Positive Ageing Associates

Promoting positive approaches to later life

Making a strategic shift towards early action:

Lessons and recommendations

June 2014

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Lessons and recommendations

About the author

Guy Robertson is Director of ***Positive Ageing Associates***, an organisation specialising in promoting positive approaches to the later life agenda at both the personal and organisational level. Guy headed up the Local Government Association's Ageing Well Programme which supported councils across England to prepare for an ageing society. Prior to that, Guy led work on prevention and early intervention within the Older People and Dementia division of the Department of Health (DH), and in particular, led the support to the Partnerships for Older People Projects (POPP) programme.

Guy has worked as head of strategic planning for older and disabled people's services in Adult Social Care and as strategic commissioning manager in a large urban unitary authority. He led work on the implementation of various modernisation themes, including joint working between health and social care. This involved improving support for people with complex needs and the development of a corporate approach to raise the quality of life of older people. As well as his significant change management experience Guy also has an academic background, having been a lecturer on local government and social care policy.

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Introduction and Overview

The Early Action Funder's Alliance

The Early Action Funders' Alliance is a network of funding organisations who believe in the importance of early action to prevent problems arising. The Alliance comprises Comic Relief, Big Lottery Fund, Esmee Fairbairn Foundation, UBS, Barrow Cadbury Foundation, Legal Education Foundation, Calouste Gulbenkian Foundation, Business in the Community, and The Royal Foundation.

The alliance has two aims:

- Demonstrating the public case for early action to other funders and to the voluntary sector
- Providing opportunities and guidance for funders to embed early action in their work.

It will do this by:

- Sharing learning, new ideas and best practice via a monthly newsletter
- Organising events, seminars and discussion groups for funders and charities to explore aspects of early action relevant to their work
- Making the case for early action through the media, particularly the sector press
- Coordinating specific projects to further promote early action.

The alliance grew out of the work of the Early Action Task Force and was launched in June 2014.

This Report

The Alliance has commissioned this literature review of early action initiatives, both past and present across the UK. The review is designed to enable the Alliance to learn from best practice and remain informed of existing and emerging schemes which may be of relevance to its work.

As the purpose of the Fund is to affect a long-term shift in statutory funding from acute to preventative spend, the review focuses on schemes which seek or have sought to do this.

This report provides a lot of information and analysis about what works in affecting long-term systemic change, rather than learning about what works in the delivery of early action projects in and of themselves. It reviews a range of schemes which have sought to shift funding upstream towards earlier action and away from crisis spending. In doing this it should help build an understanding of how one affects fundamental shifts in structures and culture that are necessary for such transformation.

In essence this report reviews learning from past early action schemes and analyses this information in order to understand the issues involved in trying to bring about such a transformation, in particular:-

- The common success factors
- The common barriers
- The elements which are common to those schemes that fail

Programmes

The programmes and initiatives analysed include:-

- Partnerships for Older People Projects (POPP)
- Total Place
- Whole Place Community Budgets
- Neighbourhood Community Budget Pilot Programme / Our Place
- Health Empowerment Leverage Project (HELP)
- Innovation Forum – Improving the Future of Older People
- Supporting People Health Pilots
- Local Area Coordination
- Health Action Zones
- Family Intervention Projects
- Every Child a Reader
- Family Nurse Practitioner
- Improving Futures Programme
- Realising Ambition
- Sure Start Children's Centres
- The Incredible Years
- The Life Programme
- Nottingham Early Intervention City Programme
- Big Lottery Wellbeing Programme
- Reshaping Care for Older People: Change Fund

It also assesses three 'tools for change':-

- Social Impact Bonds
- Local Integrated Services
- System Modelling

Interviews

In addition, a number of commentators on early intervention were interviewed:-

- **Lucy de Groot**, Chief Executive, Community Service Volunteers
- **Sue Goss**, Principal in Local Government, Office for Public Management
- **Hilary Cottam**, Chief Executive, Participle (by correspondence)
- **Donna Molloy**, Head of Implementation, The Early Intervention Foundation
- **Professor Martin Knapp**, London School of Economics
- **Alex Fox**, Chief Executive, Shared Lives
- **Dr David Oliver**, Visiting Fellow, Kings Fund

The outcome of these interviews is incorporated within the 'Key Learning' section.

Section One

Early Action – Definitions

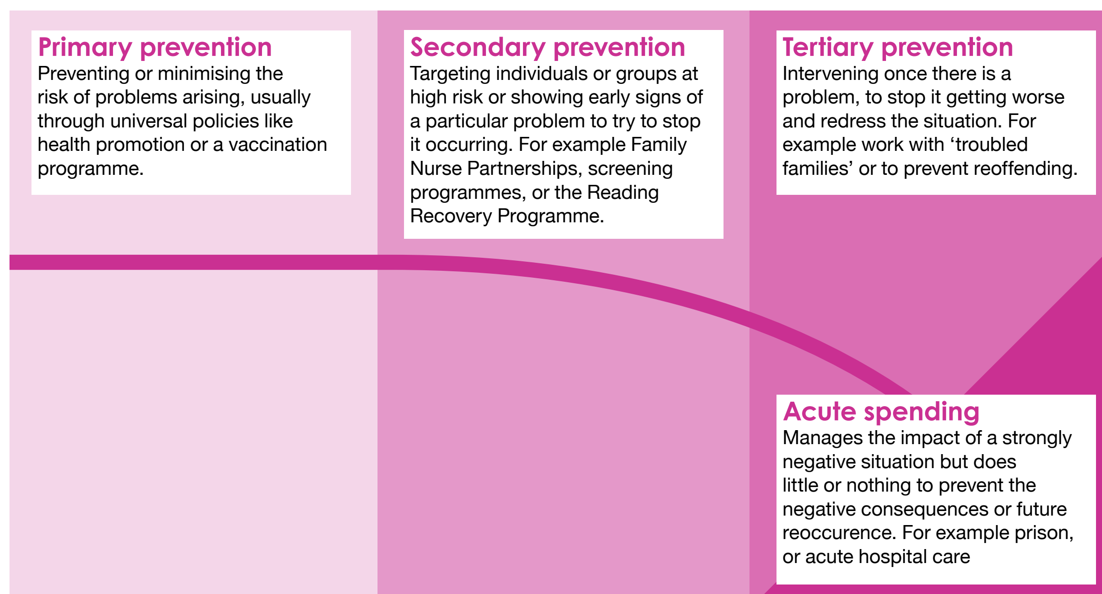
Definitions

There are a number of different terms used in debates about early action. It is important that we start with some clarity about these terms.

> *The concepts of 'prevention', 'early intervention' and 'early action' are gaining increasing prominence in UK policy, yet no strict definitions exists. Broadly, the terms are used interchangeably and imprecisely to refer to a focus on tackling the roots of social problems: pre-empting their occurrence, rather than treating their consequences. Definitions tend to be broad and conceptual—'streams' and 'cliff-tops' are common metaphors—rather than technical[1]*

The Early Action Task Force propose[2] a four-tier classification spanning early to late action:

- **Primary Prevention / building readiness:** preventing, or minimising the risk, of problems arising – usually through universal policies like health promotion or a vaccination programme. [Some call this 'prevention'].
- **Secondary Prevention:** targeting individuals or groups at high risk or showing early signs of a particular problem to try to stop it occurring. For example Family Nurse Partnerships, health screening programmes for older people. [Some call this 'Early Intervention'].
- **Tertiary Prevention:** intervening once there is a problem, to stop it getting worse and redress the situation. For example work with 'troubled families' or to prevent reoffending, or rehabilitation after a fall. [Some call this 'early remedial treatment'].
- **Acute:** interventions which act to manage the impact of a strongly negative situation but that do little or nothing to prevent negative consequences reoccurring in future. For example prison, or acute hospital care.



Source: Early Action Task Force [2]

However, for some, there are deeper philosophical issues to be addressed. For them the language of prevention frames the thinking in very negative ways and they advocate a more positive approach.

> *The conventional language of prevention, avoiding the worst, presupposes problems, victims, perpetrators. It is pessimistic, reductive, discouraging. The language of readiness, becoming the best that we can be, identifies assets and builds on strengths. It is optimistic, aspirational and motivating*
>
> *We picture a society which is defined not against the countless things that don't happen – heart disease, under-achievement at school, violence in the family – but by reference to its strengths. It's people are ready and able to benefit from opportunity, to learn at primary school, to thrive in secondary, they are job-ready at 17 and when the time comes they are ready and able to be good parents. Because we all experience difficulties at some point in our lives, they are ready and able also to manage adversity – to cope with losing a job or a relationship, to rebuild after illness or bereavement, to adapt to change*[3].

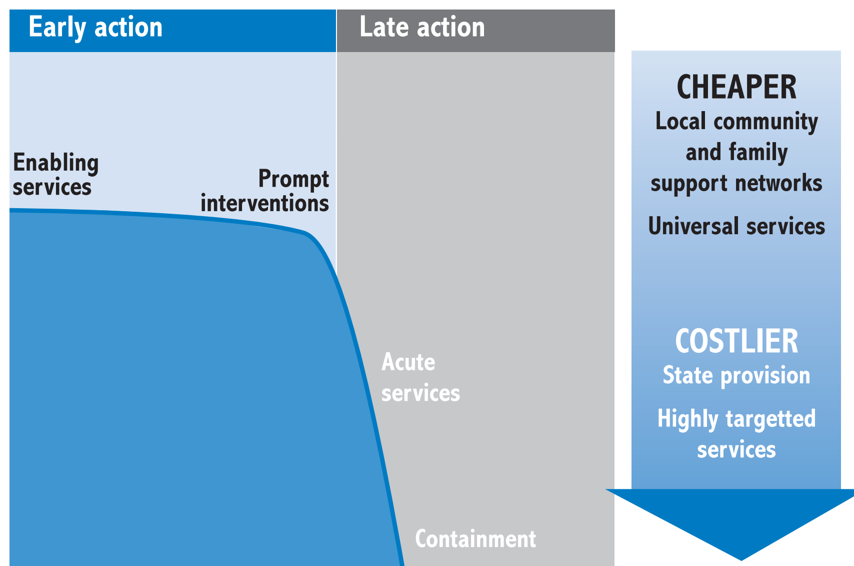
In this model the ideal is a 'ready for everything' community at the top of a cliff, where universal **Enabling Services** and clear rules equip people to flourish, protect them from harm and prepare them for change.

When things go wrong p**rompt interventions** at the cliff edge pick up the first signs of difficulty and respond to them, targeting services at individuals, families and communities with identified problems which, if not forestalled, could, in many cases, lead to more serious difficulties.

Further down the cliff face the service becomes more targeted at those with more developed problems and prompt intervention gets closer to an **Acute service**. Eventually it is primarily focused on **Containing** a problem at the bottom of the cliff rather than on forestalling it.

Looking at the diagram below**, Early action** describes the **enabling services** and the **prompt interventions** at, or close to, the top of the cliff. **Late action** kicks in once the problem has tipped over.

> *Re-imaging the prevention agenda with this different vocabulary shifts our thinking away from attacking negatives and onto developing the positives. It is from this alternative perspective that we can envisage, and build, the society we seek[3].*



Source: Early Action Task Force [3]

For the sake of simplicity it is useful to think of early action as setting out to answer the question: "*how do we build a society that prevents problems from occurring rather than one that, as now, copes with the consequences?*"[3]

Section Two

Analysis of Programmes and Initiatives

Partnerships for Older People Projects (POPP)

The Partnerships for Older People programme (POPP) provided ring-fenced funding of £60m to Councils with Social Services Responsibilities (CSSRs) to establish innovative pilot projects, which provided truly integrated preventative approaches for local older people across the whole system[4].

The aim of the POPP programme was to test out approaches for bringing about a strategic shift to 'prevention and early intervention'. Pilot sites were expected to encourage investment in approaches, which promoted health, well-being and independence for older people and thereby prevent or delay the need for higher intensity or institutionalised care.

> *POPP pilots should be geared towards delivering **large scale, systemic reform with the aim of releasing funding from across the whole system for reinvestment in preventative approaches to care**. Our definition of prevention is interventions and approaches that maintain and enhance the physical and mental health, well-being and independence of older people and thereby prevent or delay the need for more costly, higher intensity or institutionalised care… The POPP pilots will test and evaluate innovative models of service delivery, financial and partnership mechanisms, which will create a sustainable shift in resources and culture away from the focus on intensive and institutionalised care towards earlier and better targeted interventions[4]..*

The programme involved 29 sites across the UK with a total of 146 local projects aimed at improving health and well-being. Two thirds of the projects were deemed to be 'community facing' projects i.e. they focused upon reducing social isolation and promoting healthy living and wellbeing among older people. Many of these services were designed to help older people maintain independent lifestyles and included handyman schemes, gardening, shopping, leisure, social activities and signposting services. The remaining one third were characterised as 'hospital facing' services, i.e. they focused primarily on avoiding hospital admissions or facilitating the discharge of elderly people from hospital or residential care. These services included programmes such as Medicine Management, Telecare and more intensive Community Rapid Response Teams.

The National Evaluation[5] of the programme hailed it as a success.

> *The POPP programme, set up to test preventive approaches, demonstrated that prevention and early intervention can 'work' for older people. Local authority-led partnerships can help to reduce demand on secondary services, providing they are appropriately funded and performance managed[5].*

According to the National Evaluation[5], when compared with non-POPP sites, POPP sites had significantly fewer emergency bed days in hospital. This reduction in emergency bed days resulted in considerable savings; for every extra £1 spent on POPP services, there was a £1.20 reduction on required spending on emergency bed occupants (the range was between £0.80 and £1.60).

Higher efficiency gains were claimed to be available from more intensive, targeted interventions, which involved very close joint working between health and social care. For example, proactive case co-ordination services, which actively seek out people who may be at risk of deterioration, assess their needs and co-ordinate access.

Further impacts were claimed. Overnight hospital stays were said to have been reduced by 47% and use of Accident & Emergency departments by 29%. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person. Phone calls to GPs fell by 28%, visits to practice nurses reduced by 25% and GP appointments reduced by 10%

Efficiency gains in health service use appeared to have been achieved without any adverse impact on the use of social care resources

The evidence from the National Evaluation was however at odds with a detailed piece of evaluation of eight of the sites carried out by the Nuffield Trust[6].

> *We found that, when compared to matched control patients, there was no evidence of a reduction in emergency hospital admissions due to any of the eight POPP interventions we studied. In some instances, there were more admissions in the intervention group than in the control group. There were, however, encouraging signs that one of the interventions reduced admissions for a subgroup of participants at high predicted risk.*

Shift in resources

As noted above, the POPP programme was aimed at "*delivering large scale, systemic reform with the aim of releasing funding from across the whole system for reinvestment in preventative approaches to care*"[4]. In the event the results were not as clear cut as hoped. Indeed the National Evaluation was quite pessimistic:-

> *The main difficulty for sites was translating the evidenced cost-reduction into a cost saving. Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible[5].*

Resource transfers were claimed to have been achieved in a number of the sites, but even if they did take place they were relatively small scale affairs. That having been said, the fact that the overwhelming majority of the projects were sustained beyond the end of the grant funding was seen by the Dept of Health as a significant success. Only 3% of projects were closed down at the end of the programme – either because they did not deliver the intended outcomes or because local strategic priorities had changed. Moreover, within almost half of the sites, one or more of the projects were entirely sustained through PCT funding – a total of 20% of POPP projects. There were a further 14% of projects for which PCTs provided at least half of the necessary on going funding.

POPP services also appeared to have improved users' quality of life. This varied with the nature of individual projects; those providing services to individuals with complex needs were particularly successful, but low-level preventive projects also had an impact

Learning

Structures

All pilot sites were required to demonstrate joint working between health and social care. This was achieved in most cases but this might not be that surprising given the significant additional resources which were made available to the sites. In a number of sites the partnership working was relatively token but in a large proportion of them genuine joint working was in evidence. It was clear from reviewing the outcomes that those sites with the greatest degree of partnership working were able to achieve the most effective results.

> *The projects were reasonably successful in developing good working relations with the wide range of partner organisations, with some variation across areas and organisations. In most areas, service delivery teams comprised staff employed by more than one agency; several had multi-agency multi-disciplinary teams. Such teams facilitated easy discussion, mutual respect and, on a practical level, advice and referrals across agencies; this was particularly notable where staff worked together in the same location, in contrast to 'virtual' teams. In some areas, new posts developed expressly to overcome organisational barriers were introduced and found to enhance good working relations. Link roles were also helpful in this respect[5].*

In order to make a shift to early action it is therefore vital for there to be effective partnership-working between health and social care and other relevant parts of the public and private sectors.

Strategies

Bringing about a systemic shift to early action requires a joint strategic approach. The POPP sites found it very important to have a joint vision and strategy for achieving greater productivity and quality outcomes – with a strong emphasis on prevention, early intervention, and re-ablement. This then provided the framework to enable them to jointly commission a range of good-quality and affordable services, explicitly aimed at supporting people in their own homes.

Systems

There is no doubt that working in complex systems can be difficult. Particular attention needs to be paid to referral pathways and information flows.

> *Difficulties in organisational partnerships are notorious and the POPP projects reported some problems, including the sheer time and commitment needed across agencies and considerable cultural boundaries between professions. Inter-organisational referrals were found to be complex. An inherent tension was noted in policies which promoted partnership across agencies on the one hand and competition on the other. There were also both practical and ethical problems in data-sharing. Those managing multi-agency teams experienced particular problems in coping with differing organisational arrangements, for instance with respect to pay, holiday and pension systems. It was found that GPs were difficult to engage, although playing a central role with service users[5].*

Systems also need to be moderated by the involvement of service users. The POPP programme was operating at a time before user involvement was the norm. All the sites involved older people in the development and delivery of their programmes. There was strong support for the requirement to have governance structures in place which included the involvement of older people (ensuring that they are drawn from different groups and communities that are representative of the local population).

The direct involvement of older people in the design and implementation of the POPP projects, an underlying principle of the programme, was said to strengthen over time, with increasing commitment amongst project staff. In most sites, there was an effort to go beyond tokenism to involve older people fully. The nature of this involvement varied across sites, however, and was generally stronger in the design (77% of the projects) and governance (93% had older people on a steering committee) of projects, compared to service delivery. Fewer than one-third (29%) involved older people as volunteers. The older people involved tended to be newly retired (the 'young old'), healthy and well-educated[5].

When it comes to making a systemic shift towards early action the POPP sites found that it was vital to have in place an early agreement on how to share the benefits and risks associated with commissioning decisions. This was found to be particularly important in relation to making the investment in early intervention schemes sustainable. It has to be said that this is a necessary but not sufficient condition. It has to be combined with a true spirit of joint working and it has to be brokered early on in the process.

Sustainability was often achieved through early attention to the issue. Local Area Agreements, for instance, proved an important mechanism for embedding and sustaining programmes. In many sites, final decisions concerning funding were not made until late in the final year; in contrast, where early agreements were made with agencies regarding their respective responsibilities for sustaining projects – and written into initial bids – the process of ensuring sustainability appeared to be timelier[5].

Skills

Most of the public sector workforce is employed in services which are designed to address needs once they have arisen. The POPP sites found that it was important to have a workforce development approach which promoted a culture of, and competencies in, re-ablement, personalisation, and joint working to meet the needs of people with complex needs.

Culture

Intervening early and in a preventative way requires a different culture than that associated with reactive / crisis response services. At its root it requires a shift in philosophy towards supporting staff to 'do with' rather than 'do for' older people.

Leadership

POPP found that strong leadership is vital to this agenda. Leaders first of all need to have the vision and commitment to a new way of working. Without a clear direction from the top that early intervention is a better way forward, then it is unlikely that any significant change will take place.

Strong leadership is also essential to negotiating the organisational politics and barriers which are likely to surface along the way. Within the POPP programme it was clear that those sites with the most engaged senior leadership were able to demonstrate the best outcomes.

Key factors in bringing about continued enthusiasm and funding were the involvement of local councillors and older people as representatives, which raised the profile of POPP programmes both among strategic managers and the wider public[5].

Evidence

The POPP programme demonstrated that the task of making a strategic shift towards early action will only take place if there is clear evidence and data to support claims about savings from reduced pressure on acute services. The POPP programme was very much at the forefront of developing the mechanisms to enable this to happen. The programme demonstrated the need to understand the patterns of spend, activity, and outcomes across the whole system and to have benefits realisation processes in place to track productivity and delivery against agreed targets.

At the end of the day there were conflicting bodies of evidence about the effectiveness of the POPP programme. As noted above the National Evaluation cited evidence of its effectiveness in reducing demand and improving quality. However a rigorous analysis by the Nuffield Trust[6] of data from eight of the pilot sites (those considered by the DoH support team to be the most effective interventions in the programme) found no evidence of effectiveness. The important learning point here is the concept of 'regression to the mean'. The following extract from the Nuffield Trust report explains this phenomena:-

> *Without a robust control group, the evaluation of hospital avoidance interventions can be misleading. Reductions seen in hospital utilization can simply be a statistical artifact caused by selecting high risk patients for treatment. By selecting high risk patients, there is a natural tendency for subsequent measurements on those patients to show reductions in use; a statistical phenomenon called 'regression to the mean'[6].*

This phenomena and its implications are outlined in more detail in Section Four below.

Total Place – Dorset, Bournemouth and Poole

Total Place was launched as part of the 2009 Budget as a key recommendation of HM Treasury's Operational Efficiency Programme. It sought to encourage local public services to work closer together to deliver better value services to citizens by focusing on joint working and reducing waste and duplication. It's main focus as a programme was not about a systemic shift toward early action, but the Dorset, Bournemouth and Poole pilot did incorporate such an approach.

It can be argued that Total Place was a radical initiative to test out whether a whole area approach to public services can achieve better outcomes for local people at a lower cost.

The Total Place approach

The Total Place approach had a number of elements[7]. One of the most distinguishing was the way that the pilots mapped the totality of public spending in their area, and then undertook a more detailed analysis of spending on key local priorities. This mapping illustrated the complexity of public spending across local partners, and helped partners to understand how to enhance the benefits of that spend within the area. The pilots also used 'customer insight' methodologies to understand services from customers' perspectives, in order to:

- identify opportunities for genuine service transformation across organisational boundaries;
- better develop services around the needs of people in the local area, with a more integrated offer for users, especially those with complex and multiple needs; and
- identify efficiencies through collaborative working and redesigned services.

A number of broad claims have been made about what Total Place offered[8]:-

1. It offered a means of reshaping resources based on the needs of people and places rather than through the funding streams of individual organisations, putting citizens at the centre of service redesign.
2. It provided a methodology for achieving efficiencies in how public resources are used by eliminating waste and duplication.
3. It represented a different template for collaboration between local public service organisations, and the joining up of health and social care services that have thus far eluded previous initiatives based on organisational or financial models, such as care trusts or pooled budgets.
4. It was an opportunity to recast a historically tense and ambiguous relationship between local public service organisations and the centre; it could herald a new relationship with central government based on freedom from central performance and financial controls, freedom and incentives for local collaboration and investment in prevention.

Although not primarily focused on the early action agenda there was nevertheless a recognition that some of the hoped for efficiency gains form Total Place would come from a preventative shift:-

> *There are too many different organisations providing too many services to meet the same needs, making it difficult for people to understand what services are available locally. Too many public sector organisations are spending money on the same things and in the same places, leading to duplication and waste. Money is often targeted at crisis management rather than on prevention.* Cllr David Parsons[8]

Despite these ambitious aspirations, or perhaps because of them, it is generally recognised that the Total Place initiative did not lead to widespread or fundamental changes in local public services[9].

Bournemouth, Dorset and Poole pilot

From the outset, the Bournemouth, Dorset and Poole Total Place pilot concluded that the key to securing improved services for older people at less cost would be a shift in investment from the provision of "acute" care for older people (by health and local government) to community services and prevention.

The following case study was used throughout the pilot to illustrate the value of an early intervention shift:-

> *Betty is 86, and lives in rural North Dorset on her own. She often gets nervous at night, and got in the habit of dialling 999; an ambulance would come and take her to hospital. This was costing the NHS around £19,000 a year. Her GP spotted this pattern and arranged for a local voluntary group to phone Betty at least once a day; Betty could also ring them instead of 999 if she felt nervous. We discovered there were hundreds of women like Betty across Dorset, and many unnecessary hospital admissions.[10]*

Having assessed their activity and spend the pilot was able to establish that the area had a high and rising level of emergency admissions to hospital, particularly among older people. There was historically low local authority spend on social care for older people, and some stark differences between the three main authorities, with high levels of residential care in Bournemouth and very low levels of residential care in Dorset and Poole.

The pilot then set out to 'inverse the triangle of care' – to shift the focus of investment towards activity in or near people's homes rather than in hospital. It was known that at least 30 per cent of older people admitted to hospital in an unplanned way were avoidably admitted and need not be there. It was calculated that if 15 per cent of those avoidably admitted could be diverted and have their needs treated either in their homes or closer to home, the annual saving would be around £18 million.

The key calculation for shifting resources away from acute services towards more investment in early intervention was expressed as follows:-

$$A-(B+C)=Y$$

Where **A** is the saving from reducing admissions to hospital; **B** is increased investment in community services; **C** is the cost of sustained investment in universal services and wellbeing; and **Y** is the contribution to a significant reduction in public expenditure

The pilot proposed[10] a number of actions it felt were needed in order to support a 15% shift away from hospital. They included:

- Local government's contribution to enhanced community services, including reablement;
- A targeted programme of preventative activity;

- The potential contribution of locality and neighbourhood working, involving a wider range of public services and the third sector.
- The long term impact of the development of universal services and social capital.
- Income from service users assessed charges.

It was argued that, taken together, this would deliver the whole system change to secure the objective of improved services at less cost.

> *The cost of alternative provision for those people, and beginning to ramp up a genuinely preventative approach, would be about £6.6 million a year; we also identified 'social capital' – genuine low-level community-based activity – as an important element of the preventative activity. An additional £1 million investment in that low-level community activity across Bournemouth, Dorset and Poole would transform the level of provision.*
>
> *So is it possible to get improved outcomes for older people in Bournemouth, Dorset and Poole at a lower cost? The maths – £18 million savings minus £6.6 million on preventive services and £1 million on social capital – are self- evident. And it was clear from survey work that older people showed a strong preference to receive care closer to home rather than in hospital.[8]*

Learning

Lessons from the process

The process of developing the Total Place plan generated a number of learning points[8]:-

- Keep the focus of the project clear and simple and in particular maintain focus on
  - the core outcome that one is seeking to achieve
  - the centrality of the citizen's perspective

- Address the challenge of maintaining momentum without a deadline in the face of inevitable pressures to slow down by:-
  - piggy backing on unmoveable local timescales and programmes
  - using project milestones – assemblies, events – to maintain progress

- Create the space in which 'mainstream' programmes can be more ambitious, e.g. "*one the best things we did was to have an external challenge day, where we invited representatives from other authorities, from Whitehall and Westminster, and from organisations like The King's Fund, to come and constructively challenge what we were doing. The level of ambition locally shot up after that day."[8]*

Learning from failure

Ultimately the Bournemouth, Dorset and Poole Total Place pilot failed. A detailed plan for a shift to prevention and early intervention was produced but not implemented. The barriers to achieving the desired change were too powerful.

Structures

There was a major flaw in the project in that it was a 'sub regional' grouping involving three different councils and several NHS Trusts. Organisational history cast its shadow over the project. The sub regional focus had implications for ownership and level of ambition. For action to be

taken all three councils and their NHS partners had to be engaged, which was very difficult to achieve. On top of the simple organisational complexity there was the impact of historical 'baggage' between the organisations, i.e. fears of takeover in either direction.

Systems

The organisational complexity was particularly undermining of the aspiration to shift resources horizontally and vertically within the system. There needed to be different forms of governance and financial management in order to transcend the various system boundaries. There was no system in place which could manage a process which involved expenditure by one organisation being necessary to secure savings by another[10].

Culture

There were various cultural barriers which proved insurmountable. The most important was the lack of confidence amongst many senior managers in alternatives to secondary health care:-

> *Even more challenging is the whole question of building trust and confidence in alternative provision throughout the system, from paramedics through to GPs, commissioners, and clinicians in A&E departments. Part of this challenge will involve de-medicalising some of the needs and problems that are presented to the system. Betty* (see above) *did not have a health problem as such – she needed a phone call, not an ambulance or a hospital[8].*

Leadership

There were significant leadership and political challenges. The most difficult of which was the need for concerted leadership, across organisational boundaries, to make the case for potentially sensitive changes to the shape of secondary care[10]:-

> *I quickly concluded that acute hospitals are a bit like the M25. For as long as they're there, they will be full, so there has to be a grown-up debate, nationally and locally, about the need to significantly reconfigure hospital provision in order to realise the savings that we've identified. I remain unconvinced that there is the political appetite for that, either nationally or locally. Creating the conditions in which a grown-up political debate can happen is the key to achieving improved outcomes at lower cost in relation to services for older people. This applies as much locally as nationally[8].*

Leadership is also about generating trust and focusing on the future rather than on past disputes. Moving beyond historical perceptions of other organisations proved difficult:-

> *Achieving better outcomes at lower cost, in crude terms, involves local government spending a little more in order to help the health service save*
> *a lot more. But the challenge of getting a sensible debate about achieving this locally was kind of soured by a view among health colleagues that local government was underspending anyway. History, and perceptions of history, were undermining the capacity for an open dialogue about moving resources from one budget stream to another[8].*

Whole Place Community Budgets

Whole-Place Community Budgets followed on from Total Place and entailed a different way of working, rather than a specific set of programmes or projects. In common with the general principles of integration in public service delivery, the approach involves[9]:

- understanding spending patterns and identifying fragmented, high-cost, reactive and acute services;
- focusing on outcomes and selecting interventions that best deliver those outcomes, rather than being limited by existing organisational responsibilities;
- developing services that are user-focused;
- shifting the balance of resources in favour of 'early action' measures targeting prevention, early intervention and early remedial treatments; and
- identifying investment from partners in new delivery models including considering whether pooling or aligning resources could help maximise provision and minimise duplication and waste as part of a new service model.

West Cheshire

The West Cheshire Whole Place Community Budget has a particularly focus on making a shift to early intervention. It is planning to generate £56m savings over five years from an estimated total public sector budget of £2.4bn per annum through "creating proactive, preventative interventions and a focus on outcomes and citizens"[9]

The programme covers the whole life course:-

The Ageing Well plan[11] has been specifically developed to achieve a preventative shift. The financial flow analysis has been well worked out as is evident from the following:-

> *Whilst the demographic growth in demand for resource is anticipated to cost an extra £19.1m by the close of 2017/18, the scaling up of existing interventions will deliver a maximum net efficiency of £4.27m by the close of 2015/16. This is the point when the scaling up of existing interventions reaches the optimal point.*

By creating an environment that encourages innovation, non-elective bed use can be reduced by 25-30% in total and the amount of long term care placements by 15%, equating to a further net efficiency of £3.94m and £1.99m respectively achievable by the close of 2017/18. This is based on the assumption that alternative care could be provided at a third of the cost of an acute hospital bed, based on today's costs, and 40% of the cost for long term care.

However, whilst these efficiencies go a long way to contain the demographic growth pressure they do not mitigate growth entirely with the net demand pressure by the close of 2017/18 of £8.9m (cumulative).

If providers and commissioners operate within an environment that creates innovation and promotes preventative measures, further efficiencies are possible through the development of stronger communities and self care models. [11]

The new delivery model is as follows:-

Keeping People Healthy in their own Homes	Presentation and Assessment of Condition	Diagnosis, Needs Identification, Treatment and Care Plan delivery	Return to normal place of residence	End of Life Care
Information that allows people to remain healthy in their own homes will be clear and joined up	Community based pathways identified if safe and appropriate	Assessment for long term residential care is not normally carried out in an acute hospital environment	Plan for discharge on admission (Pull approach)	Opportunities for people to identify their preferred priorities of care and that these are met
Opportunities are identified to invest in community wellbeing, preventative and community services	People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions	Diagnosis and needs identification is completed as close to the community as possible	People will not be cared for in hospitals or Long Term Care for longer than is necessary	
Proactively identify individuals at high risk and provide suitable services and assistive technology	Assessment takes place as close to the community as possible	**Treatment regimes are delivered** in the least intensive appropriate setting	People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions	
Promotion of and signposting to Self management techniques and self care	Information is captured once only; built upon and shared across all agencies (Single Assessment Process)	Care is holistic and co-ordinated and integrated where appropriate	Remain at home	

The core elements of the new way of working in the transformed system are:

- A strategy to develop stronger communities in which older people are viewed as assets rather than deficits.
- Maximising the number of patients who can self-manage through systematic transfer of knowledge, and care planning.
- Integrated locality care teams including social care, community services, allied health professionals and general practice.

To secure the innovation that providers can bring and to manage the risks of large-scale change, the delivery of some elements of the integrated care strand will be premised on alternative funding and contracting arrangements.

Learning

A number of critical success factors have been identified:-
(the following material has all be taken from the following sources [11, 12] , unless otherwise stated)

Structures

West Cheshire has shown that increased collaboration has demonstrated the value of closer working with partners. Working effectively across organisational boundaries is critical. There are a number of ways that have been used to achieve this. Firstly it's important to respect the need for independent partners to take their own decisions in accordance with their own governance arrangements. It is also important to note that partners retain control over their own budgets and decision-making throughout and stakeholders need to be mindful of retaining a genuine sense of equal partnership. Giving the programme an institutionally neutral identity and profile (i.e. Ageing Well) has also been helpful in building commitment.

Strategies

Before any work on developing new ways of working can begin it's vitally important that all partners have a clear understanding of how existing services are delivered now and by whom. It is particularly important to identify those areas where multiple partners work with the same or similar groups of people, where there might be duplication and overlap. In undertaking this exercise the sort of questions which are helpful to ask include:-

- *does one partner invest but others benefit?*
- *are there time lag effects for early intervention to have an impact?*
- *scale (and costs) of issues*
- *cross-cutting characteristics and complexity, such as assets, data and systems*
- *shared strategic priorities*
- *reasonable value available from investments[12].*

Undertaking this kind of analysis can facilitate the development of new delivery models of integrated, coordinated, evidence-based interventions to help those individuals, families and neighbourhoods with the highest levels of dependency and most expensive interventions. This can then lead to the development of joint commissioning arrangements and a single performance framework, which amongst other things, has been found to be helpful in avoiding silo thinking and cultures.

Early workshops with leaders, service heads and practitioners from across the public sector were vital to identifying the fundamental issues that needed to be addressed and consequently the groups of people involved.

> *This process can be started through partnership development workshops, which the pilots found helpful in identifying which partners were working with the same people on similar issues. It was not uncommon to find that a number of professionals were actually getting together for the first time. These workshops can be augmented by creating small project groups to look in much greater detail at particular groups and issues to understand exactly what is happening currently, what is working well and what less well[12].*

Systems

If one is to make any sort of systemic shift to early action then one of the fundamental requirements is to be able to achieve disinvestment and re-investment across the system. One therefore needs to identify how the different parts of the public sector in a place are funded now, and then design mechanisms by which money could be moved around the system, for instance from acute towards community based services.

Partners in West Cheshire designed a new service model based on the following principles:

- ***Customer centric proposals** – clear evidence that people are central to the redesign, and have been engaged and involved in the process.*
- ***Shared strategic priority** – ensuring that proposals make a significant contribution to the West Cheshire vision and key strategic ambitions.*
- ***Value of investment** – proposals demonstrated value for money in comparison to the cost of business as usual, through improved outcomes or reduction in demand.*
- ***Complexity** – a multi-agency issue that has proved difficult to tackle because of the cost of intervening, and the risks of not succeeding*
- ***Scale** – the issue to be addressed places high demand or cost onto a range of public services across the area.*
- ***Prevention** – the redesign will reduce future demand on services.enable the commissioning of multiple services at a reduced cost.*
- ***Reducing conflicting incentives across partners** – allowing redesigns to remove barriers to joint investments when the rewards do not fall evenly or proportionately across partners.*
- ***Removal of bureaucracy** – the proposal removes unnecessary bureaucracy and processes.*
- ***Leverage community capacity** – the proposal takes steps to shift greater power and responsibility to individuals and communities[12].*

System change often requires up front investment. In West Cheshire, partners calculated what the new investment needed and then looked at three options for the apportionment of costs:

- *Option 1*: was calculated by apportioning costs based on the staffing headcount in joint teams. While this approach could be appropriate for splitting costs for joint teams it was noted that it placed disproportionate costs on the council as they would meet the share of any newly commissioned domestic abuse interventions in line with the staffing assumptions while other partners would capture a larger share of benefits.
- *Option 2*: was calculated by apportioning costs based on the modelled gross benefits for safer communities, families together and early support projects. While this approach suggested more balance in relation to return on investment, further work was needed to validate the benefits in 2013/14.
- *Option 3*: was calculated by apportioning implementation and running costs on the basis of staffing headcount in joint teams. Intervention costs were apportioned by net benefits resulting from the domestic abuse project.

Addressing the way that money flows within the system has been identified as a critical condition for bringing about change:-

> *Dialogue around potential longer-term and systemic reforms to the way local services are funded is critical, including financial incentives or funding arrangements that encourage partners to invest across organisational boundaries, particularly where reform takes longer to be financially sustainable[9].*

Skills

Bringing about systemic change towards early action requires skills that are not usually found in one place or one organisation. Particular skills are require to undertake business planning and cost benefit analysis. Within Cheshire West the detailed business cases that were developed to make the case for transforming local services drew in a wide resource of public service managers, front-line staff and finance specialists.

> *It was important to initiate an early recruitment process to the programme teams that was aimed to attract people with the appetite and ambition to join an exciting new venture[12].*

The learning from the wider Whole Place Community Budgets shows that cost benefit analysis is an important tool in convincing partnerships collectively and partners individually to commit on the basis of something other than a leap of faith.

> *In West Cheshire, which hadn't previously used cost benefit analysis in a partnership-wide decision making context, a number of partners were surprised about the scale of potential benefits that would flow to their organisations from the implementation of new delivery models. For example, what the cost benefit analysis said about domestic abuse, as a consequence of better understanding, the Department of Health formally committed to provide a health secondee to the project team to lead on implementation[12].*

It was found to be helpful to use an 'Insights' tool (to help understand self and others) to fast track the creation of a single team, given that individuals were coming from very different backgrounds.

Culture

The first cultural change that needs to take place is the development of a user focused approach – service user experience and outcomes need to be the starting point, with local public services jointly accountable to their communities for the delivery of services[12]. It is important to build services around people and their communities.

West Cheshire also think that the following cultural changes are important[11]:-

- A value based system that rewards positive outcomes is viewed as a key mechanism for promoting change
- Engagement with staff is essential, both to allay fears around changes and also to gain their input to services and to use their knowledge and skills to identify efficiencies

Leadership

Strong leadership is essential – either through a collaborative Programme or Public Service Board. The following approaches have also been found to be effective[12]:-

- engagement of chief executives and directors of partner organisations was fundamental to building commitment across organisations.
- selecting project sponsors from different partner organisations pulls different agencies into the programme and shares responsibility.
- Partners have found it helpful where local political leaders have been visible participants in their pilots. Their leadership has been valuable in getting buy in and maintaining momentum.
- thematic management groups were chaired by members of the public service board to ensure a direct line of accountability and a 'friendly' legal partnership agreement was created to get members used to a more formal basis of partnership working
- Focusing on the achievement of clear and agreed outcomes should be the top priority that drives all actions

Evidence

Advocates of the Whole Place Community Budget approach claim that one of the key components that takes it beyond traditional partnership cooperation is its use of evidence to make a robust case for new models of service delivery and investment. They note that if organisations are to invest in services together in new ways, they will have to be confident it's worth doing.

> *Real transformation needs to take local partners beyond 'in principle' agreement on vision and priorities, and use evidence as the basis for new business plans and models of delivery which can be jointly funded through new investment agreements. It is crucial to evaluate the effectiveness of new service models and use this to drive re-investment of resources so that successful projects can be scaled-up and sustained.[12]*

The pilots have used cost-benefit analysis and customer insight methods to gather that evidence, so their proposals are built on strong, credible foundations. Although, as pointed out in the evaluation of the programme[9], there is some room for improvement:-

> *Not all the analyses we reviewed contained an explicit comparison with the costs and benefits of the current service. Without information on the costs and effectiveness of the current service, there is a risk of over- or underestimating the benefits of a change. Comparisons are particularly important where the proposed service will require (as it often does) reducing or altering current services and the resources supporting them. Identifying a relevant comparator can be a significant task.*

Whilst the centrality of evidence is advocated, it is also pointed out that it is important to recognise the need to balance the search for evidence and knowledge with the need to come to an informed conclusion. It is too easy for people to get lost in the weight of information and data available.

