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Family 2020 Academic Research

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Executive Summary

Suffolk County Council has commissioned NEF Consulting, part of the New Economics Foundation, and UCL Institute of Health Equity to review the research and assess the evidence base behind its Family 2020 strategy.

Family 2020 is an innovative and outcomes-led strategy that addresses a fundamental need: to maintain and improve the level of support to families at a time of increasingly scarce resources. This imperative requires local authorities to find more targeted and creative ways of delivering services for families and communities.

The aim of this work is to present evidence drawn from a review of both academic and grey literature, and gained directly from commissioners and other stakeholders in the UK, to support or challenge the specific elements of the Family 2020 Strategy. To do this the research team has:

- Reviewed the most relevant literature to identifty the evidence base for the four sections of the Family Strategy: Quality, Efficiency, Integration and Early Help.
- Collected qualitative data through peer consultation with an agreed number of commissioners and other stakeholders from different local authorities.
- Critically reviewed the data to draw out key evidence for or against the underpinning principles.
- Compiled this report describing the key findings and highlighting all the relevant areas of evidence.

The research team, from NEF Consulting (New Economics Foundation) and UCL Institute for Health Equity, were selected for their specialised knowledge in various aspects of this commission. While this has not been an exhaustive review of all of the evidence, the team has accessed high quality academic reviews as well as associated references mentioned within the reviews. In addition the team has reviewed relevant literature provided directly by Suffolk County Council and has conducted primary research with commissioners of related services in other significant UK local authorities. The review has not been limited to within the shores of the UK, as a number of international examples have also been reviewed.

Focusing on the four key themes of the Family 2020 Strategy (namely, Integration, Digital, Early Help and Locality) the research considered the evidence base for the strategy's goals of delivering quality, efficiency, service integration and early intervention. In each case the evidence revealed examples of similar or related models and programmes and was used to identify successes and lessons learned.

1 http://adcs.org.uk/general-subject/article/pillars-and-foundations

Evidence to support the quality aspects of the strategy was identified, to produce Signs of Safety (SOS) a whole system practice framework for direct work with children and families, in which Suffolk County Council has become a leader. The council's approach to outcomes-based commissioning and co-production, as highlighted in the recent report, *Pillars and Foundations*[1] has been shown to be consistent with the approach that many local authorities are taking to increase community resilience and to encourage residents to engage with and support each other.

The review also considered the evidence behind Suffolk County Council's approach to early intervention and specifically how this could lead to efficiency gains. Examples include the Bercow Review of services for children and young people and a 2015 evidence review conducted by the Early Intervention Foundation. Several models were identified that highlight the potentially cashable returns on investment from similar schemes, such as The Surrey Family Support Scheme, the Westminster Family Recovery Programme and the 'Radical Efficiency' model developed by the Innovation Unit for the National Endowment of Technology, Science and the Arts (NESTA).[2]

The research identified a range of examples and case studies that show the benefits of building alliances to create integration of services. Examples include the Symphony Project in South Somerset[3] and the Stockport Targeted Prevention Alliance. The theme of integration was also explored in the context of the needs of young people during the transition to adulthood.

Evidence was explored for increasing the age of transition to 25. In this case both the Joint Commissioning Panel for Mental Health (JCPMH) and guidance from NICE suggest that there is no best-practice model for addressing mental health needs in this stage of transition, and that it is more relevant to consider the relative stability of the individual young person than to adopt a rigid age threshold. Various models were identified for evaluating emotional well-being and resilience as key outcomes. These include the Systemic Unit Model (or the Hackney Model as it is often called) and the "Getting It Right For Every Child" (GIRFEC) Resilience / Vulnerability Matrix.

The review also looked at the evidence for initiatives based on providing early help and identifying hidden or latent needs. Such programmes can be effective in improving outcomes for children, and in reducing inequality. This aspect of the research identified numerous sources of help and information, particularly a Department of Education online tool for identifying and selecting parenting interventions and the European Union Investing in Children website[4]. Perhaps unsurprisingly, the Early Intervention Foundation (EIF) provided much useful information on the case for and cost-effectiveness of early intervention.

2 http://www.innovationunit.org/our-services/how-we-work/methodologies/radical-efficiency

3 Kasteridis P. et al (2014) The Importance of Multi-morbidity in Explaining Utilisation and Costs across Health and Social Care Settings: Evidence from South Somerset's Symphony Project University of York

4 http://investinginchildren.eu/

The research identified significant programmes of early help provided by councils from Kent and Kirklees to Staffordshire and Lambeth. All of these models created locality-based multi-agency or multi-disciplinary teams that enabled families to have a single point of contact for service, thereby providing a diverse range of provision, while preventing duplication. Early engagement with a variety of internal local authority stakeholders (such as social care colleagues and external community organisations and groups), was seen as critical to success. However the early help model was found to require robust and rigorous monitoring and evaluation, and in some cases this provision is under threat from budgetary cuts. A variety of early help approaches were identified that support individual community resilience. These range from healthy living programmes in schools, community connection programmes, such as Well London[5] (developed by the University of East London), and approaches such as time-banking and encouraging volunteering – are all shown to be effective.

Finally the review considered a variety of sources to evaluate the evidence for digital services. Some current case studies were identified and the *Pillars and Foundations* report summed up the potential as follows: 'In the future, children's services will be built on proactive engagement with families rather than the reactive model of waiting for a need to become severe enough to present to the front-door or universal services. Data integration and predictive modelling will identify which families to help, and show over time which interventions are having the best impact on outcomes.[6]

5 http://welllondon.org.uk

6 http://adcs.org.uk/general-subject/article/pillars-and-foundations

Section 1: Quality

Signs of Safety

Signs of Safety[7] (SOS) is an internationally recognised model for direct work with children and families that originated in Australia in the 1990s for child protection work, and is now used across the world. It provides a risk management framework, which is child-centred and solution-focused, and includes a suite of principles, disciplines, processes and tools to guide the work.

It is recognised that it is impossible to undertake the ‘gold standard’ of randomised trials within child protection services, as it is neither ethical nor professionally responsible. Furthermore, within child protection cases there is often so much going on, it is hard to attribute the causative impact of any particular change in policy, guidance or practice.[8] The SOS approach changes focus and evolves depending on the lived experience of those involved in child protection business, including the social workers and families. It is for this reason that the majority of the evidence supporting the SOS approach is qualitative and based on constructive practice, as described by frontline practitioners, parents and children.

Since the 1999 publication of *Signs of Safety*[9] by Steve Edwards and Dr Andrew Turnell, there has been escalating interest in their approach in the UK. Over 50 local authorities are now using the SOS approach within some aspect children’s services. In the past couple of years, the nature of how SOS is applied has changed, so there is now more focus on adopting it as a whole system practice framework across the continuum of services. Suffolk County Council has been a leader in this approach.[10]

A range of evaluations and studies have been undertaken since the conception of SOS and the overall results of the studies have been positive, highlighting the efficacy of some of the key elements of SOS including:

- Strong working relationship between worker and parents that considered risk and safety.
- Strong focus on parental and family strengths.
- Sustained and detailed exploration of what exactly safe parenting looked like and how it could be achieved.
- Time to build the working relationship and do the casework.

An evaluation of SOS in Suffolk was undertaken by University College Suffolk

7 www.signsofsafety.net

8 Dr Andrew Turnell (2013) The Signs of Safety: International Use and Data Resolutions Consultancy Pty Ltd

9 Turnell A & Edwards S (1999) Signs of Safety: A solution and safety oriented approach to child protection casework, New York, Norton

10 ADCS (2016) Pillars and Foundations – next practice in Children Services – a think piece

and the London School of Economics. This research is highlighted in *Pillars and Foundations*[11] which states that:

> Findings show that practitioners feel supported by the whole system approach and report that families are more engaged, understand why services have become involved in their lives and how they need to change. Direct feedback from families, the courts and partner agencies has been equally positive.

In the USA, Minnesota has led the way in using and implementing the Signs of Safety approach, starting with Olmsted and Carver counties and with many others following their lead. The Casey Family Programs in conjunction with Wilder Research have undertaken a series of evaluations and reports regarding the implementation of SOS in Minnesota.

The longest running and most complete implementation of SOS within a statutory child protection system has occurred in Olmsted County Child and Family Services (OCCFS), Minnesota, USA. OCCFS have utilised their version of the SOS framework to organise all child protection casework since 2000, and all casework is focused around specific family-enacted safety plans[12]. The introduction of SOS accompanied a wider reform agenda and the early indications from the reforms were very positive. During the twelve years that the reforms were implemented, OCCFS tripled the number of children supported, and halved the proportion of children taken into care and the number of families taken before the courts. The Olmsted dataset provides extraordinary figures, as most jurisdictions in most countries have significantly increased the proportion of children in care and families taken to court in that period.

Following the lead of Olmsted County, a second Minnesota county, Carver County Community Social Services (CCCSS), also began implementing the SOS approach in late 2004. Using nine randomly chosen cases, Westbrock (2006)[13] undertook a 'before and after' qualitative study at Carver, looking in depth at the impact of Signs of Safety practice on service recipients during the first year of the county's implementation. The study found an increase in service recipient satisfaction in most of the cases and the research also helped CCCSS practitioners to improve their skills, particularly in providing choice and by involving parents in safety planning.

Qualitative research into practitioner and parent/child experiences of any model is of particular value in helping to establish how families and professionals might respond to an intervention. A great deal of the research around SOS focuses on these experiences.

11 ADCS (2016) Pillars and Foundations op. cit.

12 Turnell A. (2013) The Signs of Safety: International Use and Data Resolutions Consultancy Pty Ltd

13 Westbrook, S. (2006). Utilizing the Signs of Safety framework to create effective relationships with child protection service recipients. MSW Clinical Research, University of St Thomas, St Paul

A recent literature review of SOS research undertaken by Wheeler and Hogg[14] discusses these findings and outlines some of the methodological limitations of the studies involved. From reading through the studies, a number of key themes emerge consistently. These include:

- *Improvements in practitioners' experiences, skills and job satisfaction* – with studies reporting an increase in practitioners' self-evaluation of expertise and skilfulness, more time to reflect on cases, an increase in staff recruitment/retention and improved morale/ satisfaction. Staff also identified tools that help to organise practice, focus on safety/risk and measure change, providing more useful tools than previously available.
- *Improvements in relationships between parents and practitioners* – with studies reporting that relationships are becoming more open, transparent and of better quality. Parents/carers' are feeling more 'understood' and respected by workers and not feeling blamed for issues, with more positive perceptions of the caring skills of workers.
- *Greater involvement of families in the process* – with studies reporting greater involvement of families in generating outcomes, increased participation in resolving difficulties, greater belief in change (both workers and parents) and more recognition of change reported (by professionals to parents).

In the UK a number of small-scale evaluations by local authorities also confirm similar findings through interviews and self-report measures. The NSPCC[15] carried out a survey in 2011 to capture these findings in more detail. They include:

- Bracknell Forest undertook a small-scale study of the use of Signs of Safety in Child Protection Conferences. The results were largely positive.
- Brent undertook an initial evaluation of service user's experiences of case conferences where the Signs of Safety approach was used. The evaluation ran from October to December 2010 and involved 100 participants. Participants were asked if they preferred this new approach or a traditional conference format. 72% preferred the new approach, 24% traditional and 4% not sure. Further qualitative research with service users is currently being undertaken.
- West Berkshire's evaluation of Strengthening Families – where practitioners and families were interviewed and asked questions about their experience of child protection conferences. Practitioners were, on the whole, positive about the model, while families were positive about many elements of the model. The evaluation also reported that the time children spent on child protection plans has decreased as a result of the introduction of the model.[16]

14 Wheeler, J. and Hogg, V. (2012) 'Signs of safety and the child protection movement', in Franklin, C., Trepper, T.S., Gingerich, W., and McCollum, E. E.(2012) Solution-Focused Brief Therapy. A Handbook of Evidence-Based Practice. Oxford University Press.

15 Bunn A. (2013) Signs of Safety in England – an NSPCC commissioned report of the Signs of Safety Model in Child Protection

16 Griffiths D. & Roe A. (2006) A Step in the Right Direction – an evaluation of the 'strengthening families' framework within child protection

In other parts of England, some government departments are adopting the SOS approach to improve decision-making in child protection. Police, social care practitioners and Cafcass (children's guardians) thought it especially useful with neglect because:

- Parents say they are clearer about what is expected of them and receive more relevant support.
- The approach is open and encourages transparent decision-making.
- The professionals had to be specific about their concerns for the child's safety.
- The approach encouraged better presentation of evidence.[17]

In particular, Signs of Safety has been adopted by Suffolk County Council Children's Services as the overarching practice framework for all of its work with children and families. It describes a purposeful and collaborative way of working with families to secure the best outcomes for children and young people. As Suffolk has chosen to apply the approach across all of their services, the programme is called Suffolk Signs of Safety and Wellbeing.
The council has embarked on a three-year programme to implement and embed this approach, and has commissioned University Campus Suffolk to conduct an impact evaluation.

Specific findings across other jurisdictions internationally, indicate improved outcomes for children and greater job satisfaction for social workers, with good potential for cost savings. These include:[18]

- Swansea City Council implemented Signs of Safety in 2011. Two years' data shows child protection re-referrals reduced by 9% and children in care figures reduced by 13.6%.
- The number of families receiving intensive help rose from 2.5% to 13% and in the same period the number children being removed from home reduced by 24% in the initial years following implementation of Signs of Safety [Western Australia].
- The percentage of children removed from home dropped from 54% to 44% following implementation of Signs of Safety in Bureau Jeugdzorg in Drenthe [The Netherlands].
- Comparison was made of families at high risk of children and their children being removed in separate authorities in Copenhagen – in families receiving Signs of Safety support 15% of children were removed compared with 42% of those families receiving a 'normal service' [Denmark].

17 Gardner, R. (2008) 'Developing an Effective Response to Neglect and Emotional Harm to Children', Norwich: UEA/NSPCC.

18 Munro E., Turnell A.& Murphy T. et al (2014) 'Transforming Children's Services with Signs of Safety Practice at the Centre', Innovations programme proposal

- The number of children in care across Australia doubled in the years between 2000 –10 with yearly increase of approximately 9.7%. In Western Australia with the implementation of Signs of Safety the rate reduced to 5% between 2009 –13.
- Aboriginal services in Calgary report that in the period 2011-14 caseloads fell from 1041 to 798; children in care fell from 783 to 654; and children on supervision orders fell from 185 to 63 following the implementation of Signs of Safety [Canada].

Three major, independent research projects, in the UK, USA and Australia, are currently underway. In Australia, SOS is now in its eighth year of implementation and the University of South Australia has been commissioned to undertake an in-depth study of the impact and extent to which the SOS approach is associated (or not associated) with reliable improvements and outcomes for:

- Children at risk of abuse and neglect and/or who are in out-of-home care.
- Parents navigating the child protection system and process.
- Carers looking after children.
- Practitioners within the department and external partner agencies delivering the SOS approach and working in the complex field of child protection.

Additionally, the research will examine the stages of implementation, with particular focus on the key drivers and barriers. The results of the research will provide significant evidence for the future.

In the UK, a research project associated with the Department for Education Innovations Programme called, ‘Transforming children’s social care with Signs of Safety at the centre’ will be published later this year. This will include action research carried out by Professor Eileen Munro as well as research undertaken by Dr Mary Baginsky from King’s College London. The project is part of an overall research piece into a number of innovations and programmes.

Outcomes-based commissioning

All councils are currently trying to examine and implement approaches to commissioning services that both promote well-being and tackle societal problems at their root. This coincides with the need for budget reductions and increased service demand. The past three years have seen a rapid increase in the use of outcomes-based commissioning in England as a solution to these conflicting issues and the trend is expected to continue. However, the outcomes-based commissioning approach is still in the development phase and it may take a number of years before the full impact emerges.

An outcomes-based approach to commissioning services is very different to most tendering frameworks as it focuses on ***the change it wants to see*** as a result of the service and not just the activity generated. The model therefore encourages commissioners to concentrate on clearly defining what they wish to achieve, and then allowing the service provider to innovate and develop the means to achieve it.

The evidence base for using the approach in health care is limited, due partly to its novelty and the complexity of evaluating it. The quality of the evidence that is available is mixed, but it does contain promising studies (albeit from atypical contexts).[19]

Specific evidence from local authorities across England is particularly limited. In health care, musculoskeletal care in Oldham has been cited as a forerunner of some of the elements of an outcomes-based approach. That is, as a single provider acting as prime contractor across a pathway using indicators and incentives since 2006, and with a single budget since 2011. Cost and quality benefits have been reported, but not independently evaluated.[20]

In social care, outcomes-based commissioning has been implemented more in the form of outcome measures and payment incentives than as coordinated delivery or capitation – for example, for domiciliary care in Wiltshire (since 2012). Wiltshire has seen improvements in the customer experience[21] but there seem to be few substantial differences from other councils at this stage.

In 2014, the New Economics Foundation (NEF) worked with commissioners of youth services of three local authorities (Lambeth, Cornwall and Islington) to implement and test out an outcomes-based approach, which embedded co-production throughout the commissioning of processes and delivery of provision.

19 The Health Foundation (2015) Need to Nurture; outcomes based commissioning in the NHS

20 NHS Confederation (2014). Beginning with the end in mind: how outcomes-based commissioning can help unlock the potential of community services. London: NHS Federation Community Health Services Forum.

21 Bolton J. (2015) Emerging practice in outcomes-based commissioning for social care: discussion paper. Institute of Public Care

In Lambeth, the corporate drive towards becoming a co-operative council substantially supported the new approach to commissioning and helped to define the central development of co-operative commissioning. The key components of the approach were:

1. *Developing the outcomes* – The outcomes were the key element of the commissioning process and it was vital that these were accurate and representative of the service user. They were co-designed with the service users and prioritised in line with their views to ensure any commissioned provision would be relevant. The resulting outcomes framework differed significantly from outcomes previously commissioned, because it was based on greater qualitative and subjective changes, e.g. increase in autonomy, improved self-esteem, and increased emotional resilience. Additionally the framework included community-level outcomes that expected the provider to consider the environment and community within which they worked and the support system around their service users . These outcomes focused on environmental and social benefits (e.g. every person feels valued and part of their community). A set of service qualities was also developed alongside the outcomes, which defined how services would be delivered and included: via co-production, partnership working and sustainability.

2. *Understanding need and developing insight* – A needs assessment was undertaken, to identify the resource gaps and issues locally. However, a needs assessment provides only one side of the story, so an asset map was also created in association with service users and communities, to highlight resources and networks already in place to support the outcomes. This overview prevents duplication of effort and enables commissioners to view the impact of all the resources in the area, not simply those commissioned or the immediate council provision.

3. *Prioritisation and resource allocation* – This was prepared by council officers, drawing from the results of the needs assessment and asset mapping work. Themes and priorities were agreed that included distinct age groups, targeted groups and localities. However, this area of consideration requires some work to ensure it is accomplished in partnership with citizens.

4. *Procurement* – Outcomes-based commissioning and co-production are relatively new concepts in the voluntary sector. In order to ensure clarity concerning what was required from the commissioning process, a substantial amount of capacity building and training was undertaken with providers through workshops and informal support. Tendering documentation was stripped of detailed, defined specifications and those tendering were given information only on outcomes and service qualities. This allowed the space to work with service users and citizens to innovate design activities which all agreed would meet the necessary

outcomes. Within the Instruction to Tender (ITT) they were expected to explain *why* their chosen activities would achieve the required outcomes and *how* they intended to embed co-production within their service delivery. Commissioners worked with citizens to develop two of the questions which were inserted into the ITT. Ideally, those same citizens then become responsible for evaluating and scoring the responses to those two questions.

5. *Tender evaluation* – All members of the evaluation panels were trained in outcomes-based commissioning and co-production to ensure they would be able to critique the ITTs and presentations appropriately. The evaluation criteria used specific objectives which measured the responses to co-production and the rationale behind the project activities. The co-production criteria were vital, as it prevented loose definitions of approach being referred to; they were relatively heavily weighted to ensure all contracted providers would be working towards the use of co-production as their core service delivery. Citizens were included on the panel for the final stage of presentations and were trained and supported to chair and lead this panel.

6. *Monitoring and evaluation of contracts* – The performance indicators and methods of measuring against them needed to be broader and more creative as more subjective and qualitative outcomes were commissioned; commissioners needed to look beyond quantitative measures and data that focused on ‘bums on seats’ and referral numbers. Furthermore, it was vital that contracted providers and citizens were involved in the design of the indicators to ensure they would be measuring the right things rather than simply those aspects which are easy to measure. Following this period of design, all providers were expected to use some standard performance indicators to provide comparative data; others had bespoke performance indicators depending on their service delivery. All monitoring and review processes should be undertaken by commissioners in partnership with citizens and providers. By this means, measurement of impact includes a variety of approaches and goes beyond being the responsibility solely of service managers.

This approach to outcomes-based commissioning was tested and implemented twice across two tenders: ‘Youth and Play’ and ‘Early Years’. Both processes were successful to a point and some important lessons were learnt along the way:

- It is vital to have political buy-in throughout the process. This sort of commissioning will change the landscape so it is important that associated risks are mitigated against and local politicians are prepared to agree with the outcomes. If possible, keep them involved at every stage so that they remain engaged as things progress.
- Providers need time to learn about and develop their response to the change in commissioning priorities. There can be resistance to and confusion about co-production and what it means on the ground, and some providers may not be willing to work in this way. Moving towards full co-production should be seen as a stepped process as providers change their internal processes and culture to accommodate and develop it. However, commissioners need to be confident in the new approach and be prepared to only contract providers who are agreeable to trying it out.
- Involving citizens in the tender evaluation process is an important way of involving them in decision making. However, commissioners should take the time to get to know the citizens and train them efficiently, so that both sides have confidence in the citizens’ input. It is important too that a working relationship develops between commissioner and citizen. Without this relationship, citizens may not feel valued or important in the process.
- Competitive tendering does not sit well alongside collaboration and co-production because it inevitably changes the focus of the process and relationship between commissioner and provider. Additionally, it may not support the contracting of smaller, local organisations that do not have the appropriate skills to fill out a written tender with the same degree of skill as larger organisations that have dedicated departments responsible for this activity. Where possible, commissioners should consider alternatives to competitive tendering if they wish to embed co-production within service delivery and work with procurement colleagues, to develop a process that provides space, collaboration and flexibility.

NEF published a handbook and practical guide on commissioning for outcomes and co-production as the result of an eight-year collaboration with Lambeth and other local authorities, including Surrey, Kirklees and Cornwall. Researchers at NEF were able to draw out many insights and points of guidance from the practical implementation of their work. These are as follows:[22]

22 Slay J. Penny J. (2014) *Commissioning for Outcomes and Co-production* New Economics Foundation

Begin developing relationships with local people from the very start

Don't wait until the project has been defined or until there are timescales in place for a re-tendering round. Co-producing means having early discussions about what outcomes people value, how people experience current services, and what a collective vision for local support might look like. If too many parameters are already in place then people can feel they are being co-opted into the council's agenda.

