PREVENTATIVE SERVICES MARKET DEVELOPMENT BOARD

Annual Report 2016

Neil King, Director
CERT Ltd
November 2016
neil@cert-ltd.co.uk

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 organisations that can increase the market supply of third sector providers.

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.

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 react to unexpected situations.

After two years of constant activity, working with a wide range of organisations, this year the Board decided to undertake a radical review of its' work to-date and to re-purpose the project to take account of the lessons learnt from the funding of previous projects, the rapidly changing environment in which the programme operates and changes in the scale and nature of the voluntary and social enterprise sector.

As a result changes have been made across the project including a more rigorous application process through to new thinking about the size and scale of the funding available and a fresh approach to market development.

Although this has taken significant effort it is becoming apparent that this radical change of approach has significantly improved the quality of projects funded, safeguarded the funding available to groups by filtering out less robust applications and focussing efforts onto organisations that are genuinely capable of meeting all of the Boards criteria in a realistic timeframe.

That said, PSMDB has this year, attracted an additional £601,560 of funding to the area and has attracted £790,187 since its inception in the summer of 2013 and so clearly, progress is still being made.

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

Contents

Executive Summary 1

Contents 3

Background 4

Other Benefits to be realised by the Board: 5

The programme 6

Headline information to-date 8

Policy objectives 9

2016 Projects 14

St Hughs - Fresh Start Meals on Wheels 14

YMCA - Counselling Project 19

Green Futures – One Box Scheme 24

Previously funded projects - success stories 28

Time Banking 30

Social Return on Investment 33

The Lessons Learnt in 2016 34

Overarching lessons 35

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 were additional to any existing services and that had the capability of becoming financially self-sustaining over a specified period of time.

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 project had a number of 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 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

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 key criteria are selected.

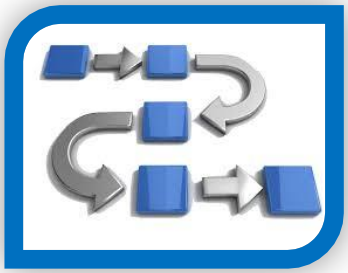
The main criteria are:

- Projects must be based on sound evidence of need for the service
- Applicants need to demonstrate how the work will impact on 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 generally generated from three sources:

- Organisations are made aware of the project through social media, mail shots and through 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 un-met 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 aim of the project is to make the application process as straight-forward as possible for the organisations applying whilst being rigorous enough to ensure that organisations are capable of delivering services to a high standard.



The process

Applicants are asked to complete a simple Initial Application form which assesses the organisations 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 make a decision 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

- 169 Initial enquiries
- 29 Applications processed
- Invested to-date = £270,222
- Average investment £24,565
- Additional funding levered in £790,187
- For every £10 spent by PSMDB it has attracted an additional £29.24
- Social Value created of £2.1m
- Total Combined funds invested in Community Health Services £1,010,410 *
- Additional £300,000 external funding in the pipeline
- Four new project applications in process in January 2017

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

Policy objectives

The PSMDB project was established to meet the challenges that changes 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

