PREVENTATIVE SERVICES MARKET DEVELOPMENT BOARD

ANNUAL REPORT 2014

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BACKGROUND

The Preventative Services Market Development Board (PSMDB) was developed by North East Lincolnshire Clinical Commissioning Group in summer of 2013. The aim of the project is to support the delivery of health and social care services by charities, voluntary organisations and social enterprises in North East Lincolnshire, and to develop new organisations that can increase the market supply of third sector providers.

The programme offers a mixture of targeted business and workforce development from a leading social enterprise support organisation (CERT Ltd), seed corn funding and linkages to mainstream services.

The Board is made up of community members and CCG staff drawn from a wide range of disciplines and acts as a mechanism for deciding on where investments are made. More importantly they add value to the projects by offering their experience and expertise and opening their networks to applicants.

2014 THE HEADLINES



- Twenty projects applied for funding – a specialist gym, I.C.T, in the home, time banking, adaptive aids advice and more
- Seven projects have received funding to-date
- Total invested to-date £183,497
- Additional funding levered in £128,538
- Every £10 spent by the fund attracts an additional £8.37 from external sources
- PLUS the social value created – more later!



POLICY OBJECTIVES

The project seeks to contribute towards a range of Health and Social care objectives including:

NHS
North East Lincolnshire
Clinical Commissioning Group

Healthy Lives, Healthy Futures

The strategic plan and delivery of the vision for North East Lincolnshire and North Lincolnshire units of planning revolves closely around our joint programme for transformational change, Healthy Lives, Healthy Futures.

The vision we have set out for the next five years in North East Lincolnshire, working with commissioning partners, local providers, stakeholders and local people is ambitious in its scope and enables local health and social care services to meet the needs of people in the area within the resources available.

A key element of this vision is to enable local people to manage their own health and wellbeing more effectively and to engage with their communities to deliver solutions based on self care and self- responsibility.

All of our reviews will be driven by national best practice recommendations around the services we offer, to ensure that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come.

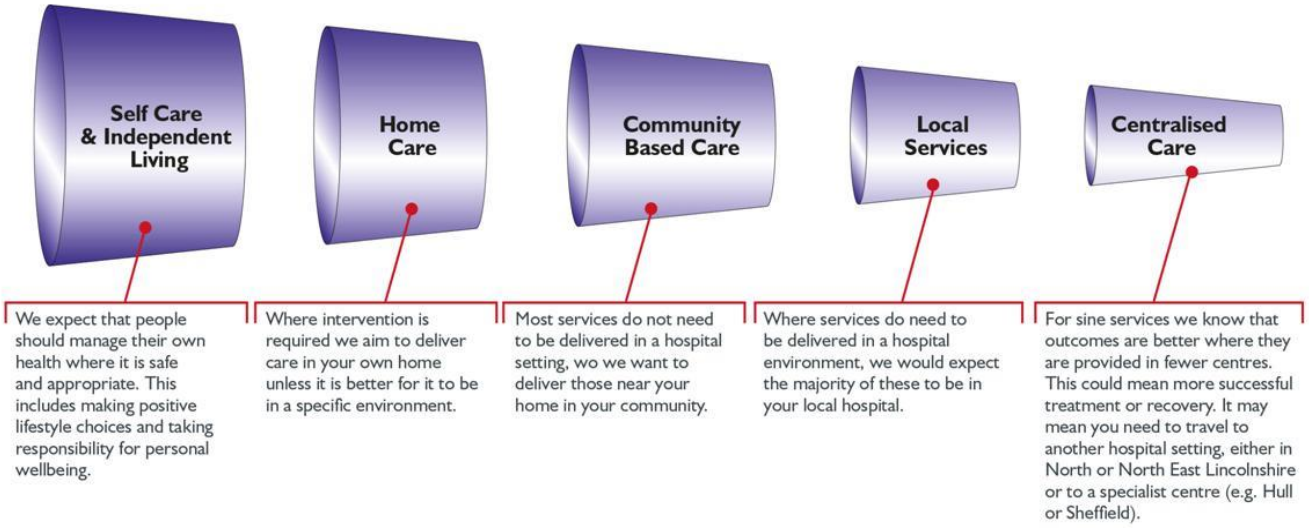
Our vision can be described in the diagrams below which are drawn from the programme and reflect a fundamental shift in the distribution of health and care services and position our community for sustainability into the future.

