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One Ilfracombe: Theory of Change evaluation and prospective 'Living Well' Value for Money assessment

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NEF Consulting is the consultancy arm of the UK think-tank, New Economics Foundation (NEF). We put NEF's ideas into practice by placing people and the planet at the heart of decision-making.

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Contents

1. Executive summary

This report examines and evaluates the robustness of One Ilfracombe's integrated service model and its potential for cost savings. A Theory of Change (ToC) evaluation and two prospective Value for Money (VfM) assessments are presented in this report to explore the coherence of One Ilfracombe's plans, and to estimate potential State savings arising from health and well-being initiatives, known collectively as 'Living Well', which target elderly residents (one of Ilfracombe's initial projects).

The Theory of Change analysis found that:

1. One Ilfracombe expects services to integrate their delivery in the short term (within 1-2 years) via co-ordination and better communication, and in the medium term (3-5 years) through the progressive pooling of budgets and the creation of new governance structures which are people-centred.

2. Resident participation is key to the success of the model and One Ilfracombe will work alongside public sector agencies to design, deliver and evaluate services. This will increase volunteering capacity in the town, adding to and complementing public resources. This is expected to contribute to the enhancement of outcomes in the social, economic and physical domains.

Value for Money assessments of the Living Well programme found that:

3. State savings could range between £518[1] and £31,711 per individual older resident, depending on medical history. As there is a high number of residents aged 50-plus living in Ilfracombe, total savings could be significant.

4. It is necessary for the Community Connector[2] to successfully address approximately 30 social and care 'needs' per year, over a two and a half year period, if the benefits of the project are to exceed its costs. Any additional successful provision will mean that the project is a net contributor to the public purse.

5. If the project resolves 100 needs per year the ratio of net fiscal Return on Investment will be between 1:2.4 and 1:3.3. i.e. for each £1 invested the return (in terms of reduced demand or savings to the State) will be over £2.

6. Areas where the highest savings are most likely to be made are:

- supporting independent living (avoiding care home costs),
- prevention of falls (a reduced need for emergency health support for older residents)
- community support for mental health; and
- treating alcohol and drug addiction.

7. The key to achieving these savings is to reduce demand, by better meeting people's needs and investing more in factors that prevent problems from arising in the first place.

1 These estimates exclude the loss to the State of tobacco duty when assessing benefits of smoking cessation activities (see section 5.2)

2 A One Ilfracombe role designed to connect individuals with relevant health services or community activities.

8. The Living Well model will involve local residents, whose active participation will lead to an increase in the capacity of services, which should avoid and reduce service costs as well as enrich the social environment in the town.

9. Costs will be reduced through the streamlining of services, but the total additional input costs for new structures and services are still unknown.

NEF Consulting concludes that the One Ilfracombe model provides an inspiring and participatory response to the tightening of public purse strings, by seeking to use the strengths of everyone working within the town to make positive impact go further.

As the One Ilfracombe team moves forward with its service integration processes, NEF Consulting recommends:

1. **Developing detailed integration pathways:** One Ilfracombe should consider outlining a model that shows how partnerships will be brokered and organisations integrated. This will allow for the evaluation of the effectiveness of the approach, alongside socio-economic outcomes.

2. **Keeping the Theories of Change alive:** The project team should continue to update their Theories of Change as the context of their work evolves; and as their assumptions develop regarding the causal relationship between integrated services, person-centric services and cost-savings.

3. **Strengthening participation channels:** Continue to develop participation forums for the achievement of co-production.

4. **Designing programmes and projects that lever enabling factors and mitigate barriers:** An understanding of what factors will hold back the achievement of short, medium and long-term change should be reflected within programme and/or project design.

5. **Maximising fiscal savings:** Further research into the costs of integration, as well as the savings, should be made. The focus on older residents (in particular the avoidance of care homes) and on mental health beneficiaries should be continued, as these areas maximise preventative cost-saving to the public sector. Use a target of at least 30 needs successfully addressed (Completed Outcomes) as a benchmark for the break-even point for the Community Connector service.

6. **Exploring holistic decision-making techniques:** One Ilfracombe should consider non-monetary participatory tools for appraising future complex decisions such as Multi-Criteria Analysis.

2. Introduction

2.1 Background to One Ilfracombe

Ilfracombe is a small seaside town in North Devon with a population of around 12,500. The town has traditionally been a popular holiday destination and today its tourist sector is growing once again. Ilfracombe also attracts a large number of retirees and has an aging population that makes up around a third of the town's total population.

One Ilfracombe aims to give residents increased participation in the design and delivery of local services. It was set up originally as a pioneer initiative within the Government's *Our Place*[3] programme (formally Neighbourhood Community Budgets); a formal not-for-profit company was set-up in 2013 to facilitate the partnership between the community and the Town Council.

There are fifteen directors on the board, several of whom represent public agencies, including Ilfracombe Town Council, Devon County Council, North Devon Council, the Northern, Eastern and Western Devon Clinical Commissioning Group (NHS), Devon and Somerset Fire & Rescue Service, Jobcentre Plus, Devon & Cornwall Police, Northern Devon Healthcare Trust and North Devon Homes. Together with six independent individuals, this group provides the leadership for One Ilfracombe's activities. Its focus is on modelling a different way of organising services in the town.

The imperative for cost reductions across the public sector over the last few years has led to an interest in finding new ways to manage resources[4]. Increased efficiency within the existing service-model structure can only reduce costs to a certain extent. Local authorities and partners are therefore looking for new, longer-term models, which will allow them to manage service delivery while also cutting budgets.

The joining up of local and national budgets by removing budget ring-fences is an idea that gained ascendancy through the *Our Place* programme. It involves using all public funding available in an area to reorganise services around local needs, by breaking down traditional 'silos' and the vertical organisation of public services. The logic follows that by working with local residents to co-produce outcomes, this approach will meet existing demand for public services more efficiently, while reducing future demand and unlocking further resources.

One Ilfracombe aims to model such integration of local, regional and national budgets. In its Operational Plan[5] of 2013 One Ilfracombe outlines the issues that service integration will tackle, including:

- **Silo working and the complexity of multiple agencies:** This means there are areas of duplication, with very little flexibility to respond to local circumstances; for example: unemployed young people must navigate a

3 *Our Place* puts communities at the heart of service delivery in their area and involves local partners within a neighbourhood coming together with local people to identify the issues that matter most to them. See http://mycommunity.org.uk/programme/our-place/ for more information.

4 Central Government, for example, announced during the 2010 spending review that local authorities' budgets would be reduced by 26%.

5 One Ilfracombe (2013) *Neighbourhood Community Budget pilot (Ilfracombe): Final Operational Plan*

complex array of organisations and meet constantly changing criteria.

- **Over-dependence on the State:** Service delivery has not promoted the involvement of individuals and there are overly professionalised checks on volunteers.
- **Disproportionate expenditure on acute services:** High demand for costly services such as health and social care increases public cost, so One Ilfracombe emphasises investment in preventative interventions such as community support.
- **Little understanding of public investment going into the area:** Services account for spend by function, rather than by local area, so it is hard to measure how effective they are at achieving outcomes.

One Ilfracombe aims to show the feasibility of horizontal integration,[6] where different services join up their activities in a local area. The organisation seeks to facilitate the sharing and alignment of budgets for local services, and to integrate this with the capacity of local people (i.e. utilising their experience, knowledge and time) so that together they can co-produce services and achieve mutually beneficial and sustainable long-term outcomes.

2.2 Overview

This report examines the effectiveness and Value for Money of the One Ilfracombe model. It first articulates the framework of the model, which was developed by the One Ilfracombe team through a co-produced Theory of Change for their work with stakeholders. This framework has the benefit of allowing the team to:

- evidence the expected outcomes and rationale of the initiative;
- determine the potential impact (benefits) of current plans;
- explore how the model can be further developed.

The Theory of Change was linked to an exploration of the Value for Money of this way of working. This was achieved by taking a case study approach and tracking the value of outcomes through a break-even analysis of one project. Medium-term savings to the State are projected by examining the links between outcomes resulting from this way of working (including individual behaviour change) and a reduced demand for publically funded services for one of One Ilfracombe's programmes. Our analysis shows where and what types of government saving the Living Well work can create and aims to inform One Ilfracombe's operational planning in terms of efficiency and effectiveness.

Chapter 3 outlines the methodological approach we took to assessing the Value for Money of the Living Well programme.

Chapter 4 documents the Theory of Change as developed by One Ilfracombe and their stakeholders. It starts by illustrating and describing the overarching ToC for One Ilfracombe, along with more detailed ToC for each of the programmatic areas – Ilfracombe Works, Living Well and Town Team. It also notes, where appropriate, supporting secondary literature. However, where we

6 Typologies of integration are outlined in National Audit Office (2013b) *Case Study on Integration: Measuring the costs and benefits of Whole-Place Community Budgets*, Department of Communities and Local Government: page 5.

think there are weaknesses in the underlying assumptions, these have been explicitly noted in **Chapter 6**.

We have also undertaken two prospective Value for Money assessments that focus on savings to the State for a single programmatic area: Living Well. **Chapter 5** determines potential savings to the State by exploring case studies from the perspective of each individual and also from the returns of one project. We have focussed on projects that serve the needs of older residents, and our case studies are based on portraits of elderly Ilfracombe residents who are expected to benefit from the Living Well programme. In this chapter, we also comment on wider Value for Money considerations.

Chapter 6 summarises conclusions from our Theory of Change evaluation and Value for Money assessment. We also provide recommendations for strengthening One Ilfracombe's work.

3. Methodology

NEF Consulting began engaging with One Ilfracombe soon after the organisation was created. As NEF Consulting has chosen to look at a ten year timeframe and One Ilfracombe is currently in year two of operations, much of what is presented here is 'forecastive' in nature.

The Theories of Change enable the three thematic teams (the town environment, employment and health) to systematically map the envisaged causal pathways of their respective interventions. This is intended to help identify how best to maximise effectiveness and to determine potential impact.

One programmatic area, Living Well, was selected by One Ilfracombe for a Value for Money assessment. The Living Well programme is intended to address the needs of all residents, though at present its most mature area of work focusses on older people who may be socially isolated or who live with dementia. This stakeholder group is the focus of our Value for Money assessment.

It was also decided to focus exclusively on an analysis of State savings. Consequently, additional outcomes for Ilfracombe residents, the voluntary sector, and other non-State entitiies have not been monetised (although these are shown in Theories of Change).

A full description of methodological limitations is included in Appendix 4.

3.1 Principles applied

Our research applies relevant principles from HM Treasury's *Magenta* and *Green Books*[7]. For the Theory of Change work this involved establishing a well defined scope and developing a clear understanding of the intended outcomes. The principles of the Social Return On Investment (SROI) methodology[8] were also employed. Specifically, for Theory of Change work this included: involve stakeholders; understand what changes; and only include what is material.

For the Living Well value for money assessment the SROI methodology was adapted such that only the outcomes to the State were valued. SROI principles have been employed for this section of work, in particular: value the things that matter; do not overclaim; andbe transparent.

3.2 Theory of Change approach

A Theory of Change evaluation involves the mapping, understanding, testing and refining of the links between an intervention, its context and the desired impacts. One Ilfracombe's Theory of Change development was conducted through:

7 HM Treasury 2003 (with 2011 amends), The Green Book: *Appraisal and Evaluation in Central Government;* HM Treasury 2011, *The Magenta Book: Guidance for Evaluation*.

8 Outlined within Cabinet Office, Office of the Third Sector (2012) *A Guide to Social Return on Investment*

- A qualitative workshop with key agency stakeholders;
- Interviews with twelve stakeholders who have been involved in Living Well projects to date;
- Paralell evaluation coaching services (which generated more detailed logic pathways of how and what changes are created);
- Review of One Ilfracombe documentation (see Appendix 2 for full list).

An initial draft of the overarching Theory of Change was created through analysis of qualitative data, to identify chains of logic; this was then tested and refined with staff stakeholders. Assumptions were then cross-referenced to secondary literature in order to test the validity of causal pathways.

During the agency stakeholder workshop, the following were explored:

- Organisational scope and programmatic areas, by time period and stakeholder;
- The context and need for new delivery models;
- The long-term aims of the organisation;
- The anticipated outcomes for the identified stakeholder groups;
- The role of One Ilfracombe;
- Other organisations, individuals, or personal circumstances that may support/have supported or prevent achievement of goals.

In addition, as part of the mentoring, programmatic teams gathered additional information on barriers and enabling factors whilst undertaking stakeholder engagement.

3.3 Living Well: Prospective Value for Money assessments

The Living Well team have begun work on this programme by engaging with service users and piloting projects. Given the early stage of programme delivery, the assessments are prospective. We conducted two assessments: one looked at the value saved in three case-studies, where individuals are likely to benefit from the Living Well programme. This gave a sense of the proportionate value per different type of beneficary. The second assessment was a break-even analysis, used to determine how much benefit one project (the Community Connector) needed to generate (termed the 'Outcome'), in order to pay back the equivalent amount of money invested by the State. The analysis has been useful in this case as, while the initial level of investment can be easily estimated, it is not possible to credibly estimate the amount of outcome created.

Our construction and assessment of the case studies followed a number of steps. These are described below:

1. The Living Well Theory of Change generated during the stakeholder workshop (Figure 4.8) was further refined in consultation with relevant staff and subject experts. The causal pathways were supplemented with information gathered through interviews, programme literature, and desk research, which permitted a Theory of Change for older people to be created (Figure 5.2).

2. As part of our stakeholder interviews, we also assessed to what extent the change would have happened anyway (the counterfactual), in the absence of the intervention.

3. Impact considerations were explored but neither displacement nor attribution were deemed relevant to this assessment. With respect to the former, it is very unlikely that achieving health outcomes will involve moving comparable value from one place to another. However, substitution effects are possible across the system. On the issue of attribution, as One Ilfracombe is a multi-stakeholder initiative that involves all organisations in the town, it was felt that benefits were being created collectively rather than by a single agency[9].

4. Pathways that linked changes of behaviour in older residents with the demand for State services were explored, leading to the identification of State outcomes.

5. Hypothetical case studies were then created, based on portraits of typical residents developed through discussion with One Ilfracombe staff and public health professionals. These case studies illustrate typical outcomes and cost savings; they were cross-checked against our State-focussed Theory of Change for consistency (see Figures 5.3, 5.4 and 5.5).

6. Incidence rates and the counterfactual for these State outcomes have been derived from One Ilfracombe's evaluation plan, with guidance from a public health official at Devon County Council. Where no data was available we used our judgment and applied conservative estimates. Benefit period, outcome lag and drop off, were all considered in a similar way. Detailed calculations are in Appendix 6.

7. Monetisation of the outcomes involved the use of proxies, identified from academic and sector-specific literature and discussed with Devon Council Council's public health staff. Details of all sources are in Appendix 7.

The break-even analysis followed a similar set of steps which are outlined below and explained in more detail in **section 5.3**:

1. The distribution of outcomes, as experienced by Community Connector contacts, were mapped. Real case load data was used to determine the types of changes that would be experienced by those who are supported by the Connector, should their cases be successfully addressed. These were mapped according to relative frequency of occurrence.

2. The outcomes mapped were then analysed with respect to their potential impact on fiscal spending (either savings or costs to the public purse).

3. Research into national and regional trends for each outcome (the deadweight) was then undertaken and the likely duration of each outcome was assessed. The values determined in terms of the impact on the public purse were also adjusted for today's rates.

9 None of the actors involved in creating change/outcomes are assumed to have changed but their roles have been modified. Or to use a football analogy, the players have been rearranged on the pitch. It is this reorganisation that we are assessing rather than the role of individual players.

4. The fiscal inputs into the project were determined in collaboration with the One Ilfracombe team, who provided figures for the salary and support costs of the project.

5. Data was then entered into a model to determine the time when a break-even point would occur, where the savings accrued from outcomes would exceed the initial investment. Further scenario testing and sensitivity testing was conducted in conjunction with One Ilfracombe staff to check assumptions in the model and to determine any means through which the benefits could be maximized in relation to the costs, such as by increasing the predicted case load.

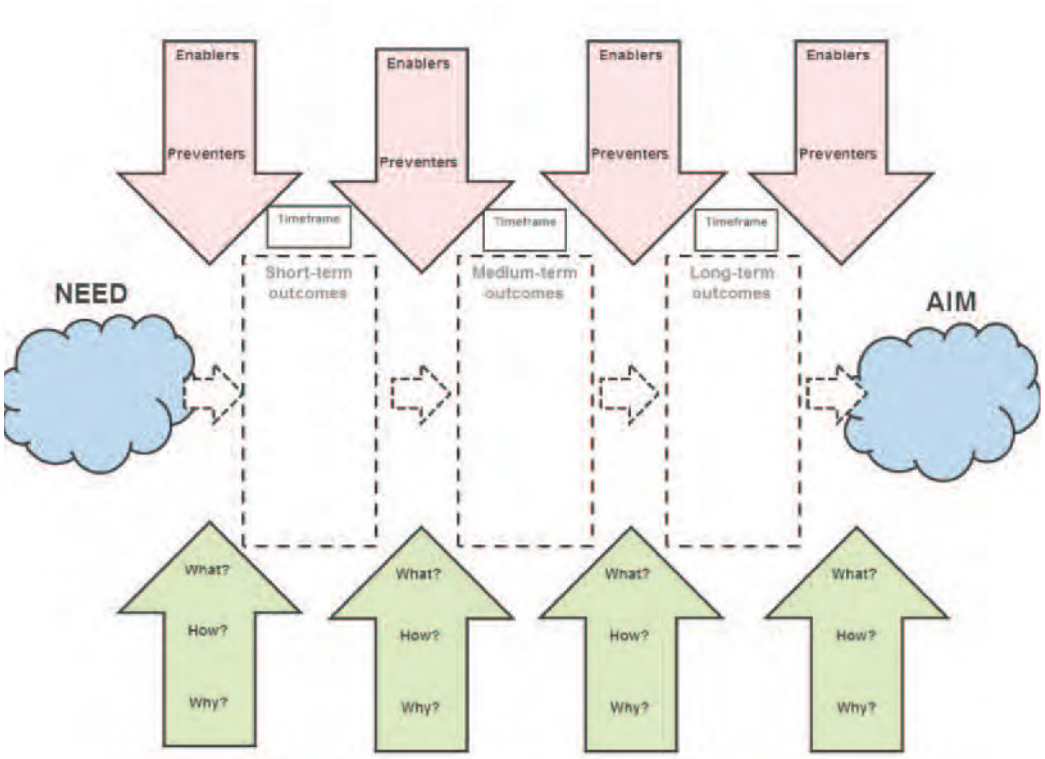
4. One Ilfracombe: Theories of Change

4.1 Introduction

A Theory of Change is a process whereby stakeholders identify the building blocks required to bring about a desired long-term goal. It is a way of representing the different elements in a complex system, and mapping the pathway through which change is anticipated. The process of creating Theories of Change for One Ilfracombe has allowed an understanding of how the organisation's work will create impact for key stakeholders over time.

NEF Consulting uses a framework (Figure 4.1) to map different aspects of a change theory. The framework is helpful for identifying the needs and challenges One Ilfracombe seeks to address (the blue 'NEED' cloud) and also where it hopes to take the town (the blue 'AIM' cloud). The framework also distinguishes between external influences that enable or prevent progress (pink arrows); key milestones: short, medium and long-term outcomes (dotted boxes); anticipated timeframes (small solid-line boxes); and activities or projects that One Ilfracombe intends to deliver (green arrows) in order to achieve outcomes and reduce the impact of hindering external influences.

Figure 4.1: NEF Consulting's Theory of Change framework



The framework recognises that change pathways happen gradually and that small changes are necessary as first steps towards bigger aims. There may be regression or feedback loops in a Theory of Change that mean stakeholders temporarily move backwards during their journey of change. This is a normal aspect of a change process.

The Theory of Change diagrams included below represent our understanding of:

- The overarching Theory of Change for One Ilfracombe as a whole (Figure 4.2); and
- The Theories of Change for the three programmatic areas: The Town Team (Figure 4.6), Ilfracombe Works (Figure 4.7) and Living Well (Figure 4.8).

The overarching Theory of Change draws out the common outcomes for all three programmatic areas which, through integrated service provision, are expected collectively to move the town towards better health, economic prosperity and a higher quality living environment, over the next ten years. In the long-term this will be expressed through a way of working known as co-production. It is also anticipated that this joined-up approach will benefit all aspects of statutory service provision for Ilfracombe, and enhance the work of voluntary and private sector organisations working in the town.

The individual programmatic areas illustrate how this transformation could emerge, through specific projects facilitated by the One Ilfracombe team. While each programmatic area follows a similar pattern, the delivery schedule of each team follows a slightly different timetable.

It should be noted that we expect the Theories of Change to evolve over time. One Ilfracombe has been provided with soft copies of the diagrams in this chapter which they will be able to modify as they see fit.