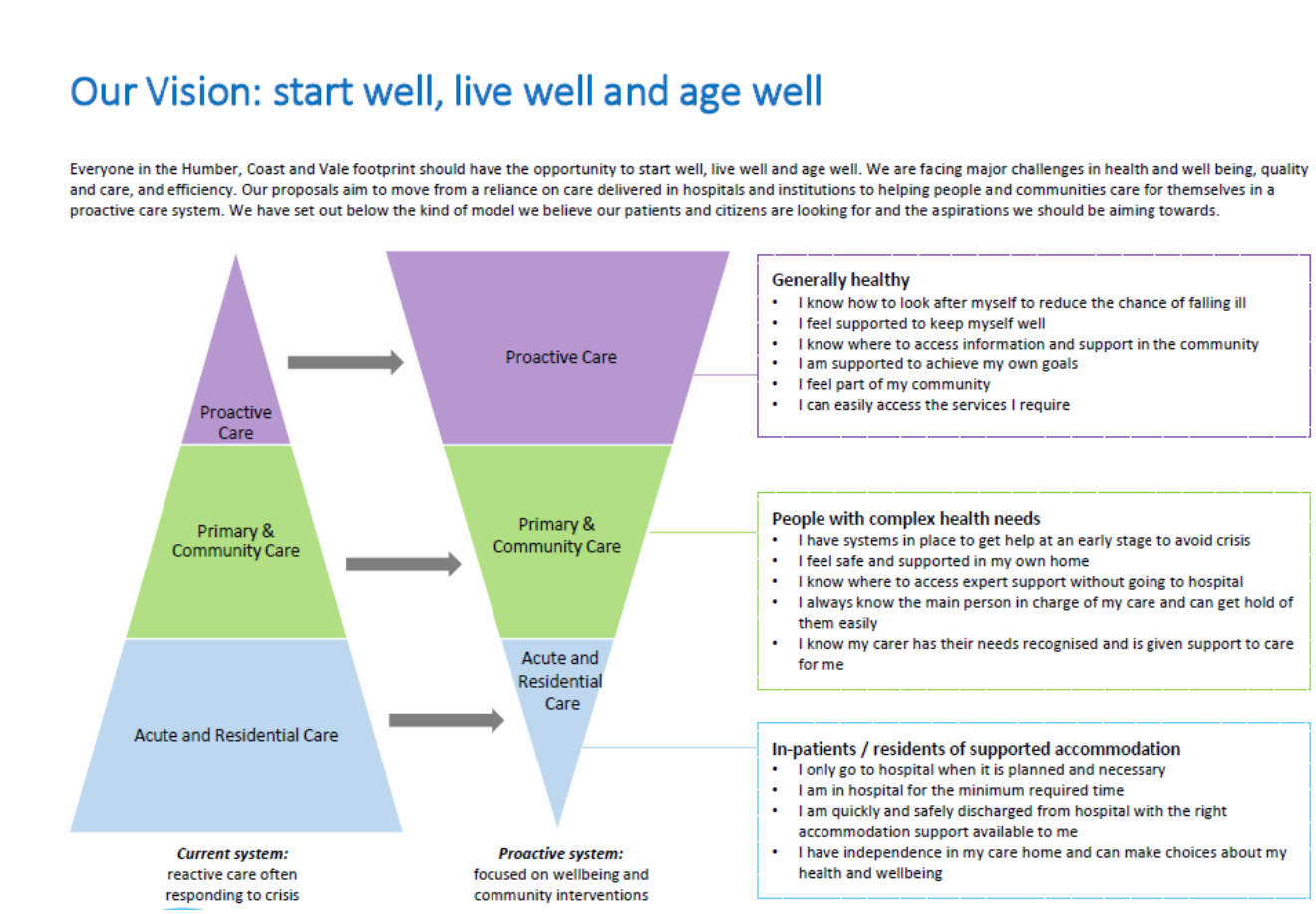
•*Many people who are in our hospital beds do not need to be there*

•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 a number of 'enablers' we will need to put in place to support us as a partnership in making this happen.*



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

Through Healthy Lives, Healthy Futures (HLHF) we are developing locality approaches from March 2017 that will operate within our Accountable Care Partnerships (ACP)

•*Through local teams will include community services, mental health services, social care, public health, GPs and acute providers, working together to respond to the needs of the population,*

therefore services will be much more 'joined up' for people who live there. Over time other partners from the community are expected to join, such as hospices, care homes and other community providers.

