Healthy Living Wessex
Active Choices Project
Dorset

Final Evaluation Report & Social Return on Investment (SROI) Analysis

Kate Blackburn & the UWE SROI Research Group
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Abbreviations

CVD – Cardiovascular Disease
DH – Department of Health
GMS – General Medical Services
GP – General Practitioner
HLW – Healthy Living Wessex
NHS – National Health Service
NICE – National Institute for Health and Clinical Excellence
PHE – Public Health England
PHOF – Public Health Outcomes Framework
Healthy Living Wessex – Active Choices Project

QOF – Quality Outcomes Framework

RSPH – Royal Society for Public Health

SROI – Social Return on Investment

UWE – University of the West of England

WHO – World Health Organisation

Glossary of SROI terms

Attribution – The credit that an organisation or person’s contribution can take, or be given, for generating an outcome

Beneficiary – People or organisations that experience positive or negative change (or outcomes) as a result of the activities

Benefit Period – The length of time outcomes and impacts last for a stakeholder

Deadweight – A measure of the amount an outcome would have happened anyway had the activity not taken place

Discounting / Discount rate – The process by which future financial costs and benefits are adjusted into present-day values, to account for the decreasing value of money over time. (Discount rate is the interest rate used to discount future costs and benefits)

Displacement – The rate or assessment of how much of the outcomes displaces other outcomes, (usually most pertinent for fiscal outcomes)

Drop-off – The deterioration rate at which an outcome would have a reduced impact over time

Impact Map – A map or table diagram, that describes and captures how an activity and resources required for it lead to particular outputs and beneficial (or non-beneficial) outcomes and changes for different stakeholders

Outcome – The essential final benefits or negative consequences that result from an activity, mainly defined from the perspective of the stakeholder

Proxy value – an approximation or derived value where an exact market-traded measure of value is not possible to obtain

SROI – Social Return on Investment

Stakeholder – People or organisation that experience negative or positive change as a result of an activity, and have an effect on, or are affected by the activity.
Executive Summary

Background

Cardiovascular Disease (CVD) is a general term used to describe a disease of the heart or blood vessels. It is estimated that every year 17 million people die globally of CVD. CVD is the leading cause of mortality in the UK killing approximately 160,000 people each year and is a significant public health issue.

There are a number of known risk factors for CVD and it is estimated that through the control of the main risk factors approximately 80% of worldwide deaths from CVD could be avoided.

One of the main risk factors is a sedentary lifestyle, lack of exercise leading to people becoming overweight and at increased risk of high blood pressure and cholesterol; all related risk factors for CVD.

Active Choices’ is a community based project coordinated by Health Living Wessex (HLW) in Dorset which aims to help people reduce their risk of developing Cardiovascular Disease (CVD) in the next ten years, in adults aged 40-74, by building physical activity into people’s daily lives.

Since 2008 HLW has been a highly active member of the South West Wellbeing (SWWB) group, a consortium of healthy living agencies in the south west of England. The Active Choices project is part of the South West Wellbeing Programme (2nd phase), a Big Lottery funded programme that is delivered by the SWWB consortium and led by Westbank Community Healthcare. The Active Choices project is based upon the premise that regular moderate exercise such as 3 sessions of 30 minutes per week can significantly reduce an individual’s chance of developing CVD. With research demonstrating that it takes 3 months to establish a new habit, individuals are offered 3 months of highly-discounted exercise in order to achieve the maximum health benefit.

As a community based and third sector led project with support from Dorset Public Health, Active Choices is designed to promote a non-medical and self-directed approach to health improvement.

Social Return On Investment is a framework for measuring and accounting for the broader concept of ‘value’, rather than money. SROI combines economic, environmental and social outcomes in order to reduce inequality and environmental degradation and improve wellbeing. SROI will be used to quantify the value produced from the Active Choices project.

Aim

The aim is to assess the Active Choices project using the SROI methodology to investigate the wider social impacts of the project and to enable organisations to understand what investment in a project of this nature can lead to. The study aims to identify the changes that occurred for individuals as a result of this project and explore what impact that has had on their lives.
Healthy Living Wessex – Active Choices Project

**Methods**

The methodology used was consistent with the recognised framework of SROI. Stakeholders in the project were interviewed on a one to one basis, and questionnaire data was gathered from participants during the Active Choices classes.

**Results**

The evaluation identified outcomes for 34 participants of Active Choices, and also for wider stakeholders such as Healthy Living Wessex staff. Nine outcomes were identified by the participants of Active Choices, these were:

- Improved levels of physical activity
- Weight Loss
- Improved mental wellbeing
- Reduced symptoms of depression
- Sense of pride and self worth
- Increased confidence
- Reduction in social isolation
- Increased sense of independence
- Less reason to go to the GP

Outcomes experienced by participants account for over 90% of the value of the social return created by the project.

**For every £1 invested in the project, an estimated £1.91 of social return is generated over a three year period.**

**Conclusions**

This evaluation demonstrates the potential of the Active Choices project to reduce the risk of developing CVD in those individuals participating. In addition, it also demonstrates a much wider impact generated amongst the participants equating to a financial return of £1.91 for every £1 invested.
Chapter 1: Background

Introduction

Social Return On Investment (SROI) is a framework which can be used to measure and account for the much broader concept of value that is produced from an activity. SROI measures changes that are relevant to the people or organisations that experience or contribute to it and tells this story of change by measuring the social, economic and environmental values resulting from a project. It seeks to develop a better understanding of the range and scale of value that an activity creates, and to inform action to address societal and environmental issues.

‘Active Choices’ is a community based project coordinated by Health Living Wessex (HLW) in Dorset which aims to help people reduce their risk of developing Cardiovascular Disease (CVD) in the next ten years, in adults aged 40-74, by building physical activity into people’s daily lives.

The principle aim of this research was to assess the social and economic impact of Healthy Living Wessex’s ‘Active Choices’ project using an SROI methodology. When health improvement projects are assessed it is usually done by evaluating the economic return on investment, but this financial value of an activity may not capture the total value which has been achieved. The research therefore sought to examine a wide range of forms of value starting from the perspectives of those most closely involved in the project.

The evaluation focuses on the first 21 months (April 2013-December 2014) of operation of the Active Choices Project and includes all those who were referred to the project and attended an exercise class.

The objectives for this analysis were:

- To produce an impact Map and SROI Report
- To identify suitable indicators that would enable the measurement of outcomes and social impact of Active Choices.
- To produce a working document that can be used to demonstrate the social value of investing in interventions like Active Choices.
- To use this initial report as a base for identifying the changes necessary to sustain and improve the social value of interventions like Active Choices.
Social Return on Investment

What is Social Return on Investment?

According to the guidance from Social Value UK, every day actions and activities create and destroy value; they change the world around us. Although the value we create goes far beyond what can be captured in financial terms, this is, for the most part, the only type of value that is measured and accounted for. As a result, things that can be bought and sold take on a greater significance and many important things get left out. Decisions made like this may not be as good as they could be as they are based on incomplete information about full impacts.

SROI is a framework for measuring and accounting for the broader concept of ‘value’, rather than money. SROI combines economic, environmental and social outcomes in order to reduce inequality and environmental degradation and improve wellbeing. It tells the story of change from the perspective of those people involved and should include all things that have changed, irrespective of whether these were positive or negative.

SROI is not about accounting for money, it is about value. SROI simply uses money as a common unit to communicate the value of social, environmental and economic outcomes to derive a ratio of benefits to costs. For example a ratio of 4:1 indicates that for every £1 invested in an activity there is a £4 social return from that activity.

SROI is based upon seven principles, which are detailed in table 1. Throughout this report further detail is provided for each principle.

Table 1. Social Return On Investment principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve stakeholders</td>
<td>Stakeholders are those people or organisations that experience change as a result of the activity and they will be best placed to describe the change.</td>
</tr>
<tr>
<td>Understand what changes</td>
<td>Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.</td>
</tr>
<tr>
<td>Value the things that matter</td>
<td>Use financial proxies in order that the value of the outcomes can be recognised. Many social outcomes are not traded in markets and as a result their value is not recognised.</td>
</tr>
<tr>
<td>Only include what is material</td>
<td>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.</td>
</tr>
<tr>
<td>Do not over-claim</td>
<td>Only claim the value that organisations are responsible for creating.</td>
</tr>
<tr>
<td>Be transparent</td>
<td>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.</td>
</tr>
<tr>
<td>Verify the result</td>
<td>Ensure appropriate independent assurance.</td>
</tr>
</tbody>
</table>

SROI can be conducted retrospectively and be based upon actual outcomes which have already taken place, or as a forecast which predicts the social value that will be created if the activities achieve their expected outcomes.
There are six stages to carrying out an SROI:

1. **Establishing scope and identifying key stakeholders.** It is important to have clear boundaries about what an SROI analysis will cover, who will be involved in the process and how.
2. **Mapping outcomes.** Through engaging with stakeholders an impact map will be developed, also known as a theory of change, which shows the relationship between inputs, outputs and outcomes.
3. **Evidencing outcomes and giving them a value.** This stage involves finding data to show whether outcomes have happened and then valuing them.
4. **Establishing 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. **Calculating the SROI.** This stage involves adding up all the benefits, subtracting any negatives and comparing the result to the investment. This is also where the sensitivity of the results can be tested.
6. **Reporting, using and embedding.** Easily forgotten, this vital last step involves sharing findings with stakeholders and responding to them, embedding good outcomes processes and verification of the report.

SROI can be used as a strategic tool for planning and improving services, for communicating wider impacts to a range of organisations and to facilitate effective investment decisions to reduce health inequalities and improve health and wellbeing.

**Host Organisation**

Healthy Living Wessex (HLW) is a not for profit social enterprise, a business with objectives which are primarily focused upon social outcomes. All surpluses made by the business are reinvested to deliver services within the most deprived and at risk communities to support the reduction of health inequalities.

HLW has three key aims:

1. To improve physical health for individuals and within communities by encouraging positive lifestyle changes.
2. To improve mental well-being of individuals and communities by enabling them to reach their full potential.
3. To ensure the corporate health of the company making it fit for purpose.

HLW’s five core values are:

1. **Fun and friendship** and a sense of humour are essential to a healthy life.
2. Positive life changes will only be made by someone when they want to and when life circumstances are not in conflict.
3. People are experts on themselves.
Healthy Living Wessex – Active Choices Project

4. Healthy Living is here to help people make the changes they choose in a way which fits in with their life needs.
5. Health Living Wessex will not dictate changes, but offer opportunities and choices around individual needs, helping people to achieve solutions that fit in with their lives.

HLW began in 2002 as a Big Lottery funded project. There is a board of four directors who contribute their time and skills at no cost to the business. There are eight members of staff at HLW who work as a team to deliver a variety of services such as:

- Healthy Choices – individuals are referred to HLW where they are then invited to call and speak to a team member who can check their eligibility for the scheme and provide 12 weeks free attendance at Slimming World or Weight Watchers.
- Active Choices – individuals are referred who are at moderate or high risk of developing CVD and are provided with 12 sessions of highly discounted circuit classes.
- Royal Society for Public Health (RSPH), Health Training – HLW is a recognised centre for the delivery of a number of RSPH courses.

HLW’s vision for the people of Dorset is to have the opportunities to be healthy and happy and have a sense of community and self-worth which will allow them to take better control of their lives and feel able to reach their full potential. Since 2008 HLW has been a highly active member of the South West Wellbeing (SWWB) group, a consortium of healthy living agencies in the south west of England. The Active Choices project is part of the South West Well-being Programme (2nd phase), a Big Lottery funded programme that is delivered by the SWWB consortium and led by Westbank Community Healthcare.

Active Choices Project Outline

Active Choices is one of a range of projects provided by HLW. It is a 12 week Big Lottery funded project which aims to help people reduce their risk of developing CVD in the next ten years, in adults aged 40-74 in vulnerable communities. This is done through the development of a new community physical activity network to build physical activity into people’s daily lives.