4.2 One Ilfracombe: Overarching Theory of Change

Figure 4.2: Summary diagram

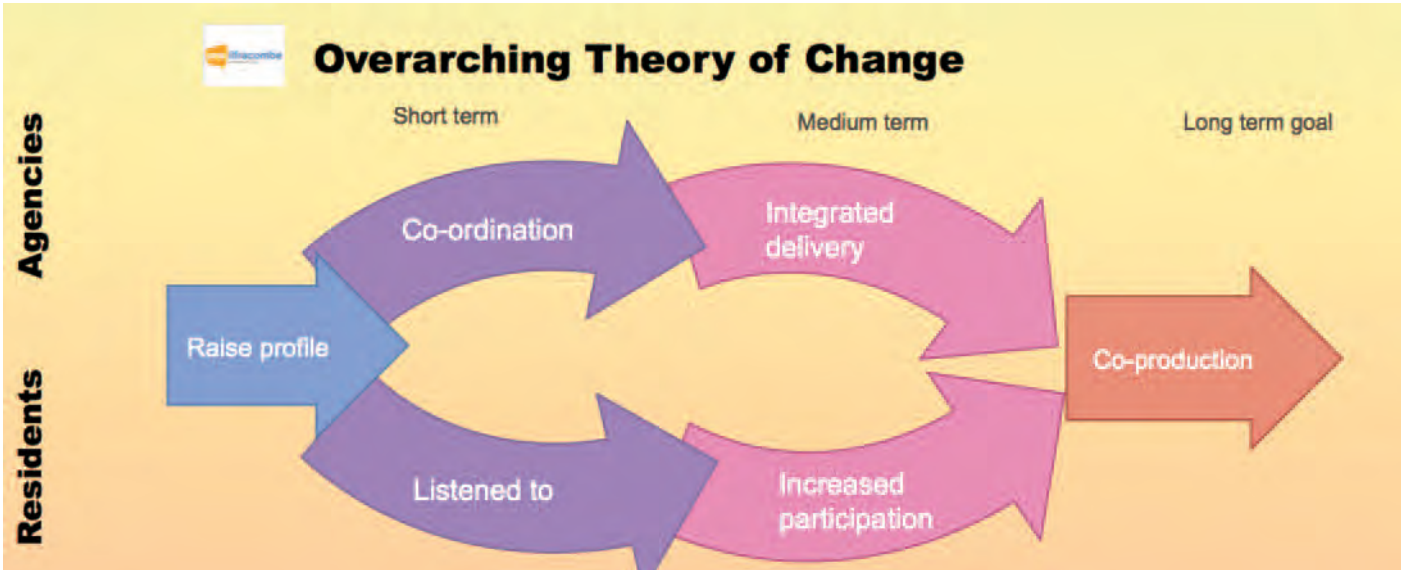


Figure 4.3: Detailed diagram

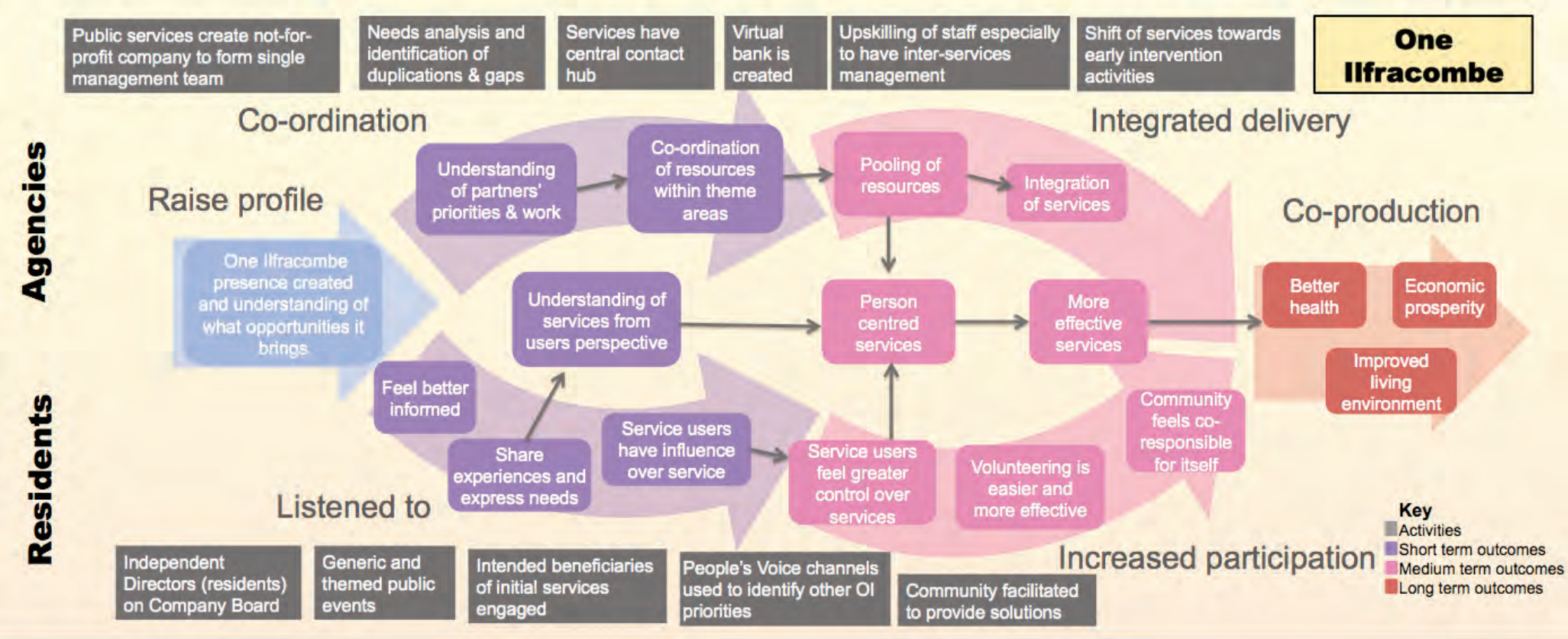


Figure 4.2, the One Ilfracombe overarching Theory of Change presents our high level understanding of the stages of change that stakeholders will experience, whilst engaging with One Ilfracombe.

Broadly there are two key stakeholder groups. Firstly, **Agencies** including public service delivery agencies, and voluntary or private sector organisations that deliver services on behalf of the Ilfracombe population[10]. **Residents** refer to the town's population of 12,500[11].

The diagram shows how, after a period of awareness-raising, agencies begin in the short-term, to work in a more co-ordinated, joined-up way. Meanwhile residents are 'listened to' by One Ilfracombe and agency staff, and consequently feel their needs are being taken seriously.

In the medium term, agencies progress their co-ordination by putting residents' perspectives at the heart of delivery. In this way they are able to integrate their offerings. Residents gain confidence in the ability of agencies to provide for their needs and begin to see themselves as active shapers of service design. Agencies now seek to increase the participation of residents in service delivery.

In the long term, One Ilfracombe sees a sustainable partnership between agencies and service users through co-production of services. This approach will require deeply collaborative work to maximise allocation of public money and create positive, sustainable socio-economic outcomes and minimise negative ones.

One Ilfracombe launched as a not-for-profit company in the spring of 2013. Figure 4.2 represents a journey of change that will take place over a period of up to ten years. Short-term outcomes (purple arrows and boxes) are intended to be achieved in the first **one to two years** of operations. Medium-term outcomes (pink arrows and boxes) are anticipated to be achieved within the first **three to five years** of One Ilfracombe's lifespan, and long-term outcomes (red arrow and boxes) are assumed to be realised between **five to ten years**. The changes and activities anticipated in each of these time frames are represented in more detail in Figure 4.3 and described below.

A summary of activities achieved as part of One Ilfracombe to date is provided in Appendix 1. These represent the short and medium term periods.

A. Raise profile

Activities in this phase took place between 2013 and 2014. Overall, this initial phase is about becoming recognised and visible to those delivering and receiving services. Preliminary work and activities in the lead up to the launch of One Ilfracombe in spring 2013, focussed on agreeing on the role of potential agency partners and creating a partnership steering group. These initial meetings built alignment, vision and commitment amongst the public agencies involved[12].

10 See Appendix 3 for full list of agencies.

11 In some cases this term is expanded to include non-residents, who come to Ilfracombe to work, shop, do business or meet residents.

12 As outlined in the National Audit Office's (2013a) report pp.26-34, this stage requires the creation of a shared vision among agencies and the provision of some staff resource.

A not-for-profit company was created by public service organisations under a single management team in spring 2013. Leadership was provided through Ilfracombe Town Council, and staff were made available to implement the plan. In addition, six independent resident directors joined the Company Board.

During this period, events and media coverage increased recognition of the One Ilfracombe brand among residents. Part of this activity involved the creation of external communication channels, including a website and a social media presence, which enabled residents to gain an understanding of One Ilfracombe's aims; and provided an opportunity to engage with the idea of integrated delivery enabling public resources to go further.

B. Short-term: Co-ordination between agencies, and residents listened to

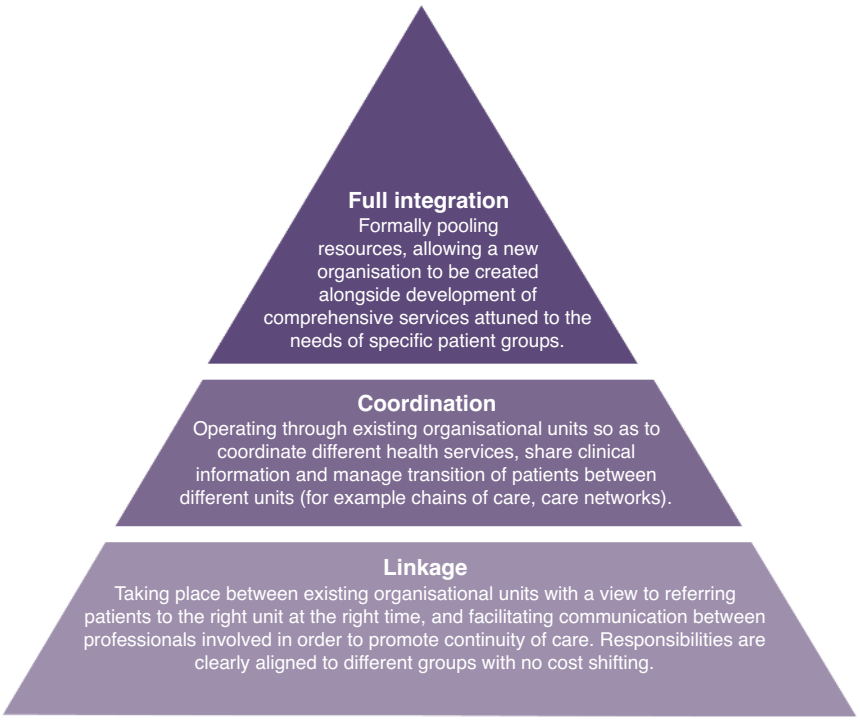
Activities in this phase will take place between 2014 and 2016.

Co-ordination involves better communication between services in order to understand each other's approaches to delivery, the needs catered for by each service, and strategic priorities. The distinction between co-ordination of services and integration is shown in Figure 4.4[13]. During this period, One Ilfracombe is facilitating the analysis of duplication and gaps in service provision. This is the first step towards removing duplication and creating common agendas.

During this stage it is envisaged that services will still operate through existing organisational structures but that data-sharing tools, such as the central online hub (website), will enable residents to become better supported in their transition between different services. Resources such as space and staff time are expected to be co-ordinated across different organisations. This coordination will be aided by the creation of a Virtual Bank, an innovative platform which estimates how much each service will spend, on a postcode basis. It will allow Ilfracombe residents and agencies to see what is being spent and how the money is being used.

13 This reflects the levels of integration, which distinguishes between co-ordination and full integration. See Shaw et al. (2011) What is integrated care? *The Nuffield Trust*.

Figure 4.4: Intensity of integration pyramid from Shaw et al 2011 adapted from Leutz, 1999



Having built up public awareness of One Ilfracombe's aims and approach, the team have hosted, and will continue to host, formal engagement events such as One Ilfracombe Annual General Meetings, and specific thematic events with partners; for example a Neighbourhood Watch event. Through these engagements, service users are expected to feel more informed about the nature of the services available and how they are organised.

The short-term aim for residents is feeling 'listened to'. The engagement events provide further space for residents to share their experience of using the services, and to express their needs. Community engagement officers also arrange interviews and focus groups with intended beneficiaries of thematic projects. These engagements help the One Ilfracombe team to gain a firm understanding of services from a user perspective: that is, how easy they find it to access help, the way assessments make them feel, and whether the choices available fit with their lifestyle needs.

This understanding is then fed back into the review of service organisation and how users are signposted between services. These initiatives are expected to help service users to realise that they have influence over services and how they are delivered.

C. Medium-term: Integrated delivery and increased participation

Activities in this period will be conducted primarily between 2015 and 2018.

In the medium term, it is expected that services will be able to pool resources strategically, perhaps through new commissioning approaches or strategic mergers. The exact shape of this resource integration will be based on an understanding of local needs and the balance of spending at the time. For example, social care, public health and primary health care may combine budgets to create better services for those affected by dementia. A key benefit of pooling resources in this way is the improved access to funds, as barriers to

joint investment (e.g. one body spending and another benefiting; or lags in benefits accruing for preventative interventions) can be more easily overcome[14].

It is expected that person-centred services will arise as a result of this reorganisation, which means that that the service users' perspective will lead design discussions and will also be the central organising principle of all service delivery[15]. Views on how services should be designed will continue to be collected through events and engagement such as the People's Voice scheme, run by the community engagement team. This will take place at Ilfracombe Town Council meetings, during One Ilfracombe Annual General Meetings, through consultation surveys, and through individual consultation with each service – including while delivering work through, for example, the Community Connector. Analysis of these views will lead to the identification of further One Ilfracombe priorities and will hopefully lead to service users feeling that they have greater control over service design and delivery.

Incrementally this will lead to a fully horizontal integration of services on a thematic basis, where appropriate. While integrating there may be some disaggregation of existing services, as part of or all of their operations and functions may be moved or changed. Staff will be upskilled to increase their inter-service perspective and management skills, so they can work across services as easily as they can deliver within them. It is equally possible that during this period there may be redundancies, both voluntary and otherwise.

For residents, the medium term will also see a rise in community involvement in the delivery of services through volunteering. Opportunities to volunteer, either directly for services or through voluntary organisations, will be made easier by the One Ilfracombe team. The team will facilitate the integration of community organisations with public service operations so as to enhance common outcomes. In some cases this has already started, for example within the Youth Providers' Network, young people are contributing to the Young People's Strategy and Vision for the town.

The One Ilfracombe team will also promote opportunities for residents to take on new roles, such as Neighbourhood Watch co-ordination for their street, mentoring a young person, or looking after a green space. The sense of guiding services and helping to deliver them is intended to create a sea change in attitude, so the community moves towards feeling co-responsible for itself.

In conclusion, integrated services will mean a shift in the portfolio towards early intervention. Early intervention projects will be enabled by sharing budgets, and will be shaped by the rounded perspective of service users. It is expected that that services will create better user experiences through collective action, which will prevent negative outcome pathways. Joint resourcing will lead to more effective service provision.

D. Long-term: Co-production

Outcomes and future activities for this phase are expected to be realised between 2018 and 2023.

Co-production refers to an approach to service delivery that radically reimagines the traditional dynamic of expert service-deliverer working on behalf of the

14 National Audit Office (2013b) p14

15 Shaw et al. (2011)

passive end-user. Instead, the design and delivery of services are undertaken by both professionals and service-users/citizens. Table 4.1 below distinguishes co-production from other approaches:

Table 4.1: Models of service design and delivery

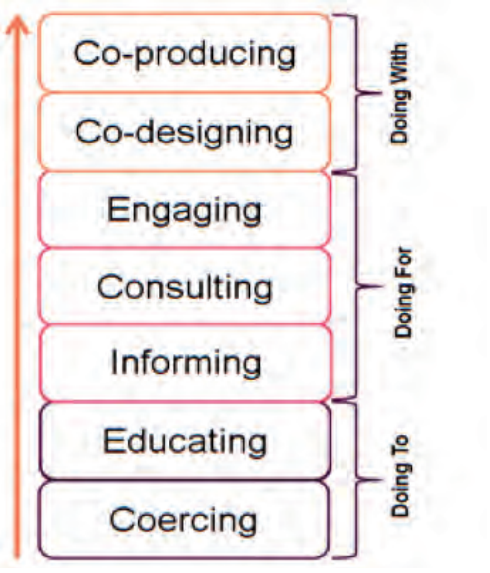
		Who designs services		
		Professionals	Professionals and citizens (Service-users)	Citizens (Service-users)
Who delivers services	Professionals	Traditional service model	Co-designed services	N/A
	Professionals and citizens (Service-users)	Co-delivered services	**Co-production**	N/A
	Citizens (Service users)	People trained to deliver services	N/A	Self-organised community provision

A co-production approach envisages a relationship of mutuality between agencies and service user, at all stages of a service's life: from design, to planning and delivery. It recognises that both parties have vital contributions to make to improve the quality of life for people and communities.

One Ilfracombe will be building this relationship amongst agencies and service users up till 2018. Increased participation and a growing feeling of co-responsibility among residents will mean more power can be shared between agencies and service users. This outcome will develop primarily from the deepening of co-design and co-delivery.

In co-design the nature of engagement with service users is a key distinguishing feature of co-production, as illustrated by the ladder of participation in Figure 4.5 below.

Figure 4.5: The ladder of participation showing the depth of engagement suggested needed to achieve co-production.



At one end of the spectrum is the traditional model of service delivery at its coercive worst which can be described as **'doing to'**. In these circumstances services are designed to educate or 'cure' beneficiaries and there is zero participation. This model is the polar opposite of what One Ilfracombe hopes to achieve.

In the middle exists the most common style of service delivery described as **'doing for'**. In this model, professionals work on behalf of service users. Participation may be tokenistic or within clear parameters set by professionals, and designed to maximise the agencies' idea of efficiency. People are invited to be heard and their opinions may influence decision-making but not on the users' own terms. This is a level of involvement that One Ilfracombe may be experiencing at present with an expectation that, by the medium term, services will be person-centred and co-designed through close consultation with users.

Finally the most advanced form of participation is known as **'doing with'**. This approach recognises that even with the best of information, positive outcomes cannot be delivered 'to' or 'for' people. An equal and reciprocal power-sharing relationship is established whereby people's voices are heard, valued and debated on their own terms; then agencies and service users act together by sharing roles and responsibilities.

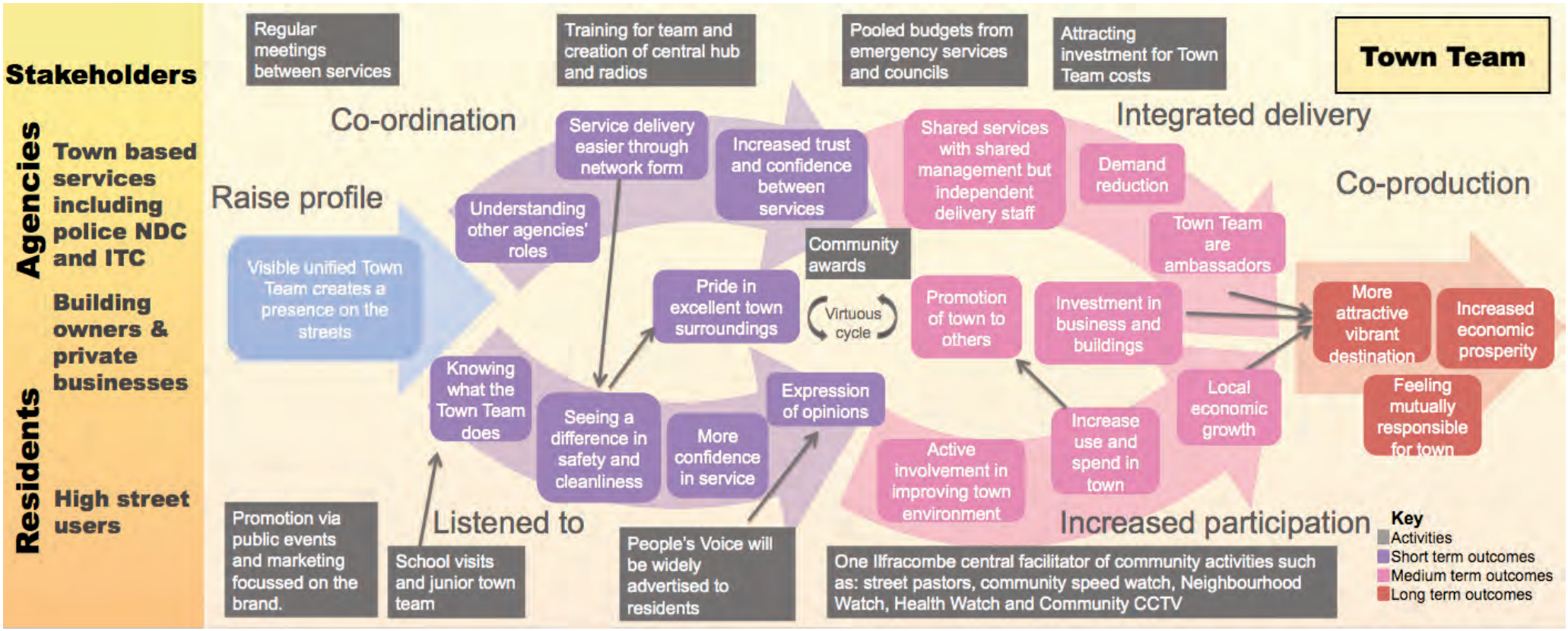
By building residents' interest, willingness and their capacity to contribute, One Ilfracombe hopes to build up to this level of engagement. In practice this will mean more people will volunteer, by taking on delivery roles and responsibilities routinely. They may be running peer support networks, for example Neighbourhood Watch; or they may be sitting on the governing bodies of services or councils (for example, the role of junior councillor may be a first step). People's assets and capabilities will be recognised and maximised by working seamlessly with the services.

It is also important to distinguish between **substitutive** co-production and **additive co-production**. The former is where public sector inputs are replaced with inputs that come from users and/or communities; this can become an excuse to remove or withdraw service provision completely, leaving people to sink or swim. The latter involves combining the new and often overlooked resources of citizens, service users and community members with the professional/public resources. While One Ilfracombe aims to remove duplications, it is dedicated to providing for people's needs. The work of One Ilfracombe intends to be additive: integrating the voluntary and public sectors along with deeper service user involvement.

