UNIVERSITY OF GLOUCESTERSHIRE

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BRISTOL CITY COUNCIL

Evaluation of the Bristol Core Cities project

FINAL REPORT

Prepared by Dr Colin Baker and Professor Paul Courtney
UNIVERSITY OF GLOUCESTERSHIRE |

Evaluation of the Bristol Core Cities project

University of Gloucestershire
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Executive Summary

Introduction

The Sport England-funded Bristol Core Cities Project (BCCP) aimed to increase levels of physical activity in three deprived wards within Bristol (Lawrence Hill, Filwood and Hartcliffe and Withywood) by helping inactive people to engage with and take part in physical activity opportunities. The project ran for approximately two years, beginning January 2018 and was targeted at people who were classed as inactive i.e. physically active for less than 30 mins per week. The BCCP sought to establish evidence concerning the impact of activities which sought to help currently inactive people engage with and take part in physical activity opportunities with a view to informing the development of future similar projects. The University of Gloucestershire was commissioned in January 2018 to undertake a summative assessment of the project, conducted between March 2018 and May 2020. This document is the final report of the evaluation

Evaluation objectives and methods

The evaluation objectives were to:

a) establish and implement effective project monitoring systems;
b) determine the impact of the project in increasing the physical activity levels of the target audience.
c) determine the contribution of the project to a) the Government's five strategic outcomes for sport detailed in DCMS' Sporting Future, and b) the Public Health outcome targets identified in Bristol City Council Public Health Priorities document
d) identify key learning from the project that can be used to inform, improve, and make the case for other such projects in the future

A mixed methods approach was developed to investigate the project's success, why and how it helped affect behaviour change, and the extent to which it achieved its intended outcomes. This included three main evaluation components: (1) project monitoring to assess data concerning the project's milestones and targets; (2) Social Return on Investment (SROI) to quantify the value of impacts in monetary terms and elicit rich qualitative data concerning programme processes and outcomes, and (3) physical activity participation via self-reported physical activity using the Sport England Single Item Metric (SIM) incorporated within a broader participant survey. This evaluation was deployed to investigate six intervention projects that made up the BCCP, including Couch to 5k, walking sports, social prescribing and app-based activities. All evaluation methods were approved by the University of Gloucestershire Research Ethics Committee prior to implementation.

Summary of findings

Project monitoring

A total of 424 separate individuals engaged in the BCCP, the mean age being 51.3 years (SD=16.6 years) with females representing the majority (73.6%, n=306) across all projects. Overall, those indicating White ethnicity made up the majority of participants (86.1%, n = 360). A total of 246 (58%) of respondents indicated some form of medical or wider physical and mental health issue. Available data indicated a mean activity time of 543.1 minutes was completed for each project, the range being between 60 and 4,680 minutes.

Social Return on Investment - process evaluation

Greater organisational knowledge and awareness helped to develop links between the BCCP projects and also to create awareness of wider services. This developed and enhanced links and networks which in turn created opportunities to share information, data and knowledge. This helped established a stronger and better offer linked to local resources including leisure centres, sports clubs and national governing bodies (NGBs). Partnership working was perceived as an effective response to challenges posed in the wider political and economic contexts when organisations were able to create and maintain communication around shared interests and objectives. This benefitted organisations by providing a mechanism through which local responses could be devised in order to secure shared outcomes and to use specialist knowledge and skills within other organisations.

The innovative nature of the project was perceived as important for ensuring that intervention projects were sensitive to needs and preferences, and the underpinning behaviour change model provided participants with a tool that helped them understand behaviour change processes and to identify and reflect on changes in the people they were supporting. Being able to devise and test flexible approaches and subsidised sessions allowed organisations to learn how to provide beneficiaries with opportunities that reflected their needs and preferences. In turn, this helped establish a positive experience and stronger connection with the activity that helped participants identify further opportunities. This served to increase the fidelity of the project with respect to providing a clear focus on groups of people with specific needs, whose motivation was fragile, and who were not necessarily catered for within 'normal' community physical activity interventions. The peer support approach was perceived positively in respect of creating closer links between residents which beneficiaries and volunteers shared the benefits of taking part including physic activity, companionship and increased social engagement, although it was not always easy to match volunteers with beneficiaries.

Some aspects of implementation provided a source of challenge for organisations including management and coordination in relation to internal processes whereby stronger central coordination could have further enhanced the overall potential of the BCCP. Some concerns regarding project monitoring and evaluation were also evident, whereby devising and agreeing on the protocols for monitoring and evaluation at the same time as initiating delivery had been challenging and time consuming. This led to some stress and anxiety which was sustained throughout the project's duration and for some, there was the sense that the potential to establish an authentic approach to co-production had been missed and that the ability to influence the parameters of the project had been lost. A perceived lack of consistency in the way relationships and resources within the project were linked together prevented the creation of conditions in which the full potential of the BCCP could be harnessed.

The diversity of stakeholders and their associated projects was potentially problematic in that issues of cooperation, trust and time pressures might have served to limit the ability of projects to embed themselves within the fabric of communities. As a consequence, it was possible that there were issues in realising the BCCP's synergistic potential which relied on the purposeful combining of knowledge, skills and resources of the projects. Similarly, the diversity of participants with respect to fundamental differences between the populations targeted within the diverse BCCP projects made it harder than anticipated to ensure that implementation was effective in terms of supporting and tracking progress, particularly for people who required sustained and bespoke support for longer periods of time in order to establish the foundations for behaviour change

Social Return on Investment – value creation

Central to the SROI methodology is the monetisation of outcomes in order that they can be measured in a consistent way using a common currency. This allows computation of a ratio of benefits to costs as the measure of impact which, expressed in monetary terms, can be set against the initial financial investment. Two principal pathways were conceptualised Via a theory of change exercise which articulated the nature of participant outcomes including individual health resilience and sustainable healthful communities. These included a number of indicators reflecting individual health and wellbeing and organisational changes.

Findings suggested that every £1 invested in the BBCP returned between **£2.17 and £3.14** to society in the form of psycho-social outcomes across the primary and secondary outcome domains, and most notably with respect to health, wellbeing, social isolation, community participation and the motivational attributes of its participants. Subject to the limitations of the study scope and related data collection issues, this represents an indicative minimum 200% return on investment for the commissioners of the BCCP.

(3) physical activity participation

A total of 228 responses were received at baseline (survey one), 56 for survey two, and eight and four for surveys three and four respectively. In total, 42 cases were matched (for Survey 1 and 2, excluding Staying Steady – no follow up data).

The mean number of reported days of physical activity using the SIM for each respective survey (one, two, three and four) were: 1.44, 2.89, 2.38 and 3.00. Extrapolating patterns of activity in the data via more rigorous comparative analyses was not possible given the level of data, but it was possible to observe a positive shift in physical activity levels during the lifespan project.

Recommendations

Recommendations for practice

Recommendation 1:	Provide time for and emphasis on devising data collection frameworks that reflect the context in which project delivery takes place in order to ensure greater understanding, appropriateness of tools, stakeholder buy-in, consistency and cohesiveness of data collection and recording;
Recommendation 2:	Ensure underpinning theories are consistent with the practical realities of project delivery so as to facilitate the acquisition of data that addresses all aspects of the theory, including follow-up;
Recommendation 3:	Establish feedback loops through (1) project steering groups and (2) evaluation cycles in order to develop responsive intervention approaches in order to maximise the inherent flexibility of approaches as adopted in BCCP;
Recommendation 4:	Establish clear and consistent reporting expectations to facilitate discussion of project progress and issues affecting implementation;
Recommendation 5:	Bristol City Council should act as an advocate for innovative intervention approaches in order to further progress their role and place within community health promotion programmes.

Recommendations for research

Recommendation 6: Develop monitoring and evaluation frameworks alongside programme proposals or designs in order to incorporate potential outcomes frameworks and theories of change from initiation in order to support project ambitions and guide project development.

Recommendation 7: Ensure that overarching research methodologies are compatible with complex interventions such as BCCP via thorough pre-intervention planning and mapping of the intervention delivery mechanisms;

Recommendation 8: Establish public involvement groups to assist with the design of intervention programmes and their evaluation from inception through to delivery to maximise data collection potential and minimise the negative impacts of engagement in research activities i.e. respondent burden.

Recommendation 9: Adopt communicative approaches to evaluation management and flexible research designs that incorporate opportunities for practitioners to assist with data collection with support from researchers.

Acknowledgements

Without the willing and enthusiastic involvement of all the participants who represented the organisations within the Bristol Core Cities Project (BCCP) and the people taking part in the activities, this evaluation would not have been possible, and in this respect, we are very grateful for all of them in sharing their support, involvement, time and experiences.

We are also grateful to Jacq Abraham (Bristol City Council), James Watmough (Sport England) and Katherine Moran (Bristol City Council) who were instrumental in establishing and implementing the evaluation together the evaluation team.

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1.0 Introduction

Overview

1.1. The Sport England-funded Bristol Core Cities Project (BCCP) aimed to increase levels of physical activity in three deprived wards within Bristol (Lawrence Hill, Filwood and Hartcliffe and Withywood) by helping inactive people to engage with and take part in physical activity opportunities. Consisting of six discrete interventions, the project ran for approximately two years, beginning January 2018. The project was part of a wider package of support for Bristol's status as European City of Sport 2017, and was targeted at people who were classed as inactive i.e. physically active for less than 30 mins per week.

1.2. The BCCP sought to establish evidence concerning the impact of the project's interventions which sought to help currently inactive people engage with and take part in physical activity opportunities with a view to informing the development of future similar projects.

1.3. The University of Gloucestershire was commissioned in January 2018 to undertake a summative assessment of the project, conducted between March 2018 and May 2020. This document is the final report of the evaluation.

Evaluation objectives

1.4. The evaluation adopted a mixed methods approach in order to investigate the project's success, why and how it helped affect behaviour change, and the extent to which it achieved its intended outcomes. The evaluation objectives were to:

e) establish and implement effective project monitoring systems;
f) determine the impact of the project in increasing the physical activity levels of the target audience.
g) determine the contribution of the project to a) the Government's five strategic outcomes for sport detailed in DCMS' Sporting Future, and b) the Public Health outcome targets identified in Bristol City Council Public Health Priorities document
h) identify key learning from the project that can be used to inform, improve, and make the case for other such projects in the future

Background and context

1.5. Bristol is one of the eight Core Cities, others include Birmingham, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield. Collectively, these cities collaborate at a strategic level to advocate for measures that support transport and connectivity, innovation, business support, skills and employment, sustainability, culture, initiatives that help tackle climate change, industry, and governance.

1.6. Bristol is a growing city, with the population set to increase by 69,300 people over the period 2018-43, to 532,700 representing a 15% increase which is higher than the average forecast for England (10%) and the highest of the eight core cities (Bristol City Council, 2020a). The population of the city is ethnically diverse. For example, it is estimated that there is a Somali population of approximately 10,000 (Bristol City Council, 2020a).

1.7. The health of people in Bristol is uneven compared with the rest of England, being one of the 20% most deprived districts / authorities, with life expectancy for both men and women lower than the England average (Public Health England, 2017; Figures 1 and 2).

Figure 1: Key health indicators - males

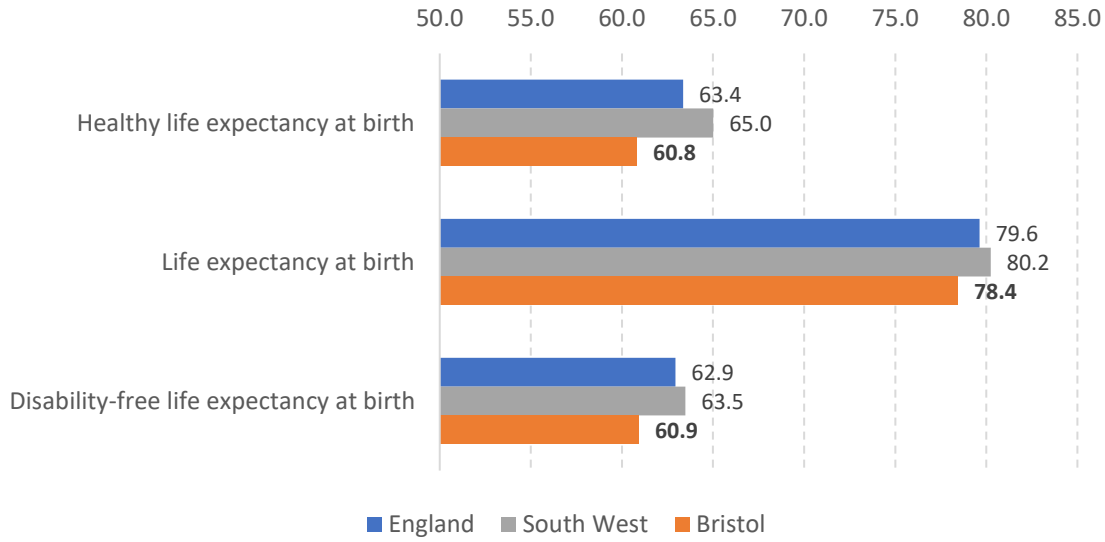
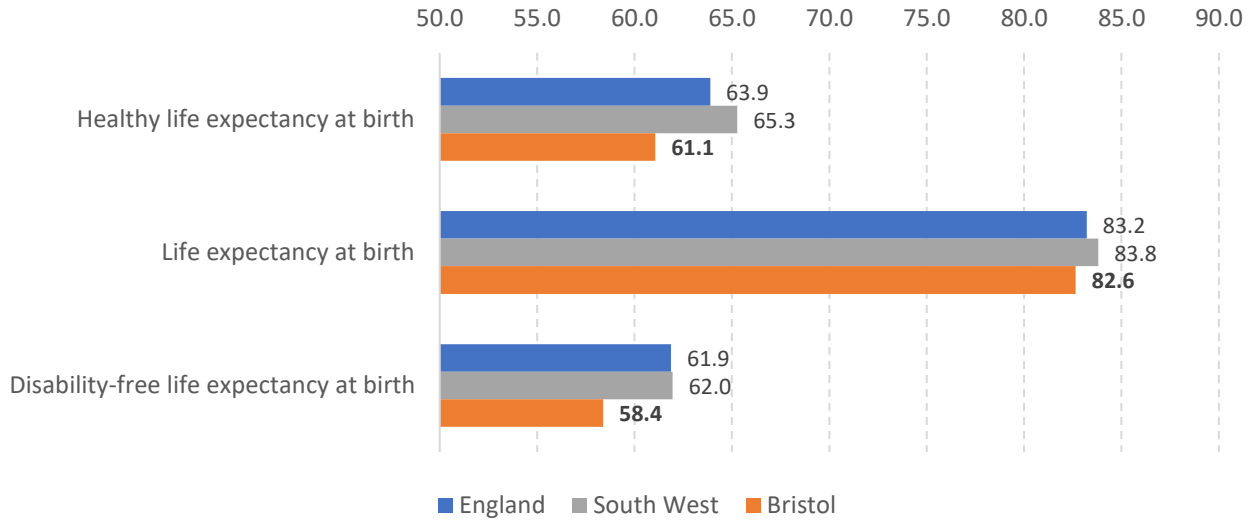


Figure 2: Key health indicators - females



(Source: Public Health England (2020), key indicators from Public health Outcomes Framework for the period 2016-2018).

1.8. Recent data suggests that Bristol has 41 areas in the most deprived 10% in England, three of which are in the most deprived 1% (Hartcliffe and Withywood, Filwood and Lawrence Hill) (Bristol City Council, 2020b).

1.9. At the time of project development, although estimated levels of excess weight and physical activity in adults were better than the England average, Bristol's residents faced a number of health inequalities and there were city-wide differences in experience between local communities and population groups (Sport England, 2017).

1.10. Data indicates that the inequalities gap in life expectancy between the most and least deprived areas of Bristol is 9.8 years and 7.7 years for men and women respectively (Bristol City Council, 2020b).

1.11. Only 56% of people living in deprived areas were physically active, the lowest rates being in parts of South Bristol, including 48% in Hartcliffe and Withywood. Evidence suggested that 25% of Bristol adults were inactive, the lowest amongst the Core Cities and lower than the national average (Bristol City Council, 2016).

1.12. The BCCP sought to understand the needs of the target group (i.e. inactive people) within the three identified wards, and the lifestyle issues and behaviour triggers that affect inactivity, and then design interventions to meet these needs. A separate evidence gathering exercise (Bristol Local Needs Insight report) was undertaken in 2017 inform the development of the BCCP.

1.13. This was consistent with Public Health Bristol's priorities (2017-2019), that focused on prevention and early intervention. Central to this was an imperative to collaborate with partners who have a part to play in improving wellbeing and reducing health inequalities, address the wider determinants of health and engage with communities to ensure their voices were heard (Bristol Public Health, 2017).

1.14. Two key types of intervention were developed, including:

a) Structural intervention – activity which were developed or enhanced to support, guide and lead inactive people to the point when they feel able to engage. Examples of this include social prescribing (e.g. GPs refer people to the service), volunteers, buddies and health champions.
b) Delivery intervention – activity which were developed or enhanced to provide a suitable and appropriate opportunity for inactive people to engage.

1.15 Qualitative research was undertaken by a behavioural consultant in the three wards during the pre-implementation development phase of the BCCP (prior to the commissioning of the evaluation). This identified key reasons for lack of activity and explored ways that these could be overcome, concluding the following audiences as areas of focus for delivery:

a) loss of structured activities, issues of self-direction, focus on college/job
b) busy mums, childcare issues, family focus
c) active social life, need to make physical activity fun
d) used to be good, age/competence, need re-engaging
e) change in body shape, would like to engage but reluctant to make fool of themselves
f) decided to lose weight, frustrated by targets, attracted by physical activity in tandem with diet-based solutions
g) certain groups for whom culture or tradition can affect their participation in sport, for example those who need women only sport sessions.

1.16 These people were perceived to have experienced some sort of life challenge, illness or reduced mobility, but were recovered or living with the condition successfully. However, they were nervous of physical activity because they wanted to protect themselves, not to do damage and had withdrawn from the idea of sport and physical activity.