Neighbourhood Community Budget Pilot Programme / Our Place

The Neighbourhood Community Budget pilot programme ran from April 2012 to March 2013. It was announced in the Community Budget Prospectus in 2011, and ran in parallel to the larger scale Whole Place Community Budget process. Twelve neighbourhoods worked closely with their communities, and the Department for Communities and Local Government (DCLG) to test how services could be devolved to the neighbourhood level, and residents engaged in service re-design and delivery. From 2012 the programme was re-named as 'Our Place' with a further £4.3m committed to help more communities take up the approach

The programme was designed to give local public service partners the freedom to work together to redesign services across boundaries to solve intractable, complex and multi- agency problems, and deliver better outcomes for people, reduce waste and produce substantial financial savings. The pilots were designed to test both how the control of services and budgets could be pushed down to communities and neighbourhoods.

The programme was not specifically designed to further early action approaches, however a number of the pilot sites did use it to attempt bring about systemic change towards early action in their area. For example:-

Castle Vale
Aimed to achieve a positive 'step change' in the health and wellbeing of Castle Vale residents. The pilot focussed on health, wellbeing and leisure, with emphasis on holistic approaches to smoking cessation and tackling obesity. Activities included elements such as an outdoor gym and a health champion service. It also tested the potential of the Health & Wellbeing Board model at neighbourhood level.

Cowgate, Kenton, Montagu
Focused on co-design and early intervention and prevention around social issues. It aimed to enable more families to be economically active; increase the take up of preventative health measures; and bring about better targeting of services. Ultimately it aimed to achieve an active community, with peer led support, choosing and commissioning the services they need.

Ilfracombe
Sought to enable the community to have control over the management of their town, improving quality of life and life chances for all. It aimed to change things so that services are redesigned the around the person, not the agency, and focus on prevention and reducing demand. It was expected that there would be a co- ordinated, multi-agency, multi-disciplinary approach and central point of contact.

Poplar
Aimed to develop a care package approach to tackling diabetes (prevention and treatment) designed by clinicians and commissioners and including activity to address the wider determinants of health – (employment, education, language, housing and welfare benefits). The pilot aimed to save the NHS a potential £4m over 5 years by investing £1m in promoting healthy lifestyles and improving treatment of those at risk of diabetes, including through the use of health volunteers. A network of trained volunteer 'Health Makers', were recruited to work with practices to support the care packages approach.

Queens Park
Local people wanted to create a 'self-sustained' neighbourhood in control of its own services, where integrated, universally-accessed early intervention services end an era of 'mopping up after tragedy has struck'. The focus was on early Years (0-4) services. The agencies worked together towards the collective aim of more comprehensive, targeted and efficient early years' services in the area, with direct feedback from residents to ensure their buy-in.

Sherwood
A community led approach to service delivery focused on preventative rather than reactive activity. Aimed to develop a new model for working with 'just coping' families - the Sherwood Family Partnership - a multi agency team co- located in a decommissioned flat on the estate. An active and engaged community involved in peer mentoring, identifying families' needs and wider voluntary activity.

Each site had to develop an Operational Plan which was expected to:

- **define a package of local services** to be managed in the neighbourhood, developed through a co-commissioning process where the Local Authority and other public services, community and partners decided how to get the best possible outcomes from the resources available
- **specify the cash budget and other resources** that would be used to deliver the plan – this might include voluntary action, community-held assets and tools, and social finance
- **specify the governance mechanism** for managing the plan and delivering the services, setting out how this will be accountable to residents and to Accountable Officers in public bodies investing in the neighbourhood budget

Financial support to the pilots ranged from £30,000 to £122,000.

Learning

Structures

The Neighbourhood Community Budgets / Our Place programme is ultimately to bring about structural change by establishing local control, facilitated by the devolution and pooling of budgets at the neighbourhood level. However, the pilots' experience showed that pooling of budgets does not have to be the initial aim, as long as (internal and external) partners are aware that local control is what is being worked towards in the long term.

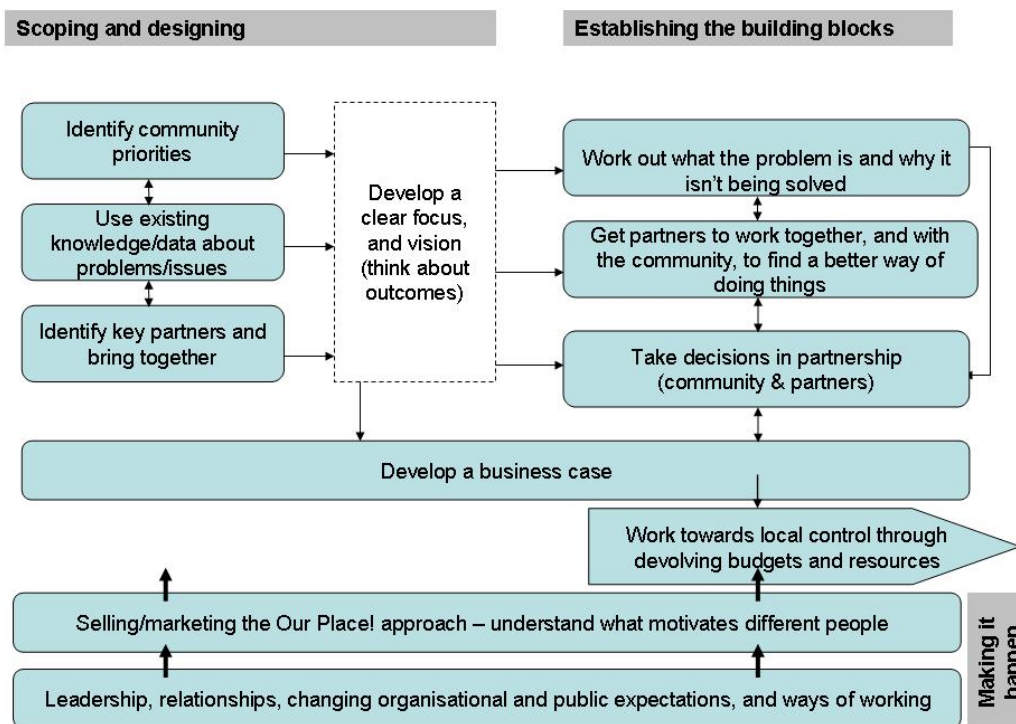
Taking neighbourhood level commissioning decisions in partnership and/or aligning budgets or creating virtual budgets was the first step for some pilots. Some pilots found presenting the Neighbourhood Community Budget as offering a new way of working to be more appropriate, allowing discussions about pooled budgets to emerge progressively. Aligning and virtual budgets was found to help build trust, demonstrate effective/efficient working and underpin commissioning decisions taken in partnership, and as such helped areas to move forwards.[13]

It was seen as important to jointly map services based on community insight to understand which services do, or should, play a significant role in achieving the objectives of the pilot. Spend and resource mapping often followed from service mapping. And an important lesson was that joining up needs to be done at senior and practitioner level and focused on and for the needs of the neighbourhood.

Strategies

The strategies employed to attempt to bring about a shift to early action in the pilots had a number of domains.

Firstly there was quite a structured approach to delivering the programme, which can be outlined as follows[13]:-



In step 1, where the pilots scoped and designed their Neighbourhood Community Budget, they conducted activities which enabled them to develop a clear outcome-based focus and vision. To achieve this they used existing knowledge and data about problems and issues in the neighbourhood (spend-mapping and harnessing existing consultation data), they developed an understanding of community priorities (through community research and/or engagement), and assessed opportunities for partner engagement. Once a focus had been established, they began developing a business case which continued to evolve during step2.

In step 2, the pilots established the building blocks for implementing their Neighbourhood Community Budget, they collaborated with the community to address the problems and achieve the aims and vision identified (through co-design); they (further) established joined up working between partners to re-design and re-shape (or design and shape) the ways services are delivered in their neighbourhood; and they began (or began to consider) taking commissioning decisions in partnership with the community and partners. Some pilots also began considering options and opportunities for co-delivery (particularly involving

volunteers). Through this process the areas began working towards control of services in their neighbourhood through the devolution of budgets and resources. As shown at the bottom of the diagram, selling and marketing their Neighbourhood Community Budget approach and culture change were vital throughout the entire process to successfully develop the and sustain the approach into the future[13].

Secondly, it was found that it was important to think about and tackle issues from the point of view of *outcomes,* which pilot leads, the community, and partners wanted to change or achieve in the neighbourhood.

Efforts could therefore be focused on, and directed towards, these outcomes. This approach was seen by pilots to provide more opportunities to tackle underlying issues/problems rather than simply improving a service and means it will be possible to incorporate a wider range of services and resources[4].

Thirdly, a key lesson from the pilots was that areas should understand their neighbourhood and take an asset-based approach to the community and its members. This enables a focus on the role the area wants the community to have and therefore how they approach and engage with them from the start.

Pilots approached their communities to explore their priorities in relation to a particular theme, creating the opportunity to understand things in more depth and establish relationships and the potential for future co-design. Areas who consulted on priorities in order to decide the focus and provide legitimacy for the Neighbourhood Community Budget, had to ensure consultation was broad based and that they properly understood the communities' concerns[4].

Fourthly, proper engagement with the community was found to be crucial. It was found that community engagement was best planned strategically to ensure that the community could be appropriately involved at each stage. A further lesson, was the importance that this co-production is approached as a joint exercise 'with' the community, not something that is 'done to' the community.

Systems

The pilots found that there is some potential to achieve significant efficiencies through service design, particular where there is a shift to early action. Many of the (community-led) business cases for new ways of working submitted with the Operational Plans demonstrated this, though it was acknowledged that they needed further development and testing in practice[13].

Whilst there was a tendency to focus on the need for pooled budgets, in practice the pilots found that they could still build trust through aligning and virtual budgets.

Skills

Two particular skill sets were identified. Areas needed to have access to skills related to community engagement and business case development. Whilst voluntary organisations and communities are more likely to have some of the community engagement skills, the issue of business case development with its attendant need to undertake a cost benefit analysis can be a particular challenge.

Culture

Devolving power to local communities and making a systemic shift to early action poses a number of cultural issues.

Firstly, with regard to community engagement, it was found that it was important for the community to be engaged at every stage of the developmental process (although it was recognised that there are various different levels and types of engagement).

Secondly, it was found that there is a need for a change of structures, priorities, incentives, and behaviours of all actors (local authorities, public sector organisations and other partners, and communities), and that this is required at the local level.

Thirdly, developing a culture of trust is required. The importance of building trust with willing partners (internal and external) from the start was recognised by the pilots, although other partners were able to be brought in at later stages. It was found that areas should consider partners' motivations and what they get out of being involved.

Fourthly, changing towards an 'asset based' philosophy was found to be important. The pilots saw the development of new ways of working and these centered around changing expectations within local, public sector organisations, and the community. This was particularly in relation to the way the community is perceived by providers and their role in service delivery and seeing neighbourhoods as an asset rather than negatively.

> *The evidence points to this involving an attitude shift within organisations about doing things with rather than to communities and providers being more responsive to the locality and valuing the input of residents. The new ways of working also involved communities being prepared to take on responsibility and accountability and get involved with co-designing and co-delivering services and solutions rather than being consulted and then supplied with services. The pilots considered that there is little point engaging the community if providers are unwilling to recognise the knowledge and expertise of users/the community[4].*

Leadership

Whilst structures that support new ways of working and provide the right incentives were found to be important (see above), leadership and 'productive relationships' (i.e. effective leadership) were found to be equally important. It is not a case of one or the other, both are required for success and sustainability. *"..good personal relationships between key individuals, with 'the drive, the personality and the seniority to make a difference' is also important lubricant to these interactions' (quoted in [13]).* The areas found, however, that it takes significant time and effort to develop and sustain relationships with (the right) service provider partners, internal colleagues, and community.

Strong and dynamic leadership was considered crucial for getting the 'right' people around the table and ensuring that decisions were made. It was also important to enroll key strategic partners to provide leadership and culture change within their own organisations.

Relationship Managers also identified the importance of leadership in driving the process forwards. As well as getting people around the table, leadership is required to manage different agendas and priorities among partners: 'different people have a kind of pretty formed idea of ... what they think ... this project offers in terms of opportunities for them and their agendas and progressing their agendas'. Leadership may be about closing down options and being pragmatic about where to take the focus and in another interview it was recognised that despite strong leadership there remained a potential need to rationalise the number of partners involved[4].

It is worth noting that leadership came from different places in the pilots, including local authorities and community organisations. In particular, there was a clear role for local politicians to fulfil a leadership role.

Councillors with their local knowledge and proximity to communities have a key leadership role. Using the Our Place! approach can invigorate their role at all levels[14].

Evidence

For those pilots which were engaged in trying to bring about a systemic shift to early action it was found to be critically important that they had well developed business cases based on sound data and incorporating a rigorous cost benefit analysis. This was a challenge for most sites but many made good progress.

Pilots considered it important to draw on existing statistical and consultation data about problems, issues, and priorities in the neighbourhood, including data on indicative spend. It was felt that this was fundamental to getting an understanding of what is being spent, who controlled that money and how it could be made better use of. Mapping current spend was also particularly useful if it helped to make spending decisions and implications of service use *real* to the community e.g. missed appointment costs and hidden costs of services.

There was a feeling however that there was a need for more guidance on obtaining meaningful data at a neighbourhood level and also that key service providers could do more to make disaggregated spend, or estimates of spend, available at neighbourhood level.

Although it could be an onerous task, overall the mapping exercise was felt to be a useful way of engaging partners. It was considered helpful to have the local authority on board when mapping spend to access data more efficiently and accurately.

Cost Benefit Analysis was an important aspect of business case development. It is a discipline to get clarity about new ways of working – what it really costs, what the benefits are and to whom they accrue. Many areas tackled this using the Manchester Cost Benefit Analysis approach[15].

Subjecting plans to the scrutiny of Cost Benefit Analysis was found to be highly valued in getting greater clarity and transparency about a proposal but it needed to be done as part of business planning. Greatest benefit was achieved from using the process to get a clear and simple logic model to underpin a proposition, and develop clarity about activities. Support from those familiar with evidence sources was necessary in order to help quantify benefits and ensure the outputs are compelling. So, while Cost Benefit Analysis was often not a specialist task, having ready access to support and guidance was seen to be necessary and, when used at the right time, can be a powerful tool to enhance decision-making[13].

The Cost Benefit Analysis enables an assessment of the overall benefit of an intervention to be considered in comparison to its costs – adjusted to take account of deadweight (outcomes which would happen anyway) and optimism bias (discounting where evidence is weak).

> *The key output of a Cost Benefit Analysis is a Cost Benefit Ratio. A ratio of 1:2, for example, shows that for every pound invested, a value of two pounds benefit is realised. These benefits can be disaggregated to fiscal (benefits or savings accruing to the public purse) economic (benefits accruing to individuals and businesses) and social (benefits to individuals enhancing subjective wellbeing). More detailed scrutiny of these Cost Benefit Analyses can allow a fuller understanding of where savings or efficiencies occur and to which agency they accrue[13].*

Feedback from the areas suggests that conducting cost benefit analysis was highly valued as a process which made areas think through all their activities and costs, and made it clear what overall benefits were, and to whom they would accrue. In addition, developing a theory of change or logic model was found to be a highly constructive process which facilitated discussions and helped clarify the business cases.

Health Empowerment Leverage Project (HELP)

(material largely taken from [16])

Overview

The Health Empowerment Leverage Project (HELP) was formed in 2009 as a small independent working party attached to the NHS Alliance. The aim was to promote better collaboration between health agencies and local communities. It had a particular interest in the potential for community development to play a wider role, in relation to both prevention and participation.

The Department of Health was at that time considering that community development had significant benefits for health and patient and public involvement, but it was unclear how far there was a business case for health agencies to invest in the approach. At the end of 2009 the Department of Health commissioned HELP to explore and demonstrate a business case for the use of community development in health in England.

Health challenges are particularly intense in disadvantaged neighbourhoods, where life expectancy is frequently up to ten years lower than in nearby better-off neighbourhoods. Poor health reflects poor social conditions in terms of employment, poverty, housing, environment and education. Conversely, improvements in these conditions correlate with improvements in health [17].

Learning

Structures

Experience from HELP suggests that for any shift in resources to take place it is necessary for local authority and health commissioners to be engaged.

> *The local authority may already provide or commission community development (CD) for other purposes or as part of its new public health responsibilities. However, provision of general community development has declined since 2008 due to the ending of a number of national programmes followed by cuts in public services.*
>
> *Resources for, and oversight of CD would suitably be shared by the main health budget and local authorities since CD amplifies Public and Patient Involvement and creates savings for primary and acute care as well as for public health. A contribution could be sought from the patient and public involvement premium of GP practices since CD will create networks to enable them to link much better with the community as a whole.*
>
> *It would also be suitable to seek input, whether in money or officer time, from other local public agencies since they too will benefit from this approach. Indeed, local authorities, police and schools may well already be more oriented to collaboration around community development than health agencies are.*

The C2 method (upon which HELP is based) was originally developed out of work by two health visitors, Hazel Stuteley and Philip Trenoweth, in the Beacon estate in Falmouth in the 1990s. As a response to coping with an impossibly demanding case load they led an intervention which reversed the decline of a heavily stigmatised estate. The Beacon project became a national flagship for resident-led community renewal and health improvement [18]. The method was consolidated in further interventions and research in Redruth and Camborne in 2002-4 and

formulated into a replicable model following two years' further analysis by researchers from the Health Complexity Group (HCG) at the Peninsula Medical School, Exeter.

Strategies

For its fieldwork projects HELP adopted the 'C2' method that had been pioneered in Cornwall since 1995. This method:-

- draws out and prioritises issues that matter most to local residents;
- helps agencies deliver more responsive services;
- and so provides an accelerated form of community development designed to achieve effects economically within a given timescale.

The HELP approach[16] is to first look at the local situation from two perspectives – public services and local residents. They start especially from the concerns of people. These concerns may not just be about health, but all sorts of health improvements come about through collaborative working on other issues too. They then help people to form or strengthen neighbourhood partnerships between residents and public services, both health and other services and stakeholders. The next step is the development of action plans which advance both the concerns of the residents and the priorities of the public agencies. It is important to find the issues which link people in the neighbourhood motivates them to seek change and, by doing so, change their own lives. They then help both sides to follow through on the improvements they seek, and show how they can measure and describe the changes they bring about and relate them to health statistics and costs.
The theory of change behind the HELP approach is expressed broadly like this[16]:

> *"(i) Baseline. The starting condition is a neighbourhood with multiple disadvantages and low levels of health. These conditions entail disproportionately high demands on the health budget and other public agencies. A concomitant factor is a low level of community organisation, articulation and negotiation with public services. Correspondingly, the public services have a low level of engagement with the community.*
>
> *(ii) The hypothesis is that the level of health and general conditions in the neighbourhood can be significantly improved, with very little new investment, if the level of community organisation, dialogue and collaboration with public services is raised in such a way that it increases community confidence, organisation and ability to negotiate with public services, whilst services staff are enabled to take a more flexible, cross- issue, problem-solving approach to their work in the neighbourhood.*
>
> *(iii) These effects can be driven most effectively and economically by the mechanism of a neighbourhood partnership, designed to be the visible central point of an expanding wave of optimism and purposeful activity both in the community and the agencies. This wave needs to gradually affect and involve the bulk of the local population even though most residents will probably never come to a formal partnership meeting. Expansion of activity means more volunteering and social networks, and less isolation and exclusion, whilst specific initiatives such as a new park, dental surgery, playscheme or youth club each generate a further wave of benefits to users in terms of health and other issues."*

The method connects communities in three ways:

- within themselves – networks and cooperation amongst local residents
- with local service providers and public agencies – building a parallel community of interest amongst the front-line workers
- with other communities – getting and giving inspiration directly from one place to another.

The key to the approach is the Seven Step Model – see below.

From Isolation to Transformation

STEP 7
Partnership firmly established and on forward trajectory of improvement. Two or three key residents employed and funded to co-ordinate activities. Measurable outcomes from community action plan and evidence of visible transformational change, e.g. new play spaces, improved residents' gardens, reduction in ASB, all leading to measurable health improvement and parallel gains for other public services

STEP 6
Evidence of community strengthening and self organization characterized by setting up of new groups and activities increasing social capital, catering for wide spectrum of age groups and targeting health priorities. Accelerated responses in service delivery from partnership agencies, leading to increased community trust, co-operation and reciprocal uptake.

STEP 5
Monthly partnership meetings, providing continuous positive feedback loop to residents. Celebration of visible 'wins' e.g. successful application to funding streams which support community priorities, and promote positive media coverage, leading to improved community confidence, more volunteering and increasing momentum towards change.

STEP 4
Constitute partnership which operates out of easily accessed hub within community setting, opening clear communication channels to wider community e.g. regular newsletter, estate 'walkabouts', links with other community groups and interface with strategic organisations.

STEP 3
Steering group hosts 'listening event' and produces report on identified issues, fed back to residents within 10 days. Commitment established for resident led, multi-agency partnership to tackle issues. Exchange visits undertaken to meet communities who successfully self-manage.

STEP 2
Deliver workshop to consolidate steering group and embed skills needed to support residents to lead change and become self-managing. Jointly plan 'listening to community' event to identify and prioritise neighbourhood health and well-being issues.

STEP 1
Identify and nurture key residents. Establish steering group of front line local service providers with a small reference group of key residents and other stakeholders who share common interest in bringing about change and improvement within a targeted neighbourhood to undertake a joint development process & action plan.

Systems

Service change is often seen as something that needs to be driven from the top by:

- developing new services
- reshaping existing services and
- improving access.

Many productive changes however can only be prompted at ground level where the detail of particular neighbourhood situations is known to residents and front-line workers. But the ability of those workers to act on the emergent issues depends also on change at a higher level, in the form of enlightened management:-

- are the front- line workers given sufficient flexibility to enter into joint problem-solving with residents and with other agencies?
- are the middle and senior managers geared to listen to the front-line experience and consider its implications for wider changes?

In order to make changes effectively, agencies need to:

- understand their populations
- communicate with them and
- become flexible and responsive to the populations they serve.

The neighbourhood partnership model opens the way to joining up not just budgets but real productivity:

- of people in their own neighbourhood
- between public services and the community
- between health and other services
- between public health and primary and acute care

This injects depth and energy into the place-based budget idea, making practical links with community participation and reviving the idea of empowering the front line.

More specifically the contribution of the HELP approach is that it:

- *helps the health services to reach disadvantaged people and reduce health inequalities*
- *fosters social networking, which is known to be intrinsically health giving*
- *channels community intelligence into health commissioning and helps communities to hold health agencies to account*
- *provides a natural way to mobilise other public services to contribute to health (whilst reciprocally benefitting their own concerns)*
- *leads to improvements in the conditions of disadvantaged neighbourhoods, which in turn contribute to improvements in health*
- *adds a collective dimension to patient and public involvement thus involving many more people.*

The HELP programme suggests that Health and Wellbeing Boards and their partners should commission two-year neighbourhood partnership development programmes in the 20% most disadvantaged neighbourhoods in the territory. This programme might consist of:-

- six months to map needs and provision
- year to establish or reinvigorate partnerships in priority neighbourhoodsa
- a year to consolidate the partnerships and extend their activities
- six months to evaluate, reprioritise and assess whether there is need for a next phase, either in these or other neighbourhoods.

The steps would include:-

- *establish baseline neighbourhood health profile in each priority neighbourhood,*
- *survey the level of social capital in terms of residents' views and the condition of local community organisations*
- *establish neighbourhood partnership and galvanise community activity*
- *add links to community engagement and public health outreach initiatives*
- *monitor outputs*
- *Assess changes annually in:*
  - *population health profile / selected health indicators*
  - *social capital (resident survey)*
  - *condition of the community sector*
- *Report annually to the commissioner and stakeholders.*

Skills

Applying the HELP method requires skilled facilitation. The amount of time required for this role depends on conditions in the community, the readiness of agencies to engage in the process, and on how well the facilitating role may fit with the remit of existing jobs or be an agreed extension of them.

Facilitation skills are required to achieve these objectives:

- *developing greater resident efficacy and increased volunteering, that comes from a sense of communities taking control of their situation*
- *development of social networks and improved social capital*
- *better feedback to decision-making within local agencies, influencing commissioning and deployment of health*
- *improved reach by public health professionals and programmes into local populations especially the most disadvantaged and most often excluded groups*
- *addressing problems identified by residents which are known to be key social health determinants such as housing and crime*
- *escalation of health up the scale of residents' priorities, by establishing trust and enabling a more open dialogue about health*
- *synergy with neighbourhood strategies of the local authority and other agencies.*

There is a set of National Occupational Standards for Community Development [19]which define this practice as:

- a long-term value-based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion.
- The process enables people to organise and work together to:
  - identify their own needs and aspirations
  - take action to exert influence on the decisions which affect their lives

- improve the quality of their own lives, the communities in which they live, and societies of which they are a part

Culture

The HELP approach is underpinned by an asset based philosophy. It shares with mainstream community development the experience that all local communities contain people who are capable, if necessary with support, of leading changes to improve their neighbourhood conditions and relationships. It also shares the conviction that the necessary changes are likely to be a mixture of internal change – relationships within the community itself – and negotiation with public services, who control so many important features of the locality.

Less common in community development are these features of the HELP approach:

- *the central objective of establishing a dynamic neighbourhood partnership within a two-year timeframe;*
- *seeing the front-line workers of the local public service as themselves likely to be in need of being brought together as a community of practice, developing their relationships both amongst themselves and then interactively with the residents;*
- *combining complete openness to residents' priorities with the knowledge that neighbourhood conditions are always to a large extent combinations of the social factors addressed by the major public agencies, and anticipating a coming-together of community and agency perspectives.*

The method approaches both residents and agency staff as human beings and dynamic players in local development. It fosters in fact not one community but two: the community of residents and a parallel local community of practice populated by professionals from local agencies. But since the professional agencies have a 'head start' in terms of organisation and resources, getting a true balance requires building up the leadership of the community participants. On the other hand, because agencies are institutions with fixed structures and rules, it can take more effort to introduce flexibility into the agencies' process, whilst residents, once active, can move flexibly to expand their horizon and agendas. But these two communities are welded together through the partnership mechanism so that, in the words of one community leader, they become 'us and us' instead of 'us and them'.

Leadership

The idea of leadership does not feature much in the HELP approach. There is a recognition of the need for sympathetic managers in local public service organisations, but little more beyond that.

Evidence

The HELP project undertook a wider ranging literature review of the effectiveness of community development[20]. In summary it arrived at the following conclusions:-

- *Community Development (CD) and Community Organising (CO) are techniques that support and increase social networks and that support and enhance participation. This increases social capital and assists associational life. CD and CO can support the process of co-production.*

- *There is a developing constellation of ideas that more flexible, place-based services are likely to offer more effective and efficient outcomes. To achieve this, statutory services will need to change and share power.*
- *There is strong evidence that strong social networks (SNs) protect people against the impact of stressors mental or physical. That is, strong SNs confer resilience. This appears to span a range of conditions, stressors and populations.*
- *Social networks have been shown to result in multiple beneficial outcomes, apart from health. These include improvements in crime rates and anti-social behaviour.*
- *The evidence seems clear that CD can improve community health through building social capital through building social networks. Such activity spreads to other aspects of civil life. Government can support this process.*
- *The evidence is clear that involvement of local people can make significant impact on the responsiveness of local services. CD is one of these effective approaches.*
- *It appears that community engagement and development are likely to have wide- ranging impacts on behaviour change.*
- *There are a variety of approaches to expressing a business case. So far as CD and community involvement is concerned, the difficulties are compounded because it is so difficult to express costs and benefits in monetary terms. Nonetheless, effective though complex techniques do exist. However, benefits can be problematic as they may take time to accumulate, impact on different stakeholders differently and also may benefit budgets other than those whose costs they are.*
- *The evidence available strongly supports the case that CD offers good value for money[20].*

Various attempts at calculating the 'cost / benefit' of community development approaches have been undertaken. An attempt to ascribe financial value to CD was made in a report from the New Economics Foundation commissioned by the Community Development Foundation in 2010 [21]. Using the Social Return on Investment (SROI) method, the report finds a social return to the value of £3.5m for an investment of £233,655 in community development activity by four local authorities, a return of 1:15 on the authorities' investment.

A review of the longer term effects of the first C2 project on the Beacon Estate in Penwerris, Cornwall, found major improvements between 1995 and 2000 in education, health, employment and crime [18]. Improvements appeared to outstrip national trends at the time, and the sense of an overall positive momentum of development driven by the project was attested in successive meetings of residents and service providers. The dynamic interaction of the physical and social improvements provided an impetus to self- generated improvement which it is claimed is still reaping rewards in 2011.

These calculations of the social return on investment , it is claimed, show that investment in neighbourhood partnerships by a health agency is highly cost-beneficial even purely in terms of reducing the cost of a number of specific treatments in a limited number of residents.

The financial value in terms of treatment, however, whilst important and reassuring, does not reflect the full significance of the intervention. Developing better relationships between health agencies and their communities is another fundamental and valuable part of long-term change in how communities function.

Innovation Forum – Improving the Future for Older People

(all the following material is taken, with slight amendments, from Henderson C [22])

The Innovation Forum (IF) was set up by the Office of the Deputy Prime Minister (ODPM) and the Local Government Association (LGA) in 2003. It was designed to provide a structure within which central government could come together with excellent-rated councils and pioneer new ways of delivering public services. There were a number of areas of focus. The one examined here had the principal purpose of prevent hospital admissions by promoting independence for older people and enabling them to experience a better quality of life in the community. This focus on better outcomes led to the project subsequently being entitled 'Improving Futures for Older People' (IFOP).

The project involved nine councils that had achieved an 'excellent' rating in the first comprehensive performance assessment exercise (CPA). Each agreed to take on a 'community leadership' role on behalf of their local residents to secure a coordinated approach from the NHS and other local statutory and voluntary partners. The project brief or 'commissioning template' for IFOP was developed jointly by Kent County Council and the Department of Health (2003), following widespread consultation and with the agreement of all nine authorities. It adopted a place-based perspective on improved outcomes, arguing that:

> *Older people thrive, retain their independence, maintain a quality of life, and stay healthy, when they live in good housing with access to a range of facilities (especially for transport, leisure and entertainment) and to families or friends. They may also need the services of a number of public agencies, sometimes only for the short-term.*

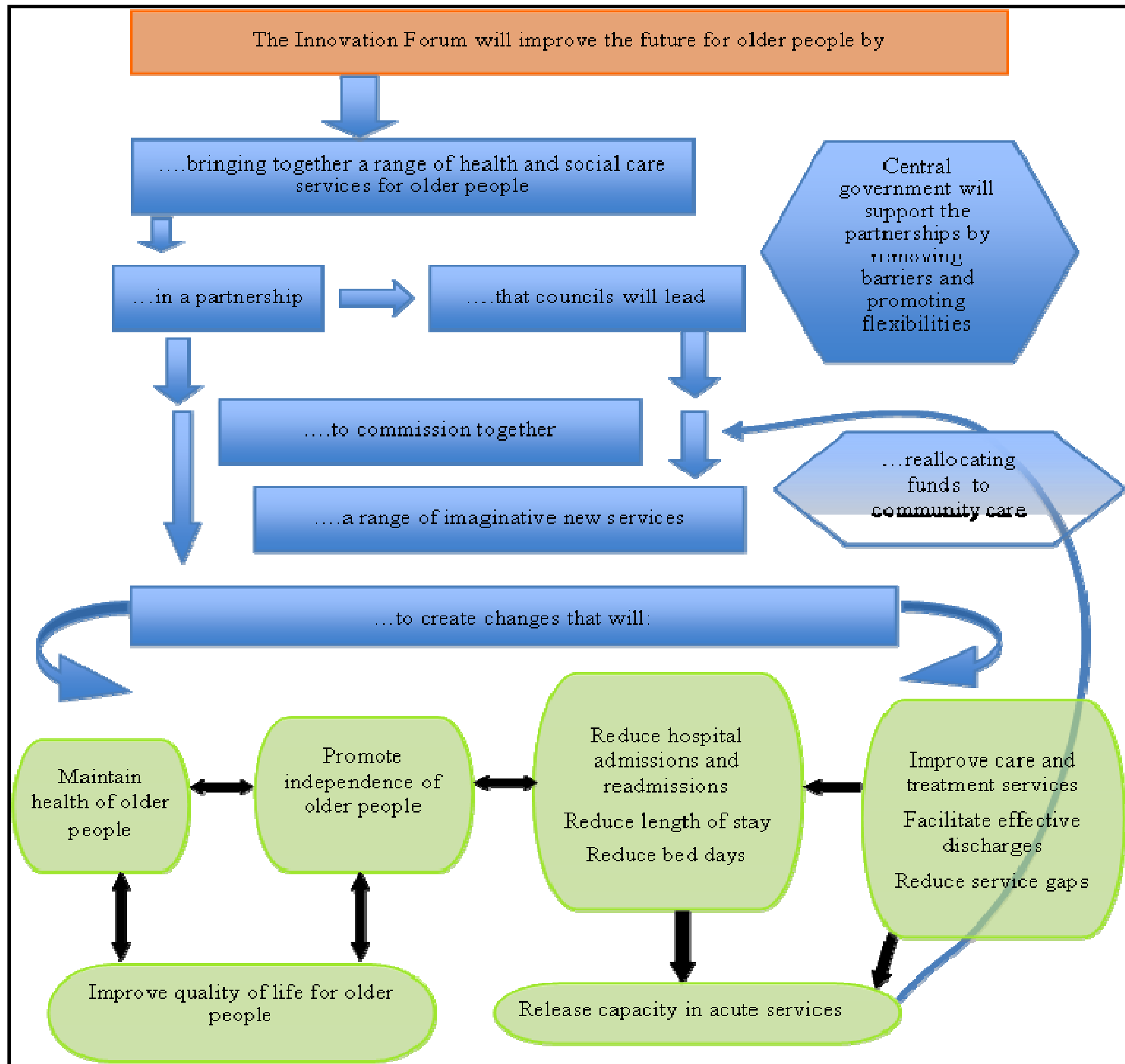
The IFOP programme would therefore, it was hoped, enable older people to live healthier and more independent lives, 'with greater choice of service, more means of support and increased community participation'. Fewer hospital admissions and shorter lengths of stay were seen as a means to a better quality of life. Specifically the nine local authorities agreed to achieve the 'headline target' of a 20% reduction in Emergency Bed Days (EBDs) for people aged 75 and over, over a three-year period from 2004 to 2007.

The 20% target was innovative and ambitious: neither local authorities nor the NHS had previously set any kind of numerical targets for reducing the use of acute hospitals; and the 20% level was seen as a figure that could reasonably be claimed to represent a significant level of achievement if it could be attained. Although it was not based on any kind of trend analysis or feasibility study within the IFOP authorities, there was an evidence- based rationale for choosing the 20% target. In general terms, there was growing evidence of acute hospital services 'being used inappropriately, either by people admitted to hospital when they could be cared for in alternative settings, or by people who are medically fit to leave but are unable to do so.....'. More specifically, the National Beds Inquiry had cited a study suggesting that the inappropriate use of hospital beds could be as great as 20%. The report also cited that study as evidence of 'inappropriate or avoidable' bed use 'if alternative facilities were in place'.

The pilot programme was based on a number of (more or less explicit) agreed and linked constructs as to what change was necessary to achieve the headline target (of reduced bed days) and associated core outcome (improving the quality of life of older people):

- *The IFOP programme partners argued that improvements in the quality of life for older people could be achieved by a focus on preventing dependence and promoting independence through the combined contribution of a wide range of community-based services and other resources mobilised through the structures and processes of whole systems commissioning.*
- *A reduction in hospital admissions and lengths of stay would also contribute to a better quality of life for older people because of the risks to health and independence associated with hospital care and the environment in which it was provided.*
- *From a service development and delivery perspective, improvements in the quality of life for older people could be secured through a range of interventions which aimed to: maintain the health of older people in the community, prevent avoidable hospital admissions by meeting their care needs in alternative ways, reduce lengths of stay when they were admitted to hospital, and facilitate effective discharge arrangements to reduce the possibility of readmission.*
- *Local authorities could adopt and operationalise a community leadership role to establish effective local partnerships capable of delivering a different balance of services and an improved quality of life for older people.*
- *These partnerships would effectively take the form of managed networks based on stronger horizontal connections at local levels of governance, organised around a single point of commissioning.*
- *A single measure would be adopted for the project: the realisation of a 20% reduction in the use of emergency bed days by older people aged 75 and over across the three years of 2004-07. The target was voluntary, negotiated and applied by the network of local councils and their local partners.*
- *The single headline target would be measured on a collective rather than individual authority basis to encourage collaboration and learning across a national network of nine councils and their partners, thereby avoiding some of the dysfunctional effects of national target setting.*
- *This national network and the local, council-led networks would be supported by central government acting to remove barriers and promote flexibilities in recognition that 'excellent' councils had earned the right to innovate and exercise a higher degree of autonomy.*
- *Vertical and horizontal networks tightly focussed on outcomes for particular populations but operating flexibly on the basis of shared objectives and mutual trust would provide an organisational environment that could deliver holistic care overcome historical disconnections between services[23].*

These elements can be summarised diagrammatically in the figure below.



Source: Wistow G [23]

Learning

Structures

Governance structures in the IFOP networks were essentially similar in a number of respects. The main decision-making body was a steering group of senior managers. Statutory bodies were much more strongly represented than other organisations, or users. IFOP networks operated in environments where other networks with closely-related remits were also operating. All the IFOP networks inherited and re-badged some of their projects for reducing unplanned bed-day use by older people from their member- organisations or from earlier networks, and so were constrained to some degree by existing managerial hierarchies. Each network had some structures for involving users, but these were somewhat marginal to the networks. Every network felt the need, above all, to respond to a complex set of policy mandates that bore more heavily upon their health than upon their local government member-organisations.

Where there were differences in governance structures, two main models were identified. One was a 'joined-at-the-top' model, where the member organisations' senior managers met to coordinate projects which remained owned, managed and implemented by those organisations severally and independently. This was a network of hierarchies. The other was a horizontal 'network-of-networks' model, where the IFOP network substantially relied on other external networks to implement its decisions and for critical inputs (such as user views) to those decisions. Both were clearly quasi-networks.

The researchers were able to draw some inferences around those structures necessary (though not always sufficient) for networks to achieve their objectives. These included:

- the necessity of a network-based implementation group;
- that localities should set up single networks to focus on specific discrete changes, rather than developing a number of competing networks with a similar remit;
- that there should be a 'joined-at-the-top' model of governance.

The Local Strategic Partnership governance structures in most of the sites were complex. Some sites had up to five layers of management. In many sites, there were subgroups tasked with delivering the Local Area Agreement outcomes or sub-outcomes. Not surprisingly, the number of layers of management and the number of steering or working subgroups increased with the number of smaller organisational units (district councils, PCTs) within the sites. All sites had some form of thematic block group related to population health, wellbeing and older people's services – often labelled as Healthy Communities and Older People (HCOP). There was a trend over the period from 2005 to 2007 to develop such subgroups, and to divide the tasks between public health- related outcomes and older people-specific outcomes.

Strategies

The majority of the service models and initiatives that sites introduced to address IFOP targets seemed to have multiple aims. These included:-

- preventing acute events and patients needing an emergency attendance at a hospital;
- diverting emergency attendees to services that provided community-based care;
- facilitating the timely hospital discharge of those patients that did need urgent care in a hospital bed.

The study's findings reinforced messages surrounding the delivery of high quality care that have been emphasised in previous research and policy papers, namely that:-

- *single-point-of-access telephone numbers should be encouraged;*
- *efforts are needed to increase the uptake of community care and treatment alternatives*
- *that community services should be are available 'out of hours'*
- *patients and carers should be involved in decision-making in regard to their hospital care, particularly in discharge planning.*
- *co-location of staff of different agencies and the development of cross-organisational networks at a practitioner level, would help practitioners to share learning and foster trust between agencies.*
- *the proposed (at the time of the report) creation of GP-led commissioning through consortia creates opportunities to strengthen links at practitioner level between primary, social and domiciliary care, with contract monitoring brought closer to the patient level[23].*

Systems

Most IFOP projects were funded and managed by PCTs and/or local authorities. Acute trusts were seldom perceived to take the lead in reducing acute bed day use by older people. Senior managers also indicated that relationships with the acute sector could be difficult. Acute trusts also tended to make up a small proportion of the membership of such groups. Given the pivotal position of acute hospitals in effecting change in terms of care pathways, this must be a concern.

