PREVENTATIVE SERVICES MARKET DEVELOPMENT BOARD

Annual Report 2017

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Executive Summary

The Preventative Services Market Development Board (PSMDB) was developed by North East Lincolnshire Clinical Commissioning Group in 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 groups that can increase the market supply of third sector providers.

The programme offers "seed corn" funding and business support to third sector organisations that have developed ideas with the potential to deliver significant impact on health and well-being but require a financial stimulus to get that idea off the ground.

As well as developing new services PSMDB also has ambitions to:

- Lever funding into the area from agencies that would not usually fund health and social care initiatives
- Increase social capital by developing new networks, relationships, and partnerships that can add value to the work of the CCG
- Create social value over and above the core work of the projects funded and demonstrate that impact in a transparent format.

In undertaking this work PSMDB is very much a pioneering organisation, learning lessons as it progresses, and as such, it takes a structured approach to programme development and reacting to changes in the environment in which it operates. This measured approach allows the board to understand the impact of programme changes and to respond to unexpected situations.

Following a root and branch review of systems last year the Board has adopted a fresh approach to development that concentrates on maximising project outcomes rather than prioritising the number of new organisations. This approach ensures that the community gains maximum opportunity to access new services and that savings to the CCG are prioritised.

This year PSMDB have trialed a new method of project development that utilises the surpluses developed by a profitable project to fund necessary but loss-making activities. The project is detailed in the body of this report.

PSMDB have also begun partnership working with an established social investor. This effectively provides resources to the health and social care sector from a source that would be unavailable to the CCG on its own. Again, the project is detailed in the body of the report.

The headlines for this year are:

Total value of Awards	£45,055.32
Additional Funds Levered into the health and social care sector	£334,780.00
For £10 spent by PSMDB, it has attracted a further	£74.30

This report outlines the successes of the project, looks at past and present projects and demonstrates what impact the Board has had on developing the marketplace, attracting new funding to the area and how added value and social impact is being created.

Contents

Background

In 2013 the CCG began a new project with the aim of developing new services that could impact on the health and social care sector, delivered by voluntary organisations and social enterprises.

The Preventative Services Market Development Board (PSMDB) was tasked with finding and developing organisations with the capacity to deliver new services that met the identified needs of service users, that was additional to any existing services, and that had the capability of becoming financially self-sustaining over a specified period.

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.

The PSMDB Board consists of;

Lisa Hilder (Chair) - Assistant Director for Strategic Planning

Christine Forman – Community Representative

Rachel Brunton – Head of Finance- Planning and Adult Social Care

Ros Davey – Single Point of Access (SPA) General Manager

The project had some distinct aims:

- To “shape the market” for the delivery of services towards self-care and independent living (the “shift to the left”)
- To act as a catalyst in the ambitions of the CCG to move towards a charging system for some services
- To enable a shift in the voluntary sector towards charging for services and a contract based method of delivery.

Projects have access to practical assistance through 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 project has been successful in developing new projects that contribute to the supply chain of services available to the residents of North East Lincolnshire and attracted considerable external funding to the health and social care sector that would not have been available to the statutory sector.

Somewhat unexpectedly the project has also acted as a catalyst in the development of new areas of work where collaboration between traditional service deliverers and the third sector is making a tremendous difference – attracting new financial resources, sharing overheads and streamlining service delivery. Please see the case studies for more detail

In addition to its primary aims, the project also has ambitions in other areas.

Other Benefits to be realised by the Board:

- Reduction of domiciliary care hours
- Improved physical and mental wellbeing – people feeling more safe and secure
- Increased opportunities for people to be independent and active
- Reduced re-admissions through supporting referrals for equipment
- Reduced impact on statutory organisations, i.e., care home provision

The programme

The programme offers "seed corn" funding to third sector organisations that have developed ideas with the potential to deliver significant impact on health and well-being but require a financial stimulus to get that idea off the ground.

Any new intervention is vetted by the Board, and only projects that are capable of meeting critical criteria are selected.

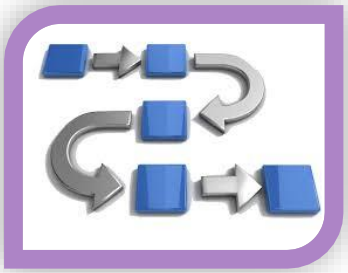
The main criteria are:

- Projects must be based on sound evidence of need for the service
- Applicants need to demonstrate how the work will impact the lives of service users and have systems in place to capture and prove impact.
- Be demonstrably financially sustainable once the funding period ends
- Have systems in place to ensure the delivery of high-quality services within current legislation.

Applications are generated from three sources:

- Organisations are made aware of the project through social media, mail shots and networking events or meetings and approach the PSMDB with their ideas to develop services that meet our aims
- The SPA (single point of access) team supply market information based on unmet need as identified through enquiries to their service
- The PSMDB Board identify gaps in provision and source and commission third sector providers to fill those identified gaps.

