



Integrated Personal Commissioning

Community capacity and peer support Summary guide



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1 Introduction

Integrated Personal Commissioning (IPC) and personal health budgets are part of a wider drive to personalise health, social care and education.

They promote a shift in power and decision-making, to enable a changed, more effective relationship between the NHS and the people it serves, aligning to the [Five Year Forward View](#).¹

IPC is a partnership programme between NHS England and the Local Government Association. It supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

This guide provides best practice advice, not statutory guidance. The IPC operating model sets out the essential components of IPC and provides a template for local areas to follow. It provides a best practice approach for implementing personal health budgets.²

The model is aimed at IPC areas, but will be of interest more widely. This includes NHS commissioners and others involved in providing health, education and social services, including the independent and voluntary sectors, as well as people interested in personal health budgets or IPC.

1.1 Who is this document for?

This summary guide is aimed at people who are leading local implementation in IPC areas. The content will be relevant also for people implementing personal health budgets across England, leading implementation of the Care Act 2014 and of the Special Educational Needs and Disability (SEND) reforms. It is also for people with lived experience of care and support and voluntary, community and social enterprise (VCSE) organisations.

1.2 What is community capacity and peer support?

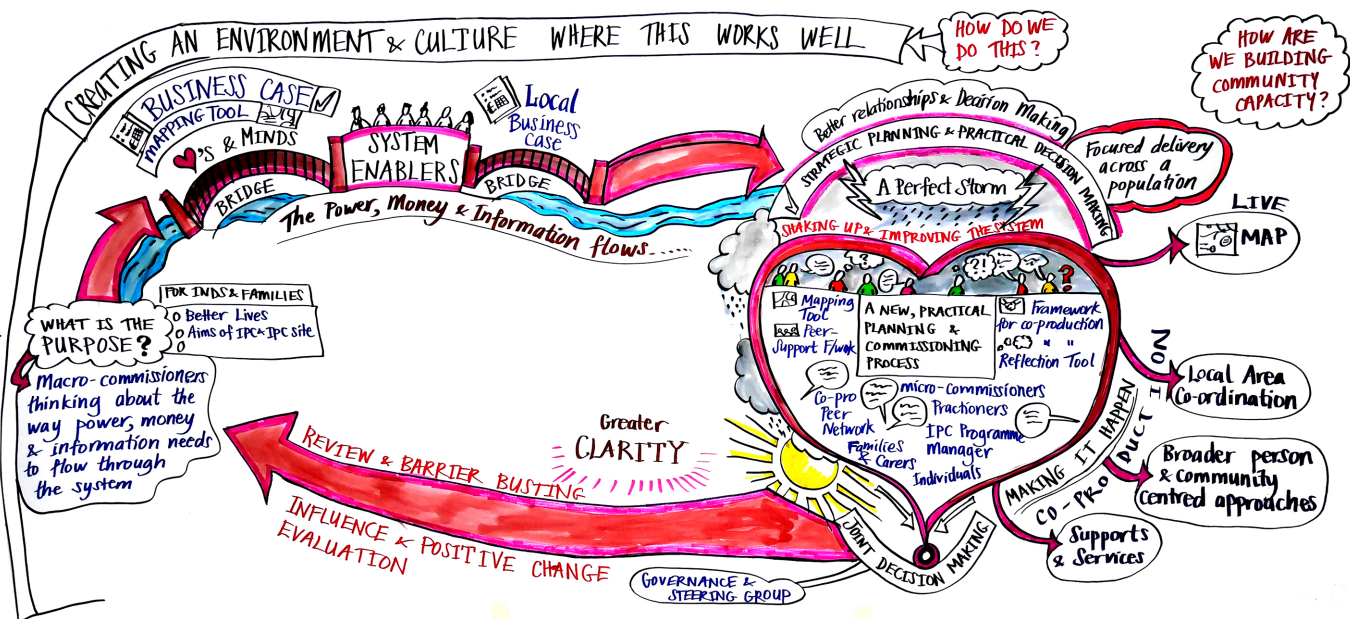
IPC takes an asset-based approach to supporting people to build their knowledge, skills and confidence, which recognises that people are experts in their own health and so best placed to identify what they need to improve their health and wellbeing. In addition, an asset-based approach explicitly values the potential in communities to support their own health and wellbeing. It does this by using peer support and community capacity to support people and improve the networking of formal care services with community resources.

Community capacity empowers people and their communities. It represents approaches that invest in people's own strengths, wider relationships and networks and have a positive impact on people's resilience, health and wellbeing. All approaches to using community capacity aim to shift away from a system that waits for people to fall into crisis to one that builds on people's strengths and their aspirations so they are able to maintain their health, wellbeing and independence.

Peer support in health and care encompasses a range of approaches through which people with similar characteristics (such as long-term conditions or health experiences) give or gain support from each other to achieve a range of health and wellbeing outcomes. These include building people's knowledge, skills and confidence to manage their condition and improving quality of life and social functioning.

At this stage, community capacity and peer support are voluntary within the IPC programme. While there is evidence supporting the positive impact of both, there are challenges in how the NHS and local authorities can fund the services and the processes required. As there is no additional funding, any new services commissioned will need to be funded from existing budgets. Work is underway within the IPC programme to release funding from existing contracts, which includes both the direct commissioning of services and the commissioning of the support functions required. More detail can be found in the IPC and personal health budget finance and commissioning handbook handbook.³

The way in which community capacity, peer support and co-production more widely all fit together is captured in the infographic below:



Graphic Facilitation by Pen Mendonça

1.3 Community capacity and peer support: What this looks like for people

- People and their families know what's available locally to help them achieve what they want from life.
- People will be encouraged to develop their knowledge, skills and confidence to manage their health condition to enable them to do what matters to them.
- People will have the chance to connect with other people who have similar experience to learn more and build their confidence to take up the IPC offer.

1.4 Community capacity and peer support: What needs to be in place

- A range of community capacity options, including local area coordination (see section 2.1).
- A range of peer support options, including one-to-one, group and online support (see section 2.2).
- A clear understanding of existing community assets and gaps, through an asset map showing what is available and a plan and business case to invest in developing what's on offer (see section 2.3).

2 Community capacity and peer support: What needs to be in place

2.1 A range of community capacity options, including local area coordination

2.1.1 What is this?

This is the establishment of community capacity approaches, including local area coordination, to play a vital part in bridging between people, the community and services.

2.1.2 Why do this?

There is evidence that community capacity and peer support can:

- build individual, family and community ability to support themselves more effectively than intervention or support by statutory services
- have positive impacts for people and communities, including improvements in access to information, building relationships and informal support networks, and confidence of individuals and communities to solve problems themselves
- lead to reductions in service usage (such as visits to GP surgeries and crisis admissions or onward referrals to social care).

Further information on the evidence base is available in [Annex D: Community capacity and peer support: developing a business case for change](#).

Community capacity approaches are central to Chapter 2 of the Five Year Forward View, as well as to the Care Act 2014 and the SEND reforms within the Children and Families Act 2014 (including the local offer and key working approach).

2.1.3 What does this mean in practice?

Local area coordination is a core component of the IPC approach. Local area coordinators offer a range of support to help people identify what is most important to them to achieve a good life and practical support to make this happen. This includes identifying, nurturing and using individual, family and community strengths, connections to community-based resources and facilitating further referrals (e.g. for social care assessment). It also includes linking to the formal care and support assessment and planning process.

Local area coordinators can be one of the options for the single, named coordinator central to personalised care and support. Coordinators may also signpost to local peer support options, VCSE organisations and groups with a defined role in improving health outcomes or linking people to each other to enhance their social connections. Local area coordination simplifies the system and provides a single, accessible, local point of contact for people in their local community.

For children and young people in their area who have special educational needs or disabilities (SEND), local authorities must develop and maintain a local offer setting out in one place information about provision they expect to be available across education, health, social care and VCSE services. The Children and Families Act 2014 also recommends that local authorities adopt a key working approach for children and young people (CYP) and their families that aligns with local area coordination.

2.1.4 What advice and tools are available?

- [Annex A: Local area coordination and IPC](#)

2.2 A range of peer support options

2.2.1 What is this?

Peer support routinely links people into groups, networks and online forums to encourage self management. By providing people with relevant information and enabling them to make connections, people can determine which approach best fits their circumstances.

Peer support sits at a boundary between formal, statutory health and care support and community-based support. As such, it may be intentionally grown from either within the system, or from within the community.

2.2.2 Why do this?

Peer support has been shown to lead to significant improvements for people with long-term physical and mental health conditions, including improved:

- knowledge, skills and confidence for individuals to manage their health and care
- physical functioning and ability to self care
- quality of life.

The reciprocity of peer support is a key benefit. The act of helping someone else as a way of paying back for help previously received can be a deeply rewarding and therapeutic experience in its own right. For example, peer support workers in mental health often experience an increased ability to cope with their own mental health issues.

Further information on the evidence base is available in [Annex D: Community capacity and peer support: developing a business case for change](#).

2.2.3 What does this mean in practice?

Research suggests that peer support is most effective when underpinned by a set of core design principles. It is:

- asset-based – recognising people’s resources and potential
- driven by what people want and need
- co-produced and provided by those who have experience of living with the condition, not by professionals
- establishing a culture of reciprocity and sharing experiences as equals.

The three most useful types of peer support are:

- Face-to-face groups run by trained peers which focus on emotional support, sharing experiences, education and specific activities such as exercise or social activities.
- One-to-one support offered face-to-face or by telephone. This may include a variety of information provision, emotional support, befriending, peer mentoring and discussion.
- Online platforms such as discussion forums. These have been found to be particularly useful for improving relevant knowledge and reducing anxiety.

To explore these approaches more fully and understand how to practically put them into practice please use the advice and tools below.

In addition to peer support, people may also access self management education, health coaching, group activities or asset-based approaches. Further information on these can be found in Realising the Value.

2.2.4 What advice and tools are available?

- [Annex B: Peer support for IPC](#)
- [Co-production for personal health budgets and Integrated Personal Commissioning: Summary guide](#)
- [Realising the Value](#)

2.3 A clear understanding of existing community assets and gaps, and business case to invest in developing what’s on offer

2.3.1 What is this?

Community assets come in many forms, including:

- people and groups as assets, such as faith groups, mother and baby groups, gardening clubs, neighbourhood watch
- capital assets, such as community buildings, church halls, theatres and pubs
- cultural assets, such as local carnivals, big lunches and local campaigns.

Local areas should have a strategic approach to community capacity building and peer support, based on an understanding of their current community assets and the evidence base. As a result, they have a clear and enhanced role for community and VCSE organisations, and a clear plan for what they need to successfully deliver IPC and personal health budgets in their local area.

2.3.2 Why do this?

There are a wide variety of assets in every area which may be unknown to the statutory sector. An asset map or audit can be helpful in capturing any area's capacity and potential to support itself.

A business case builds on the asset map or audit to identify strengths by helping areas choose where to invest in community capacity and peer support and what the most appropriate approaches are to take.

2.3.3 What does this means in practice?

For mapping and understanding the local area's community assets, there is agreement about the objective of any mapping exercise. The appropriate level of mapping is undertaken to achieve this objective, and a relevant output is produced that contains all appropriate analysis and results of the mapping exercise.

A local business case is developed for local decision on developing community capacity and peer support. This supports decision makers to understand the potential benefit of using community capacity approaches and peer support. The business case may also identify particular service developments that could be most beneficial to local people, communities and the health and care economy.

2.3.4 What advice and tools are available?

- [Annex C: Mapping and understanding community assets](#)
- [Annex D: Community capacity and peer support: developing a business case for change](#)

3 Ensuring equal access

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it
- given regard to the need to reduce inequalities between patients in access to and outcomes from healthcare services, and to ensure services are provided in an integrated way where this might reduce health inequalities.

Community capacity and peer support are important approaches in helping local authorities and the NHS to meet the needs of all sections of the population, including people who have been poorly served by conventional health and social care services. Examples of how community capacity and peer support can work for different groups are available on the NHS England website.

