University of the West of England
BRISTOL

The Social Value of a Community-based Health Project

Healthy Living Wessex

Social Return on Investment

Report

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HEALTHY LIVING wessex

Contents

Executive Summary

This report examines the social and economic value of Healthy Living Wessex's Activate Your Life, a project designed to promote healthier lifestyles for people vulnerable to poor health through weight-related issues.

It presents the findings of an assessment following Social Return on Investment (SROI) methodology.

Healthy Living Wessex (HLW) is a social enterprise with established expertise in the provision of high quality and community focused services in Dorset. The focus of this evaluation study was on two HLW services delivered as part of Big Lottery funded Activate Your Life project between September 2008 and October 2010. These are:

Lifestyle mentoring service
Family Weight Management service

Both activities work with clients who have weight management difficulties and are likely to be overweight or obese. The services offer group and one-to-one tailored interventions to help people put their lifestyle goals into manageable action-focused steps.

Previous research and evaluation has provided robust evidence of that the services are associated with positive health and well-being outcomes for participants and their families. HHLW works closely with partner agencies - particularly in health and social care - to provide a coordinated approach to health improvement. Drawing upon a wide ranging review of stakeholder perspectives this study shows set out to understand the cost-effectiveness of the services and the value provided to different interest groups.

SROI is a structured and transparent approach that follows a clear set of well recognised principles. The study identified both distinct and over-lapping outcomes for 933 clients (653 adults and 280 children) and for partner agencies in the Dorset area. There were also substantial – but not readily quantifiable outcomes – for the close families, friends, carers and neighbours of clients.

Some areas social change that this analysis explored includes:

- Client gains in terms of physical activity, diet, mental and social wellbeing, management of ill health and disability, social networks, work and caring roles.
- Service gains in terms of alleviating pressures on mainstream services, and appropriate or more efficient use of these services.

Using a set of client and service level indicators, the study adopted financial proxies to put monetary value on the social returns identified. This included placing a value on negative and unanticipated changes as well as positive changes. A total value of £753,708 (before discounting) was calculated. This was distributed across the following main groups of stakeholders as follows:

£226238 (30%) for adult clients (aged 16 or over)
£247982 (32.9%) for child clients (aged under 16)
£82,050 (10.9%) for employers
£197,437 (26%) for health and social care services

Where the outcomes lasted beyond the period of the activities it was important to ensure that the value of the change in future years has been projected. In this study the monetary value has been calculated using a discount rate of 3.5% - which is a basic rate recommended for the public sector by HM Treasury (2003, 2008). The present value of the activities identified by this analysis was valued at £1,137,272 using this calculation.

The calculation drew upon this data and the value of the Big Lottery investment (£209,964) to express as a ratio the social return on investment. The social return ratio is therefore:

$$\frac{\textbf{£1,137,272}}{\textbf{£209,964}} \quad \textbf{= 5.42 : 1}$$

This is the standard was of expressing social return and the overall figure produced by this analysis. **This means that this analysis estimates that for every £1 invested in Healthy Living Wessex's activities there is £5 of social value created.**

Given that the analysis contains estimations and assumptions, a sensitivity analysis was undertaken to examine a range of worst case and better case scenarios. **Inclusive of the outlier calculations, the present study concludes that the social value of HLW's services ranges between £4:1 to £6:1.** However, through further internal and external research on the preventative role of this type of service, it is plausible that the social value of HLW's activities could be found to be substantially higher.

Assurance Statement

This report has been submitted to an independent assurance assessment carried out by The SROI Network. The report shows a good understanding of the SROI process and complies with SROI principles. Assurance here does not include verification of stakeholder engagement, data and calculations. It is a principles-based assessment of the final report.

Acknowledgements

The analysis in this report was produced by Mat Jones. Mat Jones and Richard Kimberlee (UWE) undertook the first stage of the research data collection, with support from Toity Deave, Simon Evans and Barbara Caddick (both at UWE) with aspects of the second stage of the data collection. Debra Pattinson, Director of Healthy Living Wessex (HLW), and the HLW staff team assisted with the collection of data. The impact map and the report were written by Mat Jones.

Introduction

The increasing prevalence of obesity amongst adults and children is a major public health challenge both nationally and internationally. In England two-thirds of adults and a third of children are either overweight or obese, and without action this could rise to almost nine in ten adults and two-thirds of children by 2050 (Foresight, 2007).Being overweight or obese can increase the risk of developing a range of other health problems such as coronary heart disease, type 2 diabetes, some cancers, and stroke.

The consequences of obesity are not limited to the direct impact on health. Overweight and obesity also have adverse social consequences through discrimination, social exclusion and loss of or lower earnings, and adverse consequences on the wider economy through, for example, working days lost and increased benefit payments. They disproportionately affect lower income groups and groups at risk of marginalisation such as older isolated people, single parents and BME groups (NOO, 2010a). A National Obesity Observatory review (NOO, 2010b) found estimates of the direct NHS costs of treating overweight and obesity, and related morbidity in England have ranged from £479.3 million in 1998 to £4.2 billion in 2007. Estimates of the indirect costs (those costs arising from the impact of obesity on the wider economy such as loss of productivity) from these studies ranged between £2.6 billion and £15.8 billion.

Any effort to tackle our obesogenic environment requires coordinated and long sighted effort on the part of a wide range of stakeholders. It needs a comprehensive approach that involves collaborative working between agencies at the local level. Whilst only part of the solution, clearly preventative and early intervention services have a role to play (DoH, 2008). Notably community and voluntary sector agencies and social enterprises may be well placed to work with harder-to-reach groups. However, the value of such services can be difficult to articulate in the context of local service development (NICE, 2006). In part this is may be because there have been few transparent and widely credible methods for analysing the social value of small scale interventions. Drawing upon the Social Return of Investment (SROI) methods, this report present an analysis of the social value of weight management services offered by Healthy Living Wessex, a community based health agency based in Dorset.

Scope of the report

Aim and objectives

The aim of this analysis is to develop an evaluation of the cost effectiveness of Healthy Living Wessex (HLW)'s Activate Your Life project in its weight management work with individuals and families. The primary objective of the analysis is to draw upon multiple sources - including performance, consultation and evaluation data -to develop an Impact Map and SROI calculation. The resulting **Evaluation for the period September 2008 to October 2010** is intended to present a critical assessment of the social value that plausibly resulted from investment in HLW's Activate Your Life project.

Declaration of Interests

This analysis was conducted by Mat Jones at the University of the West of England, Bristol as part of a process of accreditation with the SROI Network. As part of a UWE research team Mat and

colleagues at UWE have previously been commissioned by HLW to conduct evaluations of HLW's services. Otherwise Mat and UWE has no links with HLW outside this piece of work.

Audience

The report is primarily for HLW for the purpose of sharing good practice, measuring outcomes effectively and demonstrating an SROI analysis. The report will be available to key partners such as the local authority and public health commissioners.

Unless individuals have provided written consent, the names of all study participants have been changed in this report.

Background

Overview of the project

Healthy Living Wessex's Activate Your Life project was a Big Lottery initiative funded as part of the South West Well-being programme. Activate Your Life's stated aims are to reduce inequalities in health for individuals and communities in most need through the provision of tailored services. The project adopted a holistic approach to improve physical health for individuals within communities by encouraging positive lifestyle changes. It also sought to improve mental well-being of individuals and communities by enabling them to reach their full potential.

Project rationale

The project has been closely linked to the health priorities of the local Strategic Partnership Strategy and supports the PCT priorities and health agendas. The project operated through two project centres based in Weymouth and Portland, and Bournemouth, Both focused their services in the most deprived communities in these areas. Each centre referred and negotiated access to other health and social service where appropriate and were delivering support in motivation, lifestyle change and weight management. They have a record of attracting hard to reach groups through making activities accessible and fun and encouraging further development through the creation of social networks and the promotion of sustainable change. These have helped those individuals who access the activities to take responsibility for improving their own physical and mental health. Both have run community interventions based on a holistic approach to supporting people, both already manage a portfolio of preventative healthcare services and have partnerships established with other more specialist service providers that beneficiaries of this programme will be able to take advantage of.

The host organisation

Weymouth and Portland Healthy Living Project was an initiative established by a partnership of local agencies in 2002. In 2004, the project was one of five Big Lottery funded Healthy Living Centre schemes to be awarded Pathfinder status for its innovative work in this area. In September 2006, the project adopted the new title Healthy Living Wessex (HLW) and was formally incorporated as a company limited by guarantee now established as a not for profit social enterprise.

The project is managed from the HLW offices located within Weymouth & Portland Housing Company head office but the activities are delivered in different community venues within Weymouth and Portland, with Healthlink being commissioned to deliver at the Littledown Centre in Bournemouth (a sports and leisure centre).

Project area

Weymouth and Portland District has concentrations of deprivation with 17% of the district's population living in areas that are defined as amongst the fifth most deprived in England. Roughly four out of ten people living in the 10% most deprived output areas in Dorset County live in Weymouth and Portland.

All districts within Dorset, apart from Weymouth and Portland, have significantly higher life expectancy rate than the national average. Services that address the development and maintenance of a healthy lifestyle have not been very accessible for those most at risk due to the lack of resources in health and social care. However, it was also clear at Health Living's inception that the voluntary and community sector in Dorset generally, and in Weymouth in particular, was under-developed. Links between the voluntary and community sector and local authorities have also been hitherto perceived as quite poor.

In Bournemouth & Poole the Joint Strategic Needs Assessment stated that tackling heart disease and cancer as two major causes of premature death (i.e. before age 75) will contribute the most to reducing inequalities in life expectancy, and all-age all-cause mortality. When viewing the maps of deprivation scores for Bournemouth and Poole, there are clear associations between areas with higher deprivation and higher rates of coronary heart disease. The evidence also shows that the health of people in the most deprived areas of Poole is deteriorating in relative terms and the gap in health inequalities widening.

The boxed section below provides a summary to HLW's two types of activity that were delivered as part of the Activate Your Life project.

How they work... HLW's Lifestyle Mentoring & Family Weight Management Services

Under the Activate Your Life project, Healthy Living Wessex set up two activities called 'Lifestyle Mentoring' and Family Weight Management.'

Lifestyle mentoring is a personalized one to one service which helps people to put their lifestyle goals into manageable action-focused steps and then supports and motivates them as they take their own steps to health change. A lifestyle mentor is someone qualified, and experienced in a variety of behaviour change techniques such as life coaching, behaviour change counselling and motivational interviewing. They work with clients on an individual basis to help them to make realistic, sustainable lifestyle changes. These can include becoming more active, eating a healthier diet, losing weight or working on improving mental well being. At initial contact, clients assessed for their readiness to change. Once it is confirmed that the service is appropriate, they are offered three one-to-one sessions initially on a weekly basis.