Create a brand

Several senior government leaders and commissioners have stressed the importance of creating a brand or separate identity for a change programme, such as an outcomes-focused commissioning approach – such as 'Vision Islington' for example. Working with local people to develop this vision can help to create a sense of shared ownership, rather than the programme being seen as just another council initiative.

Political engagement and support is vital

Elected members need to be involved throughout, to provide commitment to both the process and the outcomes that arise.

Always strive to have an even balance of people using services and professionals

Changing the default setting of meetings can be one of the most challenging parts of co-production. Continually developing new relationships with different groups of people is an essential part of co-production. Don't just invite people 'in' to your meetings, but get out into spaces where they go about their daily lives and start conversations there. For example, in Lambeth the commissioning team spent a long time working with young people on estates and in schools, pupil residential units or youth centres.

Thinking about outcomes and developing shared outcomes

Talking about 'outcomes' from the outset helps to move away from the concept of 'services' and gets people thinking about and discussing change – creating space for innovation and co-production.

Changing the professional methods that are used in commissioning is just as important as changing the service specifications – if not more so

Commissioners we worked with said that appreciative enquiry, coaching, and creative forms of facilitation were key skills, which they (and their teams) needed to learn, and that are now central to the way they work.

Using case studies and peer networks

Learning about how these approaches have been used elsewhere is very important in defining an approach, as well as getting support, critical challenge and insight from other providers, commissioners and service users. The co-production practitioners' network

(www.coproductionnetwork.com) is one good place to start. Others are the Cabinet Office Commissioning Academy and the Public Service Transformation Network.

Think long term

Remember that this change is a long-term strategy. Incremental change will happen, but the big wins are likely to emerge in the medium to long-term, as relationships are developed and strengthened, and as providers and the people they support are encouraged to take positive risks and innovate – together.

Internationally, the most commonly cited example of an outcomes-based commissioning approach in health care is the Alzira model in Valencia, Spain. This was developed by the private health care company Ribera Salud in partnership with the regional government. It seeks to improve patient outcomes through a complex care plan programme that has been running since 2012, providing integrated medical and social services for elderly patients with two or more long-term conditions. A key part of its 'triangle for success'[23] lies in the partership's approach to managing staff, which is seen as just as important as IT capability and clinical/demand management. There is a strong focus on professional development and the use of individual performance incentives. Ribera Salud has demonstrated improvements, with overall hospital admissions decreasing by 28% and readmissions decreasing by 26% since 2012, although cost-effectiveness evaluations are still underway.[24] The initiative has also seen favourable patient satisfaction scores, and staff absenteeism is well below national and regional averages.[25]

Measuring impact against outcomes

Impact measurement has become an increasingly important activity for the public sector in recent years, yet impact – and how to measure it – remains a contested issue in policy, research and practice. In particular, there is an interest in improving co-ordination and best practice in impact measurement. This is a dynamic and evolving area and there is a daunting amount of information in circulation. There is a proliferation of tools and providers in the field of impact measurement and an acknowledged lack of co-ordination among providers of impact measurement support. According to New Philanthropy Capital's report *Inspiring Impact* there are over 1,000 different methods available.[26] There also appears to be general consensus amongst funders that there is a shortage of low-cost, 'off the shelf' tools and systems.

23 de Rosa A.(2014) *New Management Models: The Experience of Ribera Salud*. NHS England.

24 Brookings Institute. (2015) *Spain: Global accountable care in action*. Brookings Institute.

25 NHS Confederation (2011) *The search for low-cost integrated healthcare: The Alzira model – from the region of Valencia*. NHS Confederation.

26 Lumley T., Rickey B.,& Pike M. (2011) *Inspiring Impact – Working together for a bigger impact in the UK social sector*, New Philanthropy Capital pdf

The research undertaken by New Philanthropy Capital identified five key factors which hindered or encouraged the measuring of impact. Listed in the box below, these are:

Incentives – *Charities and social enterprises need to have incentives to measure their impact. This could be the promise of funding or an internal drive to improve services.*

Money is not always the best incentive for organisations and teams as it may mean that they see impact measurement simply as a way of securing funding. Additionally, many commissioners do not emphasise the need for good impact measuring when commissioning external organisations and only require a demonstration of their results. Impact measurement should be core to a team's everyday work and the culture of the team should reflect a keen interest in understanding how their work impacts on their beneficiaries, from senior managers to front-line staff.

Resources – *More funding needs to be invested in impact measurement, and we need more affordable and accessible products and services to help with measurement.*

Organisations tend not to allocate sufficient funds to the measurement systems of their activity and in turn, funders often do not allow enough funding for monitoring and evaluation. There should be more investment into impact measurement from both sides and existing resources should be used more intelligently.

Capacity and skills – *We need to make affordable, user-friendly tools and systems more widely available, and we need to train staff to use them.*

Skilled people are critical to any good impact measurement work and there is a general lack of skills and capacity across the sector, not only from frontline staff but also managers and commissioners. If impact measurement is to become properly embedded into the culture of services, the research suggests that an impact measurement lead or evaluation manager should be part of every service team, to help design an impact measurement system, coordinate activities, analyse results and publish findings. As well as benefitting from specialist staff, services also need their other staff to develop impact measurement skills: frontline staff need skills to collect data; service managers need skills to use data to improve services delivery; and senior management need skills to use their findings strategically.

Support – *Organisations need more support to look at their impact, with clear standards and co-ordination*

Not enough services or commissioners have the right impact measurement tools and systems in place. When designing their impact measurement approach, they are often faced with too many options and need more guidance. Many organisations end up developing their own tools and systems from scratch, which is time-consuming and expensive.

There are hundreds of good data collection tools, such as surveys, that services could be using. They just do not know how to find them or use them. There also needs to be more efficient, easy to use monitoring and IT systems.[27]

The way that results are used – *We need to do more to learn from our impact measurement – shared measurement approaches are the key to this.*

Many services and commissioners struggle to use impact data effectively. This goes to the heart of why so many people are sceptical about impact measurement – they cannot see the point. They see it as a hoop to be jumped through, with no benefits or influence on the way that civil society organisations (CSOs) deliver services. Everyone needs to do more to learn from the data they collect. For this to happen, their impact measurement needs to be embedded in service delivery and decision-making, and leaders need to be focused on impact.[28]

Existing research suggests that third sector organisations (TSOs) and commissioners vary widely in what they measure, and how they approach impact assessment.[29] TSOs appear to undertake impact evaluations to different degrees, with some organisations carrying out fuller impact assessments involving planning and organisational learning techniques as prescribed by practice networks, including Inspiring Impact, and others engaging in more simple activities and practices such as collecting feedback about services.[30]

By far the most common practice is to collect output data and in a recent study, 84% of TSOs corresponded to this.[31] In contrast, very few organisations utilise advanced planning tools and evaluation practices, such as ‘before and after’ measures, long-term follow up, and randomised control trials, with their use concentrated among large, high capacity organisations, or those funded via government grants and contracts.[32] A small number of organisations surveyed by New Philanthropy Capital meanwhile reported utilising academic evidence in impact measurement practice to design new programmes, interpret evaluation results, and compare results to other programmes.[33]

27 Charities Evaluation Services (2008) *Accountability and Learning*

28 Lumley T., Rickey B.,& Pike M. (2011) *Inspiring Impact – Working together for a bigger impact in the UK social sector*, London: New Philanthropy Capital

29 Ogain, E. N., Lumley, T. and Pritchard, D. (2012) *Making an Impact*, London: NPC

30 Lumley, T., Rickey, B. and Pike, M. (2011) *Inspiring impact: Working together for a bigger impact in the UK social sector*, London: NPC

31 Ogain, E. N., Lumley, T. and Pritchard, D. (2012) *Making an Impact*, London: NPC

32 Chapman, T., Bell, V. and Robinson F. (2012) *Measuring Impact: easy to say, hard to do*, Newcastle-upon-Tyne, Northern Rock Foundation.

33 Ogain, E. N., Lumley, T. and Pritchard, D. (2012) *Making an Impact*, London: NPC

In 2010, Lyon et al interviewed 32 organisations in the east of England to understand what type of measurement tools were being used within the third sector. One third of these were developing their own customised approaches to measuring impact. This included gathering case stories that showed the effect of each service on people using it directly or indirectly, and the use of performance indicators, tailored to clarify and develop their strategic objectives in the delivery of their social, economic and environmental impacts. Tools requiring high levels of resource input, such as SROI and Social Accounting and Audit, were found to be utilised less by organisations than those tools requiring fewer financial resources, staff time and skills. The exception to this was when more intensive approaches were offered free of charge to organisations by external consultants, or where impact measurement systems were in effect imposed on organisations by funders. [34]

It is worth noting meanwhile, that other research reported that a high proportion of organisations used tools and systems that were prescribed by funders and public sector commissioners, often without the costs of such activities being covered in funding agreements. As well as imposing cost burdens, such tools prioritised accountability to funders/commissioners and left little room for organisational innovation and learning.[35, 36]

The overall conclusion from a review undertaken by the Third Sector Research Centre is that:

> There is a relative scarcity of robust research on impact measurement practice in the UK third sector. This is despite its recent higher profile and attention in public and third sector policy and practice. There is an extensive body of grey literature on impact measurement practice, however this has tended to be small-scale and boosterist in nature. The field has also suffered from a lack of theorisation of key concepts and critical appraisal of previous research, with a few exceptions. A number of studies are emerging which attempt to address this theoretical and empirical gap, but in general empirical research on impact measurement practice in the UK third sector, [and] particularly which organisations and subsectors are undertaking impact measurement and the practices and tools they are using, is limited.[37]

34 Lyon, F., Arvidson, M., Etherington, D., and Vickers, I. (2010) *Social impact measurement (SIM) experiences and future directions for third sector organisations in the East of England* EEDA.

35 Ellis, J. and Gregory, T. (2008) *Developing monitoring and evaluation in the third sector: Research report*, London: Charities Evaluation Service (CES).

36 Moxham, C. and Boaden, R. (2007) ‘The impact of performance measurement in the voluntary sector’, *International Journal of Operations and Production Management*, 27 (8): 826-845.

37 Harlock J. (2013) *Impact Measurement Practice in the UK Third Sector: a review of emerging evidence* Third Sector Research Centre: Working Paper 106

Co-production

Co-production has recently become the buzzword for policy makers, with the need to find new ways of delivering public services still high on their agenda. There are many reasons why this approach should be considered including its facility to deliver improved outcomes, support better use of scarce resources and improve community wellbeing.

There is a wealth of co-production already happening throughout the country. To these groups, it is nothing new; co-production means 'business as usual' despite the fact that there is now an official term for it. The majority of co-production has occurred on a relatively small-scale basis between local communities and voluntary sector agencies that have the flexibility and innovation to evolve and sustain such an approach. In order to transform larger scale public services in the same way, co-production will need to be embraced within commissioning and procurement processes, some of which may be inflexible and resistant to change.

Co-production has been highlighted by the recently published report, *Pillars and Foundations*[38] as one of the four things that local authorities are potentially looking for, in order to increase community resilience and encourage residents to engage and support each other.

There is strong evidence to suggest that interventions such as co-production, which increase people's support networks and social connections, improve health, and reduce illness and death rates. Dr Brian Fisher of the Health Empowerment Leverage Project (HELP) has written a comprehensive literature review of the impact of community development.[39] Although his findings are related to co-production in the community, the outcomes from any form of co-production including that used during commissioning, are similar – especially in relation to feeling valued and creating connections with others. Among the many findings in his review, he demonstrates that:

- Low levels of social integration, as well as loneliness, significantly increase the rate of mortality, whilst people with stronger networks are healthier and happier.[40]
- Social networks are consistently and positively associated with reduced illness and death rates.[41, 42, 43]

38 ADCS (2016) *Pillars and Foundations – next practice in Children Services* – a think piece

39 Fisher B. (2011) *Community Development in Health – A Literature Review* www.healthempowermentgroup.org.uk

40 Bennett K. (2002) 'Low level social engagement as a precursor of mortality among people in later life' Age and Ageing 31: 165-168

41 Fabrigoule C, Letenneur L, Dartigues J et al. (1995) 'Social and leisure activities and risk of dementia: A prospective longitudinal study', *Journal of American Geriatric Society* 43: 485-90

42 Bassuk S, Glass T and Berkman L. (1999) 'Social disengagement and incident cognitive decline in community-dwelling elderly persons', *Annals of Internal Medicine* 131: 165-73

43 Berkman LF and Kawachi I (2000) 'A historical framework for social epidemiology' in Berkman L.F. and Kawachi, I. (eds.) *Socialepidemiology*. Oxford: Oxford University

- Collective efficacy – the willingness of community members to look out for each other and intervene when trouble arises – is associated with reduced body mass index, being at risk of obesity, and overweight status.[44]
- An international meta-analysis of data across 308,849 individuals, followed up for an average of 7.5 years, indicates that individuals with adequate social relationships have a 50 per cent greater likelihood of survival compared to those with poor or insufficient social relationships. The analysis concludes that: 'The quality and quantity of individuals' social relationships has been linked not only to mental health but also to both morbidity and mortality [and] it is comparable with well-established risk factors for mortality,'[45] such as smoking, alcohol, body mass index and physical activity. This is consistent across other demographic factors such as age, sex, cause of death.

In *Five Ways to Wellbeing*, the New Economics Foundation highlights evidence that reciprocity and 'giving back' to others can promote well-being. They write, 'the Foresight definition of mental well-being says that it is enhanced when an individual is able to achieve a sense of purpose in society and, thus, contribute to their community. So, helping, sharing, giving and team-oriented behaviours are likely to be associated with an increased sense of self-worth and positive feelings.[46] The report states:

- Feelings of happiness and life satisfaction have been strongly associated with active participation in social and community life.[47]
- For older people, volunteering is associated with 'more positive effect and more meaning in life'.[48]
- Supporting others has been shown to be associated with reduced mortality rates.[49]
- Committing an act of kindness once a week over a six-week period is associated with an increase in well-being, when compared to control groups.[50]
- Participation in shared tasks like community service and social life can predict life satisfaction.[51]

44 Cohen, D. A., Finch, B. K., Bower, A., & Sastry, N. (2006) 'Collective efficacy and obesity: The potential influence of social factors on health', *Social Science & Medicine* 62(3):769-778.

45 Holt-Lunstadt J. et al (2010) 'Social Relationships and Mortality Risk: A Meta-analytic Review' Plos Medicine [Electronic version] **www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316**

46 Aked J., Marks N., Cordon C. et al (2011) *Five Ways to Wellbeing.* New Economics Foundation **www.neweconomics.org/sites/neweconomics.org/files/Five_Ways_to_Well-being_Evidence_1.pdf**

47 Huppert F (2008) *Psychological well-being: evidence regarding its causes and its consequences*. London: Foresight Mental Capital and Wellbeing Project

48 Greenfield EA, Marks NF (2004) 'Formal volunteering as a protective factor for older adult's psychological well-being', *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 59B: 258–264. Cited in Huppert (2008) op. cit. p16

49 Huppert (2008) *Psychological well-being: evidence regarding its causes and its consequences.* London: Foresight Mental Capital and Wellbeing Project

50 Lyubomirsky et al. (2005) '*Pursuing Happiness: The Architecture of Sustainable Change*' Review of General Psychology Vol. 9,No. 2, 111–131

51 Harlow RE, Cantor N (1996) '*Still participating after all these years: a study of life task participation in later life*' Journal of Personality and Social Psychology 71: 1235–1249.

The movement towards co-production can be conceptualised as a shift from 'public services *for* the public' towards 'public services *by* the public', within the framework of a public sector which continues to represent the public interest, not simply the interests of 'consumers' of public services. Public sector co-production activity has, until recently, been most prevalent in the adult social care sector and this is now reflected by the new Care Act (2014) which recommends that councils treat commissioning as a shared endeavour with commissioners, support providers and citizens, working together to co-produce the entire commissioning process. There are a number of examples of projects where co-production has been used specifically within services for families, children and young people including: Creative Homes[52], Learn to Lead[53] and Pop up Parks[54]. Family by Family[55] is one of the best examples of a co-produced provision.

Family By Family is a social venture developed by the Australia Centre for Social Innovation (TACS), based in Adelaide, South Australia. The programme was developed in response to a brief from the State Government to reduce the number of families requiring crisis services including child protection interventions. Family By Family links 'seeking families' (families who want something in their lives to be different) with 'sharing families' (families who are thriving despite living in circumstances that might be described as disadvantaged). Link-ups last a specific period of time and all families set goals for their involvement in the programme. Pairs of seeking and sharing families then organise the things that they will do together. These are designed to assist the families – in particular the seeking families – to achieve their goals for change. Sharing families are in turn supported by coaches employed by Family By Family.

In 2012, this programme was evaluated by Community Matters and the reports main conclusion was:

> The Family By Family programme is young and there is yet relatively little outcomes data available. Nevertheless, the outcomes to date appear very positive. The model appears to engage families in genuine need of support including those who may be considered 'difficult' in traditional services and including those with child protection concerns. It appears to enable change and enable different kinds of families to achieve different kinds of outcomes. It also appears to enable families to start with immediate goals and move on to address more fundamental concerns. The changes that families make appear to generate positive outcomes for both adults and children, the latter including some that are potentially very significant for longer term child development outcome.[56]

52 www.creativehomes.tdlp.co.uk

53 www.learntolead.org.uk

54 www.popupparks.co.uk

55 www.familybyfamily.org.au

56 Westhorpe. G (2012) Family by *Family Evaluation Report* Community Matters

Learn to Lead is a schools-based programme which provides structures and mechanisms for co-production to be enabled between students, creating the space to allow them to work in teams and to bring about the positive changes they wish for. The outcomes are transformational, with individuals growing in confidence, self-esteem and ownership.[57] The programme was started at The Blue School in Wells in 2002 and since its inception, the involvement of students has increased so that 22 teams have now been established, covering every aspect of the school life. Over the course of the programme, one team negotiated funding from the local education authority to help establish healthy school lunches, a transport team raised money to build two bike sheds, and two mini on-site recycling centres were created by a waste and recycling team.

The Learn to Lead programme was evaluated by the University of Cambridge in 2010.[58] The evidence of students, teachers, head teachers, combined with observations from the research team concluded that the Learn to Lead programme had an overwhelmingly positive impact on the young people who participated, as well as on the schools involved more generally. Evidence from Ofsted inspections supported this view. Variations in the extent to which each of these benefits were experienced in different schools can be attributed in part to the degree to which the various aspects of the approach had been adopted.

The evaluation team identified 11 specific but inter-related benefits for students, who:

1. Develop a stronger sense of commitment to their own learning.
2. Experience a strengthening of their emerging sense of moral purpose.
3. Have an enhanced sense of belonging to the community of the school.
4. Value and look after one another.
5. Acquire skills, particularly social, communication and organisational skills.
6. Develop confidence as learners and members of society.
7. Enjoy learning and enhanced achievement.
8. Become more aware of their strengths and talents.
9. Develop resilience and a positive approach to challenges.
10. Are more willing to take risks and try new things.
11. Experience enhanced autonomy.

The evaluation also concluded that Learn to Lead activities can contribute to transforming the relationships within each school. The following are seven of the benefits identified:

57 www.learntolead.org.uk

58 Frost D. & Stenton S. (2010) Learning to Lead – The Story So Far. Illuminating the nature benefits and challenges of the Learning to Lead programme University of Cambridge; Faculty of Education

1. The development of more respectful and collaborative relationships between teachers and students.
2. The development of respectful and collaborative relationships between students.
3. Improvement in the school environment and facilities.
4. Contributions to the improvement of the quality of learning and teaching.
5. Teachers becoming more aware of their students' potential.
6. Participation seen as more attractive.
7. Students play a part in building capacity and sustaining the work in the future.

The Learn to Lead programme was also shown to have benefits for the wider community as well. There was evidence of:

1. Contribution to positive changes beyond the school.
2. Projects contributing to improvements in relationships with the wider community.

Signs of Safety is an approach that is working towards the creation of a co-productive relationship with families. Much of the approach has been designed, and continues to evolve, in partnership with front-line workers using a collaborative, appreciative approach. At the heart of the Signs of Safety process is a risk assessment and case-planning format that is meaningful for professionals as well as to the parents and children.

One of the greatest problems to bedevil child protection practice is that assessment and planning processes privilege the professional voice and erase the perspectives of children, parents and other family members. The SOS risk assessment process integrates professional knowledge with local family and cultural knowledge, and balances a rigorous exploration of danger or harm alongside indicators of strengths and safety. The SOS format offers a simple yet rigorous assessment format that the practitioner can use to elicit, in common language, the professional and family members' views regarding concerns or dangers, existing strengths, safety, and envisioned safety.

Potential benefits from increased user and community co-production of public services[59]

For users

- Improved outcomes and quality of life.
- Higher quality, more realistic and sustainable public services as a result of bringing in the expertise of users and their networks.

For citizens

- Increasing social capital and social cohesion.
- Offering reassurance about availability and quality of services for the future.

For frontline staff

- More responsibility and job satisfaction from working with satisfied service users.

For senior managers

- Limiting demands on the services.
- Making services more efficient.

For politicians

- More votes through more satisfied service users.
- Less need for public funding and therefore lower taxes.

59 Bovaird T. and Loeffler E. (2012) *We're all in this together – User and Community Co-production of Public Outcomes* Discussion paper; University of Birmingham

Section 2: Efficiency

Early intervention evidence

In recent years a number of important policy documents have emphasised the value and importance of early intervention to support better outcomes for children and families, including The Bercow Report: A review of services for children and young people (0-19) with speech, language and communication needs (2008)[60], and The Munro Review of Child Protection (2011)[61].

In 2015 the Early Intervention Foundation (EIF) carried out an evidence review of interventions for children from conception to the start of primary school. The foundation examined over 100 interventions that focus on parent–child interaction, with a view to improving attachment and parental sensitivity, social and emotional development, and language and communication. Looking specifically at group-based programmes to target behavioural problems, several interventions in this category showed a positive effect not just on the child's behaviour but on parental stress and dysfunctional parenting practices. A group-based parenting programme known as Incredible Years, offering three levels: baby, toddler and preschool, was highlighted by the authors as showing strong evidence of positive effects. A randomised control trial showed that, post-intervention, 44% of high risk behaviour problem children whose parent received the training, moved to the low risk behaviour problem group, compared to only 19% of control group children.[62]

The Health Child Programme (HCP) is a universal service aimed at improving the health and wellbeing of children though parenting support, health promotion and screening and immunisation programmes. A rapid review of the evidence was recently undertaken to update the evidence base for the HCP. The review assessed 160 systematic reviews and an additional 50 randomised control trials (RCTs) as part of the primary reviews.[63]

The HCP evidence review highlights cost-benefit analysis of early years' programmes undertaken by the Social Research Unit (SRU). Using methods developed by The Washington State Institute for Public Policy (WSIPP), the SRU carried out cost–benefit analysis of numerous programmes targeted at children and families. SRU aimed to estimate how much a change in outcome is worth to the public purse, to children receiving the intervention, and to others in society.