1.17 In liaison with Bristol City Council, community organisations working within the three identified wards were funded by the BCCP to support the delivery of the project via local

interventions targeting behaviour change within community members that reflected the issues identified above. This involved a range of activities including:

a. Couch to 5k
b. Walking sports
c. Falls prevention
d. Peer volunteers / buddies to support engagement in physical activities
e. Physical activity to relieve chronic pain, increase social interaction and reduce social isolation

1.18 Consistent with Bristol Public Health priorities the activities were broadly underpinned by a social prescribing approach. Social prescribing is a health promotion strategy that seeks to connect people with non-medical health-enhancing opportunities via referrals from General Practitioners, nurses and other primary care professionals (King's Fund, 2017).

1.19 Social prescribing is a broad term that encompasses a range of interventions and contexts for delivery and therefore presents a challenge for establishing evidence concerning their impact and value (Bickerdike et al., 2017; Chatterjee et al., 2017). Given the complexity of real-world settings i.e. communities, in which health interventions are delivered there is a need to understand social prescribing as a system that incorporates a number of individual, organisational and process-based components.

1.20 The pre-intervention qualitative research (Bristol Local Needs Insight report) identified a number of factors likely to influence participation in physical activity in the three wards. These included issues relating to:

- Cost
- Transport
- Access to information
- Access things that support participation for example, apps and incentives.

Furthermore, at the individual level, barriers to participation included memory loss, anxiety, communication challenges and disability.

1.21 Knowledge and awareness were also important in respect of awareness of the health benefits of physical activity, safety of participation and the inclusive nature of activities that people could do. Similarly, attitudes were identified as important drivers and detractors of participation, including motivation, self-efficacy, confidence and fear. Within the wider field of health promotion such factors are understood to interact in complex ways so as to determine individual behaviour.

1.22 The practical implementation of the BCCP intervention activities were supported with the use of the Trans Theoretical Model (TTM) of behaviour change. Viewing peoples' behaviour through the lens of the TTM provides a means of understanding individual behaviour (DiClemente, Prochaska, and Fairhurst, 1991).

1.23 It has been refined over time and applied in a number of contexts, and includes a series of six stages through which people move, although not necessarily in a linear fashion. The six stages articulate processes and actions that influence how people behave (Figure 3).

Figure 3: Stages of the Trans Theoretical Model

(Adapted from Prochaska, Redding, and Evers, 2015).

About the BCCP intervention projects

1.24 Six discrete interventions were established that were delivered by partner organisations within the BCCP project (Table 1). The delivery partners and projects were established during the planning phase of the BCCP project, prior to the evaluation being commissioned. These reflected the needs and preferences of communities in the target areas and the availability of appropriate organisations to deliver the interventions using the BCCP funding.

1.25 The Wildgoose App (delivered by Wesport) was an activity-oriented mobile phone app based on the notion of a treasure hunt. Participants used the app to complete 'treasure hunt' style activities for example, visiting locations within the community that provided an opportunity to explore the local areas on foot and encourage one-to-three miles of walking over a one-to-two hour period. The platform gave full control over the location of hotspots with the game, as well as the questions/challenges that were set at each hotspot. Two wards were targeted including Hartcliffe and Filwood, 50 people within each area.

1.26 The social prescribing intervention (BCC) delivered by Hartcliffe Health and Environment Action Group (HHEAG, since rebranded to Heart of BS13) and Wellspring Healthy Living Centre (Wellspring) sought to enhance the existing social prescribing offer in the three wards including supporting Somali women to increase their physical activity, use physical activity to help reduce chronic pain and reduce the impact of mental and emotional stress via the Positive Minds offer which provided one-to-one support and advice to adults.

1.27 Couch to 5k is a nationwide NHS initiative that supports those who have never run before or want to become more active to increase their physical activity levels. The free-to-access plan provides a structured approach to running over a nine-week period, involving varied schedule of exercise and recovery.

1.28 The Active, Connected and Engaged Neighbourhoods (ACE) project focused on promoting and sustaining physical activity in older people. Via an activator, who discussed the benefits of increased physical activity and local opportunities, participants were supported to increase their physical activity with ongoing support (up to three meetings) to identify and address any challenges to engagement. This project was simultaneously being evaluated by the University of Bath, though completely unattached and preceding the evaluation reported here.

1.29 Walking sport was delivered as part of a wide range of activities by Bristol Sport, a group of charities including Bristol City Robins Foundation, Bristol Bears Community Foundation, Bristol Flyers Community and Bristol Sport Foundation. The project focused on people over the age of 55 years and those with learning difficulties, the aim being to increase weekly participation in physical activity and social interaction via friendly walking activities including rugby, netball and football.

1.30 The Staying Steady falls prevention programme was a strength and balance programme designed to help build strength in order to improve walking stability and reduce the risk of falling. The classes aimed to support people to remain independent and mobile for longer, improve health and to improve confidence whilst reducing the fear of falling.

Table 1: BCCP intervention projects

Activity	Ward	Funded Partner	Delivery Organisation / info	Target N participants
Wildgoose App	Filwood Hartcliffe	Wesport	Wesport	100 (2x50)
Social Prescribing	Hartcliffe Filwood Lawrence Hill	Bristol City Council (BCC)	HHEAG; enhance existing social prescribing Knowle West Health Park Wellspring	180 participants engaged 10 times
Couch to 5K	Filwood Lawrence Hill Hartcliffe	BCC BCC BCC	BCC; 4 courses per year per ward	120 per year for two years = 240
ACE Project	Filwood Lawrence Hill	St Monica Trust University of Bath	St Monica Trust St Monica Trust	60 inactive participants, 24 volunteers
Walking Sports	Filwood Lawrence Hill Hartcliffe	Bristol Sport	Bristol Sport	580 per annum
Falls Prevention Programme	Filwood Lawrence Hill Hartcliffe	BCC	BCC	150 participants - 50 per venue

Structure of this report

1.31 This report is structured in the following way:

- Section 2 outlines the methodology and methods deployed to operationalise the evaluation framework.
- Section 3 presents the main findings of the evaluation consistent with the respective components of the evaluation framework.
- Section 4 provides a discussion of the findings in light of the projects' aims
- Section 5 presents a summary of conclusions and recommendations for research and practice.

2.0 Evaluation Methodology and methods

Overview

2.1. This section outlines the evaluation framework that deployed a range of qualitative and quantitative approaches. Together, these established an overarching evaluation framework that directed data collection and analysis activities.

2.2. There were three main evaluation components (Figure 4):

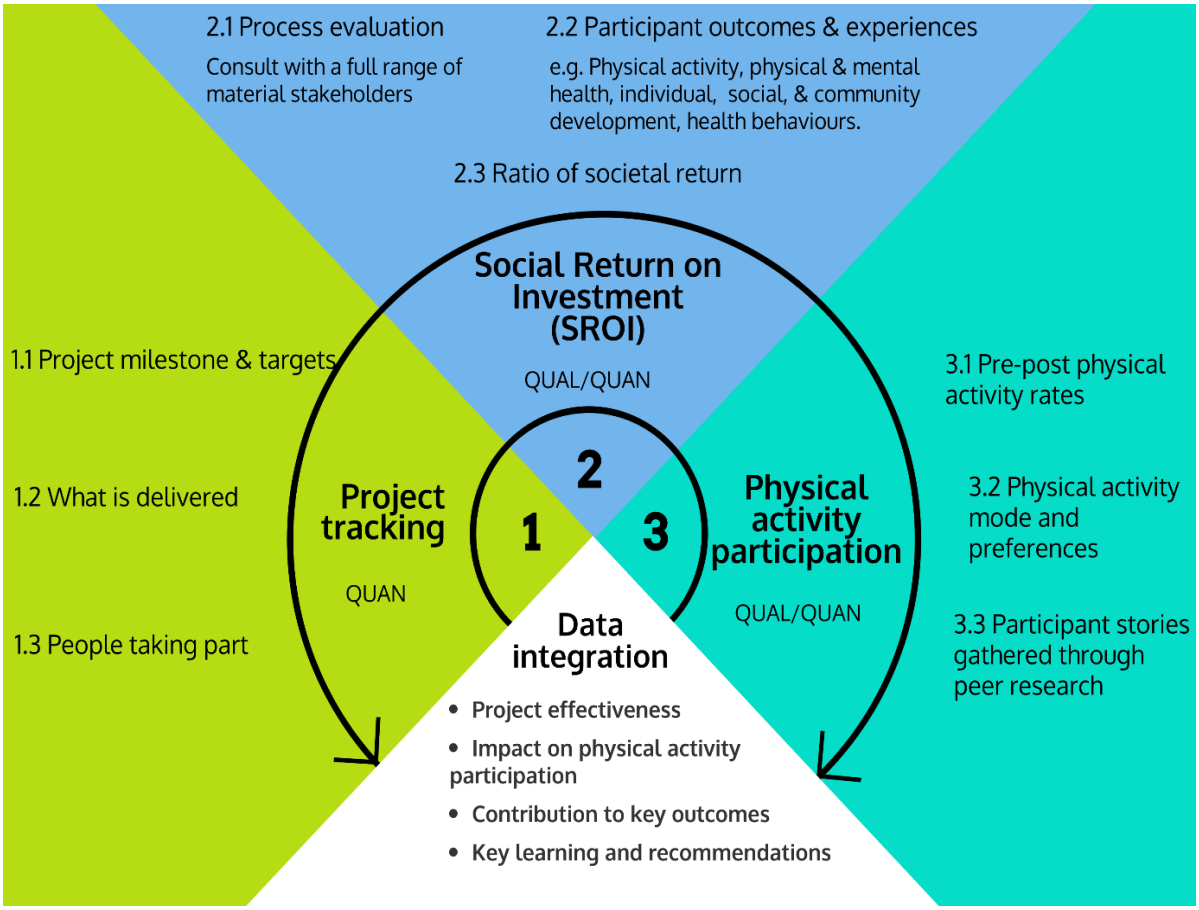
i. Project monitoring
ii. Social Return on Investment (SROI)
iii. Physical activity participation

The framework was underpinned by a mixed methods approach which sought to emphasize the relative and complementary strengths of the qualitative and quantitative methods and in doing so establish a means of developing a comprehensive account of the project's processes and impacts.

Project monitoring

2.3 This component acquired quantitative data concerning the project's milestones and targets, specifically in relation to the interventions being delivered and the people taking part. This provided data concerning how the project performed across audiences, wards, and intervention types, and provided the basis of assessments concerning it effectiveness in achieving its stated targets.

Figure 4: Evaluation framework



Social Return on Investment

2.4. This established the core evaluation component to which the first and third components were joined. Social Return on Investment (SROI) is a government-recognised methodology that measures and accounts for the broader concept of value and measures change in ways that are relevant to the people or organizations that experience or contribute to it (Nicholls et al., 2004).

2.5. Social value not only enables organisations to develop evidence that helps quantify the value of impacts in monetary terms but also to elicit rich qualitative data that provides a more complete picture of programme processes and outcomes (Department of Health, 2010; Harlock, 2013; Nicholls, Lawlor, & Neitzert, 2012).

2.6. SROI methods provide an efficient and effective means of gathering a wide range of data from diverse stakeholders including those participating in the programme and those implementing and managing the interventions. The main principles of SROI are as follows:

a) Involve material stakeholders
b) Understand what changes
c) Value what matters
d) Include only what is material
e) Avoid over claiming
f) Be transparent
g) Verify the result

2.7. The SROI component has a strong qualitative basis which provides means of exploring real world contexts and experiences. For the BCCP individual interviews with those involved in the project were used to explore perceptions, attitudes and experiences concerning, and to provide insight concerning the impact of the project on participant's lives in addition to aspects relating to the implementation and management of the project and learning for future projects. This also included a focus on the intervention processes in respect of decision making and delivery so as to understand the ways in which the project was implemented, and how this impacted delivery.

Physical activity participation

2.8. The third component sought to determine the impact of the project's interventions in increasing the physical activity levels of the target audience. Project participants completed a self-reported physical activity questionnaire (incorporated within the participant survey, see Appendix C).

2.9. The standardised survey was administered on entry to the project i.e. the point at which participants began to engage with project activities, and again at three months after engagement started. A small number of participants completed more than two surveys due the opportunity to collect long term data due to prolonged engagement in the activities.

2.10. The intention was to obtain where possible additional qualitative data in order to understand why and how the intervention helped affect behaviour change. This included a novel a peer-researcher approach whereby a small sample of participants were to be selected for further qualitative feedback collected by their peers in the interventions in which they were engaged. This was to help uncover project impacts through participant stories and to explore how and why, and for whom, the intervention worked or not, and identify key learning to inform and improve other projects.

Summary of methodology

2.11. Taken together, the three components provided a comprehensive evaluation framework to provide a means of assessing the contribution of the project's interventions to the intended outcomes via multiple sources of data (Table 2).

2.12. The evaluation framework provided a means establishing robust evidence that demonstrated the overall success of the BCCP project, as well as areas for reflection and further development or improvement.

2.13. All procedures were approved prior to deployment by the University of Gloucestershire Ethics Panel.

2.14. All data procedures complied with the General Data Protection regulations (GDPR).

Table 2: Summary of data sources

Evaluation component	Description / participants
Project monitoring	Via the Upshot platform BCCP partner organisations provided (1) project attendance data (n=128, 3 organisation); (2) participant survey data (Survey 1 n=247, Survey 2 n=56, Survey 3 n=8, Survey 4 n=4).
SROI	Participant survey data; evaluator notes from BCCP project meetings (n=6); qualitative workshop with BCCP stakeholders (n=12 participants); one-to- one interviews with BCCP project staff (n=10), Appendix F of the BCCP evaluation framework.
Physical activity participation	Participant survey data (SIM quantitative measure and text responses); anecdotal feedback from project staff.

Quantitative procedures

2.15. SROI is an outcomes-focused methodology that seeks to understand and value the most important changes that occur from an organisation, project or programme. It relies on consultation with those who are experiencing change so as to ensures that the full range of benefits to all stakeholders are considered rather than simply focusing on revenue or cost savings for one stakeholder.

2.16. The first task was to establish the scope of the BCCP via a Theory of Change (ToC) exercise. This provided the basis for establishing the SROI framework. The ToC sought to map out the likely outcomes of the programme as perceived by BCCP partners, including BCC and Sport England, via a data collection workshop conducted in April, 2018 at the Bristol City Council offices. The workshop was led by the evaluation team using a standardised template (Appendix A) to explore the perceived short, intermediate and longer-term outcomes of the project.

2.17. In parallel, a BCCP logic model (Appendix B) was established using the Final Insight Debrief (the pre-project qualitative research undertaken by a third party prior to the evaluation), evaluation tender, and the ToC workshop. The model identified factors that influenced the delivery of the project and, together with the ToC, provided the foundation on which the overall evaluation framework was based.

2.18. Discussions were recorded and transcribed verbatim for accuracy. All data were entered into a software package to look for themes using two main steps: Data were explored to identify the main types of outcomes that were relevant to the participants in the short to medium, and longer term.

2.19. All data were entered into a qualitative software data analysis package to identify themes using two main steps. Firstly, data were explored to identify the main types of outcomes that were relevant to the participants' in the short and medium to longer term. Data were explored for conditions i.e. a conceptual way of grouping data about the what, why, where, how, etc. important to the outcomes; This included the identification of an overall theme that represented the main outcome as perceived by the workshop participants.

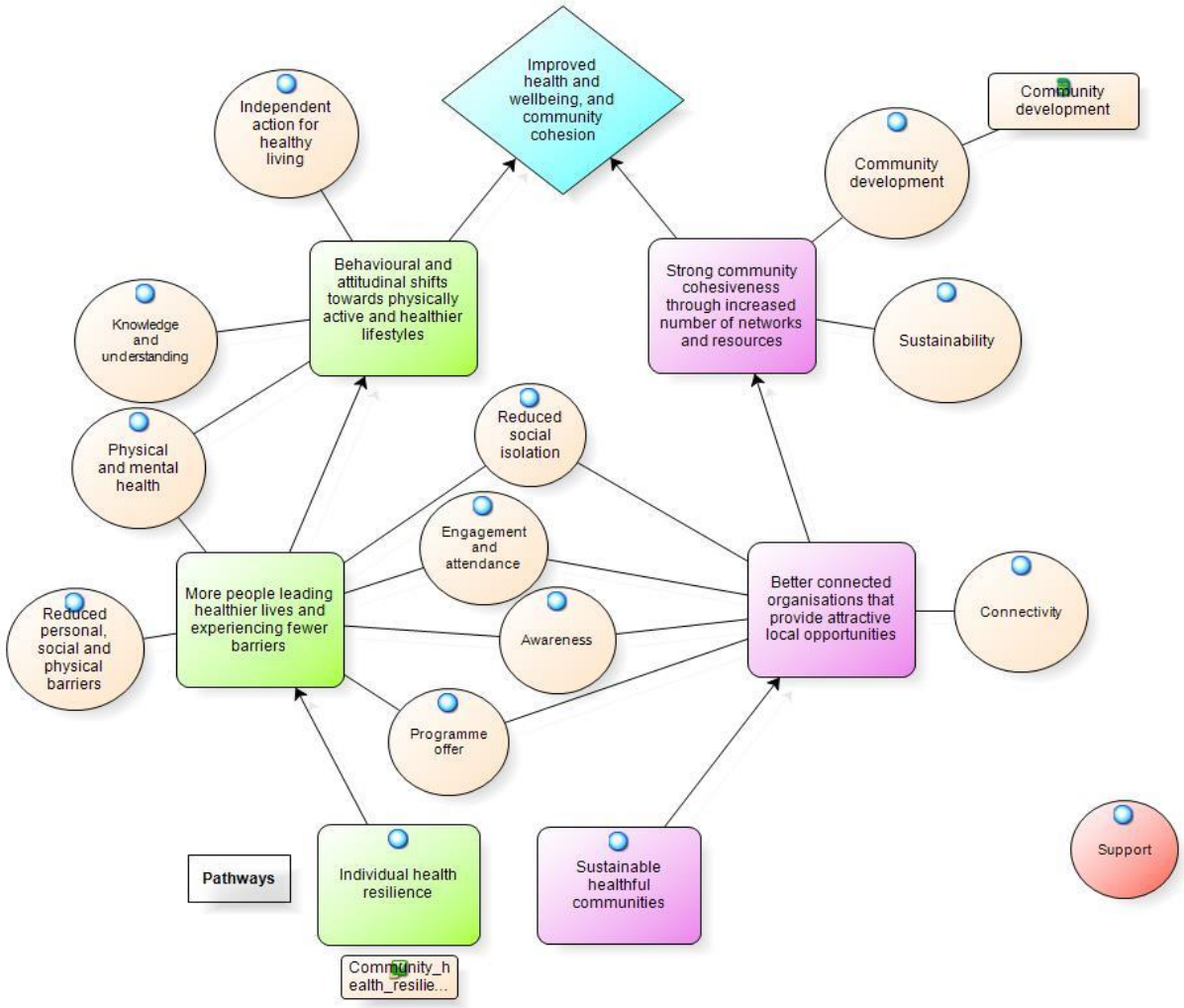
2.20. The overarching theme 'improved health and wellbeing and community cohesion' represented the main outcome of the programme (Figure 5). Necessary for achieving this was progress within two short to medium term outcomes including: (1) more people leading healthier lives

and experiencing fewer barriers; (2) better connected organisations that provide attractive local opportunities.

