

Life Changes Trust Peer Support Projects

Evaluation Report

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Summary

This report presents an evaluation of six Peer Support Projects for people living with dementia and unpaid carers. The six projects received funding from the Life Changes Trust as part of a programme of peer support initiatives that sought to improve lives. This report is a summary of the key findings, based on an evaluation of self-assessed data (provided by the projects) and new data, gathered from stakeholders connected with peer support.



The evaluation examined the benefits and value offered by peer support projects while gathering evidence that supports better practice. It also identified shared learning for those interested in facilitating peer support for people with a lived experience of dementia and for unpaid carers. Logic modelling, a social return on investment analysis and thematic analysis were used to develop a programme level theory of change model to explain how change happened through peer support to create better lives for people living with dementia and unpaid carers of people with dementia.

Key findings:

- Peer support initiatives contribute to better lives by making people more knowledgeable about dementia, facilitating emotional and practical support from peers and strengthening social connections.
- Effective networks across peer support initiatives and partner agencies enable projects to: support people to access the right support at the right time, maintain ongoing recruitment of beneficiaries to sustain membership, and facilitate strategic approaches such as partnership approaches to seeking funding.
- Flexibility and responsiveness in project delivery, by adjusting activities according to the wishes of beneficiaries as their needs evolved, enabled projects to stay relevant and appropriate
- Effective methods for capturing data on outcomes of projects provide greater insight and justification for future funding.

Section 1: Introduction

This report presents the findings of an 18-month evaluation conducted by the University of Stirling to investigate how six peer support projects in Scotland supported people living with dementia and unpaid carers. The six projects received financial support from the Life Changes Trust; in 2015 this totalled £547,118 intended investment across five years.

The evaluation examines how different projects worked towards meeting common outcomes connected with the Trust's aim to improve the quality of life and wellbeing of people who are living with dementia and unpaid carers, highlighting how key aspects either assisted or impeded the overall success of the projects. The evaluation draws on data gathered from each project's self-evaluation, as well as from interviews and focus groups carried out with beneficiaries, volunteers, project staff and community partners to highlight useful strategies for other peer support groups seeking to meet their outcomes and demonstrate their value.

The report follows the following format:

Section 1 provides background information about the Life Changes Trust, and what defines a 'peer support' project.

Section 2 outlines the research methods used for the evaluation.

Section 3 gives an insight into academic literature that discusses the value of peer support initiatives for people with dementia and unpaid carers, and key aspects of Scottish Policy that impacts on how such initiatives work in practice.

Section 4 provides an insight into the individual initiatives that were evaluated, including a written overview based on logic modelling of self-evaluation data, and a Social Return on Investment for each project.

Section 5 reports the result of thematic analysis conducted on data gathered from interviews and focus groups. The section is organised so that it focuses on the impact for people living with dementia and unpaid carers, before drawing out lessons for developing good practice.

Section 6 sets out a theory of change for the programme as a whole.

Section 7 reviews the key learning points that should be taken forward, and highlights important considerations for future peer support initiatives.

Numbered references cited in the text are provided in Appendix 12.

About the Life Changes Trust

The Life Changes Trust was established as an independent charity in 2013 following a £50 million endowment from the Big Lottery Fund Scotland (now known as the National Lottery Community Fund). The Trust focused on using this fund to support three groups of beneficiaries: young people with care experience, people living with dementia, and unpaid carers of people living with dementia.

The Trust's commitment to support projects and initiatives that improve the lives of people with dementia and unpaid carers has resulted in a significant body of work targeted towards helping people to lead better lives. As a result, the Trust has explored a number of important areas that affect the lives of people living with dementia and unpaid carers, including how they can remain engaged within their community.

About the Peer Support Programme

The Trust defines peer support as “the help and support that people with lived experience of dementia, or caring for a person with dementia, are able to give each other”¹ Projects that provide the structure and guidance necessary for effective peer support create spaces where people with dementia and unpaid carers can not only receive emotional and practical support, but where they can pass on their own knowledge and become advocates for change on a broader scale.

This evaluation explores how six peer support projects, funded by the Trust, worked to meet their goals since first receiving funding in 2015. The report highlights key lessons to help other peer support initiatives establish, run and sustain a peer support project in the long-term.

Funding operated on a sliding scale whereby projects received 100% investment from the Trust in the first year, followed by reducing levels of funding on the basis that they would seek increasing levels of matched funding across five years in order to sustain the projects longer-term.

The six projects evaluated were: Ceartas De Café, ENABLE's Cuppa Club, Health in Mind, North West Carers Side by Side Project, Outside the Box's Food Buddies Project, and VOCAL's Peer Mentoring Service.

Section 2: About the Evaluation

The evaluation was carried out between August 2019 and November 2020. The research was designed to explore how each project contributed to the Trust's aim of creating better lives for people with dementia and unpaid carers, whilst also collecting information about the strategies and approaches that helped projects to benefit from opportunities, overcome challenges and achieve their goals.

As a result, the evaluation had three core aims:

1. to determine how peer support contributes to better lives, for direct beneficiaries of the initiatives, and for family, friends, community and society more widely;
2. to demonstrate good practice in delivering peer support, with attention to what helps or hinders effective delivery, partnership-working and sustainability for achieving long-term impact;
3. to disseminate evidence about what works for effective peer support to promote greater awareness and learning across Scotland about the benefits of peer support.

Evaluation Methodology

The evaluation adopted a strengths-based approach, following the principles of appreciative enquiry laid out by Bushe and Kassam². This approach allowed the evaluation team to focus on exploring the value offered by peer support projects while gathering evidence that could support better practice overall. To achieve this, the evaluation drew upon several qualitative and quantitative methods to understand the benefits of peer support, and how peer support can be delivered effectively: logic modelling from the secondary analysis of self-evaluation data, thematic analysis of semi-structured interviews and focus group discussions, and social return on investment analysis.

Community research partnership

The evaluation team created a strong community research partnership and recruited community researchers as one of the earliest goals of the evaluation. Community researchers are volunteers who work alongside the academic team to help design, implement, and disseminate the research in a way that is meaningful and valuable to the wider community. They act as 'bridges' between academic researchers and the wider community, and represent peers to the communities under study, which is a vital component of co-creating knowledge and insight within the evaluation³.

This evaluation was able to draw upon the knowledge of both established and new community researchers; three were members of an existing community research partnership developed during a previous study with the Life Changes Trust⁴ while six further members with experience of caring and supporting people with dementia agreed to join the evaluation team to facilitate the research.

The evaluation team hosted two events to share the evaluation goals, develop strategies for accessing participants and deliver training on research methods, with the intention of holding further in-person training and events early in 2020. However, the COVID-19 pandemic meant that it was inadvisable to conduct further face-to-face sessions and the evaluation was redesigned to utilise remote online methods. While community researchers were engaged throughout the research project, and were instrumental in developing research strategies and analysing the resulting data, the character of the partnership and associated involvement was significantly impacted by the COVID-19 pandemic.

This change in way of working, in addition to the pressures of caregiving that affected some community researchers' capacity to stay involved, resulted in six members of the research partnership withdrawing over the course of 2020. As a result, by autumn 2020, the research partnership comprised three community researchers who remained active throughout the project and who contributed to each stage of the evaluation from design, to analysis, to reporting and dissemination.

Logic models

Logic models were constructed for each project (see Section 4), as well as for the peer support programme overall (see Section 5), by drawing together the self-evaluation data provided to the Trust by the projects over the course of their funding. These documents included biannual reports, testimonials and resources created by the projects themselves. This data provided key insight into each project’s resources and activities, as well as their levels of staffing, access to volunteers, engagement with service users and partners, and outcomes. Creating logic models was therefore useful to provide an appropriate framework for generating contextually relevant evaluation questions in subsequent qualitative data collection via individual interviews and focus groups.

Once collected, information was collated into individual logic models, following the Wisconsin model⁵ which mapped out the inputs for each project, their activities, and their outcomes alongside the assumptions and external factors that shaped the progress of the project. This process provided a valuable insight into the similarities and differences across projects, and highlighted the impact of external and organisational factors on the delivery and success of each project, and the peer support programme overall. The resulting Logic Models for each project are included in Appendices 1-6, with each adopting the format below to allow for easy comparison and review. The overarching theory of change for the programme, that connects inputs, activities and outcomes, is presented in Section 6.

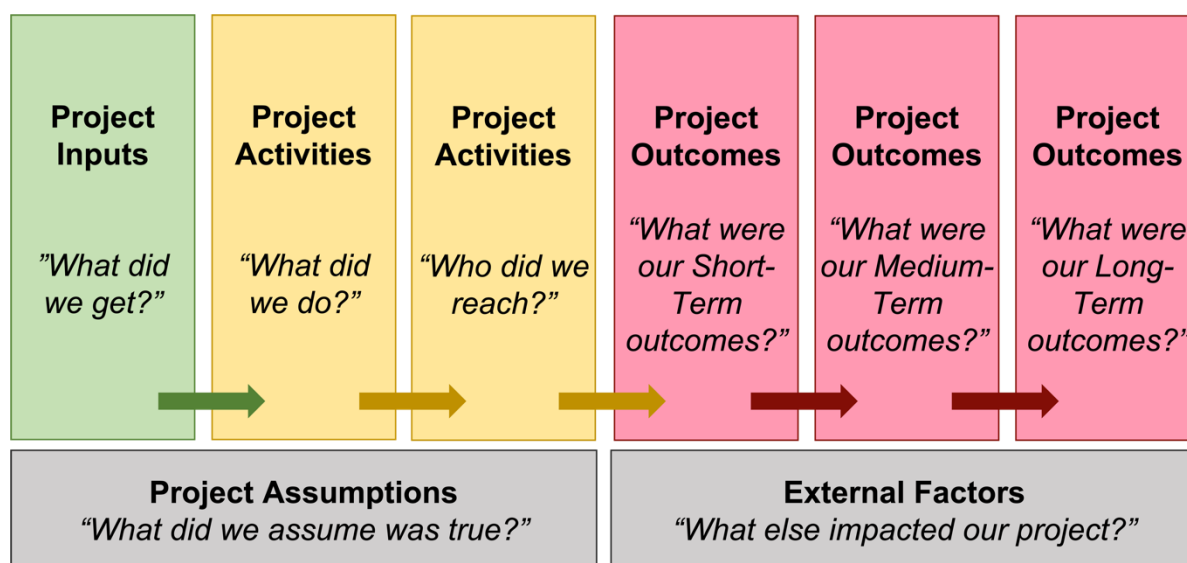


Figure 1: Peer Support Project Logic Model Framework

Semi-structured interviews and focus groups

Following the logic modelling process, the evaluation moved to the qualitative stage of data collection, where semi-structured interviews and focus groups were conducted remotely to capture the experiences of various stakeholders, as well as volunteers, staff and organisers within each project. A total of 37 people engaged with qualitative data collection activities between May and September 2020. This included 21 individual interviews (8 project beneficiaries, 7 representatives from partner organisations, 4 representatives of community organisations, 1 member of project staff and 1 project volunteer) and a further 16 people taking part across six focus groups (8 project staff and 8 volunteers).

The resulting transcriptions were examined by academic and community researchers using thematic analysis⁶. This approach allowed the evaluation team to identify themes that were directly related to the aims of the peer support programme, such as ensuring that beneficiaries had access to someone who understood their experiences. The analysis also identified unexpected patterns in the data such as the importance of shared values between organisational partners. The results of this analysis form the majority of the reporting in Section 5.

Social Return on Investment analysis

Social Return on Investment (SROI) is an analytical tool that is increasingly used by researchers and funding bodies to determine the extent to which social enterprises, groups or interventions deliver the necessary 'return' for the financial investment they represent. Advocates for the SROI approach argue that it is better able to account for the wider social benefits produced by initiatives like peer support projects, rather than focusing exclusively on financial measures to determine success⁷. Data for SROI calculations were based on qualitative and quantitative data (with some key factors influencing outcomes). The SROI analysis presented here demonstrates both the value of the method and the challenges it represents for analysis and projects alike, and is intended to give future projects an insight into how SROI analysis might play a role in their own evaluations. Specifically, when planning for an SROI analysis, organisations need to ensure that they can identify a clear series of desired outcomes relating to their activities. In addition, organisations should maintain records regarding their activities in order to facilitate the SROI to identify how far these outcomes are being achieved.

We have included a more detailed discussion about the strengths and weaknesses of the SROI approach in Appendix 7 to facilitate this. When reading this report we recommend that, when making decisions based on its findings, the reader should focus on the magnitude of social values derived by each organisation when compared to their initial investment, rather than reporting or comparing the precise monetary figures generated by each project. When doing this we can see that all organisations generated significant social value and far more than their initial monetary investment, but that differences could be seen based on the range of beneficiaries, number of people reached within each beneficiary group, scope of activities offered and the specific outcomes for activities identified by each project.

It is important to note that variations in the degree of social value generated by each project does not mean that some of the peer support organisations in this evaluation were 'better' at meeting the needs of their clients than others. Rather, the nature of the activities offered, the number of people accessing services or needs of the groups being served will each have impacts on the range and magnitude of the social returns that can be generated. For example, a peer support activity involving a greater degree of physical activity may generate a higher level of social value than those that do not, simply because the physical activity itself will generate social value over and above the benefits shared across the activities. This does not however mean that all peer support activities should involve physical activity, as this would not meet the needs of many clients needing support or may fall outside the remit of a particular organisation's activities. Such factors should be considered when making funding decisions based on SROI approaches.

These data were collected throughout the research and was supplemented by further information provided by the projects where it was requested by the project team. Details of the methodological process are provided in Appendix 7. SROI findings for Ceartas are in Appendix 8, North West Carers Centre in Appendix 9, Outside the Box in Appendix 10 and VOCAL in Appendix 11. It was not possible to complete SROI calculations for the ENABLE or Health in Mind projects, since these projects had ceased to operate before the evaluation started.

Section 3: Policy and Literature Review

Living with dementia can be difficult and unpredictable, giving rise to the oft-recited adage that “if you’ve met one person with dementia, you’ve met one person with dementia”. Though informal, such statements are well-supported within academic research, and it is widely recognised that people with dementia will experience a wide range of physical and mental challenges⁸.

What is often overlooked, however, is the social cost that often accompanies a dementia diagnosis. This can manifest through a loss of friendships, a shrinking of social networks, and a growing sense of isolation and loneliness, all of which can have a significant negative impact on an individual’s mental health and wellbeing⁹. This loss of existing networks is often further compounded by increasingly limited opportunities to make new connections and friendships, as people with dementia can find it difficult to engage in social activities, leading to further isolation¹⁰.

Nor does a diagnosis only affect the person living with dementia. Unpaid carers, who are often family members, siblings or children of the person with dementia, commonly report decreases in physical and mental health after a diagnosis¹¹ as well as increasing social isolation¹².