Steps that sites can take to help ensure community capacity and peer support approaches work well for groups with protected characteristics under the Equality Act 2010 include:

- making information about community capacity and peer support available in a range of formats
- working with VCSE organisations, peer support networks and community groups to ensure that all local people can benefit from community capacity and peer support approaches and to provide feedback on how well the local approach is working
- ensuring people who contribute to community capacity approaches are drawn from all parts of the local community
- ensuring a range of peer support options are available
- monitoring use of community capacity and peer support approaches by groups with protected characteristics.

IPC also builds in a whole life, whole family approach, which takes into account the needs of carers, including young carers. NHS England has published advice on carer health and wellbeing, setting out the responsibilities of local authorities and the NHS.

4 More information on community capacity and peer support

The Personalised health and care framework provides more detailed advice and practical tools to support local implementation.²

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5 Annex A: Local area coordination and IPC

5.1 Introduction

Local area coordination is an evidence-based approach to supporting people as valued citizens in their communities. It enables people to pursue their vision for a good life and to stay safe, strong, connected, healthy and in control.

As well as building the skills, knowledge and confidence of people and the community, local area coordination is an integral part of system transformation. It simplifies the system and provides a single, accessible, local point of contact for people in their local community.

Local area coordinators support people and families in their local community who:

- may be unknown to/ineligible for services to build their own, their family's and community's resilience and/or reduce the need for services whenever possible (capacity building)
- are at risk of crisis or dependency on services to build resilience in their local communities through the development of networks and local solutions, therefore eliminating or reducing the need for formal services (prevention and demand reduction/avoidance)
- are already dependent on services to build personal connections, community contribution, reducing reliance on formal services, wherever possible (service reduction/efficiencies).

The key to local area coordination is the implementation of the principles and values of local area coordination through consistent practice.

At this stage, local area coordination is voluntary within the IPC programme. While there is compelling evidence about local area coordination, there are challenges with how it is funded. Given its potential scale across the country, it is vital that clinical commissioning groups (CCGs) and local authorities commission local area coordination in a way that is sustainable. This means that it must be funded from existing budgets. This could be a reallocation of existing staff or could be funding moving from direct service provision to areas such as local area coordination that are more focused on prevention. This will likely be a gradual process as it is unlikely to be possible to make major changes immediately. CCGs should also work with local authorities as local area coordination is already being introduced or exists within social care, in response to specific commitments in the Care Act 2014 to promote prevention.

5.1.1 How does local area coordination work?

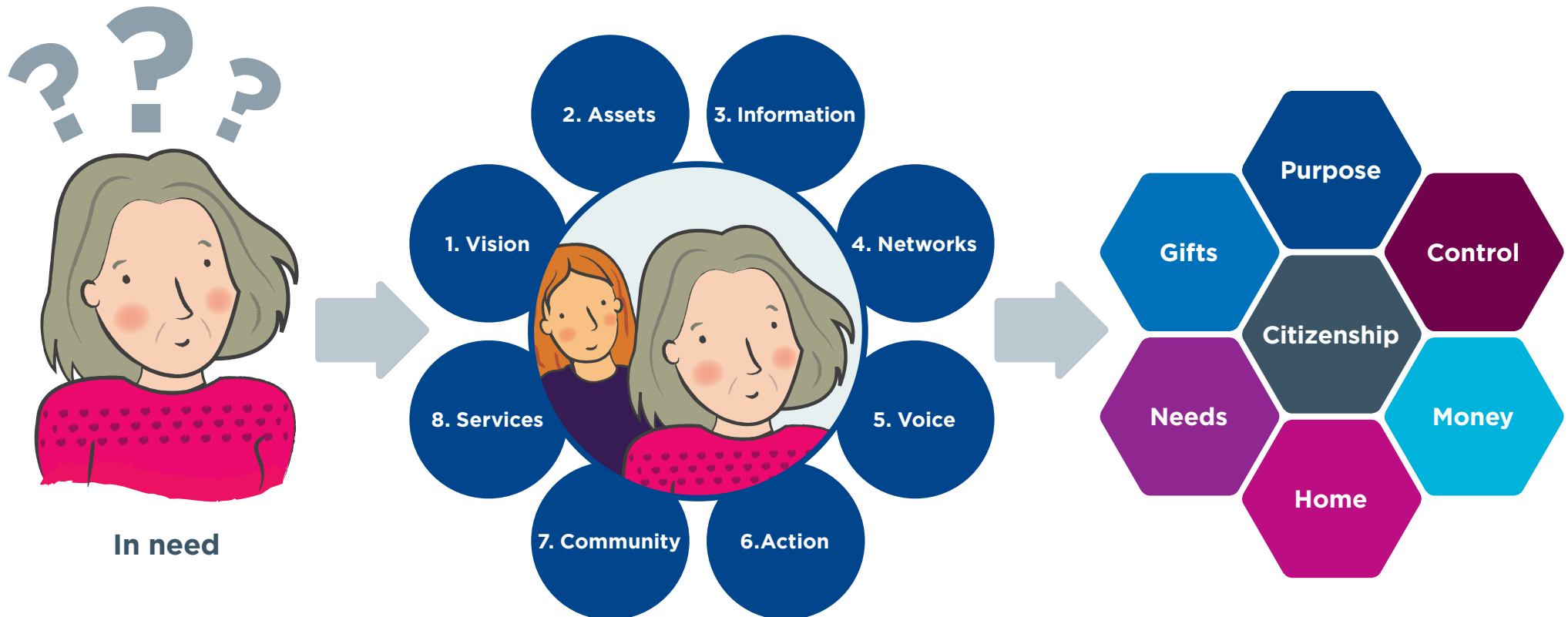
The local area coordinator role combines a range of traditionally separate roles and delivers in the community alongside local people. The role includes elements of functions often called information provision, signposting, planning, peer support, community connecting, care and support planning or service navigation. Within IPC, local area coordinators are one of the options for the single, named coordinator for personalised care and support planning.

Local area coordinators work in a defined geographical area. There is no formal assessment or eligibility to be introduced to a local area coordinator. Local area coordinators are introduced to people through their network of relationships in the community, membership of associations or groups or via formal services. Local area coordination then starts with a positive conversation with a person and a focus on strengths, self management and local solutions.

How it works from a person or community's point of view	How it works from a system's point of view
<p>The work with each person is different but will include supporting someone (or, when appropriate, them and their family) to:</p> <ul style="list-style-type: none"> • develop their vision for a good life • recognise their own strengths and real wealth • get information on what is available • make use of and build their own networks • strengthen their voice • take practical action for change • create new opportunities within the community • use local services or personal funding where relevant, but as the last consideration, not the first. 	<p>Local area coordination provides an integrated approach, bringing together:</p> <ul style="list-style-type: none"> • health • adult social care • children and family services • housing • public health • emergency services • VCSE organisations of all sizes • local community members, groups and leaders. <p>Collective action and shared responsibility is integral to the design and ongoing management of local area coordination. This is especially demonstrated through the recruitment of local area coordinators that is jointly led by people, communities and system leaders.</p>

Central to local area coordinators' practice is being alongside the person (or family) while they lead and direct the design and implementation of their vision. There is no time limit to their support, and the aim is always to be supporting people to build their capacity (doing 'with' and not 'for') and not to create dependency. The relationship between the person and local area coordinator and how they interact therefore changes over time.

Local area coordinators become a natural contact point for people in their community – intentionally pushing the service system back to create space for natural personal, family, and community solutions.



As well as building strong partnerships with services to support a personalised (or whole family) approach for the person, local area coordinators also invest in supporting people to build capacity and strength in their local community.

Further information about local area coordination is available from the [Local Area Coordination Network](#).

5.1.2 Evidence

Evidence from a variety of sources shows that where local area coordination is effectively designed and implemented with and by local people, there are highly consistent positive outcomes for people, families, communities and for systems change. Recent studies in England and Wales have shown:

System impacts	Impacts for people
<p>Reductions in:</p> <ul style="list-style-type: none"> • isolation • visits to GP surgeries and A&E • dependence on formal health and social services • referrals to mental health team and adult social care • safeguarding concerns, people leaving safeguarding sooner • evictions and costs to housing • smoking and alcohol consumption • dependence on day services • out of area placements • social return on investment: £4 return for every £1 invested. 	<p>When asked about the impact of support from local area coordination, people have reflected significant and consistent improvements in quality of life:</p> <ul style="list-style-type: none"> • increased valued, informal, support relationships – reducing isolation • increasing capacity of families to continue in caring role • improved access to information • better resourced communities • improved access to specialist services • support into volunteering, training and employment • preventing crises through early intervention • changing the balance of care to the use of more informal support and diverting people from more expensive services.

Further information is available through the [Local Area Coordination Network](#).

5.2 Putting local area coordination into practice

5.2.1 The 10 principles of local area coordination

The principles below guide the development and operation of local area coordination:

1. As citizens, people with complex needs and their families/carers have the same rights and responsibilities as all other people to participate in and contribute to the life of the community.
2. People are best placed to determine their own goals, and to plan for the future either independently, as a family, or supported by advocates of their choice.
3. Families, friends and personal networks are the foundations of a rich and valued life in the community.
4. People have natural authority and are best placed to be their most powerful and enduring leaders, decision-makers and advocates.
5. Access to information that is timely, accurate and available in appropriate formats enables people to make appropriate decisions and to gain more control over their life.
6. Communities are enriched by the inclusion and participation of people and these communities are the most important way of providing friendship, support and a meaningful life to people and/or their families and carers.
7. The lives of people and/or their families and carers are enhanced when they can determine their preferred supports and services and control the required resources, to the extent that they desire.
8. Services and supports provided through local area coordination complement and support the primary role of families, carers and communities in achieving a good life for people. These services and supports should not take over or exclude the natural networks that already exist or could be developed.
9. Partnerships between people, families and carers, communities, government, service providers and the business sector are vital in meeting the needs of people.
10. People have a lifelong capacity for learning, development and contribution.

5.2.2 Developing local area coordination

Local area coordination is a distinct approach to building community capacity. There are some unique aspects of local area coordination.

It works for everyone, so that:

- it works for people of all ages with complex needs
- it focuses on all aspects of a person, not just some elements of their life
- it takes a whole family approach
- it isn't restricted by any 'labels' applied to people by services.

It takes a particular approach so that it:

- supports local, community-based solutions instead of formal care services wherever possible
- focuses on what the person can do for themselves using their skills and experience, as well as what friends, family and the local community can do to help
- nurtures valued and supportive relationships
- supports and builds on existing resources
- helps people to stay strong and safe
- builds individual and family leadership
- builds more welcoming, inclusive and mutually supportive communities
- contributes to making services more personal, flexible, accountable and efficient.

Within IPC, local area coordinators are one of the options for the single, named coordinator for personalised care and support planning.

This may differ from other approaches to building community capacity.

The following table has a series of questions to support areas and consider the extent to which the unique aspects of local area coordination are in place locally.

