CITY HEALTH CARE PARTNERSHIP CIC

SOCIAL ACCOUNTS 2017/2018

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Introduction

City Healthcare Partnership CIC is a community interest company (CIC). This type of company was introduced by the UK Government in 2005 under the Companies (Audit, Investigations and Community Enterprise) Act 2004, designed for social enterprises that want to use their profits and assets for the 'public good'.

This report is the organisation's eighth set of social accounts. The social accounting process sets out to investigate, measure and highlight examples of the 'public good' CHCP has achieved during the period April 2017 to March 2018.

Because CHCP is in the business of providing community health care services its entire range of activities are completely focused on social purpose. However, as a community interest company (CIC) the organisation goes 'above and beyond' the contracted services it is expected to deliver and works hard to always deliver optimum social value to the communities it serves.

The social accounting process is particularly geared towards measuring and reporting some of the 'additional' benefits the organisation delivers to its communities, over and above what it is mandated to deliver through its community health care contracts.

Social Accounting (sometimes called non-financial accounting) is concerned with the 'triple bottom line' (i.e. benefiting local economic, social and environmental factors). It is an approach to identify a business's socially relevant behaviour, its social performance and appropriate measures and reporting techniques.

Jenko Limited, qualified social accountants and SROI Practitioners, have independently investigated the five specific activities included in this document and have compiled a report which presents an account of the social value each area has generated in this 12–month social accounting period.

The Organisation

City Health Care Partnership CIC is a health and care provider and socially responsible business established on 1st June 2010, separate to the commissioning organisation NHS Hull. It was formed to provide community health care services to the people of Hull. The organisation has since gone on to secure contracts for community services in other geographies including the East Riding of Yorkshire, Knowsley, Wigan and St Helens.

CHCP CIC provides over 80 diverse services in community settings, including End of Life, District Nursing, TB Clinics, Community Paediatric Nursing, Health Visitors, School Nurses, Sexual Health, Dentistry, Public Health, Prison Health, GP Practices, Minor Injury Units, Eating Disorders and Psychological Wellbeing and employs around 1900 people.

At its core CHCP CIC is a social business, investing all profits from all our growing ventures into services, staff and the communities in which we work. A recent user survey showed that 96% of all respondents would recommend our services based on their overall experience. As a socially responsible business, CHCP CIC re-invests any surpluses made back into the business, the communities it serves and its staff.

For more information: https://www.chcpcic.org.uk

The Purpose of Social Accounting for CHCP CIC

This social accounting process is in place to measure success against CHCP's Social Investment Strategy and Action Plan (the latest version of which is attached as an appendix to this document).

The Social Investment Strategy document and Action Plan outlines all of CHCP's intentions in relation to their corporate social responsibility and how they plan to invest. It is a strategic framework that is aligned with the organisation's overarching business objectives:

- Putting the customer and customer satisfaction at the heart of what they do
- Ensure they are able to compete in a competitive healthcare environment
- Be an employer of choice
- Be a provider of excellent health care services.

Their social investment strategy action plan breaks down activities under four headings:

- **Community**
  Engaging with the local community and social causes to build goodwill, trust and benefit for society.

- **Environment**
  Embedding environmental sustainability across different aspects of business practice.

- **Workplace**
  Going above and beyond statutory requirements to be a socially responsible employer.

- **Marketplace**
  Focused on how the business behaves in the marketplace – e.g. buying goods that have been ethically and sustainably produced.

A copy of CHCP CIC's Social Investment Strategy is attached under the appendix section of this report.

The Scope

To demonstrate the social investment strategy in action the Social Accountants were asked to look at the following areas for the 2017/2018 Social Accounts:

1. Blues Boys
2. Weightwise
3. Multi-Disciplinary Team – Severe Frailty
4. The Volunteer Hub
5. The CHCP Foundation – Small Grants

Although the CHCP Foundation has been included in the CHCP social accounts every year since its social accounting process began in 2010, the Foundation itself is now established its own identity separate to the CHCP CIC organisation. Therefore, the Foundation Small Grants section of this report has been included as an appendix to this report.

Each of the five areas has its own section in this report which includes:

- Reason For Being:
  A brief explanation of what the service/activity entails.

- Social Value:
  A contextual narrative explaining why it is important in terms of social impact.

- SROI:
  A Social Return On Investment Calculation presented as a ratio (i.e. for every £1 spent £x of social value is estimated to have been generated).

- Case Studies:
  Anecdotal evidence to illustrate the social value achieved.

Social Return On Investment (SROI)

In the social sector services are not traded on the commercial market therefore their value is often difficult to measure. Social Return On Investment is a tool, developed by the SROI Network (which has since become Social Value UK) and backed by the cabinet office. In the absence of financial profitability the tool enables social businesses to measure their achievements in terms of value to its stakeholders.

SROI attempts to capture the 'difficult to measure' value generated by a business and tells a story of change in terms of social, environmental and economic outcomes allowing social accountants to place monetary values on the non-financial activities. The outcome of SROI is a ratio which states for every £1 spent on an activity, £x worth of social value has been (or will be) created.

Evaluative and Forecast SROI

There are two types of SROI ratio – Evaluative SROI and Forecast SROI.

- **Evaluative** is conducted retrospectively and is based on actual outcomes that have already taken place.

- **Forecast** (often based on the outcomes of pilot programmes or early activities) predicts how much social value is likely to be achieved in a specific time period.

The SROI calculations in this report are based on actual figures wherever possible and where forecasted figures are used this is clearly highlighted in the individual sections.

This year:

- Blues Boys is a forecast calculation
- Weightwise is evaluative
- Multi-Disciplinary Team – Severe Frailty is a forecast
- The Volunteer Hub – is a forecast
- The CHCP Foundation – Small Grants is evaluative

Core Principles

There are 7 core principles for good SROI Practice:

1. **Involve stakeholders**
   Understand the way in which the organisation creates change through a dialogue with stakeholders

2. **Understand what changes**
   Acknowledge and articulate all the values, objectives and stakeholders of the organisation before agreeing which aspects of the organisation are to be included in the scope; and determine what must be included in the account in order that stakeholders can make reasonable decisions

3. **Value the things that matter**
   Use financial proxies for indicators in order to include the values of those excluded from markets in same terms as used in markets

4. **Only include what is material**
   Articulate clearly how activities create change and evaluate this through the evidence gathered

5. **Do not over-claim**
   Make comparisons of performance and impact using appropriate benchmarks, targets and external standards.

6. **Be transparent**
   Demonstrate the basis on which the findings may be considered accurate and honest; and showing that they will be reported to and discussed with stakeholders

7. **Verify the result**
   Ensure appropriate independent verification of the account

The Social Accounting Process

The social accountants from Jenko have employed a range of engagement practices including face-to-face meetings, telephone conversations, email contact, questionnaires, polling and research techniques with stakeholders to produce an accurate report.

In broad terms the time line and activities carried out were:

Level 1 Questioning (March 2018)
A questionnaire forms the basis for one to one meetings for the social accountants with the area leads to determine the reason for being for each activity and to ascertain where and what the 'real' social value being achieved is.

Level 2 Questioning (June 2018)
This phase focuses on measuring the social value and how the social accountants physically attempt to measure the social return on investment.

Direct Stakeholder Involvement (June/July 2018)
The social accountants have carried out several surveys with stakeholders for this set of social accounts. A proven tool recommended by Social Value UK, the Value Exercise, was used. This provides those being surveyed with a list of items that are available commercially (e.g. a holiday, an iPad, a trip to the cinema etc.) and asks the respondent to place the outcome of the particular activity being measured amongst those in value order. The results are recorded and a mean average is taken for the overall perceived value of the stakeholder group.

Interview CEO (June 2018)
The social accountants interviewed CHCP's CEO, Andrew Burnell posing questions on each of the areas covered in this report.

Level 3 Questioning (June - July 2018)
This is an accuracy check. The social accountants write up the separate sections of the report and give them to the area leads for checking and signing off in terms of accuracy.

Submission (July 2018)
The final report was submitted to the board of directors in July 2018. We understand a verification process will be established in the coming weeks involving the new Co-owner Forum panel.

Blues Boys

Reason For Being:

The Blues Boys project was implemented by CHCP to increase the Hull Health Visitor Service's knowledge around 'Transition to Fatherhood', paying particular interest to paternal postnatal depression (PPND). It was anticipated that by raising practitioners' awareness of these important, yet often overlooked issues, the organisation would be able to put in to place strategies to meet identified needs and aim to improve the engagement with fathers thus promoting a wider father-inclusive health visiting service in the future.

This project was funded by The Queen's Nursing Institute's (QNI) via its Burdett Trust for Nursing Fund for Innovation and Leadership programme, which had a theme of men's health for 2018. The funding was applied for, and subsequently awarded to Rebecca Price, 0-19yrs Practice Development Lead. Rebecca was the project lead, the instigator of change and the person who reported the developments to QNI.

Current evidence suggests that approximately 10% of fathers, 20% of mothers (source – QNI) are diagnosed with postnatal depression. There has long been strong, and widely-available evidence about paternal post-natal depression however, the service has not seen recognition of this in its current policy, and furthermore in society, it is generally hidden and not discussed.

The Health Visiting Service is often perceived as a purely mother/child-centric service and can unknowingly act as a barrier to fathers. However, Health Visitors are in a prime position to support fathers as well as mothers with their transition to parenthood. This project will help to promote the recognition of the mental health needs of both parents in the peri-natal period (pregnancy, birth and beyond) because evidence informs us that in most cases they are not mutually exclusive.

It was the intention of this project to raise awareness of the need to engage with fathers, identify the barriers that inhibit the process, promote a better understanding of the issue and determine how we could act in a supportive and inclusive way.

The 0-19 yrs., Public Health Nursing Service in Hull has embraced the Blues Boys project and, to date, 51 health visitors have participated in the 'Engaging Fathers' training programme which has received positive evaluation. Without doubt, affording staff with this underpinning knowledge has increased ambition and confidence to create a more father-inclusive health visiting service in Hull.

Between the months of July and December 2017, following the training, nineteen of the 51 Health Visitors took part in the screening/intervention phase of the Blues Boys project, which involved fathers completing the Edinburgh Postnatal Depression Scale (EPDS). This was undertaken following a wider, inclusive discussion about peri-natal mental health when the Health Visitor was visiting both Mums and Dads-to-be as part of the core contacts offered by the service. Through this affirmative action, fathers who are struggling with anxiety and depression have been identified that would not have been previously in health visiting if the team had not actively enquired about their emotional well-being during the peri-natal period.

NICE recommends the use of the EPDS screening tool as 'best practice' for mothers however, recommendations for screening fathers is absent in the current guidance.

The project also influenced the midwifery service to be more inclusive of fathers in its outlook and, even small changes in its language to include the term 'Mum and Dad', rather than referring to the baby's father as 'partner' brought about a meaningful sense of father-inclusion.

Rebecca Price has been invited to sit on the Hull Safeguarding Children Board, the statutory body that brings together all the key partners and organisations who work together to promote children's welfare and help protect them from abuse. The Board were looking at how better to engage with men and Rebecca's aim in her role is to put men on the agenda. As a result of this, Children's Social Services departments have changed their systems to capture more information about men and Dads and their relationships with their children.