Peer support groups have become an instrumental part of addressing the experiences of isolation for people living with dementia and unpaid carers in the UK with the Department of Health¹³ recommending that people with dementia have access to peer support immediately following diagnosis, and peer support being highlighted in Scotland’s Second and Third National Dementia Strategies as one of the five pillars of dementia post-diagnostic support (2013, 2017 respectively)^{14,15}.

This emphasis on the importance of peer support is firmly grounded in the literature, where peer support groups are often shown to improve outcomes for both people living with dementia¹⁶ and unpaid carers¹⁷. Groups often represent not only an avenue for social support but also a source of information, training, and support with personal coping skills,¹⁸ thereby helping people to lead better lives.

Section 4: Project Level Analysis

Case Study

Ceartas De Café



Ceartas De Café used funding from LCT to extend existing services and make them available to more people with dementia and unpaid carers rather than establishing a new initiative. As such, the De Cafés benefited both from name recognition, and support from Ceartas as a wider organisation. While many services arranged by the organisation had been set up to target carers specifically, the project was responsive to the needs of beneficiaries, and opportunities for carers to engage with peer support were often arranged alongside activities for people living with dementia, including Walking Football and Sporting Memories Groups.

Volunteers were trained to take on key roles, and significant efforts were made to ensure beneficiaries were heard not only within the project, but at local and national events if they wished. This advocacy occurred alongside significant engagement with the community, producing additional benefits.

Social Return on Investment for De Cafés

The SROI ratio for Ceartas indicated that Ceartas generates approximately £14.50 of social value for every £1 investmentⁱ.



Specific outcomes generating social value in Ceartas included:

People with dementia. People with dementia reported feeling valued, safe and respected, feeling better informed about their condition, increased social participation and increased participation in physical activities. People with dementia also reported reductions in loneliness, social isolation and stress associated with their illness.

Unpaid carers. Carers reported reductions in challenges associated with caregiving, social isolation and loneliness. Carers also reported improvements in quality of life and wellbeing, increased social participation and increased participation in physical activities.

Staff and Volunteers. Members of staff and volunteers each reported increased knowledge about dementia.

Health and Social Care. Ceartas De Café referred unpaid carers and people with dementia to health and social care, health and wellbeing activities, third sector care agencies and other Ceartas services, contributing to value generated through these activities. Referrals to support from other agencies contributed to the higher SROI compared to services that did not refer to health and social care services or other third sector agencies.

Ceartas De Café served the highest proportion of unpaid carers and people with dementia, with over 500 carers and over 350 people with dementia being supported through its activities over the lifetime of the peer support project. The greatest degree of value generated within De Café related to wider opportunities for social interaction and belonging between people with dementia and unpaid carers attending café events, which generated significant social value in terms of promoting the feeling of belonging to a social group.

ⁱ The data used to complete SROI analysis include some subjective elements, and the assessment should be used as a broad indicator of value, in conjunction with other measures.

North West Carers Side by Side Project



The Side by Side project was an extension to existing services at North West Carers Centre (now Capital Carers) and focused on providing support to unpaid carers. The design of the project emphasised flexibility, providing 'the right service at the right time' with carers being encouraged to move between different forms of peer support and activities in response to their needs. The project placed significant emphasis on recruiting staff and volunteers with experience of unpaid caring, meaning that carers could feel understood and supported by staff and peers when describing their experiences. The Side by Side project experienced some procedural difficulties which impacted recruitment to the project and the buildings used by the project staff. Despite this, the Side by Side project was able to train and recruit volunteers, provide access to information and education, and to provide a variety of activities for beneficiaries including a large singing group for people living with dementia and carers alongside traditional peer support groups. Additional groups were created in response to beneficiary need, most notably a group for male carers that was positively received and attended.

Social Return on Investment for Side by Side

The SROI for North West Carers Side by Side project indicates that the service generated approximately £5.50 of social value for every £1 investmentⁱⁱ.

Specific outcomes generating social value included:

People with Dementia. People with dementia reported increases in the degree to which they felt supported, increases in quality of life/wellbeing, increases in number and quality of social relationships and improvements in physical health.



Unpaid carers. Carers reported increases in the degree to which they felt supported, increases in quality of life/wellbeing, increased number and quality of social relationships, greater access to knowledge and information about caring, improvements in physical health and reduction in the challenges associated with caregiving.

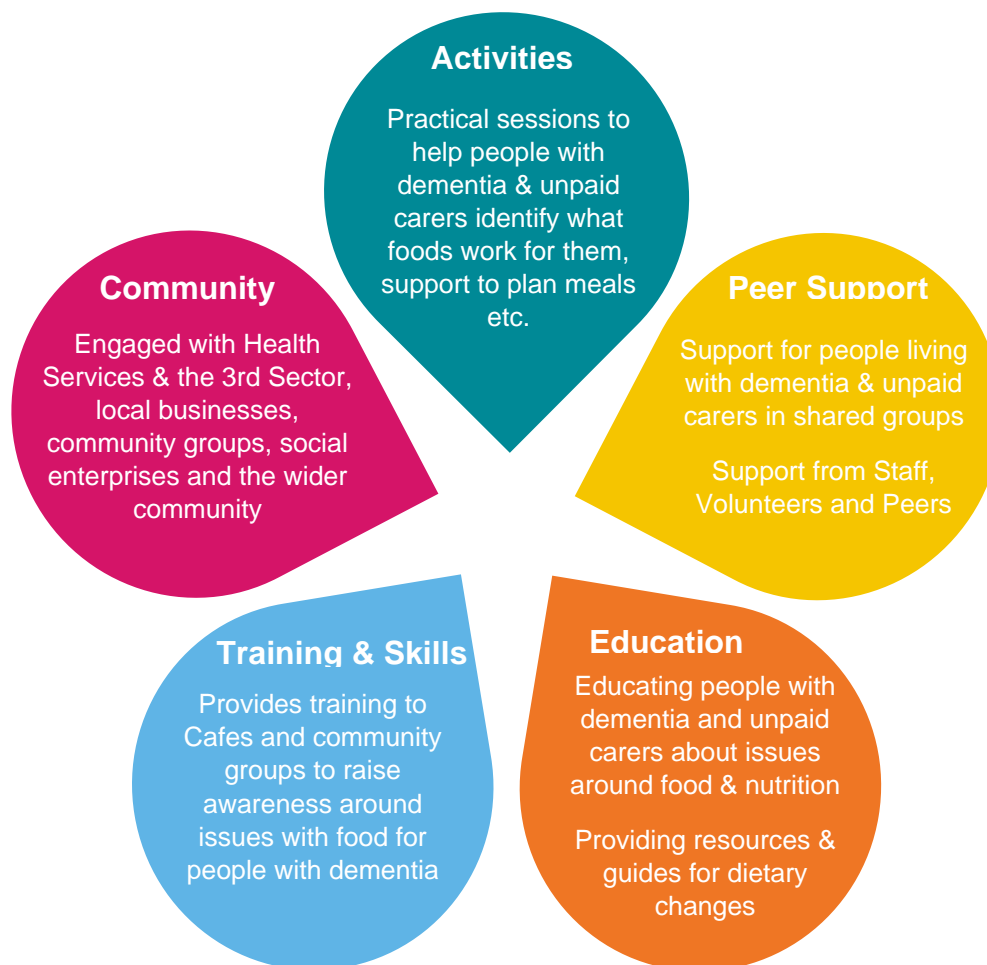
Staff and Volunteers. Staff reported feeling better able to support people with dementia. Volunteers reported experiencing increased wellbeing from their participation.

The Side by Side project supported a smaller but still significant number of people when compared to other initiatives, supporting approximately 180 unpaid carers and 150 people with dementia over the project's lifetime, alongside wider information and awareness campaigns that reached almost 400 carers.

The largest proportion of social value was attributed to improvements in physical health and physical activities, which were gained from participation in the project's dementia friendly walking group programme. This activity had a high number of attendees over its life and generated significant social value.

ⁱⁱ The data used to complete SROI analysis include some subjective elements, and the assessment should be used as a broad indicator of value, in conjunction with other measures.

Outside the Box Food Buddies



The Food Buddies Project was a new initiative provided by Outside the Box designed in response to local interest. Events focused on practical support and guidance for people with dementia and carers about topics relating to food and nutrition, while significant efforts were made to engage with community organisations and businesses to raise awareness of challenges that can occur around eating and dementia. The project also developed a significant library of resources to provide accessible guidance for people outside the local area experiencing similar challenges.

Food buddies faced particular difficulties when raising awareness of its events and resources, as stakeholders often assumed that Food Buddies would provide direct care or meal services, rather than supporting people to engage with food and maintain their connection with it. Meeting educational goals within the community also proved challenging, as the knowledge and training that was provided to local businesses was often lost when staff moved on from their position. Despite this, the project reported positive outcomes for recipients and significant engagement in the community.

Social Return on Investment for Food Buddies

The SROI for the Food Buddies project indicates that the project generates approximately £4.00 of social value for every £1 investmentⁱⁱⁱ.

Specific outcomes generating social value included:

People with Dementia. People with dementia reported increased confidence about food intake, feeling better supported, increased awareness about dementia, reduced social isolation and increased social interactions.

Unpaid Carers. Carers reported increased feelings of being listened to or understood, more friendships and social connections, increased confidence in their caring role and increased awareness of dementia.

Staff and Volunteers. Staff reported increased knowledge and awareness about dementia. Volunteers reported increased wellbeing.



The activities associated with Food Buddies generated significant social value but less than the other projects for whom an SROI analysis was conducted. This was in part because the project's activities focused on activities associated with cooking, food and food intake.

When compared to other initiatives, Food Buddies provided a smaller range of activities to engage its beneficiaries and a smaller range of outcomes which could have social value attributed to them. This negatively impacted its estimated 'value', as many of the efforts made by Food Buddies centred on developing resources that were freely available and accessible for those who wished to use them. Such impact is difficult to incorporate into the SROI, and demonstrates the importance of using SROI as one aspect of a wider evaluation, rather than relying on the method to give a measure of absolute value.

ⁱⁱⁱ The data used to complete SROI analysis include some subjective elements, and the assessment should be used as a broad indicator of value, in conjunction with other measures.

VOCAL Peer Mentoring Service



VOCAL's Peer Mentoring service is a further example of how funding from the Trust could be used by third sector organisations to extend their service with new activities for beneficiaries. In this case, the project focused on recruiting and training volunteers with experience of caring so that they could provide support to beneficiaries on a one-to-one basis for a limited amount of time. This individual support could be supplemented by attending peer support groups, or by accessing other services offered by VOCAL. Peer mentoring was provided by volunteers and arranged formally through the Project Coordinator, but carried out informally in a setting that worked for the beneficiary. This allowed volunteers to be matched with carers based on factors such as their age, gender, or relationship to the person living with dementia, depending on the carer's needs. It also allowed carers to arrange support for a time and place that worked for them, including their caring commitments. Peer support groups were also encouraged to raise topics for discussion and to invite speakers to address particular issues as they arose.

Social Return on Investment for Peer Mentoring

The SROI for VOCAL's Peer Mentoring project indicates that the service generates approximately £15.00 of social value for every £1 investment^{iv}.

Specific outcomes generating social value included;



Unpaid Carers. Carers reported increases in social wellbeing, increased awareness about dementia, improved confidence in caring roles, improvements in overall health and wellbeing, and improved confidence in influencing health and social care services.

People with Dementia. Self-evaluation data did not report any outcomes in relation to people living with dementia.

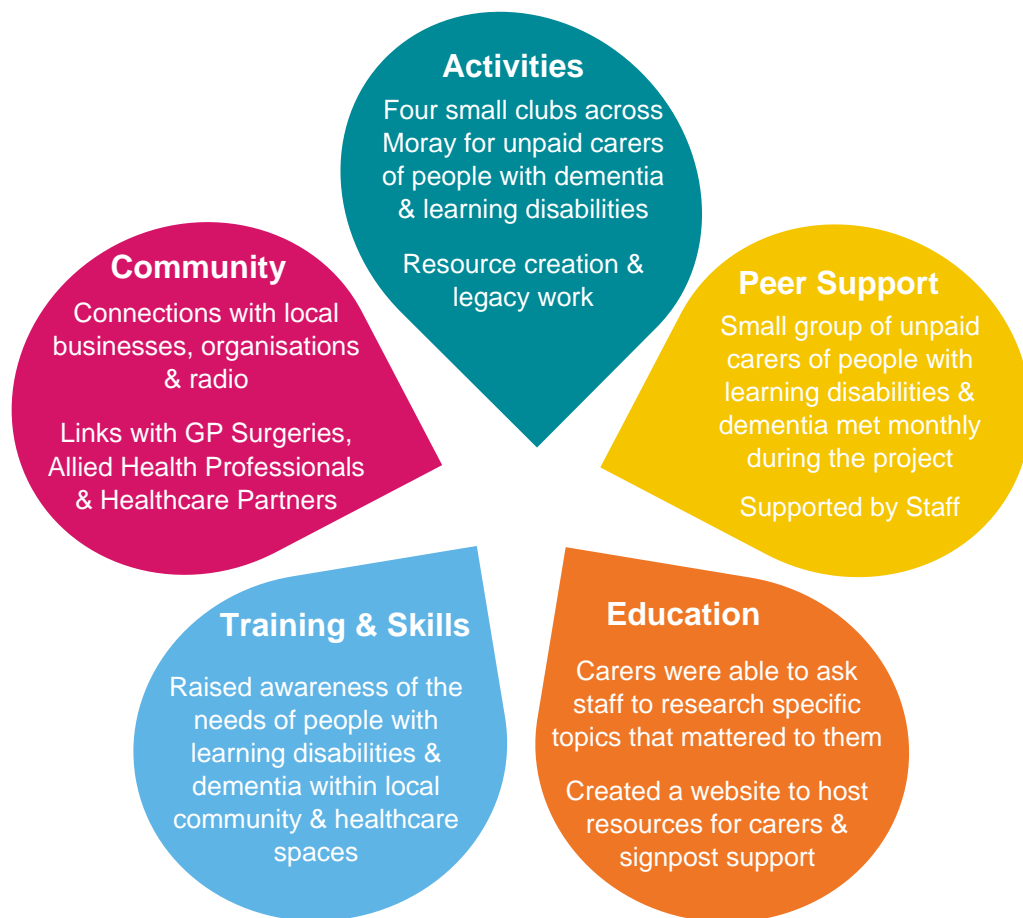
Staff and Volunteers. Staff and volunteers reported receiving increased training in dementia.

VOCAL generated the highest rate of return across the four peer support groups for whom SROI analysis was conducted. This high rate of return was despite the self-evaluation data describing a lower number of outcomes compared to the other groups. For example VOCAL reported no outcomes for people with dementia, who were not supported directly by its initiative. We would expect that people with dementia would experience significant indirect benefits which would generate significant extra social value, but could not be captured in the SROI.

