WellFed veg box social prescribing pilot

Interim evaluation report

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University of Bath · Cornwall Council · Cornwall VSF · Volunteer Cornwall · Cornwall Greener Practice · Sustainable Food Cornwall · active Cornwall · Cardiff University / Prifysgol Caerdydd · Centre for Climate Change and Social Transformations

About WellFed

The WellFed network is a collaborative group of healthcare professionals, food growers, and community partners aiming to integrate health and food systems. The WellFed programme is a 'test and learn' pilot aimed at supporting individuals at risk of or with early-stage type 2 diabetes. Participants are prescribed free veg boxes of local, agroecologically grown food, together with support to make dietary and lifestyle changes that could benefit their health and wellbeing. The WellFed programme is coordinated by the Health and Climate Resilience Team at Volunteer Cornwall, with support from NHS Cornwall & Isles of Scilly, Cornwall Council Public Health, and other project partners. For further details, see: WellFed – Health and Climate Resilience | Volunteer Cornwall

About CAST

Led by the University of Bath, the UK Centre for Climate Change and Social Transformations (CAST) is a collaboration between Bath, Cardiff, Manchester, and East Anglia universities, and the charity Climate Outreach. The Centre aims to be a global hub for understanding the profound changes required to address climate change. We research and develop the social transformations needed to produce a low-carbon and sustainable society. CAST is funded by the Economic and Social Research Council (ESRC). For further details, see: https://cast.ac.uk/

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Acknowledgements

The project lead for the WellFed pilot, Claire Judd supported by Annette Eatock, made a significant contribution to this evaluation study by engaging delivery partners and overseeing data collection activities. Social prescribers, health coaches and community food growers also made important contributions, not only in the pilot delivery, but also by facilitating survey and interview data collection. They are: Kathy Ellwand, Emma Hill, Sophia Warren, Jenny Hindson, Manda Field, Lynne Dyer, Izzy Webb, Emma Seward-Adams, Jacqui Robbins, Tarna Morrison, Laura Williams and Klara Sudbury. Nick Nash (University of Bath) and Caroline Verfuerth (Cardiff University) supported with the initial research design.

The WellFed pilot is funded by Cornwall Council and the NHS Cornwall and Isles of Scilly Integrated Care Areas. This evaluation study was funded by the UKRI agrifood4netzero Scoping Study Awards.

Executive summary

The WellFed programme is a 'test and learn' pilot which aims to reduce the risks of type 2 diabetes through social prescribing of healthy food. The two-year pilot (2025/26) is delivered through a network of local partners in Cornwall, including GP surgeries, social prescribers, health coaches, and community food growers. Researchers from the Centre for Climate Change and Social Transformations (CAST) are conducting an independent evaluation study to evidence pilot outcomes; this report presents initial findings at the interim stage.

There are three components of the WellFed intervention: 1) a free weekly veg box for 3 – 6 months, supplied by a local grower that uses agroecological farming practices; 2) group cooking classes to increase participants' confidence and competence in preparing healthy meals, and 3) wider support from social prescribers, health coaches, and growers such as dietary advice, or signposting further opportunities for community engagement.

Findings in this report are based on 1) a pre- & post-intervention survey which identified changes in participants' diet, health, and wellbeing (pilot participants n=17; control group n=300), and 2) interviews which explored participants' experiences of the pilot (n=20). The WellFed pilot is ongoing and future data collection activities include a delivery partner survey and a social return on investment analysis; the final evaluation report is due in March 2027.

Interim findings indicate several positive outcomes for the pilot participants: healthier diets, increased confidence in buying and cooking fresh vegetables, improved physical health and wellbeing, more frequent physical activity, and increased community engagement. Notably, most participants reported a reduction in their HbA1c (i.e., blood glucose level) and the average HbA1c level decreased from the diabetic range to the pre-diabetic range over the intervention period. These preliminary findings suggest a promising reduction in type 2 diabetes risks, although more evidence is needed to confirm this.

Key learnings from the pilot so far include: 1) the cooking classes increase food competences but also create a space for social connection and peer support; 2) participants look forward to receiving their veg box and become interested in using different vegetables; this inspires creativity in their cooking, which in turn supports healthier eating; 3) some participants' prepare healthy meals for members of their household and so their participation in the pilot positively influences the diets of people around them; and 4) participants have embedded healthy food habits into their daily routines, for example, by preparing packed lunches to avoid relying on unhealthy food environments; this increases the likelihood of sustaining dietary changes.

1 Overview of the WellFed pilot

The WellFed programme is a 'test and learn' pilot which aims to reduce the risks of type 2 diabetes through social prescribing of healthy food. The pilot is coordinated by Volunteer Cornwall and is delivered through a network of local partners including GP surgeries, social prescribers, health coaches, and community food growers. The pilot is funded by Cornwall Council Public Health and the three NHS Integrated Care Areas in Cornwall[1].

This report presents interim findings from an evaluation study which measures the pilot outcomes; it focuses on the experiences of individuals who were prescribed healthy food during the first WellFed cohort in 2025. A separate report, produced by the WellFed project lead, presents case studies from three pilot areas and summarises key learnings for the programme delivery[2].

What problem is the WellFed programme trying to solve?

In 2024/25, 7.6% of registered patients aged 17 and over in Cornwall had a recorded diagnosis of diabetes[3]. There are 38,418 registered diabetes patients in Cornwall and around 90% (or 33,710 patients) have type 2 diabetes[4]. The rate of type 2 diabetes is increasing

[1] The WellFed programme is funded by Cornwall Council and NHS Cornwall & Isles of Scilly. This evaluation study is funded by the UKRI Agrifood4netzero network+ Scoping Study Awards: Funded Scoping Studies - AFN Network+ (Also see: https://rootandreason.org.uk/).

[2] The 'Wellfed project: case studies & delivery report for interim evaluation' written by Claire Judd, the WellFed project lead, can be accessed from Volunteer Cornwall's website: WellFed – Health and Climate Resilience | Volunteer Cornwall.

[3] This is comparable with levels of type 2 diabetes in England. See: Office for Health Improvement Disparities (2025), Diabetes profile: statistical commentary, March 2025 - GOV.UK.

[4] GeraClinic.com (2026), Diabetes Prevalence in Cornwall and the Isles of Scilly — NHS QOF 2024/25 | GeraClinic ; NHS Cornwall & Isles of Scilly (2026), Diabetes - NHS Cornwall and Isles of Scilly.

nationally and in Cornwall, particularly among people under the age of 40[5]. In addition, the estimated prevalence of non-diabetic hyperglycaemia (i.e., pre-diabetes) in Cornwall is particularly high compared to the rest of England[6], which means many people are at risk of developing type 2 diabetes in the future[7]. This leads to negative health outcomes for those individuals as well as increased demand for health care services[8].

Encouragingly, lifestyle changes focusing on diet, physical activity and weight loss can reduce the risks of type 2 diabetes[9]. It is in this context that the WellFed programme was developed – a 'test and learn' pilot[10] to explore how effective a community-based social prescribing intervention is in supporting people to eat a healthier diet[11], reduce health risks, manage their condition, and improve their wellbeing.

How does the WellFed programme try to solve this problem?

Patients registered with a GP surgery in the pilot areas can be referred to the pilot by their doctor, social prescriber or health coach[12]. The eligibility criteria are:

1. a recent diagnosis of type 2 diabetes, indicated by a HbA1c level of 48 mmol/mol or above (i.e., blood glucose level[13])
2. a pre-diabetic / non-diabetic hypergylcaemia diagnosis, indicated by a HbA1c level of 42 – 47 mmol/mol

The intervention aims to reduce HbA1c level for pilot participants (referred to as 'clients' in this report) with type 2 diabetes and those who are pre-diabetic. There are three components of the intervention:

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[5] Diabetes UK (2024), Reverse the trend report | Diabetes UK ; Cornish Times (2024), Number of young people in Cornwall and the Isles of Scilly with diabetes rises by a quarter | Cornish times.
[6] Office for Health Improvement Disparities (2026), Diabetes profile: statistical commentary, April 2026 - GOV.UK
[7] Approximately 12 million adults are estimated to be living with diabetes or pre-diabetes in the UK. Diabetes UK (2026), How many people in the UK have diabetes?.
[8] Diabetes UK (2026), Regional Facts and Stats Dashboard | Diabetes UK ; NHS Cornwall & Isles of Scilly (2026), Diabetes - NHS Cornwall and Isles of Scilly.
[9] Diabetes UK (2026), How many people in the UK have diabetes?. There are a range of support options available in Cornwall: Type 2 Diabetes Prevention and Management - Healthy Cornwall ; Available Support for People Living with Type 2 Diabetes - Healthy Cornwall.
[10] The WellFed programme was inspired by an initial veg box trial by Watergate Primary Care Network in partnership with Newquay Orchard. This trial involved 6 clients and found promising results in terms of reductions in HbA1c, cholesterol, weight and Body Mass Index.
[11] The NHS defines a healthy diet in The Eatwell Guide - NHS and this guidance informed this intervention. Also see: 5 A Day: what counts? - NHS.
[12] The recruitment materials can be found in Appendix 7.
[13] Hemoglobin A1c (HbA1c), also called glycated hemoglobin, reflects the percentage of hemoglobin in red blood cells that has glucose attached to it. HbA1c captures long-term glycemic control by using a weighted average of blood glucose over the previous 8–12 weeks and so is considered the most accurate measurement for monitoring and predicting diabetes-related problems. See: Mehta et al. (2025), "Insights into HbA1c: Key Role in Diabetes Screening and Associated Conditions" - A Comprehensive Review - PMC.

1. A free weekly veg box for 3 – 6 months[14], supplied by a local community grower that uses agroecological farming practices.
2. Group cooking classes which aim to increase clients' food competences; these 'chop and chat' sessions suggest recipes using ingredients from the veg box each week and provide a social space to connect with other pilot participants.
3. Wider support from social prescribers, health coaches, and community growers. They offer dietary advice, highlight additional opportunities in the local community which may benefit clients, and collect data for evaluation study.

Some clients also take part in optional volunteer sessions in community gardens at the growers' sites, where this is available.

The pilot locations and delivery partners

Table 1 shows the GP surgeries that refer clients to the WellFed programme and the community growers that provide the veg boxes and cooking classes[15]. There are 15 pilots in total, and each individual pilot consists of approximately six clients[16].

Table 1, WellFed Cornwall locations and delivery partners

Location	GP Surgeries	Community growers
West Integrated Care Area		
Penzance	Atlantic Surgery, Rosmellyn Surgery, Sunnyside Surgery	Growing Links
St Just	Atlantic Surgery	Bosavern Community Farm
Redruth	Harris Memorial Surgery	Grassroots Garden, Food Troops
Hayle	Bodriggy Surgery	Sustainable Hayle, The Good Shepherd, Kehelland Trust
St Ives	St Ives Stennack	St Ives Community Orchard, Kellehand Trust (tbc)
Helston	Cober Valley Health, Helston Medical Centre	POM
Isles of Scilly	St Mary's Health Centre	Salakee Farm

[14] The frequency of veg box delivery varied; most clients received weekly veg boxes, but two clients in Cohort 1 received fortnightly veg boxes to align with their shift work pattern.
[15] The cooking classes are provided by a grower or a charity, depending on the pilot location and the local support networks that are available.
[16] The more established pilots, such as Watergate PCN & Newquay Orchard, have now run the WellFed programmes up to 3 times, with different cohorts of clients.

Location	GP Surgeries	Community growers
Camborne	Veor Surgery	Healthy Cornwall, Transformation CPR, Kehelland Trust
Redruth / Pool	Carn to Coast Surgeries	Community Roots
Central Integrated Care Area		
Newquay	Watergate PCN surgeries	Newquay Orchard
St Agnes & Porthtowan	Coastal PCN surgeries	Goonown Growers, Community Roots
Falmouth & Penryn	Falmouth Health Centre	Loveland, Falmouth Food Coop
Truro	Three Spires Medical Practice	CHAOS Farm
North and East Integrated Care Area		
Launceston	Launceston & Tamar Valley Health PCN	Tamar Grow Local
Callington	Launceston & Tamar Valley Health PCN	Tamar Grow Local

The pilot is overseen by a steering group comprising members of NHS Cornwall & Isles of Scilly, Cornwall Council Public Health, Royal Cornwall Hospitals Trust, Volunteer Cornwall, Cornwall Voluntary Sector Forum, Active Cornwall, Sustainable Food Cornwall, and the Universities of Bath and Cardiff.

2 Evaluation study methodology

The WellFed Theory of Change and the Logic Model (Figure 1) are tools which guide the pilot delivery. The Theory of Change presents the rationale and causal logic which underpins the WellFed intervention and the Logic Model provides an overview of how the project will be delivered. These tools were co-developed with WellFed delivery partners and steering group members during two workshops in May & June 2024.

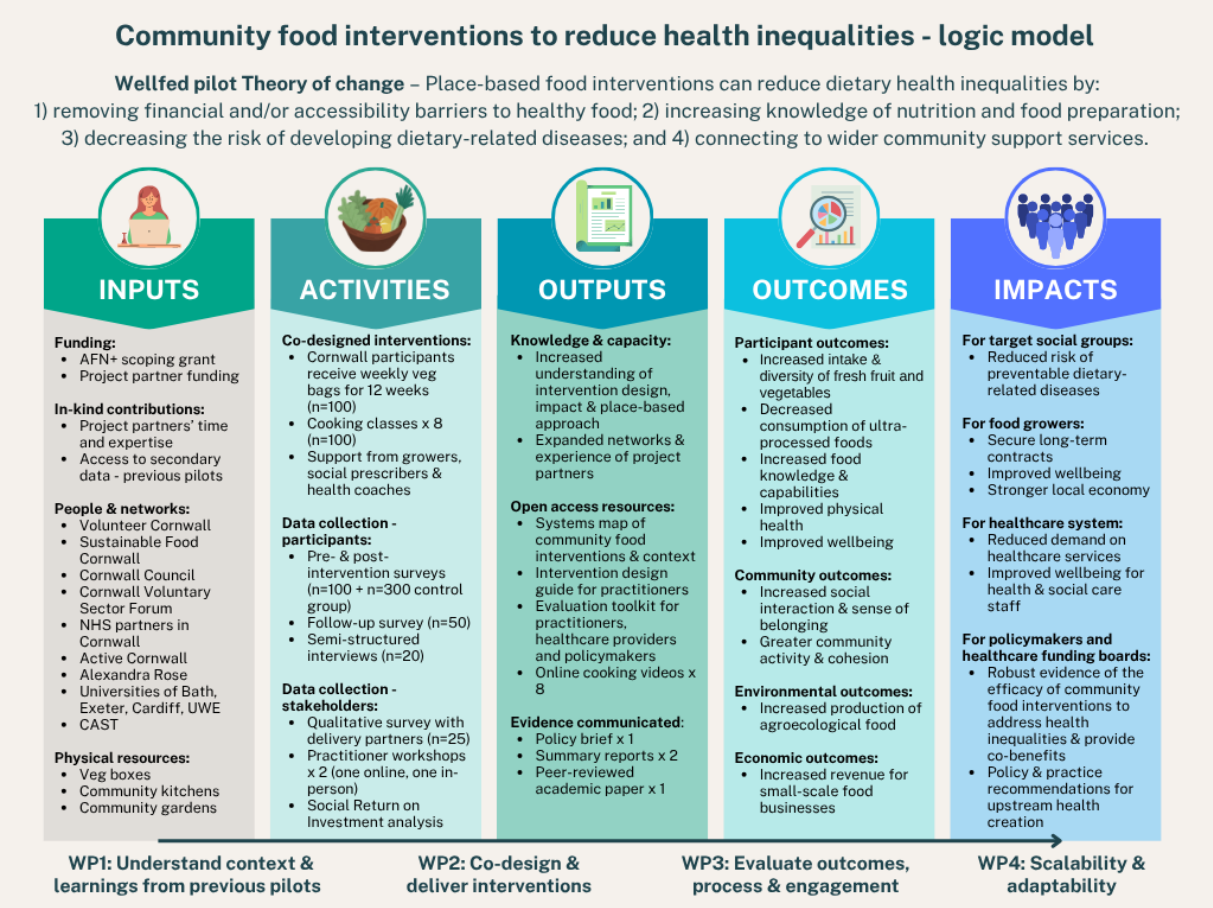


Figure 1, the WellFed Cornwall Theory of Change and Logic Model

Following our Theory of Change (Figure 1), this evaluation study seeks to evidence nine outcomes of the WellFed programme. These outcomes relate to three social groups: dietary, health and wellbeing benefits for clients who take part in the pilot; social and economic benefits for community growers who provide the veg boxes; and wellbeing benefits for health and social care practitioners who support the clients. There are also societal outcomes: reduced demand for diabetes treatment and the potential cost savings for the health care system; a more resilient and equitable food system; and reducing CO_2 emissions.

This evaluation approach is informed by the experience of health and social care practitioners; that a community-level health intervention may have multiple benefits which can be measured, rather than a narrow focus on one indicator of success (but without lessening the importance of the core outcome, in this case, reduced risks of type 2 diabetes).

The WellFed data collection framework (Figure 2) presents the nine outcomes (the inner circle) as well as the metrics we use to determine whether, and to what extent, these outcomes are achieved (outer circle). This framework was developed with input from WellFed

steering group members, together with insights from our scoping review[17] of existing metrics, in July 2024.

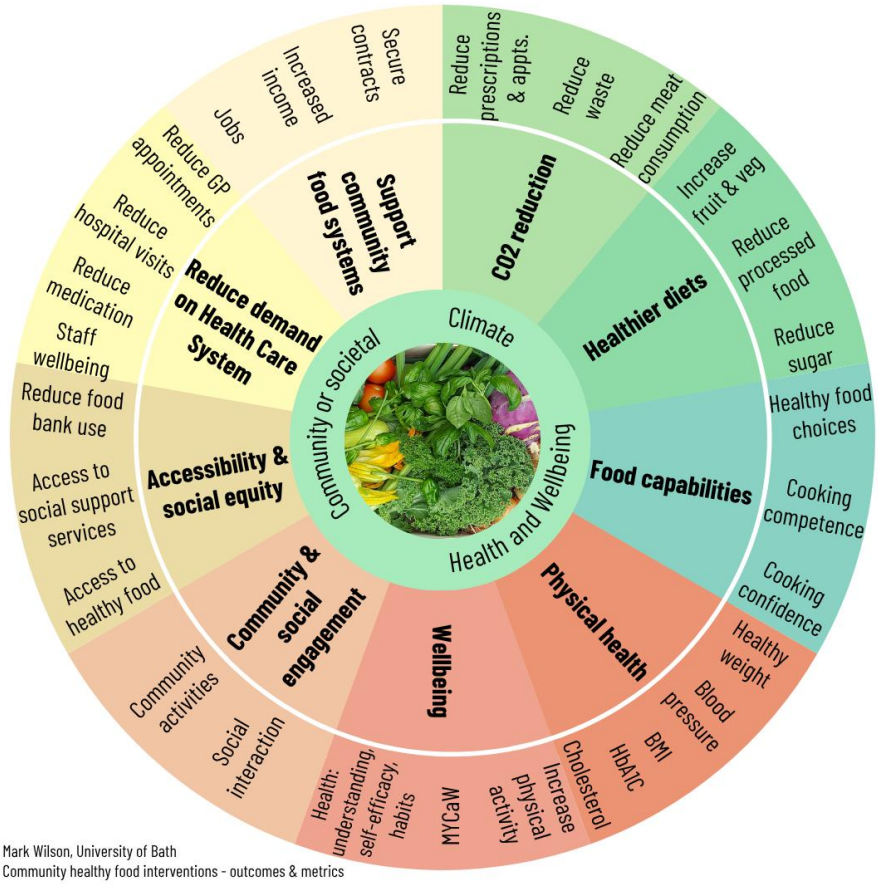


Figure 2, the WellFed Cornwall data collection framework

A mixed-method approach is used to collect data for each outcome. Table 2 provides an overview of the methods and indicates which data is presented in this evaluation report (or will be presented in the final evaluation report, due in March 2027). Data collection is ongoing and the remaining activities are scheduled to take place towards the end of the pilot, in December 2026.

The evaluation study methodology is described in more detail in Appendix 5.2, and the limitations of this study are presented in Appendix 5.1.

[17] This review considered what metrics are currently used in community food or health and social care contexts for all 9 outcomes presented in the data collection framework. See: Nash et al. (2024) https://cast.ac.uk/wp-content/uploads/2025/03/the-centre-for-climate-change-and-social-transformations-cast-report-community-healthy-food-interventions-review-of-outcome-metrics-and-toolkits-for-cornwall-council-and-the-well-fed-cornwall-network.pdf.

Table 2, Methods used in the WellFed pilot evaluation study

Method	Data included in this interim evaluation report	Data to be included in final evaluation report
1. Pre- and post-intervention survey with clients Pre-intervention survey with control group of Cornwall residents[18] (quantitative data)	client n=17[19] control group n=300	estimated client n=122 control group n=300
2. Post-intervention interview with clients (qualitative data)	n=20	n=20
3. Anonymised patient data[20] relating to clients' dietary health (quantitative data)	–	estimated client n=122
4. Monitoring data on clients' participation in community activities (quantitative data)	–	no specific n
5. Social Return on Investment analysis to quantify financial, social and environmental returns, using the Social Value Engine tool (quantitative data)	–	One analysis based on estimated client n=122
6. Survey with WellFed delivery partners and steering group members (qualitative data)	–	n=25

WellFed pilot evaluation outputs

This interim evaluation report and Volunteer Cornwall's case study report[21] are the first two outputs from this study. Future outputs include the final evaluation report, a policy brief, an academic article, knowledge sharing workshops for practitioners and project partners, and online resources for clients[22].

[18] A control group of Cornwall residents (n=300), who did not receive the WellFed intervention, also completed the pre-intervention survey to compare their responses with clients and understand potential disparities in diet, health and wellbeing in Cornwall.

[19] Nineteen clients took part in WellFed in 2025, but two dropped out of the study prior to completing the post-intervention survey, due to personal reasons.

[20] This data is collected by GP surgeries as part of clients' routine treatment for type 2 diabetes. The use of patient data for this evaluation study is subject to: 1) NHS Health Research Authority ethics approval, 2) agreement by participating GP surgeries, and 3) clients' informed consent. At the time of writing this interim evaluation report, the WellFed pilot delivery team is working to put these three prerequisites in place; we will not request access to any anonymised patient data until all three steps have been completed.

[21] The 'Wellfed project: case studies & delivery report for interim evaluation' written by Claire Judd, the WellFed project lead, can be accessed from Volunteer Cornwall's website: WellFed – Health and Climate Resilience | Volunteer Cornwall.

[22] The online cooking videos will be produced by one of WellFed delivery partners, Newquay Orchard. They are intended to support participants who may face barriers attending the in-person classes (i.e., because they live in a rural area, they do not have their own transport, or they have work or caring commitments). They will also support the legacy of the pilot by providing publicly accessible resources.

3 Interim evaluation of the WellFed pilot

This section summarises the key findings at the interim stage of the pilot. As indicated in Table 2, these findings are based on 1) a pre- & post-intervention survey which identified changes in participants' diet, health, and wellbeing (pilot participants n=17; control group n=300), and 2) interviews which explored participants' experiences of the pilot (n=20).

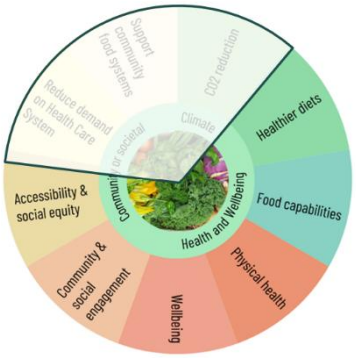
3.1 Who is taking part in the WellFed pilot?

Compared to a control group of Cornwall residents, WellFed clients tend to be older, and a higher proportion (58.8%) have a long-term health condition or disability that limits their normal day-to-day activities. Clients tend to have lower educational attainment, lower levels of full-time employment (although many are retired), and lower household income. A smaller proportion of clients have dependent children living at home, likely reflecting their older age profile. There was no difference between clients and the control group in terms of gender or ethnicity[23].

What are the outcomes for participants in the WellFed programme?

3.2 Outcomes for WellFed pilot participants

Six outcomes are evaluated based on available data at the interim stage, shown in the image to the right. The short summaries for each outcome presented below are based on survey data (see Appendices 5.3 & 5.5 of this report; quantitative data) and interview data (Appendix 5.4; qualitative). The footnotes indicate where the empirical data underpinning each summary can be found in the appendices.



Statistical tests were used to analyse the survey data and explore a) whether clients' diet, health and wellbeing changed over the intervention period, and b) differences between clients and the control group that might indicate wider diet and health inequalities in Cornwall. Throughout this report, 'SS' (i.e., statistically significant) is used where there is strong evidence that an observed change or difference is unlikely to be due to chance. Where findings are 'NS' (i.e., not statistically significant), we may still see a positive or negative trend in the data, but there is not yet enough evidence to conclude that this reflects a real change or difference rather than chance. This is particularly important at this interim stage because the relatively small number of clients (n=17) makes it harder to detect

[23] See Appendix 5.5.1.

statistically significant changes. Content and thematic analyses were conducted on interview data (qualitative) to provide further insights into clients' experiences of the pilot.

Does the WellFed programme result in healthier diets?

A shift to healthier diets is one key mechanism for reducing the risks of type 2 diabetes[24]. Clients tend to eat fewer portions of fruit and vegetables per day (4.6 portions), compared to the control group (5.6 portions; NS), although the survey identified a small increase in clients' vegetable consumption during the intervention (NS). Clients reported healthier food habits such as eating fruit as a snack more frequently, eating vegetables in cooked meals more frequently, and eating sugary or high-fat snacks less frequently (NS)[25]. These survey findings are supported by the interviews, for example: *"Before I wouldn't hesitate to buy a big packet of sweets and just eat them…[now] I'll more likely chomp on a carrot and a bowl of hummus."*

One expectation for this pilot was that receiving a weekly veg box may encourage a shift away from meat consumption, because of the increased quantity of vegetables entering the household. Clients reported an increase in the number of meat-free days each week in the survey (SS) and the interviews: *"I was a bit of a carnivore. Now vegetables are the main part of the meal for me, whereas they used to be a 'oh, just some carrots.'"*

Does the WellFed programme increase clients' food knowledge and capabilities?

Clients are less confident than the control group in buying and cooking fresh vegetables (NS). Encouragingly, clients reported an increase in their level of confidence for both activities in the post-intervention survey (Figure 3; SS).

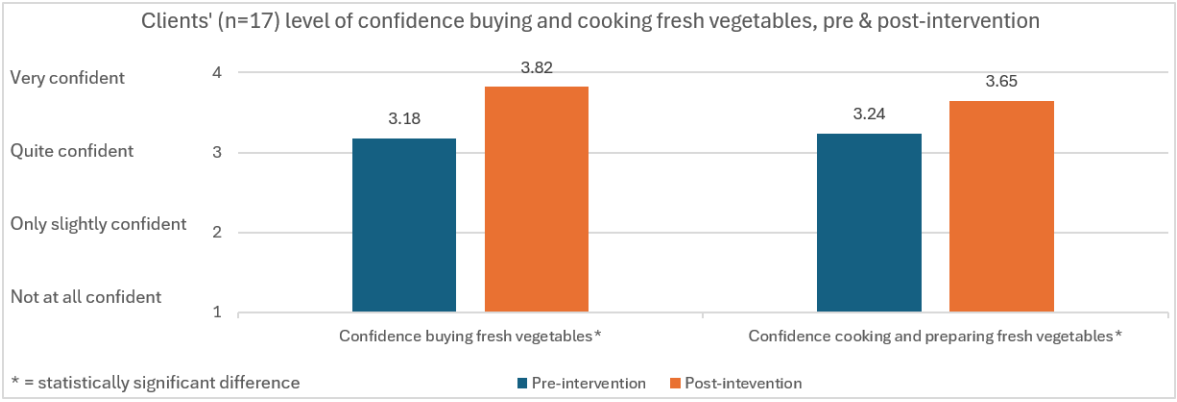


Figure 3, Clients' level of confidence buying and cooking fresh vegetables, pre- & post-intervention survey

[24] NHS Cornwall & Isles of Scilly (2026), Diabetes - NHS Cornwall and Isles of Scilly. Other mechanisms include medication and insulin.
[25] See Appendices 5.3.1, 5.4.1, 5.5.2.

Interview participants described learning specific skills such as batch cooking (n=6), meal planning (n=2), and reducing their food waste (n=12)[26]: *"I've learned a lot from, you know, the cookery classes and also experimenting with different veg that I wouldn't normally buy."* These findings indicate that dietary advice and group cooking classes, two components of the WellFed intervention, are effective in increasing food competences and enabling healthier food choices.

Does the WellFed programme improve clients' physical health?

Early findings suggest a promising reduction in type 2 diabetes risk, although more evidence is needed to confirm this. Seven clients reported a lower HbA1c level in the post-intervention survey, compared to their pre-intervention level, and only one client reported a (very slight) increase[27]. The average decrease in HbA1c across the entire sample was 4.86 mmol/mol over the intervention period and this reduction places the average post-intervention HbA1c within the pre-diabetic range, compared to the average pre-intervention HbA1c which was in the diabetic range (Table 3)[28].

