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Original citation:

Wistow, Gerald and Waddington, Eileen and Davey, Vanessa (2011) Involving older people in commissioning: more power to their elbow? Joseph Rowntree Foundation, London, UK.

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Originally available from [Joseph Rowntree Foundation](#)

Available in LSE Research Online: Feb 2012

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Involving older people in commissioning: more power to their elbow?

December 2011

Gerald Wistow, Eileen Waddington and Vanessa Davey

This report studies older people's wishes and experiences of commissioning health and personal care services.

Recent initiatives have emphasised transferring power from service providers to users. Fieldwork was carried out in two local authority areas in England (Devon and Salford), recognised as leaders in involving older people, to evaluate good practice and outcomes. Issues considered include:

- influence of older people at different levels (individual, local and strategic);
- enabling older people to play a part;
- perceptions of validity or tokenism;
- ideologies and agendas behind different approaches.

As part of the process of negotiating access to the field sites we gave assurances about how we would report statements by individuals. Thus we agreed not to identify them by name or individual role or in any other way that might enable specific comments to be attributed to specific persons. We have used generic categories such as older person, commissioner and provider to assist understanding and such attributions were accepted in discussions of our interim report. However, we hope we have done all we can to fulfil our commitment to anonymity and that individuals will feel the confidential nature of their contributions has been preserved.

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Executive summary

Background

Recent policy initiatives in the UK have sought to encourage more people to take charge of commissioning their own personal care. This can mean simply people controlling their own direct payments and individual budgets. However, it can also involve groups of service users in pooling resources or participating in planning.

The extent to which local authorities engage with service users varies. Dorset and Salford were selected for study because they are reputed to be among the more active local authorities in England in this respect and also provide socioeconomic and organisational contrasts. Twelve focus group meetings were conducted in 2007–09, in two stages: one to produce preliminary findings and one to check them against the participants' understandings. The research team studied the systems and processes in place for engaging with older people, their outcomes and the older people's perceptions of their involvement and effectiveness.

Key findings

Context and culture

True engagement requires high levels of commitment from both sides: agencies and older people. Many local authorities consider that they cannot afford the necessary resources. Likewise many older people are or feel unable to participate, so particular efforts need to be made to engage the 'hard-to-reach' groups. For example, basing consultation on formal meetings will engage only the type of people who are willing and able to attend meetings.

Structures and processes

Transparency is required in dealings between agencies and older people. It must be demonstrated that older people's input makes a difference and is not simply filed on the way to a predetermined outcome. As well as ensuring a two-way information flow, the local authorities in both sites actively delegated some tasks to older people's groups.

Focus of involvement

There appears to be a tendency for more broadly based engagement to result in basing strategies on population and place rather than concentrating on specific service users' needs. This is linked to a tacit ideological difference: viewing people as citizens or as consumers.

However, at least some of the older people involved perceived the scope of the change agenda to be limited to priorities within current resources rather than rethinking the whole system.

Conclusions and policy implications

Stakeholders need to be empowered through the development of individual and collective capacities and capabilities if they are to exercise genuine influence on commissioning. Hard-to-reach groups are typically targeted on an ad hoc rather than systematic basis. Similarly, issues tend to be approached individually rather than with a concern to identify and address the underlying causes.

Varying emphases on the individual service user as a consumer or the member of the community as a citizen may be teased out of the research and recognised by participants when pointed out, but are seldom articulated in the process of engagement. Unrecognised differing principles may lead to a clash of approaches. Progress is not possible without agreement on the destination. The report recognises that the service user paradigm is appropriate and helpful in some contexts, but recommends developing the citizenship paradigm as part of revitalising local democracy. It also recommends recognising that transfer of power need not be a zero-sum game; giving older people more of a say may not weaken but strengthen commissioners and service providers.

User involvement is not an end in itself but a means to change outcomes. There is little evidence that participation of older people in commissioning has improved outcomes. That will require a transformation of power relations rather than simply operating within current constraints.

The report recommends exploration of two strategies for future development:

- Involvement should concentrate specifically on outcomes more than on processes, and older people should insist that public services ensure that commissioning is effective as a condition of their participation.
- Older people's and other groups might find it more effective to devote their resources to scrutiny and campaigning, independent of service providers, rather than to participate in commissioning. They should at least give explicit consideration to these options rather than assume that engagement in commissioning processes is necessarily the best route to better quality experiences and outcomes.

