AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

16 JUNE 2015

REPORT OF: Pooled Budget Partnership Board

EVALUATION OF THE VCSE HEALTH INITITIVES PROGRAME 2014-15

1.0. PURPOSE OF REPORT

1.1. This report has been produced to the present to the Health & Wellbeing Board the evaluation report commissioned from FUSE: The Translational Research in Public Health[1] for the Health Initiatives Programme commissioned through Catalyst and delivered by the voluntary, community & social enterprise sector (VCSE). The FUSE evaluation report and associated research was conducted by Teesside University. (Appendix 1 is the full report; Appendix 2 is an explanatory addendum that explains more fully methodology.)

2.0. BACKGROUND

2.1. The Voluntary, Community & Social Enterprise Sector (VCSE) Health Initiatives Programme 2014-15 was a jointly funded as a pooled budget by the Hartlepool & Stockton Clinical Commissioning Groups (HaST) and by Stockton Borough Council Public Health (SPH) and managed by Catalyst Stockton. Value of the programme was £633,333 which was divided £333,333 from HaST and £300,000 from SPH. Catalyst charged a 5% management fee to deliver this programme.

2.2. The 2014-15 programme followed a HaST only funded programme in 2013-14 which was managed by Synergy VCS Consortium and delivered by their member agencies. The change of delivery in 2014-15 was due to comments received from non-Synergy agencies that a more open access to the programme would seem to be more appropriate.

2.3. Both programmes were developed and projects commissioned through a partnership approach between the funding and managing agencies. This also included the North of England Commissioning Service (NECS) which undertook the detailed monitoring and contract management on behalf of HaST.

3.0. 2014-15 HEALTH INITIATIVES PROGRAMME

3.1. The 2014-15 Health Initiatives Programme was managed by Catalyst with

[1] http://www.fuse.ac.uk/

governance on behalf of the Health & Wellbeing Board being undertaken by a multi-agency panel comprising Chair of Health & Wellbeing Board, PH Lead Commissioner, CCG GP Lead, NECS Officers & Catalyst.

3.2. Funding was agreed in March 2014 and an application process developed with clear details of expected outcomes to be met explicitly shown. Catalyst then managed the process of getting proposals for projects which included open, multi-agency briefing sessions as well as the actual application process. As a result, 31 bids were received and 16 projects were commissioned by the middle of June 2014.

3.3. One of the overarching intentions of the programme was to try out new ideas and approaches to address intractable problems. Proposals were sought that used the strength of relationship enjoyed by VCSE agencies with individuals and communities and which could be then used to develop social solutions to health concerns by exploiting social capital and existing community assets. Many of the projects were also commissioned with new initiatives such as the Better Care Fund (BCF) in mind. Criteria for proposals were geared, especially from the HaST perspective, towards meeting targets to be met under BCF priorities with an implicit suggestion that those projects that proved effective could become a part of the new BCF programme.

4.0. MONITORING

4.1. Monthly monitoring returns are received by Catalyst and reported in summary form to the Steering Group which met every two months. The format for this monitoring has been stipulated by the funding partners to be compliant with reports within local authority and HaST structures.

4.2. In addition there have been two meetings where all project leads have been brought together to discuss issues of mutual benefit or concern.

4.3. Projects have, wherever possible, collected the NHS numbers of participants so that at some time in the future an evaluation of the impact of working with the VCSE can be better assessed.

5.0. EVALUATION REPORT

5.1. HaST and NECS were both keen, following the experience of 2013-14, that a piece of formal evaluation should be undertaken to complement the returns made by projects. This was commissioned through FUSE to a specification agreed by the Steering Group. Teesside University undertook the evaluation and the approach agreed at meetings between themselves, Catalyst and NECS.

5.2. The final report is included in Appendix 1 for discussion by the Health & Wellbeing Board. The main findings of the evaluation are that, even with only a very short time for the delivery of these projects, there is evidence that the Social Return on Investment and the value to the Health Economy is positive and that finding social solutions to health issues has a real value.

5.3. When presented in draft form there were concerns expressed about a need for more detail on the methodology used. This explanation is shown in Appendix 2 again for discussion by the Health & Wellbeing Board. The explanation demonstrates that the methodology used needs to be viewed with some caution with regards to some of the absolute findings. The level of self-reporting and a lack of resource for following-up individuals involved means that, whilst the evaluation's findings are welcomed in demonstrating the value of the VCSE approach, there must be further analysis to draw a definitive conclusion.

5.4. The varied nature of the VCSE Health Initiatives Programme also made it difficult to undertake the evaluation as well as the very short time that projects are delivering their activities at full capacity. Appendix 3 gives an idea of the differences between projects start times and delivery. It is apparent, however, that those projects that had been running at capacity for longer were also the ones showing the strongest returns on investment.

6.0. RECOMMENDATIONS

6.1. The Health & Wellbeing Board accepts the evaluation and methodology

6.2. The Health & Wellbeing Board considers how the VCSE Health Initiatives Programme may progress in future years.

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June 2015

Appendix 1

Impact Evaluation and Cost Effectiveness of VCSE Health Initiatives

May 2015

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PLEASE NOTE SOME OF THESE PAGE NUMBERS MAY HAVE CHANGED DUE TO REFORMATTING FOR THE HEALTH & WELLBEING BOARD

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We would also like to express our thanks to Steve Rose, Aylia Atherley and Priya Manoharan of Catalyst for their help, support and engagement during this evaluation process.

[2] Hartlepool & Stockton-on-Tees Clinical Commissioning Group

Executive Summary

The VCS Health Initiatives Programme is a series of individual projects all of which target one or more of the joint priorities of the Hartlepool & Stockton-on-Tees Clinical Commissioning Group and Stockton on Tees Public Health. The projects are at different stages within their lifespans some have completed, some are in the early stages of development and the overall length of the projects also varies.

As the projects are required to engage with people who are less likely to access primary care services such as older people who may be socially isolated and/ or at risk of dementia, families at risk of obesity and smokers there is a clear need for projects to engage and addresses issues using a range of techniques and approaches. The procedures and activities adopted by the individual projects therefore varying according to the aims and objectives of the projects.

The evaluation was guided by recognition that social outcomes cannot be fully separated from health outcomes. Experiences and perceptions of the external social world can lead to psychological states which affect both physical and mental health and vice-versa.

Social value is a complex and contested idea, but broadly refers to the wider non financial impacts and benefits of an organisation or programme of work including the wellbeing of individuals and communities, the creation of social capital and benefits to the environment.

This evaluation has used established models of Social Return on Investment to provide measures of social value that are focused both on outputs (activities) and outcomes (effects) of the projects alongside the evaluation of Health Economic Impacts to draw attention to the value of the health outputs of the projects.

Methodology

In addition to undertaking the analysis described above semi-structured interviews were undertaken with project staff in order to provide an understanding of the history of the project and the challenges and successes encountered. This activity also gave the opportunity to identify instances of cross-project engagement and support and engagement with external agencies and organisations.

Analysis

Cost Effectiveness Analysis (CEA)/ Social Return on Investment (SROI) for all Projects (Summary)

Projects Total (n)	**Awarded (Input) (£)***	**Value of Activity (Output) (£)**	**CEA/ SROI Ratio**
14	653,067	1,843,168	2.82

*The Awarded (Input) value is the value of the total grant not the value of grant issued to date.

Health Economics Impacts for all Projects (Summary)

Projects Total (n)	**Awarded (Input) (£)***	**Value of Activity (Output) (£)**	**HEI (Current) Ratio****
14	653,067	748,097	1.15

* The Awarded (Input) value is the value of the total grant not a value of a 'health' element of the grant and not the value of
grant issued to date.

**The HEI (Current) Ratio is the value of the Health Activity (Output) divided by the value of the Awarded (Input) grant.

The ratio values are determined so that if a ratio has a value under 1 then then the value of the output is lower than the value of the input. That is, the value is negative. If the ratio has a value above 1 the converse is the case.

Discussion: Programme Overview

Individual project summaries were undertaken to identify the issues/ difficulties experienced by each project including (but not restricted to) client recruitment issues, volunteer recruitment issues, referral issues, project management issues and issues in relationship to obtaining NHS number information from clients.

A recurrent issue was the lack of referrals from GP surgeries despite engagement with Practice Mangers and GPs themselves both formally and informally. This is an area which needs addressing for future project activity which relies on such referrals to achieve its aims and objectives. It should be noted that this is not unique to this programme and that this issue has occurred in other Social Prescribing projects.

Discussion: Case Studies

Three case studies were undertaken of projects which had different approaches to addressing their aims and objectives:

Close2Home is a mature project which is at the end of its second year of funding and uses a multi-partner approach to assess the needs of it beneficiaries. It has been successful in the exhibiting significant impact in terms of SROI and HEI outcomes.

