

# Live More with Shared Lives in Greater Manchester

## Evaluation report

### September 2026

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# Executive Summary

**Live More in Greater Manchester has been a test and learn initiative, financed via the Department of Health and Social Care's Accelerating Reform Fund, to explore the potential of Shared Lives day support offered to people and families living with dementia as a model of early action and proactive prevention. The support has deliberately been made available prior to where people are typically reached by, or able to access, publicly funded adult social care support.**

**The programme was developed, designed and led jointly by Directors of Adult Social Services Greater Manchester (ADASS), NHS Greater Manchester (NHS GM) and Shared Lives Plus, in collaboration with Greater Manchester Combined Authority, Dementia United and the 10 Shared Lives schemes in Greater Manchester.**

Around 70 people and families have taken part in the pilot across all ten areas of Greater Manchester. People with dementia were matched by their local Shared Lives scheme with a Shared Lives carer and typically spent one half day a week together pursuing activities aligned with the person's interests, while family carers had time for themselves.

Using a mixed methodology, an independent evaluation has explored the operational feasibility of the approach; its value to the wellbeing of people living with dementia and their families, and its economic viability. The evaluation has begun to test a hypothesis drawn from the programme Theory of Change:

> If we are able to **reach people and families living with dementia earlier** than typically reached by publicly funded adult social care with a modest amount of **one to one, relational support**, centred on supporting people with dementia to continue being and **doing the things that matter to them** and **family carers feeling supported** and having some time out…
>
> …then we can scaffold and strengthen the ability of people and families to **stay living in the place they call home, with the people and things they love, doing the things that matter to them**…

> ...and through doing so **improve wellbeing**, while **offsetting the pressures** which are often expressed through **avoidable use of primary care services**, hospital admissions, **carer breakdown and the crisis** that typically predicts and characterises people and families first engagement with adult social care...
>
> ...and also **defer pressures on more acute adult social care services** and residential care in particular, given the majority of care home residents are living with dementia.

The findings gathered from multiple sources support this hypothesis. The Shared Lives schemes were, in a short time frame, able to operationalise an approach which involved working with a new group of people and new referral partners, drawing on existing Shared Lives carers to match people living with dementia in ways aligned to their interests and passions.

Shared Lives support was highly valued by the people with dementia and their families who took part, with qualitative and quantitative evidence confirming significant benefits for people's self-expressed wellbeing (as summarised in Figure 1 below). These in turn, combined with economic analysis, indicate a high Social Return on Investment, with every £1 invested in Live More returning close to £6 of social value on the cautious appraisal basis, and over £8 measured against the pilot's actual cost.

The findings concerning the impact and value of the support correlate strongly with evidence of factors which prevent or defer avoidable use of primary or acute health services, or admission to residential care (as summarised in Figure 1 below) and the social return on investment (SROI) does suggest that the model could contribute to some deferment of residential care admissions. However, given the scale and duration of the pilot, coupled with limitations in the evidence available to the evaluators, a longer and deeper evaluation would be required to say so conclusively, including, for example, by accessing digital health records, and through employing a 'control group', neither of which were available to the pilot initiative.

## Structure of this report

This report has been developed to provide the key findings from the programme evaluation activities. This is not an exhaustive report and there is further data and analysis not included which can be provided on request by Greater Manchester health and care partners.

The report findings are structured into the following sections:

1. Introduction
2. About the test and learn programme
3. The impact and outcomes of Live More
4. Social return on investment
5. How Live More is achieving these outcomes?

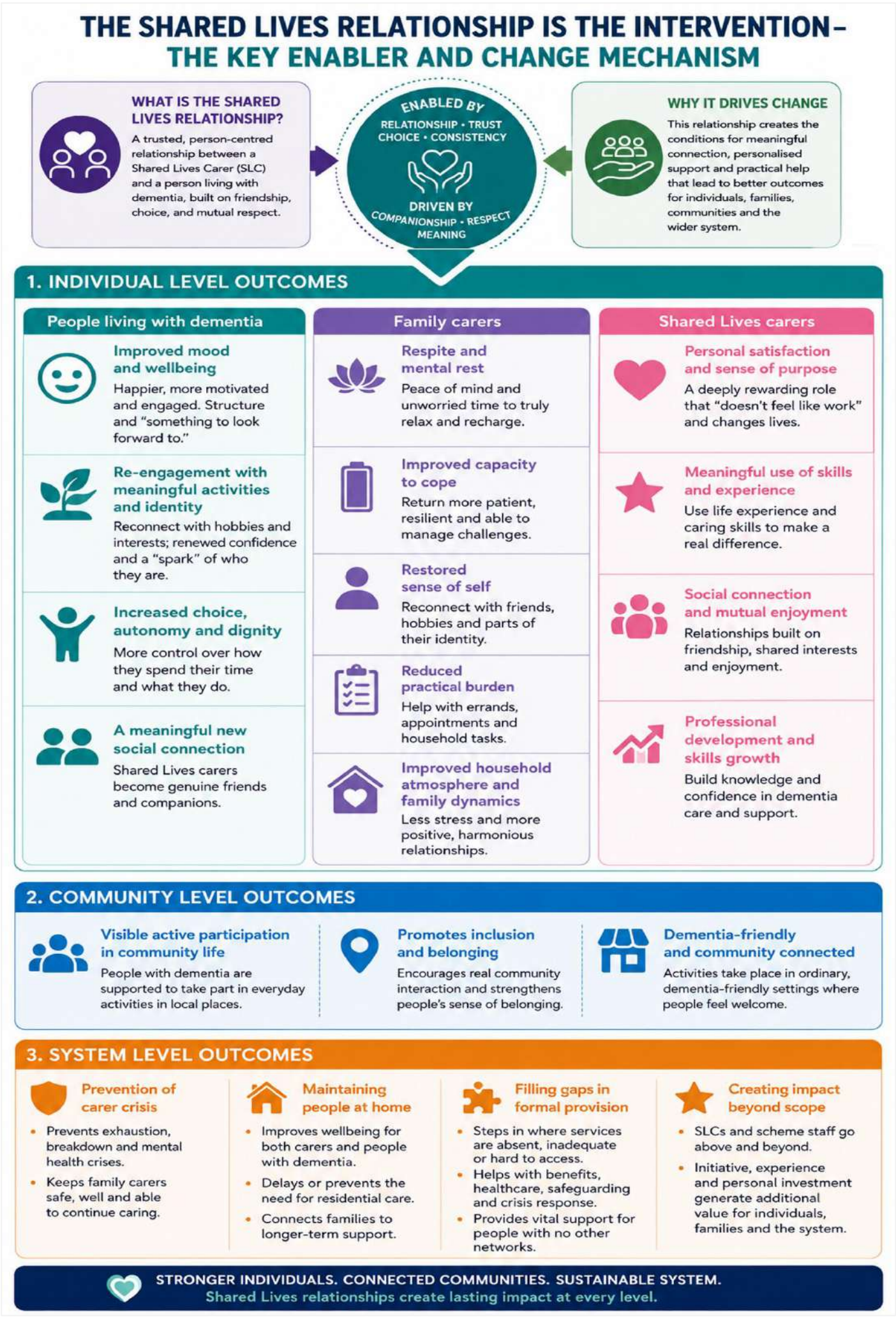



*Figure 1: Individual, community and systems outcomes of Live More*

# Introduction

## What is Live More with Shared Lives?

Live More is the name of an early action approach within the Shared Lives day support model which focuses on supporting people living with dementia and the unpaid carers who support them to stay active, connected and well, including by reaching them at an earlier stage than statutory services typically become available, given current very high thresholds of eligibility.

Live More comprises the following main features:

- People living with dementia and their family carers are identified as potential beneficiaries of Live More through primary care and community networks
- The person is referred into the Shared Lives scheme
- The scheme matches the person with an approved Shared Lives carer
- Person is supported on typically one session of day support a week
- The scheme checks in on the person, care and family to consider whether changes to support are needed

Live More aimed to test out an approach to address a well-documented challenge: the gap in pre and post diagnostic support for people living with dementia and its impact on their health and wellbeing, which in turn manifests in avoidable and unsustainable pressures on our health and care system.

Once on the way to or at the point of receiving a dementia diagnosis, people living with dementia and families are often unsupported to come to terms with and adapt to the impact that this will have on their daily lives, with 73% worried or anxious living with the symptoms of dementia[1].

This is often their first exposure to the generally unknown world of adult social care and community voluntary sector, and people are often initially left overwhelmed by a deluge of information and signposting provided to them by health and care professionals.

[1] Alzheimer's Society Personal Experiences of the Dementia Journey

Where people and families are successful in navigating these systems, often the options of support available to them are fixed, unflexible and access is variable and patchy depending on where they live. A quarter of those who know or care for someone with dementia state that they are dissatisfied with the health (25%) and social care (26%) support that is available to those who are living with dementia. 43% of people affected by dementia report feelings of loneliness and a similar proportion feel helpless.[2]

The national narrative and framing around dementia, and dementia care and support options depict an unappealing and often frightening prospect of what lies ahead, which seeds anxiety and trepidation in engaging with available options for fear of where this engagement will lead. Stigma is still impacting people living with symptoms of dementia, with two in five (42%) indicating that they have felt ashamed or stigmatised.[3]

The combination of a resulting resistance to engagement with services, and the absence of services until people's needs and the risks facing them have seriously escalated, can often lead to little or no contact with health and adult social care until people and families reach a crisis point, resulting in a crisis response by the system, typically in the form of hospital or residential care admissions. These responses result in people living with dementia being moved out of their own home environment, into one that is unfamiliar, confusing and which negatively impact their physical, mental health and wellbeing.

On the other side of this scenario is an overstretched and underfunded health and care system which often struggles to meet these crises and is only able to do at often great expense to the public purse and in ways that further divert attention and resources from prevention and earlier action.

Alzheimer's Society report that there are currently around one million people living with dementia in the UK, and this is projected to rise to 1.4million by 2040.[4] An earlier report[5] also states that there are approximately 700,000 unpaid carers supporting

[2] Alzheimer's Society Personal Experiences of the Dementia Journey
[3] Alzheimer's Society Personal Experiences of the Dementia Journey
[4] Alzheimer's Society Economic Impact of Dementia
[5] https://www.alzheimers.org.uk/what-we-do/policy-and-influencing/dementia-scale-impact-numbers

people living with dementia across the UK, with these numbers also projected to increase.

The failure of our society and systems to adapt to, support and include people and families living with dementia comes at huge cost to them, to our public services and society. For example, at present people with dementia:

- Visit GPs three times more often than people without
- Are occupying approximately 25% of acute hospital beds at any given time
- Often stay in the hospital twice as long
- Make up 70-80% of residents of residential and nursing homes[6]

Meanwhile, among family carers of people with dementia, at present:

- A third report that they spend more than 100 hours per week caring
- Seven in ten (70%) have experienced a negative impact on their daily lives because of caring for someone, often without support
- Almost half (46%) say that they spend less time doing the activities that they enjoy
- Many have also experienced a negative impact on their mental health (37%) or physical health (24%)[7]

By providing support earlier, before needs escalate, and with modest support, we set out to test that the programme will help people and families to continue living together in the place they call home for longer; strengthening their networks and improving their wellbeing.

Our hypothesis, which this evaluation reports on, was that early action Shared Lives support would improve wellbeing outcomes and reduce crises and avoidable use of more intensive services such as residential care, creating benefits for individuals, families and the wider health and social care system, and that it would be operationally feasible to achieve this.