It emerged from the evaluation that, overall, sites were either moving – or aspiring to move – towards an increasingly 'joined-up' approach to commissioning. Local Strategic Partnerships (LSPs) moved towards more elaborate management structures for public health and older people's services, separating the 'delivery' partnerships from their more general strategic partnership forums, which had much larger memberships and were less suited to implementing specific work-streams. In order to deliver on both cross-sectoral and organisational plans, health and social care partners looked at progressively more joint planning, and, more crucially, joint means of purchasing and contracting for services.

Skills

A lack of commissioning expertise and capacity within PCTs were the barriers most frequently identified as key barriers to 'shifting the money' from the acute sector to community health and social care. Lack of maturity in the NHS commissioning function has been identified as a hindrance to the progress of joint strategic commissioning across health and social care. The underdevelopment of joint commissioning poses a barrier to more integrated working. It appeared from the evaluation that joint commissioning was looked upon favourably as an integration mechanism by many senior managers involved in older people's services. This appears consistent with other partnership studies, where managers in health and social care agencies have seen such integrative mechanisms as useful in promoting, among other benefits, efficiency in commissioning and freeing up management thinking. Yet only two sites had committed to employing joint commissioners for older people's services in 2007/08, with more interest in joint commissioning boards rather than specific joint commissioner posts.

The qualitative evidence from key informant interviews sheds some light on the reasoning and the context for different stages of development of commissioning: there was a consensus that joint commissioning and pooled budgets were important. This showed a continued trend towards integration, even if some integration was planned or aspired to, rather more than implemented. Levels of trust appeared to be one important factor in integration. Other prerequisites were transparent planning and reporting structures, the infrastructure to gather required information for commissioning, and of course adequate funding levels.

Culture

The evaluation of IFOP did not focus much on cultural issues with the exception of the need to foster trust through the development of strong horizontal networks. Trust was seen as a key mechanism to combat the threat of increasing service fragmentation.

Leadership

The evaluation failed to find any simple correlation between leadership or governance models and the outcomes achieved. Strong governance conditions within networks did not necessarily predict successful achievement of outcomes. However leadership, or rather power issues, did appear to have an impact on what interventions the sites focused on. For example, the power and resources which member-organisations brought to the network influenced the choice of projects. This balance of power depended, upon whether the health organisations were numerous and fragmented.

Evidence

The nine councils that established the IFOP programme agreed that achievement of the headline target would be assessed across the programme as a whole, rather than at the level of the individual network. The 20% reduction in EBDs between 2004 and 2007 was collectively achieved. The IF sites' performance on EBDs, admissions and lengths of stay by older people (aged 75 years and over) was different from that of all other English PCTs. They had consistently lower EBDs per 1000 and lower admissions per 1000. But there was variation between sites.

The evaluation also examined patient journeys.

Adherence to IFOP goals would have been expected to generate care processes that delivered:-

- *patient-centred care*
- *timely access to appropriate preventative, assessment and treatment services with the goal of reducing avoidable acute bed use*
- *ready access to community and institutional services for supplying rehabilitation and long- term care;*
- *integrated working between all relevant service providers and adequate continuity of care.*

The evaluation did find examples of 'good practice' conforming with this vision, but also demonstrated many ways in which practice fell short of expectations These included:-

- *sub-optimal use of services for preventing crises and acute events*
- *a narrow range of services used in a crisis*
- *distrust of nursing staff*
- *concerns about poor communication between professionals*
- *delays in discharge*
- *carer burden[23].*

Supporting People Health Pilots

The Supporting People Health Pilots were designed to explore the potential for housing related support to benefit the physical and mental health of the community. There was an expectation that by providing housing related support within the community, that this would prevent the need for more intensive heath interventions later on. In this sense it was a programme which tested out a shift towards early action. There was a view within the Department of Communities and Local Government that community care services had tended to focus attention on those whose needs are greatest and that this had left a gap in the provision of low-intensity, preventive support, which the Supporting People Programme aimed to fill.

> *Low-intensity support can make a critical difference in enabling someone to remain in their own home and can prevent the development of further problems that would entail interventions by statutory services[24].*

There were six pilots, addressing the needs of a wide range of client groups. The distinctive feature of this programme was the focus on joint working between health and housing support providers.

Learning

Structures

Working across organisational boundaries was best achieved where there was a partnership approach based on joint working at both strategic and operational levels. It was felt that joint working was unlikely to be effective if those working at an operational level did not understand why they needed to work together. Similarly, without the support of those working at a strategic level, joint working at an operational level was unlikely to be successful. As well as understanding why they are working together, staff at both levels needed to be committed to the aims and objectives of the partnership, and develop strong linkages between these two levels.[24]

The pilots also demonstrated the importance of strong links between individuals working at the *same* level, whether strategic or operational and the importance of effective communication.

> *At the operational level effective partnership working depends on efficient systems that keep partners abreast of progress and that allow them to cross refer people who use services – or pass on information about them – in a timely manner. At the strategic level partners need to be able to discuss and resolve difficulties efficiently and effectively and ensure that the initiative is keyed into strategic planning processes[24].*

Systems

The experience of the pilots illustrates the importance of establishing processes for sharing information at a strategic and operational level. It also highlights the difficulties in doing so. At a strategic level agencies, particularly statutory agencies, need to be able to share data across organisational boundaries in order to evaluate the effectiveness of joint working and develop future plans and commissioning strategies. Without evidence of the impact of joint working on key targets or performance indicators it is unlikely that agencies will continue to prioritise, or indeed fund, such activities in a context of financial restraint.

Those pilots that developed new services demonstrated the importance of establishing effective ways of sharing data at an operational level. This is particularly important when services are supporting people with complex needs and often chaotic lifestyles. In these circumstances services need to be co-ordinated in a timely manner and based on up-to-date information. Most of the pilots decided to build on local practice, for example adapting existing 'release of information forms' which service users were asked to sign as proof that they had agreed to the pilot contacting other agencies as a means to seek or share relevant information.

Skills

The pilots demonstrated the important contribution that the voluntary sector can make in supporting vulnerable people to live independently in the community. First the involvement of the voluntary sector brought additional credibility to the work of several pilots. Secondly, as well as harnessing the expertise that exists within the voluntary sector, pilots were able to draw on their networks to support people to maintain their independence. Finally, the development of new services in the voluntary sector provided powerful models of how services could be provided outside of the confines of the statutory sector. The absence of specific organisational or professional allegiances appeared to enable pilot workers based in the voluntary sector to work more flexibly and intensively with service users.

Leadership

One of the key themes to emerge from the evaluation was the need for joint working to be based on clear arrangements in respect of governance and management responsibility. Transparent arrangements, agreed by all partners, ensure that staff understand to whom they are accountable and enable the work to be managed effectively. Someone needs to be ultimately accountable for the project. Evidence from the pilots indicated that confusion or diffusion of roles and responsibilities underpinned some of the problems that arose. The experiences of the pilots indicated that whilst it may appear rational to make joint services accountable to committees that are themselves 'joint' this too can diffuse responsibility. An alternative might be to ensure that joint initiatives are accountable to one organisation acting on behalf of all of the partners.

Evidence

There are many challenges inherent in framing work in terms of measurable outcomes. To do so, pilots had first to translate broad aims into discrete, measurable goals and then find ways of assessing their influence – as distinct from other factors – on those goals.

In most cases pilots came to the conclusion that it was unlikely that they could generate evidence that outcomes were directly and solely attributable to their work. What they could do was gather information about the likely contribution of the pilot, and the most sensible sources of such evidence were those whom the project had served, and those who had worked on or with the pilot. The process of establishing outcomes, even proxy outcomes, was useful in terms of building the evidence about whether or not there was a case for mainstreaming the project. Regular monitoring also prompted revisions and improvements in services in a timely fashion.

Local Area Co-ordination

Overview

Local Area Coordination (LAC)is a model which has been in existence in Australia for a number of years[25]. The Local Area Coordinator supports 50-65 individuals and their families who live in a defined local area. They provide a local, accessible and single point of contact for people of all ages who may be vulnerable due to age, disability or mental illness. They are the “front end” of the service system. They begin by helping people to be as strong and as connected as soon as possible - preventing problems and crises. They work by helping people to identify their own vision for a good life and ways to achieve it.
Building on a real relationship and a real presence within the local community the Local Area Coordinator will:

- help people identify their strengths and capacities to solve their own problems
- provide practical assistance to ensure crises are overcome or avoided
- help ensure people achieve their legitimate entitlements
- support people to maximise their contribution as citizens

Local area coordination claims that it is a preventative approach that can divert people from statutory services, increase independence, improve informal networks and community links and support people to achieve better outcomes. “*Without early intervention of the kind that local area coordinators can provide, crises will develop in people’s lives that will require more expensive intervention, individuals may experience barriers in accessing appropriate support and more people will require statutory services*”.[26]

There are currently about 80 LAC schemes in Scotland and 4 in England.

National guidance in Scotland [26] claims that Local Area Coordination:-

- has a strong base in the community
- is available for children and adults
- is based on an established set of principles and is defined by the outcomes it will achieve
- will enhance community supports as part of an overall reorientation of investment and provision
- is different from care management
- Local area coordinators have strong strategic links with health, education, social work and the voluntary sector
- Local area coordinators work directly with individuals and families but are integrated into, not marginal to, service systems and mainstream budgets.

Learning

Structures

LAC does not rely on changing the normal public sector structures. In other words there is little attention to reconfiguration of health, housing or social care organisational arrangements. Proponents of LAC claim that is more about the practical application of a powerful set of values. It is an asset based approach which does not see people as fundamentally needy. Instead it starts with the assumption that people have gifts and the right to shape and control their own lives.

A particular 'operating framework' is advocated[27]which includes:-

- Vision
- Principles and values
- Objectives
- Target groups and geographical areas
- Performance indicators
- Charter or mission
- Outcomes
- Programme strategies
- Quality framework including key risks

The Framework supports not only the effective design, development and implementation of Local Area Coordination, but also maintains programme clarity, integrity, accountability and quality.

Strategies

Local Area Coordination assumes that people have the expertise and the strength to plan and control their own lives and to make a positive contribution to the well-being of their community.

> *The gifts and assets of individuals, alongside those of their family, personal networks and their local community form the bedrock of their vision for a good life*[27].

Typically the current system focuses on "What services or money do people need?". Local Area Coordination (LAC) asks a more fundamental question: "What is your vision for a good life and how you can get there?" [27]

Systems

Local Area Coordination is a way of recognising that people are not passive "clients", "service users" or "customers" of a social care system. It puts professionals in new roles: working alongside people. Local Area Coordinators have a remit to nurture local solutions and keep people strong. They help people to access services where they are required, but they see services as the last thing to consider, not the first. [27]
LAC turns the existing system on its head and drives positive cultural change across the whole system by putting a greater emphasis on:

- Recognising the gifts, assets and contributions of local people
- Building stronger and more inclusive communities
- Promoting citizen and family leadership
- Working with communities to support inclusion and mutual contribution
- Planning for the future, staying resilient and well-connected
- Supporting people to achieve their fundamental aspirations

This is a fundamental change in both organisation and values. It is not achieved by simply renaming existing systems or by organisational restructuring. It is an approach which[27]:-

- ***starts at the start*** *- a Local Area Coordinator, from within their own local community, provides information, advice and support to help people solve their own problems*
- ***asks the right questions*** *- instead of focusing on deficits the Local Area Coordinator helps people focus on their own vision for a good life, building on their own assets and relationships*
- ***acts as a bridge to community*** *- the Local Area Coordinator builds real relationships*

with people, the local community and its multiple resources, spotting and creating new opportunities.

- ***transforms local systems*** *- the Local Area Coordinator helps people make good use of necessary services and helps to transform the impact of services on local communities.*

LAC moves the "front end" of the service system from "assessment, funding and services" to "prevention, capacity building and local, practical solutions." It diverts people from the service system and instead helps people build their capacity to become more self- sufficient and to stay strong. [27]

LAC challenges the existing system on its head by putting a greater emphasis on:

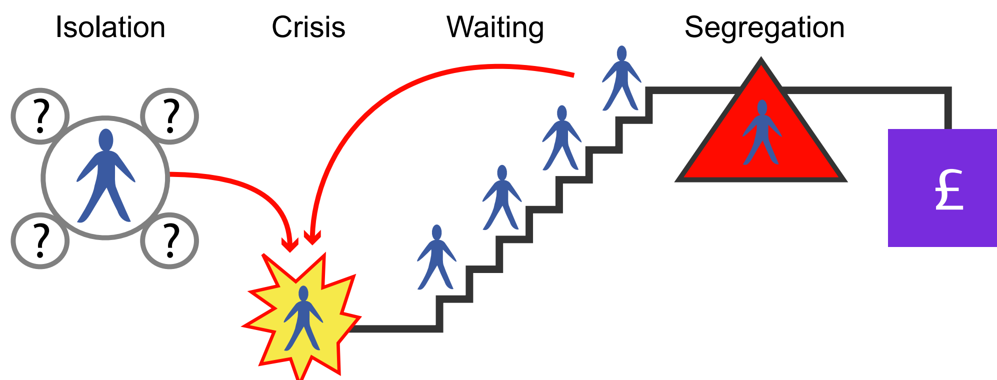
- Recognising the gifts, assets and contributions of local people
- Building stronger and more inclusive communities
- Promoting citizen and family leadership
- Working with communities to support inclusion and mutual contribution
- Planning for the future, staying resilient and well-connected
- Supporting people to achieve their fundamental aspirations

LAC is an approach that integrates a range of existing roles (usually provided by a range of different people) and delivers them locally in partnership with local people and communities. Proponents of LAC argue that the current system (see figure below):

1. leaves people in isolation as problems grow
2. only reacts when there is a crisis
3. waits until people's needs climb above the eligibility threshold
4. segregates people within services, cut-off from their community

This system drives up costs and reduces the chances of solutions that build citizenship and stronger communities.

Figure: Typical service response to need



Taken from Broad [27]

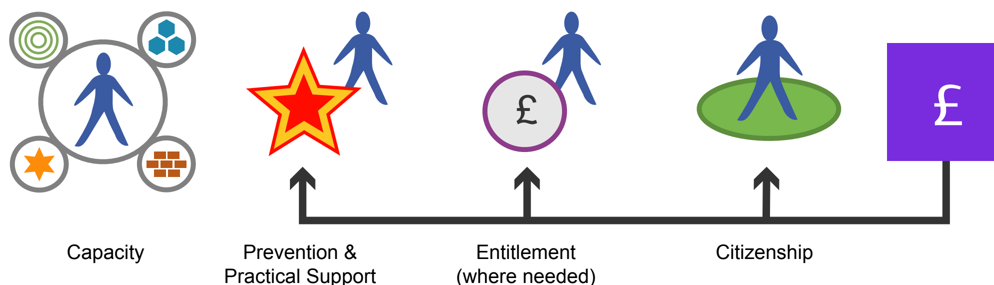
© Positive Ageing Associates

It is argued that LAC reverses the standard pattern of delayed response. Instead, the Local Area Coordinator focuses on developing a trusting, ongoing relationship with local people and with their community. They work pro-actively to support people to stay strong and support the development of solutions that don't require professional services.

Building on relationships and a presence within the local community the Local Area Coordinator will (see figure below):

1. help people identify their strengths and capacities to solve their own problems
2. provide practical assistance to ensure crises are overcome or avoided
3. help ensure people achieve their legitimate entitlements
4. support people to maximise their contribution as citizens

Figure: Local Area Coordination preventing need



Taken from Broad [27]

Eddie Bartnik, who originally developed Local Area Coordination in Western Australia, described it as an approach that "*turns the traditional system on its head and changes the power balance. Rather than fitting people into a predetermined menu of services, support is built one person at a time, in the context of their family, friends and community. The focus is on choice and control for individuals in decision making*." [28]

Skills

Evaluation of LAC implementation in Scotland[29] emphasised that the values, skills and qualities of local area coordinators are more important than formal qualifications.
Local area coordinators have been found to need[26]: -

- complex and diverse skills
- the ability to be self directing
- high motivation
- the confidence and authority to challenge other service providers
- appropriate acknowledgement and remuneration to ensure that local area coordinators obtain credibility in a professional environment

It is skilled work that integrates many of the skills that may be found in other service roles:

- information and advice work
- community building

- personal network development
- community asset mapping
- brokerage
- support planning or person-centred planning
- advocacy
- community based social work
- service coordination
- community development

However what makes the Local Area Coordinators' (LACs) role unique is the combination of these roles and the tight connection to a limited number of people in a geographical community as a single, local, accessible point of contact. As such the role demands an integration of different approaches, precisely because it is not being spread over too wide an area or being disconnected from real communities. [27]

Experience in Scotland has shown that Local Area Co-ordinators appreciate training on community capacity building and the creation of neighbourhood resources to provide natural supports for individuals and families.

The Local Area Coordinator role requires people with the right qualities, skills and attitudes which include[27]:

- *a "can do" approach - displaying creativity and the ability to take the initiative*
- *local knowledge and a real commitment to local people and communities*
- *someone living in the area - embedded in the community*
- *good at building relationships with people*
- *the functional skills to do the job*

In Scotland they have instituted national training and Action Learning Sets to promote skill development.

Evaluation in Scotland[29] has shown that:-

- *The degree to which local area coordinators are equipped (i.e. suitable office facilities), trained, remunerated and empowered to do the job.*
- *Local area coordinators' values and commitment to inclusiveness, empowerment and acknowledgement of the natural authority of families, was identified to be fundamental to the success of local area coordination.*
- *The extent to which local area coordinators have time to build relationships with individuals and families to help them to identify their own needs and work toward change in their lives. This is dependent on local area coordinators having manageable numbers of people to work with (The same as you? recommendation of 50) and how many local area coordinator posts there are in each local authority area.*
- *The extent to which local area coordinators are able to concentrate on their core functions rather than being asked to carry out a diverse range of task.*

Culture

The culture underpinning Local Area Co-ordination is an asset based philosophy which seeks to shift attention from deficits to strengths. Local Area Coordination is built on seven principles[25]:

1. ***Citizenship** - with all its responsibilities and opportunities*
2. ***Relationships** - the importance of personal networks and families*
3. ***Information** - supporting decision-making*
4. ***Gifts -** all that individuals, families and communities bring*
5. ***Expertise** - the knowledge held by people and their families*
6. ***Leadership** - the right to plan, choose and control your own life and support*
7. ***Services** - as a back up to natural support*

The culture change is cogently expressed by Broad[27]

> *We don't just need a change in perspective about the goal - from needy person to citizen - we also need to take a different perspective on the means by which we achieve citizenship. Citizenship is not achieved through services - it is achieved by building on the capacities that we too often take for granted, what Murray calls our Real Wealth (Murray, 2003). The capacities which everyone of us has, but which too often we take for granted.*

Taken from Broad [27]

The Local Area Coordinator takes the time to get to know people and build positive, trusting relationships. This relationship enables them to provide support that is flexible and responsive, and fits the context of an individual's family and community life. Local Area Coordinator can then support people to:

1. Develop their own vision for a good life
2. Recognise their own strengths and real wealth
3. Get information about what is available
4. Make use of and build on their own networks
5. Strengthen their voice
6. Take practical action for change
7. Create new opportunities within the community
8. Use local services and personal funding where relevant

Leadership

Local Area Co-ordination does not have much to say about leadership. This is because its philosophy is very much 'bottom up' and one which is based on an asset based approach which emphasizes the need to build on local strengths. That having been said, evaluation in Scotland[26] has cited the following leadership elements as being crucial:-

- Strategic vision and support for the service from the Director of Community Services
- Managerial role combines leadership with front-line work, ensuring that development is informed by direct contact with people.

Other evaluation [29] identified other leadership factors as impacting on the success of local area coordination, i.e.:

- The commitment of senior managers.
- A clear definition and understanding of the role by local area coordinators themselves, their managers, other local authority staff, service providers and individuals and families.
- The extent of confusion and/or tension between the local area coordinators role and that of social work/ care management.

Evidence

There have been over 20 evaluations across Australia and internationally, including an independent review of previous literature and evaluations[30]. Generally evaluations have showed that, where fully implemented, there has been strong evidence of a range of consistent and positive outcomes for individuals and families.[27] They have also tended to show that LAC programmes reduced demand for formal services by:

- having a primary focus on informal supports and networks
- supporting people to identify, develop and utilise personal, family and community assets to develop practical and non-service responses to needs
- nurturing mutual support
- 'leveraging' other generic supports, and reducing the demand for specialist disability services
- providing timely, relevant, accessible information to support decision making and control

Other positive outcomes have been shown to include [26, 30-32]:-

- Cost per service user 35% lower than the national average – significantly increased coverage within existing resources
- Cases of people diverted from crisis and more expensive services
- Value for money
- High value of long term local, accessible, support and relationship
- Preventing people from unnecessary out-of-home placements
- Increasing the capacity of families to continuing care
- Increasing independence, self sufficiency and community contribution
- Improved access to information
- Development of increasing informal support networks
- Improved access to specialist supports if required
- LAC support to families to access alternative funding streams
- Substantially improved coverage of support to people across the region
- Contribution to reform of services and specialist roles – rebalancing funding and system
- Improved outcomes for individuals, families and communities

Evaluation of early implementation of LAC in Scotland[29] indicated the following key implementation lessons:-

Capacity Building
Relatively little time was spent on community capacity building, although it was deemed important within the overall ethos of LAC. In only six of the 24 authorities did LACs claim to have made significant progress in that area. Apart from lack of time and the fact that community capacity building is a long term process, disinterest and sometimes resistance was reported among some local communities. Where progress had been made, this may be linked to more welcoming communities, the LACs having a strategic base in the area, their previous knowledge of the locality and/or their community development background.

Role confusion
About two thirds were aware of ongoing confusion and/or tension between the LAC role and that of social work/care management, although the relationship could work well where activities were accepted as complementary. In some areas, LACs have been drawn into care management procedures and it appears that in at least three authorities, LACs acted as care managers for part, or all, of their role. Collaboration with other agencies was unevenly developed. Partnership with the voluntary sector was generally better advanced than with statutory organisations.

Managerial sign up
Overall, line and operational managers had mixed views about the efficacy of local area co-ordination, although generally welcoming it. Those who were enthusiastic, were extremely so, largely attributing this to the skills and experience of the workers they had recruited into the posts. Where others were more skeptical, this was often due to the shortage of other resources within the local authority and the requirement that they managed this shortfall. It was in such contexts that LAC was viewed as a ‘luxury’ rather than a necessary resource.

Cultural Concerns
Many had concerns about adopting the model in practice, not least in transplanting it from Australia to Scotland where different social, cultural and governmental structures were in place. Many respondents highlighted a need for debate at national level about how certain aspects of the LAC ethos relate to the structural and political context of Scotland, as distinct from that of Australia, notably in relation to: the development of LAC without a reduction in the provision of social work and health services to those who need them; appropriate provision of family support; and a realistic approach to the development of community capacity building.

Health Action Zones (HAZ)

Overview

Health Action Zones were launched in 1998 by the new Labour Government as an area-based initiative to reduce the effects of persistent disadvantages in neighbourhoods where poverty and neglect were endemic. The government were seeking to find new ways to address intractable health problems through building cross sector capacity for collaboration, breaking down organisational barriers to create services that were more responsive to patient and public needs. Twenty six areas were selected to act as pilots over a seven year period, 15 in 1998 and a further 11 in 1999. The aim of the initiative was to provoke radical change among providers of health and social care services; changes that would result in improvements to the way providers and others in public, private and voluntary services worked together to improve health and reduce health inequalities. Participating areas were expected to be 'trailblazers' of new ways of working and to act as a stimulus for learning for others.

The 26 HAZs varied in size and complexity, and in their approach and the areas they chose to focus on. Common factors were the emphasis on local collaboration and partnership. Investment in pilot areas fell into 4 broad categories:

i. Addressing the social and economic determinants of health
ii. Promoting healthy lifestyles
iii. Empowering communities
iv. Improving health and social care services

and three distinct approaches emerged:

i. A focus on tackling the root causes of ill health and reducing health inequalities.
ii. An equity focus within an agenda to modernise health and social care provision.
iii. A primary focus - improving health in the 'zone' and reducing inequalities in health in the 'zone' against the national average.

Evaluation

An extensive evaluation programme was commissioned using a number of providers and numerous papers exist describing and commenting on the HAZ initiative including a 2009 Parliamentary Sub Committee on Health Inequalities which looked at the impact of government action to address health inequalities between 1998 and 2006. Evaluation studies, using a theory of change and realist evaluation approach, looked at:

i. Monitoring across all HAZs
ii. Capacity for collaborating (5 case studies)
iii. Whole system change (8 case studies)
iv. Progress in tackling health inequalities (3 HAZ area)

Evidence of direct impact on health inequalities was limited due to the relatively short lifetime of the pilots. In addition the complexity and scale of the initiative and many policy changes that forced a change of direction or emphasis made evaluation of impact difficult. However there was general agreement that, despite many flaws in the programme and difficulties experienced by the participating areas , HAZs did push health inequalities up the agenda locally and broadened the understanding of the wider determinants of health. As an approach they contributed to the development of ongoing partnerships and improved some mainstream services.

Learning

Much criticism has been levelled at the programme, from participants as well as commentators. Learning points include:

i. Insufficient funding for the level of ambition expected, the scale of the challenge and geographic size/population of participating areas.
ii. Insufficient support for HAZs over the lifetime of the programme and a lack of clear direction from the centre.
iii. Changes to funding regime and allocations mid way through and in the latter part of the programme.
iv. Changes in policy direction and levels of interest within central government policy makers (DH) led to loss of motivation locally.
v. The timescale for the programme was too short to deliver any significant impact on local health inequalities.
vi. Highly ambitious targets and pressure for 'quick wins' from policy makers affected local choices.
vii. Lack of significant and specific knowledge of health inequalities locally and of successful approaches to reducing health inequalities.

Additional difficulties were caused by changes to funding arrangements and the freedoms of local areas to determine their own objectives, by 2001 the DH had changed the programme to bring it in line with other national changes to the health system and it was wound up early in 2003.

Structures

Local complexity was a significant indicator of local success. Areas where local organisations were coterminous were able to develop their local programmes more quickly and with more impact. This was particularly true where strong partnerships already existed that could provide leadership for the HAZ programme. However the qualitative nature of local partnerships and relationships was also a significant factor, aspects of this included:

- structure and nature of existing partnerships.
- history of relationships between key players e.g. local government and health
- levels of inclusivity concerning the voluntary and community sector and extent to which they felt themselves to be, and were seen by other partners, to be equal with other partners.
- where dominance and power lay, in local partnership arrangements and between different organisations, and individuals.

Structures are unique to localities and it is difficult to develop or operate to a set model. Complexity at the local structural level may relate to national, regional or local arrangements; to the multiple local health, local authority, local provider and local community/voluntary arrangements; to unique individuals and their layers of influence, power and interest. These may change over time as policy moves on.

Strategies

The HAZ programme evaluation suggested that those areas that sought to integrate the HAZ approach into their mainstream operations and strategies had more success than those who set up discrete 'HAZ' projects and plans. This is particularly important in the context of changing priorities (local and national) and vulnerability of funding. Understanding how and where to integrate into, and show support for, other significant local strategies and priorities, such as regeneration, is helpful in retaining resources and capacity. Ensuring a broad understanding of objectives and how these fit into mainstream policy objectives and priorities is also essential in maintaining local support. In a health and wellbeing context this includes the ability to articulate an holistic, whole person, view which acknowledges the complex needs and challenges that no single agency can solve.

Systems

Changing national priorities had a major impact on the HAZ programme. This caused national - local tension arising from significant differences in interpretation. Pressure to conform to particular national policy objectives did not reflect local expediency and the HAZ programme became a 'moveable feast' . National policy drivers for clear 'early wins' put pressure on local participants to deliver outcomes far earlier than was feasible. Accounting for the fact that local participants were already taking action on health inequalities and outcomes made charting success and improvement difficult.

Skills

Two key issues seem to emerge here. The first is the need for a package of skills to properly manage and lead initiatives of this type. Skill areas identified as necessary and as lacking in some areas included:

- outcome management
- logical planning processes
- evaluation skills
- whole system approaches to service planning
- community development
- programme and project management

A broader 'labour market' issue also emerged as significant. In some areas of low turnover, where the labour market is static, resistance to change can be an issue. Conversely in areas of high turnover where retention is an issue, key personalities and players can move in and out of the local system too quickly with an adverse impact on continuity and availability of key skills and knowledge. Finally it was noted that in some areas a few key players moved around, in and out of positions in different parts of the local system. This had an impact on dynamics between organisations.

Culture

Cultural tensions locally between organisations had an impact on local partnership effectiveness. In some areas the extent to which local partnerships were open or closed to the voluntary or community organisations made a difference to the quality of local partnerships. Participants in the programme acknowledged the importance of all parties feeling included and having a role to play.

Participants spoke of valuing the breathing space that the reflective approach required by the HAZ process enabled and the emphasis on learning from experience, although the profile of this within individual HAZ areas depended on the commitment within individual organisations to promote learning. Tensions existed around the pressure to deliver results and the opportunity to experiment and learn from failure, the more confident the local partnership the more likely they were to be able to tolerate failure and treat it as a learning opportunity.
Some of the HAZ areas sought to integrate HAZ actions into broader partnership boards, this enabled HAZ objectives and programmes to be incorporated into mainstream priorities locally. Mainstreaming has the potential to deliver greater benefits but is more challenging to manage. Grant funded initiatives often fall naturally into discrete projects, sometimes this is required to maintain separate accounting and reporting to funders. However more impact is likely to be gained, and positive changes be more sustained, if initiatives are mainstreamed from the start.

Leadership

Partnership initiatives require dispersed leadership where time is spent building productive and inclusive relationships. Effective leadership will maintain focus and drive when outcomes take time to deliver but it is important that the stated goals benefit all and are not disproportionate to the leading organisation. Efforts must be made and maintained to ensure the roles of the community, users and patients are recognised.

Evidence

For HAZs a poor evidence base increased the risks and limited the opportunity for innovation and doing things differently. A supportive structure for risk taking and learning from failure was present in some areas and helped deliver either better results or a more sophisticated understanding of the capacity needed to address health inequalities. Variation of action between the participating areas and created a difficult context for evaluation which, when coupled with the timeframe disparity, made it difficult to find evidence of reduced health inequalities especially in the areas where there was a focus on early or upstream intervention. Evaluation processes and skills need to be built in to generate the evidence base for future actions.

Family Intervention Projects

A national network of Family Intervention Projects (FIPs) was set up as part of the Respect Action Plan, launched in January 2006. These projects aimed to reduce anti-social behaviour (ASB) perpetrated by the most anti-social and challenging families, prevent cycles of homelessness due to ASB and achieve the five Every Child Matters outcomes for children and young people. FIPs use an 'assertive' and 'persistent' style of working to challenge and support families to address the root causes of their ASB. There are different ways in which the service can be delivered: outreach support to families in their own home; support in temporary (non-secure) accommodation located in the community – the dispersed option; and 24 hour support in a residential core unit where the family live with project staff.

53 FIPs were set up during 2006 and 2007. Typically FIPs were working with families in their own homes for between six to 12 months. Most projects were either being run by a team within the Local Authority (LA) or a voluntary sector provider.

FIPs have been set up to reduce ASB perpetrated by families, prevent cycles of homelessness and achieve the five Every Child Matters outcomes for children and young people, with a specific focus on:

- *Improving children and young people's attendance and behaviour at school, and reducing the level of truancy and exclusion.*
- *Reducing the prevalence of teenage pregnancy and tackling broader sexual health issues.*
- *Reducing alcohol, drug and volatile substance misuse of both children and young people and their parents, as well as a focus on other key public health areas, such as obesity and smoking.*
- *Reducing the number of young people not in education, employment or training.*

A number of core features distinguish the FIP approach:

- *A focus on the most problematic families persistently perpetrating ASB and who are at risk of losing their homes.*
- *A whole family approach which recognises the inter-connectedness between problems faced by different family members.*
- *A dedicated key worker with a small caseload of families. Their role is to manage or 'grip' the family's problems, co-ordinate the delivery of services and - using a combination of support and sanctions, as well as an assertive and persistent style of working – motivate the family to change their behaviour.*

A contract is set between the family and the project, outlining the support to be offered and the changes in behaviour required of the family. This is reviewed on a regular basis. Sanctions are used (e.g. demoting tenancies, gaining possession orders suspended on the basis of compliance with the project, taking children into care) to motivate families to change their behaviour. Parenting skills are addressed using an evidence based parenting programme[33].

Learning

Based on detailed evaluation[33] it was concluded that there were eight features of the FIP model that are critical to its success:

1. recruitment and retention of high quality staff
2. small caseloads
3. a dedicated key worker who manages a family and works intensively with them
4. a whole-family approach
5. staying involved for as long as necessary
6. scope to use resources creatively
7. using sanctions with support
8. effective multi-agency relationships.

Structures

Partnership working

FIPs were designed to work in partnership with a wide range of different statutory and voluntary agencies who were either to refer families to the FIP and/or co- work with families alongside the FIP in a complementary way. The evaluation of the programme[33] found that:-

> *While there was a good deal of variation between FIPs in terms of which agency relationships were stronger and weaker, those that emerged as particularly strong across projects were with schools; housing officers; the police; ASB teams and the YOS. Relationships with health and social care emerged as weakest, although distinctions were drawn between different parts of the health service.*
>
> *A number of contextual factors influenced the extent to which FIPs were able to establish good working relationships with other agencies. These included the quality of multi agency relationships locally, the time and resources other professionals had to work with the FIP, and the extent to which links at a strategic level 'filtered down' to frontline workers.*
>
> *Attitudinal factors also influenced the extent to which other professionals had 'bought in' to FIPs. For example, they may have questioned the role, ethos or expertise of the FIP, or seen it as 'treading on the toes' of the professionals already involved.*
>
> *A lack of 'buy in' to FIPs could be manifested in other professionals' behaviour in a range of ways, including a lack of referrals, inappropriate referrals, or a reluctance to share information or work together.*
>
> *Local agency partners and FIP staff reported three types of impacts on other services: breaking down the barriers between families and services; reducing the burden on services; and improving multi-agency working (although this depended on the culture of multi-agency working already in existence)[33].*

The level of partnership working with other agencies was quite expensive, as indicated by the following table:

Key agencies and individuals that refer families and / or co-work with FIPs

Agencies and individuals	who refer to FIP	who co-work with FIP
Housing, including LA housing department, Housing Association/Registered Social Landlord (RSL), private landlords and homelessness prevention services	✓	✓
Police, including Police Officers, Police Community Support Officers (PCSOs) and Neighbourhood Wardens	✓	✓
ASB/ Community Safety enforcement officers	✓	✓
Social care including social services	✓	✓
Education, including education welfare, educational psychology and Pupil Referral Units (PRUs)	✓	✓
Youth Offending Service (YOS) – Youth Offending Team (YOT), Preventing Youth Offending Project (PYOP), Youth Inclusion Project (YIP), Youth Inclusion and Support Panel (YISP).	✓	✓
Health – GPs, Child and Adult Mental Health Services (CAMHS), adult mental health services, school nurses, health visitors alcohol and drug support and advisory services, teenage pregnancy interventions, counselling, family therapy, behavioural psychology and anger management	✓[4]	✓
Parenting providers		✓
JobCentre Plus		✓
Connexions	✓	✓
Probation service	✓	✓
Domestic violence support services	✓	✓
Fire service[5]	✓	✓
Providers of leisure/recreational activities[6]		✓
Childcare providers		✓
Environmental health	✓	
Citizens Advice Bureau	✓	
Home/garden maintenance and support providers		✓

Source: White C [33]

Within the broad headings of ‘referral’ and ‘co-working’ FIP staff reported a range of different ways in which they worked with professionals in other agencies.

Promotion and marketing of the FIP to raise awareness of the role of the FIP and its referral criteria and process. *This included presentations to strategic leads, managers and frontline staff within other agencies; publicity material; road shows; open days consisting of workshops/training and information sessions; and launch events.*

Engaged in multi-agency meetings. *These included steering groups, referral assessment panels and support plan meetings for particular families (see Chapter 4), child protection or ‘child in need’ case conferences convened by social services; school-convened conferences about particular children; and other multi-agency fora, e.g. to discuss ASB in the area more generally.*

Informal contacts to discuss families. *This type of contact typically involved sharing specific information in relation to families in connection with referral procedures or ongoing monitoring work. A shared database or access to a database to monitor any contacts, any*

incidents, or complaints had sometimes been set up.

Joint visits to families *made by the FIP key worker and, for example, a housing officer, to discuss tenancy issues; or a FIP key worker and a social worker to address issues around child protection.*

Jointly run activities *where, for example, activities for young people had been planned and run jointly by FIP key workers and youth workers based in the Youth Inclusion Project (YIP).*

Shared responsibility for a family such as in the case of a *key worker and a family aide based in social services had agreed to share responsibility for supervising a family's morning and evening routines in the home[33].*

Partnership arrangements varied but FIP managers typically reported having a steering group, which included a representative of the LA department in which the project was located as well as senior-level representatives of key partner agencies. The core roles of the steering group tended to be monitoring the FIP's budget and development, and supporting good relations between FIP staff and other agencies. In addition steering groups had sometimes taken on a number of other tasks, including considering referrals to the project. Some FIPs had two steering groups, which were responsible for tackling strategic-level and operational-level issues respectively. Exceptionally, a FIP may have reported to a more general multi-agency ASB panel, rather than its own dedicated steering group.

The ease with which FIPs were able to establish relationships and secure 'buy in' from other agencies depended on two related issues – the local context in which a FIP was operating and the attitudes of professionals towards a FIP.

The degree to which a FIP was embedded within a team or department appeared to underpin the extent to which the location was viewed as important. For example, staff working in FIPs based in ASB departments could feel that their location helped secure vital links with ASB enforcement officers, while those based in Children's Services felt similarly about working closely with social workers.

Staff working in YOS-based FIPs saw their projects as having a particular advantage by virtue of being located within a pre-existing team made up of seconded staff from a wide range of relevant agencies. They described how they were able to access a wealth of information on families from the shared YOS database, and from other staff within the YOS who would very often have first-hand knowledge of families referred to the FIP. Locating the FIP here was seen as providing staff with access to a sympathetic source of information, support and advice from professionals working in a comparable way with challenging families. This could be accessed on an informal basis as the FIP was seen as a part of the same overall structure, and staff were sitting in close proximity to the rest of the YOS. It was also perceived to have benefits in terms of facilitating access for FIP family members to a range of important services, including some that, it was felt, might be difficult to access quickly were the FIP based elsewhere (e.g. mental health or substance misuse services)[33].

Although partnership working was generally effective there were a number of areas or issues which gave cause for concern. A reluctance amongst certain services (e.g. health and social services) to refer families to a FIP was suggested as a reason why projects found it difficult to reach their target families. A number of reasons for this reluctance were given[33].

Professionals did not think a FIP could offer anything different to the service provided by other agencies, possibly because they did not understand what FIPs were trying to achieve.

Agencies did not 'buy in' to the principle of multi-agency working. These agencies were seen as isolating themselves from other services, offering their independent support to families but not involving other agencies in order to meet the needs of all family members. This was particularly seen as an issue with healthcare professionals.

Agencies did not accept or respect a FIP because, for example, they were skeptical about the credentials and qualifications of FIP staff, they considered the FIP to be 'treading on toes' or they were resistant to the FIP 'ethos'[33].

The evaluation found that there was a good deal of variation in the ease with which FIPs were able to establish effective co-working relationships with statutory agencies.

The relationships that emerged as particularly positive were those with housing, education and the Youth Offending Service. The qualitative evidence indicates that these relationships were typified by frequent contact and a flow of information in both directions, as well as a mutual valuing and respect between agencies.

In contrast, health and social services were among the more difficult agencies for FIPs to work with. Social services were reported as the agency that was hardest to lever-in support from compared with any other agency. A distinction was, however, drawn between different parts of the health service, with staff working in areas such as mental health and substance misuse support described as more engaged, on the grounds that they saw the work of FIPs as directly relevant to them. There were also reports of some good relationships with individual health workers, especially GPs, health visitors and school nurses[33].

The evaluation[33] concluded that the ease with which FIPs were able to establish relationships and secure 'buy in' from other agencies depended on two related issues – the local context in which the FIP was operating and the attitudes of professionals towards the FIP.

Local Context
The local context was largely but not completely determined by seven instrumental factors.