2.21. Longer term outcomes included: (1) behavioural and attitudinal shifts towards physical activity and healthier lifestyles; (2) strong community cohesiveness through increased number of networks and resources.

2.22. These outcomes were located along two distinct pathways which expressed the nature of what it was that was being sought through the delivery of the project, specifically (Pathway A) individual health and resilience, and (Pathway B) sustainable and healthful communities.

Figure 5: BCCP Theory of Change



2.23. Individual health resilience can be understood as the ability to experience challenge or disruption posed by life's situations and continue engagement in positive health behaviours.

2.24. Sustainable healthful communities refers to places, practices and systems that are conducive to good health and which establish the conditions for stronger and better connected communities.

2.25. The ToC provided a means of understanding what was important to include in the next steps of the evaluation, including the development of the identified that provided a means of assessing changes in the outcomes identified in the ToC.

2.26. Indicators (Table 3) were identified for each outcome which in turn informed the development of appropriate survey questions to evidence the change. In some cases, a number of indicators were combined to create a composite score, especially in the case of well-being outcomes so as to ensure the practical utility of the SROI framework. Question items (primary outcomes) were also included from the Sport England Evaluation Framework as per the requirements of the evaluation specification.

2.27. To check the efficacy indicators the draft survey and corresponding data collection processes was reviewed by the project partners. This ensured an equitable approach to the evaluation whereby those involved in its implementation were able to provide input in respect of its conceptual relevance and practical delivery (April to June, 2018).

2.28. The consultative approach also sought to help embed the data collection process within organisational practices, ensure the practical utility of the survey and to establish a positive and trusting relationship between the partners and the evaluation team.

2.29. A standardised participant survey was developed following the consultation exercise with project partners. This formed a core component of the overarching evaluation framework (Appendix C) which included additional data collection tools to support the evaluation objectives.

2.30. The collection of participant data was facilitated by the use of Upshot, an online platform which helps third sector organisations collect and manage data in order to evaluate impact. The bespoke system was designed and set up during the initial phase of the evaluation during which the survey format and training in its use were supported by an Upshot manager.

2.31. Project staff used the system to input data collected from participants via the use of the BCCP survey as a means of establishing a central database of participant data from across the intervention projects. This was accessed via a control panel by the evaluation team for data analysis purposes.

Qualitative procedures

2.32. Concerning the process evaluation component of the evaluation, a semi-structured interview schedule (Appendix D) was designed in collaboration with the evaluation commissioner to investigate the BCCP processes, positive and challenging factors, general and specific perceptions, and recommendations for the future.

2.33. The primary process evaluation questions were based on the government's Magenta Book (HM Treasury, 2020) and secondary questions were developed to explore aspects identified in liaison with the project commissioner.

Table 3: BCCP ToC indicators

Primary outcomes		Indicator description / information
P1		Physical activity - single item metric (SIM)
	P1a	Wellbeing – life satisfaction
	P1b	Wellbeing – happiness
	P1c	Wellbeing – anxiety
	P1d	Wellbeing – things are worthwhile
P2		Individual Development - self-efficacy
P3		Social and Community Development - social trust
Secondary outcomes		
Pathway A		
A1		Reported change in doing anything can set their mind to; overcoming barriers around family life and commitments; cost; access to information; access to transport; feeling positive about the local area
A2		Reported change in levels of physical activity; feeling healthier; visiting GP less
A3		Reported improvement in mental health
A4		Reported change in feeling lonely; in meeting socially with friends, relatives or colleagues; in feeling supported
A5		% stakeholders who feel that community resources are more accessible to them; member of more clubs or organisations
A6		Reported change in knowledge, awareness and understanding around physical activity; diet; general health
Pathway B		
B1		Percentage organisations and interest groups reporting improved links with other groups and wider community
B2		Reported change in getting involved in local events; becoming or increasing memberships in local clubs/associations
B3		Extent to which believe opportunities will remain (and evolve/grow) (what needs are e.g. money, support e.g. advice), ownership, reminders to go
B4		Reported change in volunteering in the community; participating in community activities; feeling empowered to affect local change

2.34. A series of individual interviews was conducted with local stakeholders representing the projects within the BCCP. Interviews were conducted over the duration of the project and data were supplemented with information recorded at project meetings using researcher notes.

2.35. Interviews took place between January 2019 and February 2020 and were recorded and transcribed verbatim. Information concerning the purpose of the evaluation was provided to all participants in addition to a voluntary informed consent form.

2.36. Data were analysed in NVivo 12 Pro, a qualitative analysis software package using an inductive thematic approach (Braun & Clarke, 2006) which was used to organise, identify and report themes in the data. Interview transcripts were read and re-read and initial ideas noted down following which initial codes were generated across the entire data set and then collated into emergent themes, ensuring that data relevant to each theme was collated from the entire sample.

Evaluation limitations

2.37. Limitations of the evaluation should be considered when reading the conclusions and recommendations of the report.

2.38. With respect to the sample, the limited sample size means that it is not possible to generalise the findings to other projects, locations or populations i.e. that the experiences of those who contributed to the evaluation reflected individuals in similar settings or interventions. Furthermore, whilst the process of data analysis seeks to establish a thematic overview based on the principle of abstraction which elevates data above the individual level, it is recognised that certain viewpoints or experiences may not have been representative of the wider sample.

2.39. It is not possible to rule out the possibility that those with views or experiences contrary to what is presented here were missed. Non-engagement with some of the evaluation activities meant that data were inconsistent when looked at over time with respect to the level and depth acquired. This limits its analytic potential.

2.40. Interruptions posed by the nationwide lockdown as a result of the COVID-19 pandemic were significant. This had the effect of preventing some data collection activities (specifically those that required face-to-face / group interaction, which meant that not all data were obtained. This limited the ability to run a full range descriptive and comparative analyses. As such, the data provided is indicative and provides only a snapshot of participant perceptions.

2.41. With respect to the focus of the evaluation focus, these provided data concerning the experiences of a range of participants including project partners and participants engaged in the activities. However, the data is time-limited and the limitations presented already make it difficult to state with any certainty what the long-term outcomes of the project were. Statements concerning the long-term impact of the BCCP intervention should therefore be understood in view of this issue.

2.42. In contrast, short to medium term impacts felt by those taking part in the evaluation were clear and indicated a positive effect of BCCP interventions for project partners and participants. The data failed to provide a full account reasons for non-engagement though potential reasons for non-engagement / disengagement were discussed with the partners. Future research and evaluation should look more purposefully to explore these issues in detail.

2.43. Considering sources of potential bias, it is important to note that whilst participants who engaged in the evaluation did so of their own volition the influence of peer pressure or of significant others cannot be excluded. Notwithstanding the goodwill shown by participants and the generous giving-up of time to take part, from an evaluative perspective self-selection increases the likelihood that participants take part for a number of reasons which are not necessarily apparent. There is the risk that data represent certain and unseen motivations. The effects of these are potentially disproportionate given the small sample size.

3.0 Evaluation findings

This section is organised in accordance with the overarching evaluation framework presented in Section 2, as follows:

i. Project monitoring
ii. Physical activity participation
iii. Process evaluation
iv. Participant experiences
v. Social Return on Investment (SROI)

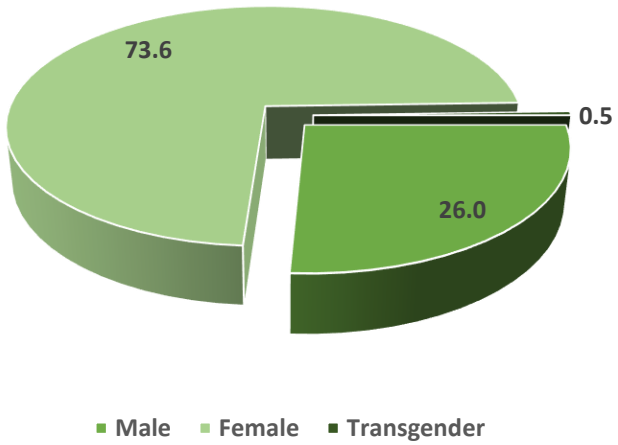
Together, these comprise the SROI component of the evaluation and provide a comprehensive account of the BCCP's impact.

Project monitoring

3.1. Using the available data retrieved from Upshot, a total of 424 separate individuals engaged in the BCCP, the mean age being 51.3 years (SD=16.6 years) with females representing the majority (73.6%, n=306) across all projects. Overall, those indicating White ethnicity made up the majority of participants (86.1%, n = 360).

3.2. Participants represented all local projects (see Tables 4 and 5 for data) and there was an unequal distribution of participants across the projects. The majority of participants were female (73.6%, n = 306, Figure 6).

Figure 6: Gender (whole project)



3.3. In terms of educational background (Figure 7), excluding responses indicating not applicable (n/a), approximately 16% (n = 67), 18% (n = 74), and 17% (n = 71), had completed a university degree, secondary school and college respectively, 7.1% (n = 30) indicating some secondary school education.

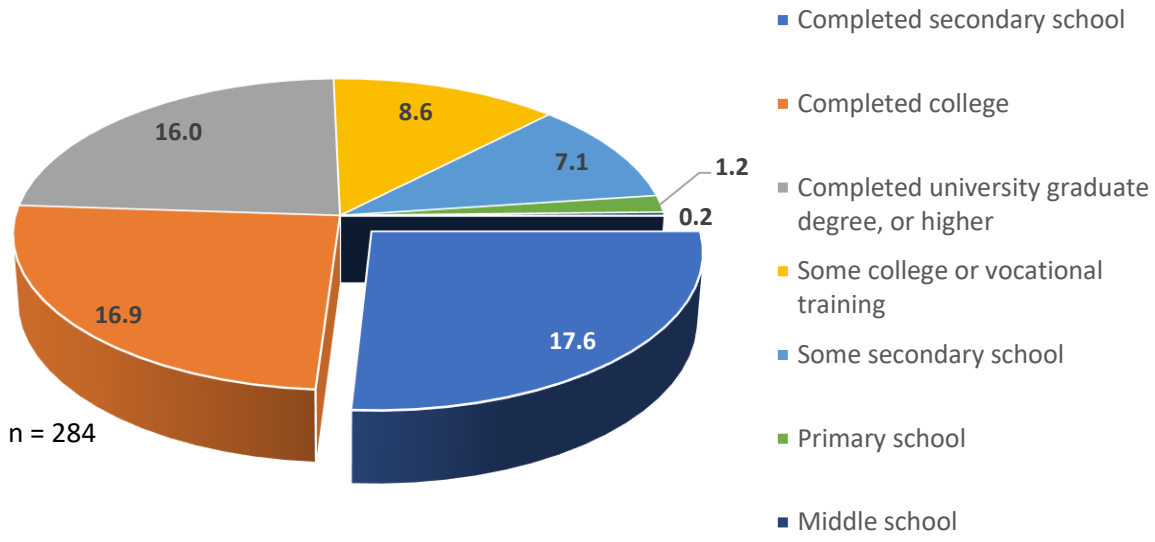
Table 4: Participant age and gender (%)

Organisation	n	%	Mean age (SD)	Males: Females	
ACE Project	13	3.1	73.6 (8.9)	38.5	61.5
Hheag Social Prescribing	38	9.0	52.3 (17.5)	28.9	71.1
Knowle West Health Park	46	11.0	51.9 (15.4)	26.7	73.3
Run4Life Bristol	172	41.0	42.3 (12.4)	5.2	94.2
Walking Sports	30	7.1	66.5 (6.0)	100.0	0
Staying Steady	51	12.1	79.3 (8.1)	35.4	64.6
Wellspring	70	16.7	50.5 (16.1)	34.5	64.5

Table 5: Participant faith, ethnicity and IMD (%)

Organisation	Faith					Ethnicity						IMD	
	None/not say	Christian	Sikh	Buddhist	Muslim	Not say	White	Black	Mixed	Asian	Other	Median rank	Mean % (SD)
ACE Project	38.5	61.5	0	0	0	15.4	76.9	0	7.7	0	0	8195	25 (16.6)
Hheag Social Prescribing	57.9	36.8	2.6	0	0	0	92.1	2.6	5.3	0	0	2094	15.3 (20.5)
Knowle West Health Park	26.7	68.9	2.2	2.2	0	0	86.7	8.9	4.4	0	0	6771	25.3 (22.2)
Run4Life Bristol	56.5	20.9	1.2	0.6	0.6	1.2	95.3	1.8	1.8	0	0	10740	33.9 (25.3)
Walking Sports	80	10	0	0	0	3.3	96.7	0	0	0	0	15081	45.9 (28.3)
Staying Steady	20	80	0	0	0	7.8	92.2	0	0	0	0	10791	36.4 (24.9)
Wellspring	40	22.9	11.4	1.4	14.3	4.3	52.9	15.7	2.9	18.6	5.7	3724	16.8 (11.9)

Figure 7: Participant educational profile – highest level (%)



3.4. A total of 246 (58%) of respondents indicated some form of medical or wider physical and mental health issues. These included:

- Arthritis
- Osteoporosis
- Other Physical Impairment
- Depression
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Coronary heart disease (CHD)
- Back pain
- Vision Impairment
- Cancer
- Anxiety or similar
- Learning Disability
- Diabetes (Type 2)
- Parkinson's disease

3.5. Attendance data were received from three of the projects: Knowle West Health Park, Run4Life and Walking Sports (Figure 8). The minimum number of sessions complete was one, the most 78. A mean of 543.1 minutes activity time was completed for each project (SD = 754), the range being between 60 and 4,680 minutes (or one, and 9.06 hours).

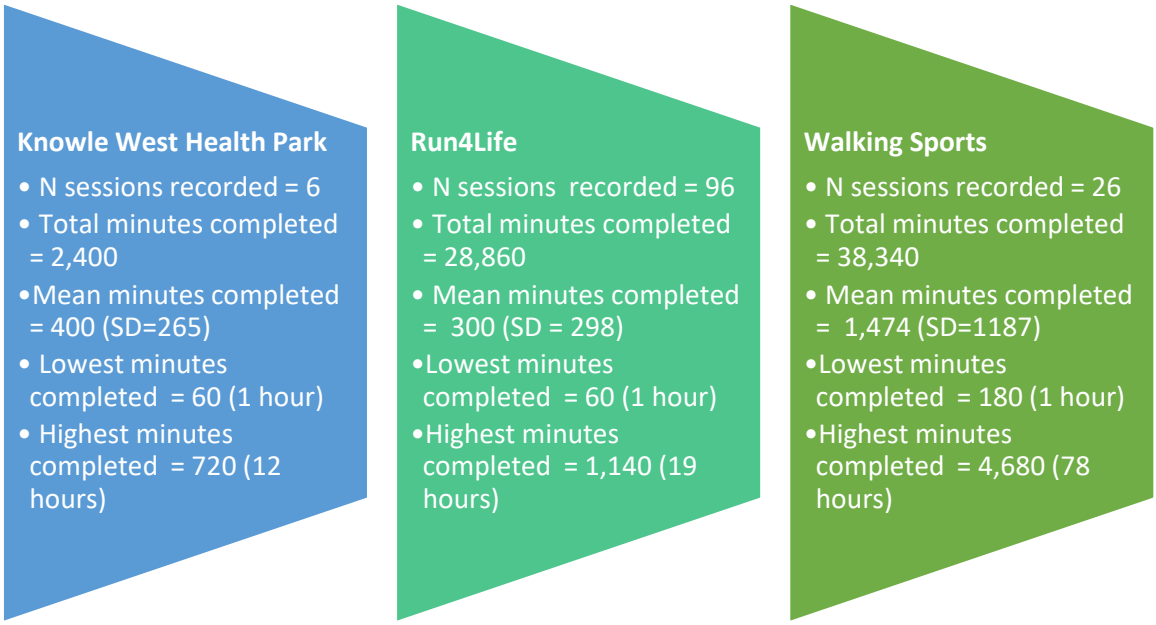
Physical activity participation

3.6. Physical activity was assessed using the Sport England Single Item Metric (SIM) administered within the standardised participant survey. A total of 228 responses were received at baseline (survey one), 56 for survey two, and eight and four for surveys three and four respectively. In total, 42 cases were matched (for Survey 1 and 2, excluding Staying Steady – no follow up data).