Table 3, Clients' HbA1c level, pre- & post-intervention survey

	Pre-intervention (n=14[29])	Post-intervention (n=14)
Mean HbA1c level	50.79	45.93
Median HbA1c level	51.00	47.00

Clients used more health care services than people in the control group: they required more GP appointments, hospital visits, and prescriptions (SS), and these health disparities reinforce why targeted support is needed for some diabetes patients. The WellFed programme uses a 'patient activation' approach[30] by equipping clients with the knowledge and skills to eat a healthier diet and make positive lifestyle changes which will hopefully be continued when the intervention finishes. Clients reported an increase in their understanding of their health condition and their ability to maintain healthy lifestyle changes (Figure 4; NS)[31], for instance:

[26] See Appendices 5.3.2, 5.4.2, 5.5.3.
[27] Six clients reported the same HbA1c level; these clients may not have had a follow-up measurement of their HbA1c within the intervention period, and so it is likely they are referring to the same measurement (i.e., their pre-intervention HbA1c level).
[28] The pre-diabetic range is a HbA1c (i.e., blood glucose level) of 42 – 47 mmol/mol and the diabetic range is a HbA1c of 48 mmol/mol or above; Clients' pre-intervention mean and median HbA1c are both above 50 mmol/mol, but following the intervention the mean and median HbA1c both fall to below 47 mmol/mol.
[29] Some post-intervention measurements for clients' HbA1c level were missing in the survey, and so only 14 listwise comparisons were possible, hence n=14 rather than n=17.
[30] See Hibbard & Gilbert (2014), Supporting people to manage their health: An introduction to patient activation.
[31] See Appendices 5.3.3, 5.4.3, 5.4.4, 5.5.4.

"I think being able to achieve what I've done diet-wise over the last what five months, it shows me that I am capable of taking control and achieving things."

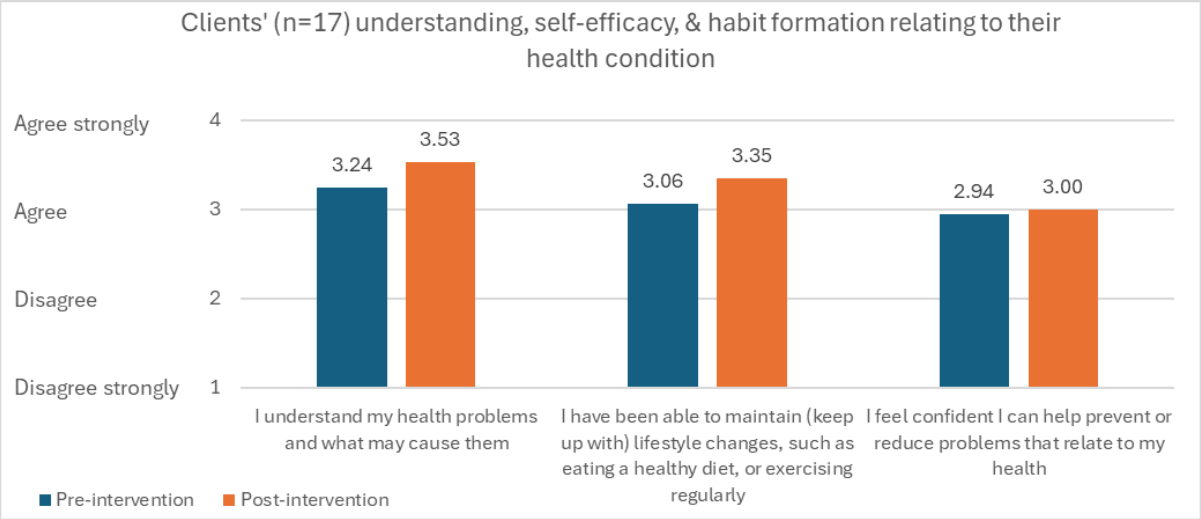


Figure 4, Clients' understanding, self-efficacy, and habit formation relating to their health condition, pre- & post-intervention survey

In the interviews, clients reported losing weight (n=11), feeling healthier (n=10), reducing their medication (n=5) and reducing their cholesterol (n=3). These positive outcomes suggest the pilot not only reduces the risks of type 2 diabetes, but also the risks associated with other health conditions which may be caused or exacerbated by poor diet.

Does the WellFed programme improve clients' wellbeing?

The survey integrated Meaningful Measures' Measure Yourself Concerns and Wellbeing (MYCaW)®, a tool widely used in health and social care settings to assess clients' wellbeing over time. Clients were asked to state one or two problems they are most worried about; the most reported problems were physical health concerns unrelated to diet (n=11), concerns about family members (n=5), and dietary-related health conditions (n=4). Clients' level of concern about these problems decreased during the pilot and their overall feeling of wellbeing improved (NS)[32]: *"I just feel good. I feel happy, yeah, positive…it's definitely benefited both of us health wise, mentally, every way."*

Does the WellFed programme increase clients' levels of physical activity?

Clients exercise less frequently and report a lower ability to be physically active, compared to the control group (NS). The WellFed programme may encourage physical activity directly because of opportunities to participate in community gardening, or indirectly because clients are feeling healthier and so have more energy or motivation for doing exercise. This study

[32] See Appendices 5.3.4, 5.4.5, 5.5.5.

found clients increased their frequency of exercise over the intervention period from 3.1 to 4.3 days per week, and the proportion who exercise every day rose from 11.8% to 29.4% (NS). They also reported an increase in their opportunity and their ability to be physically active (NS)[33]: *"I've got more confidence with physical activity…before I'd think 'that's not for me, people will look at me, look at my size' and be conscious of myself…but now I think…'we're all the same, aren't we?'"*

Does the WellFed programme encourage engagement in community activities?

Clients reported an increase in how often they participate in local activities such as social clubs or exercise groups (NS). Clients also feel part of their community more often (NS) and they reported an increase in knowing how to get the support they need (SS; Figure 5)[34]. This suggests the personalised support they receive from social prescribers and health coaches is effective at helping clients access wider services.

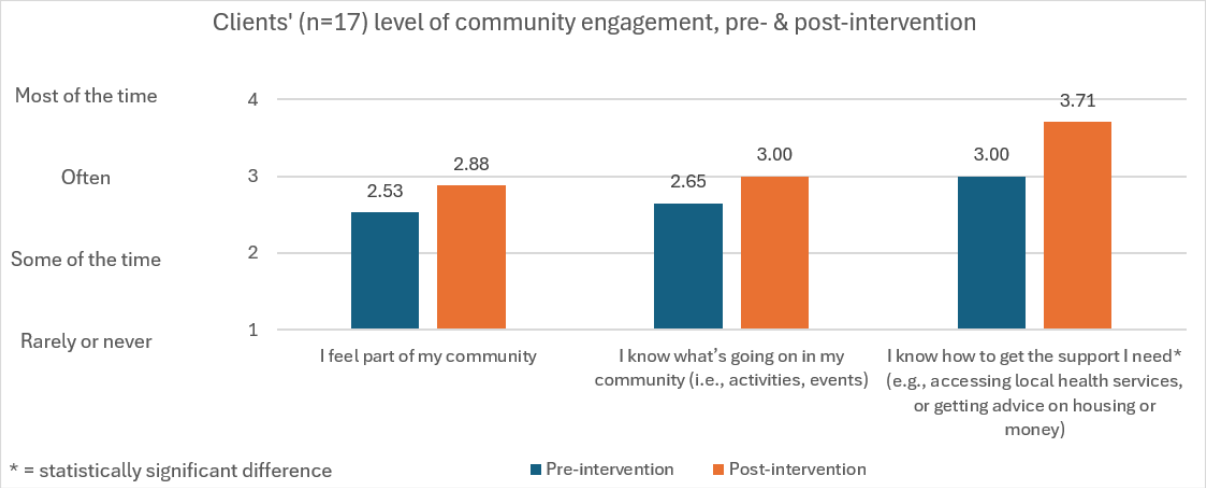


Figure 5, Clients' level of feeling connected and involved in their local community, pre & post-intervention survey

Most interview respondents (n=17) highlighted how the WellFed activities - the group cooking sessions and the community gardening - provide regular opportunities for social interaction and peer support. Clients described how the community growers and their fellow pilot participants created a friendly and inclusive environment in these sessions: *"That's been a huge part of it for me. It's the people that have made it. I just really felt that I could just switch off all my problems and be myself while I was there."*

[33] See Appendices 5.3.5, 5.4.6, 5.5.6.
[34] See Appendices 5.3.6, 5.4.7, 5.5.7.

Does the WellFed programme reduce inequalities in access to healthier food?

Clients may face multiple barriers in accessing healthy food and so they were asked about reasons why they may not eat enough fruit and vegetables. Cost, poor quality or freshness, and inadequate storage space in the kitchen were the three most reported barriers, both for clients and for the control group. Encouragingly, all barriers were less prominent in the post-intervention survey and the proportion of clients who did not experience any barriers at all increased from 29.4% to 41.2% (NS)[35]. The intervention partially mitigated cost as a barrier for clients experiencing financial constraints (NS), for example: *"The support within those 12 weeks financially was a great help…yeah, it helped 100%. Because that's a whole bag of veg that you don't have to buy for that week."*

What have we learnt about the design and delivery of healthy food social prescribing initiatives?

4 Key learnings from the WellFed pilot

The final section of this report presents four key learnings from the pilot at the interim stage.

4.1 Clients' feedback on their experience of the WellFed pilot

Figure 6 shows most clients (90.9%) were 'extremely satisfied' or 'satisfied' with their experience of taking part in the pilot and this positive feedback is reflected in the interviews (n=15): *"I think it's a good programme for anybody, to change the way they live and also to improve their health…got to be good for the NHS, got to be good for people's health, pain, everything. I just think it's a really good thing to do."*

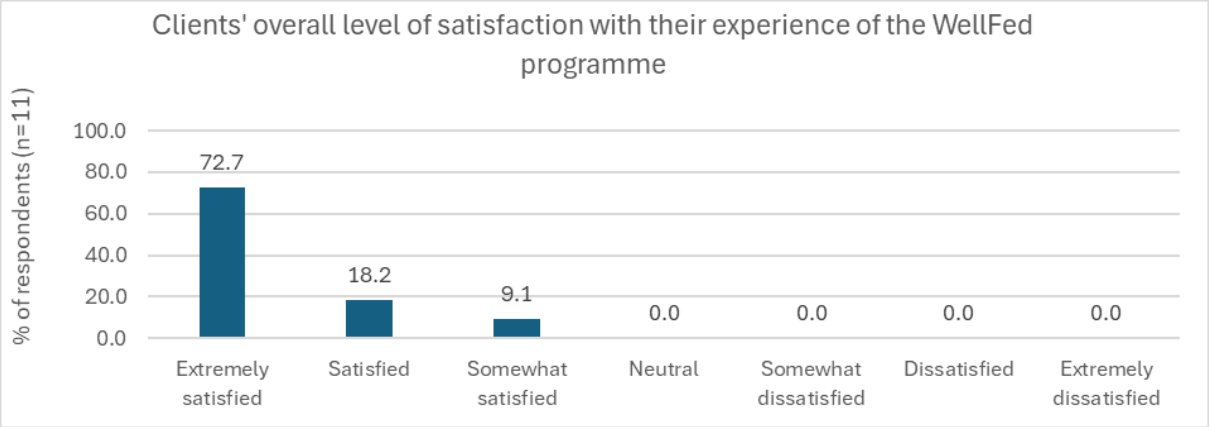


Figure 6, Clients' overall level of satisfaction of their experience of the WellFed programme

[35] See Appendices 5.3.7, 5.4.9, 5.5.8

Clients described how the WellFed model differs from other diet programmes they had attended, some of which focus on one-way information provision rather than developing practical skills or enabling peer support. Clients (n=6) appreciate this holistic approach, combining the different components: *"The food side of things, you know, apart from the people, which is a whole different side of the course for me, was the two halves make the whole. It wasn't just the food, or just the people, it was the whole."* The opportunity to collectively learn about cooking and the social connection this brings are therefore crucial elements of why the WellFed programme is effective; prescribing a veg box without the wider community engagement may not have such positive results.

Interview participants offered several useful recommendations for improving the pilot, such as making it available to more people (n=4), providing more cooking classes (n=3), keeping group sizes small (n=1), improving the accessibility of growers' sites (n=1), and offering a reduced rate for those who wish to continue the veg box when the pilot finishes (n=1)[36].

4.2 Enablers of a healthy diet

Clients described what works for them in changing their diet. Many (n=12) emphasised the support they receive from the pilot delivery partners, not only for dietary advice or linking them to the WellFed programme, but also for their empathy and being prepared to listen: *"So the social prescribing team just being so lovely…they were so personable and they seem so genuinely concerned….and that' the strength of this [programme], because there is an individual approach."*

A second enabler is the food itself. Clients emphasised the quality (n=9) and the variety of the vegetables (n=10). As the pilot progresses, they become more interested in fresh produce and deciding what meals they could cook: "*We look forward to it every week, coming to collect the bag and seeing what's in it and planning meals around what was in the bag."* Some clients (n=5) described how their meals now taste better: *"The difference in flavour with the organic vegetables, that's really enhanced it."* This discovery of less familiar vegetables and the culinary creativity this stimulates supports healthier eating.

Other enablers are more practical and relate to their kitchen space, for example, owning a freezer to store vegetables or batch cooked meals (n=3), buying kitchen appliances (n=2), or simply having more time to cook (n=1)[37].

[36] See Appendices 5.3.8, 5.4.13, 5.4.14.
[37] See Appendices 5.4.8, 5.4.11.

4.3 Improving the diet of household members

One encouraging finding is that clients' participation in the pilot can benefit others. Clients take the veg boxes and the recipes home with them, influencing the diet of family members they cook for (n=6): *"----- definitely found it more adventurous and able to try different vegetables. So it's become a kind of a family change. So it's not just me on my own working on things, it's combined and we've both seen weight drop off and improvement in our fatigue."* As indicated in this quote, family members may also have a dietary-related health condition and so would benefit from eating a healthier diet. They may also benefit from discussions in the household around healthy eating, food shopping, and lifestyle changes[38].

4.4 The role of habit in maintaining dietary changes

The challenge, as with any behaviour change intervention, is whether the positive outcomes continue beyond the intervention period. Promisingly, several clients (n=6) described how they have embedded healthy food habits into their daily routines. This could be through preparing packed lunches to avoid unhealthy food environments: *"I do work a couple of days a week now and I take my lunch and taking my homemade soup and some healthy snacks, rather than before when I'm going to the canteen and getting a full fat burger and a coke and a crunchy."* Another example is simply avoiding buying sugary snacks when food shopping, so unhealthy options are not readily available at home (n=5)[39]. This finding aligns with existing research on how behaviour change is more likely to be sustained if it becomes habitual[40].

Clients' sense of achievement

The final reflection is about clients' acknowledgement of their own progress. They intentionally change their diet, after some time they experience tangible health benefits, and they know that the person who is primarily responsible is themselves (n=10)[41]: *"I'm satisfied…I think that's a good way to describe, actually using the word 'satisfied'. I'm satisfied with what I've done."*

[38] See Appendix 5.4.1.

[39] See Appendices 5.4.1, 5.4.4.

[40] McCarthy M. B., Collins A. M., Flaherty S. J., and McCarthy S. N. (2017). Healthy eating habit: A role for goals, identity and self-control?. *Psychol Mark*. 2017; 34: 772–785. https://doi.org/10.1002/mar.21021
Also see: Verplanken, B., and Whitmarsh, L. (2021). Habit and climate change. *Current Opinion in Behavioral Sciences*, 42, 42-46. doi: 10.1016/j.cobeha.2021.02.020

[41] See Appendices 5.4.1, 5.4.4.

Appendices

5 Appendices

The appendices are as follows:

- Appendix 5.1 outlines the limitations of this evaluation study
- Appendix 5.2 is a more detailed description of the methodology
- Appendices 5.3 – 5.5 presents the empirical data collected in the evaluation study, at the interim stage
- Appendix 5.6 is the data collection protocols
- Appendix 5.7 is the recruitment materials for the programme

You can navigate to these sections by clicking on the section headings below:

5.1 Limitations of the evaluation study

There are four main limitations of this evaluation study, at the interim stage. The first limitation is the small sample size of clients for the pre- and post-intervention survey (n=17) and there are three reasons for this small sample. First, the intervention is relatively expensive and so cannot be widely rolled out, given that health care providers and local authorities face funding constraints. One rationale for this study is to evidence positive impacts for clients, community food growers, and the health care system, so these benefits can be evaluated against the intervention cost (i.e., the Social Return on Investment analysis). Second, two clients dropped out of the study, for personal reasons. High attrition rates are not unusual in intervention studies, particularly if the participants have a long-term health condition, and so a higher dropout rate was anticipated. Third, there were recruitment challenges in some pilots, particularly if a GP surgery did not have capacity to refer clients to the WellFed programme. In terms of the impact on the data, a sample size of n=17 is considered insufficient for some statistical tests and so the within- and between-group analyses presented in this report should be interpreted with caution. The second cohort of clients that will take part in WellFed during 2026 is estimated to be n=105 and so, combined with Cohort 1, this increased sample size will be sufficient for robust, statistical analysis.

A second limitation is a potential social desirability bias for clients when completing the survey. The surveys were conducted in person (as a conversation) to enable social prescribers, health coaches and community food growers to gain a better understanding of a client's individual situation and their needs with respect to their diet, health or wellbeing. This understanding would help social prescribers and growers to tailor their support for taking part in the pilot, as well as identify and signpost other relevant community activities in the client's local area. The impact on the data is that some clients may have adapted their survey responses to align with what they believe the interviewer would want to hear, for example, by underreporting their intake of sugary snacks. Although clients completing the survey independently would reduce the likelihood of a social desirability bias, supporting the clients through developing a better understanding of their needs was considered the higher priority.

A third limitation is a potential self-selection bias in the interview sample (n=20). Interview participants were recruited from Cohort 1 clients who had completed the post-intervention survey or had taken part in the initial Watergate Primary Care Network/Newquay Orchard veg box trial in 2023. The impact on the data is that more engaged clients may have chosen to take part in an interview and so would likely have a more favourable view of the pilot and its outcomes, relative to clients who chose not to take part in an interview. Nevertheless, the interviews provided valuable insights into clients' experiences of the pilot.

A fourth limitation relates to the control group, which was recruited via a market research company. Although the sample size (n=300) is more than adequate for statistical analysis, the control group would ideally be matched with the clients' health condition (i.e., a recent diagnosis of type-2 diabetes, or a pre-diabetic diagnosis) for direct comparability. However, the market research company was unable to provide a sample with this specific inclusion criteria. Another option for recruiting a control group was to apply a randomised controlled trial (RCT) design. However, this was considered unsuitable for two reasons. First, the intervention requires a high level of commitment from clients, and this must be discussed with them in advance to ensure they can make an informed decision about their participation (i.e., three months' duration of the intervention, weekly visits to collect their veg box, taking part in group cooking classes). Second, there are ethical considerations for using an RCT design in community settings, as the study participants who do not receive the intervention (i.e., the control group) may become aware they have not received it from study participants who do receive the intervention. In terms of the impact on the data, this control group is still considered to be a valid reference for identifying potential inequalities across Cornwall in terms of diet, health, wellbeing, and community engagement (see Appendix 5.5).

5.2 WellFed pilot evaluation study methodology

This appendix describes the data collection activities for measuring the pilot outcomes and evaluating its success. A mixed method approach was used for this study, combining multiple quantitative and qualitative datasets in order to achieve a more comprehensive understanding of the pilot outcomes.

5.2.1 Research questions

This study has seven research questions to guide the evaluation; questions 1 – 4 focus on client outcomes and questions 5 – 7 investigate potential community, societal or climate outcomes.

1. To what extent does the WellFed pilot result in healthier diets and increased food capabilities among clients?
2. To what extent does the WellFed pilot result in improvements in clients' physical health, including reducing the risks of type 2 diabetes?
3. To what extent does the WellFed pilot result in improved wellbeing and increased social interaction among clients?
4. To what extent does the WellFed pilot enable clients to manage their health condition and overcome barriers to eating a healthy diet?
5. Does the WellFed pilot provide an adequate social return on investment, considering outcomes for clients, community food growers, and health and social care practitioners?
6. Does the WellFed pilot reduce CO_2 emissions associated with dietary shift, minimising food waste, and reducing demand on the health care system?
7. What can we learn about the design and delivery of healthy food social prescribing initiatives?

Questions were included in the survey and interview protocols to provide data necessary for answering these research questions and evaluating the success of the pilot.

5.2.2 Pre- & post-intervention survey (quantitative data)

Clients (n=17) completed a questionnaire survey before and after they were prescribed the pilot activities to measure changes in their diet, cooking competences, health, wellbeing and community engagement. Clients completed these surveys in conversations with their social prescriber, health coach, or community food grower. Clients were assigned an anonymous ID code and their responses were recorded directly into the University of Bath's licenced QuestionPro survey platform. A control group of Cornwall residents (n=300), who did not receive the WellFed intervention, also completed the pre-intervention survey to compare their responses with clients and understand potential disparities in diet, health and wellbeing in Cornwall. The pre-intervention survey for Cohort 1 was run between July – September

2025 and constitutes the baseline for comparison with post-intervention survey data, which was collected between October 2025 – January 2026. Anonymised survey data was cleaned using Microsoft Excel and then analysed using IBM SPSS software.

Within-group statistical analysis identifies pre- and post-intervention changes in client (n=17) outcomes; the findings are presented in detail in Appendix 5.3. Between-group statistical analysis compares clients (n=17) with the control group (n=300); the findings can be found in Appendix 5.5. The survey protocols can be found in Appendices 5.6.1 and 5.6.2.

5.2.3 Semi-structured interviews (qualitative data)

Semi-structured interviews with clients (n=20) provide in-depth qualitative data on their experiences of taking part in the pilot. These interviews explored whether participation has influenced clients' diet and food competences or resulted in improvements in their health or wellbeing. Clients completed these interviews with their social prescriber, health coach, or community food grower between September 2025 – February 2026. Participation in the interviews was incentivised with a £25 Love2Shop voucher for each client. The interviews were recorded and transcribed using Microsoft Teams. Content and thematic analysis was conducted on the data through deductive and inductive coding, using Lumivero NVivo software. The interview findings are presented in detail in Appendix 5.4, and the interview protocol can be found in Appendix 5.6.3.

5.2.4 Planned data collection activities

There are four additional data collection activities which will occur towards the end of the pilot, in late Autumn 2026:

1) anonymised patient data relating to clients' dietary health (quantitative data, estimated n=122). This data is collected by GP surgeries as part of clients' routine treatment for type 2 diabetes. The use of patient data for this evaluation study is subject to: 1) NHS Health Research Authority ethics approval, 2) agreement by participating GP surgeries, and 3) clients' informed consent. At the time of writing this interim evaluation report, the WellFed pilot delivery team is working to put these three prerequisites in place; we will not request access to any anonymised patient data until all three steps have been completed

   The dietary health indicators we will request (with pre- & post-intervention measurements) are: HbA1c, cholesterol, blood pressure, Body Mass Index, and weight. We will also request the total number of GP appointments, hospital visits, and prescriptions in the 3 months immediately before the intervention and the 3 months immediately after the intervention; we request aggregate numbers only, we will not

access any details of clients' conversations with their GP or any other medical professional.

2) monitoring data on clients' participation in community activities. This anonymised, aggregated quantitative data is routinely collected by health and social care practitioners, local charities and community groups. This data will inform our understanding of whether clients increase their engagement in wider activities and support services in their local area.

3) a Social Return on Investment (SROI) analysis, using the Social Value Engine tool (quantitative and qualitative data, estimated n=122). The data which underpins this analysis is collected in the post-intervention survey and during client interviews. This analysis will be conducted when all the post-intervention surveys are completed. Cornwall Voluntary Sector Forum has expertise in SROI and is supporting the WellFed programme with this analysis.

4) a qualitative survey with WellFed delivery partners and steering group members (qualitative data, estimated n=25). These surveys will explore outcomes for the community food growers and health and social care practitioners that deliver the pilot. The surveys will also request feedback from delivery partners and steering group members on the relative success of the pilot in achieving its aims and invite suggestions for how the pilot design and delivery could be improved or adapted for other contexts.

Figure 7 is an overview of the WellFed pilot mixed method evaluation study. It maps the various datasets onto the WellFed data collection framework to (approximately) indicate which outcomes each dataset will evidence.

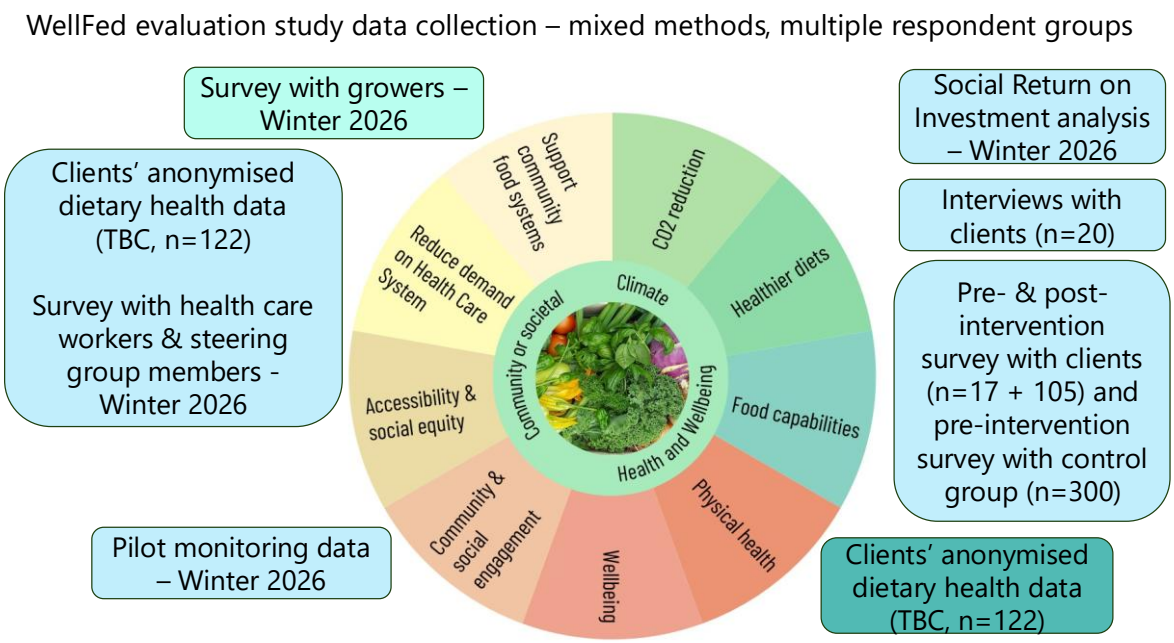


Figure 7, Overview of the WellFed pilot mixed method evaluation.

5.2.5 Research ethics committee review

The University of Bath Biomedical Research Ethics Committee reviewed the proposal for the WellFed pilot evaluation study; approval was received on 27th June 2025 and remains valid until 31st March 2027. The Research Ethics Committee reference number is 5682-6357. All client survey and interview data is anonymised at the point of data collection using anonymous ID codes. Thus, Mark Wilson, the researcher at the University of Bath who is evaluating the WellFed pilot, is unable to identify individual participants from their data. The recruitment materials, participant information sheets and consent forms can be found in Appendix 5.7.

5.2.6 Theoretical framework – the COM-B Model

The theoretical framework used for the WellFed evaluation study is the COM-B model and Behaviour Change Wheel[42], a widely used model for designing interventions and informing policy. According to the model, one or more of its components (i.e., an individual's capability, opportunity or motivation) must be changed to facilitate effective and long-standing behaviour change.

The blue circle presents nine intervention functions which support behaviour change; for example, WellFed uses training, education and enablement to encourage healthier diets and increased food competences. Finally, the outer circle of the wheel identifies seven policy categories that can enable or support these intervention functions.

