



Inside out and upside down:

Community based approaches
to social care prevention in a
time of austerity

Robin Miller & Christine Whitehead

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UNIVERSITY OF
BIRMINGHAM

IEWM
Improvement and
Efficiency
West Midlands

Directors of
adass
adult social services
West Midlands Region

“Wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible....”¹

“There are major opportunities to refocus the adult social care system and to work much more creatively with social capital and community resources. However, the risk is that the severity of the challenges facing local government prevents the careful thinking, time and investment needed to produce a long-term solution”²

1. INTRODUCTION

As part of its central focus on wellbeing the Care Act¹ emphasises the importance of local authorities taking a preventative approach, in which “at every interaction with a person, a local authority considers whether or how the person’s needs could be reduced or other needs could be delayed from arising” (p3). Prevention should be seen as an “ongoing consideration and not a single activity or intervention” (p8) that is based on a holistic view of someone’s life, and which seeks to develop individuals’ resilience and self-reliance. It will require “consideration of the role a person’s family or friends can play in helping the person to meet their goals” (p11) and the involvement of a wider range of services than adult social care alone, including “those responsible for public health, leisure, transport, and housing services” (p13). Wider community resources are also expected to be part of the overall offer, “including local support networks and facilities provided by other partners and voluntary organisations” (p14). It is recognised in the Care Act guidance that the preventative model developed by each local authority will be different due to their local need, aspirations, partnerships and community resources, but all of them are required to include the following elements – integration with the work of other relevant partners, information and advice services that are access to all, and assessment of carers’ preventative needs too.

Underpinning the vision of the Care Act then is a move from individual deficit based models of social care of the past to one in which individuals, their families and their communities are seen as assets rather than problems and have insights and resources to contribute. Central to this vision is the recognition that only by working together with individuals, families and communities can local authorities develop sustainable and positive solutions. These will draw not only on the funding provided by the state but also on social capital and informal networks of support often facilitated through the work of the third sector³. Such initiatives have been described as “community capital-building” with indications that they could have economic benefits alongside the improved quality of life outcomes with which they are often associated⁴. Such community based approaches are also being promoted within the field of public health, with recent national guidance emphasising that they need to be moved from the “fringes” into the “mainstream”⁵. In adult social care an investigation regarding the deployment of such models in local authorities discovered that they are being developed, but raised concerns of the “dangers of top-down solutions, of such approaches being misconstrued as ‘cuts’ and of trying to rush a process that many felt needed to be small-scale, bottom-up and led by communities themselves”².

There is general consensus therefore that taking a community based approach which builds on social capital and local assets is an essential component of a sustainable and progressive model of adult social care. Community based approaches can be defined as “models of social work practice which seek to work positively and in partnership with people who have a shared stake in a place, culture, faith or activity”⁶. However, the current financial environment and demands being placed on acute health care services can pressurise local authorities to take more reactive cost-saving measures that reduce, rather than enhance, their ability to engage with local people and third sector organisations. This could lead to a downward cycle, in which the local authorities reduce their engagement with and support for community capital building organisations and as a consequence individuals with social care needs have to rely on more formal social care services. An added barrier to making the case for investment is that our knowledge of what works in prevention is limited, with the evidence base often skewed

towards interventions that have received central government interest and financial pump-priming such as reablement and telecare^{7,8,9,10}.

This report seeks to respond to these challenges and contribute to regional and national thinking about how adult social care can embrace the preventative vision of the Care Act. It reflects the experiences of six local authorities in the West Midlands who were identified by the regional ADASS group as seeking to deploy community based approaches within their prevention strategies. None of the local authorities would claim to have all the answers or to have a model that can be simply replicated elsewhere, but all of them have lessons (both positive and negative) that they believe are worth sharing with other authorities and areas who wish to pursue such approaches. It begins with a short overview of the six community based approaches based on interviews with the leads in each local authority, and then pulls out key themes relating to the development of such approaches.

2. COMMUNITY BASED RESPONSES TO PREVENTION

Community Development Service (Coventry)



The Community Development Service was created as part of a council wide strategy to move towards an asset based approach. It has been running for over twelve months and covers the whole of the city. The CDS comprises of thirteen staff members split into three teams. Team members bring a wide range of skills and experiences drawn on previous roles in youth work, neighbourhood management and warden services, and community support work in health. Its role is to build local community infrastructure so that communities are more self-supporting. It is also hoped that they will be able to mitigate the impact of the austerity measures through finding innovative alternatives to traditional public services. For example, using local public houses to provide a venue for older people to meet in order to reduce social isolation and developing local sports clubs to support youth activities in the City. Impacts to date include the securing of funding for a new support service for the Roma community and a local builders merchant offering work experience and potentially apprenticeships for young people involved in sports activities. An agreed framework and process to measure impacts is yet to be agreed.