Individuals are referred to the Active Choices project if they have been assessed by their healthcare professional as being at moderate or high risk of developing CVD should they continue with their current lifestyle and lifestyle choices. The project is based upon the premise that regular moderate exercise such as 3 sessions of 30 minutes per week can significantly reduce an individual’s chance of developing CVD. With research demonstrating that it takes 3 months to establish a new habit, individuals are offered 3 months of highly-discounted exercise in order to achieve the maximum health benefit.

“The aims of the Active Choices Programme are to stimulate improved lifestyle habits, particularly through increased levels of regular increased physical activity.” Active Choices Exercise Instructor.
Individuals are offered one session of exercise per week, led by a specialist instructor, and follow the format of the traditional Phase IV cardiac rehabilitation class and are taken by Phase IV trained staff. All exercise sessions have a circuit class format to exercise all parts of the body. Individuals are encouraged to exercise at their own level and pace. All classes are subsidised by the Big Lottery, with participants paying £1 per session for 12 sessions. As a community based and third sector led project, Active Choices is designed to promote a non-medical and self-directed approach to health improvement.

The Active Choices project began in April 2013, however the first referrals into the project could not begin until October 2013 due to difficulties in recruiting a project coordinator with the necessary public health and community project management skills. The post was advertised three times before successful appointment to the role and at the initial stage the role could not be filled for the total hours required leaving a shortfall which had to be absorbed by other staff members.

The Active Choices project relied upon those identified as being at a high risk of developing CVD, through the NHS Health Check programme, being referred onto the project. However, at the time of the projects start up the organisational changes in the wider system of the establishment of Clinical Commissioning Groups, and the transfer of public health from the NHS into Local Authority resulted in very limited numbers of NHS health checks being carried out in Dorset, directly impacting upon the referral numbers to Active Choices.

In March 2014 the referral criteria was changed so that referrals no longer needed to come from a healthcare professional as a result of the NHS Health Checks programme, and could now include those people at moderate risk of developing CVD as well as those rated as high risk. In addition the project was opened up to GP practices in Bournemouth and Poole, and HLW attended numerous GP meetings to increase awareness of and referral to the project. At this point the referral rates to the project began to increase, however it should be noted that for this evaluation the time period covered included all of the initial set up months and the difficulties encountered.

A full list of available classes and locations can be found at appendix 1.
Chapter 2: Literature Review

The Aims Of The Project

The aims of the Active Choices project are to help people, aged 40-74, reduce their risk of developing CVD in the next ten years by building physical activity into their daily lives.

A literature review was undertaken to provide context and supporting evidence for this method of intervention. The literature considers the epidemiology of CVD, the national policy context and the evidence of physical activity interventions to reduce the risk of CVD.

What is Cardiovascular Disease?

CVD is a general term which is used to describe a disease of the heart or blood vessels and include:

- Coronary heart disease: disease of the blood vessels supplying the heart muscle;
- Cerebrovascular disease: disease of the blood vessels supplying the brain;
- Peripheral arterial disease: disease of blood vessels supplying the arms and legs;
- Rheumatic heart disease: damage to the heart muscle and heart valves from rheumatic fever, caused by streptococcal bacteria;
- Congenital heart disease: malformations of heart structure existing at birth;
- Deep vein thrombosis and pulmonary embolism: blood clots in the leg veins, which can dislodge and move to the heart and lungs.¹

Risk factors for CVD

The World Health Organization (WHO) estimates that globally 17 million people die every year of CVD. The predominant forms of CVD deaths recorded are heart attacks and strokes.²

There are a number of known risk factors for CVD and it is estimated that through the control of the main risk factors approximately 80% of worldwide deaths from CVD could be avoided. Many of the risk factors for CVD are known as ‘linked factors’, this means that if you have one risk factor you are more likely to have others. The recognised risk factors for CVD include³:

- High blood pressure (hypertension)
- Smoking
- Diabetes
- Lack of exercise


² WHO. Cardiovascular disease: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/cardiovascular-diseases

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- Being overweight or obese
- Family history of heart disease

If regular exercise is not part of a person’s lifestyle it is far more likely that they will have a number of the risk factors for CVD such as high blood pressure, along with higher cholesterol levels, be overweight and have higher stress levels. Another linked risk factor is often smoking; evidence shows that people who smoke are less likely to exercise.\(^4\)

Poor mental health is also associated with an increased risk of CVD, and mental illness is identified in a number of studies as an independent risk factor for the development of CVD.\(^5\) Depression alone is associated with a 67% increased mortality from CVD,\(^6\) with mental illness linked to less healthy lifestyle choices and more frequent health risk behaviour leading to poorer physical health outcomes.

**Burden of disease**

CVD is the leading cause of mortality in the UK killing approximately 160,000 people each year, and it remains a top policy priority.\(^7\) The CVD burden in the UK generates enormous economic consequences, both directly and indirectly with the overall annual costs to the UK for CVD estimated to be £30 billion.\(^8\)

Death rates from CVD have halved in the UK since the early 1970’s, with the majority of the decline in the mortality attributed to reductions in smoking, cholesterol and blood pressure. However, recent trends in age-specific rates in the UK are a cause for concern with increasing levels of obesity, diabetes and blood pressure in young adults, there is the potential for premature mortality from CVD to rise.\(^9\)

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CVD is more common in men than in women, and significant socio-economic differences can be seen in the mortality for CVD, with a higher prevalence in lower socio-economic groups.\(^\text{10}\)

**National Policy Context**

There are a number of national policy frameworks and programmes which include aims to reduce premature mortality from CVD, and to reduce the variations in the prevalence of CVD across the population. For example deaths from coronary heart disease are three times higher among unskilled men than among professionals, and around 50% higher in South Asian communities than in the general population.\(^\text{11}\) National guidance published in 2013 ‘Living Well for Longer’ focused on reducing premature deaths from the main diseases of which CVD is one, and effective interventions for disadvantaged groups were highlighted within this guidance to complement other national policy frameworks.

The main ones are detailed below and the interdependencies between them can be seen.

**Public Health Outcomes Framework**

The Public Health Outcomes Framework (PHOF) ‘Healthy lives, healthy people: Improving outcomes and supporting transparency’ sets out a vision for public health, the desired health outcomes and indicators to monitor and understand how well public health is being improved.

Reducing premature mortality from CVD is a key outcome for the PHOF within the section concerned with reducing premature mortality from the major causes of disease. The aim to reduce premature mortality from CVD is also echoed in the NHS outcomes framework.

**Quality Outcomes Framework**

The Quality Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. It is a mechanism of rewarding practices for the provision of quality care. A number of the outcomes relate indirectly to reducing the risk factors for CVD with one of the outcomes relating directly to CVD:

CVD-PP001 – In those patients with a new diagnosis of hypertension aged 30–74, who have a CVD risk factor of >20% in the preceding 15 months: the % who are currently treated with statins.

This is a medical model of risk reduction for CVD, however the Department of Health (DH) strategy ‘Improving cardiovascular outcomes: improving outcomes for people with or at risk of CVD’ identifies 10 key actions for commissioners and providers of health and care services. Two of which relate directly to the reduction of risk of CVD, and promotes the use of a wider range of interventions in addition to those medically based.\(^\text{12}\)

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\(^{11}\) Care Quality Commission. Closing the Gap 2009.

\(^{12}\) Department of Health (DH) Improving cardiovascular disease outcomes. Improving outcomes for people with or at risk of CVD. March 2013.
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- Action 3: NHS Improving Quality (IQ) will work with Public Health England (PHE), Local Authorities and the NHS to support the successful implementation of the NHS Health Check programme.
- Action 6: The NHS Commissioning Board will work with stakeholders to identify how to incentivise and support primary care consistently to provide good management of people with or at risk of CVD. This will include DH asking NICE to review the relevant QOF indicator’s and promotion of primary care liaison with local authorities, the third sector and PHE to ensure optimal provision of prevention services, including secondary prevention.

**NHS Health Checks**

The aim of the NHS health check programme is to help prevent diabetes, heart disease, kidney disease, stroke and dementia by identifying early signs for these conditions and helping to prevent them.

It checks the circulatory and vascular health of adults in England aged 40-74 without a pre-existing condition, and gives each individual a score which indicates the level of risk they are at from developing these conditions. Based on this score a plan of action can be worked out with the health professional.

The NHS health check programme was a key component of the Active Choices project in identifying those individuals who would benefit from being referred into the programme. Through the provision of an exercise referral scheme aimed specifically at individuals at risk of CVD the Active Choices project is a good mechanism of facilitating health care professionals to develop an effective plan of action for patients. However, it should be noted that the area of Dorset, Bournemouth and Poole at the time of the Active Choices project were identified as one of the areas in the South West with the lowest record of completed Health Checks which impacted upon the projects delivery.

**Interventions to reduce the risk of CVD**

There is clear evidence that demonstrates the benefits of prevention programmes to reduce the risk of developing CVD which are not medically based. A large number of individuals within the population will have at least one of the risk factors for developing CVD, and given that these factors are so often linked to others, it is vital that prevention is one of the main approaches to reducing CVD.

Prevention programmes with a focus on increasing physical activity have been shown to impact positively on a number of the risk factors for CVD, such as a decrease in body weight and blood pressure, and a reduction in cholesterol levels. However, a common limitation of prevention

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13 Butter, HS. Li, T. Ravi, N. Prevention of cardiovascular diseases: Role of exercise, dietary interventions, obesity and smoking cessation. Experimental and Clinical Cardiology, 2005, vol./is 10/4(229-249), 1205-6626

programmes is the lack of long term compliance amongst individuals and studies have demonstrated that in order to improve the levels of lifestyle change required to actually reduce the risk of CVD individuals must be engaged, and fully perceive their high level of risk.\textsuperscript{16 17}

Other key variables which may predict compliance to physical activity prevention programmes have also been identified such as the sex of participants, with females significantly more likely to maintain a programme of physical activity than males. This highlights the need to use specific tailored approaches which reflect variables such as age and gender when developing any type of physical activity based prevention programme.\textsuperscript{18}

In addition, CVD prevention programmes which are community based and have a focus on physical activity have been able to demonstrate high adherence and compliance levels which have been reflected in significant improvements in lifestyle risk factors for CVD.\textsuperscript{19}

Finally, when thinking about the service delivery of CVD prevention programmes NICE public health guidance 25 looks specifically at the services for the prevention of cardiovascular disease, they state that: ‘Local advocacy by "third sector" groups and organisations, including the voluntary sector, is an important part of cardiovascular disease prevention activities.’\textsuperscript{20}

In terms of the financial cost effectiveness of physical activity prevention programmes, NICE established that brief interventions for physical activity cost between £20 and £440 per QaLY (when compared with no intervention), which is significantly below the £30,000 threshold applied by NICE to represent value for money, and therefore represents exceptional value for money.

The return on investment in brief interventions for physical activity in primary care demonstrated by the net costs saved per QaLY gained varies from £750 to £3,150.\textsuperscript{21}

Thus the evidence and national policy context supports the aims and approach of the Active Choices Project to reduce the risk of developing CVD in its participants.