A summary of the findings is reproduced in Table 1 below.[64]

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60 Bercow, J. (2008) The Bercow Report: a review of services for children and young people (0-19) with speech, language and communication needs. Department for Children, Schools and Families

61 Munro, E. (2011) The Munro Review of Child Protection: A Child Centred System. The Stationery Office

63 Axford, N et al (2015). The Best Start at Home: A Report on what works to improve the quality of parent-child interactions from conception to age 5. Early Intervention Foundation.

64 More information about the benefits of the individual programmes can be found at the website **www.investinginchildren.eu**

The majority of the programmes presented in the table produced positive cost–benefit ratios and in several cases these were significant. It should be noted that the analysis focused on outcomes that had been measured in trials and could be monetised for future benefits using the SRU model, and so there may be other positive impacts that did not meet the inclusion criteria.

1. Abecedarian

An early education programme for children from disadvantaged backgrounds that has two core components: a preschool or childcare educational programme is provided from infancy until the children enter school (0-5); a school-age programme is provided in the first three years of school (5-8), to increase family support and the child's learning.

Table 1: Short-term outcomes and lifetime monetary benefits – by programme

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Crime	-0.27	0.41	Crime	£956
High school graduation	0.08	0.26	Earnings	£2,288
Special education	-0.62	0.27	Special education	£1,309
Test scores	0.38	0.14	Earnings (including taxes)	£13,574
Benefits minus costs	**- £38,704**			
Cost–benefit ratio	**0.32**			

2. Curiosity Corner

A preschool programme designed for children (aged 3-4) who are at risk of school failure due to poverty. Curiosity Corner helps teachers to increase language ability in children and develop high-quality learning environments through the use of materials, parental involvement and professional development.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Test scores	- 0.21	0.01	Earnings (including taxes)	£5,466
Benefits minus costs	**£5,466**			
Cost–benefit ratio	**70.08**			

3. Families and Schools Together (FAST)

A two-year programme designed to prevent school failure, aggression, delinquency and substance use in at-risk school children aged 5-10. Groups of 8-12 families meet for eight consecutive weeks after school. Meetings are facilitated by a team of trained facilitators, including, for example, parents (ideally a FAST graduate), mental health specialists, and school and community agency representatives.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Test scores	0.10	0.13	Earnings (including taxes)	£665
Externalising behaviour symptoms	-0.30	0.12	Crime	£15

Healthcare	**£17**
Benefits minus costs	**£467**
Cost–benefit ratio	**3.03**

4. Family Nurse Partnership

A programme that provides intensive visitation by nurses during a woman's pregnancy and the first two years after birth. The goal is to promote the child's development and provide support and instructive parenting skills to the parents. The programme is designed to serve low-income, at-risk pregnant women bearing their first child.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.88	0.22	Social services	£434
Crime	-0.70	0.21	Crime	£639
Disruptive behaviour symptoms	-0.22	0.09	Healthcare	£4
Education costs	£46			
CAMHS costs	£5			
High school graduation	0.04	0.16	Earnings (including taxes)	£261
Special education	0.29	0.16	Special education	-£473
Test scores	0.13	0.06	Earnings (including taxes)	£3,197
Crime (mother)	-0.26	0.37	Crime (mother)	£324
High school graduation	0.10	0.09	Earnings (mother)	£10,256
Benefits minus costs	**£7,132**			
Cost–benefit ratio	**1.94**			

5. High Scope Preschool/Perry Preschool

An early childhood education programme for children from birth to 5 years with or without special needs and from diverse socio-economic backgrounds and ethnicities. The programme aims to enhance children's cognitive, socio-emotional, and physical development.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Crime	-0.42	0.28	Crime	Crime
Test scores	0.41	0.08	Earnings (including taxes)	Earnings (including taxes)
Special education	-0.67	0.27	Special education	Special education
Benefits minus costs	**£8,205**			
Cost–benefit ratio	**1.61**			

6. Parent–Child Home Programme

This programme aims to improve child literacy and school readiness for children aged 2–3 whose parents have limited education. It involves twice weekly, half-hour visits, from trained para-professionals over a period of two years. Each week, the visitor brings a new toy or book, which is used to demonstrate verbal interaction techniques and encourage learning through play.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Test scores	0.21	0.16	Earnings (including taxes)	£2,750
Special education	-0.63	0.27	Special education	£190
Benefits minus costs	**-£1,767**			
Cost–benefit ratio	**0.62**			

7. Parent Involvement Programmes

A group of programmes that incorporate parenting, communicating, volunteering, support for learning at home, participating in decision making, and collaborating with the community. An important element is increasing parental involvement and requires changing the behaviour of both parents and school staff. Parenting, volunteering, and supporting home learning result primarily from the efforts of parents; but communicating, participating in decision making, and collaborating with the community also require commitment and effort from schools.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Test scores	0.13	0.05	Earnings (including taxes)	£1,918
Benefits minus costs	**£1,233**			
Cost–benefit ratio	**2.80**			

8. Parents as First Teachers (PAT)

A home visiting programme for parents and children. PAT develops curricula that support a parent's role in promoting school readiness and healthy development of children. Parents are visited monthly by parent educators (who typically have some form of higher education). Visits typically begin during the mother's pregnancy and may continue until the child enters school (aged 4-5).

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.38	0.54	Crime	£88
Social services	£428			
Special education	£29			
Health care	£26			
Test scores	0.11	0.08	Earnings (including taxes)	£1,991
High school graduation (mother)	-0.02	0.19	Crime (mother)	-£6
Benefits minus costs	**-£982**			
Cost–benefit ratio	**0.72**			

9. SafeCare

A parent training programme for parents who are at-risk or have been reported for child maltreatment. Trained professionals work with parents in their homes to improve skills such as planning and implementing activities with their children, responding appropriately to child behaviours, improving home safety, and addressing health and safety issues.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.11	0.06	Crime	£35

Earnings (including taxes)	**£177**
Social services	**£335**
Special education	**£20**
Health care	**£11**
Benefits minus costs	**£291**
Cost–benefit ratio	**2.02**

10. Success for All

A whole-school reform model that has components that can be also used as a stand-alone curriculum. It is delivered by teachers and takes up 90 minutes each day. The programme is designed to ensure that every child will read at grade level or above. It emphasises prevention and early intervention to respond to and solve any child's learning problems.

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Test scores	0.25	0.02	Earnings (including taxes)	£2,678

Benefits minus costs	**£2,488**
Cost–benefit ratio	**14.09**

11. Triple P Positive Parenting Programme (All Levels)

A behavioural parenting intervention that comprises five levels including: a universal media-based communications strategy (Level 1); seminars for parents interested in promoting their child's development, or individual consultations for those with specific concerns about their child's behaviour (Level 2); parenting guidance and support delivered in primary care (Level 3); and group-based or individual sessions for parents of children with identified behaviour problems (Levels 4 and 5).

Short-term outcome	Effect size	Standard error	Long-term outcome	Benefit
Child abuse and neglect	-0.14	0.00	Crime	£25
Earnings (including taxes)		£147		
Social services		£99		
Special education		£11		
Health care		£9		
Out-of-home placement	-0.31	0.00	Out-of-home placement	£306
Benefits minus costs	**£478**			
Cost–benefit ratio	**5.05**			

Models for cashable returns on investment

The following programmes that provide models for cashable returns on investment were identified by the research.

Pause

Pauses offers intense therapeutic, practical and behavioural support to women who have repeated experience of their children being removed into social care, or are at risk of repeated removals. It was awarded £3 million via The Children's Social Care Innovation Programme. Pause has achieved positive outcomes that include a reduction in pregnancies and successive removals, and increased take-up of education and work opportunities. Some women who participated have regained appropriate contact with their children. Pause predicts it will reduce the number of children entering care by nearly 300 across all the local authorities in which it is operating by 2018/19.[65] This will represent a potential cost benefit of nearly £11.5 million. A full evaluation report is not expected until late 2016.

The Surrey Family Support Programme

The Surrey Family Support Programme (FSP) is a local implementation of the national Troubled Families initiative. It is a multi-agency programme that aims to help families with complex issues who have been known to public agencies for a long time, and offers them a joined up support package led by a key worker. This programme emphasises an integrated approach and a "team around the family" that includes schools, police, education welfare officers, youth workers and health visitors.

A cost–benefit analysis of the programme that looked at high value transactions across key agencies, estimated benefits over a five year period from 2014 to be £30 million.[66] As an example, in phase 1, the FSP helped 152 adults into continuous employment, which generates savings in benefits payments to the Department for Work and Pensions of £4 million upwards.[67]

The Westminster Family Recovery Programme

The Westminster City Council Family Recovery Programme (FRP) is a multidisciplinary team that was set-up to tackle families at risk. The FRP takes a whole family approach and seeks family consent before enacting any intervention. Like the Surrey Family Support Programme and other iterations of this initiative, it assigns a team and tailors the approach to the needs of each family. Based on supporting 50 families the FRP cost approximately £975,000 and contributed to avoided costs of approximately £2 million per year, giving a return on investment of £2.10 for every £1 spent.[68]

65 Spring Consortium (2016) *Children's Social Care Innovation Programme: Interim Learning Report*

66 RAND (2015) *One Place, One Budget? Approaches to Pooling Budgets for Public Service Transformation*

67 Social Care Services Board (2016) Surrey County Council. Accessed at http://mycouncil.surreycc.gov.uk/documents/s27062/FSP%20Report%20-%2025%20Jan%202016.pdf

68 Local Government Group and City of Westminster (2011), *Repairing broken families and rescuing fractured communities: Lessons from the frontline*

The Radical Efficiency model

'Radical Efficiency' is an approach adopted by the National Endowment of Technology, Science and the Arts (NESTA) and the Innovation Unit that aims to redesign services to improve outcomes and save money. It has four key components:

- *New insights* – new sources of knowledge and ideas.
- *New customers* – re-conceptualising customers.
- *New suppliers* – looking at who is doing the work.
- *New resources* – using latent resources we take for granted.

Make It Work is a case study of the radical efficiency model in action. Sunderland Council awarded a service design company called Livework with a contract to address worklessness. Livework's approach included developing new insights and looking at existing resources that could be tapped into. They developed an 'activity coalition', integrating services at all stages of the user journey. The also pooled into one brochure the various resources of community groups they had identified.

It is reported that, in its initial phase, Make it Work helped over 1,000 people, and that 238 of those found work. The programme cost £180,000. Analysis estimated the overall cost avoidance at £435,000, which based on programme participants entering sustained work, amounts to initial savings of £255,000 (See also Table 2, below).[69]

Table 2: Benefits and cost savings from Make It Work

Benefits	Costs
Gets people back in to work, reduces worklessness. The scheme has supported more than 1,000 people, with 238 finding work. Providing ongoing support for people who are still unable to make the whole journey back into work, to improve the quality of their lives.	Initial cost savings to Sunderland Council of £255,000. The average cost per person for the Make it Work project is less than £5,000. Estimates from the Design Council and Department for Work and Pensions show that it is economically rational to spend £62,000 on getting the average person on incapacity benefits back into work. This amounts to a saving of 90 per cent (£57,000 / 62,000). In February 2010 there were 1.64 million people claiming unemployment benefits in the UK.

69 Gillinson, S et al. (2010) *Radical Efficiency: Different, better, lower cost public services*, NESTA

Additional school-based programme models that show evidence of increased efficiency, including cost-benefit ratios achieved by the programmes, are outlined in Appendix 1.

Building alliances to create integration

An alliance is, in effect, a virtual organisation consisting of a number of different organisations working towards a common vision and outcomes. The members of an alliance drive the synergy whereby the benefits of acting together are greater than those obtained by acting individually. Collective ownership of opportunities and responsibilities combines with shared decision-making. Alliancing can be applied to the delivery of services, co-design, research and development, innovation and change programmes. All alliances have the following outcomes in common:

- Formalises collaboration to accelerate and strengthen shared goals.
- Drives innovation and fresh thinking.
- Values parties equally however big or small.
- Maintains each party’s unique identity.
- Uses whole system outcomes to align success for each party.[70]

The commissioner will contract ‘the alliance’ as a whole, rather than the separate members of that alliance and this single contract creates a collaborative environment without the need for new organisational forms. The contract is based on the outcomes to be achieved so that there is freedom for providers to come up with innovative ways to deliver these. The providers are not constrained by a detailed service specification.

The basis for working in this way is that the owners recognise that putting together different people with different perspectives provides a rich source of ideas. They are signalling that they want collaboration, innovation and continuous improvement.

All those involved in delivering the service work together to make sure the whole service is successful. They know they will not be judged on their individual contribution but on the performance overall. They are collectively responsible for success and collectively at risk for failure. This collective responsibility means that everyone has a vested interest in each other. It creates the sense of ‘your problem is my problem, your success is my success’. Working together in a spirit of openness, mutual benefit and with a desire to achieve the best outcomes possible has led to people in alliances elsewhere achieving outstanding results.

There is usually a ‘gainshare / painshare’ approach – a reward and penalty type of arrangement. This means that when there is above expected performance then the parties share in additional monies. However if there is less than

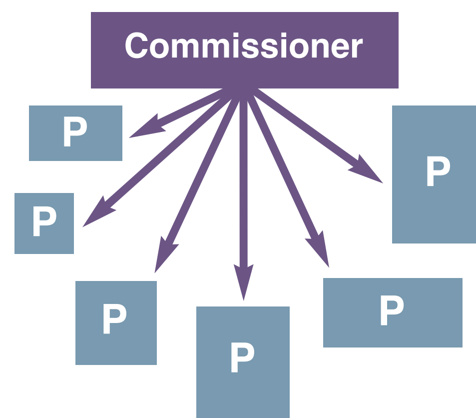
70 www.LHAlliances.org.uk

expected performance, some monies are held back. The precise form of agreement is specific to every situation and would be negotiated openly with all parties.

The use of alliances is being seen increasingly as a viable option across the public sector, especially as a mechanism to integrate services and sectors within the parameters of reduced budgets and greater demand. There are many examples of alliancing in the UK although they are fairly new developments and have yet to be tested over a prolonged period of time. See also 'Lambeth Living Well Collaborative' for an example of alliance contracting.

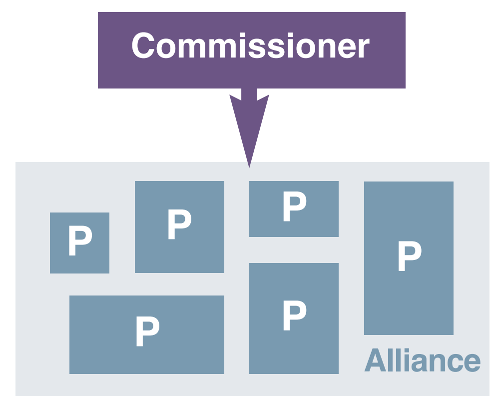
Figure 1: Alliance Contracts

Traditional contracts



- Separate contracts with each party
- Separate objectives for each party
- Performance individually judged
- Commissioner is the co-ordinator
- Provision made for disputes
- Contracts based on tight specification
- Change not easily accommodated

Alliance contract



- One contract, one performance framework
- Aligned objectives and shared risks
- Success judged on performance overall
- Shared co-ordination, collective accountability
- Based on trust and transparency
- Contract describes outcomes and relationships
- Change and innovation in delivery are expected

Source: LH Alliances Ltd 2016

Stockport Targeted Prevention Alliance (TPA)

Stockport Council had over 60 separate contracts and grants with charities and other organisations, which were providing services for those who needed additional support but who did not meet eligibility criteria. Faced with an impending severe reduction to budgets and frustration that there was little collaboration across these 'label' specific services, the council put all suppliers on notice and put out a tender for an alliance of providers to deliver a generic service. The winning bid included six providers: a mix of local and nationals. These now run a completely integrated offer on a funding envelope well below the combined previous total, with service focused on outcomes and 'style of delivery' as set by the Council. One of the outcome areas is to build community assets and social action. The TPA is formed of Threshold, Age UK Stockport, FRAG, NACRO, Relate and Stockport Homes. The staff structure of the alliance has been purposely integrated so that although each employee is employed by the parent organisation, the line management falls to the alliance manager. Additionally, the expertise of the staff is amalgamated so that each worker holds a specialism but also delivers generic work. While it is too early to be able to demonstrate clear improvements in outcomes, early indications are that the alliance relationships are more open and transparent as each member has a joint vested interest in the performance of the contract. A wealth of resources and expertise arise from each provider organisation so that the delivery grows and adapts more quickly than a single traditional contract. Alliance beneficiaries may also have more choice, as there is a larger pool of workers and resource for them to draw on.

In 2007, the district health boards (DHBs) in Canterbury, New Zealand, used a collaborative approach to bring stakeholders together, to transform the existing system into one that provided integrated care, which crosses the boundaries between primary, community, hospital and social care.

Out of these processes came key messages: that despite the many parties involved in providing health and social care in Canterbury, there had to be 'one system' – and that in reality there was only 'one budget'. 'One system, one budget' became a mantra that senior leaders in Canterbury and many others, continued to echo as the health and social care system changed. In light of this, a set of strategic goals and principles were drawn up, laying out how the health system should develop and what it should look like.

The collaborative work of the stakeholders has helped to move Canterbury from a position where its main hospital in Christchurch regularly reached 'gridlock' to one where that rarely happens. A King's Fund report[71] concluded that Canterbury demonstrates a number of positive outcomes as a result of the alliance approach:

71 Timmins T., Ham C. (2011) *The Quest for Integrated Health and Social Care – A case study in Canterbury, New Zealand,* The King's Fund

- It has low rates for acute medical admissions compared to other health boards in New Zealand and its acute readmission rate is also low.
- Good quality general practice keeps patients who do not need to be in hospital out of it, is treating them swiftly once there, and discharging them safely into good community support.
- Reduced strain on the hospital and greater efficiency within it has prompted fewer cancelled admissions.
- The proportion of elective work in Canterbury rose from less than 23 per cent of its activity in 2006/7 to 27 per cent in 2011/12. Many thousands of more elective procedures are being performed. Waiting times for elective surgery are down.
- General practitioners (GPs) have been provided with direct access to a range of diagnostic tests that substantially reduce the number of patients needing onward referral to secondary care.
- The Canterbury health system can claim it has saved patients more than one million days of waiting for treatment in four clinical areas in recent years.
- Fewer patients are entering care homes as more are being supported within the community. A rising curve of demand for residential care has been flattened.
- Better, quicker care is being delivered, and more of it provided without the need for a hospital visit.
- A health system that in 2007 was almost NZ$17m in deficit on a turnover of just under $1.2bn was on track to make an $8m surplus in 2010/11.

A key support mechanism for the system change was Canterbury's shift to the use of alliance contracting for many of its external services – for example, district nursing and mental health. The alliance contract replaced the input-defined, competitive and often 'fee per item of service' contracts, with penalties for under-performance. The idea has created a 'high trust, low bureaucracy' approach to contracting. This encourages innovation that goes beyond the means of delivery because the broader outcome – namely, 'What is best for the patient? What is best for the system?' –has become the overarching goal. During interviews with managers in the various alliances they volunteered, unprompted, the proposition that this is a 'high trust' environment, in which problems are aired rather than kept hidden from competitors or the funding body. The alliance concept also helped to drive home the idea that there is only 'one system, one budget' – within both the community setting and in the interface between the community and the hospital.

The King's Fund report highlighted the way alliance contracting involved the presiding health board giving away some of its power to the partners in the contract.

> The board is only one part of the alliance. But the gain is that 'we now have a whole heap of people working with us to make things work. So you have gone from being solely accountable to having a collection of people trying to make the whole system work.[72]

There are a number of other examples across the UK of alliances being developed to aid the integration of services, across health and social care, NHS trusts and children's trusts. These are in their infancy so there is a parcity of evidence regarding their overall impact on the systems they serve. The following are short summaries of these areas:

The Symphony Project – South Somerset

In 2012, the Symphony Project was set up to integrate health and social care in South Somerset. Somerset Clinical Commissioning Group (CCG) and local partners together defined the ambition to improve dramatically the way in which health and social care is delivered in South Somerset. As well as a shared wish to design a new, more integrated, care model there was also recognition of the need for a new approach to working together.

The partners developed a plan to adopt alliance contracting, because it embodied the collaborative spirit of the project.The 'design' alliance members included commissioners from the CCG, local authority and area teams, and providers including NHS trusts, social care and GPs.

The first step for the project was to understand the needs of the local population and to undertake an in-depth analysis into the demographics using individual level data sets. The following insight was developed:[73]

- Health and social care costs increase as people get older.
- But as people get older, they develop comorbidities.
- Costs increase the more comorbidities a person has.
- Costs are explained more by the number of chronic comorbidities (11%) than by age (3%).

This data analysis helped to shape the Symphony Project by changing the focus away from the frail elderly and towards adults with several health conditions. The analysis also influenced the decision to develop a multi-morbidity model of care and was used to gain buy-in from clinical staff – which enabled the implementation of a capitated budget.

The next step for the Symphony Project alliance was to seek ideas from current frontline staff and people with lived experience. They reviewed national and local publications, held one-to-one interviews with people with long-term conditions, and facilitated events with many other citizens, carers and frontline

72 Timmins T., Ham C. (2011) *The Quest for Integrated Health and Social Care – A case study in Canterbury, New Zealand,* The King's Fund

73 Kasteridis P. et al (2014) *The Importance of Multi-morbidity in Explaining Utilisation and Costs across Health and Social Care Settings: Evidence from South Somerset's Symphony Project* University of York

staff. The insights were used to guide design work and formulate the outcome set. The framework used a modified version of Michael Porter's heirarchy of health outcomes[74] and included defined objectives for wellbeing status, the process of care and the sustainability of services. The outcomes, performance framework and design principles were used to shape the implementation of four expert care hubs in South Somerset.

The care hubs enabled the following transformation of provision:

- Single care plan, single pathway.
- Expert generalist medical input.
- One care coordinator to manage the transition from current pathways to a single pathway.
- Provision of key workers to build relationships and act as health coaches.
- Early detection of health crisis with wraparound health plus social care.

The development and implementation of alliance contracting has been paused currently in South Somerset, but the Symphony Project is a good example of utilising an alliance for the design and transformation of a system.

Improving health and social care services for the over 65s in Croydon

Croydon CCG and Croydon Council are in the process of jointly commissioning a 10-year 'outcomes based commissioning' contract for all services for over 65s from an alliance of health and social care providers. This alliance will be expected to work with other organisations to deliver health and social care services for local people.

The following five organisations have been selected to form this new alliance following a robust selection process overseen by commissioners:

- Age UK Croydon.
- Croydon Council Adult Social Care.
- Croydon GPs Group (which aims to include all the GP practices in the borough).
- Croydon Health Services NHS Trust.
- South London and Maudsley NHS Foundation Trust.