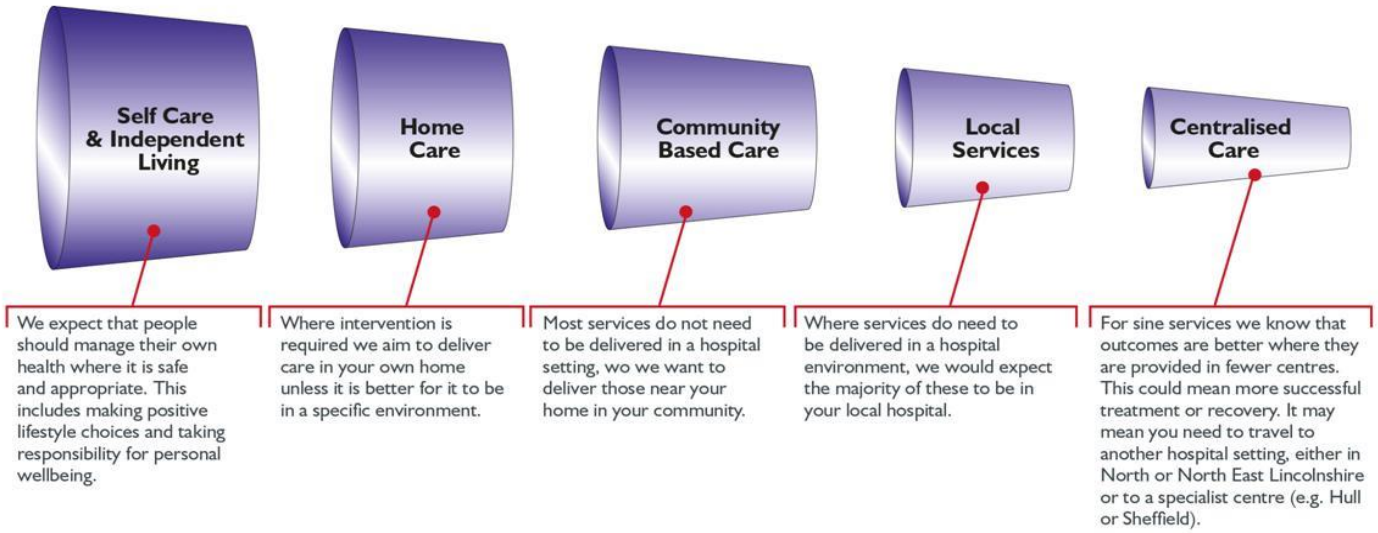
•*In North East Lincolnshire the model is being provided across two areas. Teams will be clustered around GP Practices and build on the experiences of the local social enterprise providers in delivering holistic care.*

•New services to help people stay well include -implementing over 75s wellbeing checks, community wellbeing checks, and targeted programmes to reduce smoking and alcohol misuse.

NHS
North Lincolnshire
Clinical Commissioning Group

NHS
North East Lincolnshire
Clinical Commissioning Group

The Shared Vision



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.

2016 Projects

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, 7 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.

Fresh Start Meals and Care was mostly run with a team of volunteers all of whom have a variety of roles within the meals service, such as Meals Assistants, Catering Assistants and Drivers. The project employed a Cook/ Supervisor to manage the kitchen.

Demand was growing rapidly but the organisation lacked the capacity to meet that demand.

Initially Fresh Start Meals and Care was created on the back of a very successful luncheon club held at St Hugh's Centre, Grimsby. From this single base the project had begun a small scale delivery service.

The service soon expanded out into other wards in North East Lincolnshire and into Lincolnshire. The pilot project highlighted the need for vulnerable people who would not normally be able to get into a centre to be able to access vital services, thus enabling them to remain independent in their homes longer.

The meals are only a part of the equation here, Fresh Start workers also act as befriender’s calling every day, being a friendly face and always having time for a chat, bringing shopping in and assisting with other duties where possible

Not only was there evidence of demand locally, there was a growing body of evidence that need would continue to grow. For example a report from the respected think-tank the Institute for Public Policy Research 'the generation strain: collective solutions to care in an aging society’ warned that the 'family care gap' will hit crisis point when the number of older people in need of some care will outstrip the number of family members able to provide it as soon as 2017. IPPR recommend investing in 'new neighbourhood networks' - volunteer networks to help older people stay active and healthy, help busy families balance work and care and reduce pressure on the NHS and social care.

On application the project was able to demonstrate the demand for their project and its ability to deliver a quality product – they had been inspected by Food Standards Agency three times in three years and on each occasion been awarded 5 points. All volunteers achieved Level 2 Food Hygiene qualifications.