In the long term, One Ilfracombe sees the co-production approach leading to an improved socio-economic outlook (as outcomes become more sustainable), and improvement in the town's living environment, creating more economic prosperity and leading to better health for residents. The specific programmes for achieving these aims are described in more detail in **Sections 4.3, 4.4** and **4.5** respectively.

4.3 The Town Team's Theory of Change: Improving the town environment

Figure 4.6: Theory of Change: The Town Team



The Town Team aims to improve the Ilfracombe town environment and make it an attractive, prosperous area for residents, as well as a vibrant destination for visitors. The Town Team includes officers from the police, fire and rescue services, staff from local authority departments (such as civil enforcement, anti-social behaviour, waste and refuse), and councillors. Together they are working to improve services; including parks and ground maintenance, litter collection, car parks, public toilets, crime and anti-social behaviour.

The Town Team services follow the same logic and phases to reach their goals as the overarching One Ilfracombe Theory of Change (see Figure 4.6). The unique aspects of each stage are outlined below.

Raise profile

It is important to the Town Team that they are recognised by residents as the 'go to' place for town environment issues. Team members increase their visibility by wearing armbands, T-shirts or base-ball caps, to show they are a unified group, when moving around the town. Public events and brand-focussed marketing is also used to spread the message of the Town Team's work.

Short-term changes

The first step towards good co-ordination between services is gaining an understanding of each other's work. By attending regular meetings and working alongside each other, team members learn how the other agencies work and what their responsibilities are. It was noted that while there may have been some initial reluctance to become more involved, the Town Team members have begun to enjoy hearing radio communications of their sister services as it helps them to know what is going on, and whether they can get involved.

Service delivery becomes easier through a networked forum – staff from different services effectively work as one team, which optimises agencies' ability to respond to issues. It is anticipated that for issues such as littering, the use of radios, a shared hub, shared administration and regular meetings will reduce response times to within one hour of problems being reported (and have already done so). This means inter-agency working will be strengthened and the delivery of overlapping services improved.

Trust and confidence between teams also grows in the short term through the experience of working together. Increased engagement between the Police, waste and recycling team and the Town Council to date has enabled positive relationships across teams due to information-sharing and clear lines of responsibility.

Over time, more residents are expected to learn what the Town Team does and what its responsibilities are. It is anticipated that this will be reflected through an increasing number of people contacting the Team to respond to town environment issues. School visits, junior Town Team schemes and other activities also increase awareness.

As services are improved, for example through better response times, it is anticipated that residents will begin to notice the difference created in terms of safety and cleanliness when moving around the town. For example, members of the team relate that, thanks to cross-agency call outs, members of the public

were impressed by how quickly police officers arrived at the scene following incidents of shoplifting and fly-tipping. It is also expected that there will be fewer complaints and more complimentary comments on the Town Team's social media platforms.

The above is expected to increase residents' pride in the town's environment: the well-kept streets, parks and shop areas. Awards (for example, 'Pride in Ilfracombe') will recognise and celebrate the great work being done by agencies, voluntary organisations and businesses.

As confidence in the Town Team builds, it is expected that residents will express constructive opinions on how the town environment should be managed and maintained. This will involve residents seeking to actively give their views through the People's Voice scheme (run by the community engagement team), at Ilfracombe Town Council meetings, during One Ilfracombe Annual General Meetings, via engagement events, and through consultation surveys.

Medium-term changes

As the Town Team builds their experience of working together there will be modifications to service-process design, under what will become the common management and leadership. This will be balanced by clear responsibilities for independent delivery staff. During this period, incentives to work together will be strengthened by common investment across. This pooling of budget will allow teams to cross-subsidise each other's work. For example, an investment in the street environment combined with enhancement of youth clubs could reduce the workload of the team addressing anti-social behaviour.

The Town Team anticipates that increased efficacy will also lead to a reduction in demand for many of their services. For example, people are less likely to fly-tip when streets are very clean; and anti-social behaviour is reduced as a result of (potential) community CCTV and street pastor work. This will result in further cost-savings.

The Town Team members at this point are ambassadors for the town; they represent an increase in aspirations and a desire for Ilfracombe to help itself.

Meanwhile, residents will move from expressing opinions to becoming more actively involved in improving the town environment. A number of voluntary and statutory service initiatives which they can support, will be advertised at the physical hub and online. These may include street pastors[16], Community Speed Watch[17], Neighbourhood Health Watch[18] and Community CCTV[19]. This will add to the capability of the Town Team while making the positive effects more meaningful to local people as they will have helped to design and produce them.

Visitors, tourists and investors are expected to come more frequently to Ilfracombe as the town will become a top choice for shopping, recreation and business. Their increase in spending will in turn grow the local economy.

16 Trained volunteers from local churches, who care for, listen to, and help people who are out on the streets between 10pm to 4am, to reduce violence and accidents on Friday and Saturday nights.

17 Members of the community join together with the support of the Police to monitor speeds of vehicles using speed detection devices.

18 See Living Well Theory of Change (Figure 4.8).

19 Members of the community volunteer to monitor public space CCTV output in a central control room.

The improved reputation of the town will encourage visitors to promote Ilfracombe to others, which creates a virtuous cycle with respect to local pride. The great reputation and growing economy are expected to draw investment in the buildings and local businesses.

Long-term changes

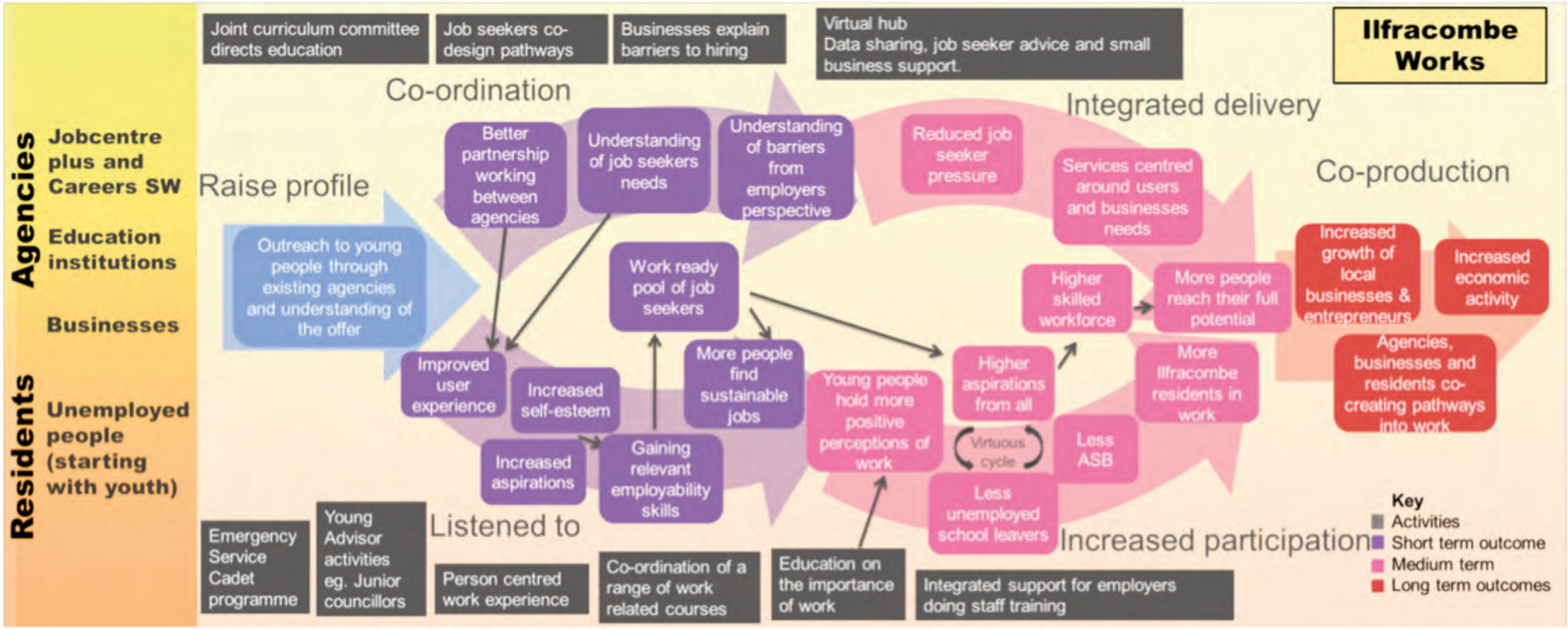
One Ilfracombe envisages that these outcomes will make the town a more attractive and vibrant destination for visitors due to its pleasant environment and safe streets. This will come hand-in-hand with an increase in economic prosperity, with more wealth in the town and higher income for residents.

Critically, everyone who lives and works in the town will feel mutually responsible for the town's condition. This may be expressed through more people helping, not only to design the services of the Town Team, but also to plan, for example, how they can look after green spaces and other community assets[20]. Ultimately, there will be a real a culture of collaboration between agencies and residents, such that roles and responsibilities are blurred.

20 The identification of community assets is expected to take place over several years. It will involve recursive mapping and significant participation from a cross-section of residents.

4.4 Ilfracombe Works' Theory of Change: Improving employment prospects

Figure 4.7: Theory of Change: Ilfracombe employability activities



Ilfracombe Works is focussed on building residents' capacity to find, secure and progress in employment, and supporting businesses to grow so as to improve the local economy (see Figure 4.7). The main partners involved include: Job Centre Plus, Careers South West, Ilfracombe Academy, North Devon Homes, Ilfracombe Voluntary Services, Petroc, COMBEBusiness, Pall Ilfracombe, TDK Lambda and Northern Devon Healthcare Trust.

Currently key projects include:

- *Pathways to Work:* A training and vocational scheme to build the employability of those not in education, employment or training (NEETs);
- *Education to Work:* A programme specifically for students;
- *Out of the Blue:* A cadet scheme where young people spend one evening a week for 9 weeks with emergency services; and
- *Young Advisors:* An advisory board of young people that gains experience through participation in various One Ilfracombe activities. Following feedback from businesses, a welcome pack to assist and attract new residents has also been funded.

The key stakeholder group for Ilfracombe Works are public employment agencies. However, there is openness to engaging with educational institutions and businesses that may be looking to employ staff. With respect to residents, the key stakeholder group is unemployed people; and, during 2014, especially the young unemployed. The outcomes anticipated for these stakeholders from joint agency work over the next ten years, are explained below.

Raise profile

Initially the Ilfracombe Works team sought to raise awareness of its support, amongst agencies that may already be delivering separate services, and also among young people who may be preparing themselves for employment. By raising its profile, the team hoped to generate commitment from agencies to work with them and interest from young people in the opportunities that Ilfracombe Works can offer.

Short-term changes

Through meetings and communication, the agencies collectively reviewed what employment schemes exist in Ilfracombe, and via what pathways users arrive at each of their services. This shared mapping was intended to lead to better partnership working.

Key to the success of this exercise was engagement with job seekers, as this allowed the Ilfracombe Works team to understand user experience of the multiple schemes. When this activity was carried out it in 2014, it became clear that there was a gap in the services for young people. There was no clear 'programme' linking schemes together and young people felt bewildered and disheartened by the number of agencies giving them different advice. This exercise led to agencies understanding job seekers' needs better and has allowed them to start addressing the issues expressed by young people.

Alongside engagement with service users, the Ilfracombe Works team have also listened to businesses, to better understand the barriers to employing people from an employer's perspective. This insight is being used to design services and education curriculum programmes that will address these barriers.

For service users, improved partnership working and greater understanding of their needs, results in an improved user experience. Person-centred work experience placements, traineeships and internships are tailored, with the help of One Ilfracombe, to address users' specific needs. The Virtual Hub (an online directory) will also gradually provide a fuller and more user-friendly directory of services that should signpost job seekers to the best schemes for them.

Through their engagement with the *Pathways to Work* project, service users gain a better understanding of their existing skills. They are signposted to schemes that align with their interests and it is expected that their self-esteem will increase, as they have a feeling of progression. Young people's confidence that they will find suitable work is also expected to be enhanced by schemes, such as *Out of the Blue*, that seek to build the aspirations of young job seekers.

These changes to their experience mean that job seekers are more likely to complete courses and build relevant employability skills. This is illustrated by outcomes from the Pathways to Work project, which has reduced the number of NEETs (individuals Not in Education Employment or Training) in Ilfracombe faster than the national average, to a point where only a small number of NEETs remain.

The work of the *Pathways to Work* project means in turn that a pool of work-ready job seekers becomes available for businesses and other employers. Key barriers to employers taking on Ilfracombe job seekers will be addressed. For example, personal presentation, interview, communication and CV skills will be developed as part of the *Education to Work* programme; better enabling young people to secure jobs or apprenticeships.

Medium-term changes

As more young job seekers are able to enter the workforce, pressure on support agencies will reduce, meaning cost savings can be realised. As agencies come to work together more closely, sharing greater knowledge and experience of serving job seekers, they will get better at designing services around job seekers' interests and the needs of employers – rather than their own operational structures. This will happen through a combination of pooling budgets, sharing physical spaces, and creating new information and technology channels.

Young people, via the same means, will meet role models from their peer group, they will have increased interaction with professional adults, and will come to understand the importance of work. Together these influences will lead to more positive perceptions of being employed; they will feel more ambitious; and the prospect of securing work that interests them will become more realistic. These outcomes will lead to a reduction in the number of school leavers without the skills for employment. Being occupied and engaged in work means the level of anti-social behaviour in Ilfracombe is also expected to reduce.

Greater levels of interest and success in the work arena will mean that the work ethic in Ilfracombe will strengthen. Uplift in aspiration among employees and business owners will increase the level of motivation to build new skills across Ilfracombe's workforce. This will be supported by separate schemes that help employers to deliver staff training which taps into the increased levels of aspiration.

The uplift should also encourage businesses to grow and create greater variety and volume of jobs. This in turn will create the potential for more Ilfracombe residents to find work where they can reach their full potential, and to be employed in jobs which they enjoy and that fit their lifestyle.

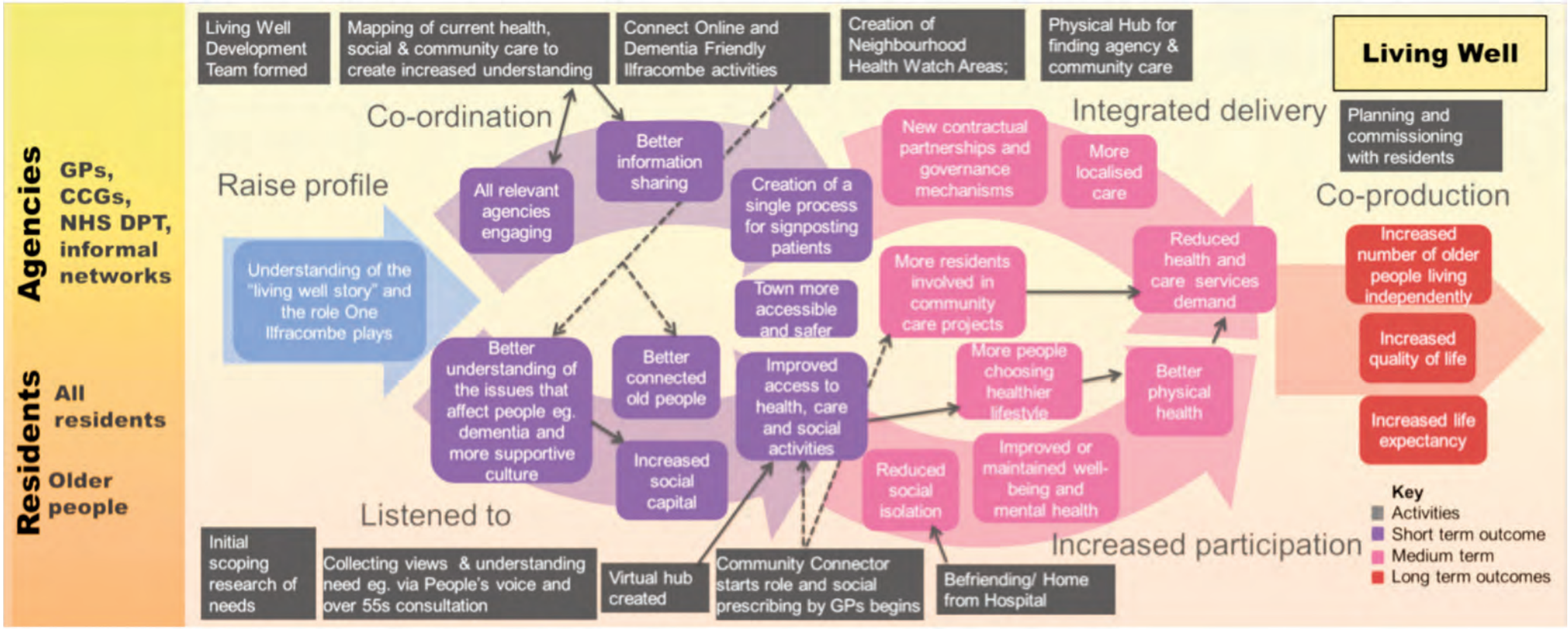
Long-term changes

In the long term, the changes noted above are expected to make Ilfracombe residents more productive and to create the right conditions for encouraging entrepreneurship and the growth of local businesses. Consequently, there will be an increase in local economic activity.

The way that career progression pathways are designed and delivered will also change, to seamlessly link educational institutions, agencies, businesses and residents.

4.5 Living Well thematic area

Figure 4.8: Theory of Change: The Living Well theme



The Living Well Team aims to raise residents' health and well-being and to reduce long-term demand on the NHS, by improving access to early intervention services and reconfiguring services so they are right for the individual (see Figure 4.8). The current priorities for the Team are to improve health and well-being in older age, to create a strong and supportive community, and promoting a healthy lifestyle. The main partners involved are: Northern, Eastern and Western Devon Clinical Commissioning Group, Northern Devon Healthcare Trust, General Practitioners, Devon Partnership NHS Trust, and community voluntary groups working on care and health issues.

Early intervention is a key principle of all Living Well work, based on the premise that if the well-being and health of residents can be enhanced at an early stage, there will be less demand for services later in their lives. Current and forthcoming projects include:

- *Dementia-friendly Ilfracombe:* A project aiming to raise awareness of the symptoms of dementia and encourage the inclusion and support of those living with dementia;
- *Connect Online:* A digital literacy project for older residents delivered by Ilfracombe academy students;
- *Social Prescribing:* A mechanism for linking patients to non-medical preventive support including physical activity, learning skills, volunteering, befriending, housing, debt advice, legal and parenting support;
- *Neighbourhood Health Watch:* A project facilitating neighbours to support and look out for one another, and to improve well-being;
- *Community Connector:* A role that understands 'preventative community care' provision within Ilfracombe and is able to direct and support older people with accessing these services;
- *Living Well Together:* A project that integrates health, mental health, social care and community services, which offers earlier support to those whose situation puts them at risk of escalation to a health crisis.

The initial key stakeholders for this team are: the partner delivery agencies and older people (over 55s) in Ilfracombe. The town attracts a large number of retirees and has an aging population. The total population of over 55s is 4003 (around one third of the town's total population). Life expectancy in Ilfracombe averages 79.8 years, which is significantly lower than the surrounding region of Devon (81.6 years)[21]. This suggests a higher incidence of health problems.

Unsurprisingly, given their age range, many of these older people receive benefits (in particular Incapacity or Severe Disablement Allowance). Some are affected by the effects of high levels of alcohol and tobacco consumption. These factors have led the Living Well Team to focus at present on improving the health and well-being of older people. However, it is envisaged that, over the next few years, the work of this Team will benefit all residents more broadly through healthy lifestyle advocacy; as well as vulnerable people through inclusion projects; and ex-offenders and troubled families through bespoke interventions.

21 Devon Public Health Intelligence Team, Devon Council and NHS Devon (2011) Joint Strategic Needs Assessment Market Town Profile 2010-11 Ilfracombe

The projects for the other stakeholders are currently at the design stage. Consequently, the narrative below focuses exclusively on older residents as there is greater clarity concerning what is achievable for this group.

Raising profile

Like the other programmatic teams, the Living Well Team initially generates interest and buy-in from stakeholders by presenting a compelling story about the need and opportunity that the programme of work can deliver. To identify needs, a steering group is formed from a cross-section of agency staff, and research undertaken. This research builds understanding of the 'living well story' and the role that One Ilfracombe can play in facilitating changes across the agencies. The results are then shared with residents through appropriate channels.

Short-term changes

The first step for the Living Well Team is to build engagement and gain the commitment of agencies and residents. An exercise that maps existing health, social and community care helps to galvanise this engagement, and also increases agencies' and residents' understanding of the service overlaps and gaps.

Once the current agency offerings are mapped, services are better able to share information, which ensures that patients are signposted to the most appropriate sources of help. Relationships are also strengthened through the joint delivery of initial projects such as social prescribing[22].

Data sharing also helps services to plan and make co-ordinated decisions about where to invest further. The creation of a Virtual Hub (website) which acts as a decision-tree directory further supports the creation of a single process for signposting patients.

For residents, the projects facilitated by One Ilfracombe build empathetic understanding of issues such as mental health and social isolation. The projects also equip people with structures and tips on how to take action; for example, businesses are encouraged to change the physical layout of shops to avoid causing unintended distress to shoppers with dementia. Stakeholder engagement suggests that a range of people around Ilfracombe have found such training empowering and it has fostered a supportive culture for older people.

Increased awareness of the issues that affect older and vulnerable people, along with new structures to enable action (for example Neighbourhood Health Watch), generates an increase in social capital. This is likely to spread on a locality basis. The increased awareness is complemented by a programme for older people that offers support with using the internet, which means they are better connected to friends and loved ones outside Ilfracombe.

The creation of the Virtual Hub directory combined with the practical support of the Community Connector means that older people feel generally better able to access health, care and social activities. For example, the Community Connector may advise older residents about physical exercise classes or how to request an accessibility assessment of their homes. This helps them to overcome the feeling that the array of services available is bewildering.