At the end of the first three sessions, is it generally anticipated that clients will have achieved one of the following outcomes:

-a weight loss of 1kg,
-an increase in physical activity by one session per week,
-an increase in the number of steps by at least 1000 steps per day,
-an increase in fruit and vegetable consumption by at least one portion per day.

Any one of these outcomes makes them eligible for up to a further three sessions arranged at appropriate times and usually longer than weekly. During these sessions the mentor will help the client set realistic health goals and break these down into manageable action steps. Each week the actions are reviewed and the next set of actions will be set. Lifestyle Mentoring intends to adopt a personalised approach and works at a pace that is right for the individual. People often find it very powerful to be held accountable for carrying out their agreed actions. This isn't about telling people what to do or 'telling them off.' It is about setting goals and agreeing action steps that will help them move towards their goal. These sessions are very flexible to the needs of the client and take place either face-to-face or on the telephone.
It is suitable for individuals who are ready and willing to make lifestyle changes, but perhaps need additional support in planning and implementing these changes. Lifestyle mentoring is particularly appropriate for people who need to lose weight prior to an operation, or for those who would benefit from improving their general lifestyle for people with diabetes, coronary heart disease, high blood pressure & high cholesterol.

HLW's **Family Weight Management** service follows the same format as Lifestyle Mentoring, although instead of a one-to-one service the practitioner works with the whole family. All participants set out their personal goals for themselves. The sessions often take place in informal environments such as a leisure centre where the HLW practitioner will combine counselling with coaching and physical activities.

Methodology: Social Return on Investment

Overview

This study draws on the Social Return of Investment (SROI) methodology. SROI is an adjusted cost-benefit analysis that quantifies the value of social, environmental and economic outcomes that result from an intervention (Nicholls et al, 2009).

Although based on traditional financial and economic tools, SROI builds on and challenges these. It includes a formal approach to identifying and measuring the things that matter to stakeholders. These are often outcomes for which no market values exist, for example an improvement in mental well-being. As such outcomes can be difficult to quantify, they have tended to be excluded from more traditional analyses, preventing a full understanding of value being created or lost for society.

Advocates of the SROI approach argue a range of benefits. It seeks to demonstrate the full impact (economic, social and environmental) of an intervention, institution or set of activities. It seeks to help resource allocation decisions by providing a common metric to compare different projects across. SROI can measure change in ways that are relevant to the people or organisations that

experience or contribute to it. It is also increasingly becoming recognised as credible and transparent approach for communicating a broad concept of value to stakeholders. However some caution needs to be exercised in the interpretation of SROIs. For example, it is important to emphasise that SROI ratios of similar areas intervention may not be directly comparable. This is because it is unlikely that the stakeholder consultation processes will lead to the identification of the same financial proxies and impact calculations. In the context of service development, SROIs are therefore best understood as a providing a basis –but not a narrow assessment metric - for an informed debate on the value of an activity or set of activities.

The SROI principles

SROI is based on a set of principles that have been developed by the SROI Network. Table 1 sets out the seven principles as defined by the SROI Network.

Table 1. The SROI Principles

Principle	Description
Involve stakeholders	Inform what gets measured and how this is measured and valued by involving stakeholders
Understand what changes	Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended or unintended
Value the things that matter	Use financial proxies in order that the value of the outcomes can be recognised. Many outcomes are not traded in markets and as a result their value is not recognised
Only include what is material	Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact
Do not over-claim	Only claim the value that organisations are responsible for creating
Be transparent	Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders
Verify the result	Ensure independent appropriate ass

The SROI process

Typically an SROI analysis involves six stages:

1. Establish scope and identify key stakeholders.
2. Map outcomes, using information gathered from stakeholders alongside research evidence develop an impact map, or theory of change, which shows the relationship between inputs, outputs and outcomes.
3. Evidence outcomes and give them a value. This stage involved finding data to show whether outcomes have happened and then valuing them.
4. Establish impact. Having collected evidence on outcomes and monetised them, those aspects of change that would have happened anyway or are a result of other factors are eliminated from consideration.
5. Calculate the SROI. This stage usually involves deducing a ratio of inputs to value of outcomes. However, as this study was only able to value an isolated number of outcomes for a handful of programmes we focused on the total value of the outcomes alone.

6. Report, use and embed. This involves sharing findings with stakeholders and responding to them, embedding good outcomes processes and verification of the report.

This report adheres to this overall framework, although as the next sections explain, there was a clearer effort to distinguish between an exploratory process of mapping outcomes with stakeholders and a formal process of collecting evidence of outcomes. The study, therefore, sought to enhance the rigour of the analysis in this respect.

Data Collection with Stakeholders

Engagement with Stakeholders

A key principle of SROI is to engage with stakeholders in order to better understand their perspectives on outcomes of the activity and to inform the focus for measurement. Stakeholders can also play an important role in making judgements about the credibility of an SROI analysis.

In this study, UWE and the project team identified a list of potential stakeholders based upon (a) pre-project open consultations (b) local strategic partnership events and (c) delivery experience of working with clients and partners agencies. Table 2 lists the key stakeholders identified in this process. The present study adopted a two stage process of engagement:

1. **Exploratory data collection stage.** This stage consisted of interviews with small purposive samples of stakeholders. The questions focused on:
   - perceived changes that resulted from the HLW activities
   - the nature of these changes in terms of duration, benefit (or lack of), evidence, relative importance
   - other factors or agents contributing to the changes identified and changes that were likely to occur in the absence of the activities.

The intention of this stage was to develop an account of the effects of the activities, on whom and for what reasons. Alongside evidence drawn from external literature this 'theory of change' informed the next stage of the research.

2. **Structured data collection stage.** This stage consisted of a questionnaire based data collection with larger samples of selected key stakeholders. The questionnaire measures focused on the types of outcomes identified by stakeholder groups in the first stage of the research. Full details of this research are provided in previous reports (Jones et al, 2010; Jones et al, 2011)

The intention of this stage was to collect data to inform an assessment of the dimensions of the outcomes in terms of, for example, salience, scale, duration and linkages.

Table 2. Stakeholders included in the study

Stakeholder	Size of Group	Exploratory data collection stage Interview sample size	Structured data collection stage Target questionnaire sample size	Structured data collection stage Achieved questionnaire sample size
Lifestyle mentoring: Adults	357	12	180	104
Lifestyle mentoring: Close	3213[1]	2 [10[3]]	-	-

relatives, carers, neighbours, work colleagues, friends				
Family Weight Management: Adults	297	12	286	131
Family Weight Management: Children & Young People	280	12	286[4]	131[4]
Family Weight management Close relatives, carers, neighbours, work colleagues, friends	5193[1]	2 [10[3]]	-	-
Health: GPs	30	2	14	8
Health: Other primary care and social care practitioners such as primary care nurses, occupational therapists, social workers, health visitors, CAMHS, social housing officers	90	6	16	12
Health: secondary/hospital care practitioners such as dieticians, physiotherapists, A&E clinicians, weight loss clinical specialists.	25	2	6	3
Sport and leisure centre organisations practitioners	4	2	2	1
Employers, training and education providers	368[2]	2	2	2
Big Lottery Well-being programme	1	No formal consultation	-	-
Local Strategic Partnership – including Primary Care Trusts & Local Authorities	4	Practitioner reps consulted as part of above	-	-
			792	392

Table Notes

1. Estimate based upon 2007 UWE research: an average of 9 close personal associates per client.
2. Estimate based upon 50% of adult clients in employment and 50 clients undertaking training or education
3. Figures in brackets represent initial data collected as part of the 2007 UWE research
4. Young people and children contributed to relevant sections of the Family Weight Management questionnaires that were mainly completed by their parent. The nature of their direct contribution was largely age dependent.

Achieved sample

Table 2 shows that the structured data collection stage achieved responses from 392 of the 792 respondents sought. This 49% response rate represents a plausible basis for interpreting the wider outcomes for the populations concerned. However, the latter section of this report revisits this subject given, for example, the possibility of a self-selection bias amongst respondents.

Limitations of the stakeholder involvement

Two limitations to the involvement of stakeholders in this study need to be acknowledged:

1. Close personal associates and employers were not involved in the structured data collection stage. In part this was because it was estimated that any robust quantifiable measurement

of outcomes would require a data collection exercise that was beyond the resources of the study. However some proxy measures were available via clients themselves.

2. Although participants were fully informed of their ethical rights and options for scrutinising the report findings, the stakeholder feedback has been informal and limited in scale. This reflects well recognised difficulties associated with longer term stakeholder involvement (HM Treasury, 2008). However this report is itself part of an ongoing dialogue with stakeholders and therefore HLW anticipate feedback from interested parties in future.

Findings

Inputs

For the evaluation period the project was funded £209,964 under the SWWB programme. This was one of a group of regionally funded initiatives supported by the Big Lottery Well-being programme. The project team explored generating revenue through small charges to clients, employers and partner agencies. However, in order to promote access for target client groups this approach was not adopted. HLW does undertake contracted work for the local health commissioner; however these services are delivered separately and are not reviewed in this study. Otherwise this study sought to include all the activities that were funded through the Big Lottery Well-being programme. These are analysed together because they represent a discrete area of work delivered by HLW.

The time of individuals and family members is considered as an input but not given a financial value in line with the standard SROI approach (SROI Network). Similarly the time of practitioners in partner agencies has not been costed. This is reviewed and discussed further later in the report.

Although it is important to be aware that there are different levels of resource allocated for the Lifestyle Mentoring and Family Weight Management services, a basic calculation gave an average cost of £224 for an adult or child to participate in a HLW service [£209,964/934] during the evaluation period. A 'per session unit cost' of £37 (£224/6) represented a plausible estimate to the project team.

Stage 1 Qualitative Findings

Outcomes for Clients

The 36 clients (see table 2) who participated in exploratory interviews reported a wide range of changes that they felt took place as a result of taking part in an HLW activity. Case study 1 provides an illustration of how one person explained the changes in his life. This case illustrates a common pattern expressed by interviewees and shows how from an individual point of view the changes can be understood holistically. In order to determine whether the emerging themes accurately reflected the views of these stakeholders, the researcher checked to confirm his interpretation during the interviews. After the interviews, the researcher also involved a small group of four clients to advise on the identification of themes. This helped ensure that clients were involved as stakeholders in determining the areas for focus in the SROI analysis. The key themes emerged that can be summarised into the following groups.

Confidence & self-esteem. This included feelings a greater sense of self worth, pleasure in personal appearance, assertiveness, pride, sense of achievement and ability to achieve new things.

Self-direction and life goals. This included making short to long term plans and decisions about family, caring and domestic roles, employment, personal ambitions and so forth.