Take Heart is a well-established organisation which is entirely volunteer run and has no paid staff. Within the range of projects within this evaluation it is therefore unique. It also has been successful in terms of exhibiting noticeable impact regarding SROI and HEI outcomes.

BELP is a long established organisation. Its project was the only project in this evaluation which used community rewards (in this case tokens which could be used towards school equipment) issued following a Healthy Heart Check. Despite considerable community engagement and publicity the evidence, to date, indicates this may not have been as successful a motivator as the literature on the subject would suggest.

The Contribution the Programme Makes to the HAST CCG[3] and Stockton on Tees Borough Council Public Health Priorities in Particular Relating to Hospital Admissions

The finding of the evaluation is that the programme does make a considerable contribution to the identified joint priorities except in the case of smoking cessation. Where data was recorded in the numbers who attended smoking cessation and subsequently stopped smoking the figures were extremely low even in the case of projects where this was the main focus of activity. However, all the individual projects within the programme disseminate and promote the availability and use of all available health checks, health programmes and support to improve the beneficiaries general health. The projects have used poster presentations, displays and attendance by staff from these organisations to address health issues.

The Wider Social Benefits of the Health Initiatives Programme

The finding of the evaluation is that the programme does deliver wider social benefits in terms of social engagement, community cohesion, social identity and improved health within the community and family in both the short, medium and long term.

Conclusion

In examining future projects we would suggest the current approach of funding 'experimental' projects whose aim is to reach traditionally 'hard-to-reach' groups should continue. It is important that this type of project continue as one or more of them may indicate more effective methods of engagement whilst not achieving their stated aims.

[3] Hartlepool & Stockton-On-Tees Clinical Commissioning Group

Introduction

The Voluntary and Community Sector (VCS) Health Initiatives Programme consists of a series of individual projects designed to target one or more of the joint priorities of the Hartlepool & Stockton-On-Tees Clinical Commissioning Group and Stockton on Tees Public Health. Catalyst proposed that delivering initiatives using the VCS would increase reach and effectiveness with traditionally hard to reach and hard to engage groups. Through addressing social isolation it was anticipated that health issues could be tackled as a part of a process of wider social engagement. Such social engagement could act as a means of delivering deeper health returns and longer-term health economic savings within the community. All projects were required to demonstrate their contribution to one or more of the joint priorities of the Hartlepool & Stockton-on-Tees Clinical Commissioning Group and Stockton on Tees Public Health. Further, there was a requirement that all projects be underpinned by an ethos of improving and increasing access to the screening services.

As projects are required to engage with people less likely to access primary care services, for example older people who may be socially isolated and/ or at risk of dementia, families at risk of obesity and smokers, there was a clear need to use a range of techniques and approaches to tackle issues determined by the social environments in which people find themselves as well as more traditional health concerns.

It is important to stress that social outcomes cannot be fully separated from health outcomes. Experiences and perceptions of the external social world can lead to psychological states that affect both physical and mental health.

This report presents the findings of an evaluation of the individual project members of the Health Initiatives Programme alongside consideration of the impacts of the projects in terms of the wider social environment and the use of differing approaches to engage potential users.

Measuring Social Return on Investment (SROI)

The evaluation described here set out to measure Social Return on Investment (SROI) for a group of 14 projects all designed to improve the health and wellbeing of people living in Stockton-on-Tees. As discussed, these projects vary in their design and objectives, but they coalesce around a generic goal of achieving social value as well as health impacts.

Social value is a complex and contested idea, but broadly refers to the wider non financial impacts and benefits of an organisation or programme of work including the wellbeing of individuals and communities, the creation of social capital and benefits to the environment. This evaluation has used established models of SROI to provide measures of social value that are focused both on outputs (activities) and outcomes (effects) of the projects. As expected, there is significant variation in levels of both outputs and outcomes across the projects due to differences in duration, scale and so on. However, despite this, the focus of what is presented here is upon the wider social benefits or value that the projects have achieved to date.

As such, less emphasis is given to *direct* health benefits, for example, measuring weight loss achieved by participants. Rather, as will become clear in what follows, a significant proportion of the evaluation has considered typically harder to measure outcomes such as reducing social isolation. This is appropriate to the brief given to the evaluation team of measuring social value and the social return on investment from the activities and interventions implemented. Consequently, in what follows there is considerable space given to social outcomes, with less discussion of more 'measurable' health outcomes. These former outcomes are invariably 'softer' and often less tangible, and must be sustainable in order to have real benefits for participants. However, if sustained, they have the potential to deliver real impact for communities and populations in Stockton-on-Tees that have been recognised through the joint priorities of HAST CCG and Stockton on Tees Borough Council Public Health as being in need of additional support and investment to improve health and wellbeing.

Methodology

Social Return on Investment (SROI) uses the measurement of change in economic, social and environmental outcomes to produce a value in monetary terms to enable a final benefit to cost ratio to be produced. SROI is not just a quantitative tool but also includes a wide range of qualitative assessments and indicators. SROI can include (where appropriate) information from focus groups, interviews, case study data as well as input and output data, for example the costs of health interventions and actions including, for example, GP appointment costs, the cost of hospital stays and the cost of prescriptions. It is in its analysis of the value of both qualitative and quantitative data[4] to produce an overall value that SROI has its main strength.

To assist in the SROI analysis interviews were undertaken with the relevant individual project members. The interviews were semi-structured in format and were divided into a number of themes and sub-themes that allowed for an assessment of the projects. The interviews also allowed for the identification and discussion of issues which may have facilitated or hindered the projects progress and direction towards meeting its specified aims and objectives.

[4] The values given for qualitative data and the impacts of quantitative data have been obtained from a number of sources including those held and validated at 'The Global Value Exchange' and values which have proven to be robust in other evaluations examining similar qualitative and quantitative outcomes in social prescribing.

Health Economic Impacts for all projects were produced and were modelled for the current value (based on the latest available returns from the individual projects)[5] and for short term and for long term impact values.

Analysis

Table 1

Cost Effectiveness Analysis (CEA)/ Social Return on Investment (SROI) for all Projects (Summary)

Projects Total (n)	Awarded (Input) (£)	Value of Activity (Output) (£)	Average CEA/ SROI Ratio
14	653,067	1,843,168	2.82

Table 2

Cost Effectiveness Analysis (CEA)/ Social Return on Investment (SROI) for all Projects

Project Name		Awarded (Input) (£)	Value of Activity (Output) (£)	CEA/ SROI Ratio
Age UK	Home Advice Service	45,000	264,425	5.88
Alzheimer's Society	Dementia Diagnosis & Support	23,105	58,163	2.52
BELP	Healthy Heart	30,000	43,053	1.44
CSV	One Small Step	19,790	28,502	1.44
Element 1	Healthy Haven	10,000	23,069	2.31
Groundwork	HEAL	52,854	81,958	1.55
Mind*	Close2Home	220,311	1,026,938	4.66
Mind	Win, Lose or Draw	15,000	21,019	1.40
Community Welfare Trust	Men's Health	12,000	17,848	1.49
My Life	My Life Programme	12,000	30,810	2.57
Nur Fitness	Family Fitness	25,000	95,424	3.82
SDAIS	No Butts	36,507	26,700	0.73
Synergy VCS Consortium	Staying Out	146,000	101,529	0.70
Take Heart Support Groups	Rehab Coronary care	5,500	23,730	4.31
Overall Total		**653,067**	**1,843,168**	**2.82**

***** NB Mind Close2Home Awarded (Input) value includes Year 1 funding of £120,000 plus Year 2 (current) Awarded value of
£100,311

[5] To assist in analysis due to the varying placement along the lifespan of the projects extant data was modelled to produce a forecast of the final values of the outputs and outcomes of the projects at their end points (as required.).

Table 3

Health Economics Impacts for all Projects (Summary)

Projects Total (n)	Awarded (Input) (£)	Value of Activity (Output) (£)	Average HEI (Current) Ratio
14	653,067	748,098	1.15

Table 4

Health Economics Impacts for all Projects

Project Name		Awarded (Input) (£)**	Value of Health Activity (Current) (Output) (£)	Value of Health Activity in Short Term Saving (Output) (£)	Value of Health Activity in Long Term Saving (Output) (£)	HEI (Current) Ratio***
Age UK	Home Advice Service	45,000	10,222	14,566	34,505	0.23
Alzheimer's Society	Dementia Diagnosis & Support	23,105	39,163	52,086	123,382	1.70
BELP	Healthy Heart	30,000	9,173	8,714	20,643	0.31
CSV	One Small Step	19,790	8,502	8,0767	19,133	0.43
Element 1	Healthy Haven	10,000	6,069	17,296	40,971	0.61
Groundwork	HEAL	52,854	23,958	29,588	70,088	0.45
Mind*	Close2Home	220,311	499,590	474,611	1,124,258	2.27
Mind	Win, Lose or Draw	15,000	5,019	7,629	18,071	0.33
Community Welfare Trust	Men's Health	12,000	10,349	9,831	23,288	0.86
My Life	My Life Programme	12,000	16,810	15,970	37,829	1.40
Nur Fitness	Family Fitness	25,000	34,624	32,893	77,916	1.38
SDAIS	No Butts	36,507	7,360	6,992	16,563	0.20
Synergy VCS Consortium	Staying Out	146,000	68,529	130,205	308,430	0.47
Take Heart Support Groups	Rehab Coronary care	5,500	8,730	16,587	39,291	1.59
Overall Total		**653,067**	**748,098**	**897,735**	**1,954,368**	**1.15**

***** NB Mind Close2Home Awarded (Input) value includes Year 1 funding of £120,000 plus Year 2 (current) Awarded value of £100,311.