\textsuperscript{15} Bulwer, BE. Sedentary lifestyles, physical activity, and cardiovascular disease: From research to practice. Critical Pathways in Cardiology, December 2004, vol./is. ¾ (184-193), 1535-282X
\textsuperscript{16} Flaherty G et al. Durability of lifestyle change and cardiovascular disease (CVD) risk factor reductions – 1 year outcomes from a community based CVD prevention programme for high risk patients in Ireland. European Heart Journal, August 2011, vol./is. 32/(225), 0195-668X
\textsuperscript{17} Craciun L et al. Increasing the regular physical activity level reduced the cardiovascular risk in assymptomatic high risk patients from EuroAspire III Romania Follow-Up. European Journal of Cardiovascular Prevention and Rehabilitation, April 2011, vol./is.18/1 SUPPL. 1(S47), 1741-8267
\textsuperscript{18} Aggarwal, B. Liao, M. Mosca, L. Predictors of physical activity at 1 year in a randomized controlled trial of family members of patients with cardiovascular disease. The Journal of cardiovascular nursing, November 2010, vol./is. 25/6(444-449), 1550-5049
\textsuperscript{19} Gibson, I et al. Reducing cardiovascular risk factors in an obese population – Preliminary findings from a community based cardiovascular disease prevention programme in Ireland. European Heart Journal, August 2011, vol./is. 32/(720), 0195-668X
\textsuperscript{20} NICE. Services for the Prevention of Cardiovascular Disease. May 2012
Chapter 3: Establishing Scope & Identifying Key Stakeholders

The scope of an SROI analysis is an explicit statement about the boundary of what is being considered, e.g. time duration, stakeholders, outcomes. It is often the result of negotiations about what is feasible for you to measure and what you would like to be able to improve or communicate.

The issues listed in table 2 must be considered in order to set the scope:

Table 2 Issues for setting the scope

<table>
<thead>
<tr>
<th>Issue</th>
<th>Explanation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>What is the purpose of the SROI analysis? Why do you want to begin this process now? Are there specific motivations driving the work, such as strategic planning or funding requirements?</td>
<td>The purpose of this research was to assess the social and economic impact of Healthy Living Wessex’s Active Choices project using a Social Return on Investment (SROI) methodology.</td>
</tr>
<tr>
<td>Audience</td>
<td>Who is this analysis for?</td>
<td>Funders of the Active Choices project are the key audience for the SROI, which includes Big Lottery and Dorset Public Health team. However, HLW may wish to use the SROI to communicate positive findings to potential investors, and to use the learning from the SROI to improve future projects relating to active lifestyle interventions.</td>
</tr>
<tr>
<td>Background</td>
<td>Consider the aims and objectives of your organisation and how it is trying to make a difference. If you are focusing on specific activities you will need to understand the objectives of those activities.</td>
<td>1. To improve physical health for individuals and within communities by encouraging positive lifestyle changes. 2. To improve mental well-being of individuals and communities by enabling them to reach their full potential.</td>
</tr>
<tr>
<td>Resources</td>
<td>What resources, such as staff time or money will be required? Are these available?</td>
<td>A public health specialty registrar dedicated two days a week to the SROI over a period of six months.</td>
</tr>
<tr>
<td>Who will carry out the work?</td>
<td>Will the analysis be undertaken internally or will it require external help?</td>
<td>The SROI will be carried out by Kate Blackburn, Public Health Specialty Registrar on behalf of the University of the West of England (UWE) and</td>
</tr>
</tbody>
</table>
The range of activities on which you will focus.

Will you be analysing all the activities of your organisation, or just specific ones?

The evaluation will focus upon all activities offered within the Active Choices Project, this consists of twelve one hour weekly group exercise sessions from one of twelve trained instructors across Dorset.

Time period

SROI analysis is often annual, corresponding with annual financial accounting timescales. This can vary though.

The SROI will review the activities and outcomes from April 2013 when funding was first provided to HLW for the project, until the end of December 2014 when the SROI of the project was started.

Forecast or Evaluation?

Will the analysis be carried out retrospectively, or as a forecasting analysis?

This SROI will be an evaluation SROI.

Identifying the Key Stakeholders

Stakeholders are defined as people or organisations that experience change or affect the activity under evaluation, whether positive or negative. An SROI analysis will try to determine how much value has been created or destroyed and for whom. Initially stakeholders are identified and included within the evaluations that have experienced material change as a result of the activity. It is therefore essential that the key stakeholders of the Active Choices project are identified at the beginning of the SROI process so that they can be involved in consultation throughout.

Figure 1: Stakeholder analysis
Participants are Active Choices main stakeholders for whom the project exists. The participants of the Active Choices project consist of residents of Dorset who are identified through the NHS Health Check to be at moderate to high risk of developing CVD within the next ten years.

This stakeholder group consists of those who are engaging with the Active Choices classes, either for the whole 12 week length of the course, or who have attended one or more sessions. This stakeholder group consists of 92 individuals. It should be recognised that due to the resources available to conduct this SROI although it was possible to separate this group of participants into discrete subgroups, which are listed below, it has not been possible to interview each sub-group as a discrete entity which may have allowed for a more sensitive evaluation of outcomes. However this information will be used later in the SROI as part of the sensitivity analysis.

1. Participants who have attended at least one session = 92 participants.
2. Participants who have attended more than one session = 58 participants
3. Participants who attended all 12 sessions = 34 participants.

Family and Friends of participants may experience some difficulties as a result of loved ones being at risk of developing CVD. Any impacts that the Active Choices project has on the wellbeing of those participating may therefore also lead to significant benefits for the family and friends of those participants.

The Big Lottery Fund is the main funder of Active Choices project at HLW. £57,672 of Big Lottery money went towards funding HLW’s Active Choices project in the 21 months specified of April 2013 - December 2014. In addition Dorset public health team provided funding of £5,000 to help with the set up costs of the project.

Staff – This Stakeholder group has been divided into two sub-groups:

1. Exercise Instructors – The Active Choices project team consists of twelve independently employed Phase IV trained staff who work directly with the participants of the Active Choices project.

2. HLW Staff - do not work directly in the delivery of the exercise classes with the participants of the group but support its running through the provision of administrative, managerial, strategic and other inputs.

All of the staff involved in the Active Choices project put significant time and energy into ensuring the success of the programme. As a reward they gain significant job satisfaction as they witness the benefits of the programme on those participating in it.

Volunteers – The Active Choices project does not use any volunteers.

Referring organizations – the majority of referrals to the Active Choices Project are from health care professionals who have carried out an NHS health check and identified a person as being at
Healthy Living Wessex – Active Choices Project

moderate to high risk of developing CVD in the next ten years. This may be a GP, practice nurse or other healthcare professional. Referring organizations are vital to Active Choices in encouraging and facilitating the use of their service. Referring agencies can also benefit from the outcomes of the Active Choices project through the reduction of demand on GP services for future CVD related health problems.

**NHS** – The NHS benefits from the Active Choices project through reduced demand for services. This reduction in demand equates to increased capacity; the resources that the NHS have saved through providing fewer GP appointments are available to be used providing these services to other individuals.

Table 3 shows the Key Stakeholders identified to be included within this SROI based upon all available information.

**Table 3. Stakeholder Evaluation Table**

<table>
<thead>
<tr>
<th>Key Stakeholders</th>
<th>Reason for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Choices participants which includes:</td>
<td>Group that is expected to gain the most benefits and experience the most change as a result of the project.</td>
</tr>
<tr>
<td>(1) Participants who have attended at least one session.</td>
<td></td>
</tr>
<tr>
<td>(2) Participants who have attended more than one session.</td>
<td></td>
</tr>
<tr>
<td>(3) Participants who attended all 12 sessions.</td>
<td></td>
</tr>
<tr>
<td>Active Choices Project Exercise Instructor’s</td>
<td>Self-employed and therefore likely to experience significant change to their working lives.</td>
</tr>
<tr>
<td>Healthy Living Wessex Staff</td>
<td>Provide time necessary to make the activity under analysis possible, and are employed through the funding for the project.</td>
</tr>
<tr>
<td>GP practices which refer individuals into the programme</td>
<td>Provide time necessary to inform the patient of the availability of the programme and make the referral. In addition GP’s may start to see a drop in GP consultation due to improved health in participants.</td>
</tr>
<tr>
<td>Dorset Public Health Team</td>
<td>Provide finance and support to the programme and therefore are affected.</td>
</tr>
<tr>
<td><strong>Key Stakeholders</strong></td>
<td><strong>Reason for exclusion</strong></td>
</tr>
<tr>
<td>Active Choices participants who were referred but did not attend any sessions</td>
<td>Group unlikely to have been affected in any way by the programme if they did not attend any sessions.</td>
</tr>
<tr>
<td>Big Lottery Funding</td>
<td>Provide funding which affects the activity but excluded because there were insufficient resources to analyse more stakeholders.</td>
</tr>
<tr>
<td>Members of the local community</td>
<td>Programme is unlikely to have had any impact on the local community as the sessions were not part of a group or community programme.</td>
</tr>
<tr>
<td>Family and friends of project participants</td>
<td>There were insufficient resources available within the scope of the SROI to include further stakeholders where the impact made may not have been significant.</td>
</tr>
</tbody>
</table>
Data Sources

Much of the primary data for this analysis was gathered from 1-1 interviews with the different stakeholder groups. Additional information was also collected through survey data of the wider stakeholder groups such as referring GP practices and exercise instructors, and questionnaire data provided by participants of Active Choices which was gathered during the Active Choices classes.

The questions asked in the 1-1 interviews included,

For participants:
- How were you feeling before you started attending the Active Choices classes?
- How do coming to the Active Choices classes make you feel?
- Has anything changed for you as a result of coming to the Active Choices classes?

For staff:
- Please describe your experiences of working on this project – if you have worked on other similar projects, how does it compare?
- If you could make any changes to the project what would they be?
- What kind of impact do you think the project has had on participants? Can you give evidence for this?

For other stakeholders:
- What do you think are the aims of the Active Choices project?
- What impact do you think the Active Choices project has on its participants / the wider community?

Copies of the interview prompt sheets can be found in Appendix 2.

HLW also collects a wide range of information regarding those participating in its programmes which has also been used to undertake the analysis in this report.

Copies of all of these data collection forms can be found in Appendix 3.
Chapter 4: Mapping Outcomes

Aim

In order to map the outcomes that a programme or intervention has produced an Impact Map is developed through engagement with the key stakeholders identified in stage 1 of the SROI process. The impact map will show details of the resources (known as inputs) that are used to deliver the activities (measured as outputs) which result in the outcomes for the stakeholders.

The relationship between these inputs, outputs and outcomes is known as the theory of change, it tells the narrative story of what difference a programme or intervention has made to the population.

Identification of Inputs

The investment which is measured using an SROI approach refers to the financial value of all inputs into the programme. Inputs can be purely financial or can include any other inputs that are used up in the course of the activity – for example an individual’s time.

Valuation of Inputs

The value of the financial inputs, especially for a single grant or a contract, is usually easy to establish, although it is important that the full cost of delivering the intervention is included.

The grant allocation for the first year of the Active Choices project was £57,606, the actual spend in the first year was £28,941. The grant allocation for the second year of the Active Choices project was £70,128 with the spend by the end of the third quarter (December 2014) of £28,731. The spend form the project was lower than anticipated due to the low referral rate, the underspend was offered back to the Wellbeing project for use in their other projects and totalled £30,000.

In addition £5,000 was identified as an input to the programme from Dorset Public Health for the production of data reports from Healthy Living Wessex to enable the public health team to monitor the effects of the programme and aid in the future planning for similar classes across Dorset.

HLW had an informal working relationship agreement with Dorset Public Health to ensure that the Public Health team were involved in the delivery and ownership of the project outcomes. Dorset Public Health were well placed to influence the delivery of the NHS Health Checks as one of their commissioned services, which was a key component in the Active Choices project. Dorset Public Health contributed significant promotion and communication materials to GP surgeries.