Introduction: research questions and methods

This study was commissioned in 2007 by the Joseph Rowntree Foundation (JRF) as part of its Independent Living Programme. It was conducted by a team of researchers from the Personal Social Services Research Unit at the London School of Economics. The aim of the JRF programme was to 'identify approaches to choice and control which have credibility with users and viability in practice. The primary purpose of the programme is to build on existing knowledge in order to bring about change'. The programme steering committee had identified two key gaps in the work to date; the first was about choice and control in nursing care and the second was about 'the leverage that might be possible when money is the main focus'. The committee identified 'that there are few examples where Users have a real say in Commissioning and more strategic approaches to service planning'. It is this second area that this research seeks to address. At the same time, JRF commissioned a further, complementary study from Age Concern London.

Our research proposal noted that public policy contained increasing references to the development of both voice and choice for service users and their carers in a context of promoting choice and control over their lives. The language of policy was that of empowering individuals as consumers of public services and also as co-producers of their own care. Given this, policy for older people was part of a wider programme of public service reform based on putting the individual rather than the service at the centre of commissioning and service delivery. However, we also noted that initiatives to develop the capacity of individuals to engage with and shape the services they received were not always well integrated with the strategic commissioning function. To the extent that key decisions about resource allocation and service design were made strategically, such experience would suggest significant limitations on the influence of older people on commissioning outcomes. In turn, however, our ability to study such issues required some explicit understandings about the conceptual underpinnings of commissioning.

From the beginning of our research, we were conscious that commissioning (like planning, before it) had tended to be described as a cyclical process comprising a number of component parts. Typically, the commissioning cycle would be represented as encompassing, for example, needs analysis, vision, outcomes, service specification, procurement and review (DH, 2006a; Wistow, *et al.*, 2010). Although such representations of commissioning can be interpreted as implying a prescribed sequence of steps or stages, the reality is more complex. The various elements are better understood, therefore, as being interdependent and shaped through multiple feedbacks rather than a single linear process. We consider the nature of commissioning in more detail later in this report. In this introductory discussion, we simply wish to highlight two issues which were central to the development of our research questions about the engagement and influence of older people in such processes.

Both revolved around specifying the terrain to be explored. If the task was to establish how far and with what effect older people were involved in commissioning, where should we be looking for answers to these questions? In which arenas and structures might such involvement be expected to take place? As we have already noted, our proposal had identified from the literature a view that, wherever such engagement did take place, it was not generally in relation to strategic commissioning. It is fair to point out that strategic commissioning was, itself, generally seen to be underdeveloped and

that much commissioning activity focused on the narrower function of purchasing or procurement (DH, 2006a; CSCI, 2006a). At the same time, the development of personalisation and self-directed support (SDS) was introducing a second set of distinctions into the discussion of strategic commissioning in terms of the relationship between commissioning for individuals and commissioning for populations. If commissioning budgets were to be allocated at the level of individuals, what would be the consequences for commissioning at the more strategic level of the local authority and primary care trust (PCT)? This question about influence at different sociogeographic levels was further reinforced by the policy commitment to strengthen the neighbourhood level and, with it, the role of community involvement in, for example, neighbourhood renewal, the New Deal for Communities (NDC) and processes of participatory budgeting.

We would be collecting data, therefore, in local policy systems where public engagement in commissioning was being promoted at three different levels: individuals and their carers; communities/neighbourhoods; and the 'strategic' authority-wide level. In recognising the multilevel characteristics of local commissioning processes, we also needed to consider the relationships between levels and the extent to which older people's agendas and influence were integrated across levels of decision-making and commissioning. An apparently decisive influence at 'strategic' or neighbourhood level which was not reflected in real choices for individuals might suggest either a break in the transmission of older people's voices between levels or a resistance to following them at service delivery level.

A final preliminary consideration was to recognise that different meanings were attached to public involvement and that these understandings were reflected in the methodologies adopted to promote it. This issue is discussed more fully in Chapter 2 but, for the present, it is sufficient to note that types of engagement are frequently conceptualised as occupying different points on a continuum of involvement. A version of this continuum we favour, prompted by McTaggart (1991), stretches from processes which aim to *implicate* the public in decisions already taken by the local state to those which aim to *empower local publics* through the devolution of powers and resources to take such decisions themselves. Such understandings meant that we needed to explore not only the level at which the influence of older people was evident but also the extent, nature and limitations of the involvement taking place. Was it, for example, primarily a process of information giving or consultation on policy and practice developments initiated by the statutory services; how far were older people able to influence the agenda and mechanisms for their involvement; was it seen as a 'stage' in the commissioning cycle or as a continuing role throughout it? Above all, of course, was the question of what difference older people's involvement was making to the outcome of local decision making.