The initial exploratory phases of the project have involved providers, local clinicians, carers, and over 400 local residents. Providers, clinicians, carers, patients, and the public will continue to be involved in all aspects of this work.

74 Porter M Professor & Teisberg E. (2009) '*A Strategy for Healthcare Reform – Toward a Value Based System', New England Journal of Medicine*

Living Longer Living Better programme – Manchester[75]

The health and social care landscape across Manchester is a complex one. Within the area covered by Manchester City Council, with a population of more than 500,000 residents, there are seven NHS organisations – three CCGs, three acute and community service providers, and a mental health trust. Social services, general practices, an ambulance trust and many providers of care within the independent and voluntary sectors also need to be taken into account, as well as informal carers who look after friends and relatives.

Together, the eight statutory organisations – the City Council and seven NHS bodies – have committed to work in partnership. The partners have been working together informally on achieving the goal of integrated care, since 2010. They had some success but there was a growing sense that the work needed to move at greater scale and pace. Consequently early in 2013 a multi-agency group of eight senior leaders was created (one from each of the partner organisations) to create a 'blueprint' for the way forward. This group captured the vision for Manchester as being 'Living Longer Living Better'. The need for a new style of leadership was explicitly recognised in the strategic outline case, which stated:

> If we are to build a new system of health and wellbeing…a whole system that works holistically for citizens and families at a neighbourhood or place level, we will need a new leadership approach. The leaders of the new world in the context of public sector reform need to be able to work upwards, outwards, horizontally and vertically in their own and other organisations.[76]

Over the past 18 months there have been a number of notable steps forward. These include the programme moving away from the focus on the sickest two per cent to encompass the whole 100 per cent of the population and an agreed approach to developing commissioning-led care models, which set out the standards of service delivery expected for particular groups in the population. The latter have enabled commissioners to create the space for providers to work together collaboratively. In more than 20 cases, formal alliances have been contracted to create new service delivery models in response to commissioning-led care specifications.

75 Fillingham D. & Weir B. (2014) *System Leadership – Lessons and learning from AQuA's Integrated Care Discovery Communities,* The King's Fund

76 Fillingham D. & Weir B. (2014), *System Leadership – Lessons and learning from AQuA's Integrated Care Discovery Communities,* The King's Fund

Umbrella

Umbrella is a service formed from an alliance of the University Hospitals Birmingham NHS Foundation Trust, health service providers, charities and community-based organisations. It provides free and confidential sexual health services in Birmingham and Solihull. The service aims to increase effectiveness and efficiency by using a joined-up approach and focusing on community engagement and self-care rather than hospital led approaches to sexual health practice. The model is focused around prevention and has five key strands of care:

1. *Health promotion* – changing behaviour through education and awareness.
2. *Self-care* – empowering patients to care for themselves.
3. *Local services* – embracing a wide network of community-based facilities.
4. *Primary care* – transforming access to care.
5. *Specialist services* – dedicated centres for sexual health.

Models of integration of health and social care

The research has identified several examples of integrated health and social care that provide useful evidence to inform Suffolk's strategy.

Sutton Uplift

Sutton Uplift is an integrated mental health service formed from a partnership between South West London, St George's Mental Health NHS Trust and local voluntary sector organisations. The service provides a single point of access where health and social care needs can be assessed concurrently. Sutton Uplift focuses on developing resilience and social capital in order to reduce healthcare needs. Increased wellbeing is a core outcome and the service provides tailored support through 'wellbeing navigators', recovery and wellbeing support and self-management courses.[77]

Connected Care

Connected Care is a model developed by Turning Point that drew upon the March 2005 Green Paper on Adult Social Care, *Independence, Well-Being and Choice*[78]. A core aim of Connected Care is to bridge the gap between health and social care and to empower communities to be part of the design of services.

Turning Point identified four key stages in the Connected Care methodology:[79]

77 http://www.suttonuplift.co.uk/index.php

78 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272101/6499.pdf

79 http://www.turning-point.co.uk/media/209014/cc0013_connectedcarebrochure_proof.pdf

1. A community-led needs assessment is conducted by trained community representatives. These community researchers drive engagement in every section of the local community through rigorous research.
2. The research leads to recommendations, based on a strict cost–benefit analysis. The recommendations are reviewed by a local steering group made up of local authority, NHS, third sector and community representatives.
3. Service redesign or reconfiguration delivers new levels of efficiency by focusing on service integration and meeting the needs of service users and commissioners alike.
4. Set-up of new services is co-produced by the community

The pilot of Connected Care launched in 2006 in Owton, a ward of Hartlepool that is one of its most deprived areas, and ranked nationally as being in the top 5% on the Index of Multiple Deprivation (IMD). The aim in Owton was to provide a connected service that met the needs of the community via joined-up commissioning, and health and social care delivery.

Key objectives identified for Owton were as follows:[80]

- Better information to residents, proactively provided at the right time and place.
- Support to empower people to make choices for themselves.
- Improving access to services by:
  - Providing better information
  - A single point of entry to all service.
  - The provision of outreach services.
  - Bringing more services closer to home
  - Integration of services
- To ensure continuity and co-ordination in service delivery.
- To tackle crime and fear of crime that can restrict access to services and a good quality of life.
- A social enterprise vehicle to deliver the above components, managed by residents and local community organisations, with statutory agencies as stakeholders.
- The development of a broader range of low-level support services that focus on maintaining independence.
- A continuing partnership between residents, councillors and agencies to commission and monitor Connected Care.

The service is run through a Community Interest Company (CIC) and functions

80 Hartlepool Connected Case Study (2010). Accessed at http://www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/Learning_network/Service_development/?parent=7817&child=8538

by using ‘navigators’ who work to grow access, support choice and promote early interventions. Alongside the navigators there is a project manager to oversee the service and a wider care team that integrates health, social care and housing support. The service also provides additional low key offers such as a mobile outreach unit, a time bank, and an emergency fund for small grants.

Connected Care operates in 14 areas. An evaluation by the University of Durham concluded that people are less likely to be disengaged from services as prevention is being achieved, and that the navigator service improved access, choice, information, continuity and coordination.[81]

81 Hartlepool Connected Case Study (2010). Accessed at http://www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/Learning_network/Service_development/?parent=7817&child=8538

Section 3: Integration

Increasing the age of transition to 25

Emerging adulthood is a period from late teens to mid-twenties that holds many transitions, such as leaving education, entering work or training, changing family dynamics, and moving away from home. Young people who access health and social care services during the period of emerging adulthood may find this time particularly challenging and stressful. For this reason, it is becoming increasingly accepted that transitioning from child services to adult services during the late teens is not in the best interest of young people. Indeed McGorry et al. argue that if the services were being designed now, with the knowledge we have, transitioning at age 16-18 would not be an option, as it would be considered harmful.[82]

The National Institute for Health and Care Excellence (NICE) identifies a range of negative outcomes that can stem from a poorly managed transition. These include:

- Worsening health.
- Disengagement from services.
- Broken relationships with health and social care practitioners.

Furthermore, poorly managed transitions leave young people, 'feeling as though they were being punished for reaching a certain age and as if they were approaching a 'cliff edge.[83] Young people who experience poor transitions in health and social care service can consequently experience negative effects in education and employment services, due to the disruption. NICE recommendations do not explicitly recommend an age range for the transition to adult services. The guidelines state that transition planning and service provision should be developmentally appropriate, taking into account maturity; cognitive abilities; psychological status; needs in respect of long-term conditions; social and personal circumstances; caring responsibilities; and communication needs.

The Joint Commissioning Panel for Mental Health states that there is no 'best practice' model for meeting the needs of young people transitioning to adult mental health services and that services should be aligned to local context and needs.[84] Some good practice principles include guidance from NICE (2016) which states that the point of transition should not be based on a rigid age threshold, and should take place at a point of relative stability for the young person. Furthermore, a study by Murcott et al. of transition points in mental health services makes the argument that, 'the importance of the therapeutic relationship, the

82 Liverpool Public Health Observatory (2015) Rapid Evidence Review Series: Effective pathway from child to adult mental health services

83 NICE guideline scope: Transition from children's to adult services

84 JCP-MH (2012). 'Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services'. London: Joint Commissioning Panel for Mental Health. JCP-MH

understanding of the cultural context of the young person and the placing of the young person in a position of autonomy and control should be central to any decision and process of transfer between two mental health services.[85]

Existing practice models for extending mental health services to the age of 25 are outlined in Liverpool Public Health Observatory's rapid evidence review:[86]

Australia

In Australia, Headspace is an expanding primary care level model of youth mental healthcare, operating nationally across the country. It provides early intervention for people aged 12-25 with mental ill-health. It is run via highly accessible youth-friendly centres that operate as a 'one-stop-shop', covering all of young people's physical and health needs. An initial evaluation shows clinicians and young people reporting how useful it was to have medical and counselling services co-located. The 'early intervention for psychosis programme', focused largely on young people aged 15-24. It is being scaled up across Australia and will be linked where possible to the expanding Headspace network. This will provide a backup for young people in Headspace who need a more specialist service with a youth-friendly culture. In Melbourne, south east Australia, a comprehensive service for the under 25s is already in place. The Orygen Youth Health programme provides a second tier backup system to Headspace, for those aged 15-25 with complex or severe conditions who need more specialist mental health services. It offers four specialised clinics and one in-patient facility, covering different mental health needs. There is a focus on vocational interventions and groups that assist clients with school, study and work goals and functioning (McGorry et al, 2013)[87].

Birmingham, UK

In the UK, Youthspace in Birmingham has provided improved youth access and care through the redesign of existing secondary mental healthcare provision. Youthspace was created by the Birmingham and Solihull Mental Health Foundation Trust, in partnership with the Prince's Trust, to jointly deliver mental health services to young people under 26 years old, placing social inclusion and employment at its heart. Young people are assessed within one week of referral and are seen on sites of the young person's choice, including primary care or Prince's Trust facilities, which have low stigma associated with them. Youthspace operates across Birmingham, providing mental awareness and interventions to promote resilience in young people in schools or targeted groups. Evaluation of Youthspace is in progress (McGorry et al, 2013). Paul et al (2013)[88]. note that some would debate whether separate youth mental health services are preferable. They suggest that there might be an argument for generic adolescent health services rather than condition-specific (e.g. psychosis-specific) or youth mental health services.

85 Murcott, W. J. (2014). 'Transitions between child and adult mental health services: Service design, philosophy and meaning at uncertain times'. *Journal of Psychiatric and Mental Health Nursing*, Vol 21(7), Sep, 2014. pp.628-634.

86 Liverpool Public Health Observatory (2015) Rapid Evidence Review Series: *Effective pathway from child to adult mental health services*

87 McGorry P., Bates T., & Birchwood M. (2013) Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. The British Journal of Psychiatry 202 (Suppl. 54), 30–35.

88 Paul, M., Islam, Z., Singh, S. P., Ford, T., Kramer, T., & Harley, K. (2013). Transfers and transitions between child and adult mental health services. British Journal of Psychiatry, 202, s36-s40.

Young people with learning disabilities are at particular risk of having a poor transition experience. This is partly because they may be educated at residential schools some distance away from both their local authority and their family. This distance during a time when transition planning should be in effect (from year 9 onwards) can lead to poorer outcomes. The international literature has also identified that disabled young people have poorer outcomes of transition than their non-disabled peers in a range of areas, including academic achievement, employment and community participation. A study by Knapp et al. (2008)[89] found that unsuccessful transitions, which fail to set up young disabled people with good educational and employment outcomes, have significant economic impacts:

> for example losses in direct and indirect tax revenue and national insurance contributions when comparing actual and potential earnings (potential being earnings of non-disabled people with equivalent qualifications) are £76 per week for employed disabled males, and £128 for unemployed disabled males (2005-2006 prices).[90]

Emotional well-being and resilience as key outcomes

Systemic thinking – a family therapy approach

Systemic thinking involves moving from focusing only on the individual, to looking at the wider 'system', made up of families, networks and organisations, which surround the individual. With this approach focusing on the child alone does not address the source of the problem.

Systemic thinking in family support can encapsulate interventions such as family therapy and parent training. There is evidence to suggest systemic therapy could be more effective than intervention such as cognitive behavioural therapy (CBT), family psychoeducation and prescription for antidepressants. Looking specifically at comparisons between individual interventions and systemic family-based interventions, family-based interventions lead to equal or better outcomes.[91]

Systemic family therapy is cost-effective when compared with individual therapy, as shown in a study of 3,000 young people with a conduct disorder who received a range of health services in the Kansas Medicaid system in the USA. The findings demonstrate that healthcare costs for those receiving in-office family therapy were 32% lower than for those receiving individual therapy, and that healthcare costs for those receiving in-home family therapy were 85% lower than individual therapy would have been.[92]

89 Knapp, M., Perkins, M., Beecham, J., Dhanasiri, S. and Rustin, C. (2008), 'Transition pathways for young people with complex disabilities: exploring the economic consequences'. *Child: Care, Health and Development*, 34: 512–520

90 SPRU (2010) *Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs*

91 About Families (2012) 'Systemic Therapy: What difference does systemic therapy make to the outcomes for children and families?' **https://aboutfamilies.files.wordpress.com/2012/12/erb_systemic-therapy_dec121.pdf**

92 Crane, D.R. and Christenson, J.D. (2012) 'A Summary Report of the Cost-Effectiveness of the Profession and Practice of Marriage and Family Therapy'. *Contemporary Family Therapy*, 34:204–216

Toxic trio – parenting support

It is common for practitioners in health and social care to encounter families experiencing what is referred to as the toxic trio – a combination of mental health problems, domestic violence and substance misuse. Families that interact with children's services may also experience a range of additional problems including emotional wellbeing issues, neglect, and learning disabilities. Despite this fact, services can often be designed around a particular problem, such as substance misuse, rather than holistically designed around the family.

The evidence suggests that parents experiencing a single problem such as poor mental health or alcohol or substance misuse may, with adequate support, be an effective parent who does not significantly harm their child.[93] However, having a parent who experiences multiple coexisting problems greatly increases the risk to a child's health and emotional wellbeing.

The Institute of Public Care (IPC) at Oxford Brookes University carried out a rapid review of the evidence on working with families experiencing the toxic trio of problems. The review found that evidence was lacking to support the use of specific interventions, to address two or more aspects of the toxic trio. Furthermore, programmes designed for a parent with both mental health and substance misuse problems rarely took a holistic approach that included child-specific outcomes as part of the recovery model. The IPC review is a good resource for identifying what works, when addressing domestic violence, substance misuse or mental health problems as individual issues.[94]

The Early Intervention Foundation (EIF) carried out a review of 'What works to enhance inter-parental relationships and improve outcomes for children'. The review examined the literature in order to determine the effects on child development and the implications for policy and practice. It found that inter-parental conflict had negative effects on children of all age groups; consequently inter-parental relationships have been identified as a site for early intervention work. Key findings from the review include:

- How parents communicate with one another is particularly relevant to child outcomes, with repeated, intense and poorly resolved conflict impacting negatively on mental health outcomes and life chances.
- Targeting the parent–child relationship for interventions needs to be done in the context of addressing ongoing inter-parental conflict, in order to improve positive outcomes for children.
- In both intact and separated families, child wellbeing is impacted by inter-parental relationships, family functioning and high parental stress.
- Family breakdown has a fiscal cost of £47 billion per year, however this does not incorporate the cost of poor inter-parental relationships and family functioning.

93 Cleaver et al (2011) *Children's needs – parenting capacity: child abuse: parental mental illness, learning disability, substance misuse and domestic violence* (2nd ed) London, The Stationary Office

94 Institute of Public Care (2015) 'Working with Families where there is Domestic Violence, Parent Substance Misuse and/or Parent Mental Health Problems: A Rapid Research Review'

- Further research is needed to identify the fiscal cost of poor family functioning, regardless of whether it leads to family breakdown or the family staying intact.
- 15 UK-based interventions designed to improve inter-parental relationships and outcomes for children were examined in the review. It found that this work is still in its early stages in the UK and more work is needed to build up the evidence, based on the effectiveness of these programmes.

The Systemic Unit Model

The Systemic Unit Model, also known as Reclaiming Social Work or the Hackney Model (named after the London borough where it was first piloted), seeks to improve outcomes for children and families by creating small work units or 'pods' to deliver high quality social care. The model emphasises multi-disciplinary teamworking and direct work with families, that looks at all the central relationships in a child's life and how they can be improved to create the best outcome for the child. An evaluation of systemic units in three local authorities (referred to as LA1, LA2 and LA3) was carried out by the University of Bedfordshire in 2013. The evaluation identified six key features of the Systemic Unit Model:[95]

1. Shared work – Cases are allocated to the consultant and held within units. This means families and children receive input from multiple workers as appropriate. It allows a higher level of input for complex families or during a crisis. It contributes to a far more consistent service for families. It also moves social work from being primarily a private activity, between worker and parents or children, to being a shared activity. As a result workers are provided with explicit and implicit feedback on things they had do well – and areas they might improve upon.

2. Quantity and quality of case discussion – Shared working necessitates far more discussion of cases. As case responsibility is held by the unit, there is informal debriefing after almost every visit and structured in-depth discussion of every child and family on a regular basis. The impact of this on the quality of decision-making is discussed below. It also appeared to contribute to emotional support and containment for workers. Discussion again involves learning from each other. Here the clinician is particularly important but all unit members contribute to an approach that inevitably involves learning from one another.

3. Shared systemic approach – A consistent feature of our observations in LA1 was that systemic ways of thinking informed much of the discussion and decision-making for children and families. These approaches seem well suited for encouraging the exploration of alternative viewpoints and explanations and for mobilising family resources. In this sense a shared systemic approach provided a common language for creatively thinking about cases. In contrast, there was very little evidence of the use of theory in the work of the other authorities. Discussions

95 Forrester, D, et al, University of Bedfordshire (2013) 'Reclaiming Social Work? An Evaluation of Systemic Units as an Approach to Delivering Children's Services'

of cases tended to be focussed around more practical issues and decision-making, with little generation of alternative hypotheses.

4. Role of the Unit Co-ordinator (UC) – UCs are more than administrators, they coordinate the work of the team. They are more like a Personal Assistant (PA) than a conventional administrator as they cover a wide range of tasks. The UC almost always has a good understanding of what was going on in every case and deals with many practical arrangements. UCs are often well known to children and parents involved with the units. They dealt with emergencies, providing back-up and support for workers and families, from minor issues such as problems with transport through to staying late to support workers during emergency proceedings. UCs provide in some senses the “glue” that keeps units together.

5. Other roles – The consultant obviously has a key role to play. They are similar to a Deputy Team Manager (DTM) in other local authorities, but the fact that they work with families and also manage cases means that they have more direct insight into families. We only observed good or very good consultants. It is a moot point how a unit would work with a less than adequate consultant. It would certainly be difficult for the unit, but it would also be very difficult for the consultant, as the role involves a constant display of one’s practice and analysis skills. Clinicians have a crucial role in the units. Their expertise and authority without managerial power provides a constant source of input, skills development and alternative viewpoint in teams. It is hard to imagine the units working as well without clinicians. The roles of child practitioner and social worker are less distinctive. We rarely observed a child practitioner being a specific ‘voice for the child’. The role appeared close to that of a social work assistant in more conventional teams – though practice varied between units.

6. Skills development – LA1 specifies the methods it wants workers to use, namely systemic and social learning approaches. It has invested heavily in these approaches, expecting workers to undertake externally provided courses. LA1 did not take part in conventional post-qualifying social work training, prioritising their preferred ways of working instead. LA2 and LA3 had a more conventional approach, delivering programmes of time-limited, in-house training and sending workers for in-depth, post-qualifying training.

Getting it Right for Every Child (GIRFEC)

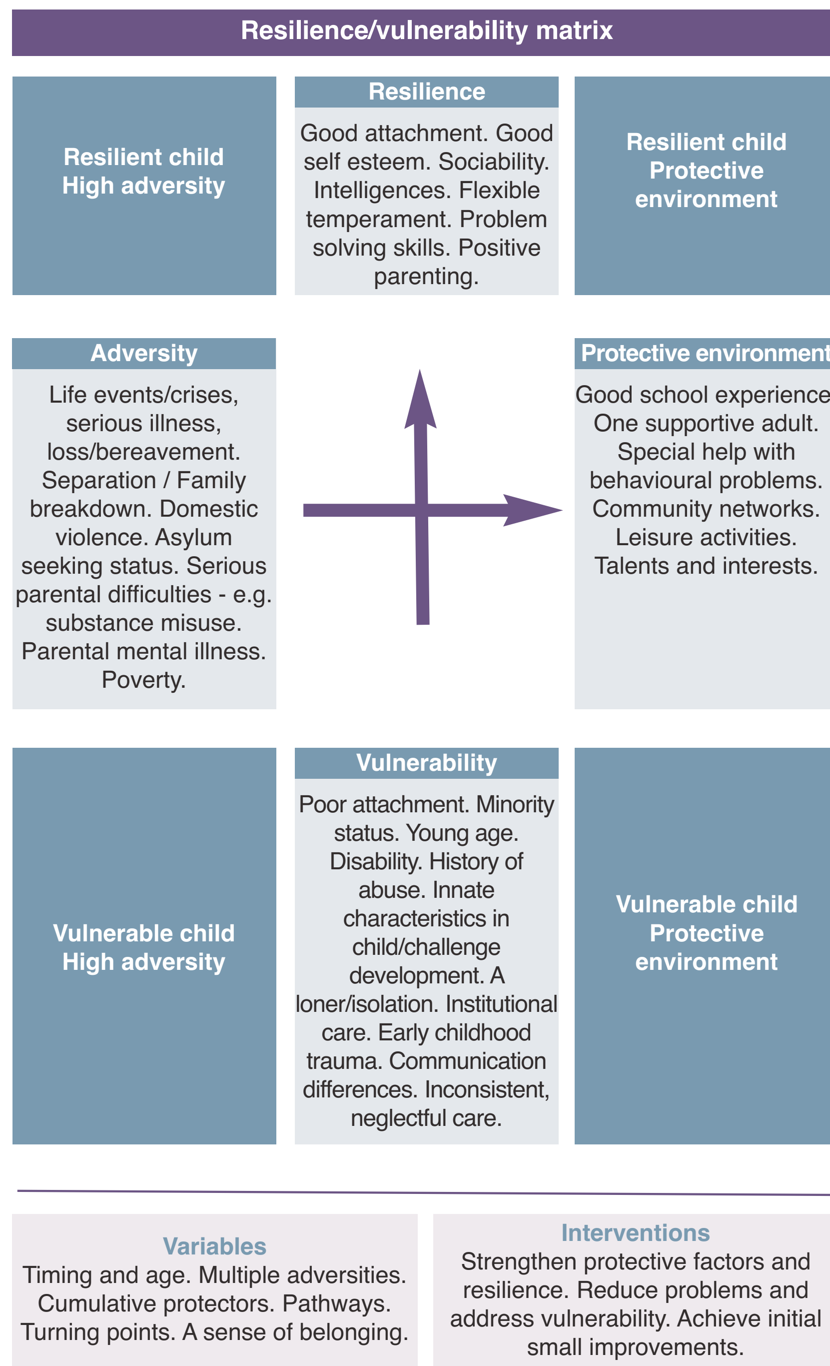
GIRFEC is a national, cross-agency strategy instigated by the Scottish Government to improve outcomes for children and young people. It provides a coordinated approach for all services working with children and families that emphasises the need for appropriate, proportionate and timely support. The goal of the programme is for children to be safe, healthy, achieving, nurtured, active, respected, responsible and included. These outcomes are called the eight SHANARRI domains and are based on resilience theory of positive wellbeing and protective factors.

