UNIVERSITY OF BIRMINGHAM

IMPLEMENTING THE CARE ACT 2014:

Building social resources to prevent, reduce or delay needs for care and support in adult social care in England

Implementing the Care Act 2014: Building social resources to prevent, reduce or delay needs for care and support in adult social care in England

Final Report for the Department of Health and Social Care

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Brief Summary

It was hoped that the Care Act 2014 would lead to a significant reorientation of local authority activity towards increasing capacity and capability at individual, family and community levels, and thereby contribute to preventing, reducing or delaying the need for adult social care services. This Report summarises findings as to how this this agenda has been taken forward – particularly with the emergence of more far-reaching and radical prevention initiatives that are predicated on a fundamental reimagining of the relationship between local authorities, citizens and communities. These are based on a new emphasis on enabling and co-production, rather than on the commissioning or provision of services (*doing with* rather than *doing to* or *doing for*). Our focus has primarily been on the 'vanguard' of local authorities that have been making substantial efforts to make progress in this way.

Our research shows that a substantial proportion of local authorities have been investing in preventative and capacity building activity, and some are already reporting that they are achieving a pay-off in terms of being able to reduce (or avert an increase in) the numbers of new people needing long-term residential or nursing care. There is some evidence that this can also result in a reduction in the unplanned use of NHS services, particularly where there is a focus on developing connectivity and capacity within communities.

A range of approaches are being trialled and implemented – and this may be seen as a strength as the diversity of initiatives is providing a surprising degree of vibrancy and creativity within (parts of) the sector. Within this study we looked at new strengths-based models of social work and social care, approaches to community capacity building and peer support, targeted use of personal budgets and ways of mobilising the effectiveness of people's family and other networks of personal support. All of these demonstrated the potential to achieve an impact in preventing, reducing or delaying the need for longer term and more expensive forms of social and nursing care.

We also explored barriers and challenges to taking forward the prevention agenda. While the need to reduce spending was identified as the strongest driver for change, financial pressures and uncertainty were seen as presenting the greatest barrier to allocating resources for preventative and capacity building activity. Another key barrier could be conflict with other policy agendas – particularly around delayed discharge. Here the current articulation of policy, including the very language of 'transfers of care', could lead to hasty decisions to provide levels of social care service input that are both inappropriate and hard to disentangle subsequently.

As well as seeking to make savings by averting the inappropriate use of expensive forms of social care, local authorities also stated a commitment to the principles of promoting wellbeing and social connectedness through their preventative and capacity building activity. However, although there can be strong aspirations to enable (potentially) vulnerable citizens to lead better lives, this was proving harder to evidence in a systematic way, and remains a challenge for the future.

Executive Summary and Recommendations

This Report is based on research into 'second wave' approaches to prevention and capacity building that have become more prominent since the implementation of the Care Act 2014. These approaches involve a fundamental revisioning of the role of local services and seek to maximise resources and opportunities through working in more co-productive ways with citizens, families and communities. Typically these involve some combination of:

- New forms of conversation and relationship between citizens, communities and service agencies – 'doing with' rather than 'doing to' or 'doing for'
- Facilitating new connections between individuals, families and communities in order to build or sustain social resources
- Finding 'smart' and non-bureaucratic ways of deploying relatively small sums of money 'upstream' so as to enable people to find solutions to their difficulties and to build effective support systems.

The research findings are based on a national survey of local authorities and in-depth case study research with stakeholders, beneficiaries and family members in seven local authorities which were promoting one or more 'second wave' preventative initiatives. We were only able to obtain responses from one third of the local authorities with social care responsibilities, and it is likely that those that responded may have been undertaking more in the way of preventative activity. Thus our findings may not be entirely representative of the sector as a whole, but instead may reflect the substantial cohort of local authorities who have been shifting the focus of their activity more towards prevention rather than direct service provision.

We found that a preventative focus is still relatively new in adult social care. Many local authorities did not have a single overall strategy for prevention, which could sometimes militate against joining up an effective strategy for prevention across social care and public health – and more widely with primary care and Clinical Commissioning Groups.   Instead, approaches to preventing, reducing or delaying the need for social care were often embedded within a variety of strategic initiatives, including

- Strengths-based models of social work and social care practice (such as 3 Conversations)
- Approaches to social networking and building community capacity (such as Local Area Coordination)
- Mobilising the resources of family and personal networks (through approaches such as Family Group Conferencing, peer support or Community Circles)
- Targeted 'upstream' use of personal budgets.

Overall, financial pressures were seen as the most important driver towards developing preventative activity, but, at the same time, this was also cited most frequently as the greatest barrier. It was seen to be hard to safeguard funding for upstream prevention when faced with the need to make substantial year-on-year savings – and this could be exacerbated by the uncertainty of not knowing what the financial settlement was likely to be in future years. This could lead to pressure to focus just on initiatives that might bring some short-term savings, although the majority of prevention initiatives undertaken by local authorities were seen as likely to achieve impact over a 1-5 year timescale.

Other frequently cited barriers to progressing the prevention agenda were competing policy imperatives and, in particular, perceived pressure to make rushed decisions in order to minimise delays in hospital discharge – sometimes resulting in the provision of expensive and sometimes unnecessary nursing or social care. However, a more considered and co-productive conversation with family and other networks – and one that started much earlier on - could potentially yield less costly and more acceptable outcomes.

The National Survey evidenced a commendably broad range of preventative activity among those local authorities that responded, targeting most user groups. However, there was a marked lack of focus on young carers and vulnerable young adults such as care leavers – indicating that the legislative join-up between the Care Act 2014 and the Children and Social Work Act 2017 has yet to be translated into much concerted action for a group where timely preventative input may be particularly important.

Much preventative activity was pitched either at the scale of the individual or the community – with less focus on increasing the capacity and effectiveness of family and close personal networks. This is an important area for development with potential pay-offs, not just for vulnerable adults, but also those who may currently be taking on an excessive burden of care – including young carers. Preventative and capacity building work at this level may be crucial in building sustainable systems of informal care.

With a thinning out of management as part of overall cost reduction in many local authorities, there can be limited strategic capacity to envision and implement the degree of system and cultural change that is integral to 'second wave' approaches to prevention. Some Case Study local authorities had managed to deliver and sustain major innovation; in others, the process had stalled somewhat between initial (and successful) pilots and effective roll-out of the innovation across the local authority, and in others, the innovation was losing support or likely to be terminated. In all instances, there were indications (and sometimes more robust evidence) of successful outcomes from the new ways of working – so issues with implementation and sustainability tended to relate to factors such as leadership and ownership within the organisation rather than any inherent unsuitability with regard to the model.

Factors which promoted success included distributed leadership rather than reliance on a single champion, support from external organisations and networks (who provided expertise, capacity and constructive challenge), and a genuinely co-productive approach in which the energy and enthusiasm of citizens and communities became part of the driving force for taking the initiative forward. There was often seen to be a need for senior management to let go and trust the 'front line' to get on with taking the innovation forward – and processes of peer support and peer challenge were seen as more effective that top-down micro-management. However, there was also a potential danger that such a devolution of initiative could lead to the emergence of different agendas and ways of working, some of which could compromise the core principles of the intended model and, perhaps inadvertently, lead to a 'slide back' to former and more familiar ways of working. Perhaps the biggest challenge was in reorienting how relationships were being enacted between staff and citizens – moving away from conversations and practices that implicitly emphasised deficits and encouraged dependency, and developing the art of enabling people to come together to find their own solutions and develop their own capabilities.

Another challenge facing local authorities was how best to evaluate the success (or otherwise) of preventative activity – recognising that this was taking place within a complex system where other changes were in progress , and where anticipated outcomes may take some years to come to pass. Overall, we found associations in the Case Study sites between the introduction of strengths-based approaches and reductions in the use of more expensive forms of long term care, such as residential and nursing care, and between community capacity building and overall reductions in social care spending and spending on unplanned healthcare. These results were encouraging but by no means definitive. At an individual level, the limited follow-up data that we were able to collect did not indicate any significant change with regard to wellbeing and capability – and further research would be helpful in relation to this.

Recommendations

1   Policy context

1.1   National leadership
While some local authorities are demonstrating considerable success in innovating and delivering preventative and capacity building activity in adult social care, this is not sector-wide. There would be value in stronger and more joined-up leadership at a national level from ADASS and DHSC – ideally in collaboration with Public Health England and relevant NHS partners. A joint focus could be around reducing social isolation, pulling together activity around community networking, social prescribing and capacity building that may currently be separately commissioned and poorly coordinated. This would complement initiatives around strengths-based social work practice that are being promoted by the Chief Social Worker for Adults.

1.2   Ability to plan within a 5 year financial horizon
Given that local authorities identified financial pressures as the greatest barrier (as well as the greatest driver) towards investment in preventative activity, and that much preventative activity is realistically aimed at bringing benefits within a 1–5 year financial horizon, it would be helpful for there to be a 5 year funding settlement for local authorities (as for the NHS) to allow more certainty to underpin the strategic implementation of prevention activity as part of business planning.

1.3   Realignment of incentives around delayed discharge
There is a need to realign incentives so that the pressure to avoid delayed discharge of people from hospital does not translate into the hasty and inappropriate provision of expensive packages of nursing or social care that may be hard to disentangle once implemented. There needs to be a responsibility on hospitals *and* local authorities to set up a joint process in which planning for discharge starts substantially before the person is deemed medically fit for discharge (often at the point of admission) – so as to enable a strengths-based dialogue in which family and community resources can be explored and mobilised where appropriate.

1.4   Thinking Family and personal networks
There has been relatively little activity directed at developing and mobilising the strengths of family and personal networks, such as through Family Group Conferencing. This can be crucial in supporting both vulnerable citizens and individual family or network members, including young carers, who may be taking on an excessive burden of responsibility. It is recommended that the existing draft Guidance *The Care Act and Whole-Family Approaches* be formally adopted and promoted across the sector.

1.5   Better integration of prevention objectives and activity between social care and public health
Sometimes reflecting different priorities and ways of conceptualising prevention, the potential synergies between social care and public health prevention activity are not always being realised within local authorities. There is a need for a more consistent shared approach to promoting the capacity and capability of communities, families, networks and individuals – which has the potential to deliver benefit in relation to both care and health needs.

2   Practice and implementation

2.1   *'You have to be radical to achieve the benefits'*
When seeking to implement a reorientation towards prevention and capacity building, local authorities should avoid a piecemeal or diluted approach or little benefit is likely to be achieved. There needs to be a degree of whole system change if 'second wave' models are to be effective.

2.2   *Relationships that do not build dependence*
Fundamental to the success of all 'second wave' approaches is for staff to be able to engage with citizens in ways that do not inadvertently build dependence. This may be characterised as 'doing with' rather than 'doing to' or 'doing for'. This may often require a new skill-set that is different from those required to assess for or provide services - so appropriate supervision and supported learning may need to be provided.

2.3   *Fidelity to intended model*
There needs to be clarity at all levels of the organisation as to the intended model and how this is different from established practice. Local adaptations and solutions can be crucial for ownership and effectiveness – but it is important to make sure that they do not compromise the core logic of the innovation. It can be helpful to have some support and scrutiny from an external implementation organisation to ensure that local modifications do not inadvertently lead to a reversion to aspects of 'business as usual'.

2.4   *Scaling up and scaling out*
Local authorities need to take a strategic approach to scaling up within the organisation and/or scaling out to other parts of local government and healthcare. In particular, there needs to be an explicit focus on systems, culture and values – and keeping all staff on board, whether or not they are part of the early innovation. In order to achieve this, it may be helpful to have an explicit logic model or Theory of Change.

2.5   *Sustainability and ownership of new ways of working*
Innovations remain vulnerable while they stand out as counter-cultural to mainstream approaches to assessment and the provision of social care or health services. Unless the 'centre of gravity' of the mainstream also changes, there may continue to be resistances and pressures within the system that can easily lead to a return to the former status quo. It is therefore important not to locate ownership of the prevention activity with a single leader within the organisation as it unlikely to continue thriving if this person moves on. It is often particularly important that lower and middle managers are fully behind the new ways of working as it is they who will ensure that it is (or is not) delivered on a sustained basis. This has implications in terms of training and support – particularly at this level.