The programme is actively developing and will continue to establish new models of care and new ways of working for the foreseeable future, ensuring the CCG's vision can be delivered.

NHS
North Lincolnshire
Clinical Commissioning Group

NHS
North East Lincolnshire
Clinical Commissioning Group

The Shared Vision



We expect that people should manage their own health where it is safe and appropriate. This includes making positive lifestyle choices and taking responsibility for personal wellbeing.

Where intervention is required we aim to deliver care in your own home unless it is better for it to be in a specific environment.

Most services do not need to be delivered in a hospital setting, wo we want to deliver those near your home in your community.

Where services do need to be delivered in a hospital environment, we would expect the majority of these to be in your local hospital.

For sine services we know that outcomes are better where they are provided in fewer centres. This could mean more successful treatment or recovery. It may mean you need to travel to another hospital setting, either in North or North East Lincolnshire or to a specialist centre (e.g. Hull or Sheffield).

Caring for our future: reforming care and support (2012 White Paper)

- People will be given better information and advice to plan ahead to prevent care needs, and will be better connected to those around them.
- More support within communities, better housing options and improved support for carers will help people maintain their independence and avoid a crisis.
- Re-ablement services and crisis response will help people regain their independence at home after a crisis.

The Adult Social Care Outcomes Framework 2013/14

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Older people

A key Government priority for adult social care is to ensure that every older person (aged 65 and older) who receives care and support receives the best quality support, and is cared for with the dignity and respect that they deserve. Keeping older people well and out of hospital, and supporting them to regain their independence after a period of support, are a vital part of supporting older people to live full lives, and to play an active role in their communities.

Quality of life for people with long term conditions and disabilities

A key aim of adult social care and support is to support those with long-term conditions and disabilities to improve their quality of life, and to empower them to have greater choice and control over their daily lives. The ASCOF supports a focus on these priorities, with direct measures on personalisation and control, as well as measures of employment and accommodation for people with a learning disability and people with mental health problems.

Loneliness and social isolation

The White Paper signalled the Government's commitment to support active and inclusive communities, which support people to develop and maintain connections to friends and family.

THE VALUE OF THE PROJECT

The project aims to deliver cost effective services that are valued by service users, and also seeks to add value to existing services and to attract additional funding to the Health and Social Care sector.

By working with the voluntary and social enterprise sector, and utilising their ability to raise funds that would not be available to mainstream health providers, **we have so far attracted additional funding of £159,306 over the lifetime of the programme.**

Additional funding levered in however, is not the only value created by the programme and an innovative key feature of this programme is the capture and recording of a range of impact information. We use a robust system that assesses not only the impact of our work but also the financial implications of our investments. Adjustments are made for the intervention of other organisations on service users and financial proxies (the savings achieved) are drawn from sources such as the London School of Economics and Manchester University

The system that we use to achieve this is **Social Return on Investment** and we utilise an Impact Mapping system that is transparent and most importantly auditable at a credible level.

Through workshops and individual mentoring sessions we have worked with all of the projects that we have invested in to establish a bespoke system that captures the impact created (example of the Impact Mapping below).

We will start to report the results of the mapping on a quarterly basis in 2015 when sufficient amount evidence has been recorded to ensure the validity of data.

THE PROJECTS

Foresight (two projects)

Specialist Gym

The main aim of this project is to offer personalised prevention and wellbeing services to people who, without time limited or ongoing support would be placed at a heightened risk of progressing to higher levels of need in the medium term significantly increasing costs to the NHS for these individuals.