[6] Alzheimer's Society Personal Experiences of the Dementia Journey
[7] Alzheimer's Society Personal Experiences of the Dementia Journey

The programme focused on the following outcomes:

**For people with dementia:**

- High levels of mental and physical wellbeing
- Choice and control over daily activities and life decisions
- Ability to live in their own homes for as long as possible
- Feeling that Shared Lives support has improved their social life
- Feeling connected to their communities, with positive relationships and meaningful activities
- A sense of purpose and enjoyment in daily life

**For family carers:**

- High levels of mental and physical wellbeing
- Feeling reassured and able to take time out when needed

**For Shared Lives carers:**

- Feeling well supported and fulfilled in their role

**For the health and social care system:**

- Reduced, delayed, or averted service utilisation, including GP appointments, unplanned hospital admissions, hospital bed occupancy, admission to residential care, use of residential respite, crisis support or care assessments, and fewer falls.

# 1. About the test and learn programme

## 1.1 Reaching people earlier

The Greater Manchester Live More programme's goal was to identify and provide targeted day support to around 100 people and families for an initial six-month period, while generating insight and data on its value and impact, both in terms of individual wellbeing and social return on investment.

The programme was designed and led jointly by GM ADASS and Shared Lives Plus, the national charity and membership organisation for Shared Lives, which involved engagement with the Greater Manchester Combined Authority, Directors of Adult Social Care, commissioners and Shared Lives schemes across all 10 Boroughs, GM wide partners such as NHS Greater Manchester and Dementia United, coproduction with people living with dementia and their families. All partners participated in promoting the programme and encouraging referrals, developing the proposals of each local area, distributing the ARF grant, commissioning and managing the independent evaluation, monitoring and reporting on progress and risks, and providing support and sharing best practice across the schemes.

Schemes used a mix of outreach strategies to promote the Live More programme, including email, community events, and direct engagement with health, social care and voluntary sector contacts. Figure 2 provides an overview of these key statistics and referral pathways into schemes in each area of Greater Manchester. Health service referrals, primarily memory clinics, were limited for some schemes while others reported significant success. Adult social care routes generally proved limited, likely due to the threshold-driven nature of the service and capacity pressures that reduce staff bandwidth for promoting preventative offers. Some schemes also found success through digital channels like Facebook and LinkedIn. Informal community connectors and word of mouth also played a role for several schemes.




*Figure 2: Overview of volumes of matches, supported people, referrals and referral routes by council area*

A shown in Figure 3 below as of April 2026, **schemes reported 171 referrals into Live More**, an increase from 131 referrals at mid-point of the programme in January, demonstrating continued interest and growing awareness of the offer locally.

Of these referrals, **76 progressed to matching with a Shared Lives carer**. An additional eight people were involved in the programme but either dropped out early for personal reasons, were deemed unsuitable for Live More or passed away and for these reasons have not been included in the evaluation analysis or final figures presented.

This resulted in a firm number of **69 people consistently supported through Live More** weekly day arrangements delivered throughout the pilot period.

This reflects a positive conversion rate at each stage of the pathway and that schemes successfully moved people from initial referral into meaningful, personalised support.

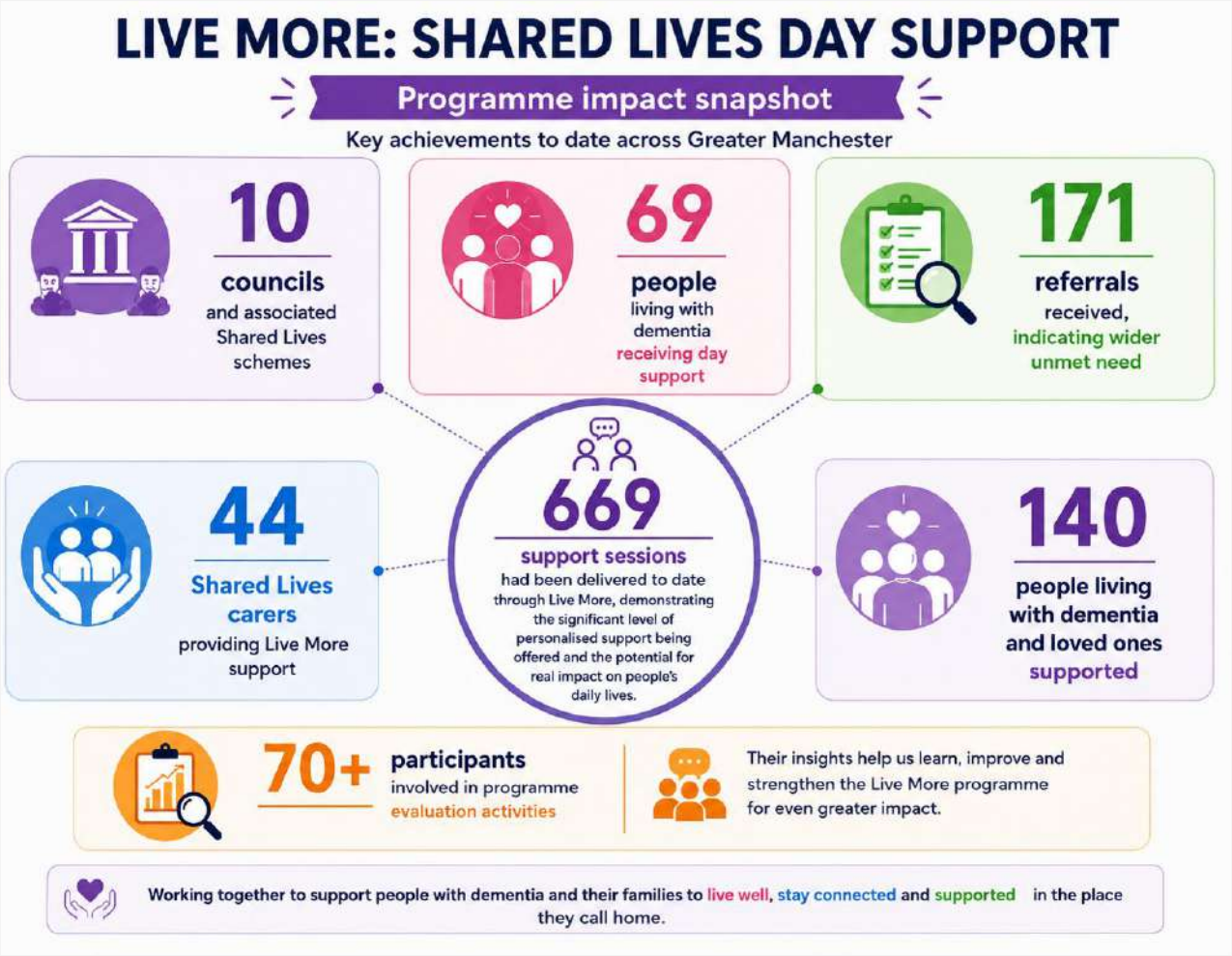



*Figure 3: Overview of key programme statistics across Greater Manchester*

## 1.2 Support focused on what matters to people

Most schemes provided one weekly day support session, although Manchester routinely offered two three-hour sessions each week. Session lengths varied from around two to six hours, with Bury uniquely supporting both people already receiving Care Act funded services and those without existing assessments. For those already receiving support, Live More provided an additional weekly session.

An analysis of these sessions identified several themes across Greater Manchester including:

- **Outdoor and community activities**, including garden centre visits, nature walks, seeing animals at the Cherwell Centre, trips to local parks, museum visits, and Coronation Street Tour outings.
- **Social outings**, such as going for coffee, lunch in cafés or pubs, visiting relatives in care homes, and attending dementia cafés or community hubs.
- **Hobbies, recreation and leisure**, including darts, pool, baking, shopping trips, watching films, attending church services, and exploring retail centres.
- **Physical activities**, such as swimming, walking, and gentle outdoor exercise.
- **Home-based companionship**, including watching TV together, looking at photo albums, reminiscence activities, conversation, and shared routines within the home.
- **Independence-building activities**, such as completing personal shopping, managing errands, supporting with appointments, and helping people maintain their own routines.
- **One-to-one wellbeing support**, including helping people re-engage with personal interests, encouraging confidence in leaving the house, and supporting people to try new or meaningful activities.
- **Access to community groups**, such as singing/memory groups, "Music in Mind" a singing memory group, and other dementia-friendly local sessions.

(As of April 2026) 669 support sessions had been delivered to date through Live More, demonstrating the significant level of personalised support being offered and the potential for real impact on people's daily lives. It should be noted that support in most arrangements continued beyond this point for a number of months.

## 1.3 The Shared Lives carers involved

A total **of 48 Shared Lives carers were matched** with and involved in offering Live More arrangements during the pilot phase. Figure 4 below shows variation in the

number of Shared Lives carers recorded as supporting (or available to support) Live More participants across the ten boroughs.

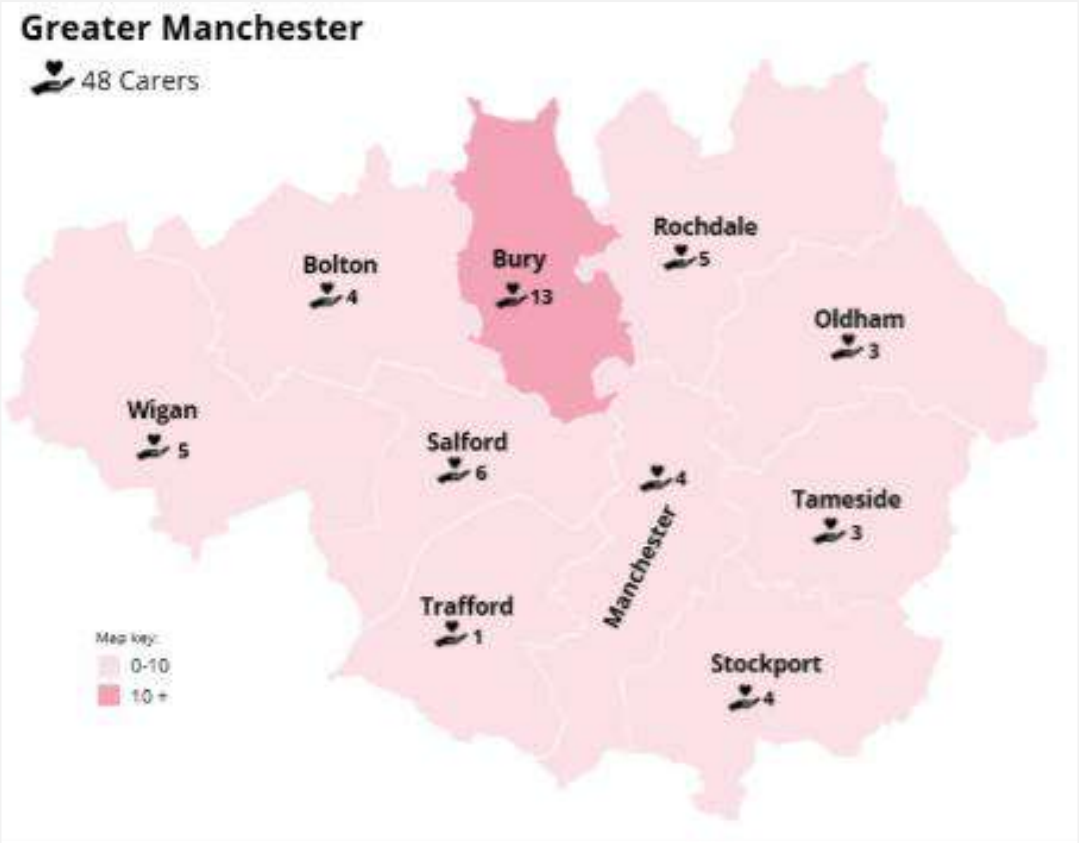



*Figure 4: Number of Shared Lives carers supporting Live More participants*

Due to the time limitations of the pilot, and the need for rapid mobilisation of arrangements to meet programme timescales, in the main schemes drew upon their existing Shared Lives carers to offer Live More day arrangements rather than recruiting to the pilot. These variations were anticipated and reflected local context, such as the size and experience of existing Shared Lives carer cohorts, how quickly schemes were able to mobilise carers for dementia-focused day support, and the pace at which referrals progressed into arrangements.