2.6   *Preventative use of personal budgets and direct payments*
There may be value in introducing systems whereby individuals (and potentially also groups and networks) may be allocated limited short-term or one-off direct payments to resolve barriers to providing support and enabling independence, or to open up new opportunities. To be effective, such systems would need to be speedy and non-bureaucratic – with authorisation at front-line level.

3   Evaluation

3.1   Tracking expenditure and savings

Local authorities need to have more transparent financial systems whereby investment in prevention and capacity building can be clearly identified and tracked through to subsequent savings (or otherwise) in expenditure. Given that this is a rapidly developing field, it may not be easy or appropriate for there to be strict national guidance as to how to do this – but some agreed guidelines across the sector may be helpful.

3.2   Measuring outcomes

At national and local level, urgent consideration needs to be given to introducing a simple, robust and user-friendly approach to assessing the sorts of outcomes that are to be achieved through 'second wave' preventative / capacity building approaches in social care. As the desired outcome for many is that they are enabled to stay out of the orbit of social care services, assessing outcomes on the basis of 'social care related quality of life' (and the ASCOT measure) may not be entirely relevant. A new outcome tool needs to capture capability, wellbeing and connectivity – and could be based on the 5 question ICECAP measure used in this study. Such a measure should be integrated within routine data collection, but would need to be trialled more extensively first.

Research Report

1   Introduction

This Report presents findings on how local authorities in England have been responding to the challenge of prioritising more preventative and capacity building activity in adult social care – a key expectation set out in the Care Act 2014. Significant prevention activity was already underway before 2014, but this 'first wave' was often conceived in relatively narrow terms, with a focus on practical and often health-related forms of intervention and support, such as reablement, falls prevention, technology based interventions and the provision of more effective information and signposting services[1] [2].

This research project sought to capture the 'second wave' of prevention activity which has involved more fundamental revisioning of the role of local services and the relationships between services, citizens and communities – and a more positive and holistic focus on enhancing wellbeing, opportunity and social connectivity, as opposed to a more defensive focus on mitigating risk and providing services in response to identified needs[3] [4] [5]. While the origins of 'second wave' approaches go back to initiatives that were already underway prior to 2014, the pace of innovation has increased since the implementation of the Care Act, and has been supported by strong leadership around strengths-based practice from the Chief Social Worker[6].

Typically such cross-cutting innovation involves:
- New forms of conversation and relationship between citizens, communities and service agencies – 'doing with' rather than 'doing to' or 'doing for'
- Facilitating new connections between individuals, families and communities in order to build or sustain forms of capital and capability[7]
- Finding 'smart' and non-bureaucratic ways of deploying relatively small sums of money (including personal budgets / direct payments) so as to enable people to find solutions that help them to live better – and outside of formal care services.

The Report is structured according to a series of Key Themes, with the analysis drawing, where appropriate, on data from both the National Survey and Case Studies.

2   Research design

The project was undertaken by a research team based at the University of Birmingham, supported by a Lived Experience Advisory Panel. The research comprised two distinct elements:
- **An online national survey** that went out to senior leaders in all local authorities in England with responsibilities for adult social care. Responses were anonymous to encourage honest reporting of challenges and difficulties as well as successes. Respondents were also invited to submit relevant strategic policy documents. Overall, we received responses from around one third of local authorities, with responses from across all ADASS Regions. While this is a good response rate for such a survey (reflecting support from some regional ADASS leads and some assertive follow up by the research team), we cannot claim that the sample is necessarily representative – as it is likely that it may be biased towards those local authorities undertaking more prevention related innovation.
- **In-depth Case Studies of innovation** in seven local authorities who were undertaking innovative work in the field of prevention (see Appendix 2). These were selected to include a city, a very rural shire county, a London Borough and a variety of unitary local authorities from different regions in England. One local authority offered the opportunity to research two different innovations and

another the opportunity to compare separate community initiatives taking place in three local sites. The sample included local authorities from the North, Midlands and South of England, and they were selected to include earlier and more recent innovators, with a particular focus on 'second wave' innovations that have come to the fore since the implementation of the Care Act. They comprised:

- o Three local authorities which were innovating new strengths-based models of social work and social care practice – '3 Conversations' and 'Let's Talk Local'
- o Three local authorities which were focusing on building community capacity – Local Area Co-ordination (two local authorities) and Neighbourhood Networking with some Asset Based Community Development (three sites in one local authority)
- o One local authority focusing on mobilising family resources through Family Group Conferencing (with subsequent introduction of 3 Conversations)
- o One local authority, working in partnership with an NHS provider Trust, which was offering targeted use of personal budgets and peer support for mental health

Findings for each Case Study are based on the following sources of evidence

- o Two waves of interviews and focus groups with staff and external stakeholders to track the process of innovation. We conducted 84 interviews in total (51 interviews at baseline, 33 interviews at follow up), together with 4 focus groups.
- o Initial and follow-up questionnaires on Quality of Life (ICECAP- A) and service use completed by a sample of beneficiaries / family members. Unfortunately, response rates were substantially poorer that was initially hoped (partly due to the level of disability or frailty among the beneficiary population). Although the ICECAP-A is brief and straightforward (with 5 questions only), the additional questions on use of other health and social care services were necessarily more onerous to complete.   There was particular difficulty in securing completion where the service that was offered was itself relatively brief. This was particularly the case for local authorities which were innovating new models of social work and social care practice. In total, 159 questionnaires were returned at baseline, but only 33 at follow-up - precluding any systematic economic evaluation.
- o Interviews with a sample of beneficiaries / family members across all sites (44 interviews).
- o Analysis of relevant service-related data available collected by each local authority, including annual returns to the Department of Health and Social Care.

ICECAP-A provides a generic capability-based measure of Quality of Life for adults that has been validated for the general adult population[8]. Unlike the narrower focus of the ASCOT measure and its associated conceptualisation of 'social care related quality of life', ICECAP-A seeks to capture the sorts of outcomes that are hoped to emerge from broader based preventative approaches, such as enhanced relationships and social connectedness, a sense of security, greater opportunities to achieve, and the ability to lead a maximally independent life. This approach has been recommended by NICE and SCIE[9].

The Lived Experience Advisory Panel was co-facilitated by people with experience of using social care services and comprised representatives recruited from the sites where Case Studies were undertaken. They not only advised on the survey tools used, but also contributed to developing the analytical framework for the thematic coding of interviews with service beneficiaries. They provided a point of liaison with local service user and voluntary organisations and contributed to the design and delivery of site feedback events. In addition, a proportion of the interviews with service beneficiaries were conducted by suitably trained researchers with lived experience.

3   How is prevention conceptualised in local authority social care?

Unlike in health, where there are more established ways of conceptualising prevention and early intervention, such ways of thinking are still relatively new within social care. Rather than using terms such as primary, secondary and tertiary prevention, there has been a tendency to follow the language of the Care Act and see prevention as activity designed to promote wellbeing and to prevent, reduce or delay the need for social care services. Crucial in articulating a more preventative vision was the need to decouple understandings of need from former expectations that this could only be met through service provision:

> *We don't have a duty to provide services. We have a duty to support people to meet unmet needs [where possible through] what is available in the community and in informal networks*. (Site F – Senior Manager)

In line with Statutory Guidance, wellbeing is increasingly seen as covering 'an intentionally broad range of the aspects of a person's life'[10]. One Council articulated its strategic vision in terms of a broad commitment to promote wellbeing, with three underpinning themes of:

- Better Lives through better conversations
- Better Lives through better living
- Better Lives through better connections.

This was then translated into the more concrete aspiration that everyone in their area should be enabled to have 'three good friends' – an aspiration around building social and relationship capital that potentially fits well with the prevention agenda in both social care and health[11].

Another Council placed community capacity building at the heart of their vision:

> *All people in [ ] live in welcoming communities that provide friendship, mutual support, equality and opportunities for everyone, including people vulnerable due to age, disability or mental health needs, their families and carers*.

Both from the National Survey and the Case Studies, it is clear that relatively few local authorities have chosen to develop a single over-arching strategy on prevention – but instead see prevention to be embedded in a range of strategic initiatives that they are undertaking around promoting wellbeing, building capacity and social connectedness, and/or strengths-based practice. Where local authorities had produced an overarching prevention strategy document, there could often be a tension between social care and public health agendas – both in terms of how prevention was conceptualised and whether the priority focus was on specific health agendas such as smoking cessation and obesity, on social care agendas around building capability and effective systems of support, and/or on wider objectives (e.g. around social connectedness).

A lack of a specific organising focus around prevention was reflected in the National Survey finding that less than half the local authorities reported having an identified budget for prevention. This may be seen as a potential limitation in the planning and evaluation of preventative activity – as it can make it harder for the local authority to track thorough whether increased spend on prevention is making an impact in terms of reduced demand for more expensive longer term services.

However, there are potential difficulties in identifying whether particular activities are or are not preventative – as what makes the difference can be much more around how an activity such as a social work assessment or a home care interaction is delivered, rather than simply counting units of activity. Such

ambiguities inevitably influence the quality of data that local authorities can return to the Department of Health and Social Care.

4   Drivers and enablers for change

Given that current ways of conceiving and delivering adults' social care have become entrenched over a number of years, local authorities were not necessarily well positioned to accept the challenge to move towards an emphasis on prevention and the promotion of wellbeing that is enshrined in the Care Act 2014. In the National Survey, we asked respondents to identify the major and minor factors driving their preventative activities (Figure 1).

Figure 1:   What are the *major* and *minor* factors driving Prevention activity?
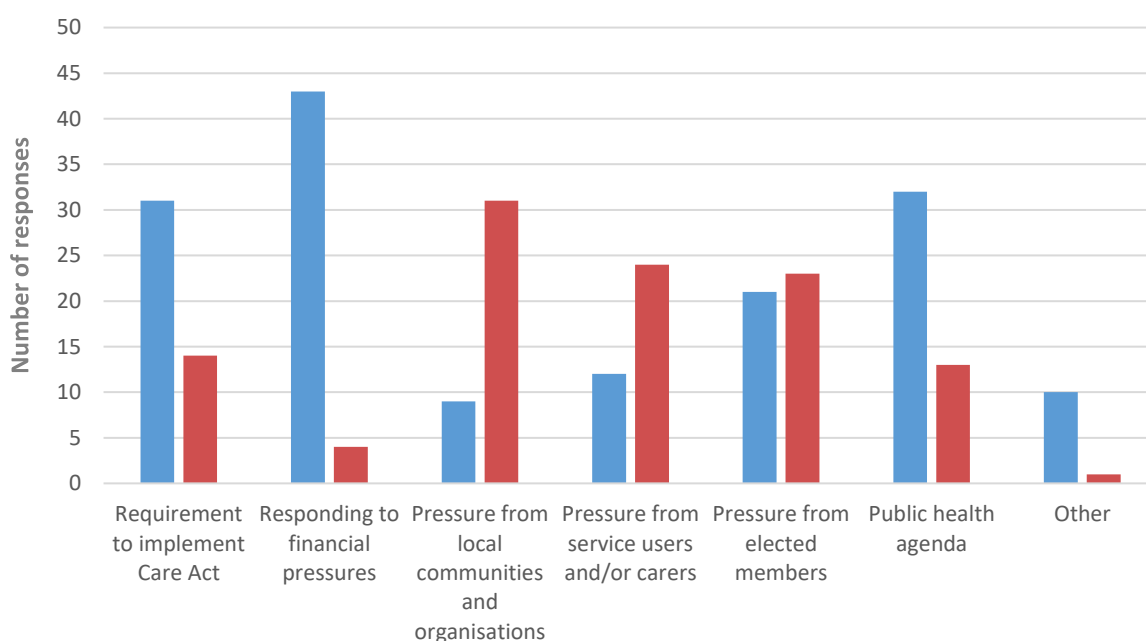
Unsurprisingly, the most important factor driving preventative activities was financial pressure, with almost all respondents citing this as a major driver for change. For many, this was coupled with a recognition that an ageing population would inevitably be placing increasing demands on existing service models. This was echoed in many of the Case Study Local Authorities:

> *Local Authority funding from central government is likely to be under continued downward pressure at the same time that demographic pressures for the county, such as an ageing population, are on the increase. The scale of these pressures that the council and its partners face means that we will need to do things differently* (Site D – Position Statement)

In the National Survey, the second largest driver came from public health – but this was not echoed so consistently in the Case Study sites – indicating that integration of public health and social care agendas within local authorities can be patchy. In one Case Study local authority, public health provided the 'glue' which enabled the joining up of local authority and health agendas at a local level:

> *I think the reason why we started to open some doors is we've got a wonderful director of public health that we didn't have to start with … he speaks their language and he speaks in very analytical and scientific ways that they tend to sit up and listen to - and through that we've been able to sell our message far more.* (Site B – Senior Manager, social care)

However, in another, a change of personnel in public health had led to a shift in resourcing away from a shared holistic focus on building social capital and connectivity at a local level, towards actions geared at specific public health targets, such as those around smoking or obesity. In another, there was pressure to use infrastructure of locally organised Neighbourhood Networks not just to help tackle social isolation, but also to put out specific public health messages as part of wider campaigns – e.g. around hydration. However, while having a preventative purpose, such top-down pressure to influence behaviour change may not necessarily have fitted with the profile and purposes of grass-roots organisations.