Furthermore, recommendations and sustainable changes have been made as to how the Health Visitor Service communicates to fathers and how we record their presence at contacts. This has enabled the service to gain a greater appreciation of how many fathers are present at Health Visitor contact visits and engaged in their baby's development. These changes include:

- Evaluated training for all service staff
- Acknowledge father's presence at Health Visitor contact (recorded on System One)
- Changed Health Visitor pamphlet material to be inclusive of father
- Changed language at Health Visitor contact to always include fathers (whether present or not)
- Greater engagement of fathers at clinics
- Recognised cases of paternal postnatal depression always referred to GP and Let's Talk

"For me, creating this project was a simple ethical decision. By asking the question 'why are we not doing for men what we are doing for women?' gave a very simple answer; I recognised there is a big gap in the Health Visitor service for fathers. By acknowledging the presence and needs of fathers at a Health Visitor contact meeting, we have brought about significant change in recognising paternal postnatal depression and other factors around Dads' wellbeing."

Rebecca Price
0-19yrs Practice Development Lead - Specialist Public Health Nursing Service
City Health Care Partnership CIC

Social Value:

Set against a background where it is said that; 'typically, men do not expect any support towards their health' (and, particularly towards their mental health), some surprising information came forward during this project. The Health Visitor service previously had a low estimation of the number of fathers present at contact visits. By simply recording 'father present' at contact visits, it was found that in fact 54% of fathers ***were*** present at birth visit and 53% ***were*** present at child health clinics. This data encouraged the project lead and team towards further father inclusion in its approach.

Of the 600 fathers that were engaged with Health Visitors during the project, 25 were signposted to their GP in order for them to access talking therapies (Let's Talk) and other services because they were displaying symptoms of PPND or anxiety and depression. Nineteen of these individual fathers went on to work directly with their Health Visitor alongside their talking therapies. The Let's Talk service was encouraged to add a 'perinatal' flag to its system so that early detection of PPND could be 'on the radar' and measured accordingly.

Mums *AND* Dads

Previously, literature presented by the service, was mother-centric and typically aimed directly at, the, baby's mum. By changing the information and language to be parent-centric and by being Dad-inclusive in its messaging, they found the literature generated greater participation by fathers at contact meetings. Specifically, a defeminised, parent-centric public health leaflet imparting information about peri-natal mental health and, addressed directly towards 'Mums ***and*** Dads', gave greater recognition of parental peri-natal depression as a 'shared' or 'family' problem and acknowledged that Dad may face these challenges in addition to the more recognised female postnatal depression. It is believed that this greater participation by Dads in the immediate postnatal Health Visitor contact, leads to a greater understanding of baby's needs, shared responsibility towards attachment and better understanding of men's postnatal mental health in the family setting.. It is documented that men can become irritable, aggressive or often avoidant of their new-father responsibilities. Improved or early detection of PPND and the general wellbeing of new fathers can only help alleviate negative behaviours towards baby and family experienced by those living with PPND.

"We need to think 'family' when it comes to peri-natal mental health and remember that if dad is the only one struggling that will impact on the whole family if unsupported. We need to be supporting all parents with their mental health which will have far better outcomes for child development with early prevention saving money, and most importantly lives, as the biggest killer in men under 45 is suicide in the UK"

Mark Williams
Peri-natal mental health Campaigner

Bonding and attachment

It is recognised that good bonding and attachment experienced by a baby with its parents, helps baby to deal with life's challenges through to adulthood. It is widely documented that if, from birth, bonding and attachment develops in response to love and attention, infants and young children usually go on to experience positive effects on their cognitive and social development. Building trusting relationships with others as a child develops helps it integrate into society more easily including at school. For example, secure attachment to a preschool teacher may help children to improve their preschool experience. Recent studies suggest that the adverse effect of inadequate preschool experiences can lead to skill deficiencies that mimic the effects of basic cognitive deficits.

Measuring the impact on bonding and attachment is a complex premise and is not the purpose of this report. However, the Social Accountants wish to recognise some aspects of the social impact the Blues Boys project will have upon society by positively impacting fathers in terms of better mental health in Hull. Having a father with better mental health can only lead to a better mental health and 'stability' for the child and other members of the family. Although there is no precise way of measuring this, in terms of the 'stability' that grows from a baby having the solid roots of good bonding and attachment with its father in the early days, there is a financial proxy available that measures school readiness. Because school readiness is all about 'stability' and children having a 'good level of development', the social accountants feel it has enough similarities to be able to apply it in this report, as part of the SROI calculation, as a conservative financial measure of the 'stability' created amongst the babies born into families that have engaged with the Blues Boys project. The school readiness proxy, has been used in other initiatives as a measurement of stability in babies including the FNP (Family Nurse Partnership) a programme for teenage parents and their babies, and is based upon Department of Education Budgeting which claims for every 'school ready' child starting in reception class the school saves £1023 per year. (Fiscal savings associated with improved school readiness on entry to reception year age 4-5 derived from Department of Education (2013) - source FNP Pitch Pack 2015.)

International studies show that when a baby's development falls behind the norm during the first year of life, it is then much more likely to fall even further behind in subsequent years, than to catch up with those who have had a better start. There is longstanding evidence that a baby's social and emotional development is strongly affected by the quality of their attachment. The best chance to turn this around is during the 1001 critical days. At least one loving, sensitive and responsive relationship with an adult caregiver teaches the baby to believe that the world is a good place and reduces the risk of them facing disruptive issues in later life.

Excerpt from: The 1001 Critical Days; The Importance of the Conception to Age Two Period. A cross party manifesto: Andrea Leadsom MP, Frank Field MP, Paul Burstow MP, Caroline Lucas MP.June 2014.

Practitioners' training

Every member of the service team undertook a six half-day training course on the topic of fathers' wellbeing, health and, how to achieve better-engagement of Dads with the Health Visitor service. Having better-prepared Health Visitors in respect of them understanding men's health and wellbeing, and by putting Dads on the agenda at Health Visitor contact visits is likely to lead to a better overall experience of their transition to fatherhood. In response to the question; "I understand what the barriers are to engaging fathers in Health Visitor practice" pre-course evaluations show 26 respondents rated their knowledge as 3 (on a scale of 1-5, five being 'good level'), whereas post-course evaluations showed 28 respondents rated their knowledge as 5 (on the same scale of 1-5) to the same question. The benefits of this retained knowledge will exist for many years, and the benefits to child development will exist for many more.

The Social Accountants believe the Blues Boys project has delivered social value above and beyond the requirements of the service that City Health Care Partnership CIC is mandated to deliver in Hull to the benefit of Dads, mums and their babies, and the wider local community as children grow and develop. These benefits are reflected in the SROI calculation and the case studies later in this report.

"There has been a long-held assumption that it is not the father's place to be present at Health Visitor meetings. However, a baby can only benefit from having a better-engaged father. Recognising paternal postnatal depression can have a massive impact on the family unit, and a few simple changes have helped us do just that. "

Andrew Burnell
Chief Executive
City Health Care Partnership CIC

SROI For Blues Boys
(Social Return On Investment)
£1 : £21.18

There are 4 lines within this SROI Impact Map.

- **Line 1 –** The benefit to the NHS in terms of cost savings in terms of early identification and treatment of male peri-natal mental health.
- **Line 2 –** Increased stability for babies in Hull as a result of receiving better bonding and attachment with their father.
- **Line 3 –** The social value generated for the Health Visitor service in Hull in terms of training delivered in paternal post-natal depression (PPND).
- **Line 4 –** The value to the local economy of early detection and treatment for PPND preventing lost working days due to depression.

Line 1 – The benefit to the NHS in terms of cost savings in terms of early identification and treatment of male peri-natal mental health

QUANTITY: 281 – The average number of babies born in Hull per annum is 5,000 and 54% of Dads were present at birth Health Visitor contact, this equals 2,700 Dads are better engaged in their baby's development and having exposure to the health visitor service in terms of their own post-natal needs. It is recognised that 10.4% (source - Paulson and Bazemore, 2010) of Dads could be expected to go on to develop PPND, which suggests a quantity of 281 fathers (2,700 x 10.4%) of this cohort could potentially be at risk of suffering unsupported.

FINANCIAL PROXY: £10,000 – The costs to the NHS for untreated peri-natal mental health problems - per UK birth, per year (This is the cost for women. The social accountants have been unable to find any similar reported costs for men). Source – Mental Health Foundation: Fundamental Facts about Mental Health - 2015.https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf (Page 7)

VALUE OF INPUTS: £27,256.47 - the total cost of implementation, administration, IT changes and training time for the area lead for the project.

DEADWEIGHT: 70% - a conservative estimate of Dads likely to take their own measures to address their depression anyway, without the health visitor dad-inclusive activity that took place because of the Blue Boys project. The social accountants are Rebecca Price agree the deadweight percentage should probably be much lower here, but in the absence of any meaningful data on this and in an effort to ensure the calculation does not over-claim they are all happy with this conservative estimate.

ATTRIBUTION: 50% - an estimate of other services (outside of Blues Boys' activity) that would have identified the fathers' PPND issues and intervened accordingly by some other means. Again in the absence of data, the social accountants and area lead, Rebecca Price, believe this is a fair if conservative estimate.

Line 2 – Increased stability for babies in Hull as a result of receiving better bonding and attachment with their father

QUANTITY: 281 – as above, the babies of the Dads that may go on to develop PPND (no concession has been made towards multiple births in order to maintain conservative social accounting).

FINANCIAL PROXY: £1,023 – the value to education services of a child that enters the education system as 'school ready'. (Source – Fiscal savings associated with improved school readiness on entry to reception year age 4-5 derived from Department of Education (2013) - source FNP Pitch Pack 2015.)

VALUE OF INPUTS: £27,256.47 – as above – the cost of the project goes across all lines.

DEADWEIGTH: 38% - based on local statistics for school readiness which show that in 2017 just under 38% of children entered school at the expected level of development, hence those expected to be 'school ready' anyway without any Blues Boys activity. (Source - Hull City Council – Standards and Improvement Office, Early Years Lead – Sue Cornwall).

ATTRIBUTION – 50% - a conservative estimate of other services (outside of Blues Boys' activity) that would have identified the fathers' PPND issues and intervened accordingly by some other means.

Line 3 – The social value generated for the Health Visitor service in Hull in terms of training delivered in paternal post-natal depression (PPND)

QUANTITY: 51 – the number of health visitors that received the Blues Boys training.

FINANCIAL PROXY: £240.00 – the aggregated value of a similar training programme as published by The Fatherhood Institute.

VALUE OF INPUTS: £27,256.47 - as above – the cost of the project goes across all lines.

DEADWEIGHT: 0% - the Social Accountants believe it is unlikely the practitioner training would have happened anyway

ATTRIBUTION – 10% - Rebecca Price has estimated the contribution of other through training material amounts to around 10%.

Line 4 – The value to the local economy of early detection and treatment for PPND preventing lost working days due to depression

QUANTITY: 6688 – the likely number of working days per annum lost through PPND in Hull in this accounting period, based on statistics from the Health & Safety Executive (source - www.hse.gov.uk/statistics/dayslost.htm) who published a figure of 23.8 working days on average per person per year are lost to depression. When applied to our 281 fathers in this cohort amounts to a potential of 6688 working days lost.

