Community Led Strategic Prevention

Summary Report

IMPACT Demonstrator Model 2024/25

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# Abstract

Prevention is a key concept for modern adult social care policy and is a duty for Welsh local authorities under the 2014 Social Services and Well-being (Wales) Act (SSWBA).

For the purposes of this paper, evidence was synthesised from findings about community led strategic prevention from two databases. Grey literature was also used following an internet search.

Strategic prevention initiatives across the United Kingdom have taken various forms and had mixed success. Prevention is often seen as a positive response to individual outcomes and financial austerity but there is more research required to support these claims, and to find the best preventative approaches.

One of the elements of strategic prevention is co-production. Local authorities in England and Wales, user-led organisations such as TLAP and Social Care Future and policy makers talk about community led change. However, community led development where power is shared, and all partners are truly equal continues to be an elusive aspiration for many.

Key enablers for community-based prevention are brave and distributed leadership, a positive and empowering workplace culture, properly supported coproduction and a community infrastructure that is sufficiently resourced to lead and embed the changes required.

**Keywords**: Prevention, Community, Community-Led Development, Adult Social Care

# Introduction

Whilst the concept of prevention in adult social care policy has been prominent since the late 1990s (Marczak et al. 2019), it was formally embedded in legislation in Wales in the 2014 Social Services and Well-being (Wales) Act (SSWBA). In this act Local Authorities in Wales are charged with preventing, delaying and reducing the need for care and support, and promoting independence. In line with similar legislation in the other nations, prevention approaches have since developed across the United Kingdom, with the majority of research focused on England.

Prevention in social care is an attractive concept due to the promise of improved outcomes for people who draw on care and support and opportunities for local authorities to reduce spend. It has, however, faced some criticism for being a ‘‘cover’ for swingeing cuts in services’ p7 (Tew 2023) (Read et al. 2024). Commentators note that there are various definitions of prevention and a wide range of different approaches (Skills for Care 2019, Marczak et al. 2019, Read et al.2024). Prevention aims and values share commonalities with strength or asset-based approaches and often the two are linked. Indeed, there is no prescriptive way that local authorities discharge their duty of prevention, which can encourage creativity but also confusion and disparity (Marczak et a. 2019, Read et al.2024).

The extent to which preventative approaches are community led varies. In many areas the stated intention of those with strategic responsibilities has been to coproduce prevention initiatives with the community. However, analysis of some approaches identifies challenges to real power sharing outside of statutory bodies.

# Methodology

The purpose of this evidence review is to synthesise research findings on community led strategic prevention. The review has taken a pragmatic approach to evidence gathering. Two databases were used (HMIC and Social Policy and Practice). The use of search terms was adapted when initial search terms did not produce adequate results.

The 3 search terms used were:

1. (Community and Involvement and Change)
2. (((Community and participation) or involvement) and strategic and change)
3. ((Prevent\* and social care and adult and community) not children)

The searches identified published and grey literature, and the dates were set from 2013 – 2024. Due to the number of articles found, it was necessary to refine by date. 2013 was chosen as the year before the SSWBA (Wales) came into force so that pre-emptive research was included.

Once the articles were identified, abstracts were read to filter for relevance. This resulted in 16 papers being selected for inclusion in the evidence review. Of these, 11 were focused on local authorities in England, one considered evidence from across Wales, 2 were UK wide and one had an international remit. All were research-based papers or evaluations, apart from one paper by TLAP which is a ‘shared commitment and call to action’ aimed at local and national governments.

Articles from the databases were evaluated for quality and relevance. Of the 16 papers selected 7 were high quality, 7 medium quality and 2 low quality. 9 were highly relevant, 1 of medium relevance and 6 of low relevance. 6 of the articles captured the views of people with lived experience, and one was coproduced. 2 articles explicitly covered equality and diversity issues, and 9 articles were based on schemes for people with disabilities and reference disability equality issues.