The key objectives that will deliver health outcomes are as follows:

- To provide a supportive, relaxed, and non- stigmatised environment to increase access to health related preventative activity for the disabled and disadvantaged communities
- To maintain people at low levels of need and maximise independence.
- To provide opportunities to disabled and disadvantaged community members that will lead to a healthier lifestyle and improved quality of life.
- To increase levels of physical activity reducing the need for health interventions caused by excess weight and obesity
- To reduce the need for longer term health related care and support.
- To develop a financially sustainable service that contuse to offer long term health related benefits to our target audience

The gym which has been named Warehouse Fitness is now fully operational. We are working with the Care Plus Employability team and we currently have two trainees working in the facility and we have a young man who has completed a traineeship who has been offered an apprenticeship. Additionally in order to meet demand for personal training we have engaged three personal trainers who will work on an as and when required basis.

Successes to-date includes:

The service has now been running for four months and we have

- 241members with 43 people enrolling during the last month.
- Following September consultation with our members we will be opening at 6.30am during for a trial period and we are also offering 8 classes across a range of disciplines to add real value to our offer.
- All members have undertaken an induction where health issues have been identified and each individual is set agreed goals and a personal assistance plan is put in place.

We expect a significant increase in the take up of disabled and elderly people accessing the gym during the next month as the project has been the feature article on the front page of our newsletter which has generated considerable interest resulting in over 50 enquiries and 28 people booking taster sessions

In addition we have put in place two bespoke two hour sessions every Friday 10 am – 12 noon for people with a disability and 1.00 pm – 3.00 pm for older people. To date we have 12 people accessing the former and11 people the latter. We expect this to increase as our time banking team are now offering support and transport for the older people's session and for the former we will be offer the sessions to all service users when our autumn timetable commences during the second week of September.

We now have in place direct referrals through the A3, Care 4All, the Community Physiotherapy team and Linkage. Additionally we are working with the Older People's Collaborative to market our Friday sessions and vibrant marketing will be at the forefront of our project during the coming months.

Timebanking

Foresight have to developed a social enterprise that offers a personalised prevention and wellbeing service providing older people who, without time limited or ongoing support would be placed at a heightened risk of progressing to higher levels of need in the medium term significantly increasing costs to the NHS for these individuals. It enables people to both receive and give support, creating ways for people to help one another to take advantage of the opportunities of an ageing society and enable all of us to age better.

People regain a sense of purpose by using their skills and abilities to help each other as well as getting the support they need. It increases health and wellbeing, energises and motivates and works against models of learnt dependency. It releases community capacity and engages people who may shy away from traditional methods of support. Once people become visible in their community it reduces their isolation and gives them a voice and influence that is essential when community services are being developed.

Successes to-date includes:

- Setting up a new lunch club in the East Marsh. This is held at St Andrews Church Hall and runs weekly. It has been up and running for a month now and has 24 members.
- Establishing a dancercise class for older people at St Michaels Church. This runs weekly and currently has 12 members.
- Promoting Christmas events for the 3 lunch clubs that we run and has sold 60 tickets for Scartho, 39 for St Michaels and 20 for St Andrews.
- Forging links with Springfield Retirement Park and working with residents there to support them to generate group activities.
- Working with Shoreline and setting up a weekly sing-along at Ronald Farmer Court in Waltham for residents and the wider community.
- Training as a dementia friend.
- Organising two day trips for the Jubilee Club with funding obtained from Freshney Forward.
- Publicising the befriending service.

Timebank activities across the week are now as follows:

Monday

Lunch Club

Singing for Fun

Jubilee Club

Writing and Performing Group

Tuesday

Lunch Club

Tai Chi

Sing along

Book Group

Wednesday

Timebank Social club

Dancercise

Thursday

Luncheon Club

With the increased capacity provided by the funding our plans for the next 6 months are to develop services from Springfield retirement Park, look at developing Scartho Library as a community/ timebank hub run by older people and increase our volunteer base.

Friendship at Home

This project delivers a service that offers low level care to older people delivered through a network of volunteers. A Volunteer support worker recruits and trains the volunteers to deliver these services and monitor the effectiveness of the programme.

The difference between residential care and / or a prolonged stay in hospital for many elderly citizens is simply an inability to cope with simple day to day tasks. The project recognises that in order for older people to remain independent and to stay in their own home they may only require low level of support. This may include help with mail, dog walking, help with going to the shops, washing, ironing etc.

