



## **The contribution of voluntary organisations to the health and care prevention agenda: A rapid review of the evidence**

Dr Llinos Haf Spencer<sup>1,2\*</sup>

Professor Mark Llewellyn<sup>1</sup>

Professor Carolyn Wallace<sup>1</sup>

1 University of South Wales

2 Royal College of Surgeons in Ireland (RCSI) University of Medicine and Health Sciences

**\*Corresponding author:** Dr Llinos Haf Spencer, Welsh Institute for Health and Social Care (WIHSC), Faculty of Life Sciences and Education, University of South Wales, Glyntaff Campus, Cemetery Road, Pontypridd, CF37 4BD.

Email: [llinos.spencer@southwales.ac.uk](mailto:llinos.spencer@southwales.ac.uk)

## Contents

Executive summary .....	3
Introduction .....	4
Methods.....	6
Findings .....	9
Thematic findings from the included studies .....	12
Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support) .....	12
Theme 2: Outdoor interventions (including gardening / walking / climbing interventions).....	19
Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions) .....	21
Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets) .....	25
Theme 5: Help at home (including palliative care and domiciliary welfare) .....	27
Discussion .....	31
Conclusions.....	34
Strengths and limitations of the available literature .....	35
Recommendations for policy and practice .....	35
Acknowledgements .....	36
Ethical approval .....	36
Conflict of interest.....	36
Funding statement .....	36
Author contributions .....	36
References.....	37
Appendices list .....	44

## Executive summary

In the context of increasing pressure on public resources, demonstrating value for money in health and care interventions is critical. This rapid review examines the economic evidence supporting the role of the voluntary sector in alleviating demand on health and care services. Employing a systematic review methodology, 28 publications (27 studies) were identified through comprehensive searches of academic databases and the grey literature. Findings from the searches were presented in accordance with PRISMA guidelines.

From the included studies, five themes were identified to describe the type of studies which provided economic evidence of the contribution of the voluntary sector. The five themes were peer support, outdoor interventions, long-term conditions, other social prescribing interventions and finally, help at home. Peer support and outdoor interventions consistently demonstrated positive Social Return on Investment (SROI), often exceeding £1 return per £1 invested. Conversely, interventions targeting long-term conditions and some digital services showed limited cost-effectiveness. Notably, the UK Recovery College initiative reported significant annual savings (£670K–£1.34M (in 2024 prices £831,778 - £1,663,557; \$1,118,242-\$1,801,496; €1,000,180-€1,930,724) annually if integrated into existing services. Help-at-home interventions yielded mixed results, with some enhancing government benefit uptake, but lacking measurable quality-of-life improvements.

The review highlights a scarcity of robust economic evidence specific to the voluntary sector in Wales, particularly within integrated health and social care systems. However, locally tailored interventions often present stronger economic justification than traditional randomised controlled trials. Recommendations include embedding economic evaluation frameworks within voluntary sector initiatives to substantiate their societal value and inform future investment decisions. More longitudinal evaluation could provide more robust evidence.

**Keywords:** Voluntary sector organisation; prevention; health and social care, economic evaluation, value

## Introduction

With increasing pressure on public resources, demonstrating value for money in health and care interventions is essential. The voluntary sector (which includes charities, voluntary organisations and social enterprises) plays a crucial role in health and social care in Wales as they often provide services that complement those offered by statutory bodies such as health boards (HBs) and local authorities (LAs). These services include health education, advocacy, community development, and wellbeing support (Newton, 2024). Many voluntary sector activities focus on long-term preventative measures and early intervention, which can help reduce the burden on acute and chronic care services. Voluntary sector organisations are very agile and able to respond quickly to changing needs and crises, despite constant changes in funding levels and sources of financial support. Their values-driven approaches enable them to innovate effectively (Newton, 2024). The voluntary sector matters to health and social care in Wales as they provide volunteers and services that would not otherwise be available to assist the people of Wales to live as healthily and independently as possible (Newton, 2024).

The 'prevention agenda' refers to a strategic focus on preventing disease and ill health and promoting healthy behaviours through research, policy and innovation, and is not about preventing people from using health and care services. Despite commitment from government regarding keeping the population healthy (Public Health Wales, 2017, 2023; Senedd Insight, 2023; Wohland et al., 2015), shrinking public health budgets could possibly lead to more use of National Health Services (NHS) in the future (Robertson et al., 2019). A review of economic evaluations of public health interventions assessed by the National Institute for Health and Care Excellence (NICE) showed that nearly 63% of the assessed public health interventions were cost-effective. However, they also found there was wide variation in their cost-effectiveness and that decision makers should be aware of this variation to maximise health gain within a limited budget (Owen et al., 2018).

Wales Council for Voluntary Action (WCVA) is the national membership body for voluntary organisations in Wales. WCVA distributes funding to charities, social enterprises, and volunteers in Wales. In 2025, over 10,000 Wales-based voluntary sector organisations contribute to health care service delivery with 15,086 people volunteering for registered health and social care charities. In Wales, 21% of registered charities support health and care ([www.wcva.cymru/datahub](http://www.wcva.cymru/datahub)). However, volunteers are not a 'free good' in that there are costs to the sector in identifying, recruiting, training and supporting volunteers in their roles across the health and care sector. The value of volunteers has been measured by Volunteer Scotland in 2025 and while the overall difference in wellbeing between volunteers and non-volunteers was not always statistically significant, weekly volunteering consistently showed significant positive effects. The impact was validated across multiple datasets, including the Scottish Household Survey and Understanding Society (Volunteer Scotland, 2025). The Wales Council for Voluntary Action (WCVA) have also published guidance documents regarding the value of volunteering. The WCVA have stated that volunteers contribute significantly to the economy of Wales, and add non-monetary elements such as social cohesion, inclusion, regeneration, and social capital (Wales Council for Voluntary Action, 2019).

The voluntary sector can contribute to reducing inequalities in health and well-being through three important ways (Torgersen & Maurud, 2024). These include, firstly, by building trust with groups in society that authorities may struggle to connect with. Secondly, advocacy and democratic watchdog: Voluntary organisations can show how policies work in real life and can promote awareness of the importance of proportionate universalism. They also have an important watchdog role and offer a voice to groups that are not often heard, including those in vulnerable situations. For example, carers of those living with dementia. Thirdly, the voluntary sector can be a co-creator of equity policies: local, regional and national authorities should establish a systematic dialogue with voluntary organisations through policy-making that supports such collaboration (Torgersen & Maurud, 2024).

The Bevan Commission has highlighted some successful collaborations and the positive impact of the voluntary sector organisations on health and social care delivery (The Bevan Commission, 2024). Collaboration between the voluntary sector and statutory services can lead to transformational changes in health and social care delivery improving overall outcomes (Newton, 2024).

Traditional economic evaluations such as cost-effectiveness (CEA), cost-utility (CUA), and cost-benefit analyses are now complemented by Social Return on Investment (SROI), which captures broader socio-economic outcomes and stakeholder perspectives in a single monetary ratio, whilst including multiple stakeholders (Banke-Thomas et al., 2015).

The aim of this rapid review was to answer the following review question: What is the economic evidence for the contribution of the voluntary sector towards preventing use of the health and care services?

The rapid review protocol has been published on PROSPERO and is available at <https://www.crd.york.ac.uk/PROSPERO/view/CRD420251016775>.

## Methods

Rapid review methods were used to conduct this review (Garritty et al., 2024; Haby et al., 2023; Harker & Kleijnen, 2012; Lewis et al., 2024; Plüddemann et al., 2018). A systematic rapid review provides evidence collected in a systematic way, similar to a full systematic review in that it aims to provide timely information for policy makers and health professionals. However, a rapid review is a streamlined version of a systematic review in the sense that it omits certain steps of a traditional systematic review such as double data extraction (Garritty et al., 2024). A SPIDER Framework explaining the sample, phenomenon of interest, design, evaluation and research type in the rapid review is presented in Table 1.

**Table 1 SPIDER framework with inclusion and exclusion criteria**

	<b>Inclusion</b>	<b>Exclusion</b>
<b>Sample</b>	Voluntary Sector Organisations	Private or public service organisations
<b>Phenomenon of Interest</b>	Prevention	Studies not focussing on prevention
<b>Design</b>	Any study design with an economic evaluation component	Any study design without an economic evaluation component
<b>Evaluation</b>	Any study with an economic evaluation component	Any study without an economic evaluation component
<b>Research type</b>	Cost-effectiveness, Cost consequence, cost-benefit, return on investment (ROI), Social Return on Investment (SROI).	Studies without an economic evidence component.
<b>Dates</b>	Between 2015-2025	Pre year 2015
<b>Language</b>	English or Welsh	Languages other than English or Welsh
<b>Other consideration</b>	N/A	N/A

### *Keywords*

The general keywords are listed under population; intervention; and economic evaluation terms below. The search strategies for the electronic databases used for the review can be seen in Appendix 1.

### *Population*

‘Voluntary service organisation\*’  
 Volunteer\*

### *Intervention*

‘community support’  
 ‘diet and exercise support’  
 ‘health promotion’  
 ‘independent living’  
 ‘prevention’

‘reducing isolation’  
‘screening’  
‘smoking cessation’  
‘social support’  
‘substance misuse prevention’  
‘support networks’  
‘wellbeing’  
‘well-being’

#### *Economic evaluation terms*

‘cost benefit’  
‘cost consequence’  
‘cost’  
‘cost-effective\*’  
‘DALY’  
‘disability adjusted life year’  
‘economic’  
‘evaluation’  
‘QALY’  
‘quality adjusted life year’  
‘return on investment’  
‘ROI’  
‘social return on investment’  
‘SROI’

#### *Databases*

Seven databases were selected to conduct the searches, these were as follows:

- **APA PsycInfo** - APA PsycInfo is a comprehensive database managed by the American Psychological Association (APA).
- Applied Social Sciences Index and Abstracts (**ASSIA**)
- Cumulative Index to Nursing and Allied Health Literature (**CINAHL**)
- Excerpta Medica Database (**EMBASE**)
- Public/Publisher MEDLINE (**PubMed**)
- **Scopus** – Scopus is a comprehensive, multidisciplinary abstract and citation database managed by Elsevier
- **Health business elite** database

#### *Grey literature*

Grey literature was searched. See Appendix 4 and the PRISMA diagram below.

### *Cost inflation*

Cost inflation will be done utilising the following on-line calculators:

Australian Dollars (AUS\$): [Inflation Calculator | RBA](#)

Euro(€): [EUR Inflation Calculator - Euro \(1990-2025\)](#)

GBP(£): <https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator>.

United States Dollars (USD\$): [USD Inflation Calculator - Brave Calculator](#)

### *Cost conversion*

Cost conversion will be done using the following on-line calculators:

AUS\$: [GBP to AUS - Search](#)

Euro (€): [Convert GBP to EUR](#)

USD\$: [Historical Rates Tables | Xe](#)

## Findings

A total of 28 papers were included in the review, describing 27 studies. Of these n=28 publications (27 studies) were from the electronic database searches and n=1 was from the grey literature. See Figure 1 for the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram (Page et al., 2021). The evidence map of included studies according to study design is shown in Table 1.

Data extraction tables can be found in Appendix 2 and the critical appraisal tables are in Appendix 3. The Grey literature searches can be found in Appendix 4 and a Table of abbreviations can be found in Appendix 5.

Table 1 – Map of the included evidence in the rapid review

Type of intervention						
Study design	Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)	Theme 2: Outdoor interventions (including gardening/walking/climbing interventions)	Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions)	Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)	Theme 5: Help at home (including domiciliary welfare and palliative care interventions)	Total
<b>Review</b>	Nickel et al (2018) (systematic review)	-	Mossabir et al (2015) (Scoping review)	-	-	<b>2</b>
<b>Randomised controlled trial (RCT)</b>	Ali et al (2021) Band et al (2025) Marshall et al (2020)	-	Anderson et al (2021) Patchwood et al (2021) Williams et al (2024)	-	Howel et al (2019)	<b>7</b>
<b>Cohort study</b>	Engel et al (2021) Foster et al (2021) Willis et al (2018)	Schoen et al (2020)	Murphy et al (2021) Kay and Edgley (2019)	Jones et al (2015)	Aoun et al (2023) Mitchell et al (2020)	<b>9</b>
<b>Mixed methods study</b>	Granger et al (2025) Kazantis et al (2024) Visram et al (2017) Visram et al (2020)	Makanjuola et al (2023) Whiteley et al (2024)		Lynch and Jones (2019) Lynch and Jones (2022) Ramachandra (2015)	Bauer et al (2017) Moffatt et al (2021)	<b>10 papers 9 studies 1 grey literature report</b>
<b>Total</b>	<b>11</b>	<b>3</b>	<b>6</b>	<b>4 papers 3 studies</b>	<b>5</b>	<b>28 papers (27 studies) 1 grey literature report</b>

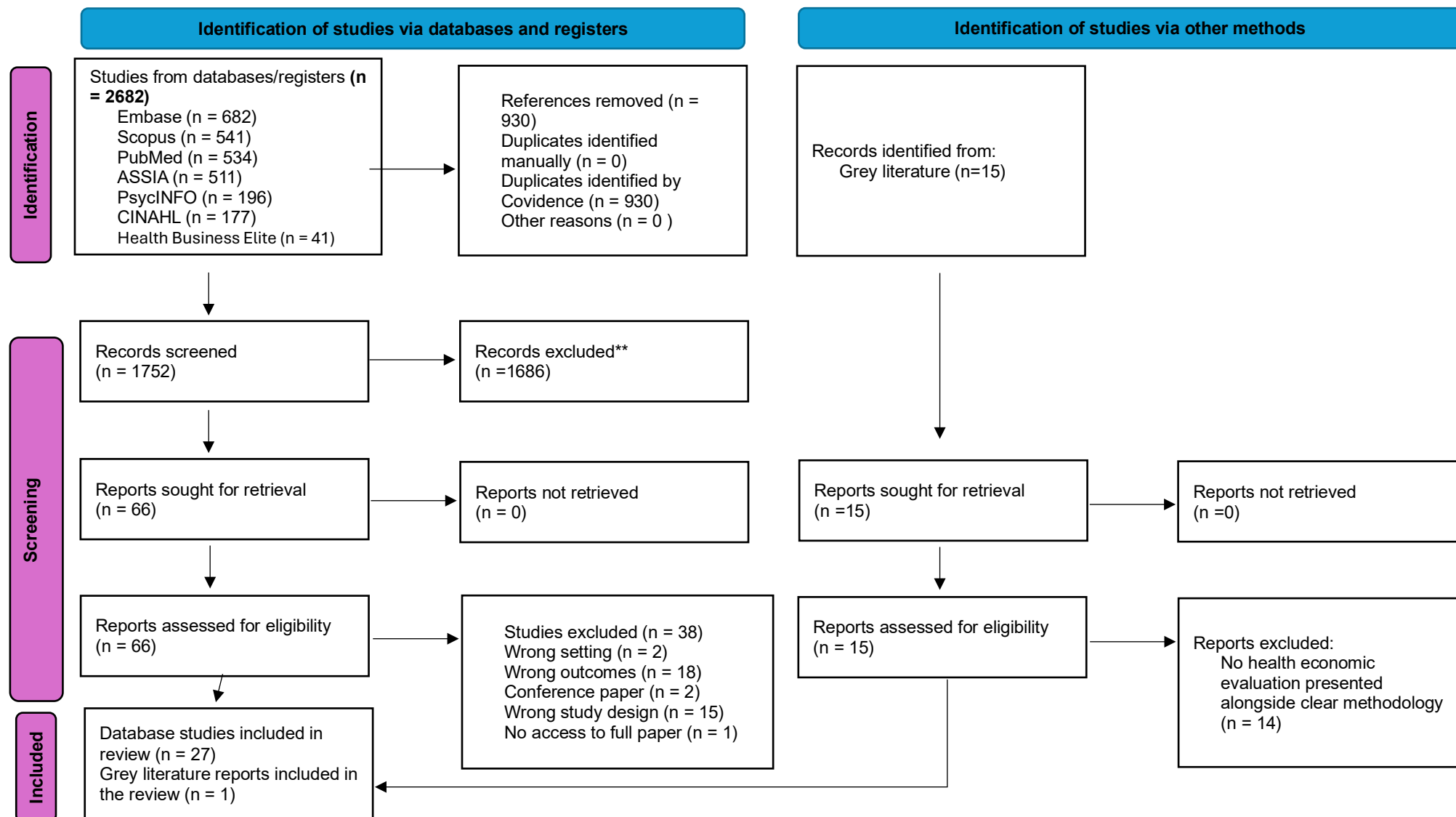


Figure 1 PRISMA diagram of included studies (Page et al., 2021)

## Thematic findings from the included studies

Of the 28 included publications, there were 27 studies. There were two reviews included, one was a systematic review (Nickel et al., 2018) and the other was a scoping review of the literature (Mossabir et al., 2015). Eight of the studies were randomised controlled trials (RCTs) (Ali et al., 2021; Anderson et al., 2021; Band et al., 2025; Howel et al., 2019; Marshall et al., 2020; Patchwood et al., 2021; Williams et al., 2024). Eight of the included studies were cohort studies (Aoun et al., 2023; Engel et al., 2021; Foster et al., 2021; Jones et al., 2015; Kay & Edgley, 2019; Mitchell et al., 2020; Murphy et al., 2021; Schoen et al., 2020a; Willis et al., 2018). Nine of the studies were mixed methods studies including Social Return on Investment (SROI) studies (Bauer et al., 2017; Granger et al., 2025; Lynch & Jones, 2022; Makanjuola et al., 2023; Moffatt et al., 2023; Ramachandra, 2015; Visram et al., 2017, 2020a; Whiteley et al., 2024). All the studies were from Organisation for Economic Co-operation and Development (OECD) countries. The studies in the following five sections are discussed in the following sequence: reviews are first, then RCT's, then cross-sectional/cohort studies, then qualitative studies followed by mixed methods studies.

### Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)

Ten studies were included in this peer support theme, including one systematic review (Nickel et al., 2018), three randomised controlled trials (RCTs) (Ali et al., 2021; Band et al., 2025; Marshall et al., 2020), and of the six other studies one was an economic modelling study (Engel et al., 2021) and five were mixed-methods studies incorporating SROI (Foster et al., 2021; Granger et al., 2025; Visram et al., 2017, 2020b; Willis et al., 2018). A wellbeing analysis from the grey literature was also included in this theme (Kazantis et al., 2024).

A systematic review published in 2018 reported on non-pharmacological interventions directly targeted at persons with dementia as well as persons with mild cognitive impairment and their respective caregivers (Nickel et al., 2018). The time frame for the systematic review was 2010-2016, and the authors identified sixteen publications which met their inclusion criteria. Health economic evaluations indicated the cost-effectiveness of physical exercise interventions and occupational therapy. There was also evidence to suggest that psychological and behavioural therapies are cost-effective. However, health economic studies investigating psychosocial interventions mainly targeted towards informal caregivers showed inconsistent results (Nickel et al., 2018).

In 2020, a RCT study from the UK was published which aimed to investigate the feasibility of delivering group social support to people with aphasia via a multi-user, virtual reality platform. It also explored the indicative effects of intervention and the costs (Marshall et al., 2020). The study type was a randomised, waitlist-controlled design. The intervention in the study was a group social support program for people with aphasia, delivered through the virtual reality platform EVA Park. The voluntary sector organisations played a crucial role in the study by providing group coordinators: Six group coordinators from various community-based aphasia groups led the intervention sessions. These coordinators had significant experience in managing community groups for people with aphasia. The data collection for the study was between May 2017 and November 2018. The intervention recipients were 34 people with aphasia who took part in small groups remotely via the EVA Park platform. The intervention consisted of 14 group sessions delivered over a period of 6 months. Each session lasted 1.5 hours and was held every two weeks. Each group included 6-9 participants with aphasia, led by a coordinator and supported by volunteers. The intervention encouraged the use of total communication devices, such as message writing and demonstration, and included pre-programmed avatar gestures to supplement communication. Participants received training on how to navigate EVA Park, create and customize avatars, and use the platform's features. A cost analysis was conducted from a provider perspective. The currency was GBP, and the cost year was 2017/2018. The costs of the intervention were calculated, and the main finding was that the average cost of implementing each group was £9,061 (in 2024 prices, £11,450; \$15,395 USD; €13,272), excluding hardware costs. The average cost per participant for the full episode of intervention was £1,364 (in 2024 prices £1,724; \$2,317 USD; €1,998). The major cost drivers included training for coordinators and volunteers, project manager inputs, and the involvement of volunteers which helped reduce costs. This innovative use of virtual reality allowed participants to engage in social support activities from their homes, overcoming barriers like physical distance and travel difficulties. These findings suggest that while the intervention is feasible, careful consideration of cost components and strategies to optimise volunteer involvement and training could help manage expenses (Marshall et al., 2020).

In 2021, a RCT feasibility study conducted in one NHS Trust in England aimed to assess the feasibility and acceptability of conducting a future full-scale randomised controlled trial of a one-to-one structured befriending service for people with intellectual disability who had depressive symptoms (Ali et al., 2021). The study began in 2019 and completed in 2021 with 30 participants recruited. Volunteers were trained and supervised by community befriending services and these services were also responsible for recruiting and matching volunteers to participants. The trained volunteer

befrienders met with the people with intellectual disabilities over a period of 6 months from recruitment. The befriending service aimed to improve the quality of life and reduce depressive symptoms in participants by providing consistent social support through volunteer befriending. A cost-effectiveness analysis was conducted and a linear regression including covariates for randomisation to befriending intervention or control, baseline costs and effects was used to calculate the mean difference in costs/effects between the befriending intervention and the control group, with 95% confidence intervals (CIs). After adjustment for baseline values, the Incremental Cost Effectiveness Ratio (ICER) was £1810 per point change on the Glasgow Depression Scale for people with a Learning Disability (GDS-LD). The befriending intervention had a 35% probability of being cost-effective at a willingness-to-pay threshold of £20,000. The befriending service for people with intellectual disabilities and depressive symptoms was not definitively cost-effective due to the small sample size and low recruitment rates. Many participants appreciated the social interaction and support provided by the volunteers. Participants reported feeling less isolated and more connected, which contributed to improvements in their mood and overall well-being. Volunteers found the experience rewarding and felt that they were making a meaningful difference in the lives of the participants. They valued the training and supervision provided, which helped them feel prepared and supported in their roles. Although the befriending intervention was generally well-received, with both participants and volunteers expressing satisfaction with the befriending sessions, the befriending intervention had a 35% probability of being cost-effective at a willingness-to-pay threshold of £20,000 (Ali et al., 2021).