The map highlights where capacity was already strong and where additional support may be needed to grow and sustain carer involvement, particularly where demand is rising but carer recruitment, confidence, or availability remains a constraint.

This approach tapped into Shared Lives carers capacity alongside their existing live in, short breaks or wider day support arrangements. An overview of how the types of Shared Lives support already provided by carers is outlined in Figure 5 below.

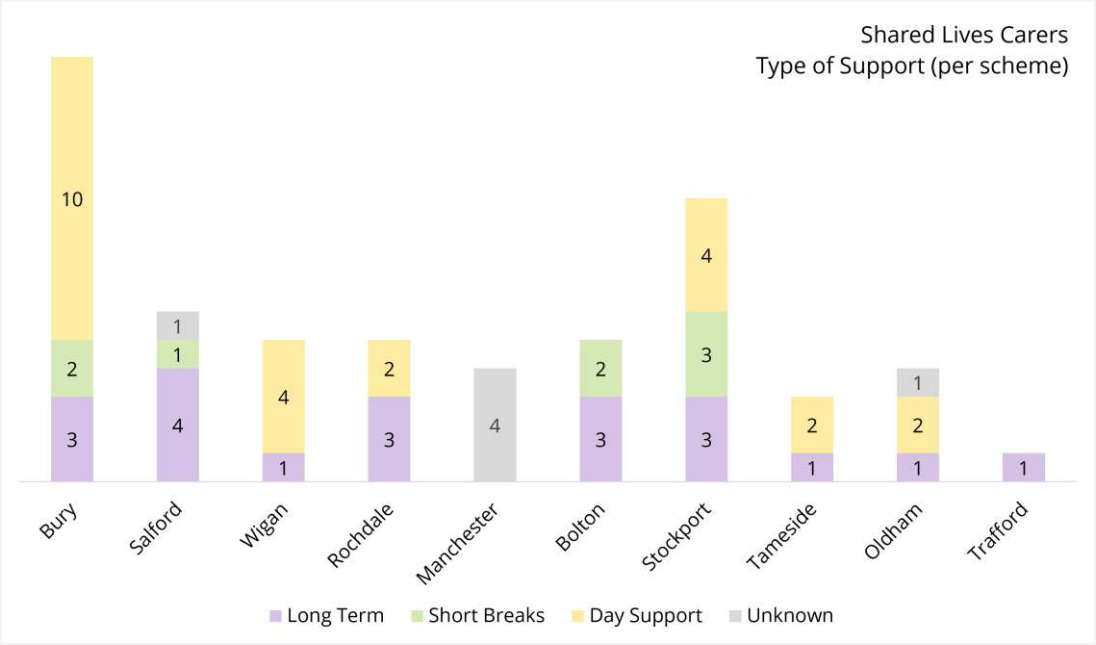



*Figure 5: Overview of Shared Lives carers existing types of support provided*

Interestingly, our analysis shows that under half of these carers previously provided day arrangements prior to this pilot, which shows an evolution in the range of support offered generated through Live More programme activity.

Programme activities also saw the recruitment of a small number of new Shared Lives carers, specifically recruited to provide Live More support initially, many of whom aim to continue providing Shared Lives support, through day arrangements but also progressing to providing short breaks and live in support as their confidence grew.

## 1.4 How was the programme evaluated?

The evaluation was couched within a theory-based approach to evaluation, which focuses on understanding the **mechanisms and causal pathways** that link an intervention to its outcomes, rather than solely measuring results. An evaluation Theory of Change was co-designed at the outset of the programme to provide a clear framework for capturing evidence as outlined in Figure 6 below.

We introduced this approach at an in-person workshop in Manchester on 24 September 2025, attended by stakeholders involved in programme governance, the evaluation team, scheme leads, and people with lived experience. This session was the first opportunity to present the evaluation design and gather feedback, which helped

shape the development of data capture tools and ensure they felt practical and inclusive.

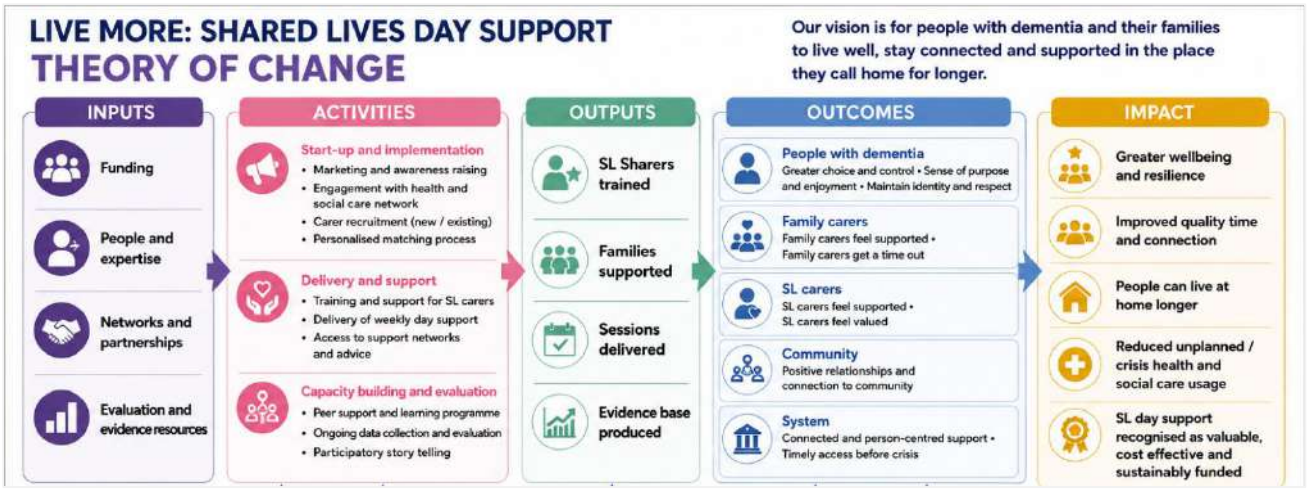



*Figure 6: Live More Evaluation Theory of Change*

In relation to this Theory of Change, data was collected through three strands of activity:

**Storytelling:** the voice and experience of people directly benefiting from Shared Lives Live More support has sat at the heart of this programme. Early experimentation sought to capture this through self-reported 'digital scrapbooks', which later evolved into structured story capturing interviews in the second half of programme delivery, quotes from which have been interweaved through this report.

**Process analysis:** led by Sanah Sheikh, an independent researcher and evaluator who conducted a review of key programme documents, as well as carried out wide scale 1-1 and group interviews with each key programme stakeholder group, at the outset and towards the end of the pilot period, including; people living with dementia, loved ones, Shared Lives carers, Shared Lives scheme staff, Greater Manchester strategic leads, Shared Lives Plus project delivery team and referral partners across the sub-region.

**Social return on investment (SROI):** led by Colligo Labs, providing an independent economic evaluation which aimed at capturing both the human and financial case for Live More. This involved drawing on self-reported outcome data from people living with dementia, loved ones and Shared Lives carers at the outset of the programme and again towards the end of the pilot period, to capture the change attributed to their

lives from the Live More intervention. As well as analysis of local and national evidence papers and datasets to determine the economic and wellbeing impacts.

**These strands are closely connected and support each other**: stories provide context for quantitative findings, process insights explain why outcomes occur, and economic modelling translates impact into financial terms. Together, they have created a rich, balanced evidence base.

**The wider challenge of measuring prevention:** Measuring early action and prevention is markedly a challenging task given that the aim is to measure the counterfactual and is often hindered by a disconnect between health and care system partnership and data sharing. This programme set out to develop an evidence base by drawing on a range of approaches, rather than relying on a single evaluation approach, to develop a robust foundation of evidence and learning.

**Pilot limitations:** The pilot was set up explicitly as a test and learn initiative. The duration was defined as a six-month period, which aimed to give a long enough timeframe to capture measurable change and to carry out evidence building evaluation activities. However, it was recognised that the limited timeframe would provide limited evidence regarding the sustainability of changes. In addition, despite schemes making every effort to mobilise quickly, there were delays in the starting of Live More arrangements due to challenges in generating referrals, in finding suitable Shared Lives carer matches, and in families needing more time to ease into arrangements. This shortened the evaluation period to a maximum of five months for most arrangements, and with some starting later, meaning that measuring the impact of Live More for a proportion of arrangements was less robust. The programme was also limited in accessing localised social care and health records. To mitigate some of these limitations the evaluation applied to the pilot the learnings from a survey of the wider academic literature on similar interventions.

# 2. The impact and outcomes of Live More

The impact and outcomes findings presented in this section are drawn primarily from in-depth qualitative interviews and storytelling with ten families and seven Shared Lives carers involved in the Live More programme. Together, these interviews provide rich, detailed accounts of how the programme has affected people's lives across individual, community and system levels. Where appropriate, these findings are reinforced and extended by findings from two workshops held with referral partners and interviews with scheme and programme managers at all ten schemes. These provide a professionally and operationally grounded perspective, particularly on cost, prevention and system value.

These qualitative findings are reinforced by analysis of 90 at the baseline and 114 exit surveys completed by the three core participant groups. Measured across a range of established wellbeing domains, the survey results provide a quantitative dimension that complements and strengthens the qualitative evidence presented throughout this evaluation.

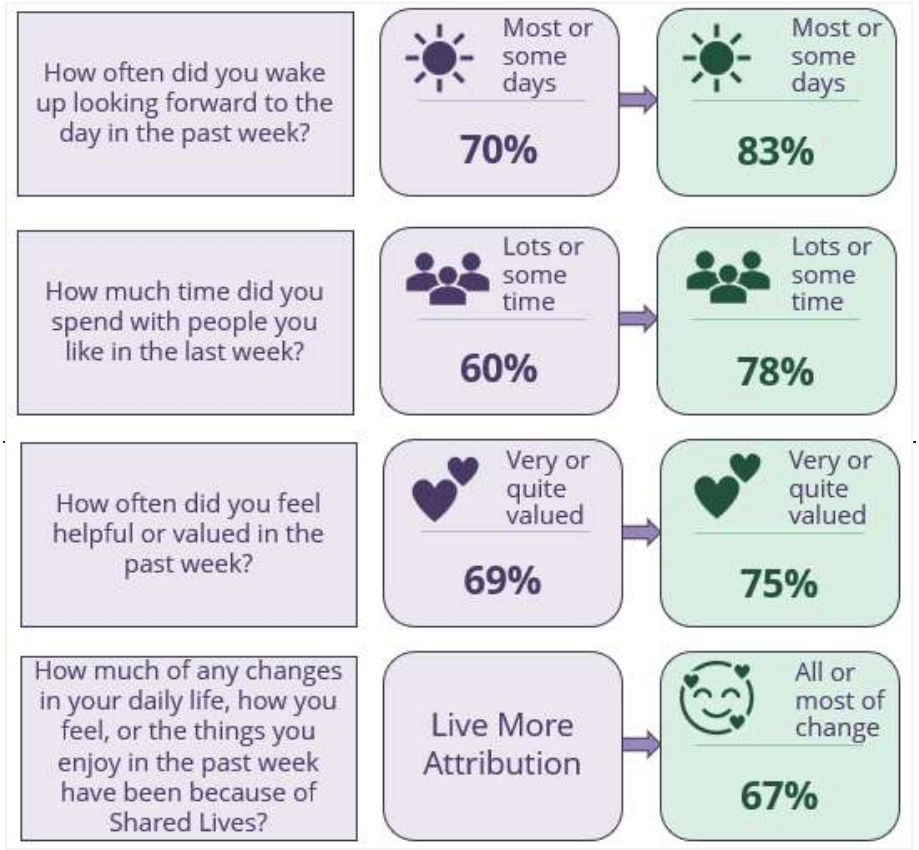
The findings are organised by outcome level - individual (people living with dementia, family carers, and Shared Lives carers), community, and system - reflecting the breadth of impact that the programme has generated across different dimensions of people's lives.