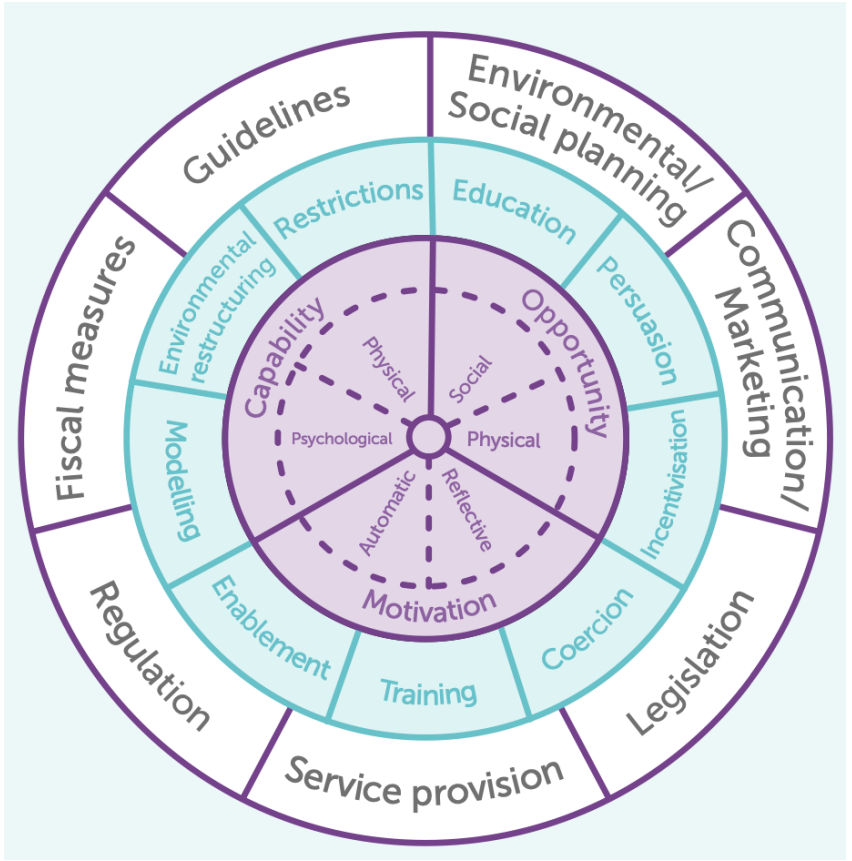


Figure 8, The COM-B model and Behaviour Change Wheel

[42] Original article: Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6:42. https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-42
Guide for the COM-B Model of Behaviour Change: https://social-change.co.uk/files/02.09.19_COM-B_and_changing_behaviour_.pdf

5.3 Changes in client outcomes over the intervention period (pre- & post-intervention survey; quantitative)

This appendix presents the results from the pre- and post-intervention survey (see Appendices 5.6.1 and 5.6.2 for the survey protocols). The within-group statistical tests used to explore pre- and post-intervention differences were: Paired-samples t-test, Wilcoxon signed rank test, and McNemar's test.

5.3.1 Healthier diets

The first client outcome is whether social prescribing of veg boxes leads to healthier diets; clients were asked 5 questions in the survey about their diet.

Clients were asked how many portions of fruit and veg they eat in a typical day. Figure 9 shows vegetable consumption increased, but fruit consumption decreased, over the intervention period. These differences are not statistically significant (Paired samples t-test). Clients eat approximately 4.5 portions of fruit and vegetables per day, which is slightly less than the recommended '5 A Day' portions[43]. For comparison, UK adults eat between 3.3 to 3.7 portions per day (depending on age) and less than 1 in 5 adults (17%) met the 5 A Day recommendation[44]. There is a potential social desirability bias/overreporting in clients' responses, as these findings indicate that clients eat more fruit and vegetables than the average UK adult.

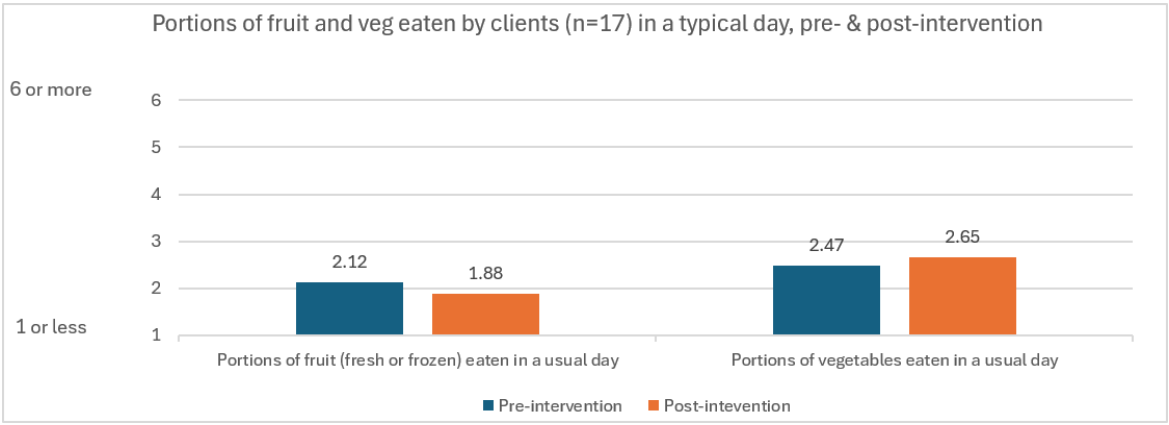


Figure 9, Portions of fruit and veg eaten by clients in a typical day, pre & post-intervention survey

[43] NHS (2026). 5 A Day: what counts? - NHS

[44] Office for Health Improvement and Disparities (2025). National Diet and Nutrition Survey 2019 to 2023: report - GOV.UK. This finding, 17% of UK adults eating 5 A Day, is notably less than previous published studies; for example, the Department for Digital, Culture, Media and Sport (2024) calculated that 32.5% of UK adults eat the recommended 5 A Day (see: Healthy eating among adults - GOV.UK Ethnicity facts and figures). The Office for Health Improvement and Disparities attribute this to a method change but suggest it may also reflect a real reduction in fruit and vegetable consumption due to financial pressures currently experienced by many households.

Clients were asked about the frequency of healthy and unhealthy food habits. They reported i) eating fruit as a snack and ii) vegetables in cooked meals more frequently post-intervention, as well as eating sugary or high-fat snacks less frequently, although these differences are not statistically significant (Figure 10; Paired samples t-test).

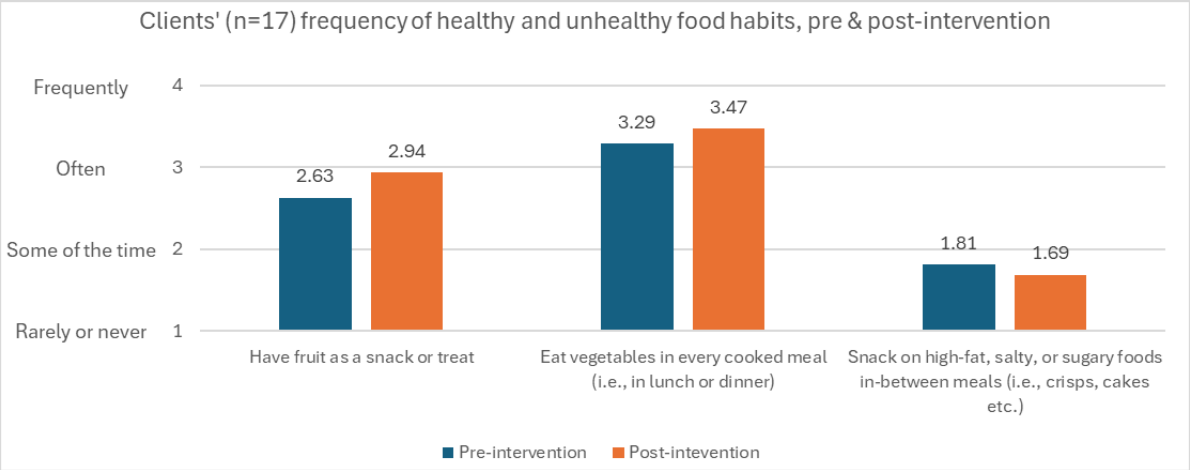


Figure 10, Clients' frequency of healthy and unhealthy food habits, pre & post-intervention survey

Clients were asked a further question about the frequency of food habits to triangulate these findings; they reported eating sugary snacks less often and this reinforces the reported shift to a healthier diet presented in Figure 10. However, there was no change in the frequency of eating chips or ready meals (Figure 11). These differences are not statistically significant (Wilcoxon signed rank test).

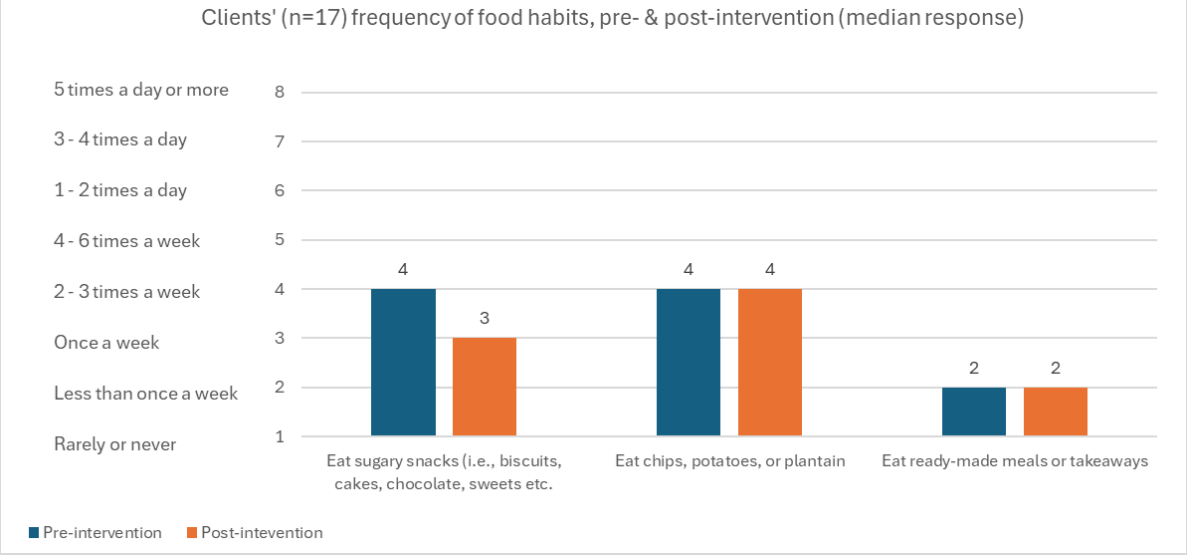


Figure 11, Clients' frequency of eating less healthy food, pre & post-intervention survey

One prior expectation for this pilot was that receiving a weekly veg box may encourage a shift away from meat consumption, because of the increased quantity of vegetables entering the household. Figure 12 shows a statistically significant increase in the number of meat-free days each week over the intervention period[45].

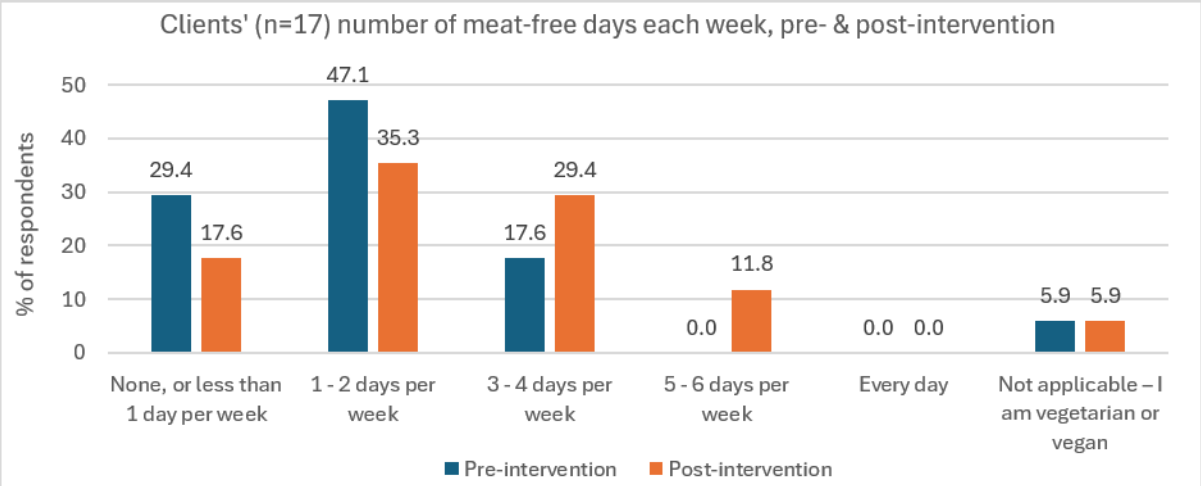


Figure 12, Clients' frequency of meat-free days per week, pre- & post-intervention survey

5.3.2 Increased food knowledge and capabilities

The second client outcome is whether the intervention leads to increased food competences and clients were asked three questions on this topic in the survey. Figure 13 shows a statistically significant increase in clients' level of confidence in buying[46] and cooking[47] fresh vegetables over the intervention period.

[45] A Paired samples t-test revealed that clients reported more frequent meat-free days per week in the post-intervention survey (2.38 ± 0.96), compared to the pre-intervention survey (1.88 ± 0.72), a statistically significant mean increase of 0.50 (95% CI, 0.16 to 0.84), $t(15) = 3.162$, $p = .006$, $d = .791$
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median frequency was '1-2 meat-free days per week', pre- and post-intervention.

[46] A Paired samples t-test revealed that clients reported a higher level of confidence in buying fresh vegetables in the post-intervention survey (3.82 ± 0.53), compared to the pre-intervention survey (3.18 ± 1.07), a statistically significant mean increase of 0.64 (95% CI, 0.02 to 1.28), $t(16) = 2.184$, $p = .044$, $d = .530$
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median response was 'very confident', pre- and post-intervention.

[47] A Paired samples t-test revealed that clients reported a higher level of confidence in preparing and cooking fresh vegetables in the post-intervention survey (3.65 ± 0.49), compared to the pre-intervention survey (3.24 ± 0.56), a statistically significant mean increase of 0.41 (95% CI, 0.09 to 0.73), $t(16) = 2.746$, $p = .014$, $d = .666$
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median response was 'quite confident' in the pre-intervention survey and 'very confident' in the post-intervention survey.

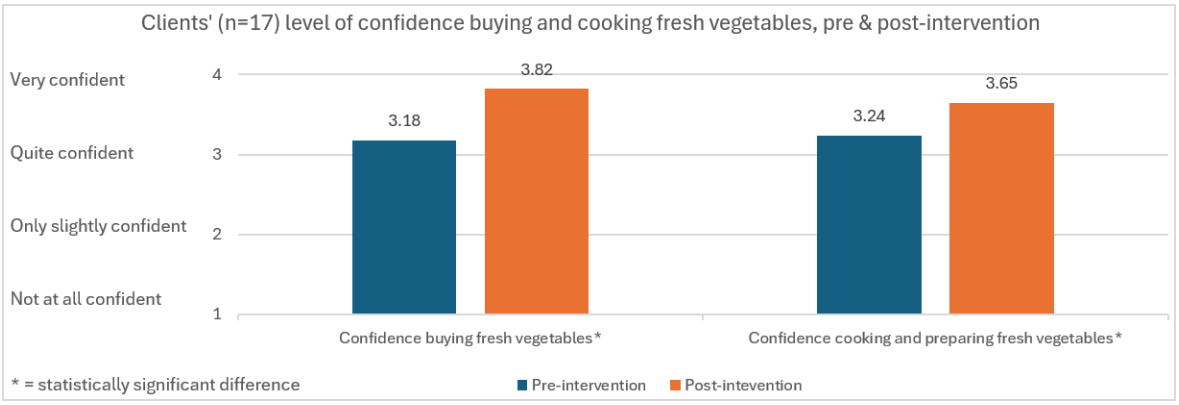


Figure 13, Clients' level of confidence buying and cooking fresh vegetables, pre- & post-intervention survey

Clients were asked how frequently they throw away different types of food; Figure 14 shows a statistically significant decrease in wasting bread[48] and vegetables[49] over the intervention period. There was no clear difference, pre- and post-intervention, for the other food categories.

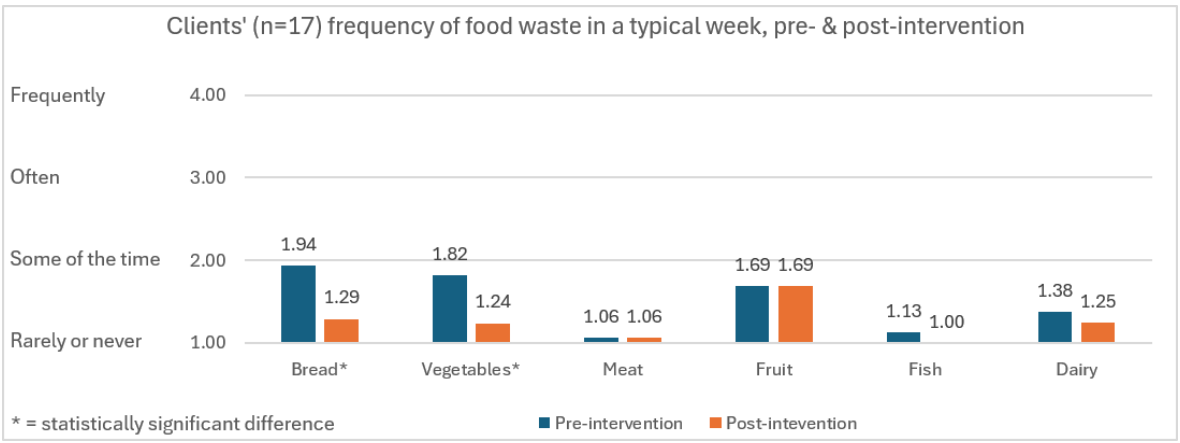


Figure 14, Clients' frequency of throwing away food in a typical week, pre- & post-intervention survey

[48] A Paired samples t-test revealed that clients reported wasting less bread in the post-intervention survey (1.29 ± 0.59), compared to the pre-intervention survey (1.94 ± 1.30), a statistically significant mean decrease of -0.65 (95% CI, -1.19 to -0.10), $t(16) = -2.524$, $p = .023$, $d = -0.612$.
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median response was 'rarely or never', pre- and post-intervention.

[49] A Paired samples t-test revealed that clients reported wasting fewer vegetables in the post-intervention survey (1.24 ± 0.44), compared to the pre-intervention survey (1.82 ± 1.02), a statistically significant mean decrease of -0.58 (95% CI, -1.10 to -0.07), $t(16) = -2.416$, $p = .028$, $d = -0.586$.
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median response was 'some of the time' in the pre-intervention survey and 'rarely or never' in the post-intervention survey.

5.3.3 Improved physical health

The third client outcome is improved physical health. The survey included seven questions which explored changes in clients' physical health over the intervention period. Seven clients reported a lower HbA1c level in the post-intervention survey, compared to their HbA1c level in the pre-intervention survey, and only one client reported a (very slight) increase. The average decrease across the entire sample was 4.86 mmol/mol over the intervention period, which is an encouraging finding, although not statistically significant (Paired samples t-test). There was one outlier in the data – one client reported a large decrease in their HbA1c level, whereas six clients reported a smaller decrease, and outliers can affect the mean considerably. However, the median response shows a similar decrease of 4.00 mmol/mol and so we can be confident in the overall level of HbA1c reduction (Table 4).

Six clients reported the same HbA1c level; these clients may not have had a follow-up measurement of their HbA1c within the intervention period, and so it is likely they are referring to the same measurement (i.e., their pre-intervention HbA1c level).

Table 4, Clients' HbA1c level, pre- & post-intervention survey

	Pre-intervention (n=14[50])	Post-intervention (n=14)
Mean HbA1c level	50.79	45.93
Median HbA1c level	51.00	47.00

Clients were asked about their use of health care services. Table 5 shows a decrease in the number of GP appointments over the past three months, but an increase in i) the number of hospital visits and ii) the number of daily medications. These differences are not statistically significant (Paired samples t-test). Four clients required medical attention for a health issue unrelated to their diet, and this accounts for the slight increase in the mean number of hospital visits and the mean number of daily medications across the sample.

[50] Some post-intervention measurements for clients' HbA1c level were missing in the survey, and so only 14 listwise comparisons were possible, hence n=14 rather than n=17.

Table 5, Clients' demand for health care services, pre- & post-intervention survey

Demand for health care	Pre-intervention (n=17)	Post-intervention (n=17)
Mean number of GP / family doctor appointments in last 3 months (about your own health)	3.65	3.50
Mean number of hospital visits in the last 3 months (about your own health)	1.82	2.88
Mean number of different medications or inhalers you take daily	5.18	5.41

Clients were presented with three statements about their health and asked: *'When thinking about yourself, how much do you agree or disagree with each statement?'*. Figure 15 shows an increase in their understanding of their health condition and their confidence to prevent problems relating to their health. They also feel more able to maintain healthy lifestyle changes. However, these differences are not statistically significant (Paired samples t-test).

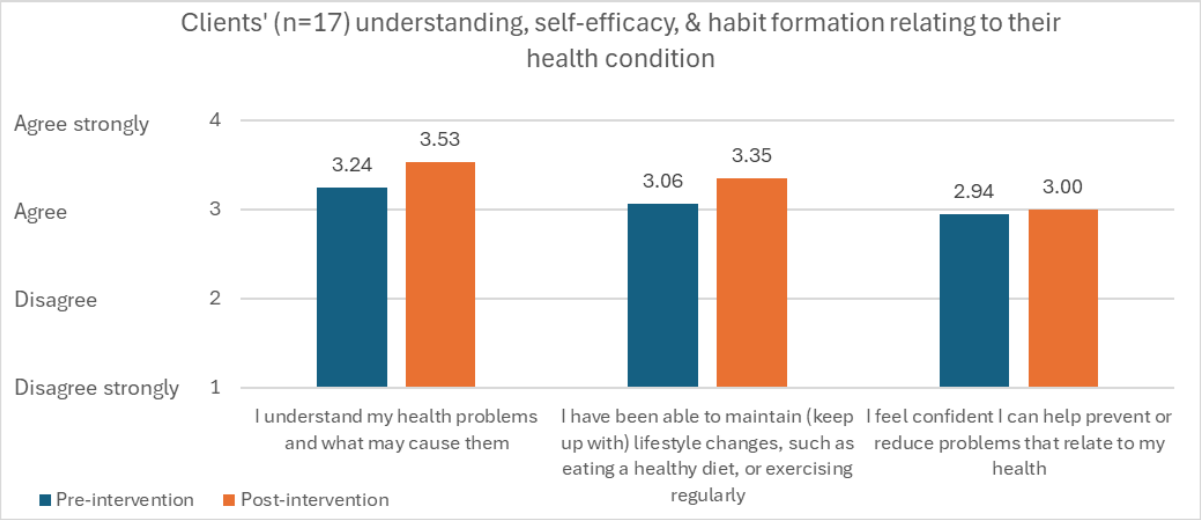


Figure 15, Clients' understanding, self-efficacy, and habit formation relating to their health condition, pre- & post-intervention survey

5.3.4 Improved wellbeing and mental health

The fourth client outcome is improved wellbeing. The survey integrated Meaningful Measures' Measure Yourself Concerns and Wellbeing (MYCaW)®, a tool widely used in health and social care settings to assess clients' wellbeing and mental health over time. This tool comprises two questions; in the pre-intervention survey, clients were asked to state one or two concerns or problems that they are most worried about now. They were then asked to indicate how severe these concern(s) or problem(s) are now, on a 7-point scale. In the post-intervention survey, the clients were reminded of their concerns or problems that were

recorded in the pre-intervention survey and asked to indicate how severe these concern(s) or problem(s) are now, using the same 7-point scale.

Table 6 shows physical health concerns unrelated to diet were the most frequently reported problem, followed by concerns about family members, and dietary-related health conditions. Mental health conditions and isolation/loneliness were also reported.

Table 6, Clients' primary and secondary concerns, identified in the pre-intervention survey using the MYCaW tool®

Concern 1 (n=16)	Frequency	Percent	Concern 2 (n=13)	Frequency	Percent
Physical health: non-dietary	6	37.5	Physical health: non-dietary	5	38.5
Family members	4	25.0	Physical health: dietary	3	23.1
Mental health	2	12.5	Finances	2	15.4
Physical health: dietary	1	6.3	Isolation/ loneliness	1	7.7
Accessing medical care	1	6.3	Family members	1	7.7
Finances	1	6.3	State of the country	1	7.7
Isolation/ loneliness	1	6.3			

Figure 16 shows a small decrease in clients' (n=17)[51] level of concern for their primary problem over the intervention period, although this difference is not statistically significant (Paired samples t-test). Some clients (n=10)[52] also chose to report a secondary problem or concern (this was optional); Figure 16 shows a statistically significant decrease in their level of concern, with the mean response decreasing from 5.00 to 2.50 over the intervention period[53].

[51] One client chose not to record what their primary or secondary concerns are, hence why Table 6 states n=16 rather than n=17. However, this client still indicated their level of concern about their primary and secondary concerns and so their responses are included in Figure 16 (which shows n=17 for the primary concern).

[52] 13 clients recorded a secondary concern in the pre-intervention survey, but only 10 clients recorded a secondary concern in the post-intervention survey. Thus, fewer listwise comparisons were possible for the within-group analysis (n=10, rather than n =13).

[53] A Paired samples t-test revealed that clients reported lower level of concern about their secondary problem in the post-intervention survey (2.50 ± 2.22), compared to the pre-intervention survey (5.00 ± 1.83), a statistically significant mean decrease of -2.50 (95% CI, -3.90 to -1.10), $t(9) = -4.038$, $p = .003$, $d = -1.277$.

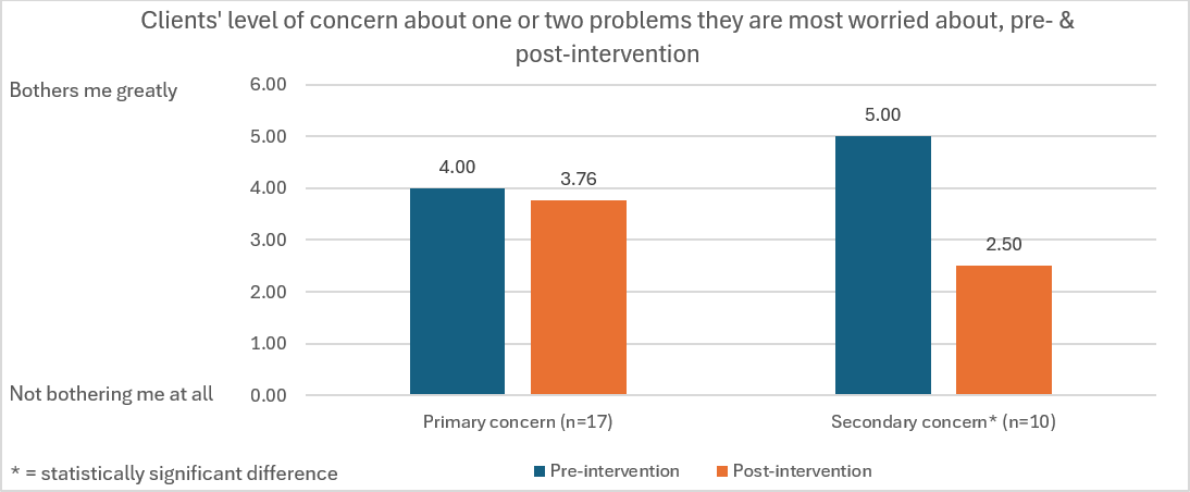


Figure 16, Clients' level of concern about one or two problems they are most worried about, pre- & post-intervention survey

Clients were also asked to rate their general feeling of wellbeing now (how they feel in themselves), on a 7-point scale (Meaningful Measures' Measure Yourself Concerns and Wellbeing®). Figure 17 shows a small increase in overall wellbeing, with the mean response shifting from 2.71 to 2.12 (i.e., moving towards a more positive state of wellbeing). This difference is not statistically significant (Paired samples t-test).

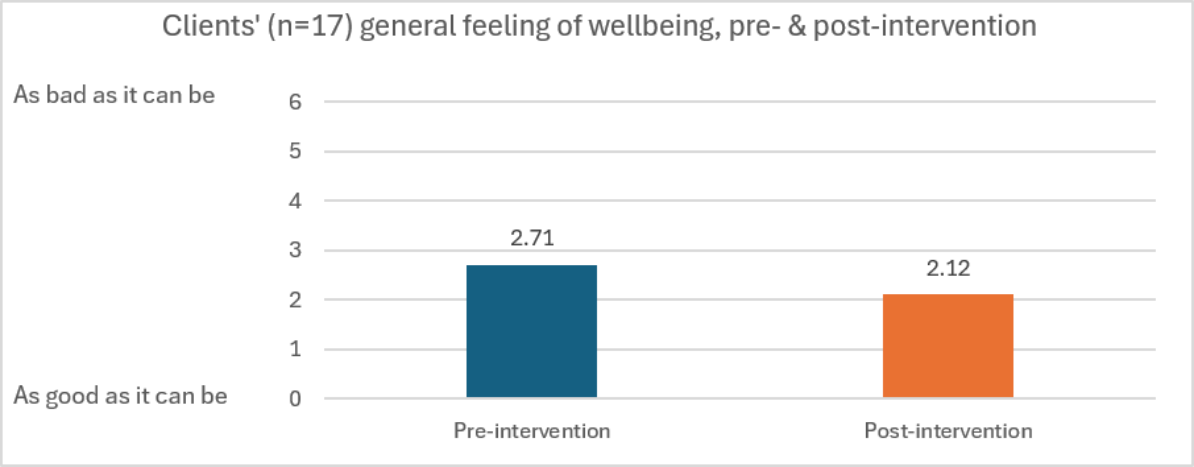


Figure 17, Clients' general feeling of wellbeing, pre- & post-intervention survey

5.3.5 Increased levels of physical activity

A fifth outcome is increased levels of physical activity; this can be directly related to the intervention because of participation in community gardening, or indirectly related because clients are feeling healthier and so have more energy or motivation for doing exercise. The survey included four questions which explored clients' levels of physical activity. Clients were asked; '*5.1 In the past seven days, on how many days have you done 15 minutes or more of physical activity?*' Figure 18 shows the frequency of physical activity increased over the intervention period for most clients, with the proportion of those exercising every day rising

from 11.8% to 29.4%. The mean frequency increased from 3.12 to 4.29 days, although this difference is not statistically significant (Paired samples t-test).