Social contact. This included making direct contacts with new people through the project's activities and indirect social contacts made through feeling more active and more motivated to engage in social activities.

Changes in diet, exercise and associated lifestyle routines. This included changes to mealtimes, snacking, drinking alcohol and both everyday and dedicated physical activity. Some interviewees who smoked felt the course had helped them reconsider their tobacco consumption. However there was no clear change reported in this respect.

Reduced weight, increased exercise, improvements in overall health and management of ill health and disability. This included reduced visits to doctors or other health and social care practitioners; and changes in prescriptions or personal healthcare.

Wider changes. This included changes in routines with regard to going into work, looking for paid employment, looking after close associates who needed care, use of leisure time and time spent in domestic activities.

Fun and enjoyment. This included overall life satisfaction as well as laughter, smiling, taking an interest in new things and so forth.

The experiences of children and young people participating in the Family Weight Management course reflected some but not all of these changes. This group has more to say about the personal and social benefits and there were fewer accounts of the management of health conditions.

Many of the changes outlined here can be understood as a chain of events – or theory of change in which one set of changes leadings to another. However, for the purpose of this analysis we have sought to maintain some distinctions between outcomes and to place a value on them in their own right – as opposed to an integrated set of changes. These are summarised in the outcomes column of the SROI Impact Map. Although loss of weight was reported as an outcome in its own right, our theory of change positions this change as one step on the way to achieving other health and well-being goals. The analysis, therefore, has not included this as a distinct outcome in order to avoid the possibility of double counting.

The changes outlined above were not universally reported amongst by all participants. Interview participants also reported some negative changes. These included:
-additional financial cost of 'healthy foods' and physical activities such as fee paying sports,
- personal emotional strains associated with effort to keep commitments or failing to meet goals,
- social strains with family, friends and other people associated with efforts to make lifestyle changes.

-personal emotional and social strains associated with 'letting down' perceived expectations of HLW practitioners, other practitioners and other clients.

The significance of the additional cost of healthy foods was considered in terms of its material implications. Although some stakeholders felt that there were additional costs, these needed to be put in the context of reduced expenditure on foods overall – particularly of less healthy foods. Food diaries made by a sub-group of clients as part of the project, indicated that increased expenditure on healthy foods did not constitute a significant negative outcome for the client stakeholder group as a whole. However, it is acknowledged that this was perceived to be the case by some individuals.

Negative outcomes are shown in red text in the Report tables and Impact Map

Case Study 1: Client Experiences of Healthy Living Wessex's Lifestyle Mentoring Programme

"I'll never go back to a lifestyle where I put on weight again"

Mr. Francis is a 71 year-old man. He had been to his annual check-up with his GP who suggested losing some weight. She referred him to Health Living Wessex and he said he attended because he *was willing to give anything a go*.

In the past he had found it difficult to lose weight so when the project worker suggested that his wife should join in with the sessions. He asked her and she agreed. All appointments were held in a local centre, the first couple were weekly and then fortnightly. He found the whole process: *very good, informative, and gave me the ability to monitor myself and it was helpful to have someone take an interest in oneself and give a different perspective.* It has been beneficial working together with his wife because they can encourage each other.

The main things that stand out for him relate to the *horrible lump of plastic fat, 5lbs, that she brought in and told me that I was carrying more than that around me. It is this and more that I have now lost. She gives you the encouragement to carry on and fulfil the programme. It was the information that she gave us about what is in food – sugars, fats etc. She gave us each a pedometer and this has been useful because it gives you an idea of the distance we have walked and encouraged us. We have put in extra bits and now I don't need to use the pedometer. I feel different in myself – a vast difference. In the past, if we walked anywhere I took a stick but I don't bother with that now. I feel fitter, walking further and more easily.*"

When asked whether there had been any spin-offs he said that his children were very fit and slim anyway but that he had spoken about his sessions to a male friend who was very overweight and started going to Weight Watchers. He feels that he has been an encouragement.

Outcomes for close personal associates of clients

Focus groups of people who were close associates of clients such as family members, friends, carers, work colleagues and neighbours were interviewed as part of the UWE 2007 exploratory research. This group represents a large number of very diverse stakeholders. Those willing to take part in the research were understandably more likely to have an interest in HLW's activities than those with less awareness. It is therefore probable that our sample over-represents accounts of positive changes.

The central themes of the respondents' views reflected many of those articulated by clients themselves. Case Study 2 illustrates some of the indirect benefits for these individuals. Close family, carers, friends and neighbours reported a range of changes. As might be expected, interviewees were less confident than clients in attributing changes directly to HLW's activities. The outcomes, therefore, were much less straightforward to assess although - bearing in mind the size of this population – there seemed little doubt that there would be important effects.

Unfortunately, it was beyond the resources of the study to undertake a robust survey of this group. The potential creation of value associated with this group of stakeholders is not therefore formally quantified in the SROI. However a best case scenario involving this group is set out in the Sensitivity Analysis section below.

Case Study 2: Client Experiences of HLW's Family Weight Management Programme

"I've stopped nagging"

Healthy Living Wessex offers a twelve week course for families who fulfil certain criteria. The programme includes family membership to the Littledown Sports and Leisure Centre. They have access to all the facilities, including the swimming pool, martial arts classes, the gym and the junior gym. An important part of the programme is a commitment to take part for the full twelve week period.

Jane is married with two teenage children, one of whom plays a lot of football anyway and a daughter who *needs to lose a bit of weight but is not keen on exercise.*

The opportunity for us has been greatly appreciated because now we don't have the money for gym membership. It is nice not to feel so isolated, I lock into the 'Emotional Intelligence' that the project worker has been talking about and I don't feel so alone. I am not nagging D [her husband], he is coming on his own even when I can't come. Before this he would have done it because I am making his life a pain by nagging. Last time we were members of a gym, if it was raining we would end up going to a film and getting a pizza instead.

The number of takeaways has gone down. We are now choosing meals carefully because if we are exercising afterwards it has felt very heavy. We are also looking at the time we eat. It is much better for us and we are feeling so much better and the atmosphere at home is so much easier. I am not nagging and that makes me feel better and we are more motivated. The biggest thing is that it will enable us to be better as a family and that is because it has raised the priority of our family health.

Practitioner and Agency Stakeholders

Practitioners and other stakeholders representing the interests of partner agencies reported a wide number of changes associated with HLW's activities. Case Studies 3 and 4 show how HLW's services helped to support the wider aims of these stakeholders as part of a strategic response to preventable ill health in Dorset.

The central themes reported are summarised under the following headings:

- Addressing gaps in services
- Alleviating short and medium term pressures on mainstream services through provision of alternatives and preventing downstream costs
- Helping to coordinate services and other actors in the promotion of public health and addressing inequalities in health and also through actions such as public advocates
- Other outcomes contributed towards were reduced claims for benefits, reduced work related ill health
- Potential longer term gains for reduced pressures on healthcare services

One rare but high impact outcome related to the acute sector healthcare provision. Although health profession interviewees could only highlight isolated and specific examples, the role of HLW's services in either alleviating the need for hospital based interventions or specialist health and social care was an important finding in this stage of the research.

Case Study 3: Developing services for under-represented groups

Lifestyle clinics for men

Males are under-represented in weight management programmes despite evidence that obesity and high weight are issues that affect many men. Healthy Living Wessex has increasingly refined its services to reach an under-represented group of clients.

Healthy Living Wessex had found that men were not engaging easily with either service. Over an 18 month period only 14% of referrals were male, and of these 23% did not sign up at all, 11% did not make contact at all with the hub and 7% were reported as not ready to change most saying they weren't interested in a slimming clubs. That was 41% of the men referred into the service not taking it up.

A high percentage of the referrals were male and 61years old and over (41.5% of male referrals). Talking to the men it seemed that the older males tended to be more receptive to the club. This led to discussions with men who were accessing the service and team discussions as to how they could adapt the Lifestyle Mentoring to meet the need of men who could not engage with the slimming club approach or who did not engage with the lifestyle mentoring service. The team used social marketing techniques to focus the promotion which went into local newspapers.

The format of the sessions stayed largely much the same. However the title of the service

changed to Lifestyle Clinic for Men and was marketed through GP surgeries but also the local newspaper magazine which came out every week with the TV listings. The length of the sessions reduced to 30 minutes rather than 45-50 minutes. This was based on feedback that men reported not really wanting the 'touchy, feely stuff'. The shorter sessions are working well & feedback from men has been positive. The use of Pedometers for those wanting to increase their physical activity levels proved helpful as a physical gadget which men liked and also could compete with themselves but one which they were also in total control of the results and who they shared them with.

The initial results have been very positive. The specific adverts in the local press resulted in the gender split moving to 60% females to 40% males (from 80/20). The team find that once men have decided to commit to the lifestyle change they do it whole heartedly and can be very focused which means they can achieve really results very quickly. Overall with the team successfully remodelled their service to target a genuine gap in local service provision.

Case Study 4: Alleviating pressures on mainstream services

An alternative to the NHS dietician service

This case illustrates how HLW's activities alleviated pressures on hospitals and provide the type of support that is welcomed by some people with weigh management issues.

Many people with weight management problems or dietary conditions are aware and prepared to make lifestyle changes. Often a major life event, such as a diagnosis of diabetes, prompts a change their outlook. This service worked from the premise that a short course of personalised coaching can make a major contribution in turning such people's intentions into reality.

Based upon positive feedback dieticians in the local hospitals and PCT have started to refer their patients to these coaching sessions. Dieticians typically see patients for a 30 minute consultation with two-three 15 minute follow-ups every two-three months. Nevertheless work with overweight patients can be a complex and challenging. The allocation of time available under the NHS contract is often insufficient to cover aspects of motivation, behaviour changes, willingness to change - as well as healthier eating advice. Dieticians have found that the HLW's lifestyle coaching service has been well placed to help patients with these wider motivational issues. The dieticians assess their individual patients' willingness to change, those who have already made changes to their diet and lifestyle but are still struggling and those who require weekly sessions to help keep them motivated.

Thirteen referrals have been received from the out -patient clinic of the acute trust in six months and none have been seen again by the dieticians since referral. These patients had either been discharged but further work was needed on behaviour change or they have not had any follow-up from this clinic. From the PCT, 7 patients have been referred in the last 5

months and been reviewed by the dietician. Dieticians viewed the HLW service as a valuable resource for overweight patients who need support to change their health behaviours.

'I have been very impressed with the pitch/theory but haven't had a chance to evaluate it yet. She [the facilitator] seems to be building on what our clinical psychologist has done with the groups but because of resource constraints, can't do anything with patients on an individual basis, so the Lifestyle Mentoring on offer seems to be highly appropriate'.
'So far I am very impressed, I have heard good reports back, patients like it; She [the facilitator] lets them talk and she listens well.'