Fresh Start recognised that the main threat to their service was that if the service grew in line with demand it lacked both the capacity and business expertise to manage that growth.

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 also generates new clients for the project.

The funding established a new kitchen in Cleethorpes which is used for 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.

There have also been some articles in the telegraph which have resulted in an increase in customers and volunteers, lots of others have heard via word of mouth. Families of elderly relatives often contact Fresh Start to ask for short term packages over holiday periods. Fresh Start is flexible they are able to pick these up and provide support on short notice.

A major benefit of the service is to keep an eye on customers and raise any issues Staff are trained in raising 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.

As the drivers are kept in the same area they get to know people and customers look forward to their call. Drivers can take time to spend speaking to the customer perhaps making a drink or some other helpful task like hanging out the washing – they often spend 10 to 15 mins on each call and can take longer if they need to.

Fresh Start have 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 cover 30 to 40 customers per day.

As well as supplying their own customers, Fresh Start has been able to assist other organisations in times of crisis by covering their provision. This has only been possible because of the PSMDB funding which has allowed them to set up the extra kitchen.

There are lots of examples of the "added value" the project has created including:

- A driver (an ex paramedic) had noted that the customer was not answering the door and did not appear to be out (his scooter was still there) Fresh Start contacted the family to alert them and his family discovered he had a fall upstairs and were advised that he may not have survived if he hadn't been found so quickly.
- In another case a customer who had been bed bound was now mobile and going out due to the improvements in her diet after two months or receiving lunches.

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 is trained in Fresh Starts policies and procedures and raise any concerns that they have so help can be sort for people where needed from families or the professional services. The major asset of the programme is the volunteers who deliver the service.

In some cases people come to them with no work experience at all and they spend time to build their confidence and to work towards an NVQ level two in food hygiene, their staff feel valued and believe in the project and feel that what they do is worthwhile. The project benefits from their labour and in turn, volunteers gain experience, qualifications and transferable skills.

Fresh Start are able to stop or start services with 24 hours' notice and support short term and long term needs. Meals are available for vegetarian and gluten free options and a meal plan is given four weeks in advance (if someone wants an alternative they can be accommodated as long as they notify in advance). At the point of referral Fresh Start do ask for a lot of information to give them some idea of the customer's circumstances and needs.

Current delivery

In the last eight months the project has:

- Served a total of 28,538 meals
- Have a total of 235 people receiving meals weekly from Fresh Start Meals and Care this currently equates to around 900 meals per week.
- Of the 235 new customers 174 are now receiving a meal as a result of the expansion since March
- Is still averaging 4 referrals a day with over 80% of people taking up our meals after enquiring

From the new starters taken over this period:

- 125 people have long term conditions
- 86 people are in rented accommodation
- 80 people receiving support from a support worker
- 125 people currently live alone in isolation
- 94 people have a current care package from an agency

Projections and actuals of the clients benefiting from the service

	Projection	Actual	Percentage +/-
Long Term conditions	40	125	+315
Rented Accommodation	35	86	+245.7
Living Alone	28	125	+446.4

The future

The project is currently exploring becoming a social enterprises and community interest company.

Although Fresh Start wants to expand further and have ambitions of 400 meals a day they don't want to change how they operate too much unless it is necessary.

The project is looking at succession planning with their sub group and at some point Fresh Start may need a volunteer manager to ensure that the volunteers are trained and that they maintain their very high standards (five points with the Environmental Health review).

They are nearing capacity in Grimsby and are looking at St Mark's church for a potential third kitchen.

Fresh Start offer a supper service which is a sandwich/salad and cake this is delivered with lunch and put in the fridge for later, as lunch is quite substantial most people would not want any more. The project is now considering providing courses such as cooking on a budget and bread making. A breakfast club was in place previously when weekend lunches were not provided and this was popular and may be revived.

Our service is quite comprehensive we are very keen to fulfil the care element of our service:

"The friendly face of the driver may be the only person they see in a day, they will chat to them whilst plating the meal and offer to do anything else within their remit...posting letters, taking rubbish out or, bringing in milk or other shopping the next time they call. They establish a professional friendship, they get to know the person and know when things are not right; early signs of something wrong are vital and may save lives. The drivers are trained to spot the unusual and contact the office with concerns, families or agencies are then alerted. "

That one visit per day helps to prevent social isolation, gives the families peace of mind, and provides nourishment - both food and mind.