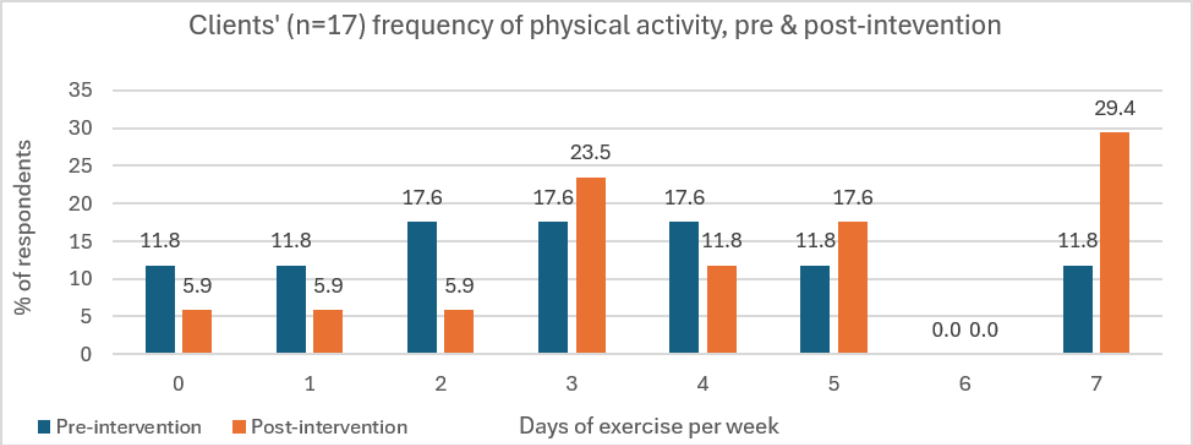


Figure 18, Clients' number of days of physical activity per week, pre- & post-intervention survey

Clients were asked to indicate their level of agreement that they: i) have the opportunity to be physically active, ii) have the ability to be physically active, and iii) if they enjoy physical activity (Figure 19). Clients reported an increase in their opportunity and ability to be physically active, but these differences are not statistically significant (Paired samples t-test).

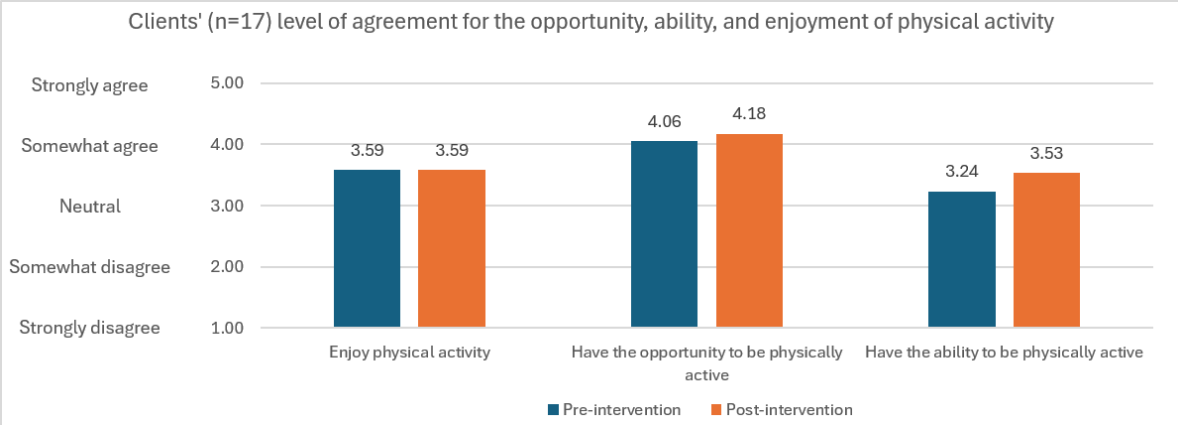


Figure 19, Clients' level of agreement that they have the opportunity, ability, and enjoyment of physical activity, pre- & post-intervention survey

5.3.6 Increased engagement in community activities

A sixth client outcome is increased engagement in their local community. The survey included four questions which measured changes in clients' engagement in community activities in their area. Clients were asked how often they take part in organised community activities, for example, social clubs or meetups, exercise groups, or volunteering activities. Figure 20 shows an increase in the mean frequency of participation over the intervention period, but this difference is not statistically significant (Paired samples t-test).

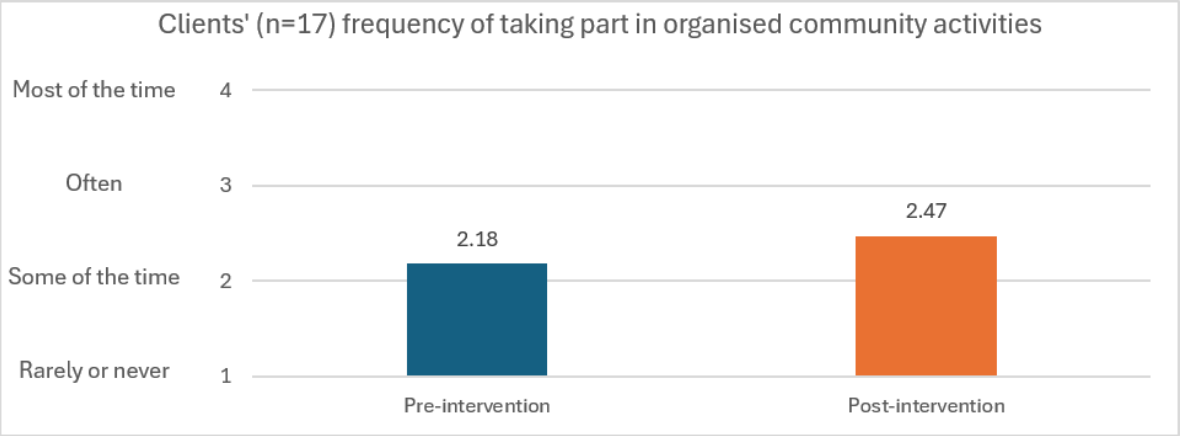


Figure 20, Clients' frequency of taking part in community activities, pre- & post-intervention survey

Clients were asked whether they feel more connected and involved in their community. Figure 21 shows an increase in feeling part of their community, knowing what's going on in their community, and knowing how to get support they need (e.g., how to access local health services). The increase in knowing how to get wider support is statistically significant[54].

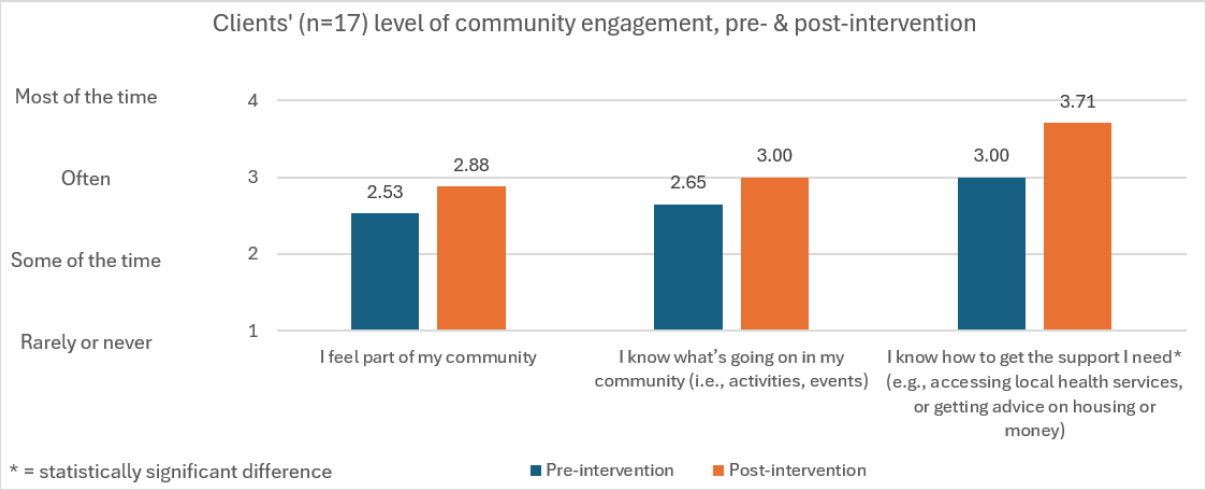


Figure 21, Clients' level of feeling connected and involved in their local community, pre & post-intervention survey

[54] A Paired samples t-test revealed that clients reported a higher level of knowing how to get the support they need in the post-intervention survey (3.71 ± 0.59), compared to the pre-intervention survey (3.00 ± 1.12), a statistically significant mean increase of 0.71 (95% CI, 0.14 to 1.27), $t(16) = 2.634$, $p = .018$, $d = .640$.
A non-parametric test was also conducted and produced a statistically significant difference (Wilcoxon Signed Rank Test). The median response was 'often' in the pre-intervention survey and 'most of the time' in the post-intervention survey.

5.3.7 Understanding barriers to eating a healthy diet

The survey included five questions which explored barriers to eating a healthy diet and overcoming these barriers is the seventh client outcome. Clients were asked whether they find it easy to get fruit and vegetables for themselves and their family; 17.6% stated in the pre-intervention survey that they did not find this easy, but this decreased to 11.8% in the post-intervention survey, although this difference is not statistically significant (McNemar's test). Clients were also asked about possible reasons why they may not eat enough fruit and veg; all of these barriers were less prominent in the post-intervention survey (Table 7), although none of the differences are statistically significant (McNemar's test). A notable finding is that the proportion of clients who did not experience any barriers at all increased from 29.4% to 41.2%.

Table 7, Barriers which prevent clients from eating plenty of fruit and vegetables, pre- & post-intervention survey

Barrier (participants could select multiple barriers)	Pre-intervention (n=17)		Post-intervention (n=17)	
	Frequency	Percent	Frequency	Percent
Cost	9	52.9	5	29.4
Quality/freshness	5	29.4	2	11.8
Storage (e.g., kitchen space, fridge, freezer)	4	23.5	2	11.8
Time to shop and cook	3	17.6	1	5.9
Not enough variety in the food shops	3	17.6	1	5.9
Health conditions make shopping or cooking difficult	3	17.6	1	5.9
Cooking knowledge (e.g., how to cook a wide range of fruit and veg)	2	11.8	1	5.9
Other pressing needs	2	11.8	2	11.8
Distance from food shops	1	5.9	0	0.0
Equipment (e.g., pots, pans, stove)	0	0.0	0	0.0
Not applicable - there is nothing that stops me from getting and eating enough fresh fruit and veg	5	29.4	7	41.2

Clients were asked about their financial situation and whether this constrains their access to food. A minority of clients (5.9-11.8%) experience difficulty in being able to afford their weekly food shop or manage household finances 'most or all of the time'. Across all participants, the frequency of experiencing these challenges decreased over the intervention

period, although these differences are not statistically significant (Figure 22; Paired-samples t-test).

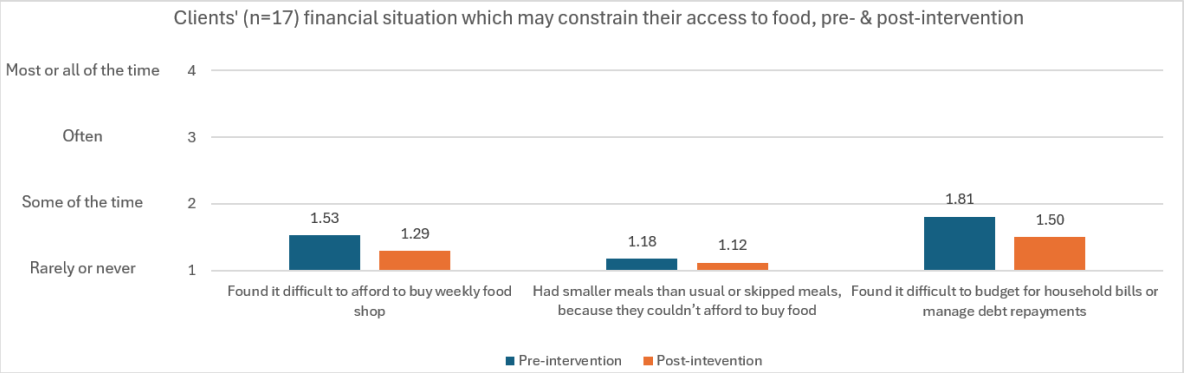


Figure 22, Clients' financial situation which may constrain their access to food, pre- & post-intervention survey

5.3.8 Attribution of positive lifestyle changes to the WellFed pilot

The following questions were presented in the post-intervention survey to evaluate clients' experience of the WellFed pilot[55].

Clients were asked: *'Thinking about the positive lifestyle changes you've made since joining the WellFed programme (e.g., improved diet, increased physical activity), how likely is it that you would have made these specific changes to the same extent, if you had not participated in WellFed?'* Table 8 shows 45.5% think it is 'highly unlikely' that they would have made these positive changes without taking part in the pilot, and a further 27.3% think it is 'unlikely' they would have made these changes without WellFed.

Table 8, Clients' reported attribution of positive lifestyle changes to the WellFed programme, post-intervention survey

Perceived level of attribution of changes to WellFed	Frequency (n=11)[56]	Valid Percent
Highly unlikely: I definitely would not have made these changes to this extent without WellFed	5	45.5
Unlikely: I probably would not have made these changes to this extent without WellFed	3	27.3
Possible: I might have made some of these changes, but perhaps not to the same extent or as quickly	3	27.3

[55] These questions also enable the Social Return on Investment analysis, which will be presented in the final evaluation report.
[56] Six participants were not presented this question in the survey, hence n=11 rather than n=17 and why 'valid percent' is presented rather than 'percent'.

Likely: I probably would have made these changes to the same extent, even without WellFed	0	0.0

Clients were then asked what percentage of the positive lifestyle changes they have experienced they would attribute directly to the WellFed programme. The mean response was 70.0%, suggesting participation in WellFed was the primary contributor to these positive changes. Clients mentioned other contributing factors in their open text feedback, such as support from family and friends (n=2) and support from their health coach (n=2).

Clients were presented with the list of potential benefits in Table 9 and asked whether their participation in WellFed had provided any of these benefits for them personally. The most frequently reported benefits were eating a healthier diet, increased confidence in cooking meals using fresh vegetables, and a better understanding of dietary-related health problems – these were some of the core aims of the pilot.

Table 9, Clients' perceived benefits from taking part in the WellFed pilot, post-intervention survey

Perceived benefits (participants could select multiple benefits)	Post-intervention (n=11)	
	Frequency	Valid Percent
Eating a healthier diet	11	100.0
Increased confidence in cooking meals using fresh vegetables	8	72.7
Better understanding of dietary-related health problems	8	72.7
More opportunities for social interaction	5	45.5
Improved physical health	4	36.4
Improved mental health or wellbeing	4	36.4
More frequent physical activity	3	27.3
More opportunities to be outside/in nature (e.g., community gardening)	3	27.3
Other benefit not listed – opportunity to try new vegetables	2	18.2
Helping me access other social support services (e.g., advice on budgeting; awareness of other health-related programmes etc.)	1	9.1
Reduced need for health care (e.g., fewer GP appointments, prescriptions etc.)	0	0.0
None of the above	0	0.0

5.4 Clients' experiences and outcomes of the pilot (interviews; qualitative)

This appendix presents findings from the semi-structured interviews with clients (n=20); qualitative data is summarised in Tables 10 – 23, below. Content analysis was conducted, initially using deductive codes based on interview questions exploring clients' diet, health, wellbeing etc., followed by inductive coding to identify unanticipated findings. Thematic analysis was then carried out to explore clients' experiences of the pilot in more depth. The interview protocol can be found in Appendix 5.6.3.

5.4.1 Clients' experiences of dietary change

Clients were asked five questions which explored dietary change and their capacity to make healthy food choices. The most prominent themes were eating more vegetables in their diet, a greater variety of vegetables, fewer sugary snacks, and reduced meat consumption (Table 10).

Table 10, Clients' experiences of dietary change during the WellFed pilot, client interviews

Theme	Example quote	Prevalence[57]
Eat more vegetables / a healthier diet	*"I still shop in the same shop by going to different aisles now. I mean, 'oh, there's vegetables there. I'll have a look.' There are more vegetables, more greenery in my diet."* (I17)	13
Reduced sugar intake	*"If I do eat chocolate, the portion of it is reduced, so like I have a little bar instead of a normal bar."* (I2)	13
Eat a greater variety of vegetables	*"I eat a greater variety of things and I think that's because of the project, because I'd just got into the habit of always buying the same things, particularly vegetables that I know how to cook and what to do with them. And doing this project, I was introduced to things I'd never seen before."* (I20)	10
Eat better quality vegetables	*"Some of the food, it tasted different 100%. I can guarantee the carrots, the onions, the leeks, they all tasted different…I could tell the difference…It was really good!"* (I16)	9
Reduced meat consumption	*"More focused on the vegetables now as opposed to the meat and potatoes. I think the vegetables form, you know, a larger part of the meal than they did before. I think we're eating less. We still do eat meat, but red meat, trying to keep to a minimum."* (I11)	8

[57] 'Prevalence' means the number of clients, out of 20, who discussed this theme during the interviews.

Theme	Example quote	Prevalence[57]
Diet is influenced by family preferences	*"Living with my mum, where there was an abundance of everything I could have, eat what I wanted all the time. Whereas when I lived on my own, I was more conscious of what I was spending on food."* (I14)	8
Veg box improves household members' diet	*"----- definitely found it more adventurous and able to try different vegetables. So it's become a kind of a family change. So it's not just me on my own working on things, it's combined and we've both seen weight drop off and improvement in our fatigue."* (I7)	6
Reduced fat and/or salt intake	*"The important thing is nothing processed, no ready meals, nothing highly refined, calorie controlled and fat controlled and sugar controlled as well. So, a massive change, no more convenience food."* (I5)	6
Meat consumption has not changed	*"It probably hasn't affected how much meat I have, but it has affected how many vegetables and pulses I have."* (I20)	5
Continue healthy diet after pilot finishes	*"I'll try and support them next year with, you know, subscribe to a box…I've certainly benefited from it…it's made me think and [I] will continue."* (I16)	4
Experience sense of achievement with diet change	*"I feel like I'm patting myself on the back sometimes because I know I'm doing the right thing, which I've never done before…I'm making the choices, informed choices that I wasn't making before."* (I8)	4
Being realistic/ moderate about dietary change	*"Sausage rolls and pork pies is another big, big problem for me. But again, just once every so often. Personally, I feel you know, if we're too all or nothing about things, then we set ourselves up to fail."* (I19)	2
Have a dietary intolerance or disease	*"I'm coeliac, so I have to be careful with that."* (I11)	2
Sugar intake has not reduced	*"I'm eating more cakes than I should do…because these places will put up cakes in front of you and when they're put there, you can't resist them."* (I15)	2
Returned to unhealthy diet after pilot finished	*"I'm not confident now the veg bag scheme has finished as I had fish and chips last night and I'm eating processed snacks more again."* (I10)	1

Theme	Example quote	Prevalence[57]
Don't want to be vegetarian	*"I couldn't live from vegetables alone. And I did wonder if the programme was kind of trying to push people down the vegetarian route."* (I13)	1

5.4.2 Clients' experiences of increased food knowledge and capabilities

Clients were asked three questions which explored whether taking part in the pilot had increased their food knowledge and skills. The most prominent themes were increased cooking competence and confidence, and reduced food waste (Table 11).

Table 11, Clients' experiences of increasing their food competences during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Cooking skills have increased	*"I'm not the best cook, but I definitely think I've learned a lot from, you know, the cookery classes and also experimenting with different veg that I wouldn't normally buy."* (I11)	12
Have reduced food waste	*"Having the fresh veg there, not wanting to waste it…I'm very good at now is using stuff up…I can actually plan myself a lot better and the waste has gone down, I would say by good 50 to 70%."* (I5)	12
Increased confidence in cooking	*"I'm not afraid of cooking, especially vegetables now. Not afraid of that at all."* (I12)	10
More batch cooking	*"What works best for me is being organised and batch cooking and things like that. That really works for me because then it's easy to cook something quickly that you know is healthy."* (I20)	6
Healthy food now tastes better	*"I don't eat cabbage, but the kale was quite good, yeah, very good…it's quite flavourful, if you do it right. With a bit of salt and pepper and maybe a bit of lemon juice or something like that."* (I9)	5
Already had good cooking skills, so no change	*"I don't think my cooking skills have changed as they were always there, I just needed the produce to cook with and the incentive of having fresh vegetables which I don't normally have."* (I10)	3
More meal planning	*"We look forward to it every week coming to collect the bag and seeing what's in it and planning meals around what was in the bag."* (I11)	2

Theme	Example quote	Prevalence
More attention to food labels or ingredients	*"I wasn't aware of the different symbols on the packets, it shows with any sugar in bold with Cornflakes… Weetabix and yeah, those sorts of things."* (I12)	1

5.4.3 Clients' experiences of improvements in their physical health

Clients were asked six questions which explored different aspects of physical health. The most prominent themes were losing weight, feeling healthier, and reducing their HbA1c level during the pilot (Table 12). Clients reported further health improvements such as reduced medication (n=5) and reduced cholesterol (n=3). Most clients (n=13) have a health condition in addition to their type 2 diabetes / pre-diabetes diagnosis.

Table 12, Clients' experiences of improvements in their physical health during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Have a non-dietary related health condition	*"I've been having problems with my hip. So that's really affected what I can do physically and, actually, just being in constant pain and not sleeping and things like that, that's impacted how I've been eating."* (I20)	13
Have lost weight	*"I have lost weight, I lost certainly about 5 kilos. I've gone off a belt hole of the last belt hole in my belt, which I hadn't actually used."* (I19)	11
Feel healthier	*"You feel better if you eat healthy food. And I've noticed if I do eat anything sugary, I don't feel good after it. You know, it's not great…I much prefer to eat healthier food now."* (I11)	10
HbA1c level has reduced	*"I was diabetic. In the diabetic range…since I've been on the course, it's come down. My last [HbA1c] test was in the non-diabetic [range]."* (I12)	6
Reduced their medication	*"When the nurse rang me up, she said that I was on tablets for diabetes and she said, 'did I want to come off them, or did I want to come off them in March?' I said I would come off them straight away…that's still the case, I'm off those."* (I12)	5
Shock of diabetes diagnosis	*"Having a problem diet…Honestly, the day she told me I was diabetic, it was like a slap in the face."* (I14)	5
Prevention is better than cure	*"To me, prevention is better than cure…if you've got the opportunity to obviously participate in something like this, then take it."* (I16)	3

Theme	Example quote	Prevalence
Lower cholesterol	*"My cholesterol has come down to normal limits so it's absolutely normal. I am on statins which has probably helped with that, but also some of the [dietary] changes I've made."* (I5)	3
HbA1c level has not changed	*"HbA1c had stayed the same after a bit going on holiday."* (I18)	2
Have not had a follow up HbA1c test after pilot	*"Yeah, not in the last three months, but yeah, if it's possible to supply that afterwards, it would probably be useful data, wouldn't it?"* (I6)	2
Difficulty maintaining weight loss	*"I find it's not losing the weight is the problem. It's keeping it off. I've lost 3 stone twice but haven't been able to keep it off."* (I18)	1
Would like to avoid medication	*"I feel that the medication is another bad food…you know the…medication is good for when you need it, but I don't want to be on it forever."* (I8)	1
Reluctance to use health care services	*"You don't use the health service unless your daughter-in-law forces you into it…it's just, you know, you don't want to make a fuss, do you?"* (I4)	1
Have not experienced health improvement	*"I'm on insulin now for diabetes because, well, since I since I had my operation and everything been all over the place. Yeah, so trying to balance it all out again."* (I15)	1

5.4.4 Clients' understanding of their health condition

Clients were asked two questions about their understanding of their health condition and their capability to manage it. Most clients (n=12) reported increased understanding and increased confidence (n=10); some (n=6) have embedding healthy food habits into daily routines (Table 13).

Table 13, Clients' understanding of their health condition and their capability to manage it, client interviews

Theme	Example quote	Prevalence
Increased understanding of their health condition	*"I seriously now look at what I'm eating and what's in it…now I feel like I've been armed with some a little bit of knowledge so I can make an informed choice…the main thing for me is the rubbish that…I've been eating it for nearly 70 years and it's not done me any good."* (I8)	12

Theme	Example quote	Prevalence
Confidence in their capability to manage their health condition	*"I think being able to achieve what I've done diet-wise over the last what five months. It shows me that I am capable of taking control and achieving things."* (I7)	10
Have embedded healthy food habits into daily routines	*"I do work a couple of days a week now and I take my lunch and taking my homemade soup and some healthy snacks, rather than before when I'm going to the canteen and getting a full fat burger and a coke and a crunchy."* (I5)	6
Importance of self-efficacy	*"Hope to be able to in the next 12 months. Maybe, you know, reverse my [diabetes]…the only person that is able to do that is me and nobody else."* (I19)	3
Role of WellFed for signposting other support services	*"When you put the whole package together, [it] was the WellFed scheme which allowed me to reach out more, right? Whereas before I'd just be indoors with a door shut….now, I feel that that allowed me to get these services."* (I8)	2

5.4.5 Clients' experiences of improved wellbeing and mental health

Clients were asked four questions about their wellbeing. Many interview participants (n=9) experience challenges with their wellbeing and the pilot aimed to address this through social connection and improvements in physical health. The most prominent themes were experiencing an improvement in their wellbeing during the pilot and feeling more confident in themselves (Table 14).

Table 14, Clients' experiences of improvements in their wellbeing during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Experienced improved wellbeing during pilot	*"Since I've been on the WellFed, everything that seems to have started clicking into place…I think maybe I've been seeing things slightly differently and reacting more positively than what I used to do and it it's paying off…life's getting easier."* (I8)	10
Experience challenges with their wellbeing in general	*"I have been unwell with a virus and struggling with my mental health, so I am not leaving the house as much or doing shopping as much."* (I10)	9

Theme	Example quote	Prevalence
Feel more confident in themselves	*"I feel different and people notice it, yeah, stop me in the street…that motivation [to] keep going. So that's sort of positive feedback."* (I14)	5
Did not experience improved wellbeing during pilot	*"Unfortunately, I'm worse after the pilot than before, but that's not because of the pilot. No, that's a fact of life…you get to my age now."* (I16)	3
Wellbeing improved, but not due to pilot	*"You get out walking your dog. Yeah, not as much as I should do, but…I think that's all good for mental health anyway. Gives you a reason to get out of bed and get to go somewhere."* (I15)	2

5.4.6 Clients' experiences of increased levels of physical activity

Clients were asked three questions which investigated whether the pilot had contributed to uptake or increased levels of physical activity. Several interview participants (n=9) experience limitations to physical activity in their daily life, primarily related to their health conditions. The most prominent themes were increased levels of physical activity and more confidence or motivation, although some (n=5) experienced no change in their physical activity during the pilot (Table 15).

Table 15, Clients' experiences of changes in their physical activity during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Experience limitations to physical activity	*"The pain I get with my back and my leg…I can't do the things that I want to do. It does restrict me quite a lot, but as I say, I'm on the list for a knee replacement."* (I11)	9
Physical activities they take part in	*"I've got one of those bikes in the houses, stationary bikes…I bought it before the WellFed programme, but I've made sure that I've not missed since the WellFed programme. I've made sure I haven't missed going on that bike every morning."* (I12)	9
Have increased their physical activity	*"I walk into town and I used to drive a lot more before. Yeah, I used to drive everywhere, but now I'll either walk or get on one of those Beryl bikes."* (I14).	7
No difference in physical activity during pilot	*"I don't think I noticed a difference, but I would imagine for some people it might."* (I13)	5

Theme	Example quote	Prevalence
More confidence or motivation for physical activity	*"I've got the same sort of physical activity level, just more energy with it and more willingness to do it…now I'm like, 'oh, I'd like, I'd really like to go for a walk'. So I guess that's the difference."* (I6)	4
Collecting the veg box increased their physical activity	*"From day one…I thought I'm going to cycle there…I actually cycled the three odd miles to get it and bring it back. And I thought, going to make that a weekly thing."* (I5)	3
Increased physical activity for a reason other than WellFed	*"Got a job in Tesco's…[you] are doing the picking and that's massively up[s] your exercise."* (I19)	3
Would like to do more physical activity	*"I need to do some more physical work. I can't just sit in an armchair all day, but I've learned that."* (I8)	3

5.4.7 Clients' experiences of engagement in community activities

Clients were asked four questions about their engagement in local community activities. The most prominent themes were increased social interaction due to pilot activities and increased peer support and inclusivity (Table 16).