One drawback seems to be that once the patients go through a course, they then cannot attend any further so the long-term support aspects may still need to be addressed. The HLW facilitator reported that
'I'm currently seeing 3 clients, 2 of whom have lost 5 lbs by the 3rd session, and due to start seeing 2 new clients.' Some clients, however, are very keen to lose weight rapidly: 'One client, despite losing 1.5-2 lbs a week, found that it wasn't quick enough, so only had 3 sessions.

Table3 : The Impact Map: stakeholders, inputs, outputs and outcomes

Stakeholders	Inputs			Outputs	The Outcomes
Who will we have an effect on? Who will have an effect on us?	What do we think will change for them?	What will they invest?	Value £	Summary of activity in numbers	Description How would we describe the change?
Adults with BMI >25	Improved physical activity	Time	£0.00	654 adults accessing a 6 or 12 session course	Client is more physically active
Adults with BMI >25	Improved mobility / flexibility	Time	£0.00	654 adults accessing a 6 or 12 session course	Client feels more mobile and flexible
Adults with BMI >25	Improved mental health	Time	£0.00	654 adults accessing a 6 or 12 session course	Client feels overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)
Adults with BMI >25	Improved diet	Time	£0.00	654 adults accessing a 6 or 12 session course	Client eats more healthier foods
Adults with BMI >25	Higher social interaction	Time	£0.00	654 adults accessing a 6 or 12 session course	Client makes new friends/acquaintances and/or has more contact with existing social network

Adults with BMI >25	Higher social interaction	Time		654 adults accessing a 6 or 12 session course	Client feels personal & social strains associated with lifestyle commitments
Adults with BMI >25 (unemployed)	Improved life satisfaction	Time	£0.00	163 adults accessing a 6 or 12 session course	Client feels healthier, happier, more confident & able to take up paid work
Adults with BMI >25 (carers of adults)	Improved life satisfaction	Time	£0.00	~218 adults accessing a 6 or 12 session course / ~218 care recipients	Client feels healthier, happier, more confident & able to take on care role
Children	Reduced BMI	Time	£0.00	280 children accessing a 12 session course	Child has lost weight
Children	Improved mental health and social well-being	Time	£0.00	280 children accessing a 12 session course	Child feels happier and has improved family life and relationships
Children	Improved diet	Time	£0.00	280 children accessing a 12 session course	Child eats more healthy foods
Children	Improved diet	Time	£0.00	280 children accessing a 12 session course	Child feels social and personal strains associated with lifestyle commitments
Children	Improved social contact	Time	£0.00	280 children accessing a 12 session course	Better friendships and peer relationships
Employers of adults with BMI >25	Reduced employer costs associated with employee ill health	Time	£0.00	~327 adults accessing a 6 or 12 session course	Client feels healthier, happier and better able to take on work related demands
NHS Hospital Trust	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced specialist consultations (e.g. dieticians)
NHS Hospital Trust	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced hospital interventions
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced GP consultations
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced primary care nurse consultations
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Client felt overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)
NHS (all)	Reduced NHS costs	Staff time	£0.00	280 child clients	Long term reduced medical costs
Big Lottery Fund	Project targets [factored above]	Funding & project expertise	£209,964		

Practitioners reported that some of their time was involved in making recommendations, referrals and reviewing outcomes associated with HLW's activities. Whilst this may be considered as a cost or negative change from the perspective of this group of stakeholders, in practice it proved hard to create measures or indicators in this area. This is largely because such activities are embedded in the routine practice of this group of professionals. This SROI therefore did not take forward this area of change in the analysis.

To conclude, the first stage of the exploratory research helped identify a range of changes that were evident to clients, their families, practitioners and other partner agencies. This process revealed areas for assessment that were unlikely to be identified by external researchers who had undertaken no such consultation. The process revealed links between different types of changes, their potential for overlap, potential negative changes and a realistic basis for identifying appropriate indicators, measures and proxies.

Valuing Outcomes

This section reports on the indicators adopted with regard to the key outcomes, the process and results of quantifying changes associated with HLW's activities and the financial proxies used to place a value on them. The SROI approach highlights how the 'creation and destruction of value' is very much a matter of stakeholder perspective. This report therefore groups the valuation of outcomes into two broad groups: those of individual clients and people who are closely associated to them; and outcomes at the wider organisational level of agencies and strategic interests. It should, however, be recognised that value from these perspectives does intersect. For example, all citizens have a personal and social interest in the best allocation of public resources for health care.

Indicators for outcomes associated with clients and their close associates

The central outcomes for clients and associated individuals relate to health and to psycho-social and material wellbeing. A before-and-after questionnaire was used to quantify the changes anticipated. The questionnaire drew upon a range of standardised and validated questionnaire measures that reflected each domain of interest (See Appendix). A six point social well-being / social capital scale was derived from six measures in Questions 16-20. This consisted of six constructs:

- Belonging (community) - belonging to something I call community
- Support (intimate) – people who really care
- Support (community) – people help one another
- Engagement (social) – regularly meet friends
- Engagement (intimate) – hobbies
- Participation (community) – attending local activities

Post analysis of the study data indicated acceptable internal consistency for the scale with a baseline cronbach's alpha of 0.714 and a follow-up cronbach's alpha of 0.708.

Indicators for the outcomes associated with partner agencies and local strategic goals

The main outcomes for these stakeholders are concerned with the benefits to service provision that accrue from the project's activities. The evidence used to quantify these outcomes is drawn from a compilation of sources that includes client outcome data, project records and the records and report from partner agencies.

Duration of the changes

The length of time that each outcome lasts is quite a complex subject in the context of HLW's activities. Client and practitioner respondents often reported that they felt that the changes had long term implications. However external research (e.g. Christina, 2007; Foresight, 2007; NICE, 2006) suggests that weight management behaviour change programmes have effects that can tail off steeply in the 3 year period that follows the completion of the intervention. This corresponds to evaluation guidance that advises on the importance of longitudinal research designs for determining longer term outcomes (HM Treasury, 2007). This report therefore caps the analysis to a maximum of 3 years.

Quantifying the Outcomes

For the purpose of the SROI, it was assumed that the outcomes for participants in the questionnaire surveys reflected outcomes for the client group as a whole. Table 4 therefore shows how the outcomes were quantified for HLW's activities based on the results of the research. This shows the figures and percentages for questionnaire respondents meeting the indicator threshold. Respondents that did not meet this threshold either reported no change or, on occasions, a negative change. Given feedback from the stakeholder interviews, the frequency and percentage of respondents reporting a significant reduction in personal and social strain were specifically analysed. The Appendices provide the Questionnaire number references given in column D.

Table 4: Quantifying the Outcomes

A	B	C	D	E	F
Client outputs: summary of activity in numbers	Description of the change?	Indicator: measurement used	Data source	Quantity & percentage of outcomes in study sample: n/respondents (percentage)	Quantity of outcomes applied to client totals A X E%
654	Client is more physically active	Achieving 5X30 minute periods of exercise per week over 28 days	Questionnaire Qs 10, 11,12	80/234 34%	222
654	Client feels more mobile and flexible*	Take up of >1 new PA activity	Questionnaire Qs 11, 13	22/234* 9.8%	64
654	Client feels overall improved mental wellbeing (improved mood, less anxious, more confident and	plus 20 per cent improved mental wellbeing rating using a scale of measures	Questionnaire Qs 14, 15	173/234 73.80%	483

	so forth)				
654	Client eats more healthier foods	Increase in one portion average daily fruit and vegetable intake	Questionnaire Qs 5-9	137/234 58.70%	384
654	Client makes new friends/acquaintances and/or has more contact with existing social network	20 per cent improved social well-being /social capital using a scale of measures	Questionnaire Qs 17-20	159/234 68%	444
654	Client feels personal & social strains associated with lifestyle commitments	20 per cent reduced social well-being /social capital using a scale of measures	Questionnaire Qs 17-20	16/234 7%	50
163	Client feels healthier, happier, more confident & able to take up paid work	Client self reports obtaining employment by end of course	Self report section of questionnaire (21-22) plus one off research	7/59 11%	18
~218	Client feels healthier, happier, more confident & able to take on care role	Client self reports increased time per week caring	Self report section of questionnaire (21-22) plus one off research	28/78 36%	78
280	Child has lost weight	Loss of >1kg weight [Aged 11-16]	Before and after project weigh-in	100/131 76% corresponding to adult data	212
280	Child feels happier and has improved family life and relationships	Child self reports positive change	End of course record of personal outcomes	86/131 65.90%	184
280	Child eats more healthy foods	Increase in one portion average daily fruit and vegetable intake	Questionnaire Qs 7	77/131 58.80%	164
280	Child feels social and personal strains associated with lifestyle commitments	Increase in one portion average daily fruit and vegetable intake	End of course record of personal outcomes Qs 21-22	13/131 10%	28
280	Better friendships and peer relationships	Additional social/recreational activity with parent per week	Questionnaire Qs 16	94/131 72%	201
~327	Client feels healthier, happier and better able to take on work related demands	Cost to the employer of lost productivity through adbsenteeism	Self report section of questionnaire (21-22) plus one off	Average 2.5 days gained for employed respondents	817

			research		
653	Reduced specialist consultations (e.g. dieticians)	Fewer specialist consultations annually	End of course record of personal outcomes	12/234 5% with average of 1.4 appointments	46
653	Reduced hospital interventions	Fewer hospital interventions annually	End of course record of personal outcomes plus Practitioner Qs	7/234 3% of cases	18
653	Reduced GP consultations	Fewer GP visits (appointments) annually	End of course record of personal outcomes plus Practitioner Qs	110/234 of clients not going to GP on one occasion 47.5%	311
653	Reduced primary care nurse consultations	Fewer primary care nurse consultations annually	End of course record of personal outcomes plus Practitioner Qs	34/234 14.5%	94
653	Client felt overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)	Reduced prescriptions for anti-depressants	Questionnaire Qs 15 Major Depressive symptoms	59/234 23% adults fall in major depressive symptoms	151
280	Long term reduced medical costs	Weight, PA and HE target achieved on HLW course completion	End of course record of personal outcomes	30/131 Estimate at least 20%	56

Note 1. There were no reports of employed clients becoming unemployed as a result of participating in HLW activities

Note 2. * Nearly all clients who reported achieving "5X30 minute periods of exercise per week over 28 days" also reported "feeling more mobile and flexible". To avoid double counting only those reporting "feeling more mobile and flexible" but NOT achieving "5X30" have been included here.

Financial Proxies

Financial proxies provide estimates of financial value where it is not possible to know an exact value, such as with social returns. As such, financial proxies are critical for accurately estimating the SROI.