In addition to the database searches, google was used to locate the relevant legislation, code of practice and related reports from the Welsh Government. Due to limited results from the database search on community led change, a Google search was also used to see whether anything further could be found on this. This identified a few helpful websites with explanations and examples of community led support.

# Defining concepts

Prevention

Prevention approaches have been categorised under three main headings:

1. *Prevent – primary prevention and promoting wellbeing*

*These approaches are aimed at maintaining and promoting healthy lifestyles and reducing loneliness so that people avoid the need for care and support.*

1. *Reduce – secondary or early intervention*

*When people are at risk of developing health and social care needs, these approaches try to stop the needs progressing. This may include things like falls prevention, housing adaptations and carer support.*

1. *Delay – tertiary or formal intervention*

*Where people already have significant health conditions and/or require social care support, this tier of prevention supports people to gain or regain skills to improve independence. This includes reablement/enablement, rehabilitation, respite care and support for carers.*

(SCIE 2021)

Whilst the legal definition of prevention appears straightforward, in reality ‘its meaning remains elusive’ (Marczak 2019, p207) and is interpreted variously. Marczak et al.(2019) researched prevention approaches in six local authorities and found that a lack of clarify about what constitutes prevention was negatively impacting translation into policy and practice and hampering efforts to evaluate different initiatives.

In 2019 Skills for Care commissioned an overview of the published and unpublished literature relating to prevention in social care. The review also included consultation with key stakeholders in the sector to understand how policy is being translated into practice. The research revealed distinct differences in what senior and front-line staff viewed as prevention. For some, social care delivery by its nature was seen as preventative, whereas others saw prevention as outside of social care’s remit, sitting with other bodies such as public health (Skills for Care 2019). The study identified that adult social care organisations use four key definitions for prevention:

* *Supporting people to live as healthily as possible, both mentally and physically*
* *Reducing the use of health services, including primary care, emergency services and hospitals*
* *Preventing or reducing the escalation of health issues*
* *Supporting people to remain as independent as possible.* (SfC 2019)

A useful definition quoted by SCIE (DHSC 2018 Prevention is better than cure) states that:

‘Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible’.

Community Led

The origins of community theory are often attributed to Ferdinand Tonnies, whose book ‘Gemeinschaft and Gesellschaft’ (translated as Community and Society) was first published in 1887 (Bell and Newby 1971). In 1971, Bell and Newby counted 94 definitions of ‘community’ with significant variations in their descriptors (Bell and Newby 1971). Clarity around the idea of community remains unclear in today’s society, and often becomes focussed on geography, when for many people their communities are based around on common interests and increasingly on engagement with digital communities. For the purposes of this paper, it is acknowledged that the idea of ‘community’ will differ based on the viewpoint of each person, but the following is a guide for the parameters of this project:

*A community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage. People who are socially isolated are also considered to be a community group.* (NICE 2024 p.36)

There is a recognition that people living in a community often know best what that community needs (TLAP 2016). The ultimate aim of community led approaches is for communities to build on their assets to develop their own services and resources based on this expert knowledge:

*Community-Led Development is a development approach in which local community members work together to identify goals that are important to them, develop and implement plans to achieve those goals, and create collaborative relationships internally and with external actors—all while building on community strengths and local leadership.*

*Community-Led Development (CLD) is characterized by 11 attributes: participation and inclusion, voice, community assets, capacity development, sustainability, transformative capacity, collective planning and action, accountability, community leadership, adaptability, and collaboration.”*

[Defining Community-led Development – The Movement for Community-led Development (mcld.org)](https://mcld.org/definition/#:~:text=%E2%80%9CCommunity%2DLed%20Development%20is%20a,building%20on%20community%20strengths%20and) [Accessed 30/08/2024]

The table below is adapted from a graphic about asset-based community development, and demonstrates this transfer of power:

|  |  |
| --- | --- |
| Traditional Medical Model | Charity Model |
| Everything is done to us and without us | Everything is done for us, without us |
| Social Model, Coproduction | Community Led, Asset-Based |
| Nothing is done for us without us | Done by us, for us |

*(Adapted from graphic by Cormac Russell in Nesta 2019)*

Where community led support is an ambition, communities may need support to develop their assets and build on their current infrastructure (Miller and Whitehead 2015).