** The Awarded (Input) value is the value of the total grant not a value of a 'health' element of the grant.

***The HEI (Current) Ratio is the value of the Health Activity (Output) divided by the value of the Awarded (Input) grant.

When examining the tables above the following should be noted:

- The CEA/ SROI ratio is an underestimate as the Award Amount is the total of funding awarded not the funding paid to the project to date.
- The Value of the Activity is the recorded outputs/ ascribed values of the projects to date.
- The ratio values are determined so that if a ratio has a value under 1 then then the value of the output is lower than the value of the input. That is, the value is negative. If the ratio has a value above 1 the converse is the case.
  In this case, for example, Table 1 can be summarised by stating that for every £1 input £2.82 of value is generated.
- The projects are not listed in terms of values or the CEA/ SROI ratio value as such a 'league table' ranking would be meaningless. Many of the projects are at different stages in their lifespans. Some projects have concluded their funding whilst others are mid-way through or starting their activities. Additionally it is impossible to undertake a direct comparison of the projects in such terms as they are all adopting different working practices and are targeting different mixes of the joint priorities of the Hartlepool & Stockton On Tees Clinical Commissioning Group and Stockton On Tees Borough Council Public Health. It would be the equivalent of comparing 'apples and oranges.'

Discussion
Programme Overview

Individual Programme Summaries[6]

Family Fitness – Nur Fitness

The intended beneficiaries of this project are BME mothers and their children living in the Stockton area. The aim of the project was to improve long term health outcomes (both mental and physical) for participants through engagement in physical activity in a positive social environment. Information on healthy eating was also included within the sessions as prior experience has demonstrated that a focus on exercise alone is ineffective in promoting sustainable long term changes in health behaviours.

Some of the sessions were attended by members of Stockton Borough Council (SBC) Public Health who spoke to the women about mental health. This was seen as essential as due to stigma within the Asian community associated with mental health issues. This makes raising awareness and promoting access to mental health support problematic.

Work was also undertaken with More Life to assist children who were, or are at risk of obesity, with an aim to mitigate this where possible. Despite a late start to the engagement with beneficiaries (as a consequence of the School Holidays and Ramadan) the project has reached its beneficiaries target. The project has also held sessions in six different locations to facilitate beneficiary access.

Health, Exercise & Allotments (HEAL) – Groundwork NE & Cumbria

The target beneficiaries for this project were obese adults and adults with mental health problems. It intended to engage beneficiaries and their families in a range of activities to promote the benefits of a healthy diet and physical activity with the aim of achieving improvements in physical and mental health. Three allotments located across Stockton/ Thornaby were used for the activities in collaboration with three different partner organisations.
Currently the project has been extended by three months to enable the recruitment of additional beneficiaries. During the first phase of the project two main issues which emerged that are now being addressed. One of the allotments used was extremely small and over-subscribed in terms of the numbers wishing to use the site. In contrast, it was found at a second allotment site that it was difficult to recruit beneficiaries as the initial timings of the sessions at this geographically remote (in terms of transport) location were timed to be the same time as a 'once-a-week' free supermarket bus service. This issue has now been resolved and the take up of project activity at this location has increased.

The Warwick-Edinburgh Mental Wellbeing Scale has recently been introduced to measure regular beneficiary attendees progress. Prior to this, initial and sessional evaluations were undertaken by beneficiaries (and if present their support workers/ carers).

Home Advice Service – Age UK

The activities of this project were focused on people aged 70 and over, and intended to reduce hospital admissions (emergency and otherwise) through interventions with those at the highest risk of being admitted. It also intended to address the issue of social isolation amongst older people and to reduce the incidence of poverty (where possible) through benefit maximisation.

[6] Three projects are not summarised in this section as they are the subjects of separate Case Studies.

The project has received referrals from a wide range of external organisations. It has simultaneously made referrals out to a wide range of external organisations including a number of Catalyst funded projects.

The project is engaged in a wide range of activities including (but not limited to) initial Health Wealth and Wellbeing assessment screenings; referrals to Warm Home Healthy People local authority provision (where permission has been granted for referral); benefit maximisation activities and the establishment of neighbourhood support groups.

The numbers of befriending sessions undertaken are not as high as expected due to delays in the DBS clearance procedure. This means that volunteer befrienders have to be accompanied by DBS cleared staff members when undertaking befriending sessions. This restricts the number of sessions which volunteers can undertake and has heavily impacted on the number of sessions delivered.

Men's Health Project - Community Welfare Trust

This project targeted the 'hard-to-reach' groups of BME taxi-drivers and take-away workers with the intention of providing health screening for men from the South Asian community. The project aimed to reduce social isolation and promote health with the hope of stimulating behavioural/ lifestyle changes. A further aim was to improve access to IAPT services for a group within which mental health issues are often stigmatised.

Project activities were delayed when a key member of staff left and had to be replaced. The project worker now in post has a wide range of contacts in the local South Asian community and was pro-active in identifying beneficiaries to attend sessions. He also has contacts within the NHS and Public Health fields in order to identify those localities in which his activities could be best targeted.

Group based exercise and health sessions were delivered in order to address issues surrounding social isolation and lack of confidence in approaching service providers amongst this group of beneficiaries. Attempts to engage this group in stopping smoking through smoking cessation support failed to produce a positive outcome indicating a different approach may need to be adopted.

This programme illustrated that there are barriers within the South Asian community and especially in these groups of workers towards accessing health provision that is in place in the local authority area.

My Life Programme – My Life CIC

This project aimed to support people with Long Term Conditions (LTC) who were at higher risk of re-admission. Additionally, the project would widen the social engagement/ networks of beneficiaries, thus addressing issues of social isolation.
A key issue for this project (as for a number of others) which made recruitment difficult was the lack of referrals (or in some cases) engagement from GP practices. This was despite continued direct contact from the project.

The project worked with two cohorts of ten people, using a modular structure of group information sessions, peer mentoring and one-to-ones. The five group information sessions focused on improving the health and wellbeing of beneficiaries through increasing their understanding of their ability to take control (to varying extents) of their reactions to their LTC, how to deal with social care

systems, the use of technology to assist in independent living, the value of engagement in volunteering and researching locally based activities and opportunities.

Following these activities the beneficiaries had between one and three 'coaching sessions' with qualified coaches to explore their individual personal goals and the barriers with which they were faced.

Peer mentors were used as appropriate to share their experiences of the project and how they used the knowledge gained to address their individual circumstances.

No Butts – SDAIS

This project aimed to increase access to the Smoking Cessation project and healthy weight promotion activities for individuals and families. Initially, during SDAIS recording individuals could also indicate if they required information on a range of other NHS checks or information related to Therapy Services. During this activity they would be able to indicate if they smoked. Now all individuals who complete the SDAIS pro-forma receive an information pack containing details on available NHS health checks and information on Therapy Services.

Due to the low numbers who indicated they wished to stop smoking, from October 2014, individuals who smoked and had debt issues were referred directly to the Project Debt Advisor who then encouraged them to stop smoking during debt sessions and ongoing meetings. It was expected that this would allow the individual to identify the true cost of smoking to their overall finances and act as an incentive for them to quit.

The project is not achieving the numbers expected in terms of information regarding smoking cessation, despite the change in criteria identified above. Of those monitored, 34 per cent indicated that they smoked whilst a much smaller number indicated that they used e-cigarettes.

One Small Step – CSV

This project was a befriending and support service that used volunteers to engage with people who were at low to medium risk of health related issues but at higher risk of social isolation and loneliness, with their consequent impacts on mental and physical health issues. It is intended that such befriending activity will, through the support it offers, reduce unnecessary hospital admissions.

The project faced substantial difficulties in locating and recruiting appropriate volunteers, possibly due to the lack of volunteer bureau in Stockton. Following a period of intensive publicity, additional potential volunteers presented, some through publicity by other Health Initiative projects and the project is now expecting to meet its targets by the end of the funding period.