*The **extent to which a culture of multi-agency working had been previously developed** locally. Where multi-agency working was already happening (e.g. where information-sharing protocols and/or multi-agency fora had been established) FIPs were particularly well-placed to establish or enhance multi- agency relationships.*

*The **length of time the FIP had been in operation** as this had a bearing on the opportunities they had to establish and build links with other agencies. For this reason the more established FIPs were further advanced in creating these links. Some of the newer FIPs felt they had been under pressure from the RTF to start working with families before multi-agency links had been fully established, which had caused them problems in the early stages.*

The amount of time and resources that other services had to work alongside the FIP. *FIP staff had encountered problems in terms of professionals not attending meetings, not returning phone calls, or requiring a lot of chasing to fulfill their responsibilities in relation to families' support plans. These sorts of challenges were particularly associated with social workers, as they received the highest 'dissatisfaction rating' from FIP staff in relation to the ease of levering-in support. While these* difficulties were partly attributed to a negative attitude towards the FIP, FIP staff also reflected that they at least partly resulted from the intense pressure some professionals were under.

The quality of the communication between strategic and operational levels within different services and agencies*. In some cases FIPs appeared to have secured good 'buy in' at a strategic level, for example with supportive representatives on a FIP steering group, but this was not felt to be filtering down effectively to frontline workers.*

The ease with which FIP staff could identify one key link at the appropriate level within an agency*. Identifying a key link person was sometimes deemed a necessary first step towards establishing a broader relationship with an agency. Being able to find a link person in health emerged as a particular problem, due to the size, complexity and re-structuring of Primary Care Trusts, plus a suggested lack of 'buy in' - to FIPs in particular or multi-agency working in general.*

Whether a FIP was being delivered by the LA or not. *As mentioned earlier in this chapter, the view was expressed that FIPs delivered directly by LAs found it less challenging to establish links with other statutory agencies than those delivered from the voluntary sector or other independent organisations (e.g. Arms Length Management Organisations).*

The actual department or agency in which the FIP was located*. It appeared from our evidence that FIPs located in certain departments of the LA (e.g. a YOS) might find it easier than others to build links with other agencies, as these departments had been set up to work across agencies. As a consequence it was easier to embed the FIP within the operation of the agency[33].*

Attitudes toward FIP

The extent to which local services had 'bought in' to the idea of a FIP also affected the quality of referral and co-working relationships. A number of factors appeared to underpin the lack of 'buy in' to the FIP:

Skepticism about FIP staff's qualifications and credentials*. Concerns were expressed that FIP staff were not required to have formal social care certification. FIP staff were also sometimes said to lack an understanding of the legal requirements under which other professionals were working, for example concerning school attendance or child protection.*

A belief that FIP families were not deserving of continued support*, as they had not responded to numerous opportunities to engage with agencies in the past and as a result had eventually been 'written off'. This view appeared to be underpinned by a degree of pessimism about any professional being able to make progress with the family, and a feeling that resources could be more effectively deployed elsewhere.*

Viewing the FIP as 'treading on toes'*. There was a sense that some professionals felt resentful about the FIP becoming involved with families for whom they had previously seen*

themselves as primarily responsible. FIP staff also felt that they ran the risk of their involvement being seen as implying others' failure. One strategic FIP manager paraphrased these attitudes. 'Hang on a minute, we've got our statutory work to do, we've already worked out our priorities, we already know what we're doing, got our protocols and everything in place, you're parachuting in saying that you've got something special - well hold on...' (FIP staff)

Resistance to the FIP 'ethos'. *This could take two contrasting forms: professionals being uncomfortable with the enforcing or 'punitive' element of the FIP model (e.g. YIPs, parenting providers); or dismissing the FIP as too 'soft' (e.g. police, ASB teams). FIP staff had also found themselves faced with the challenge of justifying to other professionals why a relatively large amount of resources were being invested in families perpetrating ASB, especially where the use of rewards had been observed; qualms of this nature tended to come from professionals who were also privy to the victims' point-of-view (e.g. housing officers).*

Being seen as a 'flash in the pan'. *The fact that FIPs' funding was short-term was felt to have obstructed staff's efforts to persuade other agencies to take the project seriously and make efforts to work together (indeed, it was commented that even the use of the word 'project' conveyed a short-term impression). It should be noted, however, that these negative reactions to the arrival of FIPs were by no means universal. In fact, FIP staff reported that some professionals had been very relieved to have a further channel of support for the most challenging families on their caseloads, with some even 'celebrating' the FIP's arrival as* a *'saviour'.*

How lack of 'buy in' affected agencies' behaviour

- **Not making referrals or making inappropriate referrals** due to a lack of understanding of the referral criteria or the work done by the FIP or the referral process.
- A lack of **respect for, or resentment towards, FIP staff**.
- A **reluctance to attend meetings, return phone calls, or to fulfill responsibilities** in relation to families' support plans.
- A **reluctance** (specifically raised in relation to social services) **to assess or take on new cases** where child protection issues were identified by the FIP.
- A **reluctance to pass on information** to the FIP. This problem was associated particularly with health. While there was some appreciation of the reasons for the reluctance of health professionals to share information with non-health specialists, it was also felt that this could lead to FIPs lacking vital information. For example, one key worker recounted how a health visitor had not informed her when a member of a FIP family had taken a drugs overdose, which she felt had been detrimental to her efforts to address the individual's drug dependency.
- **A reluctance to work jointly and instead handing over cases to the FIP**. This could cause awkwardness, as one FIP manager explained:

  > *'We have to keep pushing that message that we are not really here to pick up all of the social welfare issues of the families, we are here to support the families but in conjunction with agencies as well.' (FIP staff)'*

Source: White C [33]

System

One of the critical success factors identified in the evaluation was the way that FIPs adopted an 'whole family approach'.

> *The fact that FIPs were not just working with the person presenting the problem but instead considering the needs of all family members – parents and children alike - was felt to be a pivotal feature of the service. It was said that prior to FIPs, professionals had to refer each family member separately to, for example, social services or YOS, which had resulted in the involvement of a number of different agencies focusing on different individuals with no one person considering the whole family.*

Another critical success factor was found to be the way in which project were able to use resources flexibly.

> *Having considerable autonomy over how money was spent was voiced as another central feature of FIPs, as it enabled staff to consider a wide range of different kinds of service, and to adapt their plans according to families' changing needs and circumstances over time. This meant that they could work in a very flexible, creative and holistic way, which was remarked on and lauded by local partners. Crucially, it also allowed them to buy in services to meet families' needs where necessary.*
>
> *Flexibility over the use of funds also allowed FIPs to purchase goods and items to aid their own work with families, such as paint for the family to decorate their home; a punchbag to help a young man control his anger (though they had also accessed funds from social services and charities for this)[33].*

Skills

Recruitment and retention of high quality staff was found to be a critical success factor.

> *FIP staff and local agency partners saw the success of projects as heavily dependent on the quality of the individuals working in them.*
> *'Because you could have all these resources but then if you have got the wrong kind of people like doing it, it is not going to work.' (Local service provider)*
>
> *Much praise was levelled at the dedication, commitment, skill and enthusiasm of FIP staff. It was evident that staff working in FIPs came from a range of professional backgrounds, including social care; housing and homelessness prevention; the criminal justice system; youth services; education; parenting; and health services. Having staff with different backgrounds, areas of strength and expertise was viewed as an asset when drawn on effectively, as it ensured a more rounded service for families.*
>
> *Views varied about whether FIP staff ought to have particular types of formal qualifications or professional experience, such as in the social work field. Some concerns were raised about a lack of qualifications or relevant experience among FIP staff in relation to certain aspects of their work such as one-to-one parenting support. The view was also expressed by local partners that FIP staff could be better-informed about relevant legislation and processes such as in the case of child protection, housing law and enforcement, and data protection[33].*

Every Child a Reader (ECaR)

The ECaR programme was developed by a collaboration of the KPMG Charitable Trust with the Institute of Education and Government. The KPMG Charitable trust (later Every Child a Chance Trust) oversaw its development between 2005 and 2008. In 2008, the then-Government committed to a national roll-out of ECaR, with the intention that by the academic year 2010-11, 30,000 pupils a year would access reading support through ECaR.

ECaR offers a layered, three-wave approach to supporting children with reading in Key Stage 1. Wave 1 is the 'quality first teaching' aimed at all children through class based teaching. This encompasses the simple view of reading (focusing on word recognition and language comprehension) and systematic phonics where children are taught to sound out words. Wave 2 small group (or less intensive one-to-one) intervention is aimed at children who can be expected to catch up with their peers with some additional support. Wave 3 offers intensive reading support in the form of a one-to-one programme for children who have been identified as having specific support needs. The main intervention under Wave 3 is 'Reading Recovery', an intensive programme lasting approximately 20 weeks, for the lowest attaining five per cent of children aged five or six.

Reading Recovery had a positive impact on reading. It led to parents encouraging their children to think that reading is important and on the ability of pupils to initiate ideas and activity.

> *The evaluation provided strong evidence of the impact of the ECaR programme and Reading Recovery in relation to its central aim of improving children's reading at Key Stage 1[34].*

Learning

Structure

Reading Recovery dominated the ECaR programme in schools**.**
The implementation of ECAR at local authority level was most effective when consortia shared practice, co-ordination and administrative tasks. However it was also acknowledged that working in consortia posed particular challenges.

Two issues were identified:

- *firstly, the need for more explicit recognition of the greater resourcing, time and effort spent by the lead local authority in consortia;*
- *secondly, the impacts of consortium working on Teacher Leaders, which could dilute support for their own local authority, require them to operate in other authorities where they were unfamiliar or had less influence and increase their overall workload[34].*

A number of other structural issues were found to be important:-

- It was important to have a dedicated and discrete space, with adequate resources and in a supportive school infrastructure.
- The programme relied on the ability to engage parents and was therefore dependent on good communication from the school and the parents' willingness to become involved.
- The selection and recruitment of pupils was based on age and attainment according to the guidance.

Strategies

Implementation at local authority level was most effective when the programme aligned well with other interventions and the local authority strategy as a whole.
To promote literacy, the government set age-related standards at key points in a child's schooling. At the end of Key Stage 1 (Year 2, aged 7), children are expected to achieve at least level 2 in teacher assessments in reading, writing, mathematics and science. While the majority of children do so, a persistent minority of about 15 per cent lag behind at this stage. Given the disadvantages in life chances of poor literacy, this programme aims to improve the reading attainment of those 15 per cent.

Systems

Literacy difficulties have been linked to an array of costly negative outcomes including special educational needs provision, truancy, exclusion, reduced employment opportunities, increased health risks and involvement with the criminal justice system. It was felt that the ECaR programme could help narrow the gap between children, based on their reading ability.

Skills

Implementation at local authority level was most effective when teacher leaders were supported by managers to fulfil training requirements and maintain professional development.
The training of Reading Recovery teachers lasts for a year, following which continuing professional development encourages new teachers to reflect on their practice, consult with colleagues on their approach and stay abreast of new knowledge in the field. They teach children on a one-to-one basis for 30 minutes each day for an average of 12-20 weeks and provide support to classroom based teachers on appropriate reading interventions more generally

The role of Reading Recovery Teachers was key to the implementation of ECaR in schools. Recruiting Reading Recovery Teachers was based on the criteria set out by the Institute for Education: knowledge, skills and experience.

Leadership

Implementation was most effective where Senior Managers understood the aims of the programme and championed Reading Recovery amongst pupils and staff. The commitment of senior management to ECaR facilitated the set-up. Awareness and commitment at a senior level facilitated the provision of space and resources and the relationships of Reading Recovery Teachers with other school staff.

> *The effective delivery of the ECaR model as a whole was facilitated by a supportive Senior Management Team and a clear and shared understanding of the various roles involved in delivering ECaR. This provided Reading Recovery Teachers with the authority to drive wider literacy strategy and develop key relationships[34].*

Evidence

There is strong evidence that reading recovery improves the overall measures of attainment in key stage one. It made the wider curriculum more accessible and not just improved literacy but increased confidence, self esteem and engagement of pupils. Those whose first language was not English benefitted from the programme and boys had a greater attainment as a result of the programme than girls. Results came in years two and three of the project not in year one – it takes time to have an effect.

Family Nurse Practitioner

The Family Nurse Practitioner Programme (FNP) is an evidence based early intervention that sits at the intensive end of the prevention pathway for the most vulnerable children and families. Advocates argue that it should be embedded within universal maternity and child health services, especially the healthy child programme. It should be jointly led by the NHS and local authorities as part of a joint strategy for children.

It involves weekly or fortnightly structured home visits by a specially trained nurse from early pregnancy until children are 24 months old. The curriculum is well specified and detailed with a plan for the number, timing and content of visits. Supervision is ongoing and careful records of visits are maintained. The programme has strong theoretical underpinnings, with the formation of a strong therapeutic relationship between nurse and mother at its heart. The programme is designed for low-income mothers who have had no previous live births and starts in the second trimester of pregnancy.

The main goals are:-

- to improve the outcomes of pregnancy by helping women improve their prenatal health;
- to improve the child's health and development by helping parents to provide more sensitive and competent care of the child;
- to improve parental life course by helping parents plan future pregnancies, complete their education and find work

The evaluation found that:-

> *The Family Nurse Partnership (FNP) programme can be delivered effectively in England, in a variety of different areas, but further work needs to be done to understand and address the reasons for not meeting the fidelity targets for early recruitment, dosage, attrition and data collection[35].*

The Government made a commitment in October 2010 to double the number of places on FNP, to 13,000 places by 2015. There are now around 9,000 places in 74 teams in 80 local areas.

Learning

Structures

The implementation of this kind of early action initiative posed a number of structural issues. An evaluation of the first year FNP sites in England[35] found that the integration of the FNP with wider services indicated that health colleagues were more familiar with the FNP but the evaluation identified concerns:

- Some other professionals think that FNP teams are elitist and that they may take over existing roles;
- Local Authorities had a lower level of understanding of the FNP;
- Children's Centres in particular were not well informed and many did not understand the potential contribution of the FNP; and
- More needs to be done to promote and explain the FNP and raise its profile in Local Authorities.

It was found that to achieve a co-ordinated holistic approach to the assessment and provision of services around the child and family, greater work needs to be done in raising the awareness of what FNP can achieve and how it fits with other services. It is argued that the FNP programme should be integrated with other services delivering support to vulnerable mothers and their children – in particular, midwifery services and children's centres.

> *To maintain partnership working between midwifery and FNP, midwifery managers needed to be involved in the planning of FNP services, and to be part of the strategic board guiding the programme. Referral systems needed to minimise additional work for midwives, and the latter needed to understand the programme its specific remit and its goals. Referrals needed to be written into the antenatal care pathway. FNP needed to make sure that the midwifery service knew whether clients had been accepted onto the programme. Guidance from the central team was required for all areas where FNP is operating, to clarify issues of consent and confidentiality for referrals.*

> *The plans for FNP in England had included integration of the programme into Children's Centres. Interviews with Children's Centre managers showed a low level of understanding of the precise nature of the FNP. It was difficult to see how managers could plan the integration of this programme with other services without that understanding. Family Nurses have been able to get some young clients to use Children's Centre services, often by accompanying them there. However this report deals primarily with FNP clients during early and late pregnancy and links between the FNP and Children's Centres may strengthen once infant are born[35].*

The evaluation[35] concluded that the FNP is best viewed as a discrete intervention: focussed, complete in itself and not so much a partner in a multi-agency approach as a prelude to it, with the potential to link clients efficiently with a wider range of services when this is warranted.

> *This will not mean that the FNP should operate in a vacuum, divorced from other support services. There is every reason to suppose that helping clients participate in other services, introducing them to Children's Centres, even helping Children's Centres to set up services for them will work well, both for the clients and for the Children's Centres. But there are risks in seeing FNs as new members of the Children's Centre team, sharing family support work between them. Rather, this is a small focused resource, working with a small group of families in a very specific way, and FNs need to be able to concentrate on this[35].*

Systems

UK research[35] shows mothers who give birth for the first time under 20 years are more likely to live in social housing, receive benefits, have no qualifications, have a low household income, be in poor health, have mental health problems and have low satisfaction with life.

Working with young mothers from pregnancy to help them prepare for the birth of their child and to support them during the first two years of their child's life was intended to improve the health and wellbeing of the mother and to enable them to be a better and more confident parent. In the long term there was an expectation that the child would have improved development outcomes at school age and a reduction of anti social behaviour as a teenager.

By visiting the family at home there is an opportunity for fathers to become involved in the programme. Research has shown[35] that when fathers are involved in the upbringing of their children, the children are more likely to do better academically and emotionally.

Recruitment systems and processes were found to have not always worked well and the evaluation[35] indicated the following success factors:

- Establishing clear, simple and consistent recruitment pathways and criteria;
- Engaging midwifery leaders from the beginning and keeping them informed;
- Family Nurses (FNs) are best placed to 'sell' the FNP to at risk clients; and
- Better data collection is needed at recruitment to understand the relationship between potential eligibility, referrals, eligibility and uptake.

The evaluation also felt that further work was needed to understand why clients refuse or leave the programme and to factors associated with attrition such as dosage or client demographic characteristics.

Skills

The FNP approach requires the practitioner to follow a structured programme and to develop a different relationship with the mother and family. This meant that the nurse practitioner needed to develop new skills.

In the evaluation of the 10 pilot sites in England the FNPs found the workload heavy and demanding, both professionally and emotionally. Regular supervision was essential and good professional support. A clinical psychologist can fulfil an important role in supporting FNPs. The evaluation[35] concluded that good supervision was a core function for successful delivery of this programme. They went on to state that:-

The FNP is acceptable to the practitioners delivering the programme who, on the whole:

- *Valued the learning;*
- *Considered that it differed substantially from their previous roles (as health visitors and midwives) with the emphasis on developing a supportive relationship with the client and her family;*
- *Recognised the value of the FNP and the potential benefits for at risk clients;*
- *Nonetheless they find the work demanding both emotionally and professionally and the workload heavy with significant levels of overtime.*

Supervision is a core function of the FNP and vital to successful delivery to families but establishing this particular style of supervision was a challenge:

- *It proved difficult for first wave supervisors who were learning the programme at the same time as FNs;*
- *Meeting the requirements for one-to-one supervision and group supervision added to perceived workload problems for the FNs;*
- *On the whole supervisors were valued by the FNs but team functioning issues could get in the way of supervision; and*
- *Further work needs to be done to develop supervision in existing and future sites.*

Culture

Early action initiatives often require a different culture to be developed, particularly in relation to how practitioners view users of the service. This cultural change was in evidence with the FNP initiative.

> *Clients and their families were positive about the programme and about the FNs. While it took a while for them to understand the full extent of the programme, they liked it in comparison with other services. They noted in particular the different way they were perceived by FNP staff, not judged and undermined but supported and strengthened. Some were not sure about it when they accepted, but most found the programme better than they had expected, particularly some of the young men interviewed. They felt more involved as fathers to be. Grandmothers were generally happy to let the Family Nurse provide up-to-date information to their daughters[35].*

There were barriers to successful implementation identified through the evaluation in England[35] and so these would need to be addressed. One which potentially has a cultural dimension was the need to address the drop out rate – many mothers dropped out of the programme or moved home and lost contact. They also cancelled visits.

Some FNPs reported feeling isolated by not working as part of a team. A key issues was the lack of integration with other services.

Evidence

A strong and rigorous US evidence base[36] developed over 30 years, has shown FNP benefits the most needy young families in the short, medium and long term across a wide range of outcomes helping improve social mobility and break the cycle of intergenerational disadvantage and poverty.

Research evidence from three randomised control trials in the USA has shown it to have positive effects from pregnancy through to the time children are 15 years old. The most pervasive effects are those relating to maternal life course (such as fewer and more widely spaced pregnancies) and better financial status. The likelihood of child abuse and accidents is reduced, the children are likely to have improved developmental outcomes as they reach school age and there is clear evidence for a reduction in antisocial behaviour in children when they reach their teens.

An FNP programme in the USA[37] reported that the effects found in two or more trials included:

- reductions in child abuse/neglect and injuries (20-50%)
- reduction in mothers' subsequent births (10-20%) during their late teens and early twenties
- improvement in cognitive/educational outcomes for children of mothers with low mental health/confidence/intelligence (e.g., 6 percentile point increase in grade 1-6 reading/math achievement).

In the UK the pilot sites showed some positive benefits:

- Changes in parenting – more confident
- 17% reduction in smoking in pregnancy
- 66% breastfeeding compared to national rate of 14% (for under 20 years)
  21% still breastfeeding at 21 weeks compared to national rate of 14%
- Engagement of fathers was good, with more than half attending visits

To achieve some of the benefits realised in the USA studies, attention needs to be paid to the issues identified in the evaluation of pilot sites in England, namely:

- Integration with other services as part of a strategy for children, young people and families
- Strong supervision and support, including access to a clinical psychologist
- Manageable case loads
- Engaging families effectively
- Collecting appropriate data and information to assess impact

There were some successes from the FNP programme – however, it has to be recognised that this is just one way of achieving better life chances for children and young parents and it should therefore be considered as part of a co-ordinated and integrated approach.

Improving Futures Programme

The Improving Futures programme was launched by the Big Lottery Fund (BIG) in in March 2011. A total of £26 million in grant funding was distributed between 26 pilot projects across the UK, to test different approaches to improve outcomes for children in families with multiple and complex needs. Grants were up to a maximum of £900,000 over a period of 3 to 5 years for projects across the UK. The age range was 5 – 10 years at the point of entry.

The programme was particularly focussed on families where there are multiple and complex problems relating, for example, to unemployment, debt, poor housing conditions and health problems. The overall aims were as follows:

- Improved outcomes for children in families with multiple and complex needs
- New approaches to local delivery that demonstrate replicable models which lead to more effective, tailored and joined-up support to families with multiple and complex needs
- Improved learning and sharing of best practice between public services and voluntary and community sector organisations

Learning

Structures

Integration with a number of elements of the structures for family support are thought to be critical for this early action initiative to be successful. There is evidence that some of this has been achieved.

> *One of the key aims of the Improving Futures Programme was that projects would pursue effective, tailored and joined up family intervention support. There is emerging evidence that projects have made progress in this respect. One of the clearest examples has been the development of strong local partnerships for delivery of the projects. Improving Futures projects are characterised by the third sector leadership, in partnership with statutory services or other VCS organisations.*
>
> *It is already clear that there has been considerable success with engaging a wide range of appropriate statutory service providers in the projects at a local level and raising the profile of the programme. This has included schools, police, Jobcentre Plus, social housing teams, and – to a growing extent – adult social care teams, health partners and GPs. The requirement for DCS endorsement of the original Business Plans was widely considered to have had a galvanising effect in this respect, in providing foundations for strong levels of statutory involvement in the programme.*
>
> *The year one evaluation has also clearly identified instances where larger VCS organisations have come together to deliver joined-up support for families, with positive early results. This has included examples of collaborative projects involving some of the largest children's charities in the UK.*
>
> *There are promising early signs that Improving Futures projects are becoming embedded within local structures for children and families, in order to align with other initiatives and in some cases influence the development of early intervention models. Examples were found of project representation on Local Commissioning Boards, Early Intervention Boards, Children's Trusts, Health and Wellbeing Boards, Parenting Strategy Groups, Community*

Planning Partnerships, Substance Misuse Screening Groups, and voluntary sector forums[38].

Primary schools have provided a hub for many of the projects, as underlined by the baseline survey of families, which showed that well over half (59%) of respondents were engaged through someone at their child's school. The existing knowledge about the families held by school staff was widely reported to have been a success factor in this respect. Referrals have come from a variety of sources, however, with projects routinely making effective use of both statutory and VCS organisations within their local area to provide opportunities for different points of engagement for adult and child family members. A few projects have also used community development models to build capacity to generate new referrals[38].

Strategies

Traditionally 0-4 year olds have been the focus for early intervention work, however it is now widely recognised that each stage of childhood may bring challenges. Improving Futures recognises this and focuses on responding before problems develop, working with children up to 10 years old at the time of entry.

At this stage of delivery, there is recognition from projects that there are families with additional needs who have not yet been reached by the programme. The widespread focus on primary schools, whilst very successful overall, has resulted in a potential skewing of referrals towards families who are already known to professionals. An action point in this respect has been to strengthen the links with other local agencies supporting higher need families or those who would not engage with a school[38].

In 2011 the Troubled Families Programme was launched. This aimed to turn around the lives of the most troubled families in England by 2015. A Troubled Families Unit is based in DCLG to join up efforts across Government departments. There is a network of Troubled Families co-ordinators operating at a senior level in local authorities across England. There is a potential for overlap between the Improving Futures programme and the Troubled Families initiative.

Alongside the Troubled Families Programme, in 2011, the Department for Work and Pensions launched the Support for Families with Multiple Problems Provision, funded by the European Social Fund (ESF). This programme is aimed at families with multiple problems and complex needs specifically where there is a history of worklessness within the family. While none of the Improving Futures projects are specifically targeting the issue of worklessness as a referral criterion, it is likely that many of the Improving Futures families will face this issue. The Troubled Families Programme has a focus on providing a whole family approach, based on a key worker model, this is a core model used by Improving Futures projects.

Systems

Key success factors for supporting families have included:

- providing flexibility when support is delivered, including 'out of hours' provision in the evening, weekends and during the holidays;
- having frequent key worker contact with families during the initial stages of involvement, and providing a hands- on approach to support family members with accessing other local services or information.

One of the emerging areas of interest for the projects has been to test new and more effective ways for commissioning family support services. This has included the use of personalised budgets or 'spot purchasing' for individual families, and the development of whole new packages of support.

A number of project staff reported some surprises in families' presenting needs. Whilst some expected to focus on areas such as developing parenting skills and meeting children's emotional or learning needs, families have routinely expressed difficulties relating to their financial or housing situation requiring immediate action.

The most common problems in families are:

- Divorce or separation, leading to a family breakdown. Research has found that 1in 5 couples separate before the child's 3rd birthday.
- A history of domestic abuse - this may be historical, before separation or current.
- Worklessness and the financial difficulties that ensue including debt and rent arrears

The risk factors for adults include, parenting difficulties, low level mental health problems and to some degree educational problems. The risk factors for children are mostly behavioural problems and low level mental health issues, such as anxiety as a result of the parents' behaviour. There are also child protection issues. Interestingly educational problems are not much different in troubled families to the general population.

The Improving Futures Programme categorized families to help identify the risk factors and strengths that cluster around each cohort. It is not suggested that every family can be fitted in to one of these groups, but it does help to focus interventions.

The categories and associated risks are described below[38]

- Typology 1 - Families with strong structures and behaviours
  These families are more likely to take up their benefit entitlements and are also more likely to be engaged with the community.

- Typology 2 – Low skilled families with financial and housing difficulties
  Families scoring highly on this typology tend to have low financial capability skills, are struggling with debts and unpaid bills and have a history of worklessness.

  Adults in these families are most likely to have no qualifications and low basic literacy and numeracy skills, including low English language skills. Poor housing is also a predominant issue. This typology is also associated with adults smoking heavily or engaged alcohol or substance misuse and some child protection issues also feature.

- Typology 3 – Families with significant discipline and behavioural issues
  Children living in these families tend to be identified as struggling with persistent disruptive and violent behaviour. Child mental health issues, particular those related to behaviour including ADHD, are also very prevalent and many children are involved in bullying as a perpetrator, and to a lesser extent, a victim. Although a small number in total at primary school level, children that receive exclusions tend to come from families scoring highly on Typology 3 and there is also a high prevalence of special educational needs and underachievement. The only adult indicators falling into this typology are those directly related to parenting. Parents in these families tend to have problems with discipline and boundary-setting and are likely to be anxious and frustrated parents.

- Typology 4 – Transient families with domestic abuse, mental health and substance misuse
  The indicators most strongly associated with this typology relate to domestic abuse (both child and adult harm) and child protection concern Adults in these families also tend to suffer from suspected stress or anxiety and many are identified as having other mental health problems or instances of self- harm. Mental health issues are also prevalent to a lesser extent among children. Serious alcohol and, to a lesser extent, substance misuse involving rehabilitation or outpatient treatment is also an issue for some adults in these families. These families tend to be of a transient nature, with relationship dysfunction, custodial sentences and housing repossession also included as indicators most closely associated with this typology

- Typology 5 – Families engaged in their community
  Membership of local and community organisations, both by the adults and children, is the main defining characteristic of this typology. Adults are also more likely to engage in civic participation and participate in formal school structures and both adults and children are more likely to volunteer. Adults in these families tend to be engaged in employment or higher level education, although there are also some negative indicators associated with this typology, including worklessness and relationship dysfunction.

- Typology 6 – Families known to the police for minor disorder
  Families scoring highly on Typology 6 are likely to have been involved in a neighbour dispute, perhaps requiring a police call-out, and the children may also have received a police warnings or reprimand or been involved in anti-social behaviour. This typology is also associated with adult poor hygiene and self-care, adult emotional or behavioural disorder and child persistent unauthorised absence from school.

- Typology 7 – Socially excluded families with health problems
  Typical problems faced by families scoring highly on Typology 7 include social isolation, lack of access to safe public open space, high levels of noise or a chaotic home environment, overcrowded living conditions and worklessness. Many adults and children in these families suffer from disability or health problems while cultural, racial or religious harassment is also an issue.

  Typology 8 – Families known to the police for more serious incidents
  Adults in families scoring highly on Typology 8 are most likely to have suspected or reported involvement in anti- social or criminal behaviour, a custodial sentence or a police warning or reprimand.

The level of presenting need has been an issue in the programme.

> *A further emerging issue has been the greater number of families presenting with more complex needs than was anticipated. It was not uncommon for project staff to report having faced pressure to absorb this capacity, as a result of other services being over-stretched. This has required a balance between early intervention and offering a 'step down' for higher need families[38].*

Skills

There are many new skills that programme staff have to develop and apply.

> *Many projects have sought to address issues faced by individual adult family members. There has been a crosscutting focus on improving confidence and self-esteem, and providing support with parenting anxiety, frustration and strategies for dealing with child behavioural problems. Parenting courses have operated in over half of the projects. Where this support was provided, parents have consistently reported having acquired new techniques and / or strategies for behaviour management. Some have quickly observed improvements in their children's behaviour or levels of parent-child interaction. Many of the projects are seeking to measure these outcomes using standardised tools, such as the Tool to Measure Parenting Self-Efficacy (TOPSE). Further quantification of these outcomes is expected as greater numbers of families are engaged and supported[38].*

There is promising evidence that projects are replicating many aspects of documented good practices for family support. This includes the use of intensive key worker or lead professional models and persistent one-to-one support; educational outreach; and the use of evidence-based parenting programmes such as Incredible Years and Triple P. There was mixed evidence for the extent to which these programmes have demonstrated a 'whole family' approach, with some projects still supporting children and adults on a largely separate basis.

The Improving Futures projects used a range of assessment tools including:

- Family Outcomes Star – this shows a representation of outcomes along seven different spokes and progress with achieving these. The outcomes are predetermined (not the families own) eg. promoting good health, keeping your child safe, social networks, providing home and money.
- Statutory assessment tools such as the Common Assessment Framework and Team around the family.
- Strengths and difficulties questionnaires
- Banardo's outcome monitoring tools
- Action for Children's E-Aspire tool
- Warwick-Edinburgh Mental Health Wellbeing Scale
- Other tools such as, Children's Outcome Star, My World and bespoke tools.

It was found that where families were reluctant to engage with statutory agencies that a holistic 'pen portrait' approach was more successful than a formal assessment. The most effective assessments are those that took place over a number of contacts working at the pace of the family. Approaches that allow the family to reflect on their situation and find solutions work best[39].

> *The timing and location of the assessment were also reported to have been key factors affecting the level of engagement by families, with the most effective approaches often being staged over a number of contacts; to build relationships and to allow time for families to disclose their needs at their own pace. The most successful examples of assessment were found to have played a role in moving families forward, by providing an opportunity for them to reflect on their situation from a fresh perspective[38].*

Participants within the programme are also learning new skills.

> *There has been a smaller but growing trend towards families directly supporting their peers within the programme. This has typically occurred as a continuation activity, where families have made arrangements to keep a support group growing following the end of their intervention, such as running family drop-in classes, or adult learning activities[38].*

Culture

Therapeutic approaches are not part of mainstream culture and therefore can be challenging for families to engage with. The evaluation found that there were a few examples of families disengaging from local projects. This was either because of a crisis or in some cases when therapeutic support became difficult for them to cope with.

Other factors to consider when working with families with complex needs[39]:

- The effectiveness of family led approaches. Some projects were encouraging peer support such as family led drop ins, adult learning and in a few areas family members training as key workers.
- Ensure the buy in of stakeholders at both a strategic and operational level. A steering board of local leaders and an operational multi agency group, could help to achieve this.
- Define roles and responsibilities and be clear about the roles of different agencies.
- Joint training and shared learning can help to break down potential barriers between agencies.
- A communication strategy/plan is important to engage stakeholders, to encourage appropriate referrals and to co-ordinate services.
- A single point of contact for referrals.
- Work with community based organisations as well as schools
- Build relationships with families over time – rather than a formal assessment
- Work flexible hours – not 9-5 weekdays
- Offer practical support to do the things most needed by the family – financial support (accessing benefits) and sorting housing problems.

Evidence

At the end of year one the following observations were made as a result of evaluation[38]. There was no evidence at this early stage, of measurable outcomes or cost benefits.

The following elements recurred as effective practice:

- Key worker model
- Holistic support packages
- Evidence based parenting programmes
- Innovative financial mechanisms – family budgets and spot purchasing
- Peer support

Key success factors were:

- Out of hours provision,
- Frequent key worker contact
- A hands on approach including referral to other services.

Realising Ambition

The Realising Ambition programme was funded by the Big Lottery Fund to replicate a portfolio of 25 evidence-based and promising interventions designed to help children and young people aged 8–14 avoid pathways into offending, giving them a better chance to realise their ambitions and their potential.

Each intervention was required to:

- predominantly target children and young people aged 8–14;
- prevent problems developing or intervene early to improve poor outcomes, reduce risks and enhance proactive factors associated with entry to the criminal justice system;
- be underpinned by the best available evidence or potential for impact;
- be ready for wider replication; and
- be delivered by committed and strong organisations.

The investment was characterised by a focus on replication rather than innovation.
The portfolio comprised both internationally recognised interventions, underpinned by the highest standards of evidence, and UK home-grown and promising interventions.

Several evidence-based programmes were replicated for the first time in the UK through Realising Ambition. These have all been evaluated by at least one robust experimental evaluation. They include All Stars, Lion's Quest Skills for Adolescence and Life Skills Training (LST). Also PATHS Plus, which combines the universal social and emotional learning curriculum already implemented in the UK, with a more intensive element known as Friendship Groups, for children with greater difficulty.

There are also a number of evidence-based programmes that have already been implemented in the UK that are being more widely replicated through the programme. These include Functional Family Therapy (FFT) and Multi-Systematic Therapy (MST) both of which are targeted and intensive early interventions designed to reduce anti-social behaviour through intensive therapeutic intervention with young people and their families.

There are two universal school-based interventions, namely Roots of Empathy and the Co-operative Primary School. The Strengthening Families Programme (10–14) is being further replicated in the UK, predominately with Muslim families for the first time. These interventions represent some of the most internationally respected and well-evidenced programmes. While they are currently implemented in the UK, their reach is very low.

Realising Ambition also supported the 'innovation to proven impact pipeline' by supporting the refinement and replication of a number of promising interventions across the UK that had not yet have robust experimental evidence of impact on child outcomes. As part of Realising Ambition, these interventions will be supported to become more tightly refined and ready for experimental evaluation.

Evidence-based programmes	Promising interventions
All Stars (Barnardo's)	Anne Frank Schools and Ambassadors Programme (Anne Frank Trust UK)
Be Safe Programme (North Bristol NHS Trust)	Chance UK Early Intervention Mentoring (Chance UK)
Co-operative Primary School (Success for All UK)	Children's Parliament Community Initiative (Children's Parliament)
Functional Family Therapy (Action for Children)	Conflict Resolution: Uncut (Working with Men)
Life Skills Training (Barnardo's)	Friends of the Children (Treyla)
Lion's Quest Skills for Adolescence (Ambition)	It's Not OK (Ariel Trust)
Multi-Systemic Therapy (Extern)	Malachi Early Intervention Programme (Malachi Community Trust)
PATHS Plus (Barnardo's)	Plus One Mentoring (YMCA Scotland)
Roots of Empathy (Action for Children)	Positive Assertive Confidence Strategies (PACS; Kidscape)
Strengthening Families Programme (10–14) (Oxford Brookes)	Safer Schools Partnership (Restorative Schools, Remedi)
	Shelter: Realising Ambition (Shelter)
	Stepping Up (Bridge Foundation)
	Strength to Strength (BANG edutainment)
	SWITCH (Winston's Wish)
	Respect Young People's Programme (Respect)

Table 1
List of 25 Realising Ambition interventions (and delivery organisations)

Source: Social Research Unit at Dartington [40]

catch 22

Learning

Structures

Structural issues have been found to be challenging. The evaluation[40] reports that there is a tendency to underestimate the organisational challenges involved in the implementation of early action schemes, such as:-

- the time and resources required to recruit and train staff qualified to deliver the intervention,
- the effort required to establish strong partners and networks for replication,
- the navigation of internal organisational bureaucracies,
- the challenges in accurately predicting demand.

If organisations are going to successfully replicate and scale evidence-based programmes with quality they will have to radically change how they do business: how they recruit staff and train them, how the intervention is introduced effectively to new sites and how the organisation is structured to support high-quality delivery[40].

Strategies

The number of people coming through the programmes has been lower than expected leading the evaluators to conclude that there is a tendency for organisations to overestimate the demand for a service. They recommend that assessment of need and market research should be used more systematically to inform more sophisticated service planning and prediction of beneficiary numbers . This may take the form of epidemiological surveys of need within a community to indicate the number of likely children and families who may be eligible for a particular targeted service.

It is thought that the need actually is there but that those in need do not typically come to the attention of service delivery organisations. This may be because referral pathways, service engagement mechanisms, eligibility criteria and interventions themselves are not as socially inclusive as they could be.

There are risks from this apparent lack of demand.

> *A natural reaction of delivery organisations delivering targeted interventions to meet the expectation and promises made to funders or commissioners is to relax the eligibility criteria and work with an easier-to-engage cohort of children and families. As one would expect, this has a whole range of unfavourable consequences. Children or families not meeting specified eligibility criteria may not require the delivered intensity of the intervention, meaning the intervention's impact on outcomes is diluted (or potentially even harmful), that the investment is inefficient (or perhaps does not break even) or that children and families may inadvertently be or feel stigmatised. This in turn may undermine the favourable impacts that the intervention could have if appropriately targeted[40].*

Systems

There have been some concerns within the evaluation about the implementation of evidence based programmes in real functioning complex systems. In particular there can be a fuzzy boundary between tightly defined programmes and an array of ways of practicing.

> *It is easy to conflate evidence-based programmes with relatively flexible practices or processes. There were numerous examples of practices and processes being 'packaged' as programmes among applicants to Realising Ambition, and a couple made it into the portfolio. It is important to differentiate between them as it is harder to replicate flexible processes and practices than tightly defined programmes[40].*

The evaluators go on to explain that the distinction between programmes, practices and processes is not always clear cut.

> *There are other types of interventions that can be evidence-based. Policies refer to a course of action (or inaction) decided by policy makers to shape how people behave, for example banning smoking in public places or withdrawing welfare to encourage people to find work. Practices refer to the activities of practitioners, and may be broken down into discrete elements or techniques aimed at changing people's behaviour, for example time-out, verbal praise, rewards, traffic light signals, tutoring, monetary fines and mentoring. Processes operate in service systems, and include how children and families are expected to access services, how their needs are assessed and how staff are trained to deliver or record their work[40].*

It is harder to replicate flexible practices than it is tightly defined packages of intervention. The latter are likely to have a detailed handbook or manual for implementation, training packages and implementation tools.

Skills

Staff that delivered the interventions had to be qualified to do so. Recruiting, training and supporting staff needs to be realistically costed with contingencies made for staff turnover or absence.

Leadership

Successful implementation requires the development of strong partnerships and networks for delivery. Communicating a vision, getting buy in, ensuring a strategic fit as part of a wider strategy for children, young people and families, sharing information, holistic assessment and co-ordinated services are key to effective partnership working.

Leaders need to get better at spotting promising interventions and investing in their testing and development.