22 Social prescribing is about linking people up with non-medical sources of support to tackle underlying causes of physical and mental illness. This might include community activities or services such as debt management or refuges.

Collaboration with the Town Team will lead to changes in the physical environment of the streets, to make them more accessible and safer for older people. More publicity will also be given to transport options for elderly people who come into the town centre, and to age-friendly venues for leisure and recreation.

Medium-term changes

Agencies move incrementally from joint delivery of projects to more formal integration. This is likely to involve new contractual partnerships and governance mechanisms created by new commissions for care and healthcare. The evidence-base for such commissions will have been built up through continual community engagement; through the People's Voice and other channels, such as survey and focus group consultation.

During this period, the role of One Ilfracombe will be twofold: first, to facilitate formal relationships between groups and services that are looking to integrate or could benefit from integration; secondly, to advocate the participation of a wider group of residents, to co-deliver health and well-being services locally. The role of these preventative community care groups is critical in generating well-being and health consciousness.

These new horizontal configurations will be place-based and therefore result in more localised care. It may involve a Living Well physical hub, possibly within the Tyrrell Hospital building. This hub could also house an information centre providing local health and well-being service options as well as social space for residents.

Meanwhile the Community Connector and other One Ilfracombe staff will have been supporting residents to become more involved in community care projects. These may include voluntary groups that, for example, provide respite for carers or befriend older isolated people by visiting them in their homes.

It is envisaged that more carers and staff will be trained and equipped to provide home care, so as to enable older people to stay out of residential care homes and hospitals. This may mean upskilling and cross-training staff from different services and/or may offer an opportunity for young people seeking to enter the workforce.

Befriending and 'Home from Hospital' schemes in particular will help reduce social isolation within the older residents' population, which should also reduce mental health issues, as individuals are less likely to feel anxious and lonely, which will boost well-being in the community more generally.

In conclusion, improved access to health services, along with public health awareness work (provided by services and community groups) will lead residents to choose healthier lifestyles by moderating alcohol and tobacco consumption and making more informed eating decisions. There will also be consideration given to the social needs and wider well-being of older residents. Together these should lead to better physical and mental health for the population aged over-55, which should in turn reduce the demand on health and care services.

Long-term changes

It is envisaged that in the long term, agencies will not just gather insight from residents on how best to design services but they will also move into a phase of

full co-production. This means, for example, that residents will be involved in commissioning (co-planning) and delivering services.

Maintaining personal health will therefore be more meaningful to residents and will complement the general culture of community-supported health. It is envisaged that these changes in healthcare delivery will together lead to an increase in the number of older people living independently; an increased quality of life for all residents; and an increased average life expectancy for the town.

5. Living Well: Prospective Value for Money assessment

One Ilfracombe's approach is centred on a desire to use limited resources as effectively as possible. To gain an understanding of how much One Ilfracombe is likely to achieve in terms of savings to the public purse, two Value for Money analyses have been conducted. Focussing on the Living Well programme, these analyses estimate what level of savings can be made in health and social care as a result of older residents coming into contact with initiatives led by One Ilfracombe.

Value for Money studies typically examine one or more of: the economy, efficiency, effectiveness and equity dimensions of an intervention. One Ilfracombe is on the whole an economic public intervention as it focusses on using existing budgets better and requires only minimal further staffing costs[23] to oversee work.

The anticipated outcomes and rationale of the One Ilfracombe model have been outlined in **Section 4** by presenting the Theory of Change that underlies the model. A deeper examination of the effectiveness of the Living Well model is presented in Section 5.1 (see Figures 5.1 and 5.2). As exemplified in the Theory of Change diagrams, One Ilfracombe projects are expected to go beyond State cost savings, to also produce social and environmental value, such as: improvements in individuals' wellbeing and income, or enhancements to public outdoor spaces. However this section considers specifically the costs and benefits to public budgets[24].

In **Section 5.2** we provide estimates for the magnitude of the effectiveness for a number of typical Ilfracombe residents. While the exact nature and form of Living Well activities are developing, we can assess who may benefit from services, and the types of outcomes they will ideally experience. To construct case studies that are as realistic as possible, portraits of elderly residents were co-developed with assistance from One Ilfracombe and Devon County Public Health staff [25]. Each case study has been analysed to judge what the total saving to the State will be if needs are successfully met as per the Living Well model.

Assessment of the prospective efficiency of One Ilfracombe's work is explored in **Section 5.3** through a break-even analysis of a key Living Well project: the Community Connector role. Based on an understanding of the typical beneficiaries that will be supported by the Connector, an assessment is made of how quickly the project will produce net savings to the public purse. The fiscal payback period gives a sense of how efficient the model is compared to public

23 Additional State costs for running One Ilfracombe to date include the salaries of a Project Co-ordinator, a Project Support Officer and a Community Connector.

24 The Treasury's Green Book advises that the wider social and environmental value created by a project should be taken into account when judging the costs and benefits of government spending: HM Treasury 2003 (with 2011 amends), The Green Book: Appraisal and Evaluation in Central Government, p.19

25 One of the intrinsic challenges of ex-ante assessments is the uncertainty about the completeness of outcomes. It is possible that we have omitted both positive and negative outcomes which will become more apparent over time. As such, our calculations use the best knowledge made available to us.

investment. It also identifies the minimum number of successful caseloads (or Completed Outcomes) that need to be achieved for the project to break even.

The Value for Money in terms of savings per individual and for an example project, is examined below. Both aim to deliver key anticipated savings through supporting the independence of older people in Ilfracombe, improving their health and enhancing mental well-being, as illustrated in the detailed Theory of Change. The significance of these cost savings, including their equity are discussed in **Section 5.4**.

5.1 Detailed Theories of Change

Living Well Agencies Theory of Change

Figure 5.1: Theory of Change: Delivery agencies involved in Living Well

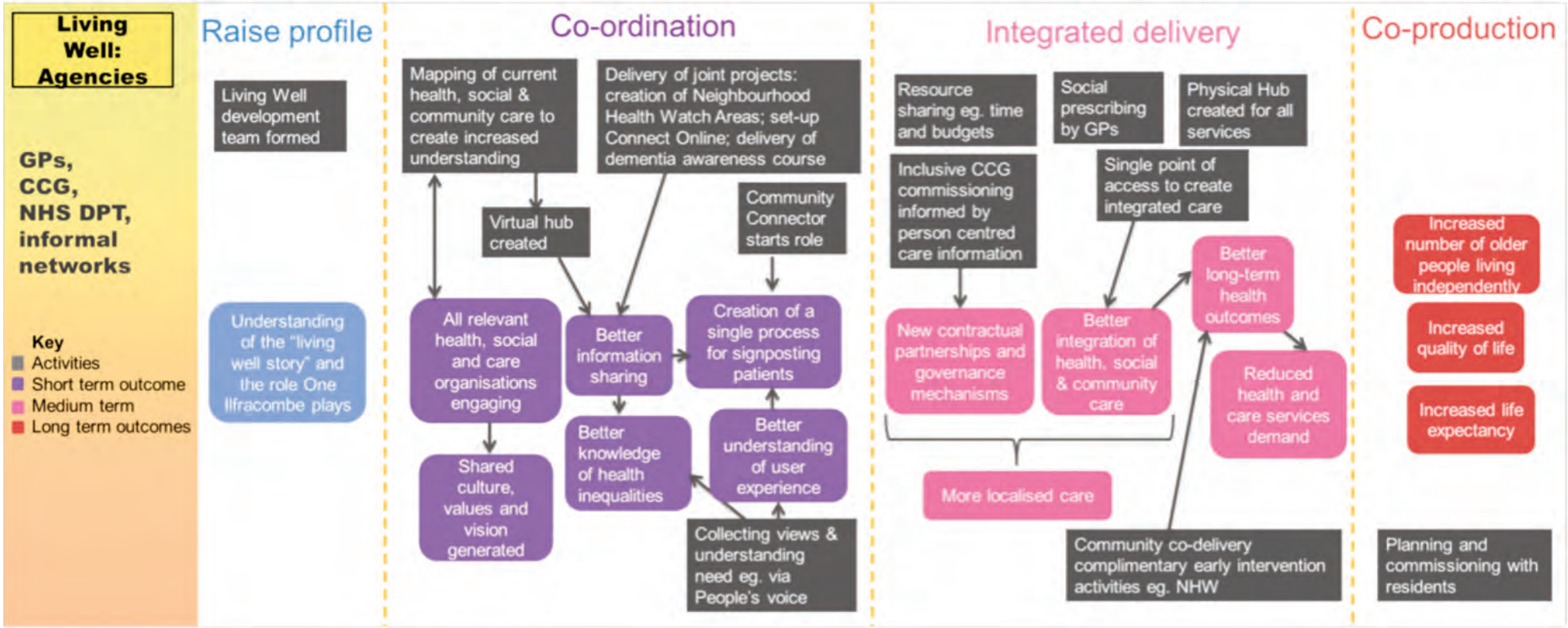
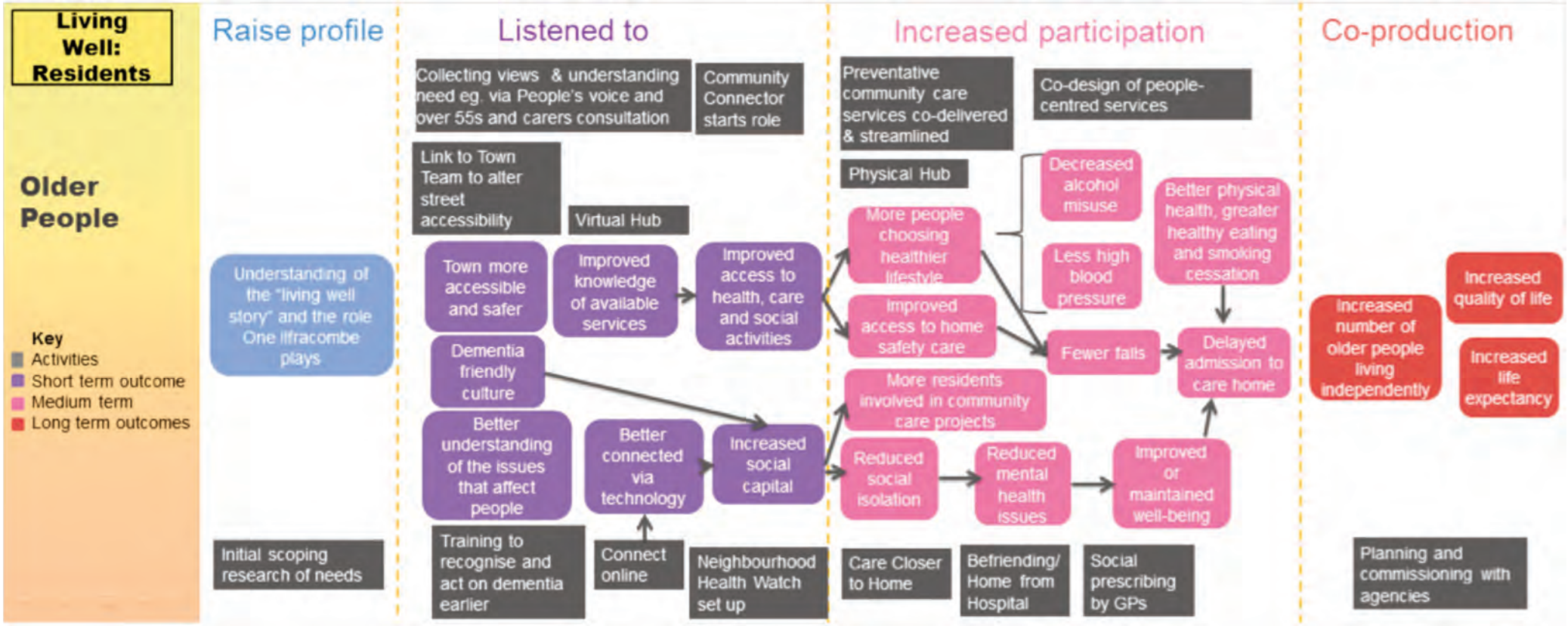


Figure 5.2: Theory of Change for older residents who benefit from Living Well activities



5.2 Living Well case studies

This section presents three case studies that illustrate the pathways through which individual behaviour change, arising from the Living Well Programme, leads to economic outcomes for the public sector as a whole. All the case studies are hypothetical but draw on portraits of older Ilfracombe residents[26] and provide forecasts of State costs avoided for each person, until their death. Case studies allow stronger assumptions to be made and as such enable more robust calculations to be made.

Case Study 1: Alice

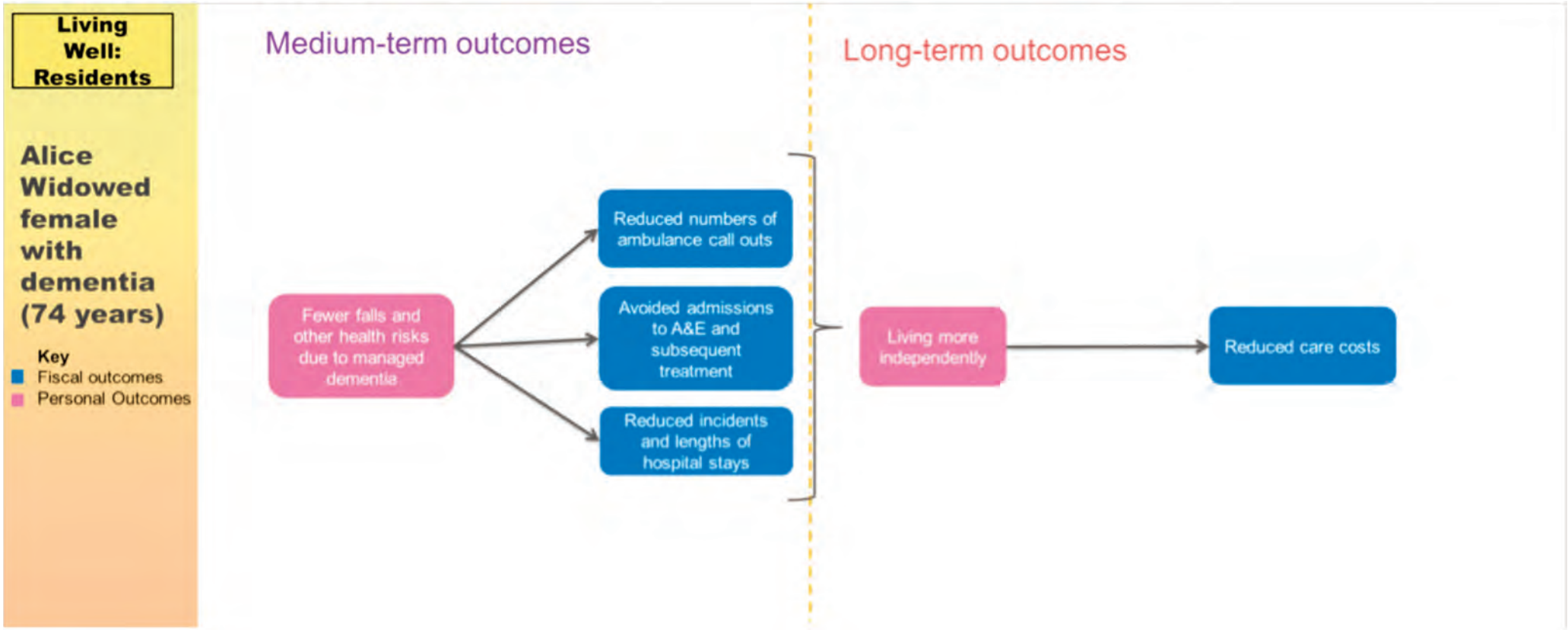
Alice is 74 years old and she has dementia. She has lived in Ilfracombe for most of her adult life, where she also worked in a local hotel; only retiring to care for her husband, after he was diagnosed with cancer, ten years ago. He died a short time afterwards. Her only child (a daughter) lives in London and visits Alice once a year. Alice was previously healthy and actively engaged with local community groups. However, since the onset of dementia two years ago, she has felt increasingly confused and scared, and now prefers not to leave her home. She often feels extremely lonely and frequently forgets to eat, which compounds her confusion and makes her increasingly frail. Alice's situation changed as a result of the newly established Neighbourhood Health Watch (NHW). The local co-ordinator popped round one Sunday, having been alerted that Alice had not drawn her curtains for a few days. He noticed the change in her behaviour, her unusually untidy home and, when trying to make a cup of tea, the empty cupboards and rotting food in the fridge. Having been on a dementia awareness course, he was able to recognise the signs of dementia and that afternoon emailed Alice's GP. Following a consultation, the GP diagnosed Alice with dementia earlier than would have otherwise been possible and contacted the Community Connector (CC). The CC visited Alice at home to better understand her needs and quickly established that there were a number of hazards in the house, which could precipitate falls. The CC helped facilitate a stair-lift to be fitted and a reminder board to be made available in the kitchen, for Alice to keep track of daily tasks. She also organised a befriender to visit Alice in

26 For methodological considerations on the profile of case-study residents see Appendix 5.

her home and accompany her to the local Living Well Hub. Over a period of three months, Alice began to re-connect with the outside world and became a regular at the Hub's dementia café, where, when she did not feel confused, she felt her condition was understood by the people around her, and she was assisted quickly.Alice's physical health has improved as a result of regular visits by members of the NHW, who continue to ensure she has enough good food to eat and will contact her GP's surgery if she appears to be unwell. Thanks to receiving help with tasks like changing lightbulbs, Alice's risk of falls has been lowered and she will be able to remain living in her own home independently for a longer period of time. When she is worried or confused, she first calls a NHW member or a befriender, instead of immediately dialling 999. She is also now at a reduced risk of developing a condition that requires more complex care needs, such as a stroke, until much later in life. Although her life expectancy is not expected to increase, Alice will able to live independently for two years, instead of requiring a care home immediately.

The diagram overleaf (Figure 5.3) illustrates how changes in Alice's behaviour arising from the Living Well programme lead to cost savings for public services.

Figure 5.3: State-focussed Theory of Change for Alice



In summary, the types of cost saving in this example due to the Living Well programme are:

- Reduced number of ambulance call outs associated with unmanaged dementia and social isolation.
- Avoided admissions to A&E and subsequent treatment associated with unmanaged dementia (i.e. forgetting and tripping).
- Reduced incidents and length of hospital stays associated with unmanaged dementia (i.e. forgetting and tripping causing a hip fracture).
- Reduced care costs, associated with living more independently.

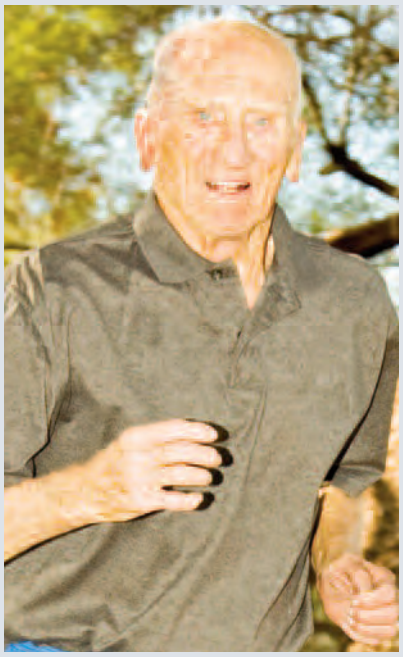
Table 5.1 presents a summary of the potential fiscal benefits that arise from Alice's behavioural changes and the effective management of her dementia. Detailed calculations are in Appendix 6 (Table A6.1).

Table 5.1: Forecast cost savings for Alice

Low forecast	Mid-level forecast	High forecast
£10,571	£21,140	£31,711

The benefits to the State are estimated to be in the range of £10,571 and £31,711, with reduced care costs associated with living more independently accounting for a significant proportion of such savings. These benefits are not cashable, but equate to the value of the additional resources that are made available by Alice's health and behavioural changes. Further benefits may also be relevant (for example, changes in GP appointments or dementia treatment costs). However, it is conservatively assumed that such medical services provision would have remained broadly similar in cost, as it will be the effectiveness and appropriateness of the dementia treatment that improves under the Living Well programme, rather than cost.

Case Study 2: Tony



Tony, at 70 years old, has been retired for nearly seven years, having lived and worked in Ilfracombe all his life. When in employment, he worked as a bricklayer and now, as a retiree, he relies on the minimum State pension. Since retirement, Tony found himself drinking daily at his local pub with friends, or drinking alone at home. At times, this proceeded into aggressive behaviour, resulting in police involvement. Consuming large quantities of alcohol, combined with unhealthy eating habits, had caused Tony to gain a significant amount of weight and develop high blood pressure. Subsequently he was diagnosed with Type II Diabetes. Visits to A&E and hospital appointments had become a regular occurrence for Tony, either as a consequence of late night drunken incidents or to treat his diabetes. Although Tony's wife and children were concerned by his unhealthy and sometimes dangerous lifestyle, they felt ill-equipped to help him. When Tony's wife, Sarah, heard about the online Virtual Hub, she was relieved to see all the local services and organisations available to support Tony, many of which she had been completely unaware of. Through contact details provided by the Virtual Hub, Sarah arranged for Tony to meet a Community Connector (CC), who was able to introduce him to the Living Well Hub in town as well as mentioning to his local Neighbourhood Health Watch (NHW) co-ordinator that Tony was a person in need. With encouragement from a befriender and members of his NHW, Tony visited the Hub increasingly, where local organisations began to help him make healthier lifestyle choices, as well as introducing him to a range of groups and alternative activities which he could enjoy in his spare time. As a consequence of his engagement with the CC, the support from his GP, the NHW scheme, and organisations he met through the community Hub, Tony joined a light exercise class to try to lose weight and also made healthier eating choices. Tony has made new friends at the community Hub and, because he is now spending less time in the pub, he has significantly reduced his alcohol consumption. This has also meant that he no longer has run-ins with local police.Collectively, the above changes have reduced Tony's blood pressure, reduced his daily insulin intake and also reduced his risk of cardiovascular disease. Overall, Tony has significantly improved his quality of life, which in turn has increased his life-expectancy by one year. Previously, he would have been expected to die by the age of 74, but now he is likely to die at home, in the care of his family, aged 75[27]. No additional quality of life improvements (e.g. deferment of old-age illnesses) are anticipated for a man with a medical history such as Tony.