Although responding to the Care Act was identified by over half of respondents in the National Survey, it was generally seen within the Case Study sites as more of an enabler that was liberating them from compliance with previous legislation and *'Finally putting the care management model to bed' (Site F – strategic manager).* This former approach was seen as having led, as budgets tightened, to a very limited practice which involved saying 'no' to people until their need was judged to be critical, by which time there was often no scope for any preventative or capacity building responses, leaving, as the only option, the provision of relatively expensive long-term care services.

Alongside these 'top-down' drivers, many survey respondents also identified 'bottom-up' pressures from citizens, service users, and carers as significant (although lesser) drivers for change. Both from the National Survey and from the Case Study sites there emerged a moral sense that a different approach to meeting need was '*the right thing to do to support local people*' (Free text response, National Survey).

5   Reported barriers to implementing prevention oriented activity

We asked survey respondents to identify the major and minor barriers to prevention (Figure 2). Most respondents identified financial pressures as the biggest major barrier to preventative activities. This finding reveals the extent to which financial pressure can act as a 'double-edged sword' - as both an enabler and a barrier to prevention. Within a stable financial situation, investing in upstream activity to make savings further down the line could be relatively straightforward. Where local authorities were having to react to an uncertain environment of annual financial settlements, with major year-on-year downscaling of government funding support for social care, ring-fencing additional resources for prevention could be much harder – and preventative initiatives could be sacrificed in order to meet current demand for services.

While in some instances, upward pressure from communities and dissatisfaction with former approaches to social care delivery was identified as a driver for change, in other instances, there was local resistance when Councils tried to change established modes of service provision – including resistance from a voluntary sector that had taken on the role of being contracted providers of conventional care services on behalf of the local authority.

Figure 2: What are the *major* and *minor* barriers to implementing prevention activity?
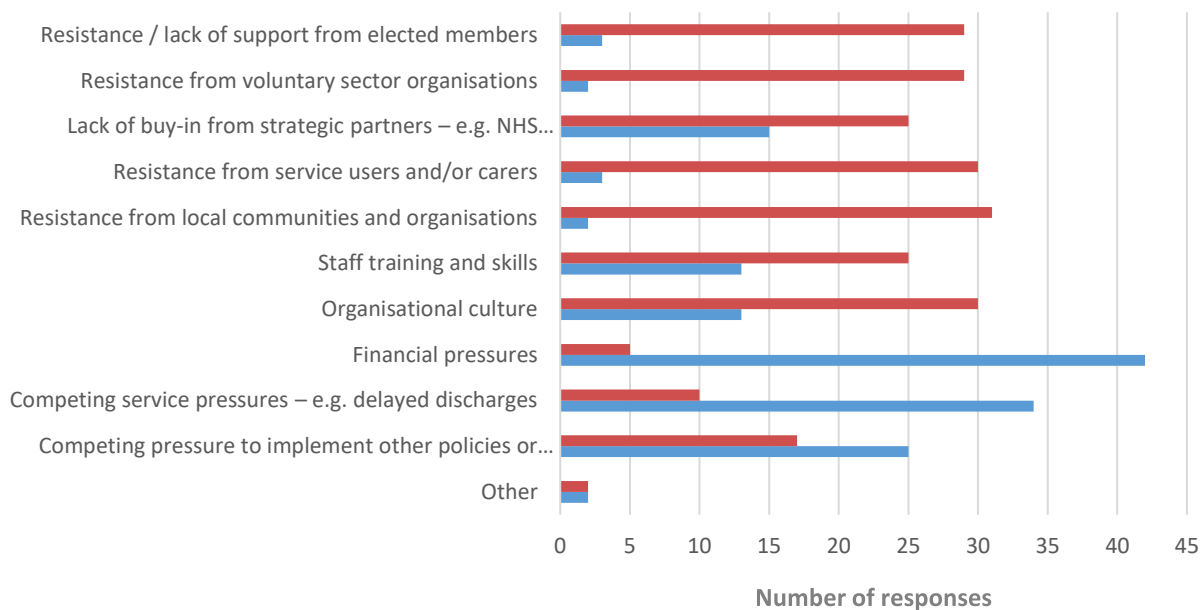
Other key barriers to prevention were identified as conflicting pressures both in terms of policy and in terms of the local health and social care economy. Most frequently cited was the pressure not to delay hospital discharges which could easily translate into hasty decisions to provide care services where this may not necessarily have been appropriate or necessary. The very language of 'Delayed Transfers of Care' can be unhelpful as there is within it the presumption that the provision of 'care' will necessarily be the most appropriate way of meeting identified need at point of discharge. Paradoxically, in Case Study sites, jointly organised pathways designed to smooth discharge – e.g. by the provision of free care for 6 weeks post-discharge – could result in de facto embedding of longer term care provision as the default option rather than the exploration of other options with the person and their family which might have prevented or delayed the need for care services.

6   Working with other stakeholders and co-production

There was considerable variation in the degree to which Case Study local authorities involved wider stakeholders in the planning and development of their prevention or capacity building initiatives. Some tended to go it alone to a large extent in order to get things moving more quickly and then involve other agencies later on in the process. Sometimes this led to duplication or confusion with other community capacity building initiatives that were, or had been, undertaken by others – principally health – such as social prescribing or care navigation. Others worked hard to engage collaboratively with strategic partners:

> *So …strategically and in partnership … we're involved with all health partners very closely in terms of development…. So what we tried to do is each step of the way, keep the meetings open, keep the conversation, communication going, inform the Trust just kind of our ideas and hear what their ideas were. You know, there was times when they were going off in one train without you know speeding off on a train and we were speeding off in a different direction and it's kind of a question of bringing it back together. So, we did talk to them a lot about our ideas for the hubs.* (Site D - Service Manager)

In the National Survey, most respondents also reported that potential beneficiaries were involved in the co-design and development, implementation and evaluation of preventative initiatives. However, the Case Studies indicate that the extent of this involvement may be somewhat variable, with a tendency for less involvement in relation to strengths-based models of social work and social care, and greater involvement in peer support and community development initiatives. In one Case Study site there had been considerable investment in adopting a co-productive approach. Under the aegis of the NESTA *People Powered Health* Programme, they had invited people recovering mental health difficulties and family members to be equal partners in developing their own infrastructure of support[12].

> *Before the service was set up…we were in a lot of consultation with the whole of the [ ] user groups and ... different groups, carer groups and professionals ... from both statutory and the voluntary sector so there was a lot of consultation and also a lot of training around co-production.* (Site G - practitioner)

However, in some other community capacity building initiatives, there could be criticism that the community was not more fully involved from the start:

> *It felt like we were there to make it look right, as opposed to making it work right. I praise the Council for trying it but I think that it was more lip service than actual real input, if I'm absolutely honest… It would have been interesting to be involved in the initial planning and ideas … It would have been nicer to be involved in the actual co-production of the solution in the first place. The community weren't involved in that.* (Site C – Community representative)

7   Intended beneficiaries and timescales for impact of preventative activity

National Survey respondents were asked to select their 'top 3' preventative activities and, for these to identify who it was hoped would benefit from the activities (see Figure 3). Overall, local authorities took a broad view of their responsibilities towards prevention, not only giving prominence to mental health and learning and physical disabilities as well initiatives for older people, but also recognising a potentially broader category of socially isolated people with seriously diminished wellbeing who had previously fallen outside social care eligibility criteria. This latter finding has been echoed in some of the Case Study sites where having a closer presence on the ground had surfaced significant unmet need among people who did not necessarily fit into conventional adult social care categories – some of whom may have sought to access support via other routes – e.g. through being frequent GP or emergency hospital attenders, coming to the attention of Police or Fire services, or making repeated enquiries to a local authority first point of contact:

> *I had quite a few of those and ones where they kept going through First Point of Contact. They kept ringing for different things but it didn't meet the threshold for Adult Social Care… What you, at first, think is the issue, once you start scratching, there is a whole lot more. It is sometimes just about them being so lonely and just wanting to get out and meet people and have that contact.* (Site C – Local Area Coordinator).

> *[It] starts to affect my mental state, you know, I have to shut the door, there's times I don't open the curtains, starting to don't even come out of the room. It's very rare that I even get dressed.* (Site B – Beneficiary of Local Area Coordination)

Figure 3: Intended beneficiary groups (for up to 3 key areas of activity per local authority):
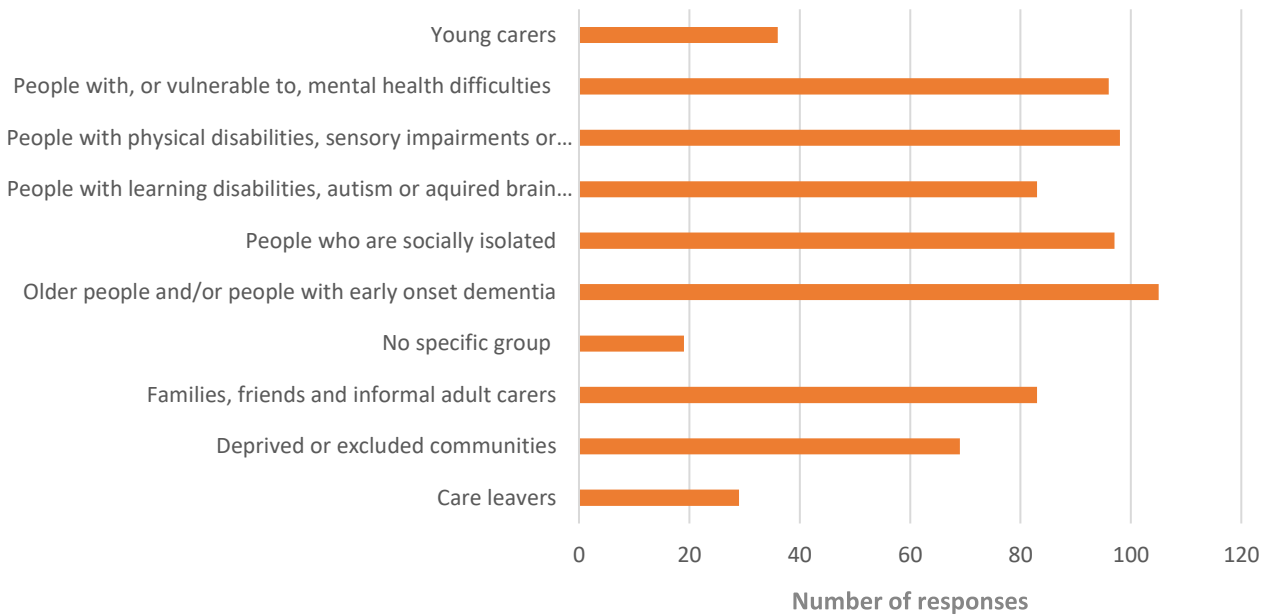
It is also to be noted how both Care Leavers and young carers are less likely to be 'on the radar' for adult social care preventative activity. While it is possible that excellent preventative input is being provided by Children's Services, there may also be concerns of a lack of join-up, and vulnerable young adults who are (or should be) known to the local authority not being tied in to the sorts of capacity building and connecting services that other groups are receiving – with the possibility of mental health issues or seriously compromised wellbeing in adult life. This is despite the attempt to better connect support for such young people with the interlinking of the Care Act and the Children and Social Work Act 2017.