Aspects unique to local area coordination	Questions to consider
<ul style="list-style-type: none"> • Coordinators are based in a range of community venues so easily accessible to a range of people. They intentionally are not based in one place or one office. • Community members are part of recruitment. 	How is the role embedded in and connected to the community it is part of?
<ul style="list-style-type: none"> • Coordinators work in areas of ideally 10,000–12,000 population. 	Is the community size one in which relationships can be built and maintained within a geographical area that local people recognise as their community?
<ul style="list-style-type: none"> • Coordinators' work starts with vision building of a good life and three associated questions of: <ul style="list-style-type: none"> • What do you have to build on? • How can your networks, friends and family contribute? • What would be the role of services? 	How does the support help people build on their existing capacity, natural relationships and networks?
<ul style="list-style-type: none"> • Coordinators consciously spend time supporting community building or building their community connections. 	How do the workers know about or help people connect to what is important to them in their community?
<ul style="list-style-type: none"> • Coordinators are a resource to local community members and groups. 	How do the workers (or the programme) contribute to the community, building capacity or supporting those community builders?
<ul style="list-style-type: none"> • Coordinators have no eligibility criteria or assessment process so meet people whatever their current situation. 	How does the support help a family or a person's network realise their good life or keep strong?
<ul style="list-style-type: none"> • Coordinators are introduced to people – always seeking to build relationships with both the person and within the local community rather than people being referred on to services or elsewhere. 	<p>How do people get access to and end the support relationship?</p> <p>Is that directed by them or a service?</p>

Aspects unique to local area coordination	Questions to consider
<ul style="list-style-type: none"> • Coordinators do not have eligibility or referral criteria. • They will help people plan or solve problems as family or with friends where that makes sense to them. 	Does access to the support depend on proving a need? Is access restricted by any labels that are typically applied to people by services?
<ul style="list-style-type: none"> • Coordinators work with people to build their vision of a good life and find practical, community-based ways of doing the things they want or need to do. 	Does the support seek to help someone solve a challenge in one or some partial aspects of their life? How does the support link to their vision of a good life?
<ul style="list-style-type: none"> • People define their good life vision and components. 	Who determines the focus or priorities of the support?
<ul style="list-style-type: none"> • Coordinators consider services last in their conversation with people. 	<p>How is the conversation between people focused on building on existing assets to create a positive future?</p> <p>How does it help find sustainable non-service solutions in the first instance or build those where people already have services?</p>

Experience and evidence from evaluations in England and Wales has shown that the way local area coordination is designed and implemented is key to securing the positive outcomes. The three critical factors for successfully introducing local area coordination are:

- design, plan, strategy/reform and leadership
- citizen-led recruitment
- implementation, mentoring and shaping practice.

This can, or should, evolve slightly differently and at a different pace in each area depending on local circumstances, structures and vision or strategy.

5.2.3 Local area coordinator role

Below is an example job purpose and responsibilities and personal characteristics for a local area coordinator. These are often adapted to reflect local communities and circumstances.

Note: if some form of community capacity approach already exists in a local area, we would advocate not simply transferring a service or team members but building the programme from the principles and values of the local area coordination framework. This could mean some of the existing work is built on, but the evidence suggests minor adaptations to the approach do not get the same results as reform.

Job purpose and responsibilities of local area coordinators:

- To act as a single, local point of contact in an agreed area in order to:
 - Provide advice, information, and support in the community to people and their families/carers across service types.
 - Build long-term relationships with around 50 to 65 people along with their families and carers, enabling them to:
 - access information in a variety of ways that are useful
 - be heard, in control and make choices
 - identify their personal strengths and aspirations
 - find practical (non-service) ways of doing the things they want or need to do
 - develop and use personal and local networks
 - plan for the future
 - connect with, be part of, and contribute to local community life
 - access support and services if required – in the right place and at the right time.
- To build strong partnerships with communities, agencies and services to develop and increase their capacity to meet people's needs and those of their families and carers.
- To contribute to the consistent and effective delivery of local area coordination.

Key responsibilities

People, family/carer, community support and coordination

- Get to know, build and maintain effective working relationships with around 50 to 65 people who are/could be facing complex life situations and their families/carers and local people within communities across a local area.
- Assist people to clarify their goals, strengths and needs and, where appropriate, enable them to develop a plan to pursue their life aspirations and build resilience.
- Support and promote opportunities for the involvement, participation and contribution of people and families/carers in a range of ways, including within community groups and cross-system initiatives, and to ensure that citizens are enabled to influence policy and decision-making at a range of levels.
- Support people to access accurate, timely and relevant information and assist people, families and communities to access information through a variety of means.
- Promote self-advocacy, provide advocacy support or enable access to independent advocacy as required.
- Assist people and families/carers to develop and utilise personal and local community networks to develop practical solutions to meet their goals and needs.
- Assist people and families to access, navigate, coordinate and control the support and resources they need to pursue their goals and needs, including access to funding as appropriate.
- Build effective partnerships and working relationships with a wide range of colleagues and partners. This will include working in multidisciplinary settings, preparing appropriate reports, making presentations and contributing to the development of appropriate initiatives and effective policy and practice.
- Build, maintain and develop effective working partnerships and relationships with statutory services regarding early identification of and effective responses to safety and safeguarding concerns.

Key responsibilities

Community development and capacity building	<ul style="list-style-type: none"> • Develop and maintain a clear understanding of local community strengths, resources, connections, gaps and opportunities. • Develop partnerships with people, families, local organisations and the broader community to promote opportunities for contribution and build a more inclusive community. • Develop a sound understanding of the key issues in the local area for people with complex needs and families/carers in order to advise and inform planning and policy development.
Administration and information management	<ul style="list-style-type: none"> • Organise and maintain administrative records/data sharing within agreed protocols and contribute to the effective operation of the programme and team. • Ensure the appropriate confidentiality of these records and ensure data sharing is carried out in line with local information sharing agreements. • Ensure proper records are maintained for all people supported in the local area through use of an endorsed data system, providing information and data for reporting purposes, updating information resources, and responding to requests for information. • Ensure people are provided with information on how their information is used and shared and gain appropriate consent for information sharing where necessary. • Manage and administer all aspects of a local area coordination discretionary budget in accordance with agreed policies and accountability benchmarks and signpost people and families to personal budget support processes. • Ensure the concept and practice of local area coordination is understood and communicated appropriately to people, families/carers, communities, colleagues, partners and senior managers. • Prepare appropriate reports and monitoring data to support evaluation, and to present information and provide advice within own area of expertise, in order to support and influence decision-making.

Key responsibilities

Professional development and supervision

- Participate effectively in supervision, performance and development reviews, team meetings, working groups and other meetings as required, with a view to ensuring personal and organisational continuous improvement.
- Pursue development opportunities as agreed with the line manager, and utilise the learning from these opportunities in practice.
- Participate in the training of new employees, colleagues, and partner agencies where required to support the development of the service.
- Participate in the introduction and development of new systems and procedures, including those based on IT, ensuring privacy impact assessments are conducted before any new systems are introduced (see further guidance in the Personal health budgets and Integrated Personal Commissioning: Finance and commissioning handbook).²
- Work in line with relevant policy, procedures and legislation including the Care Act 2014, Mental Capacity Act 2005, The Mental Health Act 1983, the Data Protection Act 1998 and the EU General Data Protection Regulation when it comes into force in 2018.

Personal characteristics: the list of examples below is provided as an aid to understanding what is meant by each criteria.

General description	Examples could include:
<p>Committed to enhancing the lives of all people and to fairness and equity in communities</p> <p>In making a positive difference, values and respects the diverse needs and contributions that each person makes in society and embraces social justice principles.</p>	<ul style="list-style-type: none"> • Shows sensitivity, respect and empathy for the values and beliefs of others, including those from culturally and linguistically diverse backgrounds. • Acts to achieve outcomes which are fair and equitable. • Understands and makes efforts to address inequities experienced by people, including those from diverse backgrounds. • Committed to empowering people to make their own decisions. • Contributes to the development of positive relationships within families and communities. • Promotes access, fairness and equity to address the needs of people from all cultural backgrounds. • Embraces contemporary attitudes to all people they work with.
<p>Skills and experience in managing change</p> <p>Understands the importance that change can have on the lives of people and realises that people can react to change in different ways. Demonstrates an understanding of change management principles and processes.</p>	<ul style="list-style-type: none"> • Recognises the positive dimensions of change within organisations and within people's lives. • Understands the potential impact of change, both positive and negative, on the lives of people. • Committed to effective change management processes. • Actively promotes positive change to deal with challenging issues and situations.

General description	Examples could include:
<p>Values people, partnerships and teamwork</p> <p>Values and respects others and encourages diverse opinion. Works constructively with people and makes a positive contribution. Actively promotes, values and strives to work collaboratively with others to achieve a common goal.</p>	<ul style="list-style-type: none"> • Has a non-judgemental approach and does not force opinions on others. • Recognises and appreciates the diversity, skills and abilities of others. • Fosters an environment of trust and actively encourages others to work as a team. • Provides advice, guidance and support to others in varied situations. • Actively communicates ideas, shares information and knowledge. • Understands and takes account of differing community perceptions of disability. • Works to empower people, families and communities.
<p>Analysing issues and reaching creative solutions</p> <p>Demonstrates a ‘can do’ approach, seeing the solutions, not the problems. Seeks innovative and creative solutions that enhance practices to achieve the objectives of people.</p>	<ul style="list-style-type: none"> • Looks for creative solutions to complex problems and consults with others. • Recognises change, assesses impacts, evaluates options and plans for the future. • Draws on a range of resources to address issues. • Sees opportunities in the analysis of problems. • Comes up with solutions that are marketable and workable. • Challenges existing processes and practices. • Gathers information from a variety of sources and makes recommendations and suggestions. • Assesses situations quickly and takes appropriate action. • Acts to understand the objectives and issues affecting people, families, communities and the local service system. • Is flexible and adjusts ideas when needed. • Acts positively and constructively to develop mistakes into learning opportunities.

6 Annex B: Peer support for IPC

6.1 Introducing peer support within IPC

Peer support, and broader person and community-centred approaches form a key part of IPC. This may be through:

- both informal and formal peer support – which may be in a group, one-to-one, online or offline
- peer support as one of a broader set of community capacity building approaches helping to achieve IPC.
- the local co-production peer network – helping to co-produce IPC at a strategic level.

The purpose of this document is to introduce actionable considerations and templates to support sites to move forward with initiating and growing peer support within an IPC context.

It is not intended to be a complete ‘how to’ guide because peer support is intentionally relational and essentially organic. Instead the document serves to introduce a set of common frameworks and useful techniques. These can be used in different ways relevant to the local context. The guide is intended for a wide-reaching audience, including system leaders and commissioners through to champions in the community who might want to set up a peer support offering locally.

At this stage, peer support is voluntary within the IPC programme. While it will be beneficial when introduced well, there are challenges with how the underpinning processes required are funded, and it will need to be introduced sustainably. This will mean releasing monies from existing contracts; while peer support itself may be free, the processes around it will not be. More information about how this can be done is set out in the Personal health budgets and Integrated Personal Commissioning: Finance and commissioning handbook.²

6.2 What does peer support for IPC mean in practice?

6.2.1 Considerations at the systems level

A broad-reaching evidence scan by National Voices and Nesta has drawn together the following types of peer support for consideration by commissioners:

Type	How delivered	Considerations
Telephone	One-to-one telephone support delivered by unpaid peers.	<ul style="list-style-type: none">• Inexpensive to set up and manage.• May have variation in quality.• Difficult to reach large numbers.• Likely to reduce anxiety and isolation.
	One-to-one telephone support delivered by paid peers.	<ul style="list-style-type: none">• Potentially more costly.• Difficult to reach large numbers.• Likely to reduce anxiety and isolation.• Moderate uptake rates.

Type	How delivered	Considerations
One-to-one	One-to-one in-person support delivered by unpaid peers.	<ul style="list-style-type: none"> • Inexpensive to set up. • Some management may be needed. • High uptake rates. • Likely to reduce anxiety and isolation. • May improve health outcomes and behaviours.
	One-to-one in-person support delivered by paid peers.	<ul style="list-style-type: none"> • Some costs for set-up/management. • High uptake rates. • Difficult to reach large numbers. • Likely to reduce anxiety and isolation. • May improve health outcomes and behaviours.
Group	Support groups led by trained but unpaid peers.	<ul style="list-style-type: none"> • Some investment in organisation required. • Likely to reduce anxiety and isolation. • Easier to reach larger numbers.
	Educational groups co-led by paid peers and professionals.	<ul style="list-style-type: none"> • Investment in organisation required. • Likely to reduce anxiety and isolation. • Easier to reach larger numbers. • May improve health outcomes and behaviours.
Online	Online support groups/forums.	<ul style="list-style-type: none"> • Inexpensive to set up and manage. • May have lower uptake rates and high drop-out. • Likely to improve knowledge and reduce anxiety by helping people feel less alone.