Evidence

The evaluators concluded that there are not enough evidence-based programmes available for funders and commissioners to choose from and that there is a need to build the evidence base in the UK

The Realising Ambition programme has demonstrated that implementing promising and evidence-based interventions is currently a challenge due to the underdeveloped nature of this approach in the UK. An evidence-based approach is defined as a an intervention that has been tested via the most robust forms of experimental evaluation and proven to have a positive impact on children's health and development.

It is felt that there are not enough evidence based programmes available and that there is a need to build the evidence base in the UK. For example, of the 240 interventions submitted to the Realising Ambition programme, only 4% met the Social Research Unit's high standard for evidence based practice. Only 10 of the Realising Ambition projects out of 25 interventions are underpinned by the highest quality evidence base and they were all developed overseas and there were no home grown interventions in the UK for children aged 8-14 years that were underpinned by high quality experimental evaluation.

> *We need to ensure that home grown interventions are properly evaluated and ready for replication and wider implementation. There is a need to better support the 'innovation to proven impact pipeline' (ie the process of moving a programme from an idea to something that we can evidence has a positive impact on people's lives) in the UK by increasing investment in the refinement and rigorous evaluation of the most promising interventions[40].*

Sure Start Children's Centres

Sure Start local programmes (SSLPs) were introduced in 1999 by the previous government, they were aimed at families with children up to the age of four living in disadvantaged areas. The aim was to bring together early education, childcare, health services and family support to promote the physical, intellectual and social development of babies and children. They also aimed to reshape, enhance and add value to existing services and to increase co- ordination between services. It was the co-ordination of these services, working towards a common goal and the geographical targeting of SSLPs to disadvantaged areas that made them unique.

The ultimate goal of SSLPs was to enhance the life chances for young children growing up in disadvantaged neighbourhoods. Children in this type of neighbourhood are at risk of doing poorly at school, having trouble with peers and agents of authority (i.e parents, teachers), and ultimately experiencing compromised life chances (e.g., early school leaving, unemployment, limited longevity).

The first 524 SSLPs were established between 1999 and 2003. These SSLPs were area based and available to all families with children under five years or age. By being universally available the intention was to avoid any stigma associated with receiving a targeted service.

Each SSLP chose its own mixture of services and delivery methods, there was no prescribed set of services or curriculum.

From 2005 to 2006, fundamental changes were made in SSLPs, as they came under the control of Local Authorities and were operated as Sure Start Children's Centres. The service model became more standardized but there was still wide variation between local authorities.

From 2010 Sure Start Children's Centres came under pressure from government for funding to cease and it has decreased significantly over recent years. They became known as Children's Centres and instead of being universally available targeted those families with the greatest need.

The Early Intervention Grant in 2011-12 replaced a number of centrally directed grants to support services for children, young people and families. The grant included money to support Sure Start Children's Centres but it was not ringfenced(6).

Learning

Structures

Aimed at deprived areas, 76% of the Sure Start Children's Centres are based in 30% of the most deprived areas[41]. They provide a wide range of services including; child care, early education, health care, social work, adult education, community engagement, benefits and employment advice. The success of co-ordinating these services around the child and their family is dependent on good partnership working and this varies between centres. The need to co-ordinate services around the child and family is a key theme in Government policy, however the challenges of partnership working continue to compromise successful implementation. Sure Start Children's Centres are one way of achieving this, but are dependent on a strong partnership approach.

The sharing of information across agencies has been a particular problem, especially health information.

The most popular and effective services as rated by 90% of children centre managers[41] are:-

- stay and play,
- evidence based parenting programmes,
- early learning and childcare,
- developing and supporting volunteers
- breast feeding support.

Strategies

The world has changed since Sure Start Centres were first introduced in 1999 and yet, despite reduced Government funding, they have continued to survive. Preschool education is now free for three to five year olds and so one of the benefits of the Sure Start Centre on providing this is no longer valid.

Originally SSLPs were offered universally in deprived areas to avoid the stigma of targeted services. This has changed due to financial constraint and they are targeted at those families most in need. The effects of this change have not been evaluated.

Systems

Pre school education and evidence based parenting programmes are the elements of the Sure Start programme that have the strongest evidence from research in improved outcomes. High quality pre school education is associated with improved cognitive and social development[42]. A long term evaluation of four service models of pre school education in the States found children and young people were:

- Likely to obtain qualifications at school
- Less likely to leave pregnant as a teenager
- More likely to go to college as an adult
- More likely to have higher earnings
- Less likely to be a persistent offender

Evidence based parenting programmes have the greatest initial impact on the health and wellbeing of the parent and this inevitably has a positive effect on the child.

Skills

A study (3) found that greater training and support is required for staff in Children's Centres, especially leaders. The centres that worked most effectively were those where staff had the confidence to contact professionals to get advice for parents or to make referrals. Also, workers that were willing to visit families at home[41].

Centre managers valued being able to talk informally to professionals such as health visitors and social workers[41].

Multi professional training opportunities are recommended[43] to improve partnership working and an understanding of each other's roles.

Leadership

An evaluation of Children's Centres recommended that leaders have the support of an advisory board for guidance especially in areas where they do not have expertise. The advisory board could include representatives from health, social work and Job Centre Plus for example. This would also help enable better partnership working[43].

It was also recommended that Chairs of Children's Boards have training, perhaps similar to the national training which is provided for Governors.

To be effective the centres need good leadership. Managers should be able to help direct staff in making decisions about using the most appropriate evidence based interventions. They should be able to support staff in managing complex cases and being alert to potential safeguarding issues.

It was found that where managers held higher leadership qualifications such as a National Professional Qualification in Integrated Leadership (NPQICL), that they were more likely to have stronger safeguarding arrangements in place and to have the confidence to delegate tasks to their senior management teams. They were also stronger in developing a vision and strategy. Those centres with poor management were found to have a higher level of staff sickness[43].

Evidence

Although evidence of improved outcomes for children and young people in terms of better health outcomes, reduced youth offending and income cannot start to be evaluated until the young person is at least fifteen years old, there are some immediate benefits for parents and the family. Evidence from studies has found[44]:

- An improved home environment
- A decrease in the use of harsh discipline
- Better life satisfaction for single parents and workless households
- A less chaotic home life for boys (not girls).

The benefits of a pre-school education are not included in the evaluations of Sure Start and Children's Centres as these are now available freely to all three to five year olds.

It is difficult to evidence outcomes associated with Sure Start and the later model of Children's Centres as they have differed widely in the range of services provided.

> *For children the economic benefits of early interventions can be high (and much higher than for interventions with similar levels of expenditure on adults), but they typically do not emerge until at least fifteen years after the intervention begins. The benefits are achieved through a higher income, avoidance of entering the criminal justice system through youth offending and improved health. It is from 2014 that the benefits of the early Sure Start programmes can start to be evaluated.*

The Incredible Years – a parenting programme

The Incredible Years Parenting Programme was developed by Carolyn Webster-Stratton within the University of Washington Parenting Clinic. The programme is based on social learning theory and is designed to promote emotional and social competence and to prevent, reduce and treat aggression and emotional problems in young people. It targets parents of children aged 0-12 with conduct/behavioural problems as well as those at risk of living in poverty.

The key aims are to:

- Enhance parenting skills
- Enhance knowledge of child development
- Enhance positive child behaviour
- Improve parent-child relationships.

Learning

Structures

The programme consists of 12 weekly 2 hour group sessions based on social learning theory which are delivered by a trained practitioner. The programme uses a collaborative approach, encouraging parents to learn from each other. Sessions include a variety of techniques including role play, group discussion, homework and DVDs. Practical support is also provided and is a key element of the programme. For example parents are offered transport, child care and snacks, which also helps to promote attendance. The programme delivers a 'basic' and 'advance' level.

Strategies

The Incredible Years Programme has been successful across eleven Sure Start areas in Wales[45]. The Welsh Assembly Government (WAG) has recently funded the implementation and evaluation of the Incredible Years Programme as part of its Parenting Action Plan.

Systems

Supporting families at significant points in their children's lives is a key Government aim.

Every Child Matters – Parenting Support: Guidance for Local Authorities in England (DFES 2006) supports evidence based parenting programmes such as The Incredible Years programme.

Skills

Practitioners should complete Incredible Years Training as it is important that the programme is delivered in the same way in each area if it is to be effective.

Practitioners should have on-going support and supervision from an experienced practitioner.

Culture

For the programme to be effective the following need to be addressed:

- Delivering the programme in a consistent way as prescribed by the programme developers, using their methods and tools.
- The length and frequency of sessions
- Effectively engaging parents

Practical help such as providing transport, child care and refreshments has encouraged attendance in some areas.

The programme can be tailored to meet individual needs provided all of the elements of the programme are included and delivered as prescribed.

Evidence

The Incredible Years programme has been described as the most carefully evaluated group-based parenting programme[46].

An example of the success of this programme comes from the Incredible Years web site[47]. At least 60% of children with Oppositional Defiant Disorder (ODD)/ Conduct Disorder (CD) were in the normal range when tested at year 1 and year 3.
Parents reported an improvement in family life, parent child relationships, a reduction in the level and frequency of problem behaviour, parents stress and overall health and wellbeing improved[47].

The incredible years programme has had positive outcomes for parents of children with a learning disability[48] and foster parents[49]

There was no information available on the financial benefits or costs of implementing this programme.

The Life Programme

The Life Programme was developed and delivered by Participle. It addresses the needs of families in entrenched social, economic and emotional crisis. It was initially designed in partnership with Swindon Council, but has continued to evolve through practice and partnership with Wigan, Lewisham and Colchester.

Life is focused on supporting families to independence (as opposed to managing immediate crises). The programme's approach is developmental: sustained, high trust relationships with the Life team support the development of new capabilities within each family to lead the independent lives they truly want. Families are offered support to foster a core set of capabilities that will support them on the road to the lives they want to lead. The programme is based around four broad stages:-

- Invitation – opening families to change;
- Aspirations – building a plan of what a better life might look like;
- Activities – developing and practising core capabilities around relationships, working and learning, health and living in community;
- Opportunities – sustaining independence and exiting the programme.

The families involved in this programme are characterised by complex inter-generational issues of neglect and deprivation. Many of those who are now parents grew up in crisis themselves and have no role models of their own to follow. The current mainstream services on offer are unlikely to deliver the radically different approach that Particple believe is needed. They say that, a family that has never lived in any other way cannot change on command, and what is needed is a developmental approach based on sustained, trusted relationships.

The programme aims to support a shift from intensive involvement with re-active, costly, enforcement based interventions to pro-active use of universal and preventative services.

Learning

Structures

The Life Programme approach challenges traditional organisational structures. It is a 'family led' approach which shifts the power relationship between professionals and their institutions and families and communities. The approach is about starting where the families themselves are and facilitating a process, as opposed to commanding change around pre-existing service targets.

> *Families are therefore supported to create their own plans and lead their own change, albeit with an awareness of the many plans surrounding them from the many services involved. Critically, these plans are not just about stopping or reducing 'problem behaviour' but, in keeping with a capabilities approach, identify individual family members' aspirations, talents and goals and work towards a more positive vision of the future. Life teams work as a reflective unit around the family[50].*

This team around the family approach is unusual in the UK context, but feedback from families and teams is that it is hugely beneficial

Advocates claim that this approach enables families to draw on the skill-set and knowledge of the entire team and ensures that there is more than one mind at work in picking up dynamics and issues, minimising the risks of collusion and drift. It also enables greater consistency for a family, as they do not need to rebuild relationships if a worker is on leave or moves on and always ensures they have a network of support. It also means that team members frequently work together engaging in activities with multiple family members or helping the family work on their relationships.

Systems

There can be quite a number of challenges in applying this kind of developmental programme within the mainstream public sector system. Currently systems and services around families are highly complex and fragmented. Often this results in an uncoordinated and inadequate response to chronic, multi-faceted needs, forcing frontline staff to 'work round' the system.

> *In each Life Programme, teams have amassed numerous examples of barriers and blockages within the wider system: head teachers who will not accept the children of families they know to be trouble, gaps in support services for families with learning disabilities, endemic mental health issues for which there is no provision, a culture of managing crisis and information, rather than gripping and solving issues, and much more. Our most ambitious partners have embraced the dilemmas and difficulties this work exposes and are working directly with this learning to think about ways to improve how they design and deliver a range of mainstream services, from social care to housing. This learning element to each programme is central to the Life approach, but quite different to many 'traditionally commissioned' family support programmes[50].*

The system is really challenged by families in chronic crisis, which the Life Programme defines as having the following characteristics[50]:

- Current and historical experience of multiple and entrenched risk factors such as domestic violence, substance misuse, housing issues, mental ill-health, child protection concerns, anti-social/offending behaviour and children with school attendance issues;
- Particularly costly to the public purse as a result of long-term engagement with services, especially social services and police; often recipients of intensive but ineffective single-focused interventions and considered 'stuck' in the system;
- Family members at risk of losing their home, children, or liberty.

And the situation can be quite endemic.

> *Families may be isolated from support networks, live in fear, have numerous and serious mental, physical and emotional health issues and – most importantly – have never known a different life. The challenges are inter-generational: just as parents and grandparents before them, children and grandchildren grow into the same patterns[50].*

Skills

The Life approach requires very well selected, trained and supported staff.

> *The training is highly experiential demonstrating the Life principles (see below) and tools through people's own personal and professional experience and examples from Life. Where possible members of families that have "graduated" or are part of the Life programme attend. One member of the Swindon team described the process as 'stripping away the system'. Others have said it is more like peeling back the layers of an onion, gradually revealing 'the person behind the professional'. Team members are invited to 'be the change', to bring themselves to the work and to share their own life experiences, in a way and at a time that is appropriate. Time and again family members talk about how this has resulted in a qualitatively different kind of relationship and feeling of support and empowerment[50].*

In addition to this there is a high quality support and supervision infrastructure.

> *'Live Supervisors' are therapeutically trained professionals (usually psychotherapists or family therapists) with extensive experience of child and family work. Their role has been designed as a flexible but tailored therapeutic resource for Life teams, which provides Life team members, who do not usually have backgrounds in mental health, the supervision to guide their very difficult work. This may be through holding reflective team discussions on family work, providing training on a particular mental health issue or visiting a family directly with a team member. Our relationship with the Tavistock has therefore enabled us to design a structure where a therapeutic approach can be accommodated within families' lives[50].*

As noted above the Life Programme is a family led approach so this requires a very different approach from staff. It requires a subtle shifting of the professional/family power balance through asking the families to decide how they want to use the team's support and what they want to change. Staff therefore need to be able to work flexibly and at the pace of the family. The Life Programme interim report[50] describes how one worker spent two months, sitting outside a house with a thermos every day, until the family eventually decided to meet with her.

The Life programme has a set of core tools: the Life Plan, the Talking Triangle and the Life Star. These tools support family members to talk about different aspects of their life, identify their aspirations and make realistic short and long-term plans to achieve them. The core tools help people visualise their own progress, reflect on setbacks and support the team and families to have difficult conversations. Beyond the core tools, there is a broad and flexible toolkit of bespoke resources for families and teams to use to support the development of various capabilities.

The Life programme has a well defined set of core competencies for staff.

Competencies of Life Team Members

Fundamentals	Characteristics	Capabilities
Being Loving	• Nurturing • Caring • Compassionate	• Ability to build real relationships based on trust and mutual respect • Ability to model loving relationships • Ability to understand importance of family relationships and dynamics
Being The Change	• Self-aware • Authentic • Perceptive	• Ability to share their own experiences, have insight into their own needs and manage the impact of work on them • Ability to use self professionally
Team not a Key Worker	• Collaborative • Communicative • Insightful	• Ability to work closely and collaboratively with families, Life team colleagues and professionals in the wider system
Co-building capabilities	• Positive • Empowering • Reflective	• Ability to help people discover and develop their strengths, overcome barriers and learn from setbacks
Development not fixing	• Curious • Patient • Perceptive	• Ability to reflect, generate insights and support families to do the same • Ability to hold close relationships with families but still 'see the bigger picture'
Offering an open invitation	• Resilient • Persistent • Supportive • Challenging	• Ability to be non-judgemental, open and honest with families • Ability to motivate and support others • Ability to challenge when needed
Being Family-Led	• Creative • Flexible	• Ability to encourage and support decision-making and planning in others

Source: Cottam H [50]

Culture

The Life programme is fundamentally about cultural change. Life is focused on supporting families to independence, as opposed to fixing a crisis or managing a risk. The programme aims to support a shift from intensive involvement with re-active, costly, enforcement based interventions to pro-active use of universal and preventative services

Life is a developmental programme – its purpose is to enable families to enjoy long, healthy and creative lives. At its core is a belief that most families, whatever their circumstances, want to, and can, develop core capabilities if given the right set of trusted relationships. To deliver Life you need to build this trust, to 'be the change'[50].

The culture change is reflected in the core principles which underpin the programme:-

The Fundamentals of the Life Programme

These are the key principles that all Life teams sign up to and underpin their work

I Offering an Open Invitation

inviting families to change rather than coercion and sanctions to do so, but being persistent in that offer.

II Being Family Led

Life teams start where families are at and help them identify what they want to change and how - being open to change is a core criteria as Life believes that sustainable change is only possible if is identified and committed to by families themselves.

III Development not Just Fixing

Life teams aim to equip families with the tools they need to develop their capabilities to live healthier, happier lives in the long-term, as well as supporting them to resolve practical problems in the short-term.

IV Co-building Capabilities

The Life Programme aims to help families discover and develop 4 key capabilities - the ability to value themselves, design a life they value, have meaningful relationships and live in their community.

V A Team, Not a Key Worker

Life Teams work as a reflective unit around families as well as building one to one relationships between individual team and family members.

VI Being The Change

team members bring themselves to their work and share personal experiences as part of their professional role.

VII Being Authentic

teams act with compassion and are open and honest in order to build and model real relationships of trust with families - relationships that involve challenge as well as support. This Fundamental was originally 'Being Loving'.

Source: Cottam H [50]

This culture change applies as much to staff as it does to the rest of the system.

> *It has been core to the philosophy of Life that the people and skills needed for this difficult work are to be found at the front line of our public services. However, in order to do the work they see as their vocation, they need to be liberated from the structures of existing systems. The challenge, in other words, is one of systemic culture change[50].*

The culture is embedded within the way that the programme engages and works with families.

> *Life starts with an open invitation. We have seen families who were previously resistant to statutory interventions, open up when offered an opportunity as opposed to being threatened with a sanction. In other cases persistence is required. One Life team Member spent two months visiting a parent and sitting on the doorstep with a thermos flask until she was finally let in to the family home. Some families can take up to six months to accept the invitation, a further crisis often being the moment of opportunity.*
>
> *The invitation is critical to the Life approach (and often initially met with suspicion by those in statutory services, who cannot believe that families who have traditionally put their energy into evading services will accept the invitation). The invitation sets a different tone – putting the family-led philosophy into practice from the first interaction. Equally importantly, it enables the Life team to expend effort at the right moment.*
>
> *Where our prescribed process has been followed, no family has ever refused the invitation, although one family in Swindon came back after a year to take it up when they were ready to engage and having seen the impact on others[50].*

Leadership

With its focus on culture change, the Life programme sees leadership, especially team leadership, as key to its effectiveness.

> *The nature of the work, the sometimes difficult relationships with other agencies and the change in personnel, make the role of team leadership absolutely critical. The strongest work is unsurprisingly taking place where the strongest team leaders are in place. Core skills for this role include both team management and the ability to lead by example and work with families. The latter has been particularly difficult for some of our team leaders to sustain in a culture where leadership is not associated with time at the front line[50].*

The programme feels that it has worked with a number of inspirational leaders however it recognises that the programme remains vulnerable when these leaders move on.

> *This challenging, culture-changing work needs to be led from the top with vigour and sustained commitment[50].*

Evidence

Collecting data has proved to be possible but difficult. Some of the partner authorities have been reluctant to share data, even in anonymised form. It has been a challenge therefore for the programme to collate comprehensive and comparable outcomes data. That having been said, they have designed a simple measurement framework, which collects cost saving data, capabilities (created and sustained) and outcome data. The central component is a capability framework based around four key capabilities - translated into vernacular as:-

- valuing myself,
- designing a life I value,
- meaningful relationships
- living in the community

Each of these capabilities are measured through 10 indicators.

The programme's outcomes and cost measurement process collates the service involvement of families for the six months prior to involvement in Life and then tracks these costs and outcomes throughout their involvement in the programme. All outcome data is collected from existing databases held by Local Authority partners. Historically each partner has collected different outcome indicators – but the process of collating these has been made simpler by the agreement of a national framework as part of the Troubled Families work.

To measure cost savings, the programme first calculates what the total spend is per family under the status quo. Then, as the families progress through the Life Programme, they measure cost savings relative to this benchmark under two headings:-

- direct cost savings
- prevented cost savings.

The calculation of direct cost savings is nevertheless a very complex and challenging process.

> *A significant challenge in estimating the potential cost savings of the Life Programme is that the data describing what is currently spent on families with multiple issues is fragmented across different agencies, and complete calculations of the costs of engaging and intervening with families are hard to assemble. However, working with 47 family members in Swindon we have created a matrix that maps the costs of services and activities against the various agencies that fund them. We initially identified 24 different council departments and other agencies and over 70 different types of service/activities. We then conservatively estimate total expenditure on these families using a mix of internal Swindon cost data and cost data reported in external research. We have used these calculations of total expenditure to estimate a 'baseline cost' - the costs incurred by the families six months prior to entry into the Life Programme[50].*

Calculating 'prevented cost savings' is undertaken in a systematic fashion.

> *Families in the Life Programme are typically on a path of escalation prior to their entry; their circumstances are getting worse. The team works with the families to prevent these escalations and to create space for the family to work on solutions. For example, children not placed in care (which was expected to have otherwise occurred with a 80- 100% probability). To measure prevented cost savings Life team members assess what interventions (and associated expenditure) families would have required were they not on the Life Programme, and the probability that those interventions would have taken place. The prevented cost savings achieved by the Swindon Life Programme are the cost of these interventions multiplied by their probability. In its first two years, 2010- 2011, the Swindon pilot achieved direct and preventative cost savings of £1.48m[50].*

When aggregated across families, the variety of data aims to show qualitatively, quantitatively, and graphically the impact of the Life Programme at the family and programme level.

Nottingham – Early Intervention City Programme

The Nottingham Early Intervention Programme was set up in 2008 with £4.2m, led by the strategic partnership – 'One Nottingham'. The aim of the programme is to bring about a strategic shift to early action

> *Our aim is to break the intergenerational nature of underachievement and deprivation in Nottingham by identifying at the earliest possible opportunity those children, young people, adults and families who are likely to experience difficulty and to intervene and empower people to transform their lives and their future children's lives[51].*

Early Intervention is claimed to be embedded throughout Nottingham's Strategic Planning Framework, starting with the Nottingham Plan. This sets the agenda for change for Nottingham over the next decade. It is a strategy for jobs and prosperity, for better neighbourhoods and for strong and aspiring families.

> *Right at the heart of this vision - and this strategy - is a determination that over the next two decades we will fashion a new direction for Nottingham where accelerated wealth creation goes hand in hand with a decisive breaking of the cycle of intergenerational poverty through early intervention, so that more of our children grow up to benefit from the City's wealth and with higher aspirations.*
>
> *In 2030, Nottingham must not only be wealthier, but fairer. The true test of whether we have succeeded will be how many of our children grow up to achieve more than their parents. These are big aspirations. We will not achieve them by 'muddling through' or by sticking to conventions. We will need to be radical in our analysis of what we must do, bold in our willingness to act and not afraid to be different[51].*

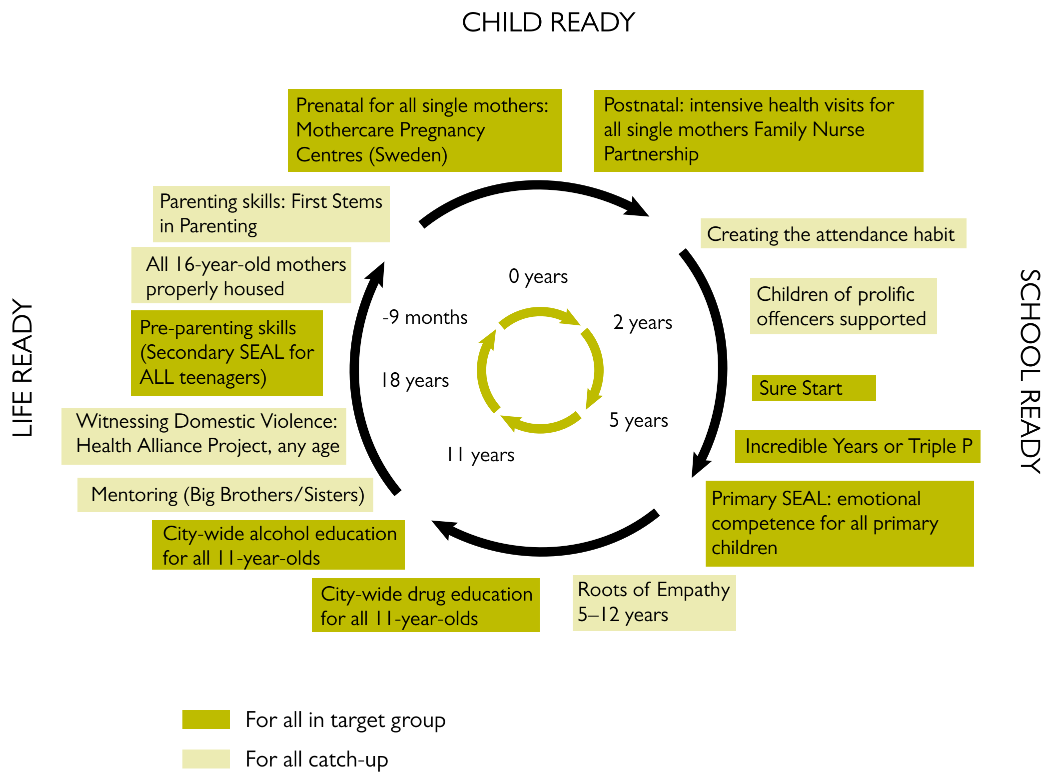
The Programme is structured around five themes:

- Governance - aligning priorities, decision-making and workforce development
- Projects - trialing new work or re-engineered services to meet needs
- Learning and Evaluation - strengthening local evidence and research into practice
- Finance - understanding costs and benefits
- Knowledge Management - better understanding how to meet the needs of our children and families

The Programme outcomes are to:

- break the intergenerational cycle of deprivation and challenges in Nottingham
- Ccose the performance gap within the City in terms of key outcome indicators for children, young people, adults and families
- close the performance gap in terms of key outcome indicators with similar cities in England
- develop a methodology and approach that allows the gradual switching of resource towards prevention and early intervention alongside working out new ways of funding
- link closely to key national policies, maximising opportunities for Nottingham to champion initiatives working to promote early intervention

Nottingham's Early Intervention model: by age, intervention and aim



Source: Allen G [52]

The guiding principles underpinning the programme are[51]:

- Focusing on tackling intergenerational issues
- Focusing on those activities that, if delivered, can reduce the number of specialist interventions
- Focusing on bringing partner resources together to make this happen
- Targeting work at those individuals or families who are very likely to have difficulties without effective support / intervention. (This is subtly different to prevention which is targeted at those individuals / families who might have difficulties)
- Focusing on coherence for the children, young people and families within the delivery model
- Shifting resources to tackle the complex causes of problems, rather than just treating the symptoms

The programme cites[53] a number of achievements:-

- 16 projects provided the opportunity to pilot evidence-based programmes from other countries and adapt or create new innovative programmes of support and create a stronger evidence base locally
- Over 15,000 children and families have been supported.
- Successful work with a strong evidence-base has been mainstreamed through core commissioning funding, some work has entered a second phase to increase sustainability

or trial in a different context and work where evidence was not strong enough has been decommissioned.
- Better links between some services and systems have been forged, adding value for families.
- Creation of Family Community Teams, so that services are more holistic.
- A new Family Support Strategy which sets out a vision of how to work with families, underpinned by early intervention principles
- Creation of a Core Standard for the Children's Workforce, to drive more consistent early intervention approaches across agencies, when working with families.
- Cost/impact analysis methods are being developed, alongside a menu of local costs.
- work has been very successful and has now moved into mainstream budgets which is now driving a shift to greater early intervention through commissioning.

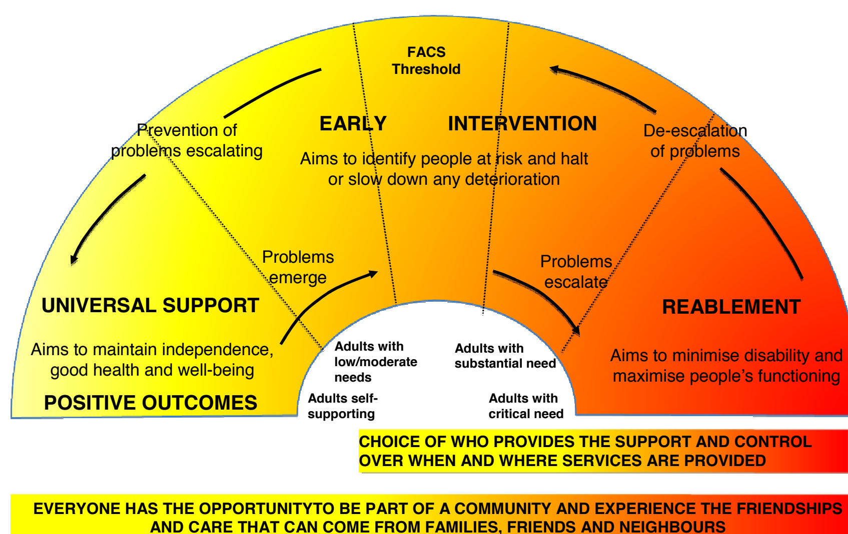
The Learning from the Early Intervention Programme so far includes[53]:-
- the importance of partnership working in order to deliver joined-up decision making and an integrated workforce
- the need to roll-out evidence-based programmes properly, and engage the right families
- the importance of evaluating delivery and building the evidence-base
- the importance of spending time and effort to understand what is really happening in the system
- how vital it is to fully know the costs of what is being delivered

Early Intervention Adult Social Care Pathway

Early intervention has been recognised as being important for adults and older people to stop problems from starting, halt or slow issues from escalating to crisis quickly. The national research is currently thought to be piecemeal, so Nottingham is piloting and evaluating a number of models, before rolling them out more widely.

Nottingham is developing an Adult Social Care Early Intervention spectrum of support (see below) which targets citizens at the current 'high-moderate' level alongside those citizens who will eventually reach this level. Some interventions will be appropriate for citizens who enter at 'substantial' level after an unexpected crisis, to support needs and de-escalate from requiring on-going care.

Early Intervention Model for ASC (DRAFT)



Big Lottery Well-being Programme

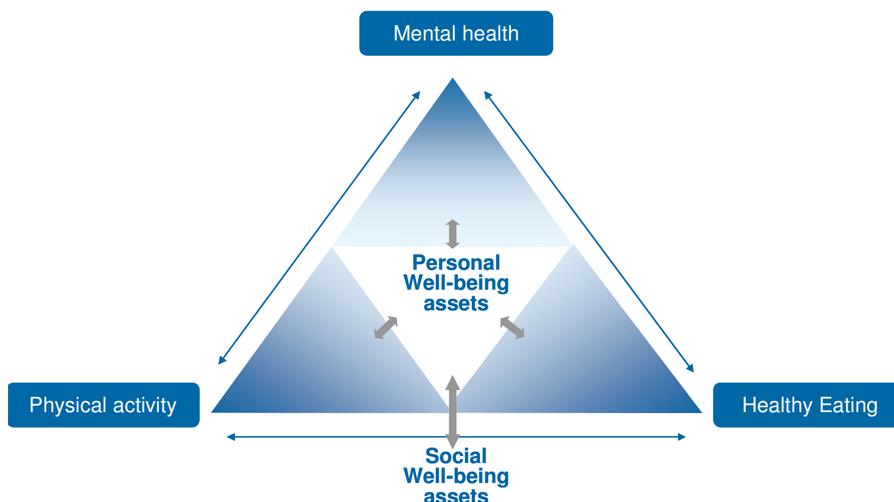
The Big Lottery Fund's Well-being Programme was a £165 million programme supporting projects across England, focusing primarily on three themes or strands of wellbeing:

- healthy eating;
- physical activity;
- mental health.

The majority of the programme began in 2007.

Well being has been defined as - '*A dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community.*'[54] In this sense, promoting wellbeing is a critical early action initiative. Enhanced wellbeing by definition means that there will be less demand on reactive and crisis services.

The model of well being used by the Big Lottery was as follows:-



Source: NEF [55]

The programme as whole was found[55] to have significant impact on all three strands of well-being; mental health, physical activity and healthy eating as well as on participants' social well-being and personal well-being. The improvements to participants' well-being were found to continue beyond participation in the programme.

> *The survey data and the case studies revealed strong connections between the different strands of well-being. The strongest correlation was found to be between improved personal well-being and improved mental health. It emerged that improved mental health and personal well-being were very important factors in enabling participants to make and sustain changes to their eating and exercise habits.*
>
> *Increased self-confidence was found to be central to improving all areas of an individual's well-being. Participants' self-confidence increased as a result of increased social well-being, improved mental health, or a sense of personal progress. Increased self-confidence led to participants feeling more motivated and determined to adopt and maintain healthier behaviour and to access other opportunities to improve their health and well-being. Adopting healthier behaviour and becoming more involved in other activities was found to lead to yet greater self-confidence; forming a positive cycle of increasing well-being.*

Much of the related research in this area suggests that increasing healthy behaviours (such as physical activity and healthy eating) improves personal well-being and mental health; however our research is suggesting that to enable healthy behaviour change you first need to improve personal well-being and mental health. Our research is supported by other research into behaviour change which suggests that gains in self-confidence need to be made before lasting behaviour change can be achieved[55].

Learning

The programme highlighted a number of success factors relevant to the early action agenda.

Factors influencing project success

Source: NEF [55]

Structures

Given the multifaceted nature of wellbeing it was clear that interventions would need to work across various organisational boundaries and structures in order to be effective. The evaluation identified a number of success factors for successful partnerships working:-

- working with public healthcare providers to address local health and well-being needs;

  It was often found that projects which worked with local healthcare and social care providers were able to better reach target participants through referrals from health and social care workers. Working with statutory health and social care providers also meant a project could target local health needs and support local public health priorities[55] .

- working with a diverse range of partners to offer expertise in a number of areas. Projects that worked in this way were able to develop complementary strategic connections, resources and expertise, which increased their reach and capacity
- forming strategic as well as delivery partnerships to promote projects' work and support projects' future commissioning bids. It was also found that recruiting volunteers who had good contacts locally assists a project to reach out to potential participants, drawing on the resources of local organisations, and embedding the project in existing local provision.
- sharing learning between partners and holding networking events to encourage people to work together and raise a project's profile;
- building a strong project brand to build confidence and interest among local partners and show that community sector organisations can be professional and capable of working effectively in partnership.

Strategies

Any successful strategy has to start by identifying the need it is seeking to address. This was found to be very true for the Wellbeing Programme.

> *Successful projects were found to have invested time in identifying local health priorities, and the health and well-being needs of specific groups in the local area. An important element of this was identifying existing service provision and which organisations were involved in planning and delivering it. Successful projects engaged with organisations to ensure their work met an existing gap in service provision[55].*

However, identifying local priority needs was not sufficient; it was important to work out strategies to fully engage the target group. An important dimension of this was working with local organisations to reach target participants, understanding the barriers to the target participants' participation in a project and designing the project to overcome these. In particular, it was found to be important to recognise new participants' low self-confidence and any practical constraints including availability of time and money.

> *A key barrier to participation for many was low self-confidence and low self-esteem, thus projects which worked to address this were often successful in reaching their target group. Engagement with individuals who were particularly hard to reach, such as women from Black and Minority Ethnic groups, was achieved by connecting with local community organisations, and employing members of staff or volunteers to specifically reach out to people who would otherwise be unlikely to participate[55].*

For projects to be successful in increasing well-being they had to consider how to sustain the participants' engagement. An effective way of doing this was to enabe friendships to develop between participants which was found to motivate them to continue attending. Providing

opportunities to become more involved, such as volunteering could also sustain participants' engagement.

> *In addition to offering enjoyable activities, successful projects often encouraged participants to be actively involved in the project and take some level of responsibility for the project's delivery. This meant that participants did not passively receive an activity but took responsibility for changing their behaviour or supporting others to change[55].*

Some projects went further and fully involved members of the community in co-producing and delivering the project – which gave people a sense of ownership which in turn – tended to increase their motivation to change their lifestyle, and increased their personal and social well-being.

> *Providing participants with an opportunity to be actively involved in a project means they are more likely to be committed and motivated to take up healthier behaviour, which would improve their well-being. Developing a long lasting relationship with a project also helps participants to feel a sense of community and social support, which is important for social and personal well-being. Involving participants in designing and delivering a project also means it is more likely to meet their current and emerging needs[55].*

Several other elements were found to be effective[55]:-

- taking a holistic approach to improving one strand of well-being or addressing multiple strands of well-being to encourage broad lifestyle changes;
- including a social element to an activity to increase participants' enjoyment, motivation and social well-being;
- building participants' self-confidence and self-esteem and providing emotional support alongside gentle activities;
- providing a programme of regular activities which allow participants to develop a routine, create a healthy habit and form friendships;
- carefully targeting and engaging with a specific target group(s);
- providing support to encourage participants to sustain their improved level of well-being beyond the project lifespan;
- involving volunteers and offering volunteering opportunities;
- addressing an existing evidenced need in the community

Systems

A key characteristic of the most successful projects was that they took a holistic approach to improving participants' well-being. By including multiple aspects of a certain well-being strand, projects were able to address participants' attitudes, enjoyment and knowledge, and provide them with the facts to adopt healthier behaviour in the long term. As with other early action initiatives, a holistic approach – i.e. addressing multiple aspects of a person's well-being is important for supporting participants to make lasting improvements to their well-being

Government can also lead by example on this by encouraging joined-up working across Departments and by using a well-being perspective to bring together work from different Departments[55].

Skills

Having project staff who were empathetic and enthusiastic is very important for increasing participants' self-confidence and supporting them to make positive changes to their lifestyles;

The research also found that having staff members of different ethnicities, ages and educational backgrounds helped a project to engage with different social groups. Likewise, having staff members with complementary skills, who could provide a range of activities, and meet the needs of different participants was important for creating a fun, interesting project which also provided emotional support.

Evidence

The evaluation strongly recommended:-

- for service providers to embed monitoring and evaluation in the project design from the beginning in order to capture information on the outcomes of the project;
- that gathering qualitative as well as quantitative data is useful for understanding how the project improves participants' well-being and for communicating findings to commissioners and partners
- recording financial information is also particularly important in order to demonstrate a project's value for money when seeking public sector commissioning.
- the methodology developed and used to evaluate the Well-being and Changing Places programmes offers lessons to Government on how to evaluate subjective well-being effectively and interpret well-being data

There was another aspect of evidence gathering which was found to be critical. Using tools to help participants to monitor their progress in improving their health and well-being can be effective in motivating participants to maintain positive changes to their lifestyle and can help people to be more aware of their own health and well-being.

An important factor to the success of well-being projects is increasing participants' self-esteem, which is important for them to feel motivated and able to make changes to their lifestyles. A way in which this was achieved by various projects was to enable participants to monitor their progress and set their own goals. For example, some projects used tools, such as the outcomes star or a pedometer, which allowed participants to see their progress and be motivated by their sense of achievement. Likewise, using food diaries was found to increase participants' awareness of healthy eating, and tracking their weight loss encouraged them to make healthy choices.

However, since participants' self-confidence is often very low at the beginning of their engagement with a project, it was important for projects to emphasise that assessment of their progress was optional[55].

As the evaluation notes, this is reflected in the findings of an evidence review by the King's Fund[56] into effective interventions for changing lifestyle behaviour among low socio-economic groups. The review highlighted that *'goal setting is a key behaviour change technique in evidence based theories of behaviour change'* and that *'setting goals that are realistic and achievable help*

people to feel more confident about being able to change their behaviour'. Goal setting is therefore a simple way of building a person's confidence and motivation to improve their health.

The review also found that adults with a low income or low level of education are likely to have a low 'patient activation measure' (PAM), which is a measure of a person's confidence, knowledge and skills to make a sustained improvement to their health.

Reshaping care for older people: Change Fund

In 2010 the Scottish Government and the Convention of Scottish Local Authorities (COSLA) jointly launched Reshaping Care for Older People: A Programme for Change 2011 – 2021 (RCOP), a ten year programme aimed at improving older people's experience of care and support. Although the Programme seeks to address the current and future economic and demographic challenges Scotland faces, its primary goal is to create a seamless, community orientated service that is accessible, person- centred and responsive and which supports people to stay as healthy and well as they can.

