Community Champions

Social Return on Investment evaluation

October 2017 to May 2018

COMMUNITY Champions

ENVOY Partnership

About Envoy Partnership

Envoy Partnership is an advisor in evidence-based research and strategic communications. We specialise in measuring and demonstrating the value of social, economic and environmental impacts. We are dedicated to providing organisations, stakeholders, investors and policy makers with the most holistic and robust evaluation tools with which to enhance their decision-making, performance management and operational practices.

About Social Return on Investment

Social Return on Investment (SROI) is a form of evaluation that enables a deeper understanding of an organisation's impact on people, the economy, and the environment. It helps assess whether a project is good *value for money* and can help decision-makers decide where to invest to maximise their impact and added value to society. The development of SROI in the UK has been funded by the Cabinet Office, and the Scottish Government (through the *SROI Project*). It is increasingly used to measure value-for-money in statutory commissioning and works procurement, to meet the requirements of the Public Services Act (2012) and is part of guidance produced by the National Audit Office.

Contents

Glossary of key terms

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

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

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

CCG – Clinical Commissioning Group

Deadweight – A measure of the amount an outcome would have happened anyway had the activity not taken place (can also be termed 'Counter-factual')

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

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

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

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

LBHF – London Borough of Hammersmith & Fulham

NICE – National Institute for Health and Care Excellence

Outcome – A change in the final benefit or dis-benefit that results from an activity, mainly defined from the perspective of the stakeholder

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

RBKC – Royal Borough of Kensington & Chelsea

SROI – Social Return on Investment

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

WCC – Westminster City Council

Community Champions
Evaluation of Social Return on Investment (SROI)

Executive Summary of findings

The Health and Social Care Act (2012) and Care Act (2015) set out to tackle health inequalities across the life course, and across the social determinants of health. The challenges for local authorities and health and care services have not been solely to reduce costs, but also to work in more joined-up ways with their resources; to tackle socially embedded health issues, yet design approaches that increase quality, choice, and access.

A significant area is the role of social capital, and how unlocking this can lead to resource efficiencies across the NHS, public health, and social care. This means that cost-effectively improving access to health and social care can be partly achieved by using local people's relationships, networks, assets (e.g. community centres) and their ability to transfer health knowledge directly and consistently to their peers.

The Community Champions programme is well-positioned to meet these challenges and support the NHS in achieving its **Five Year Forward View** (2014). Community Champions are local people who volunteer at a community centre or 'hub', to promote the health and well-being of all residents - meaningfully reaching around 200-300 households per hub a year. They support access to, and awareness of, local services; and also motivate residents towards improving health and well-being behaviours, health and wellbeing knowledge, self-care, and resident participation.

The approach is built on hub co-ordinators recruiting and *empowering* their champions to be assets for the whole community and getting Champions to 'take the initiative' in motivating and encouraging others.

At the time of the previous evaluation (2014) the Community Champions programme covered 6 hub locations co-funded by Public Health across partner boroughs: London Borough of Hammersmith & Fulham (LBHF), Royal Borough of Kensington & Chelsea (RBKC), and Westminster City Council (WCC). The programme grew and scaled up from 6 to 15 hub locations, (with additional sub-groupings for Maternity champions and Diabetes Awareness champions).

Champions are provided with accredited training to deliver guidance in a professional non-judgmental manner, on public health and mental health behaviours and improvement. Champions work across various community settings and interactions (often during activity sessions) with households, or people they know.

The partner local authorities commissioned Envoy Partnership to conduct a follow-up SROI analysis of the updated Community Champions programme. SROI is a stakeholder-informed cost-benefit analysis that uses a broader understanding of value for money. It can assign values to social and environmental measures of change (outcomes) as well as economic outcomes, and helps organisations make improved spending decisions[1].

Key estimates and progression

Our analysis indicates key output figures below, after accounting for double-counting of activities, impact, and number of households:

Table A. Output estimates for Community Champions 2016-2017

Number of households meaningfully participating (*15 hubs' catchment c.7200 homes*)	c.3500
Number of Adults meaningfully reached	c.4300
Number of Children meaningfully reached	c.3000
Number of residents participating in frequent physical exercise classes through Champions	c.450-550
Proportion of households having a member with mental health condition	7%
Proportion of households with older residents (over 65s)	13%
Average cost of diabetes (type 2) severity leading to need for long-term care (per person)	£40,000
Average cost to acute health services of cardio-vascular illness (per patient)	£7,700

[1] For more information see the SROI guide, published by the UK Cabinet Office (2008)

At least 24,500 cumulative logged volunteering hours are estimated for 2016-2017. The cumulative number of **'active' Champions grew from c.80 in 2014, to around 300 for 2016 and 2017**. (However, we have adjusted this to an 'annualised' range c.160-180, to account for a proportion of Champions dropping out, or being in tenure for more than 2 years and the related impact having dropped off). Our research included analysis of project activity data, as well as primary research through surveys with 238 resident and 75 Champions; and interviews with residents and other statutory stakeholders. We can compare the output measures in the Table A (above) to 2014 measures, where c.1100 households were actively participating and interacting with Champions activities at 6 hubs; and c.1500 Adults and 1300 Children were reached.

In this year's evaluation, there has been **a similar proportion (c.30%) of residents reporting that they have reduced their waist size** by around 1-2 inches, and lost an average of c.4kg (half a stone) of weight. This is further reflected by the numbers of residents actively participating in frequent physical exercise, having **increased by a multiple of 2.5 times**, (c.400-450 now taking up frequent exercise) compared to the previous results in 2014. Affordable yoga and zumba dances are increasingly popular.

There has also been an increase in Champions referring and signposting residents to mental and emotional health support and to activities that help to reduce social isolation and loneliness. Additionally, there has been increased demand for welfare guidance and advice; and this often coincides with relatively high levels of nutritional need and food poverty (with poor access to affordable groceries).

Other encouraging improvements in our comparative analysis include the development of Maternity Champions supporting young mothers and infant health; as well as **Junior Champions**, comprised of schoolchildren (Queen's Park) delivering health messages and positive social interactions to their peers and older people in sheltered housing schemes. This inter-generational activity is creating multiple impacts in terms of health, wellbeing and educational attainment/performance as school, and is to be commended – and arguably replicated further.

There has also been at least one case where Champions from one hub have been primed in their knowledge and skills, to a level where they have become involved in re-shaping the entity and **governance of a Tenant and Resident's Association (TRA)**. Working together with the local authority, Champions are chairing and participating in the re-vitalisation of a tenant's hall and working on its charitable status, in order to open up the hall again to the local community. This reflects the potential depth impact on enabling resident empowerment.

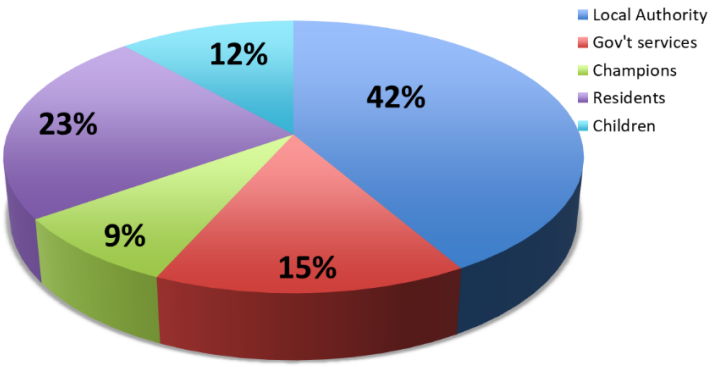
The main report explores other key improvements and progression compared to the 2014 evaluation.

SROI estimate: c.£5-£6 per £1 invested[2]

In our SROI model, we have again followed the principles and stages outlined in the Cabinet Office SROI Guide (2008), which provides a method to apply financial proxy values to measures of change in stakeholder outcomes. **Key stakeholders** in our analysis include government services in terms of NHS services and DWP/Unemployment allowance claims; Adult social care and long-term care; local residents; Champions; and children of residents.

Using output estimates combined with measures of change in key stakeholder outcomes (also see ***Charts B and C***) we have modelled the value of net impact generated for the key stakeholders (i.e. after attribution counter-factual, and double-counting of activities, impact, and households). This **value is c.£5 million**, compared to c.£930,000 invested per year, including programme staffing at local authority.

Chart A. Value distribution of socio-economic impact, by stakeholder group



[2] The range is influenced by the level of Quality Adjusted Life Year value, ranging from £20,000 to £30,000, used by the National Institute for Health and Care Excellence (NICE) and the British Medical Association

The resulting values are mainly due to higher levels of participation and scale of reach, particularly around increases in frequent physical exercise. This correlates with higher reports of weight loss and waist size reduction; as well as with reaching more vulnerable households i.e. with mental health conditions or at risk of isolation and loneliness.

The biggest beneficiaries are residents and children (35% share of value, due to improved health and wellbeing value) and also local authority services (42% share of value due to added resource value to social care). There is a larger impact in this regard for care services and local authority resource savings e.g. wheelchair provision, occupational therapy, adaptations for blindness or amputations; through more residents delaying or avoiding the onset of severe type 2 diabetes (c.400 from 4300 meaningfully reached). There are also potential resource savings from avoidance of cardio-vascular illness and mental health illness for the NHS. The average long-term cost to social care services of having to support a person who has developed diabetes type 2 can be estimated to be £40,000 over 5 years of requiring that support (Institute of Diabetes for Older People, 2013, *The Hidden Impact of Diabetes on Social Care*).

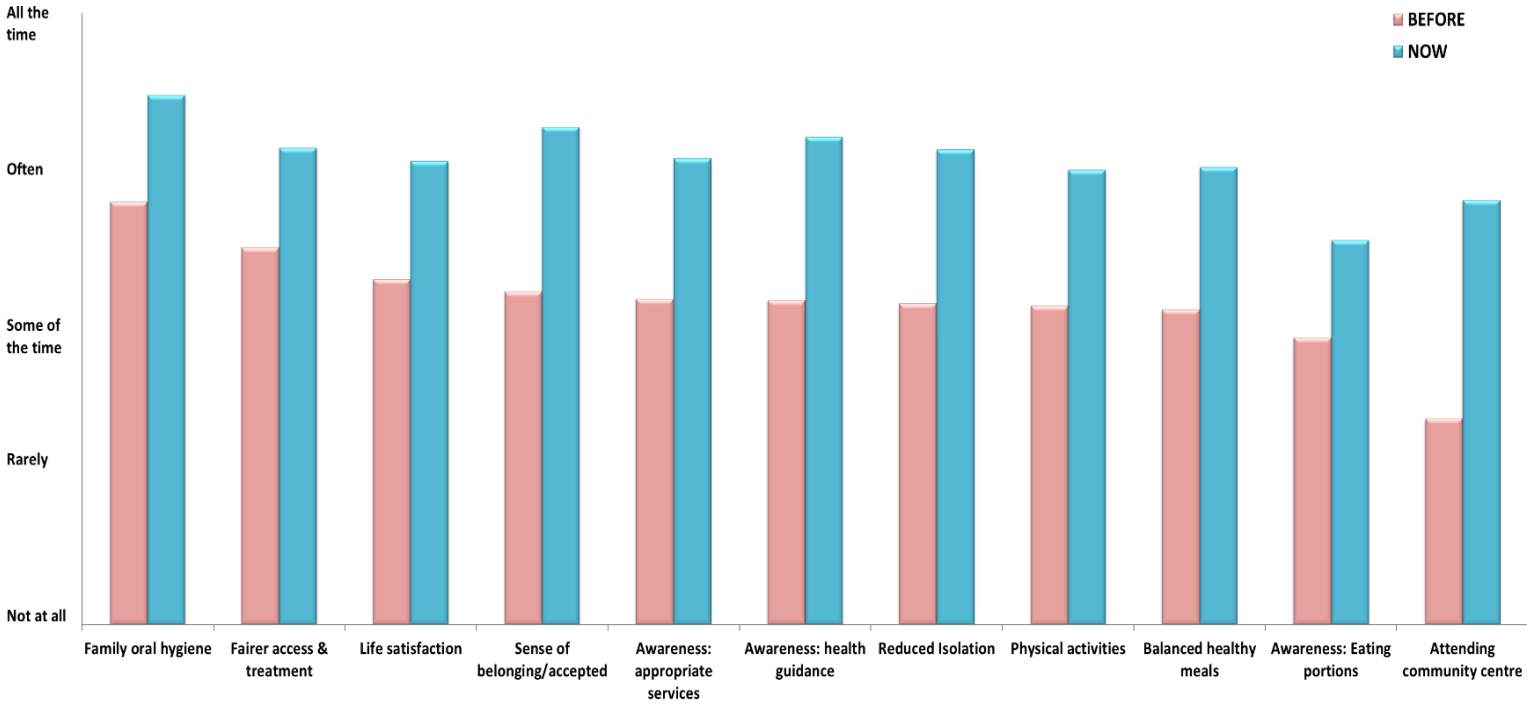
Resident health and wellbeing was valued using Quality Adjusted Life Year (QALY) values and health economics approach. This links the measures of change in certain physical health and mental wellbeing outcomes, to sub-proportions of a full QALY value[3] based on the 'distance travelled' in those measures (which we have mainly drawn from indicators in either the health questionnaire 'EQ5-d' and the short Warwick-Edinburgh Mental Wellbeing Scale). Residents and Champions reported a two-year benefit period i.e. impact lasts for two years, and we have applied a drop-off rate and discount rate to bring forward the present value of this.

Arguably, Community Champions are also well-positioned to support the 'Prevention' and 'Self-Care' agendas of local health and care commissioning, aiming to empower patients with more knowledge and motivation to manage their own health and wellbeing within community settings.

Outcome measures in detail

In term of indicators of change i.e. distance travelled in outcomes, this is presented in Chart B for Residents.