In 2025, a pragmatic RCT conducted in England aimed to assess the clinical and cost-effectiveness of implementing a social network intervention [‘project about loneliness and social networks’ (PALS)] designed to link people at risk of social isolation and loneliness to community resources and activities (Band et al., 2025). This was done through trained volunteer facilitators helping community members use GENIE, which is an on-line tool. The volunteers were trained by the PALS research team, which included researchers from Swansea University, Leeds Beckett University, University of Bristol, University of Warwick, and University of Southampton. The volunteers helped participants think about the role of people around them and how their networks might be improved by including new connections to community activities. Participants mapped and reflected on their personal social networks, including friends, family, groups, pets, and daily activities. Based on individual preferences, available support, and health and wellness needs, participants were linked to local community resources and activities dependent on personal preference (with no reference to cost of activities in the publication). Study data was collected between 2019 and 2022. The PALS study recruited a total of 469 adults from two regions (Southampton and Liverpool in

England). There were 120 withdrawals (approximately 25.6%) during the study, however the reasons for the high level of withdrawals were not stated clearly in the publication. A cost-effectiveness analysis was conducted, with the ICER for the PALS intervention calculated to be £30,000 per Quality Adjusted Life Year (QALY). Sensitivity analyses confirmed that the intervention was not cost-effective under most scenarios, reinforcing the main economic findings. The social network intervention did not significantly reduce loneliness or social isolation compared to usual care and there was little to no improvement in mental wellness, as measured by the Short Form questionnaire-12 items mental health component score, at the 6-month follow-up (Band et al., 2025).

A SROI conducted in Liverpool, England, evaluated the impact of Citizens Advice on Prescription (CAP) on service users' wellbeing (Granger et al., 2025). The intervention was delivered through the Citizens Advice Bureau (CAB) and the data was collected from n=538 service users between May 2022 and November 2023. The intervention was delivered by trained advisors from Citizens Advice Liverpool. These advisors conducted detailed assessments and provided personalised support plans to service users. The service was a collaboration between Citizens Advice Liverpool and Liverpool NHS, with referrals coming from healthcare professionals in primary and secondary care, as well as third-sector organisations. The types of costs measured were staff costs, overhead costs, office costs, room hire in GP surgeries, community partner payments, service data collection and evaluation costs. The study reported an overall positive SROI return range of £1: £3.40–£4.69. Secondary care referrals yielded the highest social value ratio, with a return of £1: £12.13, primary care referrals also showed a positive return, with a social value ratio of £1: £4.72, and perinatal referrals, however, had a lower social value ratio, with a return of £1: £0.90. This variation highlights the differing impacts of the CAP service depending on the referral source, suggesting that the service may be more effective for certain groups of users (Granger et al., 2025).

A SROI study conducted in England was published as a conference presentation in 2017 (Visram et al., 2017). The study being evaluated was the Wellbeing for Life (WFL) service in County Durham, England. The WFL service was funded by Durham County Council, delivered by a consortium of public and voluntary sector providers, and was launched on 1st April 2015. At the beginning of the study, there were 1461 clients, but by 12 months, this number had reduced to 133 clients who completed the follow-up. The intervention was delivered by a team comprising trained staff members and volunteers. The staff included professionals from various disciplines such as health, social care, and community development. Volunteers played a crucial role in supporting the delivery of services and providing peer support to clients. This collaborative approach

ensured that the intervention was comprehensive and tailored to the needs of the community. The intervention, typically delivered over a period of 8 to 12 weeks used a combination of face-to-face support, community-based activities, and volunteer involvement to promote healthy lifestyles. It targeted disadvantaged communities, focusing on improving physical activity, diet, mental wellbeing, and reducing harmful behaviours. The main aim was to reduce health inequalities and enhance overall wellbeing. A SROI of approximately £3.59 for every £1 spent was found (Visram et al., 2017).

Another SROI study published by the same author in 2020 reported on the same WFL service in the North East of England (Visram et al., 2020a). For this paper, the dates of data collection were between June 2015 and January 2017, and the sample size was 3179. Of these n=2433 individuals accessed one-to-one interventions; n=4669 individuals accessed health-promoting events; and there were n=1595 instances of signposting to other services. The intervention deliverers for the WFL service were lay health workers. These individuals were recruited from the communities they served and received specialised training to deliver health promotion programs by the national Data Collection and Reporting System (DCRS) support team, who assisted with both training and troubleshooting. Each participant received between 8 and 12 sessions and the intervention included one-to-one behaviour change interventions, group wellbeing improvement sessions, volunteering opportunities and engagement in community development activities. It was estimated that the total societal value of the service was between £3.45 and £6.03 for every £1 spent on the service, indicating a positive impact on society. There was also evidence for a positive impact on emotional wellbeing as measured by the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (Visram et al., 2020a).

In 2018 a SROI study was conducted in the UK, to quantify the social value created by peer support groups for people with dementia and their carers (Willis et al., 2018). The aim of the peer support groups for people with dementia was to provide mental stimulation, reduce loneliness, and offer support to carers, to enhance overall wellbeing. Three peer support groups, each with approximately 10-15 participants, including people with dementia, their carers, and volunteers took part in the study. These were in-person support groups in community settings run by trained facilitators and volunteers supported by the Health Innovation Network South London. The SROI analysis included the costs of staff salaries, venue hire, refreshments, training and materials for running the peer support groups. Findings showed the three groups created social value ranging from £1.17 to £5.18 for every pound (£) of investment, dependent on the design and structure of the group. Key outcomes for people with

dementia were mental stimulation and a reduction in loneliness and isolation. Carers reported a reduction in stress and burden of care. Volunteers also cited an increased knowledge of dementia. The sensitivity analysis showed that while the social value ratios varied depending on the assumptions made, the overall conclusion remained consistent: peer support groups provide significant social value (Willis et al., 2018).

An economic modelling study conducted in Australia in 2021 evaluated the cost-effectiveness of the Friendship Enrichment Programme (FEP) and a volunteer-led internet and computer training (VICT) intervention to reduce loneliness in older adults and, in turn, prevent depression (Engel et al., 2021). The interventions were the FEP and the VICT. The FEP programme consisted of 12 lessons covering various topics related to friendship, such as expectations, early experiences, self-evaluation, making new friends, improving existing friendships, and setting goals. Each session included both theoretical components and practical exercises, with participants encouraged to apply what they learned in their daily lives. The VICT intervention was structured to help older adults become more comfortable with digital technology, thereby reducing loneliness and enhancing social connections. The authors used a 5-year time horizon for the modelled cost-effectiveness analysis. The currency was AUS\$ and the cost year was 2021. The interventions were evaluated based on the cost per QALY gained, with results showing that they were generally cost saving. Both interventions generated cost savings that were greater than intervention costs, with a return on investment (ROI) of AUS\$2.87 for the FEP and AUS\$2.14 for the VICT intervention after 5 years, indicating that the interventions were less costly and more effective compared to no intervention. The findings underscore the critical role of social connections and digital literacy in enhancing the mental health and well-being of older adults. It also emphasises the importance of addressing loneliness as a modifiable risk factor for depression (Engel et al., 2021).

Also, in 2021, the British Red Cross funded a mixed method study in the UK, utilising a SROI analysis (Foster et al., 2021). The aim of the study was to understand the impact of the social prescribing service and to establish whether the service supported people to feel less lonely. The sample size for the study was 10,643 service-users. This included a subsample of 2,250 service-users who completed the UCLA questionnaire both before and after receiving support. The participants were recruited from 37 different sites throughout the UK. Service-users were referred from various sources, including statutory services (NHS and local authorities), voluntary sector organisations, community activities, and self-referrals. The intervention delivery was primarily in person. Link workers provided support through face-to-face meetings, which took place in various locations such as community activities, cafes, and home visits, over 12

weeks in 2019. The goal was to reduce loneliness and improve wellbeing by connecting individuals with appropriate local resources and fostering social connections. Different costs were measured including central organisation and service-specific costs, volunteer costs, and avoided healthcare costs. The main economic finding of the study was that the social prescribing programme showed a social value of £3.42 per £1 invested. There was a significant reduction in loneliness levels with 73% of service-users feeling less lonely after receiving support. The reduction in loneliness was statistically significant, with a mean change of  $-1.84$  ( $p < 0.001$ ) (Foster et al., 2021).

A wellbeing analysis conducted in the UK found in the grey literature investigated the health benefits of church buildings and faith-based volunteers (Kazantis et al., 2024). The aim of the wellbeing analysis was to quantify the economic value of the health-related support services provided by UK churches, chapels, and meeting houses, specifically in terms of how they improve mental and physical health and reduce cost burdens on the NHS. The report valued the impact of four key services, including foodbanks, drug and alcohol addiction support, mental health groups, and youth groups. The total estimated cost relief to the NHS was £8.4 billion per year (2024 prices). In addition, Church volunteers themselves experienced a significant wellbeing boost from their involvement in delivering health-related services.

### **Theme 1 summary: Peer support (including befriending/reducing loneliness interventions/wellness for life support)**

The systematic review and the RCT studies highlight the varied economic impacts of non-pharmacological interventions. The included systematic review found physical exercise and occupational therapy cost-effective for dementia and mild cognitive impairment, with mixed results for psychosocial interventions (Nickel et al., 2018). A virtual reality social support for aphasia patients was feasible but costly (Marshall et al., 2020). A befriending service for people with intellectual disability was not definitively cost-effective (Ali et al., 2021). An on-line social network intervention was not cost-effective for reducing loneliness (Band et al., 2025).

Six non-RCTs investigated peer support interventions, with each one showing evidence in favour of the value of support groups: A UK SROI study on dementia peer support groups showed £1.17–£5.18 social value per £1 invested (Willis et al., 2018). A cost-effectiveness of Friendship Enrichment Programme (FEP) and Volunteer-led internet training (VICT) study from Australia found a ROI of AUS\$2.87 (FEP) and AUS\$2.14 (VICT). The Citizens Advice on Prescription intervention reported an overall positive SROI return range of £1: £3.40–£4.69.

Both SROI studies conducted on the WFL service also found positive social value ratios (Visram et al., 2017, 2020). In 2017, a social value of approximately £3.59 for every £1 spent was found for the WFL service (Visram et al., 2017). In 2020, it was estimated that the total societal value of the WFL service was between £3.45 and £6.03 for every £1 spent on the service, indicating a positive impact on society (Visram et al., 2020a). Similarly, a mixed methods and SROI to evaluate social prescribing from the UK, showed a social value ratio of £3.42 social value per £1 invested, with significant loneliness reduction among service-users (Foster et al., 2021).

A UK wellbeing analysis valued church-based health services, such as foodbanks and mental health groups at £8.4 billion in NHS cost relief annually (2024 prices). It also found that faith-based volunteers gain significant wellbeing benefits from their involvement in delivering these services (Kazantis et al., 2024).

## Theme 2: Outdoor interventions (including gardening / walking / climbing interventions)

There were three outdoor interventions including community gardening interventions (Schoen et al., 2020a; Whiteley et al., 2024) and walking and climbing interventions (Makanjuola et al., 2023). One was a cohort study (Schoen et al., 2020b) and two were mixed methods SROI studies (Makanjuola et al., 2023; Whiteley et al., 2024).

The cohort study was conducted to calculate the cost-to-benefit ratio of a community garden in London, England. The volunteering programme was run by Social Farms and Gardens. The study was conducted in 2019, with 3571.5 total hours of volunteer time in a London community garden. The intervention at the London community garden involved staff and volunteers delivering a range of activities aimed at improving physical and emotional wellbeing. These included sports training for young people, community classes, horticultural therapy for adults with learning disabilities and mental health issues, and sustainable food growing to supply the onsite vegan café. The garden, established in the early 1980s, occupied approximately 1400 m<sup>2</sup>, with the food growing area accounting for about one quarter of this space. The London garden offers diverse facilities such as a football pitch, a play area for children, café, community rooms, and small allotments. A rapid cost-benefit approach was undertaken to estimate this public value ROI. Types of costs measured included water, rent, refuse collection, garden maintenance, consumables: (seeds, compost), replacement costs of small tools, salaries and employment costs and volunteer time. Volunteer labour costs were £37,679 (3572 hours at £10.55/hour). The London garden achieved a ROI of £3 for every

£1 invested. Other benefits of the community garden included improved self-confidence and self-esteem, reduced isolation, and enhanced emotional wellbeing among the volunteers. Community gardens can play a crucial role in fostering social connections and improving mental health, demonstrating their value beyond just economic returns.

Both the included mixed methods studies were conducted in North Wales. The Opening Doors to the Outdoors (ODO) evaluation was conducted in seven sites across North Wales, and the Treborth Botanic Gardens evaluation was conducted in Bangor, North Wales (Makanjuola et al., 2023; Whiteley et al., 2024).

The ODO programme was evaluated between April and November 2022 (Makanjuola et al., 2023). The intervention recipients (n=52) completed both baseline and 12-week follow-up questionnaires. The ODO programme was a 12-week outdoor walking and climbing programme. There was one four-hour session each week and the activities included walking groups and climbing groups. Each session included time for socialising, such as outdoor picnics or café visits. The programme was conducted at seven sites across North Wales, with six sites offering walking interventions and one site offering climbing interventions. Participants were referred by General Practitioners (GPs), community mental health teams, job centres, voluntary sector organisations, and substance misuse rehabilitation centres. A SROI analysis was conducted. The costs of the intervention included website costs, equipment and software, insurance, accounting, office rent, staff costs (Health and Wellbeing Officer, Programme Support Officer, Session instructors), climbing admission, refreshments and transport costs. For every £1 invested in the programme, social values ranging from £4.90 to £5.36 were generated. This indicates a significant positive ROI, highlighting the programme's effectiveness in improving physical activity, mental wellbeing, social trust, and overall health among participants. 27 out of 47 participants reported an increase of 10% or more in their social trust scores, which was valued at £3,753 per person per year (in 2024 prices £4,128; USD\$5,571; €4,788). This improvement in social trust highlights the positive impact of the programme on participants' ability to connect with others and feel a sense of belonging in their community.

The 2024 natural experiment with SROI analysis study was conducted to evaluate the well-being benefits and social value of volunteer gardening at Treborth Botanical Gardens (TBG) in Bangor, North Wales (Whiteley et al., 2024). The data was collected from 35 volunteers between November 2021 and April 2022. The volunteering group was facilitated by a team of three full-time equivalent (FTE) staff members from Bangor

University. These staff members were responsible for managing and facilitating the volunteer program at TBG. They were supported by local volunteers, including members of the Friends of Treborth Botanic Garden (FoTBG) and the Students for Treborth Action Group (STAG). The costs measured included salaries of three FTE staff members responsible for recruiting, planning, and managing volunteers, and operational running costs including expenses such as building lease, maintenance, utilities, equipment, materials, catering, and insurance. The main finding was that Treborth Botanic Gardens generates significant social value in the range of £4.02 to £5.43 for every £1 invested. Volunteers reported fewer visits to psychotherapists, counsellors, and mental health nurses after participating in the gardening program. This suggests that volunteer gardening can potentially reduce the burden on healthcare services, leading to cost savings for the NHS.

### **Theme 2 summary: Outdoor interventions (including gardening / walking / climbing interventions)**

All three intervention studies highlighted the significant social and economic benefits of community gardening and outdoor activities, with positive returns on investment in all three studies (Makanjuola et al., 2023; Schoen et al., 2020a; Whiteley et al., 2024). There were beneficial outcomes relating to mental health and social connections (Makanjuola et al., 2023).

### **Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions)**

Six studies were included in theme 3 and these were one scoping review published in 2015 (Mossabir et al., 2015), three RCTs (Anderson et al., 2021; Patchwood et al., 2021; Williams et al., 2024) and two cohort studies (Kay & Edgley, 2019; Murphy et al., 2021).

The scoping review published in 2015 investigated interventions relating to long term conditions (Mossabir et al., 2015). The scoping review aimed to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. Only one of the seven included studies investigated cost-effectiveness (Grant et al., 2000). In the Grant et al (2000)\* project (\*excluded as a primary paper from the review due to being before 2015), they used a 'liaison organisation' called the Amalthea Project, to facilitate contact between patients in primary care with psychosocial problems and voluntary organisations (Grant et al., 2000). The mean cost of the intervention arm was significantly greater than the normal GP care ( $P = 0.025$ ), but there were also

significantly greater improvements in levels of anxiety, ability to carry out everyday activities, other emotional feelings, feelings about general health, and quality of life.

A RCT study conducted in Scotland evaluated the impact of a novel community based, weight management programme (ActWELL) in women with a body mass index (BMI) > 25 kg/m<sup>2</sup> attending routine NHS breast screening clinic between August 2017 and September 2019 (Anderson et al., 2021). The intervention sample size for the ActWELL study was 279 women from four NHS Scotland Breast Screening clinics. The intervention in the ActWELL study was delivered by volunteer coaches recruited and managed by the charity Breast Cancer Now. These volunteers had relevant experience in assisting people with lifestyle changes, such as nurses, teachers, and individuals involved in church work. They underwent a bespoke training program provided by experts in the research team, including physical activity and dietetics. A cost-effectiveness study was conducted from a UK National Health Service perspective. The total cost of the intervention was £140,978 (in 2024 prices £175,019; USD\$236,171; €203,040), which was approximately £505 per participant (in 2024 prices £627; USD\$846; €728). This included costs for staff time, training, travel, and materials. The probability of the intervention being cost-effective (using the conventional threshold of £30,000 per QALY) was below 20% (Anderson et al., 2021).

Another UK RCT investigated the clinical effectiveness and cost-effectiveness of a person-centred intervention for informal carers/caregivers of stroke survivors. The name of the intervention in the OSCARSS trial was the Carer Support Needs Assessment Tool for Stroke (CSNAT-Stroke) (Patchwood et al., 2021). Data was collected between February 2017 and July 2018. There were 208 carers in the intervention group and 206 carers in the comparison group. The intervention deliverers in the OSCARSS trial were staff from a UK voluntary sector specialist provider. These staff members were trained to facilitate the Carer Support Needs Assessment Tool for Stroke (CSNAT-Stroke) and provide personalised support to carers in their homes. The intervention began at the first point of contact with the carer, and it required at least one face-to-face support contact dedicated to carers, with reviews as needed. The length of follow-up was 6 months. The cost-effectiveness analysis was from the UK NHS and social care perspective. The types of costs measured included, healthcare utilisation costs, intervention costs, and primary care services costs. The OSCARSS trial was unlikely to be cost-effective compared to usual care. The costs associated with the intervention were slightly higher (around £40 per person) than the control, primarily due to additional staff training and support activities. Also, there were no measurable health benefits observed from the intervention. The sensitivity analyses confirmed that the primary and

secondary outcomes were robust, even when considering factors such as delayed responders, missing data, and protocol deviations (Patchwood et al., 2021).

A RCT conducted in London, England, and published in 2024 evaluated the feasibility of an intervention where volunteer 'Health Champions' support people with severe mental illness (SMI) in managing their physical health (Williams et al., 2024). Data was collected between September 2021 to March 2023 from 27 individuals in the intervention group and 21 individuals in the control group. The 'Health Champions' intervention involved trained volunteers providing in-person support to individuals with SMI, helping them manage their physical health through personalised guidance, encouragement, and health promotion strategies over a six-month period. The volunteers had been trained in mental health awareness, communication skills, health promotion and safety and boundaries. The cost of implementing the 'Health Champions' intervention was £312 per participant (2024 prices). However, despite the intervention's high acceptability and feasibility, there were no significant clinical improvements (Williams et al., 2024).

A cost-analysis study conducted in England in 2019 assessed the health outcomes and cost efficiencies achieved through an educational approach (Kay & Edgley, 2019). At the Recovery College in Ashton-under-Lyne, England UK, experts by experience helped to facilitate sessions alongside the professionals. Data was collected in one academic year between September 2016 and August 2017. The sample included n=136 service users who had up-to-date contact records on the PARIS mental health data system for the 12 months before and after their enrolment in the college. The college offered a recovery-focused syllabus of courses designed to increase knowledge, understanding, coping strategies, and skills for self-management of health and wellbeing. Nearly two-thirds of the students had fewer contacts with secondary care services after enrolling in the college. This reduction equated to a saving of 1,570 practitioner hours. The cost savings per person ranged between approximately £1,000 and £2,000 per year (in 2024 prices £1241-£2,483; \$1669-2240; €1440-€2882). If the college pathway is embedded within the existing mental health services, it could potentially lead to cost savings of between £670,000 and £1,340,000 annually (in 2024 prices £831,778 - £1,663,557; \$1,118,242-\$1,801,496; €1,000,180-€1,930,724). The Recovery College success indicated the need for a holistic approach across local communities and the entire health pathway. There was a strong emphasis on working with other statutory service providers, key stakeholders, and the voluntary and community sectors to embed the college within wider public health services (Kay & Edgley, 2019).

A study conducted in Ireland aimed to estimate the impact of a community-based cancer support centre (Murphy et al., 2021). Data was collected between September 2018 and March 2019 from 238 individuals who were affected by cancer (including cancer patients). The intervention was delivered by paid professionals and volunteers over a 7-month period. Services included transport to treatment, complementary therapies (such as Reiki and bio-energy therapy), exercise classes, and counselling. These services were delivered in-person by a mix of organisations and volunteers, aiming to improve the quality of life and well-being of participants. A cost-analysis was conducted from an Irish Health Service Executive (HSE) perspective. The types of costs measured included health resource costs (bio energy therapy, counselling, exercise classes, healing touch therapy and Reiki); non-health resource costs, catering personnel, daily service operations, bus driver, bus running costs and lunches. Over a 7-month period, there were 2032 contacts with 238 clients whose average age was 60 years. The most frequently used services were transport to treatment (20%), complementary therapies (48%), exercise classes (10%) and counselling (9%). This cost analysis estimated total annual cost to provide all services was €313,744 (in 2024 prices €377,487; USD\$437,356; £325,130). Average annual cost per person was €1138 (in 2024 prices €1,363; USD\$1,579; £1,174). Current uptake at the centre represents 8% of all cancer incidences in seven counties surrounding the centre. If uptake increases by 10%, scenario analyses predict an increase in total costs and a decrease in costs per patient. There was high utilisation of complementary therapies. Specifically, 48% of the services used were complementary therapies such as Reiki, bio energy therapy, and healing touch therapy (Murphy et al., 2021).

**Theme 3 summary: Long term conditions (including health champions, weight loss, and wellness for life interventions)**

Three RCT studies were conducted regarding interventions for people with long term conditions including people living with obesity, stroke survivors, and people with severe mental health illness. The ActWELL study in Scotland, delivered by volunteer Breast Cancer Now coaches targeted weight management in women with BMI > 25 kg/m<sup>2</sup>, costing £505 per participant but was not cost-effective (Anderson et al., 2021). The OSCARSS trial assessed support for stroke carers, showing higher costs, without measurable health benefits (Patchwood et al., 2021). The Health Champions study in London supported physical health in severe mental illness patients, costing £312 per participant (2024 prices), but lacked significant clinical improvements (Williams et al., 2024). Overall, these studies highlight common challenges in community-based health interventions, including difficulties in achieving cost-effectiveness and significant health improvements. Despite innovative approaches and dedicated volunteer involvement, the interventions struggled with long-term engagement and demonstrating measurable benefits. Future research should focus on optimising these programs to

enhance their efficacy and economic viability, potentially through more robust training, support structures, and integration with existing healthcare services.