Most people said 'they want to stay at home and not go into care; they want to be as independent as possible'. Our project supports this, it's not just about the meal, the care element is very important to independence.

Families tell us they benefit from the service; reduced anxiety and continuance of their daily lives, such as work, knowing that their relative is supported. We have provided evidence of this.

"There is no question that without the input from the CCG funding these statistics would not be possible; opening a second kitchen has allowed us to reach so many more needy people. People who we monitor and support daily over 365 days a year"……Sandra Mason, Project Manager.

YMCA - Counselling Project

YMCA Humber is part of the YMCA Federation in England financed and operating independently. They are a registered charity serving the interests of vulnerable young people at the core of its extensive range of work and activities.

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

The aim was to provide quicker initial access to counselling services for YMCA clients than was currently possible - with the average waiting time locally to see a counsellor 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.

The stakeholders of the project includes YMCA clients and those of a wide range of partners including Doorstep, Harbour Place and Shalom Youth Project to name just a few, as well as members of the wider community who need to access affordable counselling.

The service sought to put in place a valuable, affordable service that did not exist in North East Lincolnshire.

Special features and benefits

The creation of "YMCA Care" was also designed to offer *additional counselling 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.

It was proposed that this additional income was to be utilised to support less well-off clients and others by offering counselling 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 counselling 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 other specialist fields to assist in their long term personal development.

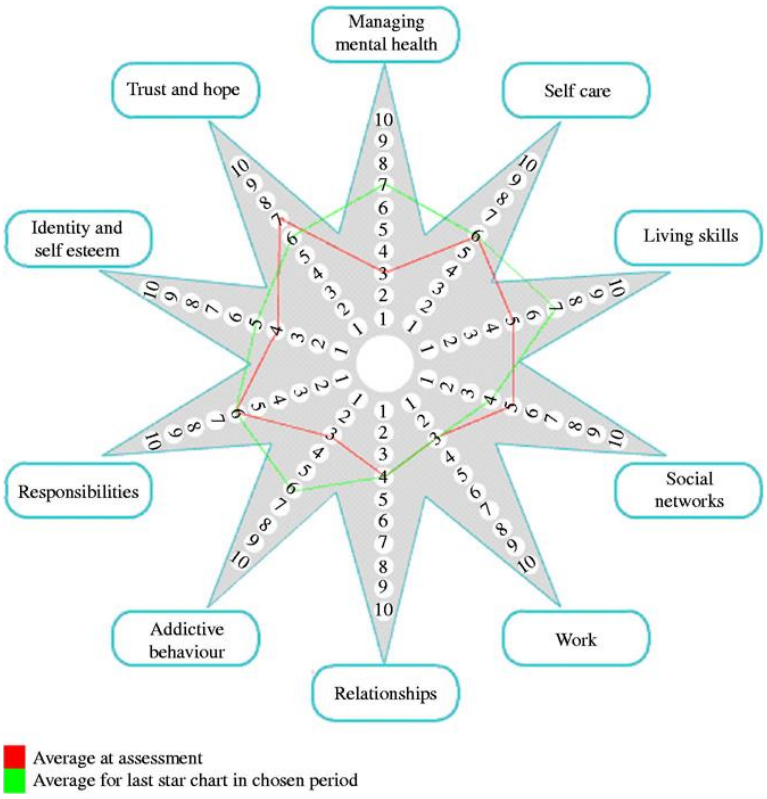
The programme was designed to support the future provision of Qualified Counsellors locally addressing the chronic shortage of counselling support for individuals of all ages but especially Young People.

Monitoring

Monitoring is used to assess the:

- The structure of care
- The process of care
- The outcome of care

During an initial client assessment coaches use the "Star Assessment Tool" to work with the client to identify an agreed programme of individual support and signposting to local Mental Health support such as Open Mind and Mindworks.