No other inputs were identified.
Table 4. Programme Budget

<table>
<thead>
<tr>
<th>Revenue Cost</th>
<th>Year 1 Actual Total by Cost Centre</th>
<th>Year 2 Actual Total by Cost Centre to December 2014 (9 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries National Insurance &amp; pension</td>
<td>£23,322</td>
<td>£25,369</td>
</tr>
<tr>
<td>Recruitment</td>
<td>£482</td>
<td>£0</td>
</tr>
<tr>
<td>General running costs</td>
<td>£2,689</td>
<td>£1,130</td>
</tr>
<tr>
<td>Training for staff and volunteers</td>
<td>£0</td>
<td>£60</td>
</tr>
<tr>
<td>Travel for staff and volunteers</td>
<td>£697</td>
<td>£566</td>
</tr>
<tr>
<td>Organisation overheads – line management</td>
<td>£0</td>
<td>£135</td>
</tr>
<tr>
<td>Organisation overheads – accommodation</td>
<td>£1,751</td>
<td>£670</td>
</tr>
<tr>
<td>Tutor costs</td>
<td>£0</td>
<td>£517</td>
</tr>
<tr>
<td>Activity costs</td>
<td>£0</td>
<td>£284</td>
</tr>
<tr>
<td>Total Revenue &amp; Capital Costs</td>
<td>£28,941</td>
<td>£28,731</td>
</tr>
</tbody>
</table>

**Clarification of Outputs**

Outputs are a quantitative summary of an activity. For example, the activity is ‘we provide 12 weekly sessions of physical activity’ and the output is ‘we enabled 30 people to exercise once a week for 12 weeks’.

Table 5 illustrates the stakeholders, inputs, and outputs identified for the Active Choices Project.
<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended/unintended changes</th>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an effect on? Who has an effect on us?</td>
<td></td>
<td>What is the value of the inputs in currency (£)</td>
<td>Summary of activity in numbers</td>
</tr>
<tr>
<td><strong>Big Lottery funders</strong></td>
<td>Intended project outcomes achieved</td>
<td>Funding</td>
<td>57672</td>
</tr>
<tr>
<td><strong>Healthy Living Wessex Staff</strong></td>
<td>Time, commitment, skills and experience</td>
<td>Time - cost included in funding above</td>
<td>0</td>
</tr>
<tr>
<td><strong>Project Beneficiaries – Participants of the Active Choices Project</strong></td>
<td>Increased physical activity levels and participation in local sport and activity groups.</td>
<td></td>
<td>335 referrals – 92 participants attending at least one session of the Active Choices project. 34 participants attending all 12 sessions. (34 x £12 = £408)</td>
</tr>
<tr>
<td></td>
<td>Weight Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved mental wellbeing (depression, anxiety, life satisfaction, personal mental wellbeing, social wellbeing,)</td>
<td>£1 per session</td>
<td>£12</td>
</tr>
<tr>
<td></td>
<td>Reduced social isolation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signposting and access to other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in GP appointments and improved use of Primary Care resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Active Choices Project Exercise Instructor’s</strong></td>
<td>Increased number of participants in the classes they provide.</td>
<td>Extra participants covered in cost included in funding above.</td>
<td>0</td>
</tr>
<tr>
<td><strong>Dorset Public Health</strong></td>
<td>Improved evidence for commissioning similar active lifestyle interventions across Dorset.</td>
<td>Funding</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>GP practices which refer individuals into the programme</strong></td>
<td>Reduction in GP appointments.</td>
<td>Time</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>£63,080</td>
</tr>
</tbody>
</table>
**Chapter 5: Evidencing Outcomes**

**Description of Outcomes**

**Outcomes for stakeholders**

SROI is an outcomes-based measurement tool, because measuring outcomes is the only way you can be sure that changes for stakeholders are taking place. It is important not to confuse outputs with outcomes. For example, if a training programme aims to get people into jobs then completion of the training itself is an output, getting the job is an outcome.

The anticipated intended or unintended outputs that it is reasonable to expect have been described in the table above. In order to be sure that this view is correct it is vital to check these assumptions with the identified stakeholders. They may describe the effects differently; perhaps even in surprising ways, for this reason, the outcomes description column can only be completed after talking to stakeholders.

**Identifying & Evidencing Outcomes**

This stage involves finding data to show whether outcomes have happened and then giving them a monetary value.

Quantitative data was collected for the Active Choices project by each individual exercise class instructor through a participant survey at the first class, and again at a 12 week follow-up session for all individuals referred to the Active Choices project. Examples of these questionnaires are attached at appendix 3. Data from these questionnaires has been used to assess the demographics of the participants referred and any change in their physical and mental health and wellbeing during the course of the project.

Accelerometer data was also collected from participants at the start of the project prior to joining the Active Choices project and again at 12 weeks after the completion of the Active Choices project. This data has been used to quantify the change in levels of activity of participants before and after participating in the programme.

Qualitative data was collected through one to one interviews which were conducted with a total of 14 stakeholders. Of these interviews four were conducted with HLW staff, and one with Dorset Public Health. For participants of the programme a random sample of 100 participants from the Active Choices project referrals of 395 was identified. Letters detailing the SROI research process and a request for interview were sent to this cohort of 100 participants with a request that individuals volunteer to be interviewed. From this process 9 participants were interviewed, representing 10% of people who participated in one or more sessions of the project. A copy of the letter sent to participants is attached at appendix 4.
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On-line survey data from wider stakeholders was collected from six organisations and two exercise instructors via an online survey monkey questionnaire. A copy of the survey’s questions is attached at appendix 5.

Qualitative data analysis – stories of change

The following data and quotes from Active Choices participants and stakeholders give a sense of how participants felt about first attending the project, as well as providing useful indicators of the impact the project has had on them, and thus of the project outcomes.

“*My GP told me I had to do something to lose weight or my life could be shortened. The group was nice, laid back and not just me me me, more us us us. I’ve got a lot more self-confidence and can get into a lot more clothes.*” Programme participant #1

“I was nervous to go at first, but they were so friendly and the instructor was so attentive, really explaining everything to us and pushing us on. I really enjoy the activities, some are hard but I really enjoy how I feel afterwards.” Programme participant #2

“The man that ran it was so nice and encouraging that I started to feel good about myself and turned a corner so that when I finished the course I felt like I’d overcome something and was able to do it, it was great for confidence and happiness and now I go to classes in the evenings.” Programme participant #3

The quotes above give a sense of the feelings that being a participant of Active Choices resulted in and begin to highlight the outcomes which were achieved for the participants. The increase in self-confidence leading to the ability to join new classes or meet new people, linked to improved physical and mental wellbeing and weight loss is a common theme. However, for some participants the project did not meet their expectations as the quotes below demonstrate.

“I was shocked that it was all 85 year olds, I felt out of place because I wanted to improve through the course but I was limited by the ability of the rest of the group. I was disappointed but I did the whole 12 weeks. I do still exercise now, I try and do every day. I think the referral scheme is a brilliant idea for anyone who is very sedentary, it made me realise I should be exercising a lot more and I try to do this now at least five times a week because I know what a positive impact it has on my mental health.” Programme participant #4
All of the participants who were interviewed confirmed that they felt this type of referral for exercise was a good idea, however common themes which emerged from participants about what did not work well for them related to the timings of the classes, and the variety of the exercise classes which were available.

Active Choices classes were only run during the day which meant for people in employment it was hard to attend the sessions. There was also frustration expressed about the limitation of the types of classes available, mainly circuit training when participants would have liked the choice of a range of classes like dance, aqua aerobics or step.

These frustrations were also shared by the HLW staff with common themes emerging around the regularity of the classes, timings of the classes only running during the day and the range of class type being limited. Staff felt that these factors may have affected the ability and desire of all people who fell within the target age group of 40-74 years to participate.

It is important at this point to note that from the projects inception the provision of suitably qualified cardiac phase IV instructors was known by HLW to be below the requirement of the project. For this reason HLW had ensured that funding for additional posts was included within the original bid. However, despite HLW and Dorset Public Health working closely with sports centres across Dorset Bournemouth and Poole no responses were received from any instructors to be involved in the funded training.

In addition, HLW were aware at the start of the project that the daytime availability of the classes would be a barrier to participants who were in full time employment, but engagement with other clubs across the area who provided a wide range of evening classes was no successful. Instructors in these classes felt that the different motivation for referred participants would be low and impact negatively upon their classes. To try and overcome this issue HLW provided incentives for new services to be run in the evenings and across the wider geography, however even with financial incentives only one provider put on one extra sessions per week.

It was not a viable option for HLW to open the referrals out to providers who did not have the required cardio phase IV training to try and increase the options for participants, this decision was
based upon advice from Dorset Public Health and was adhered to by HLW to ensure continued effective partnership working.

Qualitative Data Summary

A number of common themes emerged from the participant interviews that were conducted and the list below provides a summary of the positive outcomes experienced by individual participants identified from this qualitative data:

- Increased levels of physical activity and ability
- Weight loss
- Improved mental wellbeing: more positive outlook, lower levels of stress and anxiety
- Sense of pride and self-worth as a result of achievements in physical activity
- Increased confidence
- Reduced social isolation: new friendships, support network and sense of community
- Increased sense of independence: confidence to walk

The following quotes are typical of the stories of change that were told during one to one interviews within the identified themes.

**Improved mental wellbeing: more positive outlook, lower levels of stress and anxiety**

“It’s understanding that the older you get your body needs more effort to keep fitter and it’s difficult due to other constraints. It’s difficult to say I’m going to have that slice of time for me. Better mental health and wellbeing has to come from the head first. I have complete grip on everything I’m doing to my body and feel completely in charge of my life and it’s wonderful.” Programme participant #6

“The referral to Active Choices made me feel very positive, it made me want to try and do it, which made me feel better about myself.” Programme participant #7

**Sense of pride and self worth**

“Exercise has been brilliant, the main thing for me is the achievement for physical activity, I do it regularly now and I can play more with the grandchildren which is lovely.” Programme participant #3
Increased confidence

“I was very aware I was overweight and suffering from bouts of depression. I knew I wanted to make exercise a main part of my life. The classes really motivated me and now that they are finished I go to an exercise class at least three times a week, I feel a lot fitter and will hopefully be coming off my blood pressure medication at the end of the month.” Programme participant #2

Reduced social isolation: new friendships, support network and sense of community

“I started off with a ten minute walk and built it up to 5 miles a day. The programme is very good as the whole of my life was completely changed. I was made to feel very welcome and was impressed with what I could do. I’m pretty good and I felt 20 years younger, my self-esteem and confidence have both increased. Before the class it was starting to be an effort to get out of a chair or take the stairs, I felt the next step would be a zimmer frame, and now I can walk miles and miles, fantastic!” Programme participant #8

Although participants did highlight the negative sides of the programme in terms of choice, timing of classes and appropriateness of age group to themselves, no negative consequences were identified by the participants that had directly impacted upon them as a result of Active Choices.
Quantitative data analysis

Quantitative data provides supporting evidence for the stories above and enables estimates to be made of how many project participants experience the outcomes described. The results show improvements in all aspects of wellbeing measured.

However, although the data displayed in the following graphs is based upon questionnaire responses of participants in the Active Choices project at baseline and again at 12 weeks, it must be noted that due to the way in which the data was collected it was not possible to pair the data of the results to clearly demonstrate before and after results.

In addition, the number of completed questionnaires and accelerometry results at baseline and 12 weeks were very small and fewer responses were recorded at 12 weeks when compared to baseline. Seven participants took part in accelerometry data recording, equating to 8% of all participants, and 45 participants completed a baseline questionnaire, equating to 49% of all participants.

It should be noted that the requirement to include accelerometry data within the project was made after the funding bid was approved, and due to the large geographical area covered by the project the resources were not sufficient to allow HLW to be as effective in collecting accelerometer data as they would have liked. In addition the class instructors were not proactive in ensuring that the 12 week questionnaires were completed, and although HLW phoned participants at 7 weeks to encourage this completion it remained a challenge.

This means that drawing any statistically significant conclusions based upon this data alone is not possible, however, it is still useful data in order to help evidence the outcomes that were identified through participant 1 to 1 interviews and this is why the decision was made to include this data in the SROI analysis.

Increased levels of physical activity

Accelerometry data which was recorded from participants during the project showed a total increase in the minutes of activity done by all individuals. This equated to an average increase of activity in bouts from baseline to 12 weeks of 85.5mins per week per participant.