Chart B. Key health and wellbeing outcome indicators for residents, as a result of Community Champions: scores before vs now (n=238)



[3] £20,000 as per 2017 guidance from British Medical Association, *Exploring the cost effectiveness of Early Intervention and Prevention*

Whilst there are improvements in all of the indicators, the biggest changes for residents are in reduced isolation, increased uptake of physical exercise, improved sense of belonging and being accepted in the community, increased attendance at community centre activities, and improved awareness of health guidance and available health support services in the community.[4]

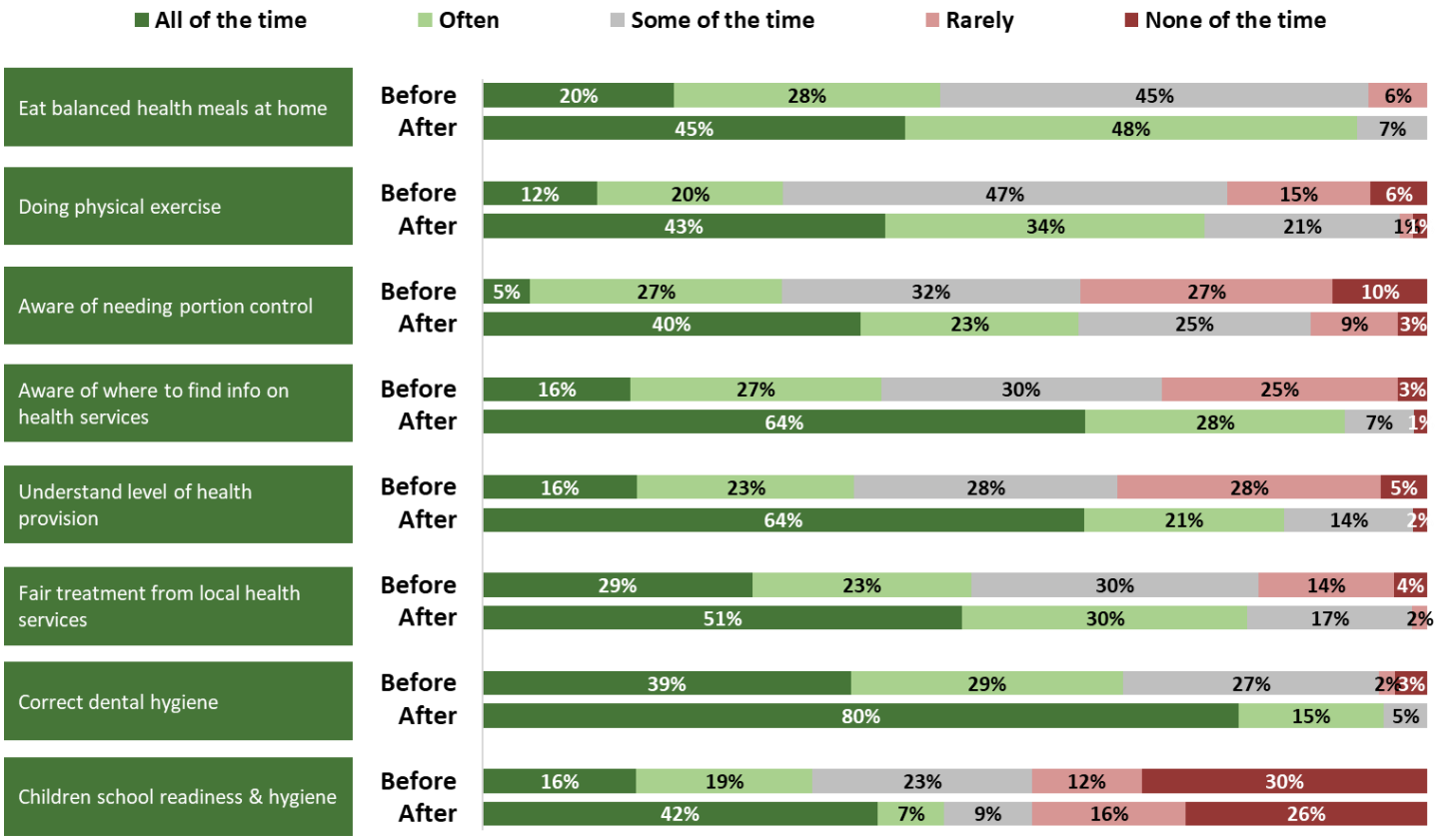
We collected survey data from 238 residents and 75 champions across the hubs. Questions were designed on a 5-point scale on a reflective 'post vs pre' format. It should be noted that consistently across the sample that the starting point for 'Before' scores were higher than in the previous 2014 evaluation, suggesting that the level of impact was somewhat sustained in those communities.

In terms of other outcomes for Champions, selected indicators of change (Before v After) are presented in Charts C(i) and C(ii). The project has also achieved success where Champions (approx. one in eight) have also built their confidence, experience, and skills, to progress to paid work in public health or community development.

To achieve broader reach and of impact, there has been a growing number of roles that Champions are being asked to provide in different situations, in particular: signposting, advocacy, intervention, knowledge-transfer, research, cross-sector referral, empowerment, awareness-raising, and participating in events. To fulfil this growing remit and sustain their reach, continued investment in training, and also leadership training of co-ordinators may be required; otherwise some Champions may be stretched too far out of their depth in future.

Table 2 (in the main report) provides a summary of activity types in which Champions are involved.

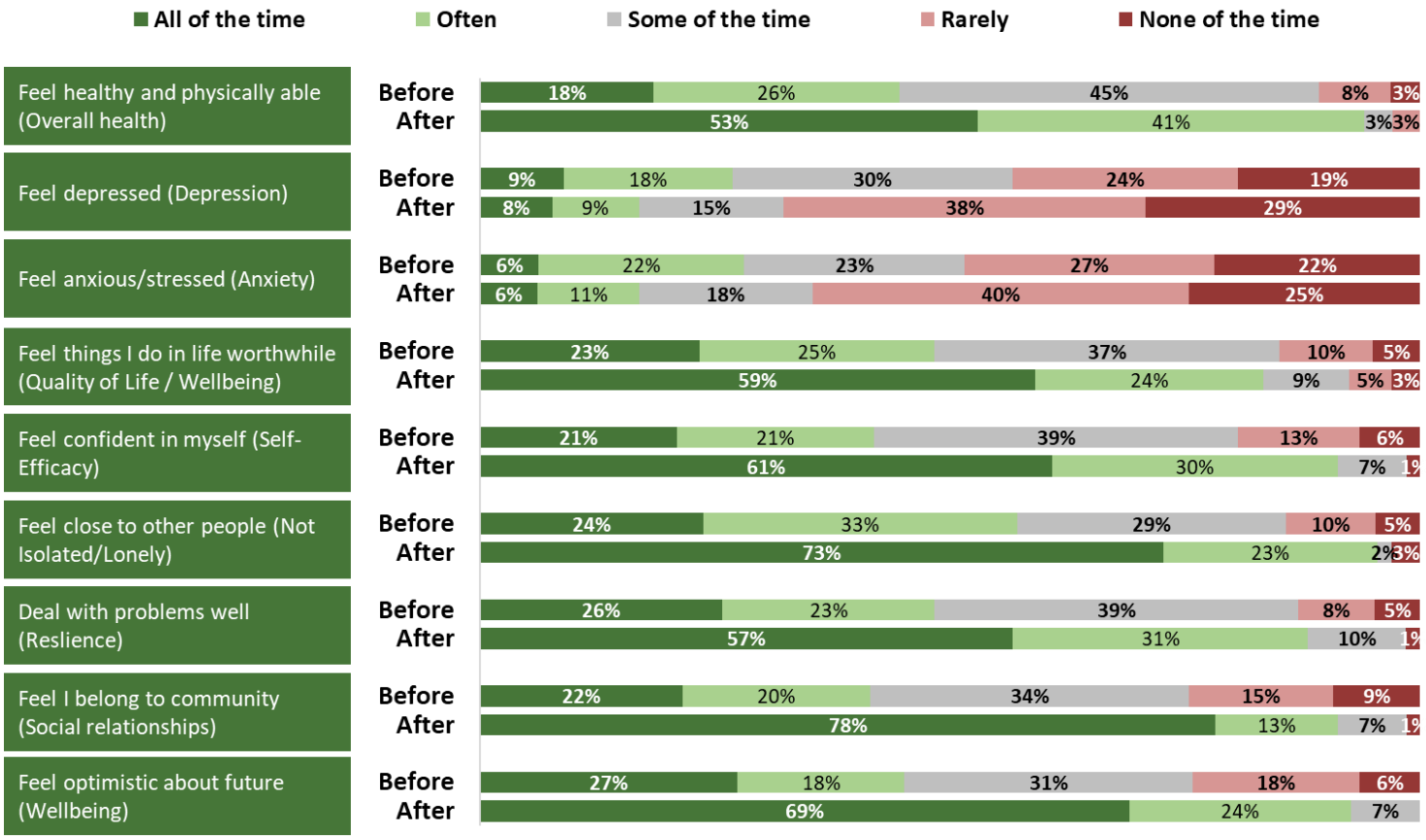
Chart C(i). Health behaviour indicators for Community Champions: scores before vs now



Q12. *"Thinking about your experience of the Community Champions project, how would you rate the following aspects?" n=75 (Except last school readiness & hygiene, n=26)*

[4] It should be noted that some households without children will have some effect on the responses regarding impact on children.

Chart C(ii). Wellbeing indicators for Community Champions: scores before vs now



Q9. *"Thinking about your experience of the Community Champions project, how would you rate the following aspects?" n=75*

The programme is still working very well and has improved diversity and inclusion and pushed forward with cross-sector working. The Community Champions programme is now characterised by more collaborative networks and higher levels of social capital – the power of this is increasingly recognised by statutory partners.

Going forward, programme staff can continue managing expectations carefully, so that collaboration with statutory partners is based on a shared understanding of how the development of Champions' capabilities and their clear remit can best support cross-sector working towards shared outcomes.

In our view the programme offers one of the strongest semi-structured community-based approaches in London, and is meeting the Public Health White Paper recommendation to deliver health and care that is "*owned by communities and shaped by their needs*". **Therefore, funding should be continued, and allocated to a small number of new hubs if resources permit this.**

Further recommendations are provided in the main report, and are mainly based on:

- Allocation of future resources vs sustainability of hubs
- Progression and involvement of experienced Champions with longer tenure
- Dementia-friendly activities/hubs
- Continued inter-generational activities
- Further alignment with the Self-Care agenda
- Resident empowerment in local decision-making through Champions
- Potential gaps for the future

1. Background to Community Champions

The UK government has allocated responsibility to the NHS and also local authorities to improve the health and wellbeing of their local populations, through better integration of health care and social care. The Health and Social Care Act (2012) and Care Act (2015) set out to '*tackle health inequalities across the life course*' and '*across the social determinants of health'*. The challenges for local authorities and health and care services are not just to reduce costs, but to work with their resources in more joined-up ways; to tackle socially embedded health issues, and design approaches that increase quality and access. These challenges need to be met while an ageing population is leading to greater stretch on health and social care services.

One significant approach to addressing these challenges is through the unlocking of social capital within local communities. Our previous 2014 evaluation of Community Champions demonstrates this has led to resource efficiencies across the NHS, public health, and social care system. This indicates that improving access to health and social care can be partly achieved by using local people's experience, relationships, networks, and community assets (e.g. community centres). It can empower the sharing of health knowledge directly between peers (for example, around effective use of health services and encouraging healthy behaviours).

This means going beyond the two-way conversation between primary care and patient, to a fully collaborative approach across sectors, involving local people and VCS groups in how local health and care services – from *both* statutory and non-statutory sectors – are designed and accessed.

How the Community Champions model works

The Community Champions model is designed to meet these challenges. Community Champions are local people who volunteer to promote the health and well-being of local residents - meaningfully reaching around 200-300 households per hub per year[5]. They support awareness of and access to local services, and motivate residents to improve their own health and well-being behaviours, self-care, and community participation. The approach is based on hub co-ordinators empowering their Champions to be assets for the whole community, and getting Champions to 'take the initiative' for outreach, engagement, and opportunities for health promotion.

The original Community Champions programme covered six hub locations co-funded by Public Health functions across London Borough of Hammersmith & Fulham (LBHF), Royal Borough of Kensington & Chelsea (RBKC), and Westminster City Council (WCC). The programme grew and scaled up from six to fifteen hub locations, with additional sub-groupings for Maternity champions and Diabetes Awareness champions. Hubs may share similar health needs, but each hub starting point and demographic profile may differ, and therefore the Champions' activities are designed around the needs that their local community has identified. Some 'clusters' of hub co-ordinators are co-managed by commissioned local VCS partner organisations, such as Paddington Development Trust (PDT) and Urban Partnership Group (UPG).

Champions are provided with training to deliver guidance in a professional manner, receiving RSPH (Royal Society for Public Health) accredited training. In addition, Champions have attended a wide range of high-quality training courses, including mental health first aid, emergency and paediatric first aid, adult and child safeguarding, scam awareness, money mentoring, nutrition and food safety.

[5] This comprises a mix of new households in the main, with some previously participating households who try completely new activities that were not part of previous provision

2. Research approach

Public Health functions across the partner local authorities commissioned Envoy Partnership to conduct a follow-up SROI analysis of the new updated Community Champions programme. This section describes the research approach and principles followed.

Research principles

Static reporting frameworks, no matter how sophisticated, often risk providing only narrow evidence on which to base decisions, rather than demonstrating the dynamic flows of value arising from different functions and outcomes, over the short and long term. SROI is unique in its ability to translate the measurement of social values into economic language. It is a stakeholder-informed cost-benefit analysis that uses a broader understanding of value-for-money. It can assign values to social and environmental outcomes as well as economic outcomes, and helps organisations make improved spending decisions.

The methodology followed in this report directly draws on the UK Cabinet Office's *Guide to Social Return on Investment*.[6] SROI proceeds via six distinct stages, as defined in the guide. It is a *mixed methodology* approach, relying on both *qualitative* research (particularly in stage 2 below) and *quantitative* research (particularly in stages 3 and 4 below):[7]

1. Establishing scope and identifying key stakeholders
2. Mapping of outcomes
3. Evidencing outcomes and giving them a value
4. Establishing impact
5. Calculating the SROI
6. Reporting, using and embedding

The Envoy research team conducted the SROI research between October 2017 and May 2018. The research was underpinned by the **Seven Principles** of SROI as set out in the Cabinet Office SROI Guide, and shown in the box on the right.