When asked to indicate the timescale in which they expected that benefits would be realised (Figure 4), respondents were optimistic that some benefits would be realised in less than 12 months, but were realistic that many potential benefits would only work through in 1-5 years.

Figure 4: Timescale by which benefits expected to be realised (up to 3 initiatives per local authority)
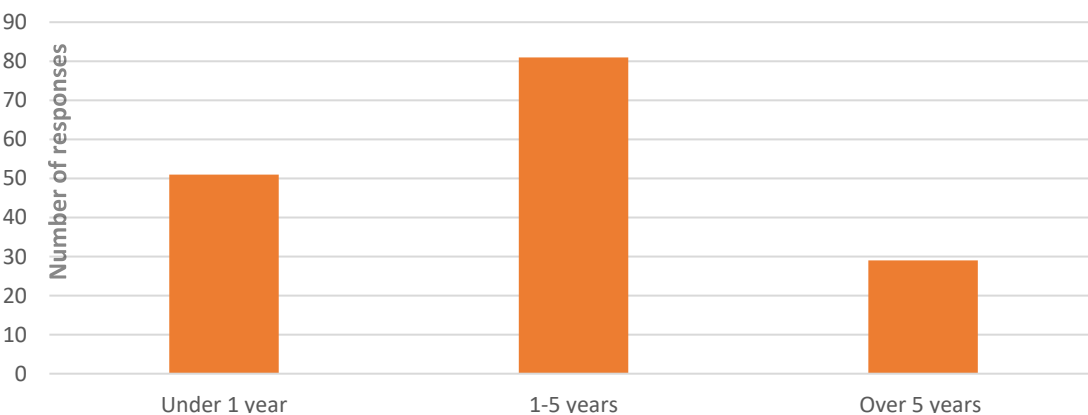

8 Range of models, approaches and activities

Perhaps not surprisingly, the most commonly reported prevention activities in the national Survey were still those that had been part of the 'first wave' of prevention activity – signposting, assistive technology and

reablement (see Figure 5). However, not far behind these were a variety of 'second wave' initiatives including the refocusing of social work towards prevention and asset/strengths based approaches, community development, shared lives, social networks and peer support, social prescribing and initiatives involving housing and housing support.

Less prevalent were approaches specifically focused on enabling families or close support networks to work more effectively together – such as Family Group Conferencing or Community Circles – and this may represent a relatively underdeveloped area of preventative practice. Interestingly, this has not been as strong a focus in national policy implementation as was anticipated around the time of Care Act implementation. Although Guidance on *The Care Act and Whole-Family Approaches* was drafted by the Department of Health, ADASS, the LGA, the Carers Trust and the Children's Society[13], and is available online via SCIE, this has not been formally issued as guidance by the Department of Health and Social Care or by local government – and is not well known or well used in the sector.

Figure 5: Prevention-orientated approaches
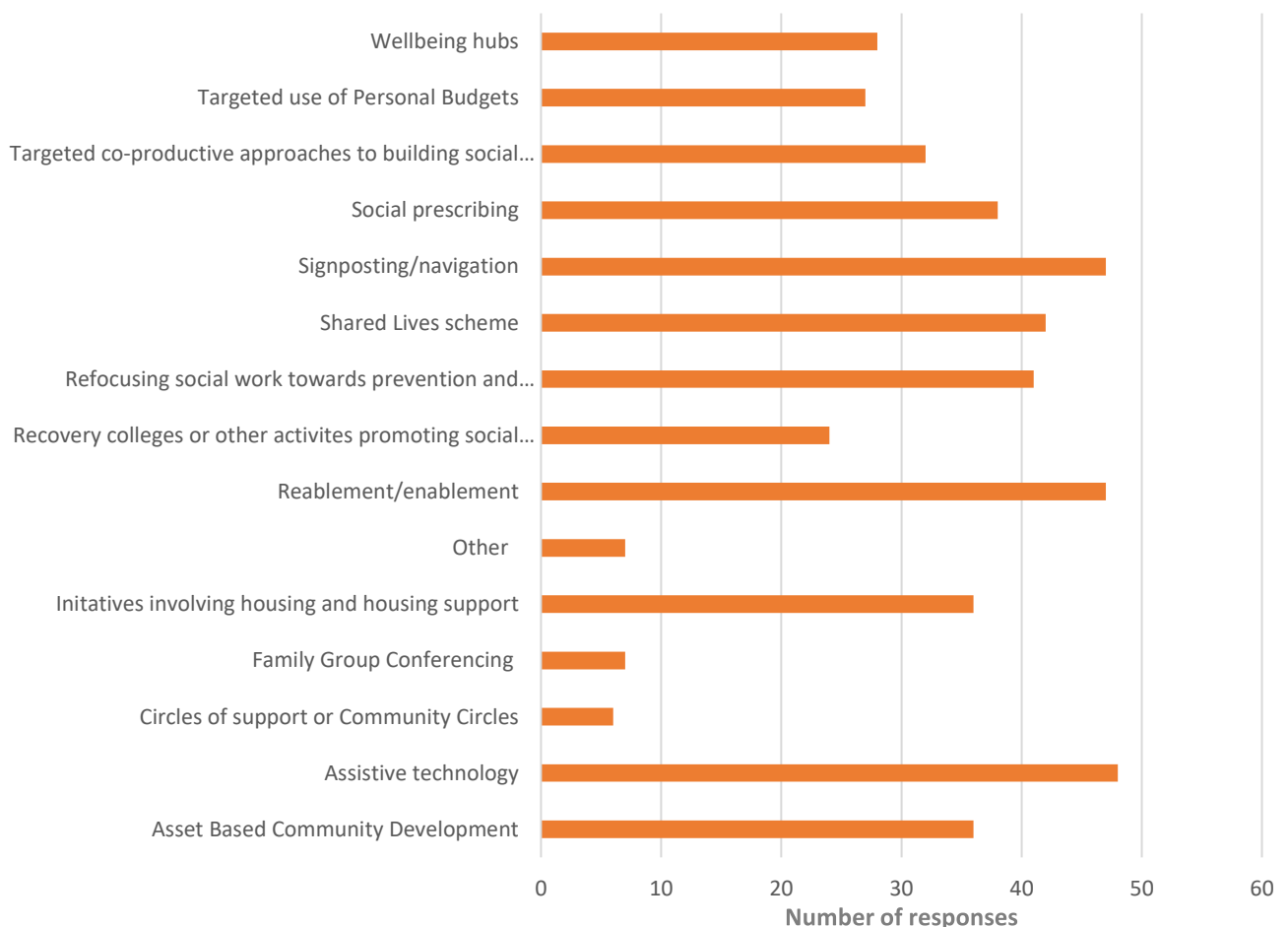
Strengths-based social work and social care

There has been growing recognition that, due to the combined impact of previous legislation and financial stringency, the conversations that social workers and social care practitioners had come to be having with citizens and family members tended just to focus on assessments of need, and eligibility, for services. These

conversations were overwhelmingly procedural and typically involved the completion of 30-40 page assessment forms, which then fed into a complex infrastructure of inputting information on IT systems and decision making on resource allocation via funding panels. This left little or no space in which to explore solutions to people's difficulties that could be achieved without recourse to service provision.

Broadly following the principles of the Exchange Model of assessment[14] some local authorities have sought to transform their offer to the community at the point at which people are asking for help – explicitly focusing on a meaningful conversation about what matters to the person and their family and friends, rather than completing a prescribed process. Such conversations focus not just on presenting difficulties, but also on the strengths, resources and solutions that may potentially be available. One such approach has been the '3 Conversations' model supported by Partners 4 Change – and two of the Case Study local authorities were at different stages of implementing this (Sites B and C). Other local authorities are developing their own practice models, but with similar aims – such as the 'Let's Talk Local' approach being rolled out in Site D.

Within the 3 Conversations approach, practitioners are required to follow a sequence in which the first conversation is about understanding and, if possible, resolving presenting issues by enabling people to find their own solutions with their families and friends, and connect with opportunities and resources in their communities. The practitioner does not normally signpost or refer on – they stay in contact with the person as new connections are established or solutions worked through. Sometimes items of equipment may be supplied in order to facilitate continued independent living. This is all done with the minimum of paperwork (only recording what is relevant and necessary) and the maximum of personal contact time.

Where more serious issues emerge (such as safeguarding) or where current systems of relational support are in crisis, the practitioner moves to Conversation 2 and 'sticks like glue' with the person and their situation to explore if solutions or arrangements can be found that do not involve the commitment of longer term care resources. These may involve short term inputs in order to 'hold' the situation safely until a more lasting solution can be found. It is only if such a solution is not possible, that the practitioner moves to Conversation 3, in which there can be consideration of what long term care resources may be needed to support the person in their chosen lifestyle, alongside the other forms of support that may be available from family and community. As before, the aim is that decision making should be 'smart', immediate and non-bureaucratic.

Across the Case Study sites using this approach there was considerable variation in where and how conversations took place. In one rural local authority, initial conversations tended to be over the phone. In the more rural parts of another, the conversations were arranged in local hubs which 'popped up' in village halls or other community facilities and would typically also involve local carers groups and other organisations being onsite at the same time.

Community capacity building and peer support
A number of different approaches to building capacity in the community were being taken forward. Broadly speaking they share common aims in terms of bringing people together, not just to reduce their social isolation, but also to enable them to do things with and for each other, and thereby open up opportunities, mobilise networks of practical and emotional support, and improve people's quality of life. While this is seen as something that is beneficial in its own right, it also has the potential to reduce people's requirement for social care services if their needs are better met 'organically' through their everyday interaction with friends and neighbours – interactions in which they may contribute as well as receive. Within public health,

it is increasingly being recognised that the impact of social isolation, in itself, can be a major contributor to the increased incidence (or severity) of a wide range of health conditions – so reducing social isolation may be seen as a key focus for primary prevention[11][15].

While such approaches may be seen to have their greatest potential impact with those whose needs are less substantial, they may significantly reduce or delay the likelihood of those needs escalating. In some instances, the goal is to join up what is available in the community with additional support from services - which may also enable those with more serious needs to be supported so that they do not have to go into residential or nursing care or, in the case of people with ongoing mental health difficulties, to be readmitted to hospital.

Within the Case Study sites, we had examples of:
- Community organisations being funded to provide a range of activities with a local centre or base acting as the hub for wider networking in the neighbourhood (Neighbourhood Networking).
- Salaried Local Area Coordinators being employed with a remit to work 'out there' in the community getting to know both the existing fabric of social connection, and those who might currently be outside of this - and to develop community resources to meet identified goals (See Box 1). Conversations would start with an exploration of what matters to the person and their family – including what they may have to offer others as well as what they might feel they need – with a view to brokering introductions with other individuals or groups with whom they might be able to connect. Such conversations could begin by asking people 'what is a good life?' (rather than 'what services do you need?'), so that the focus is on the person and their aspirations with no pre-determined outcomes and solutions.
- Local people being supported to act as paid or unpaid 'community connectors' – undertaking a broadly similar role to Local Area Coordinators but on a more informal basis. Such approaches could be (but were not always) developed under the aegis of an Asset Based Community Development (ABCD) approach (see Box 1)
- People recovering from mental health difficulties being supported to run their own informal support structure of meeting points, peer-support and shared activities in the community – with a very small team of practitioners being available to provide additional support where needed to avert potential relapses or crises.