The most important reason for the high rate of return appeared to be the breadth of activities provided for carers by VOCAL, who served the second largest number of unpaid carers across the four organisations. In addition, VOCAL provided a number of different individual and group peer support activities for unpaid carers, leading to a greater number of carers receiving support from their activities when compared to other organisations. In focusing on carers, this also likely enabled the provision of in depth peer support activities for its carers (for example individual peer counselling or befriending), which generated significant social value for their associated outcomes.

^{iv} The data used to complete SROI analysis include some subjective elements, and the assessment should be used as a broad indicator of value, in conjunction with other measures.

ENABLE Scotland Cuppa Club



ENABLE's Cuppa Club project was both an extension of the organisation's previous services in Central Scotland, and an attempt to bring an initiative to a traditionally underserved rural area. The Cuppa Clubs were intended to provide a service specifically for unpaid carers of adults with intellectual disabilities and dementia. This group often faces additional difficulties accessing appropriate services or peer support as the person with dementia is often younger, is cared for by their parent and have pre-existing health issues. The service experienced significant difficulties in identifying and recruiting participants, as well as engaging with local GPs, which ultimately limited its ability to effectively meet its objectives. Though those who used the club reported feeling supported, there were suggestions that the meeting format did not work for carers who were contacted during the outreach phase. As a result, the focus of the project ultimately shifted to raising awareness, providing education, and the creation of resources that could be shared and accessed remotely rather than via peer support. The project was closed early, and as such there were insufficient data available to complete a meaningful Social Return on Investment analysis.

Health in Mind A Sense of Me Project



The A Sense of Me project is the only initiative evaluated that adopted an intervention format. The project aimed to support people with dementia and unpaid carers who were at the start of their journey by helping them to complete a 'Wellness Recovery Action Plan' while engaging with small peer support groups. The project experienced significant difficulties, particularly around the recruitment of its primary member of staff, which impacted the start of the project. Further challenges occurred when the project moved to the recruitment phase, as the intervention method required beneficiaries to be early in their diagnosis, and to engage with a particular type of support. This resulted in recruitment occurring alongside the influx of post-diagnostic support and resulted in limited engagement as people living with dementia and carers prioritised post-diagnostic support. Ultimately, the group had limited success and ceased operating before its five years of funding were complete due to limited engagement with the group and difficulties with member retention between meetings. As such, there was insufficient data available to complete a meaningful Social Return on Investment analysis.

Section 5: Programme Level Analysis

Having explored the 'social value' of peer support initiatives using logic modelling and Social Return on Investment analysis in Section 4, this section focuses on examining the lived experiences of beneficiaries, volunteers, staff, partners and wider community using thematic analysis.

The data collected via individual interviews and focus group discussions were examined using a thematic framework derived from the three evaluation aims set out in Section 2.

This involved, firstly, determining how peer support contributed to better lives as reflected in the core outcomes for the peer support programme as identified by the Trust. These outcomes are indicated below.

The outcomes for the Trust's peer support initiatives are:

- I know that I have someone who will listen to me and who understands my situation
- I know that I have support to face the challenges in my life
- I have an increased sense of wellbeing
- I feel safe, valued and respected
- I have more confidence to make choices and do the things that matter to me

In addition to the above outcomes for beneficiaries, which had been specified as part of the Trust's programme, 'keeping socially connected' was added as a key outcome of peer support (as discussed in Section 3) to include in the analysis of how peer support contributed to better lives.

As well as exploring outcomes for beneficiaries, the evaluation investigated good practice in delivering peer support. This involved exploring key factors influencing success, including: enabling participation, recruitment and retention of staff and volunteers, what worked well and less well for partnership-working, whether there were positive benefits for the wider community, and how the funding structure and organisational context influenced projects' long-term sustainability. The impact of the COVID-19 pandemic on activities was also examined.

Creating Better Lives

Despite their differences in terms of the activities or support provided, each project was funded on the basis that it would help people living with dementia and unpaid carers to live better lives. This commitment was very visible in the data, as staff members, volunteers and community partners framed this outcome as the key indicator of a successful project, while beneficiaries talked openly about the range of ways in which accessing peer support had changed their lives positively. The following section is focused on the core outcomes of the Trust's peer support programme to provide an insight into how peer support improved people's lives.

Having someone who listens and who can understand

Having the opportunity to be heard, and understood, was one of the most important benefits of accessing peer support. Participants often reflected that peer support groups were one of the few services that would engage fully with the challenges that they were experiencing, particularly if those issues related to being a carer for someone living with dementia. This was captured by one beneficiary, who highlighted the empathetic as well as practical approach taken by staff, which meant they felt listened to in a way that made them feel that they mattered:

From the minute I met up with [coordinator] right at the beginning, throughout the whole process, they were actually there for you - if you know what I mean, and listening to me, and nobody had done that. They were empathetic, but it was not just a matter of listening to you just for the sake of listening to you, they were actually trying to help you solve your problem.

This feeling of being seen, heard, and understood was reflected within the peer support groups themselves, with members often supporting each other in a variety of practical and emotional ways.

These moments were often made possible by an attitude of empathy and non-judgemental acceptance, as one staff member explained:

[The peers] really support each other. They really have an opportunity to share ideas and understand what is happening in other people's lives and they go away thinking I am not on my own here; other people are undergoing the same stresses and things, and get a good idea as to how to support it.

The experience of being understood was not limited to carers, as one carer noted when the conversation turned towards why her husband enjoyed attending in-person intergenerational events, and what he was missing due to the restrictions imposed in response to COVID-19:

I really do not know exactly what [he] gets out of it, because he cannot communicate very well, but I can tell he likes going there: he likes the fish and chips; he likes the company of the kiddies; he thoroughly enjoyed reminiscence [...] So it is all these sorts of things, yes, it has done us both good.

This feeling of being accepted and included as a valuable member of the group, despite having issues with memory and communication, resonated strongly with the experiences of other participants who described peer support as a space where people could openly discuss their experiences without fear of being judged.

Feeling safe, valued and respected

A supportive space was a key component in allowing beneficiaries to feel safe, valued and respected during peer support activities. This could manifest in a number of ways, including taking ownership of the group by asking for particular subjects to be discussed or researched, or suggesting speakers or activities for future meetings.

A supportive space could also mean allowing people to be vulnerable, whether that was by trying new things, or by being honest and open about how they were feeling in relation to challenging situations. This supportive environment, in which people were able to talk with others who shared a similar lived experience, helped beneficiaries to feel that they could share their emotions and share their experiences without fear of judgement. As one carer explained, speaking with other people who shared the lived experience of dementia was beneficial:

I found it was much easier to talk to people who had the same problems as I had and what it was really like, rather than trying to talk to relatives [...] or even friends. [...] I think a lot of people did not know how to deal with it [...] And they had no idea what it was really, really like [...] so I found that was a great help for me to talk to people who knew what we were all talking about, to get help and support from them.

Indeed, knowing that others within the group not only conceptually understood what the person was going through, but had 'walked the same road', allowed both people living with dementia and unpaid carers to feel accepted as a valued member of the group. This was captured by a staff member, who explained the significance of everyone being valued equally and not being treated differently as a result:

They know that they are not alone. They know that they can go somewhere for help. They know they have something to look forward to. Some of them make friends with each other and phone each other outwith the groups. Some of them, yes, do get information from it. [...] The people with dementia still feel like they are included in something, they are still going to a group and they are making friends. Also, there is not any difference - I do not make any difference at groups between carers and the people who have dementia - they are all there the same. [...] I think those would be the main outcomes – social wellbeing, remaining in contact with people, being valued, being listened to and not being talked down to or treated like they are any less than what they are.

This inclusion had benefits for both unpaid carers and people living with dementia as it provided a valuable opportunity to interact with a range of different people without fear of being misunderstood or stigmatised as a result of living with dementia or caring for someone with the condition.

Feeling supported to face challenges

These experiences of being seen, heard and understood helped beneficiaries improve their wellbeing over time, as they gained access to both emotional support and practical advice that could help them to overcome challenges in their lives.

This support was not always easy to facilitate in practice, and required skill by staff and volunteers to ensure people were able to gain benefit from sharing the challenges they faced, such as having an outlet to express difficult emotions or seek advice, as opposed to ruminating on negative experiences without catharsis or progress, particularly after groups moved from face-to-face to online meetings in the wake of the COVID-19 pandemic.

As one community partner explained, the facilitator needed to support people by enabling them to express how they were feeling while creating a boundary around this and avoiding unhelpful negativity:

You can just feel when there is a moment where, maybe half a dozen people on a Zoom call [and...] it becomes something quite negative, because what has been a frank, open, loving discussion can become just people piling complaint upon complaint, and moan upon moan, and it just goes. At that point, you have to firmly, but gently, step in and steer in another direction.

This insight highlights how vital the role of the facilitator could be in a peer support setting, even though much of their work appeared subtle in the moment, or occurred behind the scenes. Indeed, volunteer and staff facilitators were vital components in helping beneficiaries to face the challenges in their life, as they acted as gatekeepers to the groups and could connect beneficiaries with practical advice, training and guidance, by inviting speakers, signposting to other services, or providing direct support. Having a 'guide' that could help direct and control the flow of information was invaluable to beneficiaries, who had often struggled to find the right information at the right time prior to joining the group.

This support and information could also be accessed remotely, and both staff and beneficiaries talked about the importance of having materials that people could refer to in their own time. As such the creation of resources that raised awareness or addressed particular problems represented an important avenue for supporting people living with dementia and carers to lead better lives.

Having increased confidence

The benefits of attending a peer support group were not limited to feeling heard and understood, or having the information and support necessary to deal with challenges.

A number of participants described how carers and people with dementia could sometimes be surprised by what they were able to take part in, and what they enjoyed, as discussed by this participant:

I would always encourage people to come, just say, 'yes, I know it is going to be a bit scary, but I will come with you' or something like that. Because, quite honestly, two minutes later, that is it. No way was I going to join a singing group, but I knew the lady that was taking it. [...] She was trying to start this thing off and I thought I will give it a go then. Singing. In the end the singing was not as important; [it was] the meeting of the other people [...]. We would get up and wander around and you just got to know people.

This quote shows how important it is to recognise the success that occurs when a beneficiary accesses a peer support initiative for the first time. It reflects the experiences of several beneficiaries who explained their own initial reluctance about attending a group, and their fears about feeling unwelcome, overwhelmed, or out of place. It is important to remember, therefore, that even 'simple' peer support initiatives - that focus on offering a facilitated space where people who have similar experiences can meet and talk openly - have significant positive effects on the confidence of the beneficiaries accessing that service.

The art is simple: we have an art person who comes and does it, but she keeps it so simple. Now maybe about fourteen people come and they go away every time with a piece of completed art, and they are so chuffed [...and] they go away and they tell everybody else - look at this! Look what I have done! And they put it up in their houses and they send it to their family or whatever [...] therefore, other people want to come now because they are now relaxed, they are not so frightened of it. [...And] once they have been and the people who have been and had success and positive self esteem through it, then they can actually spread it. They can say, look what I have done - it is okay to come. I think that is the thing that works best.

Having an increased sense of wellbeing

Being provided with a space where they could reflect honestly on their experiences, or relax and be accepted as a person with dementia or a carer, was a key aspect in improving the wellbeing of beneficiaries.

Indeed, emotional support was often one of the first things mentioned by beneficiaries when they were asked about why peer support was important to them. This was, perhaps, due to the experiences they had before joining the group, as one carer noted:

The carers' group was really a godsend. I think I would have been in the asylum or something, and that is not overstating it.

Another described the importance of others in the group accepting how they felt, including when they felt low or sad:

Talking to people who understand how you feel - if you are not in a very good mood that day they accept whatever mood you are in [... because] they are all going through the same sort of thing. You are not embarrassed, as I say, if it is just a carers' group to just have a good cry; you are not embarrassed by doing all these sorts of things.

This emphasis on recognising and engaging with how others within the group were feeling, rather than focusing exclusively on what they were doing, was highlighted by beneficiaries throughout the study. Indeed, peer support groups often seemed to be one of the few venues in which carers in particular could centre themselves and their own needs, which enabled them to engage with their own experience in a way that allowed them to recognise and feel their emotions without feeling either shame or pressure to immediately transform that reflection into an active strategy, even though practical ideas could sometimes be helpful.

As such, sharing with peers became an opportunity to reconcile with difficult emotions in an environment where others could resonate with both the emotions themselves, and the potential shame and guilt they might feel about those emotions. This release could then be met with both reassurance from others that the experiences and emotions were both valid and understandable, and examples of how others who had faced similar situations and feelings had come to terms with them.

This was captured by one staff member who reflected on the positive impact for carers who could benefit from peer support both in terms of having a break from caregiving and hearing about what others do to help themselves continue caregiving:

I think sometimes as well [... there is something important about] giving yourself permission, a lot of the time people think that it is a luxury to have some respite, to have a break, but it is actually a necessity - it is one of the most important things that they can do is to have a bit of a break, reduce their stress to help them keep going, and I think hearing that somebody else has continued caring, but been able to fit something in and being able to see the difference that it has made to them [...] I think it is part and package of support that [the group] provides. We [staff] have conversations with them about what they might like to do, but to hear how somebody has actually done it, and got through that barrier of the guilt [...] how did they get past that feeling guilty and being able to actually enjoy that space and time? Then in a light bulb moment, thinking, oh my god, [...] I could come back from this a wee bit fresher, and I know it has not changed the situation, but I am a bit changed [...] I think that for carers' health and wellbeing that can make a big difference.

Feeling socially connected

One of the most noteworthy findings of this evaluation has been the importance of social connection to beneficiaries, and the positive impact that being in a safe and supportive space can have on the social lives of people living with dementia and unpaid carers.

Beneficiaries of peer support groups often showed signs of building friendships that extended beyond the group itself, with project staff often hearing about group members meeting socially outside of the project. This ties in with existing research, which suggests that the relationships built within peer support groups can represent a counterbalance to the increasing isolation people can experience after a dementia diagnosis.

One project staff member explained this clearly, expressing the importance of carers having time with the person with dementia within a supportive environment that enabled them to feel relaxed, like they were getting a break by spending time with the person in the company of friends:

[It is important] to bring people with dementia and their carers together to give them that peer group support as well. Because [...] it is not always about getting respite away from the person, it is sometimes being able to do something together, but maybe not feeling stressed about it. [...] Sometimes if you are out and about it is actually quite good in a group like that to actually be able to support one another, and that goes for the people with dementia as well as it does for the carers [...]. A lot of carers say [...] that they feel relaxed because they know the staff are there if there are any issues [...] so] the carer still feels like they are getting a break, but they are doing something with the person [...]and] it is like going out with a group of friends.

This quote highlights the value of peer support for connecting people, not only with their peers, but in some instances supporting people with dementia and their relatives, partners or friends to feel a sense of togetherness.

People also described the value of feeling a sense of togetherness with other generations in their community, when initiatives supported intergenerational connections. For people with dementia, this could help them feel a sense of purpose from being able to share learning and experience with younger people.