3.7. The project staff administered the participant questionnaires according to their respective ability (i.e. coaching respondents through the process to alleviate concerns and to support its completion) and readiness to collect data (recognising that the projects were staggered and did not run according to one pre-determined schedule). Across the BCCP, data collection windows for each survey were as follows:

- Survey 1: 29.01.19 – 25.09.19
- Survey 2: 3.07.19 – 19.08.19
- Survey 3: 15.05.19 – 28.02.20
- Survey 4: 07.08.19 – 13.03.20

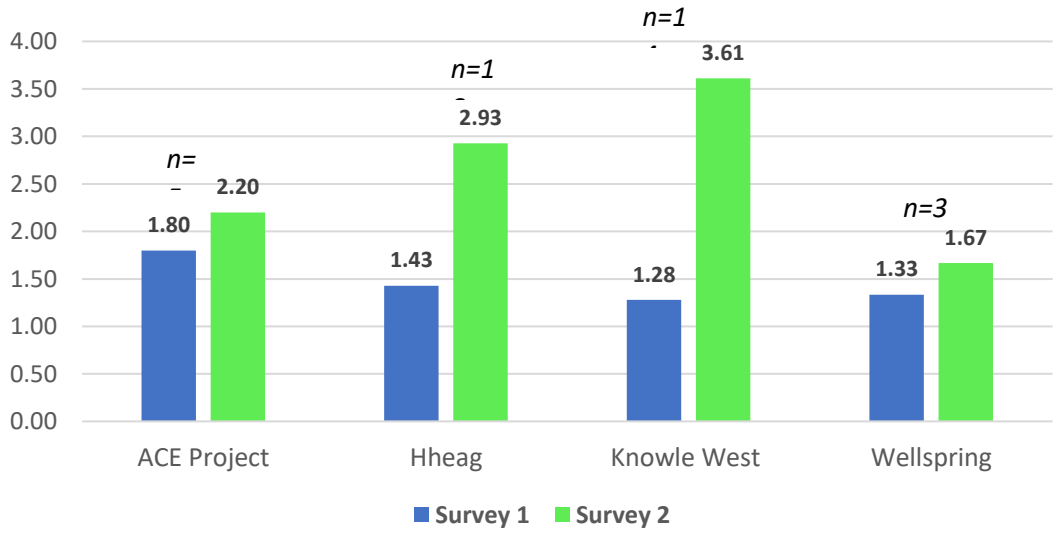
Figure 8: Attendance data



3.8. The mean number of reported days of physical activity using the SIM for each respective survey (one, two, three and four) were: 1.44, 2.89, 2.38 and 3.00. The low responses prevent detailed analysis of the data but provided a crude indication of increased participation over the duration of the project, with reported physical activity approximately 50%[1] higher for survey one than survey two.

3.9. Extrapolating patterns of activity in the data via more rigorous comparative analyses was not possible given the level of data, but it was possible to observe differences in the data for the matched participant cases using mean scores as an indicator of change. This indicated a positive shift in physical activity levels during the project (Figure 9).

Figure 9: Mean number of days physically active for each project (matched cases)



[1] Based on crude differences between means survey scores (i.e. not at the individual level as within the SROI model).

3.10. The mean time difference between participant survey response dates was 136 days, or approximately 4.5 months. This suggested a positive effect of the projects on participants' physical activity levels in the medium term.

Process evaluation

The following sections provide a composite account of the data using the three primary questions which are supplemented with information from the secondary questions, where relevant.

Contextual factors

3.11. Before presenting the findings, it is first important to outline contextual factors identified during discussions with those engaged in the BCCP. Summarising contextual factors described by the evaluation participants is important for highlighting things that influenced project implementation and help explain similarities and differences between organisations (Bryman et al., 1996).

3.12. Contextual factors provide sets of conditions with which factors react and interact and so are important for helping understand what is going on in the data (Corbin & Strauss, 2008) and also establishes trustworthiness within the data with respect to describing issues that may, or may not relate to other situations (Shenton, 2004).

3.13. **Service reductions**: Some respondents highlighted the impact of services that had been reduced or removed for example, smoking cessation, which potentially impacted the ability to fully support behaviour change whereby those in the contemplative stage might not have been able to sustain an intention to act.

3.14. **Partnership imperative**: With respect to a fragmented policy context, a distinction could be made between strategic and communicative partnerships, the former often being encouraged as a response to reduced capacity and increased competition for resources. In contrast, communicative partnerships which focused on the needs of target groups via greater collaboration and which added value to organisations' objectives were seen as less problematic, more productive and more valuable. This was important within an environment where services had been reduced which required responsibility for their provision to be shared across organisations to be effective.

3.15. **Funding**: Availability of funding was a constant concern for many respondents in terms of the level and source which were prone to change frequently over time. Financial instability and unpredictability were sources of concern and provided challenges to the sustainability of local organisations.

3.16. **Target group**: Some participants highlighted the difficulty of working with some population groups, particularly older aged people and those with complex needs who could be resistant to change and difficult to move from a basis of precontemplation to contemplation. Furthermore, beneficiaries of the projects could sometimes need more time than was available within the window of delivery, it being recognised that people needed to be supported through cycles of engagement and disengagement with the projects, and to explore other opportunities to which they were signposted.

Complex and overlapping issues of low mental health, poor physical health, domestic and professional concerns and historical issues were all cited as challenges to successful behaviour

change. Hence, engaging people could be very challenging and it was sometimes difficult to deploy the evaluation tools, align people with suitable opportunities and to track their progress over time.

3.17. **Autonomy**: The fragmentation highlighted above also provided opportunities for organisations to develop approaches that were free from the influence or control of traditional sources of power. This enabled organisations to work with these traditional organisations for example, local councils and governing bodies in a way which helped maintain a focus on target groups without being distracted by bureaucracy.

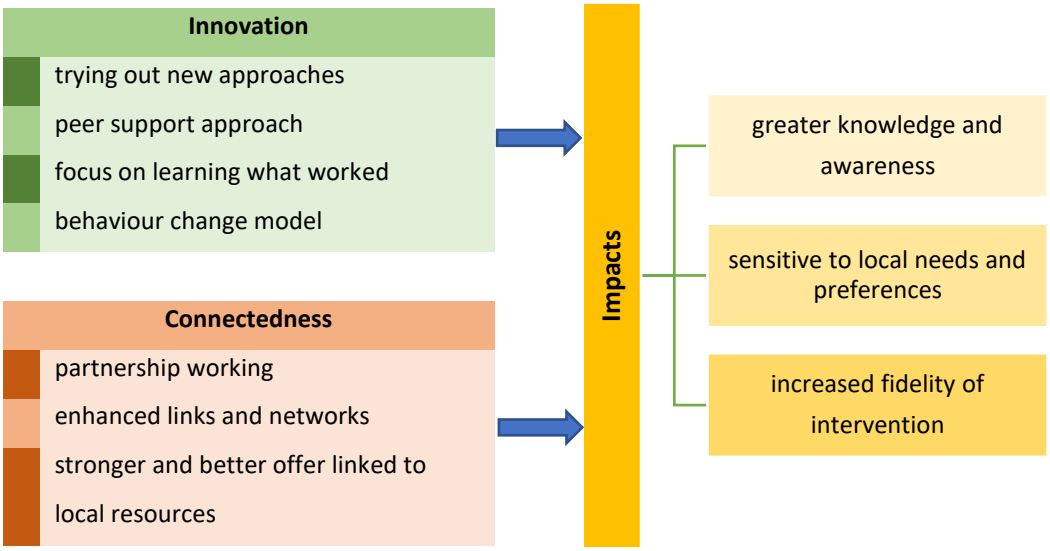
3.18. **Fragility**: Organisations were often lean in the way they were structured. Consequently, the departure of a single staff member could have significant impacts on the ability to deliver services and maintain links with external organisations.

3.19. **Intervention fatigue**: Efforts over time to support people within the targeted communities were understood to have create a potential fatiguing effect whereby the relevance or potential of new interventions was undermined by previous efforts which limited their potential.

What worked well, and why?

3.20. A number of areas were highlighted (see Figure 10). Respondents related that **greater knowledge and awareness** of each other's organisations helped to develop links with the immediate vicinity and also to create awareness of wider services whereby; '*we're beginning to join our dots up and our services better*' across the Bristol area that prior to the BCCP was not well established. This developed and **enhanced links and networks** which in turn created opportunities to share information, data and knowledge concerning communities and, ultimately, additional local opportunities and information (for example, KiActiv), for participants to engage in.

Figure 10: What worked well



3.21. This helped established a **stronger and better offer linked to local resources** including leisure centres, sports clubs and national governing body (NGB) representatives, as typified by the comment; '*…we've created a pathway and reduce the cost link to local school gym, and we've made links with a local GP surgery with their wellbeing group. And so that, in turn, has increased the link with the mental health nurse specialist*.' Consequently, participants were able to harness the potential of the wider organisational landscape by thinking expansively about what connections could be made to support project beneficiaries.

3.22. **Partnership working** was perceived as an effective response to challenges posed in the wider political and economic contexts when organisations were able to create and maintain communication around shared interests and objectives. This benefitted organisations by providing a mechanism through which local responses could be devised in order to secure shared outcomes and to use specialist knowledge and skills within other organisations. This was essential for helping organisations meet their objectives and to demonstrate impact, for example; '*being part of this project, listening to social prescribers and building on the other programmes that we deliver within those wards, we're in the right places, for sure, and it's just piecing the dots together and finding good people that are in the same conversations and trying to achieve similar outcomes*.'

3.23. The innovative nature of the project was perceived as important for ensuring that intervention projects were **sensitive to needs and preferences**. Being able to devise and test flexible approaches and subsidised sessions allowed organisations to learn how to provide beneficiaries with opportunities that were modally sensitive to a range of issues including health status, language, age and cultural traditions. These could include very specific needs, for example; '*...we tend to get more, say, more Muslim and old women who've got anxiety around being with men.*' This sensitivity was also true with respect to the ways in which organisations were able to interact with beneficiaries whereby the inherent flexibility of the project allowed organisations to determine approaches they considered most appropriate to their circumstances (see Appendix F, Case Study 1).

3.24. Furthermore, the experience of **trying out new approaches** allowed organisations to explore barriers to participation and what might encourage behaviour change, for example the Hheag motivation group, 'Ready Steady Go' which was established to look at ways of motivating people to get more physically active, including tips to start moving more, information on local activities and goal setting; '[it] *wasn't that successful because people liked sitting around and chatting about it but not actually doing so much … that's why in the end I ended up [connecting with the gym], and that's successful because I've been able to talk to people, get people's confidence and then 'come along to the gym because I'll be there*.'

3.25. Data indicated a high proportion of participants experienced some form of medical, or mental or physical health concern, some experiencing multiple challenges. These could establish barriers to physical activity and social interaction with respect to low confidence and motivation, pain management and mobility issues. Being able to try out new approaches was therefore important for identifying ways of overcoming these barriers and identifying small steps towards greater engagement.

3.26. This helped establish a positive experience and stronger connection with the activity which, in turn, could help participants identify further opportunities through referrals to other opportunities within the project. Organisationally speaking, a similar benefit was observed in that physical activity became a stronger focus within the delivery plans of some project partners

through the learning and relationships established in the project. For example, Hheag identified that a positive relationship with Wesport had been established which would result in a collaborative approach to the promotion and implementation of additional physical activity resources within the local area.

3.27. This served to **increase the fidelity of the project** with respect to providing a clear focus on groups of people with specific needs, whose motivation was fragile, and who were not necessarily catered for within 'normal' community physical activity interventions. Some individuals within the projects reported adverse childhood experiences and significant physical and mental health challenges. Being able to spend time discussing barriers to physical activity helped people to understand their own needs and preferences and so establish a more realistic basis for behaviour change, as typified in the comment; '*I think the social prescribing angle for the clients we've had, who do have very complex needs and are mostly very vulnerable adults … I'm pretty confident in saying that I don't think any of those clients would have engaged in physical activity without social prescribing service*.'

Using physical activity as a device for addressing mental health issues, including anxiety and depression was perceived as a considerable benefit with respect to establishing a stronger sense of purpose and routine in the face of complex challenges. Without the support of project staff and their peers, it was perceived that people would not have been able to follow through with activities on their own.

3.28. Some participants recognised a sense of being unconstrained by targets which was in contrast to other intervention experiences. The **focus on learning what worked** in respect of project implementation as conceived within the BCCP approach was regarded as innovative and productive, providing space to try different approaches and come up with locally-focused approaches for example, the ACE Neighbours information pack (signposting to local opportunities).

3.29. This helped projects to focus on offering opportunities that reflected people's preferences, to build relationships and offer high levels of tailored support; '*I think people who have got so many different vulnerabilities, whether it's because of very low income or ill health, and don't often take part in this kind of thing for whatever reason, you know … if you're really fixated about targets then that's what you just aim at. And the quality of people's experience … I don't think you do that so much.'*

3.30. This was in contrast to a preoccupation with delivering specific targets and helped participants to find ways of supporting beneficiaries that reflected their needs; '*I've been able to go back to those … send a few cajoling texts, because I know they'll just need a bit more prompting … I've had the flexibility of both time and mental space … to do that*.' Consequently, participants were able to explore ways of supporting people in ways which established greater levels of trust.

3.31. The underpinning **behaviour change model** provided participants with a tool that helped them understand behaviour change processes and to identify and reflect on changes in the people they were supporting. This facilitated conversations regarding behaviour and reflective practice with respect to recognising where progress had been made irrespective of the extent of any behavioural shifts that had taken place. Some participants noted the need for sensitivity with respect to explicitly using the model to guide discussions with participants because of its theoretical underpinnings and apparent complexity. In response, breaking down the relative parts of the model into very simple messages or points for discussion provided a means of

discussing and exploring simple steps for example, creating exercise charts for clients to fix to their fridges (see Appendix F, Case Study 3).

3.32. For some projects involving volunteer time the **peer support approach** was perceived positively in respect of creating closer links between residents which beneficiaries and volunteers shared the benefits of taking part including physic activity, companionship and increased social engagement. Whilst it was not always easy to match volunteers with beneficiaries, and sometimes difficult to manage boundaries and motivation (depending on what was happening in their lives), this approach allowed highly supportive and responsive approaches to develop; '*… it's entirely participant led … it comes from them what they want to do. So that's why there's a variety of things that people have done with the people they've matched up with … we do the training with the volunteers … give them information about what a difference* [physical activity] *makes ... I've got one woman and she's in her 90s … She's gone to an exercise class with her volunteer*'.

3.33. There was evidence that this approach supported positive behavioural changes as people became more confident and knowledgeable about health and local opportunities, as typified by the following comment;

> 'I would say the most successful is the lady that goes to the community café because the volunteer worked really hard to introduce her to those and she was enjoying them … but then one week the volunteer couldn't go and was saying, "oh you go because they'll pick you up" and she didn't go and we thought, oh gosh, she's not going to go on her own. Then I think the volunteer just took a different tack which was basically "I've booked transport for you so if you don't want to go ring them and tell them you're not going", and she then went on her own.'

What went less well, and why?

3.34. A number of areas were highlighted that had provide a source of challenge for organisations and which at times were perceived as problematic (Figure 11). Some of these represented a counterpoint to aspects identified above, whereby some positive elements had a corresponding negative dimension. The themes presented below were not necessarily felt equally but help to identify issues which inform future learning.

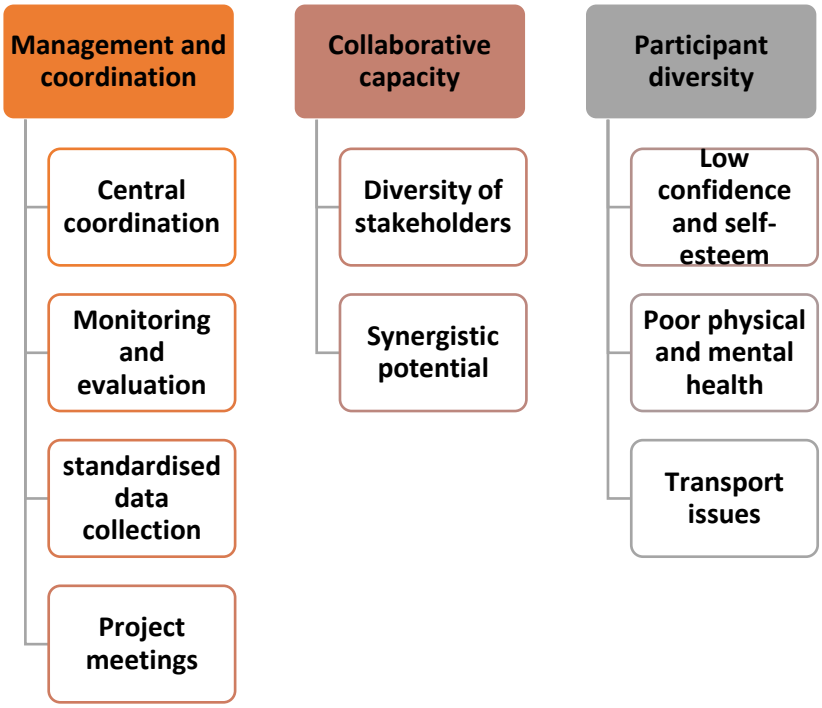
3.35. The theme **management and coordination** preferred to the sense that internal processes were insufficient to ensure adequate implementation of the project. This encompassed a number of subthemes which highlighted the complexities of the BCCP and its novel and innovative approach.

3.36. Some participants felt that **central coordination** could have been stronger. Accepting that there had been a number of additional challenges during the course of delivery, it was apparent that some participants felt that Bristol City Council could have provided a stronger sense of direction in order to create a stronger sense of identity and purpose; '*… it had been a project of lots of mini projects, which really wasn't the intention … this is not a criticism of the Council, because they did not have a funded role to do it, and I think that was the biggest mistake that was made. There needed to be somebody centrally funded to project manage, I think it's naïve to think that a project like this would just happen and all partners would work together.*'

3.37. In this sense, stronger central coordination could have served to bring clarity, where needed, and ensured that partners felt confident and secure in the way that they were delivering their

respective parts of the overall project. Consequently, there was a missed opportunity in terms of maximising the strength and quality of relationships project partners (and by association, their target population groups), some of which were already in place prior to the BCCP's implementation.

Figure 11: Themes concerning what worked less well



3.38. There was some confusion with respect to how the partners' projects fitted together more broadly so that a general sense of cohesion was lacking. Interestingly, this suggested that participants may have expected or desired a stronger BCCP identity which in some respects would have been contrary to the focus on a 'ground up' participant-focused approach with which the project was concerned.

