NEF CONSULTING

The socio-economic impact of the work of FareShare

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FareShare
fighting hunger, tackling food waste

Title: The socio-economic impact of the work of FareShare

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Authors: Will Davies, Emmet Kiberd, Jasmeet Phagoora, Graham Randles

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NEF Consulting Limited

New Economics Foundation
10 Salamanca Place
London SE1 7HB
www.nefconsulting.com
Tel: 020 7820 6361

Contents

Executive summary

FareShare redistributes surplus food to frontline charities and community groups. These include homeless hostels, breakfast clubs, lunch clubs, day centres, community cafés and more. The food redistributed comes from the food industry and would otherwise go to waste. The organisations that receive food from FareShare fall into two categories, which are referred to as Community Food Members (CFMs) and Community Food Associates (CFAs).

This study, by NEF Consulting, set out to establish a monetary value for the socio-economic impact of the work of FareShare. This was no easy task and required the development of an innovative approach, derived from the recognised and well established Social Return on Investment (SROI) methodology.

The results are hugely inspiring. NEF Consulting estimates that, by collecting food that would otherwise go to waste and distributing it to its Community Food Members, FareShare creates approximately £50.9 million of social-economic impact. This is made up of an estimated £6.9 million in social and economic value to the beneficiaries themselves and £44.0 million in savings to the State.

To understand these numbers, it's important to note some of the headline figures that lead us to say with confidence that FareShare does have such a significant socio-economic impact. The key figures are:

- FareShare provides food to over 2,974 CFMs
- FareShare also provides services to over 6,679 additional CFAs, though these have not been included in our headline estimate of social-economic impact
- The CFMs alone provide services to over 318,000 beneficiaries.

A wide variety of people ultimately benefit from FareShare's services including:

- Families and/or people on low or no income
- Older people
- People with mental health problems
- School children and their parents
- People with drug and/or alcohol addiction
- People who are homeless and/or rough sleepers

The people in all of these groups experience different kinds of outcomes from engaging with the CFMs that FareShare serves and receiving the food the FareShare provides. However, it is the very large group of charities that work particularly with homeless people and rough sleepers where a significant proportion of the savings to the State in particular are derived.

1. Introduction

1.a About FareShare

FareShare redistributes surplus food to frontline charities and community groups. These include homeless hostels, breakfast clubs, lunch clubs, day centres, community cafés and more. The food redistributed comes from the food industry and would otherwise go to waste.

The organisations that receive food from FareShare fall into two categories, which are referred to as Community Food Members (CFMs) and Community Food Associates (CFAs). FareShare provides the surplus food it receives from the food industry by delivery to CFMs. It connects CFAs to supermarkets via an app enabled service called FareShare Go, which enables these organisations to collect surplus food directly, from supermarkets. Some of the organisations FareShare serves operate as both a CFM and a CFA.

1.b Purpose of this research

NEF Consulting (NEFC) was commissioned to assess the social and economic value of FareShare's work. FareShare was interested in understanding the full impact of its food provision and in capturing potential cost savings to the State. This study is an evaluative assessment of the intangible returns on investment made by FareShare, for CFMs, CFAs and the beneficiaries they serve.

While this research is not a full Social Return on Investment (SROI) study, it is based on SROI principles. SROI is an outcomes-based evaluation method. The *changes* experienced by key stakeholders, and which are considered relevant and significant, are measured and modelled in relation to the causal influence of the intervention. Social, environmental and wellbeing changes are valued by providing an equivalent monetary value for these benefits (or costs). This systematic approach assesses the benefits for stakeholders (taking into account harder-to-measure impacts such as subjective wellbeing), and compares the value of these benefits to the total of the investments made to support the project. This comparison results in a benefit–cost ratio (BCR) which helps us to understand the value for money (VfM) of the project (that is, for every £X spent, £Y is generated in value).

This report sets out the method, qualitative research, quantitative data gathered, and other model inputs undertaken for the analysis. It summarises the findings from the model and draws conclusions and insights related to improved mental health, reduced isolation and improved nutrition.

2. Methodological approach

The methodology and the process undertaken to determine the social and economic value created by FareShare begins with the identification of stakeholders and the development of a sampling framework. We (NEFC) then developed the interview approach to uncover qualitative examples of FareShare's social impact on CFMs. This was followed by detailed desk-based research and a process to categorise outcomes, before developing the detailed social and economic value model.

2.a Identifying stakeholders

Figure 1 presents an outline of FareShare's primary stakeholders: the CFMs and CFAs, according to the project type and beneficiaries that they serve. There are a total of 2,840 recorded CFMs in FareShare's database and FareShare holds information on the number of CFMs serving each beneficiary and the number of CFMs by project type.

Figure 1: Map of stakeholders

Beneficiaries

- Families and / or people on low or no income
- School children
- Homeless and rough sleepers
- Older people
- People with drug and / or alcohol problems
- People with mental health problems
- People with life-limiting conditions
- Ex-offenders
- Pre-school children
- Asylum seekers and refugees
- People with physical health problems
- NEETs (Not in education, employment or training)
- Young people in care / care-leavers
- Socially-excluded people
- People affected by domestic violence
- Long-term unemployed
- BME
- Lone parents
- Ex-service personnel
- Lesbian, gay, bi-sexual, transgender (LBGT)

CFMs/CFAs by project type

- Addiction support
- Advice / resource centre
- Children and families centre
- Community café
- Community centre
- Day centre
- Drop-in service
- Food bank
- Hospice / care home
- Hostel
- Lunch club
- Medical facility
- Out of school club / youth centre
- Place of worship
- Prison
- Refuge
- Residential rehabilitation service
- School / school breakfast club / after school club
- Soup kitchen
- Supported housing
- Training centre

2.b Interview approach

NEF Consulting conducted a total of 20 interviews with organisations that represented a geographic spread across the UK and were varied in size. Some CFM/CFA projects served more than one beneficiary group.

Each organisation was asked the same set of questions, under the following broad headings:

- **Understanding the organisation:** The questions asked about background/contextual information, including its aims and goals. This part of the interview was used to generate an understanding of the type and number of beneficiaries that the CFM/CFA serves.
- **The project involving FareShare food:** The organisations were asked about specific projects that involved FareShare food, the outcomes they aimed to achieve, and the number of beneficiaries achieving these outcomes per year. The answers to these questions helped to inform the model and verify findings of the desk-based research.
- **Nutrition:** Additional questions were asked about improved nutrition and whether improved nutrition contributes to achieving the outcomes noted in the previous section.
- **Attribution:** We asked the organisations about the concept of attribution, meaning how much of the change or impact they create might be regarded as being a result of FareShare's support. The intention was to use the answer provided in the model.

The detailed interview guide can be found in Appendix A.

2.c Desk-based research and outcomes categorisation

In order to create a set of outcomes that broadly reflected those of the CFMs supported by FareShare, we undertook an extensive literature review of relevant Social Return on Investment (SROI) studies and evaluation reports. A systematic approach toward the literature review was guided by the sample framework outlined above for CFM interviews. This involved searching specifically for relevant SROI and evaluation reports for each CFM type and each primary beneficiary. There was considerable overlap between CFM types as categorised by FareShare CFM typology. For example, an out of school club could also be a youth centre. Therefore, to facilitate the process, CFM types were collated into categories, such as housing, community services, youth and children services, drop-in services and food banks. A search for relevant literature for each CFM category and primary beneficiary was undertaken until it reached 'saturation point' (where common themes were reappearing and it was felt little new information could be obtained from further data).

SROI terminology

To develop the social and economic value model, we needed information relating to some of the core concepts of SROI, such as 'deadweight' and 'attribution' as well as financial values and proxies. These terms are described in Table 2.1 below.

Table 2.1. SROI terminology

Concept	Explanation
Deadweight (or counterfactual)	• The amount of change that is likely to have happened in the absence of the project • This might be positive or negative • Usually determined through benchmarks
Attribution	• How much of the change is attributable to the project being evaluated • Considers input of other stakeholders, especially where a project is a catalyst for change

Once outcomes from the literature review sample had been captured we coded these to highlight the common themes. The purpose of this exercise was to distil the 'key outcomes' of these organisations, which would prove central to the model that was used to estimate the social and economic value produced by FareShare's provisions. While this approach certainly involves generalisation, these key outcomes broadly represent the kind of outcomes expected for organisations and projects that fall under each CFM category, and which serve a particular beneficiary. Appendix B presents the list of outcomes for each SROI/evaluation report reviewed, the coding of these into key outcomes, and for which CFM/beneficiary type these key outcomes relate to. The key outcomes uncovered through the coding process are as follows:

- Better employment prospects
- Improved educational performance
- Improved financial situation
- Improved housing situation
- Improved mental health
- Improved nutrition / diet
- Improved physical health
- Improved self-esteem / confidence
- Improved social relationships
- Increased knowledge and access to other services available

3. Social and economic value model

Once we had outlined the key outcomes for each CFM category or beneficiary, the social and economic value model was developed. This model estimates the social and economic value generated by FareShare's provisions to its CFMs and CFAs, either in the form of savings to the State, or in the value for the beneficiary. The process behind this calculation, for each outcome, is outlined and described in more detail below.

a) Selection of an indicator to measure the outcome. For some outcomes this involved creating several 'sub-outcomes' to better capture this measurement.
b) Calculation of the total population of beneficiaries for each CFM category and which of the beneficiaries are expected to achieve this outcome.
c) Multiplication of this total population by the 'Outcome incidence' (that is, the proportion of beneficiaries expected to achieve this outcome).
d) Calculation of Net Impact after accounting for wider influences (such as deadweight, attribution, displacement, drop-off and benefit period).
e) Multiplication of 'Total Population x Outcome Incidence x (1-Net Impact)' by the proportion of outcome attributable to FareShare.
f) Multiplication of 'Total Population x Outcome Incidence x (1-Net Impact) x FareShare attribution' by Financial Proxy/Value.

3.a Outcome indicators

For each of the outcomes selected for consideration in the social and economic value model, at least one indicator was identified to measure the change in the outcome. In many cases, these indicators were sourced from the secondary literature, and were based on indicators used in previous SROI studies for similar organisations or programmes. In the same way as outcomes that reoccurred for several stakeholder groups were standardised, so the same indicators were applied wherever possible, throughout the model, in order to ensure consistency of methodology. It is important to note that this process does introduce an element of uncertainty to the results, as there is an inherent assumption that similar outcomes will be achieved by the different programmes when working with similar beneficiary groups. For example, it could be assumed that a school breakfast club for 20 children in Glasgow would have the same impact on the children's school performance as a breakfast club for 10 schoolchildren in Leicester. This kind of approach is unavoidable; known as benefits-transfer, it is likely to have both positive and negative impacts on the results, which ought to counterbalance.

3.b Beneficiary populations

We used internal FareShare data sources to calculate an estimate of the number of beneficiaries (of a given type) that are supported through CFMs of each type. This data

analysis was undertaken separately for each of ten combinations of CFM type and primary beneficiary group, as follows:

- For **housing** CFMs (encompassing supported housing, residential rehabilitation service, hostel):
    - For people with drug and/or alcohol addiction
    - For people who are homeless and/or rough sleepers
    - For people with mental health problems
- For **food banks**:
    - For families and/or people on low or no income
- For **community services** CFMs (which included lunch clubs, community cafés, day centres and community centres):
    - For older people
    - For people with mental health problems
- For **youth and children services** CFMs (comprising children and families centres, out of school clubs, youth centres, schools, school breakfast clubs, after school clubs):
    - For school children
    - For the parents of those children
- For **drop-in services** CFMs:
    - For people who are homeless and/or rough sleepers
    - For people with mental health problems

Those CFMs of the relevant type, were extracted from a raw dataset that covered all CFMs. For example, in the case of community services CFMs, this meant extracting Lunch Clubs, Community Cafés, Day Centres and Community Centres. From this sample, the CFMs were filtered by their primary beneficiary group, i.e. the type of stakeholder that they serve more than any other, as reported to FareShare by the CFMs themselves. For all CFMs of the relevant type and with the relevant primary beneficiary group, we summed up the total number of beneficiaries served (again as reported to FareShare by the CFMs themselves), to produce the estimated population figures (shown in Table 3.1).