This finding shows that peer support can have benefits for a person's immediate social relationships as well as for their broader relationships within the wider community.

Key Factors Influencing Success

A key aim of this evaluation was to identify factors that could positively or negatively impact the ability of projects to meet their goals and achieve their outcomes. Critically, while several of these factors were highlighted in the Logic Models (Appendices 1 - 6) in the earlier stages of the evaluation, interviewees and focus group participants were able to provide significantly more detail around the impact of: staffing and funding, cultivating a network and integrating their work with the community, partnership-working, enabling participation, and adapting to the restrictions associated with the COVID-19 pandemic.

Staffing and funding

The importance of attracting, supporting, and retaining an enthusiastic and knowledgeable facilitator to support the peer support project was first highlighted at the Logic Modelling stage of the evaluation. Issues with staffing could delay the start of the project, stymie recruitment, and impact the experiences of beneficiaries to the point that it became difficult for some projects to meet their outcomes within their hoped timescale.

This theme was reinforced through interviews and focus groups, where facilitators were often specifically mentioned and positioned as central to both the group's initial success, and its ongoing ability to attract beneficiaries and integrate with the wider community.

Crucially, facilitators were often perceived by beneficiaries as trustworthy, knowledgeable and accessible. This created a space where beneficiaries could feel empowered to ask the questions or seek the advice that mattered to them, which in turn allowed them to take more ownership of the peer support process, as visiting speakers and topics of discussion were dictated by beneficiary needs.

These traits also had a significant impact on the perception of the wider organisation and the peer support project specifically when discussed with community partners about how facilitators maintained relationships and engagement with beneficiaries as well as volunteers:

She is really engaged. She does travel down sometimes, even if it is just maintaining that relationship; she always keeps in touch. If she cannot make it down then she will provide information and maintain those links with people. She is really well thought of by the volunteers and the people that have met her, and she goes out of her way to try and support things, despite the distance, which means quite a lot to people. [...] I think she does go above and beyond.

Finding and retaining staff over the course of the project often presented a challenge, however, especially when it became necessary to seek out alternate streams of income to continue to employ the staff member in their usual pattern. Ironically, the right staff member in post could also make significant progress in securing the necessary funds, whether that was through fundraising efforts, networking, or applying for funding from different organisations.

In some cases this process of fundraising became an opportunity for greater partnership-working, as one community partner reflected:

[...] most times, we have got a good sort of relationship where we can rely on each other to help out. [...] that is what we have to focus on now - funding is so limited and there are so many people trying to access the same pot. It is just a nightmare, but it has been quite good sharing things, as well, because they are in the same position as what we are. If they find somewhere that is good for a certain project, they will maybe say, you should try this funding or try this Trust. Likewise, we would do the same: we have had success with that - you should try it

This interaction between funding as it impacts staffing, and staff as they impact funding, emphasises how complex it could be for projects to attract and retain talented facilitators, when the success of future funding often relied on the efforts and knowledge base of the facilitator themselves. It was notable that staff spent significant amounts of time looking for funding to sustain their project and completing self-evaluation activities in order to report to funders when they were successful.

This interaction was significant for smaller organisations that did not have access to the infrastructure and funding of a larger organisation, especially with the increasing sliding scale of matched-funding that had to be sought across the lifetime of the projects. Conversely, staff from larger organisations described how they benefited from using extra funding to trial new initiatives, which could be incorporated into the wider organisational plans in the longer-term if the project proved to be successful following initial investment from the Trust.

As a result, this cycle often impacted not only the views of staff and volunteers, but beneficiaries themselves who reflected on the difficult financial environment that surrounded peer support groups.

Cultivating networks and partnership working

While community partners, volunteers and beneficiaries often praised the efforts of facilitators, there were aspects of the role that could be overlooked that were nevertheless central to the success of the project.

For example, raising awareness of the project was one of the functions facilitators carried out 'behind the scenes'. This work often took place within community and practice settings, and could produce less immediate results than other recruitment efforts. Initial investment in awareness-raising and communication with partners enabled each organisation to understand the particular activities offered by the other, as well as the goals and limits of peer support activities, in order to be able to refer beneficiaries to the right support at the right time.

This initial awareness-raising could be time-consuming. Yet such referrals across organisations were often integral to supporting the sustainability of projects, by setting up initiatives to co-exist rather than compete with each other, as explained by one community partner:

We obviously support carers to a degree with the people that are coming with us, but in terms of signposting when we think, actually, this is maybe a benefit issue or they are needing a wee bit more access to activities, [...] [Different Organisation] has got benefits advisers that will do surgeries in our building. We will let them have space to do that, but we are not really in competition for the carers part. Without sounding twee, I think we are all there for the same aim - helping people to get the right support, and, hopefully, at the right time.

This collaborative style of working often resulted in better outcomes for both the projects and the beneficiaries. Networked groups focused on supporting people living with dementia and unpaid carers to access the necessary support, irrespective of the organisation that was delivering the support, and thus referred beneficiaries to different services at different times, even when this meant ‘giving up’ a group member.

This, in turn, encouraged not only trust within the networked groups whereby the reciprocal pattern of referral repeated itself, but between the beneficiaries and staff facilitating the peer support groups, as beneficiaries were able to trust facilitators to act in their best interests.

An emphasis on respect and reciprocity was common in interviews with community partners. As such, approaching a peer support project with both a willingness to be guided by the needs and desires of beneficiaries, and a sensitivity to the services already being provided within the area, was a vital component to the early stages of projects.

Projects funded by LCT also had the opportunity to connect and learn from one another through attending quarterly Gatherings where were encouraged to reflect on their own practices, share their strengths and weaknesses, and learn from one another. These Gatherings also provided opportunities for beneficiaries, and representatives from different initiatives funded by the Trust to come together and identify common interests and opportunities for collaboration and growth.

Enabling participation amongst peers

One of the major barriers for peer support projects was the need to reach and attract the right group of beneficiaries for the initiative. Projects reported that reaching people with dementia and unpaid carers could be difficult, especially during the period directly after diagnosis and during periods of stress. This was a key challenge for both ENABLE’s Cuppa Club and Health in Mind’s ‘A Sense of Me’, both of which sought to attract a particular demographic of beneficiary and were ultimately unable to do so.

While it is difficult to know why certain recruitment strategies failed, several beneficiaries in the evaluation discussed how they resisted engaging with support at different points, either because they didn’t have the capacity to engage with the services offered, or because they feared it would not be appropriate for them. This is shown clearly by the quote below, with one beneficiary reflecting on their initial reluctance to attend:

I probably should have got involved earlier on. I waited until, really, I was desperate - really desperate. I tried everywhere and nobody was listening to me. [...] I do not know why I waited so long - I think my expectations of [the service...] but when I went there it was nothing like I thought it would be like. I obviously had some kind of negative image in my head that stopped me going there.

Concern about the negative associations attached to being diagnosed or associated with dementia was a related barrier that impacted on people's willingness to join a peer support group.

Indeed, several people noted the impact of the ongoing stigma around dementia, and how this could discourage people from trying different groups, even though they often found peer support groups to be accepting and supportive once they had attended.

This was captured by one member of staff who explained the importance of creating a safe environment wherein people did not feel concerned about the stigma associated with dementia:

I think it is good to join [groups that people with dementia and unpaid carers can attend together...] because maybe the person that brings their cared for is, unfortunately, quite embarrassed by the stigma about dementia and the way that their cared for might act or behave. With this service I do not think there is such a feeling of embarrassment or worry, because either [another person] has a cared for with them, as well, or has experienced that, or everyone has an understanding of it, and they can really feel like they are in a safe environment, a comfortable environment just because everyone is familiar with dementia.

The creation of this safe and supportive space could also pose its own issues, however, as supporting people to share their issues and experiences could lead to topics being raised that were difficult or unwelcome for other members of the group to hear, particularly where it led to unpaid carers discussing their difficulties around people living with dementia.

This was described by one participant who said:

One of the things that seems to come up is that they [groups] shirk away from the really hard conversations. [If] there are one or two people in the group who are at the stage where they having to put the person into a care home, [...sometimes] the folk with dementia [who] are very fit do not really want to have that conversation. So I am not sure that their experience of being in a group is as positive. [... Because] none of the people with dementia so far, in my experience, says I think I might have to go into a care home - they do not tend to have that conversation with you, whereas family and friends do. So, I think their experience of the group, while I think it is positive and just being together, I think it is harder for them, because if it was you and I you would be thinking professionally, well, actually, it will do them no harm to think that in five years' time this could be you [...] but if you are early diagnosed, living in the moment, you can go to that place and think that might happen, but you do not necessarily want to address it. So, that, I think is quite complicated for them.

These difficulties emphasise the importance of not only having an adept facilitator who is comfortable managing such situations, but having a project model that allows the group to adapt in line with the needs of beneficiaries.

A key example of this flexibility would be the steps taken by a project to create an additional group for unpaid male carers who felt disconnected and underserved by mixed gender carers group.

Such adaptability requires more time from facilitators and volunteers, but often creates greater flexibility and adaptability, which significantly improves the experiences of beneficiaries.

Adapting peer support for COVID-19

The theme of adaptability was central to many of the interviews and focus groups conducted as part of this evaluation. This is unsurprising, however, as the fieldwork took place throughout 2020 in the midst of the COVID-19 pandemic.

The restrictions associated with COVID-19 included restrictions on movement between areas, changes to statutory services, restrictions on the size and location of group meetings, and the introduction of a 'shielding' category that often included older beneficiaries who attended the peer support groups.

As a result, each active group was forced to adapt and invent new, and usually remote, ways of supporting people with dementia and unpaid carers. This often included periods of trial-and-error, as both staff and beneficiaries learned to use new digital technologies, learned their limits, and adapted to ever-changing circumstances and formal regulations. This need to adapt was reflected by one volunteer who said:

They are still doing [reminiscence] online. It seems to work and we are going to try and get one of the gentleman that plays the accordion and sings to record something to put it on our Zoom meeting (for the next one), so I think that might work, hopefully. [The meeting] is only for the 40 minutes, so it is probably long enough for online, but [facilitator] was getting people to chat. [...] They are also sending out newsletters [...] with lots of helping information: good ideas for things to do; phone numbers for contacting people in emergencies or for advice - lots of things you probably all know that. I think they are moving forward with it, so it is good it has not stopped.

Several participants discussed issues around supporting access, or maintaining engagement when moving into online spaces, while others observed how moving online had allowed beneficiaries to attend who might not have been able to do so before, for instance due to caring commitments. Importantly, the shift to remote support did not necessarily end the peer-to-peer relationships that had grown within the groups, as several beneficiaries noted that they now routinely phoned one another in addition to attending digital meetings. This provides one of the clearest examples of the benefits of the peer support model: not only were beneficiaries supported flexibly during a time of national crisis, but they were able to adapt and support one another throughout that time.

Social Return on Investment across the Programme

The following section sets out the key benefits for beneficiaries and staff/volunteers supporting the groups in terms of their 'social value'. Accompanying notes to interpret the data are provided in Appendix 7.

Benefits for people living with dementia

Key benefits of attending peer support groups highlighted by people living with dementia included:

- Reductions in feelings of loneliness and social isolation
- Improvements in the quantity and quality of social interactions
- Feeling safe, secure and valued as a result of the peer support activities
- Feeling better able to cope with their condition and the challenges it created for them
- Improvements in their general wellbeing.

In addition, as a result of the activities provided, people living with dementia attending activities provided by Food Buddies highlighted increased confidence with food, and those attending activities delivered by the Side by Side project also reported improved physical health.

Benefits for unpaid carers

Key benefits for carers highlighted within the SROI analysis and shared across all organisations included the following:

- Reductions in feelings of loneliness and social isolation
- Reductions in caregiver burden, and increases in confidence and resilience in relation to fulfilling caring roles
- Increased social interaction and friendships within and outside the groups
- Increased knowledge and awareness about dementia, including caring strategies
- Valuable opportunities for carers to have breaks during project activities
- General sense of improved wellbeing amongst carers.

In addition, a number of carers from two of the peer support projects (Side by Side and De Cafés) reported the outcome of improved physical health and fitness, resulting from physical activities provided by the two organisations (e.g. dementia-friendly walks or walking football).

Benefits for staff and volunteers

Benefits experienced among staff members and volunteers within all of the organisations included:

- Increased knowledge and awareness of dementia
- Better training in dementia and dementia care practices.

These benefits show that the peer support projects provided value that extended beyond outcomes for the beneficiaries alone.

Summary results of the SROI analysis

Each of the four groups for whom SROIs were calculated generated value far beyond the level of their investment, with groups generating between £4.00 and £15.00 for every £1 invested in them. Each of the peer support groups could be considered a worthwhile investment in terms of the ‘social value’ they achieved. All four peer support projects produced positive benefits for each of their stakeholder groups: unpaid carers, people living with dementia, staff and volunteers.

The SROI value for each project is presented as a ratio of rate of return, and is calculated by dividing the value of the impact by the value of the investment. In addition, the value of each rate of return is adjusted to reflect a net present value of 3.5% based on the HM Treasury Green book. The total SROI values for each of the peer support organisations, also reported earlier in Section 4 of the report, is repeated below.

	Rounded SROI^v
Ceartas De Café	£1: £14.50
North West Carers Side by Side Project	£1: £5.50
Outside the Box Food Buddies	£1: £4.00
VOCAL Peer Mentoring Service	£1: £15.00

Table 1: Total SROI values for Evaluated Peer Support Projects

^v SROI figures are rounded to nearest 50p

While unpaid carers were the main beneficiaries across the four groups, benefits for people living with dementia were also listed by three of the four projects. This is important and should be considered when making assessments about the value generated when investing in activities that are focused on support for carers, as their true value will also be shared by people living with dementia. In a number of activities provided by projects, people with dementia accompanied the carer, attending either the same activities or taking part in other activities provided at the same time. The evaluation collected information on benefits gained for staff and volunteers working in each organisation, as these can be considered benefits derived from each project (e.g. staff training would have significant value to those receiving it).

The strength of the ratios varied significantly, with two groups generating over three times the value compared to the other two groups. These differences were largely a result of: differences in the number of people with dementia and unpaid carers that each project engaged with, the number of outcomes identified by each of the four groups, the range of activities that were available in each of the four activities, and the relative strength of the financial proxies used to calculate social value. This highlights the importance of strategic and systematic recording where projects expect to engage with SROI analysis during their lifetime, as the robustness of the analysis, and the ultimate calculation of value, relies on the outcomes reported and recorded.

The following factors influenced the relative social value of each organisation:

- Groups with higher social value engaged with larger numbers of unpaid carers and/or people living with dementia than those with generally lower social value. For example, VOCAL provided both individual and group peer support to a larger number of carers. By having a wider reach in terms of the number of people accessing its activities, it generated a greater degree of social value when compared to other activities offered by the other initiatives.
- Groups generating higher social value had identified a wider range of outcomes from their activities than those with lower social values. By identifying more outcomes, these groups were able to evidence a wider range of benefits than those who identified fewer outcomes.