Table 16, Clients' experiences of engaging in community activities during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
WellFed pilot increased their social interaction	*"The four of us that went to the group, we did gel really well…we all sat on around a table and we'd all be chopping the veg and we'd be talking about what we'd cooked the previous week, what we tried, what we'd liked, what we hadn't liked, what we would buy again, what our health conditions were, how this group was affecting us."* (I18)	17
WellFed pilot encourages peer support and inclusivity	*"There was no stigma. There was no saying, oh, look at you. There was nothing like that whatsoever….everyone was nice…people who've never seen each other before, but because we've got something in common, yeah, health condition, it just made it a lot easier." (I17)*	11

Theme	Example quote	Prevalence
Take part in wider community activities	*"Occasionally I'll go to church and there's still quite a few people at the church that I know. I went last night actually."* (I13)	11
WellFed pilot increased confidence in social situations	*"Everybody was so welcoming…I was able to talk to people better, gave me the confidence, the additional confidence I needed to be able to cope with people and addressing people."* (I1)	3
WhatsApp is useful for social interaction & sharing recipes	*"That was actually a very good tool, WhatsApp, just for saying all the session will start at 11:30 today. And people to share what we've cooked and what we've done."* (I19)	3
Experience social anxiety	*"I've had quite a few bad experiences over the last few years…and my difficulty opening up to people, you know?...on a personal level, I tend to avoid it. I just find it difficult to open up like that."* (I8)	3

5.4.8 Clients' perceived enablers of eating a healthy diet

Clients were asked about the reasons why they have experienced improvements in their diet; this question aimed to identify specific enablers of eating healthily which may be due to participation in the WellFed pilot, or to contextual factors. The most reported enablers were receiving recipes and having accountability to others (Table 17).

Table 17, Clients' perceived enablers of eating a healthy diet, client interviews

Theme	Example quote	Prevalence
Receiving recipes (from grower or other clients)	*"It's just the education I've had from here…how to cook it, what to do with it basically, and the recipes that people sent me and I tried them all…just changed my eating habits."* (I9)	5
Accountability during WellFed pilot	*"I'm not very good at being accountable just to myself. It helps me to have someone to be accountable to…you feel accountable to something bigger than yourself…I think that really helps."* (I20)	4
Owning a freezer	*"I was stacking them up in the freezer…so when you're not feeling as motivated, you've already got it…or if I cook too much, the half is too much, I put it in the freezer for another day."* (I9)	3
Kitchen equipment	*"I bought an air fryer…I love putting chopped up vegetables and maybe a little potato in or chopped up*	2

Theme	Example quote	Prevalence
	beetroot parsnips, carrots…drizzle oil and some Rosemary…just give it a good shake and every comes lovely roast vegetables." (I9)	
Reorganise kitchen space	*"The kitchen's been redesigned to accommodate a lot more fresh fruit and my vegetable garden as well."* (I5)	1
Time to cook	*"I've seen such dramatic changes, such positive changes…I've got the time to do it."* (I5)	1
Access to fresh veg	*"Having it having access, like easy access to healthy food, that's really made a difference."* (I3)	1

5.4.9 Clients' perceived barriers to eating a healthy diet

Clients were asked if there is anything which stops them from eating a healthy diet or making other positive lifestyle changes. This question aimed to identify potential barriers they may face. The most reported barriers were cost, caring responsibilities, and maintaining a healthy diet during social occasions (Table 18).

Table 18, Clients' perceived barriers to eating a healthier diet, client interviews

Theme	Example quote	Prevalence
Healthy food is expensive	*"I want to eat nutritious food. The problem is good food tends to be expensive which seems counterproductive …cost is the main thing that makes it harder."* (I10)	7
Caring responsibilities	*"Sometimes I'm in hospital for like a week or two with ----- and then it's really hard. It's literally just packaged food…it's a limitation for us in terms of -----'s health."* (I6)	3
Social occasions	*"I am a little bit paranoid about Christmas coming because I don't know what I'm going to eat, because I don't want to eat any of the crap. Christmas revolves around eating…I have been a little bit nervous about it."* (I14)	3
Lack of will power	*"I have absolutely no willpower or self-discipline. So if I'm feeling weak, I am not confident I can make healthy food choices."* (I20)	2
Lack of time	*"Sometimes people do go into things with good, honest intentions and then stuff gets in the way. Life happens, you know, an illness or…they have to take on an extra job or something."* (I19)	2

Theme	Example quote	Prevalence
Distance from the shops or the grower's site	*"It's just the actual being able to get to things, isn't it? So there's the distance. Like if you were closer, it would have been better."* (I3)	2
Physical mobility constraints	*"With my legs, if I can't get to the supermarket so easily, you know, just tend to grab what you can quickly rather than think about what you're actually buying."* (I11)	1
Low energy levels	*"What makes it harder? Being tired really, this time of year."* (I20)	1
Hassle of cooking a meal for one person	*"I'll just do it [cooking from scratch]…I don't think you do when you live alone, because, you're not doing it to share [the food]."* (I13)	1
Personal experience of financial constraints	*"I was struggling to afford vegetables and I know it's important to get more vegetables in to make me healthier."* (I10)	1

5.4.10 Clients' initial motivation for taking part in pilot

Clients were asked why they joined the WellFed pilot; most described their referral route, rather than their personal motivation (Table 19).

Table 19, Clients' initial motivation for taking part in the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Referred by their health coach or dietician	*"It was offered to me having recently received a diagnosis of type 2 diabetes. And I spoke to ------, a dietitian at the surgery, and she said this was a project that I might be interested in."* (I20)	7
Referred by their GP surgery	*"I went to my local GP…she said about joining the ------ orchard to pick and plant vegetables and eat more vegetables, so my diet would change."* (I9)	6
They already wanted to change their diet prior to joining the pilot	*"I hadn't realised my weight had crept up and my health had deteriorated quite a bit…I was coming up for retirement and decided that that would be the perfect time to actually make some positive changes in my life…improve my health and wellbeing, but also to try and reverse the type 2 diagnosis."* (I5)	3

Theme	Example quote	Prevalence
Referral route not stated	*"I was diagnosed with diabetes back in January or February this year and then they sent me an e-mail saying would I like to be part of this study."* (I14)	2
Referred by their social prescriber	*"She became my social prescriber…she did that, and yeah, it stemmed from that, really, so word of mouth."* (I13)	1

5.4.11 Clients' attribution of positive lifestyle changes

Clients were asked three questions about the impact of the WellFed programme in motivating the diet or lifestyle changes they experienced. The most prominent themes were support from health and social care professionals, participation in WellFed, and support from friends and family (Table 20).

Table 20, Clients' attribution of positive lifestyle changes experienced during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Support from social prescriber, dietician or health coach	*"The other big one is ----- from the surgery. Yeah, she's a…health worker…She's been a great help with my diet and get me on slimming world and get me to come here [WellFed]. So she's been a great help."* (I9)	9
Connect their participation in the pilot with health outcomes	*"I think I lost about half a stone before the pilot started and ----- hadn't started her diet before the pilot, so majority of it is during the pilot. It's helped me to understand the benefits of a healthy diet."* (I7)	7
Support from friends and family	*"All my friends have been amazing… even my son actually…he's been really supportive in that sense helping me kind of, you know, not be around food that I might want to eat."* (I14)	7
Have participated in other health programmes	*"I've been doing what that is called Counterweight. OK, so it's a liquid diet. So they've taught me a lot as well about when I start eating again, what I've got to eat."* (I14)	7
Support from GP or consultant	*"I have to say my GP is phenomenal. One of the best doctors I've ever worked with."* (I5)	4
Support from community grower	*"No one judged anybody. They only encourage you. Yeah, it was the encouragement that helped me."* (I17)	3

5.4.12 Clients' experiences of growing food

There were no specific questions in the interview protocol about growing food, but this topic was nevertheless discussed by several clients (Table 21).

Table 21, Clients' experiences of growing food during the WellFed pilot, client interviews

Theme	Example quote	Prevalence
They grow veg themselves	*"I've got a little veg plot myself....so in my garden now I still got parsnips, carrots and potatoes still in the garden. So it's kept going and it's still going now."* (I9)	5
Enjoy learning about growing veg	*"I find stimulating, always have, and the learning process as well about the organic side of farming because I've not been organic."* (I1)	4
Growing veg is expensive	*"I'll talk about resources because not everyone did the privileged position to afford to go and buy the polytunnel and seeds and water them...It's not a cheap business, but for me it's a hobby."* (I5)	1
Interested in self-sufficiency	*"Self-sufficient I think is a bit of a pipe dream, but I could quite happily live off grid, I think. So the whole getting the veg box, thinking I can do this, that's led on some other things as well...I'm looking at could I get a solar panel."* (I5)	1
Would like an allotment	*"We haven't got any allotments in the parish...there's a big waiting list of people that want one and we're in Cornwall, I mean, there's plenty of land to go around."* (I8)	1

5.4.13 Clients' understanding of the food system and its impact on health

Another theme which emerged during the interviews was increased understanding of the food system and how this connects to health (Table 22). As with growing food, there were no specific interview questions on this topic.

Table 22, Increased understanding of the food system and its impact on health, client interviews

Theme	Example quote	Prevalence
Increased understanding of how diet can affect health care system	*"It's a good programme for anybody, to change the way they live and also to improve the health and that's got to be a good thing. Got to be good for the NHS, got to be good for people's health, pain, everything."* (I11)	6

Theme	Example quote	Prevalence
Conventional food system causes health problems	*"The food industry, as far as I can see, has just feeding us more and more **** over the last 30 years, certainly the last 20 years, targeting kids…the vegetables, they've all got pesticides on…the food industry then have demanded it from the farmers and to produce more for less money."* (I16)	4
Increased understanding of where food comes from	*"That's quite a big change then to think differently… You tend to think more about where it's coming from and what you're eating."* (I16)	3
Increased understanding of the environmental impacts of food production	*"Like your carbon footprint, sort of, yeah. Do you really need your food to come from miles away if it's available locally?"* (I6)	2

5.4.14 Clients' feedback on how the WellFed pilot could be improved

Clients were asked if they have any suggestions for ways the WellFed pilot could be improved. Overall, the feedback was very positive, and they appreciate the WellFed model and why it works. They offered several useful suggestions for improving the pilot, including more cooking classes, keeping groups sizes small, and addressing accessibility challenges at the growers' sites (Table 23).

Table 23, Clients' suggestions for improving the WellFed pilot, client interviews

Theme	Example quote	Prevalence
Positive feedback about WellFed pilot	*"I have absolutely no doubt in my mind that the scheme has contributed to my health hugely, I think it's contributed to my longevity…I'm extremely grateful for the scheme and everyone who supports it and wouldn't hesitate to recommend it to anyone who who's on a similar path to me."* (I5)	15
Acknowledge the holistic WellFed model	*"The food side of things, you know, apart from the people, which is a whole different side of the course for me, was the two halves make the whole. It wasn't like just the food or just the people, it was the whole."* (I8)	6
Would recommend the WellFed pilot to	*"If it's offered to you, then go for it. You've got nothing to lose…the big thing for me was trying veg that I wouldn't buy before because veg is expensive and it's*	4

Theme	Example quote	Prevalence
other potential clients	*such a waste of money, food, if you buy something and don't like it. But luckily everything that we tried, everything that we were given, I actually enjoyed…yeah, glad I did it, definitely."* (I18)	
Scale up WellFed programme	*"I think maybe make it available to more people if it was financially viable."* (I11)	4
Specific recommendations for how the pilot could be improved:		
More cooking classes	*"I can't think of any way that you could really improve it. Maybe more cookery classes."* (I11)	3
Felt apprehensive before starting the pilot	*"The night before I didn't sleep very well because anything new, you're a bit wary about. But no, it was fine."* (I18)	2
More volunteer days at the community garden	*"The volunteer day was just like, I find it really hard to commit to…a very fixed time because life just isn't like that. And it's a bit of a shame that you couldn't access that element a bit more flexibly."* (I6)	1
More variety in the veg box	*"When you're doing the course, all the vegetables we have was basically the same. OK, yeah, because they all came from the allotment and that what was growing at the time…introducing a bit of variety in the veg bags might have been good to so that you learn about the other vegetables as well."* (I15)	1
Keep group sizes small	*"I don't think it would have worked so well…if the group had been a lot bigger…I think maximum, I would have said six."* (I17)	1
Offer home delivery	*"Delivery options for the veg bag would have been really helpful for the times I struggled to get it."* (I10)	1
Improve access to the grower's site	*"One of the other ladies did have mobility problems and sometimes bags are quite heavy. I ended up bringing a little trolley, to put the bags in to make it easier for me…perhaps that people could pick their veg bags up further down towards the car park."* (I13)	1
Campaign to promote healthy eating & showcase WellFed	*"You see adverts on for all the **** foods and all the crap on the telly…there maybe should be some sort of national campaign to trigger through the NHS…in an advert, this is what happened to me."* (I16)	1

Theme	Example quote	Prevalence
More promotion locally for the pilot	*"Probably advertise it in the doctors or something like that…better marketing, more people knowing about it, I think I think that would be a big help."* (I12)	1
Smaller veg boxes	*"Eat everything and not waste it, sometimes it's a challenge and a half…having…the opportunity to have kind of smaller [veg box]."* (I20)	1
Break pilot into 3-4 week blocks	*"Maybe it could be something which could be staggered through the year…we're doing through the autumn…you were getting what was fresh…a 3-4 week chunk."* (I19)	1
Concession scheme to continue veg box after pilot finishes	*"This is your last one coming up, if you'd like to carry on, then you know here's what you do. You should find that information, I think a personalised approach to would you like to carry on. Maybe with a scheme whereby there was a reduced rate."* (I5)	1
Support for when clients receive diabetes diagnosis	*"It's nice for someone to have an immediate resource to be directed to if they get that news."* (I12)	1
Offer blood monitors to patients with type 2 diabetes	*"It would be a benefit for a type 2 diabetics to have a have a machine so…we can monitor our blood a little bit more because type ones obviously have to do it, I do wonder if we have machines, whether it will benefit."* (I13)	1
Would like financial support for growers	*"Ultimately if this was something that people could be referred to on a rolling basis, then would be that rolling payment and that helps to sustain those [growers]". (I19)*	1

5.5 Differences between WellFed clients and the control group (pre-intervention survey, quantitative)

This appendix presents the findings of the pre-intervention survey that was conducted with WellFed clients and a control group of Cornwall residents (see Appendix 5.6.1 for the survey protocol). Differences between the two groups were explored using between-group statistical tests: Independent samples t-test, Mann-Whitney U test, and Fisher's exact test.

5.5.1 Sociodemographic characteristics

A Cornwall resident control group (n=300) was recruited using a market research company to complete the pre-intervention survey and then compare their responses with those of WellFed clients (n=17). Although this is not a randomised controlled trial design[58], this comparison increases our understanding of how the WellFed clients compare with a wider sample of Cornwall residents in terms of their diet, food competences, health, wellbeing, and sociodemographic characteristics.

We can comment on the representativeness of the control group sample[59] by referring to Census 2021 data for Cornwall[60]. This control group sample is broadly representative of Cornwall's population for: % with a long-term health condition or disability, employment status (although retired people are underrepresented in this sample), and income. However, it differs for age (this sample has a slightly younger median age), gender (males are overrepresented in this sample), ethnicity (minority ethnic groups are overrepresented in this sample), education (people with an undergraduate or postgraduate degree are overrepresented in this sample), and household occupancy (families with dependent children are overrepresented in this sample).

Table 24 shows a high proportion of WellFed clients are in the older age categories, relative to the control group. The clients are statistically significantly older than the control group[61].

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[58] A randomised controlled trial (RCT) is a widely used experimental design to robustly evaluate the efficacy of an intervention by minimising bias through the random allocation of participants to one or more comparison groups. An RCT design is considered the 'gold standard' of experimental design because of this bias reduction. However, there are practical and ethical challenges with using an RCT design in community intervention settings. For example, study participants who do not receive the intervention (i.e., the control group) may become aware they have not received it from study participants who do receive the intervention. Moreover, RCT studies can be expensive to run and therefore beyond the budget of this evaluation study.

[59] Ideally, the control group would be matched with the clients on their health condition for direct comparability. However, only two market research companies were able to provide a Cornwall sample that is representative for some sociodemographic characteristics (age, gender, ethnicity) and they could not offer a matched sample on dietary health condition. Moreover, these companies are significantly more expensive and beyond the budget of this evaluation study.

[60] Cornwall census data (2021): How life has changed in Cornwall: Census 2021 (ons.gov.uk) ; Education, England and Wales - Office for National Statistics (ons.gov.uk)

[61] A Mann-Whitney U test revealed the clients are statistically significantly older (mean rank = 246.53) than the control group participants (mean rank = 154.04), $U = 4038$, $z = 4.132$, $p = .001$. The median age category for WellFed clients was '55 – 64', whereas the median age category for the control group was '35 – 44'.

Table 24, Age category, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Age category	Frequency	Percent	Frequency	Percent
18 – 24	0	0.0	20	6.7
25 – 34	0	0.0	60	20.0
35 – 44	3	17.6	82	27.3
45 – 54	2	11.8	61	20.3
55 – 64	4	23.5	51	17.0
65+	8	47.1	26	8.7
Prefer not to say	0	0.0	0	0.0

Table 25 shows a higher proportion of WellFed clients (58.8%) and the control group (55.3%) are male than female[62].

Table 25, Gender, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Gender	Frequency	Percent	Frequency	Percent
Open text response (if not listed below)	0	0.0	0	0.0
Agender	0	0.0	0	0.0
Female	7	41.2	131	43.7
Gender-fluid	0	0.0	1	0.3
Male	10	58.8	166	55.3
Non-binary	0	0.0	1	0.3
Prefer not to say	0	0.0	1	0.3

Table 26 shows most clients (94.1%) and control group participants (87.3%) stated their ethnicity as 'White British / White Cornish / Other White background'[63].

[62] Most cell counts were too small to conduct a Chi-squared test of homogeneity, but the clients' and control group's reported gender is very similar.

[63] Most cell counts were too small to conduct a Chi-squared test of homogeneity, but the clients' and control group's reported ethnicity is very similar.

Table 26, Ethnicity, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Ethnicity descriptor	Frequency	Percent	Frequency	Percent
Open text response (if not listed below)	0	0.0	0	0.0
Arab / British Arab	0	0.0	2	0.7
Asian / Asian British	0	0.0	11	3.7
Black / African / Caribbean / Black British	0	0.0	14	4.7
Minority Ethnic / Roma / Gypsy / Traveller	0	0.0	1	0.3
Mixed / Multiple ethnic groups	0	0.0	8	2.7
White British / White Cornish / Other White background	16	94.1	262	87.3
Prefer not to say	1	5.9	2	0.7

Table 27 shows almost one quarter of clients (23.6%) and over half of the control group participants (54.3%) have children under the age of 18 living at home; this difference in proportions is statistically significant[64] and likely reflects the older age profile of the WellFed clients.

Table 27, Household composition, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Household composition	Frequency	Percent	Frequency	Percent
Have children (aged under 18) living at home	4	23.6	163	54.3
No children living at home	13	76.5	136	45.3
Prefer not to say	0	0	1	0.3

Survey participants were asked '*What is the highest level of education you have achieved so far?*' The most common response for clients was 'vocational qualification' (35.3%), followed by 'GCSE or O-level' (17.6%; Table 28). The most common response the control group was

[64] An Independent samples t-test revealed that WellFed clients have fewer children living at home (0.41 ± 0.87), compared to the control group (1.02 ± 1.15), a statistically significant difference of 0.61 (95% CI, .15 to 1.07), $t(19.38) = 2.762$, $p = .012$, $d = .533$

'undergraduate degree' (37.7%) followed by 'postgraduate degree' (18.7%). This suggests a lower level of educational attainment among the clients, relative to the control group[65].

Table 28, Education level, pre-intervention survey

Highest level of education achieved so far	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
No formal qualifications	2	11.8	1	0.3
GCSE or O-level	3	17.6	47	15.7
A-level	1	5.9	49	16.3
Undergraduate degree (e.g. Bachelor's)	2	11.8	113	37.7
Postgraduate degree (e.g. Master's, PhD)	2	11.8	56	18.7
Vocational qualification	6	35.3	27	9.0
Other	0	0.0	5	1.7
Prefer not to say	1	5.9	2	0.7

Table 29 presents the survey participants' employment status; a smaller proportion of WellFed clients (5.9%) are in full-time employment than control group participants (61.7%). A higher proportion of WellFed clients (52.9%) than control group participants (9.0%) are retired[66].

Table 29, Employment status, pre-intervention survey

Current employment status	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Employed full time (30+ hours per week)	1	5.9	185	61.7
Employed part time (less than 30 hours per week)	3	17.6	32	10.7
Self-employed	2	11.8	18	6.0
Unemployed	0	0.0	17	5.7
Looking after the home or family	1	5.9	8	2.7

[65] Most cell counts were too small to conduct a Chi-squared test of homogeneity, but Table 28 indicates clear differences in the clients' and control group's educational attainment.

[66] A higher proportion of WellFed clients (52.9%) are retired, compared to the control group (9.7%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$. Most cell counts were too small to conduct a Chi-squared test of homogeneity.

	WellFed clients (n=17)		Control group (n=300)	
Current employment status	Frequency	Percent	Frequency	Percent
Studying	0	0.0	7	2.3
Retired	9	52.9	27	9.0
Volunteering	0	0.0	1	0.3
Other	1	5.9	4	1.3
Prefer not to say	0	0.0	1	0.3

For household combined income, Table 30 shows WellFed clients tend to earn statistically significantly less than the control group[67]. The median income category for the clients was '£19,000 - £25,999', whereas the median for the control group was 'more than £39,000'. Almost half of clients (47.1%) preferred not to answer the question about their income.

Table 30, Household combined income (per year, before tax deductions), pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Household income category	Frequency	Percent	Frequency	Percent
Less than £12,999	3	17.6	13	4.3
£13,000 - £18,999	0	0.0	15	5.0
£19,000 - £25,999	2	11.8	35	11.7
£26,000 - £38,999	3	17.6	72	24.0
More than £39,000	1	5.9	159	53.0
Prefer not to say	8	47.1	6	2.0

5.5.2 Diet

Clients and control group participants were asked how many portions of fruit and veg they eat in a typical day. Figure 23 shows clients typically eat less fruit and veg than control group participants, although these differences are not statistically significant (Independent samples t-test).

[67] A Mann-Whitney U test revealed the WellFed clients' combined household income (mean rank = 74.11) is statistically significantly lower than the control group participants (mean rank = 154.38), $U = 622$, $z = -2.962$, $p = .003$. The median income category for the clients was '£19,000 - £25,999', whereas the median for the control group was 'more than £39,000' (with the 'prefer not to say' responses removed from the ordinal scale).

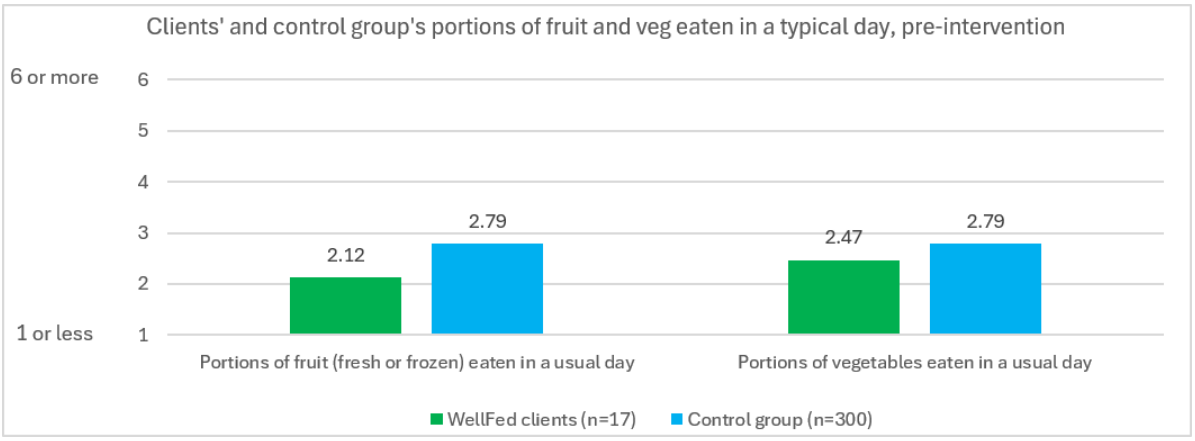

Figure 23, Portions of fruit and veg eaten by clients and control group participants in a typical day, pre-intervention survey

Survey participants were asked about the frequency of healthy and unhealthy food habits. Figure 24 shows WellFed clients reported eating sugary or high-fat snacks statistically significantly less frequently than control group participants[68].

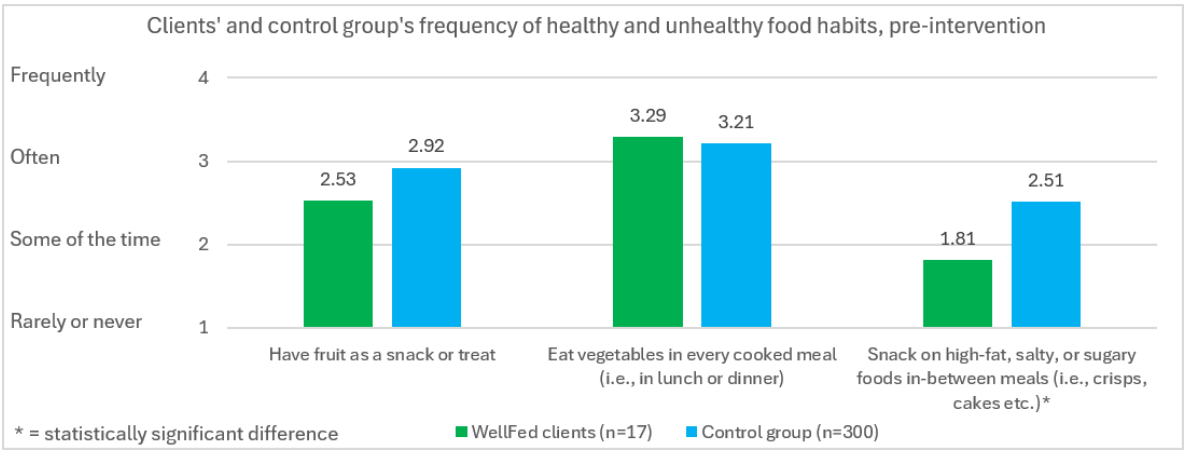

Figure 24, Clients' and control group's frequency of healthy and unhealthy food habits, pre-intervention survey

Survey participants were asked a further question about the frequency of food habits to triangulate the findings presented in Figure 24; Clients reported eating ready-made meals or takeaways less frequently than the control group, although this difference is not statistically significant (Figure 25; Mann-Whitney U test).

[68] An independent samples t-tests revealed that WellFed clients reported eating sugary or high-fat snacks less frequently (1.81 ± 0.91), compared to the control group (2.51 ± 0.95), a statistically significant difference of 0.70 (95% CI, .20 to 1.19), $t(16.794) = 2.972$, $p = .009$, $d = .734$.

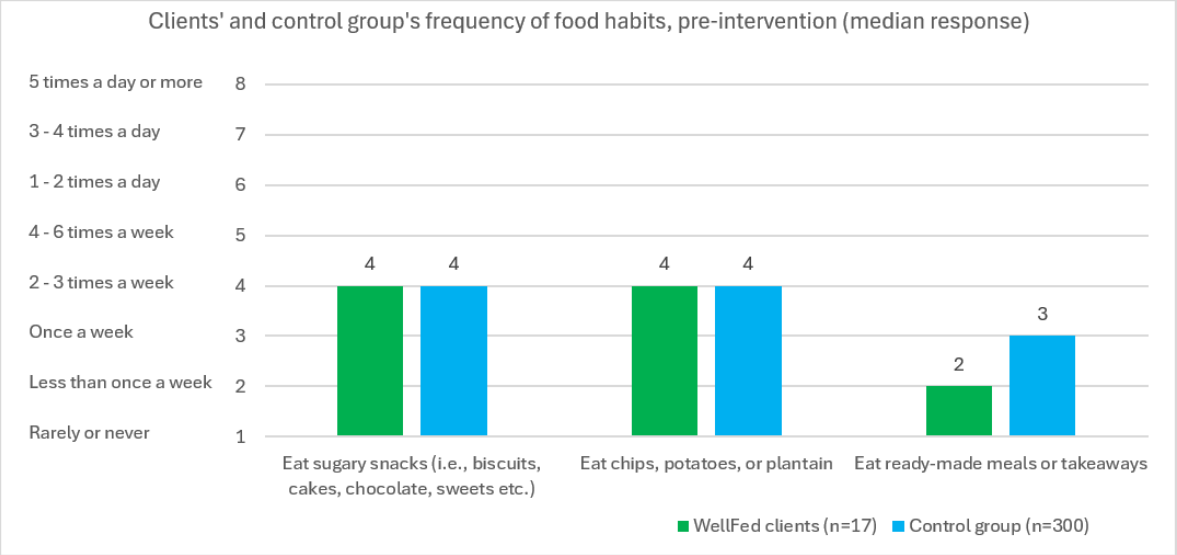

Figure 25, Clients' and control group's frequency of eating less healthy food, pre-intervention survey

Survey participants were asked about their meat consumption. Figure 26 shows clients tend to have fewer meat-free days per week than control group participants, although this difference is not statistically significant (Mann-Whitney U test).