In common with other projects that used volunteers, this project also experienced difficulties in meeting its targets through delays in recruitment, often linked to delays in the DBS procedure which were outwith the control of the individual volunteer and the project. The project is now engaged in contacting its partner agencies in order to gain further client referrals with whom the recruited volunteers can engage.

It is recognised that this project not only benefits those who are befriended but also the volunteers who are befriending. The project lead noted, in their previous experience even after the funding for the activity ceased there would be a number of befrienders who would continue to meet those who they had befriended.

Staying Out – Synergy VCS Consortium, Three Score Years & 10, ARC Stockton

This project provides an eight to ten week support course for socially isolated older people who are at the highest risk of re-admission to hospital following their release. There are three partners involved in the delivery of this project, Synergy VCS Consortium, Three Score Years & 10 and ARC Stockton. The project therefore has as an aim to reduce social isolation in older people, as well as their readmission to hospital (as indicated above).

The project has experienced a range of difficulties, including being unable to initially source a location base close to the hospital, members of staff leaving post and low referral rates from North Tees & Hartlepool Foundation Trust Hospital. To address the latter, the referral network was extended to include referrals From Thirteen Housing Group and Stockton on Tees Borough Council Adult Social Care.

Delivery of the project activities was through partner organisations including a befriending service by 3 Score Years & 10 and ARC Stockton which established alternative day care provision accessible by those referred to the project, where appropriate, once a week.

This project also made onward referrals to other Health Improvement Initiative projects.

Stockton Dementia Early Diagnosis, Advice And Support – Alzheimer's Society

This project aims to support those with dementia and their families by creating a supportive environment in which professional help is promoted as an option, alongside a reduction in stigma and, in line with need to increase dementia diagnosis rates in the Stockton Borough Council area, a need identified through the joint priorities.

As with other projects being evaluated this project has experienced difficulties in establishing relationships and referral routes from GP surgeries. It has been possible to arrange leaflet drops at eight GP surgeries which promote the services offered as a part of the project.

The project has been rescheduled to operate from November 2014 to May 2015 following the appointment of the Dementia Advisor.

The majority of referrals into the project come from the Memory Clinic, with a smaller number of direct self-referrals from individuals. The Dementia Advisor uses a range of initial engagement mechanisms, with those referred depending upon their needs and circumstances. It was noted (in interview) that sometimes all that is required by those who have been engaged is for information to be sent out by mail, whilst at other times meetings are preferred by the potential project beneficiary.

It is recognised that early diagnosis of the various forms of dementia and engagement to reduce the impacts on the individual and family have a long-term impact on the outcomes for the individual and the associated cost savings for the NHS.

Win Lose or Draw - Mind

This project is aimed at 'hard to reach' groups of men and is intended to provide information and awareness around anxiety and depression. As noted in connection with other projects, in some

BME communities and amongst some groups of men there is a stigma associated with mental health issues.

Issues surrounding mental health would be presented and discussed prior to weekly football games. The use of football itself and the social connections that the activity encouraged would also impact on the joint priority issue of social isolation.

Recruitment was an issue, with the project having some challenges in forming a large enough group for the football activity to be undertaken at a mutually convenient time for all the participants. However, the first programme is now underway working with a group of Iranian men which has ten regular attendees.

In interview it was indicated that the sport element of the project, while fulfilling a physical health issue, was also key in promoting the value of social engagement for this particular group. It was hoped that the project would act as a gateway to participation in a wider range of social activities, acting as an 'ice-breaker', promoting social involvement for hard-to-reach groups.

A Healthy Haven – Element 1 CIC

This project is based with a well established Town Choir in Stockton on Tees which uses Stockton ARC as a base for its activities. The focus of the project is on addressing issues identified within the joint priorities: improving dietary understanding to promote long term physical health and addressing social isolation and the impacts which this can have on mental health issues. There was a delay to the start of the project which is now running from January 2015 until June 2015 due to Organisational Business development.

At each choir session eight to ten people who wish to, work in a kitchen at ARC Stockton prepare healthy eating meals using a range of ingredients under the supervision of an Element 1 staff member. Meals are then served to the Choir.

A large number of those attendees are (or were) socially isolated. The Choir provides them with a network of social engagement each week that addresses some of these issues of social isolation.

There have also been talks on smoking cessation and it is intended that in the future there will be engagement by external organisations including (but not limited to) Smoking Cessation, Tees Time 2 Talk, MIND and STEPS.

Case Studies

The following Case Studies have been selected for inclusion to illustrate the range and diversity of practices and actions undertaken within the Health Initiatives Programme overall.

The three projects selected are at different stages of development, have differing means of engagement and client groups.

1. Close 2 Home

Close 2 Home is a mature project in its second year of funding. It is a partnership project led by Middlesbrough and Stockton Mind with 3 Score Years & 10 and Stockton CAB. It provides a six to ten week programme of reablement, confidence building and welfare optimisation intended to support its beneficiaries and to reduce the number of admissions and re-admissions to hospitals. The intention of the project was to engage with referrals that were in the two per cent of RAID-R caseload, those most likely to be re-admitted/ admitted to hospital and who had long term conditions (LTC). The project is staffed by a part time Team Lead, two full-time Reablement Officers and a part time CAB Worker.

The projects target was to work with 160 LTC people over its lifecourse. The latest data received indicated a total of 122 referrals, representing 76 per cent of the intended total. The intervention is short term and focused in nature in order to maximise both its cost-effectiveness and impact on the individual so that they do not become dependent on the engagement which the project provides in terms of social interaction and support.

One difficulty the project has faced has been in the identification of beneficiaries who are within the target population. In Year 1 of the project RAID-R scores were provided for two referrals from a total of 62. To address this issue the project now uses a 28 day follow-up questionnaire to capture data on any re-admissions following the conclusion of the beneficiaries engagement with the project.

In common with a number of other projects the project has had difficulties in engaging with GP surgeries as a referral route for beneficiaries. To address this issue the project attempted to develop a joint working strategy with seven GP surgeries in high hospital admission areas. Responses were received from one of the seven surgeries contacted. Additionally the project had a lower than expected number of referrals from North Tees Hospital and has attempted to address this issue by attending meetings with a number of teams within the hospital and have engaged with the Communications Department to provide information on staff notice boards.

The three main sources of referral for the project have been the Community Liaison Service, Housing Options and the Citizens Advice Bureau. There has also been referral into Close 2 Home from the Staying Out project.

Income maximisation is undertaken by CAB for all those who are referred and engage with the project. Over the period of operation of the project (Year 1 and Year 2) a total of £ 343,348.06 was obtained through this process. (This figure includes confirmed and non-confirmed sums.)

One of the features of the project was that it also focused on the social aspects of the beneficiaries life and the ways in which social isolation can interact negatively with individual perceptions of health and wellbeing. It was noted (in interview) that the project does not only look at the individuals' physical health, but considers both lifestyle and quality of life of the individual and the

ways in which they interact with others and how changes could be made to improve the individuals sense of wellbeing and social functioning. Including physical equipment loans and adaptations to items in the home.

Since April 2014, 61 per cent of those discharged from the Close 2 Home project were not readmitted to Hospital resulting in savings to the NHS.

All beneficiaries who completed the Warwick Edinburgh Mental Wellbeing Scale at the start, mid-point and end of their engagement with Close 2 Home illustrated an improvement in their mental wellbeing. Overall there was an individual improvement of 24 per cent in the Warwick Edinburgh Mental Wellbeing Scale scores for individuals across their engagement with the project.

17 of 20 people questioned described developing the coping skills as a direct result of participation in the project. Participants described these as beneficial in addressing their LTC and other issues.

Using the Wellbeing Star, there was an average individual improvement of 43 per cent by beneficiaries. This contrasts with a stated target increase of 30 per cent for three quarters of those engaged by the Close 2 Home project.

For those interviewed, the nature of the support offered by the Close 2 Home project is key in its success or otherwise. It is viewed as a project that promotes independence, self-management and the development of autonomy. Participants feel they are active participants in the decisions which can affect their daily lives and their lived experience and not passive receivers of specified services.

2. Take Heart

Take Heart is a project run by a well established local voluntary group which has been in existence for over 25 years. It is volunteer run and managed. The only exception to this is the trainer in the exercise sessions who, due to the nature of the client group, is self-employed with specific experience and qualifications.

Funding for the Take Heart project has been used to provide extra exercise sessions at locations in Stockton for participants with some history of cardiac problems. The intention of the project is to offer an on-going exercise, relaxation and support programme to those who have had cardiac issues or are at risk of developing cardiac issues. It is designed to follow on from the eight week, level three Cardiac Rehabilitation exercise programme based at North Tees Hospital. In common with other projects, Take Heart has faced low levels of referrals from GPs.