GIRFEC is embedded in Scotland through a National Practice Model that

assists with measuring progress at the national level. The model provides practitioners with a common framework for observing, recording and analysing information on child wellbeing, and also for revising the approach and action planning. The use of a common framework is a key success factor for joint working used by multiple providers in this area.

One feature of the National Practice Model is a resilience and vulnerability matrix that identifies protective and risk factors that impact outcomes, as outlined below:

Figure 2: GIRFEC Resilience/Vulnerability Matrix[96]



96 GIRFEC Resilience/Vulnerability Matrix, accessed at http://www.gov.scot/Topics/People/Young-People/gettingitright/national-practice-model/resilience-matrix

A lack of co-ordination between services has been linked to poorer outcomes for children and families. The Scottish Government recognises that strong, effective cross-agency working is vital to delivering GIRFEC, which has integration at its heart. A briefing paper by the University of Stirling identified factors from existing research that support the successful delivery of co-ordinated cross-agency programmes such as GIRFEC:

1. *Strengthen inter-agency working relationships* – This requires having a clear delineation of responsibilities, and a shared understanding of what each role brings and how it is unique, in order to recognise the contribution that each agency makes.
2. *Establish and review inter-agency processes* – Use inclusive planning and consultation with service users and member agencies. Maintaining constant communication throughout is important and is aided by having good IT systems and transparent structures for communication.
3. *Provide adequate resources for inter-agency work* – Adequate funding, staffing and time are all crucial to the success of inter-agency work, as is a clear agreement about how resources will be pooled and managed.
4. *Ensure strong leadership in management and governance:* Inter-agency work is damaged by the lack of a clear leader or coordinator and management support. Clear lines of accountability and a governance framework are also important.
5. *Draw on existing good practice to foster effective inter-agency work* – Critical success factors in this area include providing sufficient time to develop inter-agency working, an agreement of joint aims and objectives, and the provision of joint training.

How to better use space – rethinking the public estate and community buildings

Open Works

In February 2014, a pilot project was launched in West Norwood, south London, mobilising 1,000 people to reconfigure their neighbourhood for everyday benefit. In partnership with Lambeth Council, the Open Works united residents of the neighbourhood who used a collaborative platform approach to prototype 20 new, community-led initiatives. These included:

- *The Stitch* – A regular meet-up of people who want to knit, sew, tailor, upholster and craft together. It offers the chance to share and learn skills, swap tips and get inspiration for your next creation.
- *The Great Cook* – Batch cooking together.
- *The Open Orchard* – A project that encourages the planting of fruit trees in public spaces.

- *The Norwood Bzz Garage* – Creating bee-friendly habitats and shared growing spaces.
- *The Trade School* – An open learning space that runs on barter. Anyone can teach something they are skilled at, or passionate about. Pay for class with a barter item that your teacher requests (such as food supplies or advice).
- *Public Office* – A network of freelancers and home workers who meet to co-work for a couple of hours around creative, tech or enterprise in different local spaces. Just turn up, meet people and work.

An evaluation[97] of the scheme found that the small amount of seed-funding from Lambeth Council had indeed enabled success in achieving bottom-up change, building valuable social capital between those who were usually outside each other's networks.

There were significant gains across all projects in the following:

- Social capital.
- Happiness and wellbeing.
- Confidence.
- Learning.
- Access to support to develop ideas.

The idea of developing an approach based on participatory culture started with the observation that some innovative local projects were achieving inclusive participation and appeared to be attracting many different types of people. Common attributes were the social, practical and productive nature of the projects. The experience of participating looked and felt different from that in many existing volunteer, campaign or charity activities.

New projects with a culture of participation involve activities that are intrinsically appealing to more people, such as cooking, learning, making, trading, sharing, growing. Often, viewed as 'common denominator' activities, these provide an experience of co-producing something tangible, as a group of equal peers. One of the key differentiators of this model compared to others, is that these projects create mutually beneficial experiences. Participants contribute and benefit equally in the same act, as neighbours and peers, without being targeted or labelled. They offer opportunities for individuals to live more sustainably, by creating collective experiences such as repairing and sharing resources that could become part of everyday life. The experiences are enjoyable and sociable and people want to repeat them regularly.

The aim of the Open Works was to test the viability of developing a universal participatory approach to transforming a neighbourhood. Three key factors formed the evidence base: feasibility, inclusivity and value creation. The main

97 Britton T, Billings L. et al (2015) *Designed to Scale – Mass participation to build resilient neighbourhoods* Accession Social Enterprise CIC

findings from the research were:[98]

- *Feasibility* – The collaborative platform approach was effective in building a participatory system. It redesigned the existing set of infrastructures for encouraging involvement, providing compelling base level evidence to develop the approach in full.
- *Inclusivity* – A diverse mix of people from a full range of backgrounds and situations participated. The mix within activities varied and included people with temporary and long term difficulties. Participatory culture encourages people from all parts of the community to work together on a regular basis and this can be extended by ensuring that inclusivity is 'designed in' throughout the ecology.
- *Value creation* – People participating in projects reported direct positive effects both for them and their families and these positive outcomes also create value for their neighbourhood. These outcomes represent the co-creation of social, environmental and economic value.

Following the success of the Open Works project, it seems that there is sufficient evidence to upscale the platform and create a participatory culture across a larger area.

Open Hub

Open Hub in Dudley, West Midlands, is an initiative to transform Wren's Nest Estate and encourage more civic participation. It was developed by Civic Systems Lab, a laboratory that designs and tests methods, strategies and systems to grow civic engagement. Open Hub offers to residents the opportunities and spaces to come together and start activities and enterprises that anyone can start, take part in and benefit from. Activities developed included book swaps, family cooking sessions, family crafts, and a vegetable growing project.

The team at Civic System Lab were aware that the main model for covering overheads at Wren's Nest Community Centre was room rental, which meant that an activity had to be funded. Civic System Lab describes the approach taken to reimaging how the community centre space could be used:[99]

> We've made a list of over 12 things we need to change in the current system to make this kind of participation become the norm. One of them is space. These kinds of projects don't need meeting rooms or event spaces, but instead need more functional spaces like kitchens or gardens or workshops. So we need to think about how we make these spaces part of the common infrastructure. People still use the room rental model but there is such low occupation and that model means that all activity has to be funded. We are working with Dudley CVS on a project at the Wren's Nest estate in Dudley called Open Hub where their community centre has only 6% occupancy. It's really well resourced with an industrial kitchen, IT

98 Britton T, Billings L. et al (2015), *Designed to Scale – Mass participation to build resilient neighbourhoods* Accession Social Enterprise CIC

99 http://colabdudley.com/tag/open-hub-wrens-nest/

equipment, and every cupboard bulging with something they got funding for. If you take that room rental model away you can create fresh opportunities for more experimental work, for people with an idea to come forward and grow it.

Pooled and aligned budgets

Pooling budgets is typically an arrangement that develops from a desire to improve partnership working, to drive better service delivery and outcomes. Pooled budgets are an increasingly attractive approach to service delivery as budget constraints affect many areas of the public sector. CIPFA, the public services accounting body, has identified four key mechanisms for managing pooled budgets:[100]

Aligned budget arrangements – Under this arrangements budgets remain with the individual organisation but a joint board comes together to agree joint objectives and how individual organisations activities can be aligned to maximise the synergies between them.

Lead body arrangements – One of the organisations takes on a lead body role and administers a total budget on behalf of the individual organisations to achieve jointly agreed objectives. Expenditure may be controlled by a joint board but day to day financial management will be undertaken by the lead body.

Joint commissioning arrangements – The individual organisations come together to commission a third party to provide a service on their behalf. A joint board will usually set the objectives and contract terms but delivery will be down to the third party at a cost set out in the contract.

Joint venture arrangements – This is where a separate entity is established by the individual organisations to deliver the activity or function. A joint board will set objectives and key activities for the organisation which may either be freestanding of or controlled by the individual parties.

An evidence review by the Centre for Health Economics at the University of York explored the level of evidence for use of integrated resource mechanisms in joint health and social care. The review included 38 schemes across 8 countries and 31 of the schemes specifically used pooled budgets as the resource mechanism. A summary of the key evidence follows:[101]

- *Health outcomes* – 57% of the schemes that assessed health outcomes (i.e. 13 out of 23), found no significant benefit from an integrated budget approach. For the remainder the results were mixed, with only four schemes finding that health outcomes improved with an integrated approach. One of the schemes that reported improved health outcomes was the Darlington pilot.

100 CIPFA (2011) A CIPFA Introductory Guide for Clinical Commissioning Groups: Pooling Budgets and Integrated Care

101 CHE Research Paper 97 (2014) ‘Financial mechanisms for integrating funds for health and social care: an evidence review’

- *Service use and cost* – Three schemes reported a significant reduction in utilisation or costs, and one scheme found a higher rate of hospital admissions in the intervention group. Evaluations of Torbay Care Trust have reported reduced secondary care utilisation; however the evidence review did not find these evaluations to be methodologically rigorous.

The review concluded that compared with business-as-usual, the integrated budgets and resources did not lead to better health outcomes or long-term reduction in hospital use. Furthermore, 'if schemes improve co-ordination and focus greater attention on patient needs, there is a good chance that co-ordinated care "reveals rather than resolves" unmet need. Overall, although this may be a beneficial outcome for society, it may increase, rather than reduce, total costs. Therefore, decision makers would need to recognise that there may be trade-offs between different objectives, both in the short and longer term.[102]

This evidence review highlights the complexity involved when claiming to have definitive evidence of the efficiency and cost-effectiveness of pooled budgets. This difficulty is due partly to the fact that rigorous and systematic monitoring of outcomes against plans is uncommon, and also that new initiatives are often launched in the context of shifting national policy, which can make it a challenge to isolate the effects. However, there are examples of budget pooling which report successes and positive outcomes. Two case studies are outlined here.

Warm Homes Oldham

Warm Homes Oldham is an initiative aimed at alleviating fuel poverty by providing advice and measures to increase energy efficiency. Fuel poverty can have adverse effects on the health of both children and the elderly. The initiative is funded via a pooled budget from public health, the local CCG and housing associations. The group is reinvesting the savings that have been produced in order to grow the initiative. In addition to improvements in fuel poverty and subjective health and wellbeing, analysis by the CCG from a sample of nearly 800 people who were supported through the scheme, found that A&E attendance had gone down by 2% and emergency hospital admissions by 32% – with an estimated saving of nearly £40,000 to the CCG.[103]

Swindon services for children and young people and services for disabled children

In 2008, Swindon Council and Swindon Primary Care Trust (PCT) pooled their budgets and set up joint staff teams in order to integrate services for children and young people and for disabled children. The project budget was £28 million, including £10,000 in launch costs. Pooling budgets had the benefit of pushing the council and the PCT to agree common priorities and outcomes. The mechanisms put in place to support the integration of services included a common assessment framework (CAF) that all professionals on the team were trained in. Following the CAF process, a 'team around the child' meeting was

102 CHE Research Paper 97 (2014) 'Financial mechanisms for integrating funds for health and social care: an evidence review'

103 http://www.24dash.com/news/housing/2015-04-09-Warm-Homes-scheme-brings-2-000-people-out-of-fuel-poverty-and-cuts-AandE-admissions-by-30

held, where professionals across health and social care worked together with each child and family to decide what support was needed. Outcomes reported included a reduction in obesity rates for children in year six from 19% in 2008, to 16.5% one year after the initiative began.[104]

104 http://www.communitycare.co.uk/2011/02/18/pooling-budgets-and-integrated-teams-boost-swindons-childrens-services/

Section 4. Early Help

Early help programmes can be effective in improving outcomes for children and in reducing inequality. However there are a number of programmes and systems, so choosing which ones to implement can be a minefield. The Suffolk team needs to ensure that the programmes and systems they choose will meet their needs and will be cost effective. There are a number of resources that can help them to achieve this. The following box, extracted from an evidence review for Public Health England (PHE), helpfully sets out key reports.[105]

Key sources of help and information

The Department of Education online tool for choosing parenting interventions, developed by the National Academy for Parenting research, is particularly helpful for those looking to commission a programme. Commissioners can filter by the type of outcome they need, to influence and the strength of evidence:

http://www.education.gov.uk/commissioning-toolkit/Programme/Index

Another tool that does a similar job can be found at the following site:

http://investinginchildren.eu/

This also has filters, which can be used to search for interventions that impact on an outcome of interest. This site tends to have more information on cost effectiveness than the DoE resource.The Early Intervention Foundation offers helpful information on making the case for intervention. In Appendix B in the evidence review, we include a table from the EIF, which sets out effective early intervention programmes with a social return on investment figure. The EIF also provide guidance to local areas:

http://www.earlyinterventionfoundation.org.uk/

The Greater London Authority (GLA) has set out the economic case for early years' interventions, to reduce health inequalities in London. This is focused very much on US evidence, although the cost effectiveness data has been adjusted to be more relevant to the London situation:

http://www.london.gov.uk/priorities/young-people/early-years-and-family-support

105 Donkin A. (2014) 'Early Intervention to reduce inequalities in health: Increasing Access to Parenting Programmes and easing the transition from home to school: an evidence review'. *PHE Health Equity Evidence Review* 1. PHE: London

Graham Allen MP has presented two reports to Government that include information about scaling up, and those interventions which are successful:

http://grahamallenmp.co.uk/static/pdf/early-intervention-7th.pdf

Barlow J, Coren E and Stewart-Brown S. (2002) A Meta-analysis of the effectiveness of parenting programmes in improving maternal psychosocial health. British Journal of General Practice, March 2002,

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314244/pdf/12030667.pdf

Mary Rudolf, '*Tackling obesity through the healthy child programme a framework for action*', talks about successful interventions to reduce obesity.

http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf

NICE Guidance: conduct disorders in children and young people (CG158) and NICE Guidance on the promotion of emotional and social development in vulnerable under-fives.

http://www.nice.org.uk/nicemedia/live/13634/58889/58889.pdf

Early help models

There are a number of early help models that have been developed and implemented across the UK, each with different strategic and operational elements but all generated from similar origins (such as reduced budgets, increased service demand and a need to integrate key sectors) and with some clear similarities.

Kent County Council

The Kent 'Early Help' model integrates a wide range of services for children, young people and families: children's centres, youth work, targeted youth work and NEET support, the Troubled Families programme, youth offending service, family support, attendance and inclusion and pupil referral units. These services had not previously been integrated so this was the first time it had be attempted. The service does not include statutory children's social care services. The integration happened over a very short period of time (approximately 18 months) from conceiving and making the business case to completing service delivery and planning sustainability.

The model was informed by extensive analysis, workforce and stakeholder engagement and a systemic family practice approach, adapted from a model which had previously been tried and tested in the London Borough of Hackney on a much smaller scale.

The main focus of the service model stems from Early Help Units delivering intensive level family work including Troubled Family interventions, alongside more specialist youth justice work, attendance and inclusion work, and delivery of universal services and additional support from youth hubs and children's centred across the county. Early Help units and universal and additional provision are located according to the demographics of the area so that more deprived areas have more units. A significant level of diagnostic work was undertaken at the outset to establish a strong baseline for the achievement of families' outcomes, before the new model was introduced. Since the new approach was embedded, the diagnostics have been used to examine the social care data, comparing those who have had early help with those who have not.

In order to create the new Early Help service, all staff posts within the existing services, were deleted and workers were required to apply for the newly created posts. Voluntary redundancy was offered and taken up by some staff. The important factor to note about this restructure was that everyone was given the opportunity to apply for a promotion for posts for which they were eligible to apply. The budgets for each service strand were consolidated and combined so that the newly designed Early Help and Preventative model would be commissioned from one cross-cutting budget. This approach enabled the efficiency savings to be allocated from the budget before the services were designed.

Engaging and communicating with staff at the beginning of the change process was vital and a significant amount of staff resource was invested in this lead-in period. Managers led staff roadshows and maintained contact with staff on a range of levels throughout. All staff, from managers to front-facing workers, were given the opportunity to become part of a 'task and finish group' which was brought together to help design the new service provision. This enabled workers to they were feel part of the process and, as a result, less resistant to the changes taking place. The results of the task and finish group were then piloted in a *sandbox* in one area over a few months to enable processes, delivery and monitoring dashboards to be tested out and tweaked where necessary.

Each unit is a 'collaborative' and there are distinctive differences in this type of approach compared to the previous traditional 'team' approach:

- Each unit is supported by a *leader* rather than a manager who also carries a case load (albeit a smaller one).
- The staff within each unit are co-located so that there are no isolated workers.
- The different levels of support, provided by the units, are spread out across the staff. There are two basic levels of support provided by unit staff, these are *open access* and *casework*. Staff with a remit of casework will undertake 80% casework and 20% open access. For those staff who are primarily open access workers, the reverse is true so that 20% of their time is spent on more targeted casework.

- Casework is time-limited to prevent waiting lists; each case is supported for approximately 20 weeks and the open access services are then used to provide ongoing support.
- Each unit holds a weekly case review meeting, which provides the staff with peer support and supervision and enables them to discuss more complex cases where necessary.

The service delivery is monitored through the use of two dashboards which were co-designed with the front-facing staff. One focuses on the efficiency of the unit and staff and has clear performance indicators and targets (for example, the number of cases held or number of cases closed per month). The second dashboard tracks the outcomes achieved by the families over time; every case that is closed without achieving the outcomes is audited to establish why. These dashboards work on many levels so that results can be monitored on a service basis as well as county wide.

Staffordshire County Council

Staffordshire Children Services undertook some internal diagnostic work to help them understand how the support system for children and families was working operationally, and where the barriers to effective intervention were located. They discovered that the majority of their services were based on a 'break-fix' model whereby the most common referral came from a family in crisis. Their commissioning also reflected this, as services were often commissioned around the symptoms of these crises rather than the root causes. Additionally, they were not making best use of all the resources available to them.

A new Family Strategic Partnership was set up, which included many key partners. For example, CCG, the Police, social care, third sector, and so on. This partnership was tasked with implementing the new Early Help strategy. The key element of the strategy was to test out a variety of approaches to early help through a series of eight pilots located across the county. The pilots received seed-funding of £30,000 each over a period of two years, allocated from the Troubled Families budget. The models were created with partners (such as nurseries, schools or third sector) to ensure all the local expertise was combined to assist the development of the projects and to enable a buy-in from the community. A significant amount of resource was put in during these development stages to engage the third sector, schools and community and help them to understand the social action that was already being supported locally.

Each of the eight pilot projects is aligned to a different part of the family support system in Staffordshire so that each model is testing out a new approach within the specific steps of the care pathway. Many of them include outcomes to build the resilience of families and communities, with a focus on enhancing social action as well as more traditional, statutory outcomes for children and their parents.

Some examples of the pilots are:

Cannock – the Community Family Intervention Service

A coordinated, community-led, universal and targeted family intervention. Referrals will be received from partners and via other agreed referral/vulnerability identification processes. The pilot scheme will support:

- Children and families, to utilise universal services and build resilience.
- Children and families when issues arise to prevent escalation to Tier 3 services.
- An exit strategy for those families de-escalating from Tier 3.

The service will support a minimum of 150 families presenting root cause indicators.

Lichfield

The Lichfield pilot focuses on the development of community-based solutions to support families with babies or pre-school-age children, where there are known to be lower-level risk factors, and the potential for earlier and less formalised intervention to have a significant longer term impact. The pilot is being run in conjunction with Spark CIC (community interest company) and Burntwood Childcare (virtual) Hub. Development of a single (virtual) front door offering partnership integration, community-delivered activities, data capture of participation and outcomes, technology development, voluntary and community sector (VCS) funding bid-capacity development, and a 'how to' guide for others interested in setting up community-managed family centres.

Tamworth

The Tamworth pilot has a three-phased approach:

1. *Multi Agency Centre (MAC) development* – MAC provision in academy setting, includes pastoral staff support to coordinate the MAC and attending agencies.
2. *Emotional health support* – Enhancing the skills and capabilities of professionals to support children and young people experiencing Tier 2 (mild/moderate) difficulties with their emotional health and wellbeing.
3. *Targeted family support* – using 'Building Resilient Families and Communities' principles, and commissioning a Tier 2 family support service for identified families.

Staffordshire have implemented a robust monitoring and evaluation system to enable the council to benchmark where families are originating from and to track their progress. They also have diagnostic methods to undertake a cost–benefit analysis, which they hope will demonstrate how the pilots are affecting the system financially. Furthermore, some of their internal diagnostic work focuses on the identification of families who do not fit into the criteria of the Troubled Families programme, and mothers who have had multiple births and multiple

social care interventions. These families are then targeted by the pilot projects, so that the services are taken to the families rather than expecting them to self-identify and refer.

One of the unique aspects of this model is that there is little threat from ongoing cuts to funding, as the pilots have a comparatively small budget allocation and most of them are funded by investment from the Troubled Families programme.

Lambeth Clinical Commissioning Group (CCG) – Living Well Collaborative

A period of diagnostic investigation was undertaken within the Lambeth adult mental health system and it was discovered that most of the people who were referred to the specialist South London and Maudsley (SLaM) services were presenting in crisis. However, many of them had to wait weeks to be seen and some did not reach the threshold of need, and so were not seen. This led to commissioners redesigning the approach to mental health services using a process of co-production that involved all stakeholders, including: SLaM, third sector and service users.

A prototype was developed in the north end of the borough. Funding was diverted from specialist provision and used to create a multi-agency team known as the Lambeth Living Well Collaborative (LWC). It combine SLaM, primary care, peer support and third sector agencies. This team was trained to implement asset-based approaches as its core offering. All GPs in the area changed their referral procedures so that instead of referring patients to SLaM, they 'introduced' them to the LWC. This prototype has since gone mainstream and encompasses the south of the borough as well.

Some of the results of the early help approach are:

- SLaM now receives more appropriate referrals, which reduces their caseload and saves time and resource.
- More people are supported more quickly, and earlier – the LWC is a doorway to a range of different provision from third sector to peer support. These services are able to support people within a few days and are flexible to the person's needs.
- There has been a reduction in the demand on specialist SLaM services – in 2013, there were 125 referrals to SLaM; in 2015 the number of referrals was 25. The remaining 100 are being supported through the LWC.