This study identifies a range of financial proxies that correspond to the outcome indicators. The sources for the proxies cited in the Impact Map and, where appropriate, referenced at the end of this report. Over the course of the evaluation, the HLW project staff, clients and external practitioners were able offer advice on appropriate and meaningful proxies. For clients and statutory sector stakeholders several of the financial proxies have also been identified by other SROI studies in related spheres of activity. This lends further credibility to their usage, although the potential for double counting similar types of financial proxy is discussed further in the Impact section below.

A further problematic area is the long term health gains associated with the HLW's activities. Recent research undertaken on the MEND programme (MEND, 2011; York Health Economics & nef Consulting, 2010) provides a useful source for estimating the QALY health-linked outcomes for child obesity interventions. Other studies (e.g.NICE, 20006) provide a basis for estimating financial value to health services of adult based obesity interventions. However, the adult QALY proxies were not used in this SROI order to avoid double counting the shorter term values for health services that have already been identified in the analysis. Therefore it should be recognised that the net benefit calculated in this analysis could in fact be an underestimation.

Some changes have mixed financial implications for clients. This is the case for clients' consumption of healthier foods. On the one hand client interviewees reported reduced expenditure on 'unhealthy foods', such as high fat, sugar and salty foods and alcoholic and non-alcoholic high sugar drinks. On the other hand clients reported increasing their expenditure on healthy foods, such as fruit and vegetables. HLW collected food diaries with a sample of 83 participants as part of the weight management course. These were self completed and, as a result did not collect entirely complete and reliable accounts. However the records indicated that, overall, increased expenditure on healthier foods was outweighed by reduced spending in 'unhealthy foods'. The indicator and financial proxy for this area are therefore analysed to reflect the overall reduced costs associated with dietary change (see Table 5).

Table5 : Impact Map- Financial Proxies for Outcomes

Stakeholders	**The Outcomes**	**Indicator**	**Financial Proxy**	**Value £**	**Source**
	How would we describe the change?	**How would we measure it?**	**What proxy did we use to value the change?**	**What is the value of the change?**	**Where did we get the information from?**
Adult clients	Client has lost weight	Loss of >2kg weight	Cost of registration and 6 sessions with a slimming club	£39.82	Average figure based on WeightWatchers & Slimming World websites
	Client is more physically active	Achieving 5X30 minute periods of exercise per week over 28 days	Cost of membership of a fitness & leisure club for 3 month	£116.97	Local leisure centre daytime/weekend adult membership
	Client feels more mobile and flexible	Take up of >1 new PA activity	Cost of membership a local community gentle exercise club for 6 months (assume 20 sessions)	£50.00	Internet search of community centres [Average £2.50 per session]
	Client feels overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)	plus 20 per cent improved mental wellbeing rating using a scale of measures	Cost of 3 hours of psychotherapy or counselling	£120.00	VOIS database (SROI Network 2011)

	Client eats more healthier foods	Increase in one portion average daily fruit and vegetable intake	20% reduced household spending on high fat, high sugar food & non-alcoholic drinks, and alcoholic drinks	£184.08	Family Spending Survey 2009
	Client makes new friends/acquaintances and/or has more contact with existing social network	20 per cent improved social well-being /social capital using a scale of measures	Cost of membership a local community centre social club for 6 months (assume 20 sessions)	£50.00	Internet search of community centres [Average £2.50 per session]
	Client feels personal & social strains associated with lifestyle commitments	20 per cent reduced social well-being /social capital using a scale of measures	Cost of 3 hours of psychotherapy or counselling	-£50.00	VOIS database (SROI Network 2011)
Adult clients (unemployed)	Client feels healthier, happier, more confident & able to take on care role	Client self reports increased time per week caring	1 Hour national minimum wage per 52 weeks	£301.60	Low Pay Commission. 2009 prices [£5.80 p/h]
Adult clients (carers of adults)	Child has lost weight	Loss of >1kg weight [Aged 11-16]	Average cost of a MEND [child weight loss] course	£413.00	nef/York Economics (2010)
Children	Child feels happier and has improved family life and relationships	Child self reports positive change	Combined value of average family leisure spending and time-value of additional joint activities	£955.48	nef/York Economics (2010)
Clients (Children)	Child eats more healthy foods	Increase in one portion average daily fruit and vegetable intake	Included above	£0.00	Included above
	Child feels social and personal strains associated with lifestyle commitments	Increase in one portion average daily fruit and vegetable intake	Cost of 3 hours of psychotherapy or counselling	-£50.00	VOIS database (SROI Network 2011)
	Better friendships and peer relationships	Additional social/recreational activity with parent per week	Cost of 6 sessions with a family therapist	£300.00	Derived from internet service of local providers
	Reduced specialist consultations (e.g. dieticians)	Fewer specialist consultations annually	Cost of a hospital admission	£131.00	NHS Choices Annual Report (2011)
Employers of adult clients	Client feels healthier, happier, more confident & able to take up paid work	Client self reports obtaining employment by end of course	Increase in annual earnings over benefits for single individual working full-time	£4,307.00	VOIS database. Nef Community Allowance Report 2008 prices
NHS Hospital Trust	Reduced hospital interventions	Fewer hospital interventions annually	Cost of weight loss surgery (gastric banding)/ pharmacological intervention	£5,000.00	NHS Choices (2009). Costs of Private Weight Loss Surgery (2008-9)

NHS Hospital Trust	Reduced GP consultations	Fewer GP visits (appointments) annually	Cost of a GP visit	£32.00	NHS Choices Annual Report (2011)
NHS Primary Care/GP services	Reduced primary care nurse consultations	Fewer primary care nurse consultations annually	Cost of a nurse in primary care practice visit	£12.00	NHS Choices Annual Report (2011)
NHS Primary Care/GP services	Client felt overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)	Reduced prescriptions for anti-depressants	Cost of low level dose (20mg) of Fluoxetine (anti-depressant) for one year	£17.27	from British National Formulary (www.bnf.org)
NHS Primary Care/GP services	Long term reduced medical costs	Weight, PA and HE target achieved on HLW course completion	QALY linked health outcomes gained [lowest estimate]	£3,025.00	NICE (2006) nef/York Economics (2010)

Impact

A key principle of SROI is to avoid over claiming the impact of the activity under analysis. Here four processes are taken into account:

1. Deadweight: How much would have happened anyway?
2. Displacement: Is any of the change simply been at the expense of another party?
3. Attribution: Is any of the change down to the actions of others?
4. Drop off: Does the change drop off in future years?

Where any of the above processes are likely to have had an effect on the changes identified, a percentage estimate of their role has been provided by drawing upon the stakeholder data collection and external evidence.

1.Deadweight – how much would have happened anyway?

Research evidence (see NICE, 2006) shows that sustained behaviour change is very difficult for people who are overweight. Of the 36 clients interviewed as stakeholders in the formative stage of the study, only a small number – between 2 to 4 – said that they felt the changes identified would have happened anyway. At the follow up stage, questionnaires with the larger sample of clients had an open section that allowed respondents to comment on whether participation in the project had had an impact on their behaviour changes. The findings showed a similar pattern to the initial interviews: a small minority – less than 5% reported that they felt they would have achieved their goals without the assistance of the project. Overall, it is difficult to reliably quantify the extent to which the changes would have happened anyway. Drawing upon the overall NICE research evidence and the feedback from stakeholders, it is estimated that no more than one in ten clients would have been able to have made the changes by themselves. For some outcomes this is likely to have been as few as one in twenty. The estimates for deadweight therefore ranged between 5-10%.

2. Displacement – has an outcome been created at the expense of another party?

The outcomes identified through the stakeholder analysis are clearly distinctive in character and were therefore unlikely to have had a displacement effect. Outcomes through HLW's activities may have had a small impact on commercial fee-based services, some of which claim to provide a social role. HLW's activities may also have impacted on community and voluntary sector well-being and health-related services. However, the provision of similar alternatives to HLW services is very limited in most areas of Dorset. Overall, the displacement effects are considered to be minimal and range from 0% to 10% depending on the nature of the outcome.

3. Attribution – how much of an outcome is due to external factors?

Attribution presents an interesting issue in the context of HLW's services. The project team, clients and other stakeholders consulted all recognised that part of HLW's model for change concerns making effective use of supportive opportunities for change. For example, a client may be encouraged to identify a 'weight management buddy' or supportive routine that can help them achieve their goals. In this sense some of the change should be attributed to other factors in the lives of clients. However, in the context of this SROI analysis HLW's activities are considered to have helped achieve outcomes through a 'catalytic effect': thus in their absence little or no change would have occurred. This consideration led to recording attribution to other agencies or process at 0% for most of the client behavioural outcomes.

Nevertheless some of the healthcare and employer related outcomes should be considered to have occurred through partnership work with other agencies and practitioners. Stakeholders from the project and partner agencies reported that this contribution played a relatively small part – about a fifth or less. The Impact Map therefore records the attribution in these areas between 10-20%.

On exception in terms of attribution was with regard to children's improved diet. In this instance stakeholders reported that most of the behavioural change could be attributed to parental, peer, school and other influences. Therefore 90% of the change was attributed elsewhere on the Impact Map for this outcome.

4. Duration (how long does an outcome last?) and Drop Off (how does the impact decrease with time?)

HLW's activities were designed to help clients make long term and lasting changes to their lifestyle. The evaluation period of two years provided an opportunity to make some judgements about these longer term effects. At eighteen months post enrolment, clients who agreed to act as stakeholder interviewees confirmed many of the aspirations of the project team by feeding back on the transformations in their lifestyles. However, this report assumes a self-selection bias in these data: clients with less successful experiences may have been less likely to agree to participate in the stakeholder consultation. Furthermore, external evidence (see NICE, 2006; DoH 2008) suggests limited duration and a steep fall in impact over time. The SROI therefore caps the duration for all outcomes to a maximum of three years and estimates a drop off of up to 50% for many outcomes.

Excluded outcomes, missing indicators and proxies

As other sections have outlined a number of potential areas for the exploration of positive and negative outcomes have been excluded from the analysis in the present study. Outcomes for close associates of clients have not been included in the main analysis. Due to resource constraints there was no direct empirical data collection to reliably substantiate claims of material change with this stakeholder group – although the small sample of interviewees provided a description of their nature. Clients also provided proxy accounts of outcomes. These sources give a provisional basis for the analysis discussed in the Sensitivity Analysis section (below). However the data was not considered to be sufficiently robust for inclusion in the main analysis.

Financial proxies for lifetime health related outcomes are also not included in this analysis to avoid a risk of double counting short term outcomes in the same area (see above section on Financial Proxies).