The 2019 cost-analysis study evaluated the recovery college in Ashton-under-Lyne, UK, highlighting significant health and economic benefits. Data from 136 service users showed a reduction in secondary care contacts, saving 1,570 practitioner hours and £1,000-£2,000 per person annually (Kay & Edgley, 2019). If integrated into existing services, potential savings could reach £670,000-£1,340,000 (in 2024 prices £831,778 - £1,663,557; \$1,118,242-\$1,801,496; €1,000,180-€1,930,724) annually. The study emphasised the importance of a holistic approach, involving collaboration with statutory services, stakeholders, and community sectors to embed the college within broader public health services, enhancing both health outcomes and cost efficiencies.

The cancer centre cost analysis study in Ireland evaluated data from 238 individuals were collected over 7 months (September 2018 - March 2019). Services included transport, complementary therapies (Reiki, bioenergy), exercise classes, and counselling, delivered by professionals and volunteers. The total annual cost was €313,744 (in 2024 prices €377,486; \$437,393; £325,506), with an average cost of €1,138 per person (in 2024 prices €1,369; \$1,585; £1,180). If service uptake increased by 10%, costs would rise to €429,043 (in 2024 prices €615,211; \$597,772; £444,922), but per-patient costs would drop to €915 (in 2024 prices €1,001; \$1,159; £863). Complementary therapies were highly utilised, accounting for 48% of services used.

#### Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)

Four papers were included in this theme (Jones et al., 2015; Lynch & Jones, 2019, 2022; Ramachandra, 2015). These four papers included three studies conducted which were conducted separately in USA, England, and Wales.

A SROI study conducted in Plymouth, England assessed how the Plymouth Senior Net volunteers helped older people to go on-line (Jones et al., 2015). Data was collected in 2014 from 110 recipients of the service which was an in-person service delivered over 6 to 8 visits either in their own homes on a one-to-one basis, or in small group sessions (receiving 12 hours of help over six visits). A SROI analysis was conducted and for every £1 invested in the intervention, the social value created was between £1.40 and £1.80. There was significant improvement in social connections and mental well-being among the older participants. For example, increased social contacts: The number of contacts with others significantly increased from a mean score of 13.7 to 17.6 on the Lubben

Social Network Scale (LBNS-6). There were also reduced loneliness scores. Loneliness scores decreased from a mean of 2.38 to 1.80 on the De Jong Gierveld loneliness scale (DJG-6). Mental well-being scores improved from a mean of 24.06 to 24.96 on the SWEMWBS (Jones et al., 2015).

An asset based social prescribing intervention was evaluated in doctoral research conducted in the USA (Ramachandra, 2015). The aim of the research was to understand the positive influence of the built environment on the success of social programs; this study aims to elicit those individual factors of the designed environment that actively support and impact program usage. The asset studied was the Windsor Connection Resource Center (WCRC) in Vermont, USA. The social prescribing asset is in a location near to where women with low-income live. The Centre benefits the community by sorting out problems at an early stage, not letting them escalate into a medical situation. This early intervention helps to reduce pressure on both medical resources and emergency room usage. The types of costs measured for the SROI was building costs and staffing costs. Over a period of two years, for every dollar invested in Windsor Connection Resource Center (WCRC), USD\$1.20 was returned (assuming starting year as 2014) (in 2024 prices USD\$1.59; £1.18; €1.37). Having a building that was ready from the outset was cited as a strong benefit to the program. This alone saved the clinic at least \$500,000, which it would have had to find (in 2024 prices USD\$662,162; £491,589; €570,320). The cost of building procurement was USD\$0 (Ramachandra, 2015).

The two papers by Lynch and Jones reported on the same cost analysis study conducted in Wales in 2017-2018 (Lynch & Jones, 2019, 2022). The aim was to explore the economic benefits related to changes in the use of healthcare resources following a social prescribing intervention in four primary care practices in Wales. The intervention recipients were 78 patients, with 21 identified as frequent attenders at GP surgeries in South Wales, UK. The intervention aimed to improve health and wellbeing outcomes and reduce healthcare resource usage. The recruitment period was five months, and the intervention involved frequent attenders participating in structured volunteering activities, earning time credits for each hour volunteered. These credits could be exchanged for leisure activities such as cinema vouchers. The types of measured included GP visit costs, emergency department visit costs, hospital admission costs, the cost of medication prescribed to patients and community health services costs. There was a direct cost saving of £6,113 (in 2024 prices £7,725; USD\$10,406; €8,962) or £78.37 per participant over the 5 months of the intervention (in 2024 prices £99; USD\$133; €115). The intervention reduced healthcare unit usage among frequent attenders, suggesting that social prescribing can effectively decrease demand on healthcare services (Lynch & Jones, 2019, 2022).

#### **Theme 4 summary: Other social prescribing interventions (including volunteering, and social prescribing assets)**

The three studies in this section highlight the significant social and economic benefits of social prescribing interventions (Jones et al., 2015; Lynch & Jones, 2022; Ramachandra, 2015). The Plymouth Senior Net initiative demonstrated substantial improvements in social connections and mental well-being among older adults, with notable increases in social contacts and reductions in loneliness (Jones et al., 2015). Similarly, the Windsor Connection Resource Center in Vermont showed a positive return on investment by addressing community issues early, thus reducing medical resource strain (Ramachandra, 2015). The study conducted in Wales further supports these findings, showing cost savings and reduced healthcare usage among frequent GP attenders (Lynch & Jones, 2022). Collectively, these studies underscore the value of social prescribing in enhancing well-being and reducing healthcare costs.

#### **Theme 5: Help at home (including palliative care and domiciliary welfare)**

Five studies investigated the economic impact of help at home interventions (including palliative care and domiciliary welfare). One study was an RCT (Howel et al., 2019), two were cohort studies (Aoun et al., 2023; Mitchell et al., 2020) and two were mixed methods studies (Bauer et al., 2017; Moffatt et al., 2023).

The RCT was conducted in England to determine whether providing domiciliary welfare rights advice could improve the health-related quality of life for independent-living, socio-economically disadvantaged individuals aged 60 years and older in the North East of England (Howel et al., 2019). The study was a partnership between Citizens Advice Bureaus (CAB), a well-known voluntary sector organisation in the UK, and local authorities and the aim was to deliver a domiciliary welfare rights advice intervention and evaluate the economic impact and process of delivering this intervention. The data was collected between 2014 and 2016, and the recipients of the intervention were 755 people aged 60 years old and older. The intervention was delivered in-person in participants' homes by trained Welfare Rights Advisors (WRAs). The goal was to help participants claim benefits they were entitled to, thereby potentially increasing their income and improving their quality of life. The cost utility economic analysis. The types of costs measured were intervention costs, health care utilisation costs, and cost of home care services. The intervention was received as intended by 335 (88%), with 84 (22%) awarded additional benefit entitlements; 46 did not receive any welfare rights advice, and none of these were awarded additional welfare benefits. However, the mean EQ-5D scores were similar for both groups, suggesting that the intervention did not lead

to measurable improvements in health-related quality of life. The study highlighted the need for further research to explore the potential health benefits of welfare rights advice in different contexts and among different populations (Howel et al., 2019).

Another controlled study was published in 2023 in Australia to assess the effect on healthcare usage of a community-based palliative care program ('Compassionate Communities Connectors') where practical and social support was delivered by community volunteers to people living with advanced life-limiting illnesses in regional Western Australia (Aoun et al., 2023). Although not a full randomised controlled trial, they used randomisation techniques to put the control group together. The time window used to select the comparator population ('controls') was between 2017 and 2022 inclusive, compared to 2020–2022 for the intervention group. The intervention recipients were 43 community-based patients, and the comparator group included 172 individuals with advanced life-limiting illnesses. The intervention was delivered in-person by community volunteers who provided practical and social support directly to individuals with advanced life-limiting illnesses in their homes and local communities between 2020 and 2022. A cost consequence analysis was conducted from a healthcare system perspective. The types of costs measured were hospital admissions, days in hospital, emergency presentations at hospital, frequency of outpatient's contacts. The study found that participants in the program experienced 63% fewer hospital admissions, 77% fewer days in hospital, 44% fewer emergency presentations and twice the frequency of outpatient contacts compared to a control group. The study estimated that adopting the program could lead to net savings of AUD \$518,701 if 100 patients were enrolled over an average 6-month participation period (in 2024 prices AUS\$565,050; £271,846; USD\$365,474; €315,411). These results suggest that the program effectively shifted care from hospital settings to community-based care, leading to improved patient outcomes and reduced healthcare costs. The sensitivity analysis reinforced the conclusion that the program is a cost-effective approach to palliative care, with the potential to reduce healthcare costs while enhancing the quality of care for individuals with advanced life-limiting illnesses (Aoun et al., 2023).

A before and after descriptive cohort study published in 2020 aimed to examine and estimate the costs and effects of Palliative Care Day Services (PCDS) with different service configurations across three centres in the UK (England, Scotland, and Northern Ireland) (Mitchell et al., 2020). The dates of data collection were between June 2017 and September 2018. Intervention recipients included 56 attendees who completed baseline data. However, only 38 attendees provided data at the 4-week follow-up. The intervention was delivered by a mix of medical, nursing, and allied healthcare professionals, and volunteers at three different centres across the UK. The volunteers were part of the palliative care team and delivered unpaid palliative care to those who

needed it alongside the healthcare professionals. The intervention involved the provision of PCDS at three different centres across the UK. These services offered a mix of medical, nursing, and allied healthcare, alongside social and psychological support. Health and care usage costs were measured along with quality of life, health status and capability wellbeing over a period of time. At the end of the study there was insufficient evidence to conclude whether PCDS improved outcomes or reduced costs across the three different service configurations. The study found that the cost per attendee/day ranged from £121 to £190 (excluding volunteer contribution) and £172 to £264 (including volunteer contribution) across the three sites (in 2024 prices £212; €244; \$286). Volunteer time constituted a significant portion of the total costs, between 28% and 38%. The study highlighted the significant role of volunteers in PCDS, with volunteer time constituting a substantial portion of the total costs. This underscores the importance of volunteers in the sustainability and delivery of PCDS. The study included a scenario analysis as a form of sensitivity analysis. This analysis examined the cost per attendee/day using three hypothetical attendance rates (100%, 80%, and 60%) to investigate the variation in costs within and across the three Palliative Care Day Services (PCDS) centres (Mitchell et al., 2020).

A mixed methods study conducted in England aimed to address a range of well-being needs (Bauer et al., 2017). However, not much is currently known about the costs, outcomes and economic consequences of such schemes. Data was collected during 2012 and 2013 in home settings in Shropshire, England. Help-at-home scheme was provided by Age UK staff and volunteers for older people aged 55 years and above in Shropshire, England. This scheme included volunteer-provided face-to-face and telephone befriending, practical home help services for gardening, shopping, and cleaning, welfare benefit advice services. Volunteer time was valued at local rates. Health and social care services costs were also calculated. The main finding was that the help at home scheme was likely to achieve a mean net benefit of £1568 (in 2024 prices £2,031; USD\$2,741; €2,357) per person from a local government and National Health Service (NHS) perspective. The study highlights the potential contribution of voluntary sector-run help-at-home schemes to an affordable welfare system for ageing societies (Bauer et al., 2017).

Another mixed methods study was conducted in England to evaluate the impact and costs of a community-based link worker social prescribing intervention on the health and health-care utilisation of adults aged 40–74 years with type 2 diabetes mellitus (T2DM) (Moffatt et al., 2023). The intervention recipients included 8400 patients in 13 intervention and 11 control general practices in the North East of England. The intervention was delivered in-person prior to the COVID-19 pandemic and then on-line during COVID-19 lockdowns. A cost-effectiveness analysis from the perspective of the

health service was conducted as one part of the mixed method study and the types of costs measured included glycated haemoglobin level (HbA1c), BMI, blood pressure, cholesterol level, smoking status, health-care costs and utilisation, and quality of life. The intervention was found to be, on average, more costly and more effective than current practice. The reduction in costs associated with clinical complications and improvement in health-related quality of life (HRQoL) were minor. These findings assume that the intervention has a 4-year duration of effect. This social prescribing model resulted in a small improvement in glycaemic control. Outcome effects varied across different groups and the experience of social prescribing differed depending on client circumstances. Ethnographic data showed that successfully embedded, holistic social prescribing providing supported linking to navigate social determinants of health was challenging to deliver but could offer opportunities for improving health and well-being (Moffatt et al., 2023).

#### **Theme 5 summary: Help at home (including palliative care and domiciliary welfare)**

The RCT studies conducted in relation to help at home suggested some benefits for the participants. In the RCT conducted in England, it was found that the domiciliary welfare rights advice could improve the quality of life for socio-economically disadvantaged individuals aged 60+ in the North East of England (Howel et al., 2019). However, despite 88% of the participants receiving the intervention and 22% gaining additional benefits from the government, there was no significant improvement in health-related quality of life. Another study from Australia assessed a community-based palliative care program. There were significant reductions in hospital admissions and costs, suggesting that the program effectively shifted care to community settings, improving patient outcomes and reducing healthcare costs (Aoun et al., 2023).

The non-RCT studies examined various health interventions in the UK. In one study, Palliative Care Day Services (PCDS) were evaluated across three centres (Mitchell et al., 2020). Despite the significant role of volunteers in providing palliative care, there was insufficient evidence to conclude whether PCDS improved outcomes or reduced costs. A help-at-home scheme was evaluated in Shropshire, England, showing a mean net benefit of £1568 (in 2024 prices £2,031; USD\$2,741; €2,357) per person from a local government and NHS perspective, highlighting the scheme's potential contribution to affordable welfare for ageing societies (Bauer et al., 2017). And a social prescribing intervention for adults with type 2 diabetes was also evaluated in England. The intervention was more costly but slightly more effective than current practice, with an ICER which was much higher than the £20,000-£30,000 cost-effectiveness threshold suggested by the National Institute for Health and Care Excellence (NICE) (Appleby et

al., 2007). The intervention showed minor improvements in glycaemic control and varied outcomes across different groups (Moffatt et al., 2023).

## Discussion

The aim of this rapid review was to investigate the economic evidence related to the question of the contribution of the voluntary sector to the health and wellbeing agenda. Academic literature databases and grey literature were searched and reviewed for inclusion in the review. All the studies included had voluntary organisation involvement, but to different degrees, therefore these studies do not fully answer the question because many of the interventions/services are not purely delivered by the voluntary sector, but are in some way an integral part of the main findings. Some voluntary organisations were national such as Citizens Advice Bureaus, and some were small voluntary organisations such as local befriending services for people with learning disabilities or dementia.

From the included studies, five themes were identified to describe the type of studies which provided economic evidence of the contribution of the voluntary sector. The five key themes identified were peer support, which emphasizes the value of shared experiences and mutual encouragement; outdoor interventions, highlighting the therapeutic benefits of nature-based activities; long-term conditions, focusing on tailored support for individuals managing chronic health issues; other social prescribing interventions, encompassing a range of community-based services aimed at improving wellbeing; and finally, help at home, which includes practical assistance and support provided within the home environment to enhance daily living and independence.

The economic impacts of non-pharmacological peer support interventions varied. Physical exercise and occupational therapy were found to be cost-effective for dementia and mild cognitive impairment (Nickel et al., 2018), while psychosocial interventions show mixed results. Virtual reality social support for aphasia patients was found to be feasible but costly (Marshall et al., 2020) while befriending services for people with intellectual disabilities and online social network interventions for reducing loneliness were not definitively cost-effective (Ali et al., 2021). Six non-RCT studies highlighted the value of peer support interventions. A UK study on dementia peer support groups showed a social value of £1.17-£5.18 per £1 invested. In Australia, the Friendship Enrichment Programme and Volunteer-led internet training had returns on investment of AUS\$2.87 and AUS\$2.14, respectively. The Citizens Advice on Prescription intervention conducted in Liverpool, reported a positive SROI of £3.40-£4.69 per £1 invested (Granger et al., 2025). The Wellness for Life (WFL) service showed positive SROI ratios, with societal values between £3.45 and £6.03 per £1 spent

indicating significant societal benefits (Visram et al., 2017, 2020). Social prescribing in the UK also showed a SROI of £3.42 per £1 invested, reducing loneliness among users (Foster et al., 2021)

All three outdoor intervention studies highlighted the significant social and economic benefits of community gardening and outdoor activities, with positive returns on investment in all three studies (Makanjuola et al., 2023; Schoen et al., 2020a; Whiteley et al., 2024). For example, there were beneficial outcomes relating to mental health and social connections (Makanjuola et al., 2023).

Three RCT studies on interventions for long-term conditions highlight challenges in cost-effectiveness and health improvements. The ActWELL study in Scotland targeted weight management in women with BMI > 25 kg/m<sup>2</sup>, costing £505 per participant but this intervention was not cost-effective (Anderson et al., 2021). The OSCARSS trial assessed support for stroke carers, showing higher costs (£40 per person) without measurable health benefits (Patchwood et al., 2021). The Health Champions study in London supported physical health in severe mental illness patients, costing £312 per participant (in 2024 prices £312; USD\$421; €362). but lacked significant clinical improvements (Williams et al., 2024). These studies underscore the need for optimising community-based health interventions through better training, support structures, and integration with healthcare services.

The 2019 cost-analysis study of the recovery college in Ashton-under-Lyne, UK, showed significant health and economic benefits, reducing secondary care contacts and saving £1,000-£2,000 per person annually (in 2024 prices £1,241-£2,483; €1,1440-€2,882; \$1,669-3,340). The authors noted that potential savings could reach £670,000-£1,340,000 (in 2024 prices £831,778 - £1,663,557; \$1,118,242-\$1,801,496; €1,000,180-€1,930,724) annually if integrated into existing services (Kay & Edgley, 2019). In Ireland, the cancer centre cost analysis showed that increased service uptake could reduce per-patient costs to €915 (in 2024 prices €1,001; \$1,159; £863). Complementary therapies were highly utilised, accounting for 48% of services used (Murphy et al., 2021).

Of the other social prescribing interventions (including volunteering, and social prescribing assets (Jones et al., 2015; Lynch & Jones, 2022; Ramachandra, 2015) all three demonstrated substantial improvements in social connections and mental well-being among older adults, with notable increases in social contacts and reductions in loneliness (Jones et al., 2015). Similarly, the Windsor Connection Resource Center in

Vermont showed a positive return on investment by addressing community issues early, thus reducing medical resource strain (Ramachandra, 2015). The social prescribing study conducted in Wales further supports these findings, showing cost savings and reduced healthcare usage among frequent GP attenders (Lynch & Jones, 2022). Collectively, these studies underscore the value of social prescribing in enhancing well-being and reducing healthcare costs.

The RCT studies conducted in relation to help at home (including palliative care and domiciliary welfare) suggested some benefits for the participants. In the RCT conducted in England, it was found that the domiciliary welfare rights advice could improve the quality of life for socio-economically disadvantaged individuals aged 60+ in the North East of England (Howel et al., 2019). However, despite 88% of the participants receiving the intervention and 22% gaining additional monetary benefits, there was no significant improvement in health-related quality of life.

A study from Australia assessed a community-based palliative care program. There were significant reductions in hospital admissions and costs, suggesting that the program effectively shifted care to community settings, improving patient outcomes and reducing healthcare costs (Aoun et al., 2023). This study provides evidence of where the voluntary sector can enable care closer to home and deliver better outcomes for people, which is in line with the aspirations of Welsh Government policy.

The non-RCT studies examined various health interventions in the UK. In one study, Palliative Care Day Services (PCDS) were evaluated across three centres. Costs per attendee/day ranged from £121 to £264 (in 2024 prices £149-£325; USD\$201-USD\$349; €173-€377, with volunteer time constituting 28-38% of total costs (Mitchell et al., 2020). Despite the significant role of volunteers, there was insufficient evidence to conclude whether PCDS improved outcomes or reduced costs. A help-at-home scheme was evaluated in Shropshire, England, showing a mean net benefit of £1568 (in 2024 prices £2,031, USD\$2,741; €2,357) per person from a local government and NHS perspective, highlighting the scheme's potential contribution to affordable welfare for ageing societies (Bauer et al., 2017). A social prescribing intervention for adults with type 2 diabetes was also evaluated in England. The intervention was more costly but slightly more effective than current practice, with an ICER of £327,250 (in 2024 prices £331,342; \$447,179; €383,390) per QALY gained (which is higher than the £20,000-£30,000 cost-effectiveness threshold suggested by the National Institute for Health and Care Excellence (NICE) (Appleby et al., 2007). The intervention showed minor improvements in glycaemic control and there was also varied outcomes across different groups (Moffatt et al., 2023), suggesting a mixture of outcomes. As such, it is useful for us to

consider the outcome we are trying to achieve in the broadest possible context. For example, if we were to think about a more holistic assessment of what an outcome looks like, we might then ask questions about which sector is best placed to deliver against those outcomes.

For this rapid review, grey literature was sought from WCVA stakeholders throughout Wales, via a news article and circulated to WCVA's networks. In total, n = 15 pieces of grey literature were gathered from voluntary sector agencies in the United Kingdom (UK) including Age Cymru, Bipolar UK, Carers Trust Wales, Citizens Advice Cymru, Health and Care Research Wales, National Churches Trust, The House of Good, Home-Start, Medrwn Môn, New Horizons, and Race Equality First (REF). However, only one of the grey literature reports collected were included in the review as it included a wellbeing analysis and methodological information (Kazantis et al., 2024). The other grey literature were not included in the review due to either not focussing on the voluntary sector, not focussing on health economic evaluations or did not include clear and focussed methodology sections. The wellbeing analysis related to church buildings in the UK estimated that church-based health initiatives, such as foodbanks and mental health support groups, contribute approximately £8.4 billion (in 2024 prices £8.4 billion; €9.7 billion; USD\$11.3 billion) annually in savings to the NHS. The research also highlighted that volunteers involved in these services experience notable improvements in their own wellbeing (Kazantis et al., 2024).

## Conclusions

The economic evidence indicates that voluntary sector interventions can enhance clinical and wellbeing outcomes. However, understanding the specific mechanisms and target populations for these interventions remains an ongoing process. Cost effectiveness should not be the only driver in commissioning or funding the voluntary sector to deliver an intervention. Where interventions are not cost-effective does not mean that they are not good for patients or that the voluntary sector should not deliver an intervention. Pragmatic longer-term studies may provide better evidence than short term studies and voluntary sector organisations are very agile and able to respond quickly to changing needs over time. Cost-effectiveness studies tend to be very rigid and take place over a short time horizon usually.