Information is then during the project:

- Initially collected by YMCA Care coaches during 1:1 sessions
- Responsibility for collation then lies with the YMCA Care Counsellor Team.
- Findings are available in graph/report form/sharing findings with Cert Foundation during and at the end of the pilot scheme.

YMCA conduct a weekly measurement of all residents against the Recovery Star chart (see above) which assesses that project outcomes are on track and the project is meeting the individual needs of client referred for counselling. Counselling takes place with the residents on an agreed programme to meet their individual needs to ensure that the service is balanced and working well. This enables an environment in which service users are able to discuss how well each part of the new service is going/what, if anything, needs to be modified.

Data collection also includes self-reporting; interviews; management reports and reviews. An important part of the evaluation process is clients regularly responding to online surveys and reviews with their coaches requiring them to reflect on the changes in their lives. These results continue to develop strategy therefore shaping the project based on evaluations by the clients themselves.

Evaluation of the counselling service focuses around two key measures of success. Firstly 'soft outcomes' which include improved confidence and self-esteem, increased aspirations, changes in attitude, expectation of a better future and clarity and purpose as to how that might be achieved. And then secondly focusing on physical and mental well-being alongside gaining new skills and improved education.

These outcomes help to create the conditions for the individuals being supported to become thriving adults capable of contributing to the wider community through work, training and volunteering. There is recognition that this involves changing patterns of behavior

The success that this affordable counselling is having on clients is further evaluated with detailed discussions about individual clients taking place within Multi Agency Meetings where required, where further support needs identified within the counselling can be put in place by means of an agreed support plan and programme agreed by both the programme and the client.

Headline information

- The project attracted £57,000 of additional income from outside sources
- The project aims to increase its turnover this year by £28,000
- Engaging with “private paying clients” has proved difficult
- Life coaching work has generated £7,000
- YMCA Care are developing “Group based” provisions which is proving popular
- Training was delivered to 60 college staff on referring people with mild to moderate mental health needs
- The project employs a counsellor - 20 hours week
- Two students have enjoyed placements with the project and one has now been employed
- 118 people have received one to one counselling over an average 4 sessions
- 28 YMCA clients received counselling
- A £300,000 bid to Big Lottery to support the development project has reached its final stage
- YMCA are now developing a programme aimed at combatting domestic abuse aimed at young men
- YMCA have committed to financially support the work for the next 3 years

Lessons learnt

- The initial programme of six sessions has been reduced to four because of drop off after four weeks
- Referrals came mainly from the Job Centre or a waiting list at Open Door – Job Centre clients felt obliged to attend and interventions were more difficult with this group
- There has been a tendency to refer the hardest to help to the project
- People were often referred to the project who fell outside the age range and therefore more work needs to be undertaken with agencies referring clients
- The project has raised the profile of counselling in the YMCA to the extent that it is now part of the organisations core function
- YMCA now know that 3 out of 4 of their clients are experiencing some sort of mental health issue
- Early intervention is crucial especially around domestic violence which is a growing issue
- There are very few referrals from G.P's
- The project cannot sustain itself through the provision of private counselling but will survive using a variety of funding only available to a third sector organisation.

Green Futures – One Box Scheme

Green Futures is a community project located in Bradley, Grimsby. It functions via a 3.5 acre site used for growing fruit, vegetables and plants with an orchard, wetland area, woodland and a community room.

The site is used for workshops about wildlife, where food comes from and craft activities. Schools and community groups such as guides and scouts attend regularly. We deliver workshops, coffee mornings and meetings in the community room and run regular dementia cafes and a weekly walking group.

They employ 5 staff members; everyone else volunteers their time or attends as part of work placements, traineeship or a community project. The people who attend site are often referred from other organisations; most have additional support needs including behaviour problems, learning difficulties, physical health and mental health issues. In the last 2 years they have supported 90 volunteers and 125 work placements/experience. Activities include gardening, horticulture, crafts, admin, food production and delivery.