The LWC is now being formalised. There will be a single alliance contract to tie the providers into a common set of principles and outcomes. The terms should enhance the collaboration between organisations and enable commissioners to further embed their asset-based approaches. Additionally, commissioners are working towards the inclusion of other services into the collaborative approach, such as supported housing – in order to further integrate support across the sector and combine resources.

One of the difficulties faced by commissioners is the instance of different monitoring and evaluation systems used by each provider. This has made the collation of performance data and evidence complicated. Despite the clear

positive outcomes, there are still some sceptical senior managers who are keen to see robust data.

Kirklees Council

Kirklees early intervention and prevention model is still in its infancy but the framework of the model has been established and the implementation has started. This model is quite unique as it is embedding early help across children and adult services simultaneously. Early Help is one of two strategic priorities for the council, so it is being driven by very strong political influence. Two key budgets have been amalgamated from Children Centres and Youth and this overall allocation is being used primarily for the implementation of the model.

The model comprises of the development of locality-based provision which focuses on a relationship-based approach, whereby one person acts as the chief navigator for each family through the system. This person does not necessarily need to be a professional; in some family situations this key position could be held by a peer.

Each locality will be served by a community 'hub'. The hub will be intelligence-driven and data-driven and will not be based around any one particular building. All existing resources within the community will be viewed as potential opportunities that could help in the progression of the family, including schools, GPs, children centres, housing teams and so on. The primary delivery from each locality will be asset-based, promoting independence and value with the community. The support system is divided into three categories:

- *Community Plus* – which is universal.
- *Targeted* – families with additional needs.
- *Complex* – children in need, possibly in need of child protection.

Unlike the existing system, all families within the *complex* category will also be offered resources and support from both the *community plus*, and *targeted* sectors, to provide them with an all-round package of support and opportunity.

The Early Intervention and Prevention team are currently developing a set of person and community-centred outcomes with a focus on well-being and resilience. These will be included in an Early Intervention and Prevention test (EIP test). The test will set out the criteria which all external services need to reach in order to be commissioned in the future. A range of pilots are being developed and implemented to test delivery and start to measure performance against the outcomes. These will include the creation of a number of community connectors and initiators in each of the localities.

A certain amount of stakeholder engagement has taken place before and throughout the implementation of the model to date, especially with key partners such as health, housing, schools and the third sector. However, commissioners are aware that much more needs to be done and different stakeholders need to be involved to ensure a rounded response to the development.

Key findings and recommendations for the implementation of Early Help models

- All the models created locality-based, multi-agency or disciplinary teams which prevented duplication – and enabled families and individuals to have a single point of contact for a diverse range of provision. Within some of these teams, the staff were expected to retain their specialism *as well as* deliver more generic work, as part of their role. Additionally, the multi-disciplinary teams were located together in local, community-based services and in the case of the Living Well Collective, also included the provision of peer support.
- Engagement with stakeholders at the beginning of the process was seen as crucial and much time and resource was spent by commissioners as they built relationships with internal colleagues, statutory and third sector – as well as community groups and service users. This helped to develop a positive momentum about the changes and to enable people to feel valued and to take ownership over some of the design of the new provision.
- Developing a positive, trusting interface with social care providers was highlighted as an important factor for the continued success and investment of an early help model. There can be tension between early help and the social care sector. Sometimes, a lack of understanding of how early help can be effective is shown by social care colleagues; and early help teams may show frustration due to the lack of value placed on their work by social care. As budgets become more restricted, it may be too easy for strategic leads to prioritise statutory provision over early help; having an endorsement of early help from social care managers can be very helpful in this situation.
- Each Early Help model was funded through a central budget pool, which broke down the siloes between the services and helped to create a common vision and outcome. In some cases, budgets were combined from existing services whilst in others, funding was diverted from other provision, e.g. the Troubled Families programme.
- Leadership was highlighted as an important factor in two ways. Firstly, collaborative leadership was the dominant style throughout the case studies, whether through leadership of the frontline staff or when created within an alliance contract. Secondly, system leadership needs to be strong in order to maintain the momentum of the transformation and bring people along with the changes.
- Strong political buy-in is essential and goes hand-in-hand with robust system leadership. This will protect the model as it develops and prevent influence from sceptics, of which there may be many.
- Each model has a common vision and outcomes. In most cases, these have been developed or influenced by all the stakeholders involved. It was suggested that when people are committed to working towards a set of common outcomes, this jointly vested interest can help to create open, honest and transparent relationships between people.
- The Early Help model requires rigorous and robust monitoring and evaluation. This is vital, in order to collate evidence that can be used to convince strategic leads that early help should be invested in as a future priority. In some cases, the system was designed with staff, which was viewed as important, because the staff was then less resistant to embedding the measuring tools into their everyday work.

- Future budgetary cuts are the most significant threat to the Early Help and Prevention model. In Kent, the model has been embedded very quickly and the initial results are positive, however it is still too early to see whether it has had a substantial impact on social care. This is one of the reasons that Early Help services are vulnerable. Strategic leads may be less likely to consider cutting budgets in the social care sector, as these areas are politically sensitive, and can contain significant levels of risk.

To what extent is there hidden need?

It is very likely that there may be significant hidden need. Parents, wary of social services, are dis-incentivised to admit that they are having difficulty, for example. The need to be in contact with professionals in the early years is minimal and health visitors, midwives and GPs may be reliant on the stories that parents convey.

In addition to people simply not being registered as needing help, there could be a further level of hidden need among those who are in contact with services. Hidden needs, also known as latent needs, are issues and problems that the population face but have not yet realised.

Traditional methods of research using focus groups and surveys, are ineffective for identifying hidden needs, as people often struggle to articulate their deeper needs. Qualitative methods such as the repertory grid technique[106] (from psychology) and ethnographic market research[107] (based on ideas from anthropology) can be used. Much of the research is from the private sector where there is clear profitability in creating something new that fulfils a need, which has yet to be addressed elsewhere. However, some of the principles can be applied to the optimal delivery of services for the population. If services can deliver something that people really need, they are likely to be more effective. There are a number of models that have been put forward for identifying hidden need, and the text below provides some examples which could be adapted to service redesign.

For example, Thomke and von Hippel developed a new approach to developing customer products.[108] In contrast to the traditional approach, in which suppliers took on most of the work and responsibility for product development, the new approach (known as the ‘customers-as-innovators’ approach) involved customers being provided with tools. This enabled them to design and develop the application-specific aspects of a new product on their own. By incorporate their real needs directly into the development of a new product, customers thus reduced the number of trial-and-error iterations usually required when suppliers undertook the whole task themselves. The overall result was a significant increase in speed and effectiveness in new product development. This method is similar to community co-production and the implication is that taking this approach would be a cost-effective way forward.

106 http://lexicon.ft.com/Term?term=repertory-grid-technique

107 http://lexicon.ft.com/Term?term=ethnographic-market-research

108 Thomke, S., and E. von Hippel. "Customers As Innovators: A New Way to Create Value." *Harvard Business Review* 80, no. 4 (April 2002). (Translated into German and reprinted in *Harvard Business Manager* (July 2002): 51-61.)

Gulati and Oldroyd [109] studied several companies that had a good understanding of their customers' real needs and the critical attributes of products. The researchers identified certain common features in the approaches (called a customer focus journey) taken by these companies, which they summarised in four stages:

- *Communal co-ordination* – Create a centralised repository of customer information that records each interaction a customer has with the company. Collation of information is the main task at this stage.
- *Serial co-ordination* – Manage the ongoing collation and analysis of data in the repository and share the resulting information throughout the company – thus enabling the firm to gain insight into customers from their past behaviour.
- *Symbiotic co-ordination* – Shift the focus from an analysis of past customer interactions to anticipating (and even shaping) the future – thus enabling the firm to develop an understanding of likely future customer behaviour.
- *Integral co-ordination* – Focus on bringing a new sophisticated understanding of customers into the present and incorporating that understanding into all of the firm's day-to-day operations. The aim is to achieve an appropriate real-time response to customers' needs.

Companies that follow these steps will be investing more wisely and effectively and realise long-term benefits in the financial results of the company.[110] This can be correlated simply, with efforts to better understand need in a local area, by using a data-driven approach that first identifies past needs – and then, through modelling, predicts future needs. For this form of strategy to work, it is imperative that the system ensures that every contact with services counts. The system also needs to be 'joined up' so that information regarding vulnerability and need is transferred to the right teams. This will require an IT system that enables data sharing. The IT requirement has been previously recognised by the Royal College of Speech and Language Therapists, who consulted members on what type of support would be helpful to support children with speech and language difficulties. Rather than re-input all data into one big file, they are developing an IT model that enables practitioners to locate all information from different services about the same individual, and to view this data, from original sources, where permissions allow.

Ulwick[111] developed a more effective approach to innovation, known as the 'outcome-driven method'. The three key tenets of this approach were that:

- Customers buy products and services to help them get jobs done.
- Customers use a set of metrics to judge how well a job is getting done and how a product performs.
- These customer metrics make possible the systematic and predictable creation of products and services.

109 Gulati, R and Oldroyd J.B. 'The Quest for Customer Focus'. *Harvard Business Review*. 83, no. 4 (April 2005): 2004–2005.

110 Gupta, Sunil and Donald R. Lehmann (2003), 'Customers as Assets', *Journal of Interactive Marketing*, 17 (1), 9-24.

111 Anthony Ulwick, *What Customers Want: Using Outcome-Driven Innovation to Create Breakthrough Products and Services,* 2005 ISBN 0-07-140867-3

In this 'outcome-driven' paradigm, the focus is not on the customers – instead, it is on the job. In other words, the job becomes the unit of analysis. A company that focuses on helping customers to get jobs done more quickly, more conveniently, and less expensively than previously, is more likely to create products and services that their customers want. These are the products and services that can be relied upon to create customer value.

For a given job, companies therefore need to identify outcomes that are important *and* unsatisfied. They must then systematically devise and provide creative features in their products and services that do a better job of addressing these outcomes. Moreover, apart from getting more jobs done, or a specific job done better, customers also need help in overcoming the constraints that prevent them from getting a job done altogether, or under certain circumstance. Firms also need to identify outcomes that are unimportant and already over-satisfied, and then reduce the resource allocation on the related attributes. This approach will be helpful for decommissioning services.

Evidence for involving the core economy, community and volunteers

There is a plethora of evidence to suggest that multi-sectoral working that includes the core economy, community and volunteers, can help to embed a child-friendly culture and improve outcomes for more vulnerable people. The Marmot review [112] advocated more work to engage communities. It noted that the benefits to the community extend beyond the intervention, and that increased participation led to greater confidence and competence among individual citizens, which could lead to many positive real-life changes.[113]

It takes a city to raise a child – The report of the Birmingham Commission for Children[114] states clearly that everyone should play a part in making a city both child-friendly and safe. The report noted the importance of the local economy in making Birmingham child-friendly, by creating opportunities and hope for children and their parents. In addition all services that reported to the commission reported positive contributions from volunteers.

The evidence is international. In a study based in South Africa, previously untrained lay community workers provided support and guidance in parenting, the aims being to promote sensitive and responsive parenting and to secure infant attachment to the mother. A control group received no therapeutic input. The lay workers used a manual developed in the UK for health visitors, based on a book called *The Social Baby* by Lynne Murray and Liz Andrews.[115]

The use of community workers is of interest because there is the potential for community engagement to link to sustained improvement and reach less accessible groups. The intervention was delivered from the time of late

112 The Marmot Review Team. 2010. Fair Society, Healthy Lives: The Marmot *Review. IHE: London*

113 Schuller t, Preston J, Hammond C, Bassett-Grundy A and Byneer A. (Eds.) (2004) *The benefits of learning. The impact of learning on health, family life and social capital.* London: Routledge.

114 Grauberg J, Hughes D, Malik J, Davies C and Donkin A. (2014) *It Takes a City to Raise a Child:* The report of the Birmingham Commission for Children. The Children's Society: London.

115 Murray L and Andrews L (2000) *The Social Baby: Understanding Babies' Communication from Birth Paperback*. The Children's Project: Richmond.

pregnancy until six months post-birth. Mothers in the intervention group were significantly more sensitive at 6 and 12 months compared with mothers in the control group. The intervention was associated with a higher rate of secure infant attachments at 18 months (75% securely attached, compared with 63% in the control group). Although maternal depressive disorder was not significantly reduced, the intervention had benefit in terms of reduced maternal depressed mood at six months.[116]

Healthy living programmes in schools

There are a number of goals that healthy living programmes in schools might target. A key one is healthy eating. While obesity rates in less deprived populations are levelling off, obesity rates amongst those in deprived areas are increasing. In Suffolk, compared to their more affluent peers, children from the most deprived areas are 34% more likely to be obese.[117] In addition, schools can interact with parents to provide good parenting knowledge and can intervene to improve reading rates, which will improve educational outcomes and later health. In later years, schools can provide programmes that will help older children develop resilience and the strength to say no to riskier behaviours.

Appendix 1 is based on a table produced by the Early Intervention Foundation. It has been amended to document the set of programmes that have been found to be effective when delivered through a school setting. Utilising schools to deliver programmes is a practical way of reaching children and utilising existing facilities to their best advantage.

In addition, there are evidence-based programmes available, such as Reading Recovery, which have become popular in the UK, and Families and Schools Together (FAST) which is for children aged 3-11 years. In FAST, parents and children attend eight weekly sessions where they learn how to manage their stress and reduce their isolation, become more involved in their children's school, develop a warm and supportive relationship with their child and encourage their child's pro-social behaviour. After parents 'graduate' from the eight-week programme, they continue to meet together through parents' sessions that occur on a monthly basis. FAST has strong evidence of improving children's social skills and reducing their aggression and anxiety. FAST also has evidence of helping parents make friends and reducing social isolation. The 2012 aggregate evaluation report of 107 primary schools in England conducting FAST shows a wide range of outcomes, including a reduction in family conflict of 22%, a reduction in conduct problems of 18%, a reduction in hyperactivity of 13%, and a reduction in emotional symptoms of 20%[118].

116 Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, et al. 'Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial'. *BMJ*. 2009;338:b974.

117 http://www.healthysuffolk.org.uk/our-priorities/every-child-in-suffolk-has-the-best-start-in-life/. Accessed on 21st April 2016.

118 http://www.familiesandschoolstogether.com/region/England

Short-term outcomes like reduction in family conflict, depression, reductions in alcohol and drug rates, and improved reading rates can be helpful in justifying commissioning decisions. Depending on how the programmes are implemented, some changes might need to be picked up utilising area level statistics and could be difficult to attribute to specific programmes without including reference to a controlled population who were not receiving the intervention.

Suffolk should be mindful of the importance of evaluating the success of their policies and the ideal ways in which such an evaluation could be structured.

Building community resilience

There are three basic approaches to reduce the impact of negative influences on children's outcomes, such as loss of income or adverse family circumstances. The first is to reduce the number of negative events and the severity of negative influences in people's lives; the second is to make the impact of these less, for instance by having cheap resources that can be accessed on low incomes or by providing support systems; and the third is to help to build personal resilience so that an individual experiencing negative impacts has the strength and determination to work through them and resolve them.

Good strategies should include a mix of all three approaches for maximum impact. In this section we are a focusing on building community and individual resilience. A report by Sefton Council correctly notes that it is no longer the case that a family will necessarily have a strong network around them or people who can offer advice. Community networks have eroded and it is thought that if families had networks or support around them they would get the low-level help needed to overcome stress or the lack of knowledge regarding options, for example.[119]

People's health and wellbeing, resilience and social capital will impact on their ability to remain healthy and economically secure, and to overcome challenges when faced with difficulties.

Mental health

Mental health, as well as being a positive health outcome in its own right, is associated with greater wellbeing and better physical health outcomes, such as an increase in longevity of 7.5 years[120] and lower prevalence of and mortality from cardiovascular disease.[121] A WHO report on mental health, resilience and inequality notes that mental health is produced socially, and therefore requires social, as well as individual solutions. According to the WHO, 'Mental health can

119 Sefton Council: 'Promoting Resilience using an asset based approach – A literature review'.

120 Levy BR, Slade MD, Kunkel SR, Kasl SV. 'Longevity increased by positive self-perceptions of aging'. *J Pers Soc Psychol.* 2002;83(2):261-70.

121 Keyes C.L. 'The nexus of cardiovascular disease and depression revisited: the complete mental health perspective and the moderating role of age and gender'. *Aging & mental health.* 2004;8(3):266-74.

be conceptualised as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his and her community.[122]

Based on this definition, improving mental health and wellbeing across the population can be achieved through increasing people's confidence, self-esteem, resilience and empowerment, ensuring that they work in productive jobs and are able to contribute to their community.

Resilience

Resilience is, 'the capacity of an individual, community or system to adapt in order to sustain an acceptable level of function, structure, and identity.[123] It is a key factor in protecting and promoting good mental health[124] which impacts on other issues, such as children's development. Building resilience entails identifying the assets within a community that enhance people's ability to deal effectively with change and by amplifying these. According to the Young Foundation, 'it is not simply about exhorting communities to "pull themselves together" but about giving them the capacity to identify assets and utilise them.[125]

The Young Foundation developed five key points for central and local government to consider when developing plans to build long-term community resilience:

- Do not ignore the quiet communities.
- Develop localised micro funds to seed voluntary sector activity.
- Invest in community leadership.
- Focus on places *and* people.
- Strengthen public and voluntary sector partnerships.[126]

Resilience can be built in many different ways and both mental and material assets can contribute towards greater resilience. However, community resilience is thought to be built primarily through relationships.

Community development approaches

Community development is a broad term given to programmes that aim to develop and involve communities and there are many different approaches applied. It is used across sectors and departments, and projects are commonly based around one neighbourhood or community – a 'place-based' approach. It can be used to empower communities, build resilience among residents and increase social capital.

122 World Health Organization. *Mental health: a state of well-being*. 2011.

123 Cabinet Office. *Strategic National Framework on Community Resilience*. London: Cabinet Office; 2011.

124 Barnardo's Midlands. 'Arch Project: What is Resilience?' [July 2013]. Available from: http://www.barnardos.org.uk/arch/arch_what_is_resilience.htm

125 Norman W. (2012) *Adapting to Change: the Role of Community Resilience*. London: The Young Foundation.

126 Norman, W. (2012) op.cit

> Community development is a way of working with local communities, to achieve change within communities to problems that they themselves identify. It is a collective process, not a one-off intervention, co-produced with, not for, communities. Community development is fundamentally about enabling, facilitating and building capacity for a community to address its own needs.[127]

There are a wide range of studies providing evidence of the benefits for health of community activities, organisations and networking, yet there is little quantitative evaluation of community development as a form of practice.[128] Evidence from previous community development projects suggests that community development could have a beneficial effect on a number of social and health outcomes, such as childhood asthma, teenage pregnancy, crime, educational attainment and housing conditions.[129]

According to the Marmot Review, 'engagement of residents tends to have been most successful at the neighbourhood level and where there is engagement in individual projects and initiatives rather than at strategic or general consultative level.[130]

Many examples of co-produced services, such as local volunteers working with GPs to bring about more empowered and healthy communities, or communities working together to come up with and exchange the services they are able to offer in time banking, have produced positive results.[131]

Another successful example of co-production is Scallywags, a parent-run nursery in Bethnal Green, where parents manage the nursery, make decisions and are a critical part of the staff.[132] Co-production provides more control and builds empowered, resilient communities, while ensuring that it is those people who really know their area and will benefit from interventions who make the decisions that affect them. The potential positive health effects of activity are both direct (the impact of participation on the individual) and indirect (positive changes to services and the local area). Citizens can be involved at every stage of the process, from commissioning or participating in interventions, to evaluating them. Building social capital through connecting people and developing social networks is a vital part of an asset-based approach. One study, evaluating 19 asset-based projects in Scotland, found that all showed evidence of building social capital, including between similar people (bonding capital) and different types of people (bridging capital).[133]

127 Winters L, Armitage M, Stansfield J, Scott-Samuel A, Farrar A. 'Wellness Services - Evidence based review and examples of good practice. Final Report.' *Observatory Report Series* No. 76. Liverpool: Liverpool Public Health Observatory; 2010.

128 Galvin K, Sharples A, Jackson D. 'Citizens Advice Bureaux in general practice: an illuminative evaluation'. *Health & Social Care in the Community.* 2000;8(4):277-82.

129 Granville G, Bridge S. PATHway: 'An Independent Domestic Advisory service at St Mary's Maternity Hospital, Manchester. Summary of findings and recommendations from the independent evaluation'. 2010 [July 2013]. Available from: **http://www.endthefear.co.uk/wp-content/uploads/2010/10/PATHway-Project-Summary1.pdf.**

130 The Marmot Review Team. 2010. *Fair Society, Healthy Lives: The Marmot Review.* IHE: London.

131 Personal Communication with Alyson McGregor, Programme Director, Altogether Better.

132 101. Boyle D, Slay J, Stephens L. 'Public Services Inside Out: Putting co-production into practice'. London: NESTA; 2010.

133 McLean J, McNeice V. A'ssets in Action: Illustrating Asset Based Approaches for Health Improvement'. **http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf:** Glasgow Centre for Population Health; 2012.

The processes and outcomes of using an asset-based approach and community development work are shown to empower residents and improve community resilience, combatting cultures of dependency, disempowerment and deprivation, which can exist in communities who do not feel they have control. Empowering people to take control of their lives and their health, through creating the necessary conditions, can improve health and wellbeing and reduce inequalities.

Connecting communities

The 'C2 Connecting Communities' method took a similar approach to an asset-based community development (ABCD) model. It originated on an estate in Falmouth, Cornwall. On this estate, it improved varied outcomes for all in the low-income community, and many of the outcomes particularly benefitted families with children, such as the fall in child protection registrations of 42%, a reduction of 70% in post-natal depression, increased educational attainment among 10-11 year old boys, increased breastfeeding, and a lower number of unwanted teenage pregnancies.[134] It is possible within an ABCD approach that priority groups such as families can be targeted – as in the Happy 'n' Healthy Community Development Trust who chose to implement a range of programmes across six service areas, one of which was 'family health and resilience'.[135]

The Well Communities team at the University of East London is currently developing and evaluating phase two of 'Well London', which is a lottery-funded programme, administered by the Greater London Authority. Well London is a whole system framework which uses asset-based community development, to integrate and develop health-improvement activities within a locality. In phase one, Well London worked in 20 areas (lower super output level) across London, and during phase two is working in community defined neighbourhoods in 10 London boroughs. There has been a qualitative and quantitative evaluation of phase 1 using a number of research methods to ascertain the impacts both on participants and the whole area. The first evaluation found some positive results on social cohesion and eating healthily and, where it was more embedded, better outcomes at the population level.[136]

The Well London programme is made up of 'heart of the community' projects and 'themed' projects. The former use community engagement and coproduction with local people and are about developing the community as a whole, and building capacity and networks within that community. This includes – the Well London delivery teams, volunteers from the local community who are trained to become community health champions, young apprenticeship schemes and the 'Wellnet' network. Themed projects are also about coproduction with communities through engagement, and are based around a number of themes, including healthy eating, physical activity, mental wellbeing, healthy spaces, arts and culture.