The project aims to make the application process as straight-forward as possible for the organisations applying while being rigorous enough to ensure that groups are capable of delivering services to a high standard.



The process

Applicants are asked to complete a simple Initial Application form which assesses the organisation's eligibility and outlines the proposed project. This is evaluated by the project manager who presents the idea with a recommendation on eligibility and comments to the Board. The Board decides at this point as to whether the applicant should proceed to a Full Application.

There is an option at this stage to invite project sponsors to meet the Board for an informal discussion. This generally occurs where the Board are not clear about some elements of the project, can see ways that they might add value to an idea through their involvement or where a project might benefit from interaction with other service providers.

The Full Application takes the form of a concise business plan and three-year cash flow forecast. Where investment is granted organisations are funded subject to achieving agreed milestones and are asked to sign up to terms and conditions that are bespoke to their project.

Reporting

Successful organisations complete a brief monthly or quarterly report (dependent on a risk analysis of the project) based on agreed output targets and are given specialist training to put in place a system to record Social Return on Investment which forms the backbone of the evaluation process and is monitored and updated quarterly.

The PSMDB is overseen within the CCG via the Assistant Director for Strategic Planning.

Headline information to-date

Since 2013

Total awards	£315,278.16
Average Award Size	£26,273.18
Additional Funds Levered	£1,124,967.16
For £10 spent by PSMDB, it has attracted an additional	£35.68
Total Combined funds invested in Community Health Services*	£1,100,245.32
Social Value created of	£2.6m

*PSMDB grant funding, organisations own contributions and external funding attracted

Policy objectives

The PSMDB project was established to meet the challenges that change in policy made to the delivery of health and social care in North East Lincolnshire and seeks to contribute towards a range of Health and Social care objectives including:

Start well, live well, age well

HUMBER COAST AND VALE SUSTAINABILITY AND TRANSFORMATION PLAN SUMMARY

Our vision for the Humber, Coast and Vale Sustainability & Transformation Plan (STP) is to be seen as a health and care system that has the will and the ability to help patients start well, live well and age well.

To achieve our vision, we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves.

Quality

•*Many people who are in our hospital beds do not need to be there*

•Many people can't see their GP when they need to so they go to A&E

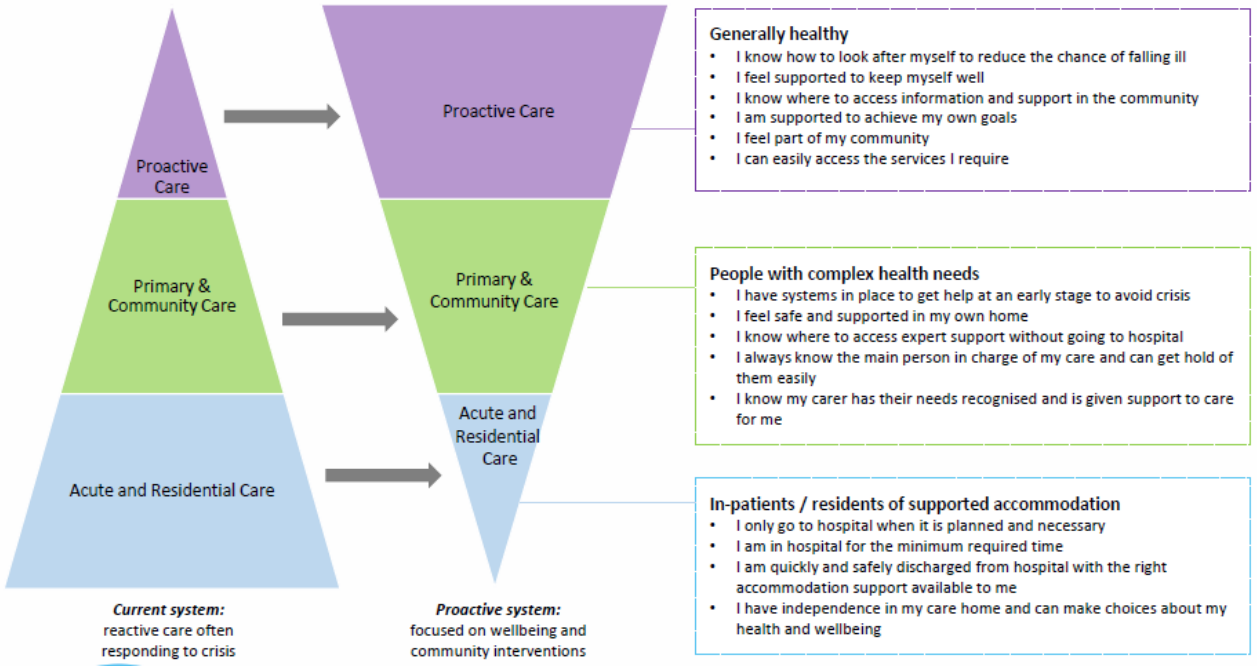
•There is a significant waiting time to access many of our services

How will we make the change happen?

