Evaluation of the Borders Community Capacity Building for Older People Project

2016-2017

and estimate/forecast of the project's Social Return on Investment

'Put a ball at my feet and it becomes fun not exercise'

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Executive Summary

This evaluation was commissioned by the Scottish Borders Council to investigate the second phase of the Borders Community Capacity Building Project (BCCBP) funded by the Integrated Care Fund. The period under study was the year to May 2017.

Older people accessing the current range of BCCBP activities were interviewed individually or in focus groups, together with a cross-section of other stakeholders.

This report

- Demonstrates the impact of the expanded project in terms of increased outputs and scope
- Benchmarks the BCCBP with other similar interventions
- Explores the preventative value of the work of the project, using a Social Return on Investment approach.
- Presents a case for embedding the capacity building approach in mainstream health and social care services.

The main findings and conclusions were:

- The project works with 2 main theories of change, both of which were validated by the research

    a) That the community development approach will lead to more sustainable outcomes within communities and for individual older people, even though the approach takes longer to develop and embed in communities

    b) That engagement in the physical and social activities set up by BCCBP will mean older people are less likely to require health and social care supports in future

- The likely social return on investment in BCCBP is in the region £10 for every £1 invested, which reflects the effectiveness of the staff team and the relatively high costs of older people's physical and mental ill health

- BCCBP has involved over 500 older people in its activities during the year, but there are an estimated 26,000 physically under-active older people living in the Borders who could benefit from access to BCCBP groups, which in turn will reduce demand on services.

- BCCBP should have a long-term role to play in reform of health and social care services, particularly the pilots currently being put in place in some Borders' communities. Without community capacity building, these pilots may be less effective.

A number of practical and strategic issues have been identified which should be addressed. The aim is to realise the value of the community development approach in reforming services for older people, to ensure there is limited duplication and overlap going forward, and to ensure the BCCBP is maximising its potential.

Contents

1. Introduction

This report was commissioned by the Borders Capacity Building Project of Scottish Borders Council as part of the evaluation framework for the Integrated Care Fund, which now funds the Project.

1 a) Introduction to the project

The Borders Community Capacity Building Project (BCCBP) was set up through the Older People's Change Fund in 2013. It employed a team leader and 2 development workers, and focused on certain areas of the Scottish Borders (Tweeddale, Cheviot and parts of Berwickshire).

In November 2015, Phase Two of the project was funded by the Integrated Care Fund (ICF), and two additional development worker posts were approved in order to extend the project Borders-wide. These posts were filled in May 2016.

The project team is employed through the Scottish Border Council and has a project Board drawn from the key partner agencies of Scottish Borders Council, NHS Borders and the Third Sector Interface.

The key document the project is working to is the ICF Project Initiation Document (PID) but it is set within the Scottish Borders Health and Social Care Strategic Plan 2016-2019, as well as a range of national and local strategies and policies.

1 b) Aims of the evaluation and its scope

The aim of this evaluation is to examine the expanded project funded by the ICF, with a focus on the geographical areas of Teviot & Liddlesdale, Gala Water and Berwickshire where new activity has been established in the last year, and on newly developed activities.

The period under evaluation is from May 2016 when the new ICF posts were filled, to May 2017.

The purposes of this evaluation are to:

- Help present a case for embedding the capacity building approach in mainstream Council services
- Demonstrate the impact of the expanded project
- Benchmark the BCCBP with what is happening across Scotland and the UK
- Explore the preventative value of the work of the project, using an approach based on the principles of Social Return on Investment.

1 c) Methodology

The work has been independently produced based on research with service users, other stakeholders and partners associated with and involved in the Borders Community Capacity Building Project.

The author, Sheila Durie, is an evaluator and is experienced in the application of the Social Return on Investment methodology (SROI). She is an Accredited SROI Practitioner, a Licensed SROI Trainer and Accredited SROI Assurance Assessor.

The sources of information used were:

- Project documentation and records kept internally for the continuous evaluation framework established by the ICF evaluation team
- Semi-structured interviews with participants involved in BCCBP's activities
- Semi-structured interviews with volunteers involved in the management of activities
- Focus groups with participants involved in project activities
- Semi-structured interviews with other main stakeholders, starting with an initial list which was extended through discussion and recommendations from stakeholders
- Desk research on examples of capacity building programmes elsewhere and on current practices and thinking on community development, asset-based approaches to service development and co-production
- Desk research on the strategic context of health and social care in Scotland, and the various pilot initiatives on public service reform being developed in Scottish Borders
- Desk research to help in preparing a forecast/estimate value map using the SROI methodology using the literature around preventative health measures and well-being measurement.

The ICF evaluation support team had helped the project staff develop a set of questionnaires for use with participants, which were designed to be used over time to identify trends and outcomes for older people involved in the activities.

At the time of the survey and interview work however (May to July 2017) the questionnaires had not been in use for long enough to allow for measurement of outcomes over time, but it is suggested that they could be the basis for an evaluation of social return at a later time.

2. Context

2a) Relevant demographics in the Scottish Borders

Like every other area in Scotland, Scottish Borders has a growing population of older people, and demand on health and social care services is rising. The rise in demand is happening at a time of constraints on public expenditure.

The population of the Scottish Borders is older on average than the rest of Scotland. There are 26,000 people over the age of 65 living in Scottish Borders. By 2032, this figure is projected to increase by 51%, a faster rate than the 49% for Scotland overall. [1]

Most people do not live in concentrated urban areas, but in towns, small settlements and scattered homes. Almost half of the over 65's in the Scottish Borders live in rural areas.

The proportion of older people living alone is also much higher than the Scottish average, and this is known to be a factor which increases the risk of loneliness and social isolation.

Overall, the population of the Borders enjoys good health, but as age increases, the proportion of those reporting that their health is bad or very bad increases to more than 10% in the over 75 age group. Those aged 65 and over are also increasingly likely to be living with two or more long-term health conditions.

The numbers of people living with dementia in Scottish Borders is estimated at around 2,500, but is projected to rise. The very recent publication of research identifying 9 risk factors gives some basis

[1] The figures are taken from The Scottish Borders Health and Social Care Strategic Plan for 2016-2019

however for developing interventions which over time could slow the projected increase in the rate of older people living with dementia, some of which could be influenced by the BCCBP. [2]

Rates of physical activity are reportedly lower than average in Scottish Borders, and obesity rates are higher than average. In the age range 65-74, only 14% of men and 8% of women meet the recommended guideline for physical activity for this age group (which is at least 2.5 hours per week of moderate intensity activity in bouts of 10 minutes or more). 17% of men and 21% of women in this age range were considered to be 'completely inactive'. [3]

Thus there could be at least 20,000 people over 65 who would benefit from more physical activity, 3,000 of whom are completely inactive.

The rural and isolated nature of much of the area, the reliance on transport, the dispersed nature of services and the poorer rates of physical activity present challenges in delivering health and social care services for older people across the Scottish Borders, and in mounting interventions such as the BCCBP designed to prevent or ameliorate the impact of long-term health issues.

2b) Health and inequality issues

Deprivation is an issue in the Borders. The two most deprived areas are Burnfoot (Hawick) and Langlee (Galashiels), which are in the top 10% most deprived areas in Scotland for domains such as income, employment and health. Around 15% of the Borders datazones are in the top Scottish ones which are access deprived.

In areas of higher deprivation, it is known that hospital admissions are higher, and rates in the Borders are higher compared to the Scottish average (11% higher than Scottish average). [4]

Deprivation is not just confined to geographical areas - it applies to vulnerable groups who live in deprived circumstances, such as those with low incomes, and those living with mental health issues and disabilities.

The burden of caring is greater in more deprived areas and particularly in areas deprived because of access. 46% of carers living in the most deprived areas of the Borders provide 35 or more hours of care per week, compared with 22% of carers living in the least deprived areas.

Research also indicates that providing care for another person often affects the carer's own health. More carers (42%) than non-carers (29%) have one or more long-term conditions or health problems. Many carers are themselves older people.

The aim of the Health and Social Care Partnership is to invest in new integrated ways of working particularly in terms of early intervention, reducing avoidable hospital admissions, reducing health inequalities, supporting carers and promoting independent living.

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[2] The Lancet Commission on Dementia Intervention, Prevention and Care, at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31363-6/fulltext

[3] The Health and Well-Being of Older People in Scotland, 2001, http://showcc.nhsscotland.com/isd/files/older.pdf . Although this is an older report, physical activity levels have been very similar for some years as reported by the Scottish Health Survey

[4] Scottish Borders Health and Well-Being Profile, ScotPHO 2016 at http://www.scotpho.org.uk/opt/Reports/hwb-la/scotpho-hwb-profiles-aug2016-scottishborders-v2.pdf

2c) Social enterprise

The Social Enterprise Census conducted in 2015 revealed an estimate of 195 social enterprises in Scottish Borders, or 4% of the total number for Scotland. Scottish Borders showed 1.7 social enterprises for every 1,000 of the population, which is higher than the Scottish average of 1.0 per 1,000. [5]

The reason for identifying social enterprise as part of the context within which BCCBP operates is the Scottish Government's commitment to social enterprise, as evidenced by the 2017-2020 strategy, their belief in the role of social enterprise in public sector reform, the existing use of social enterprise within partner agencies (e.g. Fit Borders) and the scope to do more in this area, as reported by a number of interviewees.

There is however no recognisable social enterprise policy within the Health and Social Care Partnership, NHS Borders or Scottish Borders Council, but at locality level, there is a presence from the main development agency, the Scottish Borders Social Enterprise Chamber, on the relevant forums that BCCBP works with.

2d) Public service reform

The Health and Social Care Strategic Plan 2016-2019 for the Scottish Borders notes how vital service reform is to ensure that the region can meet future challenges with reducing inputs but at the same time seek to improve service quality.

The process of reform under the integration of health and social care is advancing, based on the principles of personalising care through encouraging participation, collaboration and co-production, improving communications, reducing duplication and making better use of new technologies and new models of care.