The Seven Principles of SROI

1. Involve stakeholders
2. Understand what changes
3. Value the things that matter
4. Only include what is material
5. Do not over-claim
6. Be transparent
7. Verify the result

Mapping a theory of change

SROI analysis involves the development of a Theory of Change (under 'Stage 2 – Mapping Outcomes'), and is summarised in section four. This shows the stakeholders affected by Community Champions, the inputs and activities involved, and the outputs and outcomes that arise. Once identified and tested, it is easier to identify appropriate indicators that demonstrate the magnitude of change in outcomes. Measurement focuses on the ultimate benefit or change experienced by stakeholders, as well as the outputs - the quantifications of activities e.g. the number of residents.

Figure 1: SROI process (theory of change)

[6] *A guide to Social Return on Investment*, (2012), Cabinet Office. For more details, see http://www.socialvalueuk.org/resources/sroi-guide/
[7] *Ibid.,* pages 9-10

Establishing impact

In SROI terminology, 'Impact' is a measure of the difference made by the project or organisation being evaluated. It recognises that there is likely to be a difference between the change observed, and the change for which the project or organisation can claim credit. Such considerations are important to ensure that the analysis does not over-estimate value created.

Four key areas include the following, and are further explained in Appendices:

- Deadweight (what outcomes are likely to have happened anyway)
- Attribution (the extent to which outcomes arise because of social prescribing, rather than because of the contribution of other people or organisations)
- Displacement (whether any value is 'displaced' elsewhere)
- Drop Off (the extent to which outcomes are sustained over time)

Research

Envoy conducted a mixed-method approach, producing both qualitative data (interviews, group workshops, observations) and quantitative data (surveys, hub data), alongside project output data about activities, the participation of Champions, and numbers of residents reached.

The research tasks and samples covered the fifteen hubs, and are summarised in Table 1 below.

Table 1. Summary of research samples and tasks

Stakeholder group	Research task	Number interviewed
Local residents	Group interviews at 8 hub locations (We received written feedback from the ninth new hub located at the Grenfell Tower site)	35
	Paper surveys	238
	Observations at 5 activities (Swimming, Junior Champions, Walking Football, Women's exercise, Christmas party)	40
Community Champions	3 borough-wide workshops	29
	Telephone Interviews (for those unable to attend workshops)	3
	Paper surveys	75
Champion co-ordinators	Interviews face-to-face	16
Other stakeholders	Telephone interviews	4 (Open Age, NHS West London CCG, Urban Partnership Group, and social housing provider)
Westminster City Council	Telephone interviews	2

Regarding primary data, we collected survey data from 238 residents and 75 champions, across the hubs through surveys. Survey questions were designed on a 5-point frequency scale (e.g. ‘All of the time’ to ‘Not at all’, or ‘Strongly Agree’ to ‘Strongly Disagree’), on a ‘post vs pre’ reflective comparison format.

Secondary data

We also drew on general project data about frequency and type of activities, and about Champions involvement.

We have drawn on publicly available national statistics, health and social care unit costs, and reports, from health and NHS resources, government departments, wellbeing measurement research, and diabetes and social care research. A full list of references and sources is available in the appendices.

3. Community Champions' activities

Activity categories

Community Champions and the co-ordinating staff facilitate the process of empowering communities to articulate problems around health, well-being or community issues. This also helps to identify barriers in the overall system that may stop households from accessing available support from local agencies, independent providers, or public services.

Champions support access and awareness of local services, activities, and events for local residents at their community centre - some of which are delivered directly by the Champions themselves. They motivate residents towards improving health and well-being behaviours, knowledge and community participation. This is reinforced by the Champions' training, to at least RSPH Level 2 in 'Understanding Health Improvement' and 'Understanding Behaviour Change', and in Market Research skills (which provides research capacity to statutory partners e.g. local CCG). Champions also attend a range of 'non-core' training in addition, particularly including mental health, safeguarding, money mentoring, and health and safety issues. This enables Champions to deliver guidance to residents and feedback from residents in a professional manner, and feel confident in speaking either to small groups of people, or at a one-to-one level.

Each of the fifteen hubs' catchment varies from c.600 to 1,000 households, and on average each hub can actively reach around 200-300 households per year. We define the number of households "meaningfully reached" as those who were not previously engaged with the community centre, but have come to either regularly attend, come into contact with staff and Champions for advice, or participate in on-going community events, courses or activities related to Champions and the Community centre "hub".

In a typical quarter, activities can include: household health surveys; physical activity classes (e.g. yoga, walks, dancing, Zumba, affordable gym and aerobic exercises, swimming); healthy cooking and budgeting courses for households; awareness-raising about diet, diabetes and cardiovascular issues; oral hygiene awareness; organising and delivering community health events and promotional stands; one-to-one guidance for households; and sign-posting to appropriate support services.

This is not an exhaustive list;. additional examples are categorised in Table 2. Each hub's location, starting point, and resident demographic profile is different, and therefore the Champions' activities are designed around the needs and capabilities that their local communities have identified.

Table 2. Example activities involving Community Champions

Activities – Typical examples 2016-2017				
Physical health	**Mental and Emotional wellbeing**	**Outreach and engagement**	**Parents and Children**	**Skills & Training**
▪ Aerobics ▪ Breast health ▪ Dancing ▪ Dental/oral hygiene ▪ Healthy cooking and food budgeting ▪ First Aid skills ▪ Food Hygiene ▪ Health checks support ▪ Keep fit ▪ Nutrition and Healthy Diet ▪ Food provision, including Foodbank, Soup Kitchen etc ▪ Older People's activities ▪ Outdoor Education/Activity ▪ Exercise classes (various) ▪ Smoking Cessation ▪ Sports and games ▪ Swimming ▪ Walking ▪ Weight Aerobics ▪ Weight Control ▪ Yoga ▪ Zumba	▪ Arts-based activity ▪ Coffee Mornings ▪ DIY Happiness ▪ Mental Health First Aid ▪ Mental health support ▪ Stress Reduction ▪ Complementary therapies ▪ Social groups/reduce isolation	▪ Health awareness campaigns (relating to specific health conditions) ▪ Empowerment and civil society e.g. Champions involved in governance of community hall / asset transfer ▪ Outreach and promotion of long-term condition (e.g. diabetes campaign, cancer) ▪ Partnership work/ meetings: (CCG, housing) ▪ Signposting to local health services ▪ Winter warmth packs and advice ▪ Food donation distribution to isolated or housebound residents	▪ Benefits/welfare advice ▪ Carers support ▪ Children's activity e.g. circus skills ▪ Day trips ▪ Family events/fun days ▪ First Aid – Paediatric (e.g. for parents and grandparents) ▪ Maternity Champions ▪ Parenting classes ▪ Parents' group	▪ Employability support ▪ Team building

Activity progression from 2014

In this year's evaluation we have seen Community Champions expand from six to fifteen hub locations, and we have seen an increase in provision of particular activities (within the wider directory of services):

Food Poverty support – Food Poverty and lack of easy access to affordable grocery shopping has exacerbated the problems of rising living costs for many households, especially those who are isolated or housebound. Some of the growing number of foodbanks are being staffed and supported directly by Champions, and cooked meals are provided in addition for vulnerable residents or those who are at risk of being homeless. Some hubs also provide food distribution and food or meal transportation to vulnerable residents, which requires a high degree of logistical management and networking skills.

Resident empowerment – there has been at least one case where Champions from one hub are currently involved in re-shaping the entity and governance of a local tenant's and residents association and it's hall. Working together with the local authority, Champions are chairing and participating in the revitalisation of the tenant's hall and its charitable purpose, in order to open up the hall again to the local community. Previously, the tenant's hall had been under-used as a makeshift licensed bar by a small group of residents and non-residents. This implies that should the opportunity arise, there is potential scope for Champions to be involved in governance of community assets in future, through the skills they develop.

Older residents and intergenerational activities – hubs and Champions are required by the programme commissioner to expand access to activities and support for older people, to keep them active and engaged with community-based activities. In addition, activities are provided that are specifically designed to bring younger people and children together to help older residents, who in turn have an opportunity to share their experience and/or take an appreciative interest in the younger person's capabilities.

Affordable yoga classes - residents are increasingly aware of the health benefits of gentle core-strength and stretching exercises, for improving their mobility and reducing stress. Anxiety and stress amongst residents appears to have increased since 2014, partly because of rising living costs, and the loss of statutory services supporting households who are struggling. Yoga is seen by many as a relatively accessible, inexpensive, and less intensive form of physical exercise, allowing participants to work at their own pace to suit their level of fitness and ability.

Welfare advice and guidance - There is a general sense that significant transformational change in the statutory sector, and the economy more generally, also makes it difficult for people to cope and adapt to welfare changes – especially new application processes. This has often amplified anxieties and stress for residents.

Gender-specialisms there has been some increase in 'women-only' exercise activities (as recommended in our previous evaluation report), and also some increase in 'men-only' health activities. This has helped to encourage more participation among men, as they have traditionally been harder to engage in health-related activities. Women-only activities have been helpful for building confidence, and also provide opportunities for those who are vulnerable or have cultural needs which make mixed groups inappropriate. In either case, the gender-specialisms have

provided a good stepping stone for residents to then try other activities and attend more events, thereby helping to avoid risk of social isolation and improve self-care behaviours.

More severe social problems– some hubs and Champions are providing more support to severely challenging social problems, such as victims of domestic violence, and/or to refugees, particularly those who are involved in substance misuse. This may tie in with the demographic background in pockets of the neighbourhoods, and also reflect the recent prominence of these issues in society.

Maternity support and healthy infants – Hubs can provide Maternity Champions who are specially trained to help young mothers (and fathers) become more aware of good parenting practices, and signpost them to peer networks and specialist health providers in the area.

Junior Champions and children's functioning - at least one hub has developed a junior champions group, where schoolchildren (in Queen's Park) deliver health messages and positive social interactions to their peers, and also regularly to older people in sheltered housing schemes. This inter-generational activity is creating multiple impacts in terms of health, wellbeing and educational attainment/performance at school, and is to be commended – arguably this should be replicated further with other local schools.

Children's school readiness, co-ordination skills and executive functioning have also received a degree of extra focus at some hubs, for example through 'Circus Skills' activities, which gets children practising dexterity, co-ordination, team work, and physical activity.

Inter-cultural cohesion - generally, champions and hubs are encouraging more residents from ethnic minorities to engage with local health and support services, and participate in activities at the hubs with other people from the community. This can help to foster cross-ethnic understanding and improved integration as members of society and their local community.

4. Findings: Stakeholder outcomes

As part of the SROI analysis process, we mapped out different stakeholders of the Community Champions project and how they are materially impacted by the project's activities. This 'impact mapping' (or 'theory of change') approach is a helpful way of identifying the logic of how processes flow, from input to activity and then resulting outcomes. This approach is aligned with HM Treasury's Magenta Book guidance on evaluating outcomes.

The impact map is illustrated with 2018 updates in a summary **Theory of Change** in **Chart 1** further below. The 'Final Outcomes' comprise the outcomes valued in our SROI analysis.

Inputs are provided by the partner authorities in terms of funding and overall administration and management of the project; and by volunteers in terms of time and travel. With this funding, training is provided to Community Champions (e.g. RSPH training, Mental Health First Aid), and co-ordinators are employed for each respective hub. The co-ordinators recruit, develop, and co-ordinate their own champions and related activities in partnership with local charities and partner providers – some of whom provide activities at significant discount or pro bono. It is an important for the model that a hub is created at a community-based space or shared space, such as a community centre, children's/youth centre, tenant hall, or similar community-based asset.

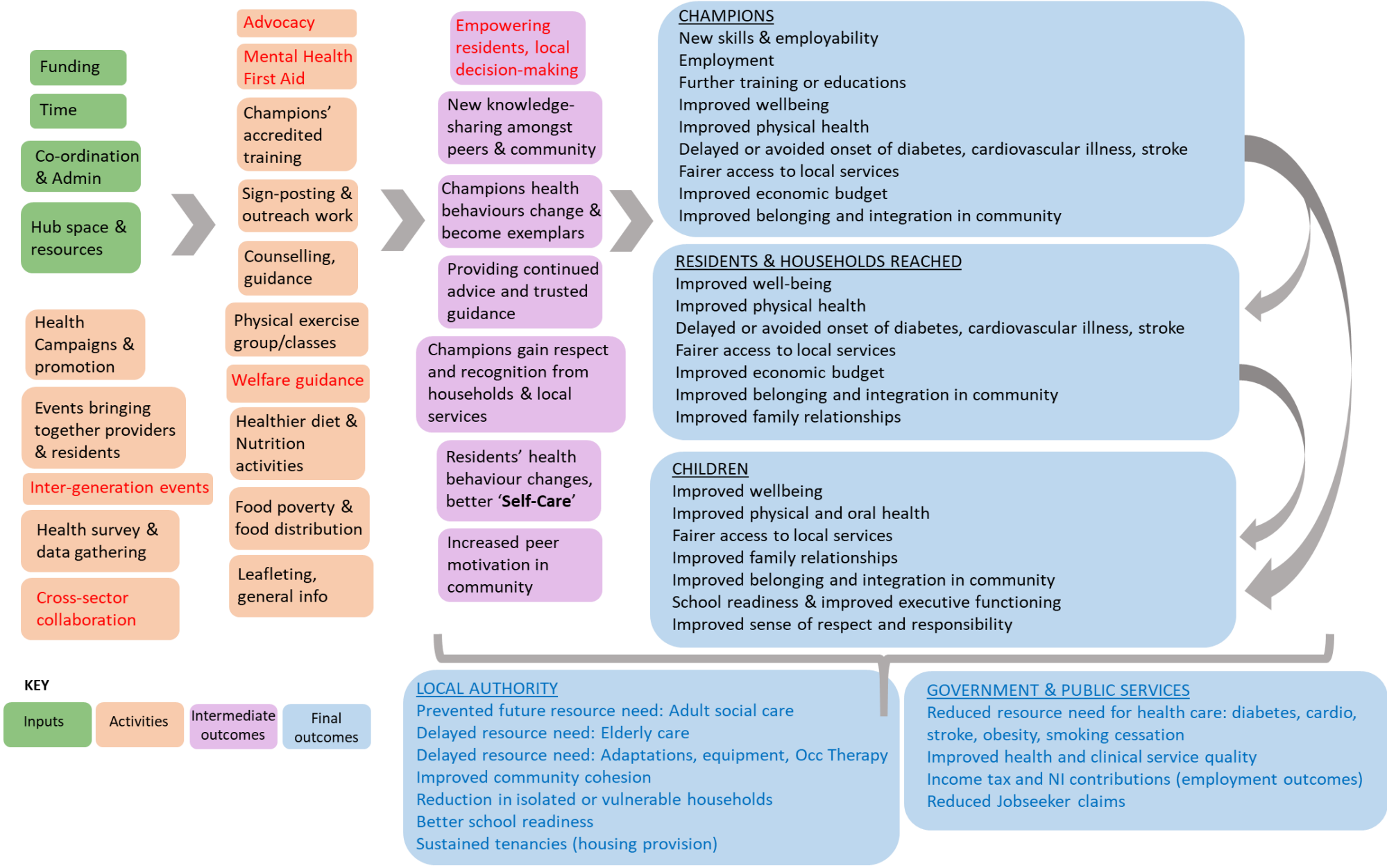
Champions then go out 'on the ground' and perform various roles – including outreach work and signposting to statutory and non-statutory health and wellbeing services; advocacy or accompanying residents to appointments; direct or indirect interventions e.g. foodbank, soup kitchens, running a group event; emotional support; knowledge-transfer and sharing of practical experience; research into available health and wellbeing information or support; awareness-raising and participating in events. As part of their experience, and need to lead by example, Champions also focus on their own health and wellbeing e.g. by doing more exercise, eating a more balanced diet, becoming more adept at 'self-care', and using health services more appropriately.