134 http://www.healthcomplexity.net/content.php?s=c2&c=c2_beacon

135 Knapp M, McDaid D, Parsonage M. 'Mental health promotion and prevention: The economic case'. London: Social Services Research Unit, London School of Economics & Political Science; 2011.

136 http://www.welllondon.org.uk/1621/phase-1.html

The projects include a mapping process, that takes into account both prescribed needs and existing opportunities. It has emerged that there is much going on, but information about projects is commonly inaccessible or not known. Well Communities is looking for partners to engage with and develop their model outside London, though this would incur a financial cost to the area. A cost–benefit analysis of the Well London programme is due to be carried out in phase three of the project. The cost of each neighbourhood project is around £100,000 per year.

Well London is beginning to work with GP practices in Newham and Hackney, carrying out engagement with patients of the practices and residents of the surrounding neighbourhood. Both areas are planning to implement a form of social prescribing and the Well London programme is integrating with this work.

On the Manton estate in North Yorkshire, the Manton Community Alliance has adopted a social capital model of neighbourhood renewal. Its focus is on changing behaviour and relationships and on achieving long-term, sustainable change, rather than traditional projects. An evaluation of this project found:

- 41% of residents surveyed said they influence what is happening compared to 30% nationally and 25% in the district.
- Crime has been reduced by 18.9% and fear of crime has also fallen.
- Levels of trust are the highest in generations, according to local surveys.
- 55% of residents surveyed said that the estate was better because of the community alliance .[137]

Located in the Stobswell area of Dundee, the StobsWELLbeing project is focused on improving community wellbeing, through building on and extending the work of existing local service providers, with a focus on addressing how they work with local people. Some of these organisations do not have a direct mental health improvement role, but have the potential to impact on the mental wellbeing of the people they work with. An extensive community consultation process formed the basis for the identification and development of a range of local activities, for example, the under-utilisation of a local park led to making use of the space for community picnics. No additional resources have been put into the area as a result of this work. A small amount of funding was provided by the Scottish Government for staff time, but the approach has been more about effective working between people and services in the area. 'There is a continued focus on the legacy of the work going forward and in sustaining the momentum created by the work of the test site.[138]

137 Foot J., Hopkins T. *A glass half-full: how an asset approach can improve community health and well-being*. London: Improvement & Development Agency (IDEA); 2010.

138 McLean J, McNeice V.Assets in Action: Illustrating Asset Based Approaches for Health Improvemen. http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf: Glasgow Centre for Population Health; 2012.

The Happy 'n' Healthy Community Development Trust is a community-led health organisation which engages with local communities in the Cambuslang and Rutherglen areas of Glasgow (around 57,000 people). It responds to the issues that local people identify as priorities. The Trust seeks to complement and add to existing strategies and bring local people, services and agencies together, ensuring local participation in, and influence on, decision-making and more responsive services. It involves a diverse range of programmes across six service areas:

- Supporting communities – consultation, engagement and development.
- Mental and emotional health and wellbeing.
- Promoting healthy choices.
- Community broadcasting and digital media.
- Volunteering opportunities and supported placements.
- Family health and resilience.

The final service area focuses specifically on families – though all of the service areas will have some effect on families and children. It is a large project, with 11 full-time, and two part-time, paid members of staff that worked with over 12,000 people across the community over the 2010/11 financial year. Volunteers reported multiple benefits from their involvement including better relationships, improved sense of community, better outlook on life and improved health and wellbeing. They identified funding as a barrier, and initiated a social enterprise trading subsidiary, Health and Happy Enterprises Ltd, to raise more money.

Community navigators

Community navigators are local volunteers or members of organisations who help other residents find their way to activities or services which they would enjoy or find useful.[139] Community navigators who provide benefit and debt advice to hard-to-reach groups cost just under £300 per person (in addition to the cost of visits to Citizens' Advice or the JobCentre, estimated to cost around £180 per person) yet are estimated to save £900 per person in the first year, because of savings in benefit payments, a reduction in time lost at work, increased productivity and fewer GP visits. Improved mental health and quality of life are likely to add further economic benefits.[140]

Time banks

Time banks are a resource in which everyone's time is valued equally in terms of what they have to offer. Time, skills, care or resources, for example, become a form of currency. For every hour a participant provides of their services, they receive the equivalent amount of time that someone else has offered, when they are in need. Time-banking can be used in many different settings and contexts

139 Care Network Cambridgeshire. Community Navigators [July 2013]. Available from: http://www.care-network.org.uk/index.php?option=com_content&view=article&id=19&Itemid=34.

140 Knapp M, Bauer A, Perkins M, Snell T.Building community capacity: Making an economic cas. Personal Social Services Research Unit (PSSRU) *Discussion Paper* 2772 2010 [July 2013]. Available from: http://www.pssru.ac.uk/pdf/dp2772.pdf

and has developed from being a person-to-person exchange to facilitating exchanges that include public agencies, voluntary organisations and social enterprises.[141]

Local authorities can play a role in encouraging local time banks to cooperate,[142] thereby building links across neighbourhoods, making them more sustainable and meaning they have more to offer members.

To ensure that these projects extend to groups that are harder to reach, co-location in GP surgeries or social housing developments may be an option, which makes them more visible and facilitates referral from GPs and others. Rushey Green Time Bank, as an example, is the first time bank in the UK to be based in a healthcare setting, and a number of evaluations have shown that it has improved the mental and physical wellbeing of contributors.[143] One evaluation found that aside from the practical benefits, time-banking attracts a wider range of people than other volunteering schemes and has a positive effect on levels of self-confidence and trust locally. People make friends and connections that would not occur naturally.[144] It is also more successful than traditional forms of volunteering in attracting socially excluded groups.[145]

Paxton Green Group Practice in south east London developed a time bank located within the community near a children's centre, a library and a housing estate. GPs can prescribe activity from the time bank. Many of the activities are health-related, such as lifts to the doctor, which extends the scope of the NHS without additional costs. Other social activities and the social connectedness developed by the time bank also increase social capital the communities. It is a co-production approach, as the ideas for activities come from the members themselves. Though a formal evaluation has not been carried out, members felt their involvement had made them more confident and positive within the first year. Members are more likely to be under 50, male, out of work and depressed.[146]

The Holy Cross Centre Trust (HCCT) is an independent organisation that provides support to the rapidly growing number of homeless people in the King's Cross area of London. In October 2007, together with two other locally based organisations – MIND in Camden and the Camden Volunteer Centre – HCCT formed a consortium to bid successfully for a £2million tender for a mental health day care service. The consortium was not the cheapest tender on a unit cost basis, but the commissioners' overall evaluation was that its focus on service-user and community involvement, as well as wider social and economic

141 Financial Inclusion Forum 2013 [September 2013]. Available from: http://www.coventrypartnership.com/financial-inclusion-forum.

142 Camden Shares [July 2013]. Available from: http://www.camdenshares.org.uk/.

143 Boyle D. More than Money: 'Platforms for exchange and reciprocity in public services'. Discussion Paper. London: NESTA; 2011.

144 Seyfang GJ, Smith K. 'The time of our lives: using time banking for neighbourhood renewal and community capacity building'. London: New Economics Foundation; 2002.

145 Knapp M, Bauer A, Perkins M, Snell T. 'Building community capacity: Making an economic case'. Personal Social Services Research Unit (PSSRU) Discussion Paper 2772 2010 [July 2013].

146 Boyle D, Slay J, Stephens L. 'Public Services Inside Out: Putting co-production into practice'. London: NESTA; 2010.

impacts, would create the most positive outcomes and make HCCT the best value for money.

Central to the service was the use of a Time Banking model to incentivise service users and the community to become involved in service provision. Through the time bank, participants earn credits for engagement with the service and for helping each other. One hour of time entitles individuals to one hour of someone else's time, or contributes towards participating in an activity organised by HCCT or another organisational member. HCCT has developed a time currency to allow the time bank members to accrue and spend their credits.

Credits can be earned for the following activities:

- Facilitating music appreciation workshop.
- Facilitating yoga group.
- Setting the table and washing the dishes.
- Shopping for milk, coffee/tea and newspapers.
- Watering plants and tidying leaflets throughout centre.

The HCCT has developed their time bank beyond the parameters of the day centre to include external services and resources through the Camden Shares Scheme. This enables time credits to be spent on other outside activities when capacity is under-used (for example, swimming sessions, cinema tickets, fitness classes). The scheme has invited other organisations to join the time bank, creating a mechanism to share resources and use space when it is available (including, room hire, equipment exchange, training and skills sharing).

Time banking rewards services users and volunteers in the King's Cross community for their contribution to the service, creating a culture of collaboration and reciprocity, which enables public funding to go much further. The substantial hours of time traded by service users represent more than just additional labour or volunteering. Because service users are both giving and receiving, they are building social networks and the resilience of the service, and helping to find peer-led solutions to their needs. This is important as clinical evidence shows that people's involvement in social networks is just as important as medical treatment in their chances of making a recovery.[147, 148]

Julia Slay's report for NESTA, *More than Money*[149] highlights the New Economics Foundation's Social Return on Investment analysis of the time bank run by the Holy Cross Centre Trust. The analysis demonstrated a social return of £3.40 for every £1 invested by Camden council. In 2009/10, the value of the mental health services contract was £689,515. The contributions of time bank

147 Department of Health (2004) *Choosing health: making healthy choices easier*, (London: Department of Health).

148 Appleby L. (2007) *Breaking down barriers – the clinical case for change*, Department of Health

149 Slay, J. (2011) *More Than Money: Literature review of the evidence base on Reciprocal Exchange Systems*. NESTA

members during this time were valued at £137,119, using the London Living Wage campaign guidelines. This generated over £4,700,000 in social value.

The New Economics Foundation report, *Budgets and Beyond*, stated that:

> Holy Cross Centre in Camden is a mental health centre, but has also demonstrated its impact on social inclusion, improved employability and reduced demand for acute health services. These cross sector benefits have a major impact on reducing the demand for services, and on increasing economic contributions to the state in the form of tax revenues, or reduced benefits, if people are supported into work. Yet we currently have neither a public accounting system, nor a means of allocating public funds, that accurately capture or encourage these benefits.[150]

Castlemilk time bank in Glasgow, had a total membership of 282 volunteers as of October 2011. They included people with mental ill health, those who were retired, lone parents and people affected by domestic abuse[151]. Members took a peer mentoring approach, with more experienced members working alongside newer members. The Castlemilk time bank links with over 60 organisations and local businesses, exchanging skills and support with many of them. People have become involved primarily through word of mouth and self-referral, as well as receiving referrals from sources such as local care homes and mental health projects. The Castlemilk time bank employs a full-time co-ordinator and two part-time administration assistants. The management committee is made up entirely of residents and works in partnership with agencies such as the domestic violence unit and the Working Links work programme.

Consultations and a service review with volunteers have indicated that the key strengths include the time bank's inclusiveness, safety, reliability, ease of access to services and the ability to respond to a range of user demands. Challenges include time-limited funding periods, a need for better marketing tools and the recognition that many volunteers are doing more than is required. Volunteers have expressed a sense of job fulfilment and pride in their work, as they are meeting people with similar interests and forming new friendships locally, and raising people's confidence.[152]

Cost-benefit analysis of time banks

Utilising the evidence presented above, the social return on investment of the Holy Cross time bank was as follows:

- **SROI 1:3.4 (Holy Cross Centre Trust time bank)** [153]

150 Slay, J. (2011) *Budgets and Beyond: Interim Report - A review of the literature on personalisation and a framework for understanding co-production in the 'Budgets and Beyond' project.* New Economics Foundation pdf

151 McLean J, McNeice V. 'Assets in Action: Illustrating Asset Based Approaches for Health Improvement'. http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf:

152 McLean J, McNeice V. 'Assets in Action: Illustrating Asset Based Approaches for Health Improvement'. http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf: Glasgow Centre for Population Health; 2012.

153 Slay, J. (2011) *More Than Money: Literature review of the evidence base on Reciprocal Exchange Systems.* NESTA

Local area co-ordination

Derby City Council first introduced local area co-ordination in 2012, by starting the service in two wards in the city. Since that time, the service has expanded to an additional ward (in April 2014) and four further wards (in September 2014). Since September 2015, local area co-ordination has increased to include 10 local area coordinators in 10 wards across Derby.

Derby City Council supports an agenda that empowers communities and shifts services to focus on the individual, with the building of social capital. Furthermore, with the introduction of the Care Act 2014 local authorities now have a duty to promote health and wellbeing, with the focus on 'prevent, reduce and delay'. Across Derby and Derbyshire, through the Better Care Fund and Joined Up Care Approach, a series of delivery groups and workstreams were developed to drive the transformation and integration of health and social care. Within the community support delivery group, four workstreams were identified to deliver this, with workstream one established to increase self-help, prevention and community resilience. Local area co-ordination was understood to be central to building social capital within communities, and together with other activities, helps communities to reduce the need for statutory services to support vulnerable people. Local area co-ordination is clearly seen as helping to build support for resilience and prevention in this move towards more community-based solutions and subsequently supported the Joined Up Care Programme.[154]

From the work in Derby there is evidence that local area co-ordination has the potential to deliver significant returns. The analysis demonstrates that for every £1 invested in local area co-ordination approximately £4 of social value is forecast to be created. The distribution of the social value highlights that the majority of the social impact is for the community – the Level 1 and Level 2 individuals experiencing improved health and wellbeing outcomes as a result of the support for the coordinator. The Council together with health, fire and police services are also positively impacted as a result of individuals becoming empowered and finding community-based solutions.[155]

Co-location and signposting

Signposting to a wide variety of services by frontline staff and/or local volunteers helps those citizens with less understanding of the available services and support to access them, even if they are not actively looking for them in the first place. It can ensure that services in an area are joined up and better address the social determinants of ill-health. For example, health professionals can be encouraged to connect patients to wider advice services such as Citizens' Advice, Legal Aid or housing services.[156] A study in Liverpool found statistically significant evidence to suggest that non-

154 Kingfishers Ltd. (2016) 'Social Value of Local Area Co-ordination: A forecast Social Return on Investment Analysis for Derby City Council' Summary Report.

155 Kingfishers op cit.

156 Allen M, Allen J, Hogarth S, Marmot M. 'Working for Health Equity: The Role of Health Professionals'. London: UCL Institute of Health Equity; 2013. Friedli L, Jackson C, Abernathy H, Stansfield J. 'Social prescribing for mental health - a guide to commissioning and delivery' Care Services Improvement Partnership; 2008. Grant C, Goodenough T, Harvey I, Hine C. 'A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector'. BMJ. 2000;320(7232):419-23.

professional support workers connecting patients to advice, support, information and advocacy may reduce the number of consultations with and new prescriptions from GPs.[157]

There are a number of challenges, including developing the necessary up-to-date knowledge and confidence among those expected to signpost others. Signposting is facilitated by cross-sector partnerships to ensure that those signposting have all of the relevant information they need. A regularly updated directory of relevant services would help in this.[158]

Co-location is another option to improve the accessibility of services, for example citing Citizens' Advice in GP surgeries has been shown to be a viable and useful option.[159] The Bromley-by-Bow Centre in East London is a large charity that hosts a local GP surgery, social enterprises, a children's centre and provides adult education courses and a range of advice services among other things.[160] All services are delivered within the centre and staff from across services work together. GP referral to advice and support services as well as exercise classes, is common.

The PATHway study involved co-locating a domestic abuse advisory service in St Mary's Maternity Hospital in Manchester. An independent evaluation reported that a greater number of referrals were made. 116 out of 126 women said they felt safer, and it was successful in accessing harder-to-reach groups, with 57 per cent of those seen, being of minority ethnic origin.[161] The cost of employing a full-time, independent domestic violence advocate (IDVA) for 15 months was £50,591, while savings to the public sector during the same period was conservatively estimated at £170,800 because the 28 cases referred to multi-agency risk assessment conferences (MARACs).[162] This is just one example of co-location of health and advice services, yet its success indicates that the approach may be worth considering in different contexts.

Cost-benefit analysis of co-location

Utilising the evidence above, the return on investment of the PATHway study was as follows:

- **ROI 1:3.4 (PATHway study)**[163]

157 Abbott S, Davidson L. 'Easing the burden on primary care in deprived urban areas: A service model'. Primary Health Care Research and Development. 2000;1:201-6.

158 RCGP Health Inequalities Standing Group. *Addressing Health Inequalities: a Guide for General Practitioners.* 2008.

159 Galvin K, Sharples A, Jackson D. 'Citizens Advice Bureaux in general practice: an illuminative evaluation'. *Health & Social Care in the Community.* 2000;8(4):277-82.

160 The Marmot Review Team. Fair Society, *Healthy Lives: Strategic review of health inequalities in England post-2010.* London: Marmot Review Team, 2010.

161 Allen M, Allen J, Hogarth S, Marmot M. *Working for Health Equity: The Role of Health Professionals. London*: UCL Institute of Health Equity; 2013.

162 Granville G, Bridge S. 'PATHway: An Independent Domestic Advisory service at St Mary's Maternity Hospital, Manchester. Summary of findings and recommendations from the independent evaluation'. 2010 [July 2013]. Available from: **http://www.endthefear.co.uk/wp-content/uploads/2010/10/PATHway-Project-Summary1.pdf.**

163 Granville G, Bridge S. 'PATHway: An Independent Domestic Advisory service at St Mary's Maternity Hospital, Manchester. Summary of findings and recommendations from the independent evaluation'. 2010 [July 2013]. Available from: **http://www.endthefear.co.uk/wp-content/uploads/2010/10/PATHway-Project-Summary1.pdf.**

Volunteering programmes

'Volunteering is defined as an activity that involves spending time, unpaid, doing something that aims to benefit the environment or individuals or groups other than (or in addition to) close relatives. [164]

In 2009-10 across England, 24% of people regularly volunteered formally through groups and organisations and 29% volunteered informally to give unpaid help to family and friends, at least once a month.[165] Clearly there are skills and enthusiasm within communities that can be harnessed by volunteering programmes, as long as they are mobilised and facilitated. Volunteering programmes have a range of benefits for communities, depending on the nature of the programme. It can and has made an impact on the health and wellbeing of service users in some instances, for example – improving self-esteem, mental health, parenting skills, physical health and functioning and reducing depression.[166]

Further, there are benefits for the volunteers themselves. Volunteering England reviewed the health impacts of volunteering and found that it is beneficial for volunteers in terms of physical and mental health, including improvements in self-rated health, depression, mortality, life satisfaction, stress, social support and interaction, quality of life, self-esteem, and adoption of healthy lifestyles.[167] A review of 19 asset-based projects in Scotland found there were many benefits for volunteers at both individual and community level, including a sense of purpose and structure, improved (family) relationships, social interaction, community cohesion and access to training opportunities.[168] Though the true economic and social value of volunteering is difficult to ascertain, one study focused on 12 small voluntary organisations providing social welfare services and estimated that for each £1 of investment in volunteer support, the organisations gained between £2 and £8 of value from their volunteers.[169]

Befriending schemes offer supportive, reliable relationships through volunteer befrienders, to people who would otherwise be socially isolated. They have been estimated to cost around £80 per older person. About £35 is estimated to be saved in the first year because of the reduced need for treatment and mental health support. Further, it is estimated that the improvements to an older person's mental health and improved quality of life creates £300 in value per year, using evidence from the Partnerships for Older People Project (POPP)

164 Norman W. *Adapting to Change: the Role of Community Resilience*. London: The Young Foundation; 2012.

165 Almedom AM. 'Social capital and mental health: an interdisciplinary review of primary evidence'. Soc Sci Med. 2005;61(5):943-64.

166 Fabrigoule C, Letenneur L, Dartigues JF, Zarrouk M, Commenges D, Barbergergateau P. 'Social and Leisure Activities and Risk of Dementia - A Prospective Longitudinal-Study'. Journal of the American Geriatrics Society. 1995;43(5):485-90.

167 Fabrigoule C et al. op cit.

168 McLean J, McNeice V. 'Assets in Action: Illustrating Asset Based Approaches for Health Improvement'. http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf: Glasgow Centre for Population Health; 2012.

169 Gaskin K, Dobson B. 'The economic equation of volunteering'. *Social Policy Research 110*. York, UK: Joseph Rowntree Foundation; 1997.

pilots[170]. The analysis does not take into account the positive effects on the volunteer befrienders, who are likely to experience health and social gains. Befriending is most commonly used by elderly people, yet it can also apply to any vulnerable adults who may be socially isolated.

The Templehall Dad's Group in Kirkaldy, Fife is a project aiming to provide meaningful activity for young dads in a deprived area where there are high rates of teenage pregnancy. The dads converted an area of waste ground into an outdoor space for children. 25 dads were engaged at the time the report was published. They reported an overall improvement in their wellbeing, increased confidence and the development of new skills. Some reported improved family relationships, better attitudes and have moved into education or employment. Aside from the positive outcomes, this project managed to engage a hard-to-reach community asset – young fathers – and cut across many of this report's priority groups: men, young adults and families with children. The barriers the group faced included an on-going need for funding, some members experiencing difficulties with their benefit payments because of their involvement in the project, and slow progress (due to funding issues) – which has made it difficult to sustain interest and motivation.[171]

Cost-benefit analysis of volunteering

Utilising the evidence above the social return on investment of volunteering has been estimated at:

- **SROI 1:2 to 1:8 (Joseph Rowntree Foundation)**[172]

And the social return on investment of befriending has been estimated at:

- **SROI 1:3.75 (Befriending)**[173]

Play Out

Play Out is becoming increasingly popular on the streets of the UK and enables people to close their streets to traffic for a specific amount of time whilst opening their streets to children and the community to purposely congregate and 'play out'. Playing out benefits children, adults, the street and wider communities. There is a wide range of evidence which supports this.

The public health recommendation states that children aged between 5 and 18

170 Knapp M, Bauer A, Perkins M, Snell T. 'Building community capacity: Making an economic case'. Personal Social Services Research Unit (PSSRU) Discussion Paper 2772 2010 [July 2013]. Available from: http://www.pssru.ac.uk/pdf/dp2772.pdf

171 McLean J, McNeice V. 'Assets in Action: Illustrating Asset Based Approaches for Health Improvement'. http://www.scdc.org.uk/media/resources/assets-alliance/0071_assets_in_action_report_web_low_res.pdf: Glasgow Centre for Population Health; 2012.

172 Gaskin K, Dobson B. 'The economic equation of volunteering'. *Social Policy Research 110.* York, UK: Joseph Rowntree Foundation; 1997.