Taking all these considerations together, therefore, our response to the JRF call for research proposals centred on the need to collect data about the involvement of older people:

- at different *levels* of commissioning;
- in different *components* of the commissioning cycle; and
- in respect of its different *objectives* and *results*.

At the same time, our key aims in conducting the study would be:

- to extend understanding of participation by older people in the commissioning process at individual, locality and strategic levels;
- to understand the tensions and connections between those levels in order to understand how older people can influence commissioning more effectively;

- to develop a framework that will specify what needs to be done in the future to ensure meaningful contributions from older people in the development and design of services in each 'stage' of the commissioning cycle.

These aims were to be met by addressing the following series of questions:

- What is the link between the promotion of user/carer participation and involvement and commissioning decisions at each of the following levels:
 - strategic;
 - locality;
 - individual?
- What are participants' experiences of the nature of service user involvement at each level and within each component of the commissioning cycle?
- What role does service user involvement play at each level and component in determining the nature of social care?
- What is the continued relevance of the existing evidence base or how does it need to be updated to take account of the changing nature of social care?

Our methodology involved both a literature review and a fieldwork component. The former was focused on gaining an understanding of the current policy context and guidance to practice on commissioning in general and on meeting the needs of older people in their own right and as members of their wider community. The literature review also considered the current literature available on the extent and effectiveness of older people's engagement in the different levels and components of commissioning. Its overall purpose was to inform the development of an analytical framework for understanding and structuring the learning from the fieldwork and the existing evidence base. Material from the literature review provides the basis for Chapters 1 and 2.

Data was collected through two rounds of focus groups in two local authority areas: Dorset and Salford. In selecting sites for fieldwork, we were guided by two principal requirements:

- The need to identify sites with dedicated structures and processes for engaging with older people and a reputation for success in this field. This criterion reflected our objective of understanding the extent to which such engagement could be proactively developed and the factors which made more extensive engagement possible as well as those which limited it. We did not wish merely to rehearse the well-known barriers to their engagement but hoped to gain greater understanding of how far such barriers could be overcome and the engagement of older people could be promoted in the different levels and components of commissioning highlighted above. In adopting this criterion, however, we recognised that the results of our work were unlikely to be typical of local patterns of engagement more generally. However, that was an inevitable consequence of seeking to gain a deeper understanding of the limits of good practice.
- The selection of sites with different structural, socioeconomic, geographic, financial and political contexts. The two sites chosen could scarcely have been more different. Dorset is a dispersed, southern, Conservative-run shire county with six district councils and (at the outset) three PCTs; Salford is a compact, northern, Labour metropolitan district with a single co-terminous PCT. Dorset has a population of around 410,000, almost 24.5 per cent being aged over 65, including 3.6 per cent

over 85 years old. Salford has just over half that population (almost 216,000) with a lower percentage of older and very old people (15.4 per cent and 2 per cent respectively). While residents in Dorset live longer than the national average, Salford residents have a shorter than average life expectancy. In addition, levels of deprivation vary significantly, with Salford experiencing significantly higher levels of deprivation in general. However, Dorset also has areas of relative deprivation including one area in the highest 10 per cent nationally. There was also considerable variation in local authority spend per head of population over 65, with Dorset currently spending approximately £575 and Salford £967.

Two rounds of focus groups were conducted in each of the local sites with older people, commissioners and providers. In all, twelve meetings took place, comprising seven in Salford and five in Dorset (see Chapter 3 for further details). In addition, we organised two national focus groups. One involved representatives of national organisations for older people and the second included people from the policy, regulatory and local government communities. These groups were specifically designed to provide a counterbalance to the local fieldwork and its location in areas of apparently good practice. In addition to helping us to set the data collected from the two local authority sites in a wider policy and practice context, they also enabled us to compare local and national perspectives on what facilitated the successful engagement of older people in commissioning.

With each of the locality and national groups we structured our discussions around a set of questions derived from our overarching research questions. We asked groups:

- What are participants' experiences of the nature of older people's involvement at each level of commissioning?
- What is the link between involvement by older people and the commissioning decisions made at each level?
- How is involvement in such decisions changing as social care gives greater emphasis to choice and personalised commissioning?
- Is it leading to the commissioning of different kinds of services and/or different relationships between those who use and those who deliver services?
- Are the kinds and opportunities for involvement by older people changing?
- What, if anything, prevents involvement by older people having greater influence on commissioning decisions?