Through Champions, residents are motivated to attend new activities at the hub and try out new health behaviours; they feel encouraged and better informed about how to best use local health support services. Residents also provide feedback to their Champions and hub about what more is needed to help local households, ideas on initiatives that could be tested, and what is most valued by them and their families.

Champions are pro-active and consistent in being approachable and visible to residents, in generating peer-to-peer motivation, and in feeding back to stakeholders. Subsequently, effective champions become a respected key local asset, not just for influencing health behaviours and helping local services, but also in terms of helping to develop services that are *owned by communities and shaped by their needs*.

Their approach helps to significantly reduce isolation within their communities. They also inspire other local people to engage and train to be Champions.

Chart 1. Community Champions – updated Theory of Change (new components are indicated in red text, compared to 2014 evaluation)



Health & Well-being benefits

According to resident surveys, the average household comprises of 1.75 adults and 1.6 children. But in the analysis for population level, we have assumed improvements for the current analysis to just 50% of children and 25% of second adults in each household i.e. residents who have been meaningfully impacted. (This is a more conservative proportion than in the previous evaluation, to further avoid over-claim).

Residents feedback: If they didn't have Community Champions

"I would be more depressed and would feel isolated and alone. Not to mention going back to how I was, before I came to the community kitchen" ***(Edward Woods)***

"With the availability of such services my health has improved considerably - it would be helpful to carry on such activities" ***(Addison)***

"We'd struggle financially for food and health-wise, because of the information they give out" … "Children and Parents wouldn't be aware of certain health issues and the impact it has on their life e.g. sugar, salt" ***(Parkview)***

"I'd lose access to events which help me keep fit and active (yoga)"…"I'd miss out on the friendships I've made" ***(Bayonne & Field Rd)***

According to residents and broader stakeholders (including the local Clinical Commissioning Group), the work of Community Champions has resulted in improved health knowledge, encouragement, and motivation among residents towards changing their health behaviours. In addition, residents fed back that they had gained a much better understanding of the support networks and services available at a local level regarding specific mental health and physical health conditions relevant to their household.

On average, residents responded they had increased their frequency of participation in community centre activities by **around a third.** This coincides with better well-being knowledge and behaviours, and is also a contributor to reducing feelings of isolation and loneliness – especially amongst older people. In terms of physical health benefits, residents and Champions have benefited through increased uptake of regular light exercise and healthier eating. This has often coincided with reduced sugar and salt intake when cooking at home. On average, residents responded that they had increased these behaviours by up to **one quarter of the time**.

Over 30% of residents surveyed reported that through exercise and a healthier lifestyle that they had both **lost an average around 4kg of weight,** and experienced a **reduction in waist size** (up to one size). This is a similar outcome compared to our 2014 evaluation, and shows consistency in overall results. We have assumed only 50% of this proportion as a proxy indicator of the number of participating residents avoiding type 2 diabetes and associated cardiovascular and long-term conditions. This would total around 390 across all fifteen hub locations.

In reality, this might be underclaiming the impact, given the reach and consistency of Champions' activities related to mentoring, educating and raising awareness about diabetes and diet, and the fact that a second adult or parent in the household may also benefit from the changes.
On the other hand, there also appears to be a higher prevalence of food poverty and poor access to affordable groceries for many households who are isolated and far from grocery and food amenities. This may be compounded by a lack of internet access or computer skills e.g. for online discounts (but this would need more evidence). There has been some increase in associated demand at foodbanks and free soup kitchens.

Further to this, some parents also reported that their children had benefitted from improving their social interaction and integration, as well as improving their general functioning, e.g. at school through Champions directing them to skills-based and family-oriented activities. These activities enabled interaction with other children and adults *beyond* their immediate family, which may have been rare. These families have benefited further from an improved sense of belonging.

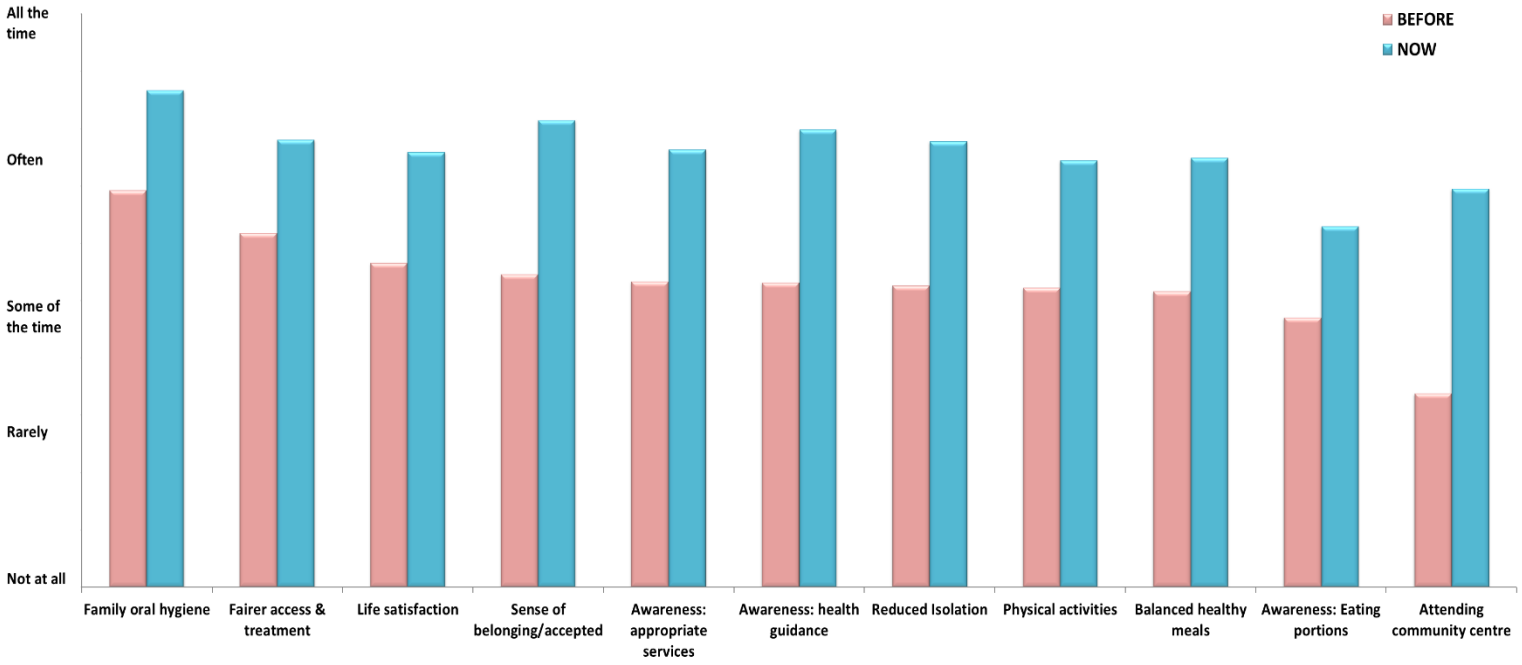
As such, our findings also include residents reached in terms of improved emotional and mental health, i.e. the proportion reporting significant improvements in overall mental well-being, reduced isolation and improved resilience. A summary of the residents and children meaningfully reached is described below.

Table 3. Output estimates for Community Champions 2016-2017

Stakeholders: Improved health & well-being based on 3800 household meaningfully reached, from 7700 coverage	**Approx number per year**
Residents improving health & well-being	3800
Residents delaying onset or prevention: type 2 diabetes	390
Champions improving health & well-being	150
Children of residents & champions	3300
Local Authority - **delayed social care need: delayed onset of diabetes** **reduced social care need: mental health** **delayed need for older people entering care** **children school readiness**	 390 260 250 3000
Reducing use of Government/Health services	3900

To accompany our findings, key indicators of resident outcomes regarding health and wellbeing are presented in Chart 2. There are improvements for all indicators.

Chart 2. Change in health and wellbeing outcomes for residents as a result of Community Champions: comparison of *before* involvement with the project, with *after* involvement with the project. n=238



Summary of key wellbeing improvements for residents

In both the 2014 and 2018 evaluations, the largest improvements for residents that Community Champions have contributed to are across the following:

- Increased participation at health, wellbeing and family activities and events
- Improved health knowledge, through information, guidance, and education about specific health conditions
- Better awareness about health service provision and access
- Increased physical activity and healthier lifestyle behaviours, (coinciding with weight loss for some)
- Improved sense of belonging and acceptance in the community, and reduced isolation

In addition, we have observed that a small number of households have been empowered to push for the provision of new activities in the local area, or for better ways of working between health professionals and non-statutory support. These improvements are often somewhat more appropriate for their personal circumstances or cultural needs. This suggests an increased sense of empowerment in local decision-making amongst some households. For example, advocating for women's only exercise groups (which can also be helpful for women from cultures where mixing openly with men is seen as not acceptable), or promoting courses for English Language skills for health service contexts.

We also observe there is a stronger de-stigmatisation and sense of openness amongst residents about accessing mental health and wellbeing support, compared to 2014. More residents are now adept at self-care approaches e.g. take up of mindfulness classes, yoga, seeking counselling, mental health courses.

On the whole, residents are starting with higher levels of health and well-being in 2017-18 than in 2013-14. This suggests that the impact of the earlier Champions project had been sustained.

Health and wellbeing benefits to Champions

Champions continue to experience a degree of benefit to their health and wellbeing, in particular around increased physical activity, balanced meals, a sense of belonging, and reduced depression and anxiety. A summary comparison of the largest improvements is presented below, with differences in bold text for 2017-18.

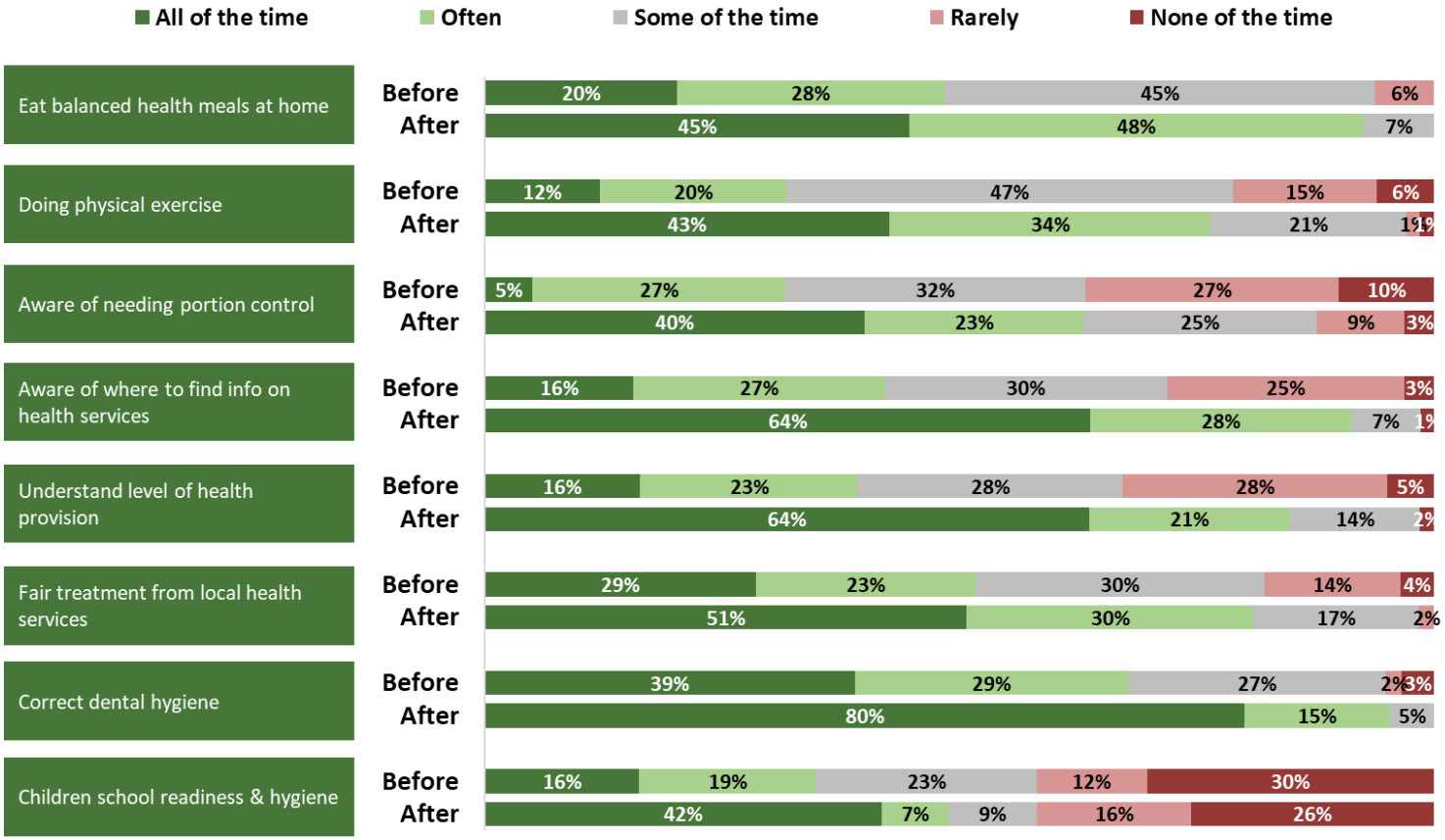
Largest improvements 2013-14	**Largest improvements 2017-18**
Confidence to gain work	Confidence to gain work
Continue volunteering	Continue volunteering
Improved skills	Improved skills
Awareness of service provision	Awareness of service provision
Self confidence	**Balanced meals**
Resilience	**Physical Exercise**
Fairer treatment from health care	**Wellbeing (feel optimistic)**
Sense of Belonging	Sense of Belonging

The project continues to achieve success with regards to Champions building their confidence and resilience. There appears to be a significant level of anxiety and depression amongst Champions: at

least **one in four** suffered depression and/or anxiety before their tenure, but this almost halves over time. Based on feedback from some Champions, the experience of being a Champion and being trained in mental health first aid has helped to support this outcome. This is reflected in the qualitative research, which showed that some Champions have significant needs and require more intense support from their co-ordinator.