At the time of the application Green futures was running a pilot Veg-Box Scheme, delivering two days per week. The pilot used food grown on-site and locally sourced and also sold preserves, free range eggs, whole-foods and eco-friendly products providing quality produce and supporting the local economy.

Proposal

The key objective of the new project was to provide a 'one-box' delivery service for people who live alone, elderly couples to promote their independence and/or people who for health reasons need to change and improve their diet. The idea was to support people to eat a healthier diet by delivering boxes of fresh produce to people's homes or community group on a weekly basis.

This was a small box of mixed Fruit and Veg (and salad when in season) made to people's dietary preferences, customers would also be able to order additional items such as whole-foods which are gluten free, GMO free, meat free, dairy and lactose free etc.

The supermarkets mostly sell items in large quantities; this is unhelpful for the people mentioned above.

Each box was designed to provide just enough to make healthy, hearty meals such as stew, soups, salads etc. Every delivery was to include a sample recipe with ideas of what to make with the Vegetables.

The day to day function of the Scheme (sorting, packing, weighing produce) was to be carried out by volunteers. Green Futures have a team of reliable van drivers who volunteer for the project on a rota.

The project needed seed corn funding for the first six months and requested help with:

- Part time member of staff (3 days) to run the project
- Part time (1 day) administration costs
- Promotional materials, resources and printing
- Vehicle costs including tax, servicing, insurance, fuel, maintenance
- Purchases for Veg-box orders – Fruit & Veg, eggs and whole-foods
- A proportion of Green Future's running costs including utilities, rent, office space, telephone & broadband, IT equipment

Total funding of £13,168 was awarded in January 2016 but with restrictions in place including monthly monitoring of outputs and the development of milestones based on the sales of boxes to new customers.

What happened?

The one-box scheme managed to achieve over 30 customers in the funding period which exceeds the target of 25 customers. Of these customers and given the information gathered we know that 13 are retired, 3 have physical disabilities, 2 have cancer, 1 is recovering from a stroke, 3 want to only purchase organic produce of which 1 has a special diet, 2 live in sheltered accommodation and 4 have become volunteers at the project. Unfortunately the project also leaked customers and so the total pool of customers was much less.

Some customers found that a £6 mixed fruit and veg box was (although good value for money) was still too much for them to eat, so reduced to a box on a fortnightly basis or telephone orders while others cancelled their order.

The project was widely promoted and staff attended Shoreline meetings, events and supported housing schemes, various fairs including Peak's Top Farm, Age UK, Older people's networks and meetings, met with the collaborative team, attended church events, provided workshops at groups such as the Women's Institute, Cleethorpes Ladybirds, Women's Guild etc. and attended Friendship at Home coffee mornings. It was also promoted via social media and leaflets sent to existing customers, neighbours and surrounding areas.

To enable the scheme to work Green Futures has been reliant upon volunteer hours. Over the period of the project volunteers became unavailable for a variety of reasons making delivery and sorting problematical.

The one-box project has reported numerous issues including the following:

- A shop called Vegan-Vegan opened in the centre of town, selling similar produce resulting in a substantial drop in customers requesting whole-foods.
- The Food for Fitness (FFF) team and the whole of the Developing Healthier Communities service went through a restructure, the FFF team were based at Green Futures and subsequently relocated with uncertainty about their roles, in this time they added a pricing structure to delivery that was previously free making the cooking sessions unviable.
- The Older People's Support Service team at Shoreline Housing were made redundant.
- The Veg-Box Scheme manager and CEO both required time off sick resulting in the project being postponed.

It was initially projected that the project would need to reach 50 – 100 regular customers to become financially viable. This included covering the costs of the Veg-Box manager, the vehicle and general running costs. This would cover the required costs of the amalgamated veg-box and one-box service. The project was not able to meet that target. Although the funding has come to an end the project still promote the one-box and have it as part of a veg box scheme offer.

The lessons learnt

This project was the first to under-go the new and more robust application process.