Contact:

Michelle McGinty: michelle.mcgintry@coventry.gov.uk

Community Offer (Sandwell)



Sandwell Council previously ran an initiative within a single ward which encouraged “friends and neighbours” networks to support vulnerable people. Whilst this had some success, it was recognised that working across such a small geographical area was limited by the local resources available, and that developing initiatives across two-three wards may provide sufficient resources whilst maintaining the local engagement. The Council therefore decided to commission Community Offer schemes in six localities of this larger size. These localities were chosen on the basis that work was already being undertaken within these wards through the Better Care Fund to reconfigure social work teams to better match general practice catchment areas. There was an initial funding allocation of £100,000 per scheme to be awarded as a grant (not a contract) to a lead provider or consortium via a competitive process. The outcomes to be

achieved were specified but not the services to be delivered to give flexibility for responses to be created in line with the local opportunities and strengths (see Table 1). The lead provider organisations or consortium are required to work with a number of additional community organisations to deliver the range of services in their scheme, including smaller ones that would possibly struggle to compete in such a tender. The lead providers have also kept some money back to fund smaller providers who suggest new ideas during the project. Some consortium bid together but others were connected during the bid process.

Table 1: Examples of services provided in the six Community Offer schemes

Scheme	Examples of services provided in scheme
Scheme 1	postural stability classes and exercise at home, befriending , dementia cafes
Scheme 2	vaccinations promotion, falls prevention toolkit, social health and exercise-based opportunities, "good neighbour" promotion, local traders discounts, befriending service, carer support and advocacy, bereavement support
Scheme 3	volunteering, dementia training, befriending, extend and walk from home service, BME dementia tool, social enterprise development and employment
Scheme 4	social prescriptions via gp and communities, signposting to health and lifestyle services, information awareness raising, vaccination campaigns, volunteering and good neighbour schemes
Scheme 5	volunteer-led pop around service to provide brief support to family carers and assess for other needs
Scheme 6	gp surgery-based volunteering schemes, targeted assessments, inter-generational befriending service, vaccination promotion, volunteer driver scheme for appointments

A framework for measuring the outcomes of the CO is being developed at present. Current performance data largely considers activities and process of the services within the schemes and is also attempting to draw upon existing data sources in public health, social care and NHS Outcomes Frameworks.

Contacts:

Chris Guest: Chris_anne_guest@sandwell.gov.uk

Jim Brennan: Jim_brennan@sandwell.gov.uk

Community Social Work (Shropshire)



Shropshire was interested in exploring locality working in which agencies could come together to identify what they could provide

collectively that would not necessarily need additional funding. This included the piloting of a social enterprise to deliver care management services on behalf of the local authority in one locality. The success of the pilot led to the social enterprise, People2People (P2P) being asked to implement the learning from the whole locality programme across the borough. "Lets talk local" (see Diagram 1) seeks to divert people who would be better supported through non-social care services to be aware of and have contact with other community resources before they undergo a community care assessment. An initial point of contact provides basic screening and signposting and if further support is required the person is passed to a team of social work assistants who engage in a solution-based conversation which explores the person's personal assets and other community-based support and resources. Accompanying these conversations are locally based "Lets Talk Local" sessions in which people can book to discuss their situation and potential options with a range of statutory and third sector agencies. This includes support with benefits, health and housing issues. Other than in a crisis or safeguarding situation, one-to-one assessments with social care professionals are only undertaken if these other approaches have not been able to resolve the issues.