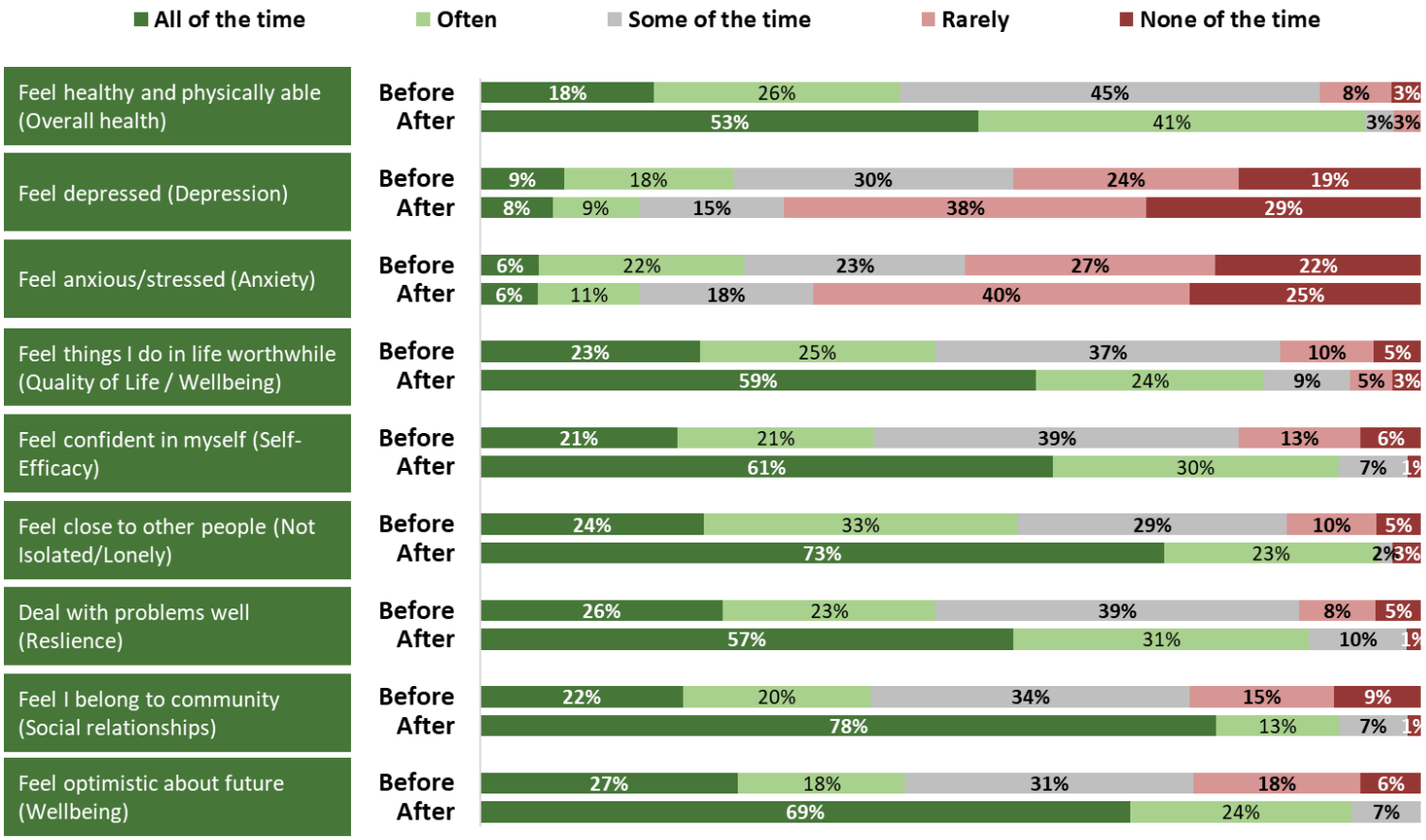
Charts 3(i) and 3(ii) show changes in health and well-being for Champions respectively. They compare levels of health and well-being *before* becoming a Champion, with *after* becoming a Champion.

Chart 3(i). Health behaviour indicators for Community Champions: scores before vs now



Q12. *"Thinking about your experience of the Community Champions project, how would you rate the following aspects?"*
n=75 (Except last school readiness & hygiene, n=26)

Chart 3(ii). Wellbeing indicators for Community Champions: scores before vs now



Q9. *"Thinking about your experience of the Community Champions project, how would you rate the following aspects?"*
n=75

Economic, fiscal, and social housing impact

A number of important economic and fiscal benefits arise from Community Champions programme, primarily for local authority and public services, and to a lesser extent for residents.

Health conditions such as diabetes cost the government a significant amount of money, on top of their human cost. For example, the average annual **adult social care cost per person, for those in local authority care with diabetes, is around £19,000**. This totals over £1.4 billion nationally[8]. Local authority costs include expenditure on long-term wheelchair provision, occupational therapy, and adaptations to people's homes, which might be necessary where the resident suffers blindness or amputation as a result of developing diabetes.

As a result, the resource savings created by Community Champions are also significant. As people are more physically active and eat healthier diets because of the work of Champions, resource savings arise from reduced NHS and adult social care need to tackle diabetes and associated long-term conditions such as stroke. Resource savings from avoiding or delayed onset of conditions are most likely to arise in households where individuals reported reductions in *both* their weight and their waist size. For these residents, the estimated resource savings across the three partner boroughs is **c.£1.3million,** resulting from the Champions' work.

[8] Institute of Diabetes for Older People, "The Hidden Impact of Diabetes in Social Care, (2013)

Separately, the Community Champions programme has also fostered an increase in hubs focusing on reaching older people, through a range of social and physical activities. This can help prevent or delay the need for older people to enter long-term care, due to improved mental and physical health. This creates savings of approximately £3 million across the partner boroughs, of which c**.£500,000** is attributed to the Champions[9]. The average annual cost of entering long-term care across West London local authorities can be estimated at c.£25,000 based on 2016-17 data.

Additionally, there are impacts on health services through the avoidance of diabetes and associated conditions. This has a value of approximately £1.6million across the partner boroughs, of which **c.£270,000** is attributed directly to the Champions.

In the 2014 evaluation it was estimated that households saved approximately £2.50 per week as a result of better understanding of healthy and affordable cooking. In this year's evaluation, **these savings have increased to approx. £7.50 per week** totalling approximately **£200,000** per year.

Social housing providers are also benefitting in terms of more sustained tenancies - as a result of healthier, less isolated and more resilient households. This is increased when tenants gain employment, or improve their money management, and where 'winter support' packs are provided to vulnerable residents who are at risk of fuel poverty and loneliness. **Rent arrears, voids and re-let costs from tenancy failure can cost a housing provider around £3,000 per tenancy at risk per year.**

We have also seen examples of residents becoming better integrated and empowered within their community – which in turn has sometimes led to improved community-led management and maintenance of key assets, e.g. local tenant hall. This has led to improved cohesion and sense of safety across households near to those community assets.

Employability for Champions

Some Champions hope that their experience of being a Champion, and the skills they have gained, may contribute to gaining future employment. Most Champions also believe that Champions overall are well regarded by organisations such as social landlords, local bank branches, and care providers etc. A reference from the Community Champions programme can therefore be particularly valuable.

Champions' confidence in finding work increase by around one-third during the programme. In addition, we estimate that around one in six Champions progresses to paid employment, or starts their own enterprise, after finishing as a Champion. Using the basic minimum wage, the combined annual salaries of Champions who go on to find paid work would equal around £165,000, of which two-thirds is attributed to the programme. This should also result in reduced Job Seekers Allowance claims (of between.£35,000 and £70,000) in addition to contributions of income tax, council tax, and national insurance.

However, the majority of volunteers get an improved sense of fulfilment and contribution from remaining in their role as Champions, particularly those who are already retired. Almost all Champions wish to continue volunteering for their community, and this sense of citizenship improves by c. 20-25%.

[9] In our analysis, we have accounted for half of older people reached already being in care homes or sheltered housing.

5. Findings: Social Value estimate 2016-2017

Our analysis presents key output figures below. They are adjusted to avoid double-counting of activities, double-counting of impact, double-counting of households, as well as rates of attribution and counter-factual.

Table 5(i). Output estimates for meaningful reach - Community Champions 2016-2017

Number of households meaningfully participating (*15 hubs' catchment c.7,200 homes*)	c.3500
Number of Adults meaningfully reached	c.4300
Number of Children meaningfully reached	c.3000
Number of residents participating in frequent physical exercise classes through Champions	c.450-550
Proportion of households with a member with mental health condition	7%
Proportion of households with older residents (over 65s)	13%
Average resource cost of diabetes type 2 severity, leading to need for long-term adult social care (per person)	£40,000
Average NHS resource cost for acute health of cardio-vascular or related illness (per patient)	£7,700

On average each hub meaningfully reaches around 200-300 households per year through Community Champions, depending on catchment.

Further programme outputs are summarised in Table 5(ii) for Champions and 5(iii) for Residents and activities.

Table 5 (ii). Additional outputs for Community Champions Jan 2016-Dec 2017

Total no. of training places attended by Champions	c.1,140
Volunteering hours total cumulative	c.24,500
Community Champions educated to **A-level**	28%
Community Champions educated to **BSc/MSc/PhD level**	34%

Table 5 (iii). Attendances and events for Residents 2016-2017 – Annualised estimates unless stated (NB rounded totals)

	All	**LBHF**	**RBKC**	**WCC**
Large Events: resident attendances	11,390	2,930	2,870	5,590
Large Events: number held	73	24	21	28
Activity Sessions/Classes or courses: number held	1,640	520	400	620
Regular Activity: resident attendances	16,900	5,740	3,720	7,430
Estimated attendances at events and activities	27,200	7,570	6,590	13,000
Public health (PH) campaigns / community research / signposting	121	45	32	44
PH campaigns / community research / signposting: Residents reached	10,100	3,300	2,260	4,530

In addition, the ethnic distribution of Champions is described as follows:

- Over two-thirds of Community Champions are from a range of ethnic minorities.
- About one third are either White British or White European/Other.
- Black African and Black Caribbean champions make up approximately a fifth.
- Around a quarter of champions comprise of Arab and North African ethnic groups.
- Roughly one in seven are from Asian or South Asian backgrounds.

This reflects an adequate mix of Champions overall, achieved through the openness of the recruitment approach to include a diverse base of volunteers. However, in some hubs, one or two ethnic groups can be the norm if a particular demographic is reflected in the immediate neighbourhood.

Approach to outcomes valuation

SROI requires the monetisation of social, environmental, and economic outcomes.[10] Outcomes have been given financial proxies to represent the annual value of those outcomes to stakeholders.

Financial proxies for statutory stakeholders were based on unit costs; for example, the unit costs of episodes of treatment in health, or long-term adult social care costs. These are sourced from NHS tariffs, research from the Personal and Social Services Research Unit (PSSRU), or from government departments (e.g. DWP for Jobseekers Allowance), as well as other research about specific health conditions. References are provided in the Appendices section.

Our approach to valuing resident's health and well-being outcomes is based on healthcare economics, and drawing on Quality Adjusted Life Years (QALYs). These are combined with research by the Centre for Mental Health, and the National Accounts of Wellbeing (nef, 2009 – see 2014 evaluation) which breaks down well-being into different sub-components. These align with similar approaches used by WLCCG, and the NHS and the National Institute for Health and Care Excellence (NICE) more broadly.

QALYs are given a value using the British Medical Association's guidance from their recent paper about preventive intervention, *Exploring the cost effectiveness of early intervention and prevention* (2017). This considers interventions costing between £20,000 up to £30,000 per QALY gained as cost effective, and we have used the £20,000 to £30,000 threshold as the value of one QALY. The BMA refers to a NICE analysis on 200 interventions between 2006 and 2010, where 70.5% (i.e. a clear majority) costed up to £20,000 per QALY gained. We also drew on guidance from other research (New Economy Manchester; and Bield, Hanover, and Trust Housing)[11] for some valuations.

Through applying these values to the amount of change experienced by patients, we calculated the social values of the outcomes experienced. We estimate **the social value generated by the current Community Champions programme is c.£5 million per year, compared to c.£930,000 investment,** including programme staffing. Depending on QALY level used and valuation of volunteering hours, **the SROI ratio ranges from c.£5 to £6[12] per £1 invested** in the programme. The distribution of social value per stakeholder is summarised in chart 4 and table 4.