- Specifically, outcomes that directly influenced health and wellbeing outcomes (e.g. reduced uptake of physical/mental health services) led to greater social value. The clarity of project reports in describing their outcomes was therefore a determinant of value – if outcomes were not identified and listed then they could not be included in the analysis.
- SROI rates were determined by the social value attributed to each outcome. As a result, some outcomes had the potential to generate higher SROI than others. For example, a peer support activity that was physical, such as a dementia-friendly walking group, generated higher social value than an activity that was not physical. This is because the physical health benefits themselves generate a social value (e.g. improved physical health will reduce uptake of health services). This does not mean that peer support should only involve physical activity, but it does indicate that some activities will inherently generate greater social value per individual than others.
- Physical/mental health or wellbeing outcomes that could be mapped onto financial proxies relating to improvements in health or reduced health/social care service uptake had a high social value, as use of such services usually had high financial costs. Over a large enough sample (e.g. the population attending a group's activities) even small improvements in physical health or small reductions in health service uptake will generate significant social value. Therefore, organisations that identified outcomes in relation to improved health or reductions in health/social care use tended to generate a higher SROI ratio.

The findings suggest that it is beneficial to think carefully about specified outcomes, in terms of the broad range of benefits activities might generate, as well as recording these benefits in ways that can be measured using SROI if social value is to be calculated. Working with recipients of services to identify (perhaps unanticipated) positive outcomes as a project develops is one effective way of identifying the full range of benefits generated from participation in peer support groups. Furthermore, providing formalised methods for evaluating activities using recognised tools or methodologies (of which SROI is one example) can be helpful in ensuring that all beneficiaries to activities are identified, and that the benefits or challenges experienced are recorded in ways that allow for meaningful evaluation.

In this evaluation, each project provided annual end of year reporting to the Trust. This information was useful in providing detailed qualitative and quantitative data that could be used to identify outcome measures and financial proxies. Ensuring comparable data is collected in each organisation can further strengthen the ability of future evaluations to generate SROI analysis that can compare social value as accurately as possible across organisations.

Section 6: Theory of Change for Programme

Following the programme level analysis, a theory of change model is presented below to explain how change happened through peer support projects to have impact by creating better lives through the outcomes discussed in Section 5. This theory draws together learning from across the projects, including analysis of key factors influencing success.

The model clarifies the links and causal mechanisms between inputs and outputs, outputs and outcomes, who was involved and how, and the context in which the projects were implemented that influenced change.

The model presents three interconnected strands of influence,

Resources - **People** - **Network**

that impacted the implementation and delivery of peer support groups and the outcomes they achieved. The evolution of change is considered across five levels representing key stages of project development. A narrative is provided below before presenting a summary diagram.

Level 1: initial set-up of project

Funding was accessed to develop a new initiative where there were clearly identified gaps or needs that were not already supported by another organisation in the area. Identifying project aims and objectives was important in clarifying the gaps or needs being supported.

Recruiting a project lead early in the process of developing the project provided consistency and leadership in recruiting and retaining beneficiaries, staff and volunteers who could support the initiative.

Employing empathetic staff and volunteers with lived experience of caring created an environment that emphasised the value of sharing and learning from peers. Initial and ongoing training and feedback for volunteers was important to keep them engaged and feeling supported.

With a project lead embedded early in the life of the project, they could communicate the project's aims and objectives to relevant partners. This was most successful when they identified partners in organisations that shared similar goals and values connected with supporting beneficiaries.

Level 2: inputs into the project

Using funding from the Trust to extend services within an organisation meant that a project could complement existing initiatives. During initial publicity and awareness-raising, a new project benefited from existing name recognition. Longer-term, it enabled the project access to a wider infrastructure within the organisation, including resources and funding.

Consistent staffing was connected to the wider organisational infrastructure surrounding projects. Access to other funding pots in larger services provided some job security when staff were awaiting the outcome of funding bids to sustain a project, with matched funding being a basic element of the Trust's funding structure to create sustainability. Access to a wider infrastructure linked staff in projects to wider networks.

Links to networks were strengthened by consistent staffing, as this fostered reciprocity to strengthen networks as they developed during a project's lifetime. A cooperative approach supported the sharing of information and was strengthened by connecting regularly with partners. It could involve in-kind contributions such as free access to buildings.

Level 3: project development

Projects were sustainable when they developed peer support activities that complemented services for beneficiaries already provided by the organisation or partner agencies. Being flexible and responsive, by adjusting activities according to the needs and wishes of beneficiaries as the project evolved, enabled a project to stay relevant and appropriate.

A responsive service supported the recruitment and retention of beneficiaries. Having reach across the local community to access a wide number and diversity of beneficiaries was important. Recruitment was also impacted by the accessibility of support; whether the physical location and accessibility of buildings, transport and access to the location, or the accessibility of technology during remote engagement.

Achieving reach across the community involved awareness-raising and publicity activities, including signposting by partner agencies. Referrals from GPs, the health care workers and third sector organisations were particularly important routes for the recruitment of beneficiaries.

Level 4: project activities and outputs

Providing a range of activities supported choice in the way beneficiaries could receive peer support. Beneficiaries described the value of both emotional and practical support, and one-to-one and group support. Some unpaid carers found value in having time with other carers separate from the person with dementia, and others valued opportunities to take part in activities together. Some carers benefited from peer support from carers matched to their own situation or demographic.

Facilitating a safe and supportive environment to deliver peer support was a key role for staff and volunteers. As well as supporting peer to peer support, staff and volunteers were an important avenue of emotional and practical support. This could relate to their own lived experience or from accessing information and resources from partners.

As networks strengthened, partnership working became more established to support cross referrals within and across organisations. This enabled beneficiaries to access the right support at the right time, maintained ongoing recruitment of beneficiaries, and facilitated strategic approaches such as partners supporting each other on funding bids.

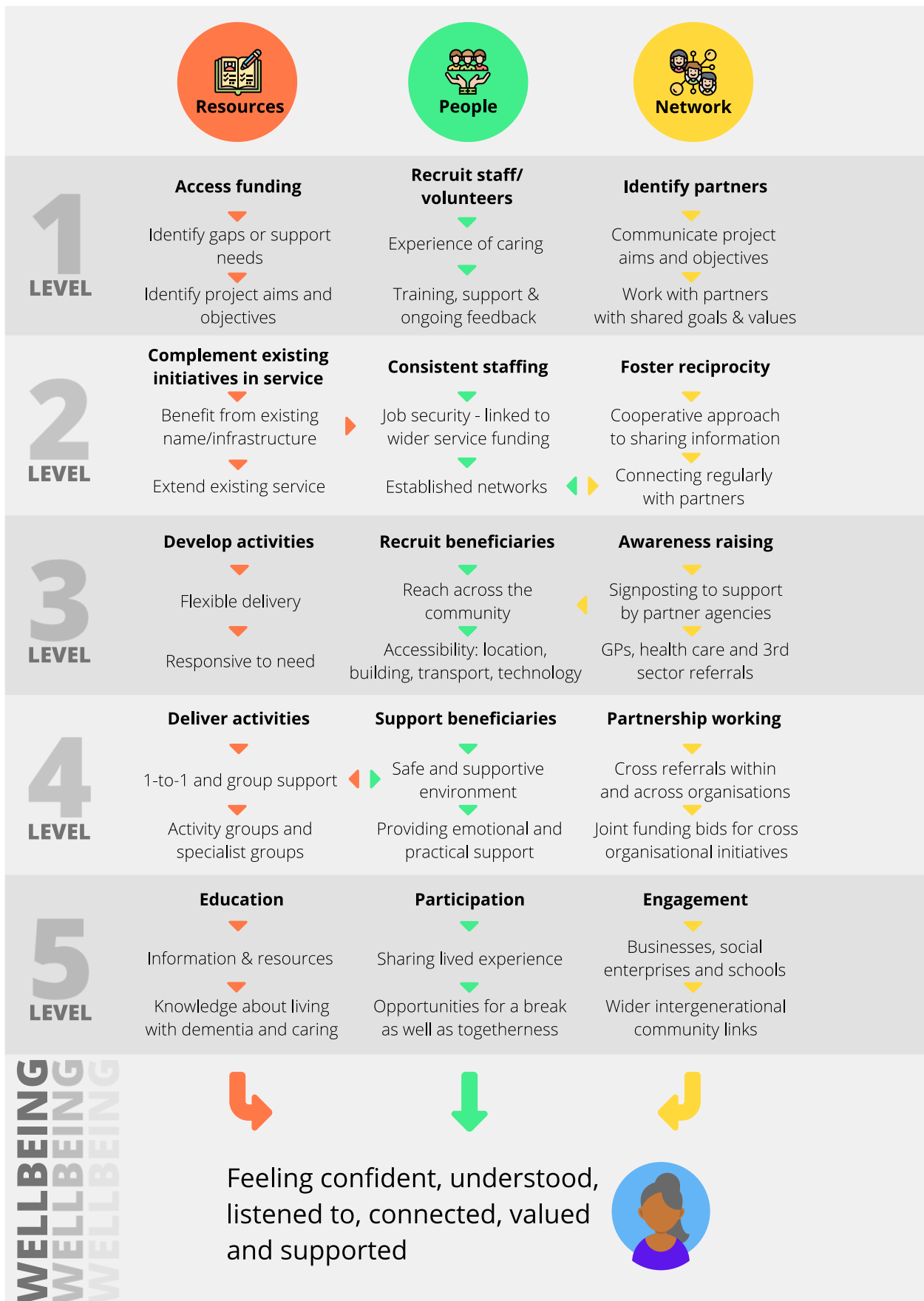
Level 5: benefits and outcomes

Education was an important benefit for some beneficiaries. This could involve improved understanding about living with dementia and caregiving. Sharing information and resources, whether amongst peers, or from staff and partner agencies, supported people to feel more confident. In the longer-term, through sharing feelings and hands-on strategies, this enabled carers to feel they could maintain caregiving.

Participation was key to beneficiaries feeling listened to and supported to face challenges. This occurred through sharing lived experience with their peers, with a break from caregiving being an additional outcome for carers. A sense of togetherness either with peers or between the person with dementia and their carer improved people's sense of wellbeing.

Engagement with the wider community was important at a project level, where activities supported connection with local businesses, social enterprises and schools. It was also important at a beneficiary level, to promote wider intergenerational links and friendships. This supported individuals to feel valued and connected to their community.

Theory of Change: creating better lives



Section 7: Key Lessons from the Evaluation

The evaluation aimed to draw insights for future projects. We consider six findings below that represent key lessons from the evaluation:

Flexible: Peer support works well when projects are willing to adapt what they provide to reflect beneficiary needs and fit the wider landscape of services within an area.

Cooperative: Building meaningful relationships with other initiatives and partners supports reciprocal referral to projects and helps projects work together to sustain funding.

Empowering: Engaging and empowering volunteers with lived experience provides beneficiaries with additional supportive social connections, and provides a route back into engagement for unpaid carers when they are bereaved or are no longer providing direct care.

Connected: Experienced, knowledgeable and well-connected staff sustain the project. The presence of a dedicated facilitator from the early stages improves a project's ability to establish networks, recruit beneficiaries and volunteers, meet outcomes and secure further funding.

Reflective: Involving beneficiaries, volunteers and project staff in the process of evaluation helps them view the peer support group and its benefits in a different way than they had before. This can support them to realise the significance of the project and their role within it.

Evidenced: Being proactive in evidencing goals, activities and outcomes helps to capture insight into the benefits people gain from peer support, particularly where these are not predicted or named at the outset of a project. This can support efforts to demonstrate 'social value'.

It is also important to recognise that while these lessons and benefits were present at the time of the evaluation, they represent a snapshot of the projects and their impact. We expect that many of these projects will continue to have an impact on the lives of people with dementia and unpaid carers long after the evaluation, as support, awareness, and education continues to move between stakeholders, carers, and people living with dementia.

Limitations

The data in this evaluation were gathered from beneficiaries, volunteers, project staff or people who partnered with the peer support initiatives. This means that the evaluation is based entirely on the perspectives of people who access or facilitate peer support. While we had intended to also recruit participants who could not or did not want to receive the types of peer support provided by the funded initiatives, so that we could understand their potentially different perspectives on what works well and less well, the challenges of recruitment during the COVID-19 pandemic meant that we were limited in the reach of our engagement.

Additionally, the restrictions impacted the methods we used. We relied on remote engagement to conduct interviews and focus groups, and were unable to host the creative workshops and conversation cafés that we had planned in communities to reach a diverse group of participants using a variety of creative methods. We were also limited in the extent to which we could record wider community benefits that we had planned to discuss during these events. Due to the necessity of using online or telephone methods to engage participants, most beneficiaries who engaged were carers rather than people with dementia, which limits the evidence about benefits for people with dementia to proxy reporting.

The SROI analysis was conducted retrospectively, and as such there are some limitations that are considered further in Appendix 7.

Acknowledgements

We thank the project leads who facilitated our access to beneficiaries, staff, volunteers and project partners. We are indebted to their support especially at a time when organisations were challenged by the restrictions and their associated impact on support. We also gratefully acknowledge the participants who gave their time to participate. In addition, we thank those community researchers who worked with us in the earlier stages of the evaluation to guide our approach and methods.