FINANCIAL PROXY: £55.35 – the social accountants have used the hourly rate of a person on minimum wage to value of a day's pay based on a worker aged 21 to 24 (i.e. 7.5 hours x £7.38 per

hour = £55.35) in the spirit of one of the key principles of social accounting which is to under-claim. Of course it is highly likely proportion of our fathers could well be over 24 years of age and could be earning more than minimum wage.

VALUE OF INPUTS: £27,256.47 - as above – the cost of the project goes across all lines.

DEADWEIGHT: 70% - a conservative estimate of Dads likely to take their own measures to address their depression anyway, without the health visitor dad-inclusive activity that took place because of the Blue Boys project.

ATTRIBUTION – 50% - an estimate of other services (outside of Blues Boys' activity) that would have identified the fathers' PPND issues and intervened accordingly by some other means.

Case Studies

Mark's story

Mark and Jade have recently become parents for the first time with the birth of their daughter, Maisie. As per the Health Visitor Protocol an antenatal contact took place when Jade was 32 weeks pregnant. This visit was carried out at the couple's home, and, whilst Mark was present throughout he did not interact with the Health Visitor other than to answer the door and show her into the front room. He then went to sit in the dining room area, with his back to the Health Visitor and played on his game station.

When the Health Visitor went back to undertake the new-birth visit (10-14days postnatal) Mark's presentation and interactions were just the same. However, on this occasion, as the Health Visitor was part of the Blues Boys project and as such, was required to undertake routine screening of both the mother's and father's emotional wellbeing and mental health. She sought to actively engage Mark with this conversation.

The Health Visitor was surprised, yet interested to hear that Mark had suffered from depression since the age of 15, when he had witnessed his best friend collapse and die on the school football pitch. He stated that 'he had tried everything but nothing worked'. The Health Visitor continued to listen to Mark's experiences and struggles with his mental health and, before she left, took the opportunity to present him with the leaflet that gave both Mark and Jade information on how Mums and Dads can be affected by postnatal depression. She explained about the Blues Boys project and that the Health Visitor service is here to support both parents, not just mums. After this discussion, Mark thanked the Health Visitor for her time spent talking with him, however, declined to complete the EPDS and have his System One records opened.

At the 6-8 week follow-up visit the Health Visitor was greeted by a very engaged and chatty Mark; who reported that he had given their last visit a lot of thought and, as a result of the information shared about Peri-natal Mental Health support for both Mums and Dads he had contacted the Let's Talk service and was starting counselling to help him manage his depression.

Further follow-up by the Health Visitor with the couple revealed that Mark has engaged well with Let's Talk and he feels a real therapeutic benefit from his counselling sessions. He reflects as a consequence of the support he has been afforded with, he has improved his relationship with his partner, Jade and, has coped better with his transition to fatherhood than he expected to. Mark ensures that he is always present for every visit from the Health Visitor and actively engages with her about his own wellbeing and the health and development of his daughter. Mark is hoping to be well enough to return to work in the near future.

Steve's story

At the Birth Visit, the Health Visitor spoke to Samantha about her emotional wellbeing. It is normal practice to discuss this and raise awareness. Mum, Samantha completed the EPDS, which indicated that she was suffering with symptoms of anxiety, however she stated that she felt ok but, that it was her husband Steve that was 'stressed'.

The Health Visitor went on speak to the couple about the emotional wellbeing following the birth of their baby. Steve described how he was feeling: 'resentful of impact on life' 'turned life upside down' 'not bonded' 'overwhelmed'.

The Health Visitor spent time with the couple, allowing Steve to talk about these issues. She offered them 1st line advice about how to manage stress, the impact they were both experiencing, and, the changes to the couple's relationship. The leaflet was helpful as Steve realised it was inclusive of fathers and it addressed the issues of both parents.

Steve was thankful for having been offered the time to talk and be listened to, in a non-judgemental way by the Health Visitor. He was signposted to both his GP and the Let's Talk counselling services. The Health Visitor arranged her next visit to the family at 8am so that the Steve could see her before he had to leave for work.

At the follow-up visit the Steve greeted the Health Visitor at the family home and stated that he felt 'so much better' for just talking about the issue and not bottling his feelings up. He has made an appointment to see his GP.

WEIGHTWISE

Tier 3 Specialist Weight Management Service

Reason For Being:

This is a service for adults with morbid obesity (BMI 30+) providing them with the opportunity to take part in a tailored programme which focuses on the 'whole person' rather than simply weight loss. The programme focuses on the aspirations of patients in terms of their unique and personal targets for weight loss, as well as their overall well-being, self-esteem, self-belief, confidence and motivation for living a better life.

It is well documented that obesity increases the risk of many long-term and serious health problems including heart disease, stroke, hypertension, type 2 diabetes, asthma, depression, musculoskeletal disorders, cancer, reproductive problems, obstructive sleep apnoea, breathlessness and liver disease.

Different tiers of weight management services cover different levels of intervention. Definitions vary nationally, yet in Hull Tier 1 covers universal services (such as health promotion); Tier 2 covers lifestyle interventions (such as tackling behaviour re eating less / moving more etc.); Tier 3 covers specialist weight management services (such as Weightwise); and Tier 4 covers bariatric surgery.

The highly specialised Tier 3 Weightwise team includes dieticians, consultants, clinical psychologists, psychological well-being practitioners and personal care coordinators. Patients are reviewed quarterly by this multi-disciplinary team during this two-year programme. Weightwise saw 134 patients in 2016/2017 and a further 258 in 2017/18 following efforts to scale up the team and bolster the service with additional consultant hours and recruiting additional staff.

Intervention options from this award-winning service (Clinical Team of the Year – nutrition winners – in the 2017 General Practice Awards) include a combination of the following and can last anywhere from 6 months to 2 years depending on patient needs:

- One-to-one group sessions with specialise diabetes / eating disorder dieticians.
- One-to-one hands-on practical cooking sessions (including home visits)
- Group courses in food portioning, binge eating disorder, emotional eating
- Clinical psychology food / mood groups
- Practice supermarket shopping sessions
- Strength / conditioning personal training programme (Hull University Partnership)
- CBT, stress control, counselling, transactional analysis and peer-support sessions
- Personal care co-ordinator sessions (for motivation, adherence, goal setting)

"Our approach looks at the 'whole self' and not merely weight loss. All too often, weight management services tend to focus on the weight loss end goal. This can exacerbate some disorders such as binge eating. We focus on regular eating, avoiding frequent weighing with more emphasis on long term outcomes and how they can be achieved and maintained for life."

Heidi Henrickson, Operations Manager – Public Health Yorkshire, City Health Care Partnership CIC

"Obesity is complex. There are always underlying reasons as to why obesity occurs and it is a unique combination of all kinds of things – from biology, psychology, societal influences, activity levels and food. It affects all aspects of a person's life. It affects mental health and leads to chronic illnesses in many cases if left. It affects patients' ability to gain and maintain employment. It's a big deal for the patients themselves and for the NHS."

Mark Doughty, Tier 3 weight Management Team Leader - Weightwise, City Health Care Partnership CIC

In line with Weightwise's holistic approach, they measure the following at the beginning of the programme and at the end:

- Weight
- Height
- BMI
- PHQ-9 (a tool for measuring depression)
- GAD-7 (a tool for measuring anxiety)
- Godin (a tool for measuring physical activity levels)

Of course, society's unhealthy behaviour of yesteryear is proving costly today and, even more costly as we look to tomorrow, next year and the next 20 years. The Foresight report (Tackling Obesities: Future choices from the Government Office for Science) states that we are in danger as a nation of allowing obesity to ultimately become the norm. The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050. The wider costs to society and business are estimated to reach £49.9 billion per year (at today's prices). As well as it being a serious healthcare challenge, obesity is a social challenge. It is about education and social norms for eating and exercise. It is about how food companies formulate their products, how they are labelled and advertised, and how they are priced and displayed in shops. Work and school play a crucial role: more and more jobs are sedentary and kids are less and less likely to expend energy playing outdoors. The quality of our public spaces and transport systems have an impact on obesity too.

Social Value:

The social accountants are of the opinion that Hull's Weightwise service is the opposite of ***'a sledgehammer to crack a nut'*** in that demand clearly outstripped capacity overnight as the service went live in April 2016. However, the significant levels of social value the team is achieving are quite remarkable.

The obesity statistics for Hull, and nationally, are pretty shocking. In Hull, and across the rest of the country, two out of 3 adults are overweight or obese. It is estimated that 170 people die each year in Hull from obesity-related illnesses and approximately 1/3 of these are below retirement age. Levels of overweight / obesity in adults are predicted to reach 70% by 2034 and the costs of obesity are predicted to double by 2050.

With a population of over 250,000 and an estimated 55,000+ people falling into the obesity bracket (BMI 30+) in Hull, the extent of the problem is widespread and colossal. Once obesity is established, weight loss becomes more difficult. Every person within the Weightwise cohort over the past 2 years started with a BMI of 33 or more and 86% started with a BMI of 40+. Looking at the current Weightwise data, those with a BMI of 40+ is down to 79% in this cohort, of course, whilst some of those patients have been with the service for almost 2 years, others have recently started.

Obesity and the burden of obesity-related illness on the NHS as well as the burden of its impact on the quality of life of our communities, is clearly close to reaching epidemic proportions and, because it is so widespread and recognised as one of the most complex health challenges of our age, there are literally thousands of reports and studies available with a wide-reaching range of statistics. In some ways, this is great for social accounting because there are so many credible studies available. However, on the other hand with limited resources it is difficult to digest the sheer volume of information that is available and select the best statistics for use in reports like this.

According to Hull City Council's Public Health Briefing (Nov 2016), at any time, an obese person costs at least a third more in health spending than someone of a healthy weight due to the increased risk of complications. The report states that moderate obesity (BMI 30-35) reduces life expectancy by an average of 3 years and morbid obesity (BMI 40-50) reduces life expectancy by 8-10 years.

The social accountants have decided to focus on 3 big rocks in terms of obesity in Hull.

1. The social value of Weightwise to the patients themselves
2. The social value of Weightwise in terms of preventing obesity related chronic illness & depression
3. The social value of Weightwise in terms of empowering patients to take back control / take responsibility

Value to the patients themselves

The social accountants discussed with Heidi Henrickson and Mark Doughty, the key people leading Weightwise, the possibility of carrying out a value exercise survey with patients to assess how much they value the service. This is a credible SROI tool often used direct with service users. The idea is to give the patient a list of commercially available items such as a holiday, a laptop, a trip to the cinema etc. arranged in order of commercial cost / value, (i.e. the highest cost item at the top, each item decreasing in value with the lowest value item at the bottom). The patient is then asked to 'slot in' the service in question in amongst the items to indicate how much they value it in their lives today.

The Weightwise leaders agreed this would be viable and went ahead and carried this out anonymously with 36 Weightwise patients. The results of this survey have been used further on in this report for the SROI calculation.