In the next two chapters of this report, we locate our study in its wider policy and practice contexts with particular reference to the development of commissioning and recent experience of developing user involvement. Chapter 3 contains the results of our fieldwork in Salford and Dorset. Chapter 4 provides our concluding analysis and reflections.

1 Strategic commissioning

In this chapter, we aim to understand more fully the nature and purpose of commissioning, including its implications for public engagement especially by older people. Commissioning for older people would primarily have been the concern of social care and health services but that traditional focus is increasingly considered too limited. As we shall show, commissioning for older people (together with their carers and supporters) has begun to adopt a wider concern with their health and wellbeing, including the role of prevention, community inclusion and ‘universal’ services. Moreover, it is our growing understandings of what is important to older people themselves and their ability to influence service development agendas that have been crucial in broadening out that focus. Before developing this theme, however, we need to clarify the origins and purpose of commissioning in the public sector and, thereby, define the nature of the activities with which we are dealing.

What is commissioning?

Commissioning is not a new activity in social care or health in the UK, though it is still less than a quarter of a century since the concept began to inform public management objectives and structures (see below). Even over this relatively brief period, however, definitions and understandings have not remained constant. A recent report from the House of Commons Health Committee (2010, para. 10) made the point that the term has ‘had numerous definitions over the past two decades and continues to be contested’. It is a function primarily exercised within the NHS in England by PCTs and in social care by ‘top tier’ local authorities. Put ‘bluntly’, the Committee argued that ‘the core role of commissioners has been to buy services for their populations, although it has always been more than this’ (ibid., para. 4). The Committee also argued that the meaning of commissioning had evolved, so as to emphasise that the role of ‘purchasers’ should be something more than ‘simply contracting with and paying ‘providers’ for supplying healthcare services’ (ibid., para. 10). However, it has become relatively commonplace to argue that in practice, commissioning in both social care and health has been overly focused on contracting and procurement processes rather than a more broadly based set of activities.

Woodin (2006, p. 203) has provided one indication of the potential scope of these activities in her distinction between the ‘proactive’ nature of commissioning and the ‘passive’ character of purchasing:

Commissioning ... tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes.

This characterisation of commissioning as a positive process of determining what kinds of services should be funded, and therefore which should not, immediately explains why public engagement in the process should be an important policy and practice priority. However, the quotation from Woodin arguably underplays the relevance of the relationship between commissioning and public engagement. In particular, it does not cover the at least equally fundamental question of who should be provided with services as well as what services should be commissioned. We still need, therefore, a more complete

account of all the elements of a comprehensive commissioning process. Traditionally, this account has been provided by the representation of commissioning as a chain of activities. In the NHS, for example, this approach was first expressed as comprising a series of linked 'steps' to successful commissioning (Mawhinney and Nicol, 1993).

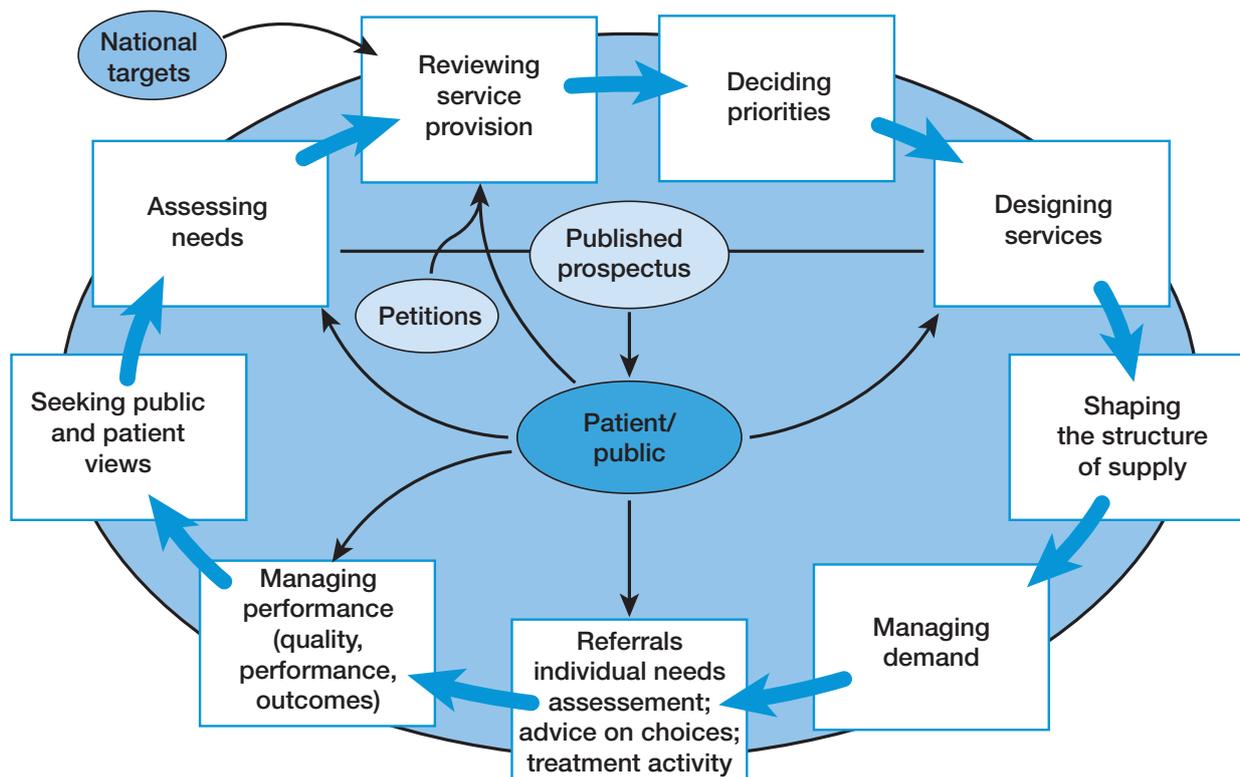
A more general metaphor has been that of the 'commissioning cycle' made up of a number of interrelated elements. For example, the 2006 NHS Commissioning Framework comprised the following ten elements:

- *Assessing Needs*
- *Reviewing Provision*
- *Deciding Priorities*
- *Designing Services*
- *Shaping the Structure of Supply and Procurement*
- *Contracting*
- *Clinical Decision Making*
- *Contract Management*
- *Seeking the Views of Patients and the Public.*

(DH, 2006a, para. 2.14)

The same document set out the relationship between these different elements diagrammatically as a succession of linked activities with patients and the public at their centre (para. 2.14; Figure 1). However, there was arguably some ambiguity about the role of public engagement in this depiction of the commissioning process, since 'seeking the views of patients and the public' was also shown as a separate and final element of the process. As such, it was described in the accompanying text in the following terms under the heading 'patient and public feedback':

Figure 1: The 2006 Department of Health Commissioning Framework. Source: DH (2006a, para. 2.14)



PCTs will be responsible for measuring and reporting on patients' experience. Practices will also want to monitor patients' satisfaction. Robust mechanisms for collecting and understanding patients' views will be required to be developed by PCTs and made available to practices. Throughout, PCTs will ensure that the public voice is heard in the development of priorities and shaping services.

(ibid.)

In line with this last sentence, the text also emphasised that 'effective commissioning means effective engagement of patients and local communities' (ibid., para. 2.9). Consequently, 'PCTs and their practices will need to work with their patients, local communities and local partners to ensure all the elements of commissioning ... below are delivered effectively' (ibid., para. 2.14). Thus, the framework appears to face two ways simultaneously: on the one hand patient and public views are to be sought out to provide feedback on their experiences of services as a separate element of the overall process; on the other, PCTs are to ensure that the public voice is heard throughout the process so that it can influence priority setting and service design, activities potentially of much more fundamental significance than providing feedback on service receipt. As a result, the departmental line seemed at best uncertain and at worst lacking in real understanding of or commitment to genuine public engagement in commissioning decisions.

In process terms, social care commissioning has also traditionally been described as a continuous cycle of interlocking elements. Probably the best-known example in currency during the study reported here is that produced by the Institute of Public Care (IPC) at Oxford Brookes University for the Community Services Improvement Programme of the Department of Health (CSIP, 2007a). Like the NHS commissioning cycle, it comprises a number of distinct elements related to each other as depicted in Figure 2. Three features are particularly noteworthy. First, it seeks to represent the interrelationship

Figure 2: The Commissioning and Contracting Framework. Source: CSIP (2007a, p. 12)



between commissioning and purchasing activities within a unified commissioning and purchasing process. Second, public and service user involvement is not shown as a separate element in the process because it is intended to permeate every element of commissioning and purchasing. In this respect, it contains none of the ambiguity of the NHS 2006 framework which we noted above.

Finally, the IPC commissioning cycle is disaggregated into four quadrants described as ‘analyse, plan, do and review’. In our fieldwork (see Chapter 3), we found this framework to be a helpful way of both discussing the commissioning process with local stakeholders and also for analysing and categorising the activities in which they were engaged. We return to this framework subsequently. Before then, however, we continue our attempt to understand the nature and purpose of commissioning by summarising its development in recent years as a backcloth to reporting our empirical findings so that we have a clearer understanding of the expectations and aspirations with which our local stakeholders were operating.

