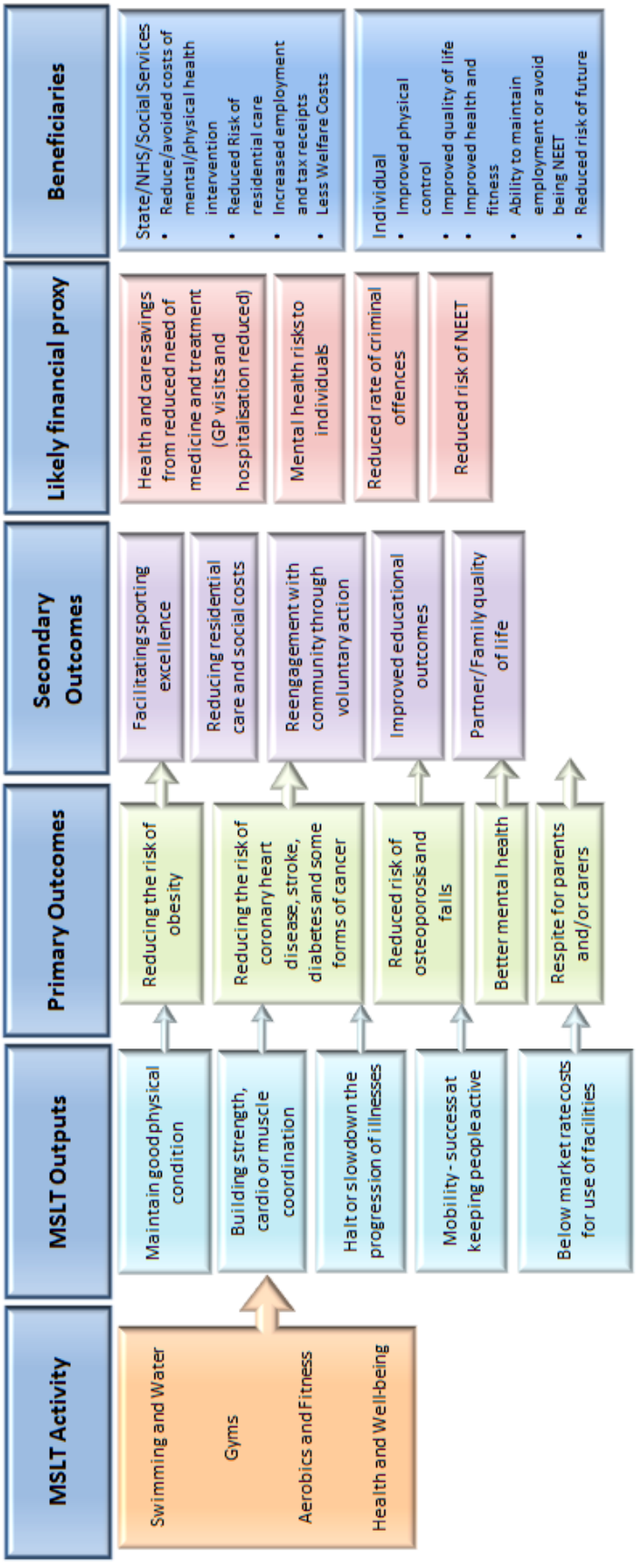
Activities for disabled users



Women-only activities



Wider sport and fitness



C. Sensitivity Analysis

Various assumptions have been made in the course of preparing this analysis and the detailed tables of calculations in Appendix A. Some relate to estimates made by the SROI project team in coming to the views of outcomes, and some relate to the interpretation of information arising from other research work and statistical analysis referenced in this work.

In order to assess the extent to which these assumptions are material, potentially key assumptions have been identified. Each has been subject to variation within what appears to be a reasonable range, and the effect on the total valued outcomes under the study has been recast. The resulting analysis is shown below:

Sensitivity Analysis	COPD and Cardiac (£'000s)	Neurological and Stroke Rehab (£'000s)	Services for those with Disabilities (£'000s)	Women-only Services (£'000s)	Wider Health and Fitness (£'000s)	Total (£'000s)
Base Case	2,751	1,834	1,756	958	29,893	**37,192**
Decrease attendees by 10%	2,712	1,638	1,574	862	27,501	**34,287**
Decrease % of regular gym visitors by 10%	2,712	1,834	1,756	958	27,979	**35,239**
Reduce value of Health and fitness by 10%	2,712	1,834	1,756	958	28,479	**35,739**
Increase Alternative Attribution by 10%	2,023	1,473	1,323	922	24,421	**30,162**

D. Discounted Cash Flow Methodology

Our analysis takes into account, where necessary, the premise that the value of money changes over time. The value of future cash flows is subject to the risk that those cash flows will not in fact occur for any number of reasons.

For the purposes of this report, assumptions provided by MSLT have been taken to be reflective of any risks associated with the likelihood of benefits actually flowing to the stakeholder concerned. This leaves the risk that the value of the benefit will fluctuate due to economic factors that are beyond the control of MSLT or its stakeholders. This can be measured using a long term average rate of inflation. Where necessary a discount rate of 3.5% has been used, which equates to the average rate of inflation in the UK measured over the past twenty years, per the Bank of England. It is also consistent with the discount rate typically used by the UK Government for project appraisal (for projects lasting for between 0 and 30 years).[zz]

For benefits only during the year in which they are funded no discounting is used as both the funding and the benefit are released during the year and the timings are therefore already matched.