Table 3.1. Estimated beneficiary populations

CFM type	Primary stakeholder	Beneficiary population
Housing	People with drug and/or alcohol addiction	1,997
Housing	Homeless & rough sleepers	14,479
Housing	People with mental health problems	590
Foodbank	Families and/or people on low or no income	29,392
Community services	Older people	16,015
Community services	People with mental health problems	2,577

Youth and children services	Parents	20,470
Youth and children services	School children	83,673
Drop-in services	People with mental health problems	380
Drop-in services	Homeless & rough sleepers	4,451

The social and economic value model assumes that CFMs serve only their primary stakeholder group, even though most CFMs are likely to serve several different beneficiary groups, rather than one exclusively. This is partly because the model was deliberately designed to be conservative in its calculations and also because more granular data, covering secondary stakeholders, was not available. Also, if a given CFM has 1,000 beneficiaries and its primary stakeholder group is older people, the model assumes it serves 1,000 older people. This simplifying assumption means that beneficiaries who *are not* 'older people' but are supported by CFMs whose primary beneficiary group *is* older people, they will be counted as if they are older people. Elsewhere, we are likely to exclude older people who *are* beneficiaries of CFMs whose primary beneficiary group *is not* older people. Consequently, the numbers contained in Table 3.1, should be treated as estimates rather than as a precise measure of the beneficiaries served by FareShare's CFMs.

The process of categorising outcomes and beneficiaries in this way resulted in a model that covered 174,024 CFM beneficiaries in total. This represented 55.5% of all CFM beneficiaries (313,388). An extrapolation of the social and economic value measured by the model to cover all 313,388 beneficiaries is detailed in Chapter 5.

3.c Outcome incidence

For the majority of outcomes, the outcome incidence was derived based on the findings of relevant secondary SROI and evaluation reports. In a few cases, where background studies for a specific, primary beneficiary group and CFM-type were unavailable, the outcome incidence for a similar outcome (but for a different beneficiary group and/or CFM type) was re-applied. For example, the outcome incidence for 'improved financial situation' for families using youth services CFMs (17%)[1] was re-applied to the same outcome for people with drug and/or alcohol addiction using housing CFMs. Outcome incidence was reapplied

[1] O'Connor, J et al. (2015). *An evaluation of Holiday Kitchen 2014: Learning, food and play for families who need it most in the West Midlands*

in this way for a total of 8 out of 53 outcome-stakeholder combinations considered in the model.[2]

For two outcome types, no secondary data on outcome incidence was available and so a different approach was taken:

- For the percentage of beneficiaries avoiding malnutrition as a result of using the food bank, secondary data from the Trussell Trust was used. This showed that of food bank users surveyed between October and December 2016, 62.4% had experienced severe chronic food insecurity, that is: 'every month or almost every month over the past year, skipping meals, feeling hungry but going without eating, or the most extreme, going whole days without eating.'[3] It is then assumed that these people would be malnourished if they did not have access to the food bank, so that, 62.4% of those who have contact with a food bank avoid malnourishment as a result.
- For the outcome of 'immediate reduction in homelessness' relating to housing CFMs, it was assumed intuitively that housing CFMs give emergency housing to all their beneficiaries. For this reason, outcome incidence was 100% in this case.

3.d Net impact after 'deadweight'

For the majority of outcomes, the secondary literature provided guidance on the deadweight: the change in the outcome that would have occurred anyway in the absence of any intervention. Secondary SROI or evaluation studies were seen to be the most robust and preferred source of deadweight information, as they often estimated the figure through primary data collection or the judgement of service providers and sectoral experts.

- For example, in the case of the outcome 'improved mental health' for older people who used community services CFMs (such as community cafés), a deadweight figure of 17% was sourced, from the 2011 SROI evaluation of the Craft Café programme in Glasgow. This figure was originally estimated from 19 one-to-one interviews with older people who were the primary users of the service.[4]

However, in the case of outcomes where comparable SROIs did not offer an estimate for the deadweight, the next best approach was to search other secondary data sources, and to use intuition to assess long-term trends in outcome incidence. In many cases this resulted in the

[2] We acknowledge that transferring the outcome incidence identified for one group to another is problematic; it simply serves to provide an estimate where there is no other supporting data. The alternative, of excluding the outcomes for which we were unable to find evidence of outcome incidence, would reduce the estimate of the social and economic value of our sample of CFMs. This would, in turn, affect the calculation of social and economic value per beneficiary. We have therefore chosen to retain this step in the model and have applied the sensitivity analysis to the results to show how they differ if these beneficiaries are excluded entirely (see Section 5.e).

[3] Loopstra, R and Lalor, D. (2017). *Financial insecurity, food insecurity, and disability: The profile of people receiving emergency food assistance from The Trussell Trust Foodbank Network in Britain.*

[4] Social and economic value Lab (2011) *Craft Café: Social Return on Investment Evaluation*, pages 15 and 35.

use of a value of 0% in the model. A deadweight of 0% means that no wider influences were identified that were likely to have contributed to the benefits created by the CFMs.

- For example, for the outcome 'improved financial situation' for people with drug and/or alcohol addiction who make use of housing CFMs, a deadweight estimate could not be found in related SROI studies. Public data on household debt in the UK, however, indicated that the average household's debt-to-disposable-income ratio had risen from 127% at the end of 2015 to 133% at the end of 2017.[5] In the context of this increase in indebtedness and the gradual bottoming out of UK interest rates, it was assumed that there would have been no improvement in the average service user's financial situation, in the absence of interacting with the CFMs. For this reason, deadweight was estimated at 0% for this outcome.

For a few outcomes, there was no background data available on long-term national trends, and the deadweight was estimated using intuition alone.

- For example, in the case of avoidance of malnutrition by users of food bank CFMs, there was an absence of data on broad trends. Qualitative accounts indicated that food bank use has risen in recent years and that people turn to food banks as a last resort, having found no other way to stave off malnutrition. For this reason, deadweight was estimated at 0% for this outcome.

3.e Net impact after 'attribution'

Stage one: Attribution to the CFM

In order to estimate the impact of FareShare's operations on a variety of final beneficiaries, a two-stage attribution process was employed. The first stage involved attribution from beneficiaries to the relevant CFMs. This was similar to how the concept of attribution is typically used in SROI studies. It represented the percentage of the change in outcome experienced by beneficiaries that was estimated to result from the CFM's service or programme.

For this study, the first stage of attribution, from the beneficiaries to CFMs, made use of a mix of primary and secondary data. The primary data consisted of responses from CFMs, who were asked how much of the impact that their beneficiaries experienced was attributable to their organisation. The secondary attribution data consisted of estimated attribution percentages from a range of SROI analyses conducted on programmes that were similar to those of our CFMs of interest. In some cases, the first stage attribution rate was calculated by averaging both primary and secondary data (see Appendices C and D for notes on the data used in attribution for each outcome).

[5] Harari, D (2018) *Household debt: statistics and impact on economy*, House of Commons Library Briefing Paper No. 7584, page 3.

Stage two: FareShare attribution

The second stage involved attribution from CFMs to FareShare: this completed the link between beneficiaries and FareShare via CFMs. The attribution represents the percentage of the service or programme that each CFM offers, resulting from the assistance the CFM receives from FareShare.

In order to estimate the second stage of attribution, from the CFMs to FareShare, the CFMs were asked, when interviewed, to estimate what percentage of their organisation's 'achieved outcomes' was attributable to the food that FareShare distributes to them. However, estimating this attribution figure proved challenging for many CFMs, with many respondents unable to state a percentage. It was also unclear whether all respondents understood the concept they were being asked to quantify.

Because of these challenges during the primary data collection stage, second-stage attribution was estimated ultimately from the findings of the 2015 survey of CFMs, undertaken by NatCen Social Research.[6] This survey asked a sample of CFMs whether their charity or community project would be able to continue to operate in the long term without FareShare. We used the findings of this survey in the social and economic value model to create a range of estimates of the impact of CFMs that could be attributed to FareShare. The first approach described below, was used to generate the primary findings from the model. Variations on this approach were then used in sensitivity analysis, to determine how the results would change according to different assumptions about the attribution to FareShare. Table 3.2, below, presents the proportion of CFMs (by type) that responded by saying they would 'probably' or 'definitely' not be able to continue to operate in the long term without FareShare.

Table 3.2: CFMs unable to operate without FareShare, by type

Type of service	Percentage of CFMs that say their project would 'probably' or 'definitely' not be able to continue to operate in the long term without FareShare	Base (number of surveyed CFMs offering this service)
Community cafe	33%	82
Breakfast club	26%	42
Food bank	24%	97
Luncheon club / service for older people	23%	77

[6] Ormston et al. (2015) *Survey of FareShare's Community Food Members (CFMs): Appendices to the main report*, Table A1, p.3

Soup kitchen	23%	30
Children and families centre	21%	61
Day centre	17%	72
Out of school / after school club	15%	39
Drop in service	15%	112
Across all CFMs and services	**19%**	**586**

We determined that these percentages could be used as a proxy for the second stage attribution percentages. For example, if 23% of soup kitchens could no longer operate without FareShare, we have assumed that 23% of the combined impact of all soup kitchens is attributable to FareShare's support. As with other stages of the analysis this is not an exact science. In particular, this assumption could be reframed to say that *all* of the impact of 23% of soup kitchens is attributable to FareShare and *no* impact of the other 77% is attributable to FareShare. This is clearly not the case but, as before, we feel that this represents a best estimate using a conservative approach. Furthermore, the sensitivity analysis enables us to model the results using different assumptions for this element of the model.

Since the analysis contained in this paper grouped CFMs into five types, as opposed to the nine CFM types listed in Table 3.2, the following adjustments were made to derive our five second stage attribution figures:

- For **housing** CFMs, second stage attribution was derived from the average figure for all CFM types (19%), due to a lack of coverage of housing CFMs in the 2015 survey.
- For **food banks** and **drop-in services**, the 2015 survey figures for the same CFM types (24% and 15%, respectively) were used directly, with no adjustment.
- For **community services** CFMs, an average was taken of the 2015 figures for community cafés, luncheon clubs, and day centres.
- For **youth and children services** CFMs, an average was taken of the 2015 figures for breakfast clubs, children and families centres, and out of school/after school clubs.

The resulting figures (listed in Table 3.3, below) were applied to the model as estimates of attribution from each type of CFM to FareShare.

Table 3.3. Estimated attribution percentages from CFMs to FareShare

CFM type	Attribution to FareShare
Housing (e.g. supported housing, residential rehabilitation service, hostel)	19%
Foodbank	24%
Community services (e.g. lunch club, community café, day centre, community centre)	24%
Youth and children services (e.g. children and families centre, out of school club, youth centre, school, school breakfast, after school)	21%
Drop-in services	15%

3.f Valuation and proxies

Outcomes were assigned 'financial proxies' to give them an indicative monetary value within the social and economic value model. These proxies might relate to cost savings to the State, such as the avoided costs of mental health provision as a result of improved mental health. Alternatively, they might involve the social and economic value to the beneficiary, such as for improved social relationships. The proxy used was 'quality of life improvements' due to the better mental health associated with improve social relationships. The sources consulted for proxies used in the model are presented below. Further details of how they relate to each outcome are provided in Appendix D.