Improving our health and care system in the way we describe in this document will not happen overnight. We are trying to resolve challenges that our communities, public and voluntary sector organisations have been tackling for a long time. It will also require consultation and a significant change in the way we work as organisations. *There are some 'enablers' we will need to put in place to support us as a partnership in making this happen.*

Our Vision: start well, live well and age well

Everyone in the Humber, Coast and Vale footprint should have the opportunity to start well, live well and age well. We are facing major challenges in health and well being, quality and care, and efficiency. Our proposals aim to move from a reliance on care delivered in hospitals and institutions to helping people and communities care for themselves in a proactive care system. We have set out below the kind of model we believe our patients and citizens are looking for and the aspirations we should be aiming towards.



What will the impact be?

•When I am referred to hospital, I quickly receive an appointment

•I receive a consistent, excellent quality of treatment from all hospitals in the HCV footprint

•I have access to hospital services which meet my need

•*I only go to hospital when it is planned and necessary*

•*I am in hospital for the minimum required time*

•*I am quickly and safely discharged from hospital with the right accommodation or support available to me*

Local Impact

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 gets 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 helping 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 principal 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 more 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 signaled the Government's commitment to support active and inclusive communities, which support people to develop and maintain connections to friends and family.

Innovation in project design and funding

The PSMDB is continually looking for new and innovative methods of funding projects. We see innovation as a vital element of the project and as a tool that helps to provide cost savings and helps to drive out duplication.

This year with have experimented with a new technique based on a key element of social enterprise development – namely the multiple uses of resources to bring about more change than would usually be created.

3 for 1

Background

The board regularly "scan the horizon" to spot emerging trends in demand for services and to understand where current provision will be unable to meet that need.

This year three areas fell into that category;

- Projects for the deaf
- Footcare services
- Access to computer and ICT skills for elderly and disadvantaged groups.

The Board put out a call for organisations interested in delivering these services. Invitations to become involved were sent via the database of third sector organisations operated by project managers (CERT Ltd) and across social media.

Foresight (North East Lincolnshire) expressed an interest and were asked to submit initial applications for the three projects.

Foresight worked with the project managers, and it soon became apparent that although there was demand for all three services, the ICT project and projects for the deaf were not able to generate sufficient income to cover the costs of delivering them in a timescale that would ensure their survival. The footcare project, on the other hand, was capable of generating a reasonable surplus within a few months.

Rather than merely dropping to two unsustainable projects, Foresight presented all three ideas as a single project that utilised the surpluses generated by footcare to subsidise the rest of the activity. Clever use of existing premises, staffing and volunteers further supported the development of the idea.

A single grant has therefore resulted in the establishment of three projects,* and more importantly, has opened up a new focus of project development based around increasing activity in identified locations that are seen as hubs by the local community.

This approach recognises that there are considerable savings to be made by grouping services together and utilising shared resources to offer a bespoke service to a geographic area based on its specific and identified needs. To facilitate this approach, the Board entered into discussions with Key Fund Yorkshire (a social investment organisation) and a partnership has been formed to commence work on developing new activity.

The need for all three services has been identified both by potential beneficiaries and through health professionals working in the relevant field and this consultation along with the research undertaken which has determined a lack of similar services in the area which provides the evidence to back the ideas.

Regarding consultation, project sponsors worked closely with other organisations working with the target audience and in total spoke to over 1000 people who would potentially benefit from their service. Additionally, the foot care and the silver surfers pilot projects were successfully run Scartho library with strong demand providing further evidence of local need.

* Further details of the projects are detailed in the body of this report

Working with banks and social investors

The Key Funds central mission is to provide finance – flexible loans and grant/loan packages – to help community and social enterprises to start-up, become sustainable, or grow. They invest in community and social enterprises who have traditionally been excluded; turned down by mainstream banks and building societies. Particularly those in disadvantaged areas.

In 2016 PSMDB worked with Key Fund to establish a package of loan and grant for organisations delivering larger scale initiatives. Key Fund offered to match any grant allocation made by the PSMDB board with their funds. Although no projects of sufficient scale came forward the relationship between the organisations was maintained.

In September of 2017, an opportunity arose when the Key Fund was asked by Big Lottery Fund to develop a project in Grimsby aimed at incubating new social enterprises. In particular, they were keen to see ideas that had a "realistic route to market" – projects that knew who they were selling services to, and who had a realistic dialogue with those markets.

They approached our project managers (CERT Ltd) who suggested that PSMDB offered such an opportunity and with the added benefit of possessing data around need and demand for services.

The project will concentrate on developing an organisations capacity to deliver new health and social care related activity and will stimulate market growth in North East Lincolnshire.

As well as helping new project start-ups the initiative will also work to support existing deliverers of services and help them with issues that they face in growing their service offer. This aspect of service delivery was designed in response to difficulties faced by some of the projects that we have helped to establish, who without assistance could be at risk.