As well as providing assistance with day to day living the programme also delivers a regular safety call, so if families are living away or going on holiday visits can be made to make sure that the older person is safe. Friendship at Home also provides medication prompts however they do not get involved in the administration of medication.

Care logs and updates are kept for each service user which ensures that after each visit so that family and friends or healthcare professional are aware of their actions and any issues that may have occurred.

The programme offers bespoke services tailored to meet the needs of the older person. Volunteers are able to undertake more than one task per visit if necessary and do not have the added pressure of having to rush from one client to client.

The project signposts to other services such as the fire service and crime prevention and is able to refer clients to other services drawn from their wide network of agencies within the voluntary and community sector

As well as providing practical support to clients the programme also offers training and employment assistance by developing skills through volunteering. All volunteers are offered recognised accredited training.

Case Study;

Alma is an 88 year old lady who is visually impaired, suffers from Polymyalgia Rheumatica and also has Dementia.

Alma's daughter Chris contacted Friendship at Home after hearing about the new service. Alma at this point already received gardening once a week from a professional gardener. However, the individual carrying out the gardening made no attempt to communicate with Alma and they felt that Alma would possibly benefit from our service assuming the volunteer could take five minutes to talk to Alma during the visit.

Friendship at Home visited Alma and Chris to discuss how the independent living service could benefit Alma and to carry out an assessment. It was identified that Alma actually had a good level of social interaction from family and also from other services she received such as the cleaner and hairdresser. However, Alma was very lonely due to the dementia and not remembering when people had visited. Chris and other family members take it in turns to ring each night and each night Alma would express feelings of sadness of being alone.
Because of the social isolation being identified it was discussed that perhaps in the warmer weather that Alma could sit outside with the volunteer who was carrying out the appointment and she could 'assist' with the visit and explain how she liked the garden. When it came to winter it was mentioned that the volunteer could just take a small amount of time in the visit to go inside and chat to Alma.

Alma now receives the gardening service once a week for an hour from our volunteer Jane. Each week even in the colder weather, Alma gets wrapped up and sits outside whilst Jane carries out the gardening. They chat about the garden and the different plants that Alma has and they both enjoy sharing their knowledge.

It is important to recognise that although Alma is benefiting from this service, Jane, the volunteer is too. Before she came to Friendship at Home to help with the independent living, she had been out of work for some time and even though she had always had a love for gardens and had a large bank of knowledge when it came to gardening she was looking for an opportunity to build her confidence and also experience in working with older people. Friendship at Home is in regular contact with Jane and every time Jane expresses how grateful she is for the opportunity and how much she enjoys the visits each week.

After carrying out a review last week with Alma and Chris, they made it very clear of how much of a difference Jane had made. Chris took me to one side and explained that all of the family are so grateful for Jane's visits and although Alma rarely remembers when they have visited, when they ring on a Tuesday evening Alma has plenty to say about Jane's visit that day. When talking to Alma about the visits she was eager to discuss Jane and how much she enjoys her 'Tuesday visits', Alma described their relationship as 'a lovely little friendship'. It is very rewarding to see the difference in Alma and the difference that has been made.

It is clear to see that a difference has been made in this case to both the member and the volunteer. Although it is easy to say that without this service Alma would be able to find another gardener, it may not be as easy to find the friendship that has been made.

Care4All

The project aim is to improve accessibility to information for people with care and support needs and has a particular focus on people who are housebound or who have very restricted access to the local community because of their long term condition.

The key objectives of the project are as follows:

- To ensure that people living in their own homes who require support and information about health and social care services, including those people who are eligible for publically funded support, are enabled to access information and guidance in a timely manner using a range of IT solutions within their own homes. The main target group for the project will be those people who are housebound or who have conditions which significantly restrict their ability to access the community.

- To support people with care needs to access IT to help them identify the options available through Services4me and then make contact with the relevant provider

- To enable people without access to IT facilities in their own homes to access such facilities through then provision of an equipment loan service.