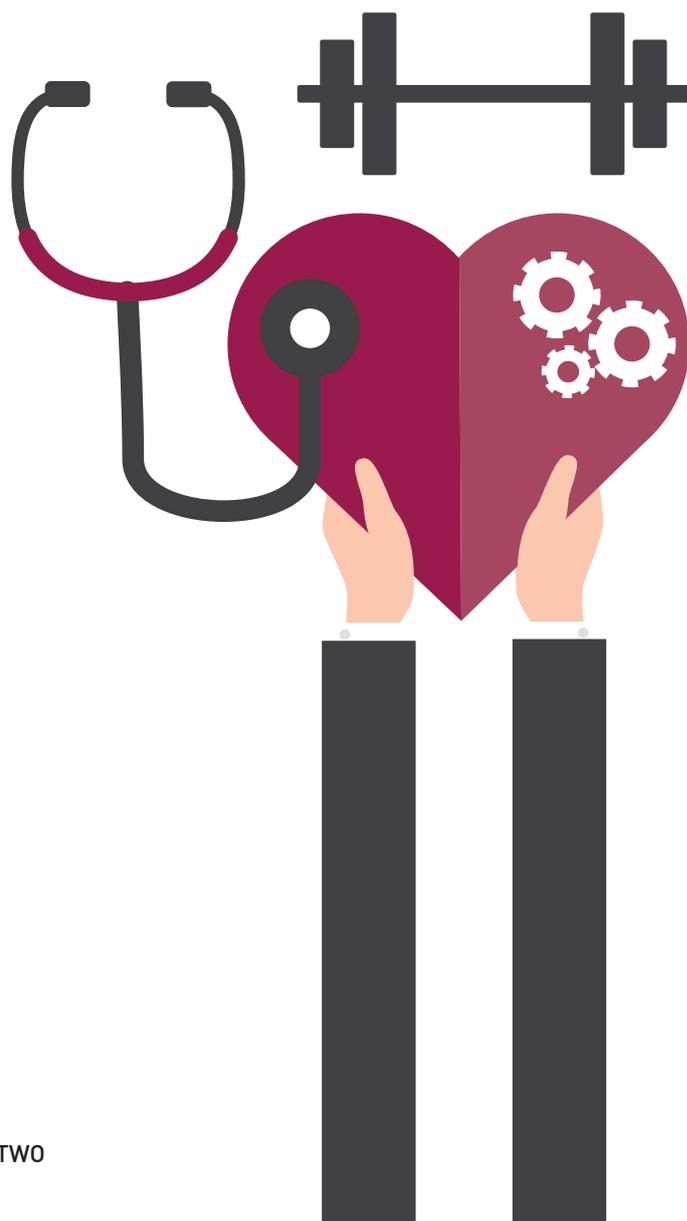
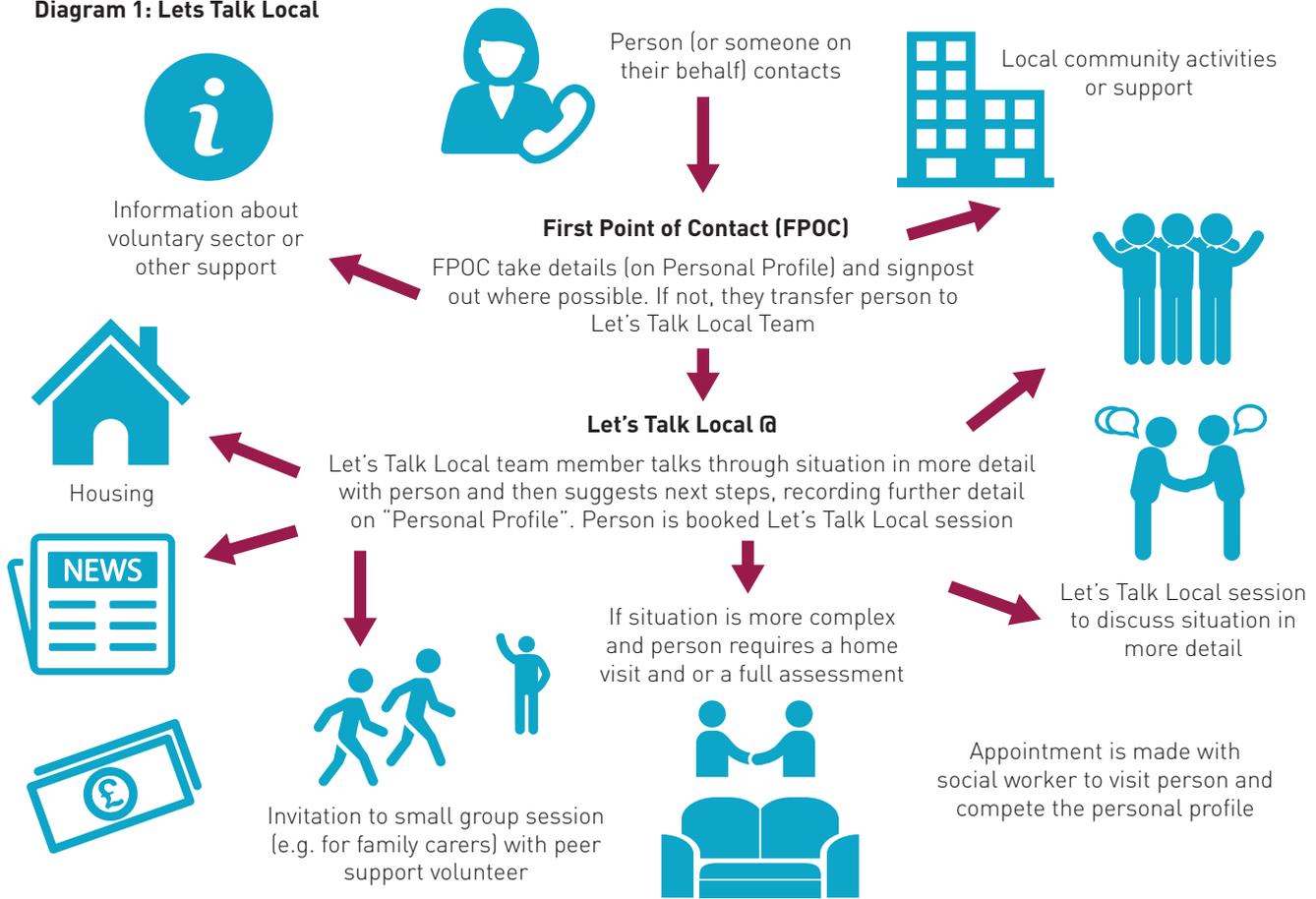