3.39. Concerns regarding **monitoring and evaluation** were also evident. This related to a perceived need for stronger pre-implementation planning with respect to the evaluators and Upshot; '*… in part the initial setting-up phase was probably the most important bit, and I think that was rushed, again, for a variety of reasons. The design phase of it was quite rushed, I think, so I don't think a lot of things were really thought through …* '. Devising and agreeing on the protocols for monitoring and evaluation at the same time as initiating delivery, overlaid by issues of staggered starts for the project, left some participants feeling concerned that they were not recording information properly and that the approach was not modally appropriate for their project; '*Despite the Upshot administrators being happy to make alterations, Upshot did not provide the best way of capturing the information from social prescribing activities … without a consistent approach between the social prescribing services and input from the University of Gloucester it was not possible to develop this into a useful or consistent way of capturing information about social prescribing*.' There were some concerns that pre-project planning had not sufficiently involved the project organisations or their participants, this instead focusing on a fact-finding rather a consultative approach. Consequently, there was the sense that the potential to establish an authentic approach to co-production had been missed and that the ability to influence the parameters on the project had been missed.

3.40. Furthermore, some participants were concerned that the notion of a **standardised data collection approach** could not be sufficiently responsive or flexible so as to allow their project participants to engage in a way appropriate to them, as typified by the statement; '*I feel like some clients have been lost because it wasn't appropriate to you know, put them on the…you know, do the questionnaire right at the beginning and so, I did do some work with them and then they disappear…*' This led to some stress and anxiety which was sustained throughout the project's duration, in part due to the issues identified in the preceding section, and also because of the concern that participants could unintentionally be excluded from data collection activities. For example, some participant was recorded via an organisational chart which was not wholly consistent with the data acquired via the data collection framework. This provided useful data but it did not align fully with the measures adopted across the wider BCCP, making it difficult to explore fully or make direct comparisons.

3.41. **Project meetings** were also identified as an area that had worked less well with respect to the format and expectations that had not been well defined. There was a desire to ensure that information and concerns were fed back appropriately and effectively but that a lack of continuity and consistency was perceived by some to have frustrated efforts to update partners and share information. This led to further anxiety and confusion; '[I was] *anxious that am I doing the right thing, and am I ticking the right boxes … if you go to a meeting and you're asked to report back you feel like you want to be… it felt like the one that I went to which was in ####, some people reported back for a long time and other people for less, you know…*'

3.42. Uncertainty served to undermine confidence in the management and oversight of the project and in doing so created a distraction from the core elements of delivery. Greater clarity and focus from the outset were recognised as important for addressing this issue because it would create clear boundaries for reporting to the funding partner and ensure key information and learning was shared between the projects.

3.43. In addition to management and coordination issues, the theme **collaborative capacity**[2] referred to the notion that, in broad terms, a lack of consistency in the way relationships and resources within the project were linked together prevented the creation of conditions in which the full potential of the BCCP could be harnessed. This related to sharing resources, opportunities and increasing connectivity between organisations; *'I tend to work in quite a collaborative way so I can find out what they're doing and see how I can support them by sharing what they're doing or signposting other people to things that other organisations do … but I don't have that connection with the groups in the Core Cities apart from a bit with the social prescribing*.'

In this scenario, the **diversity of stakeholders** and their associated projects was potentially problematic. It is likely that issues of cooperation, trust and time pressures served to prevent the full potential of the BCCP stakeholders being realised. Indeed, more than one organisational representative highlighted the importance of running interventions over a longer timeframe in order to help relationships establish and mature, and to allow projects to embed themselves within the fabric of communities through connectivity with local organisations for example, scouts, football clubs, gymnastic clubs, schools and children centres.

3.44. As a consequence, one might suggest there was a corresponding inability to realise the BCCP's **synergistic potential** which relied on the purposeful combining of knowledge, skills and resources of the projects, as evidenced by the following comment; '*it might have been quite nice to, you know, people talk about their projects and share … maybe linked up a bit more … I*

[2] The skills, knowledge, attitudes, relationships and procedures that provide the conditions needed to secure collective outcomes (Foster-Fishman et al., 2001; Ratna & Rifkin, 2007).

feel like mine is completely different from the ones that are more about organising exercise groups or ordering, you know, social prescribing.' This indicates that the nature and complexity of the contextual, process and organisational factors identified thus far hindered the creation of conditions needed to support effective implementation of the overall BCCP and to ensure the benefits of the innovative approach were felt equally across all projects.

3.45. On a related point, it was possible to detect a sense of discordance with respect to the overall aim of the BCCP in which not all project partners shared the same understanding of what the project was trying to achieve, or how it was trying to achieve its aims. Here, and accepting that organisational cultures, practices and priorities were notionally different, it was evident that some partners perceived that some of the partners' client groups were not wholly consistent with the ambition of targeting people who were pre-contemplative or contemplative with a view to affecting behaviour change in order to move them closer to, or into, physical activity, as expressed by the following comment; '*… to be working with groups of people who are putting on activities, that's fine; but those are the people who wanted to start and do exercise, but you're sort of missing the point and I feel like the social prescribers were the people who are really working with the client group that I think, supports what we're looking for*…'

3.46. The final theme concerned the **participant diversity** which referred to fundamental differences between the populations targeted within the diverse BCCP projects. Principally, this related to people who required sustained and bespoke support for longer periods of time in order to establish the foundations for behaviour change, often beyond the lifespan of projects that lasted two to three years.

3.47. This made it harder than anticipated to ensure that implementation was effective in terms of supporting and tracking progress; *'it's very much set up for those people who are running activities who needed registers and not really for those of us who were working with people who were pre-contemplative or contemplative.'* Particularly for those working in social prescribing, building trusting with people was a critical part of the behaviour change process so as to create an environment in which people could feel confident to come and go over time without fear of judgement or rejection (for example, see Appendix F, Case Study 1). However, reflecting the challenge of supporting local people who represented diverse backgrounds, needs and attitudes, it was noted by one participant that establishing supportive groups did not always work as expected due to group dynamics and so a shift in focus was required in order to try and maintain engagement.

3.48. Goal setting exercises and more structured support were not always appropriate for those people lacking confidence and motivation, and it was noted that many of these people often ceased engagement in the project. This was due to issues **of low confidence and self-esteem, poor physical and mental health, and transport issues**. However, there was the belief that even though some people may have ceased engagement, they had left the project with a greater level of knowledge and awareness concerning their health, physical activity and local opportunities, which it was hoped would help people to think more about how they could simply move more as part of their daily routines.

3.49. Table 6 provides a composite account of process evaluation data in respect of participant's perceptions of the BCCP's implementation and impact (derived through appendix F of the data collection framework and participant interviews, see Appendix E). Reflecting a social ecological model of impacts, this is arranged according to the organisational, beneficiary (target audience) and community levels.

Table 6: Summary of perceived BCCP implementation and impact

Level	Implementation *How delivery was achieved (training, resources etc..)*	Mechanisms of impact *How the project made a difference? Things that help / don't*	Outcomes / changes *What are the perceived differences?*
My organisation	Variety of 'test and learn' and enhancing normal/standard delivery models to improve reach, recruitment and sensitivity. Focus on social aspects and developing / enhancing links with BCCP projects (not consistent across the project). Some challenges posed by capacity, poor engagement and of supporting people (some with very complex needs).	☑ Establishing better quality links with other BCCP projects and local opportunities and services including GPs, community police and social care. ☒ Lack of BCCP cohesiveness and management issues including reporting and sustainability planning.	Significant organisational efforts with little perceived demonstrable progress, although a number of links have been developed and there is greater awareness, understanding and connectivity between some BCCP organisations and those external to the project.
My target audience *Knowledge, attitudes, behaviours*	Marketing and organisational campaigns with existing clients and local community. Referrals where relevant generally came from a small number of people. Some initial contact and engagement came to nothing.	☑ Tailored and responsive approach; activities that reflected preferences and need; peer support, friendships. ☒ Contextual and lifestyle challenges, overly prescriptive approaches; expectations / commitment concerns of volunteers supporting BCCP; stigma issues.	Lots of competing projects. Difficult to make claims of attribution although there is strong anecdotal evidence concerning differences made and some powerful stories that demonstrate impact and participant progress.
The community *Relationships between organisations, policy changes*	Social prescribing model approaches becoming mainstream; collaborative approaches are being emphasised and actively encouraged; closer focus on community spaces and using space creatively.	☑ Familiar and well-regarded local community spaces; multitude of other providers in the area increases collaborative capacity to support people (although there is a need to ensure that organisations do not compete for the same segments). ☒ Lack of funding to account for full cost recovery and unforeseen costs of delivery; larger organisations' approaches to contracting makes it challenging to account for diversity of smaller local organisations and specific issues within small geographical areas.	Slowly building links between organisations and across areas of need. Greater sharing of knowledge and information and connecting of people and places (social media essential); improved alignment between organisational goals and objectives. Increasing professionalisation of Social Prescribing approaches is leading to greater adoption by larger organisation who are able to provide at lower cost than smaller local independent organisations, and so are more appealing to commissioners. This potentially excludes established local organisations who are embedded and with years of experience, trust and knowledge of the community.

Participant experiences

3.50. The following data are derived from the analysis of participant surveys and interviews conducted by the ACE Neighbours project directly with participants. In addition, four case studies are provided by the Hheag project are provided in Appendix F. These further bring to life the complexities of people's lives and the impact of work undertaken within the parameters of the BCCP to support behaviour change in the targeted areas.

3.51. There were some stark statements regarding what life would have been like without the project. Whilst the effects of participation were not felt equally by all those responding to the survey it was clear that the impact should not be underestimated, not least from a mental health perspective to which the following statements related:

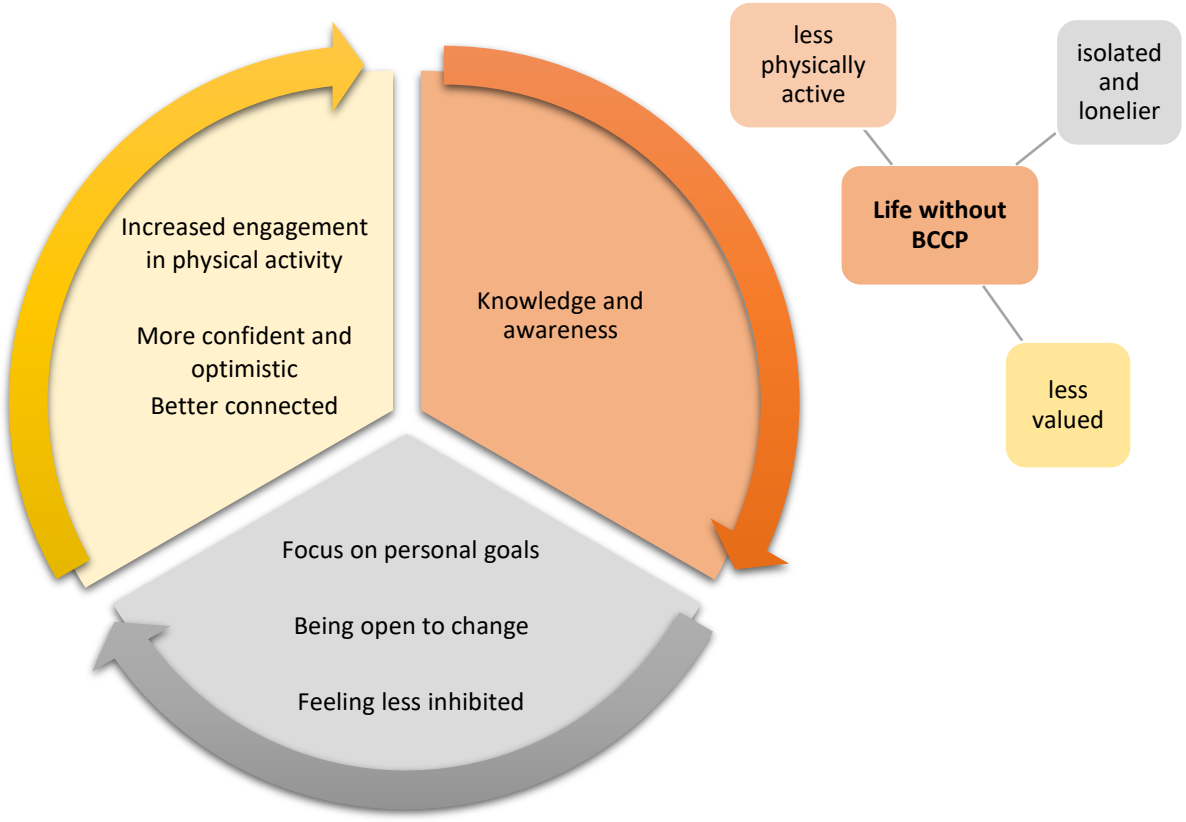
- Possibly no life at all. I could not cope, now I'm starting to cope a bit
- I suspect I would still feel stuck and would be overwhelmed by it all
- I would have still been down a more unhealthy path, stuck and feeling sad, becoming more unhappy and depressed.

Overall, statements suggested that people would have been **less physically active**, felt **less valued** and would have been more **isolated and lonelier**, as encapsulated in the following:

- Lonelier, more sedentary, I would feel less useful/valued
- I would still be sat at home, not having lost any weight
- most likely feeling as very depressed instead of moderately.

3.52. The responses indicated a clear impact of taking part in the projects (Figure 12) including **increased engagement in physical activity** and getting out and about more frequently; '*I don't think I would be as active. I am more aware of moving about more*.'

Figure 12: Impact of taking part



There was also a sense of being **better connected** through greater opportunities that had a strong social element which helped respondents to meet new people, as demonstrated by the statements;' *I do more and am less sedentary. Enjoying meeting new local people'* and *'Through going to the community café I now know that I can go anytime and bring a friend*.'

3.53. A corresponding greater **knowledge and awareness** of facilities in the local area was also evident. This helped establish the conditions in which respondents could understand and explore opportunities which reflected their needs and preference; '*The program is a gateway. As a result of this program I am exploring other physical, social and other activities that promote my mental wellbeing, which I would not have explored on my own*.' (see Appendix F, Case Study 4) Indeed, it was evident that small changes in knowledge had clear impact with respect to helping people move through the early stages of the behaviour change model (see Table 1); '*that little bit of knowledge has had a significant impact on how I view my physical activity*'.

3.54. Based on the responses received it was evident people had been able to feel **more confident and optimistic** through the projects, as highlighted by the statement; '*I wouldn't have as many things to look forward to and put in my diary and I wouldn't have got to meet so many local people*'. For some, this had the added benefit of leading to further opportunities to interact, specifically through taking up volunteering opportunities as a means through which the benefits of increased social interaction and physical activity. In this respect one can conceptualise a journey on which respondents had embarked due to their engagement in the projects which led them to seek further opportunities, as typified by a social prescribing respondents; '*Through social prescribing, I have had lots of opportunities to join various courses or groups, which I may not have been aware of previously*' and '*If I hadn't joined the program, I wouldn't have thought about joining the walking group and so would not be participating in any form of physical activity*.'

3.55. Respondents indicated feeling more confident, positive and able to **focus on personal goals**. It was apparent that for some people the project had significant effects on the way they thought about themselves and had provided a renewed sense of awareness, for example; *The group has made me think more about myself instead of trying to please everyone else*.' This sense of empowerment was echoed by another respondent who stated that; '*knowing what I want to aim for in my life, I understand that I am improving myself for me and not others or what they think - that's their problem.*' Hence, would could infer that participation in the projects helped to unlock potential in respect of identifying and pursuing positive behaviour in the future in terms of **being open to change** and **feeling less inhibited**.

3.56. For some, participation in the project had clearly provided the initial step from precontemplation towards contemplation; '*I needed that push forward, as I didn't have any get up and go in me*' so that people felt capable of taking steps to become more physically active and to engage in wider services that supported through helping people address other issues. In turn, this provided a sense of achievement which served to act as a source of motivation for further engagement, as typified by the statement; '*if I hadn't been involved I don't think I would have valued my efforts to be active as much as I do now'*. This could necessitate intensive support from organisation in order that people felt able to take a first step towards more regular physical activity (see Appendix F, Case Study 2), and highlights the importance of the quality of relationships between projects and their beneficiaries in providing the basis for action.

Social Return on Investment (SROI)

Material Stakeholders

3.57. The first task in assembling the SROI model was to identify material stakeholders, or beneficiaries, for each of the outcomes. As previously mentioned, non-engagement with some of the evaluation activities – compounded by the prevention of data collection activities as a result of the Covid-19 pandemic - means it is likely that the scale of the evaluation data collected is not a true reflection of the material impacts that arose through the programme.

3.58. For the purpose of producing impact estimations a scenario-based approach was taken, based on estimates of participation in the BCCP, informed by the wider evaluation data and consultation with programme officers. These estimates were deemed to range from between 45% and 65% of the original participant targets detailed in table 2. Thus, for the purposes of the SROI model it was estimated that between 861 and 1,244 stakeholders materially benefited from the programme.

3.59. Producing SROI estimates based on inclusion 45%, 55% and 65% of target beneficiaries in the SROI model allowed the Benefit-to-investment ratio (BIR) to be articulated as falling within an upper and lower confidence range of benefit estimates.

Investment in the BCCP

3.60. To compute a realistic ratio of benefits to investment it was important to gain an understanding of the nature and scale of inputs and investment in BCC, taking into account grant funding along with any additional sources of investment such as un-funded staff time or any in kind contributions such as meeting space or subsistence.

3.61. In this case estimating the investment side of the SROI model was relatively straightforward. The original Core Cities grant of £295,000 was supplemented by a further £20,000 invested in the BCCP by Bristol City Council - comprising expenditure of £15,000 on the Upshot data base system and an estimated £5,000 on meeting space, T&S and misc. sundries. Total investment in the BCCP was therefore estimated to be £315,000.

Measuring distance travelled in the outcomes

3.62. As described in Section 2, data from the self-completed surveys was used to evidence change in the outcomes revealed through the Theory of Change (ToC) and to populate the SROI model with proportional measures to establish the impact of the BCCP. Where relevant the 1-5 scales were standardised into proportional measures to conform with the requirements of the SROI model[3]. Indicator values for the parsimonious set of 12 outcomes are given in Table 7, with self-reported measures of Distance Travelled in each of the outcomes expressed as a percentage.