The partners are now able to offer six identified organisations;

- A package of support and mentoring
- Access to funding and investment
- The opportunity to develop ideas in conjunction with the area's leading social investor
- The opportunity to work alongside commissioners and procurers of services in the public sector including Social Prescribing
- Mentoring by sector experts

The organisations taking part include;

- Two community hubs seeking assistance with developing premises to increase the scale and scope of their activities
- Meals on wheels service seeking support to grow their activities and consolidate their current activity
- A sporting club developing a range of community initiatives designed to impact on physical and mental well-being and reduce social isolation
- A women's project developing sustainable income through interaction with the public sector to enable it to assist more women.
- A project working with the elderly to develop a new specialist centre

The community footcare project

The main aim of the 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 service is delivered over four days on a weekly basis at a range of community venues across the whole of North East Lincolnshire including outlying villages where transport may provide an issue to community members who would benefit from the service.

Currently, the project works out of venues in Scartho, Immingham, Cleethorpes, Waltham, Humberston, Habrough, Stallingborough, Laceby, Littlecoates area of Grimsby and central Grimsby. Further venues will be developed as need arises all of which will be risk assessed to ensure ease of access and beneficiary safety.

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

- To provide a supportive, relaxed, and non stigmatised environment close to people's homes to increase access to health-related preventative activity for the hearing impaired, older people and disadvantaged communities
- To maintain people at low levels of need and maximise independence.
- To provide opportunities to the hearing impaired, older people and disadvantaged community members that will lead to a healthier lifestyle and improved quality of life.
- To reduce the need for long-term health-related care and support.
- To develop a financially sustainable service that continues to offer long-term health-related benefits to our target audience

The service provides a low-cost foot care service (in most cases 50% less than private practice) delivered by a fully qualified and trained practitioner who is employed by Foresight and operates under their quality standards policies and procedures, insurance policies, recruitment standards (references and enhanced DBS check) and access the training relevant to the service e.g. Safeguarding, Lone Working

The project was developed in partnership with the Older People's collaborative to secure appropriate venues, and delivery of the service takes place when another activity relevant to our target audience is taking place. Consultation has highlighted that more and more people are no longer meeting the eligibility criteria for a free service, that private practice is too expensive, and there is no local based access to affordable provision of a similar nature (the prices range from £15 - £20)

The project is now seeing up to 80 service users a week and will soon reach its capacity. Plans are in place to train more technicians to meet the growing demand.

The service provides a range of benefits both to the customer and to local health services.

Customers have access to a much-needed service that is affordable and near their place of residence which will serve to negate the need for potentially expensive travel. Also, the service through high-quality foot care enhances mobility, lessens the potential for falls and prevents the escalation into higher need of health services related to poor foot care, e.g., diabetes.

Other benefits the service offers are that the services are delivered in community venues in tandem with other activities ensuring the project can signpost and introduce beneficiaries to potential activity that can enhance community involvement and assist in reducing social isolation.

The service aims to reduce demand on GP's, reduce visits to A and E and reduce hospital admissions through improving mobility, lessening the potential for falls, preventing the escalation into higher need of health services related to poor foot care and increasing community interaction decreasing the likelihood of depression caused by social isolation.

Silver Surfers

Silver Surfers delivers a holistic service to people who require support to fully understand and access the benefits of modern technology (laptops, tablets, smartphones).

The majority of this service is delivered by volunteers all of whom are recruited by Foresight and operate under their quality standards. Significantly within their volunteer base are two retired school teachers who provide training to new volunteers to ensure they have the skills and knowledge to provide a high-quality service which meets the needs and requirements of project beneficiaries. This is complemented by two qualified IT trainers within their staff team who are be seconded to this work stream if demand exceeds expectations.

The service is delivered Monday – Friday however given the level of volunteer input, there is potential for the service to be available on weekends. The service is provided both in community venues and through home visits for people facing mobility and access issues and sessions is delivered either 1-1 or as a group in line with personal preference.

A designated volunteer is appointed to support every individual who accesses the service and where possible the volunteer best suited to the requirements of each individual is matched to provide ongoing support until a level of competence is reached.

The volunteer workforce can advise on purchases with particular regard to budgets, general use of modern technology, enable use of the internet as a means of shopping, communication, research, etc. and any other aspects of contemporary technology that any arise and this will cover PC's, laptops, tablets, and smartphones.

Once fully established between 20 and 30 people a week will access the service, the majority of whom will be older people. The project aims to work with a minimum of 500 people a year. This figure and demographics of our client base has been determined through a pilot project and demand for the service as highlighted through consultation with potential beneficiaries and health professionals Focus and the Older People's collaborative who will also play an essential role in identifying and referring individuals to the service

The service provides a range of benefits both to the customer and to local health services.

Customers have access to a much-needed service that is affordable and near their place of residence which will serve to negate the need for potentially expensive travel. Also, the service is delivered in community venues enhancing community involvement and assisting in reducing social isolation. Additionally, they have access to support, guidance and equipment which will lessen frustration, improve everyday living and enhance quality of life through improved communication, online shopping, etc.