Social Return Calculation

The financial impact of the HLW activities under analysis is calculated using the following formula:

(financial proxy for outcome x quantity of outcome)
-
(deadweight + displacement + attribution)
x
duration (adjusted for drop off and discount rate)
=
SROI ratio

This calculation has been used for each row of the Impact Map. The total impact is provided on the basis of the total of all the impact calculations for each outcome. The total impact of the end of the period of analysis of HLW's activities was valued at £753,708 using this calculation. The value of the changes for the following main groups of stakeholders was as follows:

£226238 (30%) for adult clients (aged 16 or over)
£247982 (32.9%) for child clients (aged under 16)
£82,050 (10.9%) for employers
£197,437 (26%) for health and social care services

Discount Rate

Where the outcomes last beyond the period of the activities it is important to ensure that the value of the change in future years has been projected. In this projection it is important to taken into consideration the potential for the monetary value to be worth less over time. In this study the monetary value has been calculated using a discount rate of 3.5% - which is a basic rate recommended for the public sector by HM Treasury (2003, 2008).

The present value of the activities identified by this analysis was valued at £1,137,272 using this calculation.

Social Return

The social return is expressed as a ratio of the present value divided by the value of the inputs. For this analysis the social return ratio is therefore:

$$\frac{\text{£1,137,272}}{\text{£209,964}} = 5.42 : 1$$

This is the standard was of expressing social return and the overall figure produced by this analysis. This means that this analysis estimates that for every £1 invested in Healthy Living Wessex's activities there is £5 of social value created.

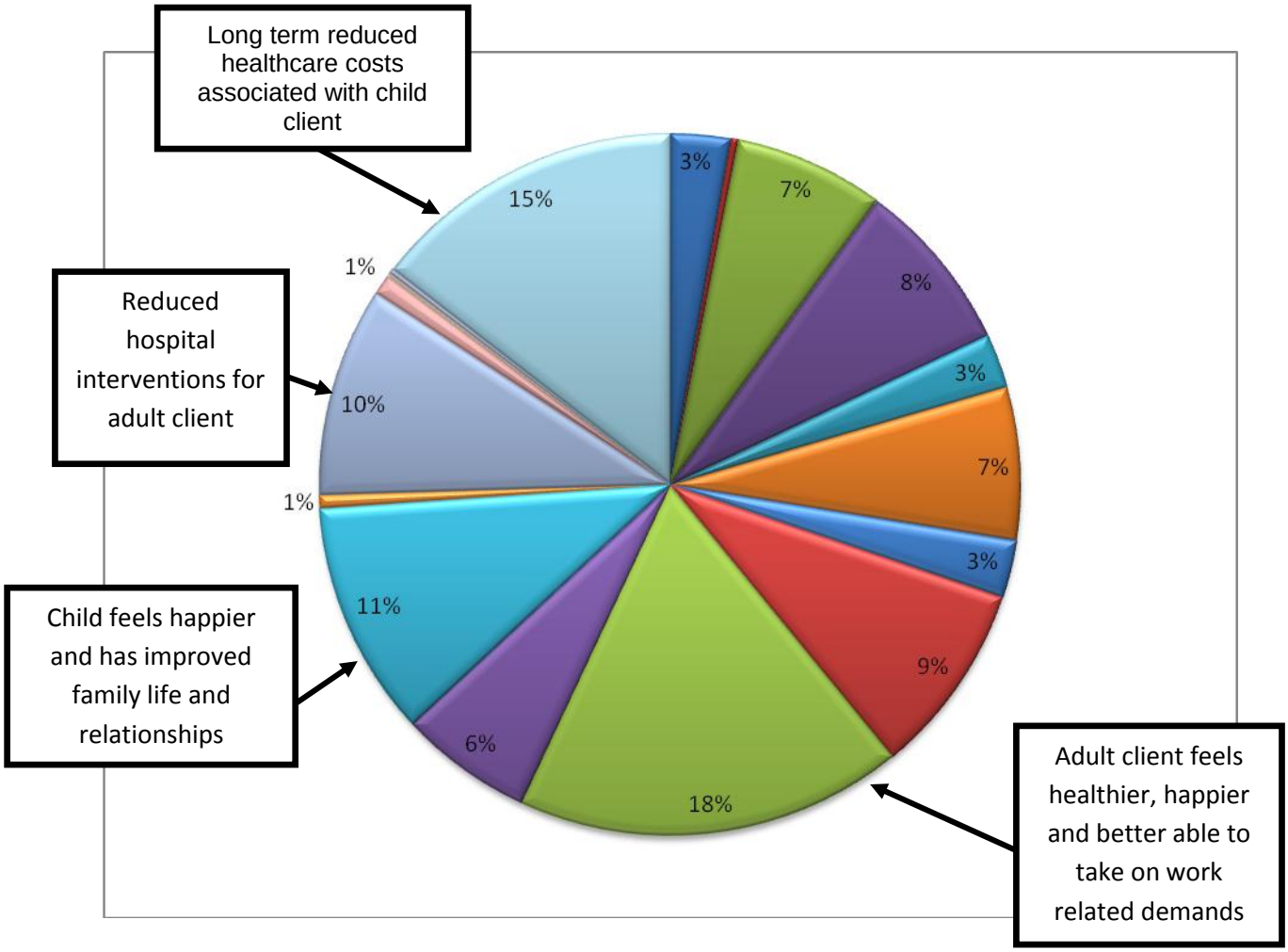
However, for any financial investment, such as a savings account for example, one would normally deduct the initial investment from the final figure in the account to consider the return on the outlay. This is the net return. So, if the initial investment (the total inputs) is deducted from the present value to give the net present value and then divide that by the value of the inputs, the net social return for this analysis will result as follows:

$$\frac{\text{(£1,137,272 - £209,964)}}{\text{£209964}} = 4.42 : 1$$

Sensitivity Analysis

Given that the analysis contains estimates, it is useful to review where these decisions have had a significant effect on the overall SROI figure and to consider the confidence placed on these estimates. Chart 1 shows a range of 17 material outcomes that contribute to the overall SROI. Outcomes associated with adult and child healthcare, child-family relationships and employment relationships constitute the major four elements, although it can be seen that 5 other outcome areas also make contributions that each constitute between 6-8% of the total.

Chart 1: Constituent outcome values for the overall SROI (percentages)



Worse case scenarios

Reviewing the main contributory factors in Chart 1 and external research, three worst case scenarios are outlined here.

1. Evidence from external research (e.g. NICE, 2006) suggests that the impact of initiatives in this area can be very limited in duration. Although client and practitioner feedback suggests otherwise in the case of HLW, one scenario involves restricting the duration of the outcomes to one year.

2. There was plausible practitioner and client based reports of an impact of HLW's activities on healthcare services. However, given the long term resourcing of hospital care, it could be argued that it is difficult to attribute foregone health care costs for weight loss surgery to HLW's activities.

3. A final worst case scenario adopts a more conservative approach to the long term value of the HLW's activities for child health. Although other research (York Economics/nef, 2010) argues for adoption of QALY data to quantify the long term value of weight management

interventions for children and younger people, there are considerable assumptions of future projected value embedded in this approach. Worst case scenario 3, therefore takes this out of the analysis.

Table 6. Worst Case Scenarios

	Original case assumptions	Revised assumptions	New SROI index
1	80-90% of hospital and secondary health care outcomes identified can be attributed to HLW activities	10% hospital and secondary health care outcomes can be attributed to HLW activities	4.39
2	Outcomes endure up to three years	Outcomes endure up to one year	3.47
3	Long term reduced healthcare saving associated with child client's participation	Long term healthcare savings cannot be reliably quantified and are omitted	4.91

By varying these more sensitive areas of judgement we can see from some less favourable scenarios that the SROI could be 31% lower. If all three scenarios are combined, the worst variation would be 22% lower (£4.25).

Better case scenarios

In order to avoid over-claiming this report has previously highlighted the omission of a number of outcomes and financial proxies – and adopted a cautious approach to the impact estimates. This section calculates three better case scenarios set out in the table below.

Table 7. Better Case Scenarios

	Original case assumptions	Revised assumptions	New SROI index
1	Inadequate resource to calculate outcomes for close associates of clients	Of the total social value that accrues to adult client stakeholder group, 10% accrues to close associates[1]	5.66
2	Outcomes endure up to three years	Outcomes endure up to five years based upon stakeholder feedback on life changing nature of HLW activities	5.87
3	Long term healthcare savings cannot be reliably estimated for adult clients	QALY linked health gains for adults [Lowest estimate][2]	6.11

Notes

1. 10% of Impact Map Rows 9-17 = £311,353 for 3 years at mean drop off

2. Calculated at 20% of a QALY child equivalent (NICE,2006; nef/York Economics,2010) for 58% of adult clients who met HLW course target on completion (383 x £605 = £150,151)

If all three scenarios are combined, the best variation would be +8% (£5.88)

Confidence Range

This section brings together the results from the sensitivity analysis. It is evident that if we factor in only the short term outcomes for HLW's activities, the SROI ratio becomes significantly lower (£3.47:1). When the longer term healthcare savings are also discounted from the analysis, it appears that the project activity delivers modest outcomes, especially for institutional stakeholders such as the NHS. This variation between long term and short term perspectives clearly reflects strategic debates on the value of preventative services.

Drawing upon a range of judgements we can see that that worse case scenarios result in an SROI mean ratio of £4.25:1 while the better case scenarios provide a mean ratio of £5.88:1. **Inclusive of the outlier calculations, the present study is concluding that the social value of HLW's services ranges between £4:1 to £6:1.** However, given further internal and external research on the preventative role of this type of service, it is plausible that the social value of HLW's activities could be found to be substantially higher.

Discussion

The aim of this report has been to provide an analysis of Healthy Living Wessex's activities in terms of their social value. The rising societal costs associated with obesity, overweight and unhealthy lifestyles are issues that need to be addressed a many levels – including those of local strategy and service development. It is essential that all stakeholders are fully engaged in debates about the options available for the allocation of public resources. In this context SROI analysis can make an important contribution because it offers a structured and systematic basis for revealing and quantifying the value of outcomes that are often excluded from debate. The SROI methodology is evolving fast and is, by no means, flawless. However a strong case for this type of approach is its advantage over traditional economic analyses that tend towards reductionist and crude metrics. It also offers an alternative to custom-and-practice forms of service commissioning that fail to address the status quo in resource allocation and often lack a transparent basis for decision-making.

At its best an SROI analysis should be used as one element in the cycle of strategic decision making. It is part of a process in which opportunities for social investment arising from one set of activities are reviewed alongside alternative options. Assumptions and data that underlie the SROI analysis need to be revisited and refined over time – ideally as part on a periodic dialogue with stakeholders.