# Policy Context

The SSWBB Wales 2014 places a duty on local authorities to provide services to achieve the following purposes:
(a) contributing towards preventing or delaying the development of people’s needs for care and support;

(b) reducing the needs for care and support of people who have such needs;

(d) minimising the effect on disabled people of their disabilities;

(e) contributing towards preventing people from suffering abuse or neglect;

(i) enabling people to live their lives as independently as possible.

This is underpinned by the Code of Practice in Rebalancing Care and Support Programme which states that:

*Local authorities should co-operate, work collaboratively, and with a variety of partners and stakeholders, including health boards and the third sector, to develop and deliver the required range and level of integrated preventative and early intervention services.* (*Part 2 Code of Practice, General Functions consultation document in Rebalancing Care and Support Programme 23, p41)*

To support the development of prevention approaches the Welsh government introduced the five-year Health and Socia Care Regional Integration Fund (RIF), which strongly encourages partnership working to establish community resilience and community-based care.(in Rebalancing Care and Support Programme 23 (Consultation Document)).

# Community Based Models of Prevention

The Skills for Care review found five key approaches to prevention:

1. Advice and Guidance
2. Physical Activity Promotion
3. Social Prescribing
4. Reablement
5. Asset-based approaches. (Skills for Care 2019)

This list is augmented by Allen and Glasby (2013) who also highlight telecare and technology, housing adaptations (major and minor), intermediate care and personalisation in their list of ‘high impact approaches to prevention’ (Allen and Glasby 2013 p.904).

Various approaches to primary, secondary and tertiary prevention have been tried across the UK. Several approaches could be classed as falling into more than one of these categories, with the majority of approaches aimed at secondary or early intervention. Below are some of the approaches discovered in the databases used. Where analysis exists, this has been summarised.