Diagram 1: Lets Talk Local



An outcomes framework has been developed (see Box 1) but a full analysis of its impact is not available as yet. The number of community care assessments does seem to have been reduced, although as yet this has not led to the expected reductions in spending patterns. So at present there are the same levels of increased budget spend even though less residential care placements are being made. Further work is underway to explore this further and to better match the information available from the two systems. Due to initial concerns that too many calls were being diverted at the first contact, Shropshire have also introduced a new process in which the call centre will call back all diverted people within fourteen days (much to people's surprise) to find out if their issues have been addressed. This helps to provide additional evidence about the outcomes of the new arrangements. Other changes are more process based and it is hoped that in time these will lead to changes in practice and then outcomes for individuals. For example, there have been considerable reductions in the length of carer's assessment forms and the funding application process being radically different in focus. Now this process is not focussed on "approval" as such but is rather a "practice based" process in which care managers present their ideas of how an individual with complex needs can be supported. These and other suggestions are then discussed. There is no cost ceilings on the ideas that can be brought. Interestingly though the alternatives the care managers now present are generally cheaper than the standard responses that were suggested previously as well as seeming to be more likely to lead to a better wellbeing.

Box 1: Example of performance indicators within Lets Talk Local

- Increased number of people who contact adult social care leaving the services with information and advice
- Increased individual resilience and reduced reliance upon paid support through the use of peer support and localised Let's Talk Local sessions.
- Reduced spend from the adult social care budgets
- Customer satisfaction and reduction in complaints
- Reduced sickness levels and turnover of staff

Contact:
Andy Begley: Andy.Begley@shropshire.gov.uk

Community Team Plus (Stoke-on-Trent)



Stoke-on-Trent undertook a review of the local health and social care system from the perspective of people who use it, and uncovered a range of issue including fragmentation between services, a lack of focus on what matters to the person concerned, and unnecessary bureaucracy and expenditure. They decided that radical transformation was required if they were going to achieve the aspirations of local people and use their resources more efficiently. They set an overall purpose that services would "help me to help myself live well" (see Box 2) and three basic rules – don't break the law, don't break the bank, don't do anything illegal. Beyond these rules nothing was set in stone and could be altered if this would help achieve the overall purpose. Community Team Plus (CTP) was developed as part of this transformation. Based around the three general practices

which have shown a commitment to integrated working, CTP has dismantled the internal assessment – provider split and teams provide reablement as well as care management. The staff members reflect this dual role and includes community care and therapy assistants alongside social workers. The team takes a “strength based approach” which is structured around a three level offer of – information advice, network building and equipment (level 1), reablement (level 2) and long term formal support (level 3). As part of level 1 they have been supporting people to develop their networks and resilience, through for example facilitating groups at community centres.

Box 2: Overall purpose of Community Team Plus

- Help me to help myself live well
- Enough help to find the right sustainable solutions
- Help me build my own networks of support
- Pull expertise as needed
- Stay with me for as long as needed
- Be proportionate

Stoke-on-Trent have developed an evaluation framework to assess what impacts the model has made in practice. This has three tiers – Individual Outcomes & Economics, Demand, Capacity & Capability, and Strategic Impact Measures (i.e. how does the model compare with the other teams and what would be the costs and benefits of extending it wider) (See table 2). The design of the measures suite and mechanism of display allow for monitoring special cause variation, trends and step change. The variation in the data will be attributed to cause and effect and compared to the previous model of operation where possible. This will allow Stoke-on-Trent to identify impact of this new way of working and evidence causality with relative robustness.