Class sizes are normally limited to 20, but if there are participants who are frail of with more problematic conditions, the tutor may reduce numbers so the class can be held in safety for all those attending. Since September 2014, 22 weekly classes have been delivered with 15 direct beneficiaries and two indirect beneficiaries attending.

Beneficiaries are welcome to bring a partner, with the intention of addressing aspects of the social isolation that they experience as a partner of someone who has developed cardiac issues that have required hospitalisation and rehabilitation. The project views the social side of the exercise activity as important in that it allows the beneficiaries to engage in sharing information and experiences of their conditions in a supportive relaxed environment. This opportunity for discussion is important as it allows for any concerns to be recognised as common and manageable.

The Take Heart project is aware of similar ongoing activities held locally for those with cardiac issues. They did note that the walking group focussed on the walking side of things which may be too much for some of their beneficiaries. Similar observations were made regarding the gym based group that was felt to prioritise physical activity over social support/ building networks.

When a beneficiary is first referred from the Hospital or GP they have a sheet which confirms that they can attend the exercise session. The tutor then fills out a further form in collaboration with them so that they are aware of any issues which the beneficiary may have that were not recorded on the referral form. If the beneficiary has a partner with them who wishes to take part in the exercise activity they also have to talk to the tutor and visit their GP for final authorisation. The same procedure occurs when individuals self-refer.

The tutor, in addition to talking to the beneficiaries when they first engage, also receives data on their condition as a part of documentation from the Hospital Cardiac Rehab Team. Alternatively the GP discusses any issues they may be having with her. Beneficiaries are also aware that they must inform the tutor if they are having any problems or if changes have been made to their medication.

The project does not collect any data on social isolation, but it was noted in interview that the subject 'just comes up' in conversation and that beneficiaries can share their experiences and how the environment of the exercise session facilitates the possibility of discussion in that it is very social, as well as exercise focussed.

The project has had/ has invited in the co-ordinators of projects in to talk to the beneficiaries or hand out information leaflets. Those who have attended to date include the 'My Life Programme', '3 Score Years & 10', Healthy Heart Check and 'Better Health Better Wealth' Age UK.

3. Working Together for a Healthier Future – Billingham Environmental Link Programme (BELP)[7]

The intention of this project is to encourage increased take-up of Healthy Heart screening via the use of community rewards. When a Healthy Heart check is undertaken a token is issued which can then be donated towards a local primary school count of tokens. The primary school with the greatest number of tokens will receive £1,000 which must be spent on resources to improve peoples health and wellbeing.

The project has engaged in numerous activities to raise public awareness of the NHS Healthy Heart Check Programme. The intention was to target at least 20 per cent of the population eligible for screening on a five year basis.

The focus of activity has been with the primary schools in the Billingham area and information sessions were held with the Head and/ or staff in each primary school to inform them as to the background and intended activities of the project. As part of the activities in the primary schools each school received playground and activity equipment including skipping ropes, footballs, hula hoops and outer outdoor equipment to encourage active play and learning.

Additional visits were made to the primary schools, with information posters relating to the project were displayed in the schools and information leaflets were sent home with a total of 2,925 pupils. To re-enforce this activity seven separate information sessions were held at school events that involved parents or families, including parents evenings and school fairs. The primary school

[7] This section should be read in parallel with the focus group discussion on the impact of community rewards regarding the take up of Healthy Heart Checks.

children were also encouraged to enter a poster competition based around the theme of the project. For this activity 445 separate entries were submitted.

This approach involves repeated re-enforcement of a health message using different methods to direct the population towards undertaking (in this case) a positive health step that they may have been unaware of or less able to undertake.

Additionally information on the 'Healthy Heart' project has been published in each issue of the Billingham Community News since the start of the project. This newspaper is delivered to 18,000 homes in Billingham. Therefore the majority of the readers at home will be outwith the target group of the project either in terms of age range, geographical location or in that they have already had a Healthy Heart check. The remainder of the 20,000 circulation is delivered to a range of venues including Community Centres, GP surgeries, Job Centre+ Offices, Leisure Centres and local commercial premises. As noted above this 'scatter gun' approach will be of more value in some locations than others.

Five meetings were held with GP surgeries with posters/ displays provided to each surgery. Healthy Heart Tokens were issued to six GP surgeries. As noted with regard to other projects, there were difficulties in contacts with GP's by, in this case members of the public wishing to have a Healthy Heart Check.

It has been reported that when attempting to make phone calls to arrange a Healthy Heart Check at the GP surgery people had to leave an ansaphone message for a telephone callback to ensure they feel into the eligible group for such a check and no callback was made to them. It was also reported that in a number of cases those attempting to make an appointment for a Healthy Heart Check were informed that there were no Healthy Heart Checks available. As a consequence of this the Project Worker, with the consent of those who had experienced difficulties in obtaining a Healthy Heart Check followed up on their difficulties with the individual surgeries involved.

It was noted (in interview) that this issue had been worse before Christmas. However, since the New Year there had been noticeable improvement, with people able to make Healthy Heart Check appointments at the GP surgeries. A continuing problem was the failure to issue tokens to be donated to schools.

To address these issues, 'pop-up' health check clinics were held with the assistance of the Coronary Vascular Disease (CVD) Screening Co-ordinator on three separate occasions. The sites were: the Billingham Food Bank where ten Healthy Heart Checks were undertaken alongside ten blood pressure checks and three mini health checks. Tesco Billingham where four Healthy Heart Checks were undertaken, 12 blood pressure checks and one mini health check and Low Grange Community Centre where four Healthy Heart Checks were undertaken alongside two mini health checks.

In order to make contact with the 'very hard to reach' groups, a total of 11 community information sessions were held which reached a total of 230 individuals. This included seven sessions at Billingham Food Bank which reached 76 people.

In terms of Healthy Heart Checks undertaken and tokens received four of the primary schools involved recorded a total of 46 tokens from Healthy Heart Checks donated to the schools. The remaining schools had either received no tokens or had not responded to queries at the time of reporting.

Until CCG analysis of GP surgeries data is undertaken for the reasons detailed above (in terms of the non-issuing of tokens) it is not possible to judge or accurately estimate the effectiveness of this project. The only way this could be assessed would be to examine quarterly recording data for Healthy Heart Checks and to observe if there had been a statistically significant increase in such checks during the period of operation of this project

What is the Contribution the Programme Makes to the HAST CCG[8] and Stockton on Tees Borough Council Public Health Priorities in Particular Relating to Hospital Admissions?

The joint priorities of HAST CCG and Stockton on Tees Borough Council Public Health are as follows:

1. Promotion and delivery of healthy weight activities for families to reduce obesity in the population;
2. Decreasing the number of people who smoke including referral to the smoking cessation service;
3. Increasing public mental health awareness of low level anxiety and depression, improving access to psychological therapies (IAPT) services and early identification of dementia;
4. Reducing social isolation in older people and preventing emergency admissions;
5. Reducing admissions to hospital through targeted interventions to those at highest risk of admission.

Addressing each priority in turn the programme has delivered multiple projects which promote healthy eating and as a consequence, in the medium to long term will address the issue of obesity in the population. Examples here will include (but are not restricted to) the Groundwork NE & Cumbria HEAL project, the Element 1 CIC project and the Nur Fitness project. In terms of projects which take a more direct approach towards the issue of healthy weight activities to reduce obesity in the population this will include (but again is not restricted to) the Community Welfare Trust project, the Nur Fitness project and the Mind 'Win Lose or Draw'' project. The HEAL project can also be seen as addressing this issue as digging and working on allotments for any period of time in addition to the therapeutic benefits of the activity will also result in weight loss.

This issue is key for the South Asian population as there is susceptibility to the development of Type 2 diabetes in middle age in this group and this tendency towards its development will be increased by obesity (as it is in the population as a whole.)

Decreasing the number of people who smoke including referral to the smoking cessation service is directly addressed in two projects both of which are directed to groups known to have high rates of smoking. The Community Welfare Trust engages taxi drivers and take-away workers and the SDAIS project targets those who need CAB assistance and provides them with information on a range of health checks and health programmes including smoking cessation. The success rate in terms of individuals who cease smoking as a consequence of these projects signposting and direction is however, low. There has been no smoking cessation recorded from the community Welfare Trust project and the SDAIS issued information on smoking cessation to 343 people that have resulted in five people stopping smoking. During this time of the clients monitored by SDAIS 34 per cent were smokers.

[8] Hartlepool & Stockton-On-Tees Clinical Commissioning Group

It must however be noted that the remaining projects within the Health Initiatives Programme do promote the smoking cessation service and other health checks and services within the area. This is accomplished either by presentations, display materials or direct contact as appropriate.