> *'We have grown a really very good peer support group without professionals having anything to do with it; it's something that's organic...'* (Site G – practitioner)

Although to some degree separately 'branded' and supported at a national level, the core principles of Local Area Coordination (LAC) and Asset-Based Community Development (ABCD) may be seen to be complementary in terms of foregrounding citizenship, strengths and assets, and the power of 'doing with' relationships at micro-community level (see Box 1).

> *My role is to get to know as many people as I can in order to find out what it is that the people want; what people have passion and enthusiasm for; not to do for them and not always support them as the more traditional services but to help them to take action on their thoughts and what's important to them. I think that's really the subtle difference but it's a really important one for what we're doing because if I step in to support people and take some of that ownership away or lead on some of it, it is actually not about them doing it themselves.* (Site C - Local Area Co-ordinator)

Box 1: Underpinning principles of Local Area Coordination and Asset-Based Community Development

Local Area Coordination – Core Principles [16]	Asset-Based Community Development principles [17]
1. The right to citizenship, responsibilities and opportunities 2. The importance of valued relationships and personal networks 3. The importance of access to relevant, timely and accessible information to inform decision making 4. Recognising and nurturing individual, family and community gifts and assets 5. Recognising the natural expertise and leadership of people labelled as vulnerable and their families 6. The right to plan, choose and control supports and resources 7. The value and complementary nature of formal services as a back up to natural supports and practical solutions	1. Citizen-led -What is it that residents in communities are best placed to do together? -What is it that residents can best do, with some outside help? -What is it that communities need outside agencies to do for them? 2. Relationship oriented While ABCD considers every person as having irreplaceable gifts, skills and passions, as an approach it goes beyond individuals and their capacities, to tap into ...the power of relationships 3. Asset-Based Starting with what's strong enables local people to get organised to address what's wrong and make what's strong even stronger 4. Placed-Based Small local places are the stage on which a good, sustainable and satisfying life unfolds ... by intentionally organising relational power at neighbourhood level 5. Inclusion focused Actively creating a welcome for those currently not included within communities

Where Neighbourhood Networking was not informed by ABCD principles, it tended to have more of a conventional voluntary service 'doing for' ethos – providing a social club where more able volunteers provided support and assistance to those who were less able – for example through the organisation of luncheon clubs for older people.

> *I went there and that's when I joined... And they said, 'It's £10 a year to join and we have various activities and trips off and this, that and the other.' So I joined and that's two or three years ago and I've been a member ever since.* (Site A - Beneficiary of Neighbourhood Network)

> *Mini bus come and pick me at my home. Yeah, come to the house to pick me up and take me at the social, I call it my social, up at the church. We use the church hall, you know, to socialise.* (Site A - Beneficiary of Neighbourhood Network)

Across all models, there was a recognition that such approaches to networking and asset building depended on working at a scale where people genuinely knew each other and were able to connect on an everyday basis. Apart from the peer supported mental health project, this translated into working, as far as possible, with natural communities with a population size of around 8000 – 12000, but this could be much smaller.

Engaging with families and social networks – Family Group Conferencing

In the draft guidance *The Care Act and Whole-Family Approaches*[13], it is proposed that social care services should adopt a 'Think Family' approach (see below) in engaging with people's relational networks in developing a response to the support needs of a (potentially) vulnerable adult.

> **Step one:** Think family.
> **Step two:** Get the whole picture.
> **Step three:** Make a plan that works for everyone.
> **Step four:** Check it's working for the whole family.

One practice model for achieving this is Family Group Conferencing. Often linked to Restorative Practice, this is an increasingly established practice approach in children's services, but is more recently being introduced in adults' services – and one of our Case Study sites was chosen as an exemplar of this. As originally conceived in response to concerns expressed by the Maori community in New Zealand, Family Group Conferencing was developed as a process of shared decision making in which all with a concern for a child (family and wider community members) would come together to draw up a plan as to how they wished that child to be supported, and what contributions they each wished to make in order for the plan to be implemented successfully. This process is facilitated by an independent coordinator who undertakes preparatory (and follow up) work, but the actual decision making takes place in private 'family time'. Any proposed involvement of care services as part of the plan is then checked with the social worker in order to make sure that this is practicable and acceptable.

This model translates relatively straightforwardly to the context of arranging appropriate support for an adult. Although not primarily conceived as being preventative – just a way of making good decisions – the model has the potential to build capacity through (a) enabling a person and their natural support network to take responsibility and feel empowered, (b) involving and mobilising a wider network of family and non-family with a concern for the person so that all responsibility does not rest on a singular carer, and (c) providing a forum for the family to restore links and to resolve issues and differences that may impair their ability to work together in support of the person for whom they care[18]. Where Family Group Conferencing has been rolled out at scale – as in Leeds Children's services – there has been a reduction in the numbers of children going into care[19], which gives a strong indication of its preventative potential.

> *FGC is pivotal in preventing service users from being more dependent on us really. It's a way of looking outside the box and looking at how we can engage with the outer network to help improve that particular person's quality of life. So I think it's quite central to prevention.* (Site F – Strategic manager)

Targeted use of personal budgets to support prevention
Within many local authorities, including the majority of the Case Study sites, the option for people to have personal budgets in the form of direct payments was only possible if their need was assessed according to

the eligibility criteria of the Council's Resource Allocation System. While the original purpose of this had been to ensure fairness and accountability, the impact of financial pressures meant that many Councils would only consider offering such payments to those judged to be in 'critical' need – and hence typically at a point where preventative activity was no longer an option. Set against this backdrop, it was positive to see that the targeted use of personal budgets still figured significantly in the responses to the National Survey (see Figure 5).

Previous research on personal budgets has tended to show how giving people choice and control over how money is spent will tend to result in it being used more creatively and efficiently – and often to support 'ordinary life' options in the community rather than to purchase formal social care services[20] [21]. Within mental health, it has been shown how short term use of personal budgets can be used to support people's recovery, including their ability to access educational opportunities or gain employment[22] [23].

It was therefore a little disappointing to find that, across most of the Case Study sites, there was no mechanism for offering personal budgets at an early preventative stage – only at the point where the person had been judged eligible for longer term care services. Instead, in sites using 3 Conversations (or similar), some flexibility was achieved by facilitating the quick and easy authorisation of small sums of money to pay for equipment or short term personal support – including giving practitioners Council debit cards. However, it was still the local authority which had control over the process of how the money was spent – thereby going against the very principles of supporting strengths and autonomy that underpinned the rest of the practice model. The exception to this was a Case Study site which had, prior to the implementation of the Care Act, been developing the use of (usually one-off or short term) personal budgets to support recovery in mental health. Not only did the actual expenditure potentially benefit recovery (and hence ongoing need for services), but the actual process of being trusted and taken seriously also brought its own psychological benefits:

> *The other good thing, fortunate thing that the Commissioner did set up for us, which is a little bit outside personal budgets, was a recovery budget. So we have a simple form that somebody comes to us and says, 'You know what? I really want to do that make-up course at the college and it's 300 quid, and it would boost my confidence to be able to go to college* (Site G – beneficiary)

> *It was a real good sort of, it was a real springboard and it, 'cause it was so different and a bit radical and people are giving, they actually believe in me 'cause they're giving me a budget* (Site G – beneficiary)
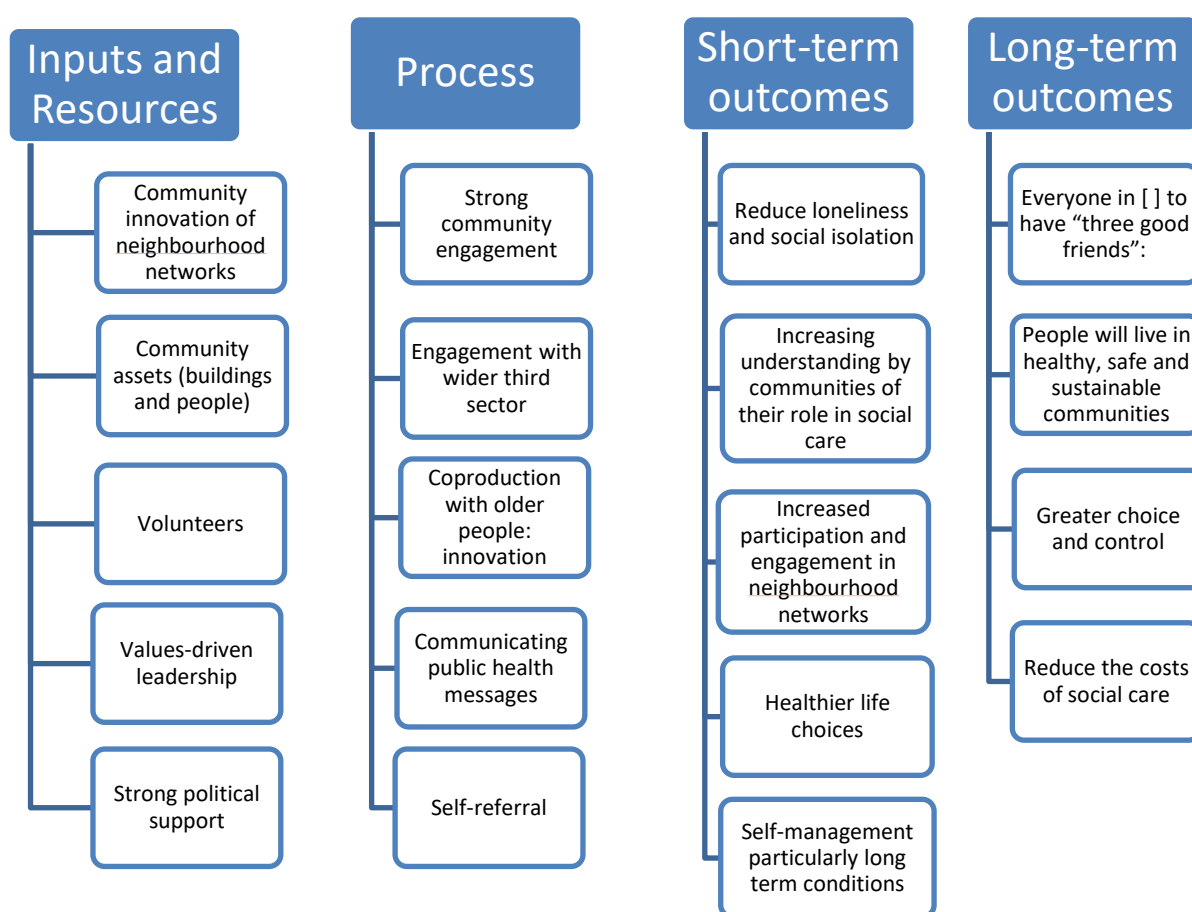
However, there was some concern that this innovative approach – and sharing of power - was still counter-cultural within the wider local authority and health systems, despite the fact that it was delivering substantial savings that could be evidenced.

10   Experience of implementation

Theory of Change and Integrity to the model

Within the Case Study local authorities, there were a variety of approaches to implementation – some more ad hoc and practically focused; others starting from a more embracing strategic vision. Only one had developed an explicit Theory of Change: a mapping of how specific combinations of inputs, resources and processes were intended to bring about particular outcomes, both short and longer term, for their intended beneficiaries. While such 'logic models' may or may not be helpful, the absence of such detailed 'whole systems' thinking at a strategic level may make it more likely that the process of implementation is less smooth than it might have been – for example, in trying to scale up across the organisation an innovation that had worked well at small scale. However, from the interviews with key stakeholders in sites with a clearer strategic vision, it was often possible to piece together an implicit Theory of Change – see Figure 6.