Weight loss

Of the 7 measured participants who had baseline and 12 week weight measurements recorded, (15% of all participants), the average weight loss over 12 weeks in pounds was 10.1lb’s. This equates to a 6.4% decrease in overall bodyweight on average per participant.

Improved mental wellbeing: a more positive outlook

Participants were asked to indicate their level of optimism about the future at baseline and 12 weeks. The results are shown in figure 2 and show that there was an overall increase in the proportion of people feeling optimistic about the future at 12 weeks. In addition there was a shift in the proportion of people feeling optimistic ‘Some of the time’, ‘Often’ and ‘Rarely’ resulting in a
higher proportion feeling optimistic about the future ‘All of the time’ at 12 weeks when compared to baseline.

**Figure 2. Improved mental wellbeing**

![Bar chart showing improved mental wellbeing](image)

These findings are further strengthened through the themes emerging from the participant interviews and the stories of change that were described in the qualitative data section.

**Sense of pride and self-worth**

Participants were asked to indicate how often they had been feeling good about themselves at baseline and 12 weeks. The results are shown in figure 3 and show that there was an overall increase in the proportion of people feeling good about themselves ‘All of the time’ at 12 weeks when compared to baseline. In addition there was a shift in the proportion of people feeling good about themselves ‘Some of the time’ and ‘Rarely’ resulting in a higher proportion feeling good about themselves ‘Often’ at 12 weeks when compared to baseline.

**Figure 3. Sense of pride and self-worth**

![Bar chart showing sense of pride and self-worth](image)
These findings are further strengthened through the themes emerging from the participant interviews and the stories of change that were described in the qualitative data section.

**Increased confidence**

Participants were asked to indicate how often they had been feeling happy or contented at baseline and 12 weeks. The results are shown in figure 4 and show that there was an overall increase in the proportion of people feeling happy or contented at all at 12 weeks when compared to baseline. In addition there was a shift in the proportion of people feeling happy or contented resulting in a higher proportion feeling happy or contented ‘At least once’, ‘Every day’ and ‘On a few days’ at 12 weeks when compared to baseline. The proportion of people feeling happy or contented on most days decreased from baseline to 12 weeks, however this could be as a result of the shift to more people feeling happy or contented ‘Every day’.

**Figure 4. Increased confidence**

These findings are further strengthened through the themes emerging from the participant interviews and the stories of change that were described in the qualitative data section.

**Reduced social isolation**

Participants were asked to indicate how often they had been feeling lonely at baseline and 12 weeks. The results are shown in figure 5 and show that there was an overall decrease in the proportion of people feeling lonely at 12 weeks when compared to baseline. In addition there was a shift in the proportion of people feeling lonely ‘On a few days’, ‘Most days’ and ‘Every day’ resulting in a higher proportion of people never feeling lonely at 12 weeks when compared to baseline.
Figure 5. Reduced social isolation

These findings are further strengthened through the themes emerging from the participant interviews and the stories of change that were described in the qualitative data section.

**Increased sense of independence**

Participants were asked to indicate how often they had been able to make up their own mind about things at baseline and 12 weeks. The results are shown in figure 6 and show that there was an overall increase in the proportion of people able to make up their own mind about things ‘Often’ and ‘All of the time’ at 12 weeks when compared to baseline.

Figure 6. Increased sense of independence
These findings are further strengthened through the themes emerging from the participant interviews and the stories of change that were described in the qualitative data section.

### Making a judgement on outcomes

When deciding on which outcomes to include in an SROI there are a number of factors to consider including the project objectives as well as the views of stakeholders. It is also important to consider whether the outcomes identified in the data should be considered as separate or intermediate outcomes in a chain of events – this is what is meant by the theory of change.

Simplistic chains of events that lead to change in the Active Choices project for individuals can be represented in the diagrams below:

![Diagram of chains of events](image)

Many of the participants revealed both through interviews and weight measurements that weight loss was a significant outcome for them from taking part in the Active Choices project.

For other participants another outcome of importance came as a result of increased levels of physical activity which led them to feel a sense of pride and self worth for what they could and had achieved.

![Diagram of chains of events](image)

These initial chains can then be traced further and identify the range of longer term impacts felt by participants as shown in table 6.

Table 6 shows examples of chains of events leading to longer term impacts from the Active Choices project.

<table>
<thead>
<tr>
<th>Reason for accessing Active Choices</th>
<th>Immediate outcomes experienced Active Choices Project</th>
<th>Outcomes measured through data tools</th>
<th>Longer term impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>At a higher risk of developing CVD</td>
<td>Feeling of being enabled to partake in physical activity.</td>
<td>Physical Activity</td>
<td>Increased sense of self-worth, and increased ability to undertake physical activity leading to improved feelings of health and wellbeing</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Listened to, understood, encouraged, reassured and emotionally</td>
<td>Blood pressure</td>
<td></td>
</tr>
<tr>
<td>Feeling physically unfit</td>
<td>Weight loss</td>
<td>Weight loss</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>Depression</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Getting out more, attending other classes due to increased</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Takes part in a physical exercise class.</th>
<th>Increased levels of physical activity.</th>
<th>Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes part in a physical</td>
<td>Increased levels of physical</td>
<td>Ability to take part</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Depression

- More relaxed as a result of spending time exercising
- Increased self-esteem as a result of doing something for oneself
- Social interaction with other participants of the programme

Wellbeing

- Social Isolation
- Confidence in self and decreased levels of stress

- Lower blood pressure
- Weight loss
- Network of friends able to assist with child-care and provide emotional support
- Improved sense of wellbeing
- Improved sense of independence

A key decision to make is what outcome in the chain should be valued. This has been done by making a judgement about what is important and what is measurable. Every effort has been made to ensure that the decision process is transparent with explanations provided as to why outcomes have been included and why not.

**Improved levels of physical activity and ability**

The interviews that were carried out with the Active Choices participants highlighted that increased levels of physical activity were achieved as an outcome for all. By definition, being referred to an exercise class will inevitably increase an individual’s levels of physical activity and therefore it could be argued that this is not a material outcome, it could be seen as a link within a chain of events leading to those other changes identified by participants. However, the interviews with participants really demonstrated that increasing their levels of physical activity was a significant outcome for individuals who had all known that they should be more active but just hadn’t quite managed to achieve it on their own. It was clearly very important to those participants and for this reason increased levels of physical activity has been retained as an outcome to be measured and valued in this SROI.

“I’m not an exercise person at all, the rest of the family are all very active. I wasn’t looking forward to it and kept looking at the clock when I was at the class and just wanted it over, BUT...................... The exercise has been brilliant, I’d recommend it to anyone.” Programme participant. #3

**Weight loss**

For some participants it was clear from their interviews that weight loss was a significant outcome for them of attending the Active Choices classes. However, it was interesting to note that all
participants who talked about weight loss did not link this to the outcome of improved physical activity, even though it could be argued that in a chain of events improved physical activity would lead to weight loss. The weight loss and sense of achievement for this weight loss appeared to come more from a belief that individuals now had a better control over their lives and had achieved the weight loss as a result of this personal ability, rather than as merely an outcome of the improved levels of physical activity.

“I have lost 3 stone in 6 months and I’m delighted – very very happy!” Programme participant #6

Weight loss appeared to be a significant outcome for participants both from qualitative and quantitative data and therefore it has been included within this SROI.

**Improved mental wellbeing**

Better mental wellbeing was a key theme amongst the participants interviewed, however it was often a difficult outcome to put into words and it could be argued that the outcome of better mental wellbeing is just a link within a chain of events to reduced symptoms of anxiety or increased confidence. The decision to include it as a material outcome in this SROI was made because of the way in which participants expressed better mental wellbeing, which did not include very specific symptoms such as anxiety or isolation; rather a more holistic feeling of being in control of one’s mind, and feeling good about it.

“Better mental health and wellbeing has to come from the head first. I have complete grip on everything I’m doing to my body and feel completely in charge of my life which is wonderful. I have an appreciation of far more things that I had before.” Programme participant #6

It should also be noted that for outcomes such as improved mental wellbeing, reduced symptoms of anxiety, sense of pride and self-worth which could be argued to be similar and a duplication of outcomes that these can be removed from the SROI in the sensitivity analysis to classes whether their inclusion or exclusion significantly alters the SROI for this project.

**Reduced symptoms of depression**

The data collection for this project did ask participants how often they felt depressed, however it was difficult to determine from the data collected through participant questionnaires whether there had been a reduction in the proportion of participants feeling depressed due to the lack of responses at week 12, however a number of the participants interviewed talked about the involvement with Active Choices resulting in a lack of depression for them and how this had impacted upon their abilities to join new groups and believe in themselves more.
It was due to these very strong messages within the interviews that this outcome has been included and valued in the SROI, however it will be one of the outcomes that is amended in the sensitivity analysis as its validity for inclusion could be questioned due to lack of triangulating evidence from participant questionnaires.

The remaining four outcomes that have been included in the SROI for project participants are:

- Sense of pride and self-worth
- Increased confidence
- Reduced social isolation
- Increased sense of independence

These outcomes were all assessed through participant questionnaire responses; however the phrasing of the outcomes did not match exactly to the phrasing of the questionnaires. For example the measures for loneliness in the questionnaires was used as a good indicator for social isolation, feeling good about myself was used as an indicator for a sense of pride and self-worth. It was through the participant interviews that the narrative and stories highlighted these very separate outcomes for individuals and it was for that reason that the decision was made to view these outcomes as independent of one another and of significant enough importance to be included in the SROI.

However, again these outcomes will all be manipulated in the sensitivity analysis to assess their impact on the overall SROI.

**Putting a value on the outcome**

The purpose of valuation is to reveal the value of outcomes and show how important they are relative to the value of other outcomes. All value is, in the end, subjective. In SROI we use financial proxies to estimate the social value of non-traded goods to different stakeholders. By estimating this value through the use of financial proxies, and combining these valuations, we arrive at an estimate of the total social value created by an intervention.

This step therefore involves identifying appropriate financial values for the outcomes experienced by project participants as a result of the project. Values are thus a way of presenting the relative importance to a stakeholder of the changes they experience.
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For some outcomes identifying a value is relatively easy as there are clear, measurable cost savings often with nationally recognised indicators e.g. the savings from reduced GP appointments. SROI also gives values to things that are harder to value so are routinely left out of traditional economic appraisal. There are several techniques available for applying a value to an outcome. For this SROI methods used with stakeholders focused mainly on stated preference and contingent valuation. This approach assesses people’s willingness to pay for a hypothetical thing. Stakeholders were asked in interviews:

- If there was a charge for the service how much do you feel you would be willing to pay?

All 9 of the participants interviewed would have been willing to pay something to attend the service. Perhaps, more significant than the amount of money that participants were willing to pay, was the fact that all of the 9 have continued to access services and facilities to continue to be physically active because the outcomes that they gain from the physical activity are so important to them.

“After 12 sessions I started going independently to the group. It has increased my self confidence, I can go to groups on my own now, I can do hard physical activity and I’m more confident that things can improve and my body can improve.” Programme Participant #2

“It was good value, it makes it much easier and manageable.” Programme participant #4

“The impact of the group wasn’t a great deal for me I don’t think, although it did spur me on to do more exercise, and it is very beneficial for the older age group. I’m still exercising which is excellent. I have a wrist band to prompt me to move.” Programme participant #5

Outcomes identified for wider stakeholders

The outcomes which were identified and included, relate to the participants of Active Choices, HLW staff and the NHS in relation to a reduction in GP appointments. The analysis was unable to accurately identify and quantify wider outcomes from the project which may have impacted upon family members of the Active Choices participants, wider NHS services such as secondary care services or local authority social care services. This was due to the resource constraints of the analysis and also the timescales in which the analysis was conducted in which did not allow for wider investigations to be undertaken with the local acute services, social care providers, and participants families.