- Via the Manchester New Economy Model (version 1.4):[7]
    - Department for Work and Pensions (n.d.), *Unpublished modelling*.
    - Shelter (2012), *Research briefing: Immediate costs to government of loss of home*.
    - Home Office (2011), *Revisions made to the multipliers and unit costs of crime used in the Integrated Offender Management Value for Money Toolkit*.
    - The King's Fund (2008), *Paying the Price: the cost of mental health care in England to 2026*.
    - Department for Business, Innovation and Skills (2011), *Returns to Intermediate and Low Level Vocational Qualifications*. pp 9-10.
- PSSRU unit cost data: Curtis, Lesley A. and Burns, Amanda (2017) *Unit Costs of Health and Social Care 2017*:
    - 2017 hourly salary of an NHS administrative and clerical staff member: £23,197 per annum.

[7] Markus, F. et al. (2015). *Unit Cost Database (v. 1.4)*. Retrieved from: http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database

    - The costs of a representative intervention, including teacher training, programme co-ordinator and materials per child per year.
    - Average cost of health and social service use, associated with debt-related mental health problems: £1,697 per annum.
- BHF National Centre (2014), *Economic Costs of physical inactivity*. Evidence briefing, University of Loughborough [for the costs of treating cardiovascular disease, type-2 diabetes and obesity].
- Knapp, M. et al (2010), *Building community capacity: making an economic case.* PSSRU Discussion Paper 2772.
- Elia, M. (2015), *The cost of malnutrition in England and potential cost savings from nutritional interventions (short version).*
- New Economics Foundation (2009), *The economic and social return of Action for Children's Wheatley Children's Centre, Doncaster*, p.21.
- Standard GDP deflator figures were sourced from the Office for National Statistics.

3.g Worked example of estimating the social and economic value of an outcome

The following section demonstrates the full application of the social and economic value model across one row: that is, for a given outcome, CFM type and beneficiary group. In this case the outcome in question is: 'increased knowledge and access to other services available', as experienced by older people who make use of community services' CFMs (such as day centres or community cafés).

- The first step is to calculate the relevant primary **beneficiary population**. Based on internal FareShare data, there are 16,015 beneficiaries of community services' CFMs whose primary beneficiary group is older people. In this way, we conservatively assume that the number of older people served by all community services' CFMs is 16,015. In other words, we are counting only the primary beneficiaries, even though there are likely to be additional older people who benefit from the services, as secondary or other beneficiaries.[8]
- The **indicator** used to measure the outcome, in this case, is the percentage of the beneficiaries who are reporting increased knowledge of the services available to them. This is derived from the 2015 SROI study of Guild Care Community Services,[9] which included an evaluation of their day centres for older people.
- An **outcome incidence** is applied, to reflect the finding that 35% of older people who use community services' CFMs experience an increase in the aforementioned

[8] This assumption is made due to the constraints of data granularity. Note that this simplifying assumption excludes older people who *are* beneficiaries of community services' CFMs whose primary beneficiary group *is not* older people. It is also likely to include some people who *are not* 'older people' but are nonetheless beneficiaries of CFMs whose primary beneficiary group *is* older people.
[9] Social and economic value Lab (2015), *Social Impact of Guild Community Services (SROI)*.

knowledge. This is derived from the Guild Care SROI.[10] Multiplying this outcome incidence by the beneficiary population, we estimate that 5,605 older people experience an increase in knowledge of the services available to them, due to their interaction with FareShare community services' CFMs. This figure of 5,605 is the **gross impact** of the CFMs' services.

- Next, a **deadweight** figure is applied. This is estimated to be 7%, based on interviews in which beneficiaries were asked to estimate the improvement they would have experienced in the absence of using Guild Care's services.[11] Applying this deadweight to the beneficiary population indicates that 1,121 older people would have experienced an increase in their knowledge of what services were available, in the counterfactual scenario. By subtracting this from the gross impact of 5,605, we estimate that 4,484 older people experience increased knowledge relative to what would have happened anyway.
- Following this, a **first-stage attribution** figure of 9% is applied, to account for the proportion of the change in the outcome that was caused by the CFMs, rather than by other people or organisations. This is similarly derived from interviews undertaken during the Guild Care SROI.[12]
- Next, a **second-stage attribution** figure is applied, to account for the proportion of the services provided by CFMs of this type that can be attributed to FareShare's support of these CFMs. This is calculated at 24% for community services' CFMs, using the methodology described in section 3.e.
- The previous figure of 4,484 is multiplied by 9% and the resultant number is multiplied by 24% in order to account for this process of **two-stage attribution**. This indicates that approximately 98 older people experienced increased knowledge of the services available to them, *with this change being caused by their interaction with the CFM and by the CFM's services being reliant on FareShare's support*. In this way, we estimate that FareShare's services are responsible for a **net impact** of increased knowledge for 98 out of 16,015 older people.
- In order to monetise this impact, a **financial proxy** is applied to represent the savings to the State, which result from an increased knowledge of service availability. Based on SROI studies in related areas,[13] the financial proxy selected was the hourly wage rate of an NHS administrative and clerical staff member, multiplied by the number of hours of effort they save when their service users know which services to seek out. It was assumed that, for each older person experiencing the net impact described above, one hour per week of an NHS administrator's time would be saved, for four weeks – equating to time spent initially trying to reach the older person. As the

[10] Ibid. p. 9: 35% of service users reported an increase in knowledge of what other services (non-Guild) were available.
[11] Ibid. p. 27.
[12] Ibid. p. 27.
[13] Malzer, S. and Wallace, D. *Housing Support Services Social Return on Investment Report.*

average hourly wage rate for these administrative NHS staff was £12.75 in 2017,[14] this equates to £51 (four hours of time) in State savings per impacted beneficiary, per annum.

- The final step is to multiply this proxy by our net impact figure, which gives us the net amount of **social and economic value** generated of £5,008 per annum, for this beneficiary group, CFM type and outcome.

[14] PSSRU unit cost data. Curtis, Lesley A. and Burns, Amanda (2017) *Unit Costs of Health and Social Care 2017*, p. 219.

4. CFM stories of FareShare's impact

The 20 interviews provided many examples of the kind of social impact deriving from FareShare's provisions to CFMs and CFAs. This section outlines some interesting case-studies of the type of impact that was found.

It is clear that FareShare serves a wide range of organisations with different delivery models. Some CFMs and CFAs are more dependent on FareShare food provision than others.

When asked what the case would be without FareShare food provision, it was recognised that some organisations would not function without it, while others use FareShare to keep costs low / spend elsewhere. Examples are provided in the case studies below:

Case study 1: Sheltered housing (FareShare delivery and FareShare Go)

FareShare provides food to an organisation providing sheltered housing for older people. The organisation is not a traditional sheltered scheme, as the activities/services it provides are also open to the surrounding community. The organisation serves approximately 40 – 50 people per week; this includes people aged 55 and over, and families with low incomes. The main aims of the community group are to enable people to: "*live a good quality life"* and *"afford to live"*.

Food is provided three times a week; twice a week from FareShare deliveries and once a week via FareShare Go. Sheltered housing residents or members of the wider community come to collect their FareShare food parcel and put £3 into a kitty when they do. The food provided is supposed to last three days. No individual pays more than £6 a week.

Both the beneficiaries and the organisation have benefitted from FareShare food provision. With the money gathered from service users, the organisation has been able to provide recreational activities to the community including: tai chi lessons (for 6 months), an arts class, gardening club, and more. The organisation even arranged day trips for the community:

"We've organised a trip to Blackpool which is coming up – the money collected is going towards the transport."

The organisation claimed that their beneficiaries, "*wouldn't be able to buy food without FareShare."* In the case of the elderly, *"some don't have much money left after paying bills"* and some are immobile, *"they can't go out shopping"*. The families this organisation serves often benefit because their, *"universal credit [is] always delayed."*

Besides the beneficiaries receiving food directly, at a cheap and affordable rate, other outcomes included:

"Building relationships with volunteers from FareShare and drivers."

"Help[ing] people to learn. We've managed to get tenants on courses … we do online training where they get food hygiene certificates."

Without FareShare food provision, the organisation claimed that their, *"gardening club might not function and people might not be able to afford to go on a trip."* If they were to receive more food from FareShare, the organisation believe they could, *"reach out to more people in the community."*

Case study 2: Secondary school (FareShare Go)

This secondary school is based in a deprived area with a high percentage of students claiming free school meals. The family liaison officer at the school signed up to FareShare Go and collects food from a supermarket to provide to families in need of it. The liaison officer sends a text to all parents (approximately 100 families) once the food has been collected, and approximately 30 – 40 families come to the family learning centre in the school to take the food home. The liaison office is *"targeting the same 30 – 40 families"* overall.

The initial purpose of food provision is to provide food for the children when they're home; however, the food is also used to *"build a relationship with the family"*. As a result of this food provision, the liaison officer claimed that their *"communication with these families has massively improved"* and families are now more responsive towards the school when they receive a phone call.

The liaison officer believes that the use of this food has enabled *"families to approach for help"*, which engenders more than just feeding them. As a result of coming to collect food and saying they need help, families have also been referred to family support services:

"I've done lots of referrals to early help services. It's a safeguarding service for the children. Families are less scared of authority and professional services."

Case study 3: Lunch club / day centre (FareShare delivery and FareShare Go)

This community-led project serves people aged 65 and over. They are collected by a minibus from their homes and taken to a community centre for the day, three times a week. They are charged £6 a day for a three-course lunch, two drinks, and social activities (such as bingo or a raffle). Some of those attending suffer from dementia or depression.

The aim of this intervention is to support the community. Approximately 150 people per week get their three-course lunch, which is made using FareShare food contributions. The community group's expenditure on food for this intervention has "*halved"* as a result of food provision from FareShare. The food provided also helps to reduce workload for the community centre staff, they no longer have to go out to buy as much food, and less of their time is spent food shopping. The food is a key part of their day as, "*Sometimes the clients*

[they] forget to eat as some suffer from dementia, there are others with diabetes too and some can no longer cook proper meals"

Improved nutrition was a key benefit as a result of the FareShare food contribution: *"It's richer and good quality food, we're providing nutrition, helping their wellbeing and reducing isolation".* The food is "[a] *BIG part of their day and if they didn't like it, they wouldn't come back".*

The organisation does also use FareShare Go, but the supermarket does not provide as much fresh goods as FareShare delivery and the food provided is often processed.

Case study 4: Supported housing (FareShare delivery)

FareShare provides food to an organisation that is responsible for managing homes on behalf of its local council. Initially, the CFM used the opportunity to work with FareShare to support young people into tenancies. Since then the project has developed, and it now provides to a range of beneficiaries, through housing hubs, support services, and specific accommodation.

Food is provided on a weekly basis to five housing hubs in different areas of the city. Individuals are able to go to the hub and collect a bag of food (if they meet specific criteria). It is not clear how many beneficiaries are served; however, the respondent said that, *"one hub provides to at least 50 individuals per week."* Specific support for young people continues, and other beneficiaries include, *"people working but on low income";* these people may have a family to support or could be single. The respondent stated that, *"different areas of the city have different needs."* However, a system records why individuals need support with food provision, and examples of why people collect food from the hubs include: welfare reform, universal credit and financial hardship.

The impact is believed to go *"[a] long way".* The organisation helps people when they are in crisis. The respondent claimed: *"I think [for] someone who is going without food, it's going to have a detrimental effect on them."*

FareShare and this particular CFM work in partnership. The CFM provides warehouse space to FareShare in return for FareShare food provision to its sites.

5. Social & Economic Value Estimations

5.a Findings

This section presents the calculations of the social and economic value of FareShare provisions.

Social and Economic Value calculation for CFM sample

Table 5.1 presents the estimated social and economic value generated by FareShare's provisions to our CFM sample. The total social and economic value generated was estimated at £28,272,419.