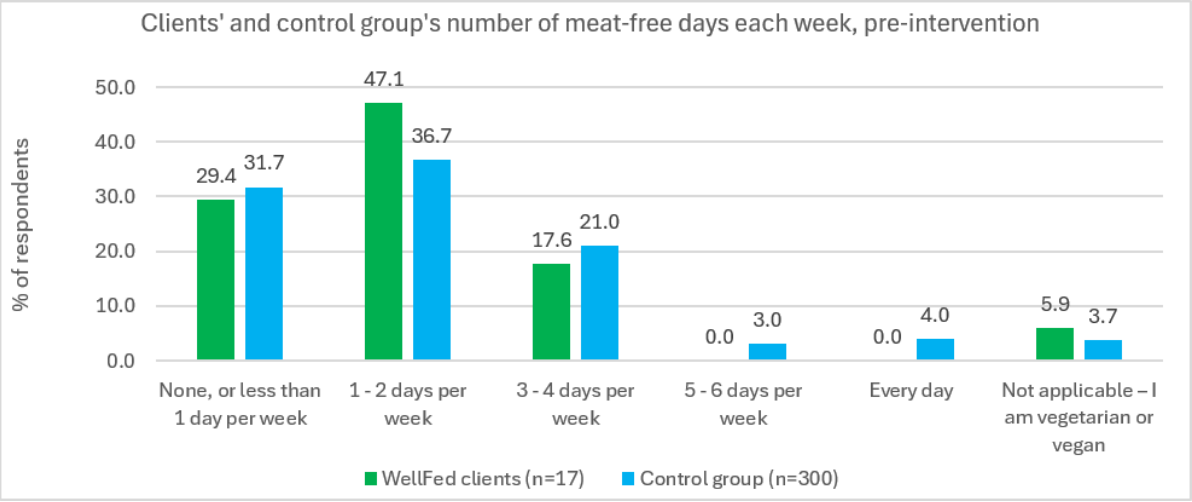

Figure 26, Clients' and control group's frequency of meat-free days per week, pre-intervention survey

Clients and control group participants were asked whether they have any dietary restrictions or intolerances. Table 31 shows a statistically significantly higher proportion of clients (29.4%) have a dietary intolerance than control group participants (10.0%)[69].

[69] A larger proportion of clients (29.4%) have a dietary intolerance than control group participants (10.0%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .024$.

Table 31, Clients' and control group's dietary intolerances, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Have a dietary intolerance	5	29.4	30	10.0
Do not have a dietary intolerance	11	64.7	265	88.3
Prefer not to say	1	5.9	5	1.7

5.5.3 Food knowledge and capabilities

Clients and control group participants were asked three questions about their food competences in the survey. Figure 27 shows WellFed clients are less confident than the control group in buying and cooking fresh vegetables, although these differences are not statistically significant (Independent samples t-test).

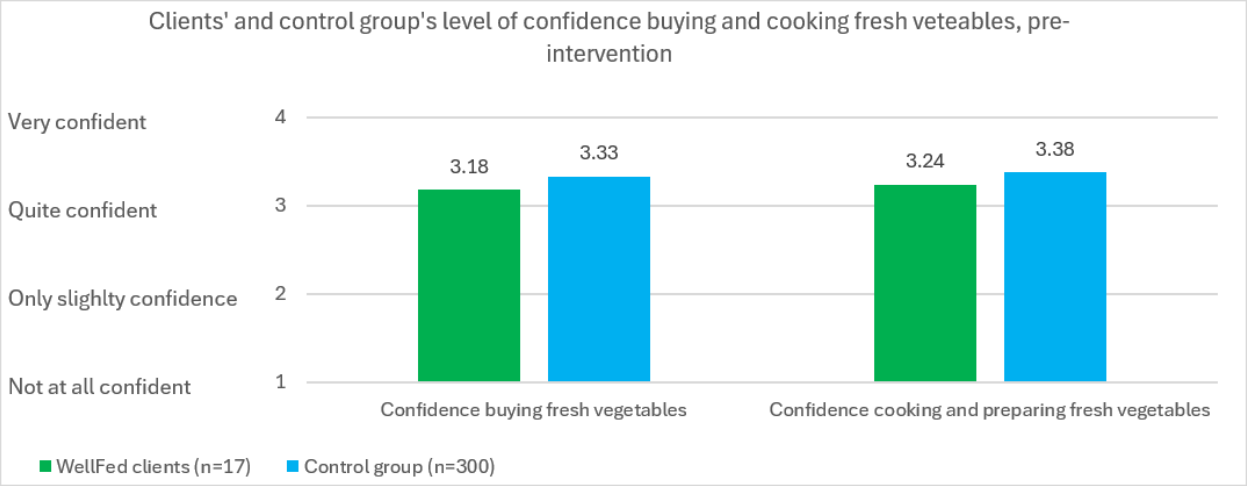

Figure 27, Clients' and control group's level of confidence buying and cooking fresh vegetables, pre-intervention survey

Participants were asked how frequently they throw away different types of food. Figure 28 shows WellFed clients typically waste less food than the control group for all food categories. Clients' food waste is statistically significantly less frequent than the control group for meat, fish and dairy[70].

[70] Independent samples t-tests revealed:

- WellFed clients reported lower levels of wasting meat each week (1.06 ± 0.25), compared to the control group (1.92 ± 1.07), a statistically significant difference of 0.86 (95% CI, .68 to 1.03), $t(58.55) = 9.585$, $p = .001$, $d = .815$
- WellFed clients reported lower levels of wasting fish each week (1.12 ± 0.33), compared to the control group (1.69 ± 1.02), a statistically significant difference of 0.57 (95% CI, .36 to .78), $t(40.90) = 5.572$, $p = .001$, $d = .574$

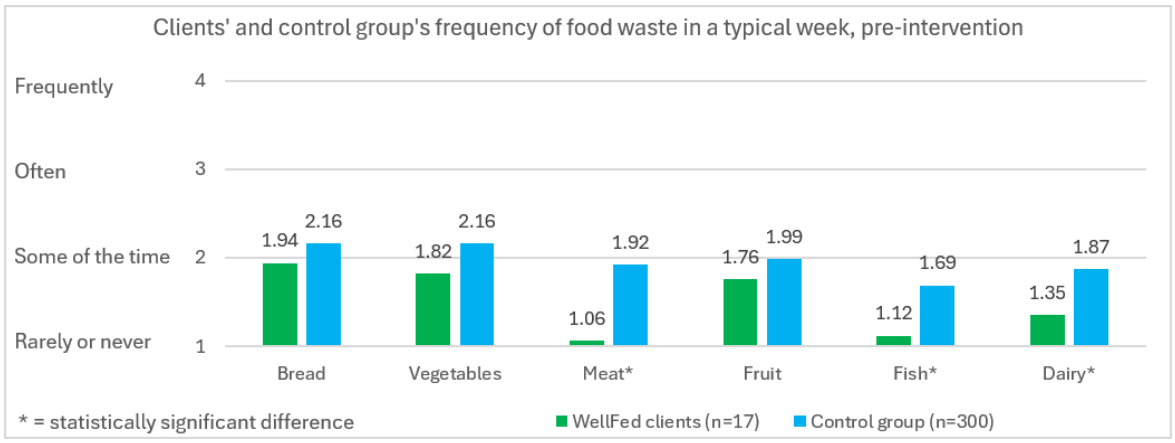

Figure 28, Clients' and control group's frequency of throwing away food in a typical week, pre-intervention survey

5.5.4 Physical health

The survey included seven questions which explored physical health. Table 32 shows most (58.8%) clients have a long-standing illness, injury or disability that limits their normal day-to-day activities; this is a statistically significantly higher proportion than the control group (16.7%)[71].

Table 32, Proportion of clients and control group participants with a long-term health condition, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
Health condition	Frequency	Percent	Frequency	Percent
Have a long-term physical or mental health condition	10	58.8	50	16.7
Do not have a long-term physical or mental health condition	7	41.2	238	79.3
Prefer not to say	0	0.0	12	4.0

Survey participants were asked about their use of health care services. Table 33 shows WellFed clients require statistically significantly more GP appointments and daily medications

— WellFed clients reported lower levels of wasting dairy products each week (1.35 ± 0.79), compared to the control group (1.87 ± 1.07), a statistically significant difference of 0.52 (95% CI, .09 to 0.93), $t(19.69) = 2.550$, $p = .019$, $d = .483$

[71] A larger proportion of WellFed clients (58.8%) have a long-term health condition, compared to the control group (16.7%). A Fisher's exact test revealed this difference in proportions is statistically significant, $p = .001$.

than the control group[72]. This is not surprising, given the prevalence of long-term health conditions among the WellFed clients.

Table 33, Clients' and control group's demand for health care services, pre-intervention survey

Demand for health care	WellFed clients (n=17)	Control group (n=300)
Mean number of GP / family doctor appointments in last 3 months (about your own health)	3.65	1.39
Mean number of hospital visits in the last 3 months (about your own health)	1.82	0.67
Mean number of different medications or inhalers you take daily	5.18	1.54

Survey participants were presented with three statements about their health and asked: *'When thinking about yourself, how much do you agree or disagree with each statement?'*. Figure 29 shows WellFed clients feel less confident than the control group that they can prevent or reduce problems that relate to their health, although this difference is not statistically significant (Independent samples t-test).

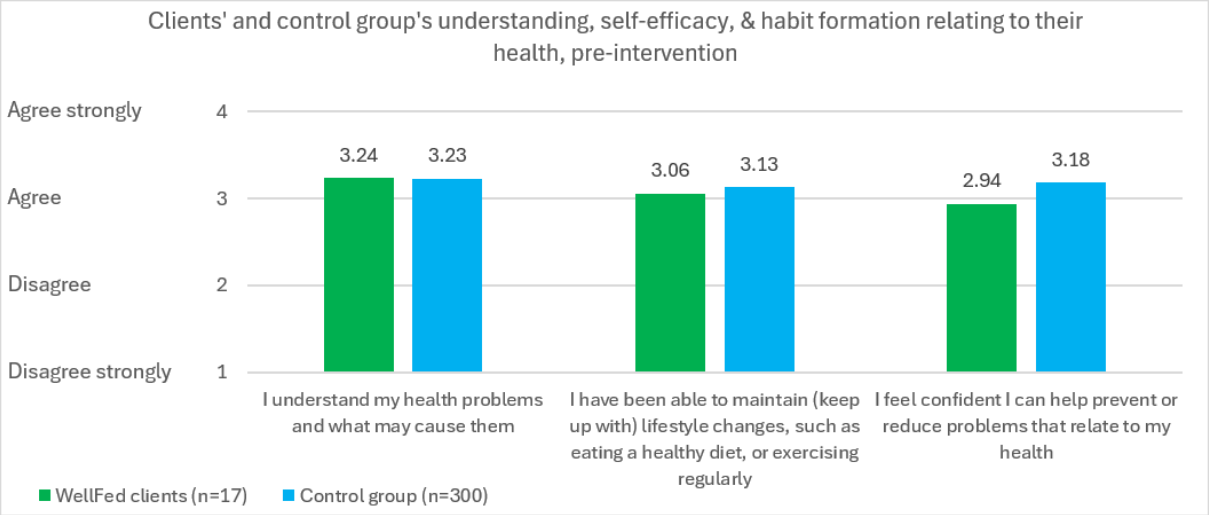

Figure 29, Clients' and control group's understanding, self-efficacy, and habit formation relating to their health, pre-intervention survey

[72] Independent samples t-tests revealed:

— WellFed clients reported requiring more GP appointments in the past 3 months (3.65 ± 3.94), compared to the control group (1.39 ± 1.53), a statistically significant difference of -2.26 (95% CI, -4.29 to -0.23), $t(16.275) = -2.354$, $p = .031$, $d = -1.302$

— WellFed clients reported requiring more daily medications (5.18 ± 3.47), compared to the control group (1.54 ± 1.96), a statistically significant difference of -3.64 (95% CI, -5.43 to -1.85), $t(16.585) = -4.288$, $p = .001$, $d = -1.763$

5.5.5 Wellbeing and mental health

The survey integrated Meaningful Measures' Measure Yourself Concerns and Wellbeing® (MYCaW), a tool widely used in health and social care settings to assess clients' wellbeing and mental health over time. Participants were asked to state one or two concerns or problems that they are most worried about now. They were then asked to indicate how severe these concern(s) or problem(s) are now, on a 7-point scale.

Table 34 shows clients' most frequently reported concerns are physical health concerns and worrying about family members, whereas the control group's most reported concerns are the cost of living and worrying about family members.

Table 34, Clients' and control group's primary and secondary concerns, pre-intervention survey

Clients' (n=16) Concern 1	Frequency	Percent	Client's (n=13) Concern 2	Frequency	Percent
Physical health: non-dietary	6	37.5	Physical health: non-dietary	5	38.5
Family members	4	25.0	Physical health: dietary	3	23.1
Mental health	2	12.5	Finances	2	15.4
Physical health: dietary	1	6.3	Isolation/ loneliness	1	7.7
Accessing medical care	1	6.3	Family members	1	7.7
Finances	1	6.3	State of the country	1	7.7
Isolation/ loneliness	1	6.3			
Control group (n=300) Concern 1	Frequency	Percent	Control group (n=300) Concern 2	Frequency	Percent
Cost of living/ finances	76	25.3	Cost of living/ finances	27	9.0
Family members	34	11.3	Physical health	10	3.3
Physical health	27	9.0	Lack of housing	10	3.3
Lack of housing	20	6.7	Lack of jobs	9	3.0
Lack of jobs	13	4.3	Family members	8	2.7
Immigration	12	4.0	Crime	5	1.7

Figure 30 shows WellFed clients[73] are slightly less concerned than control group participants about their primary and secondary concern, but these differences are not statistically significant (Independent samples t-test).

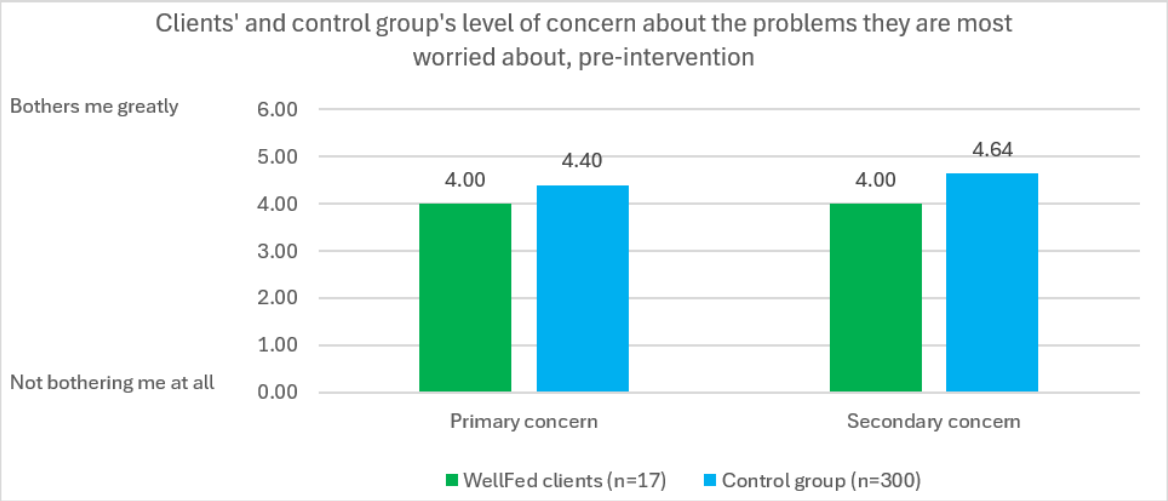

Figure 30, Clients' and control group's level of concern about problems they are most worried about, pre-intervention survey

Survey participants were asked to rate their general feeling of wellbeing now (how they feel in themselves), on a 7-point scale (Meaningful Measures' Measure Yourself Concerns and Wellbeing®). Figure 31 shows clients reported slightly more positive overall wellbeing than the control group, although this difference is not statistically significant (Independent samples t-test).

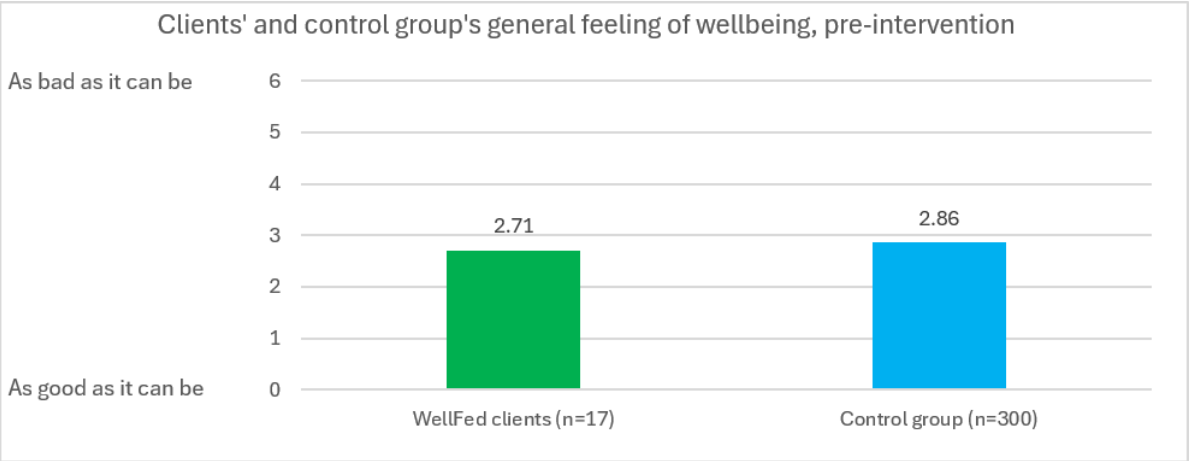

Figure 31, Clients' and control group's general feeling of wellbeing, pre-intervention survey

[73] The clients' mean for the secondary concern is lower than the clients' mean presented in Figure 16. This is because 14 clients recorded a secondary concern in the pre-intervention survey, but only 10 clients recorded a secondary concern in the post-intervention survey. Thus, fewer listwise comparisons were possible for the within-group analysis (n=10, rather than n =14), producing a slightly different mean.

5.5.6 Levels of physical activity

The survey included four questions which explored the clients' and control group's levels of physical activity. Participants were asked; *'5.1 In the past seven days, on how many days have you done 15 minutes or more of physical activity?'* Figure 32 shows WellFed clients exercise less frequently than control group participants, although this difference is not statistically significant (Independent samples t-test). The mean frequency for clients was 2.6 days of exercise per week, whereas mean frequency for the control group was 3.2 days per week.

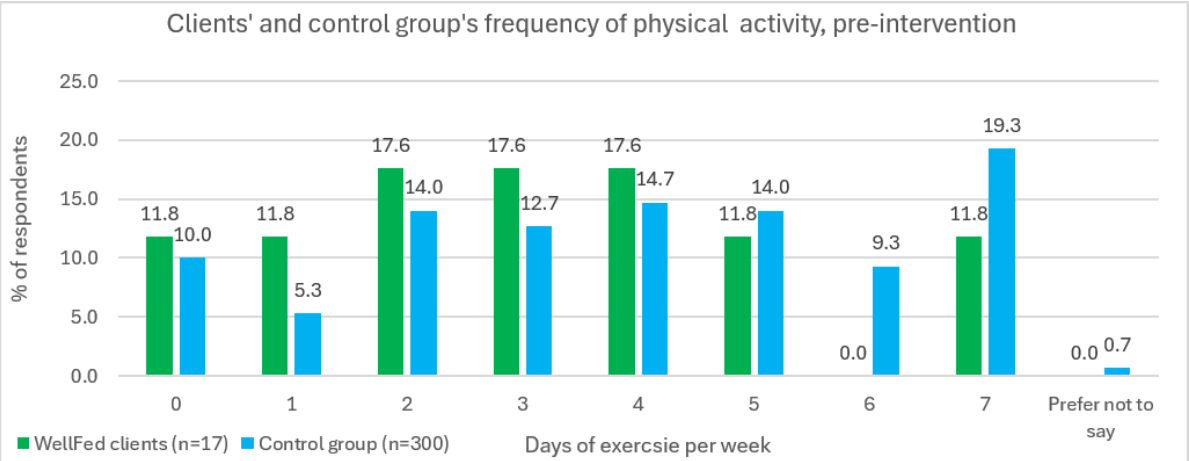

Figure 32, Clients' and control group's number of days of physical activity per week, pre-intervention survey

Participants were asked to indicate their level of agreement that they: i) have the opportunity to be physically active, ii) have the ability to be physically active, and iii) if they enjoy physical activity (Figure 33). The clients and control group are similar in terms of their enjoyment and their opportunity for physical exercise. WellFed clients reported a lower ability to be physically active than control group participants, but this difference is not statistically significant (Independent samples t-test).

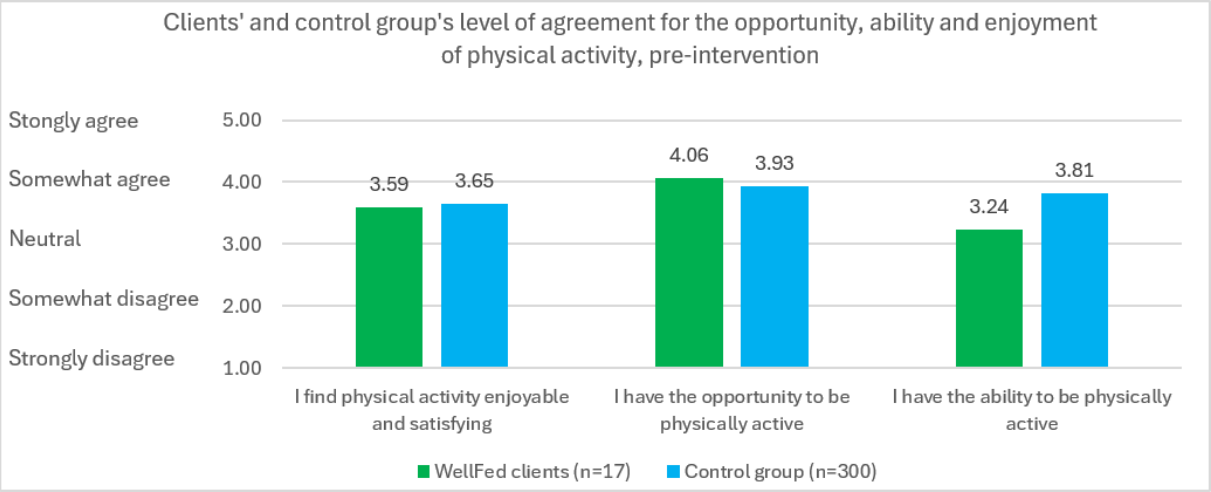

Figure 33, Clients' and control group's level of agreement that they have the opportunity, ability, and enjoyment of physical activity, pre-intervention survey

5.5.7 Engagement in community activities

The survey included four questions which measured clients' and the control group's level of engagement in community activities in their area. Participants were asked how often they take part in organised community activities, for example, social clubs or meetups, exercise groups, or volunteering activities. Table 35 shows WellFed clients take part in community activities more frequently than control group participants, although this difference is not statistically significant (Independent samples t-test).

Table 35, Frequency of taking part in community activities, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Rarely or never	4	23.5	89	29.7
Some of the time	7	41.2	116	38.7
Often	5	29.4	76	25.3
Most of the time	1	5.9	19	6.3
Mean frequency	2.18		2.08	

Participants were asked whether they feel more connected and involved in their community. Figure 34 shows the WellFed clients and the control group are similar in terms of feeling part of their community, knowing what's going on in their community, and knowing how to get support they need. These differences are not statistically significant (Independent samples t-test).

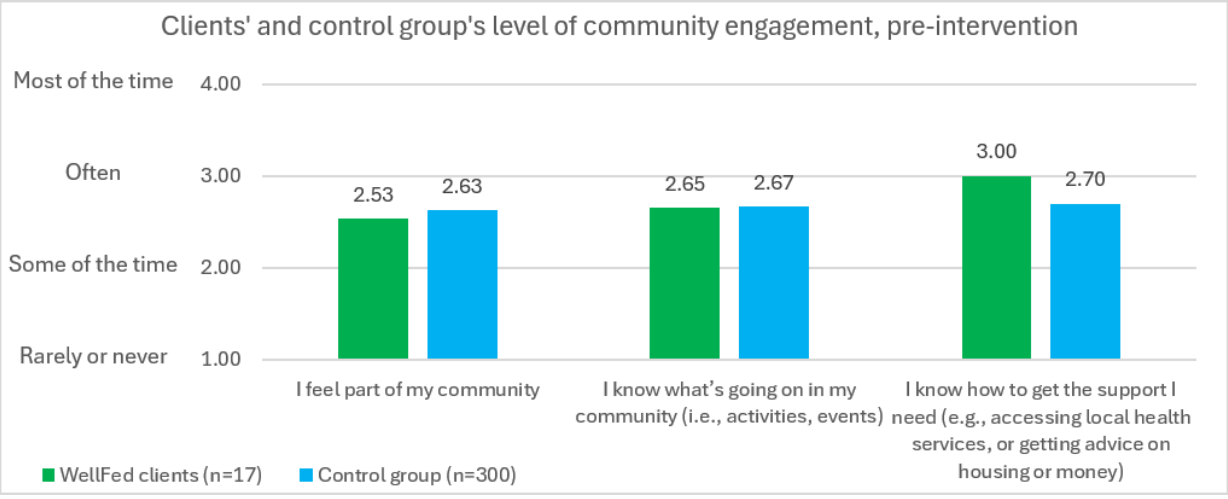

Figure 34, Clients' and control group's level of feeling connected and involved in their local community, pre-intervention survey

5.5.8 Barriers to eating a healthy diet

The survey included five questions which explored barriers to eating a healthy diet. Survey participants were asked whether they find it easy to get fruit and vegetables for themselves and their family (Table 36); 17.6% of clients and 12.7% of the control group stated they did not find this easy, although this difference is not statistically significant (Fisher's exact test).

Table 36, Clients' and control group's ease of getting fresh fruit and vegetables, pre-intervention survey

	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Find it easy to get fresh fruit & veg	14	82.4	262	87.3
Do not find it easy to get fresh fruit & veg	3	17.6	38	12.7

Survey participants were asked about possible reasons why they may not eat enough fruit and veg (Table 37). 'Cost' was the most reported barrier for clients (52.9%) and for control group participants (35.0%), while 'quality/freshness' was the second most reported barrier for both groups. None of the differences presented in Table 37 are statistically significant (Fisher's exact test).

Table 37, Barriers which prevent clients and control group participants from eating plenty of fruit and vegetables, pre-intervention survey

Barrier (participants could select multiple barriers)	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Cost	9	52.9	105	35.0
Quality/freshness	5	29.4	87	29.0
Storage (e.g., kitchen space, fridge, freezer)	4	23.5	56	18.7
Time to shop and cook	3	17.6	47	15.7
Not enough variety in the food shops	3	17.6	36	12.0
Health conditions make shopping or cooking difficult	3	17.6	26	8.7

Barrier (participants could select multiple barriers)	WellFed clients (n=17)		Control group (n=300)	
	Frequency	Percent	Frequency	Percent
Cooking knowledge (e.g., how to cook a wide range of fruit and veg)	2	11.8	40	13.3
Other pressing needs	2	11.8	11	3.7
Distance from food shops	1	5.9	30	10.0
Equipment (e.g., pots, pans, stove)	0	0.0	17	5.7
Not applicable - there is nothing that stops me from getting and eating enough fresh fruit and veg	5	29.4	93	31.0

Survey participants were asked about their financial situation and how this may affect their access to food (Figure 35). WellFed clients reported having smaller meals than usual or skipped meals statistically significantly less frequently than the control group[74]. It is not clear why this might be, given clients typically have a lower household income than the control group.