One such model is 'community led support' which is now being piloted in Scottish Borders, focused mainly on older people and adults with vulnerabilities. The community led support model provides a real opportunity to provide a direct link between communities and health and social work practice. In the Scottish Borders, community-based hubs are being established to locate social work and health and care assessment functions within communities and provide a one-stop shop to access services.

Other local initiatives that relate to community led support are the piloting on a small scale of the Buurtzog model of home care and the move towards locality planning.

In many ways, the trends are towards a return to past practices in social work and health, based on building good relationships within communities, locating services more clearly in the local community and building services around local strengths and assets.

For such models to work effectively will require an engaged and empowered community, and BCCBP is ideally placed to assist in this process.

[5] Social enterprise in Scotland: Census 2015 at http://www.socialenterprisescotland.org.uk/files/1a891c7099.pdf

3. Description of the project

3a) Aims and objectives of the BCCBP

The aims of the project, as expressed in the ICF PID are:

1. To implement a series of coordinated community support projects across the Borders
2. To adopt a person-centred approach to supporting older people
3. To encourage and support communities to create and run their own services
4. To better coordinate services and create a dynamic atmosphere in which ideas will flourish
5. To signpost people to other services
6. To work in partnership with all agencies involved in supporting older people
7. To reduce the time spent in hospitals and enable greater choice for people with long-term conditions
8. To meet unmet need in communities
9. To establish support mechanisms which improve quality of life and enable older people to live at home independently for longer.

Thus the aims of the BCCBP are a mixture of desired outcomes for different stakeholders and processes and standards for the project to meet.

The other stated aims contained in the PID are for BCCBP to:

- Integrate these community services with preventative health initiatives
- Reduce the need for day centres, GP consultations, respite care and 'even' emergency admissions.

3b) Range and scope of activities established

Project aim 1 was to extend the geographical coverage of activities to include Berwickshire, Teviotdale and Liddlesdale and other parts of Eildon, by funding additional development workers to initiate activities in these areas. The two new staff were employed in May 2016, one to focus on Berwickshire and one on Eildon. The pre-existing staff also helped develop new areas and new activities.

The towns and settlements where new activities have been developed over the last year have been:

- Berwickshire: Eyemouth; Coldstream; Greenlaw, Duns; Chirnside
- Teviotdale and Liddlesdale: Burnfoot/Hawick; Denholm; Newcastleton
- Eildon: Fountainhall; Stow; Lauder; Melrose; Selkirk
- Tweeddale: Innerleithen, Peebles; Netherurd
- Cheviot: Jedburgh.

The new activities that have been developed in Phase 2 that meet Project Aims 1, 4 and 8 are:

- Tea dances
- Soup clubs
- Mealmakers and the Food Foundation just starting
- Extending the walking football groups into other areas
- Walking netball (Peebles is only the second group set up in the whole of Scotland)
- Walking rugby (in development)

- New Age Kurling
- Mens Sheds
- Happiness Habit cafes
- Creative writing groups (just about to start in Duns)
- Events such as the Hawick Silver Sunday, Eyemough International Women's day; the Borders Shed Fest in March and the planned Health and Well-being Week in Berwickshire (September/October)
- Gala Water Directory
- Just Cycle social enterprise in Tweedbank
- Inter-generational projects such as the Jedburgh Gardening project and Eyemouth IT initiative
- The Borders Seniors Networking Forum.

Progress has been made with Project Aim 3, most obvious with the gentle exercise classes, the walking football and Men's Sheds.

Of the 8 communities where Gentle Exercise (GEx) classes have been set up so far, 4 are now self-managing and 3 are on the road to being so. Some groups have been able to attract independent funding to help with running costs.

The walking football group in Galashiels (Langlees) is now constituted, and is now part of the Gala Fairydean football club. The men involved are also helping some of their members set up clubs in other areas of the Borders.

Five Men's Sheds sheds now exist in the Borders in Galashiels, Jedburgh, Hawick, Eyemouth and Coldstream with others under development in Kelso, Selkirk and Duns. BCCBP has not been responsible for all this activity, as there are many partners, but in Berwickshire particularly, the BCCBP staff input was reported to have been absolutely vital in the development of the Coldstream Men's Shed.

Project Aims 2, 5 and 6 are reflected throughout how the BCCBP team approach their work, and the GEx case study opposite illustrates how the community development approach adopted by BCCBP works, and why it works well.

A number of activities that were established through Phase 1 of the BCCB project have been successfully replicated to other areas, which meets Project Aims 1, 4 and 6.

For example, there are now 6 walking football teams in Scottish Borders, and enough for a competition, the first of which was held in May 2016. This year's event in April attracted many more teams.

The most obvious way in which the project has met Project Aim 8 is through replication of activities into other areas. There was a lot of interest reported to the researcher in establishing Men's Sheds, soup

GEx classes case study

Class instructors are provided by Fit Borders, a local social enterprise. Fit Borders was already running GEx classes on a commercial basis. The programmes it had developed for the sessions are all scientifically based on Otago principles, and promote strength and balance for older people. Exercise can be standing or seated. The need for GEx was identified through discussions with older people, observations of older people finding Zumba Gold too hard, and being contacted by e.g. care homes to run classes.

BCCBP provided funds to subsidise classes in certain areas (e.g. Langlees) and to increase the participation rates of older people and those with health conditions, disabilities or mental health issues.

The aim at the start, with all the classes, was for them to become self-managing. This was up front during the taster sessions. Participants were involved in co-producing the classes from day one: deciding days and times of the classes, where to hold them, what level to pitch them at etc.

The partnership with Fit Borders has generated sustainable classes in areas which wouldn't otherwise have started up classes. The BCCBP budget includes funds to subsidise the costs of the instructor provided through Fit Borders where the income from class participants is low at the start. As numbers build up the classes become more self-sustaining, but fees are kept low so the classes may never become fully self-sustaining, especially in smaller communities.

clubs, tea dances and New Age Kurling in areas which didn't have them. What seems to happen as a development process is that individuals hear about classes/activities that are run in communities other than their own, they come along to them for a while, and then ask the BCCBP team to help them set up the activity in their own area.

Project Aim 8 has also been addressed by the BCCBP by supporting asset transfer discussions underway in two communities.

The Coldstream Men's Shed is constituted and in the process of taking on additional space through a negotiated asset transfer with Scottish Borders Council. The BCCBP development worker in Berwickshire has been a significant source of help to Coldstream Men's Shed in undertaking this.

She has also fulfilled the same role in Duns, where 'A Heart for Duns' Development Trust is also planning an asset transfer of a building for income generation purposes.

Project Aims 7 and 9 reflect the impact of the project's work on the situation of the older people attending the activities and getting involved in volunteering, managing and developing them. This is explored in section 4 Findings.

The activities that BCCBP has set up have therefore involved common themes: physical activities, social activities and food.

3c) Stakeholders

Social Return on Investment relies on identifying stakeholders that are materially impacted on by the activities under analysis. The main stakeholders who experience outcomes are firstly the older people who participate in the groups and activities BCCBP has helped establish.

The older people however are split into two main sub-groups: people who are attending because they gain some benefit from the groups, and people who gain benefit from the groups but who are also minded to volunteer their time to help manage and develop the groups.

Although the health issues and demographics of ageing are different for men and women, there was no clear difference in outcomes reported by older men and women. BCCBP has developed activities that appeal differently to men and women – walking football and walking netball for example – but the outcomes appeared to be similar.

Other direct beneficiaries may be the families of older people attending groups, as they feel happier that their older relatives are getting out of the house, in company, and are better connected, hence reducing their concerns. There were comments made by older people interviewed about what their families thought, but no representatives of this group were directly included in the research, so they have not been included in the analysis. This may be worth exploring in future.

The other key stakeholders are the range of health and social care services and professionals working with older people, and the range of partners helping BCCBP to develop its activities and who benefit from the increased levels of activity that BCCBP encourage and promote (e.g. the Drill Hall community association in Peebles, Fit Borders etc).

3d) Theory of change

Social Return on Investment is testing an organisation's 'theory of change' i.e. why the activities that are invested in would lead to change, and justifying a causal relationship between inputs, outputs and outcomes.

In the case of BCCBP, there are two theories of change involved:

1. That the community development approach will lead to more sustainable outcomes within communities and for individual older people, even though the approach will take longer to develop and embed

2. That engagement in the physical and social activities set up by BCCBP will mean older people are less likely to require health and social care supports in future.

To explore the first theory of change requires an agreed definition of 'community capacity building' and how it relates to the health agenda for older people.

The term 'community learning and development' acknowledges that different occupations play a role in developing local communities, and that this work encompasses not just informal learning support but also a concern for the wider development of those communities.

The United Nations defines community development as "a process where community members come together to take collective action and generate solutions to common problems." It is a broad term given to the practices of leaders, activists, involved residents and professionals to improve various aspects of communities, typically aiming to build stronger and more resilient local communities.

Community development is also understood as a professional discipline, with a set of values and practices which plays a special role in overcoming poverty and disadvantage, knitting society together at the grass roots and deepening democracy.

Community capacity building is one of the 'twin pillars' of community development, the other being community engagement. Most of the beneficial changes in communities come about through the process of engagement, whereby communities are able to respond to opportunities, or deal with problems, by bringing them to the attention of those with the ability to respond and carrying out agreed plans of action.

But such engagement cannot take place unless the community has the capacity required to engage in such discussions. Also, the most excluded groups and communities are most often the ones with the least capacity to engage. Communities with capacity are confident, organised, cohesive and influential, and mean that community

Development case study – Lauder example

Initially, it is about doing the 'market research', going along to already existing groups, local halls/venues/speaking with organisations like the Red Cross/RVS, speaking to the local community to find out what need there is in the area and what is already happening.

I also had a meeting with the local LASS (Lifestyle advisor) based in the Health Centres to discuss opportunities, what did they see was a potential 'need' in that community.

So, in Lauder, we were approached by both the Sheltered Housing Association in the area, and the Leisure Centre who had heard about some of the work we had been involved in within other areas. These meetings were initially to look at the goings on and engaging the older generation in activities/groups in the community. I fully understand that all communities have something on offer for a variety of ages, however, what's missing – who's needs are not being catered for?