|  |  |  |
| --- | --- | --- |
| Approach | Description | Analysis (where available) |
| 1. Prevent – primary prevention and promoting wellbeing
 |
| Circles of support (NIHR 2024) | Individual is supported by a circle of family, friends and others with relevant specialist knowledge | Evidence of increased independence. Alternative to residential care – more cost effective. |
| Prevention Matters, Buckinghamshire (Buckinghamshire County Council 2015) | Community Practice Workers make referrals to community services and groups.Community Links Officers review community resources and identify opportunities to develop new capacity.Volunteer Hub | More people reached who will benefit from care and support.New partnership opportunities.Better sharing of knowledge and information.Recruitment and placement of volunteers has been challenging. |
| Somerset – Community Connect (NDTi 2020) | Micro-enterprisesVillage and community agents – locally based staff who act as first point of contact |  |
| Thurrock: Neighbourhoods First(TLAP 2019) | Local Area Coordinators – support local services and groups to develop, link with existing services and connect individuals to these groups.Micro-enterprises | Strengths and place-based model.6 building blocks: Building trust-based relationships; strengths not deficits; grass roots; ownership; changing systems; autonomy |
| Timebanking (Naughton-Doe 2020) | The example analysed was person to person timebanks where someone provides a service for another person, then earns a credit to enable them to receive a service.  | Not working in practice as it should, due to concerns around safeguarding and significant resource requirements to staff it. The authors also describe a paternalistic culture which is hindering the realisation of a community led approach. |
| IMPACTAgewell® [Asset Based Approaches - IMPACT (bham.ac.uk)](https://impact.bham.ac.uk/our-projects/demonstrators/asset-based-approaches/) | A community development led, integrated model of care for Older People living in the Mid and East Antrim area of Northern Ireland. Built by a willing coalition of multi-agency partners in 2017, led by Mid and East Antrim Agewell Partnership with a vision to provide person centred services to older people via a locality hub of mixed disciplines. These 6 hubs in 2017 have grown to 20 hubs in 2022 with a plan to cover all GP areas. |  |
| 1. Reduce – secondary or early intervention
 |
| Community Led Support (national programmes supported by NDTi) (Miller et al. 2024) | Set of principles, not pre-determined model of support.NDTi act as critical friend.Assessment process became less bureaucratic and more relational based.Community hubs | Some practitioners felt liberated, some felt anxiousEarly years – more people signposted away from social care (decreasing over time).Higher QOL scores in ASCOF – community connections.More people say they have control over their lives. (Miller et al. 2024, Richardson 2021) |
| Age UK Help at Home (NIHR 2020) | Befriending, practical support, benefits advice. Run by volunteers. | Reduced isolation.Volunteers found work.Reduction in use of social care services. |
| Community Led Support, Somerset (Harflett and Brown 2020) | Early interventionLink up health and social care community | People staying in own homes, avoiding crises.Staff morale improved.Thriving community, including voluntary and community organisations.Quantitative measures positive – long-term care, waiting times, social care spend. (Harflett and Bown 2020) |
| Wigan - The Deal (TLAP 2019) | Different conversationsIncrease in staff capacity to have conversations.Better knowledge of community assetsCultural change – positive attitudes and behaviours. Reflective practice and learning.Asset-based commissioning | Challenge – scaling work with innovative providersAdapt staff practical working permissions, systems and processes.Growing evidence base of improved outcomes for residents. |
| Wellbeing Teams (TLAP 2019) | Buurtzorg model from Holland: creation of self-managing, values-led, neighbourhood based teams.▪ Services are coproduced▪ Work to outcomes▪ Use the Support Sequence to deliver outcomes.▪ Neighbourhood-based.▪ Creativity and autonomy in staff is encouraged.▪ Wellbeing teams are small and close-knit.▪ Give and get feedback to and from each other (compassionate communication).▪ The approach includes supporting the wellbeing of team members. | People working in self-managing teams are more satisfied. |
| 1. Delay – tertiary or formal intervention
 |
| Bromley Mind (NIHR 2015) | Peer support workers (volunteers) | Reduced use of MH servicesVolunteers found work |
| Thurrock: Neighbourhoods First (TLAP 2019) | Shared LivesRecommissioning homecare to focus on communities and living well at home.Social Work Approach – appreciative enquiry and strengths-based. | Better use of non-statutory resources.Has been challenging but starting to realise benefits of ‘community first’ culture’. |

Whilst not an exhaustive list, this provides a flavour of prevention approaches across the United Kingdom. Several reports note these initiatives are in their early stages, and analysis of effectiveness is inconclusive. However, other areas are able to attribute a reduction in the use of formal social care, including long-term care, and cost effectiveness to their prevention strategies (Tew 2019). More notably, several areas report improved outcomes and quality of life for local residents.

# How can communities lead strategic change in social care?

The first wave of services since prevention became a statutory duty have, perhaps not surprisingly, been largely driven by local authorities. A lack of evidence based preventative practice in social care prior to 2014 has led to significant diversity in the interpretation and development of prevention services (Tew 2019). Several initiatives have aimed to embed coproduction, but this has often been challenging and only partially achieved (Miller et al. 2024, Naughton-Doe et al. 2020). One notable exception is the ‘Talking Cafes’ in Somerset. These cafes are run by and for the community, and decision making is devolved via peer forums. These cafes are part of the NDTi’s ‘Community Led Support’ initiatives. Of all the initiatives reviewed, Community Led Support (CLS) was the clearest in its intention to empower communities to direct and lead local projects. Whilst it is clear this continues to be their aim, an evaluation of current projects found that the community were being ‘consulted’ rather than leading local change (Miller et al. 2024).