To date the analysis suggests that they are starting to see outcomes for individuals – contributing to increased resilience but have not got a baseline as did not measure previously. They had thought that the planned efficiency in working would enable care management process targets to be met, but in fact a more preventative way of working requires more time to be spent upfront which means that the model has not yet led to additional capacity to respond to increasing demands. There is also an indication that there will be savings on long term care costs – an analysis of 30 cases (out of 400 cases to date) with similar sample of people supported through the traditional model suggested a significant saving from a similar costs of local authority support.

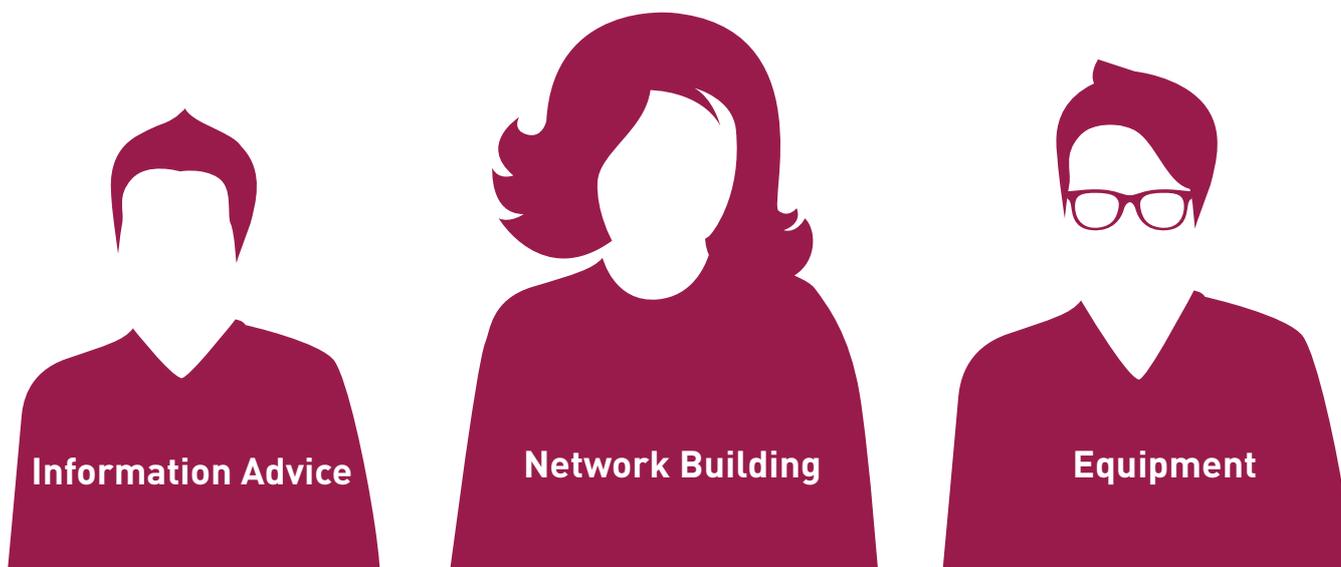


Table 2: Evaluation Framework for Community Team Plus

Tier	Example of data
1: Individual Outcomes & Economics	<ul style="list-style-type: none"> – resilience scores (comparison between first and last) – social isolation questionnaire – direct & indirect staffing spend (consumption economics) – service package cost estimate over next 6 months
2: Demand, Capacity & Capability	<ul style="list-style-type: none"> – contact data (including people who have had previously had a service) – referral sources (including analysis by general practice) – number of cases resolved at each level of service – compliments & complaints – people waiting to receive support
3: Strategic Impact Measures	<ul style="list-style-type: none"> – data as above for other teams – safeguarding referrals and outcomes – new admissions to residential & nursing care – number of people receiving direct payments – acute or unplanned admissions – delayed transfers of care

Contact:
Christine Whitehead: Christine.Whitehead@stoke.gov.uk>

Community Capacity Building (Wolverhampton)



Through a mapping exercise of current preventative support Wolverhampton discovered that out of the total contacts received by social work teams forty-

seven percent of them could be signposted elsewhere, as the individuals concerned do not require formal social care support. They looked therefore for alternatives to providing such advice and information, and identified that community associations could be a possibility. There are community associations in most wards in the which receive funding from the Council as well as generating income through other income streams Council funding this has been reduced as a result of the recent austerity measures, and there was also a recognition that the Council could be clearer as to what they see the future roles of the association and the nature of the partnership with them. Meetings were therefore held with the community associations in which they were given an opportunity to share their experiences (and frustrations) of working with the Council, and the potential of them providing advice and information about adult social care services explored.