Learning from [Realising the Value](#) points to the importance of establishing appropriate enabling mechanisms as gateways to change. In short, this means ensuring the system is set up to enable peer support to flourish. Common enabling mechanisms for peer support most relevant to IPC include:

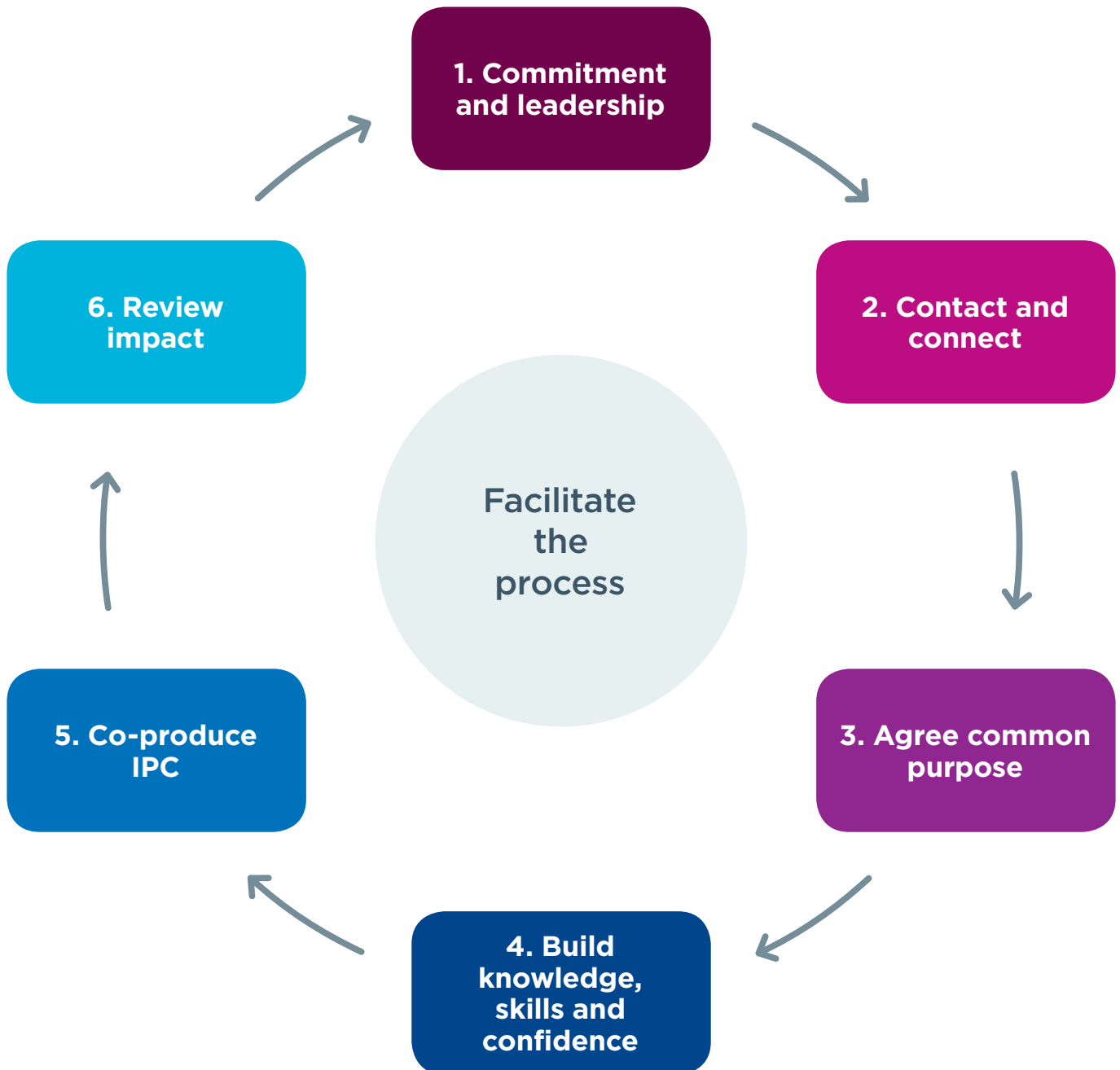
- Community capacity approaches (particularly local area coordinators, but also including health trainers, community navigators, health champions): roles undertaken by people, often drawn from the local community, who work with individuals to connect them with local services and help them to navigate them.
- Personalised care and support planning – people with long-term conditions and carers working in partnership, often with health and social care professionals, to identify their care and support needs from medical care through to support to connect with local services, peer support networks and other community groups.

Some common system-level challenges to peer support include:

- It's not free! Careful training, supervision and management of all involved, with sufficient organisational support for the programme.
- To pay or not to pay: the employment of peer support workers needs careful handling when there are paid and volunteer peer supporters.
- How do we best continue building the evidence base for peer support? What are some approaches to evidence and learning?
- Commissioners see the value of peer support but some aren't willing to invest just yet. What are the best practices to commissioning?
- We know peer support works but how do we make it sustainable?

6.2.2 Considerations at the group level

In setting up and establishing a group, Co-production for personal health budgets and Integrated Personal Commissioning: Summary guide provides a useful set of phases for establishing a co-production peer network. There are many parallels to establishing a peer support group, which follows this broad process:



Research points to four key functions that peer support should provide – in a standardised, but flexible and adaptable way, according to the group and local context:

1. Assistance in daily management – providing support around practical aspects of daily management that could be:
 - a. particular skills, e.g. group cooking sessions
 - b. overcoming particular barriers
 - c. regular encouragement/reminders, e.g. text prompts.
2. Social or emotional support – providing opportunities for encouragement and discussing emotional issues, for example:
 - a. a space to talk about wellbeing, worries or motivational issues
 - b. concerns that people may feel uncomfortable raising with professionals
 - c. offer a variety of settings, e.g. some may be more comfortable one-to-one than in a group.
3. Linking to clinical and community resources – establishing appropriate links, for example:
 - a. clinicians signposting participants to community resources
 - b. locating projects in care settings
 - c. pulling in practitioners as appropriate, e.g. sessions on disease management.
4. Ongoing support – setting up groups in a way which encourages ongoing support, for example:
 - a. flexible and convenient meetings for the group as opposed to rigid/fixed structures
 - b. encouraging informal support amongst the group, e.g. Facebook group
 - c. allowing the group to evolve according to the participants' wishes and motivations.

6.2.3 Considerations at the individual level

Learning from behavioural science points to a simple tool, the EAST framework⁴, for considering the main drivers of people's behaviour and generating effective approaches for addressing them. Through Realising the Value, this framework has been successfully applied to peer support.



This translates to the following in practice:

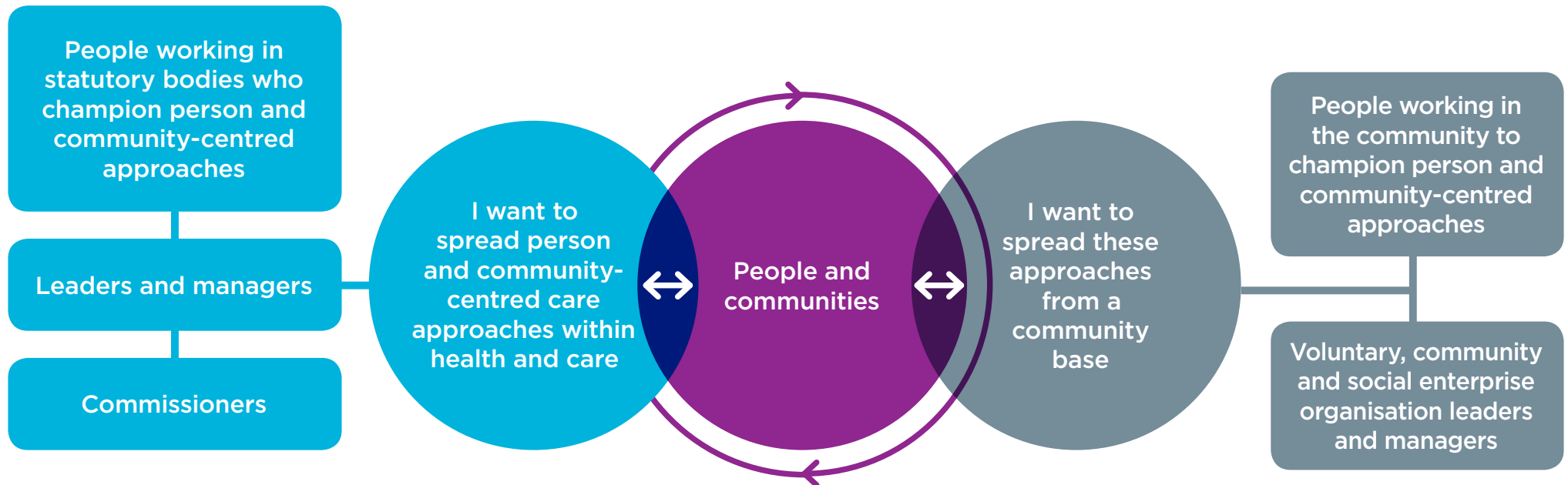
- Make it easy – giving attention to the small, practical barriers that get in the way of adopting new behaviours or ways of working, e.g. could transport to a group, or anxiety of arriving alone act as barriers?
- Make it attractive – highlight the benefits, draw attention to them, find ways to make them appealing, e.g. make it clear this is about them as a person not their diagnosis.
- Make it timely – people respond differently to prompts depending on when they occur, e.g. are there particular points in a person's journey where support may be pertinent, such as at point of diagnosis, or transition points?
- Make it social – acknowledge the importance of social processes in change, harnessing the power of networks, e.g. how might existing champions be used to bring new people on board?

Remember: not everyone will be ready for peer support or motivated to join a group.

6.3 Getting going and growing peer support

6.3.1 Who is driving peer support at a local level?

Peer support sits at a boundary between formal, statutory health and care support and community-based support. As such, there is a question of whether it should be driven formally, from within the system, or supported to grow in a more organic, informal way from within the community. This diagram shows various different options for growing peer support. The route for growth will affect the type of support needed – and each will present different opportunities and challenges. However, change is more likely to spread when both statutory organisations and community-based organisations align approaches.



6.3.2 How to grow and scale peer support

Peer support may be intentionally grown from either within the system, or from within the community. Whichever the approach, the EAST framework and behavioural insights are applicable. However, the application of these principles will vary according to where the growth of the approaches is being driven – for example, considerations for each element are shown below.

	Growing from within the system	Growing from within the community
Easy	Start small and build out. Make it easy for people to engage – quick and responsive lines of communication.	Money: if there is funding from the system, work to ensure money can flow quickly and simply through the system. Communications: keep communications with community groups as simple as possible.
Attractive	Build in feedback loops: if practitioners are being asked to refer, then be sure to share back the benefits to practitioners, managers and commissioners within the system.	Ownership: provide the community ownership of the group/support – let them develop the local offer. Send a request to them if you want to address something via the group (acknowledging the answer won't always be yes).
Social	Build in simple referral routes – and consider the role of different people within the system to support this.	Connect with champions within the community who may be in a position to help nurture and grow support. Find routes within the community to promote, e.g. community centres, existing groups.
Timely	Are there ways to ensure this is on the right people's mind at the right time? For example, what's the link with personalised care and support planning? Are there any ways to offer incentives for referral?	Engaging at timely points in the commissioning cycle – to allow priorities to be shared and developed.

Note: these are explicitly actions the system can take. Think about how these could apply, or be built on according to the local context.

6.3.3 Getting started tool

This tool will be most helpful during early stage planning. It can be used in conjunction with the IPC community mapping tool – allowing better understanding of what is out there already locally. This also emphasizes being clear on ‘why’ as a key first step – what is the need, and what is the purpose?

Who	What	Where	How	Why	When
a. Which cohort? b. Who sets up and facilitates?	Activities? Type of support?	What’s the setting or venue?	One-to-one, group or digital?	What’s the aim? How will we know if it’s working?	When and how often?

6.3.4 Mini-reflective tool for peer support

This checklist is designed to be used as a reflective tool, once peer support work is getting started. It brings together components which lead to effective peer support – in the early days of group formation, and once up and running. It also prompts a conversation around impact – the nature of how impact is considered/measured will vary according to the type of peer support; this could range from stories gathered, to hard data around outcomes. This checklist should be considered from different perspectives, e.g. group volunteers, as well as others supporting from within the system.