Social return on investment (SROI) studies are increasingly being used to evaluate the services offered by voluntary organisations, offering a mixed methods approach that can capture a broader range of outcomes. In contrast, traditional cost-effectiveness studies within RCTs often struggle to show positive results, possibly due to their more

inflexible frameworks and narrower focus. By involving community members in the design and implementation of interventions, programs can be tailored to meet the specific needs and preferences of the target population, making them more relevant and effective. Engaging the community fosters trust and acceptance, which is essential for the successful adoption and sustainability of interventions. When community members feel involved and valued, they are more likely to support and participate in the programs. Community engagement allows for the utilisation of local knowledge and resources, which can enhance the efficiency and impact of interventions. This collaborative approach can lead to more innovative and culturally appropriate solutions. Overall, community engagement is vital for ensuring that voluntary sector interventions are well-received, impactful, and sustainable. The next steps for the authors of this rapid review will involve collaborating with voluntary sector stakeholders in Wales to undertake further economic evaluation studies focused on Wales. There is a clear need for robust, high-quality research to expand and strengthen the evidence base, ensuring that future policy and funding decisions are informed by reliable and context-specific data. There is now a real opportunity for voluntary sector organisations to collaborate with health economists in Wales to better evidence their value.

The voluntary sector has an important role in creating a more integrated and effective health and social care system in Wales (The Bevan Commission, 2024). However, little is known about the economic benefit of the voluntary sector in Wales, especially on the development of the integrated health and social care systems. More evidence is needed from Wales to determine the contribution for the voluntary sector to the prevention agenda in Wales.

## Strengths and limitations of the available literature

One of the main strengths of this review is that 29 relevant papers/reports were found (describing 28 separate studies). All but one pieces of evidence came from peer reviewed academic papers, with one report coming from the grey literature. The other grey literature sought and explored for relevance, lacked detailed economic evaluation methodology, despite highlighting good practice in their annual or brief reports. Weblinks to the documents are provided for the reader (if they are available) in Appendix 4.

## Recommendations for policy and practice

Economic evaluations should be integrated into voluntary organisation initiatives to provide evidence of the value they bring to society. However, it is important to acknowledge that short term funding that is focused on service delivery limits the

potential to conduct economic evaluations. Longer term contracts and investment in research evidence infrastructure in the voluntary sector is needed.

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## Ethical approval

Ethical approval was not required for this rapid review as it involved the analysis of publicly available data and did not include any direct interaction with human participants.

## Conflict of interest

The authors declare no conflicts of interest.

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## Author contributions

Conceptualisation: Wales Council for Voluntary Action (WCVA), Llinos Haf Spencer (LHS) and Mark Llewellyn (ML). Data extraction and quality appraisal: LHS and ML. Writing and editing: LHS, ML and Carolyn Wallace (CW).

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## Appendices list

Appendix 1 – Search strategies

Appendix 2 – Data extraction tables

Appendix 3 – Quality appraisal tables

Appendix 4 – Table of grey literature

Appendix 5 – List of abbreviations

*Appendix 1 – Search strategies***Search strategy - Applied Social Sciences Index and Abstracts (ASSIA)**

((("Community enterprise" OR "community led" OR "grass roots" OR "non profit" OR non-profit OR "not for profit" OR "third sector" OR volunt\*))

AND summary(("Accommodation based" OR "activities of daily living" OR ADL OR "care closer to home" OR "Community based care" OR CBC OR (community N3 support\*) OR "community connect\*" OR (diet N2 support) OR (exercise N2 support) OR (nutrition N2 support) OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR wellbeing OR well-being OR "well being" OR "quality of life" OR QOL OR isolat\*))

AND summary((budget OR "capacity release" OR "control' commission" OR cost OR DALY OR disability adjusted life year OR economic\* OR evaluation OR finan\* OR QALY OR "quality adjusted life year" OR "return on investment" OR ROI OR SROI OR substitution OR "unit cost"))

### Search strategy - Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus with full text)

No.	Query	Last Run Via	Results
S1	"community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" OR "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR (community N3 support*) OR "community connect*" OR (diet N2 support) OR (exercise N2 support) OR (nutrition N2 support) OR "health promotion" OR "promoting health" OR "home from hospital" OR	E. Cinahl	102,593
S2	"independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" OR "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR	E. Cinahl	1,552,191
S3	"finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	E. Cinahl	815,629
S4	S1 AND S2 AND S3	E. Cinahl	4,963
S5	Limiters - Publication Date: 20150101-20251231	E. Cinahl	3,174
S6	Narrow by Language: - english (MH "Cost Effectiveness Analysis") OR (MH "Cost Benefit Analysis") OR "cost effect*" OR "cost consequence*" OR "cost benefit*" OR "return on investment" OR "roi" OR "social return on investment" OR "sroi" OR "economic evaluation"	E. Cinahl	3,058
S7		E. Cinahl	79,865
S8	S6 AND S7	E. Cinahl	177

### Search strategy - Excerpta Medica Database (EMBASE)

No.	Query	Last Run Via	Results
#1	community enterprise' OR 'community lead' OR 'grass roots' OR 'non profit' OR 'non-profit' OR 'not for profit' OR 'third sector' OR volunt* OR 'accommodation based' OR 'activities of daily living' OR 'adl' OR 'care closer to home' OR 'community based care' OR 'community-based care' OR 'cbc' OR (community NEAR/3 support*) OR 'community connect*' OR (diet NEAR/2 support) OR (exercise NEAR/2 support) OR (nutrition NEAR/2 support) OR 'health promotion' OR 'promoting health' OR 'home from hospital' OR 'independent living' OR 'peer support' OR 'physical health' OR 'mental health' OR 'emotional health' OR wellbeing OR 'well-being' OR 'quality of life' OR 'qol' OR 'isolat*' OR 'budget' OR 'capacity release' OR 'control commission' OR cost OR daly OR 'disability adjusted life year' OR economic OR evaluation OR finan* OR qaly OR 'quality adjusted life year' OR 'return on investment' OR roi OR sroi OR 'social return on investment' OR substitution OR 'unit cost'	Embase	497,747
#2		Embase	4,419,295
#3		Embase	5,124,303
#4	#1 AND #2 AND #3	Embase	11,186
#5	#4 AND [2015-2025]/py AND [english]/lim ( 'community enterprise' OR 'community lead' OR 'grass roots' OR 'non profit' OR 'non-profit' OR 'not for profit' OR 'third sector' OR volunt*) AND ('accommodation based' OR 'activities of daily living' OR 'adl' OR 'care closer to home' OR 'community based care' OR 'community-based care' OR 'cbc' OR (community NEAR/3 support*) OR 'community connect*' OR (diet NEAR/2 support) OR (exercise NEAR/2 support) OR (nutrition NEAR/2 support) OR 'health promotion' OR 'promoting health' OR 'home from hospital' OR 'independent living' OR 'peer support' OR 'physical health' OR	Embase	6,158

#6	'mental health' OR 'emotional health' OR wellbeing OR 'well-being' OR 'quality of life' OR 'qol' OR 'isolat*') AND ('budget' OR 'capacity release' OR 'control commission' OR cost OR daly OR 'disability adjusted life year' OR economic OR evaluation OR finan* OR qaly OR 'quality adjusted life year' OR 'return on investment' OR roi OR sroi OR 'social return on investment' OR substitution OR 'unit cost') AND [2015-2025]/py AND [english]/lim cost effectiveness analysis'/exp OR 'cost benefit analysis'/exp OR 'cost effect*' OR 'cost consequence*' OR 'cost benefit*' OR 'return on investment' OR 'roi' OR 'social return on investment' OR 'sroi' OR 'economic evaluation'/exp OR 'economic evaluation'	Embase	561,967
#7	#5 AND #6 ('community enterprise' OR 'community lead' OR 'grass roots' OR 'non profit' OR 'non-profit' OR 'not for profit' OR 'third sector' OR 'volunt*') AND ('accommodation based' OR 'activities of daily living' OR 'adl' OR 'care closer to home' OR 'community based care' OR 'community-based care' OR 'cbc' OR (community NEAR/3 support*) OR 'community connect*' OR (diet NEAR/2 support) OR (exercise NEAR/2 support) OR (nutrition NEAR/2 support) OR 'health promotion' OR 'promoting health' OR 'home from hospital' OR 'independent living' OR 'peer support' OR 'physical health' OR 'mental health' OR 'emotional health' OR wellbeing OR 'well-being' OR 'quality of life' OR 'qol' OR 'isolat*') AND ('budget' OR 'capacity release' OR 'control commission' OR cost OR daly OR 'disability adjusted life year' OR economic OR evaluation OR finan* OR qaly OR 'quality adjusted life year' OR 'return on investment' OR roi OR sroi OR 'social return on investment' OR substitution OR 'unit cost') AND [2015-2025]/py AND [english]/lim AND ('cost effectiveness analysis'/exp OR 'cost benefit analysis'/exp OR 'cost effect*' OR 'cost consequence*' OR 'cost benefit*' OR 'return on investment' OR 'roi' OR 'social return on investment' OR 'sroi' OR 'economic evaluation'/exp OR 'economic evaluation')	Embase	682

## Search strategy - APA PsycInfo

No.	Query	Last Run Via	Results
S1	"community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" OR "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR (community N3 support*) OR "community connect*" OR (diet N2 support) OR (exercise N2 support) OR (nutrition N2 support) OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*"	E. APA PsycInfo	102,787
S2	"DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	E. APA PsycInfo	1,163,935
S3	"budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	E. APA PsycInfo	693,897
S4	S1 AND S2 AND S3	E. APA PsycInfo	5,104
S5	Limiters - Publication Year: 2015-2025	E. APA PsycInfo	2,209
S6	Narrow by Language: - english	E. APA PsycInfo	2,160
S7	DE "Costs and Cost Analysis" OR "cost effect*" OR "cost consequence*" OR "cost benefit*" OR "return on investment" OR "roi" OR "social return on investment" OR "sroi" OR "economic evaluation"	E. APA PsycInfo	18,737
S8	S6 AND S7	E. APA PsycInfo	196

## Search strategy - Public/Publisher PubMed

No.	Query	Last Run Via	Results
#1	"community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" OR "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR "community support"[Title/Abstract:~3] OR "community supports"[Title/Abstract:~3] OR "community connect*" OR "diet support"[Title/Abstract:~2] OR "exercise support"[Title/Abstract:~2] OR "nutrition support"[Title/Abstract:~2] OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" OR "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	PubMed	373,393
#2	"community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" OR "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR "community support"[Title/Abstract:~3] OR "community supports"[Title/Abstract:~3] OR "community connect*" OR "diet support"[Title/Abstract:~2] OR "exercise support"[Title/Abstract:~2] OR "nutrition support"[Title/Abstract:~2] OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" OR "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	PubMed	3,672,078
#3	"community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" OR "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR "community support"[Title/Abstract:~3] OR "community supports"[Title/Abstract:~3] OR "community connect*" OR "diet support"[Title/Abstract:~2] OR "exercise support"[Title/Abstract:~2] OR "nutrition support"[Title/Abstract:~2] OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" OR "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost"	PubMed	4,617,276
#4	#1 AND #2 AND #3	PubMed	9,535
#5	#4 AND ("2015/01/01"[Date - Create] : "3000"[Date - Create]) AND (english[Filter] OR welsh[Filter]) ("community enterprise"[All Fields] OR "community lead"[All Fields] OR "grass roots"[All Fields] OR "non-profit"[All Fields] OR "non-profit"[All Fields] OR "not for profit"[All Fields] OR "third sector"[All Fields] OR "volunt*" [All Fields]) AND ("accommodation based"[All Fields] OR "activities of daily living"[All Fields] OR "ADL"[All Fields] OR "care closer to home"[All Fields] OR "community-based care"[All Fields] OR "community-based care"[All Fields] OR "CBC"[All Fields] OR "community support"[Title/Abstract:~3] OR "community supports"[Title/Abstract:~3] OR "community connect*" [All Fields] OR "diet support"[Title/Abstract:~2] OR "exercise support"[Title/Abstract:~2] OR "nutrition support"[Title/Abstract:~2] OR "health promotion"[All Fields] OR "promoting health"[All Fields] OR "home from hospital"[All Fields] OR "independent living"[All Fields] OR "peer support"[All Fields] OR "physical health"[All Fields] OR "mental health"[All Fields] OR "emotional health"[All Fields] OR "wellbeing"[All Fields] OR "well-being"[All Fields] OR "quality of life"[All Fields] OR "QOL"[All Fields] OR "isolat*" [All Fields]) AND ("budget"[All Fields] OR "capacity release"[All Fields] OR "control commission"[All Fields] OR "cost"[All Fields] OR "DALY"[All Fields] OR "disability adjusted life year"[All Fields] OR "economic"[All Fields] OR "evaluation"[All Fields] OR "finan*" [All Fields] OR "QALY"[All Fields] OR "quality adjusted life year"[All Fields] OR "return on investment"[All Fields] OR "ROI"[All Fields] OR "SROI"[All Fields] OR "social return on investment"[All Fields] OR "substitution"[All Fields] OR "unit cost"[All Fields]) AND 2015/01/01:3000/12/31[Date - Create] AND ("english"[Language] OR "welsh"[Language])) AND (english[Filter] OR welsh[Filter])	PubMed	6,070
#6	"Cost-Effectiveness Analysis"[Mesh] OR "Cost-Benefit Analysis"[Mesh] OR "cost effect*" OR "cost consequence*" OR "cost benefit*" OR "return on investment" OR "roi" OR "social return on investment" OR "sroi" OR "economic evaluation"	PubMed	284,292
#7	#5 AND #6 ("community enterprise"[All Fields] OR "community lead"[All Fields] OR "grass roots"[All Fields] OR "non-profit"[All Fields] OR "non-profit"[All Fields] OR "not for profit"[All Fields] OR "third sector"[All Fields] OR "volunt*" [All Fields]) AND ("accommodation based"[All Fields] OR "activities of daily living"[All Fields] OR "ADL"[All Fields] OR "care closer to home"[All Fields] OR "community-based care"[All Fields] OR "community-based care"[All Fields] OR "CBC"[All Fields] OR "community support"[Title/Abstract:~3] OR "community supports"[Title/Abstract:~3] OR "community connect*" [All Fields] OR "diet support"[Title/Abstract:~2] OR "exercise support"[Title/Abstract:~2] OR "nutrition support"[Title/Abstract:~2] OR	PubMed	584

"health promotion"[All Fields] OR "promoting health"[All Fields] OR "home from hospital"[All Fields] OR "independent living"[All Fields] OR "peer support"[All Fields] OR "physical health"[All Fields] OR "mental health"[All Fields] OR "emotional health"[All Fields] OR "wellbeing"[All Fields] OR "well-being"[All Fields] OR "quality of life"[All Fields] OR "QOL"[All Fields] OR "isolat\*"[All Fields]) AND ("budget"[All Fields] OR "capacity release"[All Fields] OR "control commission"[All Fields] OR "cost"[All Fields] OR "DALY"[All Fields] OR "disability adjusted life year"[All Fields] OR "economic"[All Fields] OR "evaluation"[All Fields] OR "finan\*"[All Fields] OR "QALY"[All Fields] OR "quality adjusted life year"[All Fields] OR "return on investment"[All Fields] OR "ROI"[All Fields] OR "SROI"[All Fields] OR "social return on investment"[All Fields] OR "substitution"[All Fields] OR "unit cost"[All Fields]) AND 2015/01/01:3000/12/31[Date - Create] AND ("english"[Language] OR "welsh"[Language]) AND ("english"[Language] OR "welsh"[Language]) AND ("Cost-Effectiveness Analysis"[MeSH Terms] OR "Cost-Benefit Analysis"[MeSH Terms] OR "cost effect\*"[All Fields] OR "cost consequence\*"[All Fields] OR "cost benefit\*"[All Fields] OR "return on investment"[All Fields] OR "ROI"[All Fields] OR "social return on investment"[All Fields] OR "SROI"[All Fields] OR "economic evaluation"[All Fields])

**Search strategy - Scopus** - Scopus is a comprehensive, multidisciplinary abstract and citation database managed by Elsevier

<i>a</i>	<i>a</i> Query	Last Run Via	Results
1	TITLE-ABS-KEY ( "community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" )	Scopus	579,233
2	TITLE-ABS-KEY ( "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR ( community W/3 support* ) OR "community connect*" OR ( diet W/2 support ) OR ( exercise W/2 support ) OR ( nutrition W/2 support ) OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" )	Scopus	5,158,513
3	TITLE-ABS-KEY ( "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost" )	Scopus	11,815,957
4	1 and 2 and 3	Scopus	11,333
5	4 AND PUBYEAR > 2014 AND PUBYEAR < 2026	Scopus	6,101
6	5 AND ( LIMIT-TO ( LANGUAGE , "English" ) ( TITLE-ABS-KEY ( "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost" ) ) AND ( TITLE-ABS-KEY ( "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR ( community W/3 support* ) OR "community connect*" OR ( diet W/2 support ) OR ( exercise W/2 support ) OR ( nutrition W/2 support ) OR "health promotion" OR "promoting health" OR "home from hospital" OR "independent living" OR "peer support" OR "physical health" OR "mental health" OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR "QOL" OR "isolat*" ) ) AND ( TITLE-ABS-KEY ( "community enterprise" OR "community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for profit" OR "third sector" OR "volunt*" ) ) AND PUBYEAR > 2014 AND PUBYEAR < 2026 AND ( LIMIT-TO ( LANGUAGE , "English" ) )	Scopus	5,824
7	TITLE-ABS-KEY ( "cost effect*" OR "cost consequence*" OR "cost benefit*" OR "return on investment" OR "roi" OR "social return on investment" OR "sroi" OR "economic evaluation" ) OR INDEXTERMS ( "Cost-Effectiveness Analysis" OR "Cost-Benefit Analysis" OR "Economic Evaluation" )	Scopus	899,938
8	6 and 7 ( TITLE-ABS-KEY ( "cost effect*" OR "cost consequence*" OR "cost benefit*" OR "return on investment" OR "roi" OR "social return on investment" OR "sroi" OR "economic evaluation" ) OR INDEXTERMS ( "Cost-Effectiveness Analysis" OR "Cost-Benefit Analysis" OR "Economic Evaluation" ) ) AND ( ( TITLE-ABS-KEY ( "budget" OR "capacity release" OR "control commission" OR "cost" OR "DALY" OR "disability adjusted life year" OR "economic" OR "evaluation" OR "finan*" OR "QALY" OR "quality adjusted life year" OR "return on investment" OR "ROI" OR "SROI" OR "social return on investment" OR "substitution" OR "unit cost" ) ) AND ( TITLE-ABS-KEY ( "accommodation based" OR "activities of daily living" OR "ADL" OR "care closer to home" OR "community based care" OR "community-based care" OR "CBC" OR ( community W/3 support* ) OR "community connect*" OR ( diet W/2 support ) OR ( exercise W/2 support ) OR ( nutrition W/2 support ) OR	Scopus	541

"health promotion" OR "promoting health" OR "home from hospital" OR  
"independent living" OR "peer support" OR "physical health" OR "mental health"  
OR "emotional health" OR "wellbeing" OR "well-being" OR "quality of life" OR  
"QOL" OR "isolat\*" ) ) AND ( TITLE-ABS-KEY ( "community enterprise" OR  
"community lead" OR "grass roots" OR "non profit" OR "non-profit" OR "not for  
profit" OR "third sector" OR "volunt\*" ) ) AND PUBYEAR > 2014 AND PUBYEAR <  
2026 ) AND ( LIMIT-TO ( LANGUAGE , "English" ) )

## Appendix 2 – Data extraction tables

Citation (Country) Aim	Intervention details	Study characteristics, health economics methods and quality appraisal	Outcome and costs measured	Main Findings
<p><b>Ali et al 2021</b> (Ali et al., 2021)</p> <p><b>Country: England, UK</b></p> <p><b>Aim:</b> To assess the feasibility and acceptability of conducting a future full-scale randomised controlled trial of one-to-one befriending for people with intellectual disability who had depressive symptoms.</p> <p><b>Voluntary sector organisation:</b> Befriending service</p> <p><b>Theme 1:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention:</b> A befriending service for people with intellectual disability who had depressive symptoms.</p> <p><b>Dates of data collection:</b> Between 2019 and 2021.</p> <p><b>Intervention recipients and sample size:</b> 30 participants were recruited.</p> <p><b>Setting:</b> One NHS Trust in England and one befriending service.</p> <p><b>Delivery mode (e.g., remotely online, in person): in-person</b></p> <p><b>Intervention deliverers:</b> Trained volunteer befrienders.</p> <p><b>Timing and duration: 6 months.</b></p> <p><b>Intervention description:</b> The befriending service aimed to improve the quality of life and reduce depressive symptoms in participants by providing consistent social support through volunteer befriending.</p>	<p><b>Study type:</b> Feasibility RCT</p> <p><b>Length of follow-up:</b> 6 months post randomization.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness</p> <p><b>Perspective of analysis: Healthcare system perspective</b></p> <p><b>Currency and cost year:</b> GBP in 2021</p> <p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest: Cost-effectiveness analysis</b></p> <p>Linear regression including covariates for randomisation to befriending intervention or control, baseline costs and effects was used to calculate the mean difference in costs/effects between the befriending intervention and the control group, and 95% CIs. After adjustment for baseline values, the ICER was –£1810 per point change in GDS-LD.</p> <p>The befriending intervention has a 35% probability of being cost-effective at a willingness-to-pay threshold of £20,000</p> <p><b>Types of costs measured:</b> Cost of the intervention.</p>	<p><b>Main finding:</b> The befriending service for people with intellectual disabilities and depressive symptoms was not definitively cost-effective due to the small sample size and low recruitment rates. The befriending intervention has a 35% probability of being cost-effective at a willingness-to-pay threshold of £20,000</p> <p><b>Additional finding:</b> Many participants appreciated the social interaction and support provided by the volunteers. They reported feeling less isolated and more connected, which contributed to improvements in their mood and overall well-being.</p> <p>Volunteers found the experience rewarding and felt that they were making a meaningful difference in the lives of the</p>

				<p>participants. They valued the training and supervision provided, which helped them feel prepared and supported in their roles.</p> <p>The intervention was generally well-received, with both participants and volunteers expressing satisfaction with the befriending sessions.</p>
<p><b>Anderson et al 2021</b> (Anderson et al., 2021)</p> <p><b>Country: Scotland, UK</b></p> <p><b>Aim:</b> To evaluate the impact of a novel community based, weight management programme (ActWELL) in women with a body mass index (BMI) &gt; 25 kg/m<sup>2</sup> attending routine NHS breast screening clinic.</p> <p><b>Voluntary sector organisation:</b> ActWELL (a novel community based, weight management programme).</p> <p><b>Theme:</b> Theme 3: Long term conditions (including health champions, weight loss, and</p>	<p><b>Intervention:</b> A community based, weight management programme (ActWELL)</p> <p><b>Dates of data collection:</b> August 2017 to September 2019.</p> <p><b>Intervention recipients and sample size:</b> The intervention sample size for the ActWELL study was 279 women.</p> <p><b>Setting:</b> Four NHS Scotland Breast Screening clinics.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention in the ActWELL study was delivered by volunteer coaches recruited and managed by the charity Breast Cancer Now. These volunteers had relevant experience in assisting people with lifestyle changes, such as nurses, teachers, and individuals involved in church work. They underwent a bespoke</p>	<p><b>Study type:</b> RCT</p> <p><b>Length of follow-up:</b> 12 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness analysis.</p> <p><b>Perspective of analysis:</b> UK National Health Service perspective.</p> <p><b>Currency and cost year:</b> Pounds sterling in 2017/2018</p> <p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> Cost-effectiveness analysis.</p> <p><b>Types of costs measured:</b></p> <p><b>Intervention Costs:</b> The total cost of the intervention was £140,978, which breaks down to approximately £505 per participant. This included costs for staff time, training, travel, and materials.</p> <p><b>Incremental Costs:</b> The incremental cost per QALY (Quality Adjusted Life Year) gained ranged from £55,255 to £99,804.</p> <p><b>Cost-Effectiveness:</b> The probability of the intervention being cost-effective (using the conventional threshold of £30,000 per QALY) was below 20%.</p> <p>The sensitivity analyses considered different scenarios, such as varying the time spent by staff on intervention-related activities and adjusting the intervention costs, which provided a range of incremental costs per QALY gained.</p>	<p><b>Main finding:</b> The ActWELL study was that the health care costs were significantly higher in the intervention group compared to the comparison group. The incremental cost per QALY (Quality Adjusted Life Year) gained values ranged from £55,255 to £99,804 per QALY gained. The probability of the intervention being judged as cost-effective was below 20%, using the conventional threshold of cost-effectiveness as cost per QALY gain of up to £30,000 or less.</p> <p><b>Additional finding:</b> Participants in the intervention group achieved significantly more weight loss than</p>