Table 5.1. Social and economic value generated through FareShare provisions

Social and economic value created through FareShare's provisions (estimated for CFM sample per annum)	**£28,272,419**

Breakdown of Social and Economic value calculation within CFM sample

This number can be broken down into several components: CFM category, Primary Beneficiary and Key Outcome. Tables 5.2, 5.3 and 5.4 present the total social and economic value disaggregated according to each of these components.

Table 5.2. Annual social and economic value broken down by CFM categories

CFM categories	Total annual social and economic value (£)	% Total annual social and economic value
Community services (e.g. lunch club, community café, day centre, community centre)	£1,945,088	6.88%
Drop-in services	£186,597	0.66%
Foodbank	£7,556,741	26.73%
Housing (e.g. supported housing, residential rehabilitation service, hostel)	£15,226,708	53.86%
Youth and children services (e.g. children and families centre, out of school club, youth centre, school, school breakfast, after school)	£3,357,284	11.87%

Table 5.3. Annual social and economic value broken down by beneficiaries

Beneficiaries	Total annual social and economic value (£)	% Total annual social and economic value
Families and/or people on low or no income	£7,556,741	26.73%
Homeless and rough sleepers	£13,506,860	47.77%
Older people	£1,766,905	6.25%
Parents	£334,535	1.18%
People with drug and or alcohol addiction	£1,836,887	6.50%
People with mental health problems	£247,741	0.88%
School children	£3,022,749	10.69%

Table 5.4. Annual social and economic value broken down by Key Outcomes

Key outcomes	Total annual social and economic value (£)	% Total annual social and economic value
Better employment prospects	£129,713	0.46%
Improved educational performance	£1,358,943	4.81%
Improved financial situation	£18,113	0.06%
Improved housing situation	£13,439,204	47.53%
Improved mental health Increased self-esteem and confidence	£2,102,000	7.43%
Improved nutrition / diet	£7,321,236	25.90%
Improved physical health	£1,307,236	4.62%
Improved social relationships	£2,520,491	8.92%
Increased knowledge and access to other services available	£75,483	0.27%

When broken down, it is clear that CFM type, beneficiary and outcomes related to housing (for example: housing, homeless and rough sleepers, improved housing situation) make up a considerable portion of the social and economic value created. This results from a combination of large State savings associated with reduced homelessness and the relatively large number of beneficiaries who used housing CFMs, or who were categorised as homeless and rough sleepers.

State savings and social and economic value to the beneficiaries of CFM sample

The social and economic value creation in this model was divided into two categories: cost savings to the State and social and economic value to the beneficiary. This study was

interested primarily in the cost savings to the State resulting from FareShare provisions, with the indicators chosen for each outcome reflecting this.

However, for some outcomes it was more appropriate to measure social and economic value to the beneficiary; for example, through improved social relationships. While this outcome could feasibly have been measured in cost savings to the State, there would have been considerable overlap with other outcomes, such as improved mental health and increased self-esteem/confidence and a risk of double-counting.

Table 5.5 presents the total annual social and economic value broken down by social and economic value type:

Table 5.5. Annual social and economic value broken down by social and economic value type

Cost Savings	Total annual social and economic value (£)	% Total annual social and economic value
Social and economic value to the beneficiaries	£3,821,989	13.52%
Cost savings to the State	£24,450,430	86.48%

5.b Estimating the total socio-economic impact of FareShare

The final stage in our model for calculating the total socio-economic impact of FareShare was to extrapolate from our CFM sample, to create an estimate of the social and economic value created for all CFM beneficiaries.

As previously discussed, the initial CFM sample used in the model only accounts for 56% of the total beneficiaries, so we need to provide an estimate for the beneficiaries of the CFMs not included in the CFM sample. In order to do so, we made the simplifying assumption that the outcomes of the remaining CFMs are similar to those found in the sample group. The total annual social and economic value for the CFMs in our sample was estimated at £28,272,419 for a total of 174,024 beneficiaries. This represents an average of £162 social and economic value per beneficiary. According to FareShare's internal data, the total number of beneficiaries stands at 313,388. Multiplying this total number of beneficiaries by the average social and economic value per beneficiary, we estimate that the **total annual social and economic value created by FareShare is £50,913,878**, as illustrated in table 5.6 below.

Table 5.6. The total socio-economic impact of FareShare

Number of beneficiaries considered in social and economic value model	**174,024**
Number of beneficiaries for all FareShare's CFMs	**313,388**

Overall value created	**£28,272,419**
Average social and economic value per beneficiary	**£162**
Extrapolation of overall value created for all CFM beneficiaries	**£50,913,878**
Total social and economic value to the beneficiaries	**£6,883,556**
Total cost savings to the State	**£44,030,322**

5.c Sensitivity analysis: varying attribution to FareShare

A sensitivity analysis was undertaken to test whether the results remained robust when underlying assumptions in the social and economic value model were varied. We calculated a range of social impact values using a combination of more conservative and more optimistic scenarios, relating to the proportion of the outcomes attributable to FareShare.

In the conservative scenario, we altered the assumptions underlying the baseline attribution to FareShare (see Section 3.e). There are likely to be very few CFMs that are either fully reliant or not at all reliant on FareShare's support. Most CFMs are likely to have a moderate level of reliance on FareShare's support. To reflect this, we adjusted the attribution percentages as indicated in the Table 5.7. Throughout these adjustments, it was assumed that there was a 50:50 split between those CFMs that said they 'definitely would not' be able to continue to operate in the long term without FareShare and those who said they 'probably would not'. It was also assumed that there was a 50:50 split between those CFMs that said they 'probably would' be able to continue to operate and those who said they 'definitely would'.

Table 5.7. Percentage alterations to assumptions underlying FareShare attribution

	Conservative	Baseline	Optimistic
'Definitely wouldn't continue'	50%	100%	100%
'Probably wouldn't continue'	25%	100%	100%
'Probably would continue'	10%	0%	25%
'Definitely would continue'	5%	0%	0%

For the optimistic example, the same process was taken as for the conservative scenario, with the addition that the CFMs who chose 'probably would continue' were assigned an attribution of 25%. Table 5.8 presents the FareShare attribution values for both conservative and optimistic, alongside the baseline value.

Table 5.8. FareShare attribution percentages for conservative, baseline and optimistic scenarios

CFM category	Conservative	Baseline	Optimistic
Housing	**13.2%**	**19%**	**24.4%**
Foodbank	**14.7%**	**24%**	**27.5%**
Community services	**14.8%**	**24%**	**27.7%**
Youth and children	**13.7%**	**21%**	**25.4%**
Drop-in services	**12.0%**	**15%**	**21.9%**

Table 5.9. Social and economic value estimated from the CFM sample under different scenarios

Social and economic value created through FareShare's provisions (estimated for CFM sample per annum): CONSERVATIVE SCENARIO	**£18,764,931**
Social and economic value created through FareShare's provisions (estimated for CFM sample per annum): OPTIMISTIC SCENARIO	**£34,808,938**

Applying these conservative and optimistic scenarios for the CFM sample to the extrapolated values, we can estimate a range of values for the total socio-economic impact for all CFMs, as illustrated in table 5.10 below.

Table 5.10. The total socio-economic impact of FareShare under different scenarios

Number of beneficiaries considered in social and economic value model	**174,024**
Number of beneficiaries of all FareShare's CFMs	**313,388**

CONSERVATIVE SCENARIO	
Overall value created	**£18,764,931**
Average social and economic value per beneficiary	**£108**
Extrapolation of overall value created for all CFM beneficiaries	**£33,792,490**
OPTIMISTIC SCENARIO	
Overall value created	**£34,808,938**
Average social and economic value per beneficiary	**£200**
Extrapolation of overall value created for all CFM beneficiaries	**£62,685,051**

5.d Adding the impact of CFAs

One further step is possible in the model to estimate the socio-economic impact of FareShare. That is to introduce CFAs into the calculations.

We are able to estimate the socio-economic impact created through FareShare's provisions to CFAs, by calculating an average social and economic value per CFA. Using internal data from FareShare, we assume the average cost saving to a CFA through the use of FareShare provisions is approximately 9.9% of that found for a CFM. This arises from internal research, which found that CFMs save an estimated £7,900 per annum by using FareShare's services, whereas CFAs save an estimated £780 per annum. FareShare's data shows there are 2,974 CFMs. When the total annual social and economic value for all CFMs (£50,913,878) is divided by this number, the average social and economic value per CFM is £17,120 per CFM. 9.9% of this number represents the average social and economic value per CFA, that is: £1,690.

FareShare estimates the number of CFAs at 6,200 (excluding those that are both CFM and CFA). Multiplying the average per CFA by the number of CFAs and then summing this figure into the total annual social and economic value for CFMs, produces a total of £61,393,713. Table 5.11 presents the values used in further estimation calculations.

Table 5.11. Total socio-economic impact, adding CFAs to the model

Number of beneficiaries considered in social and economic value model	**174,024**
Number of beneficiaries of all FareShare's CFMs	**313,388**
Social and economic value calculated from CFM sample	**£28,272,419**
Average social and economic value per beneficiary	**£162**
Extrapolation of overall value created for all CFM beneficiaries	**£50,913,878**
Average social and economic value per CFM	**£17,120**
Average social and economic value per CFA	**£1,690**
Number of CFAs (excluding those that are also CFMs)	**6,200**
Total annual social and economic value created for CFAs	**£10,479,834**
Estimated annual social and economic value created for CFMs and CFAs	**£61,393,713**

Although the stages in this final step of the model are all reasonable, there is a conceptual disconnect between the approach to estimating the socio-economic impact of the CFMs and of the CFAs. Whereas for CFMs we have estimated the social and economic value per beneficiary based on outcomes, and have extrapolated this estimate to the total number of beneficiaries; for the CFAs we have derived the social and economic value per beneficiary using data related to cost savings. With the data available, this seems to provide the most reasonable way of transferring an estimate of the benefits from one group (CFMs) to the other (CFAs). However, it does not appear to be a strong enough basis to justify claiming that FareShare creates an additional £10m plus of socio-economic impact through its work with CFAs. Even though that may turn out to be a reasonable estimate, or may even to be on the low side, we have chosen not to include this additional value in the headline findings, as it appears to require more in-depth research.

5.e Further sensitivity analysis: removing reapplied outcome incidence

As mentioned in Section 3.c, in a few cases where data on outcome incidence was not available in the background literature, an outcome incidence figure was reapplied from a similar outcome (but for a different primary stakeholder group). This was recognised to be a somewhat problematic approach to estimating these outcomes.

In order to test the robustness of the overall socio-economic impact figures to this approach, we can re-run the model after excluding the 8 out of 53 outcome-stakeholder combinations in which outcome incidence had been reapplied. The results of this sensitivity analysis are presented in Table 5.12, below.

Table 5.12. Total socio-economic impact, excluding cases of reapplied outcome incidence

Previous social and economic value calculated from full CFM sample	**£28,272,419**
Social and economic value from rows where outcome incidence was reapplied	**£1,923,026**
Social and economic value calculated from CFM sample, excluding cases of reapplied outcome incidence	**£26,349,393**
Number of beneficiaries considered in social and economic value model, excluding cases of reapplied outcome incidence	**174,024**
Average social and economic value per beneficiary, excluding cases of reapplied outcome incidence	**£151**
Number of beneficiaries of all FareShare's CFMs	**313,388**
Extrapolation of overall value created for all CFM beneficiaries, excluding cases of reapplied outcome incidence	**£47,450,832**

For each beneficiary group for which outcomes were removed, we maintain other outcomes that were supported by data from the literature. For this reason, the total number of beneficiaries considered in the model remains the same (174,024).

The removed outcomes accounted for £1,923,026 in social and economic value creation, bringing the total social and economic value creation estimated by the model to £26,349,393. When extrapolated to cover the beneficiaries not in our sample (using the same methodology outlined in Section 5.b), the total social and economic value creation for all of FareShare's CFM beneficiaries is £47,450,832.