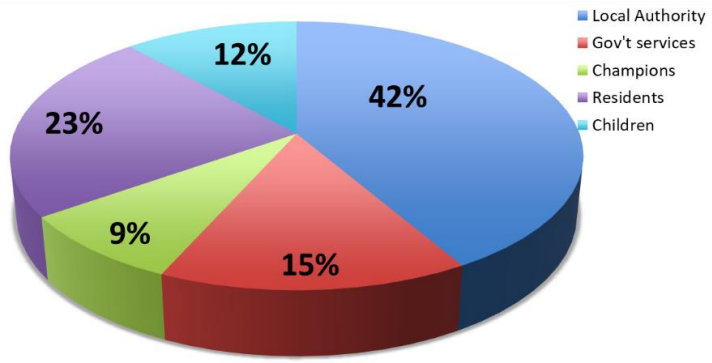


Chart 4. Value distribution of socio-economic impact, by stakeholder group

[10] However, environmental outcomes are out of scope of our research as they were deemed immaterial

[11] New Economy Manchester (2012) *Understanding the Wider Value of Public Policy Interventions*, and Bield, Hanover and Trust Housing (2012) *SROI of Stage Three Adaptations*, and *SROI of Very Sheltered Housing*

[12] The range is influenced by the level of Quality Adjusted Life Year value, ranging from £20,000 to £30,000, used by the National Institute for Health and Care Excellence (NICE) and the British Medical Association

Table 4. Comparison of value distribution of socio-economic impact, by stakeholder group 2014 vs 2018 (differences due to rounding)

Stakeholder outcomes	Present Value: Annualised attributable Value	
	2018	2014
CHAMPIONS i.e. Improved health (exercise, healthy eating); Reduced diabetes risk; Improved well-being; Skills & knowledge; Employability; Fairer access to treatment and services	**£395,000**	**£248,000**
RESIDENTS i.e. Improved health (exercise, healthy eating); Reduced diabetes risk; Reduced prevalence of long term conditions; Improved well-being; Knowledge; Fairer access to treatment and services	**£1.1million**	**£845,000**
CHILDREN (incl Champions' children) i.e. Improved health; Improved well-being; Knowledge	**£530,000**	**£526,500**
LOCAL AUTHORITY & HOUSING - Prevention i.e. Prevented care need from delayed onset of diabetes; Prevented adult and elderly care need due to poor mental health and isolation; Sustained tenancies; Community cohesion	**£2million**	**£907,500**
Central GOVERNMENT SAVINGS i.e. Resource savings to Health care and DWP	**£695,000**	**£255,500**
PRESENT SOCIAL & ECONOMIC VALUE	**c.£4.7million**	**c.£2.8 million**

These values do not include the value of the c.24,500 cumulative 'logged' volunteering hours that were logged between Jan 2016 to end Dec 2017 by Champions. This could also be classed as an input, and by using the national minimum wage (c.£7.20 for +25 year olds in 2016-2017) it is possible to value this at a total of £176,400.

Our SROI calculation reflects the total impact generated for the stakeholders by the Champions. It takes account of the contribution of other factors (attribution), what would have happened anyway (counter-factual, or deadweight), and ensures there is no double-counting of activities, impact, or households. To be conservative, we have taken only one-quarter proportion of the attribution rate reported by residents (down from one-third proportion of resident attribution reported in 2014). This lower attribution level is accounted for by the wider range of activities now on offer to residents

through community centres and other settings compared with 2014. These have tended to fill in gaps in local provision that have resulted from cuts in statutory services.

The increase in social value created is mainly due to higher levels of participation; frequent physical exercise – correlating with higher reports of weight loss and waist size reduction; and reaching more vulnerable residents, such as those with mental health conditions or at risk of isolation and loneliness. The benefit period reported (i.e. length of time for which outcomes are expected to last) is two years.

The main beneficiaries of the Champions service are the local authority services (42% share of value due to added resource savings to social care and public health) and residents, together with their children (c.35% total share of value) due to improved health and wellbeing value. Compared to 2014, statutory health and social care receive a larger proportion of value creation in the 2016-2017 period. There is a larger impact in this regard for local authority resource savings, through more residents being reached and delaying or avoiding the onset of severe type 2 diabetes (c.390 from 4300 residents meaningfully reached). This has accompanied potential resource savings for the NHS from avoidance of cardio-vascular illness and mental health illness.

The average long-term cost to social care services of having to support a person who has developed diabetes type 2 can be estimated to be £40,000 over 5 years of requiring that support (Institute of Diabetes for Older People, 2013, *The Hidden Impact of Diabetes on Social Care*).

A full list of proxy values is provided in the appendices section.

Impact progression since 2014 evaluation

There are some differences in this year's programme evaluation, compared to the 2014 evaluation. To a large extent, this is due to the Programme Management acting upon the key recommendations within that report, particularly about more integrated working with housing, health services, and cross-sector collaborative models. Our view is that this also coincides with the growing number of roles that Champions are now being asked to provide in different situations. In addition to signposting, encouragement, knowledge-transfer and awareness-raising, event facilitation, direct provision e.g. foodbank and food distribution, Champions are now also providing capacity for: advocacy, emotional support/informal counselling, community research, cross-sector referral, and empowerment of residents in governance of local tenant groups. Subsequently, Champions gain a wider range of skills.

Champions feedback on important benefits

"Being [a] champion helped me a lot to be confident more prepared to work and help other people" **(Mozart Estate)**

"It has made a difference to the whole community by reducing isolation and networking of community members and raising health awareness in the area" **(World's End)**

"Community champions are running very good programmes in this community. I often get stopped and told so, as well as being asked what other activities are going to take place. Makes me very proud!" **(Parkview)**

"I have become more active because of the classes that I had and eat more healthy [food] for energy" (Addison)

It is likely that in order to fulfil a growing remit and sustain their impact, continued investment in appropriate training for Champions, and leadership training for hub co-ordinators will be required. Otherwise there is the potential for some Champions to be stretched too far out of their depth in future – especially where other statutory stakeholders are a key partner.

Other key areas of progression and new improvements are described below:

More cross-sector collaboration
Since the programme was previously evaluated (an SROI analysis was conducted for 2013-2014), Champions have increased their involvement in collaborating with other voluntary and community services and activities. This has improved reach with residents/households with high need. For example, Champions and hubs are working more collaboratively with commissioners and self-care teams in West London Clinical Commissioning Group; the local MIND; other specialist charities providing health and wellbeing support, such as Open Age and Age UK; local schools, especially for Junior champions; and social housing providers. In these instances, Champions can cross-refer residents to new activity opportunities or sources of support.

CCG and housing providers are benefitting more
As a result of closer collaborative working models, West London CCG and local housing providers are benefitting in terms of resource value and reduced prevalence of long-term health problems amongst residents and tenants respectively. One key example is Champions' participating in the local *Health and Housing Partnership Group,* an informal group built around each project or commissioned provider in the case of those with more than one project (PDT and UPG). This group brings together the Community Champions project provider, CCG, front line workers, and housing providers. The forum facilitates feedback and sharing of knowledge and intelligence about activities being conducted within the community. This has, for example, helped a housing provider, Champions, and a VCS provider to join-up to fill in a gap in five-day provision of a key community-based school holiday activities. In other cases, Champions have helped re-vitalise tenants' associations or developed joint initiatives.

Empowerment and power re-balance in communities
There has been at least one case where Champions have progressed positively in building their knowledge and skills, that they have been primed to a level to become involved in re-shaping the entity and governance of a local TRA. Champions are chairing and participating in the re-vitalisation of a tenants' hall in LBHF. This will open up the hall again to the local community, families, and households. This is reflective of the potential depth of the project's impact on enabling resident empowerment. We have also observed examples where residents have fed back and pushed for activities they feel are needed locally e.g. women's exercise, ESL for health. In this sense Community Champions have progressed in some locations to be the conduit for a power re-balance back to residents e.g. towards participating, testing, and inputting into the development of activities at their community hub. This is further enhanced by the critical role of the community organisations who host the community champions projects, in using their voice and management skills to support this.

Reduced isolation: older people
The Champions and hubs have been required by the programme commissioners to make activities available for older people, in order to avoid risk of isolation and loneliness, and also to improve

physical activity and mobility, e.g. coffee and tea mornings, gentle exercise groups including walking and swimming, complementary therapies, and inter-generational activities such as ‘What the Tech’ where local students teach older people computer and internet skills.

Maternity Champions

Since 2016, the programme has produced a sub-group of Maternity Champions with their own co-ordinator(s), to support expectant and new parents with babies up to age one with ante-natal and post-natal guidance, tips, knowledge, sign-posting, and parenting skills. However, a key part of Champions work is to facilitate peer-to-peer support and peer networks amongst expectant and new parents. This builds their resilience and helps to avoid isolation at a crucial time in infant development.

Junior Champions

In at least one hub, schoolchildren (Queen’s Park) have been participating in delivering health messages and positive social interactions to their peers, as well as older people in sheltered housing schemes. This has been achieved with the collaboration of school staff and the charity ‘Children’s University’, in order to build alignment with curricular achievement and attainment. This inter-generational activity is creating multiple impacts, in terms of health, wellbeing and educational attainment/performance at school, and is to be commended – arguably this should be replicated further with other local schools and with the support of sheltered housing providers.

Domestic violence

In the past year, we have observed at two hubs that domestic violence is an issue that is being targeted by Champions’ activities, and due to training on the issue, has helped identify previously hidden need. The purpose is to provide a safe, confidential space to receive support, seek appropriate counselling, sign-posting, and guidance. Service users can benefit from improving their physical safety, and their emotional and mental wellbeing over the long-term. This is a sensitive and challenging issue, which often goes unnoticed, unreported and unchecked. Our view is that if this area of work grows, that it needs collaborative working with statutory services, and in addition, comprehensive specialist training for Champions.

6. Enablers of success

Strengths of the programme identified in the 2014 evaluation have been reinforced and encouraged within the programme, particularly that Champions are trusted and respected by local people more often than officials or professionals from positions of 'authority'. In addition, the core of the programme is built on the co-ordinator being given a degree of autonomy to i) secure participation from local volunteers and local residents, and ii) develop and empower Champions to succeed under their own initiative. Recognition of good works, and **co-ordinator group feedback sessions** have also been valuable. Below are further enablers of success observed from this year's evaluation:

- **Innovation, testing, and trialling capability through Champions -** Champions help hubs to test new activities and innovate, by encouraging residents to try a new activity or event, for example Circus Skills for children, 'What the Tech', yoga, mindfulness. This can often create an opportunity for generating demand for a new service or activity.

- **More cross-sector collaboration: VCS partners, housing, health, schools -** the Community Champions programme is more powerful when local health services, housing providers, schools, and VCS provision are working in a collaborative and joined-up way. This requires a demanding and sophisticated level of relationship management, and commitment to creating platforms for continual feedback and involvement within the collaborative network. **Community Organisation Partners have made a real difference in these areas,** as strong organisations supporting their Champions and getting involved in activities, events, promotion. It can take some time for this mind-set and trust to develop, especially amongst statutory services who may be protective of their service users, or fixed to their existing provision, governance, and safeguarding commitments.

- **Ensuring all Champions receive appropriate training -** it is imperative, given the growing roles that Champions are being asked to play, that they are provided comprehensive support, back-up, and accredited training – especially if they themselves have a level need or vulnerability.

- **Affordability / good value of activities -** it is important for residents that affordability is embedded in the roster of activities they can access, particularly if they are asked to make a small contribution to some activities which are being heavily subsidised or being provided pro bono by a local supplier (generally £1 to £2 per attendance).

- **Balance of group-specific and integration activities -** the success of Champions and co-ordinators relies in large part on the directory of activities provided through hubs. It is important to achieve a balance of support and activities that can bring different groups together, to facilitate interaction and integration into the community; whilst also offering group-specific participation for specialisms, e.g. women's only exercise, men's groups, maternity.

- **Food brings people together -** events involving cooking and food from different cultures and countries are excellent facilitators of resident participation and bringing different ethnic groups together – many residents have commented that this has often led to better understanding of other cultures and sharing of stories and experiences. Food distribution and food poverty support has also helped vulnerable isolated households to feel included and supported during very difficult personal circumstances.

7. Limitations and gaps

In this year's evaluation, we have also observed some limitations and gaps for the programme, which can have an influence on its effectiveness.

- **Lead-time -** it can take new hubs 12-18 months 'starting from scratch' to get traction and critical mass for volunteers and uptake of activities. This lead-in time can be exacerbated by delays in utility infrastructure and installation e.g. internet connection, equipment.

- **Advanced training/learning -** for Champions (and leadership training for co-ordinators) is needed as activities offered become more challenging and sophisticated e.g domestic violence, refugees. This relates to the wider remit and roles being offered by Champions and co-ordinators, and in some cases relates to longer-serving Champions who may no longer feel they are being 'stretched' but are happy to volunteer. A good number of Champions have fed back that they would like *training to start their own projects and on how to apply for funding.*

- **Recruitment vs progression/exit strategy –** an effective balance needs to be managed by co-ordinators; between recruiting new Champions, who can learn from currently active Champions, whilst managing the progression or exit of some longer-term Champions. There is a potential risk of hampering new Champions (e.g. on a waiting list) from gaining their opportunity to achieve, or if a longer-serving Champion (e.g. +3 years tenure) is not being stretched, or if they feel their ideas are not being heard. This can lead to elements of frustration if not effectively managed.

- **Messaging opportunity lost between roles -** in some instances, we have observed missed opportunities for joined-up messaging and awareness-raising when Champions are 'in between' roles. e.g. provision at a foodbank, but without leaflets or sign-posting to upcoming events. This may at times be a result of trying to avoid duplication, or avoiding overlap with working partners.

- **Task cross-over and shared projects –** partnership working between sectors generally creates positive value and should be encouraged, especially if residents are encouraged to volunteer and participate more. However, our view is that if the programme grows, the Programme Managers should continue to recognise and acknowledge if there are cases where Champions' are asked by their hubs to volunteer extra time or personal resources during their role as Champions, but on *non*-public health/community wellbeing-related task e.g. admin tasks on non-related projects can sometimes go unrecognised or un-recorded in personal development.

- **Expectations management –** the programme has achieved a good degree of success and partnership working, for example with housing and statutory health services. This was even to the extent that working with the Community Champions programme was viewed as a given by a local CCG during their own internal re-structuring. To avoid becoming a victim of its own success, the Programme Managers can ensure expectations continue to be managed; and to be careful that Champions are not quickly over-stretched in being asked to be all things to all people.

- **Dementia-friendly activities** – most hubs are not fully aware if they are dementia-friendly spaces; and there are few activities provided for this growing issue, given our ageing population. One or two hubs are starting to think about dementia support, and this implies for the design of the hub space, training etc. In future, light touch audits can help to i) review hubs' alignment with national dementia strategies, and ii) review local providers with whom the Programme can work e.g. Resonate (Westminster Arts) a specialist provider of dementia support through art and culture.