<p>wellness for life interventions)</p>	<p>training program provided by experts in the research team, including physical activity and dietetics.</p> <p><b>Timing and duration:</b> Face-to-Face Sessions: Two individual sessions within the first 12 weeks:</p> <p>Session 1: 60 minutes</p> <p>Session 2: 45 minutes</p> <p>Support Calls: Nine calls over the following 9 months, each lasting 15 minutes.</p> <p>Approximately 4 hours of contact over a 12-month period.</p> <p><b>Intervention description:</b></p> <p>Face-to-Face Sessions: Two individual sessions within the first 12 weeks:</p> <p>Session 1: 60 minutes</p> <p>Session 2: 45 minutes</p> <p>Support Calls: Nine calls over the following 9 months, each lasting 15 minutes.</p> <p>Approximately 4 hours of contact over a 12-month period.</p>			<p>those in the comparison group over 12 months. Specifically, the intervention group experienced a mean weight loss of 2.5 kg compared to 1.2 kg in the comparison group over 12 months. The adjusted mean difference was 1.3 kg in favor of the intervention group, with a p-value of 0.003.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> Yes, there were different scenarios including:</p> <p><b>Sensitivity Analysis 1:</b> Reducing the time spent by staff on intervention-related activities to 50% resulted in an incremental cost per QALY gained of £77,123.</p> <p><b>Sensitivity Analysis 2:</b> Increasing the time spent by staff on intervention-related activities to 70% resulted in an incremental cost per QALY gained of £89,746.</p> <p><b>Sensitivity Analysis 3:</b> Using lower intervention costs expected in a real-life rollout scenario resulted in an incremental</p>
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				cost per QALY gained of £55,255.
<p><b>Aoun et al 2023</b> (Aoun et al., 2023)</p> <p><b>Country:</b> Western Australia</p> <p><b>Aim:</b> To assess the effect on healthcare usage of a community-based palliative care program ('Compassionate Communities Connectors') where practical and social support was delivered by community volunteers to people living with advanced life-limiting illnesses in regional Western Australia.</p> <p><b>Voluntary sector organisation:</b> Compassionate Communities Connectors</p> <p><b>Theme:</b> Theme 5: Help at home (including domiciliary welfare and palliative care interventions)</p>	<p><b>Intervention:</b> Compassionate Communities connectors intervention</p> <p><b>Dates of data collection:</b> The time window used to select the comparator population ('controls') was between 2017 and 2022 inclusive, compared to 2020–2022 for the intervention group.</p> <p><b>Intervention recipients and sample size:</b> 43 community-based patients, the comparator group included 172 individuals with advanced life-limiting illnesses</p> <p><b>Setting:</b> Community settings in Western Australia</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> Community volunteers provided practical and social support directly to individuals with advanced life-limiting illnesses in their homes and local communities</p> <p><b>Timing and duration:</b> 2017 and 2022 inclusive.</p> <p><b>Intervention description:</b> The Compassionate Communities Connectors program aimed to assess the effect of a community-based palliative care intervention on healthcare usage. The intervention involved community volunteers providing practical and social support to individuals with advanced life-limiting illnesses in regional Western Australia</p>	<p><b>Study type:</b> Controlled before-and-after study design 1 2. While the intervention group consisted of 43 community-based patients, the comparator group included 172 individuals with advanced life-limiting illnesses who were randomly selected from usage data from the same health services.</p> <p><b>Length of follow-up:</b> 6 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost consequence analysis</p> <p><b>Perspective of analysis:</b> Healthcare system perspective</p> <p><b>Currency and cost year:</b> AUS\$ in 2022.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> Cost consequence</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Hospital admissions</li> <li>• Days in hospital</li> <li>• Emergency presentations at hospital</li> <li>• Frequency of outpatients contacts</li> </ul>	<p><b>Main finding:</b> The study found that participants in the program experienced: 63% fewer hospital admissions 77% fewer days in hospital 44% fewer emergency presentations Twice the frequency of outpatient contacts compared to a control group.</p> <p>The study estimated that adopting the program could lead to net savings of AUD \$518,701 if 100 patients were enrolled over an average 6-month participation period.</p> <p><b>Additional finding:</b> These results suggest that the program effectively shifted care from hospital settings to community-based care, leading to improved patient outcomes and reduced healthcare costs.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analysis reinforced the conclusion that the program is a cost-</p>

				effective approach to palliative care, with the potential to reduce healthcare costs while enhancing the quality of care for individuals with advanced life-limiting illnesses.
<p><b>Band et al 2021</b> (Band et al., 2025)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To assess the clinical and cost-effectiveness of implementing a social network intervention [‘project about loneliness and social networks’ (PALS)] designed to link people at risk of social isolation and loneliness to community resources and activities.</p> <p><b>Voluntary sector organisation:</b> Project about loneliness and social networks.</p> <p><b>Theme 1:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention:</b> Project About Loneliness and Social networks (PALS)</p> <p><b>Dates of data collection:</b> Between 2019 and 2022.</p> <p><b>Intervention recipients and sample size:</b> The PALS study recruited a total of 469 adults. Out of these, there were 120 withdrawals (approximately 25.6%) during the study.</p> <p><b>Setting:</b> Two regions in England (Southampton and Liverpool).</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> Facilitators and participants met in person to use the GENIE on-line tool.</p> <p><b>Intervention deliverers:</b> The PALS intervention was delivered by trained facilitators.</p> <p><b>Timing and duration:</b> 6 months.</p> <p><b>Intervention description:</b> Participants mapped and reflected on their personal social networks, including friends, family, groups, pets, and daily activities.</p> <p>Based on individual preferences, available support, and health and wellness needs,</p>	<p><b>Study type:</b> A pragmatic, community-based, cluster randomised controlled trial (RCT)</p> <p><b>Length of follow-up:</b> 6 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness</p> <p><b>Perspective of analysis:</b> UK National Health Service (NHS) and personal social services</p> <p><b>Currency and cost year:</b> GBP in 2022.</p> <p><b>Discounting:</b> Costs and outcomes were discounted at an annual rate of 3.5%</p> <p><b>Sensitivity analysis:</b> The sensitivity analyses confirmed that the intervention was not cost-effective under most scenarios.</p>	<p><b>Outcome/s of interest:</b> Cost-effectiveness of the loneliness intervention.</p> <p><b>Types of costs measured:</b>  <b>Intervention Costs:</b> Costs associated with delivering the GENIE tool and facilitator support.</p> <p><b>Healthcare Costs:</b> Costs related to healthcare services used by participants, such as GP visits, hospital admissions, and mental health services.</p> <p><b>Social Services Costs:</b> Costs related to social care services, including community support and social activities.</p> <p><b>Participant Costs:</b> Out-of-pocket expenses incurred by participants, such as travel costs to attend community activities.</p>	<p><b>Main finding:</b> The Incremental Cost-Effectiveness Ratio (ICER) for the PALS intervention was calculated to be £30,000 per Quality Adjusted Life Year (QALY).</p> <p><b>Additional finding:</b> The social network intervention did not significantly reduce loneliness or social isolation compared to usual care and there was little to no improvement in mental wellness, as measured by the Short Form questionnaire-12 items mental health component score (MCS), at the 6-month follow-up.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analyses confirmed that the intervention was not cost-effective under most scenarios, reinforcing the main economic findings.</p>

	<p>participants were linked to local community resources and activities.</p> <p>A facilitator helped participants think about the role of people around them and how their networks might be improved by including new connections to community activities.</p>			
<p><b>Bauer et al 2017</b> (Bauer et al., 2017)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To address a range of well-being needs. However, not much is currently known about the costs, outcomes and economic consequences of such schemes.</p> <p><b>Voluntary sector organisation:</b> Help at home schemes by the voluntary sector.</p> <p><b>Theme:</b> Help at home</p>	<p><b>Intervention:</b> Help at home scheme</p> <p><b>Dates of data collection:</b> Data was collected during 2012 and 2013.</p> <p><b>Intervention recipients and sample size:</b> 64 people.</p> <p><b>Setting:</b> Home settings in Shropshire, England</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> Volunteers and staff from Age UK Shropshire</p> <p><b>Timing and duration:</b> The duration of the intervention was 4-6 months for the primary data collection period, with follow-up assessments conducted within this timeframe.</p> <p><b>Intervention description:</b> Help-at-home scheme for older people aged 55 years and above in Shropshire, England. This scheme included:</p> <ul style="list-style-type: none"> <li>• Volunteer-provided face-to-face and telephone befriending</li> <li>• Practical home help services for gardening, shopping, and cleaning</li> <li>• Welfare benefit advice services</li> </ul>	<p><b>Study type:</b> Mixed-methods study</p> <p><b>Length of follow-up:</b> 4- 6 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost analysis and modelling</p> <p><b>Perspective of analysis:</b> Societal perspective</p> <p><b>Currency and cost year:</b> GBP in 2010/2011</p> <p><b>Discounting:</b> Yes.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> Cost analysis and modelling</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Volunteer time: Valued at local rates.</li> <li>• Practical home help: Gardening, shopping, cleaning.</li> <li>• Befriending services: Face-to-face and telephone.</li> <li>• Welfare benefits advice: Financial support services.</li> <li>• Health and social care services: GP visits, hospital admissions, social worker visits.</li> </ul>	<p><b>Main finding:</b> Costs of the scheme were established from local budget and activity data. The scheme was likely to achieve a mean net benefit of £1568 per person from a local government and National Health Service (NHS) perspective and £3766 from the perspective of the individual. An expenditure of £2851 per person accrued to central government for the additional redistribution of benefit payments to older people.</p> <p><b>Additional finding:</b> This article highlights the potential contribution of voluntary sector-run help-at-home schemes to an affordable welfare system for ageing societies.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The authors assessed the impact of the</p>

				following variations on findings: they removed outliers in the service use data; from the identified associations between involvement with the project and outcomes, they removed effects that were not statistically significant (where available); and they took lower and higher instead of mean values for unit cost data.
<p><b>Engel et al 2021</b> (Engel et al., 2021)</p> <p><b>Country:</b> Australia</p> <p><b>Aim:</b> To evaluate the cost-effectiveness of the Friendship Enrichment Programme (FEP) and a volunteer-led internet and computer training (VICT) intervention to reduce loneliness in older adults and, in turn, prevent depression.</p> <p><b>Voluntary sector organisation:</b> Friendship Enrichment Programme (FEP) and Volunteer-led internet and computer training (VICT)</p> <p><b>Theme :</b> Theme 1: Peer support (including</p>	<p><b>Intervention:</b> Two interventions were evaluated - Friendship Enrichment Programme (FEP) and Volunteer-led internet and computer training (VICT)</p> <p><b>Dates of data collection:</b> The data to build the model was collected prior to publication in 2021.</p> <p><b>Intervention recipients and sample size:</b></p> <p><b>Setting:</b> Community setting</p> <p><b>Delivery mode (e.g., remotely online, in person):</b></p> <p><b>Intervention deliverers:</b></p> <p><b>Timing and duration:</b></p> <p><b>Intervention description:</b></p> <p><b>FEP - Session Structure:</b> The program consisted of 12 lessons covering various topics related to friendship,</p>	<p><b>Study type:</b> Economic modelling study</p> <p><b>Length of follow-up:</b> The authors used a 5-year time horizon for the modelled cost-effectiveness analysis.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness</p> <p><b>Perspective of analysis:</b> Partial societal perspective</p> <p><b>Currency and cost year:</b> AUS\$ in 2021</p> <p><b>Discounting:</b> Yes, as there was a five-year time horizon.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> Cost-effectiveness</p> <p><b>Types of costs measured:</b> <b>Quality-Adjusted Life Years (QALYs):</b> The interventions were evaluated based on the cost per QALY gained, with results showing that they were generally cost-saving.</p> <p>Both interventions generated cost savings that were greater than intervention costs, with a ROI of 2.87 for the FEP and 2.14 for the VICT intervention after 5 years.</p>	<p><b>Main finding:</b> Both interventions were found to be cost-effective, with the incremental cost-effectiveness ratio (ICER) indicating that they were less costly and more effective compared to no intervention.</p> <p>Return on Investment (ROI): The FEP had an ROI of 2.87, and the VICT intervention had an ROI of 2.14 after 5 years, meaning that the cost savings generated were greater than the intervention costs.</p> <p><b>Additional finding:</b> This finding underscores the critical role of social connections and digital literacy in enhancing the mental health and well-</p>

<p>befriending/reducing loneliness interventions/wellness for life support)</p>	<p>such as expectations, early experiences, self-evaluation, making new friends, improving existing friendships, and setting goals. Each session included both theoretical components and practical exercises, with participants encouraged to apply what they learned in their daily lives.</p> <p><b>Volunteer-led Internet and Computer Training (VICT)</b> - The VICT intervention was structured to help older adults become more comfortable with digital technology, thereby reducing loneliness and enhancing social connections.</p>			<p>being of older adults. It also emphasizes the importance of addressing loneliness as a modifiable risk factor for depression.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> Results remained robust in the deterministic sensitivity analyses. However, probabilistic sensitivity analyses indicated high uncertainty, with only 55% and 68% of uncertainty iterations lying below the A\$50,000 per QALY gained willingness-to-pay threshold for FEP and VICT, respectively.</p>
<p><b>Foster et al 2021</b> (Foster et al., 2021)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To understand the impact of the social prescribing service, the British Red Cross commissioned the University of Sheffield to undertake a mixed methods evaluation between May 2017 and January 2020. The aims were to establish whether the service supported people to feel less lonely, identify the</p>	<p><b>Intervention:</b> Social prescribing link workers</p> <p><b>Dates of data collection:</b> May-December 2019.</p> <p><b>Intervention recipients and sample size:</b> The sample size for the study was 10,643 service-users. This included a subsample of 2,250 service-users who completed the UCLA questionnaire both before and after receiving support.</p> <p><b>Setting:</b> The participants were recruited from 37 different sites throughout the UK. Service-users were referred from various sources, including statutory services (NHS and local authorities), voluntary sector</p>	<p><b>Study type:</b> Mixed method evaluation with Social Return on Investment (SROI)</p> <p><b>Length of follow-up:</b> 3 months</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p> <p><b>Perspective of analysis:</b> Societal perspective</p> <p><b>Currency and cost year:</b> GBP in 2019</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b></p> <ol style="list-style-type: none"> <li><b>Service delivery costs:</b> Including central organisation and service-specific costs.</li> <li><b>Volunteer costs:</b> Time given for volunteering, including training and service delivery, valued at £10 per hour.</li> <li><b>Avoided healthcare costs:</b> The number of avoided missed health appointments, estimated at £30 each.</li> <li><b>Wellbeing valuation:</b> Improvements in service-users' wellbeing, valued</li> </ol>	<p><b>Main finding:</b> The main economic finding of the study was that the social prescribing programme had a SROI of £3.42 per £1 invested. This means that for every pound spent on the programme, there was a return of £3.42 in social value.</p> <p><b>Additional finding:</b> Reduction in Loneliness: 72.6% of service-users felt less lonely after receiving support. The mean change in University of California, Los Angeles</p>

<p>facilitators and barriers to service delivery and establish the economic impact of the service.</p> <p><b>Voluntary sector organisation:</b> British Red Cross</p> <p><b>Theme:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p>organisations, community activities, and self-referrals.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b></p> <p><b>Intervention deliverers:</b> The intervention delivery was primarily in person. Link workers provided support through face-to-face meetings, which took place in various locations such as community activities, cafes, and home visits.</p> <p><b>Timing and duration:</b> Over 12 weeks in 2019.</p> <p><b>Intervention description:</b> The intervention involved social prescribing where link workers provided up to 12 weeks of personalized support to help service-users access community activities and social groups. The goal was to reduce loneliness and improve wellbeing by connecting individuals with appropriate local resources and fostering social connections.</p>	<p><b>Discounting:</b> Discounting was applied at 3.5%.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p>using the Wellbeing Valuation Approach.</p>	<p>Loneliness Scale (UCLA) score was <math>-1.84</math>, indicating a significant improvement in loneliness levels.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The authors conducted a sensitivity analysis with the 50% estimate so that comparisons could be drawn with the previous analysis. This generated a return on investment of <math>\pounds 1.79</math> per <math>\pounds 1</math> invested and a Net Present value of <math>\pounds 3,713,771.62</math>. This represented an increase from <math>\pounds 1.48</math> for the previous analysis, using the same assumptions.</p>
<p><b>Granger et al 2025</b> (Granger et al., 2025)</p> <p><b>Country:</b> Liverpool, England, UK</p> <p><b>Aim:</b> To evaluate the impact of Citizens Advice on Prescription (CAP) on service users' wellbeing.</p> <p><b>Voluntray sector organisation:</b> Citizens Advice Bureau (CAB)</p>	<p><b>Intervention:</b> Citizens Advice on Prescription (CAP)</p> <p><b>Dates of data collection:</b> May 2022 to November 2023.</p> <p><b>Intervention recipients and sample size:</b> N=538 service users completed both the baseline and follow-up Short Warwick–Edinburgh Mental Wellbeing Survey (SWEMWBS) questionnaires.</p> <p><b>Setting:</b> Citizens Advice Liverpool and Liverpool NHS.</p>	<p><b>Study type:</b> SROI</p> <p><b>Length of follow-up:</b> 2 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI.</p> <p><b>Perspective of analysis:</b> Societal perspective.</p> <p><b>Currency and cost year:</b> GBP 2022-2023</p>	<p><b>Outcome/s of interest:</b> SROI.</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Staff costs</li> <li>• Overhead costs</li> <li>• Office costs</li> <li>• Room hire in GP surgeries</li> <li>• Community partner payments</li> <li>• Service data collection</li> <li>• Evaluation costs</li> </ul>	<p><b>Main finding:</b> The study reported an overall positive SROI return range of GBP 1: GBP 3.40–GBP 4.69.</p> <p><b>Additional finding:</b> Secondary care referrals yielded the highest SROI, with a return of GBP 1: GBP 12.13. Primary care referrals also showed a positive return,</p>

<p><b>Theme 1:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention, Citizens Advice on Prescription (CAP), was delivered by trained advisors from Citizens Advice Liverpool. These advisors conducted detailed assessments and provided personalized support plans to service users. The service was a collaboration between Citizens Advice Liverpool and Liverpool NHS, with referrals coming from healthcare professionals in primary and secondary care, as well as third-sector organisations.</p> <p><b>Timing and duration:</b> Baseline assessment was followed-up after 2 months.</p> <p><b>Intervention description:</b> The Citizens Advice on Prescription (CAP) intervention was designed to provide welfare advice and social prescription support to individuals experiencing or at risk of financial or social hardship.</p>	<p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> Yes.</p>		<p>with an SROI of GBP 1: GBP 4.72. Perinatal referrals, however, had a lower SROI, with a return of GBP 1: GBP 0.90. This variation highlights the differing impacts of the CAP service depending on the referral source, suggesting that the service may be more effective for certain groups of users.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The attribution ranges were varied for the sensitivity analysis.</p>
<p><b>Howel et al 2019</b> (Howel et al., 2019)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> to determine whether providing domiciliary welfare rights advice could improve the health-related quality of life for independent-living, socio-economically disadvantaged individuals aged 60 years and older in the North East of England. The study also</p>	<p><b>Intervention:</b> Domiciliary advice</p> <p><b>Dates of data collection:</b> The data was collected between 2014 and 2016.</p> <p><b>Intervention recipients and sample size:</b> 755 aged 60 years old and older.</p> <p><b>Setting:</b> Home setting</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> Trained welfare rights advisors.</p>	<p><b>Study type:</b> RCT</p> <p><b>Length of follow-up:</b> 2 years.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost utility analysis</p> <p><b>Perspective of analysis:</b> Health and social care perspective.</p> <p><b>Currency and cost year:</b> GBP in 2016.</p>	<p><b>Outcome/s of interest:</b> Cost-utility analysis</p> <p><b>Types of costs measured:</b></p> <p><b>Intervention Costs:</b> This included the costs associated with delivering welfare rights advice, such as advisor salaries, training, and travel expenses.</p> <p><b>Healthcare Utilization:</b> Costs related to healthcare services used by participants, including hospital admissions, primary care visits, and home care services</p>	<p><b>Main finding:</b> The intervention was received as intended by 335 (88%), with 84 (22%) awarded additional benefit entitlements; 46 did not receive any welfare rights advice, and none of these were awarded additional benefits. Mean CASP-19 scores were 42.9 (Intervention) and 42.4 (Control) (adjusted mean difference 0.3 [95%CI -0.8,</p>