It is important to note that the interviews with families and Shared Lives carers represent a small subset of the larger group of people who took part in the Live More programme across Greater Manchester. It is important to acknowledge that those who took part in interviews may not be fully representative of all participants. Families who were more engaged with the programme, or who had more positive experiences, may have been more willing or able to participate. At the same time, the consistency of the themes gives confidence that the findings reflect genuine and widespread patterns rather than isolated experiences.

# 2.1 Individual level outcomes

## Individual outcomes for people living with dementia

### *Baseline vs exit outcome survey measured change*




*Based on 30 baseline surveys and 40 exit surveys*

**Improved mood and wellbeing**

The most consistent impact of Live More was a reported improvement in mood and emotional wellbeing. Families described people living with dementia as happier, "*more upbeat*" and "*really smiling*" after spending time with their Shared Lives carer, while carers described sessions filled with smiles, laughter and enthusiasm.

These changes were particularly noticeable where families described their loved ones as having become people isolated or withdrawn. One family carer described how their parents had become "*stuck in a bubble*", whereas now his mum returned "*a bit more sprightly really*" and his dad was pleased because "*he can see she is happier*." Another

family carer reflected that her husband was "*more upbeat, more happy in himself*" rather than spending much of his time sleeping.

Several Shared Lives carers described people initially reluctant to accept support becoming genuinely enthusiastic. One reflected that the lady she supported had "*done a 360 degrees turn and really enjoys it now!*" while another said, "*the highlight of her week is me.*"

Families also described benefits extending beyond the sessions themselves. Families said their loved ones looked forward to visits, marking them on calendars, getting ready early and talking about them throughout the week. One family carer explained the sessions "*rejuvenate*" his wife for the rest of the week, giving her "*something to look forward to*" and restoring some routine and purpose.

**Re-engagement with meaningful activities and identity**

Families described how Live More enabled people to reconnect with hobbies, interests and aspects of their identity that dementia had diminished. Activities were tailored to individual interests, including shopping, gardening, dancing, DIY, swimming and nature walks.

Families described seeing a "*spark*" of the person they remembered. One husband rediscovered his love of nature and "*keeps talking about trees!*", while another regained confidence through DIY, which "*gave him a sense of achieving something*."

Shared Lives carers deliberately personalised activities around people's history, interests and abilities. This flexibility contrasted with more structured day services, where activities were fixed rather than shaped around the individual.

**Choice, autonomy and dignity**

A defining feature of the programme was enabling people to make choices about how they spent their time. Shared Lives carers consistently asked people what they wanted to do, helping preserve independence, dignity and control.

Families accounts indicated that they valued this highly: "*It gives her that feeling of being in charge a little bit as well.*" One person living with dementia reflected, "*She doesn't tell me I have to do this... it's doing what I want to do.*" Many contrasted this with more task-focused services where decisions were made for them rather than with them.

### Meaningful social connection

For many people, Shared Lives carers became genuine companions rather than care workers. Families consistently described them "*like a friend*" or "*a neighbour*" who came to spend time together.

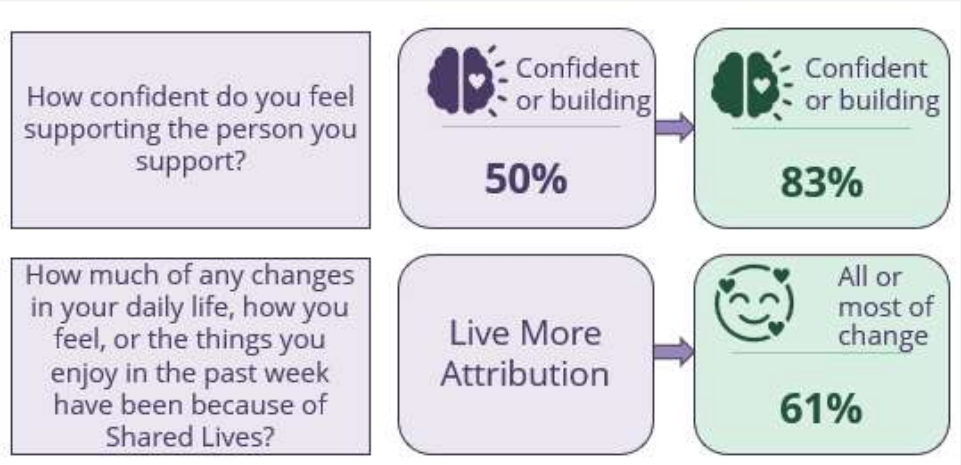
For people whose social worlds had narrowed through dementia, this represented an important new relationship. One woman explained, "*She feels more like a friend or neighbour coming to see me*", while another family said their mother "*tells people she has a friend now.*" One husband's description of his Shared Lives carer as a "*good mate*" was, for his wife, "*music to my ears.*"

This experience of friendship distinguished Live More from formal services and helped people engage with support without feeling they were becoming dependent.

## Individual outcomes for family carers

***Baseline vs exit Outcome survey Measured change***






*Based on 28 baseline surveys and 39 exit surveys*

**Respite, resilience and restored identity**

The strongest and most consistent finding across the research was the value that family carers placed on having genuine, unworried quality time to themselves during the day support sessions. The language used was highly evocative. *“Peace of mind”* was a near-universal phrase. They described being able to *"recharge"*, *"switch off completely"*, have their mind *"at rest"* and for many this was the first time in months they had felt genuinely free of the mental weight of caring, even briefly. In this sense, Live More provided family carers with much valued and valuable psychological respite, not just physical ‘time out’.

This was not simply because they had a break from their caring responsibilities for a few hours but because they knew their loved one was safe and happy, doing something meaningful with someone they knew and trusted. As one carer explained, "*I don't have to worry about him… I trust [the Shared Lives carer] implicitly.*"

A theme that was closely linked to mental rest and quality respite time was the way in which the programme improved family carers capacity to cope and sustain their caring role. Many described returning more patient, resilient and emotionally able to cope. One reflected that the sessions "*re-energise me to carry on*", while another said they gave her "*the strength to cope.*"

Another key and meaningful impact of the programme was the way in which family carers described being able to reconnect with interests, learn new skills, friendships and aspects of themselves that had become displaced by the demands of caring.

Several described this rediscovery as unexpected and significant. One family carer reflected on being surprised "*that just being able to see a friend for a coffee would make such a big difference, but it really has."* This suggests that families experienced this protected time not simply as leisure, but as restoring a sense of self and a recognition that carers have legitimate needs of their own: *"I'm able to make plans with friends, regain a sense of normality and feel like her old self again."*

**Reduced practical burden and improved family life**

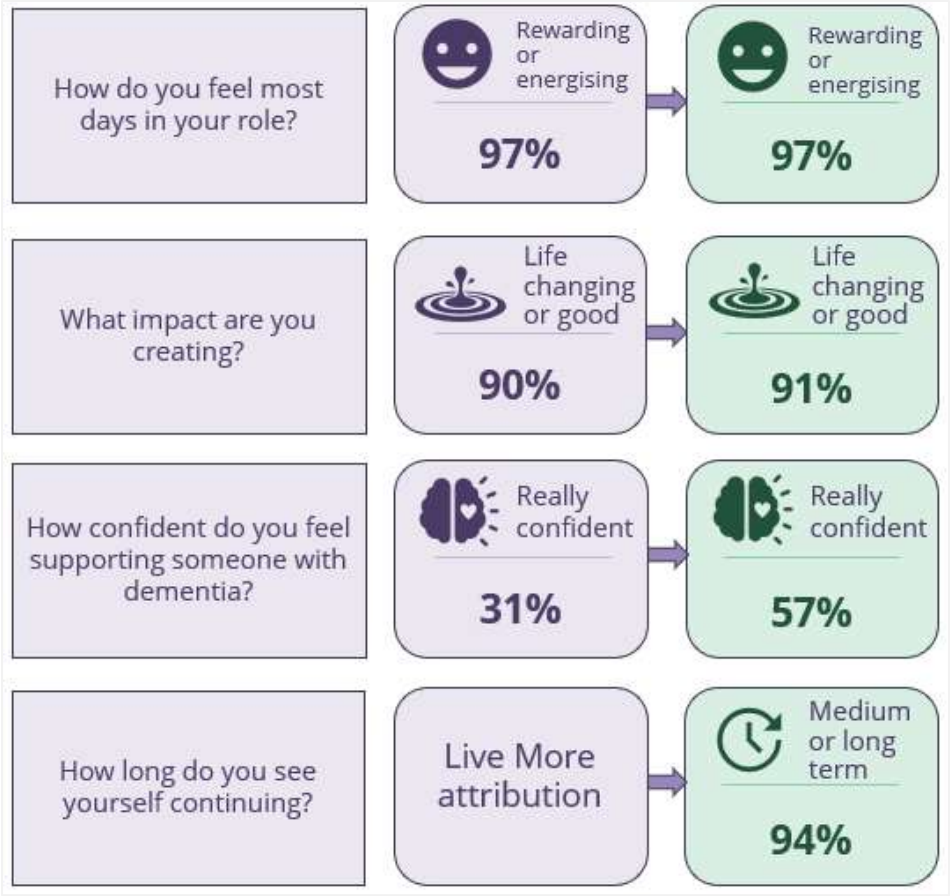
Shared Lives support also eased everyday practical pressures. Family carers described help with shopping, appointments and errands by Shared Lives carers, with one returning home to find "*The shopping's away in the cupboards... a relief, and a pressure off me.*" Some described how their inability to simply leave the house to run errands without worry had become one of the most wearing aspects of their daily lives, adding practical frustration to emotional strain.

Reduced stress for family carers, combined with improved wellbeing for the person living with dementia, created calmer households. One couple reflected, "*We're not bickering at each other*", while another family said the weekly sessions "*create a little more spice*" in family life. Several described wider benefits for the whole family, calling the programme "*such a lifeline*" with "*that knock-on effect*" extending well beyond the primary carer.

This was also corroborated by Shared Lives carers who described taking the people they support to GP appointments, hair appointments, hospital visits, that would otherwise have required family carers to take time off work or reorganise their schedules. From the Shared Lives carer's perspective, this was just a natural extension of their role: they were with the supported person anyway, had transport, and could fit these tasks into the time they were spending together: *"It's a big relief... the daughter works, and the other lady's daughter works as well - they were taking a lot of time off, where I can do that."*

## Individual outcomes for Shared Lives carers

***Baseline vs exit outcome survey measured change***




*Based on 32 baseline surveys and 35 exit surveys*

### Personal satisfaction and sense of purpose

Shared Lives carers consistently described the role as deeply rewarding. One said, *"I just get so much from this role... it's just such a rewarding job,"* whilst many said, "*it doesn't feel like work*" and valued the opportunity to make a meaningful difference more than the financial reward. Feedback from families, including "*You've just changed my life*", reinforced this sense of purpose.