Meetings are ongoing, however, we are looking to start:

- Walking football
- New age Kurling - we discovered the leisure centre already have 2 unused sets of kurling equipment.
- An afternoon drop in
- A lunch club –local businesses to assist with this
- A men's shed – initial meeting was instigated with members of the local Community Council

members are likely to enjoy a better quality of life. This means they can deal more effectively with public bodies to come up with solutions to problems or opportunities; that they can do more to set up and run projects or initiatives, and that they can encourage people to support each other.

Asset-based approaches to health improvement are becoming increasingly adopted, in recognition that communities themselves and individuals within them have some of the answers to health inequalities. These approaches involve assessing the resources, skills, and experience available in a community; organizing the community around issues that move its members into action; and then determining and taking appropriate action. This method uses the community's own assets and resources as the bases for development; it empowers the people of the community by encouraging them to utilize what they already possess.

The BCCBP staff work explicitly with a community development approach. They become visible in the community, and the community can learn to trust the staff. The first step in the process is engagement with the people in the community, and listening to what their concerns are and what could be done. Their role is facilitation, not management, and staff work alongside individuals in the community or with established groups and develop partnerships in order to set up new things. Staff can remain in the background for support but their aim is to develop individuals to take on the running of the group, get the group constituted and become sustainable in the longer term.

The interests of older people in communities and their perception of what is needed are the building blocks of activities which then go on to empower individuals to manage the activities themselves.

An example of the approach is the recent 'Re-imagining Days in Berwickshire' which were held in June in Eyemouth and Duns. Drop in events were held in both communities for anyone with an interest in making new connections in their communities. The events were supported by the National Development Team for Inclusion (NDTI) and the BCCBP, and aimed to create discussions and opportunities to explore activities suitable for all adults, including people with a learning disability, mental health issue or dementia, older people, carers groups and individuals who would like to be more engaged within their local area.

70 people altogether attended both sessions and the event had the support of the Executive Member (local Councillor) for Adult Social Care. He recognised the value of the community development approach:

"*The team has already been speaking to local people and getting their views about the types of social, leisure and learning experiences that are currently being provided across Berwickshire. They have been hearing about what is already working well and have begun to gather some ideas about other activities and ways of connecting that people might enjoy and find beneficial. They have also been listening to some of the barriers that people can face that stop them taking part in activities, such as transport, lack of choice, location or cost. I would encourage the people of Berwickshire to come along to their nearest local session so they can share their thoughts, give their suggestions and make sure their views are taken into account*."

An illustration of the difference made by the capacity building approach versus what other development practices are can be seen with some of the national sports associations. They have seen the spread of interest in walking sports and have begun promoting new groups. In Peebles, there was an idea to set up a walking rugby group associated with the local rugby club. The sports development officer did not set up taster sessions first and then invite people to come along, and did limited publicity, and it did not get off the ground as an idea. With the walking football in Peebles however, the BCCBP development worker advertised a time, brought a ball along and 4 jumpers for

goal posts, and then hooked up with the Community Association when she discovered they were also running a group at a different time. Peebles walking football is now successfully established.

Another illustration of the process concerns GEx classes. Live Borders had tried to set up GEx classes in Hawick and failed. BCCBP tried to do it as well in Hawick and it failed. Then BCCBP tried it out in Burnfoot, and it worked. The member of staff involved said that 'you need to go where the lynchpins are in the community, and find the activists and well-known people and start there'. BCCBP listened to what local people were saying, and spoke to the right people in the community in order to get it started. That requires an investment of staff time.

Thus the first theory of change is that BCCBP can contribute to public service reform by helping communities develop the capacity to specify and manage their own services to support their ageing populations.

The second theory of change the project is working with is that increasing the access to physical and mental well-being services within communities has a preventative role in reducing future demand on health and social services. The proposition is that engagement with BCCBP activities can lengthen the time before older people need health interventions and this will allow health and social care services to better manage demand in future. This proposition is supported by research evidence.

The relationship between physical exercise and avoiding chronic health conditions is evidentially strong. There is a clear causal relationship between the amount of physical activity people do and chronic health conditions:

'*Drawing from recent systematic reviews of the literature, encompassing both experimental and observational research, the evidence is strong that physically active adults aged 65 years and over have higher levels of cardio-respiratory fitness and physical function, improved disease risk factor profiles and lower incidence of numerous chronic non-communicable diseases than those who are inactive. Engaging in physical activity carries very low health and safety risks for most older adults. In contrast, the risks of poor health as a result of inactivity are very high.'* [6]

There is also good evidence that physical activity programmes which emphasise balance training, limb co-ordination and muscle strengthening activity are safe and effective in reducing the risk of falls. [7]

Physical activity can improve mental well-being e.g. the risk of depression, dementia and Alzheimer's can be reduced through physical exercise. It also shows that physical activity can enhance psychological well-being, by improving self-perception and self-esteem, mood and sleep quality, and by reducing levels of anxiety and fatigue. [8]

Conversely, there is mounting evidence that social isolation and loneliness can lead to physical illness, by making some illness more likely to occur and more serious e.g. links have been found between loneliness and heart problems and increased blood pressure. Loneliness has also been

[6] 'Start Active Stay Active 2011, Report of the four home countries Chief Medical Officers at https://www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers

[7] Start Active Stay Active op cit

[8] Start Active Stay Active op cit

associated with decline in functioning e.g. in performing daily activities such as bathing and dressing, and reduced physical mobility, which are of particular relevance to health and social care systems. [9]

The challenge is to show causal relationships between increased physical activity, improved mental well-being and reduced social isolation and changes in future demand for services in those individuals who have been participating in BCCBP groups. The research evidence strongly supports these interventions as being preventative and protective, but more study over time with participants would require to be done to prove the proposition.

3e) Outputs

The range of groups and numbers attending groups which have been running during the year under study are:

Name of Group	Activity	Reducing Isolation (RI)/ Physical Exercise (PE)	Participants	Volunteers	How often
Whim Hall	Kurling	PE	15	2	Monthly
Fountainhall (morning session)	Kurling	RI & PE	18	3	Weekly
Fountainhall (evening session)	Kurling	PE	10	2	Weekly
Netherurd	Kurling	RI & PE	10	2	Fortnightly – stopped until Autumn
Caddonfoot Village Hall Clovenfords	Kurling	RI & PE	10	1	Monthly to start with
Stow Lunch Club	Gala Water Directory	RI	16	4	Bi monthly for 8 months
Whim Hall	Happiness Habit Café	RI	16	2	Two sessions
Netherurd	Happiness Habit Café	RI	12	2	One off
Fountainhall	Happiness Habit Café	RI	31	2	One off
Stow Lunch Club	Happiness Habit Café	RI	16	4	Two sessions
Peebles drop-in	Soup Club	RI	10	2	Weekly
Peebles Craft Box	Crafts	RI	10	2	Weekly
Innerleithen Craft Box	Crafts	RI	6	2	Weekly
Peebles Walking Netball	Walking Netball	PE	10	1	Weekly
Senior Fellowship	Various Activities	RI	10	8	Weekly
Coldstream Soup Club	Soup Club	RI	20	6	Weekly through the winter months
Greenlaw Soup Club	Soup Club	RI	30	5	Weekly through the winter months
Eyemouth Diabetes Support Group	Diabetes Support Group	RI	4	1	Fortnightly

[9] For a literature review, see 'A Summary of Recent Research Evidence about Loneliness and Social Isolation, their Health Effects and the Potential Role of Befriending', Roberts, 2015 for ACVO, at http://acvo.org.uk/wp-content/uploads/2015/03/BEFRIENDING-REASEARCH-REPORT.pdf

Coldstream Men's Shed	Men's Shed	RI	50	5	Weekly
Eyemouth Tea Dance	Tea Dance	RI	25	5	Monthly
Eyemouth Walking Netball	Walking Netball	PE	9	2	Weekly
Get Connected	Intergeneration al IT Club	RI	5	3	Varies
Coldstream Walking Football	Walking Football	PE	12	1	Weekly
Eyemouth Walking Football	Walking Football	PE	12	2	Weekly
Duns Men's Shed	Mens' Shed	RI	6	4	Weekly
Lauder Men's Shed	Men's Shed	RI	10	1	Fortnightly Initial stages of set up
Lauder Soup Club	Soup Club	RI	0	1	Fortnightly Initial stages of set up
Burnfoot GEx class	GExc	PE	15	2	Weekly
Jedburgh	GExc	PE	30	5	Weekly
Peebles	GExc	PE	15	3	Weekly
Innerleithen	GExc	PE	20	2	Weekly
Kelso	GExc	PE	40	5	Weekly
Leitholm	GExc	PE	15	1	Weekly
Selkirk	GExc	PE	20	2	Weekly
Total			538	95	

Thus during 2016-2017, the BCCBP has stimulated some 260 older people to engage in regular physical activity, has involved over 500 people in activity which builds social contact and has engaged almost 100 older people in volunteering within their community by taking on elements of managing the groups.

3f) Inputs

The budget for the BCCBP for 2016-2017 was £160,000. The total budgeted expenditure for the 3 year period of ICF funding since 2015 was £400,000.

This budget supported a team manager and 4 development workers, their travel and other costs and the activities fund.

In the SROI analysis, volunteer time has also been costed and included as an investment.

Section 4 Findings

4a) Participant outcomes

Some 45 older people involved in the BCCBP groups were either interviewed individually or involved in focus groups. They were involved across most of the BCCBP range of activities: walking football, New Age Kurling, GEx classes, soup clubs, men's sheds, walking netball, craft boxes, lunch clubs and directories and in general community development activities.

The common outcomes being reported by group participants can be summarised as:

- Improved physical fitness
- Eating better

- More social contact with others in their community
- More prepared to get out of the house and do other things
- Keeping mentally well.

All participants talked about the fact that the activities were fun, that they all had a good laugh and that this was motivating them to come back time after time. 'Put a ball at my feet and it becomes fun not exercise' sums it up.