They responded positively to this new role of even though no additional funding was available. Instead the Council committed to supporting them in other ways through their position as a strategic lead within the area. For examples, a common issue raised was the difficulty of recruiting volunteers from people of working age who were not in employment due to concerns that they would be deemed as unavailable for work and so lose their benefit entitlements. The Council therefore met with the Department for Works & Pension and secured their agreement to the development of a scheme in which people not in work could volunteer as part of the developing their readiness for work. Other supports included free training to volunteers on benefit awareness, and providing administration support and venues for the associations to meet together – the first time they had done so. The Council and the associations are also developing a web-based information system which the volunteers will populate and then use as a resource when they are providing advice and information. This will include services provided by the community associations and so help with their marketing – the

“footfall” and so the take up of their services. The evaluation framework is currently being developed – as part of this process the community association are talking to their volunteers and people who access their services about how they would describe the benefits of such support.

Contact:

Tony Ivko: anthony.ivko@wolverhampton.gov.uk

Community Social Work Team in Walsall



Walsall Council have been trying to move to asset based approach across their responsibilities for some time, with the current

arrangements based around five area partnerships which seek to promote capacity building in third sector. This work is led outside of the adult social care directorate, and has been successful in enabling better communication between the Council and community groups. It is not clear as yet if it has affected demand and resource usage. The Community Social Work Team has been introduced as part of a new operating model with adult social care to build upon and contribute to this wider asset based approach. This is a relatively small team of neighbourhood community officers which works with individuals and communities. Individuals are referred in from the central contact point and the Community Social Work Team will seek to support them in identifying and accessing support other than formal social care packages. This can include participating in other initiatives such as falls prevention, deploying of assistive technology and welfare rights advice and representation. The Community Social Work Team also works hard to reach communities to help them develop their shared assets. There has not been an evaluation of its outcomes as yet, although the good reputation of the Community Social Work Team amongst communities suggests that they are doing positive work. A robust review has been hampered because of variability in practice in the different area partnerships and the limitations of the current client record system.

Contact:

Keith Skerman: skermank@walsall.gov.uk



3. WHAT CAN BE LEARNT FROM THESE INITIATIVES?

In many ways the most important lesson to be drawn from these different initiatives is that local authorities can take a community based approach within the core offer of adult social care, and that such approaches are supported and indeed encouraged by the principles and requirements of the Care Act. This is an optimistic message then in a time in which the pressures of austerity and increasing demands can lead to a sense of powerlessness and negativity. Beyond this key headline there is other learning that can be drawn from the experiences of these six local authorities.

Community based approaches to prevention can take different forms

All of these initiatives are seeking to facilitate people to strengthen their person assets and networks, to access existing resources and services provided in their local communities, and to increase the range and depth of such community resources available. Whilst the thinking behind their models is similar, the authorities are using different mechanisms to move to a more community based approach. These can be divided into three basic types – in-house specialist community development services which work alongside the general care management teams, changing of the overall care management model to incorporate community based approaches, and facilitating third sector organisations to develop and co-ordinate the new approach through commissioning or partnership arrangements.

It is important to build on the local context

All of the leads commented that being aware of, and responsive to, the context in which the new initiative, approach or model was introduced was vital. Context took a number of forms – for Walsall the wider asset based approach of the council as a whole was key as this provides an infrastructure into which the Community Social Work Team can connect individuals and communities. The adoption of “attachment based” practice across the care management teams also provided an added synergy through its emphasis on enabling people to address issues through their personal assets and networks. In Wolverhampton, the previous investment in community associations developed a legacy of organisations which have a valued presence in local communities as well as a range of experience and skills. Coventry benefited from previous community development related services such as neighbourhood warden schemes and youth service, from which they could recruit experienced and skilled staff. For Stoke an important contextual issue was that their performance in relation to care management indicators had room for improvement, meaning that local councillors were willing to try something new. If they had previously had excellent performance then it may have been more difficult to try something new and untested if this could put this performance at risk.