### Meaningful use of time, skills and life experience

Another key outcome is the extent to which the programme enables Shared Lives carers to make meaningful use of their time while drawing on their existing skills and life experience. The role is described as a fulfilling way to spend time, particularly

for those who are retired or seeking flexible work, providing structure, activity and a sense of ongoing contribution: "*I'm not quite ready for giving up yet… it lets me still do something useful while winding down from full-time work.*"

**Social connection and mutual enjoyment**

Several Shared Lives carers described the relationships they formed with families as genuinely mutual - characterised by warmth, humour and camaraderie – that emerged naturally from spending time with someone and focusing on what they enjoyed. Carers said they *"bounced off one another,"* enjoyed *"the camaraderie we have,"* and some intended to continue visiting after the pilot because *"It's gone from support to friendship."* These findings were also reinforced by several schemes. For example, one scheme manager described a Shared Lives carer who had developed such a strong relationship with the family that he was keen to continue visiting as a friend after the pilot ends: *"He sees him as a friend… I can't just not go, he said, 'if they want me going, I'll just go with me own time'."*

**Professional development and skills growth**

Many Shared Lives carers described how the programme has supported their professional knowledge and skills, particularly those for whom working in the family home or with people with dementia was new. For example, one Shared Lives carer described learning from observing the dynamics of family life, understanding the pressures on family carers in a way that his previous work had not required, and developing skills in supporting both the person with dementia and their family simultaneously. For another Shared Lives carer each new opportunity was an opportunity for professional learning - skills to be *"picked up along the way"* that would be applicable in future roles.

## 2.2 Community level outcomes

**Visible active participation in community life**

The programme helped people with dementia reconnect with everyday community life through ordinary activities in public places accompanied by someone who related to them like a friend.

Shared Lives carers described how they actively tried to encourage choices that maximised genuine community interaction and encouraged independence and belonging, with one explaining, *"He's feeling more independent, more in with the community,"* while another revisited places where *"they all played football together."*

The selection of dementia-friendly venues by another Shared Lives carer reflects a different but related approach - choosing environments where staff understand dementia and the atmosphere is appropriate, while still being everyday public, community spaces. These experiences can help reinforce people with dementia's sense of belonging and cumulatively, contribute to a community in which they are present, active and visible.

## 2.3 System level outcomes

**Prevention of carer crisis**

The strongest system-level finding was that Live More contributed to preventing family carers from reaching crisis, thereby preventing, delaying or reducing the need among family carers for more acute and costly health and social care services. Several believed they would have experienced serious breakdown without the programme, saying "*Without it I would have snapped... total emotional and physical collapse*" while another man vulnerably acknowledged *"If I was doing this 24/7 non-stop... I'd be suicidal. It destroys you."* Another lady described how she probably would have visited her GP in crisis and "*been back on antidepressants."* They did not describe this as a possibility or a worry - but instead as the likely outcome without the programme.

These findings were also corroborated by referral partners and scheme managers and staff. For example, some referral partners described families at or near crisis point at the point of referral - one case involving a physically exhausted wife whose husband has dementia and who is also managing a daughter with aggressive cancer: "*We feared if the wife didn't get a break, she wouldn't be able to care for her husband anymore."* Similarly, one scheme manager described *"carers who had felt suicidal, now having enough respite and support to keep going - three-hour sessions costing about £36 helping to prevent people 'giving up'."*

### Maintaining people at home

By improving both carers' resilience and the wellbeing of people with dementia, the programme has the potential, as established through the wider literature, to help people stay living at home and delay the point at which more intensive or residential care becomes necessary.
Family carers who indicated in their accounts that they could not have continued without the programme are continuing to support their partner or family member with dementia – they are enjoying quality respite time, and coping better mentally, emotionally and practically. At the same time there is also another mechanism at work. Several families described improvements in their loved ones emotional and physical wellbeing - greater energy, renewed interests, even improved fitness. In some cases, the improvement was striking enough to prompt families to reflect on the contrast with where their loved one had been before the programme began: *"Mum is more sprightly really, given her a new lease of life. Before, was just getting worse, sitting on the couch all day."*

Some schemes also described specific ways in which the support has helped maintain people at home by connecting them with other forms of support. For example, one scheme related how through the programme families were able to recognise their own unmet needs, were supported to approach social services, and whose hours were subsequently picked up as permanent commissioned provision. Similarly, another scheme described a specific case where the number of hours of support were being increased and funded by Adult Social Care specifically because the existing Shared Lives carer relationship made this viable: *"With her husband living with her, he will need some more sessional support. So, they're asking us to do it because our carers, our companion, know the person quite well... This would prevent and delay supported person going into 24-hour residential support."*

### Filling gaps in formal provision

Another distinct system-level finding is the extent to which Shared Lives carers and scheme staff step into spaces where formal services are absent, inadequate or not designed to reach - and do so in ways that go well beyond the programme's formal scope. This includes benefits navigation, crisis response, safeguarding, accessing health and social care networks, and ongoing safety monitoring for people without other networks.

Shared Lives carers describe helping families access entitlements and manage health situations that formal services had not addressed.  Some have helped families complete applications for and access Carers Attendance Allowance and Universal Credit. One resolved a tax debt of £1,500 for a woman she supports through negotiation with HMRC. A referral partner described how a Shared Lives carer had supported a woman consistently attend GP appointments that she kept missing due to her forgetfulness, which ultimately resulted in the diagnosis of a mental health condition that would otherwise have been missed. Scheme staff then acted as a bridge to appropriate services, alerting the mental health team: "*Our detective work enabled us to work in partnership with the council… this lady needs a different kind of support*." As the referral partner reflected, without the Shared Lives carer and scheme support "*she would have fallen through the cracks."* Another scheme manager described how two cases of confused and agitated behaviour in supported people was identified by the scheme as a possible UTI and referred for a urine check, which confirmed the infection in both cases: *"That's really quite positive that we've been able to give practical things to families who aren't from a naturally caring background. They've just started to become carers."*

Whilst Shared Lives operates predominately from the Shared Lives carer's home, Live More adapted to start introductions initially in the familiar environment of the person with dementia's home, to build their trust and relationship, focussing on doing things they enjoy in the community, with the aim of visiting the Shared Lives carer's home as the relationship progressed. At earlier stages of this pathway, Shared Lives carers sometimes described arriving to find the people they support in crisis; a flooded house with blown electrics, a severe hoarding problem, and a serious mental health deterioration that required calling 111 and setting up an emergency GP appointment that would not have been noticed or addressed without their presence. This was also reinforced by scheme managers and staff. One scheme manager described how a Shared Lives carer arrived at a supported person's house to find her on the floor after a fall - a discovery that would not have happened until the daughter returned from work*: "Now, if she hadn't gone in that day, that lady would have been on the floor until her daughter came home later in the day."* This is particularly true for people living with dementia who are living alone and/or have little family network. The Shared Lives carer may be the only person visiting regularly enough to see when something has gone wrong. As one Shared Lives carer reflected: *"There's absolutely nobody else… she has a named social worker, but that's not always there when she needs it."*

The programme is therefore creating impact and value beyond its scope and is doing so through not only the relational model of Shared Lives but also the initiative, professional experience and personal investment of Shared Lives carers and Shared Lives scheme staff.

# 3. Social return on investment

This section of the report outlines the findings from the independent analysis carried out by Colligo Labs to determine the social return on investment (SROI) of the Live More programme. It provides a comprehensive economic evaluation of both the human and financial case for Live More using the UK Government's standard approach as outlined in the HM Treasury's Magenta Book[8] and Green Book[9]. Colligo Labs' full report and supporting presentation is available on request.

The section sets out the methodology, the key findings, and the limitations and considerations that should shape how the analysis is read; aligned throughout to the programme's Theory of Change. This begins with the person with dementia, ripples out to the family carer and is realised more slowly by the wider health and care system.

## 3.1 Overview of economic evaluation methodology

The SROI evaluation draws on established HM Treasury methodology and is framed as both an evaluation of the programme as it ran and an appraisal of the likely programme outcomes should it continue:

- **The Magenta Book** governs the evaluation of the programme, at the cost it actually incurred, against a modelled counterfactual.
- **The Green Book** governs the appraisal of a continued service, costed at an estimated sustainable rate for the service. Both are reported side by side; the Green Book figure is treated as the more cautious, decision-relevant headline.
- The evaluation of the programme was projected out over a five-year period and is presented as a Net Present Value. Costs and economic benefits are discounted at the Treasury's standard rate of 3.5% and wellbeing benefits at 1.5%. The five-year period is chosen to match the period across which the modelled effects play

[8] https://www.gov.uk/government/publications/the-magenta-book
[9] https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-government

out while remaining proportionate to the strength of the evidence as required by the HM Treasury's approach.

## How wellbeing was measured

Wellbeing sits at the centre of the Live More Theory of Change and hence of the evaluation.

- Three pictorial surveys, one each for the person with dementia, the family carer and the Shared Lives carer were carried out at the beginning and again after the service had been running for several months.
- Every well-being question maps onto one of the four nationally recognised well-being dimensions; **Life Satisfaction, Worthwhile, Happiness, Anxiety/Calm**.
- The surveys were designed to ensure that the assessment of the personal wellbeing was built from several questions which reduces the error in a single question.
- The attribution of any change due to the Live More programme was explicitly measured rather than assumed.

This allowed the evaluation to build a well-established assessment of economic benefit of wellbeing known as a WELLBY[10] (Wellbeing-Adjusted Life Year) and set out in HM Treasury's Wellbeing Guidance for Appraisal.

## Other costs and benefits

The evaluation also looked at the additional costs and benefits to the health and social care system using both:

- The data captured during the programme.
- The unit costs from the NHS England Adult Social Care Finance Returns, ONS data on median care-worker wage, and the results from relevant robust peer-reviewed academic and clinical papers.

The relatively small sample size and short timeframe of the programme limited the ability to fully capture the effect on costs and benefits particularly for the public purse. Nevertheless, there is strong evidence drawn from the surveys, interviews,

[10] https://www.gov.uk/government/publications/green-book-supplementary-guidance-wellbeing

storytelling activities and related wider academic literature that the programme would support individuals being able to stay at home for longer.

The Theory of Change identified other potential benefits to the system including reduced, delayed or averted GP visits, unplanned hospital admissions, and crisis support. However, in the absence of links into the appropriate Local Authority and NHS data sets, these potential benefits cannot be linked to robust data and hence have not been included but have been referenced in wider qualitative findings elsewhere in this report.

## Stress testing and the Markov Model

The evaluation has been tested by a well-established statistical technique, the bootstrap, built on the Markov Model representing the dementia pathway as outlined in Figure 7 below.

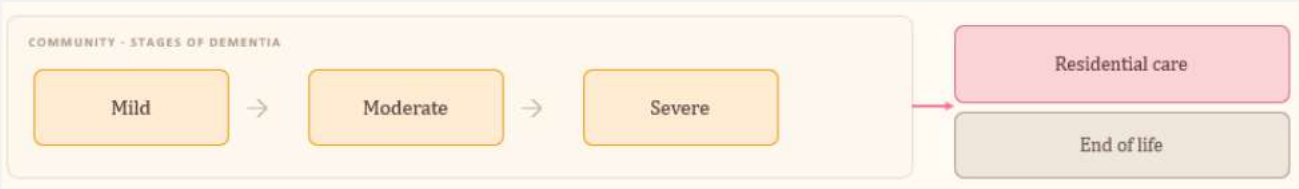



*Figure 7: Markov model representing the dementia pathway*

The Markov Model is a series of states taken from clinical literature presented as mild, moderate, and severe dementia lived in the community or residential care through to end-of-life, with the probabilities of moving through the various states taken from published evidence.