Appendix 1: Ceartas De Café Logic Model

Project Goal: Increasing integration of people with a lived experience of dementia into their community

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> • 1 Peer Coordinator (recruited Feb16) • Est £116,886 over 5 years (decreasing % from LCT) inc. funding for room/ pitch hire, minibus, equipment, additional staff & refreshments for football etc. 	<ul style="list-style-type: none"> • Run De-Café + Walking football + Sporting memories • Empower peer supporters to be welcoming, presenters, & board members • Develop & Deliver training • Run intergenerational placements with young people • Present at conferences • Refer to other orgs & services • Social media presence • Create materials, flyers, & marketing to raise awareness • Dementia advisory group • Bereavement support for attendees & volunteers 	<ul style="list-style-type: none"> • People affected by dementia (past & present) • Statutory Services • Secondary schools • Local Leisure Trust • Paths for All • Scottish Football Association • Third Sector orgs (providing training) • Post diagnostic support, GPs, Health & Social Care • University associates • Fire, Police, Library services. • Prison services (raising awareness) 	<ul style="list-style-type: none"> • Members had opportunity to contribute in multiple forums including DEEP, Dementia Strategy Steering Group, & Health and Social Care Partnership Board • Engaged with others with long term conditions (not dementia) • Members report greater health, sociability & mobility (football) • Carers socialize while football group runs 	<ul style="list-style-type: none"> • Some carers continue to attend after the person with dementia stops- increasing their network • Coordinating with mental health team resulted in input in local garden • People living with dementia took part in cultural project & university research • Members connected with local community through events • Opening dialogues with closed or reluctant groups • Community partners approaching group offering support 	<ul style="list-style-type: none"> • De Café shifted from one-stop-shop model to information/activity 'hub' • De Café as a Brand with values • Materials and leaflets designed with input from people with lived experience of dementia • Peer-to-peer referral became more common • Links to and from other projects increased opportunities for members
Assumptions <ul style="list-style-type: none"> • As De Café model already works in the area, expanding it should be effective. Increasing referral can occur through multiple avenues (peer-to-peer, referral, advertising etc). 			External Factors <ul style="list-style-type: none"> • Existing organization & links set up 		

Appendix 2: North West Carers Side by Side Project Logic Model

Project Goal: Support unpaid carers to develop skills, make connections, and access peer support

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> £105,000 over 5 years IT equipment for worker Staff training (Media & IT) 1 Care Practitioner & 1 worker (6months 0.2FTE) Volunteers (10+) New website 	<ul style="list-style-type: none"> Run courses, activities & social outings for carers Singing and walking group Social media posts and campaigns Consultations to identify carer needs Work with younger carers Group, 1:1 home or centre, telephone, post and online support for carers Provide respite while Support Workers work with people with dementia Social media training for carers Produce flyers, leaflets & run awareness events 	<ul style="list-style-type: none"> Referring agencies, Social Work, Healthcare, churches, Hospitals, Mental health team, Day centres, Funders, 3rd Sector, libraries, & local retailers Local media inc radio, newspapers, & newsletters. People with dementia, Carers & Community Male carers (special group trialled for this) 	<ul style="list-style-type: none"> Raised awareness of existing projects Carers have more awareness of dementia & related issues More awareness of needs of people with dementia Carers feel understood & supported by others with similar experiences Carers report being calm and relaxed after a meeting (vs stressed before) Joint activities with people with dementia lead to satisfaction for carers 	<ul style="list-style-type: none"> Carers report feeling supported & having access to knowledge & support inc. signposting Engagement with stakeholders for Side by Side lead to more update for other NWCC services Quarterly programme reaches professionals and members increasing awareness Members who refuse short break service are supported in other ways before retrying access Male carers access more sensitive peers support in dedicated group (inc. health discussions) 	<ul style="list-style-type: none"> Staff/members joined different dementia focused groups taking training/ethos further
Assumptions <ul style="list-style-type: none"> Initial support would naturally tailor off to produce self-sustaining peer support groups Carers have key insights into the experiences of other carers that professionals don't share 			External Factors <ul style="list-style-type: none"> Loss of premises due to funding issues Due to staff shortage recruitment & project worker didn't happen until 10 May (7 month delay) Substantial offers of support for accommodation, training 		

Appendix 3: Outside the Box Food Buddies Logic Model

Project Goal: Provide support to People Living with Dementia and Carers around food

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> 3 Staff (Development Worker, Chief Executive, Office manager). Volunteers Support for design & publication of materials & resources. Other Outside the Box staff covered for staff sickness 	<ul style="list-style-type: none"> Facilitate peer support groups & 1:1 support. Recruit & train volunteers Signpost to useful materials Create & distribute resources Signpost to other services & opportunities Raise awareness around food, nutrition and dementia Publicity & outreach via print, social media etc. Encourage people to think of food more broadly - from gardening to cooking & support this. 	<ul style="list-style-type: none"> People with dementia in the area Older people without a dementia diagnosis Carers of people with dementia Service Providers Health services/teams & 3rd Sector Local businesses, community groups & social enterprises Existing Dementia groups & networks Carers centres, churches, hairdressers etc Groups with food interest but previously low dementia awareness 	<ul style="list-style-type: none"> People with dementia encouraged to take ownership of project (logo design etc) Participants report feeling listened to/ understood by peers and staff Participants show improvements in wellbeing, health, & eating patterns. Members reported more friendships & social connections. Resources took on a 'tips' format to positive feedback 	<ul style="list-style-type: none"> Engagement with other orgs encouraged dementia inclusive ethos Presence & advocacy side lead to interest in creating Dementia Friendly area & seeking funding Members felt empowered to share 'tips' and information as part of peer support & see this as valid method of support. Members gained confidence to try other initiatives & orgs 	<ul style="list-style-type: none"> Online & print resources created and disseminated including recipes & health focused resources focusing on diabetes etc. Resources actively refer beneficiaries to other services. Resources used by other services etc. Businesses approaching & being approached re: becoming dementia friendly Similar groups starting elsewhere (no involvement)
Assumptions <ul style="list-style-type: none"> Discussions in the Borders showed an interest in personalized support around food - therefore a service is needed and timely. 			External Factors <ul style="list-style-type: none"> Staff member leave proved problematic as small scale and no back up Outside stakeholders sometimes resistant to peer-support method - wanted traditional support. 		

Appendix 4: VOCAL Peer Mentoring Service Logic Model

Project Goal: Support Unpaid Carers of People Living with Dementia through small group mentoring & peer support

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> £62,010 over 5 years Supported by existing Carers Support Team Service Manager, Care Support Worker, Peer Mentors Care management & impact system to systematically digitally record feedback 	<ul style="list-style-type: none"> Recruit and train peer supporters in solution focused approaches Provide information and signposting to other services for carers Support 1:1 mentoring for carers with peer support (3-8 meetings) Run small peer support groups (8-12 sessions) Advertise in VOCAL's existing newsletter & use pre-existing contacts Provide practical caring advice including strategies, boundary work & service access Regularly & systematically review services & carer experience 	<ul style="list-style-type: none"> GPs, Social Workers & Allied Health Other carer groups Carers of people living with dementia (mostly spouses and children) 	<ul style="list-style-type: none"> Developed new training resources for peer mentors Peer mentors received training to increase skills Carers encouraged to focus on assets & strengths Carers reported feeling supported and informed about caring & dementia Mentoring helped carers navigate immediate challenges (transition, power of attorney etc) Carers concerned about personal safety were provided with strategies to address risk & fear 	<ul style="list-style-type: none"> Production of a peer support tool kit People with dementia benefit from reduced carer stress Carers reported improvement in health and wellbeing Carers reported feeling supported as carers meaning other relationships could remain as friends/family Carers report meeting outside formal groups & mentoring with people with dementia 	<ul style="list-style-type: none"> Carers were less isolated & reported better wellbeing Carers were better able to manage caring responsibilities from diagnosis to move to residential care Carers reported feeling more empowered and less negative when looking forward or reflecting on caring Carers who received peer mentoring volunteered themselves once their caring responsibilities ended
Assumptions <ul style="list-style-type: none"> VOCAL Carers Support team will provide referrals to peer support VOCAL supports 1000+ carers and receives regular referrals indicating a need for peer support. Sharing experiences in non-judgmental spaces with others who have a similar experience is crucial to carer wellbeing. 			External Factors <ul style="list-style-type: none"> VOCAL operates more broadly as a 'one stop shop' style service so has a wide network of people who can be referred to the peer support service. 		

Appendix 5 : ENABLE Scotland Cuppa Club Logic Model

Project Goal: Support older carers of people with learning disabilities & dementia in Moray

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> £30k decreasing overtime. Staff (1 coordinator) Finances for venue hire Enable mini bus Materials inc. posters, flyers, documents etc. ENABLE Scotland inhouse benefits advisory team ENABLE Direct services Support from Age Scotland and Alzheimer Scotland 	<ul style="list-style-type: none"> Build Partnerships (GPs, 3rd sector, businesses) Raise awareness (events, speaking, radio, twitter) Facilitate 1 (then 2) Cuppa clubs for social support, group discussions and expert speakers Develop resources (legacy) Signpost to Services Support users to be heard elsewhere (surveys etc) Provide information on allowances, benefits, finance Advocate for carers e.g. cost of respite 	<ul style="list-style-type: none"> Local business Local Government Local Organizations Healthcare Professionals & AHPs Carers of people with dementia Carers of people with learning disabilities & dementia Wider community (awareness raising & radio) 	<p><i>Members</i></p> <ul style="list-style-type: none"> Awareness of risk of dementia /learning difficulties Feelings of support & increased confidence Reduced isolation Shared coping strategies Access to information & support <p><i>Community</i></p> <ul style="list-style-type: none"> Awareness dementia in LD Voices of carers heard 	<ul style="list-style-type: none"> Greater awareness of learning disability and dementia esp. at local healthcare level. Resource developed alongside 3rd sector partner Website updated to signpost carers to key resources. Users reported to have continued caring for longer. 	<ul style="list-style-type: none"> Networked partners have raised awareness and website remains to signpost carers to other resources. Awareness raised of challenges in period between diagnosis and receiving support
<p>Assumptions</p> <ul style="list-style-type: none"> Due to high rates of dementia in people with a learning disability, there will be a community of underserved carers in Moray 			<p>External Factors</p> <ul style="list-style-type: none"> GP & Stakeholder engagement (lack of) Lack of central list/resource to identify users 		

Appendix 6 : Health in Mind A Sense of Me Project Logic Model

Project Goal: Support People living with Dementia and their carers to complete a Wellness Recovery Action Plan (WRAP)

INPUTS	ACTIVITIES		OUTCOMES		
What did we get?	What did we do?	Who did we reach?	Short-term	Medium-term	Long-term
<ul style="list-style-type: none"> Personnel (Development Worker supported by WRAP Facilitator & Wider Health in Mind team). WRAP training for the Development support worker. 	<ul style="list-style-type: none"> Support people living with dementia & unpaid carers to complete a WRAP Signpost members to other groups and services Publicise group & engage social media awareness Carry out formal measures to track outcomes 	<ul style="list-style-type: none"> Local Authorities & Healthcare professionals People living with dementia & unpaid carers 3rd Sector organizations (Alzheimer Scotland) and other groups (VOCAL) 	<ul style="list-style-type: none"> Carers found it helpful to access peer support to gain advice People with dementia found it useful to have a source of emotional support 'wider than the family' 	<ul style="list-style-type: none"> Both people living with dementia and carers felt more confident in starting new hobbies 	
Assumptions <ul style="list-style-type: none"> 85% completion rate of carers/people with dementia Groups would maintain a large enough size to be delivered (over 4) 			External Factors <ul style="list-style-type: none"> Staff sickness meant no resource or provision for 6 months Delay in recruitment meant no provision for 6 months at onset Recruitment stalled as candidates had biomedical/suffering perspective. 		

Appendix 7: Step-by-step Process for SROI methodology

Step 1: Identify the relevant stakeholders, financial and other inputs into each project. This includes funding from the Trust and matched funding, as well as in-kind contributions with a financial value (e.g. volunteer time). In each group, the evaluation team identified the stakeholders: project staff, volunteers, people living with dementia, unpaid carers, health and social care organisations, and the Trust as the main project funder. The key beneficiaries for whom SROI was calculated included unpaid carers, people with dementia, staff and volunteers.

Step 2: Identify the outcome measures for each project. Each project provided a range of different activities and services for different beneficiary groups. For example, some provided activities only for unpaid carers, whereas others also provided peer support activities for people with dementia. Two organisations also provided wider training activities, or provided referrals into health, social care or third sector organisations. This meant that each organisation possessed its own distinctive outcome measures based on its stakeholders and range of activities provided. Outcome measures were identified for each of the peer support activities through secondary analysis of self-evaluation reports provided to the Trust, using qualitative data collected from stakeholders and by sending a questionnaire to each organisation. Outcome measures relevant for each project are detailed in Appendices 8-11.

Step 3: Calculate the number of participants who benefited from each outcome measure. In the majority of cases this information was based on self-evaluation data contained in annual and biannual evaluation reports. For example, several of the projects conducted evaluation surveys with their beneficiaries, and this data was used to measure the proportion of people benefiting from each identified outcome. Where such data were not available, proxy figures for the proportion of people benefiting in relation to each outcome measure were derived from existing research as reported in academic articles or non-academic reports.

Step 4: Identify suitable financial proxies for each outcome measure. Financial proxies are financial values that can be associated with each of the expected outcomes for projects, and can be used to calculate a financial value for each outcome measure. Financial proxies are used because, although the outcomes may themselves not have a financial value, their social value can be approximated using an existing, recognised financial value of the cost or benefit of a similar activity. An example of a financial proxy would be measuring the socialisation benefits of taking part in a peer support project with the financial value of participation in a social group, taken from the Social Value UK Cost Book (valued at £1897.47 per individual). The financial proxies used in this evaluation are noted for each project in Appendices 8-11.

Once financial proxies and proportion of beneficiaries experiencing the specified outcomes were identified, the financial values identified were then re-calculated using percentage proportions to control for Deadweight (the amount of benefit that would have happened had the intervention not taken place), Attribution (the amount of benefit that can be attributed to other sources) and Displacement (or amount of benefit that is displaced from other activities).

Proportions for Attribution, Deadweight and Drop Off as well as other technical aspects of the SROI are also shown in Appendices 8-11.

A note on using the findings from the SROI analysis

It is important to note that the SROI process does not replicate a cost-benefit analysis where financially measurable data can be collected, or a statistical analysis using nominal data. Instead, SROI analysis provides a means of bridging the gap between qualitative and quantitative evidence when making evaluative and/or commissioning decisions about social interventions and the social value of their impacts (Willis et al. 2018).

While a number of resources were used to inform this analysis, including the identification of appropriate financial proxy variables or identifying appropriate rates of attribution and deadweight, these figures remain 'best guess' estimations. In many cases these estimations were taken from the research literature, for others they were estimates informed by quantitative data from the projects' evaluation reports, or assumptions made using qualitative data. Reflecting best practice in SROI reporting, the assumptions made when calculating SROIs and sources of supporting evidence are also provided in Appendices 8-11.

While the evaluation team has evidenced the assumptions made when developing our SROI, minor changes in the assumptions used to calculate the SROI can lead to potentially significant changes in final SROI values. For example, in our analysis volunteer time is calculated at an average of four hours per week, over a one year (46 week) period per volunteer, charged at the national living wage (£8.72 per hour). We chose this figure as based on the existing literature and qualitative evidence it appeared to be a reasonable reflection of the time investment made by volunteers over a one year period, and because it reflects best practice to include volunteer time as a cost for the organisation (based on the cost of providing the same activities on a paid basis) within SROIs¹⁹. However, a change to these variables (for example the pay or amount of time commitment) will therefore significantly change the SROI figures. By using the same calculation for all four organisations, this means that the evaluation can make a fair comparison (i.e. if this is an overestimate, the evaluation have applied the same overestimation to each organisation, enabling a fairer comparison).

Similarly, it is not simply the case that the higher the social value the better the activity; an activity generating less social value may still provide useful activities, for example by delivering a more targeted activity, or accessing a smaller population or a group that may be excluded from other activities. In the case of this evaluation, the activities provided by Food Buddies had a specific focus on food, which may limit its scope compared to the other projects but still generate significant social value for its beneficiaries. Indeed, while Food Buddies generated the smallest SROI of the four organisations, this was still more than four times the monetary investment in its activities.