Embedded within the programme is an explicit requirement to undertake a shift towards prevention and early intervention. It was informed by findings that as much as 40% of public spending was focused on combating problems that could have been avoided had there been more investment in a preventative approach. The Scottish Government states that it has taken this on board, and progressed the agenda of prevention not solely for the financial benefits, but for the social benefit of improving people's quality of life. To this end, the Change Fund was set up to allow local partnerships across the country to distribute funding that would help maintain and develop preventative services[57].

As part of the Reshaping Care for Older People Programme, in 2011-12, Scottish Ministers allocated £70 million to the Change Fund. All 32 health and social care partnerships were required to agree a programme of change that satisfied the council, NHS Board, the third sector and independent sector. With a further allocation of £80 million in 2012/13 and 2013/14 and a final allocation of £70 million in 2014/15 across Scotland, this £300 million will continue to drive the development of services that optimise the independence and wellbeing of older people at home or in a homely setting.

There are explicit expectations of a shift in funding away from acute services towards preventative and early action initiatives:-

> *The shift will require a shift in the balance of resources, so that we are spending more money on the measures that can prevent someone needing to go into a hospital or care home, rather than what has happened in the past, where we spend money on expensive hospital or care home services to look after people whose situation could have been avoided or delayed… Preventative and anticipatory care will therefore need to be at the centre of all service planning and delivery.[57].*

The Scottish Government recognises that maintaining the status quo will not suffice and significant shifts to anticipatory and preventative approaches are required to achieve and sustain better outcomes for older people[58]. Partnerships are required show how changes in service provision demonstrate significant shifts in investment and activity into communities from institutional provision. [58].

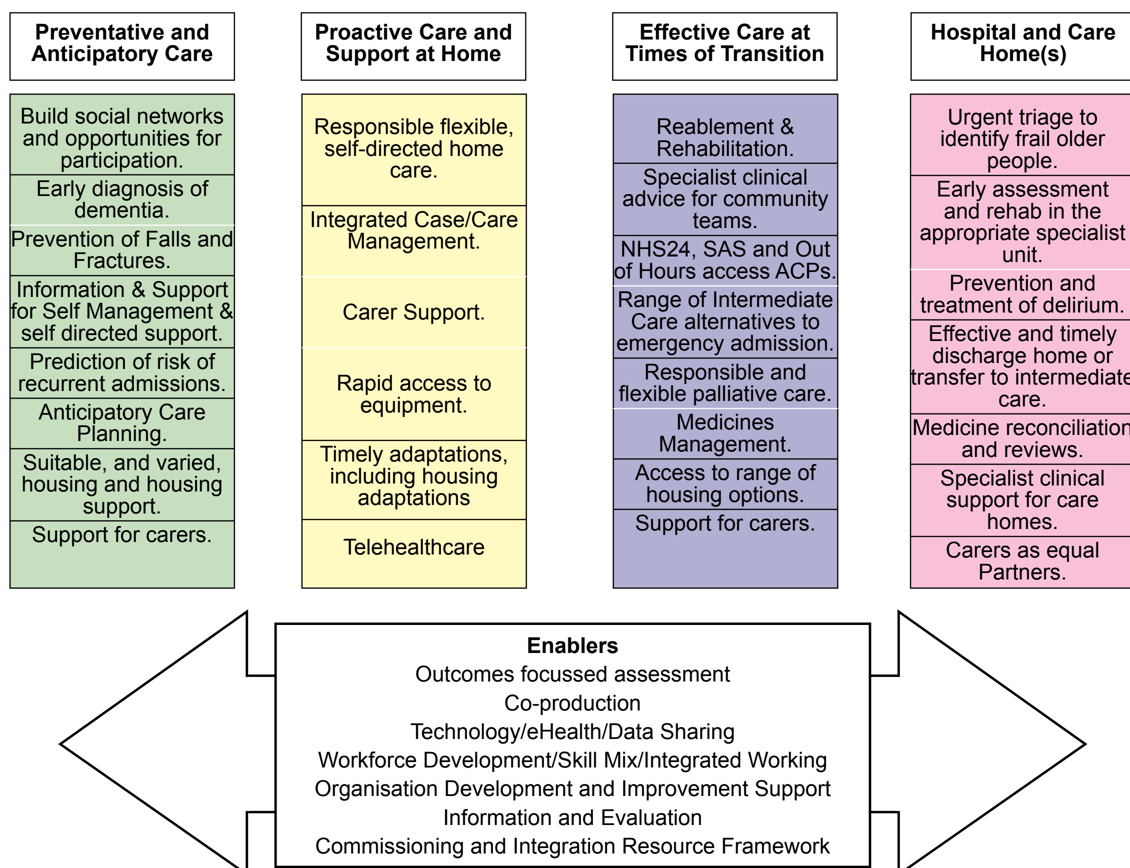
> *Partnerships must make the best use of this transitional Change Fund to lever genuine shifts in the totality of their health and care spend and to rebalance care, support and service provision towards anticipatory care and preventative services that will support older people to stay in their own homes. Partnerships must consider pathways of care and shift*

resources to build the services that support people at the very beginning of their care journey including through self directed support mechanisms.[58]

The 4 pillars of the Reshaping Care Pathway are:

- Preventative and Anticipatory Care
- Proactive Care and Support at Home
- Effective Care at Times of Transition
- Hospital and Care Home(s)

The following diagram[57] shows the pathways and the elements within them.



Source: Scottish Government [57]

In it's mid year review the Scottish Joint Improvement Team were able to report a reduction in the use of care home places and a reduction in emergency hospital bed days against projected increases[59].

Three years into the implementation of RCOP, the third sector continues to welcome and support the goal of enhancing the quality of life for older people through the shift towards preventative and outcomes focused approaches[60].

> *The third sector demonstrates a high level of commitment to the RCOP agenda in terms of its focus on prevention, outcomes and the principles of coproduction, person-centredness and innovation. This builds on a long standing ethos present within the third sector. There is general consensus that RCOP has been a catalyst for meaningful change in the way public sector services are designed and delivered, and has facilitated greater third sector involvement in this. However, it is also understood by all that it remained a work in progress. [60]*

Learning

Structures

The Scottish Government have mandated that implementation of the programme in each local area be governed by a multidisciplinary team, the RCOP Strategic Partnership. The Scottish Government also mandated the core membership of these Partnerships: the third sector, local NHS Board, Local Authority and Independent Sector[60].

Although local RCOP structures are often presented as being clearly defined and linear, in practice these can be extremely nebulous because the agenda is not confined to a single policy or service context. A review of the programme has found that in reality the work tends to be coordinated through an increasing number of formal and informal groups, forums, committees, sub-committees and work stream groups, including groups linked to local community planning[60].

The third sector feels more firmly embedded in the RCOP Strategic Partnership structures and see their role expanding beyond attending RCOP Partnership meetings to include:-

- Advocating for the interests of the sector
- Offering a different and often new perspective on issues
- Acting as a 'critical friend' for statutory sector colleagues
- Making connections between the community and statutory sector
- Reflecting on discussions and decisions from a generalist perspective, and
- Identifying where the sector could potentially make an enhanced contribution to the outcomes[60].

However, the third sector organisations within local networks, (particularly small or local ones), have required additional or specialised support to build the skills and capacity necessary to engage with the RCOP agenda. This has placed increased pressure on the developmental function of the TSIs[60].

> *The complexity of the local structures that govern and coordinate RCOP activity is also an obvious challenge. Particularly given the commonly held perception of "having a seat at the table" as a vital enabler of the sector's influence, and a key benchmark of its level of involvement. It may be that these groups are all required and that each has a distinct and discrete role and remit. It is also possible that they have evolved over time to meet specific challenges and that some are no longer required. Given this it may be helpful for Partnerships to reflect on their structures and how they inter-relate with other local partnership structures to ensure that local structures are as streamlined as possible. This would also allow the sector to revisit its involvement in the various groups and scope the core knowledge, skills[60].*

As one would expect, there is great complexity arising from the transformational change which is underway. This has given rise to comments[59] about the difficulties of developing and sustaining new and changing relationships with multiple partners. Some Partnerships suggested that their challenges have been exacerbated by changes in local organisational structures.

Systems

In reviewing progress with implementation one of the most common challenges identified were the difficulties in making long term shifts towards prevention in the face of immediate and short term pressures from rising demand and significantly reduced funding. A number of Partnerships described perceived pressure to demonstrate impact in an unreasonably short timescale in practice when the time required to effect whole system redesign and a sustained shift to prevention is such that the full impact of some longer term interventions may not be evident for several years.

Strategies

Each RCOP Partnership also has an investment fund - the RCOP Change Fund - to invest in the activities it believes will have the most significant impact on driving the change. In some areas these investment decisions are fully managed by the RCOP Strategic Partnership. However many areas have devolved some, or all, of this responsibility to the sub groups which either make investment decisions, or make recommendations to the Strategic Partnership for their approval.

There is an expectation that partnerships should develop effective Joint Commissioning Strategies. A review of implementation [59] suggests that most partnerships are making good progress on these, with a number reporting they are more able to understand the totality of resources that joint commissioning will bring together. Most partnerships have carried out some form of engagement and joint strategic needs assessment and a number are already consulting publicly on their draft plans.

In the same exercise[59] partnerships were asked to consider the extent to which local Change Fund activity has changed the spend profile of the total resource envelope for older people, and whether this has resulted in any disinvestment. The picture is mixed:-

- approximately a third of partnerships explicitly stated they are of the view that it is too early to expect evidence of a change in the profile of their programme budget. Most Partnerships are still focused on best use of their Change Fund. Their responses are generally characterised by descriptions of interventions funded by the Change Fund and not on the wider programme budget for older people
- Only three partnerships explicitly described the contribution from acute activity and/or resource use for older people.
- Twelve partnerships describe examples of marginal disinvestment, with eight providing examples of disinvestment in care home placement budgets and five examples of disinvestment resulting from bed closures in community hospitals or geriatric specialty beds.

There are clearly significant difficulties in achieving disinvestment and the shifting of resources towards early action

> *More needs to be done to target resources on preventing or delaying ill health and on supporting people to stay at home. There is little evidence of progress in moving money to community-based services and NHS boards and councils need clear plans setting out how this will happen in practice[61].*

The Audit Commission note that shifting resources from hospitals to community-based services can only happen if there is[61]:

- a good understanding of how resources are being used at a local level
- clarity about what works to deliver positive outcomes for older people
- a mechanism to move resources
- a clear plan about what resources will move and when this will happen
- routine planning and good engagement with local clinical and social care staff.

Culture

There is a strong sense that many of the cultural values commonly attributed to the third sector are now finding their way into mainstream service planning:-

> *The feedback from across the sector also emphasized that these core principles along with others such as coproduction, person-centredness, collaboration and innovation have long been the foundations upon which the third sector operates[60].*

Leadership

As the Audit Commission in Scotland[61] note, there is a need for strong national and local leadership in order to take this significant change agenda forward. There is a particular need for leadership in relation to the involvement of the third sector

> *There was a general desire for the Scottish Government to provide greater guidance about how to involve the third sector in strategic RCOP planning, and for it to be more pro-active in providing solutions to the challenges faced by the sector, particularly with regards to resourcing its role[59].*

That having been said, there is nevertheless a view that the Reshaping Care and the Change Fund has helped to refocus and reinvigorate partnership working, and in particular the role of the Third Sector and, increasingly, the Independent Sector in working with statutory services to redesign care and support[59].

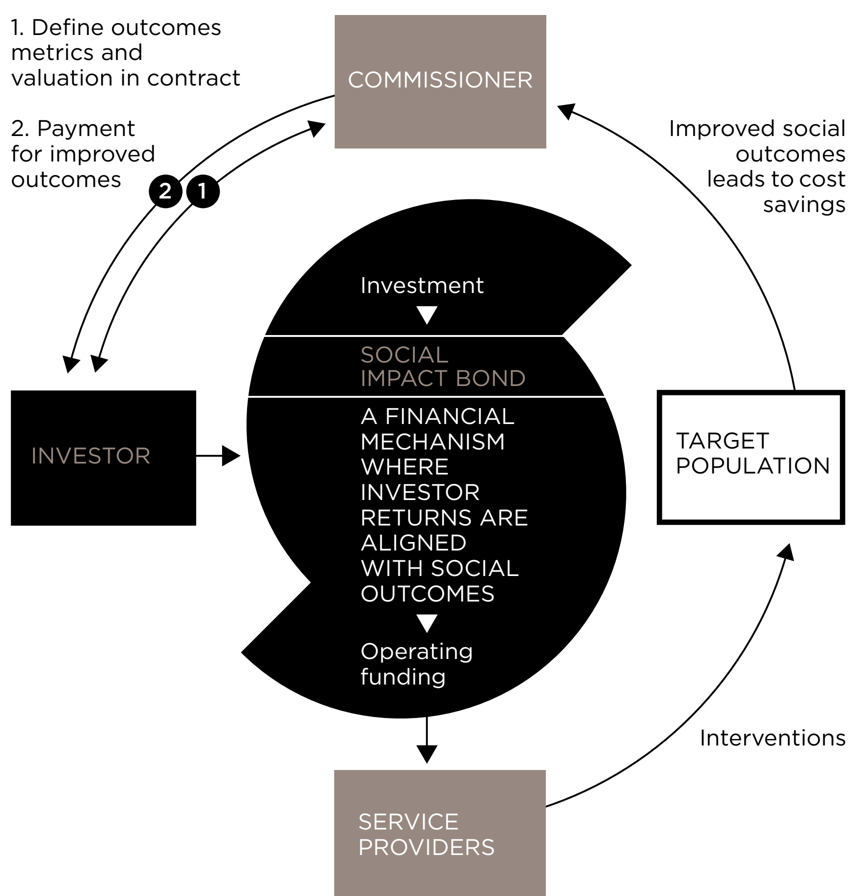
Section Three

Tools for change

Social Impact Bonds

Social Impact Bonds have the potential to be a very effective mechanism for facilitating the shift in resources towards early action. They are not a preventative mechanisms per se, however the rigor of the model and the fact that it focuses on financial flows makes it very suited to this agenda.

Under a Social Impact Bond (SIB), investors provide new, up-front funding for preventative services and manage the delivery of these services. Commissioners only pay when and if these outcomes improve. The model incentivises effective management and avoids the need to potentially pay for failure. Often, but not always, payments are made from the associated savings.



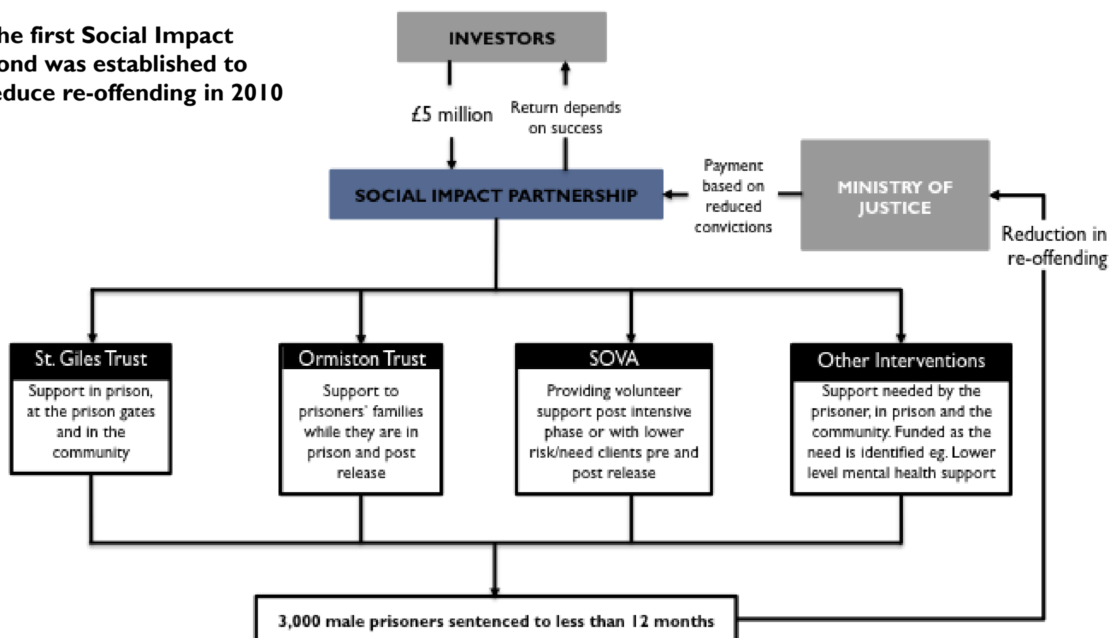
Taken from Social Finance [62]

Because of the nature of the SIB contract, several things need to be very clearly established in the agreement between the different parties. These things affect what it is viable to consider funding through SIB mechanisms.

The most important of these are:

1. *Target Population:* The SIB contract needs to very precisely specify who the recipients of the contracted services are. A defined and measurable cohort is essential both for the purpose of measuring the impact the service has and as a method of ensuring that the service is provided to the people who need it rather than the people who are most likely to ensure that a payment is triggered.
2. *Target Outcomes*: the success criteria must be precise, objective, clear, and easily measured. Ideally, they will be externally validated. The likelihood of achieving these outcomes, and the importance and value of the impact of these, are fundamental elements of the development and success of a social investment mechanism.
3. *Pay-out Mechanism:* The mapping of the achievement of outcomes to pay- outs for investors' needs to be agreed and documented unequivocally in the SIB contract.

The first Social Impact Bond in the UK was established to reduce re-offending. The following diagram sets out its structure.



Source: Jupp B [63]

Advocates of Social Impact Bonds suggest that they offer a number of benefits to the transformation of services – such as that required to shift resources to early action. The following table sets out a number of these advantages:-

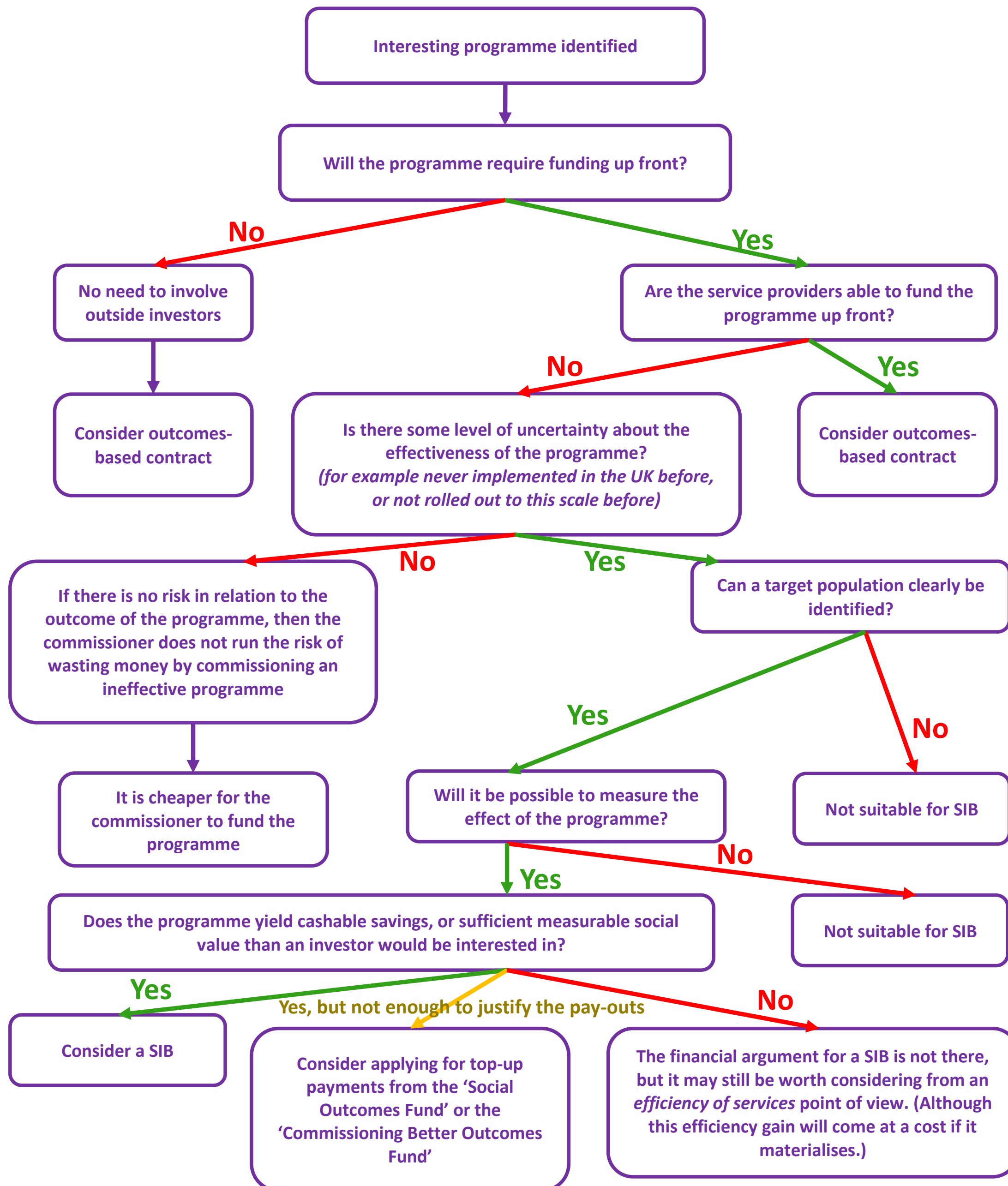
CLARIFICATION OF OBJECTIVES AND FOCUS ON OUTCOMES	• The payment-by-outcomes contracting process forces all parties to be clear on objectives and responsibilities. • The focus on outcomes can bring together new partnerships of providers and a forensic attention to the delivery of those outcomes across the system.
BRINGING RIGOUR IN DELIVERY AND MANAGEMENT	• Investors often deliver greater rigour in performance management – focusing on the need to deliver both social and financial benefits – whilst also maintaining the strong social and community ethos of voluntary and community sector organisations. • Investors often particularly support the development of management capacity.
SCALING INNOVATION APPLYING LEARNING	• Investors typically keep some resources flexible over the life of a Social Impact Bond, testing new approaches, gaining learning from rapid feedback and developing the services as a response.
OPPORTUNITY TO SHARE IMPLEMENTATION RISK	• Investment can support commissioning of services where poor implementation has produced variable results in the past. Commissioners only pay if outcomes improve. • It brings the ability to fund double-running of preventative services to reduce acute service demand, with capital repayable if reductions in acute service usage delivered. • The risk share contrasts with 'invest to save' programmes that have often failed to deliver targeted outcomes.

Taken from Jupp B [63]

However there are also some disadvantages associated with the SIB option. These are explored fully in a recent Early Intervention Foundation report[64], but can be summarised as follows:-

- SIB financing can be more expensive for the commissioner than if they financed the initiative themselves
- The development process can be long and intensive
- The scale required means that SIBs are only feasible where sufficient returns are likely to be generated
- Requires big cultural shift to achieve the required rigour of data collection and monitoring
- Require outcome metrics on which payments can be made in the short – medium term, rather than only measures of long term impact

Social Impact Bond decision tree

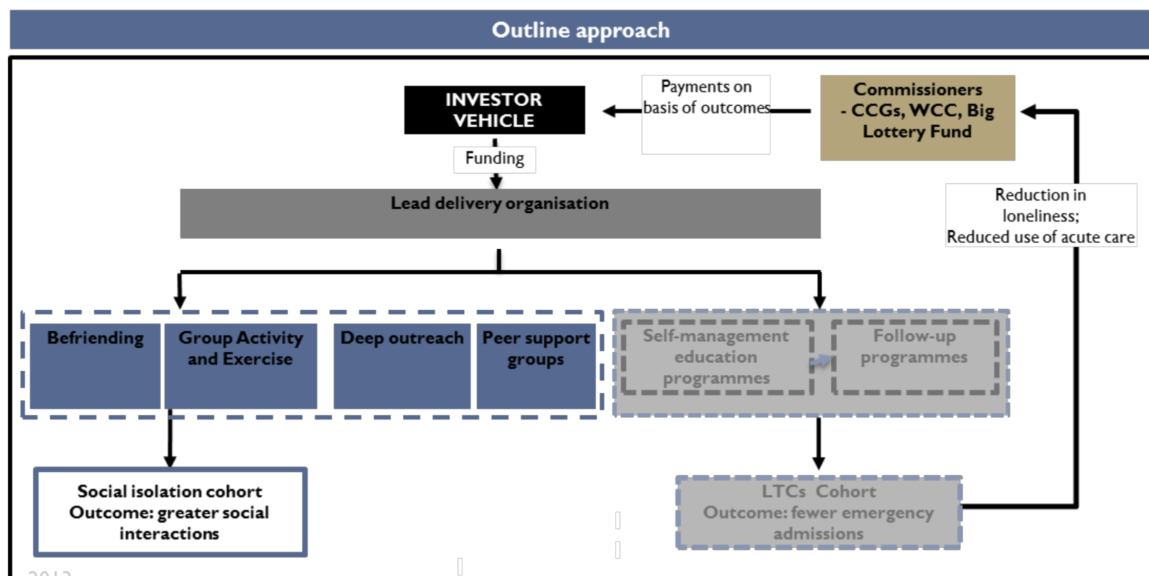


Source: Griffiths A [64]

Worcestershire Social Impact Bond

The Maintaining Health Social Impact Bond in Worcestershire is a good example of using a SIB to bring about a shift towards early action. It aims to invest in programmes that[63]:

- keep older people better socially connected, such as through peer support groups, group exercise and befriending, and therefore reduce loneliness and health and social care needs; and,
- help people to better manage long-term health conditions themselves, such as through self-management courses.



There are a range of very clear and tightly defined deliverables. It is expected that the SIB will[63]:-

- *Deliver significant value to individuals and commissioners. We have undertaken a comprehensive cost benefit analysis, to NICE standards, which has highlighted significant medium term cost-savings and QALY gains if loneliness falls. These arise from improvements in mental health, mobility and delays in the onset of dementia, together with direct reductions in the use of residential care, primary care and A&E.*
- *Ensure commissioners only pay for success: Delivering effective programmes requires rigorous implementation and oversight of the service; previous services have had a mixed track record in this area. Payment on outcomes transfers this risk to social investors.*
- *Enable a simple 'tariff' for outcomes and mechanism for attributing impact: Unlike many previous services, we propose using statistically robust methods to ensure that outcomes result from the service are attributable. We propose a tariff of £660 per loneliness point reduced on the standard revised UCLA loneliness scale.*
- *Enable integrated commissioning. The tariff would be split between commissioners and reflect both the costs of delivering the service and the value of the outcomes to commissioners. Critically, we anticipate a significant contribution from central government and/or the Big Lottery Fund: between a third and half of payments.*

The service is expected to run for three years across six parts of the county. Loneliness scores for individuals will be surveyed 6 and 18 months post- intervention start. Payment will only be made if loneliness reduced.

Social Finance have indicated that there are a number of criteria that need to be met for any social impact bond to be successful[63].

1. A compelling social need around which commissioners, investors, providers and other stakeholders can come together
2. Value to the commissioners in the social need being addressed – this will often arise from the potential to deliver a saving in acute service. The value may also arise from addressing a strategic priority for the commissioner/population.
3. Value to commissioners in transferring implementation risk to investors
4. The ability of investors to achieve outcomes if services are effectively managed e.g. promising interventions to support
5. The ability to structure an outcomes-based contract
6. A structure and commissioning approach that is attractive to social investors e.g. investment can used to support the provision of services from independent, social sector organisations

The following table illustrates how the Worcestershire SIB meets them.

Criteria for a successful Social Impact Bond	Social Isolation		Self Care	
1.A compelling social need	✓	Significant numbers older people isolated, relatively few services. An emerging health priority nationally.	✓	Self care an essential element of Well-Connected vision; commissioners looking to increase provision
2.Value to the commissioners in improving outcomes	✓	Each standard 'point' reduction in loneliness likely to deliver £1,045 value to commissioners	✓	Total direct and correlated cost of an emergency admission estimated at £3,000
3.Advantages in transferring implementation risk	✓	Previous programmes have experienced mixed success	✓	Variable track record of previous self-care programmes
4.An ability for investors to achieve outcomes e.g. promising interventions	✓	Delivery model designed which reflects good practice and value of effective targeting and coordination	✓	Delivery model designed to reflect international good practice. Some risks applying to UK environment.
5i. Identifiable target population	✓	c. 15,000 isolated older people in Worcestershire, of whom 3,000 could be initially targeted in six areas	✓	Risk stratification should enable practices to identify target population
5ii. Robust outcome metrics with clear attribution	✓	Standard 'loneliness score' can be used to develop a historical baseline, set an outcomes tariff & assess impact	?	Potential to establish an intervention group of GP practices receiving enhanced service and control group. But some questions about links to wider pathway redesign.
6.A structure and contractual approach that enables investment	✓	An issue that is of significant attraction to social investors and enables an independent Social Impact Bond to be structured	?	An issue of interest to investors. A contract should be possible to develop but would need to take into account other pathway changes.

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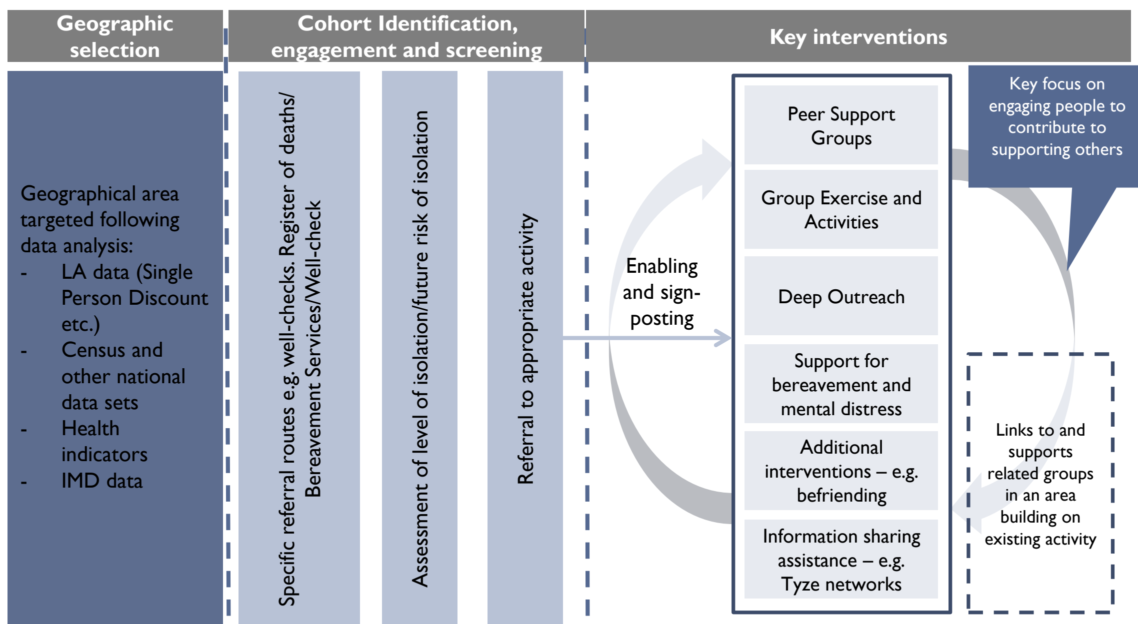
Source: Jupp B [63]

The service model being implemented to address loneliness through the Worcestershire SIB is as follows:-



Source: Jupp B [63]

The heart of the SIB is the specificity with which it calculates the impact of interventions on financial flows. This kind of methodology is vital to any attempt to shift resources towards early intervention. The following table illustrates some of the rigour of the analysis:-

Anticipated outcome	Projected value	Basis of calculation
9 entries to residential care avoided 0-5 years	£405,000 *9 x £433/wk x 104 wks*	Using NASCIS data for Worcestershire, we estimate that there is a 2.5% probability of older people entering local authority funded care over the following 4 years. For lonely older people, we have assumed that this breaks down as a c. 2% probability for the majority who have low loneliness, 3.5% for moderate and 7% for high loneliness, based on the odds ratio found by the Russell et al. (1997) study of comparative probability of entry into residential care. Our model assumes that 6% move from high loneliness to moderate loneliness and 6% from moderate to low loneliness. We assume that, for those who are lonely and enter care, the average length of stay in residential care will be two years.
2,175 GP appointments avoided 0-5 yrs	*c. 6 GP visits avoided per person x 180 people moving to lower usage bracket x 2 year measurement period*	Using Ellaway et al. (1999), we calculated the ratio of average GP appointments between the most and least lonely groups (1.86). We then used an England based study to scale up the ratio to represent today's average number of GP visits. The resulting difference between the most and least lonely average GP appointments was multiplied by the 6% of people shifting between groups to estimate this value.
92 A&E visits avoided 0-5 yrs	£10,000 *c. 0.25 A&E visits avoided per person x 180 people moving to lower usage bracket x 2 year measurement period x £108*	We have estimated the ratio of average A&E visits between the most lonely and least lonely cohort using Geller et al. (1999) and used an England based study to apply the ratio and obtain average number of A&E attendances for these populations in the UK. The resulting difference in average attendances was multiplied by the 6% of people shifting between groups to estimate this value.
26 emergency admissions avoided 0-5 yrs	£21,000 *0.07 admissions avoided per person x 180 people moving to lower usage bracket x 2 year measurement period x £800*	We have estimated the ratio of emergency admissions between the most lonely and least lonely cohort of older people from Molloy et al. (2010) and used a Worcestershire average number of emergency admissions (0.25) to calculate the admissions saved (0.07) per person. This difference was multiplied by the 6% of people shifting between groups to estimate this value.

Source: Jupp B [63]

The cost benefit analysis calculations are similarly rigorous[63]:-

> *Based on the CBA, we consider that c. £3.1 million of value would be achieved through a reduction of an average of one loneliness point per participant across a cohort of 3,000 i.e. a net reduction in 3,000 loneliness points. In practice, some people should experience significant declines and others small or no declines. As in all calculations, conservative assumptions have been used.**
>
> *We calculate that the average value of a reduction in a loneliness point is therefore £1,045. Of this total value:*
> - *£325 represents the value of anticipated QALY gain from a reduction in one loneliness point – assuming a QALY is priced at £4,000 i.e. 20% of the £20,000 which NICE considers is the threshold for a cost-effective intervention*
> - *£720 represents the anticipated Gross Present Value to the health and care system from a reduction in one loneliness point over years 0-15.*
>
> *Of the £720 Gross Present Value per reduced loneliness point, we anticipate that:*
> - *£135 will accrue to WCC Adult Social Care in years 0-5;*
> - *£165 will accrue to the NHS in years 0-5;*
> - *£420 will accrue to the health and care system in years 6-15 (2/3 health, 1/3 social care)*

Fundamental to the SIB is the ability to measure outcomes. In the Worcestershire SIB the following approach has been developed[63]:-

- *In seeking an appropriate measure of outcomes, we have sought a simple, standard metric which can be easily assessed and robustly compared over time or between groups.*
- *It is proposed that loneliness is assessed as the key outcome because of its demonstrable causal link with poor health and wellbeing outcomes, as well as its impact on immediate quality of life.*
- *Loneliness can be simply assessed using the standard 9 point revised UCLA loneliness scale. This measure is used in the majority of previous robust evaluations of interventions and is also included in standard surveys such as the English Longitudinal Study of Ageing*
- *We propose that service impact should be evaluated through a longitudinal study of cohorts pre and post- intervention, with measurements at six and 18 months.*
- *Anticipated progress will be informed by benchmarks against historical baselines from the English Longitudinal Study of Ageing*

Local Integrated Services Trust

The incentives for investing in a real shift to wards early intervention can be inadequate: either because the benefits will accrue disproportionately to organisations that are not making the investment or because the change requires investment that will need time to delivery pay- back. In-year investment for out-of-year payback is not easy to deliver in times of extreme austerity.

The purpose of a Local Integrated Services Trust is to provide an opportunity to bridge this gap by creating a local social enterprise, one owned by the local public sector stakeholders that can broker the change, backed by social investment funds where necessary, including social impact bonds.

In this model the social enterprise (the LIST) is owned by as many local public bodies as possible to ease the position of procuring services from it. It is designated as a public body in its own right and it has the ability to act on behalf of various local public authorities. The role of the LIST is to[65]:

- *Identify projects where investment in service change would provide an overall benefit in reducing waste or cost or making quality improvements for users. The outcomes of Total Place pilots would provide the starting point for many localities.*
- *Broker the change, transferring the risk of delivery away from individual organisations, pooling the opportunities and benefits, supported by social investment funds where necessary.*
- *In its brokerage role, the LIST will be principally a facilitator, extending to supply chain manager, but it could also assume a role as part commissioner and that commissioning role could expand over time, building on past successes with the encouragement and support of its member organisations.*
- *Keeping it simple means that this list should pick up easy targets to start with but over time and where there is local ambition to do so, it could develop into a procurement hub for services more generically.*
- *Profits over time can be re-invested in projects that meet local priorities, some of which may have higher risks or longer term payback.*

The Local Integrated Services Trust can act as a vehicle to broker a pooled budget within an area where there are common and joint desired outcomes. The LIST aggregates funding and acts as a public body that can commission services and manage contractual obligations. This form of integrated commissioning focuses on the desired outcomes to be achieved, and, hence uses a Payment by Results (PbR) mechanism to realise cashable savings upon successfully delivered outcomes. Once the LIST is created, it could act as a flexible entity, ready to take advantage of more opportunities for social investment, without the need to start from scratch.

The structure of a LIST is illustrated overleaf:-

Local Integrated Services Trust (LIST) structure diagram

Source: Bevan Brittan [65]

Peninsula LIST Project
In 2011 the Peninsula LIST project (Local Integrated Services Trust) came together to facilitate joint working between the public sector and to develop a vehicle to enable social investment to improve outcomes for the community. The LIST Project accessed Big Lottery Funding in 2012 to further progress this model.

Adding the Social Impact Bond (SIB) to the LIST model creates a partnership approach whereby a range of public sector bodies can integrate to commission for outcomes, including NHS trusts, Foundation Trusts, CCGs, police and fire authorities and probation trusts. Therefore, establishing a LIST is taking a longer term view, supporting integrated commissioning and enabling private investment simultaneously. Legally, the LIST is an entity owned by public sector bodies so that, for procurement law purposes, it may be considered as a public body in its own right.

> *The Peninsula LIST Project is highly ambitious as it demonstrates a brand new model for outcomes based commissioning in the country. It aims to map the potential of the Local Integrated Services Trust and a Social Impact Bond as vehicles to commission services to*

prevent young people on the edge of care entering the care system. The project is operating across the four authorities of Cornwall, Devon, Plymouth and Torbay, each of which work in different ways and at a different pace. Partnership working across the four local authorities and with the voluntary sector organisations in the four areas faces the challenges of geography and distance, political diversity and the introduction of new legal and financial commissioning concepts[66].

From the outset, the Peninsula LIST Board identified that working to prevent children from entering the care system was to be the focus of their work and that this would evolve from an evidence base, demonstrating the performance of particular therapies and services in comparison with existing interventions. This would necessitate evaluating intensive family support services and estimating the value for money and predicted cashable savings that could be elicited.

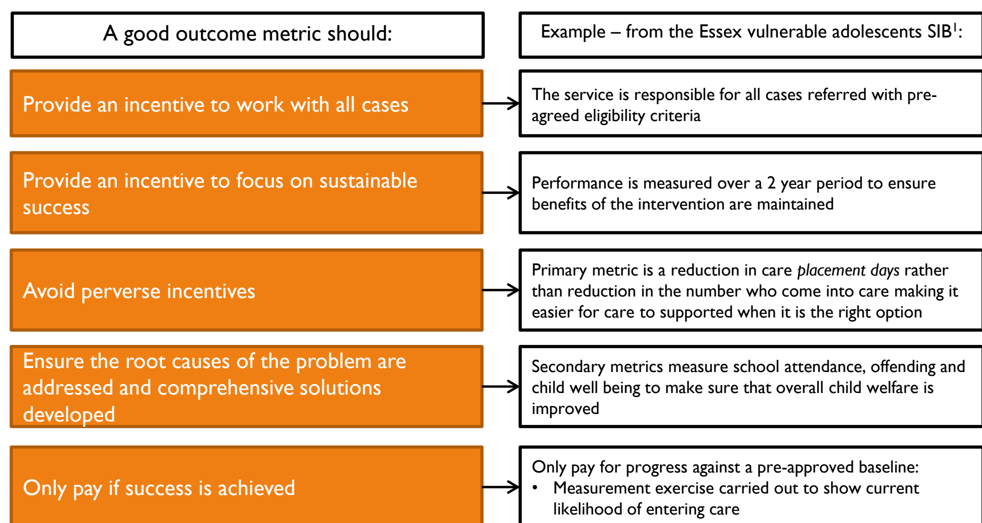
The National Children's Bureau recommended that the interventions for preventing children from entering care needed to have these features for effectiveness:

- Targeted at families who will benefit.
- Strengths-based and participative.
- A whole systems approach.
- Timeliness and sustainability.