There is an appetite for community led change, and an acknowledgement that local residents are best placed to identify and lead developments (Nesta 2020). TLAP have published a compelling report recommending a radical redesign of health and social care which recognises local people as assets with knowledge and skills. It advocates for self-help communities and commissioning priorities that are developed with the community (TLAP 2016). The principles it espouses are: Principles: Asset-based; Co-produced; Based on social capital; Inclusive and equitable; Empowerment.

# What are the success criteria for community led prevention?

There are common criteria that are identified in successful prevention approaches. This includes long-term planning and investment, strong and distributed leadership, and an ability to think creatively and be brave. A genuine desire for coproduction and empowering local communities is also key (Miller et al. 2014, Tew et al. 2019).

**Leadership**

For change to be successful, it needs brave, strong directors who encourage new ways of working and are not afraid to do things differently. (Miller et al. 2024). This courage needs to extend to distributing leadership amongst local teams and communities, enabling flexible approaches and quick decision making based on local knowledge (Tew et al. 2019, Miller et al. 2014) Whilst there is evidence of distributed leadership with practitioners in some of the examples cited, this does not generally extend to the voluntary and community sector (Miller et al. 2014). It is key that communication is accessible, regular, consistent and transparent, and that the underlying rationale for any change is explained fully to staff and communities, alongside the intended outcomes (Skills for Care 2019). Reasons for change should focus on better outcomes for people as the [riority, rather than cost savings (Skills for Care 2019). Those leading the programme of change need to demonstrate consistency in their values: what they say and how they behave (Nesta 2020).

**Culture**

Whether explicit or implicit, organisational and system culture will need to adjust to working differently. Principles of community led prevention should be embedded in all conversations, including supervision (SFC 2019). A positive workforce culture should be nurtured with well-supported, reflective staff who feel valued (Skills for Care 2019). The language used should reflect the change of culture to one of empowerment e.g. ‘citizens’ rather than ‘service users’ (Nesta 2020).

**Coproduction**

There needs to be sufficient infrastructure and investment to support and maintain coproduction. This needs to be embedded within the strategic change governance programme with proposed development and evaluation mechanisms (Miller et al. 2024). For community led change to be realised there needs to be a significant shift of power from public organisations and professionals to the community. Particular consideration should be given to empowering those who are seldom heard (TLAP 2016). The skills and knowledge of residents should be recognised and utilised, rather than people being seen as passive recipients (TLAP 2016). To encourage growth in coproduction, successful achievements should be publicised and celebrated, even where these may seem relatively small (Miller et al. 2024).

**Infrastructure**

A long-term aim of community led development is to build community infrastructure, so communities become increasingly self-supporting (Miller and Whitehead 2015). To achieve this the nurturing of social connections, community cohesiveness and civic engagement will be key (TLAP 2016). Integrated strategic prevention plans with partners – health, 3rd sector, housing etc. – will support a consistent approach to community led prevention, and the Health and Well Being Board should take a lead role in empowering communities (TLAP 2016). This should ensure that partners use comparable evidence to demonstrate the benefits of community led approaches (TLAP).

**Resources**

New approaches need resourcing adequately to ensure they are successfully implemented and sustained. This includes adequate time and money, guidance and training to enable staff to successfully integrate new approaches into practice (Skills for Care 2019). In addition, investment and planning need to be long term (Nesta 2020).

**Existing conditions**

When starting out on community building, it is worth considering the readiness of the locality. Areas where local people are invested in their community, that already have community groups and venues are good places to start. (Nesta 2020)

# Challenges

Investing resources in prevention is not always a priority. When faced with difficult decisions about funding in times of austerity, Local Authorities will prioritise immediate demand pressures over longer term prevention initiatives (Marczak et al. 2019, Miller et al. 2013, Miller and Whitehead 2014). Indeed, many Local Authorities do not have a prevention strategy or an identified budget for prevention (Tew et al. 2021).