Figure 6: Implicit Theory of Change model for Neighbourhood Networking

Inputs and Resources	Process	Short-term outcomes	Long-term outcomes
Community innovation of neighbourhood networks	Strong community engagement	Reduce loneliness and social isolation	Everyone in [ ] to have "three good friends":
Community assets (buildings and people)	Engagement with wider third sector	Increasing understanding by communities of their role in social care	People will live in healthy, safe and sustainable communities
Volunteers	Coproduction with older people: innovation	Increased participation and engagement in neighbourhood networks	Greater choice and control
Values-driven leadership	Communicating public health messages	Healthier life choices	Reduce the costs of social care
Strong political support	Self-referral	Self-management particularly long term conditions	

In some instances, innovation could be largely home-grown (Family Group Conferencing in Site F and peer support and preventative use of personal budgets in Site G). This required the work of dedicated champions and support at different levels of the organisation. In the majority of Case Study sites, additional support and consultancy was bought in from national implementation organisations – principally Partners 4 Change (3 Conversations) and the Local Area Coordination Network.

As with other research into innovations of this nature[24][25], we found some tendencies for programmes to drift back into operating as more traditional local authority services where there was not both consistent leadership and a clearly understood logic model for how implementation was going to be achieved across

the whole service system. Across the Case Study Sites, it was those that had managed to stay 'radical' in their adherence to their intended model that had started to deliver more substantial outcomes in terms of a reducing profile of spending on long term care.

There could often be tensions between, on the one hand, an aspiration to uphold the key principles of the new way of working and, on the other, practical circumstances on the ground, (such as shortages of staff, waiting lists or pressure to deliver early results) which led to pragmatic solutions to immediate pressures. For example, in one 3 Conversations site, as the model was rolled out across the local authority, the immediate pressure to reduce waiting lists could lead to practitioners foreshortening their involvements to more superficial engagements. Opportunities for the more effective mobilisation of resources 'upstream' could be missed as people could be passed on quickly (but not necessarily appropriately) with signposting information to other possible sources of help – with the possibility that they returned later at a point where alternatives to care provision were no longer feasible. Similarly when people presented in crisis, there could be pressure to reach quicker decisions (often involving provision of care services) rather than 'sticking like glue' to provide intensive support while alternative options could be explored and mobilised through family and community networks.

There were somewhat contrasting experiences in two Local Area Co-ordination sites. In one, support from the national Local Area Coordination Network played an important role as a 'critical friend' in guiding implementation. It provided a peer group of other local authorities and champions, and a helpful challenge to temptations to adapt the model away from its core principles:

> *Working alongside [] ... many times drove me insane but equally many times kept going 'If you do that, you're diluting it, if you do that you're diluting it' " (Site B – Local authority senior manager).*

In another, there was less effective leadership and challenge. Instead of acting as a catalyst and doing the difficult job of 'network knitting' (enabling isolated and vulnerable people to develop connection and support amongst themselves), coordinators could find themselves falling back into taking on more of a long term support worker role.

However, there were also instances where local practitioners and frontline managers came up with solutions that deviated a little from the originally intended model, but nevertheless upheld its core principles. In one 3 Conversations site, the Innovation Team devised an alternative way of managing the intake and work allocation process that still provided continuity of the conversation with the citizen, but allowed a different team member to take this forward where this was appropriate in terms of expertise or workload pressures.

Process of implementation
Where externally developed models were being brought in by local authorities, instead of offering formal training to practitioners or managers, the preferred approach was characterised as 'Learning by Doing' – typically with a designated group of innovators in new teams and/or roles leading the way. While many participants valued being given the space to experiment and own the new model of practice, there could also be a sense of having been thrown unnecessarily in 'at the deep end', where a bit of more preparatory training on how to deliver new ways of working could have made their journeys somewhat easier (especially for frontline managers). There was also the issue of innovators having to interface with (and sometimes battle against) a largely unreformed organisational infrastructure with procedures, systems and processes

that did not necessarily understand or support the new ways of working. Again, there was a sense that some of this could have been sorted more effectively in advance.

> *[Consultant] was very much letting us lead the way and just give advice and things, rather than having somebody say 'look this is what you have to do', they just gave advice as we went along. So I really felt our team was sort of ... trying to establish how it worked and we did a lot of experimenting ... And then sometimes we were getting into the swing of it when it was, like this is really good, I'm really enjoying what I'm doing, how do we get this agreed. And it seemed to be that some of the procedures that we'd got at [ ] wouldn't allow us to very quickly do what we wanted to do. (Site E – Practitioner)*

> *There's loads of massive like structural things in adult social care which take a long time to break down, especially when it's one little team that are doing it in a massive organisation. You have to kind of find work arounds and all of that kind of stuff, so that has taken time. (Site F - Innovation Team Manager)*

In most of the sites, the analogy of rolling a boulder up a hill seemed to be apposite. During the early stages of the journey, the innovation could run into conflict with other established systems or ways of working within the organisation, with its partners in health and the voluntary sector, and potentially with citizens and communities. This could lead to the innovation stalling or 'running out of steam' for periods of time, and for a tendency to revert back, at least in part, to old ways of working. However, there could potentially be a tipping point where the innovation started to generate its own momentum and started to be positively reinforced in its interactions with other systems.

> *I absolutely feel we've proved the point now, so the fact we've been able to sustain it and build it – at the beginning there was real scepticism about Local Area Coordination. It was something that could've been dropped easily, it was nice to do, but not essential. Everywhere in the council I go now people talk Local Area Coordination, whether it's at a leadership group where you've got planning and environment and you've got everybody in the room, everybody's seeing the benefit of Local Area Coordination, so the reward is huge. (Site B – Local authority senior manager)*

Even then, established innovations could be vulnerable with changes in senior management of organisational structure if they were seen not to 'fit in' with an overall ethos in health and social care that still saw 'old-style' service provision as its core business.

> *We've had new commissioners and new managers come in [and] the vision has sort of gradually changed…although my colleagues feel that we are very much an innovative team, it seems as if some of that's been lost within the new management that's come along ... the philosophy and the way we deliver the service is a bit lost (Site G – Manager of Voluntary Organisation)*

Particular issues were raised depending on whether the shift towards new preventative ways of working was to be achieved in-house or through commissioning arrangements with other providers. A big advantage of commissioning was the potential to 'buy in' commitment and ownership from grass-roots community organisations or informal peer networks – creating a co-productive or citizen-led ethos that would be almost impossible within the local authority. However, the 'flipside' of this was that such organisations could have their own agendas which did not necessarily correspond with those of the local authority.

In Site A, early Neighbourhood Networks tended to adopt a more conventional (and familiar) 'social club' model which provided social contact and activities for many frail or potentially vulnerable older people, but did not necessarily reach out consistently to those in the community who were most isolated or needy. Through the contracting process – and the evolution of commissioning practice moving from an open grant-based system to targeted contracting - they were encouraged or steered into adopting ABCD as their approach.

> *The Neighbourhood Networks in them days, it was a bit all over the place and that's, the council they'll give you money and they had a service level agreement so all you had to do was sign the service level agreement but the services monitoring it wasn't that tight then, now it's tight. (Site A - Neighbourhood Network representative)*

> *The last piece of work that I was working [on] with ... colleagues across the city was really to standardise their offer and to make it clear about what their roles and functions were that supported the health and social care agenda and to enable them to receive referrals from those services and to be kind of key identified community support service especially but not solely for older people. (Site A - Local authority commissioner)*

While, on the one hand, this may have broadened the reach of some of the local initiatives, this may also be seen as coming at a cost in terms of imposing more of a top-down than a co-productive relationship between the local authority and colleagues in local organisations. Our impression was that this, in turn, could lead to a degree of 'gaming' in which local organisations sought to present themselves as doing ABCD, although the actual practice on the ground may not always have quite lived up to this.

Local Authority G had sought to engender a more collaborative relationship with voluntary and community organisations through using an 'Alliance Commissioning' model in which a condition of receiving funding was to engage collaboratively with other commissioned organisations and the local authority in finding creative solutions to identified needs – rather than following the 'old-style' purchaser-provider relationship[26]. However, this approach also raised potential issues of multiple agendas:

> *I think it's difficult when you're working with lots of different organisations so I think alliance sounds nice, I don't think it works as well as it should do and I think that's dependent upon the organisations and every organisation has some self-interest but sometimes it can be very difficult for, certainly when it's charitable status, if they put all their eggs in one basket, they have to start looking at other things that protects them in case the alliance breaks down (Site G – Manager of Voluntary Organisation)*

Overall, our findings would suggest that using commissioning processes to achieve prevention outcomes may harness additional resources and energy, but they may also add an additional layer of complexity and more uncertainty as to whether desired outcomes will actually be achieved on a sustainable basis.

In some ways, developing new ways of working within the local authority could be more straightforward, but this depended on either (a) recruiting staff to new job roles such as Local Area Coordinator (with community involvement in this process) or (b) asking existing staff to take on new roles or styles of working. Given the current financial environment of local authorities, recruiting to new job roles could only be possible if either additional sources of external funding could be mobilised (such as the Better Care Fund), or existing staff

vacancies (e.g. for social workers) could be repurposed – which could lead to capacity issues and potential for conflict been established and new workforces.

Innovation teams and scaling up

Perhaps the greatest challenge in terms of implementation was to induct an existing workforce into new ways of working. There was general recognition that it was not feasible to try to embed change of this magnitude across the board at the same time – so the preferred strategy was to try out new models in the controlled environment of one or more pilot or innovation teams and then, when new practices had been established and were demonstrating success, to roll this out across the organisation.

The usual approach was to invite volunteers to put themselves forward to be part of the early innovator teams, which was typically a key to their success. If they were 'liberated' from the constraints of existing local authority procedures and expectations around recording, and encouraged to enter into strengths-based conversations with citizens and communities, it was possible for motivated staff to demonstrate a substantial level of success – perhaps halving the proportion of new contacts coming into the service where the outcome was the provision of longer term residential and nursing care.

Where the innovation process typically ran into more difficulties was at the stage of scaling up across the organisation. Not all staff – and perhaps crucially Team Managers – were necessarily as enthusiastic about taking on a form of practice that was challenging and unfamiliar.

> *I think it will be interesting as things roll out and you get more of the people that are like a bit sceptical, how much those kind of people will really embrace [it]. (Site F – Innovation Team Manager)*

Some managers – perhaps particularly those who had entered services in the last 10 – 15 years and had only known practice as 'assessment for services within timescales' – felt unequipped in terms of skills and theoretical understanding to undertake the sorts of purposive and reflective conversations that were required in new relationship-based ways of working – both on the 'front line' and in supervision.

In some sites, there was an inadvertent creation of an 'us and them' culture in the early stages of innovation where those who were not part of the innovation teams *'were varying degrees towards it'* as it was not *'something that they had owned or worked completely for'* (Site E – Practitioner). Some felt that they were being excluded or that their work was being implicitly devalued.

> *One of the big things has been the split [between] the innovation sites ... and the rest of the teams ... And I think that's led to ... a sense of feeling that the other [teams] who are not involved are somehow lesser.... So it's a bit us and them and I think that's kind of where we're at. (Site F – Innovation Team Manager)*

As a result, when the new way of working was rolled out, there could be inconsistencies in the level of commitment to it – with evidence of dilution of the model or reluctant compliance. This tended to reduce the level of positive impact of the innovation, and some local authorities experienced a 'dip' before recognising the need to reflect on the implementation process with their workforce and involve them more effectively in owning and driving the innovation.