Main intervention, as recommended by National Children's Bureau, was Functional Family Therapy.

To measure success Social Finance articulated the need for the intervention to create the right outcomes for the young people and families and that these outcomes should be linked to cost savings. Cashable cost savings can be linked to the number of care days avoided compared to a historic baseline. Social Finance recommended that secondary outcome metrics, reflecting the wider wellbeing of the young person, should be used in tracking the young person's progress, but would not be linked to outcome payments. The high-level value for money case presented in the Business Case is the savings elicited when the cost of FFT is taken away from the expected cost of a child's care journey. A technical and more detailed cost savings methodology including the cost of care journey calculations and the weighted average of the cost of current outcomes has been produced.

Measures of success should incentivise the right behaviour by focusing on the best possible outcomes for children and families



Source: Social Finance [67]

Co production
The Peninsula LIST model is strongly characterised by community engagement. Working with the voluntary and community sector and the beneficiaries of the interventions has enabled a co-commissioning approach.

Partnership Working
The Peninsula LIST Project brought together four authorities to explore better outcomes for children on the edge of care via a social investment model. In order to undertake the project all four authorities had to be engaged throughout the duration and at various different levels within the organisations. Social Finance also worked closely with each authority in order to achieve comparable data sets across the Peninsula. The project also engaged colleagues from each authority from Children's Services, Legal, Finance and Section 151 officers to help progress the knowledge base and address enquiries about social investment.

> *Partnership working is an enabler to innovative commissioning at scale and the project has demonstrated the commitment of all four authorities to progress the work streams. Partnership working is also intrinsic to the functions of the LIST, which enables public bodies to work together to commission at scale. The governance around the Peninsula partnership is articulated in the Inter Authority Agreement[66].*

Learning

The evaluation of the programme has highlighted a number of learning points.

> *Creating a Robust Evidence Base*
> *The robust data analysis undertaken by Social Finance has been highly praised by project stakeholders. The Business Case shows a comparable data set across the four authorities, which has not been done before for children on the edge of care. This is significant because the authorities involved have participated in the process of commissioning via social investment and have experienced the data analysis and collection required to create a robust needs analysis and a business case. This builds upon the work that councils are already undertaking in the "analyse" and "review" phases of the commissioning cycle.*
>
> *The focus on research and an evidence base for the chosen intervention is one of the key components to creating a SIB and to commissioning for outcomes. The strong evidence base is a factor in attracting investors and the likelihood of achieving successful outcomes (and therefore, a return on investment). However, this scenario also creates a potential obstacle for organisations which do not have the capacity to commission impact assessments or research evidence and this point has been highlighted during the interviews. This is important because social investment is often linked to building social value and capacity within the voluntary sector as delivery partners. The challenge for the VCS is to incorporate impact assessment methodologies into their performance management and this poses a capacity problem for many organisations. As stated above the VCS engagement and involvement in the project includes impact assessment training, in recognition of this issue.*

Co-production
Many stakeholders welcomed the involvement of the VCS Advisory Group in the project, as well as South West Forum as the coordinator. A significant area of integration in the project has been bringing together VCS infrastructure organisations and smaller organisations within the four areas. This is important, as before the project, there was limited opportunity to collaborate and the project has provided a good opportunity to build and strengthen relationships. The engagement with young people has also been an important and positive inclusion into the project and some stakeholders felt strongly that the results of this engagement needed to inform future commissioning proposals.

Partnership Working
The formal project processes have supported partnership working and decision making within the project and stakeholders have commented positively upon the structure of the project, the project management and leadership. This is important in demonstrating that the project has been conducted appropriately and with quality processes.
Some participants during interviews noted the challenge of gaining consensus and timely decision making across four local authorities. This demonstrates the complexities of partnership working on this scale and also the nature of the project's particular needs in enabling access to data and financial specialists. The project was able to overcome this challenge, but some interviewees felt that this made the pace of the project slow down and difficult to programme[66].

System modelling

(Diagrams and original thinking are drawn from Whole Systems Partnership http://www.thewholesystem.co.uk/default.aspx). This is based on pilot work undertaken as part of the POPP programme and is for illustrative purposes only.

Planning a systemic shift to early action can be greatly assisted by using 'system modelling' or 'decision support' tools. These tools enable complex systems to be mapped in a dynamic way and different scenarios to be projected on the basis of different assumptions about demand and service performance. This then enables local partners to plan how to manage the system, recognising:-

- Complexity within the system;
- Relationships between different parts of the system;
- Resilience in existing systems that need to change;
- The ability to manage the system given the right partnership working.

System modelling tools can:-

- Demonstrate the impact on levels of needs, and therefore the shift between care sectors effected by optimised prevention and well-being services within a specific locality;
- Reflect needs at a locality or neighbourhood level with key parameters being scalable;
- Enable local assumptions and priorities to be applied, based on but not reliant on findings from service evaluation studies and research outputs;
- Explore the impact of different strategies for investing 'upstream' – which interventions have the most significant impact and over what timescales?

Undertaking a system modelling exercise can provide insight into:-

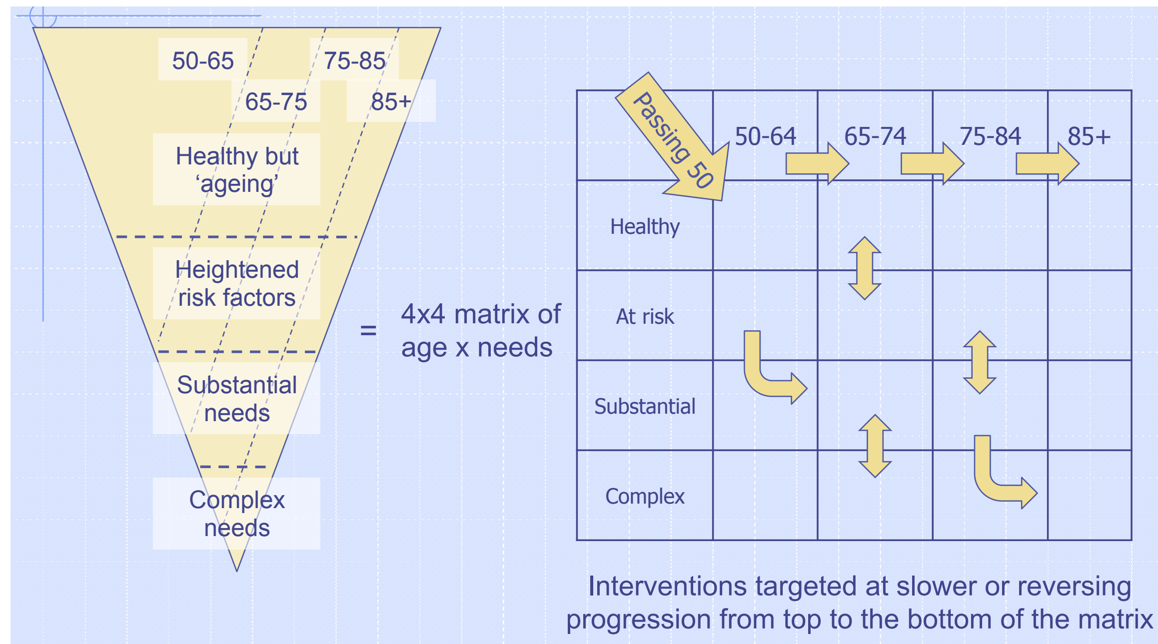
- How care needs would change into the future – the 'do nothing' scenario that identifies the extent of challenge in terms of performance and resources.
- The redesign necessary to achieve an alternative future – what would the system look like and what key redesign initiatives are needed to effect this change and deliver efficiencies.
- How planned interventions might impact on the system – will they deliver the desired change in performance, outcomes and efficiency?
- What are the implications in terms of partnership working, investment and leadership?

There are however a number of limitations to what a system modelling tool can do:-

- There are no 'silver bullets' or single solutions in what is a multi-factoral and complex situation;
- The tool does not 'reverse engineer' from a target level of spend, for example, and give you 'an answer' with regard to alternative investment strategies;

The system modelling approach can be illustrated as follows:-

Population needs analysis feeds the baseline assumptions about demand.

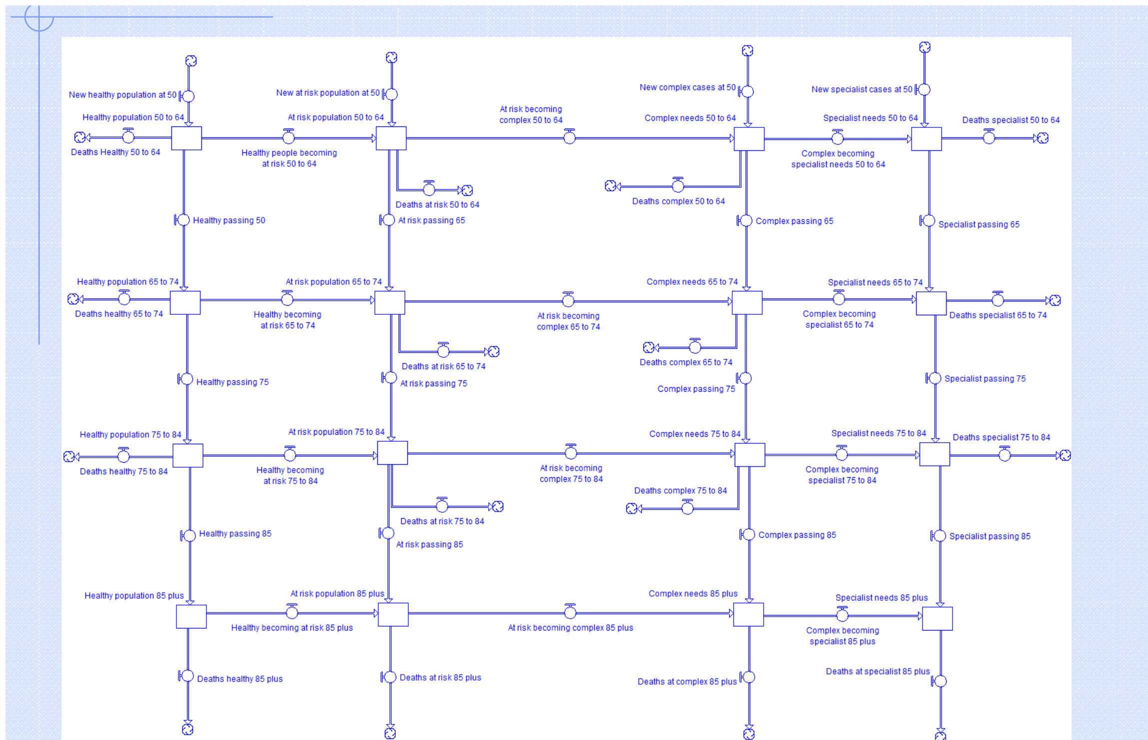


Further assumptions about how people will transition between levels of need are made. These assumptions are best when based on strong research and epidemiological data.

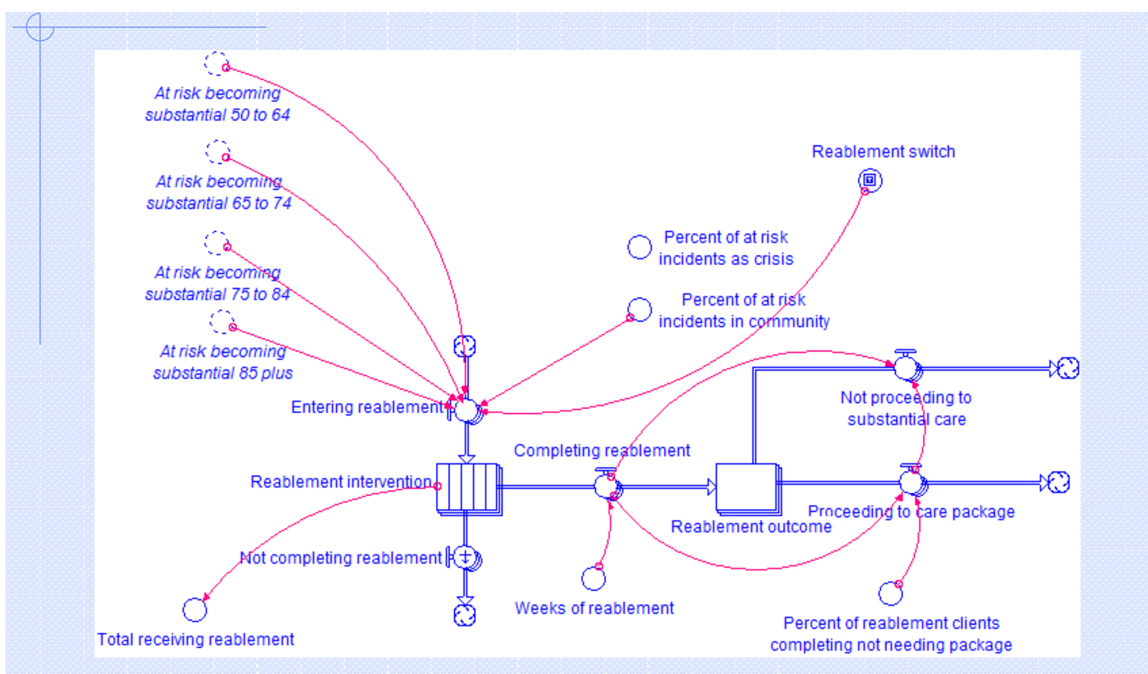
	Passing 50	50-64	65-74	75-84	85+	Overall
Healthy	70%	60%	60%	50%	40%	57.1%
At risk	20%	20%	20%	25%	30%	21.5%
Substantial	8%	15%	15%	18%	20%	15.8%
Complex	2%	5%	5%	7%	10%	5.7%

Figure: % of population at each level of need

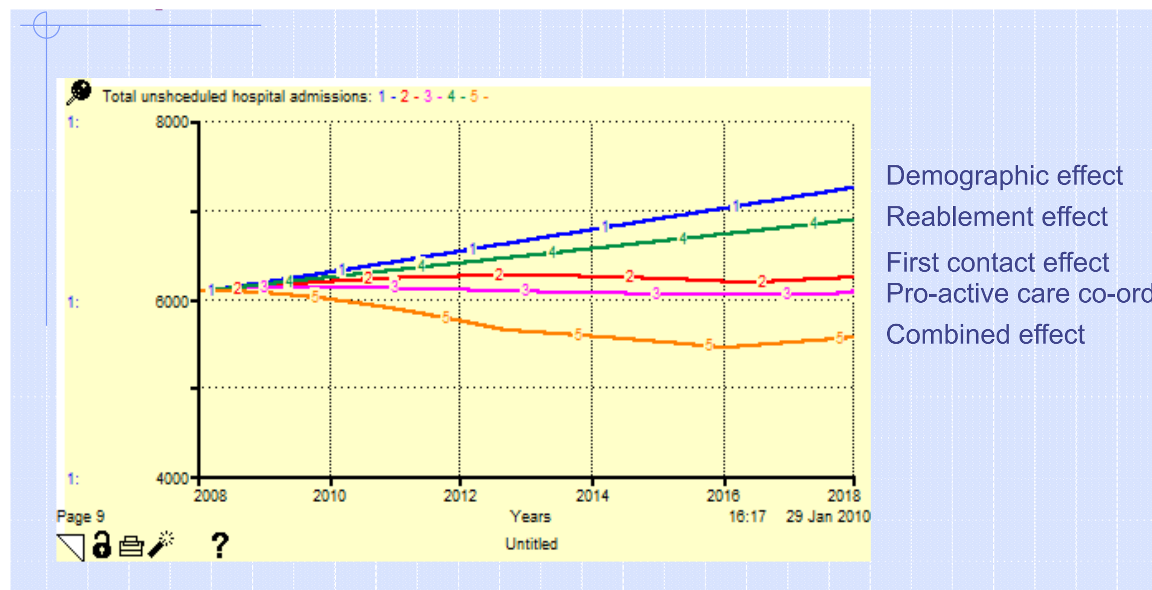
These assumptions are then incorporated into a complex system model which begins to set out the interrelationships between different population characteristics.



A map of the system is then built up. This differs from a simple spreadsheet model in that it incorporates dynamic relationships between the different elements which more closely replicate some of the complexity in real systems.



Having done this the model can then run various scenarios based on the assumptions about demand and service outcomes that are applied to the model.



Lessons learned from piloting of this sort of approach include:-

- Creates an environment for whole system discussions which in turn can lead to the development of constructive relationships and generate dialogue across difference partnership levels
- It can inform strategic thinking re transformation towards early action;
- Particularly helpful when deployed in a complex area where there are not one to one relationships between Local Authorities, Primary Care Trusts and provider Trusts.
- Provides a framework across the whole system through which high level learning on a local economy can be secured;
- Process of deployment generates confidence in the information base and outputs - providing one of the pre requisites for joint planning;
- Easy to understand yet can be enhanced with additional local information

Section Four

Key Learning

Key Learning

This section extracts the common learning points from all the programmes and initiatives outlined in Section Two. Having looked at numerous early action schemes which have sought to shift statutory spend from acute to early action this section outlines what the evaluation of such schemes tells us about:-

- the common success factors?
- the common barriers?
- which elements are common to those schemes that fail?

Systematic analysis of the programmes and initiatives has highlighted seven key domains that are associated with successful action to promote early action approaches. They are:-

- **Structures** – the 'architecture' of local statutory and voluntary sector organisations which comprise the whole system
- **Strategies** – the content and focus of strategic plans and agreements to foster an approach which is more aligned towards early action
- **Systems** – the policy and practice which drives the shift towards early action
- **Skills** – the competences that key stakeholders within a system need to have in order to make a shift to early action
- **Culture** – the 'custom and practice' which tends to encourage early action approaches
- **Leadership** - the behaviours and beliefs of key decision makers within the system
- **Evidence** - the rigor or otherwise of the data used to support the case for an early action approach and the business planning processes used to implement it

The key learning and each of the analyses of the individual programmes uses this framework as its structure.

Structures – the 'architecture' of local statutory and voluntary sector organisations which comprise the whole system

People's needs cannot be contained within neat organisational boundaries. This mean it is unrealistic to expect that one organisation can deliver an effective early action strategy on its own.

Public systems are complex with many organisational and structural boundaries and barriers getting in the way of effective interventions. Indeed the 'Total Place' and the other place based approaches (Whole Place Community Budgets / Our Place) were founded upon a view that there are too many different organisations providing too many services to meet the same needs, making it difficult for people to understand what services are available locally. Difficulties in organisational partnerships are notorious and many of the programmes analysed reported some problems, including the sheer time and commitment needed to develop relationships across agencies and the considerable cultural boundaries that can exist between professions. One factor to stand out was the way that 'organisational history' can cast a long shadow over partnership working. Relationships with acute hospital trusts has been found to be particularly difficult by a number of the early action programmes for adults and older people. This is clearly a significant challenge, but there are many examples in Section Two of initiatives which have successfully made progress.

Partnership philosophy

Organisations which are inward looking and defensive are never able to deliver successful early action initiatives. This is largely because people's lives do not fit into neat organisational boundaries; they are more complex and diffuse and no single organization can provide all that is required. So, successful early action can only flourish where there is a clear realisation of the necessity of partnership working. This is a philosophical position which needs to permeate the whole organization. It is backed up with real experience – for example both the POPP and Sure Start programmes found that those areas with the greatest degree of partnership working were able to achieve the most effective outcomes. That having been said, it has to be acknowledged that there can be significant resource implications in undertaking the relationship building which is required to support effective partnership working.

> *Involvement of the voluntary sector in commissioning conversations is a critical success factor.*
>
> Sue Goss, Principal in Local Government, Office for Public Management

Models

There are many and various models of partnership working. Structures are unique to localities, but one of the common findings across a number of programmes was the importance of securing partnership working at both operational and strategic levels. Joint working was found to be ineffective if those working at an operational level did not understand why they needed to work together. Similarly, without the support of those working at a strategic level, joint working at an operational level was unlikely to be successful. At the operational level, effective partnership working depends on efficient systems that keep partners abreast of progress and that allow them to cross refer people who use services – or pass on information about them – in a timely manner. At the strategic level, partners need to be able to discuss and resolve difficulties efficiently and effectively and ensure that the initiative is keyed into strategic planning processes.

Some systems addressed their structural issues by separating the 'delivery' partnerships from their more general strategic partnership forums, which had much larger memberships and were less suited to implementing specific work-streams. Others used a 'joined-at-the-top' model, where the member organisations' senior managers met to coordinate projects which remained owned, managed and implemented by those organisations severally and independently. Another approach was a horizontal 'network-of-networks' model, where the early action programme substantially relied on other external networks to implement its decisions and for critical inputs (such as user views) to those decisions.

Governance

There is a need for joint working to be based on clear arrangements in respect of governance and management responsibility. Whilst the aim is to secure closer partnership working, it is important to respect the need for independent partners to take their own decisions in accordance with their own governance arrangements. It is also important to note that partners need to retain control over their own budgets and decision-making throughout and stakeholders need to be mindful of retaining a genuine sense of equal partnership.

Mainstreaming

Whatever model or governance arrangement is used to address the structural issues, many of the early action initiatives found that it was helpful to integrate their actions into broader partnership boards, thus enabling early action objectives and programmes to be incorporated into mainstream local priorities. Mainstreaming has the potential to deliver greater benefits but is more challenging to manage. Early action initiatives, mostly funded through special grants, often fall into discrete projects; sometimes this is required to maintain separate accounting and reporting to funders. However more impact is likely to be gained, and positive changes to be more sustained, if initiatives are mainstreamed from the start.

> *Half of ill health in old age is entirely preventable by change of lifestyle –Public Health strategy needs to look properly at the mature life course.*
>
> Dr David Oliver, Visiting Fellow, Kings Fund

Other Success factors

As well as those covered above, a number of common success factors for developing partnership working were identified:-

- *Trust:* Partnership working does not just survive on a cold analysis of its benefits. It has to be built on a feeling of trust. Developing a culture of trust was found to be essential in so many of the early action programmes.
- *Shared learning*: joint training and shared learning can be very effective at breaking down potential barriers between agencies.
- *Partnership development workshops*: can be particularly helpful in identifying which partners are working with the same people on similar issues. Typically these events find that a number of professionals are getting together for the first time
- *Co-location of staff*: can, where appropriate, be effective, especially where they are integrated into universal services such as schools or GP surgeries.
- *Neutral branding*: building a strong institutionally neutral brand for the early action programme can be very effective in building confidence, interest and commitment among local partners
- *Functional understanding*: early action initiatives often involve the addition of new teams or processes into the already complex structure. It is essential that the role and function of these new teams or processes are fully understood within the rest of the system

- *Streamlined referral pathways*: in complex structures which are trying to support people with complex needs it is especially important for referral pathways to be joined up and streamlined.
- *Involvement of the third sector*: this sector has an important role to play, including advocating for the interests of the sector; offering a different and often new perspective on issues; acting as a critical friend for statutory colleagues; making connections between the community and the statutory sector; and identifying where the sector could make enhanced contribution to the outcomes

Strategies – the content and focus of strategic plans and agreements to foster an approach which is more aligned towards early action

No significant shift towards early action is likely to be achieved without a strategic approach. Approaches need to be strategic in terms of timescale (i.e. planning for the medium to longer term), but they also need to be strategic in terms of the 'breadth' of their approach. In other words, approaches should be 'whole system' or joint strategic approaches. And the most successful programmes also recognised that implementing a strategic shift to early action was best achieved through a commissioning framework and all the discipline that that entails.

The following strategic commissioning approach encapsulates key learning points from many of the programmes and initiatives in Section Two.

Understand need

Understanding need is a prerequisite of any strategic approach. The Joint Strategic Needs Assessment is therefore a fundamental building block for making a shift towards prevention and early intervention. This should help commissioners and programme leads to understand the local population and their needs. This requires a good understanding of different groups of people within the population.

Community engagement and asset mapping

Good needs analysis is not a purely 'technical' exercise; it needs to involve discussion with local communities so that a picture of their priorities can be established. Part of this process is about finding the issues which link people in the neighbourhood and which motivate them to seek change. Most successful early action programmes understand the importance of also assessing the strengths within a community – i.e their assets. An assessment of assets allows early action strategies to develop ways of supporting and developing what already exists, rather than injecting new professional services. As the evidence from the HELP and LAC programmes show, the task should be about helping people to form or strengthen neighbourhood partnerships between residents and public services. The hypothesis is that the level of health and general wellbeing in the neighbourhood can be significantly improved, with very little new investment, if the level of community organisation, dialogue and collaboration with public services is raised in such a way that it increases community confidence, organisation and ability to negotiate with public services. Typically, traditional needs analysis focuses on "What services or money do people need", whereas an asset based approach asks a more fundamental question "What is your vision for a good life and how can you get there?". Community engagement like this is best planned strategically to ensure that the community can be appropriately involved at each stage. It is important that this co-production is approached as a joint exercise 'with' the community, not something that is 'done to' the community.

Mapping current activity and spend
Understanding how the system is currently responding to need is crucial to working out how to re-engineer it to produce better outcomes. It is important to draw on existing statistical and consultation data about problems, issues, and priorities in the neighbourhood, including data on indicative spend. This is fundamental to getting an understanding of what is being spent, who controls that money and whether better use can be made of it. It can help identify those areas where multiple partners work with the same or similar groups of people and where there might be duplication or overlap. It is information therefore which can be used as a lever to challenge where and how money is being spent. Without information on the costs and effectiveness of the current service, there is a risk of over- or underestimating the benefits of a change. Comparisons are particularly important where the proposed service will require (as it often does) reducing or altering current services and the resources supporting them.

Mapping activity and spend in this way can be an onerous task, particularly when needing to secure data across a range of organisations. However, as many of the early action programmes found, it can be a useful way of engaging partners. There is a need for better ways of accessing the data. As the Whole Place Community Budgets pilots found, it would be helpful for service providers to do more to make disaggregated spend available at a neighbourhood level.

Joint outcomes
In order for this kind of partnership working to be achieved, most of the successful initiatives in Section Two have found that the development of a small number of shared outcomes was critical. This allows organisations to see how their service delivery can contribute to improving the lives of the people it is there to support. Shared outcomes help erode the tendency for organisations to become inward looking and lose sight of the bigger picture. Focusing on outcomes and selecting the interventions that best deliver them avoids the risk of being limited by existing organizational responsibilities.

There are now a number of national outcome frameworks which can help drive this shift to shared outcomes:-

- Public Health Outcome Framework
- NHS Outcomes Framework
- Social Care Outcomes Framework
- Better outcomes for children and young people

Having identified the core outcomes it has been found to be important to maintain a tight focus on them. Agreeing a joint performance framework and monitoring progress against it is one way of doing this.

Joint Vision and Narrative
From all of the above it is important to develop a shared narrative and vision about the outcomes which the programme is aiming for and how it is proposing to set about achieving them. A long term vision can be very powerful – as has been found to be the case with Nottingham City's twenty year vision for breaking the cycle of intergenerational poverty through early intervention.

Prioritise the areas for change
It is important to recognise what areas need to be prioritised. There are tools which can help local partnerships to recognise their strengths and areas for development. Most systems will have a number of preventative elements in place, but even with these there is a need to assess their

effectiveness and whether there is sufficient capacity. Other elements will need to be commissioned from scratch (possibly with input from other departments or agencies). Early action is best achieved when its programmes are aligned with mainstream drivers within the system.

Invest rather than spend

The commitment of resources is best thought of in terms of an 'investment'. Different investments produce different outcomes – some will produce net savings, some will produce improvements in quality of life, and others will improve service quality and/or efficiency. Savings are clearly crucial to the sustainability of any early action shift. However a sole focus on 'net savings' is too narrow and will fail to deliver the required outcomes. A broad 'investment portfolio' is required, and as noted above, many of the investments can be undertaken jointly with other partners.

Rigorous medium to long term business planning

Making a strategic shift does not happen over night – it can only be addressed over the medium to long term (i.e. 3 to 5 years). Business planning should therefore be undertaken over this kind of horizon. The experience from many of the programmes reviewed in Section Two has demonstrated that the business planning process itself needs to be rigorous. The initiatives which were able to make the greatest gains were those which were the most rigorous in their business planning processes.

Scrutinise the core spend

Mainstream expenditure warrants the same kind of scrutiny and calls for 'evidence' as that which is often demanded of preventative initiatives. Taking a rigorous, analytical approach about 'what works' is equally (if not more) applicable to the large scale expenditure on mainstream services. De- commissioning or change of non-effective services is an important dimension here. There are large budgets in any local system and there should usually be potential efficiencies and re-prioritisation which can release resources for new approaches.

Developing a joint commissioning plan – to deliver the change programme.

It will be important to incorporate within a joint commissioning plan an explicit agreement about the sharing of any financial risks and benefits associated with shifting resources towards early action alternatives. This is important:

- to avoid 'cost shunting' disputes
- to try and establish a 'virtuous cycle' of investment between health and social care towards prevention and early intervention.

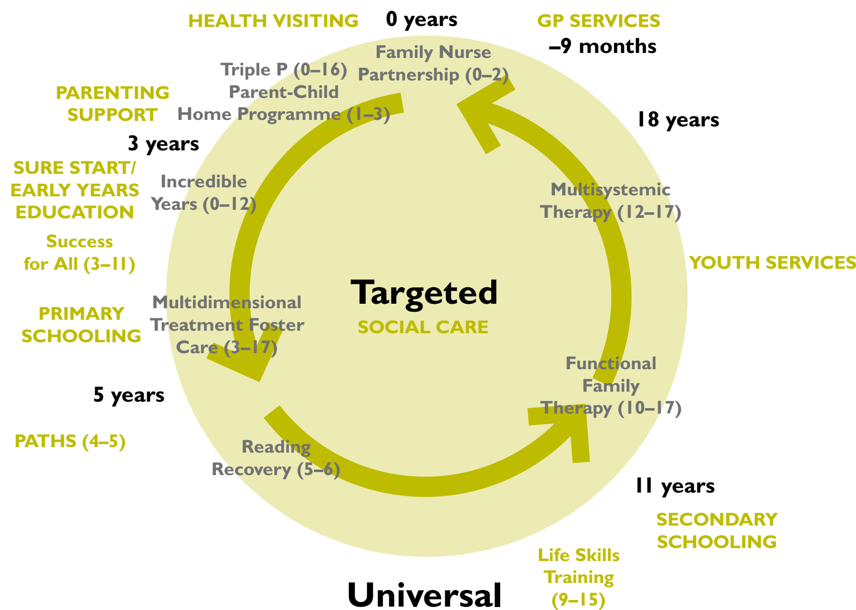
A lack of commissioning expertise and capacity within one or more of the partners can be one of the key barriers to 'shifting resources' towards early action.

Systems – the policy and practice which drives the shift towards early action

Interventions

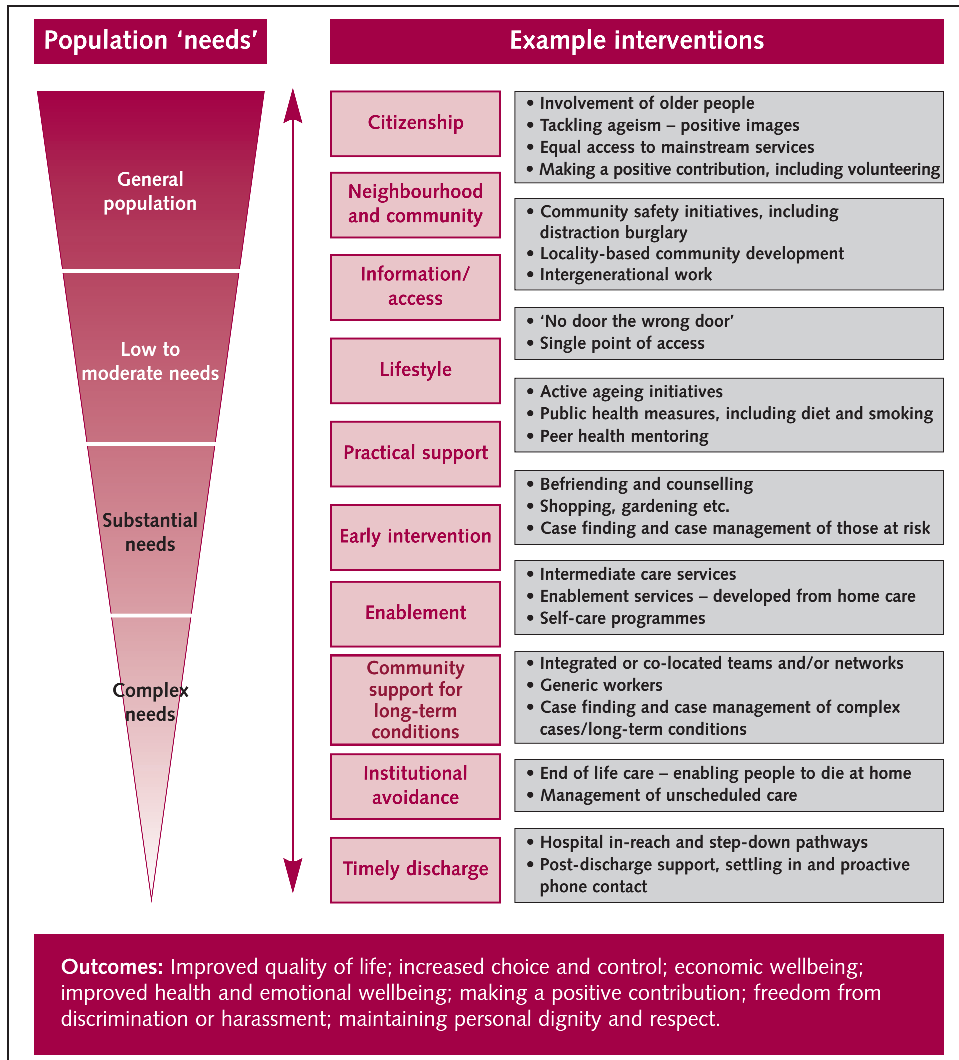
A systemic shift to early action requires a coherent framework of interventions. Section Two reviews examples of early action systems across the life course, from children through to older people. In doing this it is noticeable that, whilst there are many similarities in the learning (as is outlined in the this section), there are nevertheless some noticeable differences in approach at each end of the spectrum.

Early action in relation to children appears to be much more focussed on the psychological / emotional development of the child and behaviour change within their parents. In other words the focus is on 'primary' and 'secondary' prevention An overview of early action for children and young people is encapsulated well in the following diagram.



Source: Allen G [52]

When it comes to older people however there is very little focus on psychological, emotional or behavioural issues. Early action in relation to older people is increasingly focussed on 'tertiary prevention' as austerity budget cuts bite. In other words it is largely about the reallocation of services and interventions to shift older people into less costly parts of the system. An overview of what a more comprehensive approach to early action for older people could be is encapsulated well in the following diagram.



Source: Robertson [68]

Reactive versus Early Action services

There are those who argue that the division between reactive and early action services is not helpful. Instead, it is proposed that all interventions should be 'future focused'. In other words they should all focus on reducing the risk of increased future need. Preventative services currently do that for people with low level needs, but it is a relevant thing to do with people of all levels of need. There are three tests of whether a service is doing this; whether the service:-

- Leads to person being better informed
- Leaves people better connected to those around them
- Leaves people feeling more confident to manage their own support needs

Data sharing

The sharing of data between organisations can be difficult but it is a challenge that needs to be addressed. There are many reasons for this. Early action initiatives which are seeking to shift resources 'upstream' require good data on how shared outcomes are being achieved. At a strategic level agencies, particularly statutory agencies, need to be able to share data across organisational boundaries in order to evaluate the effectiveness of joint working and develop future plans and commissioning strategies. Without evidence of the impact of joint working on key

targets or performance indicators it is unlikely that agencies will continue to prioritise, or indeed fund, such activities in a context of financial restraint. Data sharing is also required at an operational level. This is particularly important when services are supporting people with complex needs and often chaotic lifestyles. In these circumstances services require shared assessment and referral processes and these require the sharing of information. They also need to be co-ordinated in a timely manner and based on up-to-date information

Referral pathways

A key characteristic of successful early action projects was that they took a holistic approach to improving participants' well-being. In other words, they were able to address a wide range of needs. This requires referral and assessment pathways to be well structured, simplified and able to draw in the necessary support from different organisations without the person being pushed from 'pillar to post'. Single points of access are often key to this.

The other characteristic of successful early action projects is that they are able to proactively identify people at risk and intervene early to diminish or avoid the risk completely. This kind of case finding approach is the very antithesis of many standard referral approaches which are often focussed on filtering people out of the system. By way of contrast early action initiatives require mechanisms which can seek out people who can be helped by the intervention.

> *There is a need to build 'getting in early approaches' into the design of the programme from the beginning. This is a critical success factor.*
>
> Lucy de Groot, Chief Executive, Community Service Volunteers

There are particular challenges for 'hard to reach' groups such as women from Black and Minority Ethnic groups and demand may be supressed because referral pathways, criteria and the interventions themselves are not as socially inclusive as they could be. In the 'Big Lottery Wellbeing Programme' this was addressed by connecting with local community organisations, and employing members of staff or volunteers to specifically reach out to people who would otherwise be unlikely to participate. By doing this they were able to understand the barriers to the target participants' participation in the programme and design the interventions to overcome these.

Shifting resources

Shifting resources from acute to preventative or early intervention initiatives is highly desired by those who subscribe to the early action narrative. However it is very difficult to achieve, particularly where budgets are the responsibility of more than one organization. The evidence of the programmes reviewed in Section Two indicates that shifting of resources will only be possible where there is:-

- An early agreement on how to share the benefits and risks of commissioning decisions is in place
- A good understanding of how resources are being used within the system
- Clarity about the effectiveness of early action initiatives and what they will deliver in terms of cost and activity
- A clear plan about what resources will move and when this will happen
- Good engagement with front line staff and managers

Timescale is another important dimension to consider. As the 'Reshaping Care for Older People' programme found, unreasonably short timescales can be hugely counter productive given the time required to effect whole system redesign and a sustained shift to prevention, which in turn means that the full impact of some longer term interventions may not be evident for several years.

Sifting resources will be facilitated or hindered by many other factors including culture, leadership, structures etc. Unfortunately one element which is most difficult to address is that of history. As some of the 'Total Place' pilots found, history, or perceptions of history between organisations can significantly undermine the capacity for open dialogue about moving one budget stream to another. And for some systems the barrier arose from a failure to be able to see a different way for the system to operate.

Belief

People have to believe that change is possible. Without that belief it is difficult to make any change happen. This is nicely encapsulated in the words of the manager of a programme which attemped to shift resources out of acute hospital care into early intervention community alternatives – *" I quickly concluded that acute hospitals are a bit like the M25 For as long as they are there, they will be full*." The programme spectacularly failed to deliver any resource shifts.

> *Bringing about a belief change is a critical success factor. Currently acute sector clinicians and GPs don't believe any of the claims about the effectiveness of prevention.*
>
> Sue Goss, Principal in Local Government, Office of Public Management

There is a need for some national leadership on this issue. There should be a dialogue around potential longer-term and systemic reforms to the way local services are funded, including financial incentives or funding arrangements that encourage partners to invest across organisational boundaries and in favour of early intervention.

Skills – the competences that key stakeholders within a system need to have in order to make a shift to early action

The early action agenda requires new skills to be acquired by both practioners and 'back office' staff. Often these skills are not found in one place or organization and because they are not generally part of the mainstream it is even more important that management are supportive of the need for practitioners to fulfill their training requirements. It has to be remembered that training has to be realistically costed with contingencies being made for staff turnover and absence

Culture change

Developing the skills required for the early action agenda is closely related to cultural change. There is therefore a need to support staff to understand the importance of joint working, re-ablement, personalisation and asset based philosophies, etc. In many programmes there is a need for practitioners to develop a different kind of relationship with the people they are working with, towards a more supportive kind of relationship. The cultural change issues surrounding the focus on community engagement and development are significant. When it comes to community development, workers' values and commitment to inclusiveness, empowerment and acknowledgement of the natural authority of families, has been identified by many of the programmes to be fundamental to the success of asset based approaches.