Table 3: A typology of community based approaches

Type of Community Based Approach	Examples
In-house community development team	Community Development Service (Coventry) Community Social Work Team (Walsall)
New care management model incorporating community approach	Lets Talk Local (Shropshire) Community Team Plus (Stoke)
Facilitating third sector through commissioning and / or partnership	Community Offer (Sandwell) Community Capacity Building (Wolverhampton)



The national policy context is also important. In Shropshire the national pilots in social work practices provided momentum, external support and some funding to pilot care management services being delivered by a social enterprise. For most authorities the requirements of the Care Act and the austerity cuts, acted as a catalyst or confirmer for a community based approach. The Better Care Fund and the expectation on health, social care, public health and housing to provide integrated services were also commonly mentioned as an opportunity to connect with primary care services in particular. Highlighting the variance between local contexts and their changeable nature, in one authority attempts to engage community health services were not initially successful. In this example the local authority had to choose to continue despite its local context and to try to engage these partners at a later point. Similarly, within a local authority area the existing collaborations between community

and statutory agencies and the strength of the local offer also varied, meaning that what worked well in one locality may not do so in another. One lead reflected that key personalities can make a bigger difference than systems and organisational structures to the implementation of a new model - both positive and negative.

Transformation of practice can be achieved in multiple ways

One of the common debates regarding the introduction of new working practices is the extent to which these can be considered, planned and prescribed in advance, and the extent to which they have to evolve and emerge over time. Shropshire describes a "purposefully chaotic" process, in which they "threw out the rule book" and gave staff permission to work out how they thought it should be done "so long as it was legal". Stoke took a more ordered approach in which the process was managed and controlled throughout with a log of issues being kept to ensure any gaps or uncertainties were responded to. They too though gave staff and managers the opportunity to change anything they thought would lead to achievement of their overall purpose so long as three "rules" were not broken. Tenacity and a willingness to stick to the overall vision by all concerned, including senior management and elected members, was seen as vital for the direction of travel to be maintained and the numerous setbacks overcome.

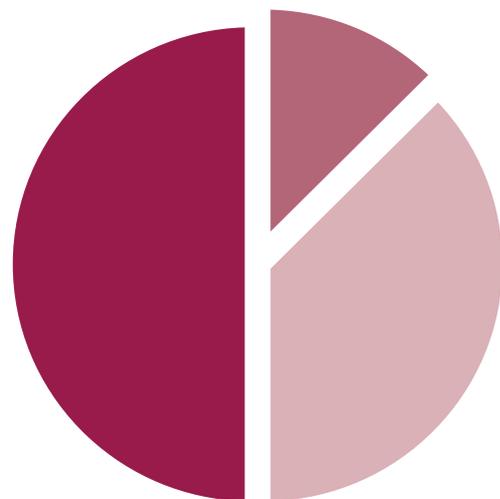
In both Shropshire and Sandwell a radical change mechanism was used to generate an initial momentum. In Shropshire this was the development of the new social enterprise to which local authority duties and accompanying staff could be delegated and transferred. According to the lead, whilst in theory the changes would have been possible within local authority structure, in practice they do not think they would have happened without externalisation to new organisation. The transfer appeared to provide the staff with a new "construct" of their responsibility and ability to change services which led to different behaviours and a more innovative working culture. In Sandwell the radical mechanism was a tender process in which third sector organisations had to compete for the opportunity to become a lead provider or consortium for a locality. This status required them to take on new leadership responsibilities in relation to their peers in the third sector, and potentially to act as a funder of these organisations. In Wolverhampton and Coventry the approach has been more incremental in nature, steadily building on existing opportunities.

Gathering relevant data is difficult but worthwhile

All of the leads described the challenge of developing an evaluation framework that would enable them to understand the short-term outcomes and longer term impacts of the initiatives. Three local authorities had not yet been able to develop this as yet, but all recognised the importance of doing so due to the difficulty in trying to draw out conclusions from generic data sets with multiple changes happening at the same time. Sandwell do have a set of indicators in place that have been suggested by the core partners and so includes those derived from NHS, Public Health and social care outcome frameworks. However, whilst these could indicate any alteration in the overall impacts, they are looking to develop a more bespoke framework that provides insights into the process and immediate outcomes of the community offer.

At Stoke-on-Trent City Council, a bespoke model of measures and data (See table 2) has been developed to support measuring impact of the new way of working, providing granular intelligence around what is working well, what support is delivering against outcomes and what potential barriers exist. This measures suite does not incorporate any of the current outcomes framework measures and is focussed solely around measuring the customer focussed purpose of the service.

The design of the measures suite and mechanism of display allow for monitoring special cause variation, trends and step change. The variation in the data will be attributed to cause and effect and compared to the previous model of operation where possible. This will allow the Council to identify impact of this new way of working and evidence causality with relative robustness.