Being alert to opportunities for preventative interventions is a different way of working for frontline social care staff. In some areas there is a lack of recognition of the different skills and knowledge needed by staff to embed a preventative approach. Training in motivational techniques, for example, may be helpful for staff when looking at strengths-based solutions with individuals (Skills for Care 2019).

There are significant challenges in evaluating the success of prevention approaches. This is due to a lack of shared understanding of prevention, along with an under-developed evidence based. A consistent challenge with evaluation is proving one specific preventative intervention has prevented something, as people are often subject to various interventions or changes in circumstance concurrently (Marczak 2019, Allen and Glasby 2013). When preventative services are commissioned with third sector organisations, there can be a lack of clarity about the required outcomes, and how to measure these (Miller et al. 2013).

Other challenges identified by online sites are:

For communities:

* Lack of trust
* Lack of awareness
* Lack of time
* Digital exclusion
* Communication barriers (e.g. language)
* Resistance to change
* Conflict
* Consultation fatigue

[Top 10 challenges in community engagement (commonplace.is)](https://www.commonplace.is/blog/top-10-challenges-in-community-engagement)

[Overcoming challenges in community engagement (techuk.org)](https://www.techuk.org/resource/overcoming-challenges-in-community-engagement.html)

# Discussion and Conclusion

There is evidence that prevention in social care is generally seen as a positive direction of travel, both for communities and the public purse:

*The underlying assumption is that preventive services will promote individuals’ well-being, quality of life, health and independence which, in the long term, will reduce demand and lower overall costs’ (Kumpers et al. 2010 in Marczak et al. 2019 p.206)*

Some concerns have been expressed about conflating discourses of individual outcomes and cost reduction when discussing prevention. Read et al. state that this risks leading to a lack of investment and creativity in the development of prevention initiatives:

*Further efforts in this regard should consider the need to more imaginatively unpack how prevention in social care can and should function were it free from the constraints of decreased budgets and drives for cost-saving. (Read et al. 2023 p.18).*

Concerns around a lack of investment in prevention may be valid.

*Although the Association of Directors of Adult Social Services emphasise the importance of prevention in reducing demand, its 2016 Budget Survey reported that councils were reducing funding for prevention to meet the costs of core statutory duties (ADASS, 2016 in Marczak et al. 2019 p.207).*

The challenge of evidencing effectiveness of preventative measures compounds the difficulties in making a business case to invest. In addition, effects of some prevention schemes that requires a change in culture across a wide area can take some time to produce results. When analysing their progress with Asset Based Community Development, Leeds gave this reflection:

*We learnt as much from what went wrong as what worked. Nothing happens at first, but that’s okay – hold your nerve, don’t rush to fill the space. At first, commissioning something where nothing much happened for the first seven months felt risky, but building trust and connections takes time.’ P28 (Nesta 2020 p.28).*

Moving away from a deficit-based culture in social care to one that promotes independence, wellbeing and resilience is a significant shift that will take time (Hall 2018). Whilst many local authorities have begun this shift, embedding an effective preventative approach on a national and local level amongst multiple partners feels some way off. Few local authorities have prevention strategies, and even fewer have integrated strategies with partners (Tew et al. 2019).

Furthermore, whilst rhetoric places the ‘community’ at the heart of strategic development in prevention, in reality true power sharing remains rare. Radical redesign and whole system change is advocated to achieve a truly community led approach (TLAP 2016). This needs national commitment, long term planning and investment, a commitment to joint aims and principles and clarity about how the approach will differ from traditional approaches (Tew 2019, TLAP 2016).

For community capacity building to have a major impact on wellbeing and quality of life, it needs to be done at scale but be responsive to local needs. (TLAP 2016, Tew 2019). Local authorities need to be prepared to look outwards to partners and communities to cultivate trust and mutual respect and to distribute their power.

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