Value in terms of preventing chronic illness and depression

The social accountants chose the WMA Economic Modelling Report from NICE- re Managing Overweight and Obesity among Adults – which is a report on economic modelling and cost consequence analysis (full report available here: https://www.nice.org.uk/guidance/ph53/evidence/economic-modelling-report-431715709)

The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop guidance on managing overweight and obesity in adults through lifestyle weight management services. The guidance will provide recommendations for good practice, based on the best available evidence of effectiveness and cost-effectiveness.

The objective of the report was to answer the following research questions, to the extent that evidence allows the likely cost effectiveness/cost utility of interventions

- To estimate the potential health and economic consequences of weight loss programmes/interventions management in adults.
- To calculate Quality Adjusted Life Years (QALYs) gained as a result of weight loss.
- To carry out cost-effectiveness analysis of weight management and calculate health benefits along with net cost saving for various levels of cost of the intervention.

Page 26-28 of the report has provided a number of financial proxies relating to 7 of the most prevalent obesity related chronic illnesses:

- Chronic Heart Disease
- Type 2 Diabetes
- Stroke
- Hypertension
- Osteoarthritis
- Breast Cancer

- Kidney Cancer

This research has been used by the social accountants later in this report for the SROI calculation which attempts to measure some of the social value being generated by the Weightwise service.

The total hospital costs of obesity related disease for the year 2011/12 (£M)

Disease	A&E Attendance (£M)	Outpatients (£M)	Admissions (£M)	Total (£M)	Cost Attributable to obesity (£M)
Chronic Heart Disease	829	301	499	1661	266
Diabetes	866	55	101	1025	482
Stroke	32	461	483	985	59
Hypertension	899		10	909	327
Osteoarthritis	451	206	14	736	88
Breast Cancer	134	434	57	634	72
Kidney Cancer	80	239	48	385	44
TOTAL				6334	1338

Average cost of obesity related disease for the year 2011/12

Disease	Total Cost (£M)	Attributable Cost	Average Total cost per person with disease (£)
Chronic Heart Disease	1661	266	741
Diabetes	1025	482	412
Stroke	985	59	998
Hypertension	909	327	71
Osteoarthritis	736	88	110
Breast Cancer	634	72	157
Kidney Cancer	385	44	764

Diabetes

The social accountants compared some of these elements with other studies to assess viability of use for this report. According to diabetes.co.uk, the cost of treating diabetes complications for a year is in the region of £1800-£2500 compared to managing the condition via diabetes outpatient services which is £300-£370 per annum.- https://www.diabetes.co.uk/cost-of-diabetes.html

diabetes.co.uk also say that the links between obesity and type 2 diabetes are firmly established - without the intervention of a healthy diet and exercise, obesity can lead to type 2 diabetes over a relatively short period of time. The good news is that reducing body weight, by even a small amount, can improve the body's insulin sensitivity and lower the risk of developing cardiovascular and metabolic conditions such as type 2 diabetes, heart disease and types of cancer. According to the NHS, a 5% reduction in body weight followed up by regular moderate intensity exercise could reduce type 2 diabetes risk by more than 50%.

A NICE costing report on managing overweight and obesity, states that there is good evidence to suggest that moderate weight loss (5 to 10% of initial body weight), is beneficial to health (McTigue et al. 2003). A study by Hamman et al., (2006) found that there was a 16% reduction in the risk of diabetes for each kilogram of weight lost.

During the social accounting year March 2017 – April 2018, the Weightwise service in Hull has helped 352 people lose 986.83 kilograms. This equates to an average of 2.8 kilograms per person. Taking 2.8 kilograms and multiplying it by 16% means a 44.8% reduction in the risk of diabetes applying the findings of the NICE costing report. Not too dissimilar to the 50% suggested by diabetes.co.uk.

From Weightwise data provided, the social accountants have surmised that 71 people have lost 5% or more of their body weight since signing up with the service. With the largest percentage weight loss standing at 23% of body weight.

Stroke

According to the Stroke Association, there are more than 100,000 strokes in the UK each year; that is around one stroke every five minutes and, there are over 1.2 million stroke survivors in the UK. Being overweight increases your risk of ischaemic stroke by 22% and being obese by 64%. Moderate exercise can reduce your risk of stroke by up to 27%, something the Weightwise service works hard to promote with its cohort. The average NHS and social care cost for each person that has a stroke is about £22,000 a year, and around £45,000 over five years. There is a large difference between this and the £998 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report. However, in the spirit of conservative social accounting, the social accountants prefer to under claim so have decided to use the £998 financial proxy from NICE relating to the treatment of patients who have suffered strokes, but recognise the costs are probably much higher.

Value in terms of preventing depression

The links between obesity and depression are well documented. Around 70% of the Weightwise cohort over the past two years have been referred to Hull's depression and anxiety service - 'Let's Talk'.

There is no overnight cure for depression and Weightwise patients needs are varied and complex. However, in the last 12 months the Weightwise data shows that using the PDQ9 depression assessment tool 207 patients scored 10+ (moderately – severely depressed) at the beginning of the year and only 171 scored 10+ by the end of the year. This represents a reduction of 36 in terms of patients suffering from depression.

According to a highly respected social return on investment report carried out by Ecorys, in 2014 and relief from depression or anxiety is valued at £43,453. The same reports provides financial proxies for the feeling of being in control of life which is valued at £14,080 per person per year, high confidence is valued at £13,080. Mental health interventions can be valued by the amount a

stakeholder may be willing to pay to achieve the same outcomes through some other means. For example, a course of CBT to build psychological resilience and self esteem costs £1,240 for 20 sessions.

The social accountants have chosen to measure the social impact weightwise has made in terms of assisting patients recover from depression using some of these proxies later on in the report.

Value in terms of feeling in control

The holistic approach adopted by Weightwise focuses very much on patient responsibility and attitude.

"Many obesity patients come to Weightwise with the attitude that 'someone needs to sort out their weight problems'. There is often a lack of recognition that it is the responsibility of the patient themselves to take control. Unless a patient has a change of mindset, taking hold of their weight and other underlying health and mental health problems will be difficult, if not impossible to tackle."

Heidi Henrickson, Operations Manager – Public Health Yorkshire, City Health Care Partnership CIC

The Weightwise holistic approach encourages patients to take control and responsibility for their own overall wellbeing and provides tools, techniques and coping mechanisms for adopting a healthy lifestyle long term. The social value in terms of giving them back this control has been measured using suggested mental health proxies from the Ecorys SROI report mentioned earlier.

The Ecorys report (mentioned above) gives details of financial proxies for the feeling of being in control of life which is valued at £14,080 per person per year. The social accountants have used this as a means of measuring the social value in this regard in the SROI calculation later on in this report.

SROI For Weightwise
(Social Return On Investment)
£1 : £17.23

There are 11 lines within this SROI Impact Map.

- **Line 1 – the perceived value of the Weightwise service to patients**
- **Line 2 – the estimated cost to the NHS in terms of the treatment of chronic heart disease**
- **Line 3 – the cost reduction to the NHS in terms of the treatment of type 2 diabetes**
- **Line 4 – the cost reduction to the NHS in terms of the treatment of stroke**
- **Line 5 – cost reduction to the NHS in terms of the treatment of hypertension**
- **Line 6 – the cost cost reduction to the NHS in terms of the treatment of osteoarthritis**
- **Line 7 – cost reduction to the NHS in terms of the treatment of breast cancer**
- **Line 8 – the cost cost reduction to the NHS in terms of the treatment of kidney cancer**
- **Line 9 – the social value to the patient in terms of relief from depression or anxiety**
- **Line 10 – the social value to the patient in terms of feeling in control**
- **Line 11 – saving to the NHS in terms of savings per person that has recovered from depression**

Line 1 the perceived value of the Weightwise service to patients

Quantity: 356 patients seen in the social accounting period by Weightwise

Financial Proxy: £3295
The results of the value exercise survey carried out direct with Weightwise patients.

Value of Inputs:
£232,200 – the cost of running Weightwise for the year.

Deadweight:
0% - without Weightwise in place the social accountants are satisfied the social value recognised here would have occurred anyway.

Attribution:
7% - on average Weightwise afford 802 minutes per patient per annum in support of their wellbeing, this is usually as a result of a referral from possibly a GP or other clinician. Of the 802 Weightwise minutes 170 minutes are dedicated to patient assessment. The average length of a GP appointment for assessment is 11.7 minutes which is approx 7% of 170 Weightwise assessment minutes, therefore the social accountants have applied a 7% attribution to this line of the calculation.

Line 2 – the estimated cost to the NHS in terms of the treatment of chronic heart disease

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £741 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - although the social accountants and Weightwise leads believe it is unlikely that as many as 15% of patients would have sought and found this kind of success with other interventions elsewhere in Hull's health care system, and that this element of the social value is unlikely to have been achieved without Weightwise, it is not impossible. They are happy to go with it to provide a highly credible picture of the social value generated.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 3 – the cost reduction to the NHS in terms of the treatment of type 2 diabetes

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £412 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 4 – the cost reduction to the NHS in terms of the treatment of stroke

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £998 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 5 – cost reduction to the NHS in terms of the treatment of hypertension

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £71 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 6 – the cost reduction to the NHS in terms of the treatment of osteoarthritis

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £110 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 7 – cost reduction to the NHS in terms of the treatment of breast cancer

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £157 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 8 – the cost reduction to the NHS in terms of the treatment of kidney cancer

Quantity: 71 patients have reduced body weight by 5% or more (up to as high as 23%) reducing their risk of contracting the disease

Financial Proxy: £764 average total annual cost per person with the disease from NICE's WMA Economic Modelling Report

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
15% - as explained above.

Attribution:
7% - in terms of assessment time by GP or other clinician during referral process as explained above.

Line 9 – the social value to the patient in terms of relief from depression or anxiety

Quantity: 36 patients have recovered from depression in the last 12 months since engaging with the Weightwise service.

Financial Proxy: £43,454 the value of the relief of recovering from depression (Ecorys SROI report 2014)

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
18% - IAPT estimated natural recovery rate.

Attribution:
50% IAPT national estimated 'talk therapy' recovery rate.

Line 10 – the social value to the patient in terms of feeling in control

Quantity: 356 patients.

Financial Proxy: £14,080 the value of the relief of recovering from depression (Ecorys SROI report 2014)

Value of Inputs:
£232,200– as above, goes across every line.

Deadweight:
18% - IAPT estimated natural recovery rate.

Attribution:
50% IAPT national estimated 'talk therapy' recovery rate.

Line 11 – saving to the NHS in terms of savings per person that has recovered from depression

- **Quantity**: 36 patients have recovered from depression in the last 12 months since engaging with the Weightwise service.

- **Financial Proxy**: £1060 total expected saving per person who recovers with regards; GP consultations, inpatient bed nights and outpatient procedures (source: Improving Access to Psychological Therapies (IAPT) NHS)

- **Value of Inputs**:
  £232,200– as above, goes across every line.

- **Deadweight**:
  18% - IAPT estimated natural recovery rate.

- **Attribution**:
  50% IAPT national estimated 'talk therapy' recovery rate.