173 Knapp M, Bauer A, Perkins M, Snell T. 'Building community capacity: Making an economic case'. Personal Social Services Research Unit (PSSRU) Discussion Paper 2772 2010 [July 2013]. Available from: http://www.pssru.ac.uk/pdf/dp2772.pdf

should take part, for at least one hour a day, in moderate to vigorous activity; however among children aged between 5 and 15, only 16% of girls and 21% of boys actually achieve this. Research by the University of Bristol has shown that children are three to five times more active during playing out sessions than they would be on a 'normal' day when they did not have a chance to play in their street.[174] An evaluation of Play Out in Hackney also highlighted the significant amount of physical activity children achieve during street play sessions. This study found street play activity to be equivalent to 14 additional weekly PE sessions, each school term.

The World Health Organisation's Commission on Ending Childhood Obesity recommends the creation of, 'safe, physical activity-friendly communities which enable the use of active transport (e.g. walking, cycling) and participation in an active lifestyle and physical activities.[175]

There is also evidence which demonstrates that playing out helps to build connections, friendships and trust between neighbours of all ages. Children who play out are making new friends and playmates, and through talking about the idea on doorsteps and during play out sessions, residents of all ages are meeting, exchanging ideas and feeling their street is a friendlier, safer place to live.[176]

Intelligence, Insight and Digital

Digital Services

Technology such as mobile phones and computers is now the ubiquitous mode of communication between citizens and, for some, social media their main tool. Many councils are still endeavouring to understand and use this form of communication, which may partly explain the difficulties in reaching this group. Instead of embracing the new technology, it is often seen as a potential threat to children and young people – largely because mobile phones and instant messaging are key tools used by perpetrators involved in sexual exploitation of vulnerable young people.[177]

In addition, the *Pillars and Foundations*[178] report highlights an important element:

> As the physical presence of services becomes prohibitively expensive and we attempt to increase the volume of early help services, there will be an inevitable shift to technology – blending face-to-face with online delivery. By volume, some services may become a predominantly online early help model in the future.

There are many reasons to consider adding multimedia tools into the mix when councils and transmission system operators (TSOs) are exploring how children

174 Page A. and Cooper A. (2014) *Outdoors and Active – Evidence Briefing* University of Bristol pdf

175 World Health Organisation (2016) *Ending Childhood Obesity* pdf

176 Page A. and Cooper A. (2014), *Outdoors and Active – Evidence Briefing* University of Bristol pdf

177 Fursland E. (2014) *The IT Crowd – How technology is helping children in care* Children and Young People Now

178 ADCS (2016) *Pillars and Foundations – next practice in Children Services – a think piece*

and young people can be engaged in influencing decisions and creating change across the sector.

In Somerset, 21 young service users took on the role of ‘young detectives’ at the Somerset Children’s Fund conference for adults from Children’s Fund projects. The young detectives, aged 9 to 13, used a range different multimedia tools (including video and tape recordings, Polaroid and digital photography) to find out from adults and each other how the projects listened and responded to their views. Their findings created an authentic record of the day and fed into the Children’s Fund evaluation process. Using multimedia tools and casting the children and young people as ‘young detectives’ allowed them to create a record of what they had heard, without needing to write everything down. This was important, as the group consisted of young people with varying levels of literacy. It helped them to develop their confidence through coming up with, and asking, constructive critical questions of their workers. It also transformed what was otherwise a standard conference for adult delegates into one that included children and young people in key roles. This altered the implicit balance of power between the adults and the children and young people present.[179]

Technology, increasingly a tool in the day-to-day work and training of social workers and other frontline staff, is also being used in innovative ways to help children and young people gain access to services, get support and have a voice. Support organisations such as the Who Cares? Trust now see social media including Twitter and Facebook as essential in promoting the views and experiences of children in care, and care leavers. Every Tuesday, the charity tweets messages from young people in care at regular intervals. “It’s getting their views to a wider audience,” says media officer Oliver Wilkinson. “The number of re-tweets we get on a Tuesday is far higher than any other day of the week.”

Lincolnshire County Council has replaced its Coming into Care Kit with a web-based app that can be used on a smartphone, tablet, laptop and PC. The app was developed with the help of young people from V4C (Voices for Choices), Lincolnshire’s looked-after children and care leavers’ council. It allows them to email their social worker and find out about facilities near to where they are living.

Warwickshire’s Children in Care Council has also produced a new resource to replace a cumbersome folder of information leaflets, in the form of a set of playing cards called Ur Say Ur Play for looked-after children aged 13 to 18. The back of each card features a different service such as alcohol misuse, advocacy or leaving care. Each card also features a QR code – a barcode that can be scanned with a smartphone – that links directly to the service’s website when the young person scans it with their phone. The old information packs dated quickly, but adopting the new approach means that the information is more likely to be up to date.[180]

179 Davies T. (2008) *How to use multimedia to engage children and young people in decision making* Participation Works: NCB

180 Fursland E. (2014) *The IT Crowd – How technology is helping children in care*, Children and Young People Now

There appears to have been little research done on the impact of digital media projects, which are primarily focused on improving the outcomes of children and young people. There are one or two examples, however. The University of Brighton evaluated the Beatbullying peer mentoring programme that included an online mentoring (cyber mentoring) element. The programme was intended to combine an effective peer support strategy (both within schools and online) with a substantial programme of opportunities for young people to bring about positive change through leadership and activism, in and out of school.

Across the five schools recruited for follow-up assessments of bullying, there was a significant drop in the proportion of pupils who experienced intentional and persistent bullying, from 28% to 20.8% overall (equating to a reduction of approximately a quarter in the numbers being bullied). Furthermore, staff leads, Beatbullying peer mentors, and other pupils had a shared, subjective perception that the introduction of Beatbullying mentors had led to a reduction of bullying problems at school. To what extent the online cyber-mentoring programme influenced these findings is not specified, but introduction of anonymous online mentoring by peers was seen as adding an important avenue of confidential support for pupils who are dealing with bullying or other related social problems.[181]

In 2014, Leicestershire schools' nurses teamed up with young people to develop a support mechanism for young people who self-harmed. The result was an online help-line called 'Chathealth' which uses Smartphone technology and SMS texting. Chathealth is secure, protects confidentiality and anonymity and is monitored by a small team of trained nurses. All text messages should be answered and automated texts are able to signpost alternative sources of help out-of-hours. The service has yet to be properly evaluated so the early indications are quantitative in nature. These include:

- The service is dealing with 11% more contacts for same number of staff.
- Chathealth moves people on more quickly to appropriate services.
- One nurse can handle all in-hours messages from across the county.

There is also a range of apps available – some evidence-based, others not. Most of them are focused on self-management and anxiety, depression and stress.

In 2015 Silver Lining was developed by Birmingham and Solihull Mental Health Foundation Trust in partnership with Appadoodle. This app complements an existing service for patients who are receiving treatment for mental health conditions. It records data on mood and possible triggers which it then stores in a dashboard area that can be accessed by the service user or clinician. The app is targeted primarily towards 16 to 24 year olds and uses a series of 'gamification' style rewards, such as unlocking achievements, badges and accessories, thus rewarding patients who use it more frequently. It is too early to

181 Banerjee R., Robinson C., & Smalley D. *Evaluation of the Beatbullying peer mentoring programme* University of Brighton

demonstrate the effectiveness of this app but the hope is that it will encourage young people to engage with their treatment and take control over their recovery, helping them to get better, more quickly.

Predictive modelling

In the face of significant budgetary cuts and ambitious savings targets, local authorities need to balance the requirement to save money with the need to provide frontline services to a growing, ageing and diversifying population. A recent report by the National Audit Office (NAO) highlights concerns about the public sector's capacity to make the right decisions quickly. The NAO cites the public sector's lack of reliable data and information management tools as important weaknesses that hamper effective decision-making, and limit the potential for making long-term savings, while protecting front line services.[182]

The report, *Pillars and Foundations*[183] suggests that:

> In the future, children's services will be built on proactive engagement with families rather than the reactive model of waiting for a need to become severe enough to present to the front-door or universal services. Data integration and predictive modelling will identify which families to help, and show over time which interventions are having the best impact on outcomes.

Most major organisations, whether public or private, have large data repositories containing valuable information about their customers and service users. The private sector has recognised the value of this data and takes its use very seriously, offering better services and products as a result. Businesses from a range of sectors have embraced analytics to help them understand their customers and optimise their performance. In particular, organisations are using analytics to take a more proactive approach to forecasting future demand, take the best course of action, reduce risk and improve outcomes. It is precisely this insight that the public sector requires if it is to manage the savings, without sacrificing the fairness or the services that the taxpayer deserves.[184]

There are a number of reasons why the public sector struggles to implement efficiency programmes and optimise performance and the NAO highlighted the following as notable:[185]

- Lack of suitable baselines for the calculation of savings.
- Insufficient data on cost, unit cost and performance.
- Difficulties in demonstrating links between savings, performance and improved frontline services.
- Insufficient quality control prior to external reporting.

182 National Audit Office (2016), Local Welfare Provision

183 ADCS (2016) *Pillars and Foundations – next practice in Children Services – a think piece*

184 SAS (2016) *The Benefits of Analytics in the Public Sector –the smart way to cut costs, optimise performance and deliver reform in the public sector* White Paper

185 National Audit Office (2010) A Short Guide to Cost Reduction

- Lack of transparency over arms-length organisations reporting processes to identify what they were doing to save money.

The NAO also highlighted that good information is essential to support decisions at all levels – whether strategic or operational – and recommended a step change, and continuous improvement, in cost management capabilities across the public sector.

In *Competing on Analytics*, Thomas Davenport and Jeanne Harris drew particular attention to the way the information pioneers (including Tescos, Amazon, Dell and UPS) make use of not only traditional business intelligence software, but also advanced analytics. The distinction is one of hindsight versus foresight. Traditional business intelligence provides better and faster hindsight by improving the quality and integrating historical data. This ability to understand what has happened is vital – particularly in the public sector, where the absence of reliable baselines and benchmarks still hampers performance. Advanced analytics also provide these top-performing organisations with both the insight to understand why things have happened, and the foresight to predict what is likely to happen next. This enables them to be proactive, rather than just reactive.[186]

There are some examples of the public sector employing similar analytical tools and systems. HMRC has adopted predictive analytics to fight fraud. For example, HMRC's Connect system has allowed it to integrate and analyse numerous separate data sources to target personal tax fraud with greater speed and efficiency, while enabling it to process deserving claims faster. In the period up to 2008/09, the implementation costs were around £18.8m, while increased yield was £572m – a remarkable return of 30:1. The pilot system alone increased tax yields by 58 percent and, ultimately, return on investment is forecast to be around 1,000 per cent over five years.[187]

The Pensions Service within the Department for Work and Pensions is making similar use of advanced analytics to improve insight into the needs of around 15 million pensioners and pre-pensioners. Faced with an aging population and decreasing budgets, the Pensions Service uses a 'customer insight engine' to identify short-term demands on resources and to target marketing campaigns that are designed to encourage pensioners to switch to lower cost channels. The system also predicts long-term demand and helps to inform policy.

In addition, the analysis supports the long-term health and independence of pensioners by encouraging them to claim their full entitlements, thus decreasing the risk of future dependence on state-funded care. The analytical system they employ segments their customer base by lifestyle and behaviour, the Pensions Service has reduced the cost of marketing campaigns – yet tripled the rate of uptake of key benefits.

186 Davenport T. & Harris J. (2007) *Competing on Analytics*, Harvard Business School Press

187 National Fraud Authority/Public Sector Taskforce (2010) *A fresh approach to combatting fraud in the public sector*

Predictive risk models for managing health systems were first developed in the United States in the 1990s, and were followed by the construction of Patients at Risk of Readmission (PARR) and the Combined Predictive Model in England. More recently, a Nuffield Trust study has shown that it is possible to use the same techniques to predict the start of intensive social care using both health and social care data.[188]

The Combined Predictive Model is an example of a model designed to produce predictions for the entire population, not just those who have had a recent period of hospitalisation. In addition to the datasets used in PARR, the Combined Model uses variables from the primary care electronic medical record (EMR). EMR data is collected and collated differently across England, so the Combined Model has to be adapted to suit local circumstances. Using the Combined Model, people in the 0.5% of the population with the highest predicted risk are 18.6 times more likely than the average patient to have an emergency admission in the year following prediction.[189]

Sheffield City Council is in the early stages of this work, but is keen to explore it further. Using care register information, a predictive model has been developed to identify patients with a learning disability, who are living with an older carer who is at risk of admission to residential care. The council use the predictions to target 'upstream' interventions to plan for moving on from living with the older carer, and thereby reduce the costs arising from emergency admission to residential care by the person with a learning disability. The council team have also begun to do some work with GP practices on predictive risk modelling. They are using this in a project called, In Sight In Mind, which targets people who have been identified as being at risk. Such people are offered signpost services, and are given the support to build community capacity, and to help people develop new social networks. One insight to emerge from this project is that many local GPs were unaware of which of their patients were receiving assistance from social services.

Sheffield City Council can see wider significant benefits from being able to link health and social care data pseudonymously. For example it could be useful in strategic planning, and in analysing health and social care provision, including continuing health care, and in a 'whole lifespan' analysis of children, young people and adults with a learning disability. In order to support such analyses in the future, the council is currently putting together a business case to promote the routine recording of the standard NHS number for all social care clients. The council also strongly supports the idea that personal budgets will offer better data on expenditure, which should lead to more accurate data for modelling social care needs.

188 Nuffield Trust (2011) *Predicting Social Care Costs: A feasibility study*. London: Nuffield Trust

189 CARE (2012) *Vulnerable Children – can administrative data be used to identify children at risk of adverse outcomes*, University of Auckland

In Essex County Council, predictive risk modelling is being used to try to predict at age 14 those vulnerable children who are at risk of becoming NEET (not in education, employment or training) by the age of 18.

This project incorporated data from the police and criminal justice systems, school census data as well as social care information, which they were able to link successfully at the individual level. They noted that currently the model lacks some very important information, such as parental criminal history, and whether or not the young person has a sibling who is a teenage parent. The Essex project has begun to think about how this type of predictive modelling could be used in practice, and have arranged a meeting to discuss data security and sharing with the local Caldicott Guardians and the senior information risk officers (SIROs) from various organisations in Essex.

In 2012, the University of Auckland[190] undertook some research into Predictive Risk Modelling (PRM). In their analysis, they used PRM to generate a risk score for the probability of a maltreatment finding, for each child, at the outset of any main welfare benefit spell involving the child. The objective of this project was to test whether an automatic risk scoring tool – or Predictive Risk Model (PRM) – could be developed and validated for New Zealand children. This tool would automatically generate a risk score for children either:

- When they arrive on the benefit system.
- Or when their circumstances change, once supported by a benefit.

The risk score would be generated by a computerised algorithm and, if implemented, could be automatically sent to frontline staff, an external provider, or a central agency for response. The conclusions from the project demonstrated that the algorithms when developed and implemented were able to show, at the age of two years, which children would be on the child protection register in the future.

The research states that:[191]

> The principal requirements for the utilisation of a PRM include: (1) a sufficiently wide net of the target population captured in the systems from which data are harvested; (2) comprehensive and timely data on risk factors; (3) risk scores that can be generated immediately; and (4) outcomes that can be predicted with sufficient accuracy. In the case of child maltreatment, it is particularly important that the protocols followed once the risk score is generated are ethical.

The researchers also offer a further word of warning concerning the ethics surrounding the use of PRM within the child protection system:[192]

190 CARE (2012) *Vulnerable Children – can administrative data be used to identify children at risk of adverse outcomes*, University of Auckland

191 CARE (2012) *Vulnerable Children – can administrative data be used to identify children at risk of adverse outcomes*, University of Auckland

192 CARE (2012) *Vulnerable Children – can administrative data be used to identify children at risk of adverse outcomes* University of Auckland

> There are a number of very difficult scenarios that could occur which need to be carefully thought through. For example, if a caregiver's risk is increased due to the history of her partner, would MSD (sic Social Services) be obliged to tell her about this history? If a very high-risk family is offered services which they turn down, and MSD (sic Social Services) evaluates the child as having an extremely high risk, and the child is subsequently abused, what is the culpability of MSD (sic Social Services)? There are a large range of such scenarios that need careful consideration, and both legal and ethical evaluation before a PRM can be operationalized.

The conclusions suggest that if the approach is going to be implemented, then a strong ethical framework is important. The significant ethical issues do not pose an insurmountable barrier to the application of the model. The research report offers a summary of the ethical issues as a guide to matters which they believe need to be considered by those applying the model.

In conclusion, it appears that predictive modelling is a fast growing field within the public sector and several PCTs and councils across England are working to introduce predictive models into the field of social care. Clearly it will be important to ensure that these ambitious plans are fully compliant with the relevant information governance requirements. It is therefore very timely that the National Information Governance Board (NIGB) has recently published some updated guidance.

Appendix 1

Examples of effective, school based, evidence-based interventions and programmes

Programme	Target group	Setting	Outcomes improved	Social benefit–cost ratio
Raising healthy children (RHC) [193] RHC is a universal intervention. The programme seeks to strengthen positive behaviour in children through: a) enhancing meaningful opportunities for young people to contribute to their family, school, and pro-social peer groups; b) reinforcing effort and accomplishment so that children are motivated to keep contributing to the social unit; and c) teaching appropriate skills so that children can be effective in their contribution.	Age 5–11	School	Crime Teen pregnancy School completion	
Good Behaviour Game (GBG)[194] This is a universal intervention and seeks to reduce aggressive behaviour, to prevent problem behaviour in middle childhood through early adulthood. The GBG strategy promotes good behaviour by rewarding teams that do not exceed maladaptive behaviour standards. During the first weeks of the intervention, the GBG is played 3 times each week for a period of 10 minutes. Over successive weeks, duration increases approximately 10 minutes per game period every 3 weeks, up to a maximum of 3 hours.	Age 6–8	School	Alcohol/drug use Depression Suicide risk	26.9

193 http://investinginchildren.eu/node/61. Accessed 25/04/16

194 http://investinginchildren.eu/node/71. Accessed 25/04/16

Programme	Target group	Setting	Outcomes improved	Social benefit–cost ratio
Project towards no drug abuse (TND)[195] Project TND is a universal school-based drug prevention programme. A set of 12 in-class interactive sessions target the use of cigarettes, alcohol, marijuana, hard drugs and violence-related behaviour. The lessons last 40-50 minutes each and are taught by health educators over a four-week period.	Age 14–18	School	Drug use	8.61
Guiding Good choices (GGC)[196] GGC is a universal multi-media substance abuse prevention programme. It aims to give parents of children the knowledge and skills needed to guide their children through early adolescence. It is designed to help parents reduce the likelihood that their children will develop problems with drugs and alcohol in adolescence. Parents take part in weekly sessions that last 2 hours.	Age 9–14	School	Alcohol/drug use Crime	2.92
Life Skills Training (LST)[197] Life skills training is designed to prevent or reduce substance use in young people. The programme targets those who have not yet developed substance abuse problems. LST is a 3-year intervention, primarily implemented in schools by regular classroom teachers. Typically there are 15 sessions in year 1, 10 sessions in year 2, and 5 sessions in year 3. Sessions last an average of 45 minutes. They can be delivered once a week or as an intensive mini-course.	Age 11–14	School	Alcohol/drug use Crime	Age 11–14

195 http://investinginchildren.eu/node/52. Accessed 25/04/16
196 http://investinginchildren.eu/node/73. Accessed 25/04/16
197 http://investinginchildren.eu/node/42. Accessed 25/04/16

Programme	Target group	Setting	Outcomes improved	Social benefit–cost ratio
Multidimensional Treatment Foster Care (MTFC)[198] MTFC is an intensive therapeutic foster care alternative to institutional placement for adolescents who have problems with chronic anti-social behaviour, emotional disturbance, and delinquency. The adolescent is placed with an MTFC foster care family while they take part in the programme. MTFC activities include skills training and therapy for young people as well as behavioural parent training and support for foster parents and biological parents.	Adolescents at risk of care	School	Crime Teen pregnancy	2.64
Positive action[199] A social and emotional learning programme for students to increase positive behaviour, reduce negative behaviour, and improve social and emotional learning and school environment. The classroom-based curriculum teaches understanding and management of self and how to interact with others through positive behaviour, with school environment programmes used to reinforce the classroom concepts school-wide.	Age 5–14	School	Diet Exercise	

198 http://investinginchildren.eu/node/43. Accessed 25/04/16

199 http://www.blueprintsprograms.com/factsheet/positive-action. Accessed 25/04/16

Programme	Target group	Setting	Outcomes improved	Social benefit–cost ratio
High Scope / Perry Pre-School [200] The High Scope curriculum is designed for children with or without special needs, from diverse socio-economic backgrounds and ethnicities. The programme aims to enhance children's cognitive, socio-emotional, and physical development, imparting skills that will help children succeed in school and be more productive and responsible throughout their lives. Children participate in the preschool programme for 1 to 3 years, with each year's teaching practices and curriculum content being developmentally and age appropriate.	Age 0–5 in poverty	Home School	Test scores Special education	1.61
Targeted Reading Intervention (TRI)[201] TRI is a dual-level professional development intervention for teachers and their struggling readers. TRI teachers work with their pupils intensively on a daily basis, initially one-on-one in 15-minute sessions before transitioning to very small groups. Teachers use a variety of word and comprehension strategies to improve reading and emphasise both identification of letter sounds in words and comprehension of words in text. Along with helping struggling readers, the programme aims to provide effective professional development for teachers so that all pupils in the classroom benefit.	Age 5–7 with reading difficulties	School	Test scores	7.98

200 http://investinginchildren.eu/node/75. Accessed 25/04/16

201 http://investinginchildren.eu/node/69. Accessed 25/04/16

Programme	Target group	Setting	Outcomes improved	Social benefit–cost ratio
Behavioural Monitoring and Reinforcement Programme (BMRP)[202] BMRP is a targeted 2-year early intervention programme. It focuses on behaviour modification, reinforcement of academic performance and obeying school rules. BMRP focuses on enhancing positive pupil behaviour, attendance and academic achievement through consistent rewards and monitoring. The programme also aims to reduce substance use, criminal activity and arrests.	Age 12–14 with school problems	School	Test scores	1.56
Early Learning and Literacy Model (ELLM) [203] ELLM is a targeted literacy-focused curriculum and support system designed for children from low-income families. It includes curriculum and literacy building blocks, assessment for instructional improvement, professional development for literacy coaches and teachers, family involvement, and collaborative partnerships. The curriculum focuses on children's early literacy skills and knowledge and is implemented for about 90 minutes per day in addition to the regular curriculum.	Age 4–5 with low income	Home School	Letter recognition Emerging literacy	

Source: School-based interventions taken from: The Early Intervention Foundation (EIF) from Investing in Children[204] and Blueprints for Healthy Youth Development.[205] Programmes listed are an indication of the available evidence, and do not constitute an NEF recommendation.

202 http://investinginchildren.eu/interventions/behavioural-monitoring-and-reinforcement-programme. Accessed 25/04/16

203 http://investinginchildren.eu/node/56. Accessed 25/04/16

204 http://investinginchildren.eu/

205 http://www.blueprintsprograms.com/

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