8. Conclusion and Recommendations

The Community Champions programme continues to generate important benefits to local communities, households, statutory services, and local authorities. The value created annually is almost **£5 million (including c.£1.9 million for the local authority)**, from an investment of £930,000. This is double the amount described in our 2014 evaluation.

This SROI analysis estimates between **£5 to £6 of social and economic value is generated for every £1 invested - of which over £2 is generated for the local authority and housing** from resource savings related to: prevention and delayed onset of health and mental well-being conditions; community cohesion and resident participation; reduced isolation of families and older people; and sustained tenancies. The estimate of value created takes account of the previous work of the Community Champions, the contribution of other factors (attribution), drop off, and deadweight, as per SROI guidance (see pages 5 and 11 of this report).

Strengths of the programme identified in the 2014 evaluation have been reinforced and built on further, through an increase in hubs (from six to fifteen), and through providing Champions with a wider and more comprehensive range of skills. The programme is still working very well and has improved diversity and inclusion and pushed forward with cross-sector working. The Community Champions programme is now characterised by more collaborative networks and higher levels of social capital – the power of this is increasingly recognised by statutory partners.

In our view the programme offers one of the strongest semi-structured community-based approaches in London, and is meeting the Public Health White Paper recommendation to deliver health and care that is "*owned by communities and shaped by their needs*". **Therefore, funding should be continued, and allocated to a small number of new hubs if possible.**

In addition, Community Champions help in a very meaningful way to indirectly improve and "*tackle health inequalities across the life course, and across the social determinants* of *health*" (Health and Social Care Act, 2012). The programme shows what can be achieved around **health as a social movement,** and is well aligned to support the prevention strategy and 'self-care' objectives arising from the NHS' **Five Year Forward View**.

However, there are areas where the programme can be refined and refreshed. This can help to ensure sustainability and to avoid the programme becoming over-stretched if Champions' remit grows further. These are outlined below.

Our recommendations anticipate significant levels of uncertainty about public funding and transformation of services, e.g. arising from changes to funding and economic opportunities, or from how the Brexit process may indirectly affect living costs.

- The programme provides **value to Self-Care approaches and Prevention strategies** across health and social care. Champions could liaise more formally with Health and Social Care Assistants (HSCAs) and Case Managers at GP clinics, to i) raise awareness about activities and

capacity provided by hubs, and ii) to relay important messages and information from HSCAs/Case Managers about partner VCS health services.

- Activities should be expanded which **encourage inter-generational activities and visits**, such as 'What the Tech', 'CommuniTea' or 'Junior Champions', to combat isolation, loneliness, and loss of connectedness and understanding between generations. As well as supporting residents, this might also affect the care system, which will be under increasing pressure in the coming years, because of our ageing and longer-living population.

- Co-ordinators and champions might look for more opportunities for becoming involved in **re-vitalising community assets** such as tenant associations. These can catalyse **resident empowerment in local decision-making and service design** around health and wellbeing, whilst creating a sense of shared ownership around health, safety, and wellbeing in the community.

- Hubs can conduct light touch audits to identify best ways to align with **dementia strategies**, and to identify local VCS services with dementia-friendly activities. This can lead to quick wins for this beneficiary group, and also help raise awareness of dementia and de-stigmatisation the issue within the community.

- Currently over 90% of community champions are women. The programme could develop new strategies and work with local partners to increase the **recruitment of male champions**. For example, Open Age has a Men's Only activities group. Male champions could have more reach with the older male resident population, who are traditionally more reluctant to discuss health and wellbeing issues, and are likely to be comfortable discussing their needs with other men.

- Training for more experienced Champions could be offered in **skills for starting-up new projects and submitting funding applications**, as part of their progression.

- **Food poverty and food distribution** is likely to be an issue that requires further investment from the hubs, as people's living costs increase in real terms i.e. accounting for inflation and low wage growth. This will likely require extra support in logistical planning and stock management (and decent catering and cooking skills). It will also rely on networks to identify and support vulnerable households and residents who are housebound or are not mobile.

- Co-ordinators can work more with **college and university students** undertaking their studies in a related field. This has worked well for a number of hubs, as students provide skills and capacity, while gaining experience and content for their assignments. It also has potential cross-over with inter-generational activities. Some local students may have time to become Champions themselves.

- **Succession planning** could be improved. For example, co-ordinators and Champions should **be better prepared for when there is a transition between key personnel**, e.g. when co-ordinators move on, retire, or are replaced. When this has happened in the past, the momentum of a cohort of Champions has been lost and work has had to be replicated. The hubs could put in place **transition action plans**, with input from Champions and co-ordinators. Such plans would include

information about the responsibilities of Champions and coordinators to each other and to the community, information on how a more experienced Champion from another hub might be supported to become an interim co-ordinator, and information on sharing roles with management or partner personnel, e.g. PDT or UPG.

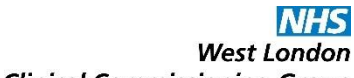
- **Hub-sharing of resource or personnel** can be considered, in either supporting newer hubs that are building their presence and participation, or in re-vitalising hubs where there is a gap in leadership.

- Community organisations, CCGs, housing providers, and local authority to work together to explore new funding partnerships – possibly with local business in addition - which **bring in more resources and share the resourcing** more across the hubs. This will also help to increase the asset development and capabilities of the programme e.g. employing a funding application specialist or resource-raising capacity, providing training to Champions for project start-up and funding skills.

- The **Community Champions website** contains good content. videos etc but needs to be invested in on a consistent basis – in particular, to create content about best practice, and communication on major annual events. This could help build presence with potential partners who are interested in working together; it should therefore also demonstrate commitment to cross-sector working and innovation. There may also be the need to include a simple resident donations page for each borough (e.g. via PayPal and/or Facebook) to supplement funding or help with specific initiatives/campaigns.

- **Housing provider** partners should be encouraged to provide estimates of the proportion of local tenancies that are vulnerable and/or at risk of arrears or tenancy failure. This will help with understanding the scope and scale of impact to be analysed in future, and to inform the directory of activities provided.

Programme Partners



Appendices to main report 2018

Community Champions
Social Return On Investment (SROI) analysis (2018)

1. Methodological note
2. List of Proxy values
3. Impact and Attribution
4. Impact Map

1. Methodological note

The methodology followed in the report draws on the UK Cabinet Office's *Guide to Social Return on Investment*.[13]

Social Return on Investment (SROI) is a form of adjusted cost-benefit analysis that can quantify the value of social, environmental, and economic outcomes to different material stakeholders, resulting from an organisation's activities. It aims to move beyond simple output-based metrics and measures the "full-life" impact and broader value-for-money of an investment.

An SROI analysis is a mixed-method approach, using qualitative and quantitative research, and is conducted via seven stages:

- Establishing scope
- Identifying material stakeholders
- Stakeholder engagement to understand the "theory of change" and mapping of outcomes (Impact Map or 'Value Map')
- Outcomes data collection and providing values
- Establishing impact
- SROI model development and financial calculations finally
- Reporting

Ideally, qualitative research informs the process of identifying quantitative measures to be used for identifying changes in outcomes i.e. what *change*s are experienced by the stakeholder.

Findings are based on research into the magnitude of change as informed by customers and stakeholder surveys and interviews; and alongside tried and tested valuation methods drawing on unit cost savings at government level, and healthcare economics for valuing wellbeing outcomes.

Valuing health and wellbeing outcomes

'Intangible' outcomes such as mental wellbeing and emotional resilience are important because there is a wealth of evidence demonstrating that high wellbeing leads to better productivity, life performance, and capacity to solve challenges and tasks in life, in learning, and in the workplace.

Additionally, health and wellbeing outcomes from volunteering, being in work, training, education, or employment accrue to the individual, and can have knock-on effects to the health care system from the subsequent reduction in need (as being unemployed can have negative health impacts).

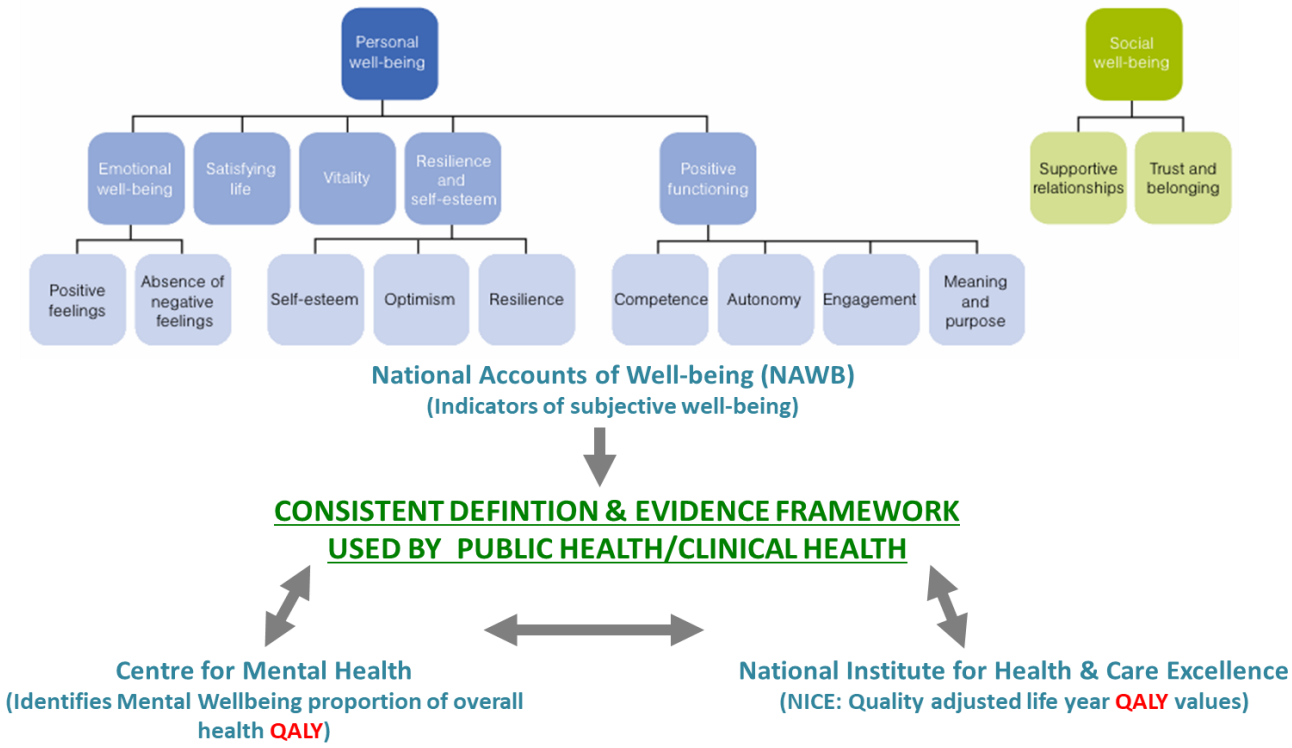
Valuing wellbeing improvements in health and wellbeing is not straightforward, and there are some variations in available approaches and tools. Given the public health setting of the project, we used assigned proportions of a Quality Adjusted Life Year, or QALY, as defined by the National Institute for Health and Care Excellence (NICE) and the Centre for Mental Health, and wellbeing domains within National Accounts of Well-being (nef, 2009).

[13] *A guide to Social Return on Investment*, (2009), nef/Cabinet Office.

Combining NICE and Centre for Mental Health research with the National Accounts of Well-being (NAWB) helps to identify and measure the different components of wellbeing, and it is useful tool in SROI for a number of reasons:

- It provides a breakdown of different components of wellbeing (see Graph 1 below), and helps inform decisions about the outcomes to measure;
- It provides a set of questions and statistical analysis that has been tested and verified, enabling high quality wellbeing measurement;
- It has been tested in previous SROI analyses focusing on wellbeing outcomes;
- It can help with the *valuation* of outcomes through the use of healthcare economics and Quality Adjusted Life Years or 'QALYs'. A description of using QALYs is explained further below;
- There is an existing evidence base linking small proportions of QALYs to magnitudes of change in scores from clinical health questionnaires e.g. EQ5d, PHQ9, Warwick-Edinburgh Mental Wellbeing Scale.

Graph 1: Wellbeing valuation framework, drawing on National Accounts of Well-being



QALYs are not perfect, but they provide a commonly accepted approach to economic valuation of quality of life linked to health and wellbeing interventions – and in a way it is an **ethical entitlement for the whole population** i.e. the threshold at which we are willing to pay for an extra year of good quality of life.

Wellbeing in this model is broadly underpinned by the UK Government Office Science definition, from the Foresight report "Mental Capital and Well-being" (2008), and drawn on by NICE for its wellbeing guidance for productive workplaces (2009):

'... a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community.'

Using this approach enables valuation of physical health and overall mental and emotional wellbeing using the NICE cost–effectiveness threshold for one QALY (ranging from £20,000 to £30,000).

In terms of specific QALY value used in the 2018 SROI model, we have used the British Medical Association's guidance from their recent paper about preventive intervention, *Exploring the cost effectiveness of early intervention and prevention* (2017). This states that NICE considers interventions costing up to £20,000 per QALY gained as cost effective. The BMA also refers to a NICE analysis on 200 interventions between 2006 and 2010, where 70.5% (i.e. a clear majority) costed less than £20,000 per QALY gained.

The proportion of one QALY assigned to mental and emotional wellbeing, derived from research by the Centre for Mental Health into the average loss of mental health status - is estimated at **0.352 of a full QALY**. This is a value for those moving into level 3 (mid-level severity) of mental and emotional wellbeing (as defined by the Centre for Mental Health). The proportional split of wellbeing outcomes is then valued and triangulated in conjunction with the National Accounts of Well-being sub-components outlined above.

Therefore, for valuing physical health improvement, we assume a pro-rated proportion (1 - 0.352) equal to £12,960 from the full QALY (£20,000 minus £7,040), e.g. to value improved health through exercise and healthy eating.

However, across the smaller proportion of the resident population in this study, who are estimated to have avoided or delayed the onset of type 2 diabetes and related cardiovascular or long-term conditions, our model claims a fully QALY but only for 50% of the ten years improved life expectancy (as stated by Department of Health and Diabetes UK).