Case Study

Jane's story

Jane found out about the Weightwise service at a point in her life when she was feeling quite negative about herself, and, she'd asked her GP about weight loss services in the area. She found it particularly reassuring that the Weightwise programme offers tailored advice that would take into account her medical conditions. This enabled her to start the programme with peace of mind that the exercises she was encouraged to carry out would not worsen her existing conditions. Jane talked about how uncomfortable she would be attending a gym class by herself, and how she found the peer-support provided by the Weightwise service incredibly motivational and beneficial.

She particularly enjoyed taking part in the physical activity programme which provided variety of exercises that focused on cardio, strength, functionality and flexibility. The gym-based classes on offer through Weightwise, offer peer-support from people who have similar health issues in common, and Jane really appreciated this. However, what Jane really enjoyed about the exercise classes was the comradeship and feels this aspect of the service is its main key to success. The classes provided an opportunity for like-minded people who were not only overweight but also had other health conditions to benefit from the group experience. Through this approach, she feels Weightwise has provided first-class mental and physical health support. Although she has plenty of support from her own family, she recognises that for participants who don't, the peer-support is even more important.

Jane particularly enjoyed input from the Weightwise dietician who came to speak to the service users. She described this as incredibly helpful and "eye opening" in terms of the knowledge she gained about nutrition, portion size and 'good' fats amongst a host of other things.

Since being discharged from Weightwise, Jane has continued to walk more as part of her daily life, and she has continued to attend the gym regularly with her new circle of friends. Jane speaks very highly of her Weightwise advisors, Kate and Mark, and now talks about how much better she feels about herself in general and how incredibly proud she is of her own achievements.

MULTI-DISCIPLINARY TEAM – SEVERE FRAILTY

(Often referred to as MDT)

Reason For Being:

A Multi-Disciplinary Team is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing programmes of care for patients with complex medical needs. City Health Care Partnership CIC has MDTs in practice in a number of service areas, however the authors of this report are looking specifically at the Multi-Disciplinary Teamwork regarding the top 2% of frail adults in Hull.

Frailty is a loss of resilience in terms of a person's ability to bounce back after a physical or mental illness, an accident or other stressful event. People living with frailty are likely to have a number of different issues which, combined have a large impact on health, confidence and wellbeing. Linked to poor mobility, difficulty doing every day activities frailty results in large increases in the cost of healthcare. In England there are 1.8 million people aged over 60 living with frailty and 0.8 million people aged over 80 living with frailty. 5% of people aged 60-69 have frailty and this rises to 65% in people aged over 90. (ELSA (2016))

Hull GPs use tools such as the Electronic Frailty Index (EFI) combined with the local intelligence provided by the MDT Co-ordinators and other health care professionals to identify the top 2% of frail patients (who are classed as people at increased risk of adverse outcomes such as unplanned hospitalisation). Those patients who fall within the top 2% of the frailty scores are classified as having severe frailty. The MDT Co-ordinators are there on the ground gathering key information direct from the patients themselves and, they also use other tools such as the Rockwood Frailty Index to enable them to feed back an accurate picture of the patients' health and social care needs to the multi-disciplinary teams at their ICC MDT meetings that take place each afternoon, to enable better informed decisions.

The CHCP MDT Service For Top 2%

The CHCP frailty MDT service started life as a pilot with 3 MDT co-ordinators working closely with GP surgeries and community nursing homes yet, more recently, the team has switched format becoming an important part of the re-designed frailty pathway in Hull which is now delivering via a brand new Integrated Care Centre (The Jean Bishop Centre).

Their remit is to prevent unnecessary A&E visits and unnecessary hospital admissions and reduce DNAs (Did Not Attend) re outpatient appointments via three distinct activities for Hull's top 2% by:

1) **visiting patients at home**
2) **facilitating MDT Frailty Meetings.**
3) **ensuring regular medication reviews are facilitated**

They visit patients at home in order to carry out assessments and 'social prescribing' – i.e. they identify those struggling with a mix of health and social issues including mobility, personal care, household safety, bereavement issues, social isolation, medication issues, financial issues, housing issues, hearing/sight deterioration, memory/dementia issues and much more. The co-ordinators are skilled at networking with community health, voluntary and charitable organsations in Hull and the East Riding enabling them to make appropriate referrals and signposting frailty patients to the most relevant service for help.

They facilitate MDT frailty meetings providing a forum into which local, community-based health, social and third sector partners and secondary care specialists can identify their most at risk patients in order to develop a person-centred, integrated plan of care.

They ensure medication reviews are happening regularly by co-ordinating between the patients and their GP practices.

Capacity

CHCP started recruiting and preparing the groundwork for the MDT Frailty pilot in October 2016 and, by February 2017 the activity was up and running with patients. From February 2017 – May 2018 the 3 Frailty MDT co-ordinators assisted 223 patients, made 153 home visits and facilitated 70 MDT frailty meetings in partnership with GP Practices and Care Homes (with approximately 4 patients reviewed at each meeting – i.e. 75 patients reviewed).

Since the Jean Bishop Integrated Care Centre opened (May 2018), the service is building up to see 10 patients per day at the Jean Bishop Centre where they spend approximately 4 hours seeing a range of professionals all in one place at morning appointments, including Consultant Geriatricians, GP with special interest in elderly, Pharmacy team, Physiotherapists, Occupational Therapists, Complex Case Managers, District Nurses, Bloods, Social Services and Carers Information Support Service (CISS). During each afternoon, the MDT co-ordinators facilitate MDT frailty meetings covering the 10 patients seen that morning involving all the necessary healthcare professionals. The capacity for 5 days per week for a year at 10 patients per day is estimated to become 2600 patients.

"The patients have welcomed us into their homes and chatted freely about their concerns and issues. They have reminisced about many aspects of their lives and many have commented how much they value our care. On the whole we are finding the main problem for our patients is social isolation."

Anne-Marie Waudby, Frailty MDT Co-ordinator,
City Health Care Partnership CIC

"It's very much driven by the Make Every Contact Count (MECC) initiative. Some people do it naturally, however, time constraints with busy professionals can frustrate the system. With the Frailty pilot and, now the MDT approach in place at the ICC there are real signs of progress. We're seeing better information sharing and joined-up thinking. People are working differently."

Andrew Burnell
CEO
City Health Care Partnership CIC

Social Value :

This report acknowledges the depth and breadth of the social impact created as a result of the Multi-Disciplinary Team approach to caring for patients living with severe frailty in Hull, and, whilst it would take an army of social accountants to measure it all, the authors have attempted to measure the key aspects of the team's efforts in the SROI calculation later on in this section. Because the MDT format of delivery has changed so much and so quickly since it began life as a pilot, the social accountants have decided to conduct a forecast SROI calculation looking conservatively at what is 'likely' to be achieved with MDT for frailty via the Jean Bishop Centre in its first year, based on what has already been achieved as a result of the pilot.

Quality Time With Patients

The time the MDT co-ordinators have spent in patients' homes during the pilot and, since the switch to the Jean Bishop Centre format has had and continues to have a positive impact on patient wellbeing. The social accountants would have liked to have carried out a value survey direct with frailty patients, however, after careful consideration it was agreed the practicalities of achieving this with this cohort would be too challenging in the timeframe available. However, after discussion with the MDT manager and the co-ordinators themselves the Social Accountants have found another way to capture the social value to the patients. They have used a financial proxy of £36 which represents the cost of an 11.7 minute GP appointment to represent social prescribing activity carried out by the MDT co-ordinators (which multiplies up to £184.61 for an hour). This is quite conservative as the cost of a GP Home visit minute costs £5.20 (£312 for an hour of GP time).

It is clear from patient feedback shared that in the absence of the MDT co-ordinators, their only port of call would be to attempt to visit their GP or request a home visit. The social accountants believe that to the patients, the social value of GP time is equivalent to the social value of MDT co-ordinator time.

The social accountants have stressed they are not comparing the CHCP co-ordinators to a GP. They are in fact comparing the outcome of the MDT intervention with GP time in terms of perceived value to the frailty patient. Both are likely to lead to the best outcome for the patient, in terms of assessment and signposting, hence similar social value is achieved. Some may argue that the MDT intervention is even more valuable to the patient than a GP appointment would be because it takes

place in the patients' homes, lasts on average an hour and the co-ordinators specialise purely in frailty, which means they are trained to communicate effectively with frail adults and they are focused on providing a multi-disciplinary health and social care approach delivering precisely what the patients need.

Reducing DNAs

Part of the MDT co-ordinator's focus is preventing frail patients from missing their outpatient appointments. This was more difficult during the pilot, but somewhat easier now the Jean Bishop Centre is up and running because the MDT approach brings clinicians to the patient and multiple appointments take place on the same day. Of course, across the board, all health care professionals do all they can to prevent DNAs, but with frail patients this is more challenging due to mobility, cognitive ability, sight and hearing issues etc. The MDT co-ordinators make this part of their assessment at home visits and ensure they do all they can to support patients in getting to their outpatient appointments.

"It's about talking to the patients and asking them why they've had difficulty attending appointments in the past and making sure they are considering all the options for getting to their appointments in the future. Sometimes a little co-ordination makes all the difference in terms of family and friends being able to help them get there. It might be a quick phone call about timing for example. If not, there are options with community and hospital transport. We make sure they have the information they need. Also, as MDT Co-ordinators, we can register as the patients' carers with GPs so we can share info and get online or on the phone and sort out appointment bookings and timings for them. We try to empower them to take responsibility for doing this kind of thing themselves as much as we can. Sometimes, the frail elderly can become confused and forgetful about their appointments. So, again, involving family and friends to ensure they get there turns out to be the answer. There are small things we can do to make a big difference to DNAs."

Anne-Marie Waudby, Frailty MDT Co-ordinator, City Health Care Partnership CIC

Reducing Unnecessary A&E Visits and Hospital Admissions

When an A&E visit or a hospital admission is unnecessary for the frailty patient it often causes untold anguish and discomfort for them, and, it also costs the NHS highly. Nobody wins. According to Age UK, in this country, people aged 65+ make up 23% of all A&E attendances and 47% of admissions to hospital from A&E. Of the 18.7Million adult admissions to hospital last year, around 41% were over the age of 65. Between April 2006 and December 2012, older people with frailty accounted for 4000 daily hospital admissions and over 1 Million hospital deaths.

The MDT approach is focused on keeping unnecessary A&E visits down and also unnecessary hospital admissions.

"The MDT Coordination Service represents a guiding principle for care that aims to improve patients experiences of services through improved coordination across health care settings. By facilitating more patient contact, treatment in the community or in the patients homes it actively prevents duplication and reduces the number of emergency and other admissions to hospital. It also facilitates timely and effective discharge from hospital to other settings."

Mike Johnson, Senior Operations Manager,
City Health Care Partnership CIC

Medication Reviews

Although medicines play an important role in health care, it is well documented they can also be a significant source of unintended harm. It is estimated that at least 5% of all hospital admissions are medicines-related, with adverse drug reactions (ADRs) directly leading to admission in 80% of cases. Medicines-related admissions (MRAs) are estimated to account for 4% of hospital bed capacity, and almost half are potentially preventable. https://www.wemerec.org/Documents/Bulletins/Medicines-related%20admissions-online.pdf

As part of the MDT co-ordinators assessment, they ask patients if they have had a medication review, and ensure they facilitate these if they have not by escalating it to the Practice where necessary. (From 1-7-17 GPs are mandated to carry out medication reviews as part of their annual clinical review of their severely frail cohort as part of their GP contract).