Although ultimately it was not successful in delivering the projected outcomes, the Boards increased scrutiny meant that when key staff was lost through illness funding stopped and only re-commenced once the organisation was ready to start delivery again. Because we measured milestones on a monthly basis we were able to halt the project once it became apparent that it was struggling and save considerable funding. We are very aware that organisations need to be sufficiently developed to take on this sort of project and that we need to be even more robust in looking at the staffing, financial resources and management of organisations if we are to reduce the quantity of failed projects.

We link the work of PSMDB to the work undertaken by the Sector Support North East Lincolnshire project which exists to provide practical support to third sector organisations seeking to build their sustainability as well as signposting to other development initiatives.

Previously funded projects - success stories

Specialist Gym Project

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 offers long term health related benefits to the target audience

Progress to-date

Warehouse Fitness is now fully operational seven days a week and in addition 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 3 staff with another 12 staff working on a self-employed basis delivering sessional classes and personal training.

The service is now in its third 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.

During the last year the gym was accessed by 1000 people with over 180 people attending on a weekly basis and this is complimented by an attendance of over 200 people at our fitness and exercise classes.

Based on previous success we have continued to implement a mandatory policy that all members undertake an induction where health issues are identified and each individual is set agreed goals with a personal assistance plan in place which is monitored on an ongoing basis by gym staff and updated as health improvements are demonstrated.

Additionally the project continues to deliver an average of 37 personal training sessions per week and continues to offer a choice of 18 classes every week with an average weekly attendance of over 200 people.

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 and the Gym currently has 47 people matched with volunteers who are benefiting from the buddying service

Through consultation with parents and families who use the gym Foresight has identified a need to engage with children and young people and we have developed gym and fitness sessions for families and junior sessions which also incorporate dance and exercise. In addition we continue to invest money into the project in order to improve our facilities and in line with community demand we have recently invested over £12,000 in new equipment.

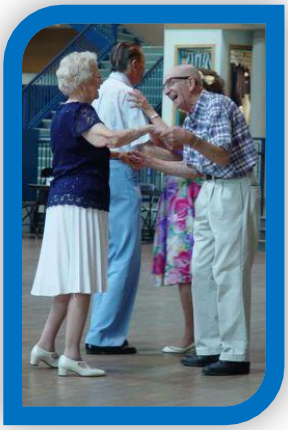
Project cost to CCG = £30,000

Total social Impact = £230,418

Benefit to CCG = £200,418

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

Total benefit to-date of £231,186



Time Banking

Foresight have 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.

Progress to-date

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:

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.

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 have 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 1020 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

Book Groups – a total of 13 people meet each month

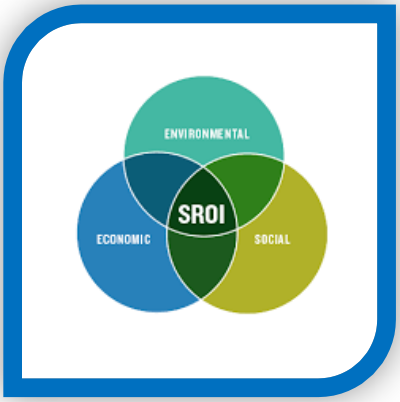
Card making – 10 people meet twice a month

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.

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 whilst 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 2016

- A more stringent application process will weed out weaker proposals but inevitably decreases the number of projects being funded
- There are a strictly limited number of third sector organisations capable of delivering high quality services in a financially sustainable model
- Work to increase this number through the newly established VCS Infrastructure Support programme will take time and cannot be expected to develop organisations capacity sufficiently in the short term
- 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 consider offering charged for services.
- There is considerable capacity within the organisations who have successfully adapted to the new environment and this capacity can be used to develop new projects that compliment those already innovated and benefit from joint use of resources, buildings and staff. Backing winners is a good way of increasing success.
- The PSMDB approach is effective in levering in new resources and income that would otherwise not be available to the health and social care sector
- 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

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 whilst only upsetting a very small 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 very difficult 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 true 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 important that when developing new initiatives organisations start a dialogue to ensure complementarity and avoid duplication
- It is essential that organisations exploring this approach are given intensive advice and guidance and if possible on-going mentoring
- This approach can attract considerable amounts of “new money” to the health and social care sector
- The approach generates considerable 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