6. Conclusions

FareShare supports thousands of charities to provide services to over 750,000 beneficiaries, by providing provisions of food that would otherwise go to waste.

This study, by NEF Consulting, set out to establish a monetary value for the socio-economic impact of the work of FareShare. This was no easy task and required the development of an innovative approach derived from the recognised and well established Social Return on Investment (SROI) methodology.

In a typical SROI analysis, the key stakeholders or beneficiaries of services provided by an organisation, such as a charity, are asked to identify the outcomes they experience from those services. In the case of FareShare this was clearly not practical. However, using the very detailed data held by FareShare on over 2,800 of the charities it serves, known as Community Food Members (CFMs), we were able to identify the range of charity and beneficiary types that receive provisions of food from FareShare. A relatively small number of these CFM groups represented a large proportion of the total number of the charities and the beneficiaries that FareShare serves, both directly and indirectly.

Having categorised these groups, we were able to identify the outcomes experienced by the beneficiaries through a combination of a very detailed review of secondary literature (primarily SROI studies) and by interviewing a small sample of organisations for each type. From this point on, our approach followed the steps of an SROI analysis to estimate the number of beneficiaries that experience each outcome, as well as a measure of the counter-factual (that is, what would have happened if the charity hadn't provided the service). However, an additional stage was also required.

In a typical SROI analysis, the aim is to understand the impact of the organisation (such as a charity), on the group of beneficiaries that is being provided with direct services. In the case of FareShare, through its provision of food, it is enabling the CFMs it serves to, in turn, meet the needs of their own service users. The challenge therefore was to attribute a value to the contribution of FareShare to the outcomes experienced by the ultimate beneficiaries. Again, we used a combination of data previously collected by FareShare, from a survey of its CFMs and our own interviews, to attribute a proportion of the value of the outcomes experienced to FareShare's activities. Finally, we ran the social impact model with various different assumptions and included a second group of charities that FareShare serves, known as Community Food Associates (CFAs).

The results of this exercise are hugely inspiring. NEF Consulting estimates that, by collecting food that would otherwise go to waste and distributing it to its Community Food Members, FareShare creates approximately £50.9 million of social-economic impact. This is made up of an estimated £6.9 million in social and economic value to the beneficiaries themselves and £44.0 million in savings to the State.

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8. Appendices

Appendix A: Interview Template

CFM Interview Guide

I'm [*insert name*] from NEF Consulting. As you may already know, I'm speaking with you today as part of the evaluation for FareShare. We're working with FareShare to understand the difference that their service has made to your service users, as well as to your organisation.

The purpose of this interview is to understand the outcomes for your organisation and beneficiaries, as a result of engaging with FareShare. By outcome, we mean the impact or change that has occurred as a result of receiving redistributed food. For example, food provision for a breakfast club may lead to an improved diet / nutritional intake for children and therefore improves academic performance.

Your responses will be used by our team internally for analysis. We may use responses internally to inform our evaluation and may quote some interviewees in a public report but your identity will always be kept anonymous.

As we go through the interview questions I will explain a couple of concepts before asking you questions about them. Do you have any questions for me? Are you happy to participate?

Thank you very much for agreeing to be interviewed. The conversation should take about 20-30 minutes.

Introduction: Understanding the context

- Could you tell me a bit about your organisation and your role?

- What are the main aims / goals of your organisation? Are you aware of any evaluation reports or theory of change documents that outline these aims / goals?
    - *Interviewer to collect information before interview as part of the introductory email (if possible).*
    - *Explanation (if needed): A theory of change expresses how your programme, project or intervention creates change and why. It is made up of inputs, activities, and outcomes that express the logic of how your work builds up towards a long-term, given aim or vision. It's normally presented visually in order to show inter-relationships and the interaction of factors.*

- What group would you describe as your primary beneficiary?
    - *Prompt: elderly, alcohol or drug addicts, socially isolated, etc.*

- Do any other beneficiaries benefit from using this service? If so, please could you tell me the secondary and tertiary groups?
    - *Prompt: families, homeless, etc.*

- How many individuals does your organisation serve?
    - *Leave this question open for the answer to be per week, per month, per year, etc.*

Outcomes / Pathways

- Can you describe the key outcomes your organisation is trying to achieve? Please describe the pathway(s) to creating impact for your beneficiaries.
    - *Prompt: This means talking through how the activities and outputs lead to outcomes for your organisation, beneficiaries and the State. Interviewer to go through activities, outputs,* ***short-term*** *outcomes and* ***long-term*** *outcomes.*

- How many beneficiaries in each category (and what beneficiaries) would you say achieve this outcome per year?
    - *If the interviewee described more than one pathway / outcome, we want to know.*

- What indicators do you use to measure the impact for beneficiaries, if any? Are these impacts audited?

- Aside from your beneficiaries, has your organisation benefitted? If yes, please describe these benefits.
    - *Prompt: time savings, more expenditure on equipment, services, etc.*

- What would the outcomes have been if they weren't supported by FareShare?
    - *Talk through the outcomes described in the previous questions from this section of the interview and whether they would be achieved as well as outcomes that have not been mentioned (e.g. more resources spent on food, less resources for elsewhere).*

- If your organisation was to receive more food from FareShare, what impact do you think this would this have, if any?

Attribution

When I speak about attribution, I want to know how much of the change / impact created is regarded as being caused by FareShare or your organisation. Please consider the input of other stakeholders when answering the following questions.

- In your opinion, how much does FareShare's food provision contribute towards improved nutrition for your beneficiaries?

- To what extent does improved nutrition contribute to the outcomes you have outlined?

- How much of the impact created do you think is attributable to your organisation's work and why?
    - *Prompt: Using a scale from 0% – 100%*

- How much do you think the food distributed from FareShare is attributable to your organisation's achieved outcomes?
    - *Prompt: Using a scale from 0% – 100%*

Appendix B: Outcomes Categorisation

	Stakeholder	Reference	Outcome	Outcome category
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Stable and Secure accommodation	Improved housing situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Structured and meaningful occupation of time	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Engagement with treatment and recovery maintenance	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Personal care	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Positive social and economic values and peer relationships	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Work skills and ethic	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Health and wellbeing	Improved mental health Improved physical health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Safety	Miscellaneous

	Stakeholder	Reference	Outcome	Outcome category
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Relationships and reintegration	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with drug and/or alcohol addiction**	Social Return on Investment (SROI) Supported Treatment Accommodation and Recovery in Suffolk (STARS)	Financial stability and employment	Better employment prospects Improved financial situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Have a home 'base' (safe housing)	Improved housing situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Make new friends and (some) improved relationships with family	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Gain practical skills and manage budgets / manage debt	Better employment prospects Improved financial situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Improved mental health	Improved mental health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Improved physical health	Improved physical health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Meaningful use of time (education, training, work)	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Increased confidence and maturity	Improved self-esteem / confidence
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Reduced offending and contact with police	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Resilience and increased ability to live unsupported	Improved self-esteem / confidence
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Increased likelihood of long-term employment	Better employment prospects
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Porchlight Young Persons' Service, Canterbury Forecast SROI	Reduced long-term (adult) homelessness	Improved housing situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased positive contact with family and friends	Improved self-esteem / confidence

	Stakeholder	Reference	Outcome	Outcome category
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased household income	Improved financial situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased citizenship	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Improved independent living skills(cleaning, cooking)	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased employability skills	Better employment prospects
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased employment	Better employment prospects
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Individual able to maintain stable home	Improved housing situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Ability to access further education while in temporary accommodation	Better employment prospects
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased personal confidence	Improved self-esteem / confidence
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased financial capability (budgeting, managing finances)	Improved financial situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Increased access to support services	Increased knowledge and access to other services available
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	An evaluation of social added value for West Bridge Mill Accommodation with Support	Reduced wellbeing due to conflict with flatmates/ other residents	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Highway House SROI	Improved wellbeing of residents	Improved self-esteem / confidence
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Highway House SROI	Improved dietary pattern	Improved nutrition / diet
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Having a home	Improved housing situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Reduced drug and alcohol use	Improved physical health

	Stakeholder	Reference	Outcome	Outcome category
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Improved health	Improved physical health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Improved mental health	Improved mental health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Relationships with children	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Reduced loneliness	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Financial Security	Improved financial situation
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Employment	Better employment prospects
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Crime (perpetrator)	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Crime (victim)	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**Homeless and rough sleepers**	Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12	Leisure	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Engagement in positive activities and getting out of the house.	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Sustaining being in my community	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Improved relationships with other people	Improved social relationships
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Improved physical health	Improved physical health
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Improved mental health	Improved mental health

	Stakeholder	Reference	Outcome	Outcome category
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Contributing to society	Miscellaneous
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	**People with mental health problems**	Glasgow Association for Mental Health, Housing Support Services SROI	Service Users that are more ready to use statutory provision	Increased knowledge and access to other services available
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Through the activities participants feel stimulated and inspired, leading to a sense of self-worth and fulfilment	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Participants make new friends, form better and stronger relationships, and are therefore less lonely	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Regular attendance brings mental stimulation, a more positive outlook, and reduced levels of anxiety and depression	Improved mental health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Over time participants become more confident, more independent, more active in their community, leading to a better quality of life	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Participants start to take more regular and more vigorous exercise	Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	Participants take greater notice of their health and reduce harmful behaviours (e.g. smoking, drinking, and poor diet)	Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Craft Café: a pilot programme from Impact Arts SROI	In order to attend the Craft Café, participants reduce their level of community and voluntary activity to make more time for themselves	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Social Impact of Guild Care Community Services (SROI) (2015)	Reduced loneliness	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Social Impact of Guild Care Community Services (SROI) (2015)	Increased interaction with the community	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Social Impact of Guild Care Community Services (SROI) (2015)	Increased confidence	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Social Impact of Guild Care Community Services (SROI) (2015)	Increased knowledge of other services available	Increased knowledge and access to other services available
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Social Impact of Guild Care Community Services (SROI) (2015)	Improved health	Improved physical health Improved mental health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Older people have the opportunity to meet with others in their community	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	The atmosphere at lunch clubs enables older people to have fun	Miscellaneous
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Older people have someone to check that they are ok/well	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Feel more part of the community	Improved social relationships

	Stakeholder	Reference	Outcome	Outcome category
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Older people feel happier	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Older people are supported to live independently	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Better emotional and physical health	Improved self-esteem / confidence Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	Forecast Social Return on Investment (SROI) of supporting the Community Meals Service in Leicestershire	Maintain independence	Miscellaneous
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	A bite and a blether: Case studies from Scotland's lunch clubs	Socialising opportunities in the local community	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	A bite and a blether: Case studies from Scotland's lunch clubs	Opportunity to build relationships	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**Older people**	A bite and a blether: Case studies from Scotland's lunch clubs	Increase knowledge of services and benefits available	Increased knowledge and access to other services available
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**People with mental health problems**	ESCAPE a Social Return on Investment (SROI) analysis of a Family Action mental health project	Reduced anxiety and stress levels	Improved mental health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**People with mental health problems**	ESCAPE a Social Return on Investment (SROI) analysis of a Family Action mental health project	Improved social confidence	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**People with mental health problems**	ESCAPE a Social Return on Investment (SROI) analysis of a Family Action mental health project	Improved social networks	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**People with mental health problems**	ESCAPE a Social Return on Investment (SROI) analysis of a Family Action mental health project	Improved physical health	Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Spend time socialising, feel less isolated	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Greater ability to cope with emotions	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Degree of change customers report in ability to cope with emotions	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Increased feeling of belonging to community and increased involvement	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	More money weekly to afford basic shop	Improved financial situation