This independent evaluation was subjected to a number of tests, each aimed at different areas of uncertainty:

- Bootstrap resampling recalculated the analysis ten thousand times
- Where wellbeing valued at the low-end range
- Where wellbeing assumed to fade quickly
- By removing the single most influential respondent

Drawing on these approaches, it is possible to deliver a robust conclusion of the evaluation whilst recognising the fact that the analysis is built from a relatively small group of people.

## 3.2 Key SROI findings

### Wellbeing value

A WELLBY values a one-point change in life satisfaction, per person, per year. HM Treasury guidance provides a range of values for the WELLBY. The report uses the central value of £13,000 in 2019 prices, uprated to about £16,446 in 2024 prices, then discounted at 1.5 per cent. The table below shows the overall wellbeing point changes, across the four wellbeing dimensions and a collective score.

| **Dimension** | **Person** | **Loved one** | **Carer** |
|---|---|---|---|
| Life Satisfaction | +1.111 | +1.667 | −0.606 |
| Worthwhile | +1.481 | +0.833 | +0.152 |
| Happiness | +1.852 | +0.833 | +0.909 |
| Anxiety/Calm | +0.648 | +1.667 | +0.152 |
| **Collective** | **+1.273** | **+1.250** | **+0.152** |
| Attribution | 0.708 | 0.577 | 0.682 |
| **Wellbeing Value** (across the programme) | **£2.10million** | **£1.54million** | **£0.16million** |

To calculate the value of this improvement in wellbeing the evaluation takes a conservative approach, strictly following HM Treasury guidance. Only the share of the wellbeing improvement which is directly attributed to the programme is considered and the wellbeing gain is assumed to decay year on year, at a rate grounded in the established evidence on the length of time the benefits of dementia and carer interventions last before applying the HM Treasury's discount rate.

The overall assessed value for wellbeing of £3.8million as shown in the table above.

## Cost benefit ratio

The detailed SROI evaluation of the Live More programme provides a clear assessment of both:

- What the pilot delivered - Magenta Book
- What a continued version is likely to return - Green Book

In both cases the programme produces a measurable improvement in the wellbeing of the people it served, the people living with dementia and the family carer.

This improvement is the largest part of the social return representing **£5.96 analysis for each £1 spent using the more cautious Green Book appraisal** basis and **£8.45 for each £1 spent using the Magenta Book evaluation of the pilot.** A breakdown of this assessment is outlined in Figure 8.




*Figure 8: Breakdown of benefit to cost ratio across Magenta Book evaluation and Green Book appraisal*

*In plain terms: every £1 invested in Live More returns close to £6 of social value on the cautious appraisal basis, and over £8 measured against the pilot's actual cost*

## Breakdown by domain

The composition of this total is the clearest expression of the Theory of Change: value is created overwhelmingly through wellbeing, and within that, overwhelmingly for the person and the family carer around them, with system savings a smaller and slower-maturing share.

Focusing on the more cautious Green Book appraisal:

- The overall present value of benefits over a five-year period is **£4,329,434**
- Against a present value cost of **£726,301**
- A net social value of **£3,603,133**

The breakdown of the net present social value across key domains is outlined in Figure 9 below as aligned to the Theory of Change.

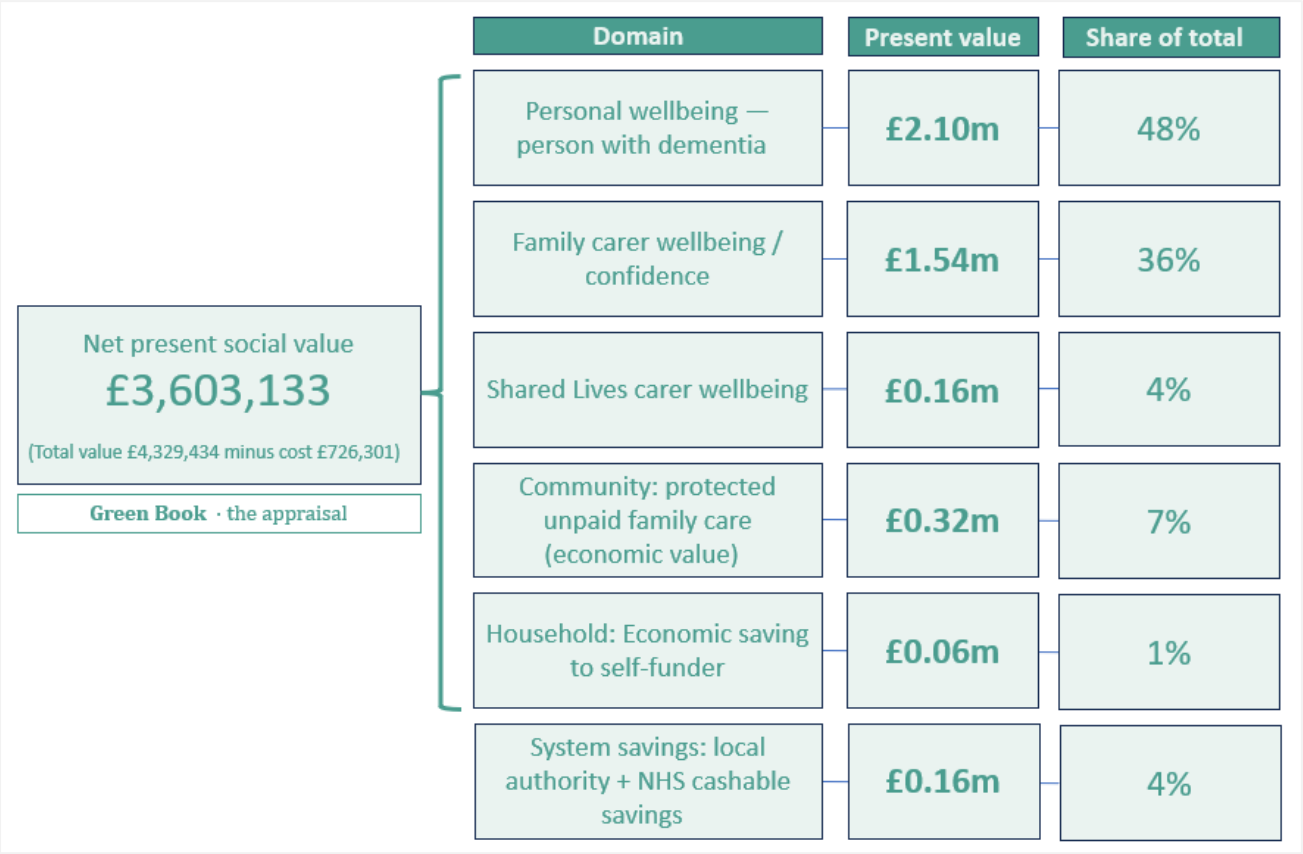



*Figure 9: Net social value breakdown across individual, community and system levels*

Wellbeing accounts for approximately 88% of total value, consistent with Live More's design as a relational rather than a task-based service. System savings are real but modest within the five-year window, because they arise from deferring - not

preventing - admission, and a five-year horizon from a six-month pilot capture only the early part of that curve.

## Time at home and the placements it defers

The valuation confidently identified that the programme would delay the requirement for individuals to move into a care home. This conclusion is drawn from peer reviewed literature evaluating similar projects and applying the results to this programme[11].

A range was established, all of which identified a small but significant delay. The central case is that 2.7 care home placements would be deferred over the 5 years with individuals collectively spending an extra 6 years at home. A deferred care home year is a single event, but the money it saves does not come out of one budget. Care home places are funded by a mix of the council, the NHS and the family, so avoiding a year of care saves each a share.

One avoided care home year is worth about £40,432 across Greater Manchester as reported by NHS England in their Adult Social Care Finance Return 2024/25, the cost of which would be borne by the Council (53%), the NHS (21%) and by Households/Families (27%).

Overall, the direct cashable savings that have been identified by the study is modest, but it could be considered a conservative minimum. A continued service may be able to evidence more savings as it grows with time and with better data, notably linked to Digital Care Records and other Local Authority or NHS data.

## Stress testing results

The key findings from the evaluation can survive every stress that is applied to it:

- 98% of 10,000 resampled recalculations return more than they cost
- Under no reasonable assumption does the overall evaluation fall below a value of £4.8 for each £1 invested

[11] Gaugler, J.E., Reese, M. and Mittelman, M.S. (2013) 'Effects of the NYU caregiver intervention on assisted living and nursing home placement', The Gerontologist, 53(6), pp. 985-997.
Andrén, S. and Elmståhl, S. (2008) 'Effective psychosocial intervention for family caregivers lengthens time before nursing home placement of people with dementia: a five-year follow-up study', International Psychogeriatrics, 20(6), pp. 1177-1192

## 3.3 SROI – limitations and considerations

An independent evaluation earns its conclusions by being explicit about what it cannot yet show, as much as by what it can. The following limitations should be read alongside every figure in this section.

- **Sample size and long-term outcomes not yet realised**. The wellbeing valuation rests on matched baseline-and-follow-up survey responses. Whilst all the survey data has been used to inform other parts of this report, the independent economic valuation relied on those baseline and follow-up surveys that could be explicitly linked and hence changes from the programme directly identified. This represented nine people with dementia, eight family carers and eleven Shared Lives carers. At this scale, no single group's average change is statistically significant on its own, though the finding is robust in aggregate. The slower system outcome that the programme targets - delayed entry to residential care - unfolds over years that the six-month pilot could not itself observe and is instead modelled from peer-reviewed academic and clinical evaluations of comparable interventions, applied to this cohort through a calibrated model of dementia progression.

- **Variation in the length and intensity of support offered.** Matches were established at different points during the pilot and depended on local referral volumes and carer availability; where referral pools were thin, matching (and therefore the strength of relationship and outcome) was less consistent. This variation is carried through honestly in the interview evidence rather than smoothed away and is one reason the programme-level result is read as an aggregate finding rather than a guarantee for every arrangement.

- **The limits of a six-month pilot, and what longer tracking would add.** A single-year (six-month delivery) pilot without a control group can establish wellbeing change and the mechanism behind it but cannot reliably establish changes in wider health and care service use (GP contacts, unplanned hospital admissions) - the survey data collected for this purpose was too sparse to support an estimate and has been excluded from the SROI headlines rather than used to construct a saving the evidence cannot bear. The single most valuable extension to this evidence base would be a longer, larger evaluation using a

validated dementia wellbeing instrument (e.g. QOL-AD or DEMQOL) against a comparison group, ideally in collaboration with the NHS to track linked service-use records over time

- **A narrow cohort**. The people supported were largely at an early stage of dementia, overwhelmingly White British, and in the main living with a co-resident family carer. The findings should be read as evidence for early-stage, co-resident households specifically, and the reach of the model to more diverse communities and to people living alone who may need it most, remains mostly untested by this pilot.

- **Fees paid to Shared Lives carers**. The programme surfaced a genuine concern about the funding of Shared Lives carers, including their travel costs, time and expenses. This was partially recognised by raising fees in the Green Book evaluation to represent a rate similar to the real living wage for the forward cost of the service. The evaluation notes that step and the wider context around it. Frontline care work in the United Kingdom is paid below comparable roles; a structural issue the government's Fair Pay Agreement for adult social care is intended to address. The payment to carers is not incidental to the model. The quality of the matched relationship, which is where the programme's value is created, depends on attracting and keeping carers who find the role viable as well as fulfilling.