The BELP project has indirectly addressed potential smoking behaviour by engaging in its project promotion primary aged school children engaging in activities related to health and wellbeing as a means of promoting the Healthy Heart Check for adults in the community. As noted elsewhere in this report it may well be that these activities act as a 'nudge' towards childrens future lifestyles when they become adult in the same fashion as the 'Change4Life' programme operates regarding health issues.

Given these findings it may be that the ways in which this priority is addressed needs to be subject to a change in approach.

Increasing public mental health awareness of low level anxiety and depression, improving access to psychological therapies (IAPT) services and early identification of dementia occurs across a range of projects. For some of the projects these issues are explicit as in the 'Win, Lose or Draw' project, the Community Welfare Trust project, the Alzheimer's Society project whilst for the remaining the issues are addressed within the wider context of the project, for example the Age UK project in terms of the early identification and diagnosis of dementia.

Reducing social isolation in older people and preventing emergency admissions are explicit criteria in a number of projects including the 'Close 2 Home' project, the My Life CIC project, the Age UK project, the Synergy VCS Consortium project and the Take Heart project. Results from 'Close 2 Home' show the efficacy of its approach and engagement towards those at risk.

Explicitly focused on the prevention of social isolation is the CSV befriending project although, as described within this report this project also plays a role in the reduction of unnecessary admissions to hospital. The majority of projects within the Health Initiatives Programme work to reduce social isolation in older people except in the case of some tightly defined projects such as BELP. These projects are not explicitly directed towards older people but older people can engage with the project if its activities are of interest to them.

There are a number of Health Initiative Programme projects which are directed towards the reduction of admissions to hospital of those at highest risk of admission these include the 'Close 2 Home' project, the Synergy VCS Consortium project, the My Life CIC project, the Age UK project, the 'Win, Lose or Draw' project, the Alzheimer's Society project, the Community Welfare Trust project, the Nur Fitness project and the Take Heart project.

From this overview it is clear that all of the projects which are of the Health Initiatives Programme engage with one, or more, of the joint priorities listed above. In many cases projects are addressing two or more of the joint priorities within the same

project. However, one priority which is not being successfully addressed is the priority of decreasing the numbers who smoke. Smoking and the effects of smoking are a cost issue of concern given18 per cent of deaths in adults aged over 35 are related to smoking.[9]

[9] Poppleton, R (2014) *Smoking Cessation*, http://www.catalyststockton.org/temp/wp-content/uploads/2014/05/Smoking-Cessation.ppt (Accessed 2nd May 2015)

Do Financial Rewards for the Community Promote Healthy Behaviours Among its Members? Focus Group Responses Regarding the Working Together for a Healthier Future – Billingham Environmental Link Programme (BELP)

The Working Together for a Healthier Future Project is intended to promote the better take-up of the Healthy Heart Check in Billingham in exchange for tokens (issued by the GP following the conclusion of the Healthy Heart Check). The token may then be donated towards a local primary school. It is intended that the primary school which has acquired the greatest number of tokens will be awarded £1,000 to be used for the purchase of equipment and resources which promote healthy living and lifestyles. This project is an example of a community benefit reward approach to health promotion and engagement in that the reward is not towards the individual accessing the service but towards the community in which they live.

A focus group was held with a number of individuals who had been aware of the campaign to encourage individuals to access the NHS Healthy Heart Check and the activities surrounding schools participation in promoting the checks. All participants had had a Healthy Heart Check.

When asked if the Healthy Heart Check had been useful for them all participants replied that it had been useful. Two of the participants stated they had had the Healthy Heart Check as a form of reassurance that all was OK. One referred to the Healthy Heart Check as a 'maintenance check'. The remaining participant stated she had had a check for her piece of mind as she had had a check in 2010 which had omitted a cholesterol check which she felt she needed as in recent years her wider family had had issues with high Cholesterol levels.

When asked what would make them more likely to go for a Healthy Heart Check there was no response as one of the two women respondents felt she had answered this question previously, the male respondent did not give a response and the third respondent who had previously replied that the check was for 'maintenance' stated that there were a history of high blood pressure and heart attacks in her family so she had attended for that reason and for the fact it was free and easily available.
Two of the respondents (one male, one female) stated that having a school reward token had assisted them in making the decision to attend the Healthy Heart Check. The male respondent stated that the reward token had, "Helped to make the decision as it was something my daughter could take part in." A female respondent stated that she would have attended the GP surgery rather than a 'pop-up' clinic had she been invited by the surgery.

When asked whether or not they would have attended for the check had the reward for the school been of lower value, all replied they would have done so all indicating they would have done so even if there was not a community reward available.

When asked would the previous answer be the same if the tokens were for a different organisation, all respondents indicated this would be the case.
When asked if they would have had the Healthy Heart Check even if there were no tokens available all respondents replied this was the case. For the two female respondents this was based on family medical history and for the male respondent as it was a sensible thing to do commenting, "…prevention is better than cure."
One of the female respondents had heard about the Healthy Heart Check from the other female respondent. She, in turn, had heard of it from BELP publicity whilst the male respondent had heard about it through 'word of mouth.'

When asked how they had found the process of booking the Healthy Heart Check at the GP surgery, the male respondent stated he had found it difficult to make a booking, "…when I contacted the surgery the receptionist could not take a booking and promised someone would call back but it didn't happen. I then contacted the surgery twice after that before getting a booking." The female respondent who did not attend the pop-up clinic had by contrast found the process straightforward just made the appointment at the surgery reception desk by telephoning.
On two occasions (once in a GP surgery and once in a pop-up clinic) the respondents had to ask for a token for the school rather than the issuing of the token being a routine part of the procedure. The final respondent was issued the token without any problems.

When asked their opinion of the Healthy Heart Check process the male respondent noted it had been a positive and welcoming experience while for the female respondents it was regarded as invaluable. One of the two stated she would not have had the check despite her family history had she not been talking to the other who had mentioned the check as she wouldn't have thought of it.

All respondents were aged 40-50 and were White British. One was a full time facilities manager, one working part time as a project co-ordinator and one a volunteer at a foodbank. The levels of qualification held were GCSE, HND and Cert Ed.

These responses show, for the people engaged in this focus group that community rewards for the promotion of healthy behaviours within a population appears to be of limited value. However, it must be borne in mind that within this group the majority of those engaged had over-riding issues connected to family medical histories which acted as a greater spur to engagement than the offer of extrinsic rewards. This is not an unexpected finding, indeed it would be surprising if this were not the case.

The collection of 46 tokens from schools to date would tend to indicate, at this point in time that the use of community rewards to promote healthy behaviour via the undertaking of the NHS Healthy Heart Check in the Billingham area is a possibly inappropriate means of health promotion. However, this may not be the case as until GP surgeries returns are subject to analysis it will not be possible to detect if there has been a significant uptake in the Healthy Heart Check compared to previous comparator period. Counting the number of tokens received by schools may not be accurate as, as has noted above on occasions tokens are not issued as a matter of routine following the check.
It is possible the school based activities around the Healthy Heart Check and the provision of exercise equipment for the schools may result in a move towards healthier behaviours not by the adult members of the community but by the primary aged school children in the area who may carry some, if not all, of these behaviours into adult life. In attempting to address one issue, the uptake of Healthy Heart Checks it may be than another more long term health issue has been addressed in a similar way of 'nudge' behaviours as the 'Change4Life' campaign.

The Wider Social Benefits of the Health Initiatives Programme

In addition to the benefits, in terms of financial savings, which the Health Initiative Programme delivers, a key feature that informs and assists in the delivery of such savings is the impact of the wider social benefits of the programme. For example, social isolation has an impact on an individuals mental and physical health and can lead to (especially in people above retirement age) significant and serious deterioration of mental and physical health that potentially incur greater financial cost than upstream preventative and proactive treatments. If individuals can engage socially then negative outcomes (especially those related to developing mental health issues) may be avoided.

Examples of this activity are seen directly in the befriending[10] activities offered either as a single project (One Small Step) or as an element in a wider range of activities directed towards reducing the risk of hospital readmission for those at highest risk. (Close 2 Home, Age UK Home Advice Service, Staying Out). The advantage of befriending in these projects is that they are directly addressed towards older individuals who are explicitly socially isolated and have identified themselves as such or who are at increased risk of hospital admission/ re-admission and may also be self-identified or assessed as being socially isolated. In these cases the befriender may identify issues relating to the health of the client of which the client themselves was unaware and the client may therefore take action to addresses the change in health.

The remaining projects in the Health Initiatives Programme address the issue of social isolation explicitly as a part of their activities. For a number of the projects the addressing of social isolation is a key function of their activities (Nur Fitness, Community Welfare Trust, MIND (Win Lose or Draw)) alongside a focus on raising the awareness of low level anxiety and depression amongst groups for whom mental health issues may still be subject to a level of stigma and opprobrium within their community. An advantage, in this case, is that the issue of mental health and psychological wellbeing is integrated into the same sphere of activity as physical exercise, which is the stated main function of the activity in publicity, but this activity is the 'hook' on which issues of social isolation and mental health awareness can be addressed.