	Stakeholder	Reference	Outcome	Outcome category
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Eating more healthy food (nutrition)	Improved nutrition / diet
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Skipping fewer meals (calories)	Improved nutrition / diet
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	More awareness of food waste	Miscellaneous
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Satisfaction in helping others	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Greater confidence	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Opportunity to learn new skills	Miscellaneous
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Improved skills and experience	Miscellaneous
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Spend time socializing, feel less isolated	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Real Junk Food Project at All Hallows Café Social Return on Investment Evaluation	Increased feeling of belonging to community and increased involvement	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased food affordability	Improved financial situation
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Improved competence, engagement and purpose	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Improved physical health	Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased employability	Better employment prospects
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Improved mental health	Improved mental health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Improved physical health (Children)	Improved physical health
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased resilience and self-esteem	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased sense of trust and belonging	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased sense of trust and belonging (Children)	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased vibrancy and efficiency of VCS	Miscellaneous

	Stakeholder	Reference	Outcome	Outcome category
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased job satisfaction for teachers	Improved self-esteem / confidence
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Increased community membership and participation	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Reduced income leakage through increased local food expenditure	Improved financial situation
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Closer integration of schools with local community	Improved social relationships
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	**General**	The Local Food programme. Final Report: A Social Return on Investment Approach	Generation of local income through contracting	Improved financial situation
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Increase in confidence and self-esteem	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved social interaction skills	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved educational attendance	Improved educational performance
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved physical health	Improved physical health
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved mental and emotional health	Improved mental health
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved social (non-family) relationships	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Pre-school children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved educational performance	Improved educational performance
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Parents**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved self-esteem	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Parents**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved self-confidence / empowerment	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Parents**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Healthier diet	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Parents**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Better employment prospects	Better employment prospects

	Stakeholder	Reference	Outcome	Outcome category
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Reduction in social isolation	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Improved emotional wellbeing	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Social outlet – some mainly attended for social aspect	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Helping with financial difficulties	Improved financial situation
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Provision of routine: Children still have a routine – maintained and easy to fall back into school routine	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	The impact of cooking courses on families: A summary of a research study comparing three different approaches (2013)	Increased knowledge about food and health	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	An evaluation of Holiday Kitchen (2015)	Improved family knowledge of nutrition	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	An evaluation of Holiday Kitchen (2015)	Improved knowledge of budget recreational holiday activities	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	An evaluation of Holiday Kitchen (2015)	Improved social inclusion	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	The impact of cooking courses on families: A summary of a research study comparing three different approaches (2013)	Building confidence - around the ability and desire to try new foods and try new recipes	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	The impact of cooking courses on families: A summary of a research study comparing three different approaches (2013)	Improved cooking skills	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	The impact of cooking courses on families: A summary of a research study comparing three different approaches (2013)	Some impact linked to improved nutrition	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	The impact of cooking courses on families: A summary of a research study comparing three different approaches (2013)	Improved food budgeting	Improved financial situation
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Families	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Supporting children and families	Miscellaneous

	Stakeholder	Reference	Outcome	Outcome category
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	More likely to consume healthy items	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Social outlet / reduce isolation	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	A qualitative evaluation of holiday breakfast clubs in the UK: Views of adult attendees, children, and staff	Helping families become involved in community groups and accessing help beyond breakfast club	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	The Derbyshire School Holiday Food Programme. Evaluation	Working with vulnerable families and linking them into other services and skills training	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	The Derbyshire School Holiday Food Programme. Evaluation	Families enjoying time together	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	The Derbyshire School Holiday Food Programme. Evaluation	good range of activities and opportunities to try new activities and go to new locations	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**Families**	The Derbyshire School Holiday Food Programme. Evaluation	Increased awareness and greater understanding of problems facing families	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	NEF: The economic and social return of Actions for Children's Wheatley Children's Centre, Doncaster (2009)	Better overall education performance	Improved educational performance
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	ESCAPE A Social Return on Investment (SROI) analysis of a Family Action mental health project	Improved self-confidence and aptitude towards school	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of Breakfast Clubs in Schools with High Levels of Deprivation (2017)	Improving behaviour and concentration in class	Improved educational performance
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of Breakfast Clubs in Schools with High Levels of Deprivation (2017)	Social development - making wider friendship groups	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of Breakfast Clubs in Schools with High Levels of Deprivation (2017)	More confidence	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of the Let's Get Cooking programme Final Report (2012)	New food preparation / cooking skills enabling participants to prepare healthier food	Improved nutrition / diet

	Stakeholder	Reference	Outcome	Outcome category
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of the Let's Get Cooking programme Final Report (2012)	92% of club members replicated a skill learnt at the club	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	Evaluation of the Let's Get Cooking programme Final Report (2012)	58% increased nutritional intake	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	A qualitative evaluation of holiday breakfast clubs in the UK: views of adult attendees, children, and staff	Social outlet	Improved social relationships
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Improved holiday nutrition	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Increased positive holiday activities	Miscellaneous
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Improved child holiday emotional health	Improved mental health
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Improved confidence	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Improved wellbeing	Improved self-esteem / confidence
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Reduced child food poverty	Improved nutrition / diet
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Reduced health inequalities	Improved mental health Improved physical health
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	**School children**	An evaluation of Holiday Kitchen (2015)	Improved educational outcomes	Improved educational performance
Drop-in services	**People with mental health problems**	An economic analysis of Acacia Family Support's befriending service	Increased awareness of PND and PND support	Increased knowledge and access to other services available
Drop-in services	**People with mental health problems**	An economic analysis of Acacia Family Support's befriending service	Improvements in mental health	Improved mental health

	Stakeholder	Reference	Outcome	Outcome category
Drop-in services	**People with mental health problems**	An economic analysis of Acacia Family Support's befriending service	Increased ability to cope	Improved self-esteem / confidence
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Stability in home life	Improved housing situation
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Renewed family contact	Improved social relationships
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Improved self-esteem	Improved self-esteem / confidence
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Increased sense of home ownership	Improved housing situation
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Making new social contacts	Improved social relationships
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Creating a sense of completion and achievement	Improved self-esteem / confidence
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Budgeting skills	Miscellaneous
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Improved concentration	Miscellaneous
Drop-in services	**Homeless and rough sleepers**	North Ayrshire Fab Pad Project Impact Arts Social Return on Investment Report	Keeping appointments and maintaining contacts	Miscellaneous

Appendix C: Explanation of Assumptions

Probability-based assumptions for physical health outcomes

A standard set of physical health outcomes was considered for various stakeholder groups, with increased physical activity assumed to result in a reduced risk of cardiovascular disease (CVD), type-2 diabetes and obesity. However, in order to avoid over-claiming the State savings associated with increased physical activity, adjustments were made for the percentage of cases where health issues were likely to have been prevented as a result of increased physical activity.

- For the outcome describing the reduction in the prevalence of CVD, British Heart Foundation[15] provided data on the current occurrence of cardiovascular incidents for UK adults, by age range. This was assumed to represent the probability of experiencing CVD, among CFM beneficiaries. Additionally, secondary medical research indicated that, 'for heart attack patients who participated in a formal exercise program, the death rate is reduced by 20% to 25%.'[16] Taking all of this information in combination, it was calculated that 20% of the 1.4% of beneficiaries who would have experienced CVD in the counterfactual scenario, did not do so, due to improved physical health. This meant that 0.29% of those service users who experienced an improvement in physical health, avoided a cardiovascular incident, as a consequence of this improvement in physical health.
- For the outcome describing the reduction in the prevalence of type-2 diabetes, Diabetes UK[17] provided data on the current prevalence of type-2 diabetes for UK citizens, by age range. This was assumed to represent the probability of developing type-2 diabetes, among CFM beneficiaries. Additionally, secondary medical research indicated that, 'high adherence to a plant-based diet that was low in animal foods was associated with a 20% reduced risk of type 2 diabetes compared with low adherence to such a diet.'[18] Taking all of this information in combination, it was calculated that 20% of the 7.0% of beneficiaries who would have developed type-2 diabetes in the counterfactual scenario, did not develop type-2 diabetes because of improved physical health (in the form of a healthier diet). This meant that 1.4% of those service users who experienced an improvement in physical health, avoided type-2 diabetes as a consequence of this improvement in physical health.
- For the outcome describing the reduction in obesity, it is assumed that all beneficiaries who experience improved physical health following their contact with a

[15] Townsend, N. et al. (2014). *Cardiovascular Disease Statistics 2014.* British Heart Foundation Centre on Population Approaches for Non-Communicable Disease Prevention, p. 61, Table 2.4.
[16] Myers, J. (2003). 'Exercise and Cardiovascular Health', *Circulation, 107, e2-e5.*
[17] Diabetes UK (2014). *Diabetes: Facts and Stats.*
[18] Satija, A. et al. (2016). Plant-based dietary patterns and incidence of type 2 diabetes in US men and women: results from three prospective cohort studies. PLoS medicine, 13(6), e1002039, as cited in https://www.hsph.harvard.edu/news/press-releases/plant-based-diet-reduced-diabetes-risk-hu-satija/

given CFM, will avoid obesity as a result of that improved physical health. Thus, each beneficiary who experiences improved physical health is assumed to save the State the equivalent to the average annual treatment costs to the NHS per person associated with obesity.

- For the outcome describing the reduction in malnutrition for food bank users, secondary research estimated that in 2012, the difference in costs for hospital treatment between a malnourished individual versus a non-malnourished individual was £5,253.[19]
- The same paper found that only 2% of malnourished people in the UK are in hospital at any given time. Department of Health figures for 2015-16 indicated that the average length of hospital stay for malnutrition was approximately 23 days[20], meaning that an average year contains (365/23) = 15.9 hospital stays. Thus, it is assumed that the proportion of malnourished UK citizens who visit hospital in a given year is 2% multiplied by 15.9, which equals 31.7%. It follows that, of those people who avoid malnourishment by using a food bank, only 31.7% would have gone to hospital within a year had they become malnourished. For this reason, the difference in treatment cost, listed above, is multiplied by 31.7% so as not to over-claim savings to the State of malnourishment avoided.

[19] Elia, M. (2015) *The cost of malnutrition in England and potential cost savings from nutritional interventions (short version)*, National Institute for Health Research Southampton Biomedical Research Centre

[20] As cited in https://www.theguardian.com/society/2016/nov/25/huge-rise-in-hospital-beds-in-england-taken-up-by-people-with-malnutrition

Appendix D: Impact map (Values, Proxies and Assumptions)