Of the frailty cohort, between April 2018 and June 2018, 210 patients had medication reviews resulting in an average saving per patient of £171.50. The ICC (Jean Bishop Centre) reviews did not commence until 24-5-18, hence in 5 weeks of the ICC and Care Homes working together 210 medication reviews were conducted. These figures have been used later on in this report to calculate the 12 month forecast social return on investment ratio.

In line with the MDT remit to reduced unnecessary hospital admissions, it is encouraging to see that in the same 5 week period 9 hospital admissions were recorded to have been prevented as a direct result of the MDT approach via the ICC and Care Homes joint working initiative as a result of medication reviews alone.

Clinician Time and Patient Confidence

It is evident to the social accountants that better use of clinician time as well as improved levels of confidence in patients and their carers are both significant outcomes being achieved through the MDT approach for frailty patients. The SROI calculation later on in this report which attempts to measure the social impact MDT is having in Hull as CHCP strive to improve community care for patients living with severe frailty does not include any proxies that measure better use of clinician time or patient/carer confidence. This highlights just how conservative the SROI calculation is in that despite this absence of data regarding these key aspects of the service, the SROI ratio is still incredibly positive.

Signposting

Signposting is at the heart of MDT and this is very much entwined with the visits to patients home already mentioned above. However, the co-ordinators are also accessible over the telephone to frailty patients enabling additional signposting advice and guidance to take place.

SROI For MDT Frailty
(Social Return On Investment)
£1 : £56.80

There are 5 lines within this SROI Impact Map.

- **Line 1 –** The social impact to frailty patients of quality time with MDT Co-ordinators in patients' homes.
- **Line 2 –** The social impact to the NHS of preventing DNAs (Did Not Attend) re outpatient appointments for frailty patients through the MDT approach.
- **Line 3 –** The social impact to the NHS in terms of cost re the prevention of unnecessary A&E visits
- **Line 4 –** The social impact to the NHS in terms of cost re the prevention of unnecessary hospital admissions
- **Line 5 –** The social impact to the NHS in terms of drug cost savings through MDT frailty medication reviews.

Line 1 – The value to frailty patients of quality time with MDT Co-ordinators in patients' homes.

Quantity: 1794 hours in patients' homes.
During the pilot, the team of 3 MDT co-ordinators conducted 153 homes visits out of a case load of 223 frailty patients. This equates to 69%. The Social Accountants have applied the 69% to the 2600 patients – the likely MDT case load via the new Jean Bishop Centre / MDT approach for its first year, with existing staff, to get 1794 home visits. Each visit lasts on average one hour, hence 1794 hours of quality MDT Co-ordinator time with patients in their homes.

Financial Proxy: £184.61
The cost of a GP appointment is believed to be in the region of £36 for on average an 11.7 minute GP consultation. When multiplied up to an hour this equates to £184.61.
https://www.pssru.ac.uk/pub/uc/uc2010/uc2010_s10.pdf

Value of Inputs:
£71,154– which has been the cost for running year 2 of the MDT service with a team of 3.

Deadweight:
The social accountants have decided discussed deadweight with the MDT pilot manager and an MDT co-ordinator, and they understand the frailty patients would not have had health and social care attention, in this way, in their homes, if it hadn't been for the MDT service. However, the patients are visited by other practitioners e.g. district nurses and although this kind of social prescribing co-ordination is not the remit of the district nurse, some of this activity may well have been picked up by this team. Therefore, the social accountants have applied a 10% deadweight as a conservative, yet fair discount for this line of the calculation.

Attribution:
The social accountants have again agreed with Mike Johnson, an attribution of 80% although, the kind of attention the patients are getting in their homes would not have happened without the MDT service, the ICC structure, plus the involvement and buy in from all those involved in frailty care is required to enable the MDT approach to work – therefore the social accountants have agreed with Mike Johnson that an 80% attribution provides a credible and fair estimate of attribution for this element of the calculation.

Line 2 – The value to the NHS of preventing DNAs (Did Not Attend) re outpatient appointments for frailty patients through the MDT approach.

Quantity: 13000 DNAs prevented
It would not be unusual for frailty patients, prior to the Jean Bishop Centre, to have 5 separate outpatient appointment in a 12 month period often spanning across several locations. E.g. Physiotherapy appointments, blood tests, specialist consultant outpatient appointments x-ray, nutrition, podiatry and social worker assessments etc. The MDT approach enables the MDT Co-ordinators to encourage patients to attend more of their appointments, when it would have been difficult before. With a year's case-load 2600 patients x 5 appointments each, this gives us 13,000 outpatient appointments in a year.

Financial Proxy: £160.00
£160 – the average cost of an outpatient appointment has been used. However, this is believed to be a conservative proxy as we understand that some outpatient appointments that involve multiple clinicians are very likely to cost much more than £160.
http://www.telegraph.co.uk/news/health/news/11858339/Patients-less-likely-to-miss-NHS-appointments-if-they-warned-of-cost.html

Value of Inputs:
£71,154– as above, goes across all lines in this calculation.

Deadweight:
The social accountants discussed DNAs with the MDT team and, because not all frailty patients would do all they could not to miss their outpatient appointments anyway, without encouragement and support from the MDT, it is felt that a 50% deadweight would be a conservative statistic to use for this line of the calculation. In terms of 50% of appointments that would not have been missed anyway, even in the absence of the efforts of the MDT service.

Attribution:
Although the social accountants believe this is probably on the high side, they have again agreed with Mike Johnson, that an attribution of 80% should be applied to this line of the calculation in the spirit of conservative social accounting, because the kind of encouragement and support the patients are getting in order to prevent DNAs re outpatient appointments, is less likely to have happened without the ICC structure being in place as well as the involvement and buy-in from all those involved in the frailty care pathway in Hull.

Line 3 – The social impact to the NHS in terms of cost re the prevention of unnecessary A&E visits

Quantity: 2600 A&E visits
In the absence of hospital admission data for frailty patients in Hull, the social accountants have discussed the cohort's A&E habits with the team. On reflection, they suggested a highly conservative estimation of 1 A&E visit per year prevented by MDT intervention. Both the MDT team and the social accountants believe this is exceptionally low as according to Age UK as patients of the age of 65+ make up 23% of all A&E attendances in this country. 1 A&E visit prevented per frailty patient equates to 2600 A&E visits prevented in the year.

Financial Proxy: £114.00
£114 – the average cost of an A&E visit has been used here.
https://www.gov.uk/government/collections/nhs-reference-costs

Value of Inputs:
£71,154– as above, goes across all lines in this calculation.

Deadweight:
0% has been used for the deadweight for this line because the social accountants and the MDT believe the service probably prevents a lot more that 1 A&E visits per patient per year and without this effort these preventions would not have occurred anyway.

Attribution:
80% has been applied for attribution, for similar reasons as the previous lines.

Line 4 – The social impact to the NHS in terms of cost re the prevention of unnecessary hospital admissions

Quantity: 5200 Hospital Admissions
In the absence of hospital admission data for frailty patients in Hull, the social accountants have discussed the cohort's likelihood of hospitalisation with the team. On reflection, they suggested a highly conservative estimation of 2 hospital admissions per year prevented by MDT intervention. Both the MDT team and the social accountants believe this is exceptionally low as according to Age UK, 41% of all hospital admissions last year were patients of the age of 65+. 2 hospital admission prevented per frailty patient equates to 5200 prevented in the year.

Financial Proxy: £3500
£3500 – According to NICE evidence, the cost of a hospital bed day is £350 per patient per day. Coupled with evidence from Carlisle Housing Association that states an average COPD hospital stay is 10 days – has led the social accounts to arrive at a proxy of £3500. Also, according to the National Heart Failure Audit of 2010 published by NHS Improvement, Hospital Episode Statistics (HES) data showed there were 73,752 hospital spells for heart failure in 2010 with a mean length of stay of 11.76 days. Ten percent of patients (8,385) were readmitted with heart failure in under 29 days with an average stay of 5 days. file:///C:/Users/Joanne/Downloads/GuidelineNHS.pdf

Although not all frailty patients have COPD or Heart conditions, the social accountants feel that at this stage in their life as patients living with severe frailty that an estimate of 10 bed days @ £350 per day - £3500 is as an acceptable financial proxy for this line of the calculation.

Value of Inputs:
£71,154– as above, goes across all lines in this calculation.

Deadweight:
0% has been used for the deadweight for this line because the social accountants and the MDT believe the service probably prevents a lot more than 1 hospital admission per patient per year and, without this effort these preventions would not have occurred anyway.

Attribution:
80% has been applied for attribution, for similar reasons as the two previous lines.

Line 5 – The social impact to the NHS in terms of drug cost savings through MDT frailty medication reviews.

Quantity: 2184 medication reviews likely to be facilitated by MDTs in 12 months.

MDT records show that between Apr-June 2018 210 patients underwent medication reviews as a result of MDT input via care homes and the Jean Bishop Centre. The ICC reviews did not commence until 24-5-18. This means in a 5 week period the ICC/MDT joint approach to medication reviewed achieved 210 medication reviews. Multiplied up to a year this equates to 2184.

Financial Proxy: £171.50
The MDT records show that the average cost saving as a result of the medication reviews for the 210 patients (above Apr-Jun 2018) was £171.50.

Value of Inputs:
£71,154– as above, goes across all lines in this calculation.

Deadweight:
The social accountants have used a 0% deadweight for this line of the calculation for similar reasons as above.

Attribution:
The social accountants have used 80% attribution for this line of the calculation for similar reasons as above.

Case Studies

Eileen's Story

Eileen, who is currently undergoing a programme of chemotherapy is quite independent. She is mobile but does use a wheeled walking frame or walking stick. Her memory and hearing is good and she wears glasses (and has an eye check-up annually). She drives herself to Castle Hill for treatment and she manages her own personal care and nutrition, cooking, cleaning and laundry – albeit slowly. She also manages with her bills and finances and has access to the internet for online shopping. She has 2 sons nearby who check on her regularly and a son who lives in New Zealand who visited recently.

However, Eileen 's district nurse requested an MDT visit because she was in need of help being re-housed. Although Eileen was managing financially in her flat, unfortunately, her neighbours above were very noisy and this wasn't a great scenario for her to cope with especially immediately after sessions of chemotherapy treatment. The MDT Co-ordinator helped Eileen with a 25-page form which she needed to complete in order to be re-housed.

She has lost weight (3 stone) over the past year and is maintaining at 8 stone at present. Because of the weight loss she was experiencing pain on sitting so a pressure cushion was ordered by the MDT co-ordinator. Eileen told the co-ordinator she had weaned herself off anti-depressant medication and, that she was feeling fine. She had been offered counselling by the Oncology team but declined. The MDT co-ordinator advised her she could be referred to Let's Talk via District Nursing or the Macmillan Team if she ever feels she is starting to experience low mood again.