27 75.1 is the Ilfracombe life expectancy for men (*Ilfracombe Town Study*, 2011).

The diagram overleaf (Figure 5.4) illustrates how changes in Tony's behaviour arising from the Living Well programme lead to cost savings for the State.

- In summary, the types of cost saving for the State due to the Living Well programme are:
- Reduced ambulance call outs associated with a reduction in alcohol consumption.
- Reduced number of admissions to A&E and subsequent treatment, associated with a reduction in alcohol consumption.
- Avoided medical costs of GP visits, associated with healthier eating and better physical health.
- Avoided criminal justice costs associated with alcohol misuse.

Unlike Alice's case (see above) , there is no opportunity for State savings from increased independent living as Tony's situation and health conditions enable him to live with his family until he passes away.

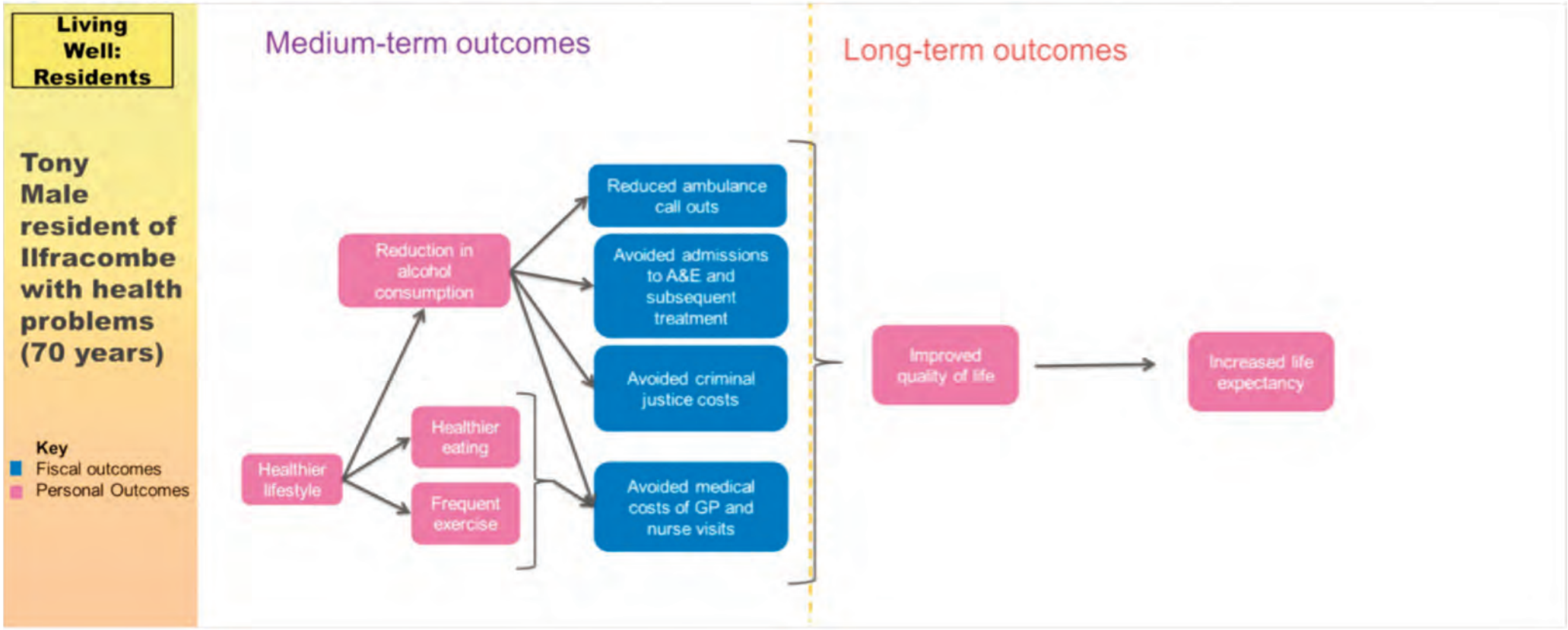
Table 5.2 presents a summary of the potential economic benefits that arise from Tony's lifestyle changes. Detailed calculations are in Appendix 6 (Table A6.2).

Table 5.2: Forecast cost savings for Tony

Low forecast	Mid-level forecast	High forecast
£1,768	£3,535	£5,303

The cost savings are estimated to be in the range of between £1,768 and £5,303. A conservative approach has been taken in highlighting potential economic outcomes and the length of time such outcomes endure. As per the previous case study (Alice), these benefits reflect the value of the additional resources that are made available by Tony's health and behavioural changes.

Figure 5.4: State-focussed Theory of Change for Tony

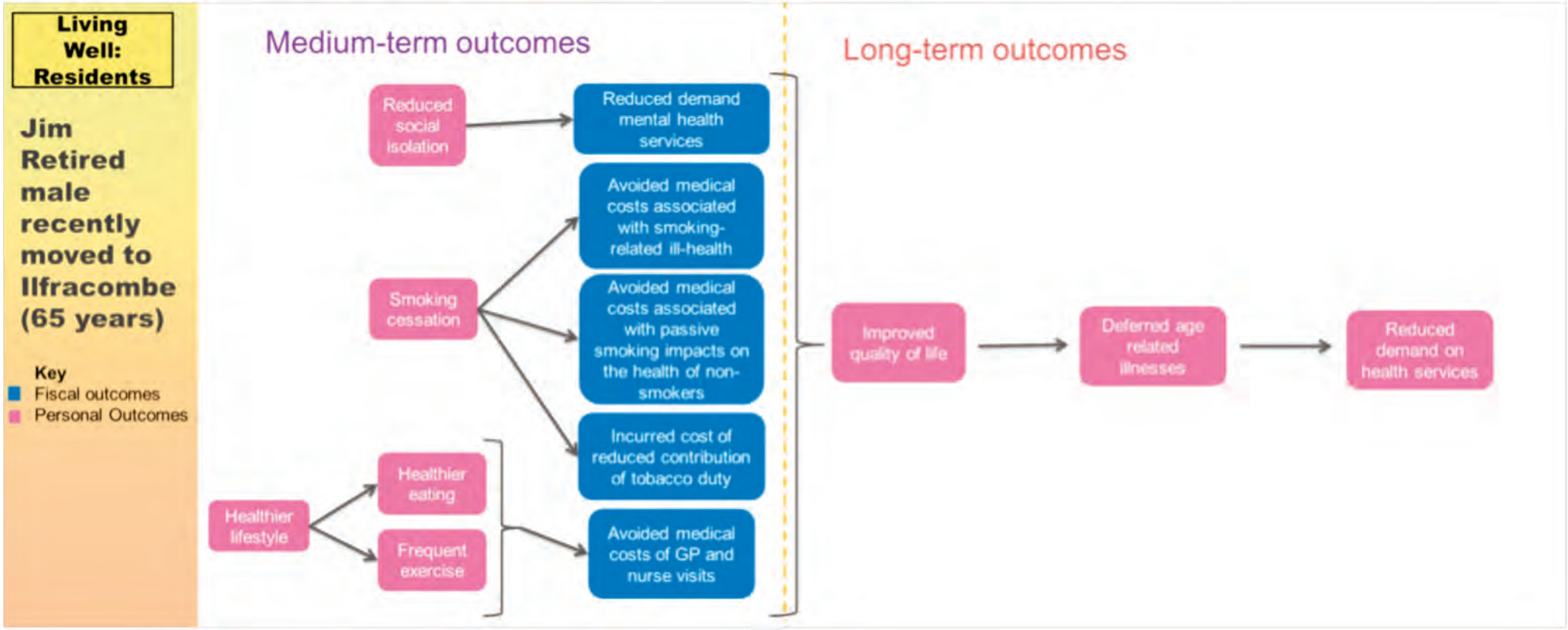


Case Study 3: Jim

Jim, at 65 years old, has recently retired from a long career as an engineer for National Rail. As a divorcee of over five years and with his adult children living abroad, he relocated to Ilfracombe by himself to be on the coast and enjoy his retirement. Jim has been a smoker for just over 40 years and since his divorce has become a frequent consumer of ready meals and takeaways. In the absence of regular exercise, he has developed high blood pressure. Although having a wide circle of friends from his time at National Rail, after moving to Ilfracombe Jim found it hard to meet new people and make friends. He then lost confidence in his ability to socialise and eventually started to feel depressed. At a routine health check-up with his GP, Jim mentioned that he was feeling low. With a bit of probing, the GP, who was part of the new social prescribing initiative, was able to identify that Jim was lonely, and put him in touch with Ilfracombe's Community Connector (CC). The CC linked Jim up with a 'befriender' who accompanied him to the Living Well Hub a few times and introduced him to friendly people.At the Living Well Hub, Jim was able to access numerous services and groups (such as painting workshops and light exercise classes) which helped him to meet new people and try new things. As well as social events, the Hub also gave Jim access to organisations that promoted healthy lifestyles. These organisations helped Jim to make positive steps towards stopping smoking and making healthier eating choices.As a result of joining groups such as the weekly painting classes, and accessing the Hub regularly, Jim was quickly able to make new friends and stopped feeling depressed. Over a period of three years, he stopped smoking and his healthy eating practices and light exercise lowered his blood pressure to within a much lower risk range. The long-term effects of Jim's change in lifestyle and mental health are such that he's likely to defer many age-related illnesses until much later in life, gaining many more years of increased well-being, although the changes are unlikely to extend his lifespan.An individual with Jim's medical history is not anticipated to spend his later years in a care home. Therefore, there is no opportunity for State savings from increased independent living for someone with Jim's profile.

The diagram overleaf (Figure 5.5) illustrates how changes in Jim's behaviour arising from the Living Well programme lead to cost savings for the State.

Figure 5.5: State-focussed Theory of Change for Jim



In summary, the types of cost saving for the State due to the Living Well programme are:

- Reduced demand on mental health services associated with social isolation.
- Avoided medical costs associated with smoking-related ill-health.
- Avoided medical costs associated with passive smoking impacts, on the health of non-smokers.
- Incurred cost of reduced contribution of tobacco duty.
- Avoided medical costs of GP and nurse visits, associated with healthier eating and better physical health.
- Reduced demand on health services.

We found it too speculative to monetise the State saving for reduced demand for health services arising from deferred age-related illnesses; we have therefore excluded it from our calculations.

Table 5.3 presents a summary of the potential economic benefits that arise from Jim's lifestyle changes. Detailed calculations are in Appendix 6 (Table A6.3).

Table 5.3: Cost-savings forecast for Jim

Low forecast	Mid-level forecast	High forecast
-£2,074	- £692	£690

The financial implications to the State for Jim range from a net loss of **-£2,074** to a saving of **£690**. These negative figures are due to the loss of State revenue from tobacco duty, due to Jim quitting smoking. If one was to exclude the tobacco duty, cost savings arise in the range of **£518** to **£1,554**. These savings and costs reflect the value of the additional resources that are made available (or used) due to Jim's behaviour changes.

5.3 Community Connector: Break-even analysis

The Community Connector project is central to the Living Well model. It is a signposting service to help individuals to access services, facilities and activities. The Community Connector role
therefore supports co-ordination between different services and listens to residents so as to improve their access to health, care and social activities. As it works in alignment with the logic of the Living Well Theory of Change (Section 4.5) it has therefore been chosen as an example project to determine the likely efficiency of the programme's work.

5.3.1 Rationale for break-even analysis

This break-even analysis determines how quickly work delivered by the Community Connector will pay back to the public purse. Therefore the effects of different volumes of referrals on efficiency are also explored.

A break-even analysis can be used to determine the amount of outcome that is required to create the same amount of value (in this case value for the State) in monetary terms as is being invested in the project. If the value of the outcomes created is greater than the value of the inputs specified in the break-even analysis, then the project will make a surplus (i.e. the return is greater than the investment). If the amount of outcome created is less than that specified by the break-even analysis, then the project will make a loss (i.e. the return is less than the investment). The break-even point can therefore be used as a target to ensure that a project is worthwhile. A break-even analysis is useful in this context because, while the level of investment can be estimated, it is not possible to credibly estimate the amount of outcome that can be created.

This break-even analysis examines the value created by the Community Connector project, and only examines value created for the State. It does not take account of social value created for members of the community in Ilfracombe or for any other people or organisations. For example the potential economic benefits from participation in the workforce, or the wellbeing value from reduced social isolation, will not be valued in this analysis. Therefore the project could still be judged good Value for Money, if for example the amount of outcome relative to total social value inputs goes beyond that specified in the break-even model.

5.3.2 Research and calculations

5.3.2.1 Determining the distribution of outcomes

Throughout this chapter, the terminology 'outcome' and 'Completed Outcome' will be used. One 'Completed Outcome' refers to the successful resolution of an issue presented by an individual to One Ilfracombe. The types of issue (and therefore the types of Completed Outcome) are discussed further below. It is important to note that a Completed Outcome refers to the resolution of the issue presented, and not referral on to another agency. So for example, if an individual presents mental health issues, then a Completed Outcome only occurs if these mental health issues are addressed successfully. Referring to a mental health service does not in itself constitute a Completed Outcome.

The early pilot of the Community Connector sheds some light on the types of issue that will be presented. By mid May 2015 (after four months of operation), 40 people had accessed the services and presented issues such as Mental

Health issues, a need to access community events and take part in social activities, and inability to access government benefits that they were entitled to. This distribution of the issues identified is shown in Table 5.4.

This analysis does not attempt to estimate the number of Completed Outcomes that will be created in the future by One Ilfracombe over a given time period. Nonetheless, it is important to estimate the distribution of Completed Outcomes; this is because each different type of Completed Outcome leads to a different amount of value being created, and so in order to understand the amount of value that is likely to be created by (for example) 20 Completed Outcomes, it is necessary to estimate the likely frequency of different outcomes that will be included within these 20 Completed Outcomes.

One Ilfracombe is also planning to develop further referral routes in order to help more people. These were not in operation during the pilot. In particular, more referrals are expected for older people who may require extra support at home in order to avoid or delay moving into a care home. This analysis estimates that 35 per cent of referrals will come about through this new referral route, and hence 35 per cent of the Completed Outcomes will come about through this new referral route. The expected distribution of issues, once this new referral route is taken into account, is shown in Table 5.5.

Underpinning this is the assumption that the distribution of Completed Outcomes will be the same as the distribution of issues presented to One Ilfracombe. For example, if 20 per cent of the issues presented were substance misuse issues, then 20 per cent of the Completed Outcomes would be reductions in substance misuse (with the corresponding impact on government finances that comes about because of a reduction in substance misuse).

Not all of the outcomes shown in Table 5.4 were given monetary values; in some instances there were no likely monetary benefits to the Government, and in other instances the number of cases was so small that they were judged to be not material.

Table 5.4: Distribution of outcomes from One Ilfracombe pilot scheme

Access social groups or community courses	49%
Mental health services	31%
Health trainer to improve well-being	28%
Lose weight / getting active	23%
Gain Benefits or entitlements (PIP, Carer's Allowance etc)	15%
Avoid care home	8%
Reduced social isolation	8%
Adaptations / move to safer home / avoid falls	5%
Alcohol / drugs	5%
Anti-social behaviour	5%
Employability course - including English	5%
Green Deal	3%
Help with poor accommodation and related health issues (esp. from damp)	3%
Smoking	3%
Homeless / sofa surfing	3%
Others	10%

Table 5.5: Predicted distribution of outcomes, incorporating One Ilfracombe pilot scheme and new referral routes

Avoid care home	40%
Access social groups or community courses	32%
Mental health services	20%
Health trainer to improve well-being	18 %
Lose weight / getting active	15%
Gain Benefits (PIP, Carers Allowance, Blue Badge etc)	10%
Reduced social isolation	5%
Adaptations / move to safer home / avoid falls	3%
Alcohol / drugs	3%
Anti-social behaviour	3%
Employability course - including English	3%
Green Deal	2%
Help with poor accommodation and related health issues (esp. from damp)	2%
Smoking	2%
Homeless / sofa surfing	2%
Others	7%

5.3.2.2 Monetising outcomes and attributing value

For most of the outcomes outlined above, the negative and positive impacts (or costs and benefits) on public finances were considered. Positive impacts include a reduction in care home costs or mental health services. Negative impacts include an increase in community support costs (if an individual avoids having to move in to a care home) or a reduction in tax revenue from tobacco duty if an individual stops smoking. The unit costs are outlined in Appendix 8. For a number of outcomes there were no identified fiscal benefits or costs to the Government. These outcomes were:

- Access social groups or community courses
- Access to Green Deal
- Reduced social isolation

The valuations are taken from different sources that were not all published at the same time. Therefore the valuations have been adjusted to take account of inflation. These are also outlined in Appendix 7 below.

The outcomes were also assessed for the amount of attribution that could be apportioned to One Ilfracombe. Attribution is an assessment of how much credit an individual or organisation can claim for the total impact. This will vary according to the role played by an organisation; for example, an organisation that refers an individual to a service which provides intensive support will take less credit (or attribution) for the outcome than the service that provides the intensive support. This is a separate consideration from Deadweight (or what would have happened anyway), which is discussed below.

The outcomes and their related costs and benefits fall into two groups:

1. Outcomes where the costs of the service (that a person is referred to by One Ilfracombe) are more predictable, and the costs of this service can therefore be included in this analysis. Three outcomes fall in to this category: adaptations, avoidance of care home, and employment.

2. Outcomes where the costs of the service (that a person is referred to by One Ilfracombe) are less predictable, and the costs cannot therefore be included in this analysis. The remaining outcomes fall in to this category.

This has an implication on the attribution that can be claimed for the value created in this analysis.

- Where the costs of the service (that a person is referred to by One Ilfracombe) are not included, a smaller share of attribution can be claimed in this analysis. This attribution represents the credit given to One Ilfracombe for referring the individual to the service.
- Where the costs of the service (that a person is referred to by One Ilfracombe) are included, a larger share of attribution can be claimed in this analysis. This attribution represents the credit given to One Ilfracombe for referring the individual to the service and the credit given to the service provider themselves. The total will still be less than 100 per cent, as other factors will still contribute towards the outcome that are not included in this analysis (such as the input and support of other services, friends and family).

The ‘referral’ attribution, i.e. the amount of attribution given to One Ilfracombe for referring an individual to a service, is estimated as 15 per cent. The ‘service’ attribution, i.e. the amount of attribution given to the service provider for delivering the service in the first instance, is estimated as two-thirds. So when the cost of the service is included in the analysis, then the attribution is 82 per cent (15 per cent ‘referral’ attribution plus 67 per cent ‘service’ attribution), and when the cost of the service is not included in the analysis, then the attribution is 15 per cent (‘referral’ attribution only).

5.3.2.3 Deadweight, Benefit Period and Discount Rate

Three further considerations are included in the analysis, in order to keep the estimate of value creation as realistic as possible and to avoid over-claiming:

1. The first issue is ‘Deadweight’, or the proportion of change that is expected to happen anyway without the intervention. Deadweight is considered on an outcome-by-outcome basis, and the judgements about the amount of change that is likely to have happened anyway are outlined in Appendix 9.

2. The analysis also includes a ‘Benefit Period’, or the length of time for which outcomes are expected to last. Some outcomes are expected to increase over time, while others are expected to remain fairly consistent at first and then reduce in magnitude later. Outcomes have not been judged to last more than five years unless there is strong evidence that this is the case.

   When the Benefit Period ends and no more value is assumed to be created, this can be for one of two reasons. In some instances - such as in the avoidance of going into a care home - the outcome itself will have reduced over time; some of these individuals will still need to enter a care home eventually. In other instances - such as gaining employment - the attribution will reduce over time; after five years the amount of attribution that One Ilfracombe could claim for the employment status of an individual who has remained in employment will be negligible. The judgements around benefit period are outlined in Appendix 10.

3. A discount rate of 3.5 per cent is applied to outcomes, as recommended by the UK Government. This means that the amount of value accrued is reduced by 3.5 per cent for each year that passes between when the investment in the project takes place and when the value is actually accrued.

5.3.2.4 Inputs

The primary investment cost considered in this break-even analysis is the cost of a Community Connector. The analysis is based on one Community Connector; therefore the investment reflects the cost of one part-time Community Connector (£16,296, including overheads). The required number of Completed Outcomes specified by the analysis therefore indicates the number required to break even on this investment, in one Community Connector.

Some activities incur further costs to the State, for example the cost of installing an adaptation in an older person’s home. However these costs are considered as negative benefits rather than investments for the purpose of this analysis.

It may be that in the future One Ilfracombe can use volunteers to assist the Connectors and to increase the number of Completed Outcomes. This might increase the number of Completed Outcomes created per Community Connector, but it does not change the workings of this analysis.

5.3.3 Analysis

5.3.3.1 Break-even point

This analysis suggests that the break-even point is 30 Completed Outcomes per year. This means that in order for the intervention to break even, One Ilfracombe would need to create 30 Completed Outcomes per year for each Community Connector employed.

As outlined above, a Completed Outcome occurs when the issue presented is resolved, not when the individual is referred on to another agency. Because of this, if the progress towards the break-even point is to be tracked over time, One Ilfracombe would need to track whether or not clients' issues are successfully resolved after they have been referred on to other services.

The analysis suggests costs for each Completed Outcome (see Table 5.6).