One participant of Active Choices did identify that their participation in the Active Choices project had affected their family:
However, there was not a mechanism for following this information up further with other participants and their wider families and social networks to see if this was a recurrent theme. The Active Choices project did not include a group element outside of the exercise classes to bring participants together, and therefore all investigations had to be conducted one to one with participants which required all available resources allocated to the analysis. For this reason only outcomes clearly articulated and identified by stakeholders who could be engaged were included but it is important to understand that these may not have been the only outcomes from the project, particularly with the wealth of evidence from the current literature which clearly illustrates the wider economic impacts and benefits from physical activity prevention projects on the risk of CVD.

### Outcomes and proxy values

The final set of outcomes and financial proxies presented have been identified through data analysis, stakeholder interviews, wider beneficiary survey results, discussion with the Active Choices staff, and colleagues in the SROI team at the University of the West of England, and review of published SROI reports.

<table>
<thead>
<tr>
<th>How would the stakeholder describe the changes?</th>
<th>How would you measure it?</th>
<th>Where did you get the information from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised awareness of the importance of physical activity for HLW staff</td>
<td>Number of staff members reporting a raised awareness of importance of physical activity and participating in physical activity.</td>
<td>Interviews with HLW staff</td>
</tr>
<tr>
<td>Improved workplace wellbeing for HLW staff</td>
<td>Number of staff members reporting improved wellbeing in the workplace</td>
<td>Interviews with HLW staff</td>
</tr>
<tr>
<td>Improved levels of physical activity and ability</td>
<td>Number of participants reporting improved physical activity</td>
<td>Number of days mild, moderate and strenuous exercise recorded at baseline and follow up</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Number of participants reporting a reduction in weight</td>
<td>Weight recorded at baseline and follow-up</td>
</tr>
<tr>
<td>Improved mental well-being.</td>
<td>Number of participants reporting improved mental well-being</td>
<td>Wellbeing Questions recorded at baseline and follow-up</td>
</tr>
</tbody>
</table>

*I live with my husband and son, I think it has made them both aware about putting exercise into their lives as I have been so dedicated to it and they can see the benefits in me looking fitter and better and having good moods.* Programme participant #2
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<table>
<thead>
<tr>
<th>How would the stakeholder describe the changes?</th>
<th>How would you measure it?</th>
<th>Where did you get the information from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced symptoms of depression</td>
<td>Number of participants reporting reduced symptoms of depression</td>
<td>Participant and stakeholder interview. Questionnaires at baselines and follow-up.</td>
</tr>
<tr>
<td>Sense of pride and self-worth</td>
<td>Number of participants who state that attending Active Choices gave them a sense of pride and self-worth</td>
<td>Participant and stakeholder interview. Questionnaires at baselines and follow-up.</td>
</tr>
<tr>
<td>Increased confidence</td>
<td>Number of participants who state that attending Active Choices resulted in an increased confidence level.</td>
<td>Participant and stakeholder interview. Questionnaires at baselines and follow-up.</td>
</tr>
<tr>
<td>Reduced social isolation</td>
<td>Number of participants reporting new friendships and support networks as a result of Active Choices.</td>
<td>Participant and stakeholder interview. Questionnaires at baselines and follow-up.</td>
</tr>
<tr>
<td>Increased sense of independence</td>
<td>Number of participants who report improved independence in their daily life as a result of Active Choices</td>
<td>Participant and stakeholder interview. Questionnaires at baselines and follow-up.</td>
</tr>
<tr>
<td>Less reason to go to the GP</td>
<td>Number of participants who report a reduction in the appointments required with their GP.</td>
<td>Participant and stakeholder interview.</td>
</tr>
</tbody>
</table>

With these outcomes identified to be included in the SROI a financial value must then be assigned to them. Table 8 provides details of the evidence sources that are used as a proxy to assign a value to each outcome.

**Table 8: Outcomes and proxy values**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Proxy</th>
<th>Evidence Source for Proxy</th>
<th>Value per unit £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised awareness of the importance of physical activity for HLW staff</td>
<td>Cost of gym membership/local activity</td>
<td>Gym casual session (Healthy Hearts) <a href="http://www.everyoneactive.com/Uploads/Media/Price_Lists/Easton.pdf">http://www.everyoneactive.com/Uploads/Media/Price_Lists/Easton.pdf</a></td>
<td>£ 2.10/week</td>
</tr>
<tr>
<td>Outcome</td>
<td>Proxy</td>
<td>Evidence Source for Proxy</td>
<td>Value per unit £</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Improved workplace wellbeing for HLW staff</td>
<td>Cost of a multi-component intervention to promote wellbeing in the workplace.</td>
<td>Cost is estimated at £83 per employee per year. <a href="http://www.pssru.ac.uk/project-pages/unit-costs/2014/">Http://www.pssru.ac.uk/project-pages/unit-costs/2014/</a></td>
<td>£83/year</td>
</tr>
<tr>
<td>Improved levels of physical activity and ability</td>
<td>Cost of gym membership/local activity</td>
<td>Gym casual session (Healthy Hearts) <a href="http://www.everyoneactive.com/Uploads/Media/Price_Lists/Easton.pdf">http://www.everyoneactive.com/Uploads/Media/Price_Lists/Easton.pdf</a></td>
<td>£2.10/week</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Cost of weightwatchers/slimming world</td>
<td>Cost of initial 12 week membership to Weightwatchers. <a href="https://signup.weightwatchers.co.uk/SignupVersions/MonthlyPass/StepOne.aspx">https://signup.weightwatchers.co.uk/SignupVersions/MonthlyPass/StepOne.aspx</a></td>
<td>£52.90/3 months</td>
</tr>
<tr>
<td>Improved mental wellbeing.</td>
<td>A course of CBT to build psychological resilience and self-esteem.</td>
<td>A course of CBT to build psychological resilience and self-esteem. A course of CBT may last for 10 sessions at £93 per session <a href="http://www.pssru.ac.uk/uc/uc.htm">http://www.pssru.ac.uk/uc/uc.htm</a></td>
<td>£930</td>
</tr>
<tr>
<td>Increased confidence</td>
<td>Cost of lifestyle coaching package.</td>
<td>Average cost of local life-coaching service – initial 12 week course. <a href="http://www.lifecoach-directory.org.uk/lifecoaches">http://www.lifecoach-directory.org.uk/lifecoaches</a></td>
<td>£750 for 12 sessions</td>
</tr>
<tr>
<td>Outcome</td>
<td>Proxy</td>
<td>Evidence Source for Proxy</td>
<td>Value per unit £</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Reduced social isolation</td>
<td>Cost of befriending</td>
<td>The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is Estimated at £60, based on the lower end of the Cost range for befriending interventions. <a href="http://www.pssru.ac.uk/project-pages/unit-costs/2014/">http://www.pssru.ac.uk/project-pages/unit-costs/2014/</a></td>
<td>£60-120</td>
</tr>
<tr>
<td></td>
<td>Cost of social club membership and attendance at activities</td>
<td>Cost of social club membership and attendance at activities <a href="http://www.spicebristolcardiff.com">http://www.spicebristolcardiff.com</a></td>
<td></td>
</tr>
<tr>
<td>Increased sense of independence</td>
<td>Half an hour domiciliary care visit to the home.</td>
<td>Cost of a half hour visit from a domiciliary carer once a day for 12 months. (Monday – Friday only) <a href="http://www.surecaredorset.co.uk/service.asp">http://www.surecaredorset.co.uk/service.asp</a></td>
<td>£2106</td>
</tr>
<tr>
<td>Reduction in GP appointments</td>
<td>One GP appointment.</td>
<td>Cost of a single GP appointment.</td>
<td>£42</td>
</tr>
</tbody>
</table>

In order to assign a financial proxy to the outcomes identified a number of assumptions had to be made, for example improved levels of physical activity and ability were achieved after 12 session of the Active Choices project. If an individual had not attended Active Choices to achieve this they may have attended a local gym on a casual pay per session basis, so this is the proxy value that has been assigned for this outcome.

A common method of weight loss is to join a slimming club, a 12 week membership to Weight Watchers was assumed to give the same benefit as being a member of the Active Choices project for 12 weeks.
Reduction in GP appointments was assumed on a conservative level to have decreased by one per annum for participants based on the identified outcomes of better mental health, decrease in weight and increase in physical activity. It can be assumed that these outcomes would all lead to better health and less reliance on primary care, therefore an estimate of one less GP consultation may be considered too few but, without any evidence to triangulate this assumption it is appropriate to make a conservative estimate.

The financial proxy’s for these three outcomes are more straightforward to apply and value. However, for those outcomes of increased self confidence, increased self-worth, increased sense of independence, reduced social isolation and reduced symptoms of depression it is less clear what the proxy’s may be and how to value these.

Therefore courses of counselling specifically aimed at reducing depression, or increasing confidence in life skills were applied as it can be assumed that these courses would have enabled the participant to achieve the same outcome.

To value a reduction in isolation it has been assumed that attendance at a local social club would result in the same outcome being achieved through interactions with other like minded individuals with a similar end goal to achieve. To value the sense of increased independence an individual feels it was assumed that the cost of additional help in the home for day to day activities which are often purchased to enable an individual to remain independent at home, would be what it may have cost that individual to achieve the same level of independence.

**Chapter 6: Establishing Impact**

Establishing impact involves identifying those aspects of change within the SROI analysis that would have happened anyway or are a result of other factors to ensure that this is taken out of the analysis. This is important as it reduces the risk of over claiming and means that the results are more credible.

There are some key concepts within this stage:

**Deadweight**

Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage. Since implementation of Active Choices was not planned as a controlled study there is no direct comparison group available to estimate deadweight from. Deadweight was explored in interviews with stakeholders through questions about what would have happened without Active Choices. Findings from these interviews suggested that very little would have changed for the project beneficiaries without Active Choices.

"Would have **Health check and be told need to be more active but wouldn’t be referred to anything and would be left for them to do it alone. Considerably less people would do anything about increasing exercise.**“ HLW employee

"If the **Active Choices programme wasn’t there**["They wouldn’t go because gym or normal exercise classes is too scarey and so they wouldn’t do anything at all." HLW employee]"
An alternative way to calculate deadweight is to look at population level data. The Public Health Outcomes Framework\textsuperscript{22} includes some measures of population wellbeing captured by the Office for National Statistics (ONS) Annual Population Survey. Data about two aspects of physical activity (% of physically active adults, % physically inactive adults) is available for each Local Authority in England for two time periods; 2011/12 and 2012/13. This data suggests that overall there may have been some very small positive changes at a population level (2% increase in active adults); however in Dorset these changes do not appear to be statistically significant.

This population level data, combined with qualitative data from stakeholder interviews suggests that other more practical changes such as accessing other services to increase levels of physical activity would not have happened. It would therefore seem reasonable to apply a deadweight value of 10% which is a similar value to that used in other similar SROI evaluations.

**Displacement**

Displacement is another component of impact and is an assessment of how much of the outcome displaced other outcomes. For example, has the increased involvement in physical activity classes observed in Active Choices participants meant that they have stopped engaging in physical activities somewhere else or doing other things with a social value? Interviews with stakeholders and beneficiaries revealed very limited evidence of displacement. Many participants reflected that without Active Choices they would not have started exercising independently.

With this limited evidence that contact with Active Choices was displacing other activities with a social value the displacement for this project has been calculated at 5% to ensure that any possible activities not identified through participant interview have been factored into the final value of the SROI.

**Attribution**

Attribution is an assessment of how much of the outcome was caused by the contribution of other organisations or people. Attribution is calculated as a percentage (i.e. the proportion of the outcome that is attributable to your organisation). It shows the part of deadweight for which you have better information and where you can attribute outcome to other people or organisations. This stage is more about being aware that your activity may not be the only one contributing to the change observed than getting an exact calculation. Information was gathered from stakeholders about attribution in qualitative interviews.

This is difficult to judge as for many participants Active Choices was the only form of exercise that they were taking at that time, and therefore it is hard to accurately identify attribution linked to physical activity and weight loss. Some participants were attending other classes for slimming at the same time as Active Choices and this may have made a contribution to those weight and exercise outcomes identified in this SROI.