A few weeks later, Eileen contacted the MDT team to say she had been re-housed and was very happy in her new flat. She asked for advice about a letter from Hull City Council demanding arrears re housing money. The co-ordinator provided guidance empowering Eileen to phone the council. She phoned back a few hours later with an update saying that the call she had made to the council had got to the bottom of it confirming she did not owe any arrears. She told the MDT co-ordinator she was now a very happy lady, and was very grateful for all their help.

Mary's Story

Mary is 91 years old and is one of the top 2% in terms of scoring severely frail in Hull. Her case was discussed at an MDT review meeting as Mary, who lives alone in a bungalow, had been contacting the GP Surgery weekly for a variety of reasons. It was clear to those who had spoken to her she was feeling socially isolated and was suffering badly with pain caused by arthritis.

The MDT co-ordinator visited Mary and was able to refer her to a pain management clinic and she commenced acupuncture treatment with the aim to bring her arthritis pain under better control. Mary was also referred to Age UK and Silverline for befriending and will receive a weekly call.

The patient was having problems with her hearing aid. The MDT co-ordinator referred Mary to 'Hear To Help' who visited her soon after and unblocked a tube in her hearing aid.

Volunteer Hub

Reason For Being:

The Volunteer Hub is a fairly new and innovative way of managing volunteers across all relevant services delivered by CHCP. It was established in 2017 to streamline and centralise the recruitment and management of volunteers with flexibility, longevity and retention in mind. It has been designed to make better use of the service volunteers across the organisation. Rather than having volunteers operating independently in 'silos' within just one service area, the Volunteer Hub has brought together the recruitment, training and deployment of volunteers from across a range of service areas so they can move across volunteer roles easily, according their skill set, experience and training. The aim of the Hub is to enhance and add value to existing community health services.

The vision for the Hub is the brainchild of Mike Johnson, Senior Operations Manager who developed a passport system that allows volunteers to move with ease between volunteering roles within the organisation and, to be flexible around their situation, their desire to help and, their areas of interest. The hub set-up ensures this is achieved by centralising recruitment, statutory checks, training, legal matters, safeguarding, and HR requirements as well as the sharing of information regarding the volunteers' skills, availability and areas of expertise giving relevant services timely and easy access to available volunteers. The new passport style volunteer hub system helps the organisation to identify volunteers who can give their time in an ad-hoc capacity to fulfil some of the short-term objectives of the CHCP services.

CHCP CIC successfully deploys volunteering in a variety of areas or the organisation from the volunteer hub, including the following, and the plan is to steadily incorporate more as the hub establishes itself.

- Empower (previously known as 'Expert Patients Programme' – whereby expert patients empower, support and train other patients in the self management of their chronic conditions. It is about educating patients on their role in managing their own health, how they can continue to do the things they enjoy, and how to manage emotional changes that come with a long-term diagnosis.)
- Macmillan Volunteers (The Macmillan are a key part of a multi-disciplinary team that provides integrated, community-based care to individuals with life-limiting conditions. They take part in befriending activities, become chemo friends and dementia supporters.)
- Wellbeing – differently abled (addressing the physical health inequalities experienced by people with learning disabilities)
- Differently Abled Event – (CHCP Volunteers ran a 'differently abled' event in February 2018 in partnership with the learning disabilities team and the Carers Information & Support Service where people with learning disabilities, their friends, family and carers in Hull and the East Riding could get advice and information about the support available to them. There was an Information Zone, where visitors could receive details on day services, social activities, benefit advice and employment, and a Communication Zone, at which speech and language therapists showcased equipment and demonstrated how to create a communication friendly environment.

- Café – (At both the Bransholme Health Centre and Morrill Street Health Centre, CHCP have volunteers running cafes located at the health centre entrances, providing patients with tea, snacks, support and time.)
- Let's Talk Stress Management (volunteers facilitate the delivery of stress management programmes for patients, and also allotment therapy at the Newland Avenue site to help patients reduce stress and anxiety. The Allotment hosts 'Men In Sheds' local support group once a week where men aged 18+ can tend the land and grow produce in a non-judgemental environment).
- Beverley Community Ward (volunteers support ward patients by providing tea, coffee, snacks and quizzes).
- East Riding Community Transport (The CHCP volunteer co-ordinator spent 4 hours with lead volunteers training and advising them on CHCP policy. Hull has offered East Riding Safeguarding training and East Riding has offered Hull MIDAS training re vehicles.)

"I have always worked with volunteers throughout my career in health care, and I believe strongly in the value they bring, often in unexpected ways. In many cases, the volunteer benefits as much as the beneficiary of the volunteering. It can expose individuals to new activities, new challenges and new ways of thinking. I am aware of several instances where volunteers have gone on to become employed in their field of interest, sparked by their will to volunteer."

Mike Johnson
Senior Operations Manager
City Health Care Partnership CIC

A Volunteer Co-ordinator was appointed in 2017 (Nicole Wild). Nicole's remit is to support the expansion of the organisation through the development of the volunteer hub in the Hull and East riding area by co-ordinating the recruitment and retention of volunteers under CHCP, as well as acting as the central point of contact to liaise with volunteers, service coordinators and key CHCP stakeholders for the delivery of an effective volunteer program. The co-ordinator is responsible for developing and supporting volunteer roles that are in line with the aims and integrity of CHCP to benefit the organisation, the community and the volunteers themselves.

A good example of additional social value brought to the hub as a result of Nicole Wild's appointment as the Volunteer Hub Co-ordinator, is her approach to the Hull City of Culture Volunteers and Hull's Freedom Festival volunteer systems. The CHCP Volunteer Hub Co-ordinator is in touch with both organisations about sharing best practice and there are discussions about cross-pollination of volunteers, skills and processes.

Social Value:

As mentioned in the introduction to this document, although everything CHCP CIC does carries some level of social value because of the very nature of their work, for CHCP CIC, social accounting is about capturing the 'additionality' the organisation delivers over and above the services they are mandated to provide through their contracts. The extra social value they generate in terms of the way the organisation manages and delivers volunteering is a good example of 'additionality'. For this report theSocial Accountants have looked at social value from a forecast point of view in terms of the SROI calculation, to review the kind of social value this relatively new Volunteer Hub / Volunteer Passport concept is likely to achieve for patients and volunteers alike in the next 12 months and the coming years.

"The Volunteer Hub is an extremely important development. Managing volunteers is just as important as managing staff. It is just as challenging and as costly. The hub provides a much better structure for achieving best practice in volunteer management and the passport idea is excellent offering a win/win to the service areas as well as the volunteers, and of course ultimately that has got to be a good thing for the end-users themselves."

Andrew Burnell
CEO
City Health Care Partnership CIC

Recruitment Savings

A volunteer entering into the organisation will undertake relevant checks, complete registration forms, undertake the volunteer induction and training package through the volunteer hub directly. Centralising the processes in this way allows all fully-inducted volunteers to engage with any one of the available volunteering roles across the company (for Hull and the East Riding) without having to duplicate any of the necessary recruitment / HR processes.

This generates social value in terms of making life easier for volunteers, yet also, in terms of savings on volunteer recruitment costs and volunteer retention. The Social Accountants have attempted to measure the savings in terms of recruitment costs of the hub and passport concept. It costs as much to recruit and induct a volunteer as it does a paid member of staff and, it is often harder to retain a volunteer when the correct support systems are not in place. The perpetual re-recruitment of volunteers often becomes a significant challenge and ever-increasing cost. Because volunteers are not paid, they look at commitment and loyalty differently. When you recruit a member of staff and train them, you can expect them to turn up and fulfil their role. Volunteers are giving up their time free of charge. The motivators for volunteers are entirely different to those of a paid member of staff. Volunteers are largely donating their time to a cause without expecting tangible payment or reward and the support system required to support this is different. Hence the Volunteer co-ordinator role explained above. The concept of the hub demonstrates to volunteers that CHCP is invested in them in other ways; through training and support and communication shows the volunteers that they are valued and expectations are set.

The Social Accountants can see the potential savings in recruitment and retention of volunteers and have attempted to measure the recruitment savings in terms of the hub opening up one volunteer to multiple roles.

Value to patients

One method of measuring SROI direct with stakeholders, is the value exercise survey; a credible social value tool often used direct with stakeholders to capture impact. The Social Accountants spoke to Mike Johnson and Nicole Wild, the key people driving the volunteer activities at CHCP CIC, about the possibility of carrying out a value exercise survey direct with CHCP patients to assess how much value the volunteers bring. The survey presents the stakeholder with a list of commercially available items such as a holiday, a laptop, a trip to the cinema etc., arranged in order of commercial cost/value, (i.e., the highest cost item at the top, each item decreasing in value with the lowest value item at the bottom). The stakeholder is then asked to 'slot in' the volunteer service they receive in amongst the items to indicate how much they 'value' their support.

Mike and Nicole both agreed this would be entirely possible and went ahead with the survey (June/July 2018) generating 17 patient responses across a variety of volunteering activities. The results of this survey has been used further on in this report for the SROI calculation.

Additional Volunteer Hours

Because of the Volunteer hub with the extra roles taken on by volunteers, the number of volunteer hours likely to be delivered is significant. The Social Accountants have looked at what has been achieved already, and what was achieved prior to the hub and conservatively estimated a forecast of the year ahead of additional volunteer hours likely to be achieved because of the hub set up. The estimate includes additional patient-hours, additional stress management courses and additional chronic disease management courses.

Fewer GP visits, A&E visits and Outpatient Appointments

Nicole Wild shared with the Social Accountants the results of national research of 1,000 empower participants that showed taking part in empower activities resulted in:

- 7% fewer GP consultations
- 10% fewer outpatient appointments
- 16% fewer A&E attendances

The Social Accountants saw that the nature of empower chronic self-management training (for 67 participants) is not dissimilar to the stress management training volunteers are training via Let's Talk (240 participants). They have used these figures to calculate the savings to the NHS in terms of fewer GP, A&E and outpatient visits by applying the percentages above in terms of the additional volunteer roles and volunteer hours generated by the hub. They believe this is a conservative estimate of the social value in terms of savings to the NHS.

"The MDT Coordination Service represents a guiding principle for care delivery that aims to improve patients' experiences of services through improved coordination across health care settings by facilitating more patient contact, treatment in the community or in the patients' homes. It will prevent duplication and reduce the number of emergency and other admissions to hospital and facilitate timely and effective discharge from hospital to other settings."

Mike Johnson
Senior Operations Manager
City Health Care Partnership CIC

Value to Volunteers

There is also social value in terms of experience for volunteers. The Social Accountants have captured the number of extra hours the volunteers are likely to deliver in a year as a result of the Volunteer Hub as part of their SROI calculation and multiplied it by a conservative proxy of minimum wage to represent 'volunteer experience' which can be used on CVs. Although some of the volunteers earned and have earned much more than minimum wage during their careers, the Social Accountants are happy to under-claim to show that the volunteer experience generated represents, at the very least, this level of social value, but probably a lot more.

SROI For Volunteer Hub
(Social Return On Investment)
£1 : £21.76

There are 9 lines within this SROI Impact Map.