Where a benefit occurs in a future year, the value of the benefit is multiplied by a discount factor to allow comparison with the cost of funding. The discount factor is calculated using the formula below:

Where:

- 'DF' is the discount factor by which a future benefit is multiplied to restate it in current terms;
- 'r' is the discount rate used; and
- 't' is the time, stated in years, between the date at which value is measured and the date at which the benefit is achieved.

To measure benefits that occur at a fixed value over a period of time, MSLT has assumed that any future benefits occur in the form of a constant annuity over a fixed period. The expected annual cash flow is then multiplied by an annuity factor to give the value in present day terms of the benefit. The annuity factor is calculated using a modified discount formula, as shown below:

Where:

- 'AF' is the factor by which a constant annuity is multiplied in order to obtain the present value of that annuity over a given period of time;
- 'r' is the discount rate used; and
- 't' is the number of years the annuity is expected to occur over.

Where an annuity is to be deferred for a number of years (e.g. a project is being developed now but the savings will not be realised for several years), an annuity factor is used to calculate the present value of the incremental benefits in the future which is then multiplied by a discount factor to restate it in present day terms.

[zz] Lowe, J., 2008, Intergenerational wealth transfers and social discounting: Supplementary Green Book guidance, London, HM Treasury

E. SROI Project Team

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Manchester City Council

Richard Forshaw
Fitness Instructor
Serco Leisure Manchester

F. MSLT Facilities

Abraham Moss Leisure Centre* Crescent Road, Crumpsall Manchester M8 5UF 0161 720 7622	**Arcadia Leisure Centre** Yew Tree Lane Avenue, Levenshulme Manchester M19 3PH 0161 224 0938	**Ardwick Sports Hall** Stockport Road Manchester M12 4NE 0161 272 8076
Belle Vue Leisure Centre Kirkmanshulme Lane Manchester M12 4TF 0161 953 2470	**Broadway Leisure Centre*** New Moston Manchester M40 0LN 0161 681 1060	**Chorlton Leisure Centre*** Manchester Road, Chorlton Manchester M21 9PQ 0161 861 0790
Levenshulme Swimming Pools* Barlow Road, Levenshulme Manchester M19 3HE 0161 224 4370	**Manchester National Squash Centre** Sportcity, Gate 13 Rowsley Street Manchester M11 3FF 0161 220 3800	**Manchester Aquatics Centre*** 2 Booth Street East, Ardwick Manchester M13 9SS 0161 275 9450
Manchester Regional Arena Sportcity, Gate 13 Rowsley Street, Manchester M11 3FF 0161 220 3800	**Manchester Tennis & Football Centre** Sportcity, Gate 2 Alan Turing Way Manchester M11 3FF 0161 220 3840	**Manchester Regional Hockey Arena** Kirkmanshulme Lane Manchester M12 4TF 0161 953 2470
Manchester Regional Gymnastics Centre Garratt Way, Gorton Manchester M18 8HE 0161 223 5705	**Miles Platting Swimming Pools*** Varley Street, Miles Platting Manchester M40 8EE 0161 205 8939	**Moss Side Leisure Centre*** Moss Lane East, Moss Side Manchester M15 5NN 0161 226 5015
North City Family & Fitness Centre Upper Conran Street, Harpurhey Manchester M9 4DA 0161 277 1900	**Ten Acres Leisure Centre** Ten Acre Lane, Newton Heath Manchester M40 2SP 0161 205 0241	**Withington Leisure Centre*** Burton Road, Withington Manchester M20 3EB 0161 445 1046
For a complete list of sports and facilities available at each centre – visit: www.manchestersportandleisure.org		

G. Case Studies

This appendix shows a sample of testimonials and case studies that highlight the impact of certain projects included in this study. Several of these are derived from letters received by MSLT from participants, and have been included in unedited form below, although we have changed names or otherwise anonymised unpublished sources.

Case Study one: C

C started volunteering for Manchester City Council aged 15 years on the CADS school holiday programme, she became interested in the work through her mum who worked on the programme. She volunteered every school holiday supporting the young people accessing the activities. During this time she was also part of a cheerleading group and started to volunteer on a cheerleading project for disabled girls. Aged 17 years C was successful in applying for a casual coach's position. C has gained the following qualifications through Manchester City Council and Serco/Trust - Enhanced CRB, Safeguarding and Child Protection, First Aid, National Pool Lifeguard, Level 2 Basketball and Streetdance. C currently delivers sessions for Manchester City Council Disability Officer and works at the Manchester Aquatics Centre (Serco/Trust) as a lifeguard.

Case Study two: S

S has volunteered at tennis sessions and events since the age of 13 - she become involved in volunteering through playing tennis and her volunteer hours were logged on the Manchester Volunteer Bureau once she was aged 16. S lives in East Manchester and as well as being a carer for her disabled mother she is also in her last year at college where she is studying sport. Last year when S was 17 years she was supported through her Level one Tennis; Level one Squash and Level one Badminton qualifications. This was supported (financially) through the Us Girls externally funded project managed by Manchester City Council. S has now gained her Level two squash qualification a long with her first aid, CRB check, equity in coaching and competition organiser qualifications and is now a paid member of staff on the Manchester City Council payroll - she still volunteers at events held in Manchester and is an asset to the team.

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