- Principles of peer support. Looking objectively at the peer support offer, does it:
 - ensure services are co-produced?
 - take an asset-based approach?
 - listen to what participants want and need?
 - ensure that people with lived experience are driving the service?
 - establish a culture of reciprocity?
 - target the service towards wellbeing and recovery (if applicable)?
 - incorporate learning around behavioural insights, e.g. EAST framework?
- Functional elements. Looking objectively at the peer support offer, does it:
 - assist people in daily management of their condition?
 - provide social and emotional support to encourage management behaviours and coping with negative emotions?
 - provide ongoing support because chronic disease/disability is for the rest of a person's life?
 - facilitate linkage to clinical care and community resources?
- Good peer support and positive outcomes. Looking objectively at the peer support offer, does it:
 - support the aims of IPC?
 - improve quality of life?
 - improve patient experience?
 - lead to fewer crises and unplanned hospital and institutional care?

For any item that hasn't been checked, agree key next steps in conjunction with participants in peer support, including when the tool will next be revisited.

7 Annex C: Mapping and understanding community assets

7.1 Introduction and purpose

This document is designed to support delivery of key shift two of the Integrated Personal Commissioning (IPC) programme: community capacity and peer support.

It has been produced in partnership with [Spice Innovations Ltd](#), a registered charity and social enterprise.

7.1.1 What is a mapping tool?

There are assets in every area which are unknown to the statutory sector. Community assets come in many forms, including:

- people and groups as assets, such as faith groups, mother and baby groups, gardening clubs, neighbourhood watch
- capital assets, such as community buildings, church halls, theatres and pubs
- cultural assets, such as local carnivals, big lunches and local campaigns.

A mapping tool can be a starting point for understanding any area's capacity and potential including 'unknown unknowns'. It is a resource to help identify and understand:

- what assets and community capacity are already available in service and community provision
- gaps and assets available for peer support and in the community
- where resources will need to be invested to deliver the common framework.

It is an opportunity to:

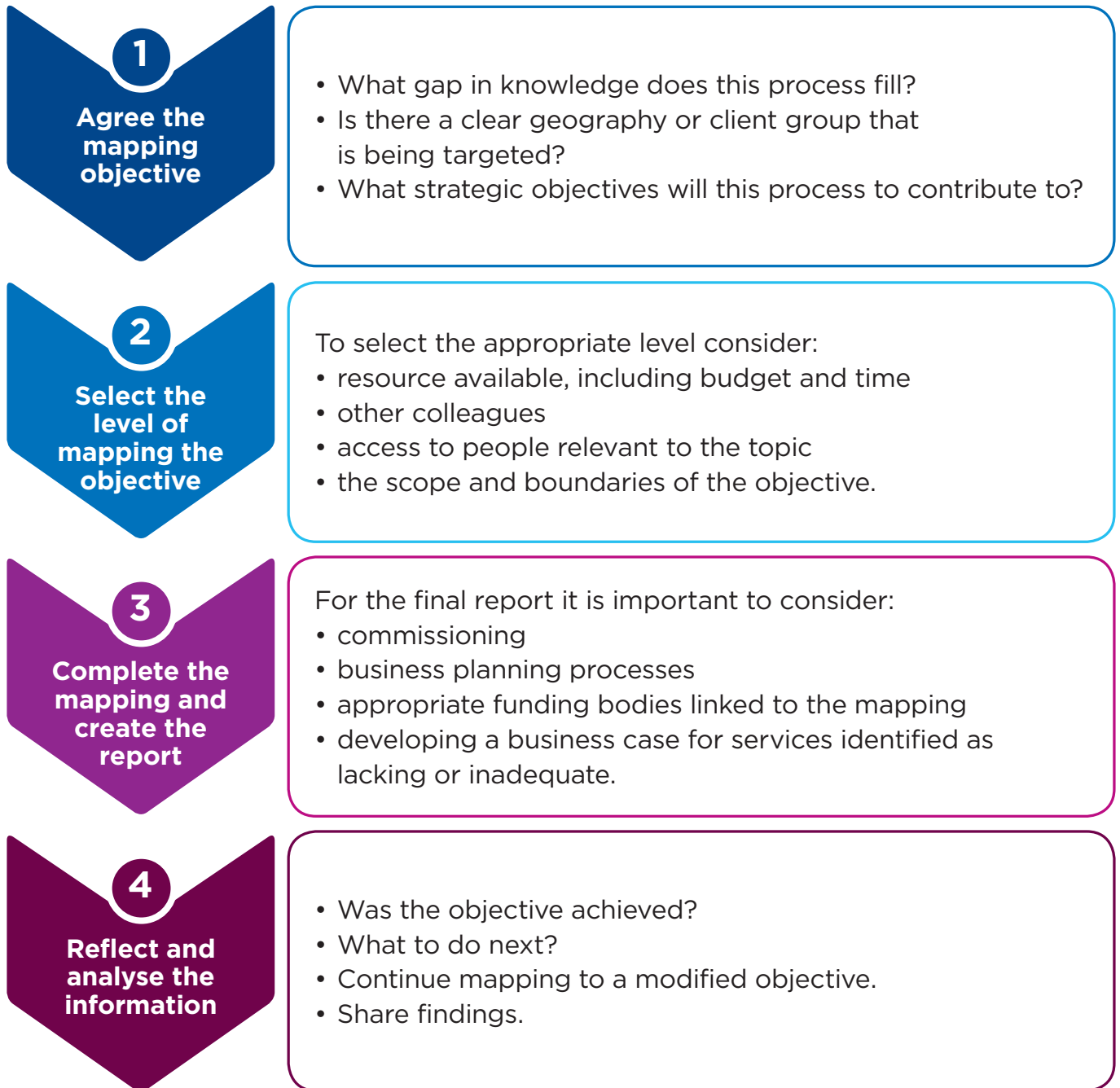
- reflect on the selected approach to build community capacity and peer support
- review the evidence in the business case
- review, analyse and understand the outputs from the mapping
- take stock of the most appropriate areas to focus community capacity and peer support on using the information they have reviewed and gathered.

This process allows the development of a strategic approach to community capacity building in IPC by developing a detailed understanding of the local context, including both assets and gaps. It also helps local IPC sites to choose where to invest in community capacity and peer support and what are the most appropriate approaches to take. This information may then be used to support the commissioning business case.

7.1.2 Who is this tool for?

This tool can be used by anyone who is interested in or needs to understand the assets and gaps in services for a particular group of people, or within a particular area. It can be used by commissioners of services, local organisations providing services, and by individuals with lived experience who want to contribute to the local business case for community capacity.

7.1.3 An overview of the mapping and reflective process



7.2 Agreeing the mapping objective

Working through this section will develop the question into a mapping objective. This objective will be the basis of all the mapping activity that is completed, so it is important to take the time to develop and refine the objective to be clear and specific to what is being mapped.

The setting of the mapping objective will usually begin from a question or problem, which will then need to be reflected on. It is crucial to give time to consider, assess and reassess the mapping objective as this is the foundation for all decisions, resources and activity that are planned and completed throughout the mapping process, as well as how useful the mapping will be strategically going forward.

These are examples of starting questions or issues to address:

- There is a gap in peer support for people with complex mental health needs and there is a need to gain a greater understanding of existing provision across the statutory and VCSE sectors to help commissioning and service design planning.
- There is a need to signpost people to community-based services across a range of areas and a need to develop a database that can be accessed by teams who will do these referrals.
- A 10-year dementia strategy is planned in an area which is a mix of urban and rural areas, and will include development of existing services in addition to commissioning of new services.

When deciding on the mapping objective it should be SMART, meaning:

- specific
- measurable and meaningful
- achievable
- realistic and relevant
- time-bound

Guidance on setting SMART objectives is given by the National Audit Office.

7.2.1 Telling a story with mapping

When mapping the objective, it is important to give context to the services and support that are being mapped. This means going beyond the basic facts of the service or support being mapped, such as opening times, attendance rates, etc., and capturing the whole picture through conversations with providers and users. This could give a context to services that appear costly or under used at first assessment and provide a 'why' through a broader perspective to support this, such as time of services, challenges with access, scheduling with other services in the area, etc.

This will structure mapping methodologies to generate detailed and complete answers to the mapping objective, and also ensure findings can be interpreted accurately and appropriately.

7.2.2 Linking with outputs and existing local information

It is essential to take time at the beginning to think about the end of the mapping – what outputs will be created, and how to maximise the use of them. By considering and identifying appropriate outputs that link with the objective, the potential impact and influence that could be achieved is enhanced.

It is also good practice to reach out to partners and stakeholders and share the mapping objective, as some may have completed other mapping work and be willing to share this. Use of social media and working with local bodies at this stage can be useful to contact a large audience quickly and make connections.

7.2.3 Setting the objective: the five Ws

To test how refined or robust the mapping objective is, consider the following set of questions against the mapping objective.

Who?

- Is there a client or population group that is being targeted?
- Who is best placed to do the mapping?
- Who else may need to support or collaborate?
- Who are the key stakeholders that have a say in decision-making about this process and how do they want/need to be involved?
- Are there other experts/expertise that will be needed to complete this?

What?

- What type of activity is being explored?
- What gaps is it hoped will be uncovered?
- What mapping has been completed before, and can this be accessed and used?

Where?

- Is there a defined geography in which the mapping will take place?
- And/or is there a service system (e.g. learning disability service) to be mapped and understood?

When?

- What are the start and end dates? What is the reasoning behind this?
- Are they reasonable and possible within existing resources and timelines?

Why?

- What is the ultimate reason for this mapping?
- How will the information produced from the mapping be used?
- How does it align to IPC development and strategic objectives locally?
- Does the objective cross over with any other similar work happening or has it happened in the past?
- What outputs could the mapping feed into?

7.2.4 Creating the objective

Can this sentence be completed for the objective?

“We are completing this mapping exercise to _____ and _____ in order to _____. This fits with our local IPC objectives through helping to _____ and _____. The mapping exercise will start on _____ (date) and we intend that it be completed by _____ (date).”

If so it is possible to move to the next stage of the process. If the objective cannot fit into this template, it may be worth reassessing the purpose of the objective, and refine this through the steps previously outlined, until satisfied with how it fits to this template.

7.3 Setting the level of the objective

Once the objective is set, the next step is to decide on the level of mapping to undertake. There are two levels of mapping to choose from:

- Level 1: Desk-based review combined with outreach events. This level combines some initial desk-based research with some targeted outreach to produce detailed information linked to key groups or specific places or both.
- Level 2: In-depth, large-scale mapping process involving local people and organisations. This level will produce a range of data and experiential information. It is useful to assess complex systems and should unearth a range of formal and informal support in communities.

In order to make the decision on which level is most suitable to map the objective, consider the depth and breadth of the information to be collected to inform the objective.

If starting with an objective mapping a large population or working across a large geographical area, the approach will need to enable contact and engagement with large numbers of participants easily.

If the objective seeks to uncover trends in thought and opinions, and dive deeper into the mapping objective, it may be more appropriate to begin with a broad dataset relevant for the objective and drill down using a representative sample of participants.

There are also practical elements to consider when assessing the most appropriate level for the mapping, including:

- Time
- Other colleagues that can contribute (and their available capacity)
- Access to people relevant to the topic, including (but not limited to):
 - organisations
 - service providers
 - frontline workers
 - people with lived experience
 - commissioners
 - families and friends of the cohort group.
- The scope and boundaries of the objective, including (but not limited to):
 - geographic location
 - cohort/age/need
 - ethnicity and diversity of the local population
 - natural connections in the community, e.g. culture, faith links.

7.3.1 Defining the levels

Level 1: Desk-based review combined with selected outreach events

This is an in-depth method of mapping a wide evidence base to investigate the objective. This level of mapping may be most appropriate where the objective is focusing on broader examination and consideration of statutory, community and peer support relative to the objective, and identifying unknown assets in the area.

The desk-based element of this level will be complemented and supported by the outreach events organised.

Examples of desk-based research to use include:

- longitudinal studies of existing datasets
- various forms of surveys – online and/or paper surveys
- telephone or face-to-face interviews.