In the physical activities sessions, when asked what they got out of it they replied 'a lot of pleasure'; 'it's good fun'; 'it's the only physical activity I can do but it makes a real difference to my long-term condition'; 'I've lost a lot of weight'; 'it helps with my coordination, balance and reactions because I have Parkinson's'', 'lots of us have arthritis and the walking netball helps with that', 'I can't remember the last time I went to my GP'; 'the longer we do it the longer we'll last'.

For those involved in the walking football, it was a way of being involved in something they loved but had thought they had lost forever – playing football.

The walking football team in Langlees reported considerable physical benefits from the regular exercise. The researcher was shown photographs of the group members at a tournament a year before, and the amount of weight loss between then and the present day was considerable (over a stone). One member reported huge improvements in stamina, and most reported that they had taken up other physical activities like regular walking, playing golf and cycling because they now felt much fitter, and were able to do more. Most now reported they were taking the equivalent of the recommended minimum exercise.

It had taken the group members about a year to get to this point and to experience the health benefits. The walking netball group would agree with this: they had been going about 6 months and were starting to feel the difference, but felt they could go further and improve their fitness.

The walking football group in Langlees recognise that they are becoming very competitive and physical as a team. They plan to set up a second group of newer recruits, who can go on the same journey as they did and start at a gentler pace, and extend the benefits to others.

The GEx classes help less physically able people make small but vital improvements to their physical situation. The classes are designed to – and were reported to – improve core body strength, improve coordination, encourage more walking and maintain well-being. They reported doing the exercises at home – they just needed to hear the music and they'd be doing the routines. One woman reported that even after 4 months, she could now bend down to her bottom cupboards and didn't have to ask her husband to do it, one said she could cut her own toenails again and another women who had been unable to use her mobility scooter because she could not raise her head up enough due to her arthritis had now overcome that and was getting out and about again.

During the year, the walking football group relied less and less on the BCCBP but still wanted their involvement to help with sponsorship, setting up a league etc – 'they're part of the team'. The group was very motivated and self-organising and very committed to what they were doing: 'there's places where this could go that even we can't see'.

Even although the aim of the group is primarily about exercise all participants reported that the social side was just as important. People reported that by concentrating on playing the sport, even at a walking level, or doing the exercise, meant all their problems were left behind, and so the session

helped to improve well-being. Then after the exercise, there was a cup of tea and a chat as a group, and this could be just as important a part of the session.

Women involved in the walking netball talked about how keep fit classes could be quite solitary, whereas the netball involved teams. None of the group had known each other before they started attending the group.

Friendships are formed, and if someone is not at the group, then someone else might decide to check out that they were OK. In one of the GEx classes, a woman became unable to attend because of her long-term health condition, but the women from the group go round to her house after their session, so she keeps up the social contact.

The GEx classes made a real difference to the self-esteem of the women who participated – 'the class is uplifting and I always come away feeling good. I've been in tears with laughter'.

The social contact was important within the community: 'it brings people together that wouldn't normally socialise together', 'anyone can do it but it's a lot better doing it with other people' (referring to craft activity); 'I know some people have met up with folk they haven't seen for 60 years – and they were only living on the other side of town!', 'they probably wouldn't meet up with each other without the soup club'.

One commonly reported feature of the BCCBP projects was the inclusive nature of the group. The walking football group in Langlees reported that everyone was welcome, and very few new recruits to the group didn't come back, but that was 'because we actively work at it'.

The men involved in the Men's Shed in Coldstream also talked about this. They started in November 2016, with around 12 members, and now have 50. The men there talked about how they had to work at not becoming a club just for a few men, and acknowledged the key role of the development worker in taking them to task when she felt they had lost sight of this. The members in the focus group said they had the biggest membership of any shed in the Borders, and put that down to the development workers' work in making sure the inclusive ethos was kept to, and keeping reminding them when they slipped. Now it had just become second nature.

Some men came in very unsure of themselves, some came just for the company, and some had come 'just for a laugh and a giggle'. Some wives are also involved in the shed, but even if they were not directly involved, the men know that they were benefitting. All the wives had been down to 'check it out' and give their approval. The wives benefitted by having 'more me time' with the men out of the house actively involved in doing something they loved doing. It gave many wives peace of mind.

Their outcomes were the pleasure of using their brains and skills they hadn't used for years and problem solving - people in the community brought in items for repair that no one else would repair, which taxed their skills and creativity. It's engaging them in a way that other activities haven't. A story was told about a man who was assaulted in the street and was left with a hairline hip fracture. He came back to the Men's Shed 4 weeks after coming out of hospital, and those who knew him reckoned the Men's Shed gave him the motivation and focus to recover much more quickly than he would otherwise have done.

Another reported that he had retired to Coldstream but didn't know anyone, but the moment he entered the shed 'I knew I was in a community'. The walking football participants also mentioned that those who had retired to the area but didn't know anyone had found an instant network of pals

through the walking football. ‘We helped one guy pave his driveway – we just turned up and helped him out’.

A number of participants talked about the importance of knowing that the activity, whatever it was, was going to be sustained. This came mainly from older people involved with activities that were longer established and which were pretty well self-managing. They contrasted this with other projects and initiatives – ‘some things just disappear because the funding has dried up – that’s really demoralising’.

This is fact was one of the key issues for the new staff when they started in post working in new areas – the scepticism and even downright hostility that met them because they were seen as ‘the Council’ and some communities had felt let down before by short-term initiatives.

A number of respondents reported feeling let down in the past when classes had stopped. There was some discussion about the difference in policy that allowed BCCBP GEx classes to continue even with small numbers, as BCCBP supported Fit Borders financially to run them if numbers were low, whereas Live Borders could be asked in to an area to run classes, but if numbers were below the minimum level, the classes stopped.

The finding here that it could take a year to turn around older people who were physically inactive beforehand into regular exercisers who reported feeling fitter and healthier, would suggest that a long-term investment is required if the majority of the 20,000 underactive older people in Scottish Borders are to experience health benefits.

As well as physical activity and social contact/reducing isolation, the other main thematic area was food.

The two soup clubs have really taken off from a standing start, with the support of supermarkets and volunteers from within the staff group in supermarkets.

Lunch clubs have always featured as community activity to support older people but reportedly, some of these are struggling to find volunteers. Soup clubs are a new name for an old activity, and this re-branding seems to have struck a chord and galvanised communities into action – ‘as long as they don’t think they are soup kitchens’.

Their popularity may also be a reflection of the growing issue of poverty, and the growing importance of foodbanks to support low income families. The soup clubs have developed an inter-generational aspect without that being an original aim. One operates after school closes on Fridays, so it attracts women and their kids to eat with the older people. For some people, old and younger, this might be their main meal of the day, and for families, it helps without stigmatising them as living in poverty and needing food banks.

4b) Volunteers

A few of the activities and groups set up by BCCBP are inter-generational and involve the participation of young people as volunteers.

The Jedburgh Gardening project was an inter-generational example which involved young people volunteering. This project may be more challenging to maintain as young people in secondary school inevitably move on, and the young people needed supervision and so it was a time-consuming project. Pupils volunteered to help with gardening duties, but were also helping to keep isolated

older people socially connected. The older householders reported really valuing the social contact as well as the practical assistance.

One of the development workers had involved 7 secondary school pupils in evaluating activities with walking footballers. The young people reported that the experience would make them volunteer again with older people: they were surprised at how much fun the walking football was and how engaging it was. Interestingly, the walking footballers found that the young people were not working well together as a team, and they began mentoring them to do a better job.

For BCCBP, the volunteers are group members who are prepared to step up and play a role in delivering some of the activities (e.g. organising the teas and coffees, home baking etc) or in managing the group as a whole e.g. developing a constitution and sitting on a management committee. By definition, these older people are likely to be more able.

Many respondents spoke of the difficulties and many barriers in encouraging older people to volunteer. Physical and mental inactivity would be just two, but others play a role as well, for example feeling 'I've done my bit' when they had had a working life.

Most groups and staff interviewed thought that as time went on, and the groups became more established, it was more likely that volunteers would come forward to sit on management committees. With the Eyemouth Tea Dances for example, which have been going for just a few months, the last tea dance attracted 27 people and more were offering to help. The worker involved in a partner agency thought that if they could only get a volunteer to set up a bank account then that group would be self-managing.

This echoes the finding that community development and capacity building outcomes need time (and investment) in order to materialise, but can be long-lasting. The main roles and skills that staff contribute are leadership and promotion and reaching out to partners/others. 'There's more to activities than just turning up'.

The volunteers who were interviewed reported that their main outcome, over and above those reported arising from the activity itself, was about the pleasure of 'giving something back' to their community. This was particularly apparent with people who had been working at a senior level and had been very busy, or who had retired to the area and didn't really know many people, so volunteering was a way of getting involved in the community and getting to know people.

There appear to be some differences between BCCBP and other agencies in how they perceive the relationship between services and volunteers and therefore different expectations about how volunteers should be supported. It may be, as one respondent suggested, that BCCBP is attracting more able volunteers.

Other agencies e.g. NHS Borders and the Third Sector Interface have programmes of volunteer training and the trend over the last few years has been to treat volunteers increasingly as employees, with similar rights and responsibilities as employers placed on the agencies who are 'utilising' them as volunteers. BCCBP volunteers however are local older people who are participating in the activity, and who may or may not take on a role of managing activities they are interested in. BCCBP staff have to undertake risk assessments for activities etc., but the actual volunteering role is much more informal in most stages in the group's development, until they become constituted.

There is an important point here which merits further discussion. If 'the community' is going to be involved in co-production of new services that build resilience which are preventative and supportive of older people living well as they age, and local people are genuinely involved in leading them, then the definition of what a service is may have to change. Some of the formality and regulation surrounding volunteering etc may have to be relaxed. Otherwise these co-produced services will slide back into the inflexibility that integrated services are at the moment trying to get away from.