CFM catergories	Stakeholder	Outcome	Sub-outcomes	Indicator description	Outcome Incidence	Outcome incidence references / notes	Deadweight	Deadweight description / notes	Attribution	Attribution reference / notes	Financial proxy	Financial proxy	Financial proxy reference / notes	Other notes
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved housing situation	Immediate reduction in homelessness	Reduction in emergency accommodation funded by Local Authority	1.00	Outcome incidence is 100% as all beneficiaries of a housing service go from being homeless to housed	0.25	Number was informed by background SRoI/impact assessment literature. Source: Porchlight SRoI page18. Their staff working group estimated deadweight of 25% for this kind of outcome.	0.90	Background SRoI studies suggest that almost all of the benefit of housing services are attributed to the provider. Reduced from 100% due to the likely influence of other organisations in directing the beneficiary to the housing service.	£6,258	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved housing situation	Reduction in offending and associated costs to police/justice	Proportion of SUs experiencing significant reduction in offending (outcomes star measure)	0.13	Highway House SRoI found an improvement of 23 outcomes star points across 4 service users.Assume threshold effect: 4 out of 30 users experienced a significant drop in risk of offending.	0.00	Number was informed by background SRoI/impact assessment literature. Source: Highway House study, page 19: 0%	0.50	Number was informed by background SRoI/impact assessment literature. Source: Highway House study, page 20: 50%.	£401	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.20	West Bridge Mill SRoI found 20% reported "increased positive contact with family or friends"	0.00	Assuming zero: there would have been no improvement in social relationships in the absence of engaging with the programme	0.30	The SRoI of GAMH found attribution of 25% for social relationships. Primary research gave estimates of 30-40% and 75%, with two other CFMs finding it impossible to give a precise figure. Conservative average assumption: 30%	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Better employment prospects		% of SUs gaining a formal qualification while using the service	0.45	10 out of 22 people gained qualification through involvement with programme - Porchlight SRoI	0.02	Research has found that 85% of people suffering from addiction relapse within a year of quitting. So 15% stay off for at least one year, and these people are as likely as the average person to gain a qualification. Assume that 10% of those who stay clean, achieve a qualification within a year (this figure of 10% is a rough estimate, in the absence of data availability): 15% multiplied by 10% = 1.5% https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3674771/#R2	0.19	Number was informed by background SRoI/impact assessment literature. Source: SRoI of Adfam Drug and Alcohol Support Services: 19%	£496	From Manchester Unit Cost Database: fiscal benefit to HM Treasury of an NVQ Level 2 Qualification. Adjusted for inflation to 2017/18 prices.	From Manchester Unit Cost Database: fiscal benefit to HM Treasury of an NVQ Level 2 Qualification. Adjusted for inflation to 2017/18 prices.	There is an implicit assumption that getting a qualification guarantees that a person moves from being on benefits to having a job. This may not be true in all cases.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.69	Outcome incidence estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.20	Deadweight estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.90	Attribution estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p32	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£18	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of cardio-vascular disease in the UK by age and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 0.29% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 0.29%, before subsequently being adjusted upwards for inflation.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People With Drug and Or Alcohol Addiction	Improved financial situation		Reduction in debt-related mental health problems	0.17	Evaluation of Holiday Kitchen, page 30. Reused from Youth CFM type due to lack of available data for Housing CFM type.	0.00	UK personal debt as % of income rose from 127% at end of 2015 to 133% at end of 2017. This implies that the average person's financial situation is unlikely to have improved in the counterfactual scenario. Conservative assumption of deadweight = 0 (rather than less than zero)	0.01	Only 10.5% of HH spending goes to food and non-alcoholic drinks (ONS HH Spending Survey 2018). If we assume that one month a year of food spending is covered by the CFM's service, then this equates to only 0.87% of expenditure.	£1,697	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved housing situation	Immediate reduction in homelessness	Reduction in emergency accommodation funded by Local Authority	1.00	Outcome incidence is 100% as all beneficiaries of a housing service go from being homeless to housed	0.25	Number was informed by background SRoI/impact assessment literature. Source: Porchlight SRoI page18. Their staff working group estimated deadweight of 25% for this kind of outcome.	0.90	Background SRoI studies suggest that almost all of the benefit of housing services are attributed to the provider. Reduced from 100% due to the likely influence of other organisations in directing the beneficiary to the housing service.	£6,258	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	

CFM categories	Stakeholder	Outcome	Sub-outcomes	Indicator description	Outcome incidence	Outcome incidence references / notes	Deadweight	Deadweight description / notes	Attribution	Attribution reference / notes	Financial proxy	Financial proxy	Financial proxy reference / notes	Other notes
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved housing situation	Reduction in offending and associated costs to police/justice	Proportion of SUs experiencing significant reduction in offending (outcomes star measure)	0.13	Highway House SRoI found an improvement of 23 outcomes star points across 4 service users.Assume threshold effect: 4 out of 30 users experienced a significant drop in risk of offending.	0.00	Number was informed by background SRoI/impact assessment literature. Source: Highway House study, page 19: 0%	0.50	Number was informed by background SRoI/impact assessment literature. Source: Highway House study, page 20: 50%	£401	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.69	Outcome incidence estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.20	Deadweight estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.90	Attribution estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p32	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£18	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of cardio-vascular disease in the UK by age and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 0.29% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 0.29%, before subsequently being adjusted upwards for inflation.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Increased knowledge and access to other services available		Percentage of service users experiencing increased knowledge of what services were available	0.60	Emmaus SRoI study: 60% of SUs have a positive 'move on' from their services. Assume that all of these SUs increased their knowledge of services available	0.05	Glasgow Association for Mental Health Housing Support Services SROI	0.90	Emmaus SRoI figure	£51	1 hour of time saved per week, for the first four weeks trying to reach each service user, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. At four weeks per year, this equates to a state saving of £51 per annum per person.	1 hour of time saved per week, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. Over a 52-week year, this equates to a state saving of £663 per annum per person. We scale this up by a factor of 3 to compensate for the higher number of state services relevant for homeless people.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Better employment prospects		% of SUs gaining a formal qualification while using the service	0.45	10 out of 22 people gained qualification through involvement with programme - Porchlight SRoI	0.02	Research has found that 85% of people suffering from addiction relapse within a year of quitting. So 15% stay off for at least one year, and these people are as likely as the average person to gain a qualification. Assume that 10% of those who stay clean, achieve a qualification within a year 1.5% https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3674771/#R2	0.19	Number was informed by background SRoI/impact assessment literature. Source: SRoI of Adfam Drug and Alcohol Support Services: 19%	£496	From Manchester Unit Cost Database: fiscal benefit to HM Treasury of a NVQ Level 2 Qualification	From Manchester Unit Cost Database: fiscal benefit to HM Treasury of a NVQ Level 2 Qualification	There is an implicit assumption that getting a qualification guarantees that a person moves from being on benefits to having a job. This may not be true in all cases.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	Homeless & Rough Sleepers	Improved financial situation		Reduction in debt-related mental health problems	0.17	Evaluation of Holiday Kitchen, page 30. Reused from Youth CFM type due to lack of available data for Housing CFM type.	0.00	UK personal debt as % of income rose from 127% at end of 2015 to 133% at end of 2017. This implies that the average person's financial situation is unlikely to have improved in the counterfactual scenario. Conservative assumption of deadweight = 0 (rather than less than zero)	0.01	Only 10.5% of HH spending goes to food and non-alcoholic drinks (ONS HH Spending Survey 2018). If we assume that one month a year of food spending is covered by the CFM's service, then this equates to only 0.87% of expenditure.	£1,697	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.69	Outcome incidence estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.20	Deadweight estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p56	0.90	Attribution estimate taken from Making an Impact: A Social Return on Investment (SROI) study of Emmaus UK 2011/12, p32	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£18	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of cardio-vascular disease in the UK by age and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 0.29% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 0.29%, before subsequently being adjusted upwards for inflation.
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.

CFM categories	Stakeholder	Outcome	Sub-outcomes	Indicator description	Outcome Incidence	Outcome incidence references / notes	Deadweight	Deadweight description / notes	Attribution	Attribution reference / notes	Financial proxy	Financial proxy	Financial proxy reference / notes	Other notes
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Increased knowledge and access to other services available	Time savings for Community Health staff; Time savings for social workers	Percentage of community health service staff reporting increased capacity as a result of the CFM's activities	0.88	Number was informed by background SRoI/Impact assessment literature. Source: Glasgow Association for Mental Health Housing Support Services SROI	0.05	Number was informed by background SRoI/Impact assessment literature. Source: Glasgow Association for Mental Health Housing Support Services SROI	0.20	Number was informed by background SRoI/Impact assessment literature. Source: Glasgow Association for Mental Health Housing Support Services SROI	£51	1 hour of time saved per week, for the first four weeks trying to reach each service user, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. At four weeks per year, this equates to a state saving of £51 per annum per person.	1 hour of time saved per week, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. Over a 52-week year, this equates to a state saving of £663 per annum per person.	
Housing (e.g. Supported Housing, Residential Rehabilitation Service, Hostel)	People with mental health problems	Improved social relationships	Ability to form relationships; ability to sustain relationships	Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.64	Number was informed by background SRoI/Impact assessment literature. Source: Glasgow Association for Mental Health Housing Support Services SROI	0.0	Zero: If you are a person whose mental health problems are preventing you from forming social relationships, you are unlikely to form more relationships in the absence of some programme to help with this	0.30	The SRoI of GAMH found attribution of 25% for social relationships. Primary research gave estimates of 30-40% and 75%, with two other CFMs finding it impossible to give a precise figure. Conservative average assumption: 30%	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772). Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772). Adjusted for inflation from 2012 to 2018.	
Foodbank	Families and/or People On Low Or No Income	Improved nutrition / diet	People avoiding malnutrition and nutritional deficiency	Percentage of food bank SUs who avoided malnutrition by using the food bank	0.62	Based on finding in Trussell Trust (Loopstra & Lalor, 2017) report that of Food Bank users, 62.4% had experienced severe chronic food insecurity, i.e. "every month or almost every month over the past year, skipping meals, feeling hungry but going without eating, or the most extreme, going whole days without eating". We then assume that these people are would be malnourished if they did not have access to the food bank	0.0	Malnutrition and food bank use are rising in the UK. We assume that people turn to food banks as a last resort, having found no other way to stave off malnutrition.	0.80	Based on primary research: interview with a food bank.	£2,079	[Difference in cost to state of hospital treatment when patient is malnourished vs when patient is not (adjusted for inflation from 2012 to 2018)] multiplied by [probability of going to hospital for malnourishment in a given year, given that you are malnourished]. Cost difference = £6,550.50 Probability = 2% multiplied by number of average hospital stays for malnourishment that would fit in one year Source: Elia (2015) The cost of malnutrition in England and potential cost savings from nutritional interventions (short version)	[Difference in cost to state of hospital treatment when patient is malnourished vs when patient is not (adjusted for inflation from 2012 to 2018)] multiplied by [probability of going to hospital for malnourishment in a given year, given that you are malnourished]. Cost difference = £6,550.50 Probability = 2% multiplied by number of average hospital stays for malnourishment that would fit in one year Source: Elia (2015) The cost of malnutrition in England and potential cost savings from nutritional interventions (short version)	
Foodbank	Families and/or People On Low Or No Income	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£18	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Based on secondary data on the prevalence of cardio-vascular disease in the UK by age and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 0.29% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 0.29%, before subsequently being adjusted upwards for inflation.
Foodbank	Families and/or People On Low Or No Income	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.
Foodbank	Families and/or People On Low Or No Income	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person	Obesity and overweight costs to NHS per person Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.67	Guild SRoI: 85% reported reduced loneliness and increased social interaction; Leicestershire: 16-19% for similar outcomes; Craft Café: 100% of respondents saw improvement Avg of these = 67%	0.10	Guild = 7%; Leicestershire = 5%; Craft Café = 17%; The average of these is 10%	0.75	One CFM reported a figure of 75% in primary research, while others were unable to put a figure on attribution but suggested that it was quite high.	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772). Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 (Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772). Adjusted for inflation from 2012 to 2018.	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.90	Outcome incidence estimate from Craft Café: Social Return on Investment Evaluation (68/72). P29	0.17	Deadweight estimate taken from Craft Café: Social Return on Investment Evaluation, p35	0.12	Attribution estimate taken from ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, p28	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs Inflation adjusted	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008)	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Increased knowledge and access to other services available		Percentage of service users reporting increased knowledge of what services were available	0.35	Guild Care SRoI p12: roughly 35% of service users reported an increase in knowledge of what other services (non-Guild) were available	0.07	As estimated in Guild Care SROI	0.09	As estimated in Guild Care SROI	£51	1 hour of time saved per week, for the first four weeks trying to reach each service user, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. At four weeks per year, this equates to a state saving of £51 per annum per person.	1 hour of time saved per week, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. Over a 52-week year, this equates to a state saving of £663 per annum per person.	