It was noted in the Groundwork NE & Cumbria (HEAL) project that a number of participants who had originally attended with a carer or befriender as they were unsure of engaging in the wider environment or socially with others had become more independent of the support offered by the carer or befriender and had engaged in social chat and encouragement with others. This example illustrates with the support of the carer/ befriender and the activities within the project how an individuals self-confidence and therefore mental health state, may be improved by engagement in a social activity.

A key feature of the Take Heart project, which on the surface would appear to be a purely health orientated project, was the importance that the social environment played for those attending the exercise session. The sessions give those who are at different stages of recovery the chance to engage socially with others, all of whom to a degree, have had the similar challenging physical and psychological issues and this shared cultural understanding acts as reassurance, alongside specialist advice from the tutor as to when an issue may be viewed as needing further attention or is a normal stage in the recovery process.

[10] Volunteer befrienders in these projects also gain in terms of psychological wellbeing from engaging in new situations and may benefit in the future economically by using the befriending activity as information within their CV.

What could be seen as a purely social outcome for a number of the projects, that of benefit maximisation is, in reality, of key importance in addressing issues of social isolation and mental and physical health. If a client is not in receipt of the monies to which they are entitled they may, by necessity, have to constrain their social activities. Over time this could lead to increasing social isolation and a decline in mental health due to the lack of social engagement and as a consequence of ending up in debt. It has been noted in terms of debt and mental health the annual costs of health and social service use per case is £1,631[11]. This figure does not however, include the costs in terms of the impact on physical health of being in debt and the restrictions this places upon adequate home heating, the purchase of appropriate foodstuff and ensuring continued good health.

In encouraging a mix of clients to engage in the projects with different life experiences and expectations the Health Initiative Programme is developing interpersonal relationships and common understandings either explicitly (as in the case of befriending activities) or implicitly as an element of project activity. For example the Alzheimer's Society project has as an explicit outcome of increasing the dementia diagnosis rate in the area. Whilst this may be seen as a direct explicit health outcome the project is also engaged in activities which allow those who are at different stages of dementia development (and their carers) to interact with each other and not to feel socially isolated within their local, narrowing, community of social engagement but in turn be supported by, and in turn, support others. Such support networks are known to have a positive effect in terms of the mental health status of those engaged within their framework.

A key issue is that projects which may appear to be more of a social engagement project or whose health outcomes and outputs may at first assessment appear to be low are, in reality, buttressing and supporting the individual clients mental and physical health state through the social engagement and interactions which these projects support. Even projects which have a clear direct health approach such as the My Life CIC have a large component of social engagement built into their structure.

Through the initial supported social engagement offered within Health Initiative Programme projects a network of wider social communication and engagement can develop within the projects by the beneficiaries. This in turn promotes positive changes in psychological health as social isolation is reduced and may result in the establishment of new social networks for the individual participant. It is in this fashion that increased social cohesion develops as individuals who may have been formally socially isolated through physical ill health and/ or low level psychological conditions may be encouraged to re-engage, at an appropriate pace to meet their needs and expectations, in the wider community.

Conclusion

The VCSE Health Initiatives evaluated here have all demonstrated to varying degrees the importance of the interplay between two different areas of focus and engagement: the social and the physical health. Projects which have an involvement in the social or public sphere in terms of, for example, welfare maximisation and the reduction of fuel poverty have direct impacts upon physical health. An example of this may be in the reduction of the health impacts of social isolation through investing in projects that provide great opportunities for participation and inclusion. Such approaches can

[11] Curtis (L) (ed), (2014) *Unit Costs of Health & Social Care 2014*, p58, Canterbury, Personal Social Services Research Unit (PSSRU),

have direct health impacts by, for example, reducing the number of hospital admissions due to respiratory ill-health or hypothermia during the winter[12].

In preparing future projects we would suggest that the current approach of funding 'experimental' projects whose aim is to reach traditionally 'hard-to-reach' groups should continue. It is important that this type of project continue as one or more of them may indicate more effective methods of engagement whilst simultaneously failing to achieve their stated aims.

A recurrent finding of this research was the lack of referrals from GP surgeries. This was despite engagement with Practice Mangers and GPs, both formally and informally. This problem needs addressing for future project activity that relies on such referrals to achieve its aims and objectives. It must be stressed however that this is not a local issue restricted to this programme. Similar difficulties have been experienced in other Social Prescribing projects.

The VCSE Health Initiatives Programme, despite the issue identified above and within this report, has been effective in selecting projects that have been innovative and have covered the joint priorities of the Hartlepool & Stockton-on-Tees Clinical Commissioning Group and Stockton on Tees Public Health. The degree of success of the projects varies but this is only to be expected given the diverse range of activities, beneficiaries and varying timescales of the individual projects.

[12] Further examples have been discussed within the body of this report see for example discussion of the importance of the social environment in the Take Heart project.

Appendix 2

Briefing Note: Methodology used to Calculate Health Economic Impact of CATALYST Health Improvements Programme

Prepared for Stockton Health & Wellbeing Board

Following discussion with Dono Widiatmoko, health economic impacts for each of the projects were modeled as described below. Where available, project data returns were used as well as relevant external data sources, including the NHS (England) (2013*) Tariff Information Spreadsheet 2013-14 v6-1*[13] and Curtis (2014)[14]

In what follows the Close2Home project is used as an example. This project ran for two years. Some data for Year 1 was unavailable. Where appropriate data from Year 2 was used for modeling. This was made explicit. The total funding awarded to this project was £**220,300**. Given the limited time allocated for analysis/ evaluation, a key set of limited outcomes/ outputs were identified from which the health economic impacts were calculated.

Close2Home used the *Warwick Edinburgh Mental Wellbeing Scale* to measure changes in the mental wellbeing of clients at entry point to, and exit point from, the service. The value of improvement or reduction in the *Warwick Edinburgh Mental Wellbeing Scale* for an individual client has been recorded at The Global Value Exchange[15] as equivalent to £1,000 per individual[16].

Close2Home also used the *Wellbeing Star* to measure individual improvement in the management of long-term conditions and self-care. No valuation is available for the W*ellbeing Star*, however, it is assumed that it is equal in value to the improvement, or otherwise, of the individual client assumed by the *Warwick Edinburgh Mental Wellbeing Scale* i.e. a value to the client of £1,000 per individual. Not all the clients used this scale. For those who did not alternative measures were available. No data on use was available from Year 1, however as noted it was assumed that all clients had experienced improvement, as reflected in scores from the *Wellbeing Star*, or from positive engagement and improvements in the other identified measures. Not all clients used the scale in Year 2 and other measures were available. It is assumed that 75 per cent of clients used the *Wellbeing Star*, and of those used it, it was reported by Close2 Home that all had improved self-care by a value of 29 per cent.

A key measure of success for this project was Reduced Hospital Re-Admission Costs. Close2Home obtained data on hospital admissions for clients they had served between January 2014 and January 2015. Data were reported for 86 clients who had completed involvement with Close2Home, with a further 25 who were clients at the time of report issue. Close2Home noted this data was cross referenced to referral data. Admissions three months prior to engagement and 3 months after engagement were compared to give a percentage reduction in admissions and an approximate cost saving.

It was expected, based upon extant research on social isolation and befriending studies, that there would be a saving through reduction in attendance at GPs[17]. To reducing over claiming, a mid-point

[13] https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs (Date accessed 08 February 2015 onward)

[14] Curtis, (L) (ed), (2014) *Unit Costs of Health & Social Care 2014*, Canterbury, Personal Social Services Research Unit (PSSRU)

[15] http://www.globalvaluexchange.org/ (Date accessed 03 December 2014 onward)

[16] 2012 value of £994 + compounded inflated totalling 0.7per cent = £1000 (rounded down)

[17] http://www.scie.org.uk/publications/briefings/files/briefing39.pdf reported reduction in GP surgery visits of between 2 and 4 (rounded values) for participants engaged in scheme. (Date accessed 02 February 2015)

value of GP surgery attendances was selected (three). It is assumed that the decrease in GP attendance would be achieved by two thirds of the client group across Year 1 and Year 2 (i.e. 122 clients) with a fall off effect of two per cent following immediate engagement. It is further assumed that there would have been no prescriptions issued had these GP visits actually occurred. Consequently there is no saving from this source. No volunteers were used during the course of this project; therefore there are no health economic impacts to consider. In terms of deadweight it was assumed that the situation would have continued as recorded before the commencement of the project. See information presented above.