4c) Outcomes for other stakeholders

Under the SROI approach, partners and collaborators usually experience outcomes as a result of the activity's impact on participants. In this case, the statutory health and social care services could expect a gradual reduction in demand for health and social care services over time from older people as BCCBP continues to run and develop its activities.

As the older people involved in physical activity groups regain some measure of fitness and reach physical activity targets, this could translate into a reduction in GP visits, reduced need for medication, reduced falls and delay the onset of long-term health conditions, or prevent long-term health conditions worsening at the same rate as would have been the case without intervention.

There were enough reports from group participants during this research to suggest that all these outcomes are happening – the question is to what degree. The forecast of social return in section 5 below will attempt to model some answers.

All the groups however reported that social and mental well-being outcomes were just as important. Mental well-being contributes towards good physical health, whilst loneliness and isolation lead to deterioration in physical health. Mental health is one of the priority areas for the NHS in the Borders, so anything that supports mental well-being of older people could also contribute to managing demand for services.

'Meeting strategic objectives' is not generally defined as an outcome for partners as there are many ways of achieving this, but Scottish Borders Council, and specifically the CLD service, were reported to have few targets for work with older people, and therefore BCCBP is fulfilling this strategic objective. CLD were widely reported to want to work more with older people, but there are limitations on resources to allow them to do this, so the partnership with BCCBP is an important one for them.

In the view of a local Councillor involved with some of BCCBP's activities, the project has significantly enhanced the Council's reputation within some communities because of their approach. One stakeholder reported being surprised when she realised the staff were Council staff as they obviously had a different approach. Many others recognised that the community development approach as characterised by the flexible approach of the staff was important. Scottish Borders is an area that needs flexibility of approach, as every community appears to operate differently, and what works in one place will not necessarily work in another. Knowing this and being able to deliver it in practice were seen to be two different things, and BCCBP was acknowledged as being good at delivery that matched the needs of individual communities.

The BCCBP resuscitated a previous care forum as the Borders Seniors Networking Forum in 2016 and recruited an active Chair to drive it forward with admin support from one of the development workers. The Forum now has around 50 organisations on the database and meetings are well attended.

It addresses the lack of communication between statutory staff and between them and third sector workers across the Borders, and its primary aim is to bring people together to share information. There is a need for a body to understand all the policy changes that affect older people and share that information, as well as communicate vertically to represent the views of older people. It has been successful enough for there to be a discussion about the Forum standing on its own without the support of BCCBP and finding its own funding.

When asked what impact BCCBP had in developing the work of partners, there was almost universal agreement that the work proceeded much more quickly. The practical organisational and promotional skills of the staff were extremely important in moving things along rapidly. 'I would have done something myself eventually but it would have taken me much longer and I would have been less effective'.

BCCBP can help local groups do things they couldn't do themselves. The Stow Lunch Club is a very successful lunch club. The organiser had made contact with BCCBP as she was concerned however that the lunch club was not reaching out to isolated people. Conversations with lunch club members led to the idea of creating a directory for the Gala Water area. The organiser had wanted to do this for some time, but wouldn't have done it without BCCBP. The members made the decisions about the information in the Directory and the presentation of it, so the Directory was co-produced. The members had taken a while to voice their views, but the development worker listened to them and was very good at feeding back. The Directory has been well used, and all copies are circulating in the community.

BCCBP can also add value to statutory partner's activities e.g. by promotional activity, using social media, contributing own networks to get things done and giving practical assistance.

BCCBP may also be creating outcomes that are not just about health. It has helped establish one social enterprise – Just Cycle – and has been involved in a very recent partnership with another one – the Food Foundation in Peebles – to pilot provision of hot meals for older isolated people. Both of these deliver employability and training outcomes for those out of the labour market or who have difficulties in accessing mainstream employment.

Just Cycle is an emerging social enterprise, which is to say that it is still working to build up its earned income and reduce its reliance on grants. The BCCBP helped Just Cycle get started, paid for some initial expenses, helped find its own premises, supported the development of a new website and fundraised for some costs. It helped establish a relationship with Criminal Justice, where trainees are involved in the bike maintenance workshops. Most recently the Coldstream Men's Shed have been generating funds by selling bikes, and men there are being trained in bike maintenance.

Perspective of a development worker

Interestingly, I feel since my return [from maternity leave], there has been more of a steer to look at food and nutritional opportunities for older adults. For example, lunch clubs. I personally feel like this could be because other groups relating to physical activities (football/gentle exercise) become almost a necessity for a community as they have heard about them elsewhere and would like it themselves. From an internal point of view, I think looking at food and nutritional projects may impact on costs for homecare and be an advantage for costs within SBC.

Using the example of the football, it became very clear very quickly to me, that apart from some marketing costs, the core of the group can be set up for minimal cost, with 2-4 participants initially, some grass land, a football and jumpers….Word of mouth has been a great asset to the project.

Since my return, a number of the classes have sustained their numbers of people attending, however, in some cases, the numbers have increased. This without a doubt has to be down to the advertising and people becoming a lot more aware of our existence, there have been a few of the groups who have had to relocate to bigger premises due to large numbers attending.

With every project/group/activity, it is important to be aware of the financial impact, that generally, people are happy to pay no more than £2.50.

Setting up a new organisation however is almost a full-time job in its own right, and the key need for Just Cycle is to find funding to employ a full-time worker. The link with BCCBP themes however is clear: encouraging physical activity through stimulating communities to organise activities for themselves, and linking community initiatives together in order to increase capacity.

There was agreement from the agencies most involved with social enterprise that there was more scope for BCCBP to get involved in developing social enterprises but the project is restricted by its Local Authority status.

It is clear that BCCBP has had a tricky relationship with the third sector, especially in its earlier days, which may be construed as a negative outcome. Initially, the project was seen as being in direct competition to the third sector, and as resources reduce over time, this could resurface as an issue.

There also appears to be a conceptual issue over to what extent BCCBP is perceived to be about community development and the comparison with the models other agencies are using to underpin their work that are also about community development or capacity building. There appear to be perceptions of duplication or differences which are not helpful. As one respondent put it 'the whole of the community development ground has got very muddied and crowded'.

In the health field with older people, where the more recent emphasis is on the community doing more for itself and being supported to do so, there is a danger of this issue becoming less clear as more community-based initiatives are developed. There appears to be a need for some clearer leadership and definition and practice development.

4d) Process Evaluation

The view from the staff about why what they do works is that proactivity is the key. By going out into communities and initiating conversations, things happen.

Promotion appears to be one of the staff's most important project activities. The role of staff in promoting activity was mentioned by a lot of community respondents as being an extremely important role. Persistence pays off, and many people from the community reported that without this promotional effort, involving both the budget and the skills of the staff, many activities may not have got off the ground or been sustained.

Talking to community activists also highlighted creativity as a key ingredient. The researcher was struck by the enthusiasm of all those involved, and how engaged many participants were in their groups, and how they talked about their future plans and were interested in developing new things. The role of the development workers was critical in creating that atmosphere: 'she might only be in for an hour but there's such a buzz you think she's been here all day'.

The dispersed nature of the Borders and having a Borders-wide remit both places restrictions on the team and makes effective functioning more challenging.

There is no office for the development workers to be based in, they are working from their cars and using phones and tablets as IT support, team meetings are more difficult to schedule due to dispersed working, and there is just less time available to harmonise, practice and promote learning amongst team members. It appears that flexibility is a key strength in the team.

It is not surprising therefore that there appears to be subtle differences of approach discerned by the researcher between team members. This is mainly about the emphasis on sustainability of services from the outset, how up front that is in discussions with community leaders and how much responsibility is taken on by individual development workers for activities.

However the team do all learn from each other and adopt new practice, so a bit more time for discussing underpinning issues and philosophy would be a worthwhile investment.

4e) Aims and objectives not achieved

In terms of the main ICF PID aims and objectives, all appear to have been met, but those which are critically dependent on SBC and the NHS have been only partially met. These are the 2 supplementary objectives:

- Integrate these community services with preventative health initiatives
- Reduce the need for day centres, GP consultations, respite care and 'even' emergency admissions.

Staff and community respondents mentioned the need for better partnership working with NHS services (whether preventative or not) at a very local level e.g. with district nurses. Respondents said that more promotional information about activities could be handed out to more isolated people by those who could encourage them to join in. District nurses, home care providers and GP's could all help promote the activities to those least likely to find out about them through friends and family.

This is an area where the involvement of the BCCBP project in piloting the Buurtzog model could be tested on a small scale. More could be done for example visiting people discharged from hospital and/or ensuring care provider staff and district nurses give out leaflets advertising new groups aimed at helping people regain some fitness through Gentle Exercise.

Providing evidence that the BCCBP can reduce the need for mainstream primary health and social care services is outwith the scope of this evaluation, but has been looked at and modelled in Section 5 below.

4f) Best practice review

One of the most striking features of work in this field is how little work has actually been written up over the last decade in community capacity building, despite the Scottish Government still recognising that community capacity building underpins achievement of national outcomes and is one of 3 priorities for Community Learning and Development (CLD).

A survey of community capacity building [10] showed that the understanding of the different terms vary enormously, and a very extensive list of activities was presented which staff regarded as being evidence of community capacity building, from youth work to volunteering events to provision of mobile childcare services.

A quarter of CLD staff however were reported not to have much involvement with community capacity building.

[10] 'A snapshot of community capacity building in Scotland', 2011, Learning and Teaching Scotland at https://blogs.glowscotland.org.uk/glowblogs/WALT/files/2011/03/FINAL-Community-Capacity-Building-in-Scotland-survey-2011.pdf

Scottish Borders is one of the few areas in Scotland which has a dedicated Council community capacity building team [11] and Scottish Borders is unique in having a team that focuses on older people. In other areas, these functions are performed by CLD teams. Most CLD staff view community capacity building as part of what they do rather than all of what they do. The BCCBP as an entity therefore appears to be unique.

There is now however a widening scope of policy where community capacity building and community engagement are becoming recognised as necessary and effective. The National Standards for Community Engagement cite many examples where community engagement underpins effective practice, from participatory budgeting to town centre design to asset transfers to communities, all of which were mentioned in the interviews with stakeholders and partners of BCCBP as being areas where BCCBP could add further value.