\textsuperscript{22} Public Health England Public Health Outcomes Framework \url{http://www.phoutcomes.info/}
Attendance at or involvement with other organisations was not captured during participant interviews and therefore it is not possible to accurately quantify the level of attribution that may have been present for the wider mental health and wellbeing outcomes measured in the SROI.

In selecting outcomes and financial proxies to include in the SROI great efforts have been made to take into account what proportion of change it would be reasonable to assign to Active Choices alone. Given the efforts to take into account attribution within the proxies themselves, and reflecting on values for attribution used in similar SROI calculations it was felt that 25% attribution is a fair estimate.

**Drop-off**

Drop-off is used to account for the fact that the amount of outcome attributed to the project is likely to be less or, if the same, will be more likely to be influenced by other factors in future years. It is only calculated for outcomes that last more than one year. The HM Treasury Green Book recommends that costs and benefits occurring in the first 30 years of a programme, project or policy be discounted at an annual rate of 3.5%, and recommends a schedule of declining discount rates thereafter.

Since Active Choices provides only a short intervention in the lives of beneficiaries it is difficult to judge how long the impact of Active Choices alone is likely to last. For most outcomes drop-off is likely to be much higher than 3.5% although this will vary between outcomes.

**Calculating the impact**

This stage involves adding up all of the benefits of the Active Choices project, subtracting any negatives and comparing the result with the overall investment.

The impact for each outcome is calculated as follows:

1. The financial proxy given for each outcome is multiplied by the quantity of the outcome to give a total value.
2. From this total value any percentages for deadweight, displacement or attribution are deducted to give an impact for each.
3. The total of all the outcomes is added up to arrive at the overall impact of all the outcomes included.

If all 92 beneficiaries who received an intervention in the first 21 months of the Active Choices project experienced the outcomes that have been identified through qualitative data capture in this SROI then the total impact calculated from this analysis is £248,982.75, which would give a social return on investment that equated to £4.28 returned for every £1 invested.

However, it is not sensible to assume that 100% of participants in the Active Choices project did experience all of the stated outcomes particularly as there is limited quantitative data to validate these assumptions. Therefore, as a starting point for calculating the impact of this project it would

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appear sensible to only apply these outcomes to the 34 participants who completed the whole 12 session of the project as they are more likely to have been able to benefit fully from the identified potential outcomes.

This has been done due to the lack of available matched data from all participants involved in the project, and based upon the common themes which emerged from all one to one interviews and from the limited quantitative data that was available. These assumptions will be tested in the sensitivity analysis in chapter 7 in order to assess what the impact may have been if differing numbers of participants are assumed to have benefited from the programme based upon the number of classes that they attended and the % of participants identifying outcomes achieved.

This would give a total impact calculated of £120,535.33. Full details show how this has been calculated in the impact map below displayed in table 9.

**Table 9 Impact Map Outcomes and Values**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>n</th>
<th>Financial Proxy</th>
<th>Value per beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting increased levels of physical activity.</td>
<td>Active participants in the Active Choices Project for Big Lottery</td>
<td>34</td>
<td>Cost of casual gym membership</td>
<td>£25.20</td>
</tr>
<tr>
<td>Raised awareness of the importance of physical activity in HLW staff.</td>
<td>4 HLW staff</td>
<td>4</td>
<td>Cost of casual gym membership</td>
<td>£25.20</td>
</tr>
<tr>
<td>Improved wellbeing.</td>
<td>Number of HLW staff reporting improved wellbeing.</td>
<td>4</td>
<td>Workplace mental wellbeing intervention.</td>
<td>£83</td>
</tr>
<tr>
<td>Improved levels of physical activity and ability.</td>
<td>Number of participants reporting improved physical activity.</td>
<td>34</td>
<td>Cost of casual gym membership</td>
<td>£25.20</td>
</tr>
<tr>
<td>Weight loss.</td>
<td>Number of participants reporting a reduction in weight.</td>
<td>34</td>
<td>Cost of weightwatchers/slimming world</td>
<td>£52.90</td>
</tr>
<tr>
<td>Improved mental well-being.</td>
<td>Number of participants reporting improved mental well-being</td>
<td>34</td>
<td>A course of CBT to build psychological resilience and self-esteem.</td>
<td>£930</td>
</tr>
</tbody>
</table>
## Chapter 7: Calculating the SROI

This final section which is concerned with the impact and calculation of the SROI summarises the financial information recorded in the previous stages of the SROI to provide the financial value of the investment and the financial value of the social costs and benefits.

### Projecting into the future

The financial value for the impact of Active Choices is shown as £120,535.33, which is based on calculations made from identified outcomes data available for the 34 participants, 4 HLW staff and the wider NHS from the first 21 months of the Active Choices project. This data does not include information about outcomes for longer than a 12 month period after the start of the intervention.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>n</th>
<th>Financial Proxy</th>
<th>Value per beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced symptoms of depression.</td>
<td>Number of participants reporting reduced symptoms of depression</td>
<td>34</td>
<td>Cost of counselling</td>
<td>£180</td>
</tr>
<tr>
<td>Sense of pride and self-worth.</td>
<td>Number of participants who state that attending Active Choices gave them a sense of pride and self-worth</td>
<td>34</td>
<td>Attendance at a community art group</td>
<td>£14.40</td>
</tr>
<tr>
<td>Increased sense of independence.</td>
<td>Number of participants who report improved independence in their daily life as a result of Active Choices</td>
<td>34</td>
<td>Half an hour domiciliary care visit to the home.</td>
<td>£2106</td>
</tr>
<tr>
<td>Reduced social isolation.</td>
<td>Number of participants reporting new friendships and support networks as a result of Active Choices</td>
<td>34</td>
<td>Cost of be-friending service</td>
<td>£90</td>
</tr>
<tr>
<td>Increased confidence.</td>
<td>Number of participants who state that attending Active Choices resulted in an increased confidence level.</td>
<td>34</td>
<td>Cost of lifestyle coaching package</td>
<td>£750</td>
</tr>
<tr>
<td>Less reason to go to the GP.</td>
<td>Number of participants who report a reduction in the appointments required with their GP.</td>
<td>34</td>
<td>Cost of one GP appointment</td>
<td>£42</td>
</tr>
</tbody>
</table>
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However, using the techniques of SROI it is possible to put a value on the anticipated change in future years.

Information collected from participants in one to one interviews suggest that for the majority of beneficiaries positive changes were maintained and even expanded upon. However, there is no quantitative data to validate these findings, and it was only possible to speak to a small sample of beneficiaries. Therefore the longevity of any changes is hard to accurately quantify.

The Active Choices project is a short term 12 week intervention, therefore it is difficult to judge how long the positive impacts will last and what proportion can be attributed to it in the longer term. Other SROI reports have used drop-off values in the range of 10% for wellbeing outcomes, however based upon the feedback from beneficiaries this seems like a very low estimate. This SROI will cap the duration for all outcomes to a maximum of three years and estimates a drop off of up to 50% for many outcomes. These percentages are detailed in the impact map.

**Net Present Value**

Using these assumptions the Present Value of the Active Choices project benefits can be calculated for the first 21 months of the project and subsequent years. Deducting the total input (£63,080) provides the Net Present Value (NPV).

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input (21 months)</td>
<td>£63,080</td>
<td></td>
</tr>
<tr>
<td>Present value of each year</td>
<td>£88,867</td>
<td>£21,352</td>
</tr>
<tr>
<td>Total Present Value (PV)</td>
<td>£120,535</td>
<td></td>
</tr>
<tr>
<td>Net Present Value (PV minus the investment)</td>
<td>£57,455</td>
<td></td>
</tr>
</tbody>
</table>

**Social Return on Investment**

The social return of the Active Choices project is expressed as a ratio of present value divided by value of inputs.

\[
\text{SROI ratio} = \frac{\text{Present Value}}{\text{Value of inputs}}
\]

For Active Choices the ratio is 1:1.91

This means that the analysis estimates that for every £1 invested in Active Choices there is £1.91 of social value created.
It is useful at this point to try and identify which proportion of the overall value produced can be assigned to which stakeholder, or indeed to wider individuals, groups or organisations in society.

The majority of outcomes identified through the analysis relate to value created for the programme participant, the total value for programme participants equates to 98% of the total value produced by the project. 1% of the total value can be assigned to the NHS in terms of money saved through reductions in GP appointments and the remainder of the value split between the funders and HLW in terms of staff awareness of physical activity and improved mental wellbeing. This is illustrated in the pie chart below.

However, it is reasonable to assume that without the Active Choices project the NHS may have had to cover the cost of some interventions for the outcomes identified such as improved mental wellbeing and reduced symptoms of depression. Equally there may have been a component that social care services may have had to fund for interventions to increase independence and reduce social isolation. It would be unlikely that all participants of the Active Choices project would meet the NHS and social care eligibility criteria for an intervention and therefore a conservative estimate of 25% of the value has been applied for four outcomes that could be assigned to either NHS or social care services. For the outcomes of mental wellbeing and reduced depression 25% of this value can be assigned to the NHS as a ROI, and 25% of the value for reduced social isolation and increased independence can be assigned to social care as a ROI.
In this scenario it can be seen from the pie chart that although programme participants remain the main beneficiary with 78.6% of the value generated, social care also benefits from 13% of the overall value created and the NHS with 7.5% of the overall value created.

This is useful information for helping health and social care commissioners to identify projects and interventions which will award them with positive financial benefits.

**Sensitivity analysis**

The calculations above are based on a great number of assumptions. Sensitivity analysis allows these assumptions to be tested to assess the extent to which the SROI results would change if some of the assumptions made in the previous stages were changed. The aim of such an analysis is to test which assumptions have the greatest effect on the model.

The standard requirement is to check changes to:

- Estimates of deadweight, attribution and drop-off;
- Financial proxies;
- The quantity of the outcome; and
- The value of non-financial inputs

No non-financial inputs were included in the analyses. Sensitivity analyses based on changes to other assumptions were undertaken.

**Deadweight, attribution and drop off**

The concept and rationale for deadweight, attribution and drop off have been discussed in stage 4 of this SROI in detail. However, as explained these estimates are based on a range of assumptions which are made based upon the data available from participant engagement and stakeholder
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questionnaires. If these assumptions were altered to a worst case scenario then the impact on the SROI ratio can be assessed. Table 11 illustrates the impact on the SROI ratio that increasing the estimates of these factors would have.

Table 11 Deadweight, attribution and drop off changes

<table>
<thead>
<tr>
<th>SROI Ratio</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deadweight at 50% for all outcomes</strong></td>
<td>1:1.06</td>
</tr>
<tr>
<td><strong>Drop-off at 60% for all outcomes</strong></td>
<td>1:1.78</td>
</tr>
<tr>
<td><strong>Attribution at 50% for all outcomes</strong></td>
<td>1:1.27</td>
</tr>
<tr>
<td><strong>Deadweight at 50% and drop-off at 60% for all outcomes</strong></td>
<td>1:0.99</td>
</tr>
<tr>
<td><strong>Deadweight at 50% and attribution at 50% for all outcomes</strong></td>
<td>1:0.71</td>
</tr>
<tr>
<td><strong>Attribution at 50% and drop-off at 60% for all outcomes</strong></td>
<td>1:1.19</td>
</tr>
<tr>
<td><strong>Attribution, deadweight at 50% and drop-off at 60% for all outcomes</strong></td>
<td>1:0.66</td>
</tr>
</tbody>
</table>

It can be seen that changing these factors to the worst case scenario alters the SROI ratio, so that the social value generated would be £0.66 for every £1 invested. In this scenario the SROI is therefore a negative value, and the investment for the project would not be deemed to be effective in producing a positive gain. However, we can assume from the information and data generated through stakeholder engagement that it would be very unlikely that deadweight, and attribution would equate to 50% each, and that drop-off would be as high as 60%.