# 4. How is Live More achieving these outcomes?

### The core mechanism: a relationship that feels like friendship

The clearest and most consistent finding across all strands of the evaluation is that the families and people living with dementia experience relationships with their Shared Lives carers as friendship, not care. People described Shared Lives carers as someone who *"sits and chats,"* who *"comes to see yo*u," a *"friend"* or *"neighbour"* - rarely, if ever, as a support worker or a service. This distinction is important as it is closely linked to how and why the programme has achieved the outcomes described earlier. For people living with dementia, many of whom were initially reluctant to accept support or resistant to being seen as needing help, this framing offered a way to engage with Live More on terms that felt safe and acceptable. For family carers, it was closely linked to their ability to step back fully during sessions, 'switch off', trusting that their loved one was with someone they knew and liked. Across the schemes, and as a programme as a whole, a number of key enablers and facilitators were closely linked to producing this mechanism consistently.

## 4.1 Key enablers and facilitators

**Strategic leadership and engagement –** The leadership of GM ADASS and NHS Greater Manchester was critical to the success of the programme in building buy in and ownership, encouraging senior leaders to commit to the programme, galvanising GM-wide partners and raising awareness and building plans for sustainability.

### Careful, deliberate matching

Matching was treated as a relationship to be built. Staff used their detailed knowledge of Shared Lives carers to identify suitable matches based on shared interests, personalities, routines, location and practical considerations (e.g. location, transport), reflecting the programme's relationship-based approach, a key tenet of Shared Lives. In several cases this process was deliberately staged. Scheme staff visited families more than once before proposing an introduction or stepped back to identify the right person and returned once they felt confident in the match. Shared Lives carers

received background information beforehand, allowing them to decide whether a match felt appropriate. One Shared Lives carer went further by researching the person's history and local connections, bringing photographs to the first meeting to create an immediate sense of familiarity. Some families were offered a choice between potential Shared Lives carers and others described the eventual match as having been considered so carefully that it felt, as one family put it, *"perfect."*

Introductions themselves were also typically gradual, starting with shorter sessions and building up, giving both the person with dementia and their family time to adjust. Some people with dementia were initially reluctant to engage because they wished to remain independent or were anxious about meeting someone new. As confidence grew, this reluctance usually diminished, with one family member reflecting *“I think it was all down to [Shared Lives carer’s] ability to hone in on his personality."* The gradual pace, absence of pressure, and emphasis on finding the right relationship gave families confidence to participate.

**Person-led flexible delivery**

Shared Lives carers and schemes worked with families to shape day support sessions around what the individual wanted to do that day. This ranged from everyday activities - shopping, a café visit, a walk - to re-engagement with hobbies and interests specific to that person's history and identity. The emphasis was on maintaining purpose, confidence, and social connection, not as a set of ‘activities’, but people living ordinary lives.

This flexibility also extended to the practicalities of delivery, with several schemes adapting the frequency and duration of sessions to individual needs and circumstances. Oldham introduced shorter sessions before gradually increasing them where appropriate, while reducing session length for people who found longer visits overwhelming, depending on *"how they're feeling on the day."* It is therefore not surprising that several families explicitly contrasted this with more structured day centre models, describing them as offering fixed activities on fixed days regardless of whether these suited the person on a given occasion.

**Consistency of relationship**

The same Shared Lives carer supported a person over the life of their involvement in the programme. Family carers repeatedly described knowing that the same, trusted

familiar person would be arriving each week as central to being able to relax fully during their time away. This continuity did more than sustain familiarity; it was also what allowed changes in a person's wellbeing, health or circumstances to be noticed. A Shared Lives carer seeing someone weekly was often the person best positioned to pick up on a deterioration, a fall, or a health issue that would otherwise have gone unaddressed. As Bury described, Shared Lives carers provided *"a pair of eyes in there"*, helping families acknowledge unmet needs that had previously gone unrecognised.

**Deliberate non-clinical framing**

Schemes and referral partners made active choices in the language used to describe Live More to families. Families recalled the programme being explained in simple, practical terms that focused on companionship rather than care. One carer remembered being told it was *“a break for her but also gives the person something to do outside the home in a different environment.”* Referral partners similarly explained, *“We emphasised it could benefit both the husband and provide some respite for the wife."* Stockport's decision to describe Shared Lives carers as *"companions"* rather than support or care workers offers a clear example - reflecting a considered effort to signal choice and control rather than dependency from the first point of contact.

This same instinct extended into the assessment process, which across schemes was consistently framed as a conversation to get to know the person rather than a form-filling exercise focused on need or risk. Families consistently described assessment visits as relaxed and welcoming, often taking place over a cup of tea. One family carer described the conversation as *"very natural"* and contrasted it with a carer’s assessment that *"felt very clinical."* Families valued the time staff took to understand the person's history, interests, and personality rather than focusing solely on dementia. As one reflected*: "He was really nice... he wanted to take a history... he asked lots of questions about my mum - where she was born, her interests, family, everything."* Referral partners echoed this, describing: *“The level of detail and care - where they sit and get to know you - not typical of services."*

**Trust, relationships and partnerships**

Trust and relationships operated at two levels across the programme. At the scheme level, referrals depended on schemes dedicating a significant amount of time and effort to build relationships with individual ‘champions’ within partner organisations.

Bury's relationship with the local carer's hub and Stockport's connection with a manager at the memory clinic, both of whom were described as 'really believing in the programme' were key sources of referrals. Tameside similarly highlighted a key memory clinic contact who was *"quite passionate about the gap that this pilot was filling."*

At the governance level, the programme's management and governance team - drawn from NHS Greater Manchester, ADASS Greater Manchester and Shared Lives Plus - brought pre-existing relationships and, in several cases, shared personal motivation including lived experience of dementia. This created a high degree of early alignment and a collective willingness to be open about risk and uncertainty, described by the team as a shared commitment to *"build the plane while flying it."* This was reinforced by a deliberate division of labour: system leaders used their authority and standing to engage commissioners, while Shared Lives Plus worked alongside schemes in a supportive capacity, avoiding any sense of performance management or scrutiny. It was this governance-level trust that underpinned the permissive conditions schemes experienced day to day.

**Live More filled a significant gap**

Families and referrals partners consistently described how the programme filled a significant gap between dementia diagnosis and formal care, providing personalised, relationship-based support that existing services often lacked. For many families, the period following diagnosis was often overwhelming. One reported taking eight weeks off work to manage appointments and phone calls after her mother's diagnosis, while another observed, *"no one ever gives you a list to tell you what's available... be it support or monetary help."* Many felt existing options including day centres, group activities and task-focused care, did not meet their needs. Shared Lives was valued because it offered personalised, relationship-based support. As one family carer explained, "*I thought that Shared Lives stood out, particularly because it was somebody that would do something with mum, something that she wanted to do, as opposed to going to something."* This was also echoed by referral partners - existing services were viewed as either task-focused or unsuitable for people in the early stages of dementia. As one reflected: *"It sits right in that gap - between getting a diagnosis and things getting bad enough that a care package kicks in."*

**Dedicated and experienced teams and Shared Lives carers**

Live More was driven forward by small core teams who brought real motivation and commitment to the programme. Staff were prepared to push forward despite setbacks and disappointments and were proactive in building the relationships the programme depended on, rather than waiting for systems or processes to catch up. Bolton offers a good example of this in practice. Despite having no prior day support experience and having to build a model from scratch, staff brought social work backgrounds and a strong commitment that carried the scheme through a harder starting position than most. This sentiment was also echoed by referral partners who reflected that their confidence in referring families was underpinned by trust in Shared Lives schemes and their staff, with one partner explaining they referred people because *"you could tell they really wanted to help people."* This dedication was reinforced by protected staff time at many schemes, which allowed careful matching and paced introductions to happen as intended.

The programme was also supported by schemes' reliance on already-experienced Shared Lives carers, many with prior personal or professional experience of dementia. This existing experience gave them confidence to support families and enabled schemes to mobilise quickly. Across schemes, carers described intrinsic motivation as the main reason for participating. As one Shared Lives carer explained, *"Because I like a challenge. I like to make a difference. I like to keep busy."*

In most cases Shared Lives carers did not access any additional training, which was not an oversight by schemes but reflected their judgement that existing experience made it unnecessary. Similarly, the experienced Shared Lives carers required minimal additional support. It typically consisted of regular, light-touch contact through weekly phone calls, visits or session logs, alongside an open-door approach that allowed carers to seek advice whenever needed. Most queries related to practical issues such as mileage claims, activities or discussing individual session arrangements generally ran smoothly and one scheme reflected: *“They’ve been a pleasure to work with.”*

**Proportionate processes**

All schemes deliberately moved away from full statutory, Care Act-style assessments, adopting proportionate processes focused on essential information only. Stockport's approach stands out as the clearest example. They moved away from a form-heavy approach to informal conversations with a bespoke one-page profile capturing what

mattered to each individual. This extended beyond the assessment conversation itself; several schemes also developed simplified referral forms, payment systems and arrangement agreements, avoiding the delays and bureaucracy that a fuller process would have introduced. This proportionate approach was also closely linked to pace. Referral partners repeatedly described the speed of the process - support beginning within two weeks of referral, compared with eight-week waits or longer for other services - as significant, building confidence among families and professional partners alike that the offer was genuinely accessible. One referral partner described the process as *"Absolutely brilliant, so quick and flawless."*

**Test-and-learn culture**

A test-and-learn culture was intentionally established and sustained across the programme through several related conditions. Programme leadership gave schemes explicit permission to adapt and move quickly, framing funding as a space to test and learn rather than deliver against fixed outputs, which schemes described as highly motivating within a sector which is often regarded as an otherwise risk-averse sector. Upfront, block-style funding reinforced this even though its lack of flexibility to move resources between schemes created challenges of its own. This culture was also sustained through a peer-learning infrastructure. More experienced schemes shared tools, templates and learning directly with schemes newer to dementia day support, and a centralised SharePoint hub gave every scheme a single reference point for documentation and guidance. Many schemes also valued regular conversations with and support from Shared Lives Plus, which helped clarify expectations and processes and gave them guidance and feedback on progress and next steps.

## 4.2 Challenges and key learning

While the previous section set out the conditions that enabled the programme's core mechanism to take hold, there are also several factors that constrained the pace, scale and consistency with which schemes were able to work.

**Shared Lives carer availability**

Most schemes relied on their existing cohort of Shared Lives carers, reflecting the short pilot timescales and the lengthy recruitment and approval process required for new

carers. However, this approach was not viable for some schemes. They reported that many Shared Lives carers were already fully committed or felt they did not have the skills or confidence to support people living with dementia. Some Shared Lives carers withdrew late in the process, sometimes after introductions, whilst others no longer had capacity, or their personal circumstances had changed after delays in schemes securing referrals. The independent scheme which supports Trafford, for example, had to rely on a single couple from its existing cohort because of recruitment difficulties and Tameside identified this as their single biggest challenge, reflecting that additional recruitment would likely have produced meaningfully different results. Some schemes also found it difficult to achieve a balanced cohort of carers, despite recognising the importance of gender matching for some participants. Stockport was the only scheme to recruit specifically for Live More through a fast-track approval process, attracting people with health and social care backgrounds through word of mouth.

Schemes consistently recognised that growing the programme would require more Shared Lives carers recruited through dedicated strategies rather than relying on existing cohorts. Wigan reflected that they had been fortunate existing carers had volunteered, but future growth would require people *"specifically willing to support people with dementia."* Some schemes also proposed dedicated recruitment roles, with Tameside suggesting a shared recruitment worker across Greater Manchester.