3.63. As the distance travelled data in Table 7 illustrates, the BCCP produced positive self-reported distance travelled values across all of its primary and secondary outcomes, with the positive impacts on physical and mental health, social isolation and the motivational attributes of participants especially notable. While this is solid evidence of the power of the BCCP in affecting material change for its participants, the relative consistency in change magnitude across the

[3] Scale data was transformed into an appropriate functional range of 0-1, whereby scaled variables were transformed in the form (X-min[X]/(max[X] – min[X]). This produced a transformation of the ordinal codes 1 through 5 (i.e. Strongly Disagree through Strongly Agree): 1=0; 2=0.25; 3=0.50; 4=0.75; 5=1.0.

outcomes is also testament to the robustness of the evaluation methodology. Nevertheless, the relatively small sample (54) from which complete distance travelled data was collected at two distinct points in time – itself a reflection of the non-engagement and Covid-19 disruption as previously mentioned – should be borne in mind when interpreting the benefit estimates.

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Table7: BCCP SROI Outcomes, indicators and Distance Travelled values

Pathway	Outcome	Indicator / Composite Indicator (All relate to self-reported change unless indicated otherwise)	Distance Travelled* (%)
Primary Outcomes	Increased physical activity	Number of days a week with 30 minutes or more of physical activity	+24
	Improved mental health	Feeling anxious; Feeling on edge; make mind up	+12
	Improved personal well being	Feeling satisfied with life; Feeling Happy	+5
	Improved self-efficacy	Feelings that personal goals can be achieved; Feelings that life activities are worthwhile; make mind up	+19
	Increased social trust	Feeling that most people in the local area can be trusted; Having support in a time of crisis	+12
Secondary outcomes - A	Improved agency and motivational attributes	Being able to do most things (I) set (my) mind to; Feeling able to stay healthy	+16
	Knowledge and awareness of physical activity	Positive beliefs about physical activity; knowledge about physical activity; reduced financial and temporal barriers to physical activity	+16
	Improved physical health	Having a lot of energy; perception of good / very good health; not visiting a GP regularly	+14
	Reduced social isolation	Not feeling lonely most of the time; often meeting socially with friends/relatives and colleagues; Having support in a time of crisis	+16
	Increased community involvement and participation	Being a member of clubs /associations; regularly participating in the community	+10
Secondary outcomes - B	Improved organisational links and partnerships in the local community	Qualitative estimate of the proportion of organisations perceiving improved or more purposeful links with other organisations	+50
	Increased volunteering and community empowerment	Regularly volunteering in the community; Feelings of being able to influence decisions in the local area	+4

*n= 54

Accounting for Deadweight and Attribution

3.65. Accounting for deadweight and attribution is an important element of the SROI methodology. Deadweight relates to the extent to which outcomes would have happened anyway without the BCCP while Attribution refers to the extent to which observed and anticipated outcomes can be attributed to the programme as opposed to other projects, activities or initiatives. Both measures are represented as proportions in the SROI model and were informed through the collection of data in three stages: the ToC workshop and subsequent partner meetings; the on-line surveys, and in the case of deadweight, secondary data relating to salient metrics on health, education and community activity.

3.66. Standard SROI survey techniques were employed to gather primary evidence of attribution through the participant survey. Context and outcome-specific information relating to deadweight was gathered through a series of open questions with responses used to moderate the proportional estimates produced through the analysis of secondary data. Respondents were asked to rank the extent to which observed changes occurring within the principal outcome groups could be attributed to the BCC projects as opposed to other projects or activities, using a Likert scale similar to that used for evidencing the outcomes.

3.67. Responses demonstrated that 55% of self-reported change could be attributed to the primary outcomes, 50% to secondary (A) outcomes and 37% to secondary (B) outcomes.

3.68. It was equally important to take account of similar changes or trends that may have occurred for society as a whole over the same time period. The potential for over-estimating deadweight could therefore be greatly reduced and the impact estimations made more robust. A range of national level secondary data was assembled to represent the main outcomes revealed through the Theory of Change with proportional changes used to produce estimates of deadweight (by outcome group) in the model. These estimates were triangulated against the qualitative information gathered through the ToC exercises and online surveys to further improve their accuracy. Values for deadweight and attribution calculated by outcome domain are given in Table 8.

Table 8:BCCP SROI Deadweight and Attribution values

BCCP Outcome domain	Deadweight Value	Attribution Value
Primary	7%	55%
Secondary (A)	15%	50%
Secondary (B)	11%	37%

Drop off and discount rate

3.69. It was important for the SROI ratios to account for diminishing impacts of the BCCP over time, and for the value of money to change over time, and these were accounted for by the inclusion of estimates for drop-off and discount rate.

3.70. Drop-off is calculated by deducting a fixed percentage from the remaining level of outcome at the end of each year. For example, an outcome of 100 that lasts for 3 years but drops off by 10% per annum would be 100, 90 and 81 in years 1, 2 and 3 respectively. In this case a relatively steep drop-off coefficient of 90% was applied to all outcomes where the benefit period was

longer than one year, on the basis that given insufficient knowledge about the legacy of the project one might assume that benefits were likely to fall away relatively quickly.

3.71. Discounting recognises that people generally prefer to receive money today rather than tomorrow because there is a risk (e.g. that the money will not be paid) or because there is an opportunity cost of investing the money elsewhere. This is known as the 'time value of money' and it is standard practice to incorporate an annual discount rate into the impact calculation. The basic rate recommended by HM Treasury is 3.5% and this is the rate used in the majority of SROI studies. A yearly discount rate of 0.035 was therefore applied to all outcomes in the BCCP SROI model.

Valuation of outcomes

3.72. Central to the SROI methodology is the monetisation of outcomes in order that they can be measured in a consistent way using a common currency. This allows computation of a ratio of benefits to costs as the measure of impact which, expressed in monetary terms, can be set against the initial financial investment.

3.73. The process of monetising the relevant outcomes involves identifying financial proxies for each separate outcome. In other words, approximations of value were sought for each outcome, which in some cases may not be wholly representative of the specific outcome in question. They are instead the 'best approximation' (or one of the best) available through which to assess the significance of the outcome to society or the state, and thus allow comparison with other (monetised) outcomes.

3.74. A description of the financial proxies assigned to the relevant outcomes, including their source and rationale for inclusion, is provided in Appendix G.

3.75. Despite favourable distance travelled scores and the availability of suitable financial proxies, three outcomes were not included in the final model on the basis of potential double counting with other outcomes. Increased physical activity (Primary) and knowledge and awareness of physical activity (Secondary A) were both excluded as for impact estimation purposes they were deemed to be largely contextual, and a precursor for outcomes such as improved physical and mental health to occur. Thus, to include impact estimates from these two outcomes is likely to have introduced a potential source of double counting into the model, leading to over-estimates of programme impact.

Similarly, the two personal and motivational outcomes - improved self-efficacy (primary) and improved motivational attributes (secondary) were deemed to be too similar to warrant separate valuations in the model. To resolve the question of which one to favour the qualitative narrative was consulted, which reinforced the concept of personal motivation as being crucial to the success and impact of the BCCP. The self-efficacy outcome was therefore removed from the final SROI model to avoid any potential double counting.

Calculating the social return of the BCCP

3.76. All of the information set out in the previous sections was brought together in order to calculate the impact and produce an indicative set of SROI ratios for the BCCP.

3.77. This involved first calculating the Present Value (PV) of benefits, which involved multiplying the number of material stakeholders for each outcome by the indicator value before reducing the

outcome incidence to take account of deadweight and attribution. Annual total value figures were calculated for outcomes lasting more than one year using compound drop-off estimates. Finally, total values were converted to Present Values by applying HM Treasury's coefficient of 0.035.

3.78. This process was repeated for each outcome with the totals then summed to arrive at the Total PV. It was then possible to calculate an initial SROI ratio that would indicate the financial return to society for every pound invested in the BCCP. To arrive at the ratio the discounted value of benefits was divided by the total investment:

$$\text{SROI ratio} = \frac{\text{Present Value}}{\text{Value of Investment}}$$

3.79. In this case three scenarios of benefit to investment (BIR) are presented, based on estimated proportions of target participants that engaged fully with the BCCP. A summary of the core impact estimates from the SROI model is given in Table 9, which also illustrates the proportional return according to the primary and secondary outcome domains derived through the theory of change.

3.80. Findings suggest that every £1 invested in the BBCP has returned between **£2.17 and £3.14** to society in the form of psycho-social outcomes across the primary and secondary outcome domains, and most notably with respect to health, wellbeing, social isolation, community participation and the motivational attributes of its participants. Subject to the limitations of the study scope and related data collection issues, this represents an indicative minimum 200% return on investment for the commissioners of the BCCP.

3.81. The preceding qualitative and quantitative findings demonstrate areas of change which align with those mapped out in the BCCP ToC. A summary of these findings is presented in Table 10 which seeks to report these changes against those that were expected, together with factors that facilitated or impeded progress.

Table 9:BCCP SROI benefit-to-investment ratios

Scenario A – 1,244 participants (65% of target)		
Total investment	**£315,000**	**% of societal return**
Present value (PV) of all benefits	**£988,459**	**100%**
Primary (Mental health and wellbeing)	£425,355	43%
Secondary A (Physical health, knowledge and motivational)	£353,192	36%
Secondary B (Community and organisational)	£209,912	21%
Ratio of benefit-to-investment (BIR)	**3.14:1**	
Scenario B – 1,053 participants (55% of target)		
Total investment	**£315,000**	**% of societal return**
Present value (PV) of all benefits	**£836,388**	**100%**
Primary (Mental health and wellbeing)	£359,915	43%
Secondary A (Physical health, knowledge and motivational)	£298,855	36%
Secondary B (Community and organisational)	£177,618	21%
Ratio of benefit-to-investment (BIR)	**2.66:1**	
Scenario C – 861 participants (45% of target)		
Total investment	**£315,000**	**% of societal return**
Present value (PV) of all benefits	**£684,318**	**100%**
Primary (Mental health and wellbeing)	£294,476	43%
Secondary A (Physical health, knowledge and motivational)	£244,518	36%
Secondary B (Community and organisational)	£145,323	21%
Ratio of benefit-to-investment (BIR)	**2.17:1**	

Table 10: Summary of progress towards intended outcomes

Pathway	Outcomes	Description
A. Individual health resilience	*Short to medium term*	*More people leading healthier lives and experiencing fewer barriers*
	Findings • The BCCP produced positive self-reported distance travelled values across all of its primary and secondary outcomes, with the positive impacts on physical and mental health, social isolation and the motivational attributes of participants especially notable. • The project provided valuable opportunities for community members to access activities that sought to recognise their needs and preferences in a sensitive and responsive way. Data suggested that for some participants the activities provided a gateway to more physically active lifestyles and greater knowledge and confidence to support these. • The complex nature of people's lives and personal circumstances could serve to undermine the projects' abilities to support greater engagement in physical activity even when there had been perceived improvements in knowledge and awareness concerning healthy lifestyles of those taking part. • The projects' flexibility helped people to engage in activities in ways that suited their circumstances, as evidenced by the attendance data and levels of engagement. Crude analysis of the SIM data indicated that participation increased over time, being approximately 50% higher than survey one for surveys two to four. • Respondent data from the surveys indicated greater awareness of the importance of healthy lifestyles and the sorts of activities that could help improve mental and physical health. • The underpinning behavioural model provided a tool with which to provide targeted support although this often needed a great deal of sensitivity from organisational staff. • Some project staff noted the difficulty of engaging people in the projects and of supporting transition through the stages of behaviour change. Some of those engaged in the project activities were already at the stage of taking action and the BCCP provided a further local opportunity to engage in physical activity. • Combined, the data suggested a strong social component which was as important as any participation in physical activity itself. Increased confidence and social interaction, and a corresponding reduction in a sense of isolation demonstrated that the projects supported greater connectivity and therefore a potential improvement in community cohesion. • Some concerns regarding transport and distance to the activities were highlighted although it was evident that the social support provided within some of the social prescribing projects were useful in supporting engagement and attendance.	

	Long term	*Behavioural and attitudinal shifts towards physically active and healthier lives*
	Findings • Moving people from the early stages of behaviour change toward increased physical activity was extremely challenging. It was understood that achieving long term behavioural changes might not involve meaningful improvements in physical activity levels for a number of years. • The 'open door' approach with respect to the degree of engagement afforded to project participants is an important element in addition to providing a strong social component, and emotional and behavioural support. • The reported improvements in knowledge and awareness of healthy lifestyles and the local resources available to support this indicate the presence of conditions to support long term changes. Anecdotal evidence pointed towards examples of greater independent action and increased confidence to engage in local opportunities.	
B. Sustainable and healthful communities	*Short to medium term outcome*	*Better connected organisations that provide attractive local opportunities*
	Findings • BCCP project representatives highlighted a greater awareness and understanding of organisations in their local area, specifically concerning the BCCP partners but also more widely as knowledge accumulated regarding the nature of local services. There was the sense that the BCCP enhanced the quality of links between organisations although this was not felt equally among the participating projects. • For some, partnership working was perceived as strategically important with regard to meeting organisational objectives but, importantly, there was a wider and more general sense that partnerships provided an important response to local needs. • The sharing of resources, knowledge and skills was recognised as important for addressing significant challenges in the political, social and economic sectors. • There was some evidence of organisations within the BCCP linking purposefully to provide a greater level of support and access to community activities in addition to signposting to additional relevant services. • A lack of consistency in the way relationships and resources within the project were linked together prevented the creation of conditions in which the full potential of the BCCP could be harnessed with respect to sharing resources. • Taking an overall view, the data indicated a degree of positive changes with respect to participants' confidence and social interaction, and a corresponding reduction in a sense of isolation. This suggested that the projects supported greater connectivity and therefore a potential improvement in community cohesion.	

	Long term outcomes	*strong community cohesiveness through increased number of networks and resources*
	Findings • There was evidence that the BCCP had stimulated interaction between organisations who had not previously interacted to support people in the community. Although this was not wholescale with respect to project partners, some understanding that there had been limited impact, there was a genuine ambition to collaborate with other local organisations. • Whilst it was not possible to fully understand the quality of links between a full range of local organisations and resources, some participants highlighted how they had been able to continue and enhance existing relationships and to take initial steps toward developing and consolidating additional links. • The BCCP focused on organisations with a strong community focus. The active engagement of target audiences in the design and planning of organisational activities was not clear across the project. However, evidence of this taking place in some projects suggests the basis of longer-term people-centred developments and opportunities for purposeful community participation is developing. • The strong social aspects of the BCCP projects provide a basis on which to develop a stronger sense of community cohesion within the BCCP targeted communities although challenges to this include: ▪ Availability of and access to financial and other resources e.g. community spaces and places ▪ Political and economic uncertainty ▪ Managing and responding to the complexity of target participants' needs, lifestyles and preferences	

4.0 Discussion

Implementation of an effective project monitoring system

4.1 Whilst the evaluation framework established a consistent and coherent approach to the collection of data from participants engaged in the respective projects it was clear that, overall, monitoring across the BCCP was inconsistent.

The design process engaged all stakeholders via the theory of change exercise and subsequent development of questions in order that the data collection tools reflected the needs of the evaluation and those at which they were targeted. This took considerable time (circa 12 months from inception) and the added complexity of aligning the Upshot system with the evaluation tools and responding to queries and glitches concerning this process was a significant challenge to the development process. Further sources of challenge were:

- Difficulties in administering the participant survey either online or via paper-based copies (to be added to Upshot at a later date) due to individual's circumstances (i.e. poor mental health, disability status), whereby there was a perceived sense of participant burden;
- The time required for some participants to respond the question items and the level of support required from project staff to do so;
- Potential mismatches between established organisational data collection and monitoring practices and the BCCP data collection tools e.g. the potential to ask the same or similar questions.

4.2 The time taken to develop and finalise the overarching data collection framework limited the potential to capture data within the confines of the tools that were developed resulting in; (1) missing data, and (2) data that were not recorded in a way that was consistent with the BCCP evaluation framework.

Changes in physical activity levels

4.3 The data available suggested a positive effect on participants' physical activity levels in the medium term, matched participant data from the SROI model indicating an increase of approximately 25% higher. Qualitative findings also highlighted greater knowledge and awareness of the benefits of physical activity, how to incorporate this into daily routines and local opportunities for engaging in project activities.

4.4 The project's focus on structural interventions (those that support, guide and lead inactive people to the point when they feel able to engage) and delivery interventions (those that provide suitable and appropriate opportunities for inactive people to engage) was, in principal, a valid approach. It is important to qualify this statement with a cautionary note regarding the ability to make claims of attribution due to inconsistencies in the collecting and reporting of data. However, compelling anecdotal evidence and qualitative data derived through the evaluation activities suggest that augmenting existing project activities in addition to creating highly responsive approaches is a key learning outcome with respect to the project format.

4.5 Many of the contextual issues highlighted in Section 2 were borne out in comments made by stakeholders participating in the organisation. These added an additional layer of complexity to the delivery of the projects and potential for long term sustainability. Notwithstanding these issues, it was evident that some projects were able to engage people more successfully than

others. Overall, the findings appear to indicate that projects providing supportive and empowering approaches experienced the most engagement.

This is consistent with findings presented in the Bristol Local Needs Insight report which highlighted the need for developing autonomy, linking opportunities that reflected needs, and which were essentially 'hands on' in terms of support. Further possible reasons to explain difference in uptake include individual preferences of those taking part, organisational collaboration, marketing and communications and BCCP project management. This underscores the importance of providing sufficient flexibility and autonomy for projects to respond to poor uptake and to explore alternative approaches to implementation.

Contribution of the project to key strategic outcomes

4.6 Overall, the observed outcomes are consistent with the strategic objectives in respect of improving the health and wellbeing of the communities targeted in the BCCP and of strengthening relationships between community actors and residents.

4.7 Data from the SROI exercise demonstrated positive changes across all of the BCCP's primary and secondary outcomes, with the positive impacts on physical and mental health, social isolation and the motivational attributes of participants especially notable. This suggests a positive degree of efficacy with respect to achieving the intended outcomes. The SROI model was largely supported by the associated qualitative data which forms an essential part of the overarching evaluation framework, where references to greater collaboration, the focus on community spaces and greater knowledge and awareness for stakeholders and beneficiaries alike indicated positive changes in respect of social and community development aspects.