> *Need to recognise that the system is not just services; it is the whole resources of the community and individuals.*
>
> Alex Fox, Chief Executive, Shared Lives

Practitioners

For practitioners the required skill sets differ depending on different aspects of the life course. Early action with children, young people and families requires the ability to develop therapeutic relationships, deliver educational programmes and bring about behavioural change. Having staff who are empathetic and enthusiastic is very important for increasing vulnerable adults or childrens' self-confidence and supporting them to make positive changes to their lifestyles. Skills which enable families or other vulnerable adults to reflect on their situation and find their own solutions are particularly important.

Early action with older people requires a rehabilitative approach where the practitioner is focused on 'doing with' rather than 'doing for' the other person.

Asset based approaches to community development require particular facilitation and asset mapping skills. The amount of time required for this development role depends on conditions in the community, the readiness of agencies to engage in the process, and on how well the facilitating role may fit with the remit of existing jobs.

Back office staff

As already noted elsewhere, any significant early action initiative requires skills around data management, business planning and cost benefit analysis. There is also often a need for competence in outcome management, logical planning processes, evaluation skills, whole system approaches to service planning, community development, programme and project management. These are skills which are often not well developed within some public sector organisations.

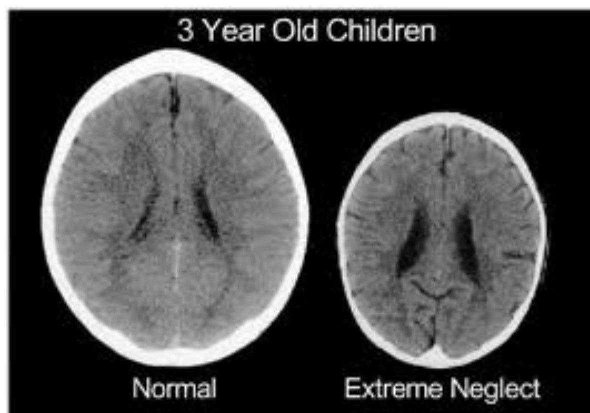
Culture – *the 'custom and practice' which tends to encourage early action approaches*

Most of the programmes reviewed in Section Two indicated that cultural change was fundamental to achieving a shift toward early action. There are a number of key areas of culture change that need to be addressed.

> *Achieving a fundamental culture shift is a critical success factor. It is also the hardest part of the process.*
>
> Hilary Cottam, Chief Executive, Participle

Narrative

People can be influenced by metaphors and finding a metaphor or narrative that sets out the early action agenda clearly can be one of the most important drivers for cultural change. The following is an example of an image which has been used in a number of reports to make the case for early intervention. A graphical image like this can be very powerful.



Source: Allen G [69]

This kind of image then supports the development of a narrative about the problem and what is to be done about it. Narratives are at the heart of what determines the culture in an organisation or programme.

> *Producing iconic images and metaphors about why things need to change is a critical success factor*
>
> Donna Molloy, Head of Implementation, The Early Intervention Foundation

Relationship with users

In most cases early action requires the development of a different kind of relationship with the users of services. As a minimum, and predominantly in services for older people and adults, there needs to be a shift away from trying to 'do things for' people, towards 'doing things with' them. In other words a facilitative or rehabilitative approach is required. But that is the minimum cultural shift required. Ideally, as evidenced in many of the programmes reviewed in Section Two, there is a need for a more fundamental shift in how members of the public / service users are viewed. With regard to children, young people and families the culture needs to move away from a supervisory and punitive one towards a therapeutic relationship which seeks to empower and support people.

Asset Based philosophy

An asset based philosophy is fundamental to many early action approaches. It seeks to build on people's strengths rather than trying to fix their deficits through the provision of professional services. As such it is closely tied up with community development type approaches. The philosophy underpinning an asset based approach is well expressed through the following 12 principles[70]:-

> *Getting professionals to believe in the value of an asset based approach is a critical success factor.*
>
> Lucy de Groot, Chief Executive, Community Service Volunteers

- Everyone has gifts. There are unrecognised capacities and assets in every community. Find them and provide opportunities for people to offer them.
- Relationships build a community. See them, build them and utilise them.
- Citizens are at the centre. It is essential to engage the wider community as actors not just as recipients of services.
- Leaders involve others as active members of the community.
- People care about something. Find out what motivates individuals.
- Identify what motivates people to act. Every community is filled with invisible 'motivations for action'.
- A listening conversation is the way to discover motivation and invite participation.
- Ask, ask and ask. People must be offered an opportunity to act.
- Asking questions rather than giving answers invites stronger participation. A powerful way to engage people is to invite communities to find their own answers – with agencies following to help.
- A citizen-centred 'inside-out' organisation is the key to community engagement.
- Institutions have reached their problem solving limits. They are stretched thin and need more skilful and wider engagement with communities.
- Institutions are servants. Ask people what they need and offer help, step back and create opportunities for people to act together.

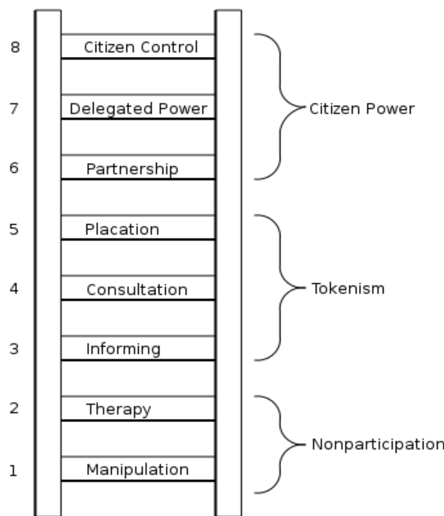
The cultural shift required is set out in the following table:-

Moving from a deficit approach to an asset approach	
Where we are now - the deficit approach	**Where an asset way of thinking takes us**
Start with deficiencies and needs in the community	Start with the assets in the community
Respond to problems	Identify opportunities and strengths
Provide services to users	Invest in people as citizens
Emphasise the role of agencies	Emphasise the role of civil society
Focus on individuals	Focus on communities/ neighbourhoods and the common good
See people as clients and consumers receiving services	See people as citizens and co-producers with something to offer
Treat people as passive and done-to	Help people to take control of their lives
'Fix people'	Support people to develop their potential
Implement programmes as the answer	See people as the answer

Source: Foot J [71]

User involvement

Separate, but related, is the cultural shift towards involving potential users of the programme in the planning and delivery of it. User involvement was found to be critical in nearly all the programmes reviewed in Section Two. There are various degrees of user involvement as indicated in the graphic below.



Source: Arnstein S [72]

The stages can be explained as follows:-

1 Manipulation and 2 Therapy. Both are non participative. The aim is to cure or educate the participants. The proposed plan is best and the job of participation is to achieve public support by public relations.
3 Informing. A most important first step to legitimise participation. But too frequently the emphasis is on a one way flow of information. No channel for feedback.
4 Consultation. Again a legitimate step - attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window dressing ritual.

5 Placation. For example, co-option of hand-picked 'worthies' onto committees. It allows citizens to advise or plan ad infinitum but retains for power holders the right to judge the legitimacy or feasibility of the advice.
6 Partnership. Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.
7 Delegated power. Citizens holding a clear majority of seats on committees with delegated powers to make decisions. Public now has the power to assure accountability of the programme to them.
8 Citizen Control. Citizens handle the entire job of planning, policy making and managing a programme e.g. neighbourhood corporation with no intermediaries between it and the source of funds.

Whole systems philosophy

The point has been made in many places elsewhere in this section that a systemic shift towards early action is unlikely to be achieved by a single organisation operating on its own. Given the complexity of people's needs, early action initiatives require all the relevant public bodies within a system to work together. This approach has to be reflected in the cultures of the various organisations involved. This can be a challenge, especially in times of austerity, where organisations can prefer to foster an insular and defensive culture.

Business like approach

Any attempt to make a systemic shift towards early action requires the adoption of a business like philosophy and culture. The setting and measurement of outcomes, along with business planning and cost benefit analyses all need to be supported by an organisational culture which values these approaches. They cannot be techniques which are just 'bolted on to' a programme – they need to be at its heart in order for it to be successful.

Leadership *- the behaviours and beliefs of key decision makers within the system*

Strong visionary leadership which seeks to proactively develop partnership approaches to addressing shared outcomes is critical to achieving success with early action initiatives. The culture change which is required by successful early action programmes needs to be led from the top.

Vision

Firstly there needs to be a clear vision about the desirability of a shift to early action and the possibilities that this could achieve in terms of better outcomes for people. Developing and pursuing such a vision requires leadership.

> *Leadership is a critical success factor. You need powerful advocates locally and nationally*
>
> Donna Molloy, Head of Implementation, The Early Intervention Foundation

Levels of leadership

Leadership is required at all levels. Firstly, it is required at a national level. This can be so powerful in bringing about widespread change across a range of public sector systems. The example of Scotland's 'Reshaping Care for Older People' programme is a case in point. The opposite is true – as the Health Action Zones programme experienced, a lack of national leadership, as evidenced in changing national priorities, can have a devastating effect on local motivation.

Within individual organisations, leadership at chief officer level is critical. They need to set the direction and champion the early action agenda against the pressures of reactive demand. And leadership in support of early action needs to be developed across all organizations in the system, including third sector organisations.

Further down the organizational hierarchy, team leadership can be an essential driver for success. The nature of the work, the sometimes difficult relationships with other agencies, make the role of team leadership absolutely critical. As the 'Life Programme' found, the strongest work tends to take place where the strongest team leaders are in place. It is important that these middle managers are given sufficient flexibility to enter into joint problem-solving with other agencies.

Partnership working

Leadership is required to break down the silo mentality in many organisations. If this isn't challenged at the top of the organisation it is very difficult for those at an operational level to work successfully with the partners they need to engage with. It is important that leaders in each organisation articulate the same early action vision and their organisation's role in delivering it. Leadership is also about generating trust and focusing on the future rather than on past disputes. This means that it is often about good personal relationships between key individuals with the drive, personality and the seniority to make a difference.

> *You need top level 'buy in', even if the evidence base is strong.*
>
> Professor Martin Knapp, London School of Economics

Strong leadership was considered by many of the programmes as being crucial to getting the right people around the table and ensuring that decisions are made. As well as getting people round the table, leadership is required to manage different agendas and priorities among partners. As the POPP programme found, strong leadership is also essential to negotiating the organisational politics and barriers which are likely to surface along the way.

Training

Training in leadership can be important. For example, within the Sure Start programme it was found that where managers held higher leadership qualifications such as a National Professional Qualification in Integrated Leadership (NPQICL), they were more likely to have stronger safeguarding arrangements in place and to have the confidence to delegate tasks to their senior management teams. They were also stronger in developing a vision and strategy.

Evidence - the rigour or otherwise of the data used to support the case for an early action approach and the business planning processes used to implement it

The experience of the wide range of programmes outlined in Section Two indicates that no shift in the balance of resources towards early action will be achieved without a strong evidence base. Any intervention needs to be based on sound research. For it to be commissioned and for resources to be shifted towards early action it requires a clear business plan with cost benefit analysis and accompanying monitoring of outcomes achieved.

> *Measurement is a critical success factor. You need to be able to show what outcomes have been delivered and make a strong case for how the impact on other services has been reduced.*
>
> Donna Molloy, Head of Implementation, The Early Intervention Foundation

Research

There is a growing body of research evidence on the effectiveness of early action initiatives. But care needs to be taken in assessing the strength of the evidence base. Randomised control trials are clearly the gold standard, where they are feasible and relevant. However randomised control studies do not fit all research questions. For example, longitudinal studies have added considerably to the evidence base on child development, even without randomising allocation to treatment and control groups. That having been said, where the question of assessing impact is paramount it is important to have a relevant comparison group and good pre and post measurement.

It is important to take a balanced approach to the use of the evidence. In reality there is a continuum of evidence. The Early Intervention Foundation have rated[73] the evidence of what works using the following 'standards of evidence' table:-

Evidence or rationale for programme	Description of evidence	Description of programme	Evidence strength rating	Recommendation for commissioner or provider
Multiple well-designed, well-implemented RCT/QED* evaluations with consistently positive impact across populations and environments	Consistently Positive	Consistently Effective	5	Take to scale (subject to local feasibility and appraisal)
Single well-designed, well-implemented RCT/QED* evaluation with positive impact	Positive	Effective	4	Commission and evaluate
Lower-quality evaluation (not RCT or QED*) showing better outcomes for programme participants	Tentative	Potentially Effective	3	Pilot and evaluate rigorously
Logic model and testable features, but not current evidence of outcomes or impact	Non-existent	Theory based	2	Track performance and outcome measures
No logic model, testable features, or current evidence of outcomes or impact		Unfounded	1	Develop logic/measurement model
Evidence from at least one high-quality evaluation (RCT/QED) indicating null or negative impact	Negative	Ineffective / Harmful	–	Redesign / Avoid / Decommission
Programmes not yet rated, including those rated by evidence bodies whose standards are not yet mapped to the EIF standards, and submissions from providers or local areas of innovative or promising interventions	TBD	TBD	?	

*RCT = Randomised Controlled Trial: An evaluation where children or families are randomly assigned to the programme of interest or to a comparison group which receives existing support. In this case the intervention and comparison groups are plausibly similar in all respects apart from intervention status.

*QED = Quasi-Experimental Design: An evaluation where assignment of children or families to an intervention is not randomly controlled. Instead, the researcher attempts to identify a plausibly similar comparison group on the basis of programme enrolment criteria/barriers, or statistical methods and analysis.

Source: Early Intervention Foundation [73]

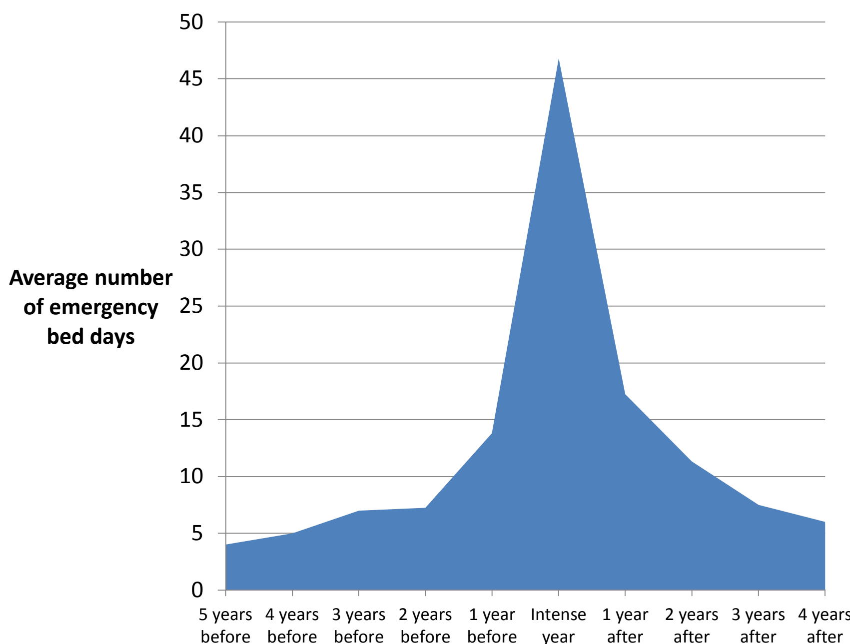
'Regression to the Mean'

It is important to be very careful of 'before and after' studies which do not have any control group comparisons. Such studies can fail to take account of the concept of 'regression to the mean'.

Without a robust control group such before and after studies can be misleading. This is clearly demonstrated in the example of POPP in Section Two. Where one selects individuals at high risk of experiencing an adverse outcome (e.g. admission to hospital), there is a natural tendency for subsequent measurements of those individuals to show a reduction their experience of that outcome. This is a statistical phenomenon called 'regression to the mean'.

> *This effect is illustrated below, which is based on the Hospital Episode Statistics for England. The chart spans a ten-year period and illustrates hospital admissions for a cohort of frequent hospital users identified in the central intense year. Hospital admissions were tracked for this cohort of people for five years beforehand and five years afterwards. The chart illustrates that, if patients are chosen for an intervention based on their current high rates of hospital admissions, we would expect their rates of hospital admission to reduce over time, even in the absence of a specific intervention. This would mean that an evaluation without an appropriate control group would tend to overestimate the effectiveness of the intervention on hospital use, since some or all of the observed reductions would have happened anyway[6].*

Regression to the mean in the absence of intervention

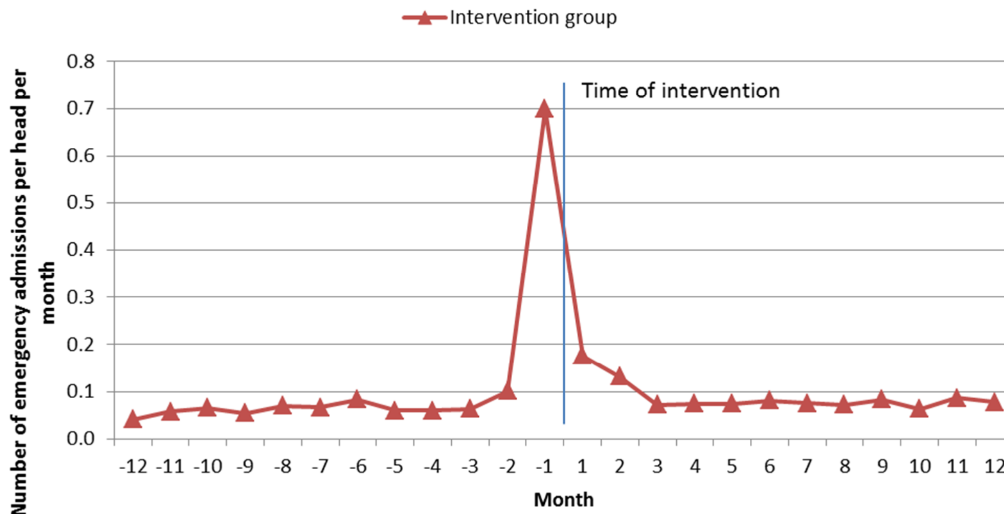


Source: Department of Health for England analysis of hospital episode statistics

Whilst the Nuffield study concerned hospital admissions, the phenomenon of regression to the mean applies to any other study of the outcomes of high risk individuals. Understanding this issue is therefore critical when assessing the evidence base for early action initiatives.

The importance can be seen in looking further at the data in the Nuffield Trust study of POPP sites. The important fact was that Nuffield were able to construct a control group and use it to compare the outcomes with the intervention groups.

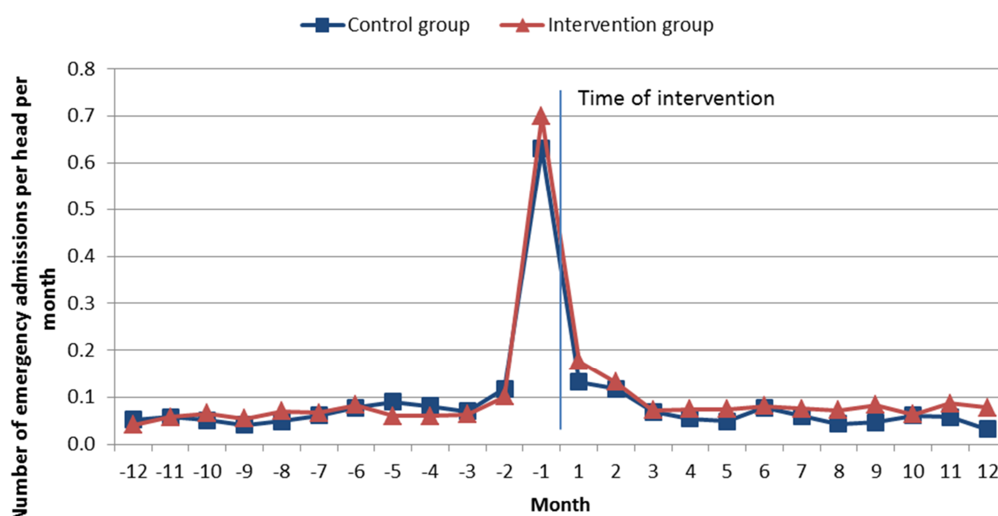
So when one looks at the data for a typical POPP intervention in the study, the data showed the following:-



Source: Steventon [6]

To most lay people this would be conclusive proof that the intervention had had a dramatic effect on tackling the issue (in this case hospital admissions). It would be claimed that this demonstrated the efficacy of the preventative initiative.

However, when the data from the control group is mapped on, a very different picture emerges. It can be seen that the intervention has had no impact whatsoever.



Source: Steventon [6]

Taking account of regression to the mean is a critical point of learning from the POPP programme's evaluation. It is a lesson that needs to be incorporated into all evaluations of early action initiatives.

Business Case

Strong research evidence is the first step, but it is not in itself a justification for commissioning. The intervention may be effective, but one has to question whether the cost outweighs the benefit. This question has to be answered through the development of a business case.

> *Taking account of the economic case is a critical success factor. There is hesitation is some areas because the economic case is somehow seen to jar with some of the principles of early action programmes. This needs to change.*
>
> Professor Martin Knapp, London School of Economics

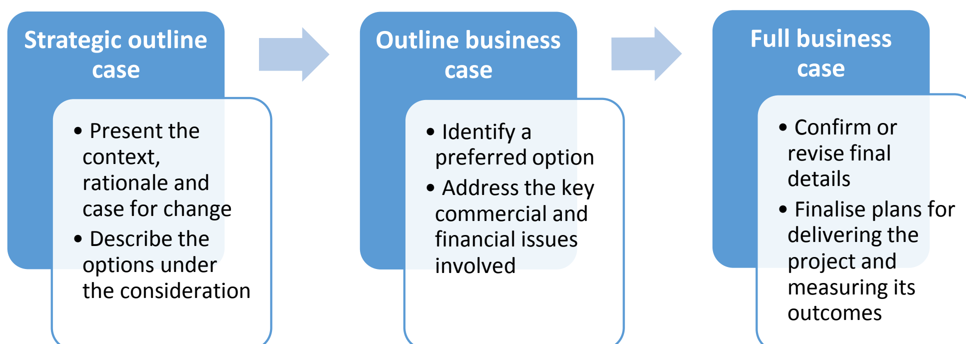
An early action business case will set out the anticipated costs of the programme along with the expected benefits (financial and social) that it will achieve. It is the business case which commissioners of funders will require to guide their investment decisions.

The Early Intervention Foundation have produced some helpful guidance[74] on developing an early intervention business case. They state that business cases are a management and planning tool written to justify a project, by providing all necessary information to support its adoption. There are five different types of business case, each of which supports the policy decision in a different way.

Strategic case	Rationale for the project, including context and the case for change
Economic case	Assessment of the expected costs and benefits of the project
Commercial case	Procurement and contractual steps required to deliver the project
Financial case	Sources of funding and provisions for liabilities or cost over-runs
Management case	Arrangements for project delivery, governance and performance monitoring

Source: Early Intervention Foundation [74]

During the planning cycle business cases tend to progress in stages, starting with a strategic outline case and ending in a full business case which contains the full detail required to support the policy decision. The following diagram shows what the different stages of the business case process look like.



Source: Early Intervention Foundation [74]

There are a number of key questions a cost benefit analysis should answer

What is the expected impact of the option being considered?	Assessing the *improvement* in outcomes that would happen if an option is selected, taking into account: • Outcomes that would have arisen anyway – known as 'deadweight'[1] • Other services or factors which could drive outcomes • Any side-effects (beneficial or otherwise) that may arise elsewhere[2]
What is its value for money?	• Placing a monetary value on option's expected impact • Assessing costs and benefits over the same time frame • Measuring costs and benefits which arise in a different time periods on a comparable basis[3]
How much caution is built in to the analysis?	• Identifying risks and uncertainties which could alter the estimated value for money of an option and the conclusions • Assessing costs and benefits under different scenarios to see how sensitive the conclusions are to the uncertainties identified

Source: Early Intervention Foundation [74]

Some requirements of a good business case include:

Mapping outcomes	• Have you given the inputs a financial value? • Have you checked to make sure that the inputs you have recorded include whole costs of delivering the service (e.g. overheads, rent)? • Have you included a description of the outcomes?
Evidencing outcomes and giving them a value	• Have you identified indicators for the outcomes? • How long do the outcomes last? • Do you already have information in relation to each indicator? • Have you identified a financial value for each outcome?
Establishing impact	• Do you have information for deadweight (outcomes which would have occurred anyway)? • If the outcomes last for more than one time period, what happens to the outcome over this time period (drop-off)?
Calculating the SROI	• Have you set out the financial values of the indicators for each time period? • Have you checked the sensitivity of your result for amounts of change, financial values, and measures of impact?

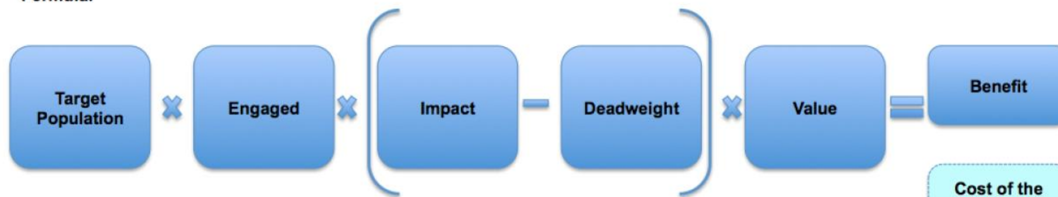
Source: Early Intervention Foundation [74]

Cost Benefit Analysis

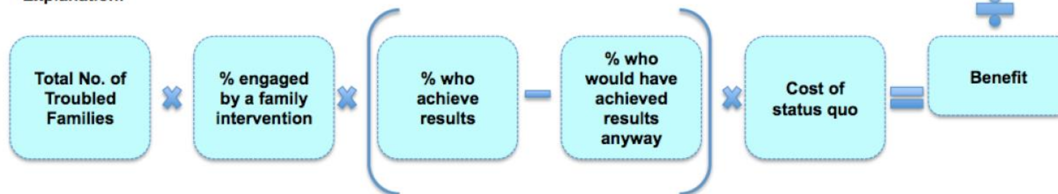
As part of the business planning process it will be important to establish whether the early action programme will generate sufficient benefits (outcomes) to justify the level of investment. In other words there is a need for a cost benefit analysis. The figure below, developed by New Economy Manchester and Greater Manchester[75], provides a general illustration of the thought process that might be involved when attempting to map out a cost benefit analysis. This process is particularly helpful when trying to calculate the potential cost savings or benefits associated with a particular programme or intervention, but it also generalises to broader propositions involving reforms to systems and working practices.

Greater Manchester framework for cost-benefit analysis

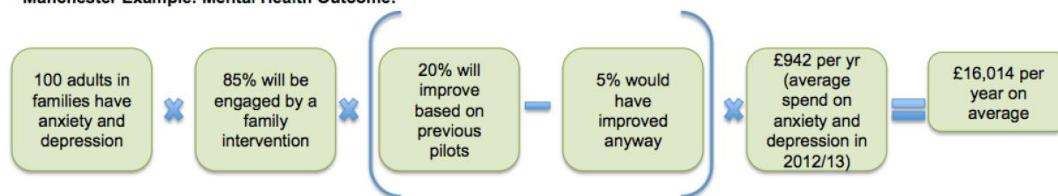
Formula:



Explanation:



Manchester Example: Mental Health Outcome:



Source: DCLG (2013), *The Cost of Troubled Families*.

Further information on cost benefit analysis can be found at the Early Intervention Foundation [75] website.

Theory of Change

Although not used in the majority of the programmes outlined in Section Two, the development of a theory of change or logic model was found to be particularly useful in a number of them and warrants further consideration. It has a number of uses, but can be particularly helpful as part of the evaluation process.

> *A theory of change is a crucial basis for measurement, because it provides a theoretical framework that can be used to assess whether an intervention is working as planned and how it can be improved[76].*

A theory of change shows the path from needs to activities to outcomes to impact. It describes the desired change and the steps involved in making that change happen.

The stages for undertaking a theory of change can be summarised as follows[76]:-

- identify a realistic and definite goal – the ultimate end of the programme or initiative
- work backwards from that goal to work out the intermediate outcomes. Do this by constantly asking – *What has to happen in order for this to be achieved?* Working this way ensures that the focus is on what has to be done to achieve the goal rather than on what the programme's activities are.
- establish the links between outcomes and their order by working out causes and effects
- work out which activities within the programme lead to which outcomes
- identify what else is needed for the intervention to work

A theory of change is a crucial basis for measurement because it provides a theoretical framework that can be used to assess whether an intervention is working as planned and how it can be improved. If measurement is not based on a theory of change it risks not measuring the most important things[76]. It allows one to focus on concrete, defined aims and outcomes which are potentially measurable. It can also help one to understand *how* change is happening as well as *whether* it is happening.

Monitoring performance

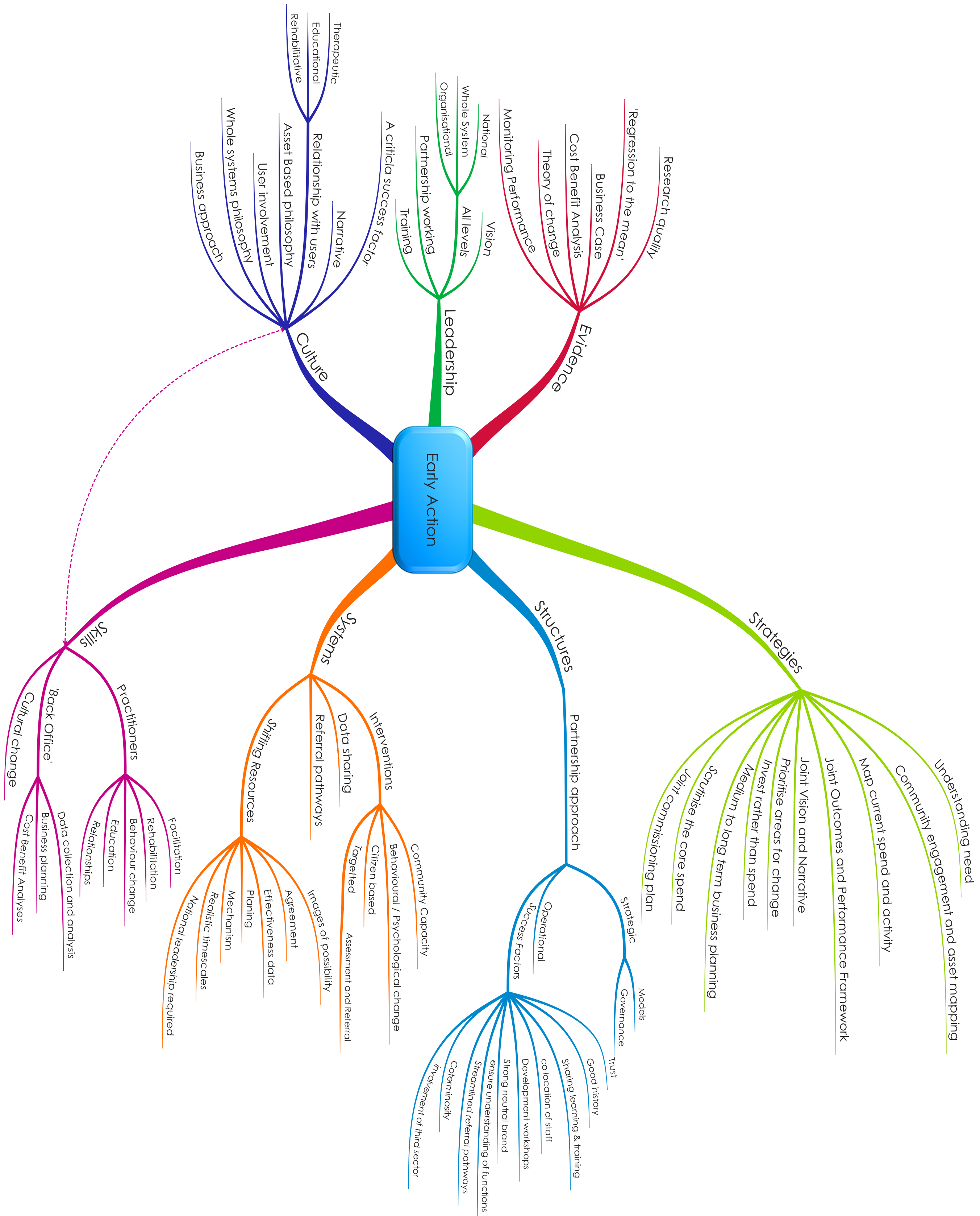
One of the most important lessons from early action programmes has been the importance of monitoring activity and using this data to evaluate effectiveness. Resourcing 'good ideas' without paying attention to what they deliver is of little value. It is vital to:

- develop evaluation frameworks which set out what outcomes are expected
- establish baselines
- undertake regular monitoring of performance indicators and other deliverables

This approach requires investment in performance management and the capacity to monitor outcomes. This kind of capacity is essential and should not be underestimated, particularly if 'savings' are to be generated for re-investment in other parts of the system.

Mind Map

The following 'mind map' sets out the key learning points covered in this section.



 © Positive Ageing Associates

The barriers to prevention approaches

The following is taken from "Prevention and early intervention: Scoping study for the Big Lottery Fund" [1].

Evidence

A lack of robust evidence is often stated as a major barrier to preventative approaches, and most experts that New Philanthropy Capital spoke to struggled to identify evidence based preventative programmes. There are numerous challenges to impact measurement in general, including its cost, knowing what to measure, proportionality and attribution. There are additional, specific barriers to developing evidence around prevention, including:

- *Preventative interventions often aim to bring about benefits over the long term, sometimes resulting in delays before meaningful outcomes can be evidenced. The tendency to fund short-term pilots of preventative initiatives, often means that even interventions with promising signs of success fail to gain continued funding.*

- *The difficulty of proving the 'counterfactual', ie, demonstrating that a problem has been avoided. It is particularly difficult to attribute change to preventative interventions as opposed to wider factors. This challenge in determining the counterfactual creates an 'evaluation bias' against the earliest action.*

In attempting to reconcile the need for a more robust evidence base with the need for innovation and trialling of early intervention approaches, the Early Action Task Force suggests a distinction is made between 'first stage' and 'second stage' evaluation: the first relatively light touch and applied to small scale, early stage programmes, the second used to evaluate significant investment.

Although there is clearly a challenge to strengthen the evidence around preventative approaches, experts also expressed an underlying feeling that evidence is often used as an excuse not to fund prevention. Even where there does seem to be some evidence (eg, early years and healthy lifestyles) spending on prevention is constrained by other factors identified in this section.

There is also a challenge around implementation, as well as evidence—less effective but well implemented preventative programmes can outperform more effective programmes that are poorly implemented. Evaluation of impact must therefore be accompanied by evaluation of process to identify factors—eg, high quality staff, proper training, appropriate referrals—that influence successful outcomes and enable effective interventions to be replicated.

Funding

The potential to implement preventative approaches is limited by pressures to direct spending at addressing immediate acute needs. If government is to invest in preventative approaches, this means shifting spending away from reactive interventions. Yet this runs counter to the 'rescue principle' which underlies much of the charity sector and health services—helping the most needy. Public opinion is also a challenge: it is difficult to explain to someone waiting for a hospital bed that the delay is due to funding being diverted to a public health campaign that has less immediate and tangible benefits. Alongside the lack of convincing evidence on the effectiveness of specific preventative interventions, this provides little incentive for the government to experiment and innovate in the context of budget cuts.

Social investment is frequently identified as an opportunity to bring in a new source of funding for early intervention measures. However, such suggestions often lack a detailed appraisal of opportunities in practice, in particular the challenges of gaining investment for measures where returns are likely to be significantly delayed and there is a lack of robust evidence for effectiveness, and attribution.

The case for shifting funding to prevention is not helped by the lack of knowledge of current spending on acute versus preventative approaches. It has been suggested that government bodies should be set targets for the proportion of budgets directed at prevention, but first baselines of current spending must be established.

Targeting interventions

Although preventative approaches can be cheaper and more effective than dealing with serious, entrenched problems, the latter are much easier to identify and target. Preventative approaches can be extremely costly when directed at large populations, yet, it is sometimes difficult to identify who is most at risk of developing problems in the future. There is a risk of funding 'deadweight'—people receiving an intervention who would have been fine without it. Furthermore, a cost effective intervention may nevertheless be unaffordable given current cash constraints. Where there is a case for universal, blanket approaches, means testing can be a way for government to focus limited resources on those in greatest need.

Structural issues

Short political timescales and government funding cycles act as a disincentive to investing in interventions which are unlikely to bring short-term returns.
Separate and uncoordinated governmental structures are a barrier, as effective prevention is often reliant on cross-cutting approaches as a means to tackle multiple disadvantages. Public bodies and government departments have little incentive to work collaboratively and implement preventative approaches if cost savings will accrue to a different departmental budget. For example, the financial case for local authorities to fund crime prevention and youth services is undermined by the fact that many of the savings (eg, through reduced custody) accrue to central government and the Youth Justice Board. One solution currently being explored is the creation of a profit sharing scheme through which government departments can pool their budgets to invest in a preventative approach, and later share profits when savings are realised. Private investment through Social Impact Bonds could also contribute to such schemes.

Culture and leadership

A lack of strong leadership has been identified as a further barrier to challenging and transforming the culture of late reaction across government. 'Strong leadership at a national and local level is the single most critical factor in extending Early Intervention to all those who would benefit.''[52]

Recommendations

Investment

Although there have been a number of early action programmes over recent years they still account for a tiny fraction of overall spend.

- **Recommendation 1**: that the Early Action Funders Alliance invests in further early action initiatives across the life course.
- **Recommendation 2**: that the Early Action Funders Alliance works with others to press for more Government leadership and investment in the early action agenda

Funding criteria

Partnership working and user involvement are critical success factors in making a shift towards early action.

- **Recommendation 3**: that the Early Action Funders Alliance ensures that any support that they provide requires partnership working and the involvement of service users in the planning and development of the programmes.

Equal support across the life course

There is a much more developed and sophisticated range of tools and resources to support early action with regard to children and young people (i.e. Early Intervention Foundation) than there is for adult and older people services. This imbalance needs to be rectified and an equivalent early action agenda should be promoted across the life course.

- **Recommendation 4**: that the Early Action Funders Alliance promotes the same richness of support, tools and resources for early action in relation to adults and older people as there currently is for children and young people.

Business like approach

Many early intervention initiatives have been strong on aspiration and weak on rigorous business sense. It is not possible to make a systemic shift towards early intervention without strong business processes.

- **Recommendation 5**: that the Early Action Funders Alliance provides support to early action initiatives on undertaking rigorous cost benefit analyses and business planning processes. It could do this by building on some of the excellent resources already produced by the Early Intervention Foundation.

Asset Based Philosophy

Supporting the strengths within communities and individuals, rather than focusing on their deficits, should be fundamental to the early action agenda. However this is not always the case.

- **Recommendation 6**: that the Early Action Funders Alliance should promote the integration of an 'asset based' philosophy into the early action agenda. One way of doing this would be to begin to construct a 'narrative' which illustrates the connection.

Shifting resources

There are very few examples of programmes which have managed to take resources out of one part of the system in order to invest them in early action initiatives instead. Some of the barriers to undertaking this are surmountable, as is evidenced in the work of Social Impact Bonds. However there is a need for more development work to construct mechanisms and approaches to facilitate this kind of action.

- **Recommendation 7:** that the Early Action Funders Alliance commissions development work to construct mechanisms to facilitate the shifting of resources from reactive to early action spend.

Leadership

Strong leadership is critical to promoting early action approaches. However leaders are often unaware of the evidence for, or recent approaches to, early action.

- **Recommendation 8:** that the Early Action Funders Alliance seeks to influence those organisations that provide leadership training in the statutory and voluntary sector, so that they incorporate early action perspectives in their leadership courses.

Evidence

Some of the evidence base for early action is not sufficiently rigorous. In particular many 'before and after' studies may not take account of statistical phenomena such as 'regression to the mean'. Within the children and families' early action arena, people such as Graham Allen MP have identified a number of high quality evidence based interventions (there is nothing similar in relation to adults or older people).

- **Recommendation 9:** that the Early Action Funders Alliance commissions a review of the evidence, across the life course, and identifies those initiatives which meet a high standard of evidential rigor.

System modeling

Running various scenarios of demand and intervention configurations within a system can be a very powerful tool for stimulating early action planning. It is not however an approach which is yet used widely.

- **Recommendation 10:** that the Early Action Funders Alliance promotes the use of system modeling as a useful tool in developing early action approaches.

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