In addition, many indirect benefits of groups may not be identified through the self-evaluation data and new qualitative data generated in the research. For example, VOCAL did not list benefits for people with dementia that may be gained from carers' participation in peer support activities. There would undoubtedly be indirect benefits for people with dementia, but because we did not have information to make evidenced decisions about these benefits, they were not included in the analysis.

The data reported here were based on data collected over the first four years of peer support activities. The choice was made not to include the fifth year of activities because only partial information was provided to us within the timescale in which the SROI was conducted. Therefore, to ensure groups were compared on a like-for-like basis, we limited our analysis to data from the first four years of project reporting.

When reading this report the evaluation team recommend that, when making decisions based on its findings, the reader should focus on the magnitude of social values derived by each organisation when compared to their initial investment, rather than reporting or comparing the precise monetary figures generated by each project. When doing this we can see that all organisations generated significant social value and far more than their initial monetary investment, but that differences could be seen based on the range of beneficiaries, number of people reached within each beneficiary group, scope of activities offered and the specific outcomes that activities targeted. This does not mean that some organisations were 'better' at generating social value than others. Rather, the activities offered, number of people accessing services or needs of the groups being served will shape the social returns that can be generated and should be considered when making funding decisions.

Appendix 8 Ceartas De Café SROI

Stakeholder	Total Population	Outcome	Indicator Description	Indicator Result	Outcome Incidence	Deadweight Description	Deadweight Amount	Deadweight Incidence	Outcome Incidence – Deadweight	Attribution Proportion	Outcome Incidence – (Deadweight & Attribution)
Unpaid Carer	535	Number of people feeling safe and secure	Number of people feeling safe and secure	1.0	535.0	Average proportion of adults 65+ who report feeling happy	0.95	508.25	26.8	0.5	13.4
Unpaid Carer	508	Number of people reporting feeling less lonely	Number of people reporting feeling less lonely	1.0	508.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.19	96.52	411.5	0.5	205.7
Unpaid Carer	455	Number of people reporting reduction in stress/burden	Number of people reporting reduction in stress/burden	1.0	455.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.19	86.45	368.6	0.6	221.1
Unpaid Carer	519	Number of people reporting increase in quality of life	Number of people reporting increase in quality of life	1.0	519.0	Number of Unpaid Carers not experiencing depression	0.7	378.9	140.1	0.14	19.6
Unpaid Carer	490	Number of people reporting they are better informed	Number of people reporting they are better informed	1.0	490.0	Proportion of UK population who are dementia friends	0.0	19.6	470.4	0.5	235.2
Unpaid Carer	508	Increased participation in social activities	Increased participation in social activities	1.0	508.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.2	96.5	411.5	0.5	205.7
Unpaid Carer	5	Increased participation in physical activities	Increased participation in physical activities	1.0	5.0	Number of Unpaid Carers who do not have improved physical health	0.2	0.8	4.3	0.5	2.1
Person Living with Dementia	364	Person Living with Dementia report feeling safe, valued and respected	Person Living with Dementia report feeling safe, valued and respected	1.0	364.0	Average proportion of adults 65+ who report feeling happy	1.0	345.8	18.2	0.4	7.3
Person Living with Dementia	346	Person Living with Dementia experiences reduction in loneliness/social isolation	Person Living with Dementia experienced reduction in loneliness/social isolation	1.0	346.0	Proportion of Person Living with Dementia who do not feel lonely or isolated	0.7	224.9	121.1	0.5	60.6
Person Living with Dementia	309	Person Living with Dementia experiences reduction in stress, being more able to cope	Person Living with Dementia experienced reduction in stress, being more able to cope	1.0	309.0	Proportion of Person Living with Dementia who do not feel lonely or isolated	0.7	216.3	92.7	0.6	55.6
Person Living with Dementia	353	Person Living with Dementia report increased wellbeing/quality of life	Person Living with Dementia reported increased wellbeing/quality of life	1.0	353.0	Number of people with dementia not experiencing depression	0.6	211.8	141.2	0.14	19.8
Person Living with Dementia	333	Person Living with Dementia report being better informed	Person Living with Dementia reported being better informed	1.0	333.0	Proportion of UK population who are dementia friends	0.0	13.3	319.7	0.5	159.8
Person Living with Dementia	346	Person Living with Dementia report joining new groups or engaging in new social activities	Person Living with Dementia reported joining new groups or engaging in new social activities	1.0	346.0	Number of Person Living with Dementia not experiencing depression	0.6	207.6	138.4	0.5	69.2
Person Living with Dementia	5	Person Living with Dementia report increased participation in physical activities	Person Living with Dementia reported increased participation in physical activities	1.0	5.0	Number of Unpaid Carers who do not have improved physical health	0.2	0.8	4.3	0.5	2.1
Staff	81	Staff exhibit increased knowledge about dementia after training	Staff exhibited increased knowledge about dementia after training	1.0	81.0	Proportion of UK population who are dementia friends	0.0	3.2	77.8	0.8	62.2
Volunteer	238	Volunteers exhibit increased knowledge about dementia after training	Volunteers exhibited increased knowledge about dementia after training	1.0	238.0	Proportion of UK population who are dementia friends	0.0	9.5	228.5	0.8	182.8
Unpaid Carer	36	Unpaid Carer referral to health and wellbeing activities	Unpaid Carer referred to health and wellbeing activities	1.0	36.0	Proportion attending mental health service appointments (based on Did not attend rates)	0.9	32.4	3.6	1.00	3.6
Unpaid Carer	37	Unpaid Carer referral to Health and Social Care	Unpaid Carer referred to Health and Social Care	1.0	37.0	Proportion attending mental health service appointments (based on Did not attend rates)	0.9	33.3	3.7	1.00	3.7
Unpaid Carer	29	Unpaid Carer referral to 3rd sector agencies	Unpaid Carer referred to 3rd sector agencies	1.0	29.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	26.1	2.9	1.00	2.9
Unpaid Carer	18	Unpaid Carer referral to other CEARTAS services	Unpaid Carer referred to other CEARTAS services	1.0	18.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	16.2	1.8	1.00	1.8
Person Living with Dementia	27	Person Living with Dementia referral to health and wellbeing activities	Person Living with Dementia referred to health and wellbeing activities	1.0	27.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	24.3	2.7	1.00	2.7
Person Living with Dementia	21	Person Living with Dementia referral to Health and social Care	Person Living with Dementia referred to Health and social Care	1.0	21.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	18.9	2.1	1.00	2.1
Person Living with Dementia	21	Person Living with Dementia referral to 3rd sector agencies	Person Living with Dementia referred to 3rd sector agencies	1.0	21.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	18.9	2.1	1.00	2.1
Person Living with Dementia	22	Person Living with Dementia referral to other CEARTAS services	Person Living with Dementia referred to other CEARTAS services	1.0	22.0	Proportion attending mental health service appointments (based on did not attend rates)	0.9	19.8	2.2	1.00	2.2

Displacement Proportion	Outcome Incidence – (Deadweight, Attribution & Displacement)	Financial Proxy Description	Proxy	Total Annual Value Produced	Annual Drop Off	Year 1 Value	Year 2 Value	Year 3 Value	Year 4 Value	Year 5 Value	Total Value	Present Value
0.0	13.4	Average of mental health services per individual	£1,151	£15,394.63	0.7	£15,394.63	£4,618.39	£1,385.52	£415.65	£124.70	£21,938.88	£20,902.21
0.0	205.7	Talks to neighbours regularly	£4,627	£951,958.98	0.7	£951,958.98	£285,587.69	£85,676.31	£25,702.89	£7,710.87	£1,356,636.74	£1,292,532.35
0.0	221.1	Average of mental health services per individual	£1,151	£254,520.63	0.7	£254,520.63	£76,356.19	£22,906.86	£6,872.06	£2,061.62	£362,717.35	£345,578.07
0.0	19.6	Value of being a member of a social group	£1,897.47	£37,224.95	0.7	£37,224.95	£11,167.48	£3,350.25	£1,005.07	£301.52	£53,049.27	£50,542.56
0.0	235.2	Dementia train the trainer training for home care providers	£338.00	£79,497.60	0.7	£79,497.60	£23,849.28	£7,154.78	£2,146.44	£643.93	£113,292.03	£107,938.71
0.0	205.7	Value of being a member of a social group	£1,897.47	£390,385.48	0.7	£390,385.48	£117,115.64	£35,134.69	£10,540.41	£3,162.12	£556,338.34	£530,050.00
0.0	2.1	Weekly walking activity for 2 months	£5,417.00	£11,511.13	0.7	£11,511.13	£3,453.34	£1,036.00	£310.80	£93.24	£16,404.50	£15,629.35
0.0	7.3	Average of mental health services per individual	£1,151.00	£8,379.28	1.0	£8,379.28	£418.96	£20.95	£1.05	£0.05	£8,820.29	£8,506.88
0.0	60.6	Talks to neighbours regularly	£4,627.00	£280,164.85	1.0	£280,164.85	£14,008.24	£700.41	£35.02	£1.75	£294,910.28	£284,431.24
0.0	55.6	Average of mental health services per individual	£1,151.00	£64,018.62	1.0	£64,018.62	£3,200.93	£160.05	£8.00	£0.40	£67,388.00	£64,993.51
0.0	19.8	Value of being a member of a social group	£1,897.47	£37,509.19	1.0	£37,509.19	£1,875.46	£93.77	£4.69	£0.23	£39,483.34	£38,080.38
0.0	159.8	Dementia train the trainer training for home care providers	£338.00	£54,025.92	1.0	£54,025.92	£2,701.30	£135.06	£6.75	£0.34	£56,869.37	£54,848.64
0.0	69.2	Value of being a member of a social group	£1,897.47	£131,304.92	1.0	£131,304.92	£6,565.25	£328.26	£16.41	£0.82	£138,215.67	£133,304.46
0.0	2.1	Weekly walking activity for 2 months	£5,417.00	£11,511.13	1.0	£11,511.13	£575.56	£28.78	£1.44	£0.07	£12,116.97	£11,686.42
0.0	62.2	Dementia train the trainer training for home care providers	£338.00	£21,026.30	0.3	£21,026.30	£15,769.73	£11,827.30	£8,870.47	£6,652.85	£64,146.65	£59,035.65
0.0	182.8	Dementia train the trainer training for home care providers	£338.00	£61,780.99	0.3	£61,780.99	£46,335.74	£34,751.81	£26,063.86	£19,547.89	£188,480.29	£173,462.78
0.0	3.6	Cost of geriatric outpatient assessment per person	£283.00	£1,018.80	1.0	£1,018.80	£10.19	£0.10	£0.00	£0.00	£1,029.09	£993.95
0.0	3.7	Cost of geriatric outpatient assessment per person	£283.00	£1,047.10	1.0	£1,047.10	£0.00	£0.00	£0.00	£0.00	£1,047.10	£1,011.69
0.0	2.9	Cost of geriatric outpatient assessment per person	£283.00	£820.70	1.0	£820.70	£0.00	£0.00	£0.00	£0.00	£820.70	£792.95
0.0	1.8	Cost of geriatric outpatient assessment per person	£283.00	£509.40	1.0	£509.40	£0.00	£0.00	£0.00	£0.00	£509.40	£492.17
0.0	2.7	Cost of geriatric outpatient assessment per person	£283.00	£764.10	1.0	£764.10	£0.00	£0.00	£0.00	£0.00	£764.10	£738.26
0.0	2.1	Cost of geriatric outpatient assessment per person	£283.00	£594.30	1.0	£594.30	£0.00	£0.00	£0.00	£0.00	£594.30	£574.20
0.0	2.1	Cost of geriatric outpatient assessment per person	£283.00	£594.30	1.0	£594.30	£0.00	£0.00	£0.00	£0.00	£594.30	£574.20
0.0	2.2	Cost of geriatric outpatient assessment per person	£283.00	£622.60	1.0	£622.60	£0.00	£0.00	£0.00	£0.00	£622.60	£601.55
											Total Benefits	£3,197,302.18
											Total Inputs	£219,811.00
											SROI Ratio	14.55

Appendix 9: North West Carers Side by Side Project SROI

Stakeholder	Total Population	Outcome	Indicator Description	Indicator Result	Outcome Incidence	Deadweight Description	Deadweight Amount	Deadweight Incidence	Outcome Incidence – Deadweight	Attribution Proportion
Unpaid Carer	209	Increase in Unpaid Carers feeling supported	Proportion people feeling they have someone to listen to/support them	1.0	209.0	Number of Unpaid Carers not experiencing depression	0.73	152.57	56.4	0.60
Unpaid Carer	187	Increase in Unpaid Carer wellbeing	Proportion reporting increased social participation	1.0	187.0	Average proportion of adults 65+ who report feeling happy	0.95	177.65	9.3	0.40
Unpaid Carer	196	Improved physical health	Proportion reporting increased social participation	1.0	196.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.19	37.24	158.8	0.14
Unpaid Carer	388	Unpaid Carers have access to knowledge information about dementia	Unpaid Carers had access to knowledge information about dementia	1.0	388.0	Proportion of UK population who are dementia friends	0.0	15.5	372.5	0.50
Unpaid Carer	168	Unpaid Carers experience improved physical health	Increased participation in physical activities	1.0	168.0	Number of Unpaid Carers who do not have improved physical health	0.2	31.9	136.1	0.50
Unpaid Carer	182	Reduction in caregiver burden	Proportion of Unpaid Carers reporting decreased Unpaid Carer burden	1.0	182.0	Proportion of Unpaid Carers who have access to respite	0.2	27.3	154.7	0.30
Person Living with Dementia	164	Increase in Person Living with Dementia feeling supported	Proportion people feeling they have someone to listen to/support them	1.0	164.0	Number of people with dementia not experiencing depression	0.60	98.40	65.6	0.14
Person Living with Dementia	143	Increase in Person Living with Dementia well being	Proportion of Unpaid Carers reporting increased wellbeing	1.0	143.0	Average proportion of adults 65+ who report feeling happy	0.95	135.85	7.2	0.40
Person Living with Dementia	154	Increase in Person Living with Dementia social relationships	Proportion reporting increased social participation.	1.0	154.0	Number of people with dementia not experiencing depression	0.60	92.40	61.6	0.50
Person Living with Dementia	31	Person Living with Dementia experience improved physical health	Increased participation in physical activities	1.0	31.0	Proportion of adults 65+ who are physically active	0.46	14.26	16.7	0.50
Volunteer	60	Increased volunteer wellbeing	Increased wellbeing gained from volunteering	1.0	60.0	Proportion who do report benefit of volunteering	0.9	54.6	5.4	0.20
Volunteer	60	Increased knowledge about dementia	Increase in volunteer knowledge about dementia	1.0	60.0	Proportion of UK population who are dementia friends	0.0	2.4	57.6	0.80
Staff	30	Increased knowledge about dementia	Increase in volunteer knowledge about dementia	1.0	30.0	Proportion of UK population who are dementia friends	0.0	1.2	28.8	0.80