All of the Local Authorities began their initiatives with limited or no formal evidence that it would work in practice, and so instead had to use their previous experience and practice knowledge to identify what could make the difference within the available local authority and community resources. In Stoke and Shropshire they began with pilot services that enabled them to test out the model in discrete areas before deciding if it was worth implementing across the Local Authority. Whilst pilots delay the potential benefits from a successful model being deployed more widely they do enable assumptions to be tested out in practice and provide an opportunity to amend the model before whole scale roll-out. Thinking through the data that could be realistically gathered during the pilot phase and which could meaningfully contribute to the decision to mainstream or not also appears to be time well spent.

Genuine engagement and co-production with community and staff are central

Engaging local communities was unsurprisingly seen as a core part of the development process. In Wolverhampton this took the form of the adult social care lead for Community Capacity Building being willing to meet community leaders face to face, accept initial criticisms of the previous relationship and funding, and be willing to seek progress on their major frustrations. Once their concerns had been listened and responded to, the community associations felt ready to work with the Council and seek opportunities for mutual benefit. This required the lead to not pre-determine what the shared solutions would be and instead to let these emerge. In Sandwell a major consultation event was held which was attended by representatives from over 40 community organisations. The event included workshops to explore what the Community Offer could achieve, and what support the voluntary sector needed in order to make it happen. This event was influential in shaping the project and thus ensuring the voluntary sector was able to respond to the resulting tender. A working group was then established to take the project forward, consisting of representatives of the voluntary sector and service users, along with officers from across the council and the Clinical Commissioning Group. To maintain a wide engagement, each lead provider is expected to hold regular public meetings in their scheme area to which local community groups and providers are invited. The potential for the interests of the local authority and community groups to be different was also recognised, but it was seen as more productive for these to openly discussed and debated than for the different opinions to lead to disengagement.



Front line staff and managers were also important contributors, with Shropshire and Stoke both commenting on the level of innovation that was suggested by those with regular contact with people accessing services and their families. As mentioned above, Shropshire highlighted that the new organisational form led to staff members having a different relationship with the Local Authority duties and functions. In Stoke there were staff members who seemed to take longer to connect with and be committed to the new model, but this appears to no longer be the case. Staff members in the Stoke and Coventry services have a range of professional backgrounds and experience which is seen as beneficial for the development of a more holistic and flexible offer. The creation of integrated care arrangements with community health and primary care staff was seen as a further opportunity to develop multi-professional working.

CONCLUSION

A common metaphor for transforming to a more preventative based social care system is “inverting the triangle of care”¹¹. This seeks to represent a change in which local authorities focus the majority of their time and resources responding to people in crisis, to one in which they instead deploy a significant proportion of their resources to promoting wellbeing in collaboration with statutory and third sector partners. The prevention duties within the Care Act highlight that such a transformation is a relevant today as it was a decade ago, and the reality that it has yet to be achieved highlights that this is a complex and uncertain task. Perhaps though the metaphor now requires a refresh to reflect our aspirations for a more personalised and co-produced approach to adult social care in which the main resources of interest are those held by the individual and the community rather than by the state. Rather than primarily being a gatekeeper of public resources, though maintaining defined boundaries based on eligible need and financial assessment, local authorities become focused on opening up and sharing their resources, insights and influence as a means to support individuals and local communities develop their capacity and resilience. In this model prevention is not divided into the classic levels of primary, secondary and tertiary but rather seeks to provide all three whenever they meet with the wishes, needs and situation of the individual concerned.

The initiatives described within this paper suggest that moving to such an “inside-out model” is a difficult but not an unsurmountable challenge. With vision, commitment and a supportive local context it is possible to use community based approaches to make positive changes. At the beginning of this paper we underlined that none of the authorities would see themselves as having completed this transformation, and all recognise that they have much more to do if they are to fully realise the potential benefits of community based approaches. Improving the gathering and analysis of evidence on how the wellbeing of individuals, the social capital of communities and the usage of resources will be a key factor to understanding and improving their impacts. Opportunities to blend the three types of community approaches may discover added synergies and testing them out in different local contexts will provide new insights and adaptations. However, realising this potential will require not only changes in the expectations, roles and practice of senior leaders, managers and practitioners within adult social care, but also in the wider local authority and their partners. The opportunity to work with Public Health seems key to this, and in particular their experience in combing population level interventions with crisis responses to epidemics, and skills in gathering and analysing needs data. Health and Wellbeing Boards will also have a key role, as will local Healthwatch and third sector infrastructure bodies. And central to all this work will need to be the views, experiences and aspirations of local older people and their communities.

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