The origins and development of commissioning

We noted at the outset that commissioning is not a new activity in social care or health. However, it is notable that in recent years the function has been given renewed emphasis by central government in England (for example DH, 2005a, 2006a, 2007a; Audit Commission, 2007), though less so by the devolved administrations, and especially the Scottish. The first appearance of the concept in UK health or social care was in Sir Roy Griffiths’s (1988) community care report in the admittedly embryonic form of social services departments as the designers and funders but not necessarily providers of community care. This ‘enabling’ role for social care had, itself, been foreshadowed some years earlier by the then Secretary of State for Social Services, Norman Fowler (1984), in a speech announcing a Green Paper on the future of personal social services (though the promised document was, in fact, never published). At this time, the principal focus of the enabling function was not on the private, for profit sector but on mobilising voluntary and community resources (Barclay, 1982). This dimension of social care had been emphasised in its founding vision but had remained underdeveloped in policy and practice systems dominated by state welfare.

It was true that the relationships between statutory and voluntary sectors were beginning to be reframed in terms of the need to adopt a ‘contract culture’, a concept largely imported from the United States (Gutch, 1992; Laming, 1985). Yet the private, for profit sector was a minority provider of publicly funded social care services until the very substantial increase in independent sector residential and nursing home care from the early 1980s onward. In the meantime, the NHS had continued to operate within a unified organisational framework in which funding and provision were closely integrated. It was not until the Thatcher government’s third term (1987–92) that serious attention was given to the introduction of market forces into health care, again drawing on influences from the US (for example Enthoven, 1985).

In 1989, the White Paper *Working for Patients* (DH, 1989) proposed the disaggregation of the NHS into two types of organisation: purchasers (health authorities and some ‘fundholding’ GPs with their own budgets) and providers (NHS Trusts, directly managed units and GPs). The rationale for this conceptual and organisational distinction between the purchaser and provider functions was that commissioners would be freed up from the self-interest of providers and purchase services which genuinely met the needs of patients on whose behalf they were to act. Instead of a single integrated structure, there would now be the two separate types of NHS organisation locally, each with its own management arrangements.

A subsequent White Paper on community care (DH, 1990) proposed a purchaser/provider split for social care under which local authorities were required to use 85 per cent of the £3 billion transferred to them from the social security system to purchase services from the independent sector. Although those resources had supported the growth of residential and nursing home care hitherto, councils were

also required to allocate them on the basis of assessments of individuals' care needs and to reshape local care markets so that a full range of day, home care and residential services were available in the independent sector.

Despite the almost simultaneous introduction of a purchaser/provider split in both services, there were significant differences between the arrangements. All the NHS structures remained integral parts of the service and there was no significant attempt to open up the market to the independent sector. In addition, purchasing processes were based on what were effectively service level agreements rather than legally enforceable contracts. By contrast, social services departments were expected to promote the independent sector's role and purchase its services through a combination of block and spot contracts under the terms of normal contract law. In practice, councils progressively reduced the scale of in-house provision and, within a decade, the great majority of adult care services (by cost) were being contracted from private and not-for-profit providers.

Although there have been some detailed changes, the purchaser/provider split has become embedded, therefore, in the day-to-day systems of adult social care over a period of some two decades. However, the quality, appropriateness and adequacy of services commissioned by councils have been increasingly challenged and radical changes in social care commissioning are now under way, as we describe below. The same evolutionary pattern has not been evident in the NHS. Although the purchaser/provider split has remained in place in England, organisational forms and systems have changed with great regularity. This is not the place to detail these shifts in structure and responsibility (see House of Commons Health Committee, 2010, para. 9 Box 1 for a useful summary).

For our purposes here, the principal point to note is that the underdevelopment of the commissioning function has been a repeated feature of the case advanced to support such frequent changes. For example, the 2005 paper 'Commissioning a Patient-Led NHS' was predicated on the belief that the commissioning function needed to be strengthened to provide 'a strong voice for their patients and the public' (Hewitt, 2005, p. 6) In practice, this objective was seen to imply, among other changes, larger PCTs capable of using more leverage in negotiations with the large acute trusts:

they need ... to have the weight and expertise to challenge acute hospitals, to reduce unnecessary admissions and long hospital stays ... They have to analyse and understand local health needs and, crucially, shift the emphasis from treatment to prevention and public health.