This project reduces demand on GP's, prevent regress into a downward spiral of health through improving quality of life both for the individual and family circle and by increasing community interaction and communication with the family circle lessen the likelihood of depression caused by social isolation.

An unexpected outcome of the project is a developing partnership that would enable service users to use online health checks and improve access to telecare services and as a result, save costs and assist the rollout of new technology in the area.

Hearing service

This project is now in its final stages of development.

The service will offer access to deaf awareness/ coping with hearing impairment courses which have been identified as essential at the point of diagnosis, and this programme has been developed in partnership with potential beneficiaries and health professionals and will be delivered by a qualified trainer.

There will be a small charge for this aspect of the service to cover costs and ensure ongoing sustainability.

To complement the training, there is access to a volunteer-led buddying/befriending service offering ongoing support within the home environment to assist beneficiaries to adjust to their hearing impairment and to cope with their situation and changing environment including advice on available aids and equipment available to enhance the quality of everyday living.

The programme will work closely with the audiology department, GP practices and Focus to refer individuals to this service.

To ensure sustainability of this aspect of the service, there will be a charge which will cover the out of pocket expenses of the volunteers.

The third aspect of this service will be the opportunity to purchase aids and equipment to assist with everyday living and improve quality of life. A partnership between Foresight and Connevans, a leading equipment supplier to hearing impaired people has been developed.

This will provide a service where clients will be able to view the catalogue and order and collect equipment at community-based activity venues ensuring access close to their homes. This will also be complemented by the supply of batteries and re-tubing being available at all these venues.

To add value to this service Foresight have worked closely with Connevans who have agreed to train designated volunteers to install equipment where relevant, and allow the return of equipment at no cost if it proves to be unsuitable.

Also, there will be quarterly exhibition and demonstration days Foresights Warehouse facility allowing people to view and test equipment with further added value through working with suppliers of sensory impairment aids, mobility aids, and the Assisted Living Centre.

This aspect of the service will become sustainable through the commission Foresight will collect on every sale and a charge for the fitting service.

The final aspect of this strand project is the development of social activity within community venues specifically for people with a hearing impairment. Working in tandem with existing organisations and utilising a range of venues located in recognised community hubs in Scartho, Cleethorpes, Humberston, Waltham and Immingham specialist activities will be offered and suitable adaptations such as hearing loops will be installed. Once these are established there will be access to social activity and community integration on a daily basis at a local venue. These clubs will be volunteer-led, and a small charge will be levied to cover expenses which will ensure the sustainability of this aspect of the proposed service.

There are over 1000 people registered with hearing impairments with Focus. Once established it is estimated that between 25 and 30 people a day, the majority of whom will be older people, will access the social clubs, with an average of 200 people a year accessing other aspects of the service. This is based on a consultation exercise, however, given the need for this service, this may well prove to be a conservative estimate.

Previously funded projects - success stories

St Hughs - Fresh Start Meals on Wheels

The St Hughs Centre is situated in the West Marsh area of Grimsby. The centre provides activities for all the family including a "Meals on Wheels" service which provides meals and support services to elderly and disabled people across North East Lincolnshire, seven days a week, 365 days a year as well as a daily lunch club.

At the time the project applied for assistance they were providing around 400 meals a week.

An application was made to PSMDB to gain funding for:

Smarrt Software (financial and management tool)	£5,584
Kitchen equipment	£795
Hire of a second kitchen for 6 months	£7,280
Driver costs for 6 months	£15, 946

This application was approved by PSMDB and was granted Total £29,605. The project was then able to begin its planned expansion.

The project

Referrals mostly come from the Hospital Discharge Team and Social Services and by being able to take new cases on when required Fresh Start often are assisting preventing bed blocking which in turn saves the local authority money in fees in charges made by the NHS. Word of mouth generates new clients for the project.

The funding established a new kitchen in Cleethorpes which is used as a base for Cleethorpes and New Waltham customers; this is working very well and saves a lot of travel. The Cleethorpes kitchen is based in St Aiden's, and that is now also near capacity, and they are considering looking at another kitchen.

A significant benefit of the service is to keep an eye on customers and raise any issues Staff are trained in referring these to the appropriate agencies and have established procedures to work through. People want to stay at home, and they support people to do this.

Fresh Start has a higher number of drivers to customers and only cover about 15 each per day which allows for the time to be taken – other providers service 30 to 40 customers per day.

One of the key features of the project is the provision of freshly cooked food made from fresh ingredients and the health benefits that a nutritious brings. The project encourages people to be as independent as possible but adjusts for others who need more help. In these cases, they will often do little jobs for people to help them out as well as offering social interaction and contact with people. Staff are trained in Fresh Starts policies and procedures and raise any concerns that they have so help can be sought for people where needed from families or the professional services. The principal asset of the programme is the volunteers who deliver the service.