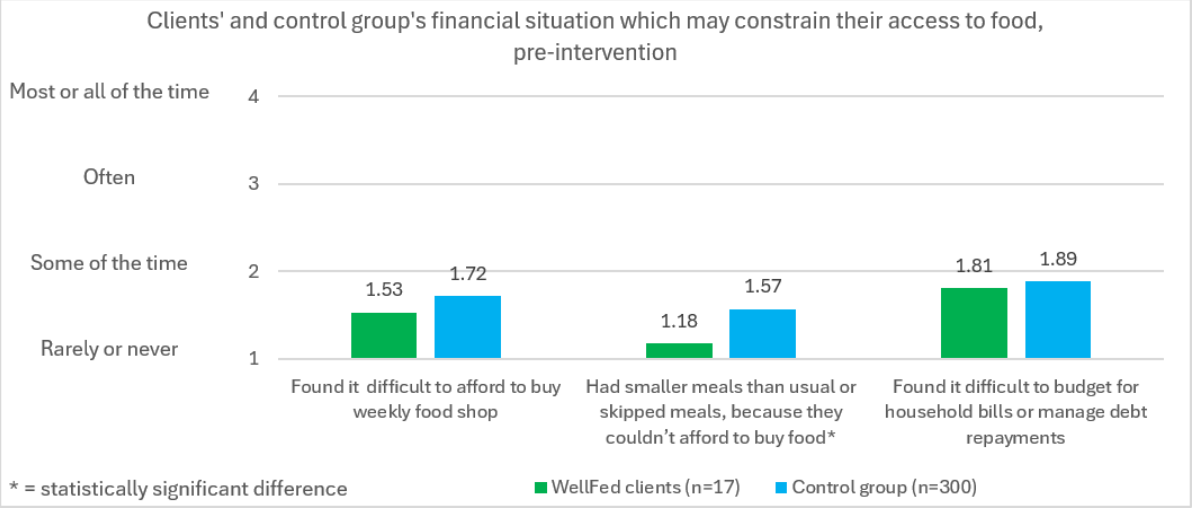

Figure 35, Clients' and control group's financial situation which may constrain their access to food, pre-intervention survey

[74] An Independent samples t-test revealed that WellFed clients reported having smaller meals than usual or skipped meals less frequently (1.18 ± 0.73), compared to the control group (1.57 ± 0.84), a statistically significant difference of 0.39 (95% CI, .01 to .78), $t(18.528) = 2.144$, $p = .046$, $d = .470$

5.6 Data collection protocols

This appendix is the data collection protocols that were used for the WellFed pilot evaluation study. Table 38 presents the pre- and post-intervention survey structure.

Table 38, Overview of the pre- and post-intervention survey to measure participant outcomes of the WellFed pilot

Block	Theme	Sub-themes	Survey
1	ID number	Anonymous participant ID number	Pre- & Post-
2	Community and social engagement	Awareness of community activities; frequency of taking part in community activities; social interaction	Pre- & Post-
3	Wellbeing	Meaningful Measures' Measure Yourself Concerns and Wellbeing® tool; Understanding of health condition, perceived self-efficacy, habit formation	Pre- & Post-
4	Reported physical health	Number of GP appointments, hospital visits and prescriptions in past 3 months; HbA1c level	Pre- & Post-
5	Physical activity	Frequency of physical activity; ability, opportunity and enjoyment of physical activity	Pre- & Post-
6	Sociodemographic characteristics	Partial postcode; age; gender; ethnicity; household composition; long-term health condition; education level; employment status; income level	Pre-
7	Food capabilities	Confidence buying and preparing fresh vegetables; food waste	Pre- & Post-
8	Healthier diets	Healthy food choices; dietary restrictions; portions of daily fruit & veg; barriers to eating a healthy diet; meat consumption	Pre- & Post-
9	Accessibility and social equity	Affordability and access to healthy food	Pre- & Post-
10	Open feedback		Pre- & Post-
11	Impact of pilot	Perceived benefits of participation; attribution of positive lifestyle changes; benefits the clients' experience to the pilot	Post-

Block	Theme	Sub-themes	Survey
12	Experience of the pilot	Level of satisfaction with the WellFed pilot; open feedback on experience	Post-
13	Debrief		Pre- & Post-

5.6.1 Pre-intervention survey protocol – WellFed pilot clients and the control group

Pre-intervention survey part A – Health, wellbeing, and community

1 Participant information sheet and ID number
Instructions on navigating the survey goes here.

Participant information sheet goes here (client's consent is captured in a separate survey to ensure their anonymity).

_____

1.1) Which community food project is the client connected with?

Please select the grower or project name and then enter the client's anonymous ID number in the box below (For example, for the first client to work with Community Roots, please enter '**CR 1**', the third client working with Goonown Growers would be '**GG 3**', and so on).

Important! Please keep a record of the client's ID number yourself, so we can match their responses for the pre- and post-intervention surveys.

- Bosavern Community Farm (**BCF**)
- Camborne - Veor Surgery (**V**)
- Wadebridge / Camelford - Camel CSA / Nourish Kernow CIC (**CNK**)
- Community Roots (**CR**)
- Food Troops CIC / Grassroots Garden CIC (**FTG**)
- Hayle - Sustainable Hayle (**SH**)
- Helston (**POM**)
- Goonown Growers (**GG**)
- Growing Links (**GL**)
- Newquay Orchard (**NO**)
- **Not listed**

- Falmouth - Loveland (**LOV**)
- Liskeard - Tamar Grow Local / Healthy Cornwall (**TGL**)
- Scilly - Salakee Farm (**SAL**)
- St Ives (**SICO**)
- Truro - CHAOS Farm (**CHA**)

Survey logic: once the community grower is selected, a box appears at the bottom of the screen with this instruction:

Please enter the client's anonymous ID number below: _____

(Open text, response is compulsory for matching the survey data sets)

_____

2 Community and social engagement
Intro: The first few questions are about your involvement in your local community.

_____

2.1) How often do you take part in organised community activities?
For example, social clubs or meetups, exercise groups, or volunteering activities.

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most of the time).

_____

2.2) Please complete these statements using one of the four options below:

- 2.2a) I feel part of my community
- 2.2b) I know what's going on in my community (i.e., activities, events)
- 2.3b) I know how to get the support I need (e.g., accessing local health services, or getting advice on housing or money)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most of the time).
Survey logic: randomise the order the statements are presented.

_____

3 Wellbeing
Intro: The next few questions ask about your health and wellbeing.

_____

3.1) Please tell me one or two concerns or problems that you are most worried about.

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- Concern or problem 1_____
- Concern or problem 2 (optional)_____

(Open text response)

3.2) Please select a number to show how severe each concern or problem is now, on a scale of 0 (Not bothering me at all) to 6 (Bothers me greatly).

This should be your opinion, no-one else's!

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- Concern or problem 1
- Concern or problem 2 (optional)

(Scale: Q3.2 uses a 7-point scale, 0-6, supported with (non-)smiley faces visual cue, e.g.,

3.3) How would you rate your general feeling of wellbeing now, on a scale of 0 (As good as it can be) to 6 (As bad as it can be)?
(i.e., How do you feel in yourself?)

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- My wellbeing now

(Scale: Q3.3 uses a 7-point scale, 0-6, supported with (non-)smiley faces visual cue, e.g.,

---

4 Physical health
Intro: Next, a few questions about your physical health.

4.1) Below are some statements that people sometimes make when they talk about their health.

When thinking about yourself, how much do you agree or disagree with each statement?

Your answers should be what is true for you and not just what you think the doctor or anyone else wants you to say.

- 4.1a) I understand my health problems and what may cause them
- 4.1b) I have been able to maintain (keep up with) lifestyle changes, such as eating a healthy diet, or exercising regularly
- 4.1c) I feel confident I can help prevent or reduce problems that relate to my health

(Scale: 1 = Disagree strongly ; 2 = Disagree ; 3 = Agree ; 4 = Agree strongly; 5 = Prefer not to say).
Survey logic: randomise the order the statements are presented.

4.2) In the last 3 months, approximately how many times have you talked to or visited a GP / family doctor about your own health?

Please move the slider into the correct position.
If 'zero' appointments, please click on slider to register '0'.
If 'prefer not to say', skip through this question.

(Scale: 0 appointments – 20 appointments or more)

4.3) In the last 3 months, approximately how many times have you visited hospital about your own health?

Please move the slider into the correct position.
If 'zero' visits, please click on slider to register '0'.
If 'prefer not to say', skip through this question.

(Scale: 0 visits – 20 visits or more)

4.4) Approximately how many different medications or inhalers do you take daily?

Please move the slider into the correct position.
If 'zero' medications or inhalers, please click on slider to register '0'.
If 'prefer not to say', skip through this question.

(Scale: 0 medications/inhalers – 10 medications/inhalers or more)

_____

4.5) If you know it, what was your most recent HbA1c level?

(Slider question; Scale: 10 or under (mmol/mol) to 75 or above (mmol/mol)

_____

5 Physical activity
Intro: These questions ask about physical activity or exercise that you do.

_____

5.1) In the past seven days, on how many days have you done 15 minutes or more of physical activity?

By 'physical activity', we mean movement that raises your breathing rate. It includes exercise, brisk walking, or cycling for recreation or to get to and from places. Please do not include housework or physical activity that is part of your job.

(Scale: 0 – 7 days, 8 = Prefer not to say).

_____

5.2) Please rate your level of agreement with the following statements:

By 'physical activity', we mean movement that raises your breathing rate. It includes exercise, brisk walking, or cycling for recreation or to get to and from places. Please do not include housework or physical activity that is part of your job.

- 5.2a) I find physical activity enjoyable and satisfying
- 5.2b) I have the opportunity to be physically active
- 5.2c) I have the ability to be physically active

(Scale: 1 = Strongly agree; 2 = somewhat agree; 3 = neither agree nor disagree; 4 = somewhat disagree; 5 = strongly disagree; 6 = prefer not to say)

6 Sociodemographic characteristics

Intro: We'd like to know a bit more about you. This will help us understand who is taking part in the pilot.

As we mentioned earlier, all of your responses are confidential and will be anonymised.

_____

6.1) What is your partial postcode?

This is your postcode without the final two letters (e.g., PL31 2)

1. Select to enter postcode _____
2. Prefer not to say

Open text response

_____

6.2) What is your age?

1. 18 - 24
2. 25 - 34
3. 35 - 44
4. 45 - 54
5. 55 - 64
6. 65 and over
7. Prefer not to say

_____

6.3) How would you describe your gender?

1. Open text response (if not listed below)_____
2. Agender
3. Female
4. Gender-fluid
5. Male
6. Non-binary
7. Prefer not to say

This question is asked by the Health Coach/Social Prescriber/Community Food Grower as an open text question, but we provide a list of the more frequently identified genders to facilitate data entry, as well as providing an open text response if the participant's gender is not listed (i.e., option 1 above).

_____

6.4) How would you describe your ethnic group or background?

1. Open text response (if not listed below)_____
2. Arab / British Arab
3. Asian / Asian British
4. Black / African / Caribbean / Black British
5. Minority Ethnic / Roma / Gypsy / Traveller
6. Mixed / Multiple ethnic groups
7. White British / White Cornish / Other White background
8. Prefer not to say

As with 6.3) Gender, this question is asked by the Health Coach/Social Prescriber/Community Food Grower as an open text question, but we provide a list of the more frequently identified ethnic groups to facilitate data entry, as well as providing an open text response option if the ethnic group is not listed (i.e., option 1 above)

_____

6.5) How many children or young people live in your household? (i.e., aged under 18)
We ask this question to understand whether family responsibilities may affect your food choices.

1. 0
2. 1
3. 2
4. 3
5. 4
6. 5 or more
7. Prefer not to say

_____

6.6) Do you have a long-standing illness, injury or disability that limits your normal day-to-day activities?

By 'long-standing' we mean anything that has troubled you over a period of time. 'Normal day-to-day activities' includes things like eating, washing, walking, and going shopping.

1. Yes
2. No
3. Prefer not to say

_____

6.7) What is the highest level of education you have achieved so far?

1. No formal qualifications
2. GCSE or O-level
3. A-level
4. Undergraduate degree (e.g. Bachelor's)
5. Postgraduate degree (e.g. Master's, PhD)
6. Vocational qualification
7. Other
8. Prefer not to say

_____

6.8) Which of the following best describes your current employment status:

1. Employed full time (30+ hours per week)
2. Employed part time (less than 30 hours per week)
3. Self-employed
4. Unemployed
5. Looking after the home or family
6. Studying
7. Retired
8. Volunteering
9. Other
10. Prefer not to say

_____

6.9) Please indicate the approximate combined income of your household (per year, before tax deductions):

1. Less than £12,999
2. £13,000 - £18,999
3. £19,000 - £25,999
4. £26,000 - £38,999
5. More than £39,000

6. Prefer not to say

In the online survey tool the survey is separated into two surveys here (Part A and Part B), in case the participant cannot complete all of the questions in one go.

Pre-intervention survey part B – Dietary choices, food capabilities, access to food
If pre-survey part B is conducted in a different session or with a different facilitator, please briefly present the participant information sheet again and verbally reaffirm the participant's informed consent before completing Part B.

7 Food capabilities
Intro: These questions are about the food you buy and cook.

7.1) How confident do you feel about buying fresh vegetables?

(Scale: 1 = Not at all confident ; 2 = Only slightly confident ; 3 = Quite confident ; 4 = Very confident)

7.2) How confident do you feel about preparing and cooking fresh vegetables?

(Scale: 1 = Not at all confident ; 2 = Only slightly confident ; 3 = Quite confident ; 4 = Very confident)

7.3) In a typical week, how often do you throw away these types of food? (part 1)

Please include food past its 'use by' date and leftovers from meals.

- 7.3a) Bread
- 7.3b) Vegetables
- 7.3c) Meat

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food).
Survey logic: randomise the order the food types are presented.

7.4) In a typical week, how often do you throw away these types of food? (part 2)

Please include food past its 'use by' date and leftovers from meals.

- 7.4a) Fruit
- 7.4b) Fish
- 7.4c) Dairy (e.g., milk, cheese, yoghurt etc.)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food).
Survey logic: randomise the order the food types are presented.

---

8 Healthier diets
Intro: The next few questions are about the food you eat.

There is no judgement here.

Please just be as honest as you can, it really helps us to work with you.

8.1) How often do you:

- 8.1a) Have fruit as a snack or treat
- 8.1b) Eat vegetables in every cooked meal (i.e., in lunch or dinner)
- 8.1c) Snack on high-fat, salty, or sugary foods in-between meals (i.e., crisps, cakes etc.)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food). *Randomise the order the food practices are presented.*

8.2) Do you have any dietary restrictions or intolerances?

1. Yes (if you wish, please specify:_____)
2. No
3. Prefer not to say

8.3) How often do you eat:

- 8.3a) Sugary snacks (i.e., biscuits, cakes, chocolate, sweets etc.)

- 8.3b) Chips, potatoes, or plantain
- 8.3c) Ready-made meals or takeaways

(Scale: 1 = Rarely or never ; 2 = Less than once a week ; 3 = Once a week ; 4 = 2 - 3 times a week ; 5 = 4 - 6 times a week ; 6 = 1 - 2 times a day ; 7 = 3 - 4 times a day ; 8 = 5 times a day or more)

(Pictures included as a visual cue)
Survey logic: randomise the order the food items are presented.

8.4) How many portions of fruit (fresh or frozen) do you eat in a usual day?

An example of a portion could be 1 x handful of grapes or berries or 1 x medium-sized orange, apple or banana.

(Scale: 1 or less; 2; 3; 4; 5; 6 or more)
(Pictures included as a visual cue)

8.5) How many portions of vegetables do you eat in a usual day?

An example of a portion could be 1 x cup of leafy raw vegetables or salad, or half a cup of root vegetables like carrots, potatoes, celery, beetroot.

(Scale: 1 or less; 2; 3; 4; 5; 6 or more)
(Pictures included as a visual cue)

8.6) Do you find it easy to get fruit and vegetables for you and your family

1. Yes
2. No

8.7) What do you feel are the main reasons or barriers that stop you from eating plenty of fruit and vegetables?
Please tick all the boxes that apply to you

1. Cost
2. Distance from food shops

3. Time to shop and cook
4. Not enough variety in the food shops
5. Quality/freshness
6. Storage (e.g., kitchen space, fridge, freezer)
7. Equipment (e.g., pots, pans, stove)
8. Cooking knowledge (e.g., how to cook a wide range of fruit and veg)
9. Health conditions make shopping or cooking difficult
10. Other pressing needs
11. Not applicable - there is nothing that stops me from getting and eating enough fresh fruit and veg (exclusive response option)

Survey logic: randomise the order the barriers are presented.

8.8) In a typical week, how many days is your diet 'meat-free'? (i.e., you do not eat any meat or fish)

1. None, or less than 1 day per week
2. 1 - 2 days per week
3. 3 - 4 days per week
4. 5 - 6 days per week
5. Every day
6. Not applicable – I am vegetarian or vegan

---

9 Accessibility and social equity

Intro: Finally, we'd like to ask you a few questions about your personal circumstances.

9.1) In the last month, have you found it difficult to afford to buy your weekly food shop?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

9.2) In the last month have you, or anyone else in your household, had smaller meals than usual or skipped meals, because you couldn't afford to buy food?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

_____

9.3) In the last month, have you found it difficult to budget for household bills or manage debt repayments?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

_____

10 Open feedback
10.1) Is there anything else you would like to say about your experience of taking part in the pilot, or the topics you were asked about in this survey?
Open text response_____

_____

10.2) Are you interested in taking part in an interview about your experience of the veg box pilot?

This interview would be with your Health Coach/Social Prescriber/Community Food Grower, in a few months' time.

- Yes
- No

_____

If answering any of the questions in this survey has caused you to experience distress, please be aware there are a number of support services available. This includes your GP, and two charities: **Mind** and **Samaritans.**

_____

Debrief goes here.

_____

5.6.2 Post-intervention survey protocol – WellFed pilot clients

Pre-intervention survey part A – Health, wellbeing, and community

1 Participant information sheet and ID number

Instructions on navigating the survey goes here.

Participant information sheet goes here (client's consent is captured in a separate survey to ensure their anonymity).

_____

1.1) Which community food project is the client connected with?

Please select the grower or project name and then enter the client's anonymous ID number in the box below (For example, for the first client to work with Community Roots, please enter '**CR 1'**, the third client working with Goonown Growers would be '**GG 3**', and so on).

Important! Please keep a record of the client's ID number yourself, so we can match their responses for the pre- and post-intervention surveys.

- Bosavern Community Farm (**BCF**)
- Camborne - Veor Surgery (**V**)
- Wadebridge / Camelford - Camel CSA / Nourish Kernow CIC (**CNK**)
- Community Roots (**CR**)
- Food Troops CIC / Grassroots Garden CIC (**FTG**)
- Hayle - Sustainable Hayle (**SH**)
- Helston (**POM**)
- Goonown Growers (**GG**)
- Growing Links (**GL**)
- Newquay Orchard (**NO**)
- **Not listed**
- Falmouth - Loveland (**LOV**)
- Liskeard - Tamar Grow Local / Healthy Cornwall (**TGL**)
- Scilly - Salakee Farm (**SAL**)
- St Ives (**SICO**)
- Truro - CHAOS Farm (**CHA**)

Survey logic: once the community grower is selected, a box appears at the bottom of the screen with this instruction:

Please enter the client's anonymous ID number below: _____

(Open text, response is compulsory for matching the survey data sets)

_____

2 Community and social engagement

Intro: The first few questions are about your involvement in your local community.

_____

2.1) How often do you take part in organised community activities?

For example, social clubs or meetups, exercise groups, or volunteering activities.

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most of the time).

_____

2.2) Please complete these statements using one of the four options below:

- 2.2a) I feel part of my community
- 2.2b) I know what's going on in my community (i.e., activities, events)
- 2.3b) I know how to get the support I need (e.g., accessing local health services, or getting advice on housing or money)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most of the time).

Survey logic: randomise the order the statements are presented.

_____

3 Wellbeing

Intro: The next few questions ask about your health and wellbeing.

_____

3.1) Please tell me one or two concerns or problems that you are most worried about.

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- Concern or problem 1_____
- Concern or problem 2 (optional)_____

(Open text response)

_____

3.2) Please select a number to show how severe each concern or problem is now, on a scale of 0 (Not bothering me at all) to 6 (Bothers me greatly).

This should be your opinion, no-one else's!

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- Concern or problem 1
- Concern or problem 2 (optional)

(Scale: Q3.2 uses a 7-point scale, 0-6, supported with (non-)smiley faces visual cue, e.g.,

_____

3.3) How would you rate your general feeling of wellbeing now, on a scale of 0 (As good as it can be) to 6 (As bad as it can be)?
(i.e., How do you feel in yourself?)

Meaningful Measures' Measure Yourself Concerns and Wellbeing®

- My wellbeing now

(Scale: Q3.3 uses a 7-point scale, 0-6, supported with (non-)smiley faces visual cue, e.g.,

_____

4 Physical health
Intro: Next, a few questions about your physical health.

_____

4.1) Below are some statements that people sometimes make when they talk about their health.

When thinking about yourself, how much do you agree or disagree with each statement?

Your answers should be what is true for you and not just what you think the doctor or anyone else wants you to say.

- 4.1a) I understand my health problems and what may cause them
- 4.1b) I have been able to maintain (keep up with) lifestyle changes, such as eating a healthy diet, or exercising regularly
- 4.1c) I feel confident I can help prevent or reduce problems that relate to my health

(Scale: 1 = Disagree strongly ; 2 = Disagree ; 3 = Agree ; 4 = Agree strongly; 5 = Prefer not to say).
Survey logic: randomise the order the statements are presented.

4.2) In the last 3 months, approximately how many times have you talked to or visited a GP / family doctor about your own health?

Please move the slider into the correct position.
*If '**zero**' appointments, please click on slider to register '**0**'.*
If 'prefer not to say', skip through this question.

(Scale: 0 appointments – 20 appointments or more)

4.3) In the last 3 months, approximately how many times have you visited hospital about your own health?

Please move the slider into the correct position.
*If '**zero**' visits, please click on slider to register '**0**'.*
If 'prefer not to say', skip through this question.

(Scale: 0 visits – 20 visits or more)

4.4) Approximately how many different medications or inhalers do you take daily?

Please move the slider into the correct position.
*If '**zero**' medications or inhalers, please click on slider to register '**0**'.*
*If '**prefer not to say**', skip through this question.*

(Scale: 0 medications/inhalers – 10 medications/inhalers or more)

4.4b) In the last 3 months, have you required more frequent GP appointments or more prescriptions for a different health issue, which is not related to diet?

- Yes
- no

4.5) If you know it, what was your most recent HbA1c level?

(Slider question; Scale: 10 or under (mmol/mol) to 75 or above (mmol/mol)

---

5 Physical activity
Intro: These questions ask about physical activity or exercise that you do.

5.1) In the past seven days, on how many days have you done 15 minutes or more of physical activity?

By 'physical activity', we mean movement that raises your breathing rate. It includes exercise, brisk walking, or cycling for recreation or to get to and from places. Please do not include housework or physical activity that is part of your job.

(Scale: 0 – 7 days, 8 = Prefer not to say).

5.2) Please rate your level of agreement with the following statements:

By 'physical activity', we mean movement that raises your breathing rate. It includes exercise, brisk walking, or cycling for recreation or to get to and from places. Please do not include housework or physical activity that is part of your job.

- 5.2a) I find physical activity enjoyable and satisfying
- 5.2b) I have the opportunity to be physically active
- 5.2c) I have the ability to be physically active

(Scale: 1 = Strongly agree; 2 = somewhat agree; 3 = neither agree nor disagree; 4 = somewhat disagree; 5 = strongly disagree; 6 = prefer not to say)

6 Sociodemographic characteristics

Intro: We'd like to know a bit more about you. This will help us understand who is taking part in the pilot.

As we mentioned earlier, all of your responses are confidential and will be anonymised.

_____

6.1) What is your partial postcode?

This is your postcode without the final two letters (e.g., PL31 2)

3. Select to enter postcode _____
4. Prefer not to say

Open text response

_____

6.2) What is your age?

8. 18 - 24
9. 25 - 34
10. 35 - 44
11. 45 - 54
12. 55 - 64
13. 65 and over
14. Prefer not to say

_____

6.3) How would you describe your gender?

8. Open text response (if not listed below)_____
9. Agender
10. Female
11. Gender-fluid
12. Male
13. Non-binary
14. Prefer not to say

This question is asked by the Health Coach/Social Prescriber/Community Food Grower as an open text question, but we provide a list of the more frequently identified genders to facilitate data entry, as well as providing an open text response if the participant's gender is not listed (i.e., option 1 above).

_____

6.4) How would you describe your ethnic group or background?

9. Open text response (if not listed below)_____
10. Arab / British Arab
11. Asian / Asian British
12. Black / African / Caribbean / Black British
13. Minority Ethnic / Roma / Gypsy / Traveller
14. Mixed / Multiple ethnic groups
15. White British / White Cornish / Other White background
16. Prefer not to say

As with 6.3) Gender, this question is asked by the Health Coach/Social Prescriber/Community Food Grower as an open text question, but we provide a list of the more frequently identified ethnic groups to facilitate data entry, as well as providing an open text response option if the ethnic group is not listed (i.e., option 1 above)

_____

6.5) How many children or young people live in your household? (i.e., aged under 18)
We ask this question to understand whether family responsibilities may affect your food choices.

8. 0
9. 1
10. 2
11. 3
12. 4
13. 5 or more
14. Prefer not to say

_____

6.6) Do you have a long-standing illness, injury or disability that limits your normal day-to-day activities?

By 'long-standing' we mean anything that has troubled you over a period of time. 'Normal day-to-day activities' includes things like eating, washing, walking, and going shopping.

4. Yes
5. No

6. Prefer not to say

6.7) What is the highest level of education you have achieved so far?

9. No formal qualifications
10. GCSE or O-level
11. A-level
12. Undergraduate degree (e.g. Bachelor's)
13. Postgraduate degree (e.g. Master's, PhD)
14. Vocational qualification
15. Other
16. Prefer not to say

6.8) Which of the following best describes your current employment status:

11. Employed full time (30+ hours per week)
12. Employed part time (less than 30 hours per week)
13. Self-employed
14. Unemployed
15. Looking after the home or family
16. Studying
17. Retired
18. Volunteering
19. Other
20. Prefer not to say

6.9) Please indicate the approximate combined income of your household (per year, before tax deductions):

7. Less than £12,999
8. £13,000 - £18,999
9. £19,000 - £25,999
10. £26,000 - £38,999
11. More than £39,000
12. Prefer not to say

In the online survey tool the survey is separated into two surveys here (Part A and Part B), in case the participant cannot complete all of the questions in one go.

Pre-intervention survey part B – Dietary choices, food capabilities, access to food
If pre-survey part B is conducted in a different session or with a different facilitator, please briefly present the participant information sheet again and verbally reaffirm the participant's informed consent before completing Part B.

7 Food capabilities
Intro: These questions are about the food you buy and cook.

_____

7.1) How confident do you feel about buying fresh vegetables?

(Scale: 1 = Not at all confident ; 2 = Only slightly confident ; 3 = Quite confident ; 4 = Very confident)

_____

7.2) How confident do you feel about preparing and cooking fresh vegetables?

(Scale: 1 = Not at all confident ; 2 = Only slightly confident ; 3 = Quite confident ; 4 = Very confident)

_____

7.3) In a typical week, how often do you throw away these types of food? (part 1)

Please include food past its 'use by' date and leftovers from meals.

- 7.3a) Bread
- 7.3b) Vegetables
- 7.3c) Meat

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food).
Survey logic: randomise the order the food types are presented.

_____

7.4) In a typical week, how often do you throw away these types of food? (part 2)

Please include food past its 'use by' date and leftovers from meals.

- 7.4a) Fruit
- 7.4b) Fish

- 7.4c) Dairy (e.g., milk, cheese, yoghurt etc.)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food).
Survey logic: randomise the order the food types are presented.

---

8 Healthier diets
Intro: The next few questions are about the food you eat.

There is no judgement here.

Please just be as honest as you can, it really helps us to work with you.

8.1) How often do you:
- 8.1a) Have fruit as a snack or treat
- 8.1b) Eat vegetables in every cooked meal (i.e., in lunch or dinner)
- 8.1c) Snack on high-fat, salty, or sugary foods in-between meals (i.e., crisps, cakes etc.)

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Frequently ; 5 = Not applicable – I don't eat this type of food). *Randomise the order the food practices are presented.*

8.2) Do you have any dietary restrictions or intolerances?
4. Yes (if you wish, please specify:_____)
5. No
6. Prefer not to say

8.3) How often do you eat:
- 8.3a) Sugary snacks (i.e., biscuits, cakes, chocolate, sweets etc.)
- 8.3b) Chips, potatoes, or plantain
- 8.3c) Ready-made meals or takeaways

(Scale: 1 = Rarely or never ; 2 = Less than once a week ; 3 = Once a week ; 4 = 2 - 3 times a week ; 5 = 4 - 6 times a week ; 6 = 1 - 2 times a day ; 7 = 3 - 4 times a day ; 8 = 5 times a day or more)

(Pictures included as a visual cue)
Survey logic: randomise the order the food items are presented.

_____

8.4) How many portions of fruit (fresh or frozen) do you eat in a usual day?

An example of a portion could be 1 x handful of grapes or berries or 1 x medium-sized orange, apple or banana.

(Scale: 1 or less; 2; 3; 4; 5; 6 or more)
(Pictures included as a visual cue)

_____

8.5) How many portions of vegetables do you eat in a usual day?

An example of a portion could be 1 x cup of leafy raw vegetables or salad, or half a cup of root vegetables like carrots, potatoes, celery, beetroot.