<p>aimed to evaluate the economic impact and process of delivering this intervention.</p> <p><b>Voluntary sector organisation:</b> Specific voluntary sector organisations were not named.</p> <p><b>Theme:</b> Theme 5: Help at home (including domiciliary welfare and palliative care interventions)</p>	<p><b>Timing and duration:</b> The intervention was conducted over a period of 24 months.</p> <p><b>Intervention description:</b> The domiciliary advice was delivered in participants' homes by trained advisors. The goal was to help participants claim benefits they were entitled to, thereby potentially increasing their income and improving their quality of life.</p>	<p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>		<p>1.5]). There were no significant differences in secondary outcomes except Intervention participants reported receiving more care at home at 24m (53.7 (Intervention) vs 42.0 (Control) hours/week (adjusted mean difference 26.3 [95%CIs 0.8, 56.1])). Exploratory analyses did not support an intervention effect and economic evaluation suggested the intervention was unlikely to be cost-effective. Qualitative data from 50 interviews suggested there were improvements in quality of life among those receiving additional benefits.</p> <p>The mean EQ-5D scores were similar for both groups, suggesting that the intervention did not lead to measurable improvements in health-related quality of life</p> <p><b>Additional finding:</b> The study highlighted the need for further research to explore the potential health benefits of welfare rights advice in different</p>
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				<p>contexts and among different populations.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> Sensitivity analyses assessed the impact of different data sources and varying key assumptions and parameters.</p>
<p><b>Jones et al 2015</b> (Jones et al., 2015)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To assess the feasibility and workloads of recruiting volunteers aged 50 years and older, and to support them to help people (ie, beneficiaries) aged 65 and older go online. 2. To assess the impact of using the Internet on contact with others, loneliness, mental health, life satisfaction, and independence using standardized measures. 3. To assess how beneficiaries perceived the value of going online.</p> <p><b>Voluntary sector organisation:</b> Plymouth SeniorNet</p> <p><b>Theme 4:</b></p>	<p><b>Intervention:</b> Plymouth SeniorNet (Helping older people to use the internet)</p> <p><b>Dates of data collection:</b> 2014</p> <p><b>Intervention recipients and sample size:</b> Baselines = 144 Follow-up: n= 110</p> <p><b>Setting:</b> Community settings in Plymouth, England.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> Volunteers</p> <p><b>Timing and duration:</b> Help using the internet over 6-8 visits.</p> <p><b>Intervention description:</b> Beneficiaries received help in using the Internet from 32 volunteers in one of two ways: (1) one-on-one in their own homes, receiving an average of 12 hours of help over eight visits, or (2) in small group sessions, receiving 12 hours of help over six visits.</p>	<p><b>Study type:</b> SROI</p> <p><b>Length of follow-up:</b> Up to 44 weeks later.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI.</p> <p><b>Perspective of analysis:</b> The perspective of analysis was beneficiary-focused.</p> <p><b>Currency and cost year:</b> GBP in 2014.</p> <p><b>Discounting:</b> Yes.</p> <p><b>Sensitivity analysis:</b> Yes.</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Annual Value</li> <li>• Cost of Intervention.</li> <li>• Scaling Up</li> <li>• Payback Period</li> </ul>	<p><b>Main finding:</b> For every £1 invested in the intervention, the social value created was between £1.40 and £1.80.</p> <p><b>Additional finding:</b> There were significant improvement in social connections and mental well-being among the older participants. For example, increased social contacts: The number of contacts with others significantly increased from a mean score of 13.7 to 17.6 on the Lubben Social Network Scale (LBNS-6). There were also reduced loneliness scores. Loneliness scores decreased from a mean of 2.38 to 1.80 on the De Jong Gierveld loneliness scale (DJG-6). Mental well-being scores improved from a mean of 24.06 to 24.96 on the</p>

<p>Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)</p>				<p>Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS).</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The authors varied the duration of benefits: The length of time beneficiaries would continue to experience the benefits of being online; value of benefits: The monetary value assigned to the benefits, such as improved social contacts and reduced loneliness. They also varied the cost of Intervention: The total costs associated with the intervention, including volunteer support and equipment, and discounted future benefits to their present value.</p>
<p><b>Kay and Edgley 2019</b> (Kay &amp; Edgley, 2019)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To assess the health outcomes and cost efficiencies achieved through an educational approach.</p> <p><b>Voluntary sector organisation:</b> Experts by</p>	<p><b>Intervention:</b> Recovery college</p> <p><b>Dates of data collection:</b> September 2016 to August 2017.</p> <p><b>Intervention recipients and sample size:</b> Of the 176 PCFT service users, 137 had up-to-date contact records on the PARIS mental health data system for the 12 months before and after their enrollment in the college.</p> <p><b>Setting:</b> Health and Wellbeing College at the Pennine Care NHS Foundation Trust in Ashton-under-Lyne, UK. The college served</p>	<p><b>Study type:</b> Service evaluation.</p> <p><b>Length of follow-up:</b> 12 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost analysis.</p> <p><b>Perspective of analysis:</b> Healthcare provider perspective.</p>	<p><b>Outcome/s of interest:</b> Costs.</p> <p><b>Types of costs measured:</b></p> <p><b>Practitioner time:</b> The number of practitioner hours saved due to reduced secondary care contacts.</p> <p><b>Staff costs:</b> The cost savings associated with the reduction in practitioner hours, calculated based on NHS pay scales.</p> <p><b>Secondary care contacts:</b> The reduction in the number of contacts with secondary care services.</p> <p><b>Overall cost savings:</b> The potential annual cost savings if the recovery college pathway is</p>	<p><b>Main finding:</b> Nearly two-thirds of the students had fewer contacts with secondary care services after enrolling in the college.</p> <p>Saved practitioner hours: This reduction equated to a saving of 1,570 practitioner hours.</p> <p>Cost savings per person: The cost savings per</p>

<p>experience facilitating the session with professionals.</p> <p><b>Theme 3:</b> Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions)</p>	<p>students from across the five boroughs covered by the Trust.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> The courses were facilitated through a recovery-based curriculum, co-produced and co-delivered by experts by experience (peer trainers) and experts by expertise (professional staff).</p> <p><b>Timing and duration:</b> Evaluation period: One academic year from September 2016 to August 2017.</p> <p><b>Intervention description:</b> The college offered a recovery-focused syllabus of courses designed to increase knowledge, understanding, coping strategies, and skills for self-management of health and wellbeing.</p>	<p><b>Currency and cost year:</b> GBP in 2017.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> No.</p>	<p>embedded within existing mental health services.</p>	<p>person ranged between approximately £1,000 and £2,000 per year.</p> <p>Potential overall savings: If the college pathway is embedded within the existing mental health services, it could potentially lead to cost savings of between £670,000 and £1,340,000 annually.</p> <p><b>Additional finding:</b> The model's success indicated the need for a holistic approach across local communities and the entire health pathway. There was a strong emphasis on working with other statutory service providers, key stakeholders, and the voluntary and community sectors to embed the college within wider public health services.</p>
<p><b>Kazantis et al 2024</b> (Kazantis et al., 2024)</p> <p><b>Country:</b> UK</p> <p><b>Aim:</b> To assess the role of church buildings in social prescribing initiatives in the UK.</p>	<p><b>Intervention:</b> Church buildings and social prescribing initiatives.</p> <p><b>Dates of data collection:</b> 2024 is the base-year.</p> <p><b>Intervention recipients and sample size:</b> People using church buildings as part of social prescribing.</p>	<p><b>Study type:</b> Social impact and economic valuation study.</p> <p><b>Length of follow-up:</b> N/A</p> <p><b>Type of economic evaluation/cost analysis:</b> Wellbeing analysis (using Wellbys).</p>	<p><b>Outcome/s of interest:</b> Wellbeing analysis</p> <p><b>Types of costs measured:</b> The report values the impact of four key services:</p> <ul style="list-style-type: none"> <li>• Food banks</li> <li>• Drug and alcohol addiction support</li> <li>• Mental health groups</li> <li>• Youth groups</li> </ul>	<p><b>Main finding:</b> The total estimated cost relief to the NHS is £8.4 billion per year.</p> <p><b>Additional finding:</b> Church volunteers themselves experience a significant wellbeing boost from their involvement in</p>

<p><b>Voluntary sector organisation:</b> Church volunteers</p> <p><b>Theme 1:</b> <b>Theme 1:</b> Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> Faith groups and others using church buildings for social prescribing activities.</p> <p><b>Timing and duration:</b> Case studies and SROI studies.</p> <p><b>Intervention description:</b> People are referred to social prescribing initiatives in church buildings.</p>	<p><b>Perspective of analysis:</b> Social impact perspective.</p> <p><b>Currency and cost year:</b> GBP in 2024</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> No.</p>		<p>delivering health-related services.</p>
<p><b>Lynch and Jones 2019</b> (Lynch &amp; Jones, 2019)</p> <p><b>Country:</b> Wales, UK</p> <p><b>Aim:</b> To explore whether the participation of frequent attenders in a pilot social prescribing intervention affected their health and wellbeing outcomes and use of health-care resources as a consequence of the intervention.</p> <p><b>Voluntary sector organisation:</b> Various organisations.</p> <p><b>Theme 4:</b> Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)</p>	<p><b>Intervention:</b> Frequent flyers at GP Surgeries to take part in volunteering for credits.</p> <p><b>Dates of data collection:</b> September 2017 to January 2018.</p> <p><b>Intervention recipients and sample size:</b> 78 patients were recruited, with 21 identified as frequent attenders,</p> <p><b>Setting:</b> GP surgeries in South Wales, UK</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> Delivered by social prescribers across three GP practices in South Wales, the intervention aimed to improve health and wellbeing outcomes and reduce healthcare resource usage. Over five months, 78 patients were recruited, with 21 identified as frequent attenders, leading to significant cost savings and improved social support</p>	<p><b>Study type:</b> Mixed methods study including a cost-analysis.</p> <p><b>Length of follow-up:</b> 5 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost analysis.</p> <p><b>Perspective of analysis:</b> healthcare perspective.</p> <p><b>Currency and cost year:</b> GBP in 2019.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> No.</p>	<p><b>Outcome/s of interest:</b> Cost analysis</p> <p><b>Types of costs measured:</b> <b>GP consultations:</b> The number and cost of face-to-face consultations with general practitioners. <b>Prescriptions issued:</b> The cost associated with medications prescribed to the participants. <b>Healthcare unit usage:</b> Overall usage of healthcare services, including visits to specialists and other medical services</p>	<p><b>Main finding:</b> The study found that the intervention led to a cost saving of £8109 or £77.22 per frequent attender over the 5-month period.</p> <p><b>Additional finding:</b> Participants, especially frequent attenders, showed improved mental and physical health, enhanced social support, and reduced isolation.</p>

	<p><b>Timing and duration:</b> The recruitment period was five months.</p> <p><b>Intervention description:</b> The intervention involved frequent attenders participating in structured volunteering activities, earning time credits for each hour volunteered. These credits could be exchanged for leisure activities like cinema vouchers.</p>			
<p><b>Lynch and Jones 2022</b> (Lynch &amp; Jones, 2022)</p> <p><b>Country:</b> Wales, UK</p> <p><b>Aim:</b> To explore the economic benefits related to changes in the use of healthcare resources following a social prescribing intervention in four primary care practices in Wales.</p> <p><b>Voluntary sector organisation:</b> Community voluntary organisations (not named)</p> <p><b>Theme 4:</b> Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)</p>	<p><b>Intervention:</b> Frequent flyers at GP Surgeries to take part in volunteering for credits.</p> <p><b>Dates of data collection:</b> September 2017 to January 2018.</p> <p><b>Intervention recipients and sample size:</b> 78 patients were recruited, with 21 identified as frequent attenders,</p> <p><b>Setting:</b> GP surgeries in South Wales, UK</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> Delivered by social prescribers across three GP practices in South Wales, the intervention aimed to improve health and wellbeing outcomes and reduce healthcare resource usage. Over five months, 78 patients were recruited, with 21 identified as frequent attenders, leading to significant cost savings and improved social support</p> <p><b>Timing and duration:</b> The recruitment period was five months.</p>	<p><b>Study type:</b> Mixed method study</p> <p><b>Length of follow-up:</b> 5 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-analysis.</p> <p><b>Perspective of analysis:</b> Healthcare system perspective.</p> <p><b>Currency and cost year:</b> GBP in 2022.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> No.</p>	<p><b>Outcome/s of interest:</b> Cost-analysis.</p> <p><b>Types of costs measured:</b></p> <ol style="list-style-type: none"> <li>1. General Practitioner (GP) Visits: The frequency and cost of visits to GPs.</li> <li>2. Emergency Department (ED) Visits: Costs associated with visits to emergency departments.</li> <li>3. Hospital Admissions: Costs related to inpatient hospital stays.</li> <li>4. Prescriptions: Costs of medications prescribed to patients.</li> <li>5. Community Health Services Costs for services provided by community health organisations</li> </ol>	<p><b>Main finding:</b> There was a direct cost saving of £6,113 or £78.37 per participant over the 5 months of the intervention.</p> <p><b>Additional finding:</b> The intervention reduced healthcare unit usage among frequent attenders, suggesting that social prescribing can effectively decrease demand on healthcare services.</p>

	<p><b>Intervention description:</b> The intervention involved frequent attenders participating in structured volunteering activities, earning time credits for each hour volunteered. These credits could be exchanged for leisure activities like cinema vouchers.</p>			
<p><b>Makanjuola et al 2023</b> (Makanjuola et al., 2023)</p> <p><b>Country:</b> Wales, UK</p> <p><b>Aim:</b> To evaluate the effectiveness of the "Opening Doors to the Outdoors" (ODO) programme.</p> <p><b>Voluntary sector organisation:</b> Outdoor Partnerships - Opening Doors to the Outdoors.</p> <p><b>Theme:</b> Theme 2: Outdoor interventions (including gardening/walking/climbing interventions)</p>	<p><b>Intervention:</b> Opening doors to the outdoors.</p> <p><b>Dates of data collection:</b> April – November 2022.</p> <p><b>Intervention recipients and sample size:</b> 52 participants completed both the baseline and follow-up questionnaires.</p> <p><b>Setting:</b> Outdoor settings in North Wales</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b></p> <p><b>Timing and duration:</b> One four-hour session per week for 12 weeks.</p> <p><b>Intervention description:</b> The Opening Doors to the Outdoors Programme was a 12-week outdoor walking and climbing programme. There was one four-hour session each week and the activities included walking groups and climbing groups. Each session included time for socialization, such as outdoor picnics or café visits. The programme was conducted at seven sites across North Wales, with six sites offering walking interventions and one site offering climbing interventions.</p>	<p><b>Study type:</b> Mixed methods SROI</p> <p><b>Length of follow-up:</b> 12 weeks.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p> <p><b>Perspective of analysis:</b> Social value perspective</p> <p><b>Currency and cost year:</b> GBP in 2022.</p> <p><b>Discounting:</b> Yes, as standard in an SROI.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b> Costs included:</p> <ul style="list-style-type: none"> <li>• Website: Domain hosting, secure payment systems.</li> <li>• Equipment &amp; Software: Laptop, mobile phone, waterproof materials.</li> <li>• Overheads: Insurance, accounting, office rent.</li> <li>• Staff: 40% FTE for Health and Wellbeing Officer, Programme Support Officer.</li> <li>• Sessions: Instructor fees, climbing admission, refreshments.</li> <li>• Transport: Van lease, insurance, road tax, petrol/mileage.</li> </ul>	<p><b>Main finding:</b> For the "Green Social Prescribing Opening Doors to the Outdoors Programme" was that for every £1 invested in the programme, social values ranging from £4.90 to £5.36 were generated. This indicates a significant positive return on investment, highlighting the programme's effectiveness in improving physical activity, mental wellbeing, social trust, and overall health among participants.</p> <p><b>Additional finding:</b> The study found that 27 out of 47 participants reported an increase of 10% or more in their social trust scores, which was valued at £3,753 per person per year. This improvement in social trust highlights the positive impact of the programme on participants' ability to</p>

	Participants were referred by GPs, community mental health teams, job centres, voluntary sector organisations, and substance misuse rehabilitation centres.			connect with others and feel a sense of belonging in their community.  <b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analysis focused on social trust and physical activity levels, and the most conservative estimate was used to report the final social value ratio.
<p><b>Marshall et al 2020</b> (Marshall et al., 2020)</p> <p><b>Country:</b> UK</p> <p><b>Aim:</b> To investigate the feasibility of delivering group social support to people with aphasia via a multi-user, virtual reality platform. It also explored the indicative effects of intervention and the costs.</p> <p><b>Voluntary sector organisation:</b> Voluntary sector community groups for people with aphasia.</p> <p><b>Theme 1:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention:</b> The intervention in the study was a group social support program for people with aphasia, delivered through the virtual reality platform EVA Park.</p> <p><b>Dates of data collection:</b> The data collection for the study began on May 16, 2017 (date of the first screening appointment) and ended on November 17, 2018 (date of the final follow-up assessment).</p> <p><b>Intervention recipients and sample size:</b> e 34 people with aphasia took part in the study.</p> <p><b>Setting:</b> In small groups remotely via the EVA Park platform.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> On-line</p> <p><b>Intervention deliverers:</b> Six group coordinators from various community-based aphasia groups led the intervention sessions</p>	<p><b>Study type:</b> A randomised, waitlist-controlled design</p> <p><b>Length of follow-up:</b> 6 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost analysis</p> <p><b>Perspective of analysis:</b> Provider perspective</p> <p><b>Currency and cost year:</b> GBP 2017/2018</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> Cost of the intervention</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Training for coordinators and volunteers: £3,414</li> <li>• Project manager inputs: £1,284</li> <li>• Coordinator inputs: £2,032</li> <li>• Volunteer inputs: £915</li> <li>• Hardware costs: £901</li> <li>• Software costs: £1,416</li> </ul>	<p><b>Main finding:</b> Total Costs: The average cost of implementing each group was £9,061 (\$13,283 USD), with a range of £6,516 to £11,316 (\$9,552 USD to \$16,589 USD), excluding hardware costs.</p> <p><b>Per Participant Costs:</b> The average cost per participant for the full episode of intervention was £1,364 (\$2,000 USD), with a range of £724 to £2,263 (\$1,061 USD to \$3,318 USD).</p> <p><b>Cost Drivers:</b> Major cost drivers included training for coordinators and volunteers, project manager inputs, and the involvement of volunteers which helped reduce costs.</p>

	<p><b>Timing and duration:</b> The intervention consisted of 14 group sessions delivered over a period of 6 months. Each session lasted 1.5 hours and was held every two weeks.</p> <p><b>Intervention description:</b></p> <p><b>Session Structure:</b> The intervention consisted of 14 group sessions, each lasting 1.5 hours, delivered over six months. Sessions were held every two weeks.</p> <p><b>Group Composition:</b> Each group included 6-9 participants with aphasia, led by a coordinator and supported by volunteers.</p> <p><b>Content and Activities:</b> Sessions were based on various topics such as "You," "Aphasia," "Resilience," "Personal Strengths," "Comedy," "Music," "Art," "Literature," and "Eating Out." Activities aimed to promote well-being, communicative success, and social connections.</p> <p><b>Use of Avatars:</b> Participants used personalized avatars to interact in EVA Park, which included functional locations like a café and hair salon, as well as fantasy settings.</p> <p><b>Supportive Communication:</b> The intervention encouraged the use of total communication devices, such as message writing and demonstration, and included pre-programmed avatar gestures to supplement communication.</p> <p><b>Training and Setup:</b> Participants received training on how to navigate EVA Park, create</p>			<p><b>Hardware Costs:</b> Hardware provision inflated costs, with total hardware costs averaging £901 (\$1,320 USD) per group.</p> <p>These findings suggest that while the intervention is feasible, careful consideration of cost components and strategies to optimize volunteer involvement and training could help manage expenses.</p> <p><b>Additional finding:</b> This innovative use of virtual reality allowed participants to engage in social support activities from their homes, overcoming barriers like physical distance and travel difficulties.</p> <p><b>Sensitivity analysis results (for economic evaluations): Sensitivity analysis:</b> A sensitivity analysis was conducted to explore the impact of high travel costs on the total costs of the intervention.</p> <p><b>Scenario Analysis:</b> The analysis substituted high travel costs with lower</p>
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	and customize avatars, and use the platform's features.			<p>values to gauge their impact.</p> <p><b>Adjusted costs:</b> For three groups requiring the greatest trainer time due to travel, the trainer time cost was substituted with the lowest cost observed among the groups.</p> <p>Additionally, for the group with the highest researcher travel expenses, the average travel expenses for the other groups were used.</p> <p>Results: These adjustments resulted in the average total costs per group falling from £9,061 to £7,824 (\$13,283 USD to \$11,470 USD).</p>
<p><b>Mitchell et al 2020</b> (Mitchell et al., 2020)</p> <p><b>Country:</b> UK (England, Scotland, and Northern Ireland).</p> <p><b>Aim:</b> to examine and estimate the costs and effects of Palliative Care Day Services (PCDS) with different service configurations across three centres in the UK (England, Scotland, and Northern Ireland).</p>	<p><b>Intervention:</b> Palliative Care Day Services (PCDS)</p> <p><b>Dates of data collection:</b> June 2017 to September 2018.</p> <p><b>Intervention recipients and sample size:</b> 56 attendees who completed baseline data. However, only 38 attendees provided data at the 4-week follow-up.</p> <p><b>Setting:</b> Community settings in England</p> <p><b>Delivery mode (e.g., remotely online, in person):</b></p>	<p><b>Study type:</b> Pragmatic before-and-after descriptive cohort study.</p> <p><b>Length of follow-up:</b> 4 weeks</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost consequence analysis</p> <p><b>Perspective of analysis:</b> Health and social care perspective</p> <p><b>Currency and cost year:</b> GBP in 2018.</p>	<p><b>Outcome/s of interest:</b> Cost consequence</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Health and care usage</li> <li>• Quality of life,</li> <li>• Health status</li> <li>• Capability wellbeing over a period of time.</li> </ul>	<p><b>Main finding:</b> There was insufficient evidence to conclude whether Palliative Care Day Services (PCDS) improved outcomes or reduced costs across the three different service configurations. The study found that the cost per attendee/day ranged from £121 to £190 (excluding volunteer contribution) and £172 to £264 (including volunteer contribution) across the three sites. Volunteer</p>

<p><b>Voluntary sector organisation:</b> Palliative Care Day Services (PCDS)</p> <p><b>Theme:</b> Theme 5: Help at home (including domiciliary welfare and palliative care interventions)</p>	<p><b>Intervention deliverers:</b> The intervention was delivered by a mix of medical, nursing, and allied healthcare professionals at three different centres across the UK.</p> <p><b>Timing and duration:</b> The timing of the intervention varied across the three centres:</p> <ul style="list-style-type: none"> <li>• Centre 1: June to October 2017 and July to September 2018.</li> <li>• Centre 2: January to March 2018.</li> <li>• Centre 3: January to June 2018.</li> </ul> <p><b>Intervention description:</b> The intervention involved the provision of Palliative Care Day Services (PCDS) at three different centres across the UK. These services offered a mix of medical, nursing, and allied healthcare, alongside social and psychological support.</p>	<p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes.</p>		<p>time constituted a significant portion of the total costs, between 28% and 38%.</p> <p><b>Additional finding:</b> The study highlighted the significant role of volunteers in Palliative Care Day Services (PCDS), with volunteer time constituting a substantial portion of the total costs. This underscores the importance of volunteers in the sustainability and delivery of PCDS.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The study included a scenario analysis as a form of sensitivity analysis. This analysis examined the cost per attendee/day using three hypothetical attendance rates (100%, 80%, and 60%) to investigate the variation in costs within and across the three Palliative Care Day Services (PCDS) centres.</p>
<p><b>Moffatt et al 2023</b> (Moffatt et al., 2023)</p> <p><b>Country:</b> England, UK</p>	<p><b>Intervention:</b> Community-based link worker social prescribing intervention</p> <p><b>Dates of data collection:</b> The study started in 2018 and finished post-covid around 2020.</p>	<p><b>Study type:</b> Mixed methods</p> <p><b>Length of follow-up:</b> 12 months for EQ-5D</p>	<p><b>Outcome/s of interest:</b> Cost-effectiveness was one part of the analysis.</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Glycated haemoglobin level (HbA1c)</li> <li>• primary outcome</li> </ul>	<p><b>Main finding:</b> The intervention was found to be, on average, more costly and more effective than current practice. The reduction in</p>