- To offer IT access support to people in their own homes through the recruitment of a bank of IT literate volunteer 'buddies' who would enable people to access online products through the use of IPads/Android tablets which would be made available as part of this project This would include supporting people to access other online services apart from Services4me, including on line shopping, email/Skype/FaceTime, enabling social inclusion and independence, thereby improving health and wellbeing.

- To develop a loan service for IT equipment to support accessibility for people on low incomes

- To develop and deliver a range of IT training options within peoples own homes and also where appropriate, in our Health and Wellbeing Centres/other community venues. This offer would be open to everyone who would benefit from access to the project including people from hard to reach groups who would be targeted through our connections with a number of community and voluntary organisations.

Project benefits

The project benefits include the following:

- Putting people in control, enabling them to choose how support is provided and by whom through access to Services4me
- Access to timely information and subsequent support enabling people to remain in their own homes for longer, thereby reducing costs to the NHS
- The development of new skills and knowledge leading to increased health and wellbeing
- Supporting social inclusion through the use of social media/FaceTime/Skype and also access to IT group training sessions where appropriate

Red Cross

Independent Living Outreach service

Red Cross have identified a need to provide an Independent Living Outreach service based North East Lincolnshire. This outreach service will be provided for 28 hours per week covering North East Lincolnshire, complementing existing service delivery.

The key objectives are:

- To provide a person centred trusted assessment to people within their own homes.
- To offer advice and information on simple aids to daily living that could make a difference to a person's ability to maintain independence at home.
- To signpost individuals and their carers to organisations offering longer term solutions.
- To enable individuals to recover from a crisis

Project benefits

- Tackles health inequalities
- Builds volunteer base to support the needs of vulnerable people, improves community skills and supports employment
- Communities at the heart of health and well-being
- Builds community confidence and improve individual self-esteem and mental wellbeing
- Increases the range of community based preventative services to maintain independence and active living, and promote self-support;
- Increases opportunities for people to be active citizens
- People feel more safe and secure
- Improved ability to manage day-to-day activities
- Increased satisfaction with home environment
- Improved awareness of and access to further services
- Improved social networks and friendships
- Improved ability to cope in caring role

Case study

Richard is a 61 year old male who is blind and diabetic, due to his diabetes; he recently had his toes and part of his right heel amputated.

Richard's mother is in her nineties and has for many weeks been in Grimsby Hospital, a mother and son who dote on each other, their respective ailments has meant little or no contact with each other.

The Red Cross visited the home, a ground floor flat, and ascertained apart from emotional support, he desperately needed practical support to move about, thus increasing his independence and ability to interact with the outside world. Richard's inability to visit his mother was causing stress and the possibility of further breakdowns in day to day living coupled with the toil of his disabilities new and old.

Personal goals were identified, improved ability to manage day to day activities, access further services, improve the social network to meet new people and not be isolated for hours in his flat and the ability to cope even more following his loss of toes and heel.

His aspiration was to be mobile again and get out, to visit his mother and resume some sort of normal life.

Richard is now able to get out with the aid of a wheel chair and walking stick, able to interact with the outside world. He can now visit his mother who had not seen him for a number of weeks. His ability to have more freedom has been such a boost to him - he is clearly happier and in turn settled into life upon discharge from Hospital.

Richard is more cheerful and upbeat about coping with what he describes as a life changing operation, knowing that people do care and can help have in his words, made a vast difference.

Without intervention from the Red Cross he would not get out, be isolated in his flat with no contact with his mother or the wider community.

The project worker was able to swiftly provide a suitable wheel chair, sticks, ensuring access and egress was possible without hazards, supplementing that with emotional support.

Social Marketing Apprentices

The PSMDB is developing a range of innovative projects designed to meet the identified needs of a range of services users. Clearly it is not enough to simply develop projects and it is essential that as many people as possible are made aware of their existence and use them.

Currently services are promoted through the Services4Me website and by word of mouth. It is difficult to reliably assess the effectiveness of these methods or to develop alternative strategies given the limitations of a website to produce meaningful statistical information. We do know however, that a large number of people do not have access to I.T. and as a result are in danger of not being properly informed about the services available to them.