**Referrals and readiness**

Many schemes described how converting referrals into genuine engagement, and ensuring those referrals were well suited to the programme proved challenging. Salford reflected on the need to accept that some people who would clearly benefit were simply not ready or willing to engage. In Manchester and Bolton, the low volume of referrals or the pressure to fill places early meant referrals were not always well aligned with early-stage dementia.

Beyond this, turning a willing referral into a working arrangement required significant time and emotional effort. Several families were new to social care services, processing a new dementia diagnosis and unfamiliar with Shared Lives. Some felt that they 'should' be able to cope or worried that accepting support meant failing their loved ones.  Building trust with these families took sustained effort. Rochdale, for example, described spending considerable time reassuring families over several conversations,

giving them the space to process information at their own pace. Referral partners also described managing reluctance on the part of families – for many accepting any form of support felt like a first step towards losing independence or, as several feared, a care home. Despite this reassurance, some families ultimately decided not to proceed, which schemes found disheartening after the investment made in reaching them. Sustaining and growing the programme will require continued staff investment, adequately resourced, in building trust with families.

**Capacity, workload and staffing pressures**

Across the ten schemes Live More was delivered on top of already stretched workloads often alongside other Accelerating Reform Fund projects, service changes or inspection activity. This created a persistent tension between the relational, unhurried way of working the programme depended on and the practical reality of limited staff time. In Manchester the pilot had to be delivered within a much larger service of 350-400 people, compounded by a long-term staff absence, leaving one person carrying much of the work largely alone. Oldham experienced additional pressure through staff sickness and retirements, while Bury reported operating at or near full capacity and needing to bring in dedicated additional resource to manage the programme's workload. Trafford's lack of staff presence on the ground made local outreach and relationship-building particularly difficult. Even once referrals had been converted into successfully matched arrangements, many schemes found that supporting family carers could also be quite intensive. Whether through emotional support, practical advice, signposting or ongoing communication, they frequently filled gaps that no other service addressed. Across schemes, the set-up and delivery of the programme was consistently described as more time-consuming than anticipated.

It is therefore not surprising that the main barrier to sustaining or expanding Live More was staffing capacity rather than demand. Several schemes reported strong interest from families but insufficient capacity to respond. Bury reflected, *"I do believe we could have got to 40 people, and if I'd have had a team, it would have carried on and carried on."* Bolton similarly reported that its limited coordinator hours constrained growth, while Manchester and Wigan also identified the need for additional project management or coordination.

**Uneven system engagement and equity of access**

Engagement from adult social care and statutory front-door teams was consistently low across schemes, despite genuine efforts to build these relationships. This was attributed less to the relevance of the offer and more to the threshold-driven nature of these services and the capacity pressures limiting staff's ability to promote preventative, non-statutory support. Stockport found the programme was *not "taken as seriously as I would have liked",* instead being viewed as *"community provision"* rather than an in-house service. Bolton reported stronger engagement from frontline staff and felt the pilot should have been *"got hold of by very senior people"* from the outset, believing this contributed to fewer referrals, more difficult matching, and a weaker evidence base.

A related pattern emerged in who the programme was able to reach. Referrals consistently favoured people with strong family advocacy, existing connections to voluntary sector support, and relative financial security. Families accessed Live More through carers centres, memory clinics, dementia groups, and word of mouth. Some noted that access depended heavily on existing knowledge or connections. One reflected*, "I hadn't seen anything to know about this scheme."* Another acknowledged that her professional background had given her an advantage *"that other people without connections wouldn't have."* People living alone, in more deprived circumstances, or without a strong network of family support were harder to reach across nearly all schemes - a gap schemes attributed to a lack of touchpoints and trust rather than to any lack of need. Expanding the programme will therefore require building new partnerships beyond established networks, with stronger senior level engagement improving visibility and supporting implementation.

Among the **69 supported people**, 65% are recorded as White British and 32% as British, with small numbers identifying as Bangladeshi or Ukrainian. Among the **48 carers**, 54% were recorded as White British and 33% as British, alongside a small but meaningful mix of **Black African, Brazilian, Irish, Lithuanian, and Pakistani** carers.

Viewed together, the two profiles suggest that the pool of Shared Lives carers broadly reflected the ethnicity of the people being supported. This means that, for most participants, ethnicity was unlikely to be a limiting factor in matching. In these cases, matches are shaped far more by shared interests, personality fit, location, and availability, aligning well with the relational, personalised ethos of Live More.

However, the data also highlights some important considerations for the future. For supported people from minoritised ethnic backgrounds, the current carer cohort is small, which can make culturally aligned matching more challenging. This does not always mean shared ethnicity is required, but for some individuals and families, cultural familiarity, such as language, food, faith, gender preferences, or norms around privacy and support, can be an important factor in feeling safe and understood. In these situations, schemes may need to spend more time preparing introductions, providing reassurance, and exploring what culturally attuned support looks like for each family.  Separately from this project, but informed by the findings as they have emerged, Shared Lives Plus is conducting in depth research to explore both how we increase the number of carers and the numbers of people referred into Shared Lives from ethnic minoritised backgrounds to identify areas for improvement.

**Referral information not reflecting level of need**

While most arrangements ran smoothly, some ended and this was usually because people's needs had progressed beyond what Live More could safely provide. Bolton reported two arrangements ending because increasing physical health problems and anxiety made community support unsuitable. Manchester ended one arrangement after it became clear the person's dementia was more advanced than initially understood. Tameside also described occasions where the full extent of someone's needs only became apparent after support had begun because of pressures on recruitment and matching. Similarly, some arrangements also developed beyond the programme’s remit, with support becoming more complex. In Bury, some people transitioned to increased Care Act-funded support or residential care as their needs progressed. Where arrangements became more complex or ended, schemes also recognised that referral information did not always accurately reflect the stage of dementia or level of need.

**Commissioning, funding and timescales**

Programme funding was routed through local councils in all cases, but this created difficulty for independent schemes such as Bury and Bolton, who experienced delays and blockages in accessing funds, adding administrative burden at an already pressured time.  Additionally, because funding was pre-allocated based on estimated numbers, there was little flexibility to move resources toward schemes that were progressing faster than expected, even as others exceeded their targets. Bolton also

described the difficulty of navigating council-based commissioning processes despite Live More sitting outside formally commissioned services, needing approval at multiple stages before progressing. This sat alongside a degree of early uncertainty that slowed progress more broadly. Many schemes described a lack of clarity at the outset around eligibility criteria, onboarding documentation and evaluation requirements, with governance and reporting arrangements refined during delivery rather than established upfront.

**Sustaining arrangements beyond the pilot**

A concern raised consistently across schemes was what would happen once the six-month support period ended. Families had built strong, valued relationships with their Shared Lives carer, and schemes were conscious that the loss of this relational continuity in a vacuum could leave them feeling like they are 'back to square one'.  For Stockport, the biggest challenge of the pilot was working to ensure that support could continue for those who wanted it. Readiness to manage this transition varied. Schemes further advanced in this process used structured systems such as dashboards to track arrangements and begin discussions in some areas up to eight weeks before support ended. Transition planning generally followed two routes: signposting families towards local authority-funded support through Care Act or carers' assessments or supporting them to self-fund ongoing Shared Lives arrangements. Schemes also differed in how prepared they were to support self-funding. Stockport was actively developing financial processes, while Rochdale had calculated sustainable ongoing fees. Other schemes had delayed introducing self-funding until there was greater certainty about future commissioning. For people who did not meet Care Act thresholds at the end of the pilot and could not self-fund alternative support, no clear route forward had yet been established.

Alongside these transition challenges, schemes and the programme's management and governance teams also reflected on the conditions needed for Live More to continue more broadly. Genuine senior commissioner and Director-level buy-in was highlighted as particularly important for sustainability. This was linked to a continued shift among system leaders away from crisis and threshold-driven thinking, toward a model that more fully recognises and commissions preventative, relationship-based support.

**Framing early action interventions:** The framing of Live More was considered early on and led to being critical to its success in reaching and engaging with people living dementia, families and community-based partners. However, this framing sat outside the typical systemic language and approach to describing a community support option and support required ongoing refinement to best describe the offer to health, care and community partners in ways that fit within their current strategic delivery and commissioning planning.

**Placed between current 'systems':** Live More intentionally exists in 'a space in-between' health, social care and public health systems, in response to a recognised gap in support for people living with dementia and families. This test and learn initiative in Greater Manchester was able to dedicate considerable funding from the Department of Health and Social Care Accelerating Reform innovation fund, allowing for a time limited opportunity to try out Live More and measure its impact. Moving forward, there are still questions to further explore which parts of the system are responsible for the gap which Live More sits, which parts fund Live More, and which parts need to back the approach.

# Building on the evidence base

The three-strand evaluation has generated a robust and compelling evidence base for the value of early action Shared Lives support and concludes that it reaches families in the gap between diagnosis and crisis with a few hours of personalised support each week.

**We know people want it:** The high number of referrals during the short pilot timeframe (171) and with 69 people consistently supported throughout the period, shows that there is a strong appetite and need for Shared Lives day support by people and families at this earlier stage.

**We know it is viable:** The pilot which tested the development of Live More across 10 different areas, with variations in alternative local support options, and differing Shared Lives delivery approaches, validates that the approach can be viability implemented across various local settings.

**We know why it works:** The evaluation has learned why and how this approach works, which is centred on building relationships between people and families living with dementia, and Shared Lives carers. These relationships are the intervention.

**We know it changes peoples experiences:** The findings show that with a modest amount of consistent, personalised Shared Lives support producing substantial and meaningful improvements in wellbeing, social connection, autonomy and everyday life for people with relatively early-stage dementia, while importantly giving family carers psychologically valuable respite and improving their perceived capacity to continue caring.

**We know it has value:** The SROI produces a measurable economic impact of Shared Lives day support for people living with dementia, at approximately £6 for each £1 spent.

88% of this return on investment associated with the value of improved wellbeing (HM Treasury Green Book validated), spread across people living with dementia (48%), family carers (36%) and Shared Lives carers (4%).

The remainder relates to measured cashable savings to the local authority and NHS (4%), protected unpaid family care (7%) and self-funders (1%).

Due to the short timeframe of the pilot period and the limitations in accessing linked health and care records, the SROI was confidently able to measure the wellbeing impacts of Live More, however was unable to extensively measure the broader and longer term cashable impacts of Live More during the lifetime of the pilot.

The qualitative findings of the evaluation point to a modest care home avoidance, however due to the pilot limitations, a next phase of activity which broadens the reach, extends the timeframe of the evaluation, alongside directly carrying out analysis using linked care records, will allow for broader cashable savings to be robustly measured.

## What comes next?

We believe that Live more has huge potential. The focus of Live More on reaching people living with dementia and their loved ones early resonates strongly with the Government's vision for a reformed approach to adult social care.  As the Prime Minister Andy Burnham – who has already provided his support to Live more in Greater Manchester when he was the Mayor - said in his keynote address on 29 July social care '*must start with prevention, supporting people to live independently for longer*'.

With support of the Rayne Foundation, and with interest from individual local health and care systems, we are now exploring how to grow and develop Live More in several other parts England. Through doing so, we will further build the evidence base about the impact and value of the approach as a model of early action and prevention.

We do not see Live More as a stand-alone initiative, but as existing alongside other innovations which aim to bring social support to people and families living with dementia earlier to help people live as well as possible. We are particularly interested in its role as part of local 'neighbourhood ecosystems' of support.



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