From the outset of the agency, HLW has sought to develop an evidence-based, needs-led and stakeholder-informed approach to its service development. As part of the agencies commitment to service improvement, the Director of Healthy Living Wessex, Debra Pattinson has been able to discuss key points with agency practitioners and clients and compiled the following feedback on this report:

Positive aspects of the SROI study

The report puts a comparable value to the service achievements using financial measures, which the commissioners can understand and begin to judge investments based on all of the outcomes whether

qualitative or quantitative, which has not been possible before. The qualitative measures are often overlooked and lost but are equally important for the individual and their ability to be healthy.

It is of great value to staff who have been committed to the service approach and have developed and delivered the service. Their faith and quality of service delivery in achieving outcomes based on a client focused delivery has been measured using all of the outcomes and offers them independent acknowledgement of what they have known all along that supporting a person along their health journey in an holistic way achieves results but also benefits their family, friends and community.

The SROI offers us a new perspective to initiate discussion and debate with commissioners concerning developing new approaches to service delivery and investment in preventative services which may offer us new opportunities to tender for services as the economic climate eases with the new GP consortiums.

<u>Less good aspects - or challenges- associated with the SROI study</u>

I see the commissioners who are hard pressed for time looking at the ratio only without reading the full report as a means to compare services (if in fact they have any other services which have gone through this process to compare with) and to look at the ratio only has difficulties in that there are different challenges for each service with differing client need and service delivery.

Commissioners today despite saying they want value for money which this ration will show in abundance, they also want a service which is cheaper or as cheap as it can be. The bottom line is still what is important in tendering for work.

While this study has helped us engage stakeholders in thinking about social value here has been limited discussion locally about SROI. I think there is a vague understanding of it being there. I therefore I wonder how much commissioners will be swayed by seeing it. We will soon find out. Locally the public sector does not traditionally invest in prevention which has caused problems in that it does not matter how successful a service could be there is no new money to invest in it.

A final comment is that this programme funded set up and development costs not just service delivery and therefore the final ratio has the potential to be lower than in a situation where the service is directly delivered. Now we have developed the mentoring and family weight management services through the programme and had them independently evaluated for health and well being improvements I will be looking for different models of delivering the service only so that it can be economically viable in the long term. For example the costs included extensive evaluation costs including the administration of the evaluation which we would not normally do at that level for pure service delivery, plus, we had two full time project officers who were also mentors, who developed the stakeholder relationships, the referral routes and the service delivery. In the beginning until these relationships had been established the mentoring service was not running at full capacity which it would be if delivered now. To deliver this mentoring service I would be looking at sessional work rather than full time employment of mentors until the service was at full capacity which would affect the financial costs.

However, having said that I am happy that the report gives a good basis for comparison and more importantly includes the aspects of achievement we have only otherwise been able to state but not prove.

Conclusion and Recommendations

For the period reviewed in this report, Healthy Living Wessex offered an important service for individuals, communities and agencies across Dorset. Whilst the health improvement agenda requires the recognition and coordinated response of a range of actors, HLW has not only sought to take direct action but has offered a leadership role in the agenda for change. It is on this basis and the findings of the SROI analysis that the following recommendations are made.

1. Although stakeholders and, particularly service users, have been engaged in SROI report production process, there is greater scope for consulting stakeholders in reviewing the results of the report. Therefore a formal process of reviewing the report findings by stakeholders is recommended.
2. Community-based health projects such as Healthy Living Wessex need sector wide support to help them communicate the social value of their activities. This report demonstrates that an SROI analysis can be conducted on the relatively small scale of a single organisation's activities; many organisations in this area do not have the extensive data to draw upon to inform an SROI. Any such analysis is therefore beyond the resources of many community-based health agencies.
3. Local strategic actors and commissioners need to be mindful of how existing health care, social care and other public resources budgets are currently allocated for promoting healthier lifestyles and addressing overweight and obesity. In the local context, this SROI analysis lends further support for the importance of re-balancing spending to reflect preventative, early intervention and enabling approaches.
4. Future HLW services commissioned should, ideally, continue to have in-built resources for monitoring of client outcomes and partner agency referral and recommendation patterns. This SROI report clearly highlights the value of HLW's M&E systems for providing evidence-based review and development of services.
5. HLW should continue to provide a balanced service that both meets the needs of targeted clients with higher level health needs and the needs of wider populations. The SROI analysis in this report highlights the creation of considerable social value through offsetting specialised healthcare interventions. However there are also gains for the wider social networks of clients that are less visible or quantifiable.

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Appendix A: The Impact Map

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Social Return on Investment - The Impact Map

SROI Network

Stage 1		Stage 2			Stage 3			
Stakeholders	**Intended/unintended changes**	**Inputs**		**Outputs**	**The Outcomes (what changes)**			
Who will we have an effect on? Who will have an effect on us?	What do we think will change for them?	What will they invest?	Value £	Summary of activity in numbers	Description	Indicator	Source	Quantity
					How would we describe the change?	How would we measure it?	Where did we get the information from?	How much change will there be?
Adults with BMI >25	Improved physical activity	Time	£0.00	654 adults accessing a 6 or 12 session course	Client is more physically active	Achieving 5X30 minute periods of exercise per week over 28 days	Questionnaires	222
Adults with BMI >25	Improved mobility / flexibility	Time	£0.00	654 adults accessing a 6 or 12 session course	Client feels more mobile and flexible	Take up of >1 new PA activity	Questionnaires	64
Adults with BMI >25	Improved mental health	Time	£0.00	654 adults accessing a 6 or 12 session course	Client feels overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)	plus 20 per cent improved mental wellbeing rating using a scale of measures	Questionnaires	483
Adults with BMI >25	Improved diet	Time	£0.00	654 adults accessing a 6 or 12 session course	Client eats more healthier foods	Increase in one portion average daily fruit and vegetable intake	Questionnaires	384
Adults with BMI >25	Higher social interaction	Time	£0.00	654 adults accessing a 6 or 12 session course	Client makes new friends/acquaintances and/or has more contact with existing social network	20 per cent improved social well-being /social capital using a scale of measures	Questionnaires	444
Adults with BMI >25	Higher social interaction	Time		654 adults accessing a 6 or 12 session course	Client feels personal & social strains associated with lifestyle commitments	20 per cent reduced social well-being /social capital using a scale of measures	Questionnaires	50
Adults with BMI >25 (unemployed)	Improved life satisfaction	Time	£0.00	163 adults accessing a 6 or 12 session course	Client feels healthier, happier, more confident & able to take up paid work	Client self reports obtaining employment by end of course	Questionnaires plus one off research	18
Adults with BMI >25 (carers of adults)	Improved life satisfaction	Time	£0.00	~218 adults accessing a 6 or 12 session course / ~218 care recipients	Client feels healthier, happier, more confident & able to take on care role	Client self reports increased time per week caring	Questionnaires plus one off research	78
Children	Reduced BMI	Time	£0.00	280 children accessing a 12 session course	Child has lost weight	Loss of >1kg weight [Aged 11-16]	Before and after project weigh-in	212
Children	Improved mental health and social well-being	Time	£0.00	280 children accessing a 12 session course	Child feels happier and has improved family life and relationships	Child self reports positive change	End of course record of personal outcomes	184
Children	Improved diet	Time	£0.00	280 children accessing a 12 session course	Child eats more healthy foods	Increase in one portion average daily fruit and vegetable intake	Questionnaires	164
Children	Improved diet	Time	£0.00	280 children accessing a 12 session course	Child feels social and personal strains associated with lifestyle commitments	Increase in one portion average daily fruit and vegetable intake	Questionnaires	28
Employers of adults with BMI >25	Reduced employer costs associated with employee ill health	Time	£0.00	~327 adults accessing a 6 or 12 session course	Client feels healthier, happier and better able to take on work related demands	Reduced cost to the employer of lost productivity through absenteeism	Questionnaires plus one off research	817
NHS Hospital Trust	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced specialist consultations (e.g. dieticians)	Fewer specialist consultations annually	Questionnaire and interviews	46
NHS Hospital Trust	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced hospital interventions	Fewer hospital interventions annually	Questionnaire and interviews	20
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced GP consultations	Fewer GP visits (appointments) annually	Questionnaire and interviews	311
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Reduced primary care nurse consultations	Fewer primary care nurse consultations annually	Questionnaire and interviews	94
NHS Primary Care/GP services	Reduced NHS costs	Staff time	£0.00	653 adult clients	Client felt overall improved mental wellbeing (improved mood, less anxious, more confident and so forth)	Reduced prescriptions for anti-depressants	Questionnaire	151
NHS	Reduced NHS costs	Staff time	£0.00	280 child clients	Long term reduced medical costs	Weight, PA and HE target achieved on HLW course completion	End of course record of personal outcomes	56

Stage 4					Stage 5				
Deadweight %	**Displacement %**	**Attribution %**	**Drop off %**	**Impact**	**Calculating Social Return**				
What would have happened without the activity?	What activity would we displace?	Who else would contribute to the change?	Will the outcome drop off in future years?	Quantity times financial proxy, less deadweight, displacement and attribution	**Discount rate**		3.5%		
					Year 1 (after activity)	**Year 2**	**Year 3**	**Year 4**	**Year 5**
10%	10%	0%	50%	£21,033.55	£21,033.55	£10,516.77	£5,258.39		
10%	10%	0%	50%	£2,592.00	£2,592.00	£1,296.00	£648.00		
5%	5%	0%	50%	£52,308.90	£52,308.90	£26,154.45	£13,077.23		
10%	5%	0%	50%	£60,437.15	£60,437.15	£30,218.57	£15,109.29		
5%	10%	0%	50%	£18,981.00	£18,981.00	£9,490.50	£4,745.25		
5%	5%	0%	50%	-£2,256.25	-£2,256.25	-£1,128.13	-£564.06		
10%	5%	20%	50%	£53,027.78	£53,027.78	£0.00	£0.00		
10%	5%	0%	50%	£20,113.70	£20,113.70	£10,056.85	£5,028.43		
10%	5%	10%	50%	£67,374.34	£67,374.34	£33,687.17	£16,843.59		
10%	5%	10%	50%	£135,284.50	£135,284.50	£67,642.25	£33,821.13		
10%	5%	90%	50%	£0.00	£0.00	£0.00	£0.00		
10%	5%	10%	50%	-£1,077.30	-£1,077.30	-£538.65	-£269.33		
10%	5%	0%	50%	£82,049.92	£82,049.92	£41,024.96	£20,512.48		
10%	5%	10%	50%	£4,637.01	£4,637.01	£2,318.50	£1,159.25		
10%	10%	10%	50%	£72,900.00	£72,900.00	£36,450.00	£18,225.00		
10%	10%	10%	50%	£7,255.01	£7,255.01	£3,627.50	£1,813.75		
10%	5%	10%	50%	£868.00	£868.00	£434.00	£217.00		
10%	5%	10%	50%	£2,006.68	£2,006.68	£1,003.34	£501.67		
10%	10%	20%	100%	£109,771.20	£109,771.20	£0.00	£0.00		
					£0.00	£0.00	£0.00		
				£753,708.03	£753,708.03	£295,454.53	£147,727.26		

Present value of each year (after discounting)	£728,220.32	£275,809.96	£133,241.53	£0.00	£0.00
Total Present Value (PV)					£1,137,271.81
Net Present Value (PV minus the investment)					£927,307.81
Social Return £ per £					5.42

Appendix B: Data Collection Tools

This Appendix has three examples of tools used for stakeholder consultations and for quantifying outcomes.