- **Line 1 – The social value in terms of recruitment cost savings as a result of the Volunteer Hub management concept.**
- **Line 2 – The social value in terms of the additional volunteers hours the Volunteer Hub is likely to bring in a 12 month period.**
- **Line 3 – The value to volunteers in terms of experience on their CVs**
- **Line 4 – The value to the NHS in terms of delivering additional stress management courses to patients suffering with depression and anxiety as a result of the Volunteer Hub approach to volunteer management.**
- **Line 5 – The value to the NHS in terms of delivering additional chronic disease self management training to patients as a result of the Volunteer Hub approach to volunteer management.**
- **Line 6 – the savings to the NHS in terms of fewer GP visits as a result of the additional volunteer support provided by the hub**

- **Line 7 – the savings to the NHS in terms of fewer outpatient appointments as a result of the additional volunteer support provided by the hub**
- **Line 8 – the savings to the NHS in terms of fewer outpatient appointments as a result of the additional volunteer support provided by the hub**
- **Line 9 – the perceived social value to the patients themselves in terms of the support they receive via the additional volunteer roles/hours generated by the volunteer hub.**

Line 1 –The social value in terms of recruitment cost savings as a result of the Volunteer Hub management concept.

Quantity: 86 additional volunteer roles - currently CHCP has 43 volunteers – the social accountants have reviewed the potential for generating additional volunteer roles via the same 43 volunteers with the area leads and have agreed it would be reasonable to expect, in the next 12 months that an additional 86 additional volunteer roles could be enabled as a result of the Volunteer Hub / Volunteer Passport programme.

Financial Proxy: £1361 –online Magazine, HR Review, Magazine reported recently that it costs £30K to replace a member of staff and gave a breakdown of the costs involved. The social accountants have taken some of these costs and applied them to the recruitment of a volunteer i.e. management time £767 advertising £398 HR time £196.

Value of Inputs: £30,000 – The total cost of running Volunteer Hub.

Deadweight: 30% - the Social Accountants understand from Mike Johnson, Senior Operations Manager at CHCP, that the taking on of additional roles will not apply to all volunteers, i.e. some of them will be happy delivering one role. He feels 30% deadweight in terms of those who are not likely to take on additional roles as a result of the hub, is a fair and accurate estimate.

Attribution: 50% - although the volunteer hub is innovative, efficient and exciting in terms of the potential social value it is likely to create, the Social Accountants acknowledge that the established set up of the likes of Macmillan, Empower and other volunteering structures across the organisations provide a significant contribution in allowing the new hub style management to work. Hence, they have applied a 50% discount here to account for this level of contribution.

Line 2 – The social value in terms of the additional volunteers hours the Volunteer Hub is likely to bring in a 12 month period

Quantity: 1032 additional volunteer hours - currently CHCP has 43 volunteers and they have delivered 6125 hours in the last 12 months – an average 12 hours per month per volunteer. Having discussed the likelihood of additional volunteer roles / hours from the same group of volunteers the social accountants have summised that an additional 86 additional volunteer roles could be enabled. Potentially each additional role could reasonably be expected to generate a further 12 hours per month per role (a further 144 hours per year potentially). However, to be absolutely conservative the social accountants have agreed with the area lead that it would be fair to assume that at least a 1 extra volunteer hour per month per role could be generated as a result of managing the volunteer programme via the new hub / passport approach – i.e. 86 x 12 gives us an additional 1032 hours of volunteer time to disseminate across the services where needed.

Financial Proxy: £15 the cost per hour of hiring a private carer (again this is conservative because some of the volunteer time / activity is worth more than £15 per hour).

Value of Inputs: £30,000 as above.

Deadweight: 30% - as above.

Attribution: 50% as above.

Line 3 – The value to volunteers in terms of experience on their CVs

Quantity: 1032 extra hours as explained above, but from a different perspective, i.e. on this calculation line it is the number of hours experience the volunteers will be able to put on their CVs.

Financial Proxy: £15 per hour (cost of private carer per hour)

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 4 – The value to the NHS in terms of savings as a result of volunteers delivering additional stress management courses to patients suffering with depression and anxiety as a result of the Volunteer Hub approach to volunteer management.

Quantity: 144 hours

Financial Proxy: £50 per hour commercially available stress management course
(Source –www. happy.co.uk shows £295 for a one day course of 6 hours = £50 per hour.)

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 5 – The value to the NHS in terms cost savings as a result of volunteers delivering chronic disease self-management training to patients as a result of the Volunteer Hub approach to volunteer management.

Quantity: 102 hours

Financial Proxy: £50 per hour – cost of commercially available chronic disease management course. (Source - https://www.diabetes.co.uk/education/london-medical-education-courses.html - a diabetes course – 5 hours costs £250).

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 6 – the savings to the NHS in terms of fewer GP visits as a result of the additional volunteer support provided by the hub

Quantity: 316 GP visits likely to be prevented as a result of extra volunteer hours generated by the Volunteer Hub.

CHCP volunteers have supported an estimated 23,000+ patients and carers in the last 12 months. The Social Accountants have taken out the café goers to whittle it down to the 377 patients helped by volunteers through services such as Macmillan, Empower, Let's Talk. With the additional 2 roles per volunteer estimated above the 377 becomes 754. The general public visits the GP on average 6 times per year*. The Social Accountants have multiplied the 674 x 6 to give 4524 GP visits (which is

probably very conservative as a proportion of these patients have chronic illnesses and depression and anxiety). They have then applied the 7% reduction in GP appointments as a result of the Empower national research (as the 377 includes empower patients as well as other services believed to be on par with empower) to give an estimated 316 fewer GP appointments due to the Volunteer Hub approach to volunteer management.

* Source – BMA Media Brief April 2017 – General Practice in the UK Background Briefing

Financial Proxy: £36 – the cost of a GP appointment –
Source- https://www.pssru.ac.uk/pub/uc/uc2010/uc2010_s10.pdf

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 7 – the savings to the NHS in terms of fewer outpatient appointments as a result of the additional volunteer support provided by the hub.

Quantity: 166 outpatient appointments likely to be prevented as a result of extra volunteer hours generated by the Volunteer Hub.

Again taking the 377 patients above and multiplying it by 2 to account for the additional 2 roles per volunteer then by 2.2 (the average number of outpatient appointments per head for the general public in one year*) we get 1658 outpatient appointments. Again the social accountants believe this is probably highly conservative as they understand a significant proportion of these patients have chronic diseases and/or depression and anxiety. The national Empower research suggests that this kind of volunteer support reduces outpatient appointments by 10% which gives us a potential 166 fewer appointments as a result of the volunteer hub.

* Source - https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/hospital-outpatient-activity-2016-17

Financial Proxy: £108 which is the cost of an outpatient appointment

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 8 the savings to the NHS in terms of fewer A&E visits as a result of the additional volunteer support provided by the hub

Quantity: 53 A&E visits likely to be prevented as a result of extra volunteer hours generated by the Volunteer Hub

The general public visit A&E 0.44 times per year* so taking the 377 patients multiplying it by 2 to account for the extra patients receiving support from volunteers as a result of the additional 2 volunteer roles gives us 377 x 2 = 754 x 0.44 = 332 – if we apply the 16% to this from the national Empower research that suggests this kind of support can reduce A&E visits by 16% we get we are looking at a potential of 53 A&E visits prevented. The Social Accountants believe this to be conservative because the 0.44 is the figure for the general public, whereas this cohort have health conditions of some kind.

* source – House of Commons Library Briefing Paper – Accident & Emergency Statistics (Number 6964, 21 Feb 2017)

Financial Proxy: £114 – the cost of an A&E appointment

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 50% as explained above.

Line 9 - the perceived social value to the patients themselves in terms of the support they receive via the additional volunteer roles/hours generated by the Volunteer Hub.

Quantity: 954 patients – taking the 377 patients x 2 to account for the extra patients likely to be supported as a result of generating 2 extra roles per volunteer.

Financial Proxy: £4428 – the result of the value exercise survey based on the positions selected by respondents re where they would slot the 'volunteer support' they have received in amongst commercial items, the mean average value of the 17 patients that took part was £4428.

Value of Inputs: £30,000 as above.

Deadweight: 30% as explained above.

Attribution: 75% - the Social Accountants have discounted this line of social value in the calculation more heavily than the other lines because this is based on a survey with a small sample of patients. It is a valid result as it was a survey direct with stakeholder, yet at only 4.5% of the patient population took part, the Social Accountants feel it is probably wise to reduce the social value here.

Case Studies

Michaela's Story

Michaela was quickly losing her sight, and, as a result of this was, struggling to find work. Because of her sight-loss which, had now, developed into a long-term condition, Michaela was offered a course with Empower. At first, she did not want to go, because previously she had had several bad experiences with other courses she had been on. Michaela was worried because she thought the course wasn't going to help and that she would be told she would have to completely change her diet or stop doing things she enjoyed. However, even from the first day, she could see that the course and the tutors who delivered it were very positive and they actually listened to her instead of dictating what she had to do. Realising this difference, Michaela couldn't wait to attend the course on Thursday mornings to see the volunteers! She felt the tutors really knew what they were doing and the course was cheerful and friendly.

When the Empower course ended, Michaela was offered a volunteer position with Empower. She was made to feel at home and got a strong sense she was giving back to the people that had helped her.

Since ending the course, Michaela has been doing a lot of the relaxation techniques she had learned at Empower for coping with pain and stress, which she found was fun to do with her two sons, together with lots of walking and taking exercise.

Michaela's sons aged 14 and 19 attended Empower with her to discuss her experience whilst on the course, and they reported the following:

"Since mum has been on the course, we've all been going on lots more walks around where we live and to the shops and, she's been doing the relaxation talk on us. It's been really fun and we enjoy it. Sometimes when we are out walking, she struggles because of her condition, but now she really pushes herself. She seems a lot happier now and more active."

After completing the course under the two tutors, Michaela is going on to be a volunteer with Empower, and is excited to take the lead putting together a support group that participants can join at the end of the course. Michaela and her two sons will be joining the volunteer hub on a sponsored walk with Alzheimer's UK IN August 2018 and they will also attend the CISS (Carers Information Support Service) picnic in the park as volunteer support.

Marguerite's story

Following the diagnosis of a chronic health condition which rendered her unable to work or drive, Marguerite started to look around for volunteer work to help her begin to take more control of her life and, to share her experience of chronic ill-health with others that are in a similar position. Marguerite has been a volunteer for Empower for 14 years and she describes her experiences whilst at Empower as 'life-changing'. People have shared their stories with her about their fears, anxiety, depression, frustration and, their hurt at the attitudes of others who do not understand what it is like to live with a chronic illness. She said, "We have laughed and cried together, empathised and

supported each other. It has been a wonderful (and sometimes, painful) experience for which I am so grateful. Being a volunteer with CHCP is a two-way experience, you gain as much as you give!"

Marguerite would definitely recommend CHCP Volunteering to other people because she knows there are many people out in the community who do not have the support they need. Marguerite says: "As a volunteer, I am free to befriend and support those who are lonely, afraid and not coping. Volunteering helps with my growth and development, improves confidence and communication skills and, at the end of the day, you feel satisfied that you've made a difference to a person's life."

Appendices

1. Social Investment Strategy Document & Action Plan

CHCP Social Investment Strategy

2. Blues Boys Report

QNI Final report 2017BPf.doc

3. SROI report for City Health Care Foundation – small grants scheme

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