Examples of outreach events to use include:

- focus groups
- workshops.

When using existing surveys or datasets as a starting point to map the objective, ensure that the data collected matches with the objective, otherwise there is a risk of undermining the outputs/final report of the mapping.

Through well-designed questions in a survey there is potential to identify and map more informal or unknown sources of support and activity, such as peer support. This is also possible by ensuring there is a good diversity of participants in focus groups or other outreach events that are organised. This should allow the ability to drill down to the appropriate depth to map the objective comprehensively, and also provide greater insight and understanding of the complexity of need of the group the mapping is being done with, which can be included in the final report.

Level 2: In-depth mapping with local people and organisations

This level of mapping is recommended for an objective that has specific elements of focus which will necessitate mapping of significant breadth and depth of information to answer the objective effectively. Mapping at this level will engage with people with lived experience and help to understand complex service systems to produce rich, deep and meaningful data for the objective through in-depth interaction with those taking part in the mapping.

Information collection methods for this level may include:

- focus groups
- structured or semi-structured interviews with small groups or individuals
- shadow sessions with the population being mapped.

Mapping at this level must be planned and considered in detail, as it can be intensive and requires appropriate resources and time to produce meaningful and high-quality outputs. This may also mean identifying and sourcing specialist skills if not available in-house.

7.3.2 Summary

Before the level of mapping for the objective is selected, take time to consider and identify the most appropriate outputs to map the objective successfully. Failure to pre-plan adequately before beginning this level of mapping will increase the risk of escalation of time and resource necessary to complete the mapping of the objective to the standard necessary for meaningful outputs.

The most important question to ask when considering which level to choose is: “Can I achieve my objective with the mapping level I have chosen?”

7.3.3 Practical tips and hints to consider

1. Manage expectations

When meeting with people as part of research activities, it is important to be clear about the purpose of the research so those participating are clear about the reason for the mapping. It must also be ensured that the process of the mapping is explained to all participants, including the methods being using to generate data and information, how this will be used, the organisations responsible, and the confidentiality of the mapping. Data should be anonymised wherever possible and explicit consent of participants obtained to take part if identifiable information is needed.

2. Make sure mapping researchers are supported

Mapping is a powerful activity. While this is an incredible opportunity to meet and understand the opportunities and challenges facing populations in our community, it can also be emotional. To remain focused, professional and empathetic during the work, it is important there is practical and emotional support.

3. Understand the cohort group

It is good practice to engage with and refer to specialist support at all necessary stages of the mapping, particularly where experience may be limited, and there may be safeguarding considerations. It is important to remain objective when completing mapping. Limiting the scope of mapping to narrow experiences or feelings will jeopardise the potential of mapping, and may produce biased outputs based on feelings, not fact.

4. Recognise and manage the resources needed

It is important that there is continuous assessment and reassessment of the resources necessary at the start and throughout the mapping work. Overambitious planning beyond the limits of the resources available (time and money), or lack of review as the mapping progresses, is poor practice and will negatively impact on the outputs that the mapping produces.

5. Be realistic and flexible with the mapping objective

When considering the levels for mapping, and the resources necessary for the outreach events most suited to the objective, it may be necessary to return to the objective and refine, or, if resources are limited, rewrite the objective, so the mapping to be done is possible with the resources available.

7.4 Reflection and analysis of mapping findings

The final stage of a mapping exercise is to reflect on the process and outputs and analyse the findings of the mapping itself. Analysis of findings must be completed using a structured and objective approach, which develops and models the findings into evidence-based outputs for the final report.

7.4.1 Reflection questions

Before drilling down into the outputs produced through the mapping, it is useful to reflect on the overall story that has been mapped. By reflecting on the whole community capacity process this will provide direction to make an informed choice about the approaches to community capacity that the report will focus on.

Questions to consider at this stage include:

- What were the initial expectations?
- Have these expectations changed? How? Why?
- What was observed?
- What seem to be the root causes of the issue addressed in the objective?
- What other work is currently happening to address the issue?
- What follow-up is needed to address any challenges or difficulties?
- What information can be shared with peers or the community?

The following questions are an introduction to a general analytical assessment of the outcomes the mapping experience has achieved, in relation the mapping objective:

- What was the mapping objective and was it achieved? If not, why not?
- What were the strengths and weaknesses of the process and what could have been better?
- How could the mapping process be evaluated in relation to outcomes, resources needed and clarity of next steps?

7.4.2 Data and findings analysis

At this stage, identified key stakeholders should be appointed to review the data and findings (evidence) to produce the outputs from this mapping, and the person who completed the mapping should step back. Production of an evidence-based analysis of the information collected by mapping must follow a factually structured procedure which is impartial. If this is not possible, then the person leading the analysis must ensure that their approach is without personal opinion or emotion, and get peers or key stakeholders to review the analysis throughout the overall procedure, not just at the end when the report is completed.

7.4.3 Data preparation

This involves practical checking and logging of the data collected, such as checking the data for accuracy, entering the data into a spreadsheet or transcribing interviews/focus group work and developing and documenting a database structure that allows the mapping and tracking of data collectively and comparatively against other sources of evidence (such as the joint strategic needs assessment, other datasets, published research findings that relate to the mapping objective, etc.). Consideration should be given to the security and confidentiality of this information, ensuring that it is only being used in the way that the participants have agreed to. Descriptions of how the data were prepared tend to be brief and to focus on only the more unique aspects to the study, such as specific questions that are asked via survey/questionnaire and relate directly to the mapping objective.

7.4.4 Descriptive statistics

This is using the data collected to simply describe what the data shows, e.g. number of participants, gender, age range, etc. as well as proportional responses to specific questions which are created by analysing responses to surveys/questionnaires collected through the mapping. By using descriptive statistics summaries are produced about the group being mapped and the measures (data collected through answers to questions) used to generate this data. This information is typically presented using simple graphics analysis like bar/pie charts or graphs, and is simply describing what is, what the data shows.

If mapping an objective for which there are published findings from a recognised dataset (e.g. Office for National Statistics survey, the local joint strategic needs assessment (JSNA), etc.) then this can compare descriptive findings against this larger dataset, and draw comparisons and conclusions about the local situation against these datasets. This will allow demonstration of how similar or different the mapping output is compared with national trends and expectations.

At this stage, it is critical to constantly question the findings in relation to the mapping objective, to make sure only the most relevant or important information is shown. Otherwise, the central line of the results could become diluted or buried within too much information. Typically, extensive analysis details are relegated to supporting appendices or through access to the whole dataset (by sharing the anonymised dataset/transcripts separately), reserving only the most relevant data analysis for the report itself.

7.4.5 Findings and outputs

Identifying and developing outputs through findings from the data collected by the mapping is a critical part of analysis, and also the most vulnerable to bias, as the conclusions presented extend beyond the immediate data alone. This method can be used to draw out and identify trends and themes that are consistent or significant enough to draw conclusions about the needs or opinions of a larger, similar population from the data collected through interviews or shadow sessions.

Each output or finding that is presented should be supported by evidence-based analysis of the information the mapping collected. This gives a robustness to the findings that will stand up under external scrutiny and validity to the final report. As this is a particularly complex method of analysis, it is recommended that other key stakeholders are involved in this stage, if not leading on it. This is because the activity of mapping is an intimate experience and the person mapping may struggle to be objective when identifying trends and themes from people's stories.

7.5 Completing the mapping: writing the report

At this final stage, the mapping, outputs and analysis are collated into a final piece that can be used to achieve the objective set. This final piece of work could be:

- a written set of recommendations
- a report which answers the objective originally set.

The format of the final report will depend on the information and evidence being presented and the target audience, which could be the body or organisation that commissioned the mapping work, or the body or organisation that is considering the work completed.

The most fundamental output of any mapping activity is to:

- present the findings and outputs of the analysis which responds to the questions set in the objective
- describe the services and support available
- detail how well these services and support meet the needs of those using them
- identify what gaps there are and how these might be filled.

7.5.1 Informing, influencing and impact

The outcomes of the mapping can be used to inform, influence and impact on the following:

- Developing a business case for change. The mapping can contribute to any business cases being made, either as part of IPC or more widely.
- Influencing and contributing to strategies. This can be at a local, organisational or regional level with other organisations such as local authorities, CCGs, VCSE organisations, etc.

7.5.2 Partnership working

Through the mapping research, providers or services may be identified that, by working together, could develop working partnerships or complementary programmes which could provide for the gaps in service and need identified by the mapping. It may also be worth considering engaging with lead providers in the private or commercial sector to provide pilot services where gaps have been identified, as they are often able to carry risk and manage services successfully.

In addition, the findings of the mapping could also aim to link in with organisational, local, regional or national programmes or campaigns if appropriate. This will give a focus to the mapping and a framework to structure the findings against.

Successful mapping will give a clear and detailed report of the reality the objective is focusing on, while also proposing future actions that would improve this via solution-focused outcomes evidenced by the findings and conclusions of any outreach events.

All mapping should be seen as an ongoing and 'live' part of an organisation's practice, and rolling review dates should be scheduled for all mapping completed, where content can be reviewed and updated as necessary, and output targets assessed and re-agreed as appropriate with current climates. It is also advisable that responsibility for regular review, updating and recirculating of mapping outputs is embedded with a role in an organisation, not a person. There is also potential to share work internally within an organisation, or externally with other organisations or stakeholders if the information is sharable.

8 Annex D: Community capacity and peer support: developing a business case for change

8.1 Introduction

This document is designed to assist local areas to develop a business case for change to support delivery of key shift two of IPC: community capacity and peer support. It is recognised that localities will be at varying stages of development. The document can therefore be used flexibly, to suit local circumstances.

It has been produced in partnership with [Think Local Act Personal](#) (TLAP).

8.1.1 Who is this document for?

The document is primarily for people working in IPC localities and is intended to help influence local health, social care and education leaders, some as decision-makers, others as concerned partners and stakeholders. Moving toward a health and care system that understands the value of community-centred approaches will require strategic commitment. In signing up to the vision, local leaders should ensure that agreed goals for developing community capacity and peer support locally are embedded in 'whole system' priorities and local plans such as health and wellbeing strategies and Sustainability and Transformation Plans.

Priorities and plans of all partner organisations, such as local authority accounts and CCG operating plans, should also include details of how community-centred approaches will be embedded. Commissioners should set out (for example, in the local authority's market position statement) how important levers such as personal budgets and personal health budgets can support opportunities to embed community capacity and peer support.

The potential benefits will be seen at different levels:

- Individual: improved health and social outcomes. Individuals in turn are better able to act as active and engaged citizens.
- Local systems: a way of managing demand and developing resilient and healthy communities and reducing health inequalities.
- Nationally: contribute to creating a social movement for health and, in turn, sustainability of the health and social care system.

8.2 The case for change: community capacity and peer support: what are the economic impacts?

This section describes models for building community capacity and what is currently known about their economic impact.

8.2.1 Local area coordination

- What is local area coordination?

Local area coordination (LAC) is an evidence-based model for connecting communities which embodies both new roles and different ways of working. A local area coordinator brings together a range of roles that have often been kept separate. They are based locally and act as a single, knowledgeable, and accessible point of contact for people and they:

- support people to identify and develop personal networks (friends, family, neighbours, work colleagues, community)
- support people to access and control resources or services where needed
- link people with existing community resources.

Local area coordinators provide a firm foundation for helping people to remain connected and in staying strong and valued in their place. They provide an important bridge between local people, community networks and formal services and are able to take a longer-term approach to providing support than is often the case with other services. LAC can provide support for people alongside more formal support and as an alternative.

Further details on how [local area coordination works](#) can be found from the Local Area Coordination Network.

Evaluations of local area coordination schemes⁵ are reporting promising benefits and cost benefits – both in terms of the outcomes for people (e.g. increase in valued and informal support relationships, reduced isolation) and for services and systems in terms of helping people manage demand for formal services.

8.2.2 Community navigators

Community navigators are typically volunteers from the community who have been trained to reach out to local people. Their assistance can be both relational and practical – helping people to manage the interface between the person and the service and access and connect to local resources.