CFM categories	Stakeholder	Outcome	Sub-outcomes	Indicator description	Outcome incidence	Outcome incidence references / notes	Deadweight	Deadweight description / notes	Attribution	Attribution reference / notes	Financial proxy	Financial proxy	Financial proxy reference / notes	Other notes
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.65	Outcome incidence estimate from Craft Café: Social Return on Investment Evaluation (30/72). p29	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£228	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of cardio-vascular disease among older people in the UK and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 3.6% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 3.6%, before subsequently being adjusted upwards for inflation.
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.65	Outcome incidence estimate from Craft Café: Social Return on Investment Evaluation (30/72). p29	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	Older people	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.65	Outcome incidence estimate from Craft Café: Social Return on Investment Evaluation (30/72). p29	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	People with mental health problems	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.25	Outcome incidence estimate taken from The Local Food programme: A Social Return on Investment Approach (p23)	0.19	Deadweight estimate taken from Craft Café: Social Return on Investment Evaluation, p35	0.12	Attribution estimate taken from ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, p28	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	People with mental health problems	Improved physical health	Reduction in the prevalence of cardiovascular disease	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£18	The average cost of a hospital admission for a CVD event is £4,614. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	Based on secondary data on the prevalence of cardio-vascular disease in the UK by age and on the link between physical health and the risk of cardio-vascular disease, it was estimated that 0.29% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £4,614 was multiplied by 0.29%, before subsequently being adjusted upwards for inflation.
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	People with mental health problems	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£19	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s).	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	Based on secondary data on the prevalence of type-2 diabetes in the UK by age and on the link between physical health and the risk of type-2 diabetes, it was estimated that 1.4% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 1.4%, before subsequently being adjusted upwards for inflation.
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	People with mental health problems	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.25	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48)	£257	Obesity and overweight costs to NHS per person	Obesity and overweight costs to NHS per person Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough	
Community Services (e.g. Lunch Club, Community Café, Day Centre, Community Centre)	People with mental health problems	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	1.00	Based on ESCAPE SRoI (p18) survey findings: 100% experienced improvement	0.22	ESCAPE SRoI survey found a figure of 22%	0.78	Escape SRoI found a figure of 78%. One CFM contacted in primary research gave a similar figure of 75%	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	Improved financial situation		Reduction in debt-related mental health problems	0.17	Evaluation of Holiday Kitchen, page 30	0.00	UK personal debt as % of income rose from 127% at end of 2015 to 133% at end of 2017. This implies that the average person's financial situation is unlikely to have improved in the counterfactual scenario. Conservative assumption of deadweight = 0 (rather than less than zero)	0.01	Only 10.9% of HH spending goes to food and non-alcoholic drinks (ONS HH Spending Survey 2018). If we assume that one month a year of food spending is covered by the food clubs, then this equates to only 0.87% of expenditure.	£1,697	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	PSSRU 2017 page 52: on average, "the annual costs of health and social service use [associated with debt-related mental health problems] are £1,697"	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	Parents	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.64	Glasgow Association for Mental Health Housing Support Services SROI. Reused for this type of CFM in the absence of more precise secondary research.	0.0	No data available on the change in social relationships that would have occurred anyway for these stakeholders. Assume no long-term trend, so that deadweight equals zero.	0.30	No data available for this type of CFM in background literature. No figure given for this type of CFM in primary research. Assumed the same attribution as used for this outcome for the housing CFMs, which was based on the GAMH SRoI and primary data collection. Conservative attribution estimate of 30%.	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	

CFM categories	Stakeholder	Outcome	Sub-outcomes	Indicator description	Outcome incidence	Outcome incidence references / notes	Deadweight	Deadweight description / notes	Attribution	Attribution reference / notes	Financial proxy	Financial proxy	Financial proxy reference / notes	Other notes
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved educational performance	Reduction in children with conduct problems	% improvement in conduct and behaviour	0.11	Percentage increase of educational attainment found in study of breakfast clubs (Evaluating the Magic Breakfast intervention, p11) We make the simplifying assumption that higher educational attainment is accompanied by better conduct.	0.00	Assumption there is no long-term trend in child conduct	0.20	No attribution data available. A conservative estimate of 20% considered	£151	The costs of a representative intervention, including teacher training, programme co-ordinator and materials per child per year	Source: Unit Costs of Health and Social Care 2017 - PSSRU	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved educational performance	Increased educational attainment	% increase in educational attainment achieved by child in a year	0.11	Percentage increase of educational attainment found in study of breakfast clubs (Evaluating the Magic Breakfast intervention, p11)	0.08	Percentage of children reaching "expected standard" at KS2 level in UK in 2017 was 8% higher than in 2016	0.20	No attribution data available. A conservative estimate of 20% considered	£12,544	Opportunity cost: average annual salary of 16–17-year-olds in full-time work	Source: The economic and social return of Action for Children's Wheatley Children's Centre, Doncaster p21	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.64	Glasgow Association for Mental Health Housing Support Services SROI. Reused for this type of CFM in the absence of more precise secondary research. Corroborated by Evaluation of Breakfast Clubs in Schools with High Levels of Deprivation (2017): "Interviewees in most schools emphasised the social benefits of pupils attending breakfast clubs… Most schools emphasised the benefits that breakfast clubs brought to some of their most socially reserved pupils."	0.00	No data available on the change in social relationships that would have occurred anyway for these stakeholders. Assume no long-term trend, so that deadweight equals zero.	0.30	No data available for this type of CFM in background literature. No figure given for this type of CFM in primary research. Assumed the same attribution as used for this outcome for the housing CFMs, which was based on the GAMH SRoI and primary data collection. Conservative attribution estimate of 30%.	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.25	Outcome incidence estimate taken from The Local Food programme: A Social Return on Investment Approach (p23)	0.07	Deadweight estimate taken from The Local Food programme: A Social Return on Investment Approach (p25)	0.12	Attribution estimate taken from ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, p28	£307	Average cost of service provision for children/ adolescents suffering from mental health disorders, per person per year - total fiscal cost (to the NHS)	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved physical health	Reduction in the prevalence of type 2 diabetes	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.15	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	£0	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s). Note: because the incidence of type-2 diabetes among children is very low in the UK, this financial proxy is very low (approximately £0.02) for the average child.	Medication and healthcare for type-2 diabetes is £1,000. This has been adjusted down for the % of cases likely to be prevented by the CFMs' programme(s). Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	Based on secondary data on the prevalence of type-2 diabetes among children in the UK and on the link between physical health and the risk of type-2 diabetes, it was estimated that 0.0014% of cases would be prevented by the CFMs' programmes. Therefore the unit cost of £1,000 was multiplied by 0.0014%, before subsequently being adjusted upwards for inflation.
Youth and Children services (e.g. Children and Families Centre, Out of School Club, Youth Centre, School, School Breakfast, After School)	School children	Improved physical health	Reduction in the prevalence of obesity	Percentage of service users reporting an improvement in physical health, via more regular exercise and a reduction in harmful behaviours (e.g. smoking, drinking, unhealthy eating)	0.15	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	0.07	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	0.63	Incidence, deadweight, attribution, drop-off taken from The Local Food programme: A Social Return on Investment Approach (p23, 25, 48) Adjusted for Children	£257	Obesity and overweight costs to NHS per person	Obesity and overweight costs to NHS per person Source: BHF National Centre. 2014. Economic Costs of physical inactivity - Evidence briefing, University of Loughborough Inflation adjusted	
Drop-in services	People with mental health problems	Improved mental health Increased self-esteem and confidence	Reduction in the use of mental health service provisions	Reduction in the use of mental health service provisions	0.25	Outcome incidence estimate taken from The Local Food programme: A Social Return on Investment Approach (p23)	0.07	Deadweight estimate taken from The Local Food programme: A Social Return on Investment Approach (p25)	0.12	Attribution estimate taken from ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, p28	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008) Inflation adjusted	
Drop-in services	People with mental health problems	Increased knowledge and access to other services available		Percentage of service users reporting increased knowledge of what services were available	0.35	Guild Care SRoI p12: roughly 35% of service users reported an increase in knowledge of what other services (non-Guild) were available	0.07	Number was informed by background SRoI/impact assessment literature. Source: Guild Care SROI	0.09	Number was informed by background SRoI/impact assessment literature. Source: Guild Care SROI	£51	1 hour of time saved per week, for the first four weeks trying to reach each service user, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. At four weeks per year, this equates to a state saving of £51 per annum per person.	1 hour of time saved per week, valued at hourly salary of an NHS administrative and clerical staff member. This was £23,197 per annum in 2017, which at 52 weeks of 35 hours, gives an hourly rate of £12.75. Over a 52-week year, this equates to a state saving of £663 per annum per person.	
Drop-in services	Homeless & Rough Sleepers	Improved mental health Increased self-esteem and confidence		Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs Note: outcomes considered the same as 'improved mental health'	0.25	Outcome incidence estimate taken from The Local Food programme: A Social Return on Investment Approach (p23)	0.07	Deadweight estimate taken from The Local Food programme: A Social Return on Investment Approach (p25)	0.12	Attribution estimate taken from ESCAPE: a Social Return on Investment (SROI) analysis of a Family Action mental health project, p28	£1,109	Average cost of service provision for adults suffering from depression and/or anxiety disorders, per person per year - fiscal and economic costs Inflation adjusted	Source: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008), p.118	
Drop-in services	Homeless & Rough Sleepers	Improved housing situation	Immediate reduction in homelessness	Reduction in emergency accommodation funded by Local Authority	0.40	North Ayrshire Fab Pad SRoI estimated that 9 out of their 22 service users had avoided homelessness during the first year of using their drop-in service	0.09	Number was informed by background SRoI/impact assessment literature. Source: North Ayrshire Fab Pad SRoI estimated deadweight at 9%	0.10	Data on this attribution figure were not available. Attribution from a drop-in service to securing housing was assumed to be low, and conservatively estimated at 10%	£6,258	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	From Manchester Unit Cost Database: Temporary accommodation - average weekly cost of housing a homeless household in hostel accommodation. Multiplied by 52 to get annual cost. Adjusted for inflation to 2017/18 prices.This in turn comes from Research briefing: Immediate costs to government of loss of home (Shelter, 2012), p.4 Note: we make the simplifying assumption that homeless beneficiaries are single and without children, so that each beneficiary is a household.	
Drop-in services	Homeless & Rough Sleepers	Improved housing situation	Reduction in offending and associated costs to police/justice	Proportion of SUs experiencing significant reduction in offending	0.18	North Ayrshire Fab Pad SRoI estimated that 4 out of their 22 service users experienced a significant reduction in offending	0.09	Number was informed by background SRoI/impact assessment literature. Source: North Ayrshire Fab Pad SRoI estimated deadweight at 9%	0.10	Data on this attribution figure were not available. Attribution from a drop-in service to securing housing was assumed to be low, and conservatively estimated at 10%	£401	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	Assume that using the service leads to avoiding one incident of theft per year per service user. Proxy from Manchester Unit Cost Database (adjusted to 2017/18 prices): cost to state of £401 per incident. Includes cost to Police and Criminal Justice System.	
Drop-in services	Homeless & Rough Sleepers	Improved social relationships		Proportion of SUs expressing improvement in their ability to form or sustain relationships	0.46	Number was informed by background SRoI/impact assessment literature. Source: Porchlight SRoI study: 46% experienced better relationships with their families	0.00	No data available on the change in social relationships that would have occurred anyway for these stakeholders. Assume no long-term trend, so that deadweight equlas zero.	0.30	No data available for this type of CFM in background literature. No figure given for this type of CFM in primary research. Assumed the same attribution as used for this outcome for the housing CFMs, which was based on the GAMH SRoI and primary data collection. Conservative attribution estimate of 30%.	£399	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	Quality of life improvements from better mental health as a result of attending a befriending programme was estimated at £300 in 2010 [Knapp et al (2010) Building community capacity: making an economic case. PSSRU Discussion Paper 2772]. Adjusted for inflation from 2012 to 2018.	