<p><b>Aim:</b> To evaluate the impact and costs of a community-based link worker social prescribing intervention on the health and health-care utilisation of adults aged 40–74 years with type 2 diabetes mellitus (T2DM). In addition, to observe how link workers deliver the intervention and how patients engage with social prescribing, and to capture the experiences of participants with long-term conditions (LTCs) in receipt of social prescribing during and immediately after the first COVID-19 pandemic lockdown.</p> <p><b>Voluntary sector organisation:</b> Ways to wellness</p> <p><b>Theme:</b> Theme 5: Help at home (including domiciliary welfare and palliative care interventions)</p>	<p><b>Intervention recipients and sample size:</b> There were 8400 patients in 13 intervention and 11 control general practices</p> <p><b>Setting:</b> Community settings in the North East of England, UK</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person and on-line during COVID-19 lockdowns.</p> <p><b>Intervention deliverers:</b> Community link workers.</p> <p><b>Timing and duration:</b> As and when needed, weekly, monthly etc.</p> <p><b>Intervention description:</b> Contact with the social prescribing link workers over the phone or face to face.</p>	<p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness analysis</p> <p><b>Perspective of analysis:</b> Healthcare perspective</p> <p><b>Currency and cost year:</b> GBP in 2022</p> <p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<ul style="list-style-type: none"> <li>• Body mass index (BMI)</li> <li>• Blood pressure</li> <li>• Cholesterol level</li> <li>• Smoking status</li> <li>• Health-care costs and utilisation</li> <li>• EQ-5D-5L score</li> </ul>	<p>costs associated with clinical complications and improvement in HRQoL were minor. The mean cost of the intervention itself was £1345 per participant; the incremental mean health gain was 0.004 quality-adjusted life-years (QALYs) (95% confidence interval –0.022 to 0.029) and the ICER was £327,250 per QALY gained. These findings are based on the assumption that the intervention has a 4-year duration of effect.</p> <p>This social prescribing model resulted in a small improvement in glycaemic control. Outcome effects varied across different groups and the experience of social prescribing differed depending on client circumstances.</p> <p><b>Additional finding:</b> Ethnographic data showed that successfully embedded, holistic social prescribing providing supported linking to navigate social determinants of health was challenging to deliver</p>
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				but could offer opportunities for improving health and well-being.  <b>Sensitivity analysis results (for economic evaluations):</b> Eight separate sensitivity analysis were conducted.
<p><b>Mossabir et al 2015</b> (Mossabir et al., 2015)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions.</p> <p><b>Voluntary sector organisation:</b> 'Voluntary organisations' not named, but things like 'community allotments' and 'line dancing' mentioned in some papers.</p> <p><b>Theme:</b> Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions).</p>	<p><b>Intervention:</b> This was a scoping review</p> <p><b>Dates of data collection:</b> A literature search between May and June 2013, involving five electronic databases, hand searching of two journals and the use of Google search engine, identified seven studies relevant to the review question.</p> <p><b>Intervention recipients and sample size:</b> N/A</p> <p><b>Setting:</b> England UK</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> N/A</p> <p><b>Intervention deliverers:</b> N/A</p> <p><b>Timing and duration:</b> N/A</p> <p><b>Intervention description:</b> N/A</p>	<p><b>Study type:</b> This was a scoping review</p> <p><b>Length of follow-up:</b> N/A</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness</p> <p><b>Perspective of analysis:</b> Health service</p> <p><b>Currency and cost year.</b> GBP in 2000.</p> <p><b>Discounting:</b> Not stated in the review paper.</p> <p><b>Sensitivity analysis:</b> Not stated in the review paper.</p>	<p><b>Outcome/s of interest:</b> Only one of the seven included studies investigated cost-effectiveness.</p> <p><b>Types of costs measured:</b> In the Grant et al (2000)* project, they used a 'liaison organisation' called the Amalthea Project, to facilitate contact between patients in primary care with psychosocial problems and voluntary organisations. The mean cost of the intervention arm was significantly greater than the normal GP care (£153 compared to £133, P = 0.025), but there were also significantly greater improvements in levels of anxiety, ability to carry out everyday activities, other feelings about general health and quality of life.</p> <p><b>*This paper was published prior to 2015 (exclusion criteria)</b></p>	<p><b>Main finding:</b> The mean cost of the intervention arm was significantly greater than the normal GP care (£153 compared to £133, P = 0.025), but there were also significantly greater improvements in levels of anxiety, ability to carry out everyday activities, other emotional feelings, feelings about general health and quality of life.</p>
<p><b>Murphy et al 2021</b> (Murphy et al., 2021)</p>	<p><b>Intervention:</b> A support service for those affected by cancer.</p>	<p><b>Study type:</b> Cost analysis</p>	<p><b>Outcome/s of interest:</b> Costs.</p>	<p><b>Main finding:</b> Over a 7-month period, there were</p>

<p><b>Country:</b> Ireland</p> <p><b>Aim:</b> To estimate the resource impact of a community-based cancer support centre.</p> <p><b>Voluntary sector organisation:</b> EVeCANs (community-based support services to cancer patients and their families).</p> <p><b>Theme:</b> Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions).</p>	<p><b>Dates of data collection:</b> September 2018 to March 2019.</p> <p><b>Intervention recipients and sample size:</b> 238 individuals.</p> <p><b>Setting:</b> Community setting in Ireland.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> Paid professionals and volunteers.</p> <p><b>Timing and duration:</b> 7-month period.</p> <p><b>Intervention description:</b> The EVeCANs study intervention involved providing community-based support services to cancer patients and their families over a 7-month period. Services included transport to treatment, complementary therapies (like Reiki and bio-energy therapy), exercise classes, and counselling. These services were delivered in-person by a mix of paid professionals and volunteers, aiming to improve the quality of life and well-being of participants.</p>	<p><b>Length of follow-up:</b> 7 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-analysis.</p> <p><b>Perspective of analysis:</b> Irish Health Service Executive (HSE) perspective.</p> <p><b>Currency and cost year:</b> Euros (€) in 2019.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> Yes.</p>	<p><b>Types of costs measured:</b></p> <p><b>Health Resource Costs (7-month period)</b></p> <ul style="list-style-type: none"> <li>• Bio energy therapy</li> <li>• Counselling:</li> <li>• Exercise classes</li> <li>• Healing touch therapy</li> <li>• Reiki</li> </ul> <p><b>Non-Health Resource Costs (per month)</b></p> <ul style="list-style-type: none"> <li>• Catering personnel</li> <li>• Daily service operations</li> <li>• Bus driver</li> <li>• Bus running costs</li> <li>• Lunches</li> </ul> <p><b>Annual Costs</b></p> <ul style="list-style-type: none"> <li>• Total annual cost</li> </ul>	<p>2032 contacts with 238 clients whose average age was 60 years. The most frequently used services were transport to treatment (20%), complementary therapies (48%), exercise classes (10%) and counselling (9%). This cost analysis estimated total annual cost to provide all services was €313,744. Average annual cost per person was €1138. Current uptake at the centre represents 8% of all cancer incidences in seven counties surrounding the centre. If uptake increases by 10%, scenario analyses predict an increase in total costs increase to €429,043 and a decrease in costs per patient to €915.</p> <p><b>Additional finding:</b> There was the high utilization of complementary therapies. Specifically, 48% of the services used were complementary therapies such as Reiki, bio energy therapy, and healing touch therapy.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> Within the</p>
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				<p>probabilistic sensitivity analysis, a Monte Carlo simulation was conducted around the total cost estimate to account for uncertainty. The sensitivity analysis results indicate a 95-percentile range for the average annual total costs of €259,324 to €397,719, suggesting a robust estimation of the total costs.</p>
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<p><b>Nickel et al 2018</b> (Nickel et al., 2018)</p> <p><b>Country:</b> Germany</p> <p><b>Aim:</b> To review the literature on trial-based economic evaluations of non-pharmacological interventions directly targeted at persons with dementia as well as persons with mild cognitive impairment and their respective caregivers.</p> <p><b>Voluntary sector organisation:</b> e.g. START intervention (Strategies for RelaTives).</p> <p><b>Theme 1:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention:</b> Systematic review</p> <p><b>Dates of data collection:</b> A systematic literature research was conducted for the timeframe from 2010 to 2016.</p> <p><b>Intervention recipients and sample size:</b> In total sixteen publications were identified. Health economic evaluations indicated the cost-effectiveness of physical exercise interventions and occupational therapy. There was also evidence to suggest that psychological and behavioural therapies are cost-effective. Health economic studies investigating psychosocial interventions mainly targeted towards informal caregivers showed inconsistent results.</p> <p><b>Setting:</b> Community settings</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> N/A</p> <p><b>Intervention deliverers:</b> N/A</p> <p><b>Timing and duration:</b> N/A</p> <p><b>Intervention description:</b> N/A</p>	<p><b>Study type:</b> Systematic review</p> <p><b>Length of follow-up:</b> N/A</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness</p> <p><b>Perspective of analysis:</b> The most prevalent perspective was the health and social care perspective, which is not taking into account informal care costs.</p> <p><b>Currency and cost year:</b> 2018</p> <p><b>Discounting:</b> N/A</p> <p><b>Sensitivity analysis:</b> N/A</p>	<p><b>Outcome/s of interest:</b> The systematic review provided evidence on economic aspects of non-pharmacological interventions in the therapeutic field of dementia. Health economic evaluations suggest that exercise programs, occupational therapy as well as cognitive and psychological interventions directly delivered to persons with dementia demonstrate cost-effectiveness compared to care as usual with regard to specific outcomes.</p> <p><b>Types of costs measured:</b>  <b>Direct Medical Costs:</b> Costs related to healthcare services such as hospital stays, outpatient visits, medications, and medical procedures.  <b>Direct Non-Medical Costs:</b> Costs associated with non-medical services like social care, home help services, and transportation.  <b>Informal Care Costs:</b> The value of unpaid care provided by family members or friends, often calculated based on the time spent on caregiving activities.  <b>Intervention Costs:</b> Costs directly related to the implementation of the non-pharmacological interventions, including materials, training, and personnel.  <b>Indirect Costs:</b> Costs related to lost productivity, both for the person with dementia and their caregivers, due to time taken off work or reduced work capacity.</p>	<p><b>Main finding:</b> Health economic evaluations suggest that exercise programs, occupational therapy as well as cognitive and psychological interventions directly delivered to persons with dementia demonstrate cost-effectiveness compared to care as usual with regard to specific outcomes.</p> <p><b>Additional finding:</b> Psychosocial interventions targeted at informal caregivers had inconsistent results.</p>
<p><b>Patchwood et al 2021</b> (Patchwood et al., 2021)</p> <p><b>Country:</b> UK</p> <p><b>Aim:</b> To investigate the clinical effectiveness and cost-effectiveness of a</p>	<p><b>Intervention:</b> The name of the intervention in the OSCARSS trial was the Carer Support Needs Assessment Tool for Stroke (CSNAT-Stroke).</p> <p><b>Dates of data collection:</b> February 1, 2017, to July 31, 2018</p>	<p><b>Study type:</b> Cluster RCT</p> <p><b>Length of follow-up:</b> 6 months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-effectiveness analysis</p>	<p><b>Outcome/s of interest:</b> Cost-effectiveness</p> <p><b>Types of costs measured:</b>  <b>Healthcare Utilization Costs:</b> Costs associated with the use of NHS and social care services by carers.  <b>Intervention Costs:</b> Costs related to the delivery of the intervention, including staff training and time spent providing support.</p>	<p><b>Main finding:</b> The OSCARSS trial was unlikely to be cost-effective compared to usual care. The costs associated with the intervention were slightly higher (around £40 per person) than the control, primarily due to</p>

<p>person-centred intervention for informal carers/caregivers of stroke survivors.</p> <p><b>Voluntary sector organisation:</b> Stroke Association</p> <p><b>Theme:</b> Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions).</p>	<p><b>Intervention recipients and sample size:</b> <b>Intervention sample size:</b> 208 carers. <b>Control group:</b> 206 carers.</p> <p><b>Setting:</b> Personalised, in-home support tailored to the needs of carers and stroke survivors.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention deliverers in the OSCARSS trial were staff from a UK voluntary sector specialist provider. These staff members were trained to facilitate the Carer Support Needs Assessment Tool for Stroke (CSNAT-Stroke) and provide personalized support to carers in their homes.</p> <p><b>Timing and duration:</b> The intervention began at the first point of contact with the carer, and it required at least one face-to-face support contact dedicated to carers, with reviews as needed.</p> <p><b>Intervention description:</b> The OSCARSS tool was designed to help identify, prioritize, and address the specific support needs of carers through a structured, carer-led approach facilitated by staff.</p>	<p><b>Perspective of analysis:</b> NHS and social care perspective.</p> <p><b>Currency and cost year:</b> GBP in 2018.</p> <p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Primary Care Services Costs:</b> Specifically, costs related to carers accessing general practice nurses.</p>	<p>additional staff training and support activities.</p> <p><b>Additional finding:</b> There were no measurable health benefits observed from the intervention.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analyses confirmed that the primary and secondary outcomes were robust, even when considering factors such as delayed responders, missing data, and protocol deviations.</p>
<p><b>Ramachandra et al 2015</b> (Ramachandra, 2015)</p> <p><b>Country:</b> USA</p> <p><b>Aim:</b> In order to understand the positive influence of the built environment on the success of social programs,</p>	<p><b>Intervention:</b> Windsor Connection Resource Center (WCRC)</p> <p><b>Dates of data collection:</b> 2014</p> <p><b>Intervention recipients and sample size:</b></p> <p><b>Setting:</b> Community setting in the USA</p>	<p><b>Study type:</b> Mixed methods study including a SROI.</p> <p><b>Length of follow-up:</b> Unclear.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p>	<p><b>Outcome/s of interest:</b> SROI.</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Cost of having a building</li> <li>• Building maintenance costs</li> <li>• Cost of staffing</li> </ul>	<p><b>Main finding:</b> Over a period of two years, for every dollar invested in Windsor Connection Resource Center (WCRC), the ROI for the program is 1.2 (assuming starting year as 2014).</p>

<p>this study aims to elicit those individual factors of the designed environment that actively support and impact program usage.</p> <p><b>Voluntary sector organisation:</b> Windsor Connection Resource Center (WCRC)</p> <p><b>Theme 4:</b> Theme 4: Other social prescribing interventions (including volunteering, and social prescribing assets)</p>	<p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> WCRC Centre staff and volunteers.</p> <p><b>Timing and duration:</b> The SROI was conducted for the WCRC located at No. 1 Railroad Plaza, Windsor Vermont, USA, for the (projected) years 2014–16.</p> <p><b>Intervention description:</b> WCRC /Mt. Ascutney Health Center, Windsor: At WCRC, the city of Windsor’s location has left many, especially the low-income women, with no direct access to social services and other facilities. For a nominal fee (which is usually waived) of \$15 an hour, the center brings all those facilities to Windsor. While this certainly benefits the community, the clinic benefits by sorting out problems at an early stage, not letting them escalate into a medical situation. This early intervention helps to reduce pressure on both medical resources and emergency room usage.</p>	<p><b>Perspective of analysis:</b> Societal perspective</p> <p><b>Currency and cost year:</b> US\$ in 2016</p> <p><b>Discounting:</b> Yes.</p> <p><b>Sensitivity analysis:</b> No.</p>		<p><b>Additional finding:</b> Having a building that was ready from the outset has been cited as a distinct plus to the program. This alone has saved the clinic at least \$500,000, which it would have had to find. The cost of building procurement was \$0.</p>
<p><b>Schoen et al 2020</b> (Schoen et al., 2020a)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To calculate the cost-to-benefit ratio of a London community garden.</p> <p><b>Voluntary sector organisation:</b> Social Farms and Gardens</p>	<p><b>Intervention:</b> A community garden in London</p> <p><b>Dates of data collection:</b> 2019</p> <p><b>Intervention recipients and sample size:</b> 3571.5 total hours of volunteer time @ £10.55 per hour (London Living Wage)</p> <p><b>Setting:</b> London community garden</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p>	<p><b>Study type:</b> A rapid cost-benefit analysis</p> <p><b>Length of follow-up:</b> No-follow up.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p> <p><b>Perspective of analysis:</b></p> <p><b>Currency and cost year:</b> GBP in 2019/2020</p>	<p><b>Outcome/s of interest:</b> A rapid cost-benefit approach to estimate this public value return on investment (ROI).</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Site-wide costs: £4476 (water, rent, refuse collection, etc.)</li> <li>• Garden maintenance: £637</li> <li>• Consumables: £1038 (seeds, compost, etc.)</li> <li>• Replacement costs: £221 (small tools)</li> <li>• Salaries and employment costs: £41,098</li> </ul>	<p><b>Main finding:</b> The London community garden achieved a return on investment (ROI) of £3 for every £1 invested. This demonstrates the significant economic value that community gardens can contribute to social wellbeing within cities.</p> <p><b>Additional finding:</b> Other benefits of the community garden included improved self-confidence and self-</p>

<p><b>Theme:</b> Theme 2: Outdoor interventions (including gardening/walking/climbing interventions)</p>	<p><b>Intervention deliverers:</b> Staff and volunteers at the London community garden</p> <p><b>Timing and duration:</b> The 2019 growing season</p> <p><b>Intervention description:</b> The intervention at the London community garden involved staff and volunteers delivering a range of activities aimed at improving physical and emotional wellbeing. These included sports training for young people, community classes, horticultural therapy for adults with learning disabilities and mental health issues, and sustainable food growing to supply the onsite vegan café. The garden, established in the early 1980s, occupies approximately 1400 m<sup>2</sup>, with the food growing area accounting for about one quarter of this space. It offers diverse facilities such as a football pitch, children's play area, café, community rooms, and small allotments.</p>	<p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<ul style="list-style-type: none"> <li>• Volunteer labor: £37,679 (3572 hours at £10.55/hour)</li> </ul>	<p>esteem, reduced isolation, and enhanced emotional wellbeing among the volunteers. Community gardens can play a crucial role in fostering social connections and improving mental health, demonstrating their value beyond just economic returns.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The key assumptions tested in the sensitivity analysis were: Retention Rate: Initially set at 60%, tested at 40%, 60%, and 80%. Impact Percentage: Initially set at 30%, tested at 20%, 30%, and 50%. Value of Volunteer Labour: Initially valued at £10.55 per hour, tested at £5.275 per hour and £0. Price of Produce: Tested the effect of doubling and tripling the price of produce.</p>
<p><b>Visram et al 2017</b> (Visram et al., 2017)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To evaluate the Wellbeing for Life (WFL) service in County Durham.</p>	<p><b>Intervention:</b> Wellbeing for Life (WFL) service in County Durham.</p> <p><b>Dates of data collection:</b> Unclear from this conference abstract.</p> <p><b>Intervention recipients and sample size:</b></p> <ul style="list-style-type: none"> <li>• <b>Baseline:</b> 1461 clients</li> <li>• <b>Three months:</b> 1201 clients</li> </ul>	<p><b>Study type:</b> Mixed methods (including SROI).</p> <p><b>Length of follow-up:</b> 12-months.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• Costs associated with delivering the intervention</li> <li>• Costs related to client participation</li> <li>• Healthcare costs</li> <li>• Social costs</li> </ul>	<p><b>Main finding:</b> A SROI of approximately £3.59 for every £1 spent was found.</p> <p><b>Additional finding:</b> The cost per quality-adjusted life year (QALY) was £3900.</p>

<p><b>Voluntary sector organisation:</b> The WFL service was funded by Durham County Council, delivered by a consortium of public and voluntary sector providers, and launched on 1st April 2015.</p> <p><b>Theme :</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<ul style="list-style-type: none"> <li>• <b>Six months:</b> 380 clients</li> <li>• <b>Twelve months:</b> 133 clients</li> </ul> <p><b>Setting:</b> Community settings in County Durham, North East England.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention was delivered by a team comprising trained staff members and volunteers. The staff included professionals from various disciplines such as health, social care, and community development. Volunteers played a crucial role in supporting the delivery of services and providing peer support to clients. This collaborative approach ensured that the intervention was comprehensive and tailored to the needs of the community.</p> <p><b>Timing and duration:</b> The intervention was typically delivered over a period of 8 to 12 weeks.</p> <p><b>Intervention description:</b> The intervention combined face-to-face support, community-based activities, and volunteer involvement to promote healthy lifestyles. It targeted disadvantaged communities, focusing on improving physical activity, diet, mental wellbeing, and reducing harmful behaviours. The program lasted 8-12 weeks, aiming to reduce health inequalities and enhance overall wellbeing.</p>	<p><b>Perspective of analysis:</b> Societal perspective</p> <p><b>Currency and cost year:</b> GBP in 2017.</p> <p><b>Discounting:</b> Yes.</p> <p><b>Sensitivity analysis:</b> No.</p>		
<p><b>Visram et al 2020</b> (Visram et al., 2020a)</p> <p><b>Country:</b> England, UK</p>	<p><b>Intervention:</b> Wellbeing for Life (WFL) service in County Durham.</p> <p><b>Dates of data collection:</b> June 2015 and January 2017.</p>	<p><b>Study type:</b> Mixed methods study including cost analysis and SROI</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li>• One-to-one intervention</li> </ul>	<p><b>Main finding:</b> The total estimated societal value of the service was between £3.45 and £6.03</p>