An evaluation of community capacity initiatives undertaken by the Personal Social Services Research Unit⁶ estimated the annual cost of community navigators at just under £300 per person, but with economic benefits – including savings from GP visits – of £900 per person in the first year.

8.2.3 Peer support

Peer support aims to link people with similar long-term conditions or health experiences to provide mutual support to better understand the condition and issues they face and to find ways for promoting self management and/or aid recovery. For children and young people with long-term conditions, peer support may be as much about support to parents and carers as it is about support for the individual child or young person. The key element is that the support is provided by those who have experience of living with the condition, not by professionals. Most peer support is provided on a voluntary basis, although in some cases people are paid for acting as peer mentors. Peer mentoring involves actively working with the person to improve their self management and access wider resources to manage recovery. Peer support can be provided on a one-to-one basis (either face-to-face, via telephone or on web platforms) or in groups. It can often be part of a wider support offer to the person.

Nesta's report, *At the Heart of Health*⁷, offers a comprehensive summary of the evidence for peer support and shows that it can lead to significant improvements for people with long-term conditions across a range of health and wellbeing outcomes. It also notes a range of economic benefits to the health and care system. For example, a peer support scheme for people with mental health issues in Nottingham contributed to a 14% reduction in inpatient stays with savings estimated at £260,000 for a cohort of 247 people.

8.3 Developing a local business case for community capacity and peer support

This section provides a template to help create a local business case for developing community capacity and peer support.

Making the shift will require local transformation with strong leadership and vision, co-production throughout, and a strong narrative that links the strategic intention with a clear plan for delivery. The business case will need to convey the strategic shift intended, as well the particular service developments that are required in support of this.

The template provides guidance on six core components of developing the business case to support investment decisions:

1. Scope
2. Outcomes
3. Processes and outputs
4. Benefits
5. Inputs
6. Risks.

It is intended to be used flexibly to suit local circumstances, either as a free-standing document to complete and use, or as a guide to help with completing local template(s) for business cases. If the locality is already well advanced with planning it can be used for self-audit, to make sure all the essential points are covered.

Core component: Scoping

Define the business case and pull together all the issues that impact on and affect its focus.

Audience	<ul style="list-style-type: none"> • Confirm who the business case is for. • Decide the scope in order to have a range of community capacity-based approaches. • Describe the array of services and resources that are required.
Co-production	<ul style="list-style-type: none"> • Explain how engagement with local people and families will happen throughout. • Use the IPC co-production framework to embed co-production principles from the outset.
Consider these questions	<ul style="list-style-type: none"> • What is the business case about? Is it about the strategic approach to community capacity approaches, about integrating community approaches within a service, or about a specific initiative/model? In most cases it is likely to be a combination. • Make sure that the 5% of the population with long-term complex conditions are in clear focus. What are the estimated numbers and split between those benefiting from community capacity and peer support and those who will have care and support plans and IPC budgets? • Who are the decision-makers and those that support is needed from? • Are existing mechanisms for co-production good enough to ensure the voices of people who use services can contribute to the business case? If not, what needs to be done to strengthen them? • Is there a need to explore different community capacity approaches described in this document? • Is there clarity on which parts of the local VCSE sector need to be involved and how best to secure this? • What kind of financial investment is required and potential sources to ensure the key service components are developed? • What are the timescales for producing the business case, getting it approved and for delivery of the changes sought?

Core component: Scoping

Define the business case and pull together all the issues that impact on and affect its focus.

Tips and examples	<ul style="list-style-type: none"> • There is a strong and ambitious legislative (e.g. Care Act 2014) and national policy context (e.g. Care Act 2014 and Five Year Forward View 2014) that will inform local priorities, and this in itself provides a helpful rationale and justification for the business case. Moreover, areas that have signed up to be involved in the IPC programme have committed to deliver ambitious change – the business case should include reference to that. • Where possible draw on existing strategies and plans that support the direction being taken, e.g. Joint Strategic Needs Assessment, Health and Wellbeing Strategy, Better Care Fund, Sustainability and Transformation Plan, Care Quality Commission and OFSTED findings. • The intention is that the health and social care system is transformed by 2020 and so this should guide the timeline for developments. Consider whether there should be phased development, and if so, what the timelines will be. • Make it clear how the business case fits within the overall IPC business case, cross-referencing where necessary.
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Core Component: Identify and agree outcomes

Outcomes	Describe the longer term outcomes of building community capacity and peer support.
Co-production	Explain how local people will be involved, at the strategic level and in service design and delivery.
Evaluation	Decide the approach to evaluation to work out how to judge success and to establish a baseline (current position).

Core Component: Identify and agree outcomes

Consider these questions	<ul style="list-style-type: none"> • Outcomes. How to agree and define the desired outcomes at the following levels: <ul style="list-style-type: none"> • individual – those receiving low-level support only and those with personal budgets and carers • communities • local health and care system. • Baseline. How to establish the existing position (availability and cost) with regard to each service component of Key Shift 2, as no one is starting from scratch. • Evaluation. What type of evaluation methods will be used to assess progress? Consider quantitative and qualitative measures, including how feedback will be regularly and routinely obtained from people receiving support. What outcome measures and indicators will be put in place?
Tips and examples	<ul style="list-style-type: none"> • The IPC emerging framework and operating model will support the identification of key outcomes. For example, the outcomes may be framed as follows: <ul style="list-style-type: none"> • Individuals of all ages are supported to be active co-producers of their health and wellbeing. • Individuals are better connected to community-based resources and are routinely linked into peer groups and networks. • The VCSE sector plays a key role in supporting enhanced health and wellbeing. • Individuals have more choice over how they receive their support from a vibrant local market of providers and other organisations. • Examples of the cost benefit of community capacity approaches can be found throughout this document. These should help inform thinking around financial and social value. • Consider how to make best use of indicators contained in the national outcome frameworks for the NHS, public health, and adult social care. Look at whether existing local indicators can help (e.g. from the Better Care Fund). Identify where new measures might need to be developed. • This tool supports identification of both assets and gaps.

Core Component: Identify and agree outcomes

<p>Tips and examples continued</p>	<ul style="list-style-type: none"> • The TLAP resource “Does it work? A guide to evaluating community capacity initiatives” provides useful advice on measuring networks and connections. • Consider whether a strengths, weaknesses, opportunities and threats (SWOT) analysis might help reach a shared agreement on what the current position is (the baseline) with regards to the service components in Key Shift 2. This could be carried out with a cross-section of people receiving support, front-line staff and leaders. • Recognise the importance of establishing a baseline in order to inform subsequent measurement, monitoring and evaluation. • Make sure the outcomes are consistent with the other elements of the IPC programme.
<p>Examples of setting outcomes</p>	<p>Altogether Better, a national health champion programme, set out its outcomes as follows:</p> <ul style="list-style-type: none"> • Staff morale improves, GPs and practice staff generally will work under less pressure. • Patients get better outcomes. Champions support other people on the list. This could be setting up groups, helping the practice engage with groups of patients, e.g. increasing uptake of cervical cytology screening or flu vaccinations. • The practice evolves new ways of doing things and new models of service delivery emerge as the practice sees how peer support groups can be effective. For example, one practice has replaced its annual diabetes review meeting with an invitation to diabetic patients to come to ‘tea’ and meet as a group. • The practice list gets more sophisticated about its use of services, for example, whether it’s better to see a nurse, chat to another mother/friend, consult a pharmacist or go to A&E. • Citizens engage in activities that evidence tells us will reduce the need for interventions further down the line.

Core component: Processes and outputs

Setting out the processes and outputs necessary for developing community capacity and community-centred approaches.

Key enablers	<p>Making sure that the core ingredients necessary to make change happen to achieve the outcomes are covered in the business case:</p> <ul style="list-style-type: none"> • leadership • co-production • finance • commissioning • workforce • systems and processes.
Consider these questions	<ul style="list-style-type: none"> • Is ownership secured at the right level, both at the higher strategic reaches and for implementation and delivery? • Have the costs been estimated of developing the required service components and sources of funding, including joint budgets, contribution from individual partners and external sources? • Are there existing services/resources that can be adapted to fulfil the requirements of Key Shift 2? • Will anything need to be decommissioned to make funding available and/or because it does not fit with the model being developed? • Are there areas where formal commissioning is not appropriate and the best way is to provide support in kind and give people the space to self organise, perhaps with seed funding? • Have changes (immediate and longer term) been identified to roles and practice, training and development needs, taking a broad view of the workforce (i.e. not just those in statutory agencies)? • Is the infrastructure for co-production adequate for the task, including the capacity of the local VCSE sector? If not, how will this be addressed? • Whether or not the systems and processes (including those in the other key shifts) support rather than hinder easy access to community capacity and peer support to maximise take-up.

Core component: Processes and outputs

Setting out the processes and outputs necessary for developing community capacity and community-centred approaches.

Tips and examples	<ul style="list-style-type: none"> • Use any local tools such as logic models and/or benefits maps to show the relationship between inputs/outputs/processes. • Make sure that at the earliest point the objectives and progress with Shift 2 is integrated into existing strategic plans and priorities such as the Health and Wellbeing Strategy and the Sustainability and Transformation Plan. • In reviewing the ‘fitness for purpose’ of current commissioning (a key enabler) use the intelligence that already exists, e.g. from the local authority’s market position statement, local account and feedback from personal health budgets, including findings from the Personal Outcomes Evaluation Tool (POET) if this has been used locally. • Look at Skills for Care resources on developing the workforce, particularly community skills development.
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Core component: Benefits

Setting out the benefits that have been, or are anticipated as, a result of the inputs and processes.

Identifying benefits	Being able to explain the benefits of community capacity and peer support in a way that can be easily understood by the various contributors and partners. The benefits will need to align with the outcomes identified.
Consider these questions	<ul style="list-style-type: none"> • What benefits, changes or differences is a community and person-centred approach aiming to deliver? • What is the anticipated scale of change to cost and demand across the system and within partner organisations (before and after)? • What intended effect will there be on reducing health inequalities?

Core component: Benefits

Setting out the benefits that have been, or are anticipated as, a result of the inputs and processes.

<p>Consider these questions continued</p>	<ul style="list-style-type: none"> • What processes exist for evaluating benefits and impact and what needs to be put in place so there is a robust evaluation metric? (cross-reference to evaluation in core component one) • How are the benefits and impact going to be documented and described – benefits and impact for whom (people who use services, staff, organisations)? • Is the evidence fit for purpose?
<p>Tips and examples</p>	<ul style="list-style-type: none"> • Use existing national and local evaluations and related evidence. • Use/adapt the evidenced examples set out elsewhere in this document to flesh out the benefits in the business case. • Set out the benefits of this approach for the different levels, for example: <p>People</p> <ul style="list-style-type: none"> • People have greater choice and control and are better connected with their communities. They are recognised as experts in their own care and this impacts positively on their approach to managing their health and wellbeing. • People benefit from peer support and become contributors themselves, e.g. by becoming champions/volunteers. • Children and young people build up social capital. <p>Families</p> <ul style="list-style-type: none"> • Parents can remain in or return to employment. • Families report improved health and wellbeing. • Siblings enjoy regular family life. <p>Community</p> <ul style="list-style-type: none"> • As social capital is developed, membership of community groups and associations is enhanced.

Core component: Benefits

Setting out the benefits that have been, or are anticipated as, a result of the inputs and processes.

Tips and examples continued

Local health and social care system

- Health and care practitioners develop better relationships with the people using their services and this both impacts the person's sense of empowerment and enhances workforce satisfaction.
- The role of the VCSE sector is enhanced as statutory organisations recognise the critical role this sector can offer in supporting health and wellbeing.
- Statutory organisations may experience a reduction in the need for formal care services as the VCSE sector complements or even replaces the need for formal health or social care services.
- Longer term, sustainability of the sector is supported by the cost-effectiveness of community capacity building.

Core component: Risks

Identify the potential risks of community capacity approaches and the risk of not taking a new approach but continuing with business as usual. Risks should be identified through local partnerships.