4.8 It is important to qualify the extent of the changes that were observed because these were likely to have been experienced unequally (although not necessarily disproportionately) across the projects, as was evidenced by the differences in engagement data. The three scenarios in the SROI modelling seek to accommodate some uncertainty with respect to the extent to which the BCCP was able to impact its target audiences.

From a beneficiary perspective, reasons for this relate to missing or incomplete data (preventing robust analysis), individual factors relating personal circumstances, access to opportunities and support to facilitate engagement, and the varying durations over which the BCCP projects were run.

From a stakeholder perspective, contrasting organisational agendas and activities, concerns over funding and issues relating to implementation (including data capture, the level of support needed for those with complex needs, and overall project coordination) are likely to have established challenges to the delivery of project activities as originally intended.

Key learning from the project

4.9 We can conclude that the BCCP established a unique approach to an intervention designed to promote health and wellbeing in the targeted areas. The focus on learning, inherent flexibility in delivery and collaboration with community organisations provided conditions which facilitated progress towards the intended goals. However, as outlined above there were certain aspect of the BCCP which served to limit this progress.

4.10 The view of those involved in the evaluation was that the concept was generally sound and the approach acceptable, but it was clear that overall effectiveness was limited. The potential to build on the approach is clear but this will likely require a number of areas to be reviewed including pre-project planning and consultation, project management and data monitoring systems. Attention to these aspects will likely help deal with nature and complexity of process, individual and organisational factors at play and support the sharing of beneficial outcomes more widely and consistently.

4.11 Although pre-project planning and consultation took place it was not possible to make an assessment as to the overall impact this had on the BCCP's design and implementation. It is essential that health interventions try different approaches and evaluate these to determine their effectiveness (Michie and West, 2013) and in this respect the BCCP's focus on learning is commendable.

Ensuring the voices of key stakeholders are maintained throughout the pre-planning, planning and delivery stages will likely ensure a sense of cohesion and cooperation that was not always evident in the data acquired. This is also true with respect to ensuring that the principles of any underpinning theories are widely understood and that the practical implications of these are understood in the context delivery i.e. the use of goal setting.

4.12 There were widespread concerns regarding the overall approach to project management. The causes of this are likely to reflect a combination of a number of things rather than any specific issue. Beginning the process of designing project management systems early on will likely ensure greater clarity and agreement on key activities which provide certainty and confidence for those responsible for collecting and recording data.

Whilst the flexibility and autonomy afforded to the organisations delivering the projects, it is likely that there remains a need for some form of 'central' or locus of control to ensure greater quality of coordination. One approach might be to appoint a project officer with responsibility for overall coordination and relationship management and who is able to spend time in the field with project staff over the duration of the intervention.

4.13 The issues identified above and concerning the overall depth and completeness of data suggests that the design of evaluation approaches should begin, and run in parallel, with activities that take place within the pre-planning, planning and delivery stages. Such approaches would allow the development of approaches that represent, and are highly sensitive to, the complexity of community interventions of this type. The inclusion of Upshot provided a number of process and technical challenges which served to complicate the evaluation design process. Early engagement of third-party suppliers will assist in developing appropriate and effective evaluation tools.

5.0 Conclusions and recommendations

This section outlines the main conclusions and presents a number of recommendations for research and practice.

Project effectiveness

5.1 There was a positive overall effect on participants' physical activity levels in the medium term and the qualitative data indicated that people engaged in the project interventions had greater knowledge and awareness of the benefits of physical activity, how to incorporate this into daily routines and local opportunities for engaging in project activities.

5.2 In observing positive impacts on physical and mental health, social isolation and the motivational attributes of participants we conclude that projects of this type which involve discrete interventions have the potential to make meaningful impacts in the communities in which they are located.

5.3 However, the evaluation highlighted inconsistencies across the project's interventions with respect to evidence of impact on the target groups. These are explored further below.

Intervention type

5.4 Structural interventions (those that support, guide and lead inactive people to the point when they feel able to engage) appeared to be effective at engaging participants and supporting behaviour change in individuals with complex needs who benefitted from the close support offered by social prescribing approaches. The bespoke-style guidance and support offered in this approach established a safe space in which participants could navigate their way towards positive behaviour change. Delivery interventions that provided discrete opportunities for inactive people to move towards physical activity appeared to be effective for individuals seeking structured physical activity opportunities that offered a strong social element. In this respect, we conclude that interventions that provided a blend of supportive, social and empowering approaches were the most effective.

5.5 Conversely, whilst the availability of data regarding impact on physical activity and knowledge was not consistent across the intervention projects, interventions focusing on self-directed opportunities with the support of technology appeared to be less effective with respect to interest and engagement. Factors that might explain this outcome include individual demographics and preferences of those taking part, marketing and communications issues and challenges with using technology.

5.6 It is not possible to determine how instrumental the underpinning model of behaviour change was in producing participant outcomes. Similarly, it was not possible to determine whether its use was consistent across the whole project and whether it was more effective for certain interventions (i.e. via use of control groups). However, it was evident that the model provided a useful practical tool that equipped staff delivering interventions to consider, reflect on and discuss behaviour in a sensitive way with participants. The Trans Theoretical Model is largely ignorant of the context in which change occurs and without the evaluation framework that was deployed it is likely that much important information would have been missed had it been used in a more instrumental sense. Recognising the inherent limitations of the model we conclude that it is important, where such models are utilised, to ensure that interventions maintain a focus on

exploring and assessing the complexity of peoples' lives irrespective of where they might be located within such behavioural models.

Differences in target population

5.7 Participants reflected a wide range of demographic backgrounds in terms of age, gender, ethnicity, education and health status. It is recognised that the three wards targeted in the project interventions experience some of the highest levels of deprivation in England, suffer from more long-term health issues and do not speak English as a first language. Whilst there is no evidence to suggest that projects were unable to respond to these challenges by establish unique and responsive physical activity offers, neither is there evidence to suggest that, overall, the interventions were able to appeal consistently across a range of individual needs and preferences. Prima facie, this might be explained by differences in peoples' understanding of the level of risk posed by their behaviours. Consequently, we conclude that continuing to provide knowledge-building opportunities and resources to increase individual health literacy is an important consideration for the BCCP and its partners.

5.8 It is likely that structural barriers (i.e. income inequality and access to appropriate spaces and places), environmental barriers (i.e. fears over personal safety) and individual barriers (i.e. knowledge, awareness and perceptions of others) which are both difficult to see and hard to address due their complicated contextual nature will likely impact intervention uptake irrespective of efforts to maximise the opportunities provided. We conclude that differences in uptake within and between project interventions does not necessarily indicate any concerns about the efficacy of the approach but that it is important to continue to develop projects of this type which intentionally seek to work closely with those at which the project activities are directed.

Future enhancements

5.9 As a consequence of completing the evaluation it is possible to make a number of observations concerning lessons that can be learned for future similar projects.

- The number and level of data was lower than anticipated. Given the complex nature of the BCCP project interventions in terms of the diverse organisations involved and concomitant practices and operations, consideration should be given to how to boost response rates to participant surveys and qualitative data collection processes.

- One amendment worth considering is to ensure that the project monitoring and evaluation framework is established in parallel with the project's overall development. Developing this alongside programme proposals and designs will help incorporate potential outcomes frameworks and theories of change from the outset and will likely support overall project ambitions and guide project development.

- Such an approach would ensure that all parties are aware of the data required, the processes to obtain it and their role in supporting its acquisition. Furthermore, this would ensure that the systems employed e.g. online platforms or third-party support are embedded in the evaluation protocols and that stakeholders are able to communicate with participants from the outset regarding the purpose and importance of data collection activities.

- Establishing a steering group, or similar, which involves elements of the project management team, representatives of target beneficiaries and project evaluators will ensure clarity of communication regarding technical and practical issues, and overall progress.

- A further enhancement worth considering is to create a reporting mechanism that, whilst not imposing artificial or unrealistic expectations on delivery partners, seeks to provide a space for the discussion of feedback concerning data collection activities and the extent to which this meets expectations. Examples might include the number of participants engaged, their level of involvement and staff time spent on all aspects of delivery.

  We conclude, therefore, that a mixed methods evaluation framework as deployed in this evaluation is appropriate for this type of project and that further revisions to the planning and development process will further enhance its potential to maximise the level of data acquired.

Recommendations

Based on the considerable empirical evidence presented above the following recommendations are made.

Recommendations for practice

Recommendation 1: Provide time for and emphasis on devising data collection frameworks that reflect the context in which project delivery takes place in order to ensure greater understanding, appropriateness of tools, stakeholder buy-in, consistency and cohesiveness of data collection and recording;

Recommendation 2: Ensure underpinning theories are consistent with the practical realities of project delivery so as to facilitate the acquisition of data that addresses all aspects of the theory, including follow-up;

Recommendation 3: Establish feedback loops through (1) project steering groups and (2) evaluation cycles in order to develop responsive intervention approaches in order to maximise the inherent flexibility of approaches as adopted in BCCP;

Recommendation 4: Establish clear and consistent reporting expectations to facilitate discussion of project progress and issues affecting implementation;

Recommendation 5: Bristol City Council should act as an advocate for innovative intervention approaches in order to further progress their role and place within community health promotion programmes.

Recommendations for research

Recommendation 6: Develop monitoring and evaluation frameworks alongside programme proposals or designs in order to incorporate potential outcomes frameworks and theories of change from initiation in order to support project ambitions and guide project development.

Recommendation 7: Ensure that overarching research methodologies are compatible with complex interventions such as BCCP via thorough pre-intervention planning and mapping of the intervention delivery mechanisms;

Recommendation 8: Establish public involvement groups to assist with the design of intervention programmes and their evaluation from inception through to delivery to maximise data collection potential and minimise the negative impacts of engagement in research activities i.e. respondent burden.

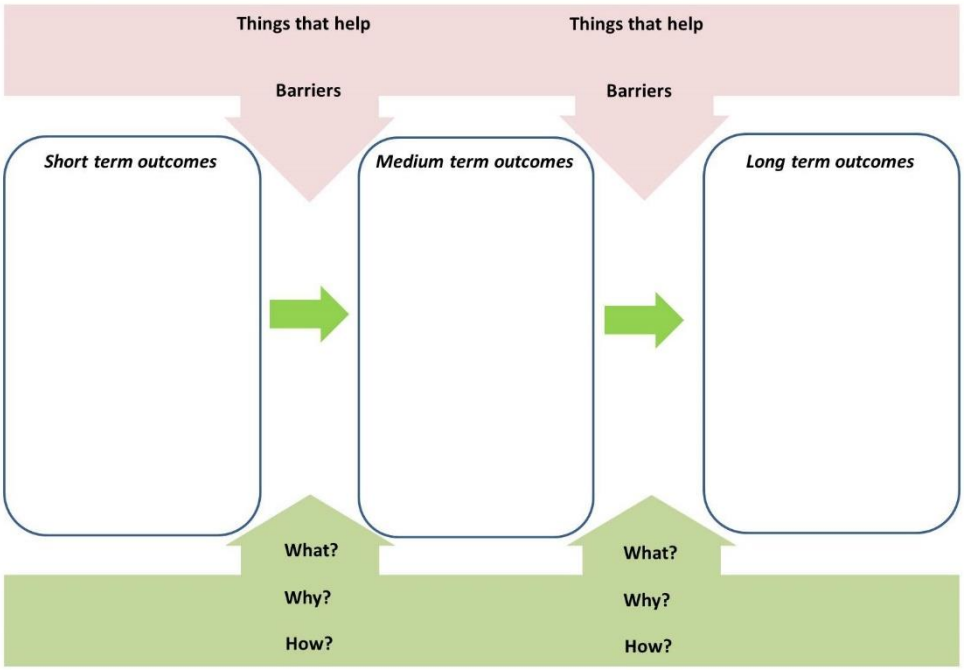
Recommendation 9: Adopt communicative approaches to evaluation management and flexible research designs that incorporate opportunities for practitioners to assist with data collection with support from researchers.

6.0 Appendices

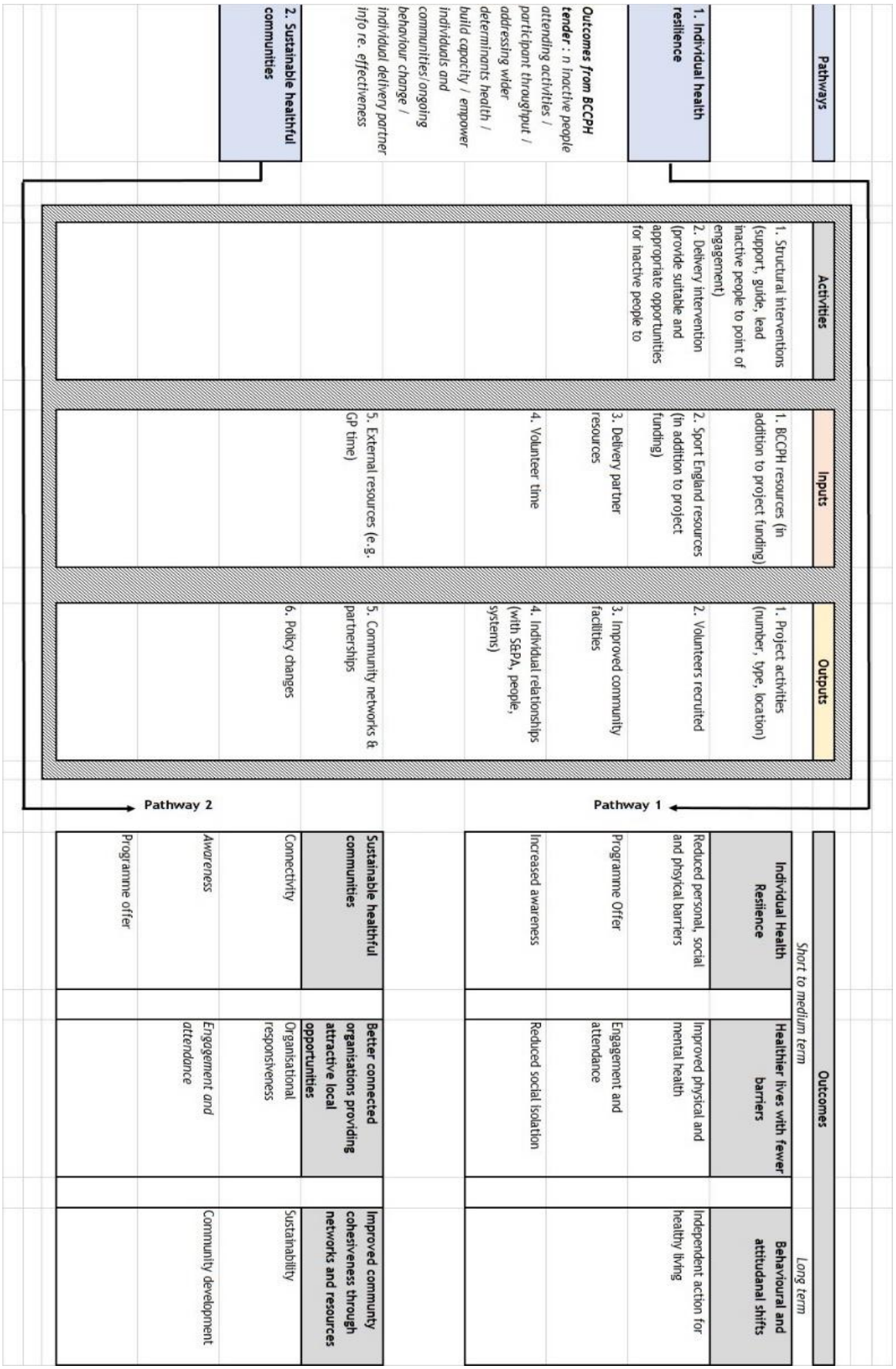
Appendix A – 'Journey of Change' data collection template

Journey of Change

Need for the project	
Aim of the project	



Appendix B – BCCP logic model



Appendix C – Participant survey

BRISTOL CORE CITIES

Participant survey

[QUESTIONS 1 – 11 ON FIRST-TIME SURVEY ONLY]

Thank you for agreeing to take part in this survey.

We have sent you this invitation because of your involvement in activities which have been supported by Bristol County Council's Core Cities programme.

The aim of the survey is to help us understand the impact of the Bristol Core Cities programme. Please place a tick in the relevant box, or respond to the questions asked.

The survey should approximately 10 minutes to complete. The findings will be used to understand the impact of the Bristol Core Cities programme.

We would also like you to complete the survey again at a later date so that we can understand the long term impacts of the programme.

Please be assured that all results will be treated in the strictest confidence. Your details will not be revealed at any point to any third party organisations. We very much appreciate your participation.

If you have any questions about the survey or the Bristol Core Cities Evaluation, please do not hesitate to contact the evaluation manager, Dr Colin Baker, University of Gloucestershire: 01242 715198, or cmbaker@glos.ac.uk..

About you

1. **First name** _
2. **Last name** _
3. **Gender:**
   Male
   - ☐ Female
   - ☐ Transgender male
   - ☐ Transgender female
   - ☐ Gender variation non-conforming
   - ☐ Not listed
4. **Date of birth (Day, month, year):** _ _ / _ _ / _ _ _ _
5. **Postcode:** _ _ _ _ _ _ _ _ _ _ _ _ _
6. **Email address:** _
7. **Medical conditions (tick all that apply):**

- ☐ Alzheimer's disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Coronary heart disease (CHD)
- ☐ High cholesterol
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Dementia
- ☐ Depression, anxiety or similar
- ☐ Diabetes (Type 1)
- ☐ Diabetes (Type 2)
- ☐ High blood pressure / Hypertension
- ☐ Back pain
- ☐ Drug misuse
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Learning Disability
- ☐ Long standing illness or health condition
- ☐ Mental Health Condition
- ☐ Physical Impairment
- ☐ Vision Impairment
- ☐ Other

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

8. Ethnicity

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Mixed
- ☐ Other
- ☐ Prefer not to say

9. Faith:

- ☐ No religion
- ☐ Christian
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion
- ☐ Prefer not to say

10. Sexual orientation

- ☐ Heterosexual or Straight
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Other

11. What was your highest education level completed?

- ☐ Primary school
- ☐ Middle school
- ☐ Some secondary school
- ☐ Completed secondary school
- ☐ Some college or vocational training
- ☐ Completed college
- ☐ Completed university graduate degree, or higher

12. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate? This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.