Leadership, culture and ownership

The findings from four case study sites reveal how their initiatives benefited from sustained commitment and passion from particular senior leaders. In other sites, leadership was more distributed within the organisation, including an unusual instance in one site where one innovation was being championed by a service manager (with permissive support from senior leadership) while simultaneously another innovation was being led in a more 'top-down' way by senior managers. There were evident strengths and limitations in both approaches. Although permissive support nurtured early innovation and the development of the model, it did not provide the level of structured support for wider roll-out:

> *They create a lot of space and freedom' but 'they're not kind of coming to me going, well okay [ ] we need to take this to the next level and let's build in structure and resource it (Site F – FGC Service Manager)*

Conversely, while the more 'top-down' approach allowed a more strategic drive towards implementation, not all front line managers were necessarily on board with this:

> *It was done at a very high level in the organisation. So it was done at like a... the Director and the Principal Social Worker, basically, did ... all of the kind of background of going and seeing other places that were doing it, and brought it in and didn't really talk to Team Managers... It's obviously meant to be a bottom-up thing but it was brought in as a top-down - as in, 'This is what's happening.' The whole of the Management Team were not on board with that (Site F – Innovation Team Manager)*

Most senior managers saw their role as not just promoting different ways of doing things, but also anchoring the culture and values that were needed to underpin the shift from hierarchical process-driven working to more co-productive engagement with citizens, staff and external stakeholders.

> *We had a really inspirational commissioner at the time and he really worked hard for us to get this service going and to change the culture within mental health services with the NHS as well. He brought everybody along with him (Site G - Practitioner)*

> *I think you have to set – you have to set a much broader sort of cultural and organisational change that means that everything you do in the future will be predicated upon those kinds of core values. (Site B – Senior Manager)*

In particular, there was seen to be a need for senior leaders to embed, within the organisational 'DNA', a shift away from dominant risk-averse governance models, towards a new ethos characterised by trust-based relationships with staff and citizens, giving them the space to be creative and act on their own initiative.

> *We need to trust people and we need to give them permission (Site B – Senior Manager)*

Thus, while a degree of top-down directiveness may be needed in order to shift the organisational direction and culture, and to map the process of roll-out, the secret would then seem to be to find ways of pulling

back and giving space and permission – and management 'cover' if things sometimes go wrong – for those at all levels of the organisation to take on and own new ways of working.

For one case study site, lack of clear and consistent leadership was identified as a contributing factor to the ultimate demise of a community capacity building initiative. There was perceived to be a lack of clarity from the outset as to its strategic purpose, and where this fitted with other initiatives around community engagement, advice and support that were also being promoted locally:

> *It seems to me that from the beginning the CCG went for one thing and the Council went for another thing and I don't think the Council's convinced of the worth of the care navigators ... and I don't think the CCG necessarily understood Local Area Coordination. So there, there wasn't a collective approach. (Site C, LAC manager)*

After a period of uncertainty, and despite evidence of some positive local outcomes, a decision was taken not to continue funding beyond the initial period. There were concerns that this may leave a gap in community infrastructure:

> *The council is stopping it. And I think that's a stupid idea ... because they bring something out, they introduce ... you to stuff like that and then they just take it away. Like she's helped me - if it weren't for [Local Area Coordinator] really, I wouldn't be able to get my bills sorted and I wouldn't be able to like go to ... Slimming World and like going to bingo and stuff like that. (Site C, LAC beneficiary)*

11 Outcomes, expenditure and indications of wellbeing

Measuring wellbeing outcomes

Only one site routinely collected data on wellbeing for those in contact with services. In no sites had the Adult Social Care Outcomes Toolkit (ASCOT) been considered as suitable for routine use. While this was mainly for practical reasons (such as size and complexity), there were also concerns about its relevance to the experience of 'second wave' innovations, given its narrower focus on idea of 'social care related quality of life' which implicitly presumes that people have lives that are defined around their need for social care services. The mental health site made routine use of the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) and found this both acceptable to those engaged with peer support and effective in charting whether people's mental wellbeing was or was not improving over the time that this engagement took place. In most instances, improvements could be demonstrated, which created valuable evidence for the effectiveness of the service in terms of supporting recovery and inclusion[12]. While the scale includes a balance of questions around subjective aspects of wellbeing (such as feeling good and being able to think clearly) and flourishing in the world (such as feeling loved), its focus on *mental* wellbeing, rather than broader quality of life, means that it is unsuitable for wider use across adult social care.

The sorts of outcomes that we would expect from preventative and capacity building initiatives would include enhanced relationships and social connectedness, greater opportunities to achieve and undertake valued social activities, and the ability to live an independent life (with or without some degree of personal assistance). Such outcomes correspond to what may be termed the eudaemonic or 'flourishing' aspect of wellbeing[27] and, at a theoretical level, this links well to concepts of 'capability'[28] and 'capitals' [29] [7].

The Social Care Institute for Excellence has emphasised the relevance and potential value of capability based measures in terms of capturing outcomes in terms of such a broader appreciation of quality of life[9]. Such methodologies derive from Amartya Sen's approach to social justice[28] - and foregrounds the degree to which people are able to maintain wellbeing (even with ongoing impairment, health issues or frailty) through being able to access a range of supports and opportunities – either in their 'ordinary life' and inter-relationships with others, or via care services. A capability approach emphasises the importance of people's ability to make their own choices in terms of lifestyle, social opportunities and use of support and care, and the actual availability of such valued options within their social world. This fits well with the core philosophy of the Care Act, and the idea of enhancing capability may be seen as helpful in conceptualising what would constitute a positive outcome – both for recipients of preventative activity and for family members or carers.

This study provided an early opportunity to try out validated capability-based measures of wellbeing with samples of beneficiaries of the various 'second wave' approaches that were examined in the Case Study sites. For consistency across sites, it was decided to use the more generic measure ICECAP-A throughout (which has been validated for use across the adult population), although its 'sister' measure ICECAP-O (which was primarily designed for use with older people) has also been used more widely, including with people with impairments[30]. Both versions of ICECAP comprise five simple questions, each with four response levels.

Evidence of wellbeing and outcomes from Case Study sites

There were substantial variations in reported in levels of wellbeing within and between the samples of questionnaire respondents from the different sites, with those sites offering Local Area Co-ordination or

peer support (for mental health) being, on average, in contact with those with poorer wellbeing at baseline than those offering Neighbourhood Networking (see Table 1). The sample of those with experience of new models of social work and social care was too small to be considered representative – but the average score was similar to that for Neighbourhood Networking.

Table 1: ICECAP-A Values at baseline

Site	Minimum	Maximum	Mean	Standard deviation
Neighbourhood Networking (n=56)	0.4415	1.0000	0.8059	0.0178
Local Area Coordination (n=77)	0.0773	1.0000	0.6400	0.0224
Peer support (mental health) (n=20)	0.3394	0.8879	0.6296	0.0407
Strengths based social work and social care (n=7)	0.2943	1.0000	0.7489	0.0983

We also compared selected NHS Healthcare Costs at baseline - excluding elective hospital admissions, prescription costs and planned treatment in the community (for derivation of these costs, see Appendix 1). We included attendances at Accident and Emergency (including subsequent non-elective hospital stays) and contact with primary care (including practice nurses) over the one month preceding baseline data collection. Those who were in contact with Local Area Co-ordination emerged as the group that were incurring higher expenditure in terms of their use of NHS Services – again indicating higher levels of unmet need (Figure 7) in the sample recruited through these sites. Despite focusing almost exclusively on older people, who might be expected to be higher users of unplanned NHS services, those using Neighbourhood Networking were incurring lower such costs – which may indicate that the ability to access social activities and connect with others may indeed have had a positive preventative impact. A similar picture emerges in relation to those recovering from mental health difficulties who had engaged with the various peer support options – again a group where a more frequent need to access NHS services might be expected. This also lends support to the contention that such options were being successful in reducing demand on primary care and emergency services.

Figure 7: Comparison of per beneficiary selected NHS Healthcare Costs
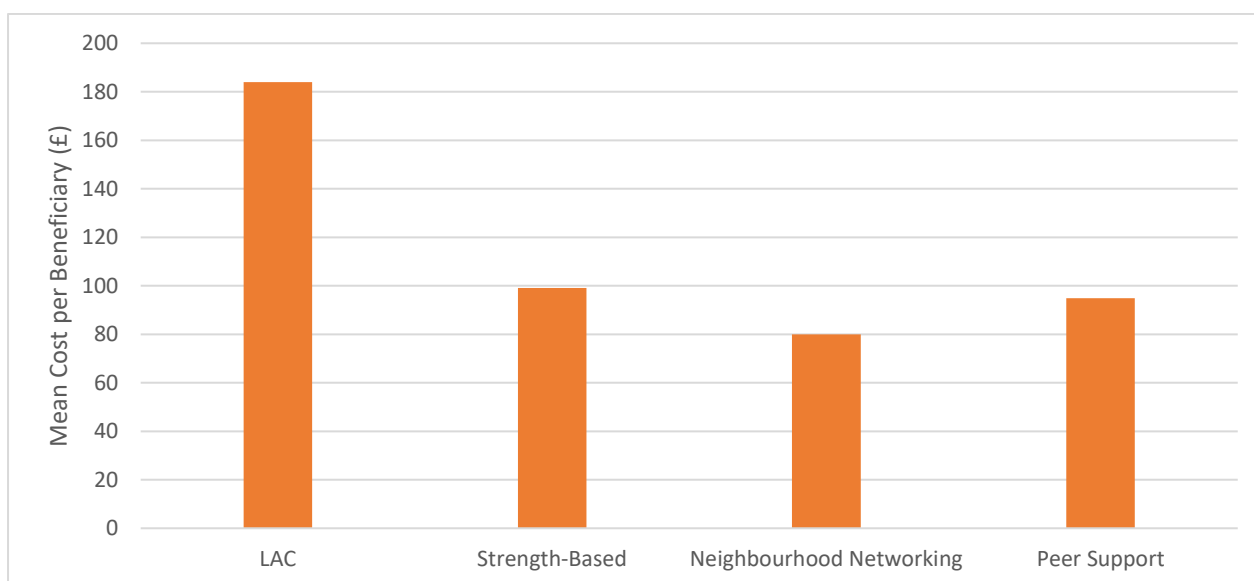
For reasons of logistics and consent, we were less successful than we had hoped in terms of the numbers of follow-up questionnaires completed. Overall numbers were insufficient to make any meaningful comparison between models, so only aggregated data is presented on wellbeing and healthcare costs for those that returned both baseline and follow-up questionnaires - i.e. for matched cases (Table 2). Perhaps disappointingly, there was no evidence of improved wellbeing over the study period, although there was some reduction in healthcare costs for the sub-sample returning both baseline and follow-up questionnaires).

Table 2: Comparison of Baseline & Follow-up Data – Community capacity building and peer support

|	ICECAP-A Value Baseline	ICECAP-A Value Follow-Up	Healthcare Costs Baseline	Healthcare Costs Follow-up
Neighbourhood Networking, Local Area Coordination and Peer support (mental health) (n=33)	0.8137	0.7838	£57.68	£34.96

In addition to the larger sample completing baseline surveys on wellbeing and service use, a smaller sample were later directly interviewed and, using an ecomap approach, the size and closeness of connection of their active relational and support network was assessed – including family, friends and significant others (Table 3). Unfortunately, we were not able to obtain sufficient data for those accessing strengths-based social work and social care services. Although firm conclusions cannot be drawn due to the sample size, it was nevertheless striking that reported network sizes across different community capacity building approaches did not present a picture (on average at least) from either total social isolation or a set-up with a singular carer struggling to hold things together. This suggests that Local Area Coordination, Neighbourhood Networking and Peer Support may all have contributed to maintaining wider social connection.

Table 3: Network Size from EcoMapping – beneficiaries of community capacity building and peer support

| Model	Mean Network Size	Mean Extremely Close	Mean Very Close	Mean Quite Close
Local Area Coordination (n=9)	8.7	2.2	2.1	4.3
Neighbourhood Networking (n=17)	10.2	3.1	2.3	4.8
Peer Support (n=10)	9.5	3.6	2.1	3.8

For the sites that were rolling out strengths-based models of social work and social care, significant impact was being achieved in terms of both the absolute numbers of people being admitted into long term residential or nursing care, and the proportion of new contacts for which this was the eventual outcome. In one site, combined numbers of new admissions had fallen from 454 in 2014/15 to 344 in 2017/18 despite an ageing population – a fall of nearly 25%. Similarly, in another site, they had been successful in reducing the proportion of new contacts from the community ending up with long term domiciliary or residential care from around 10% to around 5%. Figure 8 shows the aggregated trajectories of residential and nursing home admissions for the three Case Study local authorities using such approaches in comparison with the national trend.