The Board decided that we needed to innovative a process that would undertake marketing in a variety of ways across a range of geographic locations. Any initiative in this area needed to progress the programmes ambitions to create work and training opportunities for disadvantaged groups.

The programme manager (CERT Ltd.) offered to use its business development expertise to establish a small scale project that would employ two young people to assemble a marketing plan and undertake marketing activity in new and innovative ways. CERT host two marketing apprentices and have trained them to a national standard whilst the PSMDB simply supports a small wage subsidy.

After initial recruitment and an extended training period the apprentices have now assembled a comprehensive marketing strategy and are currently undertaking marketing.

As well as testing the impact of a range of social media the apprentices are undertaking leaflet drops, attending G.P. surgeries and attending community led events and meetings. They work closely with the CCG marketing team to ensure the effectiveness of the marketing and to begin to assess what methods work best and to understand the different.

This approach means that we can test all sorts of ways of promoting services in a wide range of geographic locations and assess the effectiveness of each in a very cost effective way. Once we understand what works best in each situation we will be able to assist the CCG to make the most of its marketing budget and ensure that we are able to communicate with some of the hardest to reach potential service users

THE LESSONS LEARNT

As in any new programme things didn't always go as expected and early in the process the Board realised that there was as much value in learning about what didn't work as what did.

By its very nature the programme is innovative and in many ways ground-breaking, and by capturing key lessons we can help to shape new developments and innovations within the Health and Social Care sector.

It's fair to say that there were no "universal" lessons to be learned – things that were major issues to some organisations were of no consequence to others. Some common themes however, were identified and as the project progresses solutions will be found to tackle these issues.

The need for long term specialised business support for these fledgling organisations is readily apparent. The transition from a charity to a contracted deliverer of public services is complex. Not only do organisations need to develop their quality and management systems and become more entrepreneurial – three major issues in themselves, but they also need to adapt their organisational cultures. This means working in new ways for managers and Delivery staff but just as importantly for Trustees and Volunteers.For some organisations this process has meant delays to project start and has raised issues about the business skills levels within those organisations (not altogether surprising given that they are not mainstream businesses!).

Marketing of services has proved problematical particularly to new service users. Many of the groups have traditionally worked within very tight communities and do not have the skills to market new services. The marketing Apprentice project is designed to ease that pressure and as the project works with more organisations should begin to address this issue.

Marketing the concept of the overall project has been an interesting experience – the same marketing and promotional methods have attracted either very high or relatively low quality applications. Given the dearth of funding in the sector perhaps it is not surprising that organisations are willing to take a chance on an application that has little or no bearing on its activities.

Collecting Social Return on Investment data has proved to be a revelation in assessing the true impact of the projects, however training organisations to undertake the work has proved much more time consuming than originally thought and with hindsight we should have allocated more resource to this area of work.

Overall we need to marry the expectations of the statutory sector to the capabilities of the VCS and recognise that at the present time the two are somewhat distant from each other.

Marketing Plan (extracts)

Action	Resources	Nov Week 1	Nov Week 2	Nov Week 3	Nov Week 4
Grimsby Minster/Church Christmas events	Posters & Travel				Poster display at NE Lincs churches
Garden Centres - Info bags & leaflets	Bags & Travel				
Local Weight Watchers groups - Information packs & short presentation	Bags & Travel				
Grimsby Auditorium - Poster & info display	Posters & Travel	Poster & Info display			
Christmas Craft Market (Discovery Centre, Clee)	Bags & Travel		9th Nov		
N E Lincs Community Centres - Target events & gatherings	Bags, pens etc				Attend event - Pass on info
Waltham Windmill event 8th of November	Bags, flyers		8th Nov		
Residential Leaflet drop - Specific areas of NE Lincs	Leaflet	Immingham x 1	Immingham x 1	Immingham x 1	Immingham x 1
Farmers market 21st Nov - Victoria Street, Gy (Informal chats & info packs)	Bags, flyers etc			21st November	
Christmas Brass Show (Choir) - December	Bags, flyers				
Knitting Clubs x2 (Short presentation & hand out info)	Kiosk & Flyers				
Bingo - St Hughes Centre (Short presentation & hand out info)	Kiosk & Flyers				
CERT Courses i.e. Silver surfers (Presentation)	Flyers			CERT Course	