<p><b>Aim:</b> To evaluate the Wellbeing for Life (WFL) service in County Durham</p> <p><b>Voluntary sector organisation:</b> The WFL service was funded by Durham County Council, <b>delivered by a consortium of public and voluntary sector providers</b>, and launched on 1st April 2015.</p> <p><b>Theme :</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention recipients and sample size:</b> The intervention involved 3179 individuals who became clients of the Wellbeing for Life (WFL) service.</p> <p>2433 individuals accessed one-to-one interventions. 4669 health-promoting events were conducted. 1595 instances of signposting to other services occurred.</p> <p><b>Setting:</b> <b>Setting:</b> Community settings in County Durham, North East England.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention deliverers for the Wellbeing for Life (WFL) service were lay health workers, also known as health trainers. These individuals were recruited from the communities they served and received specialized training to deliver health promotion programs.</p> <p><b>Timing and duration:</b> Participants received between 8 and 12 sessions.</p> <p>Intervention description: The intervention included:</p> <ul style="list-style-type: none"> <li>• Conducting one-to-one behaviour change interventions.</li> <li>• Leading group wellbeing improvement sessions.</li> <li>• Supporting volunteering opportunities.</li> </ul>	<p><b>Length of follow-up:</b> 18 month follow-up.</p> <p><b>Type of economic evaluation/cost analysis:</b> Various methods including cost-consequence and SROI.</p> <p><b>Perspective of analysis:</b> Societal perspective.</p> <p><b>Currency and cost year:</b> Unclear.</p> <p><b>Discounting:</b> Yes.</p> <p><b>Sensitivity analysis:</b> Yes.</p>	<ul style="list-style-type: none"> <li>• Personalised behaviour change interventions (8–12 weeks) delivered by general or specialist WFL health trainers</li> <li>• Volunteer service</li> <li>• Recruitment, training and mentoring of volunteers to support, deliver and sustain community-based activities</li> <li>• Wellbeing groups</li> <li>• Group-based wellbeing improvement interventions, usually involving a minimum of 4 sessions</li> <li>• Capacity building</li> <li>• Training sessions delivered by WFL staff to public health and other relevant practitioners</li> <li>• Community development</li> <li>• Asset mapping, community engagement and other activities carried out by WFL community development workers</li> </ul>	<p>for every £1 spent on the service, indicating a positive impact on society.</p> <p><b>Additional finding:</b> There was a positive impact on emotional wellbeing.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analysis tested the robustness of the results by varying key assumptions by <math>\pm 10\%</math> and applying a discount rate of 3.5% to long-term outcomes. The analysis showed that these variations did not materially change the cost-effectiveness results.</p>
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	<ul style="list-style-type: none"> <li>Engaging in community development activities.</li> </ul>			
<p><b>Whiteley et al 2024</b> (Whiteley et al., 2024)</p> <p><b>Country:</b> Wales, UK</p> <p><b>Aim:</b> To evaluate the Well-being benefits and social value of volunteer Gardening at Treborth Botanic Gardens (TBG).</p> <p><b>Voluntary sector organisation:</b> Treborth Botanic Gardens, Bangor, North Wales</p> <p><b>Theme:</b> Theme 2: Outdoor interventions (including gardening/walking/climbing interventions)</p>	<p><b>Intervention:</b> Treboth Botanic Garden</p> <p><b>Dates of data collection:</b> November 2021 – April 2022.</p> <p><b>Intervention recipients and sample size:</b> The sample size for the study was 35 volunteers out of a total of 96 registered volunteers at Treborth Botanic Garden.</p> <p><b>Setting:</b> Treboth Botanic Garden, Bangor, North Wales</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person</p> <p><b>Intervention deliverers:</b> The intervention was delivered by a team of three full-time equivalent (FTE) staff members from Bangor University.</p> <p><b>Timing and duration:</b> Over six months (November 2021 – April 2022).</p> <p><b>Intervention description:</b> Three members of FTE staff were responsible for managing and facilitating the volunteer program at Treborth Botanic Garden (TBG). They were supported by local volunteers, including members of the Friends of Treborth Botanic Garden (FoTBG) and the Students for Treborth Action Group (STAG).</p>	<p><b>Study type:</b> Natural experiment with SROI analysis</p> <p><b>Length of follow-up:</b> Six months</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p> <p><b>Perspective of analysis:</b> Societal perspective</p> <p><b>Currency and cost year:</b> GBP in 2022.</p> <p><b>Discounting:</b> Yes, as standard in an SROI.</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b></p> <ul style="list-style-type: none"> <li><b>Staffing Costs:</b> Included salaries of three full-time equivalent (FTE) staff members responsible for recruiting, planning, and managing volunteers.</li> <li><b>Operational Running Costs:</b> Covered expenses like building lease, maintenance, utilities, equipment, materials, catering, and insurance.</li> <li><b>Volunteer Program Costs.</b></li> </ul>	<p><b>Main finding:</b> Treborth Botanic Garden generates significant social value in the range of GBP 4.02 to GBP 5.43 for every GBP 1 invested. includes cost savings to the NHS.</p> <p><b>Additional finding:</b> Volunteers reported fewer visits to psychotherapists, counselors, and mental health nurses after participating in the gardening program. This suggests that volunteer gardening can potentially reduce the burden on healthcare services, leading to cost savings for the NHS.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analysis used two social value calculators (HACT SVC and MHSVC), adjusted for deadweight (10%), attribution (57%), and displacement (43%).</p>
<p><b>Williams et al 2024</b> (Williams et al., 2024)</p> <p><b>Country:</b> England, UK</p>	<p><b>Intervention:</b> 'Health Champions'.</p> <p><b>Dates of data collection:</b> September 2021 to March 2023.</p>	<p><b>Study type:</b> Feasibility hybrid randomised controlled trial.</p>	<p><b>Outcome/s of interest:</b> Cost-analysis</p> <p><b>Types of costs measured</b></p> <ul style="list-style-type: none"> <li>Cost of Implementation</li> </ul>	<p><b>Main finding:</b> There were no clinical differences between the intervention and control groups.</p>

<p><b>Aim:</b> To evaluate the feasibility of an intervention where volunteer 'Health Champions' support people with severe mental illness (SMI) in managing their physical health.</p> <p><b>Voluntary sector organisation:</b> 'Health champions'.</p> <p><b>Theme:</b> Theme 3: Long term conditions (including health champions, weight loss, and wellness for life interventions)</p>	<p><b>Intervention recipients and sample size:</b> Total: 48 participants Intervention group = 27 Control group = 21.</p> <p><b>Setting:</b> This study took place in community mental health teams (CMHTs) in the South London and Maudsley NHS Foundation Trust in London, UK.</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> The volunteers, known as 'Health Champions,' received comprehensive training to effectively support participants. This training included:</p> <p><b>Mental Health Awareness:</b> Understanding severe mental illness and its impact on physical health.</p> <p><b>Communication Skills:</b> Techniques for effective and empathetic communication with participants.</p> <p><b>Health Promotion:</b> Strategies to encourage and support healthy lifestyle changes.</p> <p><b>Safety and Boundaries:</b> Ensuring safe interactions and maintaining professional boundaries.</p> <p><b>Timing and duration:</b> Support over six months.</p> <p><b>Intervention description:</b> The 'Health Champions' intervention involved trained volunteers providing in-person support to individuals with severe mental illness, helping them manage their physical health through personalized guidance,</p>	<p><b>Length of follow-up:</b> Six months</p> <p><b>Type of economic evaluation/cost analysis:</b> Cost-analysis.</p> <p><b>Perspective of analysis:</b> Healthcare provider perspective.</p> <p><b>Currency and cost year:</b> GBP in 2023.</p> <p><b>Discounting:</b> No.</p> <p><b>Sensitivity analysis:</b> No</p>	<ul style="list-style-type: none"> <li>• Feasibility and Acceptability</li> <li>• Resource Utilization</li> <li>• Sensitivity Analysis</li> </ul>	<p>The cost of implementing the 'Health Champions' intervention was £312 per participant.</p> <p><b>Additional finding:</b> Despite the intervention's high acceptability and feasibility, the lack of significant clinical improvements meant that the costs did not translate into measurable health benefits.</p>
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	encouragement, and health promotion strategies over a six-month period.			
<p><b>Willis et al 2018</b> (Willis et al., 2018)</p> <p><b>Country:</b> England, UK</p> <p><b>Aim:</b> To use the ‘Social Return on Investment’ (SROI) methodology to quantify the social value created by peer support groups for people with dementia and their carers.</p> <p><b>Voluntary sector organisation:</b> Dementia peer support groups.</p> <p><b>Theme:</b> Theme 1: Peer support (including befriending/reducing loneliness interventions/wellness for life support)</p>	<p><b>Intervention:</b> Peer support groups for people with dementia, providing mental stimulation, reducing loneliness, and offering support to carers, enhancing overall well-being.</p> <p><b>Dates of data collection:</b> 2017</p> <p><b>Intervention recipients and sample size:</b> There were 3 peer support groups, each with approximately 10-15 participants, including people with dementia, their carers, and volunteers.</p> <p><b>Setting:</b> Community setting</p> <p><b>Delivery mode (e.g., remotely online, in person):</b> In-person.</p> <p><b>Intervention deliverers:</b> Trained facilitators and volunteers.</p> <p><b>Timing and duration:</b></p> <p><b>Intervention description:</b> Peer support groups for people with dementia, providing mental stimulation, reducing loneliness, and offering support to carers, enhancing overall well-being.</p>	<p><b>Study type:</b> SROI</p> <p><b>Length of follow-up:</b> 12 months.</p> <p><b>Type of economic evaluation/cost analysis:</b> SROI</p> <p><b>Perspective of analysis:</b> Stakeholder focused.</p> <p><b>Currency and cost year:</b> GBP in 2019.</p> <p><b>Discounting:</b> Yes</p> <p><b>Sensitivity analysis:</b> Yes</p>	<p><b>Outcome/s of interest:</b> SROI</p> <p><b>Types of costs measured:</b> <b>Costs included:</b></p> <ul style="list-style-type: none"> <li>• Staff salaries</li> <li>• Venue hire</li> <li>• Refreshments</li> <li>• Training</li> <li>• Materials for peer support groups</li> </ul>	<p><b>Main finding:</b> Findings showed the three groups created social value ranging from £1.17 to £5.18 for every pound (£) of investment, dependent on the design and structure of the group.</p> <p><b>Additional finding:</b> Key outcomes for people with dementia were mental stimulation and a reduction in loneliness and isolation. Carers reported a reduction in stress and burden of care. Volunteers cited an increased knowledge of dementia.</p> <p><b>Sensitivity analysis results (for economic evaluations):</b> The sensitivity analysis showed that while the SROI ratios varied depending on the assumptions made, the overall conclusion remained consistent: peer support groups provide significant social value.</p>

### Appendix 3 – Quality appraisal tables

See Tables 2-5 for the quality appraisal tables for the systematic review studies, randomised controlled trials (RCTs), cohort studies, and mixed methods studies (Joanna Briggs Institute, 2017, 2021, 2022; Munn et al., 2021; The Joanna Briggs Institute, 2020)

**Table 3.1** Quality appraisal of the review papers (Joanna Briggs Institute, 2017)

Citation	Q1. Is the review question clearly and explicitly stated?	Q2. Were the inclusion criteria appropriate for the review question?	Q3. Was the search strategy appropriate?	Q4. Were the sources and resources used to search for studies adequate?	Q5. Were the criteria for appraising studies appropriate?	Q6. Was critical appraisal conducted by two or more reviewers independently?	Q7. Were there methods to minimize errors in data extraction?	Q8. Were the methods used to combine studies appropriate?	Q9. Was the likelihood of publication bias assessed?	Q10. Were recommendations for policy and/or practice supported by the reported data?	Q11. Were the specific directives for new research appropriate?	Quality Appraisal rating
<b>Mossabir et al 2015</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	10/11 High
<b>Nickel et al 2018</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11 High

**Key:** Score between 1 and 4 is low quality; score between 5 and 8 is moderate quality; score between 9 and 11 is high quality.

Table 3.2 Quality appraisal of the randomised controlled studies (The Joanna Briggs Institute, 2020)

Citation	Q1. Was true randomization used for assignment of participants to treatment groups?	Q2. Was allocation to treatment groups concealed?	Q3. Were treatment groups similar at the baseline?	Q4. Were participants blind to treatment assignment?	Q5. Were those delivering treatment blind to treatment assignment?	Q6. Were outcomes assessors blind to treatment assignment?	Q7. Were outcomes assessors blind to treatment assignment?	Q8. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?	Q9. Were participants analysed in the groups to which they were randomized?	Q10. Were outcomes measured in the same way for treatment groups?	Q11. Were outcomes measured in a reliable way?	Q12. Was appropriate statistical analysis used?	Q13. Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	Quality appraisal rating
Ali et al 2021	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	10/13 High
Anderson et al 2021	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	10/13 High
Band et al 2025	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	10/13 High
Howel et al 2019	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	10/13 High
Marshall et al 2020	Yes	No	No	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	8/13 Moderate
Patchwood et al 2021	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	10/13 High
Williams et al 2024	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	8/13 Moderate

**Key:** Score between 1 and 5 is low quality; score between 6 and 9 is moderate quality; score between 10 and 13 is high quality.

Table 3.3 Quality appraisal of the cohort studies (Joanna Briggs Institute, 2021)

Citation	Q1. Were the two groups similar and recruited from the same population?	Q2. Were the exposures measured similarly to assign people to both exposed and unexposed groups?	Q3. Was the exposure measured in a valid and reliable way?	Q4. Were confounding factors identified?	Q5. Were strategies to deal with confounding factors stated?	Q6. Were the groups/ participants free of the outcome at the start of the study (or at the moment of exposure)?	Q7. Were the outcomes measured in a valid and reliable way?	Q8. Was the follow up time reported and sufficient to be long enough for outcomes to occur?	Q9. Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	Q10. Were strategies to address incomplete follow up utilized?	Q11. Was appropriate statistical analysis used?	Quality appraisal rating
Aoun et al 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	10/11 High
Foster et al 2021	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	9/11 High
Jones et al 2015	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	9/11 High
Kay and Edgley 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	10/11 High
Mitchell et al 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	10/11 High
Murphy et al 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	10/11 High
Schoen et al 2020	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Unclear	Unclear	Yes	8/11 Moderate
Willis et al 2018	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	8/11 Moderate

**Key:** Score between 1 and 4 is low quality; score between 5 and 8 is moderate quality; score between 9 and 11 is high quality.

Table 3.4 Quality appraisal of the mixed methods studies (Munn et al., 2021)

Citation	5.1 Is there an adequate rationale for using a mixed methods design to address the research question?	5.2 Are the different components of the study effectively integrated to answer the research question?	5.3 Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4 Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5 Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Quality appraisal rating
<b>Bauer et al 2017</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Granger et al 2025</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Kazantis et al 2024</b>	Yes	No	No	No	No	<b>1/5 Low</b>
<b>Lynch and Jones 2022</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Makanjuola et al 2023</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Moffatt et al 2021</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Ramachandra 2015</b>	Yes	Yes	No	No	Yes	<b>3/5 Moderate</b>
<b>Visram et al 2017</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Visram et al 2022</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>
<b>Whiteley et al 2024</b>	Yes	Yes	Yes	Yes	Yes	<b>5/5 High</b>

**Key:** Score between 1 and 2 is low quality; score between 3 and 4 is moderate quality, score of 5 is high quality.

Table 3.5 Quality appraisal of the economic evaluation studies (Joanna Briggs Institute, 2022)

Citation	Q1. Is there a well-defined question?	Q2. Is there comprehensive description of alternatives?	Q3. Are all important and relevant costs and outcomes for each alternative identified?	Q4. Has clinical effectiveness been established	Q5. Are costs and outcomes measured accurately?	Q6. Are costs and outcomes valued credibly	Q7. Are costs and outcomes adjusted for differential timing?	Q8. Is there an incremental analysis of costs and consequences?	Q9. Were sensitivity analyses conducted to investigate uncertainty in estimates of cost or consequences?	Q10. Do study results include all issues of concern to users?	Q11. Are the results generalizable to the setting of interest in the review?	Quality Appraisal
Engel et al 2021	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/11 High

**Key:** Score between 1 and 4 is low quality; score between 5 and 8 is moderate quality; score between 9 and 11 is high quality.

## Appendix 4 – Grey literature sources

#	Source of grey literature	Last date searched	Number found in search	Number included in review
1.	<a href="#">JISC Library Hub Discovery</a>	15/04/2025	166	0
2.	<a href="#">The King's Fund Library Catalogue</a>	15/04/2025	9	0
3.	<a href="#">Trip Medical Database</a>	15/04/2025	2	0
4.	<a href="#">Welcome to GOV.UK</a> (First 50 hits)	15/04/2025	50	0
5.	<a href="#">Home   The Health Foundation</a>	15/04/2025	1	0
6.	<a href="#">Home   NHS Transformation Directorate</a> (First 50 hits)	15/04/2025	50	0
7.	<a href="#">Google Scholar</a> (First 50 hits)	15/04/2025	50	0
8.	WCVA Newsletter request	16/06/2025	15	1
	<b>Total</b>		<b>343</b>	<b>1</b>

*List of grey literature from WCVA newsletter request*

Grey literature was sought from WCVA stakeholders throughout Wales, via a news article and circulated to WCVA's networks. N = 15 pieces of grey literature were gathered from voluntary sector agencies in the United Kingdom (UK) including Age Cymru, Bipolar UK, Carers Trust Wales, Citizens Advice Cymru, Health and Care Research Wales, National Churches Trust, The House of Good, Home-Start, Medrwn Môn, New Horizons, and Race Equality First (REF). However, only one of the grey literature collected were included in the review. The other grey literature were not included in the review due to either not focussing on the voluntary sector, not focussing on health economic evaluations or did not include clear and focussed methodology sections.

#	Author and date (including weblink or doi where available)	Title	Included in the review (Yes or No)	Reason for not including the grey literature in the review
1.	<b>Age Cymru – West Glamorgan (Response to our request in 2025)</b>	The Economic Value of Age Cymru West Glamorgan in Health and Care Services	No	Although this report did include examples of how Age Cymru West Glamorgan help carers, there was no economic evaluation study with clear methodology sections.
2.	<b>Bipolar UK (Response to our request in 2025)</b>	Bipolar Uk – Voluntary sector response	No	Although this brief report did include examples of how Bipolar UK help clients, there was no economic evaluation study with clear methodology

				sections within this report.
3.	<b>Carers Trust Wales (Response to our request in 2025)</b>	Short Breaks Scheme and reducing the burden on health and care services: Briefing for WCVA and USW	No	Although this report did include examples of how Carers Trust Wales help carers, there was no economic evaluation study with clear methodology sections.
4.	<b>Citizens Advice Cymru – Gwent (2025)</b> <a href="#">SHARED WCVA USW Citizens Advice Cymru - Advice_ tackling the social determinants of ill health May 2025.pdf</a>	Citizens Advice Cymru Advice and Healthcare Impact data	No	Three slide document. Lack of methodological details.
5.	<b>Health and Care Research Wales (2025)</b>	Parental Advocacy in Wales: A Mixed-Methods Evaluation of its Effectiveness in Supporting Parents	No	Although this report included mixed methods evaluation regarding parental advocacy in Wales, there was no economic evaluation study with clear methodology sections.
6.	<b>National Churches Trust</b> <a href="https://www.nationalchurchestrust.org/thehouseofgood">https://www.nationalchurchestrust.org/thehouseofgood</a>	The house of good	No	The website did not include a clear methodology section. General information about where to get help.

7.	<b>The House of Good</b> <a href="#">GADS1880 – NCT - House of Good – Health Report WEB 09.10.2024.pdf</a>	House of Good: Health report	No	General cost benefit of churches based on Wellby's – no specific methodology of a specific intervention.
8.	<b>The House of Good</b> <a href="#">GADS1468 – NCT full Exec Summary and Technical Report-V13 WEB.pdf</a>	The House of Good: The economic and social value of church buildings in the UK. Key findings and technical report.	Yes	Social Return on Investment technical report included.
9.	<b>Home-Start Leeds (2023)</b> <a href="#">Home-Start Leeds : Parent to Parent Service</a>	Home-Start Leeds: 'Parent to Parent' Year Three & Service Evaluation Report	No	Although this report did include case studies and costs, there was no economic evaluation study with clear methodology sections.
10.	<b>Medrwn Môn (no date)</b>	The social impact of the 'technology in care' project	No	Poster only. Lack of methodological details.
11.	<b>New Horizons (2020)</b> <a href="#">New Horizons -RC report- 2020 Oct.pdf</a>	New Horizons: Report into data collected 2015-2019.	No	Although this New Horizons report did not include health economic evaluation, a paper by Kay and Edgley (2019) on Recovery Colleges was included in the review as it was a cost-analysis study.

12.	<b>Race Equality First (no date)</b> <u>“The Health Fair saved my mums life”</u>	The Health Fair saved my mums life	No	Case study description only with no health economic evaluation.
13.	<b>Race Equality First (REF) (2025)</b>	Race Equality First (REF): Submission to WCVA Call for Evidence – The Economic Value of the Voluntary Sector in Health and Care Services	No	Although this brief report did include examples and some financial costs, there was no economic evaluation study with clear methodology sections.
14.	<b>Warner et al (2021)</b> <a href="#">Improvements in Parental Emotional Well-Being During Home Visiting Support: What Works for Whom?   The British Journal of Social Work   Oxford Academic</a>	Improvements in Parental Emotional Well-Being During Home Visiting Support: What Works for Whom?	No	Paid support workers (not voluntary sector) and no health economic evaluation
15.	<b>Young &amp; Kenkre (2015)</b> <a href="#">vims_report_2015.pdf</a>	The impact of volunteering on volunteers: Home-starts volunteer impact management system [VIMS] London pilot study	No	Although the impact of volunteering was considered, there was no health economic evaluation in the report.

## Appendix 5 – Table of abbreviations

<b>Abbreviation</b>	<b>Abbreviation in full</b>
ActWELL	A novel approach to increasing community capacity for weight management a volunteer-delivered programme.
ASSIA	Applied Social Sciences Index and Abstracts
BMI	Body Mass Index
CAB	Citizens Advice Bureau
CAP	Citizens Advice on Prescription
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CMHT	Community Mental Health Team
EMBASE	Excerpta Medica Database
FEP	Friendship Enrichment Programme
FTE	Full Time Equivalent
GDS-LD	Glasgow Depression Scale for people with a Learning Disability
GP	General Practitioner
HB	Health Board
HRQoL	Health Related Quality of Life
HSE	Irish Health Service Executive (HSE)
ICER	Incremental Cost Effectiveness Ratio
LA	Local Authority
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
Non-RCT	Non-Randomised Controlled Trial (experimental study without true randomisation)
PALS	Project About Loneliness and Social networks (study name)
PCDS	Palliative Care Day Services
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PubMed	Public/Publisher MEDLINE
QALY	Quality Adjusted Life Year
QoL	Quality of Life
REF	Race Equality First
RCSI	Royal College of Surgeons in Ireland
RCT	Randomised Controlled Trial
SDS	Supported Discharge Service
SMI	Severe Mental Illness
SPIDER	<ul style="list-style-type: none"> <li>• <b>Sample:</b> The group of people being studied.</li> <li>• <b>PI (Phenomenon of Interest):</b> The specific experiences, behaviours, or conditions being examined.</li> <li>• <b>Design:</b> The type of study design used (e.g., qualitative, mixed-methods).</li> <li>• <b>Evaluation:</b> The outcomes or measures used to assess the phenomenon of interest.</li> </ul> <p><b>Research type:</b> The overall approach to the research (e.g., qualitative, quantitative, mixed-methods).</p>
SROI	Social Return of Investment (SROI)
STAG	Students for Treborth Action Group

TBG	Treborth Botanic Garden (Bangor, North Wales)
UCLA	University of California, Los Angeles Loneliness Scale (UCLA)
UK	United Kingdom
USA	United States of America
VICT	Volunteer-led internet and computer training
WCRC	Windsor Connection Resource Center
WCVA	Wales Council for Voluntary Action is the national membership body for voluntary organisations in Wales.
WELLBY	Wellbeing-years (WELLBYs): This metric is based on changes in life satisfaction, measured on a scale from 0 to 10. A one-point improvement in life satisfaction for one year equals one WELLBY.
WFL	Wellbeing For Life (study name)
WRAs	Welfare Rights Advisors
WTP	Willingness To Pay

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