The recent Community Empowerment Bill has given new impetus to community capacity building, as has the Christie Commission and the integration of health and social care.

The issues which affect delivery of community capacity building practice have been identified as:

1. Resourcing/funding
2. Commitment of the host body – is it 'mission critical' or not?
3. Staff development and training in community development practice and theory
4. Policy and practice development
5. Issues for community groups in building their capacity, e.g. involving new people
6. Accountability to the communities being worked with.

All of these issues affect BCCBP to a greater or lesser extent. What might be done to ameliorate the impact of these issue on the BCCBP and older people's integrated services, will be discussed in Section 6 below.

Section 5 Forecasted Social Return on Investment

5a) Introduction to the methodology

SROI is a principles-based approach to measuring, accounting for and managing social value. It explores what difference activities make to people's lives, examines how significant these changes are and gives an account of the importance of these changes by assigning financial values to outcomes for stakeholders. The key principles are:

- Stakeholder involvement
- Understanding change
- Valuing what matters
- Only include what is material
- Do not overclaim
- Be transparent
- Verify the result.

[11] Perth and Kinross Council, Moray Council, Shetland Islands Council and Argyll and Bute Council were found to be the only ones that have a dedicated capacity building team separate from CLD staff

The framework for developing an SROI analysis has been set out in the SROI Guide, and this analysis for the BCCBP has followed the principles and standards for SROI contained in this Guide.[12] SROI is now used across the world, in 35 countries, as a way of exploring value creation in a huge range of activities.

The key tool for SROI analysis is the value map. This records the relationship between BCCBP's activities and the changes created for the different stakeholders involved, shows how these changes have been measured and valued, and results in a calculation of the ratio of social value resulting from the investment in BCCBP's activities.

In this case, the value map is a forecast, or estimate. This means that the level of rigour required of an evaluative study could not be guaranteed due to lack of time given for the evaluation overall, and so the quantities of outcomes for each stakeholder have been based on estimates, or on desk research where it exists. The financial proxies however are likely to be those used in an evaluation study.

The value map is contained in a separate Excel spreadsheet, but elements of it are presented in the Appendix.

During the Older People's Change Fund, Scottish Borders used a scorecard system for deciding on investment, and set a benchmark of a return on 3:1, which the Joint Improvement Team thought was 'ambitious'. [13]

5b) Construction of the value map

The outcomes from this evaluation for different stakeholders were clearly expressed during the interviews and focus groups (see Sections 4a to 4c).

The project records provided information about numbers of participants, volunteers and the breakdown of physical versus mental well-being/reducing isolation aims of each activity.

We know from previous surveys conducted by the BCCBP project that 86% of participants stated that the gentle exercise classes had improved their fitness and 67% of men said that walking football had increased their fitness. Applying these to the numbers of participants gives us an estimate of participant outcomes, and then an estimated range of health and social care outcomes for other stakeholders such as reduced demand.

These numbers were backed up by what the 45 participants involved in this study reported. This is a relatively small sample of the participants, and may not be representative of older people as a whole, however guidance on SROI suggests that when you stop hearing new reports from participants then there may not be anything new to uncover even if a larger sample is interviewed. This in the researcher's view is the case here.

5c) Valuation using financial proxies

SROI is different from other methods in taking valuations from different stakeholder groups and adding them together to calculate overall value. Value is perceived differently by different

[12] First produced in 2009 by the SROI Network, funded and supported by the Office of the Third Sector and the Scottish Government and subsequently updated by Social Value UK. See http://www.socialvalueuk.org/resources/sroi-guide/

[13] Change Fund report 2015, at www.jitscotland.org.uk/change-fund-report-june-2015-final/

stakeholders, but SROI principles have been developed to ensure we understand as much of the impact as possible, rather than take the perspective of one stakeholder only. The way to do this is to find financial proxies that represent the value from the stakeholder's perspective for each outcome.

This approach is also in accordance with HM Treasury's Green Book, which now recommends that stakeholder valuation should be attempted whenever possible. [14]

In a full SROI evaluation analysis, information about how some stakeholder groups value outcomes would be secured directly from engaging with that stakeholder group.

The purpose of valuing participants' outcomes is to understand how relatively important these outcomes are, in the whole scheme of things. If an intervention has really made a difference to someone's life then participants should value it more highly. When asked, Gex participants reported that on a scale of 1 to 10, where 1 was not important and 10 was hugely important, that GEx classes were scored as 10 and so were very important in their lives.

As SROI has developed over the last 10 years more commonality in valuing some outcomes has been created and there are now numerous sources of financial proxies. [15]

There are a range of methods based on existing economic evaluation approaches which are recommended for use in developing financial proxies, some of which are relevant to particular stakeholders, and some of which have been used to evaluate the outcomes here:

- Changes to unit or marginal costs (whether potential or actual cash savings)
- Changes to income
- Revealed preference i.e. the preferences of individuals can be revealed by the market price for an equivalent outcome
- Hedonic pricing, which is a type of revealed preference proxy i.e. valuing the change in the utility of something by seeing how the valuation of it changes as its characteristics change. (This approach has mainly been used to value changes in environmental amenity by seeing how they affect house prices)
- Stated preference i.e. directly asking people to give their valuations through surveys of large samples
- Contingent valuation, which is a type of stated preference proxy i.e. directly asking people to give an estimate of their willingness to pay to have something or avoid or accept something
- Travel cost method, which is a type of stated preference proxy, i.e. directly asking people to state the time and travel costs that they are willing to incur in order to have something, which can represent the value of access to something.

However, recent work[16] on Subjective Well-Being Valuation has allowed robust methods to be applied which overcome some of the limitations of some of these more traditional approaches.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209107/greenbook_valuationtechniques.pdf

15 Global Value Exchange, 2015, 'Discover your social value', Glasgow: Social value UK. Available from: www.globalvaluexchange.org

16 Fujiwara, Kudrna. and Dolan, 2014. 'Quantifying and Valuing the Wellbeing Impacts of Culture and Sport', London: Department for Culture Media and Sport. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304899/Quantifying_and_valuing_the_wellbeing_impacts_of_sport_and_culture.pdf [Accessed February 2016].

Wellbeing valuation takes data on people's subjective wellbeing (SWB) from large surveys and uses statistical or econometric techniques to assess how different life events impact on SWB. The British Household Panel Survey (BHPS) for example has surveyed over 10,000 people year-on-year asking them about 500 questions on different aspects of their lives, including questions about wellbeing and happiness.

Data like the BHPS can be used to estimate the impact that a non-market good - or outcome - has on a dimension of SWB, such as improved life satisfaction. The BHPS can then be used to look at the impact that extra income has on SWB. From a comparison of these two estimates, we can then calculate the equivalent value of the particular non-market good i.e. the amount of extra income that would be required to produce the equivalent impact on life satisfaction.

So for example, having a skin condition or allergy can reduce life satisfaction. The SWB approach calculates that you would need an extra £895 in income per year to return you to the same level of life satisfaction you would have if you did not suffer from the condition. This figure could be used to value a treatment that removed the skin condition or allergy, from the perspective of the patient. [17]

Using this type of approach has found values for a range of long-term health conditions, and found that improvements in mental well-being have a very high valuation, as do increased independence. The value of volunteering has also been studied using the SWB method. [18]

5d) Deductions to avoid overclaiming

Once the quantities of outcomes multiplied by their value has been calculated for each stakeholder for each outcome, deductions are applied to get the final value. There are two main deductions: deadweight and attribution.

'Deadweight' recognises that some outcomes might happen anyway, that participants have other choices they can make to get the same outcomes and if they weren't taking part in the BCCBP activity they might be doing something else that delivered the same outcome for them.

Duplication and overlap between BCCBP and other activities (such as those of Local Area Coordinators) was mentioned by some statutory stakeholders. It may be that as resources for each initiative have reduced, there has been a greater need to develop activities in partnership, and this practical situation may be giving rise to the perception that there is duplication going on. There could also be some confusion operating about the different terminology.

Older people interviewed however did not see this. In their view, the BCCBP activities are occupying a niche that nobody else is in, so duplication is less of an issue than perceived. Even when there were other similar activities going on in a community e.g. GEx and other exercise classes for older people, participants stated that the GEx classes were different, as they were more explicitly based on addressing the health conditions they had. They would not attend the other classes because they did not explicitly help their health condition, and with GEx, there was more emphasis on the social aspects.

[17] Fujiwara, Kudrna. and Dolan, 2014, 'Valuing Mental Health: how a subjective wellbeing approach can show just how much it matter', London: UK Council for Psychotherapy. Available from: http://media.wix.com/ugd/9ccf1d_b3cfc47c5b2043ec92b32f558d15d97f.pdf

[18] 'Well-being and civil society: estimating the value of volunteering using subjective well-being data', 2013, Fujiwara et al for Department of Work and Pensions at https://www.gov.uk/government/publications/wellbeing-and-civil-society-estimating-the-value-of-volunteering-using-subjective-wellbeing-data-wp112

Other participants however reported they were quite active in their community, and if they weren't going to e.g. walking netball they might be going to a craft session. This would obviously not get them as fit, but would still reduce their risk of isolation. In an evaluation study, this would be looked at explicitly, and although each participant in this study was asked what they might do if BCCBP and its activity wasn't there, responses varied a lot, so it became difficult to estimate an average figure for deadweight.

The other factor is attribution: who else contributed to achievement of outcomes. Friends and family might be an example of another stakeholder with power to influence how people participated and the outcomes they achieved. TV advertising trends may have an effect, a GP prompting someone to do more exercise – these are all examples of attribution. This is a difficult factor to isolate, as generally speaking there is limited research in this area and individuals vary significantly. More in-depth interviewing would help, as well as knowing who else was supporting the older people involved in the activity, such as a home care worker or a district nurse. Attribution is clearer where outcomes relate to community organisations, as BCCBP works closely in partnership in different communities.