Figure 8: Residential and nursing home admissions per 1000 population (data from Adult Social Care Activity and Finance: England. Table 1. *NHS Digital*)
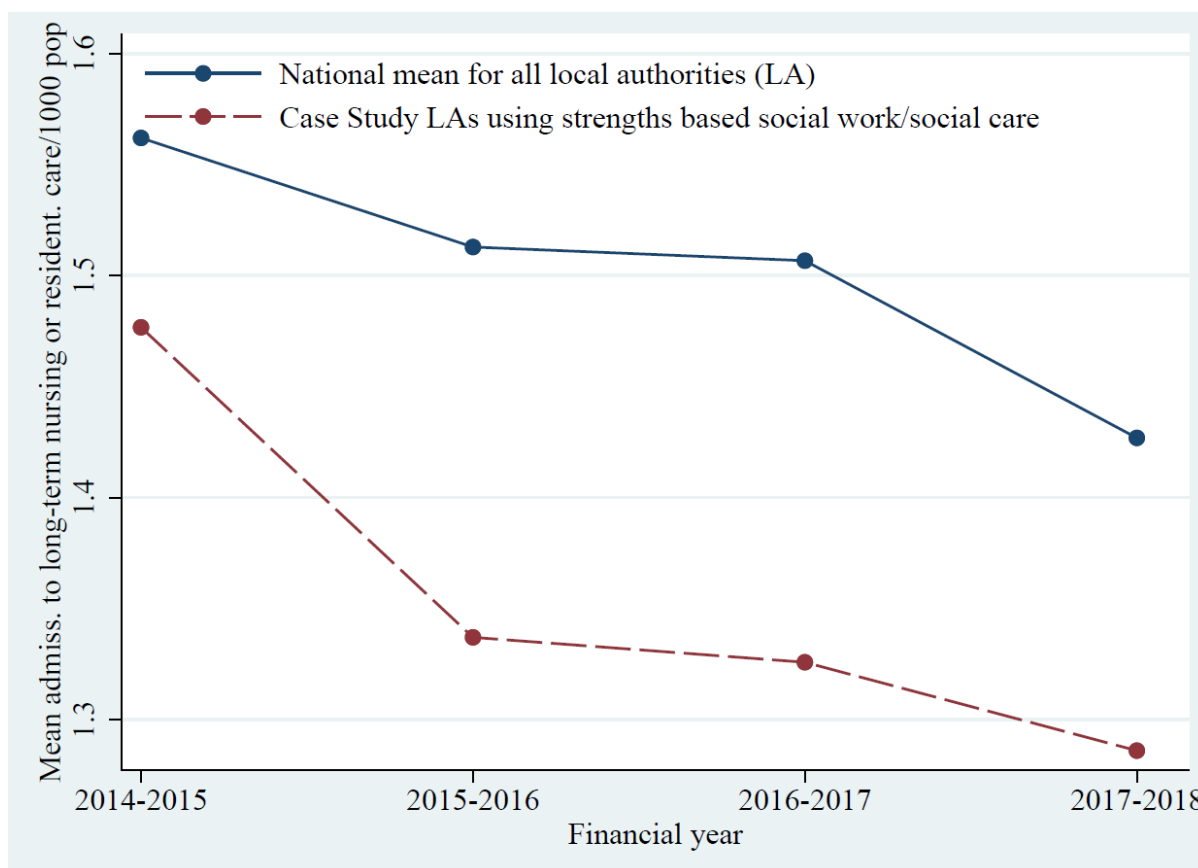
For the local authorities rolling out community capacity building approaches, a key objective was to use this as a way of enabling a reduction in overall expenditure on social care. We therefore looked at trends in Net Total Expenditure on social care and the picture that emerges does support the contention that investment in community building can have a pay-off in terms of the ability to make savings in overall expenditure (see Figure 9).

Figure 9: Net total expenditure per 1000 population (data from Adult Social Care Activity and Finance: England. Table 2. *NHS Digital*)
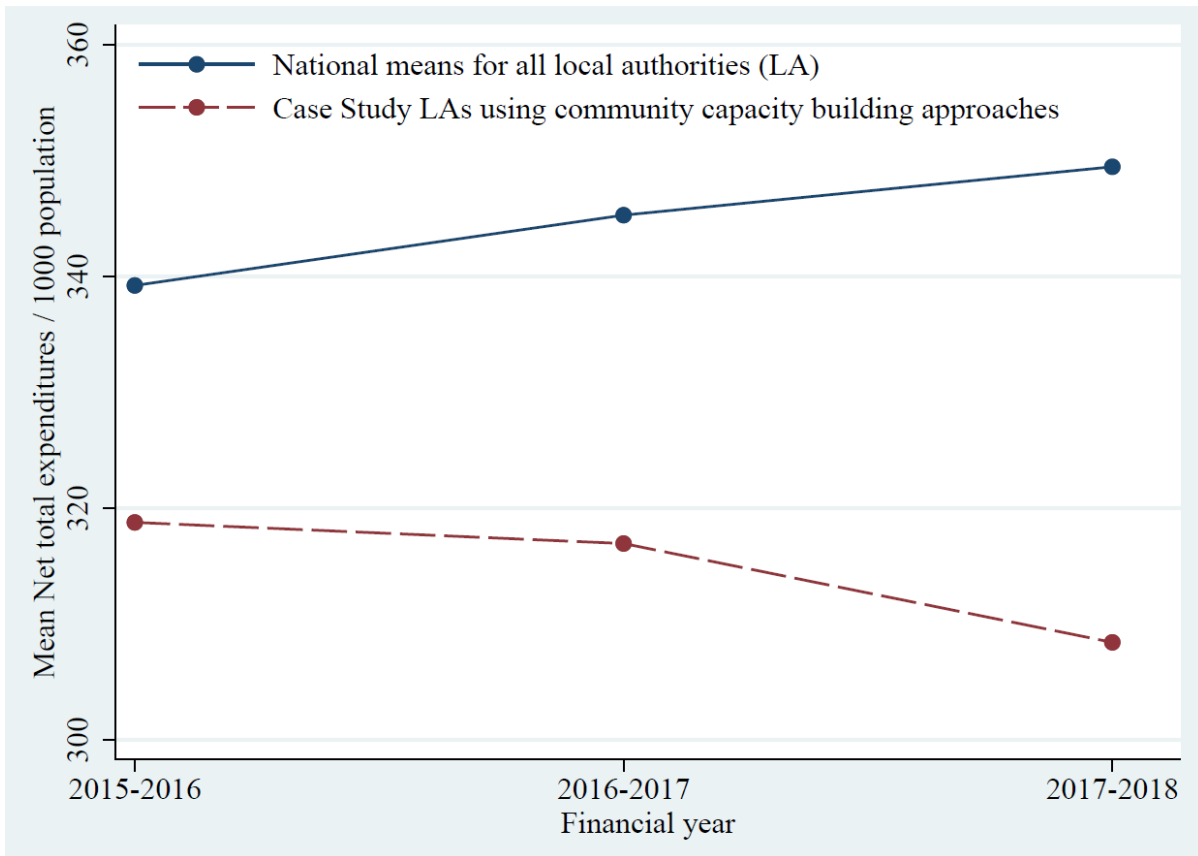
The conclusions that may be drawn from such data alone must be seen as tentative. Local authority adult social care is part of a complex system with multiple influences, so attributing trends to particular causes depends on triangulating such data with other evidence – such as the qualitative data from the Case Studies. However, putting this evidence together, we can be reasonably confident to assert that preventative and capacity building initiatives, when delivered at scale, are contributing to substantial reductions in spending on long term residential and nursing care, with a consequent impact on overall expenditure on adult social care.

Conclusions

Both our National Survey and local Case Studies provided strong evidence of the creativity and innovation that is taking place in a significant proportion of local authorities. Although progress may not be consistent across the sector, our research shows that a sizable proportion of local authorities have been investing in activity that is designed to increase capacity and capability at individual, family and community levels, and thereby to contribute to preventing, reducing or delaying the need for adult social care services. Particularly positive was the diversity of initiatives being undertaken – moving beyond just the 'first wave' of practically focused activity, such as signposting or reablement, to more fundamental reimagining of a co-productive rather than a service delivery relationship between the citizens and services.

It has to be recognised that this innovation is being undertaken against a backdrop of financial uncertainty and major downward revision of levels of central government support. This has been identified as both the strongest driver for change, but also as presenting the greatest barrier to allocating resources towards preventative and capacity building activity. Another key barrier can be conflict with other policy agendas – particularly around delayed discharge, where the current articulation of policy (particularly at local level) may lead to hasty decisions to provide levels of social care service input that are both inappropriate and hard to disentangle subsequently.

While we are still some way from proving the effectiveness (or otherwise) of the various preventative and capacity building approaches that were studied, some tentative conclusions may be drawn. With the exception of the improved mental wellbeing reported as a result of peer support in mental health recovery, we found a picture of levels of wellbeing being maintained rather than enhanced. As this is based on a relatively small number of survey returns, there is a need to collect such data on a more systematic basis. We have stronger data in relation to the potential of preventative and capacity building approaches to impact on the need to provide long term residential and nursing care and on overall social care expenditure. Particularly where there was a focus on developing connectivity and capacity within communities, there was some evidence that this can also result in reduced unplanned use of NHS services.

It must be recognised that such reductions and potential for savings are likely to be finite. There is a proportion of people who may be enabled to have better connected and supported lives in the community, and thereby prevent, reduce or delay the need for formal care services. Once new capacity building models are fully bedded in and effective, then perhaps 25 – 50% of current demand for more intensive care services may be diverted to alternative and more inclusive community-based ways of providing support – and a level of saving may be achieved. However, after this, there may be very little scope for further savings through additional investment in prevention, as those with more serious physical or learning disabilities, or mental health issues (including dementia), may still require specialist support and care – whether residential or otherwise.

As well as seeking to make savings by averting the inappropriate use of expensive forms of social care, local authorities also stated a commitment to the principle of promoting wellbeing which is also enshrined in the Care Act 2014. In going forward, it may be important to evaluate the success of capacity-building initiatives on the basis of their impact on people's wellbeing and capability. The potential advantage of more routine use of a measure such as ICECAP is that, as part of its validation, it is now possible to ascribe monetary values to increases or decreases in scores – opening up the potential for much more rigorous evaluation of impact.

Appendix 1

Derivation of NHS Healthcare Costs (Whole Sample (n=152))

NHS Resource	Unit Cost	Data source	Average Cost per Beneficiary
A&E Visits	£124	NHS Manchester CCG	£24.47
Non-elective inpatient stay (short-stay)	£626	PSSRU Unit Costs of Health & Social Care 2018	£49.21
Visits to the GP	£37.40[1]	PSSRU Unit Costs of Health & Social Care 2018	£45.57
GP Home Visit	£130.43	PSSRU Unit Costs of Health & Social Care 2010[3]	£13.73
Visit to Practice Nurse	£10.85[2]	PSSRU Unit Costs of Health & Social Care 2018	£5.43

[1] Assumes a standard 9.22 minute consultation (PSSRU Unit Costs of Health & Social Care 2018); [2] assumes a 15.5 minute consultation (based upon PSSRU Unit Costs of Health & Social Care 2010); [3] with adjustment for inflation

Appendix 2 – Preventative and Capacity building initiatives taking place in Case Study sites

Case Study Site	Approaches being implemented
A	Neighbourhood Networking Asset Based Community Development
B	Local Area Coordination
C	Local Area Coordination
D	Strengths based social work and social care (Let's Talk Local)
E	Strengths based social work and social care (3 Conversations)
F	Family Group Conferencing Strengths based social work and social care (3 Conversations)
G	Peer Support Targeted use of personal budgets

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