Financial proxies

The financial proxies that were used for the outcomes generated through the Active Choices project are subjective. Rationale has been given in previous sections in this report as to why these proxies were chosen, however it is possible that other proxies would have generated a lower outcome value and as such would alter the SROI ratio. Table 12 illustrates the value and quantity assigned to each outcome and in order to explore the sensitivity of these proxy measures the two highest proxies will be replaced with zero in the sensitivity analysis.

Table 12 Impact and value for each outcome

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Impact (quantity times financial proxy, less deadweight, displacement and attribution)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting increased levels of physical activity</td>
<td>£1,486.67</td>
</tr>
<tr>
<td>Raised awareness of the importance of physical activity</td>
<td>£64.64</td>
</tr>
<tr>
<td>Improved wellbeing</td>
<td>£212.90</td>
</tr>
<tr>
<td>Improved levels of physical activity and ability</td>
<td>£1,486.67</td>
</tr>
<tr>
<td>Weight loss</td>
<td>£3,120.84</td>
</tr>
<tr>
<td>Improved mental wellbeing</td>
<td>£54,865.35</td>
</tr>
<tr>
<td>Reduced symptoms of depression</td>
<td>£10,619.10</td>
</tr>
<tr>
<td>Sense of pride and self-worth</td>
<td>£849.53</td>
</tr>
<tr>
<td>Increased sense of independence</td>
<td>£124,243.47</td>
</tr>
<tr>
<td>Reduced social isolation</td>
<td>£5,309.55</td>
</tr>
</tbody>
</table>
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<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Increased confidence</td>
<td>£44,246.25</td>
</tr>
<tr>
<td>Less reason to go to the GP</td>
<td>£2,477.79</td>
</tr>
</tbody>
</table>

The two proxy measures with the highest financial value were:
- increased sense of independence
- improved mental wellbeing.

If these two values are replaced with zero the SROI ratio equates to 1:0.67, which would therefore display a negative return on investment.

**The quantity of the outcome**

Stage 3 of the SROI process is to collect outcomes data. However, not all participants in the Active Choices project could be interviewed due to available resource; in addition not all participants had completed patient data questionnaires. Therefore the quantity of the outcomes was extrapolated from the participant interviews and validated with the information available through participant questionnaires at baseline and 12 weeks.

Again, this means that the quantity of outcomes is based on a variety of assumptions, such as if 100% of participants interviewed experienced the outcomes stated, and this could be validated with positive findings within the patients questionnaires then the assumption was that all people referred into the project who attended all 12 sessions would have benefited with the same outcomes. If only these participants experienced the outcomes identified then the SROI ratio is 1:1.91.

In addition by extrapolating the outcomes identified from the participant interviews and converting these to a percentage of all participants who attended all 12 sessions we can add further sensitivity to the analysis. For example 100% of participants interviewed reported an increased in physical activity and weight loss. 63% reported improved mental health, reduced depression, a sense of pride and self-worth and increased confidence. 50% reported a reduction in their social isolation and 50% reported an increased sense of independence. Only 13% reported less reason to visit their gp. When these assumptions are applied to the model the SROI ratio becomes 1:1.11.

This sensitivity analysis show that when significant changes are made to the analysis the results demonstrate that the range of values that is produced could be from a negative return on investment of -£0.28, to a positive value of £1.91.

**Chapter 8: Limitations, challenges and criticisms, conclusions and recommendations**

**Limitations**

The sampling methodology used in this SROI analysis may have led to the inclusion of bias within the results. All 395 individuals referred to the Active Choices project were included in the assignment of a unique number. These were then randomised to identify a cohort of 100 individuals that included a mix of people who attended all 12 sessions of Active Choices, only some sessions and no sessions.
These 100 individuals were contacted by letter to explain the SROI process and to be invited for interview to inform the analysis. Due to resource limitations it was not possible to contact all those individuals who had been referred to the project but it was assumed that by randomising a sample of 100 from this then any bias in those selected would be reduced to a minimum level.

Only 9 participants identified themselves as available for interview and with such a small sample size it is possible that those individuals who were willing to be interviewed were the ones who had gained the most benefit and seen the biggest change. It could be argued that individuals who had experienced no change may have been less likely to participate in the evaluation and therefore the qualitative results would be an overstatement of the true outcomes experienced by all participants.

However, there is no evidence to confirm this view and it is just as possible to assume that people who did not respond for interview were limited by work or family commitments, or even sporting commitments, as a result of being more active. In this instance the outcomes identified would be an underestimate.

Due to the method of randomisation and self selection of individuals for qualitative data capture, and the time constraints of this SROI analysis the time of one to one interviews was held with individuals at different durations post intervention. These differences in follow up times may have affected the ability of individuals to accurately report outcomes attributable solely to the Active Choices project and re-call of information may have been affected for some individuals. This could have impacted on the SROI by both over and underestimating the outcomes identified.

The process of SROI should include both positive and negative outcomes in its analysis. Whilst there were some negative aspects of the project identified there were no material negative outcomes identified at the individual level. This may have been a limitation of the methodology used. The design and delivery of the Active Choices project meant that there were no group sessions for participants, and therefore the use of focus groups to bring participants together was not deemed appropriate for this project. However, it is possible that individuals may have felt unable to express negative outcomes in a one to one situation which could have been explored in a focus group dynamic. If this is true then the SROI could have been an overestimate.

The number of participants with baseline and 12 month data was small, and for the majority the data was not matched, inevitably this means that the results of the quantitative analysis contain a number of assumptions which lead to a degree of uncertainty. For this reason the main analysis and identification of outcomes was done using the qualitative data and the quantitative data that was available was used to strengthen these findings.

Assigning a proxy value to identified outcomes is a subjective process which can inevitably lead to questions about the validity of the proxies chosen. In order to maximise the validity of the values, assumptions made in this analysis was based upon analysis done in other SROI’s. In addition the outcomes which gave the two highest financial values were removed in the sensitivity analysis to clarify how these were affecting the SROI. In this instance when the two highest outcomes were removed the overall ROI became a negative value.
Information from referring GP practices and the Active Choice exercise instructor’s was limited due to low response rate to survey questionnaires, in addition there was not enough resource available in the analysis to capture information from family and friends of participants. Therefore some of the wider impacts of Active Choices may not have been identified in the analysis, for example the degree to which engagement with Active Choices may lead to family members increasing their own levels of physical activity and experiencing some of the identified outcomes, or of increased levels of confidence in professional groups in dealing with patients at high risk of developing CVD.

**Challenges and Criticisms**

Although no material negative outcomes were identified by stakeholders a number of negative issues were identified relating to the content and delivery of Active Choices by all stakeholders. If these constructive criticisms were assessed and successfully addressed there is potential that Active Choices could generate additional value for the investment made.

The three main challenges identified through stakeholder engagement were:

- Referrals to the Active Choices classes
- Content and variety of Active Choice classes
- Time of Active Choices Classes

**Referrals to the Active Choices Classes**

Referrals to Active Choices from GP surgeries in the area were very low at the beginning of the project and the project operated well below its intended capacity with a low throughput of participants as a consequence. Some of the reasons for this low referral rate were identified within the analysis and related to the low levels of NHS health checks being carried out in the area at a time of wide scale organisational reform in the NHS, but this is certainly an ongoing area to explore for future interventions which rely upon referrals from primary care in terms of involvement with the intervention and effective communications of the benefits to patients from participating by their GP.

**Time of Active Choices Classes**

The Active Choices Classes were held during the day which for some individuals limited their ability to attend. The NHS Health Checks programme is offered to all individuals aged 40-74 years, and this was the diagnostic tool used to identify those at high risk of developing CVD, a group where a large proportion will still be in employment and therefore unlikely to be able to attend a day time class.

“Regularity of classes was a weakness. Classes are no in the evening therefore unattainable for people who work, also commonly at lunchtime which can put people off. Availability of classes is a big problem.” HLW staff
The slow uptake rate of Active Choices at the start of the project may have been a reflection of the timing of the classes, although no data was collected specifically to identify the reasons for limited referrals. Certainly, if the timetable for the provision of Phase IV Cardiac Rehabilitation classes could have been amended to offer those of working age a more convenient time in relation to their employment requirements then the participation rates for Active Choices would potentially have been a lot higher equating to a higher ROI. HLW were aware of this issue from the projects inception and tried numerous ways and incentives to change this, but were ultimately constrained by the requirements of the project and its partners.

**Content and Variety of Active Choice classes**

All classes offered through the Active Choices project were based upon the principle of circuit training and were provided by trained Phase IV Cardiac Rehabilitation instructors. For this reason the style and content of the classes incorporated specific elements. However, for those identified through the NHS Health Checks programme as being at risk of developing CVD, but with no prior cardiac related health condition there was frustration expressed that these sessions were not challenging or varied enough to meet their needs.

“Personally I think it had the potential to be a good programme but could have included zumba and aqua aerobics which would have been good.” Active Choices participant.

“The timing of the class was so difficult and when you get there you feel like you could have been doing something else which was better exercise.” Active Choices participant.

Cardiac rehabilitation is defined by the British Heart Foundation as ‘A programme of exercise and information sessions to help you get back on your feet again after a heart attack, heart surgery or procedure.’ For many of those people identified and referred this was not necessarily relevant and may have affected the low uptake of the sessions offered. The Active Choices project may have received more participants if it had been able to offer a larger number of classes, of varied ability across the specified geographical patch had been available at different times of the day. However, availability of instructors was a limitation for the project and although funding was available to train more instructors there was no uptake of this offer within the area.
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Conclusions

CVD is the leading cause of mortality in the UK, with an overall financial cost to the UK estimated to be £30 billion. National policy frameworks and programmes include aims to reduce premature mortality from CVD and there is clear evidence that demonstrates the benefits of prevention programmes in reducing the risk of developing CVD.

Prevention programmes with a focus on increasing physical activity have demonstrated positive results and there are clear financial benefits to investing in prevention programmes like the Active Choices project.

The qualitative data analysis highlighted improvements of participants of increased levels of physical activity and weight loss but in addition it also identified other outcomes such as improved mental well being, reduced social isolation, increased independence and increased confidence and self-worth.

The data also suggests that participants who attended all 12 sessions of the Active Choices project continued to exercise after this period and have incorporated exercise into their lifestyles.

This evaluation demonstrates the potential of the Active Choices project to reduce the risk of developing CVD in those individuals participating. In addition, it also demonstrates a much wider impact generated amongst the participants equating to a financial return of £1.91 for every £1 invested.

This SROI provides further evidence to support the use of community based physical activity programmes to support individuals to reduce their risk of developing CVD and improve their physical and mental health and wellbeing.

Recommendations

During the course of this SROI study, Healthy Living Wessex went through a process of tendering for a contract to act as a hub for weight management services in Dorset. Unfortunately HLW were not successful in this tender and, alongside the completion of the Big Lottery Fund grant period, the organisation has had to undertake a major review of its viability as a service provider. These recommendations present actions that HLW might want to take forward drawing upon the conclusions of this report. However we recognise that recent developments introduces a considerable challenge for their implementation, and that the audience for these recommendations includes partner agencies both locally and those engaged in the Big Lottery Fund funded SWWB programme.

- To use this report as a tool to demonstrate the value of the Active Choices project model to potential funders and commissioners to improve the physical and mental health of individuals, whilst helping to reduce their risk of developing CVD.

- To investigate appropriate alternative forms of physical activity that can be used to reduce the risk of CVD in the target population of people aged 40-74 which may enable improved uptake and adherence of the exercise sessions.
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- Ensure collaborative partnerships between organisations that deliver physical activity classes within the geographical area to improve the availability of classes for reducing the risk of CVD at times when people in employment are still able to access them in order to maximise uptake within the target population.

- Work with key stakeholders to identify appropriate data capture methodology for ongoing community based physical activity programmes to ensure robust evaluation of future projects can be successfully undertaken.