Table 5.6: Suggested costs for each Completed Outcome

The total costs created for the Government	£12,061
The total fiscal benefits created for the Government	£15,672
The total fiscal return created for the Government	£ 3,611
The total attributable costs created for the Government	£11,655
The total attributable fiscal benefits created for the Government	£12,198
The total *attributable* return created for the Government	**£ 542**

Therefore the total number of Completed Outcomes required per year in order to break even on the investment of £16,296 per Community Connector is just over 30. (30 Completed Outcomes multiplied by £542 per Completed Outcome = £16,260).

Some of the costs created should be considered positive. For example, One Ilfracombe helps some people claim the benefits that they are entitled to, which is a positive thing for society. Nonetheless, they still have an impact on government finances, and are therefore included in this analysis.

Most of the value (87 per cent) is created through avoiding older people entering a care home. This is largely because of the assumption (outlined above) that 35 per cent of referrals will come through the new referral route and will only include people whose primary issue is avoiding a care home. If this new referral route was to be excluded from the analysis, then the largest contributor of value would be the avoidance of the need for mental health services.

It is possible that assumptions made in estimating the likely distribution of outcomes, or in the likely number of Completed Outcomes, are subject to optimism bias, where judgements tend to be overly positive. Guidance from New Economy Manchester recommends that outcomes be discounted by up to 40 per cent to take account of this. It might be wise, therefore, to assume a break-even point 40 per cent higher than that given by the analysis, i.e. 42 Completed Outcomes per Community Connector per year.

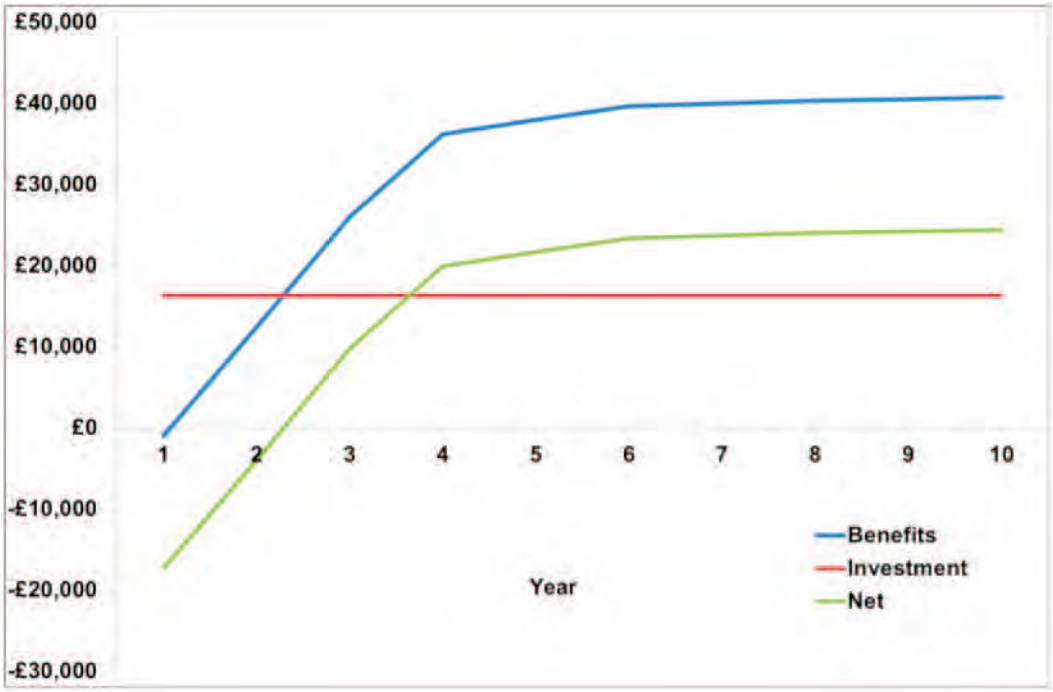
5.3.3.2 Scenario Testing

Two scenarios have also been explored, to show how the return might vary over time, depending on different variables. The scenarios show what might happen going forward given a certain set of assumptions. These are not predictions as to the actual amount of change but show potential future pathways. The first scenario assumes that:

- One Ilfracombe will achieve 75 Completed Outcomes per year per Community Connector;
- Only one year of investment is considered (one year of Community Connector delivery) but the long-term benefits are accounted for.

Figure 5.6 shows the cumulative investment, benefits, and net return over time. The cumulative investment is a flat line, as all of the investment is made in the first year. In this instance, a positive return is achieved by year 3, breaking even in just under 2.5 years.

Figure 5.6: Scenario 1



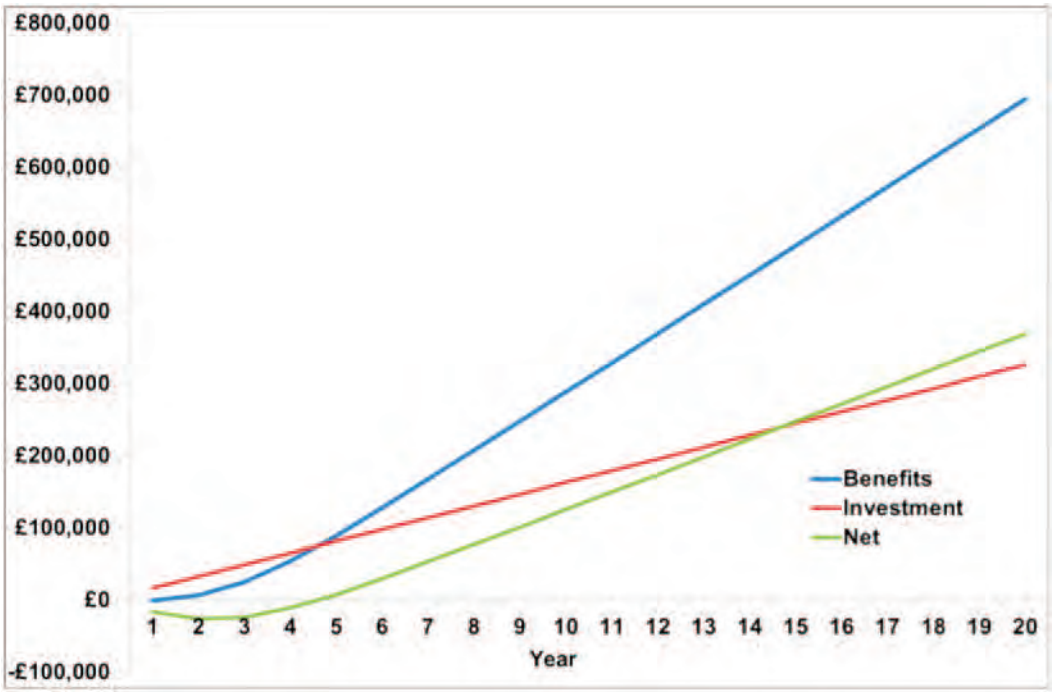
The second scenario assumes that:

- One Ilfracombe will eventually create 75 Outcomes Completes per year per Community Connector;
- The project is invested in for 20 years, and this investment is consistent for those 20 years. In other words a Community Connector is employed for 20 years.
- The efficiency of the project improves, reflecting the increase in the skill and experience of the Community Connectors:
  - In the first year the project is only 60 per cent efficient (i.e. 45 Completed Outcomes are created per year per Community Connector);

- In the second year the project is 80 per cent efficient (i.e. 60 Completed Outcomes are created per year per Community Connector);
- In year 3 onwards the project is 100 per cent efficient i.e. 75 Completed Outcomes are created per year per Community Connector).

Figure 5.7 shows the cumulative investment, benefits, and net return over time. The cumulative investment increases at a constant rate, as the investment is the same every year. The cumulative benefits start slowly but gradually increase more rapidly; this is because benefits (such as healthcare savings due to healthier eating or mental health support) take some time to accrue, and once the project is a few years old then benefits are being simultaneously accrued from several years' worth of investment. In this scenario, a positive return is reached by year 5.

Figure 5.7: Scenario 2



5.4 Value for Money implications

5.4.1 Comparative analysis of case study personas

The exact level of need in Ilfracombe for outcomes like those in Alice, Tony and Jim's case-studies is unknown, so the forecast estimates cannot be extrapolated to the wider Living Well programme. However Ilfracombe has a statistically higher number of older residents with over 8000 people aged 50 and over in 2014[28], suggesting the scale of these savings could be significant.

Table 5.7 shows the mid-level forecast savings for Alice, Tony and Jim.

Table 5.7 Summary of forecast cost savings by individual

Name	Cost saving
Alice	£ 21,140
Tony	£ 3,535
Jim (excluding lost tobacco duty)	£1,036
Jim (including lost tobacco duty)	- £692

Residents like Alice present the biggest opportunity for One Ilfracombe to make savings to the public purse. Unlike the others, she is on the cusp of entering a care home and Living Well projects are able to defer this outcome.

The largest source of cost savings for the State, demonstrated by our three case studies, is undoubtedly the increased number of years of independent living[29]. This potential saving outweighs all other cost savings in our case studies. Living Well has chosen to focus strategically on supporting independent living for older residents and this study illustrates why this is a smart decision for conserving public funds.

Tony's life time cost savings are just 17 per cent of Alice's. Prioritising resource for supporting individuals like Alice, by investing proportionately more of the total budget in such cases would maximise public cost savings; however this would compromise the health and well-being needs of other individuals in the town.

One Ilfracombe is right therefore to provide for wider but less cost-effective needs, firstly because decisions should not be made on partial analysis. Our focus on cost savings does not stretch to include Treasury's Green Book advice that the wider social and environmental value created by a project should be taken into account. Social valuation[30] of well-being benefits would potentially balance out the forecasts, particularly for Jim who is aged 65 and has more years of life than Alice who is aged 74 when she starts to engage with Living Well.

28 Public Health Devon (2013-14) Joint Strategic Needs Assessment Town Profile: Ilfracombe

29 See Appendix 7 for a summary of unit costs that we applied for our case study analysis.

30 Applying a monetary proxy to social outcomes such as improved mental well-being and personal income.

Secondly, there is no clear ethical principle that suggests individuals like Tony and Jim are less deserving of health and well-being services. The equity dimension of Value for Money also needs to be considered by One Ilfracombe when deciding if residents with certain medical profiles will be targeted or whether all will be catered for.

A further observation from the case study analysis, is that savings in Jim's case are highly sensitive to the inclusion of tobacco duty. The outcome is obviously a positive thing despite its net negative effect on the public purse. One Ilfracombe's work in reducing addiction is important from a public health perspective and the tobacco duty should be kept in perspective as a separate but important deterrent tool.

5.4.2 Key findings from Community Connector break-even model

To break even, One Ilfracombe's Community Connector project needs to create 30 Completed Outcomes per year (that is, to resolve 30 needs presented) for every Community Connector employed. An intervention that generates savings in excess of the financial input suggests it is worthwhile to pursue it as part of an approach of budget savings. The project should therefore use this as a baseline target.

The target might be increased by up to 40 per cent to take account of optimism bias. Since One Ilfracombe will be aiming to create a positive return (rather than to just break even), a higher target should be set; for example, if the project was to create 100 Completed Outcomes per year per Community Connector, then this would create a Return on Investment of between 1: 2.4 and 1:3.3, depending on the level of optimism bias considered. This would be a strong return.

These benefits will take several years to accrue, and this is accounted for in the use of a discount rate, to reduce the value of outcomes that are accrued in the future. Living Well is a preventive programme, so it is not surprising that it takes some time for the savings to build up.

As found through the case-studies personas, the biggest saving by far comes through the avoidance of the need for care homes. Falls prevention: referrals for adaptations to people's houses, also creates reasonable returns. Again, this chimes with One Ilfracombe's strategic focus on independent living and the particular needs of the older community in Ilfracombe.

Other key saving areas are (i) through improved access to psychological therapies (mental health needs provision) as this reduces the long-term demand on the healthcare system; and (ii) reduced healthcare costs through accessing help with alcohol and drug addiction. While it may be strategic for Living Well to focus on these areas and therefore achieve the biggest savings, serving other needs in the community such as housing and access to benefits is also a socially positive ambition.

5.4.3 Insights for Living Well overall

The Community Connector is a project that is already up and running, so it is indicative of the efficiency of other projects in the medium term co-ordination phase. The break-even model suggests that One Ilfracombe's approach towards joining up services and reducing duplication has a relatively quick payback period of 2.5 years if achieving 30 successful Completed Outcomes. Conducting

the two Value for Money analyses revealed three aspects of the Living Well model that enhance this efficiency and effectiveness.

Firstly, the case studies and the break-even model show that savings are maximised when there is early intervention to address public health issues. Without the Living Well programme, agencies would struggle to identify and address such needs, due to the prioritisation of budgets for acute services. Jim, for example, is able to overcome social isolation with help from a befriender and by engagement with the Living Well Hub, rather than going through a more expensive standard mental health pathway. Similarly Tony's wife is able to help Tony herself, before acute care is needed, through information she can access on the Virtual Hub. The break-even model also demonstrates how savings from early intervention (Community Connector work) accumulate slowly over many years.

Secondly, integrated models like One Ilfracombe, enable cost savings through the creation of connections between people (social capital) and services. The social capital-driven savings can be seen in the persona case studies. For example the importance of volunteers in the Neighbourhood Health Watch are evident as they assist people in situations similar to Alice's, where community volunteers help by flagging needs earlier than might be expected, and also by helping older people live more independently at home. This reduced dependence on the State is created when individuals feel more responsible and involved in their community and then become more involved in the delivery of services (bottom arrows on the Theory of Change (Figure 4.8).

It is anticipated that the Community Connector's ability to maximise successful Completed Outcomes will increase, through the support of volunteers. Volunteers generated through programmes such as the befriender and Neighbourhood Watch schemes are expected to increase the number of referrals. Ultimately volunteers will reduce some of the costs specified in the break-even model as they will reduce the need for state-funded community carers and specialist advisors.

Thirdly connections between services are likely to save money, by not duplicating visits: for example, Fire Officers may carry out health-related assessments whilst undertaking home safety visits on elderly people. On the other hand, the true cost of integrating services is uncertain as it may either save or incur costs to the State in the long-term, depending on how integration happens in practice.

Currently there are minimal additional public costs required for Living Well projects and programmatic outcomes to be realised. This is because most resources are being pooled amongst existing agencies. The reality is that service delivery integration and community decisions on services provision are likely to require additional State expenditure. For example, funding may be needed for staffing a physical hub and there may be costs associated with recruitment and staff retraining. These costs cannot currently be quantified.

Early intervention, maximising social capital, and streamlining services are features of the Living Well model that are likely to create significant efficiencies for the State in the coming years. On top of this, a strategic focus on supporting older people to live independently has been shown to be a key area of saving.

6. Conclusions and recommendations

6.1 Findings

This assessment of One Ilfracombe was undertaken to evaluate the effectiveness of its integrated partnership model in enhancing employment, the town environment and health outcomes for local residents. It also sought to explore whether the model could deliver long-term savings to the State. Key insights into these two areas of research are outlined below.

6.1.1 Coherence of the Theory of Change

Overall model

One Ilfracombe has presented an exciting and logical step-by-step model of how they will integrate services in a town. The Theory of Change is explained in the context of a town that has multiple agencies delivering overlapping services that can be confusing to users. The incremental steps of agencies coming together in new formations, and residents' gradually building engagement followed by co-responsibility, are the overarching assumptions. The logic and principles behind this model are sound and it has the potential to significantly improve residents' lives.

The model provides enough flexibility to accommodate the varying delivery experiences that the One Ilfracombe team have had to date. For example, the Town Team has managed to co-ordinate agencies relatively quickly, while Ilfracombe Works managed to establish a user perspective faster.

If other local areas are seeking to replicate One Ilfracombe's model, the short and medium-term overarching outcomes provide a coherent framework for measuring progress over time. This should therefore inform future monitoring and evaluation. The critical links between these steps and expected long-term socio-economic outcomes are presented in more detail in each thematic Theory of Change.

Resident outcome pathways

On the whole, pathways to socio-economic outcomes hold true at a high level. In some cases there appears not to be a clear logic chain between the intervention and some outcomes; for example, the expectation that increased access to health, care, and social activities will lead more people to choose healthier lifestyles and ultimately to an increase in life expectancy and quality of life in the town. The team may wish to do further precursory mapping of outcomes, and should be careful to make sure there are clear, evidenced-based activities of an appropriate scale to support such ambitions.

Integrated delivery pathways

One information gap in this model appears to be the causal link between integrated delivery structures and the realisation of resident outcomes. The central assumption for this link is that new service formations will be organised in a 'person-centric' way that reflects the needs and perspectives of users, as well as maximising preventative activities (for example, if someone explains that many of their illnesses are worsened by feeling chilly at home, money could

be spent on installing a new boiler, rather than on extra GP appointments).

One question needs to be answered in more depth: Why are person-centred approaches (and in the long-term co-production) best achieved by integrated structures? For example, as the Community Connector plays a critical role in listening to residents and directing them to the appropriate services, it is unclear why this couldn't shortcut the need for integrated health and social services, and save the State money. It would be useful to have further measurable evidence on the added-value of deeper service integration.

This leads onto another critical gap in the Theory of Change: One Ilfracombe is still at the 'Co-ordination' stage of the Theory of Change so has not yet agreed the legal, budgetary or physical expressions of the next stage of integration. There does not seem to be an agency perspective on the costs and benefits of pooling budgets or creating new governance systems. Consideration of what is being given up through divestment and decommissioning of existing services needs to be factored into the pathway. Previous government attempts at integration have been unsuccessful due to such implementation barriers[31]. Further research is needed into the causal pathway to integration and how barriers will be addressed.

Participation and reaching co-production

Key to realising a person-centric model of delivery is the deep engagement of residents. While there are multiple channels for collecting residents' views (for example through the People's Voice and Community Engagement Officers), at this point the central mechanism for how this creates a feedback loop between services and residents lacks clarity.

The Town Council is ultimately responsible for representing local people within One Ilfracombe and time is set aside in meetings for the People's Voice. This is an opportunity for residents to express concerns and interests in areas that are governed by One Ilfracombe. Increasing the visibility of this channel and what to expect from it, in terms of influencing the design of actual services, may widen participation.

At the moment One Ilfracombe appears to be moving towards a combination of co-design and co-delivery with residents (see Figure 4.1). To achieve full co-production, plans must be put in place to create a solid cyclic mechanism through which residents are involved in all stages of service development: from design, to planning, to delivery and finally evaluation. Some of this is already operationalised through project initiation requests but how this is linked to the People's Voice (via the Town Council) in an accountable, transparent system needs to be clearer.

6.1.2. Living Well project: Value for Money assessments

This study has found that for a group of projects in one thematic area focusing on older residents, One Ilfracombe's work has the potential to save the Government between £518[32] and £31,711 for each individual resident engaged[33]. There are approximately 4300[34] further over-65s who are likely to benefit in some way from the health outcomes that One Ilfracombe is looking to achieve.

31 National Audit Office (2013a), see page 6 points 4-6.

32 Excluding the loss to the State of tobacco duty.

33 The former figure excludes inevitable losses to the State as result of smokers no longer contributing tobacco tax. One Ilfracombe is also conducting separate Town Team activities to reduce illegal tobacco trade which will also bolster State tobacco duty income.

34 Public Health Devon (2013-14) *Joint Strategic Needs Assessment Town Profile: Ilfracombe.*

The Community Connector study found that the service needs to successfully help resolve 30 needs (Completed Outcomes) per year to pay back its investment. With tracking of clients through referral services and the support of volunteers this seems like a very reasonable target and One Ilfracombe should be able to create good returns to the State.

Areas where key savings are possible include: any early intervention, particularly with progressive diseases (such as dementia) and health (such as alcohol misuse); and in addressing public health issues that agencies would have struggled to address previously due to the prioritisation of budgets for acute services. This is particularly the case in issues such as lack of exercise in older people.

The analysis signals the potential savings that could be realised across One Ilfracombe, although research limitations prevent extrapolation. The analysis also highlights the importance of the wider social and environmental outcomes created by the programme, which a limited public perspective on public savings does not fully value.

A key issue that needs to be investigated is the relationship between new integrated models of delivery and enhanced outcomes. For example, reduction in A&E admissions through improved management of the symptoms of dementia may not be unique to integrated working; and Devon is introducing a fall-prevention strategy that is expected to see a significant decrease in the number of older people tripping. Similarly, community-based care for those with mental health issues is being practiced through the Improved Access to Psychological Therapies NHS programme, so the added benefit of One Ilfracombe as a facilitator must be made very clear. On the whole the benefit appears to be the ability to broker partnerships and streamline service experiences so that nobody falls through the net.

6.2 Recommendations

Develop detailed integration pathways

As noted in the methodology discussion (Chapter 3) the make or break of One Ilfracombe's success will be its ability to create an effective process for forming new partnerships. This includes the organisation's ability to create new joint strategies, share knowledge, find governance, and make budget arrangements that maximise outcomes and create a culture of participation across the town. The dividends of such collaborative working at this point may be unknown, as it is only by creating the right conditions for integration that the best formations for agency working may emerge. However, a model or integration pathway would be useful for the team to evaluate their own effectiveness. A process evaluation is therefore recommended, alongside measurement of socio-economic outcomes.

Keep the Theories of Change alive

The Theory of Change diagrams are living documents for One Ilfracombe. The programme teams have been equipped with the skills to update their Theories of Change. As the programmes and projects evolve, they should continue to update the outcomes and compile an evidence base to support assumptions underlying causal pathways.

Strengthen participation channels

Co-production is as much a journey as it is a destination. Joining the co-production practitioners' network[35] will enable One Ilfracombe to gain from the knowledge and experience of peers in applying co-production principles. This is particularly important for the creation of an accountable, consistent and transparent system for gathering residents' views on services. Tools such as NEF's co-production self-assessment audit framework[36] may help One Ilfracombe to review and strengthen existing systems.