(ibid.)

As a result, the number of PCTs was halved and with it, perceived opportunities for the influence of local voice. The fact that PCTs had been only recently established under the banner of 'shifting the balance of power' (DH, 2001) did much to raise questions about the continuing relationship between more effective commissioning and local voices.

Commissioning for outcomes, not services

In our earlier discussion, we focused on the process of commissioning and particularly on identifying different elements of the commissioning cycle. This focus is important if service users are to have sufficient understanding of how commissioning is structured and is intended to work so that they can engage at relevant points and times. However, it is also important to recognise that these are essentially second-order issues concerned with the 'how' of commissioning rather than the 'what' and 'why'. In the first instance, a major plank of the case for making a purchaser/provider split was an economic one. It would enable the creation of quasi markets and the introduction of market forces into the provision of publicly funded services. Consumer choice, provider competition (or 'contestability' in the new Labour lexicon) and the power of the purchaser's purse to drive down costs would reduce public sector waste and improve efficiency.

Other purposes have also been increasingly recognised, including the potential for the commissioning process to drive better social outcomes for individuals and their communities. One of the more significant developments in social care and NHS commissioning has been the recognition that the focus of commissioning should shift from services to outcomes for end users. For example, the 2006 NHS commissioning framework was seen as being primarily about hospital services. It was followed up within a few months, however, by a 'Commissioning Framework for Health and Wellbeing' which explicitly sought to maximise such outcomes rather than simply improve the procurement of publicly funded services (DH, 2007b, para. 1.11). The framework proposed eight steps that would help to overcome barriers to commissioning and delivering improved health and wellbeing outcomes: putting people at the centre of commissioning; understanding the needs of populations and individuals; sharing and using information more effectively; assuring high-quality providers for all services; recognising the interdependence between work, health and wellbeing; developing incentives for commissioning for health and wellbeing; making it happen – accountability; and making it happen – capability and leadership (ibid., para. 1.13).

The document appeared under the joint signatures of the Secretary of State for Health and the Secretary of State for Communities and Local Government. In their joint foreword, they described it as being 'for everyone involved in commissioning local services – so they can work together to improve the health, well-being and independence of everyone living in their local area' (ibid., p. 4). They also recorded their belief that 'local commissioners have the opportunity to make a real difference by focusing on the outcomes that people want for themselves and for their communities' (ibid.). These outcomes had emerged from the process of consultation surrounding the preparation of the Green Paper *Independence, Choice and Wellbeing* (DH, 2005b) and the White Paper *Our Health, Our Care, Our Say* (DH, 2006b). Although originally developed in the context of adult social care, the latter document confirmed that they would be applied across the NHS as well (ibid.). As a result, the following seven outcomes were to have become the intended focus for commissioning across health and social care and within the context of Local Strategic Partnerships and their Sustainable Community Plans:

- Improved health;
- Improved quality of life;
- Making a positive contribution;
- Exercise of choice and control;
- Freedom from discrimination or harassment;
- Economic wellbeing;
- Personal dignity.

The former Commission for Social Inspection (CSCI) based its assessment of commissioning performance on a framework derived from these outcomes. In addition, CSCI argued that people's voices and expectations would be a significant driver of the way services were commissioned and provided in a context where current models did not meet the ambitions of the 'baby boomer' generation (Behan, 2006, p. 2). Its report *Real Choices, Real Voices* (CSCI, 2006b) similarly highlighted what people told CSCI mattered to them and the order in which they ranked them.

- 1 Choice;
- 2 Flexibility;
- 3 Information;
- 4 Being like other people and taking risks;
- 5 Respect and being heard;
- 6 Fairness and non-discrimination;
- 7 Cost and value;
- 8 Safety.

Those outcomes and ambitions formed the foundation for CSCI's definition of commissioning as 'the process of translating aspirations and need into timely and quality services for people which: meet their care needs; promote their independence; provide choice; are cost effective, and support the whole community' (CSCI, 2006a, para. 6.1). As its then Chief Inspector was to argue, such a definition meant that the commissioning process was 'about transforming and changing lives, it is not about commissioning commodities, or as [one] person said to me last week "It isn't the same as arranging for 1000 reams of photocopying paper" '(Behan, 2006, p. 4).