Consider these questions

- How have risks, from a range of perspectives, been identified?
- What are the risks for the community from this work?
- What are the risks for the community from not doing this work and what is the appetite for change?
- What risks does the local health and social care system face from undertaking this project/work and what risks are there for individual participating organisations?
- What risks are faced from not doing this work, including the risks to sustainability and managing demand?
- How will the risks be managed and mitigated?

Core component: Risks

Identify the potential risks of community capacity approaches and the risk of not taking a new approach but continuing with business as usual. Risks should be identified through local partnerships.

Tips and examples	<ul style="list-style-type: none"> • Co-producing the local business case should ensure not only a balanced approach to risk but one which emphasises the positive benefits of risk taking. Using the IPC co-production framework will support this. • Co-production can also help when making potential difficult decisions over changes to services. • Organisations may wish to work with partners to identify a risk schedule for each phase of activity, setting out the actions to mitigate and agreed lines of accountability.
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Core component: Inputs

Identifying what is needed to get the business case off the ground, once approval is given.

Resources	Identifying the financial and people resources required to deliver the business case, as part of the overall delivery of IPC locally.
Ownership	Ensuring that the project is owned at the right level, strategically and to manage effective delivery.
Co-production	Making sure that co-production is woven into taking forward the business case from the outset.
Consider these questions	<ul style="list-style-type: none"> • Have the people who need to be involved in taking the business case forward been properly identified? • Are there any additional skills that need to be brought in? • Have the financial resources required been calculated and if these cannot be met from existing resources where will the money come from? Include 'cash in kind' from partners and the costs of co-production. • Is there a sound project structure with clear timescales (e.g. milestones, risk analysis) and is co-production integral to it?
Tips and examples	Consider whether a communication plan is needed, to let people know what will be happening, as part of the wider communication that goes with the local IPC programme.

8.4 Cost benefits of community capacity approaches to health and wellbeing

The tables below set out some of the cost benefits associated with delivering community capacity approaches ('new delivery models') and compares these to traditional services ('business as usual models'). An important caveat here is that, as new delivery approaches are still emerging and remain developmental, it is not possible to make precise comparisons with conventional services; but we can make reasonable assumptions based on the available data.

Wherever possible, the details provided have been taken from independent evaluations and reviews. The information sets out the value of community-centred approaches across a number of dimensions: financial, public and social. While not an exact science – nor an exhaustive summary – the data summary and reference links should help inform local commissioning and business case development for person-centred, community-based approaches.

	Business as usual	New delivery model	New delivery model
Name	Support for people who are experiencing or could be developing a mental health crisis	Safe Haven Project in Hampshire⁸ – a community capacity approach	Personal health budgets in Stockport
Description	<ul style="list-style-type: none"> • People with mental health difficulties often have no option but to access A&E services during a period of crisis. • People who use mental health services are 3.2 times more likely to access A&E services and 4.9 times more likely to be admitted as emergency inpatients.⁹ 	Established to act as an alternative to A&E. Co-designed with people who use services and funded by the local CCG. The service offers support from trained staff, peer support and promotes integration into the community.	NHS Stockport CCG, in partnership with Stockport local authority, All Together Positive (ATP) and Pennine Care NHS Foundation Trust, began work around the development and implementation of personal health budgets in mental health. A cohort of people with complex needs was identified for whom it was thought having a personal health budget would be particularly beneficial.

	Business as usual	New delivery model	New delivery model
Name	Support for people who are experiencing or could be developing a mental health crisis	Safe Haven Project in Hampshire⁸ – a community capacity approach	Personal health budgets in Stockport
Description continued			It was intended that early work would focus on young people aged 16-30 years, who had attended the local Emergency Department a minimum of three occasions in the last 12 months, as a result of self-harm, alcohol or drug abuse or attempted suicide.
Cost	<ul style="list-style-type: none"> • Average A&E attendance cost: £114-117.¹⁰ • A&E and psychiatric liaison: £321.¹¹ • Additional related clinical activity (follow-up appointments, prescriptions, assessments, etc): £400-600 per individual episode.¹² • Over the last five years, a total of £35m has been spent on A&E care for people with mental health difficulties.¹³ 	Initial bid: £70,000 – supporting up to 1,000 people.	£10,000 (around £750 per personal health budget).
Financial case	–	Reduced psychiatric admissions by 33%.	Estimated reduction in emergency department episodes was 144 = saving of £16,146 (net).

	Business as usual	New delivery model	New delivery model
Name	Support for people who are experiencing or could be developing a mental health crisis	Safe Haven Project in Hampshire⁸ – a community capacity approach	Personal health budgets in Stockport
Public value and wider social benefits	–	Reduction in need for acute medical care. Savings likely to be realised from reducing police time, approved mental health professionals, time, acute hospital interventions and admissions.	<ul style="list-style-type: none"> • Reductions in GP appointments, use of emergency services and self-harm. • Reported improvement in wellbeing. • Improved interaction with family and friends. • Improved conversation with GPs. • Improved coping strategies.

	Business as usual	New delivery model	New delivery model
Name	Support for people with long-term conditions (reducing emergency admissions)	Community capacity, co-produced approach in Cornwall	‘Esther’¹⁴
Description	<ul style="list-style-type: none"> • 15 million people in England have a long-term condition (1 in 4 people). • The number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018. 	This transformative programme aims to prevent people falling into ill health and a cycle of dependency by providing integrated and seamless care and support. Interventions include asset-based conversations, developing social networks and connecting people with their community.	Approach to continuous improvement developed in Jönköping County, Sweden. Esther is a theoretical patient – an older woman with complex health needs.

	Business as usual	New delivery model	New delivery model
Name	Support for people with long-term conditions (reducing emergency admissions)	Community capacity, co-produced approach in Cornwall	'Esther' ¹⁴
Description continued	<ul style="list-style-type: none"> The ageing population and increased prevalence of long-term conditions have a significant impact on health and social care and may require £5 billion additional expenditure by 2018.¹⁵ People with long-term conditions use a significant proportion of health and care services (50% of all GP appointments and 70% of days spent in hospital beds), and their care absorbs 70% of hospital and primary care budgets. 	<p>People supported by the 'Newquay Pathfinder' have seen significant improvements to their health and wellbeing and the programme has now been rolled out in West Cornwall (Penwith Pioneer).</p> <p>The Penwith rollout included a matched cohort evaluation which looked at the first 12 months of the Living Well programme in Penwith, from January 2013 to December 2014, to identify whether any attributable change in use and costs of health and social care services could be identified among the Living Well cohort compared to the matched cohort who were not in receipt of the Living Well intervention. The trial highlighted clear outcomes for the Living Well cohort as set out in 'financial case'. 2,000 people supported by the programme.</p>	<p>Esther has supported the culture change required to deliver a person-centred health and care approach with, amongst other aims, an explicit strategy to educate patients in self management skills. The question is always: 'What will work for Esther?'</p>

	Business as usual	New delivery model	New delivery model
Name	Support for people with long-term conditions (reducing emergency admissions)	Community capacity, co-produced approach in Cornwall	'Esther' ¹⁴
Cost	£2,500 per admission. ¹⁶	£400 per person.	<p>There is no special budget for the Esther model within any of the clinical departments.¹⁷ One person is paid as a coordinator – all others involved in Esther accommodate this as part of their normal work.</p> <p>The 2011 budget for Esther was 1.8 million Swedish kronor (£170,740) including the salary of the coordinator, coach education and new improvement projects. In 2012 the budget was reduced to SEK 1.6 million (£151,705). In 2013 there will be a very small budget for Esther, forecast to be SEK 800,000 (£75,850), which is meant to pay for 100% of the coordinator's time and to provide SEK 40,000 (£3,800) to do activities (which is unlikely to be enough to continue activities at their former level).</p>

	Business as usual	New delivery model	New delivery model
Name	Support for people with long-term conditions (reducing emergency admissions)	Community capacity, co-produced approach in Cornwall	‘Esther’¹⁴
Financial case	–	£4.40 efficiency for every £1 spent. Based on 30% reduction of unplanned admissions across cohort of 106 people in Newquay: £80,000.	The Esther approach has saved the Jönköping health sector, roughly £680,000 a year since 2002. ¹⁸
Public value and wider social benefits	–	<ul style="list-style-type: none"> • 23% improvement in people’s self reported wellbeing. • 87% of practitioners say integration is working very well and their work is meaningful. • 30% reduction in non-elective admission cost. • 40% drop in acute admissions for long-term conditions. • 5% cost reduction and reduction in demand for adult social care.¹⁹ 	<ul style="list-style-type: none"> • An overall reduction in hospital admissions by over 20% (9,300 to 7,300) and a redeployment of resources to the community. • A reduction in hospital days for heart failure by 30% (from 3,500 days per year to 2,500). • A reduction by more than 30 days of wait times for referral appointments with specialists, such as neurologists.²⁰

8.5 Resources and references

This is a summary of key documents and resources to promote action on community capacity approaches and to support business case development.

- The Health Foundation. **Head, hands and heart: asset-based approaches in health care**. This report summarises the theory and evidence behind asset-based approaches in health, care and wellbeing and gives details of six case studies, describing these approaches in action. The report also sets out some of the opportunities and challenges in adopting asset-based approaches for improving health and wellbeing.
- Local Area Coordination Network. **Local Area Coordination: Catalyst for a System Wide Prevention Approach**. This report provides the case for adoption on LAC; it offers background to the model and is supported by a series of case studies that illustrate impact and focus.
- Think Local Act Personal (TLAP). **A Social Return on Investment Analysis for Derby City Council (SROI)** has found that for a three-year forecast period with 10 Local Area Coordinators, £4.00 of social value would be earned for every £1.00 invested.
- Think Local Act Personal has a resource page for **person-centred coordinated care**. There is also a page which provides links to the **programmes supporting reports on building community capacity**.
- Nesta – **Realising the Value (RtV) programme**: builds on a large body of work by the Realising the Value consortium partners and beyond, who have strong track records and expertise in this area, and puts people at the heart of health and care and develops community-centred approaches.
- PSSRU discussion paper. **Building community capacity: making an economic case (2010)**.
- Public Health England: **A guide to community-centred approaches for health and wellbeing**. This guide outlines a ‘family of approaches’ for evidence-based community-centred approaches to health and wellbeing.
- NICE. **The guideline NG44 gives evidence-based information on community engagement**.
- **Health Empowerment Leverage Project (HELP)**: This literature review on community development in health aims to offer relevant definitions, a brief background to the current state of play in the statutory services, the nature of community development, its relationship to community health and to enhancing the responsiveness of commissioning.
- Think Local Act Personal. **Building Community Capacity: Evidence, efficiency and cost-effectiveness**. This paper briefly draws together some of the evidence that Think Local Act Personal is aware of that contributes to demonstrating better outcomes, or in some cases, the financial benefits of nurturing stronger communities.

1. **NHS Five Year Forward View**, NHS England, October 2015.
2. The IPC Operating Model and wider framework documents can be found on the **personalised health and care section of the NHS England** website.
3. The Personal Health Budgets and IPC Finance and Commissioning Handbook and wider framework documents can be found on the **personalised health and care section of the NHS England** website.
4. **EAST: Four Simple Ways to Apply Behavioural Insights**.
5. **Local area coordination: Catalyst for a system wide prevention approach**.
6. **Building community capacity: making an economic case**. PSSRU 2010.
7. **At the heart of health: Realising the value of people and communities**. NESTA 2016.
8. www.liveitwell.org.uk/wp-content/uploads/2014/10/Hampshire-Crisis-Cafe-Evaluation-Report.pdf
9. www.qualitywatch.org.uk/content/summary-people-mental-ill-health-and-hospital-use
10. Based on DH reference costs 2012-2013 and 2013-2014.
11. DH reference costs 2013-2014.
12. **Learning from personal health budgets in Stockport** (2016).
13. **No health without mental health**.
14. **The Esther Model** was developed in Jönköping County, Sweden.
15. King's Fund, **Long-term conditions and multimorbidity**.
16. Based on costings expressed in **Cornwall and the Isles of Scilly Pioneer Programme**.
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Community capacity and peer support
Summary guide

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