A: HLW Service Users Interview Topic Guide

B: Project Links Stakeholder Questionnaire

C: Client Activity Completion Questionnaire

(a) HLW Service Users Interview Topic Guide

University of the West of England

Clarify Confidentiality and Anonymity
Complete consent forms
Explain the evaluation
Form: participant characteristics: age group, gender, postcode, activity enrolment

1. Round Robin (quick) Could you tell me your name and where you live?
2. What are your previous experiences of similar activities?
3. How did you come to hear about this HLW activity?
4. Why did you to join this HLW activity?
5. Have you got what you expected from taking part?
6. What has changed for you as a result of taking part? [Specific examples]
7. Overall tell me what you think is the vision behind the HLW
8. Compared to other activities (attended/heard of) what stands out as different about the HLW activities ? How would you put a value on the activity?
9. If you had not taken part in this activity would you be doing otherwise?
10. Assess overall most attractive aspect & how different?
11. Have you recommended any HLP activities to your friends & family?
12. What would you like to see the HLP achieve over the next five years?
13. Is there other things you would like to tell me about?

Thank participants. Inform on next steps on the evaluation

(b) Project Links Stakeholder Questionnaire

Your job title ……

Your organisation ……

Have you heard of any of the Activate Your Life project activities? (Please tick)

Yes ☐ No ☐

If **No** there is no need to complete the rest of this questionnaire.

Please return it in the freepost envelope provided. Thank you for your help.

1. **Have you had any contact with Activate Your Life project?**
   This can include any forms of direct or indirect contacts with above activities (Please tick)

Yes ☐ No ☐

If yes:

Less than 1 year ☐ More than 1 year ☐

2. **What are the links between your agency, or area of practice, and the Activate Your Life project?** (Please tick any that apply)

You recommend the Activate Your Life activities to individuals ☐

You refer clients to Activate Your Life activities ☐

Activate Your Life project staff recommends individuals to your agency ☐

Activate Your Life project staff refer clients to your agency ☐

You share information about service users ☐

The project is contracted to deliver services for your agency ☐

The project contracts your agency to deliver services ☐

You collaborate or share venues for service delivery ☐

You collaborate on joint funding proposals

If you have other links please specify……..……..

……

3. In your view…
How effective is communication between the Activate Your Life project team and yourself/your agency?
(Please tick one option)

Excellent ☐ ☐ ☐ ☐ ☐ Poor Don't know/Not applicable ☐

How effective has your working relationship been with the Activate Your Life project team?

Excellent ☐ ☐ ☐ ☐ ☐ Poor Don't know/Not applicable ☐

How effective is the Activate Your Life project team in supporting people's needs?

Excellent ☐ ☐ ☐ ☐ ☐ Poor Don't know/Not applicable ☐

How effective is the Activate Your Life project team in working with in local community needs?

Excellent ☐ ☐ ☐ ☐ ☐ Poor Don't know/Not applicable ☐

4. How well informed do you feel about the Activate Your Life project in terms of…(Please tick an option)

	Very well informed				Not well informed
	5	**4**	**3**	**2**	**1**
The target, or priority, groups for the activities?	☐	☐	☐	☐	☐
What the activities aim to achieve for individuals?	☐	☐	☐	☐	☐

The outcomes for participating individuals? ☐ ☐ ☐ ☐ ☐

Availability and accessibility of activities? ☐ ☐ ☐ ☐ ☐

How activities fit with existing local services? ☐ ☐ ☐ ☐ ☐

What the project aims to achieve overall? ☐ ☐ ☐ ☐ ☐

5. To what extent do you agree with the following statements on potential benefits and drawbacks of the project? (Please tick one option)

	Strongly agree				Strongly disagree	Don't know
	5	**4**	**3**	**2**	**1**	
The project supports the NHS by providing preventative and/or alternative services	☐	☐	☐	☐	☐	☐
The project supports other statutory services by providing preventative and/or alternative services	☐	☐	☐	☐	☐	☐
The project appears to lack clear outcomes for participants	☐	☐	☐	☐	☐	☐
The project addresses local priorities for promoting health and well-being	☐	☐	☐	☐	☐	☐
The project appears to duplicate other locally available services	☐	☐	☐	☐	☐	☐

Local communities / target groups have a good awareness of the project's services ☐ ☐ ☐ ☐ ☐ ☐

Local statutory bodies have a good awareness of the project's services ☐ ☐ ☐ ☐ ☐ ☐

6. **Do you have evidence that the Activate Your Life project supports the health and well-being of your service users?** *The evidence may be in the form of client self evaluation, practitioner feedback, clinical indicators etc. You may not necessarily have evidence for all service users.*

Yes ☐ No ☐ Don't know ☐

Please comment further

……

……

……

7. **Are there any barriers to closer working links between Activate Your Life project and your agency?**

Yes ☐ No ☐ Don't know ☐

Please give details

……

……

……

8. **Are there any opportunities for closer working links between Activate Your Life project and your agency?**

Yes ☐ No ☐ Don't know ☐

Please give details

……

……

……

9. Would you be willing to be contacted by a member of the research team for further details?
You will be asked for written consent and any reporting of your views will be anonymised

Yes ☐ No ☐

If yes, please give your telephone number…….

… and your email……..

Thank you for taking time to complete this questionnaire

Please return your completed questionnaire in the FREEPOST envelope

(c) Client Activity Completion Questionnaire

This form will ask you questions about your health, your diet, your community and your lifestyle. Please answer all questions.

1) Please tell us your postcode and date of birth.

Your Postcode	Your Date of Birth

2) How would you describe your health generally over the **last week**?

Excellent	Very good	Good	Fair	Poor

3) Do you smoke?

Yes	
No	

(Go to question 5)

4) How many cigarettes per day do you usually smoke?

_____ cigarettes per day.

I don't smoke daily. ☐

5) Do you drink alcohol?

Yes	
No	

(Go to question 7)

6) How many units do you drink in an average week?

_____units per average week

A unit of alcohol is half a pint of beer, lager or cider; a pub measure of spirit, a small glass of wine.

7) On average how many portions of fruit and vegetables do you eat a **day**?

_____ per day on average

A portion is e.g. an apple, a glass of fruit juice, 3 handfuls of carrots. Do not include potatoes.

8) In a **normal week**, how often do you eat a meal that has been prepared and

cooked from basic ingredients, either by yourself or someone else?

Never	Less than once a week	Once a week	2-3 times a week	4-6 times a week	Daily

For example Shepherd's Pie made with raw mince and potatoes, or curry made with fresh vegetables and boiled rice?

9) Please indicate how much you agree with the following statements.

		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a)	**I enjoy putting effort and care into the food I eat.**					
b)	**I enjoy eating healthy food.**					

10) Please tell us the type and amount of physical activity involved in your work.

I am not in employment e.g. retired, retired for health reasons, unemployed, full time carer	
I spend most of my time at work sitting e.g. in an office	
I spend most of my time at work standing or walking However, my work does not require much intense physical effort (e.g. shop assistant, hair dresser, childminder etc).	
My work involves definite physical activity Including handling heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, nurse etc).	
My work involves vigorous physical activity - including handling of heavy objects - (e.g. scaffolder, construction worker, refuse collector etc).	

11) During the **last week,** how many hours did you spend on each of the following activities?

		None	Some but less than 1 hour	More than 1 hour, but less than 3 hours	3 hours or more
a)	**Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.**				
b)	**Cycling, including cycling to work and during leisure time**				
c)	**Walking, including walking to work, shopping, for pleasure, etc.**				
d)	**Housework / Childcare**				
e)	**Gardening / DIY**				

12) **I**n the **past 4 weeks**, on how many days have you done 30 minutes of physical activity such as brisk walking, cycling, sport, exercise, active recreation, sufficient to cause you to breathe more deeply? Please do not include physical activity as part of your job.

0 days	1-3 days	4-6 days	7-12 days	13-19 days	20+ days

13) Now read the following statements and indicate on the sliding scale the point that best describes your feelings around physical activity**.**

I wish I didn't have to do physical activity, but I know it's important for my health	1	2	3	4	5	**As well as being important for my health, physical activity is something I enjoy**

14) All things considered, how satisfied are you with your life as a whole nowadays?

	0	1	2	3	4	5	6	7	8	9	10	
Extremely Dissatisfied												**Extremely Satisfied**

15) Below are a number of things people might say that they feel. Please tick the box that best describes how often during the **past week** each description would have applied to you?

		Never	At least once	On a few days	Most days	Every day
a)	**You felt happy or contented**					
b)	**You felt depressed**					

c)	**You felt engaged or focused in what you were doing**					
d)	**You felt energised or lively**					
e)	**You felt lonely**					
f)	**You felt everything you did was an effort**					
g)	**Your sleep was restless**					

16) Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the **past four weeks**.

		None of the time	Rarely	Some of the time	Often	All of the time
a)	**I've been feeling optimistic about the future**					
b)	**I've been feeling useful**					
c)	**I've been feeling relaxed**					
d)	**I've been dealing with problems well**					
e)	**I've been thinking clearly**					
f)	**I've been feeling close to other people**					
g)	**I've been able to make up my own mind about things**					
h)	**I've been feeling like a failure**					
i)	**I've felt like I belong to something I would call a community**					
j)	**I've been feeling good about myself**					

17) Please indicate how much you agree with the following statements by ticking the appropriate box on each line.

		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a)	**There are people in my life who really care about me**					
b)	**I regularly meet socially with friends and relatives**					
c)	**I find it difficult to meet with people who share my hobbies or interests**					
d)	**People in my local area help one another**					

18) How often in the last **twelve months** did you help with or attend activities organised in your local area?

At least once a week	At least once a month	At least once every three months	At least once every six months	Less often	Never	Don't know

19) How strongly do you feel you belong to your immediate neighbourhood?

Very strongly	Fairly strongly	Not very strongly	Not at all strongly

20) Overall, how satisfied or dissatisfied are you with your neighbourhood as a place to live?

Extremely Dissatisfied	1	2	3	4	5	**Extremely Satisfied**

21) Is there anything else you would like to tell us about yourself or the activity you have been doing? What would you have been doing otherwise?

22) What are your health goals? What did get out of this activity?