Use Theory of Change as a design tool

Active listening to stakeholders to understand what factors hold them back from achieving short, medium and long-term change should be reflected in programme and/or project design. For example, if the absence of transport options is a key factor in the social isolation of older people, then this issue needs to be actively addressed. Similarly, if social media is the best way to connect with younger residents (i.e. as an enabling factor), then this should be built into programme and project design.

The choice of projects and activities to date for Ilfracombe Works and Living Well have mixed relevance to the outcomes presented in the Theories of Change. Some activities such as the Community Connector role clearly contribute to achieving better co-ordination between services and create significant and relevant change for residents if delivered at scale. However other activities such as the Connect Online project appear to have limited uptake by beneficiaries (the first iteration of this project had only three or four regular attendees) and it is questionable as to whether this contributes to the social capital within the town, or significantly supports older people in accessing services.

One Ilfracombe is at its best when it is facilitating connections and helping other projects to scale their work through collaboration. During project initiation screening, the team and the board should make sure that potential outcomes that could be realised, will map logically onto the Theories of Change presented here (or those updated by the team), and maximise One Ilfracombe's strength as a facilitator rather than a delivery body.

Maximise fiscal savings

As plans for integration become clearer One Ilfracombe should examine the total costs of divesting resources from existing services and the creation of new integrated structures alongside expected savings.

Fiscal savings can also be maximised by continuing to focus on older residents, and other areas of high need like mental health, as a strategic focus for prevention, cost savings to the public sector, and in particular, avoidance of care homes. A target of at least 30 successful needs addressed (Completed Outcomes) should be used as a benchmark for the fiscal break-even point for the Community Connector service.

35 See *Co-production practitioners network* at **http://coproductionnetwork.com/**

36 See *Co-production self-assessment framework* available at **http://www.cornwall.gov.uk/media/6979651/CoProduction-Self-Assessment-Framework-NEF-.pdf**

Explore holistic decision-making techniques

Our Value for Money analysis has shown the challenges of monetising economic outcomes as well as the existence of competing objectives and stakeholders. One Ilfracombe is at a stage where it needs to make decisions about where to allocate resources to improve the socio-economic outlook for the town. Rather than embarking upon a more holistic Value for Money study that monetises social and environmental impacts, the organisation could benefit from applying project appraisal techniques, for example multi-criteria analysis[37]. This technique explicitly acknowledges power dynamics and seeks to build consensus for designing and implementing sustainable interventions, over time.

6.3 Conclusion

One Ilfracombe provides an inspiring and participatory response to the financial constraints in public service delivery. It seeks to use the strengths of everyone working within the town to make positive impact go further.

Once the team has further developed its theory of how services will integrate practically within each of the thematic areas, and has established a clear, accountable channel for achieving co-production, it will have a high-level blueprint for enhancing residents' health, employment and the town environment.

The key to One Ilfracombe's success will be to maximise its unique role as a facilitator of these integrations, to spot opportunities for bringing services together (where outcomes can be maximised), and to weave in residents' and other groups' efforts. If One Ilfracombe is able to perform this role with focus (assuming no benefit is lost elsewhere in the system through localisation), it will certainly save public money by reducing demand on services and increasing the town's capacity to help itself.

37 http://www.neweconomics.org/page/-/publications/Economics_in_policymaking_Briefing_6.pdf

Appendices

Appendix 1: Summary of One Ilfracombe activities 2013 to summer 2015

Living Well Team

Consultation

- 100 people have been consulted on what would enable them to be more active. Feedback included better promotion of existing services and activities, accessibility, companions, and specific support for people living with dementia and their families.

Community Connector

- A Community Connector started work in February. She helps connect people with a variety of services and existing community activities including NHS health training, art groups, employability services and courses and support with accommodation. By mid-May 40 people had accessed the service.
- One Ilfracombe also linked the Community Connector to GP visitors through their social prescribing initiative. Since February GPs have been encouraged to refer patients onto the Connector for non-NHS solutions.

Connect Online

- Local Academy students have offered their time to help older residents build confidence in using the internet in the local library. The project was piloted in summer 2014 and since February seven 6th form volunteers have provided three weekly sessions for eight older learners.

Volunteering

- In January a Volunteer Coordinator was employed by Ilfracombe Town Council to support and connect volunteer groups so that older residents could find out about volunteering opportunities more easily. One of the new volunteer groups 'One Ilfracombe Old Gits Club' has installed four new benches around the town in response to feedback from older residents that they would benefit from more resting spots.
- One Ilfracombe has taken over the volunteer car scheme and has 20 volunteer drivers who help ferry people to hospital and other vital appointments.
- One Ilfracombe has initiated its own befriending scheme to help people find companions for activities and is signposting to the existing befriending scheme in the town.

Dementia-friendly Ilfracombe

One Ilfracombe is working towards making the town dementia-friendly. This includes:

Awareness

- Three volunteers have been trained as Dementia Awareness Trainers and they have delivered sessions to 186 people including 69 front line workers (police, fire, council hygiene operatives, GPs and Ilfracombe Centre staff). 26 private businesses have been trained and 92 residents.
- Information has been provided to 71 businesses in Ilfracombe on dementia, and mystery shoppers have been used to identify the most dementia-friendly shops in the town.
- Events were organised as part of National Dementia Week 18th-24th May including a film screening and a social event for 30 people affected by dementia.

Services

- Greater promotion has been made for existing services and referrals via the Community Connector.
    - For example the Fire Service has teamed up with the Community Engagement team to promote their free safety home checks.
- The Town Team have also completed Dementia Awareness training and have used this to improve identification and support for vulnerable individuals.

Diagnosis

- A referral map and strategy have been introduced to help vulnerable individuals, their friends and families signal to a GP if they think symptoms exist. Early diagnosis will make treatment much easier.

Good Neighbours

- In January One Ilfracombe launched their Good Neighbours scheme (Neighbourhood Health Watch model). A package of support was developed for neighbours in two villages, which focussed on: helping unwell neighbours, helping out during floods or other emergencies, and helping with local security issues.

Ilfracombe Works

Consultation

- Young people were initially asked what barriers they experience in finding employment; they discovered that the system felt complex and that they were often passed between ‘pillar and post’.

Pathways to work

Internships with the Town Team and the Community Engagment officer have been offered.

- A summer season transport project was created in 2014 carrying 163 people during its first summer in operation, to seasonable tourism jobs during unsociable hours, in the neighbouring town of Woolacombe.
- An Education to Work programme has been run at Ilfracombe Academy to improve young people’s ‘work-readiness’ by providing more opportunities for the students to interact with businesses.

- For example,18 local employers provided workshops for 180 year-10 students as part of the You're Hired event.

Out of the Blue

- A nine-week course for young cadets has been introduced through which young people increase their aspirations by training with the Fire Service, Police, RNLI and SWASFT.

Welcome Pack

- A brochure collating all the information a person moving to Ilfracombe could need has been produced for employers and estate agents wishing to attract people into the town.

Town Team

- The Town Team has bought 40 members of staff together from seven different agencies.
- Responsibilities have been shared where possible (in addition to core roles), so different agency staff can report on issues like littering and antisocial behaviour through a shared radio system.
- The road sweeper is now parked at the Fire Station, saving a significant amount of time and petrol money compared to when it was previously kept in Barnstaple.
- Response time for dealing with fly tipping has been reduced from around three days, to under an hour, and the streets are visibly cleaner.
- Increased awareness of illegal tobacco trading which led in turn to increased intelligence gathered for Trading Standards, and a successful prosecution.
- Better co-ordination between services:
  - For example between parking enforcement, Devon County Council and the Fire Service on issues to do with railings.
  - Hygiene operatives were able to apprehend a shoplifter until police arrived, who were alerted by radio.
- More waste and dog waste bins have been installed.

Young Ilfracombe

- Feedback on what could be better about Ilfracombe for young people was gathered from one thousand 6-24 year olds. A network has been set up to support a new youth strategy that young people will advise on.

Virtual Bank

- An online listing of unit costs spent per person on public services in Ilfracombe is due to be released in 2016.

Appendix 2: One Ilfracombe literature reviewed

One Ilfracombe operating plan

One Ilfracombe website

One Ilfracombe Evaluation Plan 2013/14

Ageing Well and Happiness Survey Report

Priority flow diagrams for thematic areas (Oct/Nov 2014)

Responding to community priorities – the One Ilfracombe Way

Transcripts and recordings from community engagements conducted by One Ilfracombe team members

Ilfracombe Town Team 3 Month Review - Report

Transform 4 Work flyer

What is Neighbourhood Watch? Start-up Pack

Appendix 3: List of agencies

Town Council

Devon County Council

North Devon Council

Devon and Cornwall Police

Devon and Somerset Fire & Rescue Service

Job Centre Plus

Careers South West

COMBEBusiness

Petroc

Northern, Eastern and Western Devon Clinical Commissioning Group (NHS)

NHS Trust

North Devon Healthcare Trust

North Devon Homes

Devon and Cornwall Constabulary

Ilfracombe Academy

Ilfracombe Infants and Nursery

North Devon Voluntary Service

Westward Pathfinder

Ilfracombe Harbour Board

Citizens Advice Bureau

North Devon Hospice

North Devon Coast AONB

NHS Devon Warwick and Waterside GP practice

Appendix 4: Limitations to our research

Below we outline the limitations affecting different areas of research on this project. Some apply exclusively to the Theory of Change evaluation and others the prospective Value for Money assessments. Some others apply to both.

4.1. Cross-cutting issues

I. Intrinsic challenges of prospective assessments

Prospective evaluations are inherently challenging as the exact nature of future interventions and the social trends affecting their outcomes are unknown. One primary limitation to conducting a comprehensive Theory of Change evaluation and Value for Money assessment, has been the uncertainty beyond the next couple of years, as to the types of projects that will be delivered: at what scale, for which specific beneficaries, and in what kind of agency structure.

Even with perfect knowledge of the form of intervention, the effects are likely to be diverse, and dependent on the individual background of each beneficary. For example, one individual may respond well to healthy eating advice while another may find it hard to break old habits. This means that the accuracy of local data is important in order to draw strong conclusions. It was for these reasons that lower and upper values were used for our case studies, to try to mitigate such uncertainties.

II. Attribution

The scope and nature of One Ilfracombe's work is extensive, involving many actors and pathways. The achievement of outcomes will be inherently dependent upon a broad range of factors, such as national agency budgets, competencies of partners and the decisons of businesses and voluntary groups. As One Ilfracombe considers all partner agencies (i.e. private, public and third sector) and residents who fall within their scope, the concept of attribution is not considered for the Theory of Change or personal case-studies (bar the role of families and friends). Attribution has been considered for the Community Connector study which has a narrower project remit and this has been accounted for on an outcome by outcome basis.

III. Optimism bias in stakeholder engagement

Convenience sampling was used as the basis of stakeholder engagement conducted. This means that the views of the professionals and One Ilfracombe partners who had more favourable experiences are likely to dominate. Consequently, negative outcomes have not been fully considered for the Theory of Change evaluation. The Value for Money estimations have accounted for this optimism bias by providing upper and lower bounds or by suggesting that a further 40 per cent should be added to target Completed Outcomes.

4.2. Theory of Change evaluation

There are two issues which impacted exclusively on our Theory of Change evaluation.

I. Network dynamics

As One Ilfracombe is a multi-stakeholder network, its success in achieving desired outcomes will be largely dependent upon the effectiveness of its process, or the way in which the process is delivered. Features such as: articulating a joint strategy; designing effective projects; appropriate

management; co-ordinating resources; knowledge sharing and developing rules; norms and standards; will determine the success or failure of this initiative.

Outcomes from networks like this one may have time-lags or take on unexpected forms. Literature suggests that a process evaluation that looks at the ability of the collaborative network itself to change systems should be considered as closely as the outcomes[38]. One Ilfracombe's convening skills appear to be a great strength and all the partners we met were very happy with their partnerships. Further assessment may be desirable to judge their likely performance in achieving the specifiied longer-term outcomes.

4.3. Prospective Value for Money assessments

I. Extrapolating cost-savings from case studies

To provide an aggregate Value for Money assessment for older people benefiting from the Living Well Programme, we would have needed to estimate the number of older residents affected and have knowledge of their medical history. As the programme is still emerging, we cannot make these estimations confidently; nor did we have access to the requisite medical history. Consequently, we have opted for a case-study approach to show the cost savings for three hypothetical individuals. It is not plausible to extrapolate the estimations to other older residents and/or infer that similar savings would apply to the other programmes i.e. Ilfracombe Works and the Town Team.

Limited resources also meant that the full value of the intervention i.e. placing a value on all outcomes (for individuals and communities, not just those for the State)[39] could not be undertaken.

II. Availability and quality of local data

Neither extensive quantitative data collection nor analysis of secondary data sources were possible within the scope and timings of the evaluation. It was therefore not possible to provide a robust counterfactual scenario to understand the longer term impact of the programme.

The national average has been used as the counterfactual for Value for Money calculations, apart from in a few instances where Devon statistics were available. We also found there was a paucity of public data on Ilfracombe health and well-being, meaning a number of conservative estimates have been made in the calculations.

III. Substitution

If Living Well is funded by redirecting regional or national budgets then there will be a reduction in services through those regional and national programmes. This imposes another limitation on the study's ability to assess the total cost-benefit to the State. Localisation of services will inevitably involve some separation of existing services and operations. A reasonable concern expressed in literature[40] and by stakeholders is that this will cause a loss in outcomes or efficiency (assumed from the delivery of services at scale). This is known as substitution and is very difficult to fully model.

38 Mandel and Keast (2007) *Evaluating Network Arrangements: Toward revised performance measures, public performance and management review*

39 As noted above this is advised in HM Treasury 2003 (with 2011 amends), p.19

40 National Audit Office (2013b) *Case study on integration: Measuring the costs and benefits of Whole-Place Community Budget:* p.14

The benefits generated in Ilfracombe in this case may be a substitution for benefits (outcomes or efficiency) that could have been realised in a different configuration. For example, by localising social care budgets within the town to reduce social isolation, there could be less overall resource available for training county-wide social workers in non-specific professional development skills; thus leading to a loss of benefit elsewhere in the system. More social isolation may be experienced elsewhere. For the Value for Money assessment this means that we are not examining the total net effect of the changes. To do this we would have to construct a counterfactual calculation of outcomes that would have been achieved without One Ilfracombe, for example by a Devon-wide community-based care strategy that had invested Living Well funds more broadly.

Appendix 5: Methodological considerations in selecting case-studies

5.1 Selecting outcomes

It should be noted that none of the individuals in our case studies are described as being in receipt of benefit entitlements. This is consistent with the current demographic profiling of Living Well projects. For example, current projects are not designed to meet the needs of elderly residents in receipt of severe disablement allowance. Similarly, existing initiatives do not target individuals below the retirement age who are entitled to incapacity benefits.

We also considered whether it would be relevant to feature in the case studies any of the benefits available to people over the state retirement age. For example, state retirement pension, pension credit, attendance allowance and help with travel costs. We concluded that eligibility for these benefits was unlikely to be affected by the Living Well programme and therefore excluded it from the narrative case studies and consequently calculations

The eligibility for these benefits (such as the ‘attendance allowance’) is age-related, means-tested or needs related. If the needs of an older person qualify him or her for the Living Well programme it is assumed that the outcomes are likely to improve quality of life only, and not change a person’s physical needs; therefore eligibility for a benefit claim is unaffected.

5.2 Calculation ranges

The calculations would have benefitted from further availability of public health data on outcome incidence, benefit periods and trends. A number of conservative estimates for outcome incidence and the benefit period have been made. All data sources, including where we have applied our judgement in the absence of secondary literature, are noted in Appendix 6. As discussed above, attribution is considered only with respect to families and friends.

For each individual, we provide three projections for cost savings. The medium value is a calculation based on national and local data, subject to the caveats noted in Appendix 4. The low value equates to the medium value, adjusted down by a factor of 50 per cent, and the high value is 150 per cent of the medium value. This high-level sensitivity analysis provides an indication of pessimistic and optimistic scenarios.

Appendix 6: Detailed calculations for case study cost-savings

Case Study 1: Alice

Table A6.1: Valuation of Alice's State outcomes

Outcomes for the State	Unit cost (£)	Unit Cost Rationale	Assumption	Lower value [41]	Medium Value	Upper value[42]
Reduced number of ambulance call outs associated with unmanaged dementia and social isolation	£155 per call on average	£239 is the average cost of call out for Ambulance services per incident. *Reference: National Schedule of Reference Costs (2011-12)* £70 is the cost of emergency nurse advisor (ENA) provision (completed call). *Reference: Personal Social Services Expenditure and Unit Costs (2012-13)* Therefore, assuming that 50% of Alice's ambulance calls require (or are assessed as requiring) an Ambulance, and the remaining 50% require advice only on the telephone; the unit cost is £155 per call on average.	In the absence of the Living Well project, Alice would have called for an ambulance 3 times a year (twice for medical assistance from tripping and falling[43] and once because she was worried or confused). Now, Alice only calls 999 for medical emergencies (which have reduced, due the reduction in the number of hazards in her home), and she first calls a NHW member or a befriender for any non-medical reasons. Therefore, she needs an ambulance only 1.5 times a year[44] , or 3 times every 2 years. Alice will live a further 6 years[45] and the benefit continues until her death as the NHW members, and befriender, continue to be key in assisting her, instead of medical professionals. *Assumption Strength: Poor [46]*	£698	£1,395	£2,093

41 The lower values are 50% of the medium and represent a pessimistic forecast (this is the same for all case studies).

42 The higher values are 150% of the medium and represent an optimistic forecast (this is the same for all case studies).

43 Masud and Morris (2001) show that about one-third of all people aged over 65 fall each year. As Alice has dementia and as she may require an ambulance for medical reasons other than for a fall, this figure has been doubled to twice a year.

44 Falls prevention strategy could reduce the number of falls by 15-30% (23% on average): NHS Confederation (2012).

45 79.5 is the Ilfracombe life expectancy for women (Ilfracombe Town Study, 2011).

Avoided admissions to A&E and subsequent treatment associated with unmanaged dementia Reduced incidents of hospital stays associated with unmanaged dementia	£140 per incident	£140 is the cost of A&E attendance (investigation with subsequent treatment) per incident. Reference: National Schedule of Reference Costs (2011-12)	Alice would have attended an A&E every time an ambulance was called due to requiring medical assistance (such as for a fall). Therefore (as above), Alice would have attended A&E twice a year prior to the Living Well project, and now attends 1.5 times a year, or 3 times every 2 years. Similarly to above, Alice will live a further 6 years and the benefits continue until her death. *Assumption Strength: Moderate* [47]	£210	£420	£630
Reduced incidents of hospital stays associated with unmanaged dementia	£1,916 per episode	£1,916 is the average cost of hospital inpatients per episode (elective and non-elective admissions). *Reference: National Schedule of Reference Costs (2011-12)*	Similarly to above, before the Living Well programme, Alice would have attended A&E twice a year, and now attends 1.5 times a year, or 3 times every 2 years. Of those A&E attendances, it is assumed that 25% lead to a hospital stay. Therefore, Alice would have required a hospital stay 0.5 times a year, and now requires a hospital stay 0.375 times a year, saving 0.125 stays in the hospital per year. Similarly to above, Alice lives a further 6 years and the benefits continue until her death. *Assumption Strength: Poor* [48]	£719	£1,437	£2,156

47 The NHS Confederation (2012) study suggests that a falls prevention strategy could reduce the number of falls by 15-30% (23% on average). Therefore, this estimate is more reliable and does not require speculative estimates about calling 999 for other reasons.

48 Informed estimate of 25%.

Reduced care-costs associated with living more independently	£172 per person per week	561 is the average gross weekly expenditure for residential care for older people in England per person. *Reference: Personal Social Services Expenditure and Unit Costs (2012-13)* £389 is the median total weekly cost of a community care package for an older person (excludes accommodation and living expenses). *Reference: PSSRU (2011)* Therefore, the difference in cost of community care compared to residential care is £172 per person per week.	It is assumed that without the Living Well programme, Alice would have gone immediately into residential care, until her death, as there would not have been the community care alternative in Ilfracombe. Instead, Alice was able to live at home, with the assistance of a community care package, delaying the need for her to enter a residential home by 2 years. The full benefit is attributed to One Ilfracombe, as without community provision this could not have happened. *Assumption Strength: Poor* [49]	£8,944	£17,888	£26,832
TOTAL				**£10,571**	**£21,140**	**£31,711**

49 The relationship between delayed entry into a residential home and social prescribing/the Living Well Hub approach is not established.

Case Study 2: Tony

Table A6.2: Valuation of Tony's State outcomes

Outcomes for the State	Unit cost (£)	Unit Cost Rationale	Assumption	Lower value	Medium Value	Upper value
Reduced ambulance call outs associated with a reduction in alcohol consumption	£239 per incident	£239 is the average cost of call out for ambulance services per incident. *Reference: National Schedule of Reference Costs (2011-12)*	Before the Living Well project, Tony was frequently (fortnightly) engaged in drunken incidents, which often (50% of the time) resulted in a need for an ambulance to be called. Since the project, and the assistance from alcohol programmes he met through the Hub, this has reduced to once a month. The drop-off of this benefit will be for 1.5 years, as after that it will require long-term behaviour change and other factors will have greater influence (such as family and friends). *Assumption Strength: Poor* [50]	£1,076	£2,151	£3,227
Reduced admissions to A&E and subsequent treatment associated with a reduction in alcohol consumption	£140 per incident.	£140 is the cost of A&E attendance (investigation with subsequent treatment) per incident. Reference: National Schedule of Reference Costs (2011-12)	As above. Therefore, the reduction in ambulance call outs is the same as the reduction in A&E attendance, as it is likely that he will need investigation with subsequent treatment once he arrives at A&E. Assumption Strength: Poor [51]	£630	£1,260	£1,890

50 There is no reliable data on this, therefore the numbers are estimates based on our own judgement.

51 As above.

Avoided medical costs of GP visits associated with better healthy eating and better physical health	£130 per hour	£129.69 is the GP cost per hour *Reference: Personal Social Services Expenditure and Unit Costs (2012-13)*	Tony would have required a 30-minute visit to the GP about once every 3 months due to ill-health related to his unhealthy lifestyle and heavy drinking. The proportion of disease incidence avoided on average[52] was 0.302 by providing twice-weekly exercise classes. *Reference: Munro et al. (1997)* Therefore, as a result of taking mild exercise regularly, eating more healthily, and reducing he alcohol intake, instead of visiting the GP for 2 hours over a year, Tony is expected to only visit the GP for (approximately) 84 minutes a year, a reduction in 36 minutes a year. The drop-off of this benefit will be for 1.5 years, as after that it will require long-term behaviour change and other factors will have greater influence (such as family and friends). *Assumption Strength: Poor* [53]	£39	£78	£117

52 Based on coronary heart disease and hypertension, cerebrovascular disease, diabetes, fractured neck or femur and mental disorders.