Organisation	Foresight (North East Lincolnshire) Grimsby	
Scope:	• Warehouse Fitness • Existing and Prospective Work • Impact Map covers 1 year	
Name	Paul Silvester	Date 10th September 2015

Stakeholder	***Inputs***	***Outputs***	***Outcomes***				***Attribution %***	***Deadweight %***	***Impacts***
Who we have an effect on **Who has an effect on us**	**Finance (a contract) time skills etc**	**Summary of activities (contract outputs)**	**Things that happen AS A RESULT of you delivering the outputs. Try to focus on things that wouldn't happen if other organisations delivered the outputs**				**Has anyone else contributed to the delivery of these outcomes?**	**Would they have happened anyway without us**	**Outcomes MINUS attribution and deadweight**
			Description	*Indicator*	*Quantity*	*Fin Proxy*			
Funders (CCG)	Grant	Delivery of gym sessions	Income into a local charity	Registers and accounts	80 fee payer at £2.00 Wk	Admission fee of £2.00	0	0	£8,000
Focus	Referrals	Additional services for clients	Avoided GP visits	Personal plan	18 visits	£60	10%	10%	£1,488
Volunteers	Time, Support	Develop new skills	Employment and Support Allowance / Incapacity Benefit Fiscal benefit from a workless claimant entering work	Exit interview	5 people off benefits	£8831	0	0	£44,145
Staff	Time	Developing sector specific skills	Job Seeker's Allowance Fiscal benefit from a workless claimant entering work	Application form	4 staff – fta	£10,025	5%	0	£38,095

Stakeholder	*Inputs*	*Outputs*	*Outcomes*				*Attribution %*	*Deadweight %*	*Impacts*
Who we have an effect on Who has an effect on us	**Finance (a contract) time skills etc**	**Summary of activities (contract outputs)**	**Things that happen AS A RESULT of you delivering the outputs. Try to focus on things that wouldn't happen if other organisations delivered the outputs**				**Has anyone else contributed to the delivery of these outcomes?**	**Would they have happened anyway without us**	**Outcomes MINUS attribution and deadweight**
			Description	*Indicator*	*Quantity*	*Fin Proxy*			
Care Plus Group Employability Scheme	Time	Apprenticeships/Trainees hips	Job Seeker's Allowance Fiscal benefit from a workless claimant entering work	Staff time sheets	1	£8,831	25%	0	£6,623
Service Users		Improved health and well being	Less visits to GP	Evaluation personal fitness plan	120 per year	£60	50%	0	£3,600
Volunteers	Time, Support	Financial savings	Savings in staffing at minimum wage(£6.50)	Time sheets	80 hrs week	£6.50 per Hour	0	0	£27,040
			General savings						
			Hospital inpatients - average cost per episode (elective and non-elective admissions)	Evaluation personal fitness plan	10 per year	£1779	50%	0	£8,895
			Reduction in obesity	Evaluation personal fitness plan	30	£16,688	50%	0	£25,032
			Reduced social isolation	Evaluation personal fitness plan	120 week users– 250 members	£900 per annum	50%	20%	£67,500

Project cost to CCG = £30,000

Total social Impact = £230,418

Benefit to CCG = £200,418

Plus an additional £30,768 in funding attracted from other sources

Total benefit of £231,186

Financial proxies derived from:

- PSSRU - Unit Costs of Health & Social Care 2013
- Unit Cost Database - Department for Communities and Local Government's (DCLG) Troubled Families Unit, and Greater Manchester and Birmingham City Council - update of the database undertaken by New Economy
- Knapp, M. Bauer, B., Perkins, M. and Snell, T. (2010) Building Community Capacity: Making an economic case. PSSRU Discussion paper 2772, PSSRU: London.