In addition to the use of QALYs to value wellbeing outcomes, a range of tried and tested proxy values and public service unit costs were utilised to quantify the worth of the outcomes to local authority (e.g. adult social care) and public services (e.g. health care). These are all publicly available from NHS tariffs, Personal and Social Services Research Unit (PSSRU), ONS, other government departments, and secondary research.

It should be noted that the values described are then reduced to the equivalent proportion or magnitude of change in each outcome e.g. if there has been **a 10% change over time in an outcome, then only 10% of the proxy value for that outcome is claimed in the analysis**. This helps to further reduce any likelihood of over-claiming value.

2. List of proxy values

Stakeholder	Outcome	Financial Proxy	Value (£) NB proxy values are reduced to reflect proportion of magnitude of outcome change	Rationale	Source
Champions	Overall Wellbeing / No negative feelings (excludes number avoiding diabetes, for double-counting reasons, see below)	Assigned proportion of a QALY value for overall mental & emotional wellbeing (under personal wellbeing)	1056	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Reduced isolation	Assigned proportion of a QALY value for social relationships (under personal wellbeing)	1173	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Resilience / self reliance	Assigned proportion of a QALY value for resilience and confidence (under personal wellbeing)	352	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)

	Improved overall physical health (i.e. from physical exercise & healthier eating)	Quarter proportion of QALY value for overall physical health due to vigorous exercise / healthy diet	3240	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health
	Improved years Life Expectancy from avoiding diabetes and associated complications (cardiovascular, hypertension, blindness etc)	Present value of Full QALY (£20,000) applied to half proportion of 10 years estimated improved life expectancy (Department of Health). Adjusted by 3.5% discount rate for 20 years into future (present value of future QALY)	42315	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	Department of Health, combined with National Institute for Health and Care Excellence, and Centre for Mental Health, and National Accounts of Well-being (nef)
	Fairer access to health services	Average NHS spend per person UK	2200	The logic of this indicator is based on the principle that citizens would want to benefit in at least the same way as other citizens; and that other citizens should be able to access the benefit they would receive themselves i.e. an ethical entitlement for whole population	National Audit Office and Personal and Social Services Research Unit (PSSRU) adjusted for inflation
	Smoking cessation	Value of smoking cessation to individual, as a function of household income and behaviours	2406	Used as a measure of value, including health benefit, as a function of UK household panel survey income & expenditure data	HACT, 2014-2016
	Improved skills	Half of school/college graduate wage differential	953	Reflective of the value in attaining Other educational/skills equivalent to Certified Level 2-3;	nef, Degrees of value, (2011)

				proportion of NVQ or GCSE value	
	Further volunteering	Value to individual of volunteering	1180	Reflective value to individual based on function of income, spend, and behaviours, 25-49 yrs range, "Regular attendance" London	HACT, 2014-2016
	Work readiness	Value of employability course over 5 weeks	978	Reflects what the individual would have to pay in order to attain similar level of work readiness or re-training	http: //www.sbskills. com/prices.html Accessed 07/2013
	Paid work FTE	Minimum wage salary as conservative estimate (2016-2017 hourly rate £7.20, assume 35hr week)	13100	Reflects value of financial gain accepted from salaried work (conservative estimate)	UK Gov
	Economic savings in weekly budget	£7.93 per week saved per household food bill (attending healthy cooking class)	7.93 (or 413 per year)	Reflects value of cost savings to family per year	Average based on testimonial from healthy cooking teachers
Residents	Improved 10 years Life Expectancy from avoiding diabetes and associated complications (cardiovascular, hypertension, blindness etc)	Present value of Full QALY (£30,000) for half proportion of 10 years estimated reduced life expectancy from developing diabetes (Department of Health). Adjusted by 3.5% discount rate for 20 years into future (present value of a future QALY)	42315	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	Department of Health, combined with National Institute for Health and Care Excellence, and Centre for Mental Health, and National Accounts of Well-being (nef)
	Overall Wellbeing / No negative feelings (excluding number avoiding diabetes for double-counting reasons)	Assigned proportion of a QALY value for overall mental & emotional wellbeing (under personal wellbeing)	1056	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)

				mental wellbeing is valued as an ethical entitlement by the whole population	
	Improved overall physical health (i.e. from physical exercise & healthier eating)	Quarter proportion of QALY value for overall physical health due to vigourous exercise / healthy diet	3240	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Fairer access to health services	Average NHS spend per person UK	2200	The logic of this indicator is based on the principle that citizens would want to benefit in at least the same way as other citizens; and that other citizens should be able to access the benefit they would receive themselves i.e. an ethical entitlement for whole population	National Audit Office and Personal and Social Services Research Unit (PSSRU)
	Reduced isolation	Assigned proportion of a QALY value for social relationships (under personal wellbeing)	1173	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Smoking cessation	Value of smoking cessation to individual, as a function of household income and behaviours	2406	Used as a measure of value, including health benefit, as a function of UK household panel survey income & expenditure data	HACT, 2014-2016

	Economic savings in weekly budget	£7.93 per week saved per household food bill (healthy cooking class)	7.93 (or 413 per year)	Reflects value of cost savings to family per year	Average based on testimonial from healthy cooking teachers
Children (of residents and Champions)	Improved overall physical health (i.e. from physical exercise & healthier eating)	Quarter proportion of QALY value for overall physical health due to vigourous exercise / healthy diet	3240	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Fairer access to health services	Average NHS spend per person UK	2200	The logic of this indicator is based on the principle that citizens would want to benefit in at least the same way as other citizens; and that other citizens should be able to access the benefit they would receive themselves i.e. an ethical entitlement for whole population	National Audit Office and Personal and Social Services Research Unit (PSSRU), adjusted for inflation
	Improved relationships with family	Assigned proportion of a QALY value for personal and social relationships (under personal wellbeing)	1173	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with National Accounts of Well-being (nef)
	Sense of belonging	Assigned proportion of a QALY value for sense of belonging (under personal wellbeing)	1173	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra	National Institute for Health and Care Excellence, and Centre for Mental Health, combined with

				year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population	National Accounts of Well-being (nef)
	Correct dental hygiene	Combined QALY value of self-confidence + wellbeing from avoiding pain as a function of lost school days (dentist visit)	191	QALYs are publicly validated and used by governments and academics as a threshold measure to value the worth of achieving one extra year of improved quality of health and life; also reflects how our health and mental wellbeing is valued as an ethical entitlement by the whole population. This is combined with evidence demonstrating the self-confidence impact from poor dental hygiene.	Combination of NICE QALY values, and University of Carolina research, Dr S.L. Jackson (2010) + Journal of Pediatrics 2012
	Executive functioning for School readiness	Combined QALY and educational attainment valuation	7222	Taken from existing research by Basildon Council in Highcliffe Community Budget pilot project	Basildon Council and Envoy Partnership 2014
Local Authority	Reduced Adult social care need from Mental Heath and isolation issues	Average cost of social worker support for 6 months	4204	Evidence of direct cost	PSSRU
	Reduced Adult social care need from reduced Diabetes	Cost per adult in social care due to diabetes; present value of 5 yrs spending / half 10 yrs saved life expectancy	39990	Evidence of direct cost	Community Champions financial data (percentage calculation of contract values with Local Authority bodies)
	Reduced number of older people entering long term care early	Cost per older person in long term social care without nursing support	24263	Evidence of direct cost	West London CCG and RBKC, comparable to Bield, Trust, and Hanover housing 'SROI of Adaptations and Very Sheltered Housing' (2012)
	School readiness	Internal cost to school of extra readiness support	260	Evidence of direct cost	Basildon Council and Envoy Partnership 2014

Government & Public services	Reduced level of diabetes (taking half proportion of 10 year saved life expectancy)	Future cost to health services person with diabetes, present value using 3.5% discount rate (occurrence after 20 years assumed)	6070	Evidence of direct cost	Department of Health life expectancy data (diabetes), combined with Kanavos, van den Aardweg and Schurer: Diabetes expenditure, burden of disease and management in 5 EU countries, LSE (Jan 2012) from http://www.diabetes.co.uk/cost-of-diabetes.html
	Overall improved health	NHS spend per person	2200	Evidence of direct cost	National Audit Office & PSSRU (2013 adjusted for inflation)
	Smoking cessation	NHS spend per person on smoking related issues (non-surgical)	450	Evidence of direct cost	PSSRU (2013, adjusted for inflation)
	Cost of cardiovascular illness (minus diabetes proportion for double-count)	NHS spend per person on cardiovascular episode	5502	Evidence of direct cost	PSSRU (2013, adjusted for inflation)
	Individual Income tax & National Insurance on minimum wage	Calculation using government tax and NI rates	809	Evidence of direct amount to government	UK GOV / Listentotaxman.com
	Reduced Job Seekers Allowance (JSA)	Annual cost of weekly JSA claim (over 25 years old)	3011	Direct unit cost to government (Excluding administration cost)	www.gov.uk
Social Landlord	Sustained tenancies	Cost to public authority of tenancy failure, as a function of reported wellbeing change	2909	Reflects direct cost to the State of eviction and tenancy failure	Octavia & OPDM, SROI report (2008), adjusted for inflation

3. Impact and Attribution

This SROI analysis measures these adjustments by triangulating a number of different primary and secondary research elements to help establish impact credibly, specifically:

- *Attribution*: Responses to surveys and consultation gave credit, or "attribution" of outcomes at around 65%, however this was further reduced to a quarter (c.16%) for Residents and Children, to account for more contributing factors in 2018 than in 2014, e.g. increased activities at the community centre or school, and other settings, as a result of reduced statutory provision. This is an even more conservative reduction than in 2014 which was one third proportion of the reported attribution (c.21%).

- *Deadweight*: The majority of respondents reported that it was highly unlikely that these outcomes would have occurred anyway or that alternative forms of outreach and access to health services would arise. i.e. a low deadweight likelihood. However, we have conservatively used a 50% likelihood of deadweight, for adult residents and children. This further reduces the amount of impact claimed. Calculations are significantly sensitive to deadweight in this model, for example increasing the deadweight by 10% reduces the SROI to approximately £4:£1 and increasing to 75% deadweight reduces the SROI to just under £2.80:£1. It should be noted that we have only used a deadweight of 10% for Champions, as they are more directly impacted; and also similar opportunities were not prevalent/far less available in their neighbourhoods.

- *Displacement* is zero, as we have assumed improving a person's health does not have a negative unintended consequence on another stakeholder, with the exception of employment outcomes where we have used a 20% displacement factor i.e. one person misses out on gaining a job.

- *Benefit period* reported by survey and stakeholder engagement were identified as up to 2 years for health, wellbeing and financial/economic outcomes.

- *Drop-off* of impact is 66% drop off per year over a 2-year benefit period, as "drop-off" is used to reflect that impact is reduced in strength over time.

- *Discount rate* of 3.5% was used (suggested in HM Treasury Green Book) for calculating the present value of future benefits.

- In 2014 we had been advised by Public Health commissioners in the partner boroughs to use a one third (c.33.3%) likelihood that Champions double-count or cross over the households they reach between them. In 2018 we increased this to 50% likelihood, to further reduce the chance of over-claiming impact. As part of our primary research, Champions and hub co-ordinators identified the difference between number of new households and repeat households that they reached per month.

4. Impact Map

Stakeholder	Activities	Outputs related to Stakeholder	Long term Outcomes related to stakeholder: Social, Economic / Fiscal
Champions	Varied physical and mental health awareness-raising activities for the community, across a broad range of family and individual health needs Participation in health training and healthier lifestyle activities Dissemination and promotion One to one guidance Motivating behaviour change in others Educating and mentoring local households about health behaviours and practices Signposting to local services and agencies/Supporting fairer access Feeding back community needs to local services Advocacy Informal welfare guidance Informal emotional counselling	Number of households reached and participating or changing behaviours Sustained tenancies for vulnerable older / isolated residents Increased attendances at community centre More variety of activities at community centre Number of Champions going on to further volunteering, training, roles of responsibility or paid work	• Improved skills • Overall wellbeing • Not Isolated • Resilience / Confidence • Improved life expectancy (diabetes type 2 and/or cardio) • Improved health mild weight loss: physical activity, healthy eating etc • Fairer access to appropriate health services • Smoking cessation • Further volunteering • Work readiness • Paid work FTE • Economic gain through better household food budgeting
Residents	Varied physical and mental health awareness-raising activities for the community, across a broad range of family and individual health needs Participation in health training and healthier lifestyle activities	Number of households participating or changing behaviours Increased attendances at community centre	• Improved life expectancy through delayed onset or avoidance of diabetes type 2, related conditions, and/or cardio problems • Improved health - mild weight loss: physical activity, healthy eating etc • Fairer access to appropriate health services • Overall wellbeing • Sense of belonging and acceptance in community • Not isolated • Smoking cessation • Economic gain through better household food budgeting

Government / Local Authority	Health care provision Social care provision Provision of School/education Provision of benefit payments, (including Job Seekers Allowance) Local services engage with local community needs and varied cultural needs Engaging with local residents' needs and issues through Champions Providing health and care information through Champions Monitoring and performance checking of outcomes	Number of residents with improved health and reduced health care need Number of residents with reduced social care need Number of Champions entering Employment or Training Improved number of children at a "school-ready" level	• Delayed or avoided need - Adult Social care: reduced risk of diabetes (and associated wheelchair provision, occupational therapy, adaptations) • Delayed or avoided need - Older people entering long term care • Education – Executive functioning and school readiness • NHS resources - reduced level of diabetes need (also associated to obesity) • NHS - overall improved health • Smoking cessation • Cost of cardiovascular illness to NHS • Economic contribution (FTE) • Reduced JSA likelihood • Cohesion and integration – resilient neighbourhoods
Children	Varied physical and mental health awareness-raising activities for the community, across a broad range of family and individual health needs Participation in health training and healthier lifestyle activities	Number of households participating or changing behaviours Increased attendances at community centre	• Improved physical health • Fairer access to appropriate health services • Improved oral hygiene • Improved relationships with family • Improved sense of belonging • Improved executive functioning and School readiness • Improved sense of responsibility and respect

Housing Associations / Registered Social Landlord	Community centre support Funding, promotion	Number of households reached experiencing health and wellbeing change / reduced isolation	• Improved tenants' health • Sustained tenancy and reduced likelihood of vacancy