(Scale: 1 or less; 2; 3; 4; 5; 6 or more)
(Pictures included as a visual cue)

_____

8.6) Do you find it easy to get fruit and vegetables for you and your family

3. Yes
4. No

_____

8.7) What do you feel are the main reasons or barriers that stop you from eating plenty of fruit and vegetables?
Please tick all the boxes that apply to you

12. Cost
13. Distance from food shops
14. Time to shop and cook
15. Not enough variety in the food shops
16. Quality/freshness

17. Storage (e.g., kitchen space, fridge, freezer)
18. Equipment (e.g., pots, pans, stove)
19. Cooking knowledge (e.g., how to cook a wide range of fruit and veg)
20. Health conditions make shopping or cooking difficult
21. Other pressing needs
22. Not applicable - there is nothing that stops me from getting and eating enough fresh fruit and veg (exclusive response option)

Survey logic: randomise the order the barriers are presented.

8.8) In a typical week, how many days is your diet 'meat-free'? (i.e., you do not eat any meat or fish)

7. None, or less than 1 day per week
8. 1 - 2 days per week
9. 3 - 4 days per week
10. 5 - 6 days per week
11. Every day
12. Not applicable – I am vegetarian or vegan

---

9 Accessibility and social equity

Intro: We'd like to ask you a few questions about your personal circumstances.

9.1) In the last month, have you found it difficult to afford to buy your weekly food shop?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

9.2) In the last month have you, or anyone else in your household, had smaller meals than usual or skipped meals, because you couldn't afford to buy food?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

9.3) In the last month, have you found it difficult to budget for household bills or manage debt repayments?

(Scale: 1 = Rarely or never ; 2 = Some of the time ; 3 = Often ; 4 = Most or all of the time; 5 = Prefer not to say).

---

11 Impact of WellFed pilot (post survey only)
Intro: Finally, a few questions about the impact of the WellFed programme.

11.1) For you personally, has taking part in the WellFed programme provided any of the following benefits:
Please select all that apply

1. Eating a healthier diet
2. Improved physical health
3. Improved mental health or wellbeing
4. Increased confidence in cooking meals using fresh vegetables
5. Better understanding of dietary-related health problems
6. More frequent physical activity
7. More opportunities for social interaction
8. Reduced need for health care (e.g., fewer GP appointments, prescriptions etc.)
9. More opportunities to be outside/in nature (e.g., community gardening)
10. Helping me access other social support services (e.g., advice on budgeting; awareness of other health-related programmes etc.)
11. Other benefit not listed above (Please specify which other benefit _____)
12. None of the above (exclusive option)

Survey logic: randomise order of benefits, except: Other benefit not listed above; None of the above

---

11.2) Thinking about the positive lifestyle changes you've made since joining the WellFed programme (e.g., improved diet, increased physical activity), how likely is it that you would have made these specific changes to the same extent, if you had not participated in WellFed?

Please choose one option:

- **Highly unlikely**: I definitely would not have made these changes to this extent without WellFed

- **Unlikely**: I probably would not have made these changes to this extent without WellFed
- **Possible**: I might have made some of these changes, but perhaps not to the same extent or as quickly
- **Likely**: I probably would have made these changes to the same extent, even without WellFed
- **Highly likely**: I definitely would have made these changes to the same extent, even without WellFed

Note – Q11.2 is duplicated from interview protocol (but not every pilot participant will take part in an interview)

11.3) In addition to the WellFed programme, what other sources of support, advice, or guidance, if any, have contributed to the lifestyle changes you've made (e.g., improved diet, increased physical activity)?

Please consider all relevant sources, such as family or friends, other health services (e.g., GP, dietitian, nurse), other community groups or charities, other diet interventions or programmes etc.

Note – Q11.3 is duplicated in interview protocol (but not every pilot participant will take part in an interview)

11.4) Based on this, what percentage of the positive changes you've experienced would you attribute directly to the WellFed programme?

Please provide a number between 0% and 100%, where 100% means WellFed was the only contributor to these changes, and 0% means WellFed contributed nothing.

Note – Q11.4 is duplicated in interview protocol (but not every pilot participant will take part in an interview)

---

12 Open feedback (post survey only)
12.1) Please rate your overall level of satisfaction for your experience of the WellFed programme?

(Scale: Q12.1 uses a 7-point scale: 1 = Extremely satisfied, 2 = Satisfied, 3 = Somewhat satisfied, 4 = Neutral, 5 = Somewhat dissatisfied, 6 = Dissatisfied, 7 = Extremely dissatisfied)

_____

12.2) WellFed is a 'test and learn' pilot to explore whether prescribing veg boxes improves people's health and wellbeing. Do you have any suggestions for ways we could improve the pilot?
Your feedback is very useful for us.
Open text response_____

Note – Q12.2 is duplicated in interview protocol (but not every pilot participant will take part in an interview)

_____

12.3) Please can we contact you in a few months' time to ask you a couple of questions about the longer-term impact of the WellFed pilot?

- Yes, I consent to be contacted again about the WellFed pilot
- No, I do not consent to be contacted again about the WellFed pilot

_____

If answering any of the questions in this survey has caused you to experience distress, please be aware there are a number of support services available. This includes your GP, and two charities: **Mind** and **Samaritans.**

_____

Debrief goes here.

_____

5.6.3 Semi-structured interview protocol – WellFed pilot clients

Wellfed interview protocol v4

Instructions for interviewers

This is a semi-structured interview, which means the interviewer (i.e., the Health Coach/Social Prescriber/Community Food Worker) can vary the order in which the questions are asked so the conversation flows more naturally. They can also ask ad-hoc questions, not included in this protocol, if a participant says something interesting or relevant to the pilot delivery and its outcomes that the interviewer would like to explore further. Some questions have bullet point follow up questions, which try to explore participant's responses in more detail (i.e., to understand 'why' has something changed, in addition to describing 'what' has changed). You do not have to complete all questions if you run out of time (the estimated interview time is 1 hour), but please do complete Sections 8 & 9.

Please emphasise that there are no right or wrong answers, we are just interested in the client's experience of taking part in the pilot, the outcomes in terms of their health and wellbeing, and any barriers or enablers of eating a healthy diet.

Informed consent process

The interviewer reviews the 'HFSP interviews - participant information sheet' with the client and ensures the client has a (digital or paper) copy to keep. The interviewer asks the client if they have any questions about the interview or the pilot, and then asks them to complete this online consent form for the interview:
https://uniofbath.questionpro.eu/Wellfed-client-interview-consent-form

The consent form requests the client's name for two purposes: 1) recording their consent to take part in the interview, and 2) recording that we have allocated a Love2Shop voucher to them, if they want it. The client's name is not linked to their interview responses. We do need to know which Community Food Grower the client is supported by.

Recording the interview

Once the consent form has been completed and the client is happy to continue, the interviewer starts the Teams call, selects 'record and transcribe', and selects 'start recording'. Please switch off the camera.

Interview incentive

When the interview has been completed, please give the £25 Love2Shop Gift voucher to the client (Claire has the vouchers).

Thanks very much for your help conducting the interviews!

1 Ice breaker

Interviewer first records their own name and the Community Food Grower that is supporting the client.

1.1 First, could you tell me a little bit about why you joined the Wellfed pilot?

2 Diet change

Intro: Let's talk a bit about the food you eat.

2.1 What is most important to you about the food you eat?

2.2 Have you noticed any changes in the types of meals you prepare while taking part in the pilot?

- **If yes**, what changes have you noticed?
- Why do you think these changes have happened?

- **If no or don't know**, why do you think nothing has changed?

2.3 Have you noticed any changes in your cooking skills while taking part in the pilot?

- **If yes**, what changes have you noticed?
- Why do you think these changes have happened?

- **If no or don't know**, why do you think nothing has changed?

2.4 Have you noticed any changes in how many sugary snacks or high-fat foods you eat while taking part in the pilot? (i.e., crisps, cakes, sweets etc.)

- **If yes**, what changes have you noticed?
- Why do you think these changes have happened?

- **If no or don't know**, why do you think nothing has changed?

2.5 Have you noticed any changes in how much meat you eat while taking part in the pilot?

- **If yes**, please could you describe these changes?
- Why do you think these changes have happened?

2.6 Have you noticed any changes in how much food you throw away while taking part in the pilot?

- **If yes**, what changes have you noticed?
- Why do you think these changes have happened?

3 Food choices

Intro: Now let's talk about healthy food.

3.1 What does 'healthy food' mean to you?

3.2 How confident are you that you can make healthy food choices, even when it's difficult or inconvenient?

- Why is this?

3.3 What makes it easier or harder for you to make healthy food choices?

- Why does this make it easier or harder?

3.4 If applicable, in what ways are your food choices influenced by what family members want to eat?

4 Physical Health

Intro: Let's talk a bit about your physical health, if that's ok.

(Note to interviewer – not all questions in block 4 may be necessary, if the client has already answered a particular question in their response to a previous question)

4.1 Have you noticed any changes in your physical health or how you feel in general while taking part in the Wellfed pilot?

- **If yes**, please could you describe these changes?

4.2 *(if not already answered in 4.1)* If you have visited your GP, nurse or dietician in the past 3 months, have you been told about any changes in your HbA1c level, blood pressure, cholesterol, or anything else related to your dietary health?

- **If yes**, please could you describe these changes?

4.3 Do you feel you understand your health problems and what may cause them?

- **If yes**, has taking part in the pilot helped you to understand your health problems?

- **If no**, what would help you to better understand your health problems? (e.g., More support from…)

4.4. How confident do you feel that you can help prevent or reduce problems that relate to your health?

- Why is this?

4.5 Is there anything that stops you from improving your physical health?

4.6 What would help you improve your physical health?

5 Wellbeing

Intro: Let's talk about your wellbeing.

5.1 How would you describe your general feeling of wellbeing recently?

5.2 Is this different to how you felt before starting the pilot?

- **If yes**, what has changed?
- Why do you think it has changed?

5.3 Is there anything that stops you from maintaining positive mental health and wellbeing?

- **If yes**, what stops you?

5.4 Is there anything that would help you improve your wellbeing?

6 Community engagement

Intro: Now let's talk a bit about your local community.

6.1 How involved do you feel in your local community?

6.2 Is this important to you?

- Why/why not?

6.3 Do you take part in any organised community activities?
(Examples: community clubs, church, library, leisure centre, community gardens etc.)

- **If yes**, which activities and how often?
- Has this changed since taking part in the pilot?

- Why do you think this change has happened?

- **If no**, would you like to take part in organised community activities?

6.4 Is there anything that stops you from developing connections with people in your local community?

- **If yes**, what stops you?

7 Physical activity

Intro: Next, I have a couple of questions about physical activity.

7.1 Have you noticed any changes in your level of physical activity while taking part in the Wellfed pilot?

- **If yes**, what changes?

7.2 How easy or otherwise have you found it to maintain lifestyle changes, for example, eating a healthy diet, or exercising more regularly?

- Why is this?

7.3 What would help you to be more physically active?

8 Impact of Wellfed

Intro: To finish, I have a couple of questions about the impact of the Wellfed programme.

8.1 Thinking about the positive lifestyle changes you've made since joining the Wellfed programme (e.g., improved diet, increased physical activity, better meal planning), how likely is it that you would have made these specific changes to the same extent, even if you hadn't participated in Wellfed?

Please choose one option:

- **Highly Unlikely**: I definitely would not have made these changes to this extent without Wellfed.
- **Unlikely**: I probably wouldn't have made these changes to this extent without Wellfed.
- **Possible**: I might have made some of these changes, but perhaps not to the same extent or as quickly.

- **Likely**: I probably would have made these changes to a similar extent, even without Wellfed.
- **Highly Likely**: I definitely would have made these changes to the same extent without Wellfed.

8.2 In addition to the Wellfed programme, what other sources of support, advice, or guidance, if any, have contributed to the lifestyle changes you've made (e.g., improved diet, increased physical activity, better meal planning)?

Please consider all relevant sources, such as family or friends, other health services (e.g., GP, dietitian, nurse), other community groups or charities, other diet interventions or programmes etc.

8.3 Based on this, what percentage of the positive changes you've experienced would you attribute directly to the Wellfed programme?
Please provide a number between 0% and 100%, where 100% means Wellfed was the only contributor to these changes, and 0% means Wellfed contributed nothing.

9 Open feedback

9.1 Wellfed is a 'test and learn' pilot to explore whether prescribing veg boxes improves people's health and wellbeing. Do you have any suggestions for ways we could improve the pilot?

9.2 Is there anything else you would like to add that we haven't discussed so far?

If answering any of the questions in this survey has caused you to experience distress, please be aware there are a number of support services available. This includes your GP, and two charities: **Mind** and **Samaritans.**

Debrief

The interviewer stops the recording and stops the Teams call. They present the debrief sheet to the participant and asks if the client has any further questions about the pilot or the evaluation study.

The interviewer thanks the participant for their time and gives them the £25 Love2Shop voucher.

5.7 Recruitment materials and participant information sheets

This appendix includes the recruitment materials and the participant information sheets that were provided to clients for each data collection activity, so they could make an informed decision about their participation. Clients had the opportunity to discuss the pilot and what is involved with their social prescriber or health coach prior to taking part.

5.7.1 Recruitment information sheet

This information is for people who have been invited to take part in a WellFed pilot. WellFed pilots are for people with type 2 diabetes or at risk of developing type 2 diabetes.
WellFed started when a Cornwall GP tried 'prescribing' healthy vegetables to patients with type 2 diabetes. Using the vegetables helped most of the patients reduce or reverse their diabetes. For some, it worked better than medication. It improved health and wellbeing in other ways too.
To find out whether this approach could benefit more people in Cornwall, we are running some more pilots.

Each one will be a partnership between a GP surgery and a community food grower / group. NAME OF SURGERY OR PCN is partnering with GROWER OR GROUP (OPTIONAL DESCRIPTION HERE) and NAMES OF ANY OTHER PARTNER GROUPS in LOCATION to run a pilot in your area. It's completely free to take part.

What's involved in a WellFed pilot?

- Every week for 12 weeks, you'll get a free box of vegetables. The vegetables are grown locally and organically.
- You'll also be offered free support to use the veg – for example, through simple cookery skills workshops or demonstrations and easy recipes.
- You'll also be offered the chance to take part in activities at the local community growing site where your veg are grown or at a local community food project. All the activities on offer can help improve health and wellbeing and are free. All the activities are optional - you don't have to take part.
- We'll ask you to carry out a short survey before you start receiving your veg box and at the end of the trial. The survey will ask you how you feel in yourself and about your health and wellbeing.

Why is the trial happening?

Type 2 diabetes is preventable but is on the increase. Diabetes has negative effects on people's health and wellbeing, as well as putting pressure on the NHS.

We know that having a healthy diet and an active lifestyle can prevent, reduce and often reverse type 2 diabetes. So we are investigating whether prescribing good food can be a better way of helping people stay healthy and preventing them getting sick than prescribing medicine. We are looking at the best ways to make this work, based on peoples' feedback and experience.

Who can join the trial?

If you have a recent diagnosis of type 2 diabetes or are at risk of developing type 2 diabetes - and your surgery is participating in WellFed - you could be referred to join a pilot.
You'll need to be willing to carry out a health and wellbeing survey before and after the pilot and to try out a free veg box for 12 weeks. Of course you can opt out at any time.

What can participants expect?

Once you've agreed to take part, we'll invite you to a WellFed welcome session. You'll usually get your first free veg box there. (In some places you might get your veg at a different time.) You'll be able to find out about the support and activities on offer and you'll have a chance to meet other people on the programme. You can meet the people growing the veg and providing the activities.

The WellFed welcome usually takes place at a community growing site or another community venue and will often include lunch, made on site using freshly-prepared local produce. Support to attend can be provided as appropriate.

WellFed welcome and cooking sessions, mid Cornwall

At your welcome session, you'll be able to find out about the activities on offer to you. These might include food preparation skills and cooking (tailored to people's needs and the veg you'll be getting), gardening and food growing. Sometimes other activities such as

mindfulness or gentle physical activity such as chair yoga could be on offer too. The activities will vary between places and the groups involved.

All activities are optional. Support and encouragement are the name of the game and no one is asked to take part in anything they don't want to. Changing your mind is OK too!

> *"I'm cooking from scratch and eating more healthily. It's made me love my food even more. Some of the veg I've never seen before and had to google!*
>
> *It's been great being part of a team and has really improved my mental health. I just feel I fit. It's made me look at the environment and what I'm eating. I always leave feeling positive!"*

About NAME OF DELIVERY GROUP

HYPERLINK TO DELIVERY GROUP is DESCRIPTION OF PARTNER AND LOCATION HERE. The WellFed welcome and many of the optional activities and support will take place at LOCATION.
HYPERLINK TO SECOND DELIVERY PARTNER IF APPROPRIATE, AND SUMMARY INFO AS ABOVE

5.7.2 Participant information sheet – survey

Healthy Food Social Prescribing pilot - Information for participants about the study (surveys)

What is this study about?
WellFed Cornwall is a group of food growers, health care professionals, voluntary sector organisations, members of Cornwall Council's Public Health Team, and researchers from the Universities of Bath and Cardiff. Together, we are carrying out a pilot of social prescribing of healthy food. This is a free weekly veg box from a local grower for 3 months, as well as support services such as dietary advice, social activities, and free cooking classes. You can find more information about WellFed Cornwall here.

This study is to understand whether prescribing veg boxes leads to healthier diets, improved wellbeing, more confidence in preparing meals, and reduced need for health care services.

What does the study involve?

You will be asked to complete two surveys in conversations with your Health Coach/Social Prescriber/Community Food Grower. Each survey will take about 45 minutes. We will ask you to:

1. Complete the first survey when you start receiving the veg box
2. Complete the second survey in 3 months' time, after you have received the veg box for a while and have had some time to get used to using different fresh ingredients

We will ask you questions about your diet, your health and wellbeing, your day-to-day cooking and food preparation, and what you think about this pilot. We will also ask if you are interested in taking part in an interview about your experience of taking part in the pilot at a later date.

Who can take part?
Anyone (aged 18 or over) who is taking part in WellFed Cornwall's healthy food social prescribing pilots.

What are the benefits and risks of taking part?
The information you provide will be very useful for Cornwall Council and local Health Care Services to understand the possible benefits of veg box prescribing, as well as the views of people taking part. This will inform their approach to future health care services. There is a minor risk of experiencing psychological discomfort when answering questions about your health or wellbeing.

This research has been reviewed and approved by the University of Bath Biomedical Research Ethics Committee.

Do I have to take part?
Taking part in the Wellfed pilot is entirely voluntary - you can opt out of the pilot at any time, and you do not have to give a reason for withdrawing. When completing the survey, you do not have to answer any questions that you do not want to. You can ask for your data to be removed from the study at any time until 1 month after you have completed the second survey, by asking your Health Coach/Social Prescriber/Community Food Grower, or the researcher (see contact details below). From this point, your data will then be anonymous and cannot be traced back to you, and so we would be unable to identify and remove your data.

What happens to all the information?
All the information you provide is confidential. Your Health Coach/Social Prescriber/Community Food Grower will enter your responses directly into the University of

Bath online survey tool - they will not keep any of your data. Your survey responses will be anonymised, so you cannot be identified in any reports or research outputs. The anonymised data will be stored on a secure drive at the University of Bath (password-protected) for 10 years before being permanently deleted. The University of Bath may use anonymised data collected for this project in a future research project. The University of Bath privacy notice can be found here. Anonymised data (3 questions only) will be shared with Meaningful Measures, the company which licences the tool we use to measure your wellbeing. Your responses to the other survey questions will not be shared with Meaningful Measures. Anonymised data will also be shared with Volunteer Cornwall, which is overseeing the pilot, and Cardiff University which is working with University of Bath to analyse the data.

What do I do if I have any questions?
You can speak to your Health Coach/Social Prescriber/Community Food Grower; they will be happy to answer any questions you may have. You can also contact the researcher at the University of Bath: Mark Wilson (mw2640@bath.ac.uk).

Or if you have any concerns about this study, please contact the University of Bath Research Governance and Compliance Team: (research-ethics@bath.ac.uk; University of Bath, Claverton Down, Bath, BA2 7AY). The REC reference number is: 5682-6357

Your Health Coach/Social Prescriber/Community Food Grower will send you a copy of this information sheet.

How can I take part in the study?
Please tell your Health Coach/Social Prescriber/Community Food Grower that you would like to take part.

5.7.3 Survey consent form

Wellfed Cornwall HFSP pilot - Survey consent form

Your Health Coach/Social Prescriber/Community Food Grower will read 8 statements to you. Please let your Health Coach/Social Prescriber/Community Food Grower know that you have understood these statements before deciding whether or not you wish to take part in this study. You can ask any questions that you want to.

1. I understand the purpose of this study and what is involved. These have been communicated to me on the information sheet. My Health Coach/Social Prescriber/Community Food Grower will send me a copy of the information sheet.

2. I understand that my participation in this pilot and the evaluation study is entirely voluntary. I can withdraw my data at any time until 1 month after I complete the second survey by telling my Health Coach/Social Prescriber/Community Food Grower, or the researcher (see contact details below). At that point, my data will be anonymised and can no longer be withdrawn from the study.

3. I understand that my Health Coach/Social Prescriber/Community Food Grower will not keep any of my responses to the survey questions. My anonymised survey responses will be stored on a secure drive at the University of Bath and will be permanently deleted within 10 years. I will not be identifiable in any reports or outputs from this study.

4. I understand that I do not have to answer any questions that I do not want to.

5. I understand that this study will be used by Cornwall Council and local Health Care Services to inform their health and social care policy and delivery.

6. I understand that the University of Bath may use the data collected for this project in a future research project, but the conditions stated on this form will still apply.

7. I understand that my personal data will be processed in accordance with current UK data protection legislation. The University of Bath privacy notice can be found here.

8. I understand that I am free to discuss any concerns I may have, at any time during the study, with my Health Coach/Social Prescriber/Community Food Grower, or with the researcher at the University of Bath: Mark Wilson (mw2640@bath.ac.uk).

If they are unable to resolve your concern, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 5682-6357

I understand these statements and I provide my verbal consent to take part in the study:

- I CONSENT to take part in the study
- I DO NOT CONSENT to take part in the study

What is your first name and surname?
We ask this for the consent form only. Your name will not be linked to your survey responses.

_____

5.7.4 Participant information sheet – interviews

Healthy Food Social Prescribing pilot - Information for participants about the study (interviews)

What is this study about?
WellFed Cornwall is a group of food growers, health care professionals, voluntary sector organisations, members of Cornwall Council's Public Health Team, and researchers from the Universities of Bath and Cardiff. Together, we are carrying out a pilot of social prescribing of healthy food. This is a free weekly veg box from a local grower for 3 months, as well as support services such as dietary advice, social activities, and free cooking classes. You can find more information about WellFed Cornwall here.

This study is to understand whether prescribing veg boxes leads to healthier diets, improved wellbeing, more confidence in preparing meals, and reduced need for health care services.

What does the interview involve?
Your Health Coach/Social Prescriber/Community Food Grower will ask you questions about your diet, your health and wellbeing, your day-to-day cooking and food preparation, and what you think about this pilot. The interview will take approximately one hour. We will record and transcribe your interview using Microsoft Teams; this is so Mark Wilson, the researcher at the University of Bath, can read your anonymised interview transcript to evaluate whether the pilot was successful in leading to positive health and wellbeing outcomes.

Who can take part?
Anyone (aged 18 or over) who is taking part in WellFed Cornwall's healthy food social prescribing pilots.

What are the benefits and risks of taking part?
The information you provide will be very useful for Cornwall Council and local Health Care Services to understand the possible benefits of veg box prescribing, as well as the views of people taking part. This will inform their approach to future health care services. You will receive a £25 'Love to Shop' gift voucher for taking part in the interview, which can be used in multiple retailers.

There is a minor risk of experiencing psychological discomfort when answering questions about your health or wellbeing.

This research has been reviewed and approved by the University of Bath Biomedical Research Ethics Committee.

Do I have to take part?
Taking part in the Wellfed pilot is entirely voluntary - you can opt out of the pilot at any time, and you do not have to give a reason for withdrawing. When taking part in the interview, you do not have to answer any questions that you do not want to. You can ask for your data to be removed from the study at any time until 1 month after you have completed the interview, by asking your Health Coach/Social Prescriber/Community Food Grower, or the researcher (see contact details below). From this point, your data will then be anonymous and cannot be traced back to you, and so we would be unable to identify and remove your data.

What happens to all the information?
All the information you provide is confidential. Your Health Coach/Social Prescriber/Community Food Grower will not keep any of your data. Your interview responses will be anonymised, so you cannot be identified in any reports or research outputs. Any information which could potential identify you will be removed from the interview transcript. The anonymised data will be stored on a secure drive at the University of Bath (password-protected) for 10 years before being permanently deleted. The University of Bath may use anonymised data collected for this project in a future research project. The University of Bath privacy notice can be found here.

What do I do if I have any questions?
You can speak to your Health Coach/Social Prescriber/Community Food Grower; they will be happy to answer any questions you may have. You can also contact the researcher at the University of Bath: Mark Wilson (mw2640@bath.ac.uk).

Or if you have any concerns about this study, please contact the University of Bath Research Governance and Compliance Team: (research-ethics@bath.ac.uk; University of Bath, Claverton Down, Bath, BA2 7AY). The REC reference number is: 5682-6357

Your Health Coach or Social Prescriber will send you a copy of this information sheet.

How can I take part in the study?
Please tell your Health Coach/Social Prescriber/Community Food Grower that you would like to take part.

5.7.6 Interview Consent Form

Cornwall Welled HFSP pilot - Interview Consent Form

Your Health Coach/Social Prescriber/Community Food Grower will read 10 statements to you. Please let your Health Coach/Social Prescriber/Community Food Grower know that you have understood these statements before deciding whether or not you wish to take part in this interview. You can ask any questions that you want to.

1. I understand the purpose of this study and what is involved. These have been communicated to me on the information sheet. My Health Coach/Social Prescriber/Community Food Grower will send me a copy of the information sheet.

2. I understand that my participation in this evaluation study is entirely voluntary. I can withdraw my data at any time until 1 month after I complete the interview by telling my Health Coach/Social Prescriber/Community Food Grower, or the researcher (see contact details below). At that point, my data will be anonymised and can no longer be withdrawn from the study.

3. I understand that my interview will be recorded and transcribed using Microsoft Teams. This is so Mark Wilson, the researcher at the University of Bath, can read my interview transcript to evaluate whether the pilot was successful. My anonymised interview transcript will be stored on a secure drive at the University of Bath and will be permanently deleted within 10 years.

4. I understand my Health Coach/Social Prescriber/Community Food Grower will not keep any of my responses to the interview questions.

5. I understand I will not be identifiable in any reports or outputs from this study. Any information which could identify me will be removed from the interview transcript.

6. I understand that I do not have to answer any questions that I do not want to.

7. I understand that this study will be used by Cornwall Council and local Health Care Services to inform their health and social care policy and delivery.

8. I understand that the University of Bath may use the data collected for this project in a future research project, but the conditions stated on this form will still apply.

9. I understand that my personal data will be processed in accordance with current UK data protection legislation. The University of Bath privacy notice can be found here.

10. I understand that I am free to discuss any concerns I may have, at any time during the study, with my Health Coach/Social Prescriber/Community Food Grower, or with the researcher at the University of Bath: Mark Wilson (mw2640@bath.ac.uk).

If they are unable to resolve your concern, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number is: 5682-6357

I understand these statements and I provide my consent to take part in the interview:

- I CONSENT to take part in the interview
- I DO NOT CONSENT to take part in the interview

_____

What is your first name and surname?
We ask this for the consent form only. Your name will not be linked to your interview responses.

_____

I would like to receive a £25 Love2shop gift voucher for taking part in the interview.

- Yes
- No

5.7.7 Debrief sheet – surveys and interviews

Debrief – HFSP pre/post-intervention survey & interviews
Department of Psychology, University of Bath

Thank you very much for taking part in this study!

Further information

This study is a collaboration between Cornwall Council, food growers and voluntary sector organisations in Cornwall, and researchers from the Universities of Bath and Cardiff. The aim of the study is to evaluate the WellFed Cornwall Healthy Food Social Prescribing pilots (HFSP pilots). Your responses to the questions will be used to understand how successful the pilots are in enabling healthier diets and more confidence in preparing meals, improving wellbeing, and reducing the need for health care services. This information will be used by Cornwall Council and local Health Care Services to inform their health and social care policy and delivery.

If you have any questions about the study, please contact your Health Coach/Social Prescriber/Community Food Grower. You can also contact the researcher at the University of Bath: Mark Wilson (mw2640@bath.ac.uk)

If you have concerns about your participation in this study, please contact the University of Bath Research Governance and Compliance Team (research-ethics@bath.ac.uk). The REC reference number for this study is: 5682-6357

Privacy Notice: Your data will be used only for the purposes set out in the information sheet. Your consent is conditional upon the University complying with its duties and obligations under current UK data protection legislation. The University of Bath privacy notice can be found here.

You can ask for a copy of the information sheet from your Health Coach/Social Prescriber/Community Food Grower.