Outcome Incidence – (Deadweight & Attribution)	Displacement Proportion	Outcome Incidence – (Deadweight, Attribution & Displacement)	Financial Proxy Description	Proxy	Total Annual Value Produced	Annual Drop Off	Year 1 Value	Year 2 Value	Year 3 Value	Year 4 Value	Year 5 Value	Total Value	Present Value
33.9	0.0	33.9	Unit cost treatment for depression	£2,696	£91,293.02	0.7	£91,293.02	£27,387.91	£8,216.37	£2,464.91	£739.47	£130,101.68	£123,954.06
3.7	0.0	3.7	Value of being in a social group	£1,897	£7,096.54	0.7	£7,096.54	£2,128.96	£638.69	£191.61	£57.48	£10,113.28	£9,635.40
22.2	0.0	22.2	Value of being in a social group	£1,897	£42,163.48	0.7	£42,163.48	£12,649.04	£3,794.71	£1,138.41	£341.52	£60,087.18	£57,247.91
186.2	0.0	186.2	Dementia train the trainer training for home care providers	£278.00	£51,774.72	0.7	£51,774.72	£15,532.42	£4,659.72	£1,397.92	£419.38	£73,784.15	£70,297.67
68.0	0.0	68.0	Walking activity once a week for 2 months	£5,417.00	£368,572.68	0.7	£368,572.68	£110,571.80	£33,171.54	£9,951.46	£2,985.44	£525,252.93	£500,433.45
46.4	0.0	46.4	Average cost of mental health services per individual per year (Anxiety & Depression)	£1,508.31	£70,000.67	0.7	£70,000.67	£21,000.20	£6,300.06	£1,890.02	£567.01	£99,757.95	£95,044.14
9.2	0.0	9.2	Addressing loneliness to protect mental health of older people	£2,696.34	£24,763.19	0.95	£24,763.19	£1,238.16	£61.91	£3.10	£0.15	£26,066.50	£25,140.28
2.9	0.0	2.9	Unit cost of treatment for depression	£2,696.34	£7,711.53	0.95	£7,711.53	£385.58	£19.28	£0.96	£0.05	£8,117.40	£7,828.96
30.8	0.0	30.8	Value of being in a social group	£1,897	£58,427.60	0.95	£58,427.60	£2,921.38	£146.07	£7.30	£0.37	£61,502.72	£59,317.34
8.4	0.0	8.4	Value of walking activity once a week for 2 months	£5,417	£45,340.29	0.95	£45,340.29	£2,267.01	£113.35	£5.67	£0.28	£47,726.61	£46,030.74
1.1	0.0	1.1	Value of regular volunteering once per month for two months	£3,332.00	£3,598.56	0.3	£3,598.56	£2,698.92	£2,024.19	£1,518.14	£1,138.61	£10,978.42	£10,103.69
46.1	0.0	46.1	Average cost of mental health services per individual per year (Anxiety & Depression)	£1,266.00	£58,337.28	0.3	£58,337.28	£43,752.96	£32,814.72	£24,611.04	£18,458.28	£177,974.28	£163,793.85
23.0	0.0	23.0	Average cost of mental health services per individual per year (Anxiety & Depression)	£1,266.00	£29,168.64	0.3	£29,168.64	£21,876.48	£16,407.36	£12,305.52	£9,229.14	£88,987.14	£81,896.93
												Total Benefits	£1,250,724.43
												Total Inputs	£234,569.00
												SROI Ratio	5.33

Appendix 10: Outside the Box Food Buddies SROI

Stakeholder	Total Stakeholder	Outcome	Outcome Description	Indicator Result	Outcome Incidence	Deadweight Description	Deadweight Amount	Deadweight Incidence	Outcome Incidence - Deadweight	Attribution Proportion	Outcome Incidence - (Deadweight &
Person Living with Dementia	99	Increased confidence in food and eating	Person Living with Dementia have increased confidence in food and eating	1.0	99.0	Proportion over 65 either overweight or obese	0.77	76.23	22.8	0.20	4.6
Person Living with Dementia	99	Increased social contact/reduction in loneliness or social isolation	Person Living with Dementia experienced reduction in loneliness	1.0	99.0	Number of People Living with Dementia not experiencing depression	0.60	59.40	39.6	0.40	15.8
Person Living with Dementia	904	Increased awareness about dementia	Person Living with Dementia had increased awareness about dementia	1.0	904.0	Proportion of UK population who are dementia friends	0.0	36.2	867.8	0.20	173.6
Person Living with Dementia	99	Increased psychosocial support	Person Living with Dementia experienced increased psychosocial support	1.0	99.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.19	18.81	80.2	0.14	11.2
Unpaid Carers	134	Reduction in caregiver burden	Unpaid carers reported feeling more listened to and understood, reducing their burden	1.0	134.0	Number of Unpaid Carers not experiencing depression	0.60	80.40	53.6	0.40	21.4
Unpaid Carers	134	Increase in social contact	Unpaid carers reported more friendships and social contact	1.0	134.0	Proportion of Unpaid Carers who do not feel lonely or isolated	0.19	25.46	108.5	0.40	43.4
Unpaid Carers	134	Increase in psychosocial support.	Unpaid carers reported feeling increased confidence in caring role	1.0	134.0	Number of Unpaid Carers not experiencing depression	0.7	97.8	36.2	0.20	7.2
Unpaid Carers	6000	Increased awareness of dementia	Unpaid carers reported increased awareness of dementia	1.0	6000.0	Proportion of UK population who are dementia friends	0.0	240.0	5760.0	0.20	1152.0
General Public	2700	Increased awareness of dementia	Increased awareness of dementia among general public	1.0	2700.0	Proportion of UK population who are dementia friends	0.0	108.0	2592.0	0.20	518.4
Staff	33	Staff were better trained to deliver services	Staff were better trained to deliver services	1.0	33.0	Proportion who report benefit of volunteering	0.9	29.7	3.3	0.80	2.6
Volunteers	10	Volunteers were better trained to deliver services	Volunteers were better trained to deliver services.	1.0	10.0	Proportion who report benefit of volunteering	0.9	9.0	1.0	0.80	0.8
Volunteers	10	Volunteers gained wellbeing from taking part in project	Volunteers gained wellbeing from taking part in project	1.0	10.0	Proportion who report benefit of volunteering	0.9	9.0	1.0	0.80	0.8

Displacement Proportion	Outcome Incidence - (Deadweight, Attribution &)	Financial Proxy Description	Proxy	Total Annual Value Produced	Annual Drop Off	Year 1 Value	Year 2 Value	Year 3 Value	Year 4 Value	Year 5 Value	Total Value	Present Value
0.0	4.6	Increased confidence about health	£13,416	£61,096.46	0.7	£61,096.46	£18,328.94	£5,498.68	£1,649.60	£494.88	£87,068.57	£82,954.37
0.0	15.8	Value of being in a social group	£1,897	£30,048.48	0.7	£30,048.48	£9,014.54	£2,704.36	£811.31	£243.39	£42,822.09	£40,798.64
0.0	173.6	Cost of 1 hour of Alzheimer's Society Dementia Awareness training	£20.00	£3,471.36	0.3	£3,471.36	£2,603.52	£1,952.64	£1,464.48	£1,098.36	£10,590.36	£9,746.55
0.0	11.2	Average cost of treating someone with depression	£2,696	£30,266.91	0.7	£30,266.91	£9,080.07	£2,724.02	£817.21	£245.16	£43,133.38	£41,095.22
0.0	21.4	Addressing loneliness to protect mental health of older people	£2,696	£57,802.24	0.95	£57,802.24	£2,890.11	£144.51	£7.23	£0.36	£60,844.44	£58,682.46
0.0	43.4	Value of being in a social group	£1,897	£82,360.15	0.95	£82,360.15	£4,118.01	£205.90	£10.30	£0.51	£86,694.87	£83,614.35
0.0	7.2	Increased confidence about health	£13,416.00	£97,078.18	0.3	£97,078.18	£72,808.63	£54,606.47	£40,954.86	£30,716.14	£296,164.26	£272,566.84
0.0	1152.0	Cost of 1 hour of Alzheimer's Society Dementia Awareness training	£20.00	£23,040.00	0.3	£23,040.00	£17,280.00	£12,960.00	£9,720.00	£7,290.00	£70,290.00	£64,689.51
0.0	518.4	Cost of 1 hour of Alzheimer's Society Dementia Awareness training	£20.00	£10,368.00	0.3	£10,368.00	£7,776.00	£5,832.00	£4,374.00	£3,280.50	£31,630.50	£29,110.28
0.0	2.6	Dementia train the trainer training	£338.00	£892.32	0.3	£892.32	£669.24	£501.93	£376.45	£282.34	£2,722.27	£2,505.37
0.0	0.8	Dementia train the trainer training	£338.00	£270.40	0.3	£270.40	£202.80	£152.10	£114.08	£85.56	£824.93	£759.20
0.0	0.8	Average cost of mental health services per individual per year (Anxiety & Depression)	£1,266.00	£1,012.80	0.3	£1,012.80	£759.60	£569.70	£427.28	£320.46	£3,089.83	£2,843.64
											Total	£689,366.45
											Total Inputs	£166,150.00
											SROI Ratio	4.15

Appendix 11: VOCAL Peer Mentoring Service SROI

Stakeholder	Total Population	Outcome	Indicator Description	Indicator Result	Outcome Incidence	Deadweight Description	Deadweight Amount	Deadweight Incidence	Outcome Incidence – Deadweight	Attribution Proportion
Carer (Individual Peer Support)	132	Improved social wellbeing	Unpaid Carers reported improvement in wellbeing	1.0	132.0	Average proportion of adults 65+ who report feeling happy	0.95	125.40	6.6	0.14
Carer (Individual Peer Support)	173	Improvement in being informed about caring	Unpaid Carers reported being better informed	1.0	173.0	Proportion of UK population who are dementia friends	0.04	6.92	166.1	0.75
Carer (Individual Peer Support)	149	Improved confidence in caring role	Unpaid Carers reported greater levels of confidence in caring	1.0	149.0	Proportion individual cares not reporting more confidence in caring	0.00	0.00	149.0	0.75
Carer (Individual Peer Support)	149	Improvement in overall health and wellbeing	Unpaid Carers reported greater levels of confidence in caring	1.0	149.0	Proportion of older people aged 65+ reporting no difficulty with ADLs	0.80	119.20	29.8	0.20
Carer (Individual Peer Support)	144	Improved confidence in shaping services	Unpaid Carers felt more able to shape services	1.0	144.0	Proportion of group carers who did who do not feel more confident in shaping services	0.19	27.36	116.6	0.20
Carer (Group Peer Support)	211	Improved social wellbeing	Unpaid Carers reported improvement in wellbeing	1.0	211.0	Average proportion of adults 65+ who report feeling happy	0.95	200.45	10.6	0.20
Carer (Group Peer Support)	272	Improvement in being informed about caring	Unpaid Carers reported being better informed	1.0	272.0	Proportion of UK population who are dementia friends	0.04	10.88	261.1	0.50
Carer (Group Peer Support)	288	Improved confidence in caring role	Unpaid Carers reported greater levels of confidence in caring	1.0	288.0	Proportion group cares not reporting more confidence in caring	0.06	17.28	270.7	0.50
Carer (Group Peer Support)	269	Improvement in overall health and wellbeing	Unpaid Carers reported greater levels of confidence in caring	1.0	269.0	Proportion of older people age 65+ reporting no difficulty with ADLs	0.60	161.40	107.6	0.20
Carer (Group Peer Support)	260	Improved confidence in shaping services	Unpaid Carers felt more able to shape services	1.0	260.0	Proportion of group carers who did who do not feel more confident in shaping services	0.15	39.00	221.0	0.20
Carer (Volunteers)	19	Volunteers have increased training in dementia care	Volunteers experienced increased knowledge about dementia	1.0	19.0	Proportion of UK population who are dementia friends	0.04	0.76	18.2	0.20

Outcome Incidence – (Deadweight & Attribution)	Displacement Proportion	Outcome Incidence – (Deadweight, Attribution & Displacement)	Financial Proxy Description	Proxy	Total Annual Value Produced	Annual Drop Off	Year 1 Value	Year 2 Value	Year 3 Value	Year 4 Value	Year 5 Value	Total Value	Present Value
0.9	0.0	0.9	Value of being a member of a social group	£1,897	£1,753.26	0.7	£1,753.26	£525.98	£157.79	£47.34	£14.20	£2,498.57	£2,380.51
124.6	0.0	124.6	Dementia train the trainer training for home care providers	£338	£42,101.28	0.7	£42,101.28	£12,630.38	£3,789.12	£1,136.73	£341.02	£59,998.53	£57,163.46
111.8	0.0	111.8	Average cost of mental health services per individual	£1,151	£128,624.25	0.7	£128,624.25	£38,587.28	£11,576.18	£3,472.85	£1,041.86	£183,302.42	£174,640.93
6.0	0.0	6.0	Feeling of being in overall good health	£20,658	£123,121.68	0.7	£123,121.68	£36,936.50	£11,080.95	£3,324.29	£997.29	£175,460.71	£167,169.76
23.3	0.0	23.3	Value of regular volunteering once per week for 2 months	£3,332	£77,728.90	0.7	£77,728.90	£23,318.67	£6,995.60	£2,098.68	£629.60	£110,771.45	£105,537.23
2.1	0.0	2.1	Value of being a member of a social group	£1,897	£4,003.66	0.7	£4,003.66	£1,201.10	£360.33	£108.10	£32.43	£5,705.62	£5,436.01
130.6	0.0	130.6	Dementia train the trainer training for home care providers	£338	£44,129.28	0.7	£44,129.28	£13,238.78	£3,971.64	£1,191.49	£357.45	£62,888.64	£59,917.00
135.4	0.0	135.4	Average cost of mental health services per individual	£1,151	£155,799.36	0.7	£155,799.36	£46,739.81	£14,021.94	£4,206.58	£1,261.97	£222,029.67	£211,538.22
21.5	0.0	21.5	Feeling of being in overall good health	£20,658	£444,560.16	0.7	£444,560.16	£133,368.05	£40,010.41	£12,003.12	£3,600.94	£633,542.68	£603,606.25
44.2	0.0	44.2	Value of regular volunteering once per week for 2 months	£3,332	£147,274.40	0.7	£147,274.40	£44,182.32	£13,254.70	£3,976.41	£1,192.92	£209,880.75	£199,963.37
3.6	0.0	3.6	Dementia train the trainer training for home care providers	£338	£1,233.02	0.3	£1,233.02	£863.12	£604.18	£422.93	£296.05	£3,419.30	£3,159.82
												Total Benefits	£1,590,512.56
												Total Inputs	£106,636.00
												SROI Ratio	14.92

Appendix 12: References

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