53 As there is no reliable data identified on how often a person with ill-health due to an unhealthy lifestyle will visit their GP for that exact reason, this is expert judgement. Furthermore, the Journal of Public Health (1997) study on how exercise relates to avoided disease is dated, so is less relevant, and does not take into account other healthier lifestyle choices (such as healthier eating and drinking less alcohol). Additionally, it is assumed that disease incidence avoided is equivalent to a person's desire to visit the GP which is a weak assumption (e.g. he may continue to visit out of habit).

Avoided criminal justice costs associated with alcohol misuse	£51 per incident	£51 is the cost of anti-social behaviour with no further action taken (simple police reporting) per incident. *Reference: Whitehead et al. (2003)*	As above, before, Tony was engaged in drunken incidents on about a fortnightly basis. Since the programme, this has reduced to once a month. Furthermore, since Tony's behavioural has changed as a result of the Living Well project, instead of 1 in 10 (10%) of his drunken incidents requiring police involvement, it is now 1 in 20 (5%). Therefore, previously there would have been police involvement 0.2 times a month, now, there is police involvement 0.05 times a month. The drop-off of this benefit will be for 1.5 years, as after that it will require long-term behaviour change and other factors will have greater influence (such as family and friends). *Assumption Strength: Poor*[54]	£23	£46	£69
TOTAL				**£1,768**	**£3,535**	**£5,303**

54 Expert judgement.

Case Study 3: Jim

Table A6.3: Valuation of Jim's State outcomes

Outcomes for the State	Unit cost (£)[55]	Unit Cost Rationale	Assumption	Lower value	Medium Value	Upper value
Reduced demand on mental health services	£443 per recovered patient	£1,166.39 is the average cost per recovered patient with low intensity treatment for mental health issues under the Improving Access to Psychological Therapies (IAPT) programme *Reference: Radhakrishnan et al. (2012)* 38% is the cost difference of community provision for mild mental health issues compared to IAPT *Reference: Pitkala et al. (2009)* Therefore, £1,166.39 * 0.38 = £443.23	In the absence of the Living Well project, Jim would have been referred to the IAPT programme, rather than being put in touch with the Community Connecter and, in turn, the Living Well Hub, where he was able to make friends and recover from social isolation through a social prescribing approach. As a result of the programme Jim now no longer goes to see his GP for reasons associated with loneliness. *Assumption Strength: Weak* [56]	£222	£443	£665
Avoided medical costs associated with smoking-related ill-health	£325 per person per year	£548,100 is the total annual cost to NHS trusts as a direct result of smoking-related ill-health in Ilfracombe and there are 1689 people that smoke in Ilfracombe. *Reference: ASH (2014) Ready Reckoner Update* Therefore, £548,100 / 1689 = £324.51 is the unit cost per person	Jim would have continued to smoke without the support from organisations he met at the local Hub. However, the reasonable benefit drop-off of Jim quitting is 1.5 years, as after that it will require long-term behaviour change and other factors will have greater influence (such as family and friends). *Assumption Strength: Moderate*[57]	£243	£487	£730

55 All values calculated to be equivalent to 2014 prices using a GDP deflator and rounded to the nearest £1 (this is the same for all case studies and all prices).

56 The assumption is weak as it is based on an international study, so less relevant to Ilfracombe specifically, and as the Living Well programme is yet to materialise it is difficult to know how similar the community provision in the study and the community provision of One Ilfracombe will be.

57 As the unit cost is based on studies of Ilfracombe, it is a robust assumption; the uncertainty lies with the likelihood of the Living Well Hub assisting Jim to stop smoking completely

Avoided medical costs associated with passive smoking impacts on the health of non-smokers	£32 per person per year	£53,400 is the total cost of passive smoking impacts on the health of non-smokers to the local healthcare system annually in Ilfracombe and there are 1689 people that smoke in Ilfracombe *Reference: ASH (2014) Ready Reckoner Update* Therefore, £53,400 / 1689 = £31.62 is the unit cost per person	As above. *Assumption Strength: Moderate*	£24	£47	£71
Incurred cost of reduced contribution of tobacco duty	-£1,152 per person per year	£1,945,400 is the total contribution in tobacco duty for Ilfracombe annually and there are 1689 people that smoke in Ilfracombe *Reference: ASH (2014) Ready Reckoner Update Therefore, £1,945,400 / 1689 = £1,151.81 is the unit*	As above. *Assumption Strength: Moderate*	-£2,592	-£1,728	-£864

Avoided medical costs of GP visits associated with better healthy eating and better physical health	£130 per hour	£129.69 is the GP cost per hour *Reference: Personal Social Services Expenditure and Unit Costs (2012-13)*	Jim would have required a 15-minute visit to the GP about once every 3 months due to ill-health related to his unhealthy lifestyle. The proportion of disease incidence[58] avoided on average was 0.302 by providing twice-weekly exercise classes. *Reference: Munro et al. (1997)* Therefore, as a result of taking mild exercise regularly and eating more healthily, instead of visiting the GP for 1 hour over a year, Jim is expected to only visit the GP for (approximately) 42 minutes a year. The drop-off of this benefit will be for 1.5 years, as after that it will require long-term behaviour change and other factors will have greater influence (such as family and friends). *Assumption Strength: Poor* [59]	£29	£29	£88
TOTAL				**-£2,074**	**-£692**	**£690**

58 Based on coronary heart disease and hypertension, cerebrovascular disease, diabetes, fractured neck or femur and mental disorders.

59 As there is no reliable data identified on how often a person with ill-health due to an unhealthy lifestyle will visit their GP for that reason, this is a very speculative estimate. Furthermore, the Munro et al. (1997) study on how exercise relates to avoided disease is dated, so less relevant, and does not take into account other healthier lifestyle choices (such as healthier eating). Additionally, it is assumed that disease incidence avoided is equivalent to a person's desire to visit the GP which is a weak assumption (e.g. he may continue to visit out of habit).

Appendix 7: Unit costs for case studies

Table A7.1: Description and sources of unit costs used for case studies

Unit Cost (2014 prices)	Description	Source
£239 per call	The average cost of call out for Ambulance services per incident.	National Schedule of Reference Costs (2011-12)
£70 per call	The cost of emergency nurse advisor (ENA) provision (completed call).	Personal Social Services Expenditure and Unit Costs (2012-13)
£140 per incident	The cost of A&E attendance (investigation with subsequent treatment) per incident.	National Schedule of Reference Costs (2011-12)
£1,916 per episode	The average cost of hospital inpatients per episode (elective and non-elective admissions).	National Schedule of Reference Costs (2011-12)
£561 per person per week	The average gross weekly expenditure for residential care for older people in England per person.	Personal Social Services Expenditure and Unit Costs (2012-13)
£389 per person per week	The median total weekly cost of a community care package for older people (excludes accommodation and living expenses).	PSSRU (2011)
£130 per hour	The GP cost per hour.	Personal Social Services Expenditure and Unit Costs (2012-13)
£51 per incident	The cost of anti-social behaviour with no further action taken (simple police reporting of incident) per incident.	Whitehead et al. (2003)
£1,166.39 per recovered patient	The average cost per recovered patient with low intensity treatment for mental health issues under the Improving Access to Psychological Therapies (IAPT) programme.	Radhakrishnan et al. (2012)
£548,100 total annual cost	The total annual cost to NHS trusts as a direct result of smoking-related ill-health in Ilfracombe.	ASH (2014) Ready Reckoner Update
£53,400 total annual cost	The total cost of passive smoking impacts on the health of non-smokers to the local healthcare system annually in Ilfracombe.	ASH (2014) Ready Reckoner Update
£1,945,400 total annual contribution	The total contribution in tobacco duty for Ilfracombe annually	ASH (2014) Ready Reckoner Update

Appendix 8: Unit costs for break-even model

Table A8.1: Description and sources of unit costs used for case studies

Outcomes	Costs / Benefits to the State	Unit cost (£) -ve = Cost to State +ve = Benefit to State	Source/ Rationale
Gain Benefits (e.g. Career's allowance)	Cost of benefits provided	-£3,435	Carers allowance per week: £62.10, PIP midpoint per week, £80.78. Annualised weighted average taken (assuming 80% carers allowance, 20% PIP, as seen in case studies). From: GOV.UK (2014)
Adaptations / move to safer home / avoid falls	Average resource saving to NHS & Social Care created by adaptation	£10,333	Cost saving to government through adaptations (present value over 10 years), From: Envoy Partnership (2011).
	Cost of adaptation	-£2,800	Average cost of adaptations, From: Envoy Partnership (2011).
Lose weight / getting active / healthy eating	Reduced demand on health and social care services	£60.10	Assuming 80% of over-65s do not currently exercise to recommended levels, the proportion of disease incidence avoided on average (based on coronary heart disease and hypertension, cerebrovascular disease, diabetes, fractured neck or femur and mental disorders) was 0.302. Providing twice-weekly exercise classes for 10 000 participants will avoid annual health care costs of approximately £601 000. Source: Munro et al. (1997) Therefore, using the benefit of exercise classed as a proxy measure and indicator for the benefit of general improved health from community based groups/classes/education the State saves £601,000 / 10 000 = £60.10 pp/per annum To equate to the whole population of Ilfracombe 65+ this is multiplied by the total no. of 65+ that do not meet the minimum levels of physical activity necessary to achieve health benefits (3513) as the measure already takes into account the (approx.) 80% that do not exercise to recommended levels (which is in agreement with other research i.e. Health Survey for England-2012 Adult Trend Tables) but by only multiplying it to the low number means it is less likely to be overestimating the benefit in Ilfracombe
Avoid care home	Cost of residential care for older people	£27,550	Residential care for older people - average gross weekly expenditure per person, England (SS70) – converted into annual figure. From Personal Social Services Expenditure and Unit Costs (2012-13) - England, Final Release: CASSR level unit costs.

Outcomes	Costs / Benefits to the State	Unit cost (£) -ve = Cost to State +ve = Benefit to State	Source/ Rationale
	Cost of Community Care Package for older people	-£19,081	If person does not need to move in to a care home, they will still require some support at home. This is represented here by the average cost of a Community Care Package. Community care package for older people: median cost Total weekly cost of health and social care package (excludes accommodation and living expenses) – converted into annual figure. From PSSRU (2011) *Unit Costs of Health and Social Care*
Help with poor accommodation & related health issues (esp. from damp)	Costs to NHS of poor housing	£125	Davidson et al. (2010) study The Real Cost of Poor Housing found that 4.8 million homes in England (22%) have what are called category 1 hazards arising from defects as assessed using the Housing Health and Safety Rating System. The cost of these housing hazards was £1.5bn per year, including costs to the NHS (£600m) and to the individual and to society through loss of earnings associated with the health impacts of these hazards. Based on these numbers, £600m/4.8m = £125
	Cost of advice	-£50	Citizens Advice Bureau (2014): "For this paper, we have applied an average value of advice of £50 per client per year."
Mental health services	Reduced demand on mental health services	£1,043	The cost per recovered patient with low intensity treatment for mental health issues under the Improving Access to Psychological Therapies (IAPT) programme, from Radhakrishnan, et al. (2012).
Avoidance of alcohol / drugs problems	Avoided NHS costs associated with alcohol misuse	£1,800	Alcohol misuse - estimated annual cost to the NHS of alcohol dependency, per year per dependent drinker, NICE (2011).
	Avoided criminal justice costs associated with alcohol misuse	£3,419	Drugs misuse - average annual fiscal savings resulting from reductions in drug-related offending and health and social care costs as a result of delivery of a structured, effective treatment programme, From: National Treatment Agency for Substance Misuse (2012)
	Cost of advice	-£50	Citizens Advice Bureau (2014): "For this paper, we have applied an average value of advice of £50 per client per year."

Outcomes	Costs / Benefits to the State	Unit cost (£) -ve = Cost to State +ve = Benefit to State	Source/ Rationale
Smoking cessation	Reduced contribution of tobacco duty	-£1,152	Total contribution in tobacco duty for Ilfracombe annually (2014), from ASH Ready Reckoner (2014). Divided by number of people that smoke in Ilfracombe (also from ASH Ready Reckoner).
	Reduced cost to healthcare system due to smoking-related ill-health AND Reduced cost to healthcare system due to passive smoking impacts on the health of non-smokers	£356	Total annual cost to NHS trusts as a direct result of smoking-related ill health (£584,100) + Total cost of passive smoking impacts on the health of non-smokers to the local healthcare system (£53,400), both from ASH Ready Reckoner (2014). Divided by number of people that smoke in Ilfracombe (Also from Ash Ready Reckoner)
Avoidance of homeless / sofa surfing	Homelessness advice and support	£642	This outcome doesn't represent the hardest-to-reach victims of homelessness. Therefore the most appropriate proxy is the cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness. Homelessness advice and support - cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness, from Shelter (2012).
Avoidance of anti-social behaviour	Reduced cost of one ASB incident per year	£35	Anti-social behaviour - no further action taken (simple police reporting of incident) per incident, from Whitehead et al. (2003).
Access to employability course - including English	Value of NVQ Level 2	£83	NVQ Level 2 Qualification annual benefits the exchequer, Department for Business Innovation and Skills (2011)
	Cost of English language course	-£280	Online IGCSE English Language course cost accessed June 2015: http://www.reed.co.uk/courses/igcse-english-language/57642#/courses/english

Table A8.2: Community Connector break-even: unit costs adjusted for inflation.

Source	Original value	Year of valuation	New valuation
Benefit levels	£3,435	2015	£3,435
Average cost of adaptation	£2,800	2011	£3,206
Community care package for older people: median cost. Total weekly cost of health and social care package (Excludes accommodation and living expenses)	£19,081	2010	£22,853
Cost of advice per client	£50	2014	£51
Reduced contribution of tobacco duty	£1,152	2014	£1,179
Cost of English language course	£280	2015	£280
Average value of adaptation to NHS & Social Care	£10,333	2012	£11,248
Reduced demand on health and social care services including: primary care, community health services, out-patient visits, in-patient stays, home care, residential and nursing home care	£60.10	1997	£101
Residential care for older people - average gross weekly expenditure per person, England (SS7)	£27,550	2013	£29,057
NHS Costs of poor housing	£125	2010	£150
Reduced demand on mental health services (i.e. the Improving Access to Psychological Therapies scheme) - including sessions, treatment and consultation until recovery (on the other hand, greater numbers of older people with dementia will be diagnosed and helped by the NHS, therefore costs may increase).	£1,043	2011	£1,194
Reduced healthcare costs	£1,800	2010	£2,156
Avoided criminal justice costs associated with alcohol misuse	£3,419	2003	£4,970
Reduced cost to healthcare system due to smoking-related ill-health AND Reduced cost to healthcare system due to passive smoking impacts on the health of non-smokers	£356	2014	£365
Homelessness advice and support - cost of a homelessness prevention or housing options scheme that leads to successful prevention of homelessness	£642	2011	£735
Reduced cost of 1 ASB incident per year	£35	2014	£36
Value of NVQ Level 2	£83	2011	£95

Appendix 9: Deadweight for break-even outcomes

Table A9.1: Deadweight levels and rationales for Community Connector work

Outcome	Level	Deadweight rationale
Gain Benefits (PIP, Carers Allowance, Blue Badge etc)	75%	Depending on benefit type, take-up is in the range of 60-89% Department for Work and Pensions, (2013)
Adaptations / move to safer home / avoid falls	90%	Devon already has a fall prevention strategy so is expected to see a significant decrease anyway (estimated that 90% of change would have happened anyway)
Lose weight / getting active	0%	Both Devon and national statistics suggest levels of obesity are increasing and those classed as overweight or obese are likely to increase in weight according to current trends. Levels in Devon rose despite healthy weight strategy up to 2011. See Foresight (2007) p.35, and Healthy Weight Strategy for Devon 2008-11 figure 7.
Avoid care home	50%	As this is an existing strategy of Ilfracombe, say 50% would happen anyway.
Help with poor accommodation & related health issues (esp. from damp)	0.5%	2% of the population seek housing advice and the majority of this is for extreme cases such as homelessness rather than housing. So it can be assumed that 0.5% of advice requests are for bad housing.
Mental health services	47%	Recovery rate for Devon measured by the IAPT scheme. Recovery rate is the no. of people moving to recovery (anyway) divided by the number of people who have completed treatments. North East Public Health Observatory (2013).
Alcohol / drugs: Reduced healthcare costs	75%	Alcohol and drug related hospital admissions increased by 15% in 2009-10 in Devon. However recovery is not guaranteed and One Ilfracombe is only providing tier 1 information and referral. Some patients may recover independently, others may recover then relapse. Therefore a conservative Deadweight of 75% is used.
Alcohol / drugs: Reduced Criminal Justice System Costs	65%	Drugs related crime in Ilfracombe increased significantly from 2008-2011 and alcohol related crime is statistically higher than the regional average (JSNA 2010-11 & JSNA 2013-14). However recovery is not guaranteed and One Ilfracombe is only providing tier 1 information and referral. Some patients may recover independently, others may recover then relapse. Therefore a conservative deadweight of 65% is used.
Smoking	1%	The existing quit rate for North Devon
Homeless / sofa surfing	20%	Homeless Link research suggests that Councils are preventing homelessness in 19% of cases (for young people).
Anti-social behaviour	5%	Based on crime statistics for Ilfracombe there is a 5% per annum decrease in anti-social behaviour
Employability course - including English	50%	From looking at the Community Connector case notes, individuals seeking courses/ appeared to be looking for courses.

Appendix 10: Benefit period for break-even outcomes

Table A10.1: Assumed benefit periods and the rationale behind choices for Community Connector model.

Outcome area	Assumption/ Rationale	Outcome level per year after intervention									
		1	2	3	4	5	6	7	8	9	10
Gain Benefits (PIP, Carers Allowance, Blue Badge etc.)	Once on benefits (after filling in paperwork) they are maintained as long as entitled or until system changes. Most people likely to stay on benefits for this reason.	0%	100%	100%	100%	100%	100%	0%	0%	0%	0%
Green Deal	Securing the Green Deal can take several months as involves an assessment. 10% represents the assessment. Once installed the house is locked into the finance scheme.	0%	10%	100%	100%	100%	100%	100%	100%	100%	100%
Adaptations / move to safer home / avoid falls	Unlike the other outcomes, the value for adaptations is the total value across several years (rather than an annual value). Hence the figures given here show how this single total value is distributed across a number of years.	0%	14%	14%	14%	13%	12%	11%	9%	8%	6%
Lose weight / getting active	Weight will decrease gradually over 2 years. If the weight loss is combined with a change of lifestyle (eating different food and more active behaviours) the weight will stay off.	0%	30%	60%	100%	100%	100%	0%	0%	0%	0%
Healthy eating	Health will improve gradually over 2-3 years. If the change of lifestyle is maintained (eating different food and more active behaviours) the health benefits will remain.	0%	30%	60%	100%	100%	100%	0%	0%	0%	0%
Avoid care home	Supporting someone to be independent will only be effective until serious decline in health and mobility. 7-10 years is likely for decline but this is after the 5-year threshold.	0%	100%	100%	70%	0%	0%	0%	0%	0%	0%
Help with poor accommodation & related health issues (esp. from damp)	Measures to improve house may have a delayed start and tail off after 8 years if the house is poor quality.	0%	0%	100%	100%	100%	100%	100%	100%	100%	50%

Outcome area	Assumption/ Rationale	Outcome level per year after intervention									
		1	2	3	4	5	6	7	8	9	10
Mental health services	Gradual improvement. Relapses may occur several years after treatment, but assuming in this case it is successful.	10%	30%	70%	100%	100%	100%	0%	0%	0%	0%
Alcohol / drugs	Immediate cessation but gradual health improvement. Again relapse may occur but assumed successful.	0%	30%	60%	100%	100%	100%	0%	0%	0%	0%
Alcohol / drugs	Crime will cease earlier as new behaviours introduced.	0%	100%	100%	100%	100%	100%	0%	0%	0%	0%
Smoking	Benefits in health gained from smoking cessation will be immediate. There will be longer-term preventive benefits, however only immediate ones are represented here.	0%	50%	100%	100%	100%	100%	0%	0%	0%	0%
Maternal health	Antenatal health support will be around the time of the baby's birth and drop off afterwards.	0%	100%	80%	20%	0%	0%	0%	0%	0%	0%
Homeless / sofa surfing	If a long-term housing solution is found this outcome should endure.	0%	100%	100%	100%	100%	100%	0%	0%	0%	0%
Anti-social behaviour	If referred to the right person it is assumed that this will endure.	0%	100%	100%	100%	100%	100%	0%	0%	0%	0%
Employability course - including English	Likely to increase over time.	0%	20%	60%	100%	100%	100%	0%	0%	0%	0%

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