5e) Duration

Another factor which can make a huge impact on the SROI ratio is the duration of individual outcomes. Duration is about how outcomes last into the future, without the intervention being present.

The aim of the BCCBP is that the groups can sustain themselves after a period of time. The evidence from the research is that this is largely the case, but for how many years is uncertain. The groups' answer to the question varied with how long they had been established, so the only way to determine duration is to monitor this as the BCCBP continues into the future.

Judgements and estimates however can be made.

If a group stopped, then the mental well-being outcomes would presumably stop, although they might be sustained for a period, based on what respondents said in this study about developing friendships amongst the group.

The physical outcomes would last, but would drop off over time, unless the new levels of fitness were maintained by other activities, as was suggested by the walking football group.

Thus in this forecast the assumption has been a conservative one of relatively limited duration, but this may prove to be too pessimistic in reality.

5f) Estimated SROI ratio

The Appendix contains details of the estimates and judgements made in exploring the social return from the BCCBP, but the best estimate of the social return for the BCCBP is around £10 for every £1 invested.

80% of this value accrues to older people themselves, and 16% to the health and social care system in terms of reduced demand.

5g) Sensitivity analysis

Analysis suggests that the range of social return varies between £5 and £18, depending on the assumptions made about duration, deductions and quantities.

The longer term impact of improvements in fitness, exercise levels and mental well-being could lead to a delay in the onset of health conditions that require treatment and/or a better ability to self-manage health conditions.

If a delay of 5 years for the onset of conditions is modelled, then based on the average NHS spend per person at different ages, the ratio is likely to be around £14 to £1 invested.

The individual return to the health and social care system as a stakeholder would be in the region of £6 to £1.

5h) Conclusion and recommendations about the SROI method

Other SROI studies that have looked at interventions similar to BCCBP's are:

- The Paths for All study from 2012 found a return on £8 for every £1 invested in walking projects for older people [19]
- the Bums off Seats study found a £4 return [20]
- The Extra Time intervention of using football as the basis for social and physical activity for older people found a £5 return [21]
- Peer support for people with dementia designed to reduce isolation found a range between £1.15 and £5 [22]
- The Community Champions capacity building programme to promote health and well-being suggested a return of £5 and a Community Assets programme suggested returns of £6. [23]

Thus this forecast/estimate of SROI is in the same ballpark as previous studies, if not slightly higher, as BCCBP encompasses a number of aims.

The SROI analysis supports both theories of change that BCCBP works with:

- The community development approach, although more resource intensive, delivers better and more sustainable outcomes
- The return for the health and social care system in terms of reduced demand in future is likely to be well over the 3 to 1 benchmark stipulated.

The longer term impact of the BCCBP in reducing demand in the health and social care system could be significant. The theory of change is that by BCCBP setting up groups in Borders communities aimed at improving physical fitness and reducing social isolation will help older people manage their own health better and reduce the burden of ill health in later life.

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[19] 'Walk Glasgow SROI Study' 2012, Paths for All at http://www.pathsforall.org.uk/sroi

[20] 'Bums off Seats' 2011 at http://greenspacescotland.org.uk/sroi.aspx

[21] Quoted in 'Translating the evidence: What works for physical activity?, 2010, BHF at https://www.nice.org.uk/.../health-economics-4-review-of-sroi-evaluations-23682624

[22] 'Peer support for people with dementia', Semple et al 2015 at http://www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a11G000000CbjT1IAJ

[23] Reported in 'Community Engagement SROI review' 2015 for NICE at https://www.nice.org.uk/guidance/ng44/evidence/health-economics-4-review-of-sroi-evaluations-2368262416

This evaluation has found evidence of health improvements reported by individuals that would suggest this longer-term reduction on health and social care demand would be realised in practice, but it would be helpful if BCCBP were able to measure physical health indicators in some groups to show this linkage more clearly and gather more in-depth evidence of this effect.

Section 6 Conclusions

6a) Main Conclusions

The findings here support the following conclusions:

- BCCBP has met all its project aims and objectives 1-8
- The level of outputs has significantly increased with the expansion of the team in 2016
- The project staff are very well regarded and valued within the communities where they operate
- The staff would benefit from more support to articulate and embed the community development principles inherent in their methods
- The outcomes for older people in terms of improved health and well-being are significant, but a new group designed to increase physical activity levels needs around a year before it can be said to be generating significant health outcomes
- Groups can be set up in less time, but they are not worth investing in, as they are not sustainable, do not led to sustained outcomes and do not contribute to the aim of building community resilience and capacity
- The community development approach therefore delivers value for investors
- The BCCBP has not met its two supplementary aims as they rely on cooperation with other health and social care professionals, which has not been within the power of the project staff to influence, and this should be addressed as a strategic issue
- There are some challenges with partnership working with the third sector which should be addressed as a strategic issue
- BCCBP is not realising its full potential to contribute to the strategic development of the health and social care agenda for older people in the Scottish Borders
- There is more scope to develop local social enterprise responses to health and social care service needs and there are local partners to work with
- There is significant potential for BCCBP to provide the underpinning community development activity that will be necessary in ensuring public service reform for older people and supporting the introduction of new models such as community led support, Buurtzog care model and participatory budgeting as part of its longer-term development beyond the ICF.

6b) What's in a name?

Many respondents stated that they thought the name of the project was not right and had led to misunderstandings of what the project was trying to achieve. Many suggested the project should be re-branded, but no one could suggest a better name that encapsulated the dual focus on older people and building community capacity.

If the project is to continue beyond March 2018, it would be worth organising a workshop with stakeholders to explore a new brand identity.

6c) Opportunities

Respondents thought new activities could usefully be developed in:

- music
- creative writing
- more cultural and artistic activities
- more food projects
- more inter-generational work
- mindfulness.

One worker noted however that 'the project has slowly moved out to fill in the gaps', and so there is currently some development work going on in all the above areas.

There is a need to continue to extend the geographical coverage of existing activities especially to smaller areas and some under-represented areas such as Hawick.

The total size of the target group who need help to increase their physical activity – some 3,000 totally inactive and 20,000 under-active people - suggests the BCCBP team could justify being made permanent.

Going forward, the project may require a larger budget to subsidise classes in the smaller areas, but this would be a much cheaper option than setting up a project to say develop new transport options or in dealing with the consequences of loneliness and social isolation.

6d) Strategic role going forward

There is a role for BCCBP in supporting service reform, most clearly with the pilots of community led support, the Buurtzog model and participatory budgeting with older people. These all require community engagement, and building motivation and skills within communities to generate more services. BCCBP has proved it can do this cost effectively.

Duplication between BCCBP and other services was mentioned by some statutory stakeholders, and this could be a legitimate concern between community learning and development, local area coordinators and the LASS and HLN services. This requires some teasing out and discussion at a strategic level of where these different services fit in what is a changing landscape and what their role is going forward.

The BCCBP is best thought of as a preventative resource for older people that can also be linked in to help services gain more involvement from communities.

As public resources are tightened, those whose needs are significant but not high enough to meet eligibility criteria for assistance are at risk of being neglected, but if they receive no interventions then the risk is that as they age, their health conditions become worse than they might otherwise have been. Engagement with BCCBP activities can lengthen the time before older people need health interventions and better manage demand.

The recent research into risk factors for dementia highlights that some of the preventative activities are those BCCBP has specialised in: better physical activity levels, more mental stimulation and lifelong learning, reduced social isolation and less depression. It may be that more could be done by BCCBP working specifically with people and carers with lived experience of dementia.

Working in partnership with other agencies, BCCBP could manage a process of community engagement with older people and prospective partners around the potential for new local social enterprises in the health and social care field.

6e) Recommendations

- BCCBP could use the information that will be flowing from the outcomes questionnaires, combined with a more rigorous and extensive approach to data collection (including collecting data on physical health indicators) to do a more robust evaluation of SROI. The value map included here provides a starting point to define what additional data is needed.

- BCCBP should be mainstreamed as an important component of the reform of public services as they affect the health and social care of older people.

- Further thought should be given to BCCBP's legal status. On the one hand, being a unit of Scottish Borders Council is very helpful in terms of future involvement in the health and social care agenda as outlined above and capturing the benefits over time of reducing demand on services. On the other hand, the unit is unable to access some funding that might allow it to develop new activities more quickly, or pursue new avenues for building capacity or provide a vehicle for social enterprises in health and social care.

- The project staff should receive more promotional training and support to enhance their key strength in community development and in promotion, and specifically to help their groups access the harder to reach and more isolated older people.

- The project should take the lead and facilitate a practice forum involving staff from relevant partners to embed better understanding of the principles and practice of community development across different sectors. There are external agencies who could help with this process.

- The project should be asked to pilot a participatory budgeting exercise with older people in an appropriate area, both geographically and thematically, to build the teams' skills, allow them to work together on one project and learn from each other, and to link this with the other health pilots that are on-going.