The last 12 months at Fresh Start – Managers Report

In the months between December 2016 and 23 October 2017, they have sold 37,325 meals. Fresh Start took a total of 229 Referrals in that period averaging out at 4.7 referrals per week. The breakdown of information taken from the referrals is as follows: Of the 229 referrals -

Long-Term Conditions	197	86%
In Rented Accommodation	63	27%
Have Support Worker	44	19%
Live Alone	146	63%
Care Package in situ	117	51%

Looking more deeply at the long-term conditions we can see what this means:

Dementia	46	23%
Parkinson's	9	4%
Cancer	16	8%
COPD	16	8%
Angina	4	2%
Heart conditions	36	18%
CVA inc TIA	15	7.%
Lung Disease	2	1%
Kidney Disease	4	2%
Learning Disabilities	1	0.5%
Liver Disease	2	1%
MS	1	0.5%
Mental Health	5	2%
Total		**77%**

The remaining 23% comes from Arthritics conditions plus non-medical conditions specified.

We have a total of 55 service users from the initial referrals who have dual conditions and in some case more

It is important to say that the work Fresh Start is doing in the North East Lincolnshire area is a vital component to many people staying at home who would have otherwise ended up admitted to care long before they need to be. It is also worth noting that 25% of their clients have no family living in the county. These are the vulnerable users who do not get regular visits and who are more prone to incidents than those who are regularly monitored by family members purely because of the lack of being observed. (other than professional agencies and then not always!)

A comment passed by the daughter of a service user and because of the services that her father received, she was in awe of the help we gave him when he needed it. "Pauline" a Dietician who lives and works out of the county said that without our regular support she would not have been able to carry on with her job without interruptions, and she would have had to relocate her father which would not have been the best thing for him at the time, being frail and in his 90's. When eventually he had to go into care she completed our comments sheet and said the following:

You not only deliver food but also look out for your customers. Mally (driver) was very caring, and if he had any worries about Dad's wellbeing he would contact the office, and we would be told. We very much appreciate everything you did for Dad. Keep up the good work.

She also went on to say how good the food was being home cooked and how varied the menu is.

Another client who we found collapsed at her home was supported well by her daughter, but because her daughter's job was quite demanding, she was unable to visit her mother most days only weekends, although they did keep in touch by phone. The driver was very instrumental in getting the service user the support she needed promptly, calling for an ambulance and then asking a neighbour to sit with her until the ambulance arrived. Meanwhile, the driver contacted the office and made contact with the family and the family we so grateful because no one else was expected to call and see her that day and spending a night on the floor could have been disastrous.

YMCA - Counselling Project

The key object of the project was to develop and form an Independent affordable counseling service, to provide counseling for YMCA clients, partner organisations, and private clients.

The aim was to provide quicker initial access to counseling services for YMCA clients than was currently possible - with the average waiting time locally to see a counselor being about eight weeks. This would lead to a quicker assessment, and it is this assessment that is the most vital element of dealing with an individual presenting themselves with Mental Health issues. This prevents the individual presenting themselves at their GP's Surgery or A&E, saving a significant amount of time and money for local health providers.

Special features and benefits

The creation of "YMCA Care" was also designed to offer *additional counseling provision to private customers who can afford the market rate* and an extra referral point for GP's willing to pay for their patients to be referred - this is over and above standard commissioned services.

It was proposed that this additional income was to be utilised to support less well-off clients and others by offering counseling to those on low incomes at an affordable rate. This would impact on the health and social care sector by reducing large numbers of YMCA and partner organisations clients and others presenting at their GP's or local A & E when they are unable to get a GP appointment, resulting in significant savings to local health budgets.

The counseling allows young people to overcome barriers to education, training, employment and independent living. The long-term sustainable benefits of the Social Enterprise are ongoing yearly programmes of training and other opportunities for trainees including volunteering places in different specialist fields to assist in their long-term personal development.

The programme was designed to support the future provision of Qualified Counsellors locally addressing the chronic shortage of counseling support for individuals of all ages but especially Young People.

Headline information

- The project attracted £57,000 of additional income from outside sources
- YMCA Care is now delivering "Group-based" provisions which are proving popular
- Training was delivered to 60 college staff on referring people with mild to moderate mental health needs
- The project employs a counselor - 20 hours week
- A £300,000 bid to Big Lottery to support the development project was successful and will finance the programme for three years with a possibility of on-going funding
- YMCA is now developing a programme aimed at combatting domestic abuse aimed at young men

Specialist Gym Project

The primary 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 minimize the need for longer-term health-related care and support.
- To develop a financially sustainable service that offers long-term health-related benefits to the target audience

Progress to-date

Warehouse Fitness is now fully operational seven days a week and also, to open access gym sessions it offers both personal training and an extensive range of fitness and personal health classes led by qualified instructors with availability seven days a week. To date, the project continues to employ three staff with another 12 staff working on a self-employed basis delivering sessional classes and personal training.

The service is now in its fourth year of operation, and without doubt, it is now well established within the disabled community, the local East Marsh community, and it is also attracting people from the wider community of North East Lincolnshire.