☐ 0 days
☐ 1 day
☐ 2 days
☐ 3 days
☐ 4 days
☐ 5 days
☐ 6 days
☐ 7 days

13. On a scale of 0-10, where 0 is not at all satisfied and 10 is completely satisfied, overall, how satisfied are you with your life nowadays?

☐ 0 (not at all satisfied)
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 (completely satisfied)
☐ Don't know

14. On a scale of 0-10, where 0 is not at all happy and 10 is completely happy, overall, how happy did you feel yesterday?

☐ 0 (not at all happy)
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 (completely happy)
☐ Don't know

15. On a scale of 0-10, where 0 is not at all anxious and 10 is completely anxious, overall, how anxious did you feel yesterday?

☐ 0 (not at all anxious)
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 (completely anxious)
☐ Don't know

16. On a scale of 0-10, where 0 is not at all worthwhile and 10 is completely worthwhile, overall, to what extent do you feel the things you do in your life are worthwhile?

☐ 0 (not at all worthwhile)
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 (completely worthwhile)
☐ Don't know

17. To what extent do you agree with the statement 'I can achieve most of the goals I set myself'?

☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ Don't know
☐ Prefer not to say

18. To what extent do you agree or disagree that most people in your local area can be trusted?

☐ Strongly agree
☐ Agree
☐ Neither agree nor disagree
☐ Disagree
☐ Strongly disagree
☐ Don't know
☐ Prefer not to say

Impact of taking part in activities

The remainder of the survey is about the ways in which your participation affects you. The majority of questions ask you to reflect upon your attitudes, behaviour and feelings.

You will also be asked about the extent to which you think changes may have happened anyway without your participation in activities, or because of other projects or things that you do.

We appreciate that this may be easier for some questions than others, but please do try and complete every question as best you can.

MY HEALTH

How much do you agree with the statement below?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
19. I believe that physical activity is a good thing to do	☐	☐	☐	☐	☐
20. I know how much physical activity I need to do	☐	☐	☐	☐	☐
21. I have enough money to participate in physical activity	☐	☐	☐	☐	☐
22. I have time to participate in physical activity	☐	☐	☐	☐	☐
23. I have a lot of energy	☐	☐	☐	☐	☐
24. I perceive my health to be good or very good	☐	☐	☐	☐	☐
25. I am never bothered by feeling on edge	☐	☐	☐	☐	☐
26. I never have trouble concentrating	☐	☐	☐	☐	☐
27. I don't feel lonely most of the time	☐	☐	☐	☐	☐
28. I know about the best ways of being active	☐	☐	☐	☐	☐
29. I feel I am living a healthy lifestyle	☐	☐	☐	☐	☐

30. Think about the way you have responded to the questions in this section. If you feel you have seen an improvement overall, approximately how much of this change would you say is down to the things you have been doing in this activity?

None at all (0%)	A little (25%)	Some (50%)	Quite a lot (75%)	A great deal (100%)
☐	☐	☐	☐	☐

MY LIFESTYLE

How much do you agree with the statement below?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
31. I can do pretty much anything I set my mind to	☐	☐	☐	☐	☐
32. I don't visit my GP regularly	☐	☐	☐	☐	☐
33. Over the past week I have been feeling optimistic about the future	☐	☐	☐	☐	☐
34. Over the past week I have been able to make my mind up	☐	☐	☐	☐	☐
35. I often meet socially with friends, relatives or colleagues	☐	☐	☐	☐	☐
36. I have people to rely on for support in a crisis	☐	☐	☐	☐	☐
37. I feel able to do the things that keep me healthy (like eating well)	☐	☐	☐	☐	☐
38. I feel I am influencing my health in a positive way	☐	☐	☐	☐	☐
39. I always look forward to doing physical activity	☐	☐	☐	☐	☐
40. I plan to be more active	☐	☐	☐	☐	☐

41. Think about the way you have responded to the questions in this section. If you feel you have seen an improvement overall, approximately how much of this change would you say is down to the things you have been doing in this activity?

None at all (0%)	A little (25%)	Some (50%)	Quite a lot (75%)	A great deal (100%)
☐	☐	☐	☐	☐

DOING THINGS WHERE I LIVE

How much do you agree with the statement below?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
42. I am a member of clubs and/or associations	☐	☐	☐	☐	☐
43. I participate in community and charity events	☐	☐	☐	☐	☐
44. I find it easy to find physical activity opportunities	☐	☐	☐	☐	☐
45. I volunteer in the community	☐	☐	☐	☐	☐
46. I feel that I can influence decisions in my local area	☐	☐	☐	☐	☐

47. Think about the way you have responded to the questions in this section. If you feel you have seen an improvement overall, approximately how much of this change would you say is down to the things you have been doing in this activity?

None at all (0%)	A little (25%)	Some (50%)	Quite a lot (75%)	A great deal (100%)
☐	☐	☐	☐	☐

48. Please take a moment to imagine what life would be like if you hadn't become involved with the activities you do. Briefly describe what would your life be like:

49. Do you think you would feel the same as you do now? Please explain:

50. Do you think you would you spend your time doing different things, or do you think you would be doing similar things? Please explain:

51. Please feel free to add any other comments you would like to make about the Bristol Core Cities activity or activities you have been doing:

Thank you

Thank you once again for taking the time to complete this survey. Your feedback is extremely valuable and is much appreciated. Please be assured that all results will be treated in the strictest confidence.

If you have any questions about the survey or the Bristol Core Cities Evaluation, please do not hesitate to contact the evaluation manager, Dr Colin Baker, University of Gloucestershire: 01242 715198 or cmbaker@glos.ac.uk

Appendix D - Interview schedule, process evaluation

Primary questions:

1. what worked well and less well, and why?
2. what could be improved?
3. how has the context influenced delivery?

Secondary questions:

4. How did you come to be involved? (role, etc.)
5. What is your personal / organisational goal for the programme?
6. Overall, what have been your experiences to date (processes e.g. decision making, communication; perceived impact on target audience)
7. What things do you think can help this? (consider aspects of partnership working, local resources, individual and organisational factors)
8. What things might not help this? (consider aspects of partnership working, local resources, individual and organisational factors)
9. Any other comments

Appendix E - Process evaluation monitoring tool (appendix F)

Project name			
Description			
Level	**Implementation** *How delivery is being achieved (training, resources etc..)*	**Mechanisms of impact** *How has the project made a difference? Things that help / don't*	**Outcomes / changes** *What are the differences?*
My organisation			
My target audience *Knowledge, attitudes, behaviours*			
The community *Relationships between organisations, policy changes*			

Appendix F – Case study material

Hheag Tackling Inactivity Hartcliffe and Withywood

Case Study 1

OVERVIEW

- TM is a 45-year-old woman. She was referred to Positive Minds via a job coach at the local job centre because she was anxious. TM struggled to get to sessions, needing to be accompanied by a friend. We started to meet halfway between her home and the community centre to complete the journey together.

- She cancelled a lot of sessions (8 attended 6 cancelled). TM was finding it too difficult to consider any other activity apart from very short accompanied walks. She was referred on to the Freedom programme for support with past domestic abuse. Sessions with P.M were stopped due to the high level of cancellations, with the offer that she could contact us again in the future.

- TM made contact 10 months later for further sessions having been hospitalised for 6 weeks for a serious illness as a consequence of hidden long-term drinking. She had not felt able to access the Freedom programme.

- During the second set of sessions TM's ex-partner was released from prison without her knowledge and was attempting to make contact. We referred her to a domestic abuse project who supported her to make a safety plan. He was subsequently was recalled to prison. TM appreciated the domestic abuse support which made her reconsider accessing the Freedom programme.

- TM had stopped drinking and was getting support from a specialist agency. TM was now ready and wanting to engage in physical activity and community activities but was in poor health. Before starting any exercise, TM needed a physio referral.

- Anxiety continues to be a barrier to engaging in activities, but now she is much more able to understand and discuss this. She can see how adverse childhood experiences have affected her. By the end of sessions TM was able to walk, unaccompanied, the short distance for appointments. She is interested in swimming and walking netball in the future.

- We have also worked on coping with public transport, this will unlock more possibilities. TM practised taking the bus to the leisure centre and is looking to attend the swimming rehab sessions if she has too long to wait for physio which is significant progress.

- After the 6 sessions ended TM contacted us again to say she had started to volunteer with the agency that had supported her to stop drinking.

Hheag Tackling Inactivity Hartcliffe and Withywood

Case Study 2

OVERVIEW

- JM is a 24-year-old man. He was referred to Positive Minds by the mental health nurse specialist at his GP surgery. She said he was very socially isolated, so needed to access community-based activities.

- JM lives at home with his mother and younger brother who has Autism. Over the past few years JM has spent an increasing amount of time in his room. He is affected by anxiety and low mood. He is awaiting a formal diagnosis of Asperger's syndrome.

- JM spends a lot of time playing computer games with online friends. He can sleep for large parts of the day. At first, he said he didn't know what he wanted to achieve from the sessions as he felt ok as he was. Later he said that there were some things that were difficult. He had stopped taking medication saying he didn't feel it made any difference, but he also found going to the pharmacy very stressful. He had a friend two streets away but felt it was too stressful to visit him, preferring online contact.

- JM is driven to sessions by his mum who waits for him across the hall. After four 1:1 sessions JM agreed to try out the midweek walking group with me. He picked the walk nearest to his home and brought his dog with him.

- He stayed towards the back of the group and cut short the walk when the route went near to his house. When talking about his experience of the walk JM said he found it difficult and he had hardly slept the night before. He could see that it was an achievement to attend but didn't want to come regularly.

- JM said he would try and come to the weekly gym group. He then sent a text before the group to say he couldn't make it. He had felt too anxious and had had very little sleep. At this point in the sessions we felt that just coming to appointments with Positive Minds was enough for the time being as it was the main time he left the house. At the next session we talked again about exercise and how it can help your mood. I challenged him to do a few exercises when the house was empty to see if it made a difference.

- On the seventh session JM arrived out of breath as he had walked in on his own from home, a 20-minute walk. He said he hadn't done the exercises we suggested but had found some dumbbells and started using them with online tutorials. He said he would like to try again at coming to the gym and he has asked to change our sessions to fortnightly to extend the support.

- On the 8th session JM walked to his session again. He said his Mum had been reluctant for him to come (due to the risk of Covid 19) but he had insisted. Due to Covid 19 it looked certain that the remaining 1:1 sessions would need to go on hold. We offered phone or email contact but JM just wanted to wait until the 1:1 session could start again.

Hheag Tackling Inactivity Hartcliffe and Withywood

Case Study 3

OVERVIEW

- JB is a 63-year-old woman. She self-referred to the project as she worked in the same building as Positive. Minds. She asked specifically for support with exercise.

- JB is diabetic and had been struggling with her weight. JB has a complex and often stressful family situation and money can be tight. She said she often struggled with low mood and motivation to look after herself.

- JB had a block of 12 sessions. They were shorter than the normal 60-minute session at 30 minutes, but this seemed to be useful to motivate JB. We talked about her lifestyle and any exercise she had enjoyed in the past. As money was an issue for activities we looked at home based exercise and walking.

- She decided on skipping at home and walking faster when out. We drew up an exercise sheet for her fridge so she could monitor when she had done her exercise, and how she felt.

- We also persuaded JB to have some 1:1 support with our nutritionist to support her with her diet. JB reported that this was helpful JB also attended the motivation group, and supported a friend to access the Fit 4 life gym group.

- JB did lose weight and felt motivated to exercise and walk more and went to the gym for occasional drop in sessions. On several occasions since JB has been able to contact me for a session which has acted as a boost and refocus, when things have been difficult.

Hheag Tackling Inactivity Hartcliffe and Withywood

Case Study 4

OVERVIEW

- JP is a 60-year-old man. His presenting issue was social isolation due to progressive sight loss condition. He was diabetic and had other health conditions.

- JP was keen to get out of the house more and meet new people. JP needed information about activities and 'first step support' into the activity this was an introduction to the session leader, or finding out further information about accessibility.

- JP regularly attended a local walking group, joined a tandem group for sight impaired adults, started going to walking football weekly sessions, and is due to start volunteering as a guide on a history walk around Arnos Vale cemetery.

- Alongside the activities we linked JP to the Sensory Support Service for help with benefits. Through the sessions JP talked about his very difficult relationship with his partner and how he feels about his deteriorating eyesight. JP was referred for some long-term counselling sessions with a volunteer counsellor through Bristol MIND.

- Just before the Covid 19 pandemic resulted in lock-down JP came back to us to because he decided he wanted to attend the Fit-4-life Gym group. He had an induction before sessions had to end due to Covid 19.

- JP has been advised to shield so we are ringing him weekly to check in with him and will support him to get back out to activities when it is safe to.

Appendix G - Description of the financial proxies

Outcome	Financial Proxy Description	Proxy Value 2019 prices (£)	Unit	Source	Source Year	Notes/Rationale
Improved mental health	Mental health service costs per individual (anxiety and depression)	1,217	per person (p.p)	SROI Wiki Vois Database - The Troubled Families Cost Database http://neweconomymanchester.com/stories/1336-evaluation_and_costbenefit_analysis	2010	Reduction in the number of young people and adults suffering from depression will reduce pressure on NHS over longer term
Improved personal wellbeing	Effect of sports club membership on wellbeing	5,416	£ per person p.a	Global Value Exchange http://www.globalvaluexchange.org/valuations/search?q=sports%20well%20being	2005	According to the GVE evidence shows that membership of a sports club has the same impact on individual well-being as an increase in income of £3,600 per year (2005 prices)
Increased social trust	Value to an individual (aged 25-49) of feeling like they belong in their neighbourhood.	2,540	p.p pa	Global Value Exchange, SROI Network (Campbell)	2014	Increased feelings of trust in the community is a legitimate precursor to feelings of belonging to one's neighbourhood
Improved agency and motivational attributes	Value attributed to positive functioning for volunteers based additional median wages earned	3,498	per person p.a	SROI on Growing Social Capital (Wright and Schifferes, 2012) http://www.thinklocalactpersonal.org.uk/_assets/BCC/Growing_Social_Capital_SROI_-_March_2012.pdf	2012	Positive functioning is a similar outcome to agency and motivational attributes. Thus, one could expect the same wage differential.
Improved physical health	Cost of reduced health care to maintain good physical health (based one A&E and 4 GP visits p.a)	285	per person p.a	Personal Social Services Research Unit (PSSRU) 2011	2011	Many people with long-term physical health conditions raise total health care costs by at least 45 per cent for each person including hospital admissions and GP consultations for physical complaints (PSSRU, 2011)
Reduced social isolation	Average spending on social interaction	66.0	£ per person p.a	Global Value Exchange 2013 (From SROi report by Social value lab)	2013	Has been used to value increased opportunity to interact with people from different backgrounds in a previous SROI by the social value lab.

Increased community involvement and participation	Estimated cost per mile of a vehicle movement for leisure purposes	760	£ p.a	SROI Wiki Vois Database	2002	Previously used by NEF in evaluating the impact on local communities of re-allocating resources. Based on cost saving of 4.46 per hr (2002 prices) and 2 hours travel per week.
Improved organisational links and partnerships in the community	Cost of time spent collaborating	928	Cost per organisation p.a	Global Value Exchange, Whitebarn Consulting	2014	It would cost organisations staff time in order to develop meaningful collaborations
Increased volunteering and community empowerment	Value of volunteering in England	1708	£ per annum	Unique search	2019	Volunteering would produce a similar set of outcomes to those associated with strengthened social capital and civic engagement. Based on living wage rate of £8.21 per hr) multiplied by average number of hours per week volunteers undertake in UK = 4 hrs per week.

References

Bickerdike et al., 2017;

Bristol City Council, 2020a the pop of Bristol

Bristol City Council, 2020b state of Bristol key facts

Bristol City Council (2016). Joint Strategic Needs Assessment (JSNA) 2016-2017. https://tinyurl.com/ycobx8wg

Bryman, A., Stephens, M., à Campo, C. (1996). The importance of context: Qualitative research and the study of leadership. The Leadership Quarterly, 7(3), 353-370

Chatterjee et al., 2017

Corbin, J. M. & Strauss, A. (2008). *Basics of qualitative research* (3rd). London: Sage

Department of Health (2010). *Measuring Social Value.* London: The Stationary Office.

DiClemente, Prochaska, and Fairhurst, 1991 Health Behavior: Theory, Research, and Practice. Karen Glanz, Barbara K. Rimer, K. Viswanath John Wiley & Sons, 1 Jul 2015

Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobson, S. & Allen, A.A. (2001). Building collaborative capacity in community coalitions: a review and integrative framework. *American Journal of Community Psychology*. 29(2), 241-261.

Harlock, J. (2013). *Impact measurement practice in the UK third sector: a review of emerging evidence*. Birmingham: Birmingham University Third Sector Research Centre.

HM Treasury, 2020. Magenta Book Central Government guidance on evaluation

King's Fund, 2017 SP

Michie, S. & West, R. (2013). Behaviour change theory and evidence: a presentation to Government, *Health Psychology Review*, 7:1, 1-22, DOI:10.1080/17437199.2011.649445

Nicholls, J., Lawlor, E., & Neitzert, E. (2012). *A Guide to Social Return on Investment* (2nd ed). London: Office of the Third Sector, The Cabinet Office.

PHE (2017). Health Profile for Bristol 2017. https://tinyurl.com/yas9jfouv

Ch7 The Transtheoretical model and Stages of Change. Prochaska, J.O., Redding, C.A., & Evers, K.E. pp

Ratna, J. & Rikin, S.B. (2007). Equity, empowerment and choice from theory to practice in public health. *Journal of Health Psychology*, 12(3), 517-530.

Shenton, A. K. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.

Sport England (2017). Market Segmentation Data. https://tinyurl.com/y7577nqs