Displacement was not considered as the researchers were informed that the project was unique in its approach and engagement with other projects in the Health Initiatives Programme that contained elements of the methods used but which targeted different client groups. It is not possible to apportion attribution effects to this project, since such effects would be generated within the wider environment and hence be outside the remit of this research.

Value of Health Activity in Short Term Saving

To assess the short-term savings of the health activity, the final total (as calculated above) was subject to a five per cent reduction in order to account for 'Drop Off' effects on clients and former clients.

Value of Health Activity in Long Term Saving

To determine the value of health activity in long term saving, a span of four iterations was considered appropriate.

- To account for 'Drop Off' in phase one, a percentage reduction of 10 per cent was viewed as appropriate following benchmarking with other studies. The reduction was applied to the value of the health activity in the short term, as derived above.
- To account for 'Drop Off' in phase two, the final figure from phase one was subject to a percentage reduction of 20 per cent.
- To account for 'Drop Off' in phase three, the final figure from phase two was subject to a percentage reduction of 35 per cent.
- Finally, to account for 'Drop Off' in phase four, the final figure from phase three was subject to a percentage reduction of 40 per cent.

To calculate the overall long term impact of the health activity in terms of savings, the final figures from phase one, phase two, phase three and phase four were added together.

It is important to note that the long term savings value of the health activity figures produced by the process should be regarded as *broadly indicative ONLY. They are not, and should NOT be assumed to be, precise values. Rather they are broad estimates*. This is because a small deviation in the early stages of long term analysis can lead, through additive error, to large variation from the approximate 'true value'. Other factors outside of the scope of this analysis may also compromise the accuracy of the determined final values.

Data Analysis

Stage A: Warwick Edinburgh Mental Wellbeing Scale and the 'Wellbeing Star' Values.

Improvement in Warwick Edinburgh Mental Wellbeing Scale Year 1 - Not stated in Year 1 Evaluation Report assume equivalence with Year 2 i.e. 75% of 62 clients =47 clients (approx.)	Improvement in individual wellbeing scores using Warwick Edinburgh Mental Wellbeing Scale Year 1 .	Close2Home Catalyst Monitoring and Global Value Exchange (at £1400 per client x number of clients improved 75% = 47 clients approx. (62/100) x75) x £1400 = £65,800) The Global Value Exchange value is for an improvement in one point in the Edinburgh Warwick Scale.	Close2Home Catalyst Monitoring (for Year 1) and Global Value Exchange	65,100
Improvement in Warwick Edinburgh Mental Wellbeing Scale Year 2 - Stated in Year 2 Evaluation Report to be 75% of 122 clients = 92 clients (approx.)	Improvement in individual wellbeing scores using Warwick Edinburgh Mental Wellbeing Scale Year 2.	Close2Home Catalyst Monitoring and Global Value Exchange (at £1400 per client x number of clients improved 75% of them = (122/100)x75) x 1400 = £128800 (rounded)) The Global Value Exchange is for an improvement in one point in the Edinburgh Warwick Scale.	Close2Home Catalyst Monitoring (for Year 2) and Global Value Exchange	128,800
Improvement in Individual wellbeing score Year 1	Improvement in individual wellbeing scores using Wellbeing Star Year 1	Close2Home Catalyst Monitoring and Global Value Exchange (at £1400 per client x number of clients=62 x 1400 = £86800) The Global Value Exchange is for an improvement in one point in the Edinburgh Warwick Scale. No data available for Wellbeing Star so assume equivalent value. Not all used the Wellbeing Star but assume this was the case	Close2Home Catalyst Monitoring (for Year 1) and Global Value Exchange	86,800
Improvement in Individual wellbeing score Year 2	Improvement in individual wellbeing scores using Wellbeing Star Year 2	Close2Home Catalyst Monitoring and Global Value Exchange (at £1400 per client x number of clients x percentage increase = £1400 x 122 x 75 % = £128100) The Global Value Exchange is for an improvement in one point in the Edinburgh Warwick Scale. No data available for Wellbeing Star so assume equivalent value Not all used the Wellbeing Star but assume this was the case	Close2Home Catalyst Monitoring (for Year 2) and Global Value Exchange	128,100
Total				**408,800**

Stage B: Reduced Hospital Readmission Rates Compared to Previous Situation.

Reduced hospital re-admission rates compared to previous situation (see Close2Home Year 2 end of Year Report)	Reduced hospital re-admissions (Jan 2014-Jan 2015) Data from North Tees Hospital. This is a combined Year 1 and Year 2 figure for during and after engagement (time of Close 2 Home plus 3 months follow up)	Close2Home Catalyst monitoring using data obtained from North Tess Hospital = baseline prior to referral of 53 admissions with a total length of stay of 340 days and 53 admissions. Post Close2Home = 12 admissions with a total length of stay of 50 days =savings total of £ 74,235 or £863.20 per person based on Kings Fund cost of £250 overnight + A&E cost of £90	Close2Home Catalyst Monitoring and North Tees Hospital Data	74,235.00
Total				**74,235**

Stage C: Reduction in GP Visits to the Surgery by Two Thirds of Clients

Reduction in GP visits - for 122 referrals at a forecast reduction level of 3 visits per person Assumption is that this will apply for 2/3 of all participants across Year 1 and Year 2 = 184-64 = 122	Reduction in GP visits - for 122 referrals at a forecast reduction level of 3 visits per person Assumption is that this will apply for 2/3 of all participants across Year 1 and Year 2 = 184-64 = 122) with a 2 per cent reduction	PSSRU Unit Costs of Health & Social Care 2014 GP visit to surgery Table 10.8b Per Patient Contact of 11.7 min inc direct care staff cost with qualification = £46 For this project (122 x 3 x £46) - 2 per cent = £1,655.40 Assume no prescription issued	Research as detailed	16,555.40
Total				**16,555.40**

Stage D: Value of Health Activity (Current) Total

The current value of the health activity is the sum of Stage A + Stage B + Stage C = £408.800 + £74,235 + £16,555.40 = **£499,590.40** (rounded - £**499,590**).

Stage E: Value of Health Activity in Short Term Saving

To determine the value of health activity in short term saving the current value of the health activity was subject to a five per cent reduction to account for 'Drop Off' effects in past (and current) clients. This gives a total of £499,590.40 - £ 24,979 (5 percent) = £**474,610.88** (rounded = **£474,611**).

Stage F: Value of Health Activity in Long Term Saving

To determine the value of health activity in long term saving the value of the health activity in short term saving was subject to a ten per cent reduction to account for 'Drop Off' effects in past clients for phase one iteration. This gives a total of £474,610.88 - £47461.09 (10 percent) = £**427149.79** value for iteration one.

To determine the value of health activity in long term saving the value of the health activity iteration one saving was subject to a 20 per cent reduction to account for 'Drop Off' effects in past clients. This gives a total of £427,149.79 - £85,429.96 (20 percent) = £**341,719.83** value for iteration two.

To determine the value of health activity in long term saving the value of the health activity iteration two saving was subject to a 35 per cent reduction to account for 'Drop Off' effects in past clients. This gives a total of £341,719.83 - £119,601.90 (35 percent) = £**222,117.89** value for iteration three.

To determine the value of health activity in long term saving the value of the health activity iteration three saving was subject to a 40 per cent reduction to account for 'Drop Off' effects in past clients. This gives a total of £222,117.89 - £88,847.16 (40 percent) = £**133,270.74** value for iteration four.
The final value of the health activity in long term saving is given by the summed values of iterations one to four (inclusive) as stated above this gives a total of £**1,124,258.25** (rounded = £**1,124,258**)

	Iteration Value
Iteration 1	427,149.79
Iteration 2	341,719.83
Iteration 3	222,117.89
Iteration 4	133,270.74
Total	**1,124,258.25**

However, (as previously indicated) it is <u>important</u> to note that the long term savings value of the health activity figures produced by this process should be regarded as broadly indicative ONLY. They are not, and should NOT be assumed to be precise values. Rather they are broad estimates. As noted, a small deviation in the early stages of long term analysis can lead, through additive (and/ or multiplicative) error to large variation from the approximate 'true value'. Other factors outside of the consideration of this analysis may also compromise the accuracy of the determined final values.

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May 2015

Appendix 3

VCSE Health Initiatives 2014-15

Key	Commission	Set Up	Building Capacity	Delivery	Evaluation			SROI value over 1:1		SROI value under 1:1		SROI value approx. 1:1	

	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	SROI
Age UK																			
Alzheimers Society																			
BELP – Healthy Heart																			
Com. Welfare Trust																			
CSV – One Small Step																			
Eastern Ravens Trust																			N/A
Element 1																			
Groundwork NE																			
Mind: Close2Home																			
Mind: Win, Lose, Draw																			
My Life Programme																			
Nur Fitness																			
Relate NE																			N/A
SDAIS																			
Synergy																			
Take Heart																			