At the time of the last report, the gym was accessed by 1000 people with over 180 people attending on a weekly basis, and this is complemented by an attendance of over 200 people at our fitness and exercise classes.

Current levels of activity

This year the number of Adults accessing the service has increased by 25% to nearly 1300 and over 250 people attending on a weekly basis.

The number of Foresight Disability Users has increased to around 50 a week.

Again, this is complemented by more than 300 people attending a growing range of fitness and exercise classes.

Additionally, the warehouse Gym delivers 3 x 2-hour general fitness classes per week during daytime hours specifically for disabled people which have had an average attendance of 18 individuals. These sessions complement the weekly gym sessions that Foresight host for disabled people which average around 22 people a session.

The project has always sought to improve access and availability to the disabled community and have been developing a buddying system utilising their volunteer base to provide support on a one to one basis in return for free use of the gym. This system is now fully operational and embedded in their volunteering programme.

Headline information

Project cost to CCG = £30,000

Total social Impact = £320,420

Benefit to CCG = £200,418

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

Total benefit to-date of £581,606

Time Banking

Foresight has 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 learned 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.

Progress to-date

New activities developed by the project in the last 12 months

Without any further funding from PSMDB, the project has continued to develop its activities.

- *A breakfast and Lunch Club at St Francis Church Cleethorpes started in June 2017 and has developed quickly, now catering to 40 people on average each week.*
- *Library membership has increased to 1800, and the group has developed a drama project for people with dementia as a way of using reminiscence to tap into people's creative abilities. Each person attends a weekly workshop over a period of 10 weeks*
- *The number of volunteers has grown by 27%*

From a standing start in June 2014 the project has seen phenomenal growth in the range of services that it has facilitated. The current programme includes:

Initial Lunch Clubs:

Scartho – held every Thursday and caters for 60 people on average each week.

St Michaels Littlecoates – held every Monday and caters for 30 people on average each week.

St Andrews Immingham – held every Friday and caters for 30 people on average each week.

The lunch clubs provide affordable, nutritious meals and this helps people to improve and maintain their health.

People have formed friendships, renewed old ones and meet at other times of the week for cinema visits, etc.

A group at Scartho have a telephone checking system where they ring each other to make sure that everything is well with the members.

Existing Social and Activity Groups:

Singing for Fun:

This meets every Monday at St Michaels. It is volunteer-led, and the group of 16 now sing regularly at Residential homes and at the Community Carol Concert at St Michaels. Apart from the benefits of singing together the group has started to meet earlier to share tea and cake and chat.

Tai Chi.

This meets every Tuesday at St Michaels, and an average of 17 people attend each week. This exercise helps with balance, mobility, and breathing. It can also reduce stress and anxiety levels.

Social group:

This meets at The Warehouse each Wednesday. People meet together, an average of 10 each week to socialise and join in different activities such as Kurling.

Dancercise:

This is a low impact exercise group and an average of 10 people each week meets to enjoy music and movement. This has obvious health benefits.

Scartho Community Library:

This now has 1800 members and activities take place 5 days a week.

Tai Chi – 15 meet each Monday.

Dancercise – 12 meet each Monday.

Jazz afternoons – held fortnightly with a quartet of retired musicians. This event attracts an average audience attendance of 60.

Over 50's keep fit – 12 people meet each Tuesday.

Chair Based exercise – 10 people meet each Tuesday.

Mah Jong/board games – 16 people meet each Tuesday

Bokwa - (cardiovascular exercise) – 11 people meet each Tuesday

Mosaic Workshops – 12 people meet once a month.

Art – 12 people meet each Thursday

Bingo – 26 people attend each Thursday

Step – 12 people meet each Thursday

Card making – 10 people meet twice a month

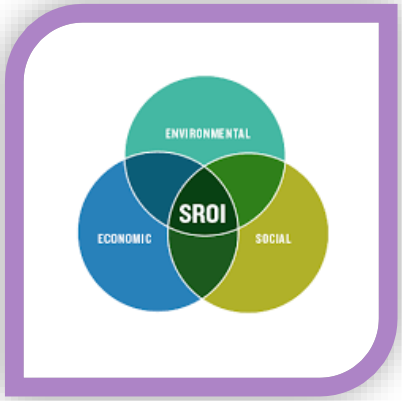
Knit and Knatter – 14 people meet every Friday.

The library is also a meeting place for the **diabetes support group**, **cancer support group**, **PCSO drop in** and **Ward Councillor surgeries**.

The library is developing its role as a community hub, information point and meeting place. It is part of the Safe Place Scheme.

Two extensions to the building are planned which will enable a range of new exercise and fitness to take place, communal space for dancing and recreational activities, changing and showering facilities that will facilitate the use of the hub by cycling and running organisations and plans for an artificial all-weather pitch are well advanced.

From a small initial investment made through PSMDB, a whole network of financially self-sustaining services have been developed that impact on health and social care, add vibrancy to the community, tackle social exclusion and offer opportunities to develop volunteering while building considerable social capital.