Appendix 1. Value Map of the SROI forecast

Outcomes, Indicators and Quantities

Stakeholder: Older people who are participants in BCCBP groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
	Time, energy	261 older people regularly involved in physical activity groups	Reduced impact of long-term health conditions on daily life	86% of older people involved in gentle exercise and kurling groups reported their fitness had improved	Interviews and focus groups plus participant surveys and project records	187 86% of 218 people participating in New Age Kurling and Gex classes
			Taking responsibility for one's own physical health by taking more exercise and improving fitness	67% of older people involved in walking sports groups reported their fitness had improved	Interviews and focus groups plus participant surveys and project records	29 67% of 43 older people involved in walking netball and football
				Number of people who now take the recommended level of physical activity each week - estimated at 20%	Interviews and focus groups	9 20% of 43 people involved in walking sports
		202 older people regularly involved in groups which are aimed at improving mental well-bering and social contact	People are more connected in their community and doing activities and leads to improved mental well-being from the social contacts involved in groups	Proportion of older people who report that they value the social contact and it makes them feel happier and motivated to sustain the group - estimated at 85%	Interviews and focus groups	398 85% of whole group (without happiness cafe participants) i.e. 463
				Proportion of older people who report being more socially active - estimated at 75%	Interviews and focus groups	347 75% of whole group (without happiness cafe participants) i.e. 463
			Older people have access to better quality information	Number of people accessing the Gala Water Directory as a	Interviews and focus groups plus project records	375 Estimate 25% - of

			through Directory	proportion of the elderly population		approx 1500 pensioners living in isolated circumstances

Stakeholder: Older people who are also volunteering to manage groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
Time and energy	£41,040	95 volunteers providing an estimated1.5 hours of input to group management per week	Increased sense of personal self-esteem and a sense of giving back to the community	Proportion of participants who volunteer who sustain their involvement as volunteers	Interviews and focus groups	80 Estimated as 85%

Stakeholder: Community-based organisations who are supporting BCCBP groups	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Stronger and more sustainable local community organisations	Number of additional participants involved in other Community Association activities	Interviews	60
				Number of groups that BCCBP have set up that are now self-sustaining	Interviews and project records	10
			Improved sustainability of local social enterprises	Increased revenue estimated from BCCBP activities for Fit Borders and grant funds raised for Just Cycle	Interviews	1
			Better networking support for services and workers through the Borders Seniors Networking Forum	Number of regular attendees and those receiving information through the Forum	Interviews	50

Stakeholder: NHS Primary Care services	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Reduced demand on GP services by people who are improving their own physical health and managing their LTC	Number of older people with LTC's who have taken up physical activity and improved their fitness	Interviews and focus groups plus participant surveys and project records	187
			Reduced demand on GP's due to improved mental-well being and resilience of patients	Number of older people whose mental well-being has improved	Interviews and focus groups plus participant surveys and project records	398
			Reduction in older people needed hospitalisation for falls	Number of older people who have improved their core strength, coordination and balance through physical exercise	Interviews and focus groups plus participant surveys and project records	187
				Number of falls that would be expected amongst those doing physical exercise classes	Chartered Institute of Physiotherapits and NICE guidelines	86

Stakeholder: Scottish Borders Council	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity
			Improved reputation in local communities	The number of local communities who have extensively cooperated with BCCBP	Interviews	5
			Avoided costs of strengthening CLD teams to work with older people	The cost of locating a development worker in each locality to work with older people 50% iof time	Interviews	1

Stakeholder:	Input	Outputs	Outcome description	Indicator	Source of measurement information	Quantity

Health and Social Care Partnership	Funding for year 3	£160,000	Outcomes are experienced by other stakeholders			

Outcomes and financial proxies

Stakeholder: Older people who are participants in BCCBP groups	Outcome description	Financial proxy description	Value	Source
	Reduced impact of long-term health conditions on daily life	SWB valuation of the negative effect on life satisfaction of a range of LTC's and the income required to return someone to the same level of life satisfaction.	£2,160	'Valuing mental health', Fujiwara and Dolan, 2014, UK Council for Psychotherapy at https://www.simetrica.co.uk/wwwsimetricacouk-resources
	Taking responsibility for one's own physical health by taking more exercise and improving fitness	HACT valuation of indirect health impact from being in control of one's life is £3424, but older people less likely to value it so highly due to limited ability to change activity patterns or behaviour and the valuation so assumed 25% of value	£856	'Measuring the indirect impact of improved health on wellbeing', 2015, HACT at http://www.hact.org.uk
	People are more connected in their community and doing activities and leads to improved mental well-being from the social contacts involved in groups	SWB valuation of the negative effect on life satisfaction of poor mental health is £44,237, but assume 10% of this value	£4,424	Valuing mental health, Fujiwara and Dolan, 2014, UK Council for Psychotherapy
	Older people have access to better quality information through Directory	Average cost per annum for the 4 main broadband providers as a proxy for better access to information	£163	At http://www.moneysavingexpert.com/phones/cheap-broadband

Stakeholder: Older people who are also volunteering to manage groups	Outcome description	Financial proxy description	Value	Source
	Increased sense of personal self-esteem and a sense of giving back to the community	HACT valuation of indirect health impact from REGULAR volunteering is £892	£892	'Measuring the indirect impact of improved health on wellbeing', 2015, HACT at http://www.hact.org.uk

Stakeholder: Community-based organisations who are supporting BCCBP groups	Outcome description	Financial proxy description	Value	Source
	Stronger and more sustainable local community organisations	Cost of replacing volunteer labour with paid staff ONS study of 2.8 hrs nationally volunteered per week, assume for 40 wks pa Take NMW as proxy for time Assume 7 volunteers per group	£6,145	http://blogs.ncvo.org.uk/2014/06/26/its-the-economic-value-stupidbut-is-volunteering-really-worth-100bn-to-the-uk/
	Improved sustainability of local social enterprises	Additional funding input to Just Cycle as a result of BCCBP and the contribution made to Fit Borders from GEx classes	£8,200	Interviews
	Better networking support for services and workers through the Borders Seniors Networking Forum	The value of time contributed to the Borders SNF by participants, 4 quarterly meetings, 3 hours per time, £15 on average hourly rate	£180	Interviews

Stakeholder: NHS Primary Care services	Outcome description	Financial proxy description	Value	Source
	Reduced demand on GP services by people who are improving their own physical health and managing their LTC	Unit cost of a GP consultation is £65 per 17 minute consultation, assume on less consultation per month	£780	http://www.pssru.ac.uk/project-pages/unit-costs/2015/

	Reduced demand on GP's due to improved mental-well being and resilience of patients	Unit cost of a GP consultation is £65 per 17 minute consultation, assume on less consultation per month	£780	http://www.pssru.ac.uk/project-pages/unit-costs/2015/
	Reduction in older people needed hospitalisation for falls	30% of people older than 65 and 50% of people older than 80 fall at least once a year so assume 86 fewer falls, savings per fall for all types of treatment in hospital in the Borders	£1,651	Falls prevention economic model from Chartered Institute of Physiotherapists at http://www.csp.org.uk/documents/falls-prevention-economic-model

Stakeholder: Scottish Borders Council	Outcome description	Financial proxy description	Value	Source
	Improved reputation in local communities	Cost of a community engagement process to enhance reputation. Assume 5 hours per month @ £80 per hour plus 8% account fee as per Holyrood Partnership	£5,184	https://www.holyroodpr.co.uk/why-us/cost-charges/
	Avoided costs of strengthening CLD teams to work with older people	Would need 1 worker per locality. Assume average CLD salary is £29K, assume 20% travel and on costs and 50% of time spent on older people	£87,000	Salary from My Jobs Scotland

Deductions to avoid overclaiming, duration and drop off

Deadweight

For older people interviewed, reported deadweight for physical and mental well-being seemed to vary significantly between groups and areas from 0% to 50%
Only 14% of men and 8% of women meet recommended guidelines for physical activity
17% of men and 21% of women are completely inactive.
Suggests average rate of 11%

For volunteers, 19% of over 65's volunteer on elderly projects Scottish Household Survey 2016 at http://www.gov.scot/Publications/2016/09/7673/13
For community organisations, 0% deadweight where participants said activity would not have happened without BCCBP
For social enterprise, estimate of 25% deadweight

Attribution
If 50% of GP appointments are with people with LTC's (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf) then attribution to existing primary care support should be 50%.
However, participant interviews suggested attribution of 0 to anyone else.
If the average person with an LTC spends 0.05% with a health professional (http://www.nuffieldtrust.org.uk/blog/fact-or-fiction-demand-gp-appointments-driving-crisis-general-practice) then attribution should be very low.

Conclusion : use 10% to allow for interviewer bias
And 5% to allow for friends and neighbours

For non-individual outcomes - 50% to reflect partnerships with other organisations

Duration
The outcomes which are assumed to endure for longer than the activity are:

Older people who are participants in BCCBP groups:
Reduced impact of long-term health conditions on daily life
Taking responsibility for one's own physical health by taking more exercise and improving fitness
Community-based organisations who are supporting BCCBP groups:
Stronger and more sustainable local community organisations
NHS Primary Care services:
Reduced demand on GP services by people who are improving their own physical health and managing their LTC
Scottish Borders Council:
Improved reputation in local communities

Drop off
For those outcomes which endure, the value in year 2 reduces by 25%.

SROI calculation

The investment is £160,000 of funding plus £41,040 of volunteer time

	Year1	Year2	Total
Total present value of all outcomes for all stakeholders added together	£1,977,383.31	£308,301.31	£1,981,883.31
Total net present value (discounted by 3.5%)	£1,910,515.28	£287,802.57	£2,198,317.85
Investment			£201,040
SROI Ratio			10.93

Sensitivity analysis

Item	Base case	New assumption	Base result	New result	Difference	Sensitive or not
Deadweight	Average of 9.75%	Average of 25%	10.93	9.67	-12%	No
		Average of 40%	10.93	7.74	-29%	Yes
Attribution	Average of 31%	Average of 50%	10.93	7.29	-33%	Yes
		Average of 40%	10.93	8.75	-20%	Yes
Duration	1 year	2 years	10.93	18.23	67%	Yes
Quantities		25% lower	10.91	8.19	-25%	Yes
Investment figure used	2016-2017	Total for 3 years	10.93	5.49	-50%	Yes
Valuations		50% lower	10.93	5.46	-50%	Yes

All assumptions have the power to affect the result, but the most sensitive ones are attribution and duration, and these should be paid particular attention to if an evaluation is to be attempted.

If BCCBP does have a role in preventing the long-term deterioration in health status of older people, then what could be added to the value map is an outcome for the NHS, which is a reduction in the spend per person which has been avoided because older people require less services. One way to value this is to compare the average spend at different ages, and assume the spend for someone aged 75 is reduced to that of someone aged 65. This would result in a 'saving' of £1,800 per person, which over the population in the last year of 463 people would have produced a notional value to the NHS of £833,400, and a return of £5.89 to the health and social care system.

Another way to value this effect would be to look at the increased in QUALY's arising from improved physical and mental health and to apply the NICE benchmark of £20,000 cost per QUALY gained. Further work could be done on this approach.