Social Return on Investment

One of the key measures of success for projects is the levels of Social Return on Investment that projects are capable of producing.

Social Return on Investment is an analytic tool for measuring and accounting for a much broader concept of value, taking into account social, economic and environmental factors. It is particularly appropriate for the PSMDB project where we are keen to understand the full impact of projects and not only the cash savings that they produce.

This approach produces many benefits including:

- Quantitative analysis of outcomes
- Continuous improvement and monitoring of performance
- The ability to design more effective service provision
- Stakeholder input

An example of the Impact Map that collects and reports social impact is appended to this report as Appendix 1

The Lessons Learnt in 2017

This year sees some of the projects developed coming into maturity.

While it is satisfying to see that the Boards aims of developing financially sustainable enterprises coming to fruition, this isn't a straightforward process.

Organisational issues

Organisations have to some extent, suffered from “growing pains” as they have developed and expanded.

Critical areas of difficulty have been;

- Cash flow
- Adopting a robust company structure that meets the needs of the organisation and its stakeholders.
- Tax and VAT issues
- Capacity – finding staff and in particular volunteers
- Capacity – capable trustees and business/management skills

The Board has worked with these organisations and signposted some to external sources of support. However, there are still gaps in provision for organisations who are not at the start-up stages of their development.

The Board this year has continued to widen the envelope of its strategy and has again looked at fresh approaches to funding and partnership and in doing so has made great strides in attracting new resources to the health and social care sector **(Key Fund)** and making the best use of existing resources **(3 for 1)**

Building capacity

There is considerable capacity within the organisations who have successfully adapted to the new environment where grant funding is shrinking and earning income becomes the norm.

This capacity can be used to develop new projects that complement those already innovated and benefit from the joint use of resources, buildings, and staff. Backing winners is a good way of increasing success. With this in mind, the Board is looking at a different approach to development by identifying organisations or venues that already have significant relationships with our target service users and offering support to grow the diversity of services on offer. This approach makes the best use of people, resources, and buildings and builds hubs that people in need will instinctively turn to in times of need.

Demand

Identifying demands for services has proved a more complex process as the project matures. There is no lack of people and organisations approaching the Board with projects to address needs. However, it is quite often a very niche need, lacking sufficient demand to sustain financially sustain a structure in the mid to long term. Given the nature of the issues that we seek to address it is difficult to assess demand and time has been wasted in developing ideas that eventually prove not to have a market. The application process has now been adapted and demands much more rigorous research. This has resulted in a much lower level of applications but much higher quality projects. The balance here will always be to back winners but not to be so risk-averse as to miss opportunities to impact on some of the hardest to reach in society.

We need to be better at capturing evidence of need from a wider range of sources – this is market information and should better inform the projects we support

Time

The length of time it takes for a third sector organisation to adapt from a fully funded to an income generating model is much longer than we originally envisaged. We expected that 12 months should be a realistic time. For mature organisations, this proved to be realistic, but for less mature organisations this has proved problematic. Many third sector organisations do not fully appreciate the difficulties of putting in place a charging system for their existing clients. Some third sector organisations are unwilling to even to consider offering charged for services.

Many organisations have reported difficulties in changing the ethos of their organisations with volunteers and trustees being wary of any business model that involves charging for services.

Another critical issue is "mission drift" – the idea that in adopting a business-like model the original mission of the organisation is watered down or lost.

Overarching lessons

The PSMDB programme and its successes need to be seen in context.

The aims of the project are ambitious, the approach is very innovative, and it operates in a potentially hostile environment. Within that environment, there are many vested interests, potential conflicts, and some very entrenched bureaucratic processes.

Despite all of this the programme has managed to implement new thinking and approaches to tackling some of the major issues in developing preventative services while only upsetting a tiny number of people! This has led to increasingly diverse partners becoming involved or consulted during service development and new partnerships and co-working scenarios being developed.

Our root and branch review told us……

- Small is beautiful – PSMDB is a tight group of people with a common purpose from diverse backgrounds and able to make swift decisions and this has enabled the project able to react to situations and develop solutions without the “baggage” of a larger organisational structure
- Robust contracting and monitoring is essential even though it is sometimes difficult to quantify outcomes
- The journey way from grant funding to a charging model is a tough one for some organisations and impossible for a minority. This isn't always obvious, and so a limited project failure rate should be anticipated
- By working in a spirit of genuine partnership the public sector and third sector can innovate solutions to issues that could not be solved working alone

- The health and social care sector tends to work in silos, and it is essential that when developing new initiatives organisations start a dialogue to ensure complementarity and avoid duplication
- It is crucial that organisations exploring this approach are given intensive advice and guidance and if possible on-going mentoring
- This method can attract considerable amounts of "new money" to the health and social care sector
- The approach generates significant social capital
- Sometimes it is almost impossible to capture all the benefits of a preventative service – it's difficult proving that something *hasn't* happened as the result of an intervention!

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/Traineeships	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