A comparable approach to defining the purpose of commissioning began to develop in the NHS. This similarity apparently reflected the common influence of the *Our Health, Our Care, Our Say* wellbeing outcomes and the joint Commissioning Framework for Health and Wellbeing. Thus, the major NHS initiative to develop 'World Class Commissioning' (WCC) confirmed the intention to move the emphasis in commissioning from 'spending on services to investing in health and well-being outcomes' (DH, 2007a, p. 1). At the same time, and responding to the need to strengthen commissioning capacities and capabilities of the new PCTs, it aimed to develop 'a consensus on the characteristics of world class commissioning' by specifying eleven organisational competencies and evaluating PCT performance in respect of each of them through an annual assessment process (ibid.). One of these competencies – 'commissioners act on behalf of the public and patients' – was defined as follows:

They are responsible for investing funds on behalf of their communities, and building local trust and legitimacy through the process of engagement with their local population. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, world class commissioners will engage with the public, and actively seek the views of patients, carers and the wider community. This new relationship with the public is long term, inclusive and enduring, and has been forged through a sustained effort and commitment on the part of commissioners. Decisions are made with a strong mandate from the local population and other partners.

By any standards, this competency is a demanding one and all the more so in a national, hierarchically managed organisation. Quite how the local NHS squares the circle between national targets, standards and bottom-up accountability, on the one hand, and local priorities and mandates, on the other, is not immediately clear, especially in an organisational culture that has traditionally looked upwards rather than outwards. We return at subsequent points to the challenge to effective public engagement posed by this tension between centralisation and localisation. For the moment, however, it

is important to register another important tension posed by such statements of intent: one between the reality of public service management and accountability systems, on the one hand, and the expectations generated by the rhetoric of public engagement, on the other. CSCI reports make observations about the limited extent to which this gap has been closed in social care as well (for example CSCI, 2006a).

As we have observed, the purpose of both social care and NHS commissioning has been redefined in terms of securing better outcomes rather than funding services. In addition, both sets of agencies are operating in a national policy framework which expresses those outcomes in terms of improvements in health and wellbeing. The various policy frameworks envisage that a strategic shift to prevention, early intervention and more independent living will produce such outcomes. At the same time, however, these outcomes depend on commissioning a wider range and mix of services, not all of them within the traditional remit of health and social care. Following the publication of *Our Health, Our Care, Our Say* in 2006, for example, a then Department of Health (DH) minister referred to local government as a whole bringing together ‘a well-being package of transport, housing, education, welfare to work, regeneration and all the other factors necessary to strong social care. Health is part of that package [also]’ (L. Byrne, 2005, p. 19.) Similarly, the 2007 *Putting People First* concordat on transforming adult social care argued that:

ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population. Binding [sic] together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.

(HM Government, 2007)

These two quotations are not only useful in illustrating the breadth of the commissioning agenda once it switches from procuring specific services for which a single agency has purchasing responsibility to commissioning for outcomes. They also help to distinguish between commissioning packages of ‘care’, which takes place at the level of individuals, and commissioning systems of ‘care’, at the level of populations. This distinction between micro and macro commissioning is one that has grown in significance, as we now describe.

Together with the objective of reorienting the purpose of commissioning from delivering services to improving outcomes was the even more radical view that individuals should commission for themselves. If commissioning was intended to be about using the power of the purse to ensure personal needs were met and opportunities for independent living maximised, the allocation of personal budgets for care and support could be seen as the most fundamental form of empowerment. At least this was the standpoint unequivocally adopted in the White Paper *Our Health, Our Care, Our Say* following the recommendation of an earlier report from the Prime Minister’s Strategy Unit (2005). As a result, the introduction of pilot individual budgets was seen as the first step through which people who used social care services and their families could shape and commission their own care and support services. However, NHS resources were excluded from individual budgets and the introduction of ‘choose and book’ together with practice-based commissioning (PBC) represented a different approach to devolved and more personalised commissioning.

Nonetheless, in his ‘Next Steps Review’, Lord Darzi (2008) declared himself impressed with the social care initiative and recommended that personal health budgets should be introduced, especially for people with long-term conditions, and a pilot programme is now under way. Most recently, following the enactment of a statutory ‘right to control’, a further pilot programme has been initiated by the Office of Disability Issues, under which personal budgets for a series of employment-related funding streams will be aligned with those for adult social care and, in one of the pilot areas, potentially with personal health budgets as well. The relative novelty of the concept inevitably means that the evidence base for personal budgets remains underdeveloped (Glendinning *et al.*, 2008; Carr and Robbins, 2009), and their

introduction is not without its critics (Beresford, 2007; Ferguson, 2007). Nonetheless, the development of personal commissioning seems likely to be a growing feature of commissioning for health and wellbeing. As a result, it seems clear that any discussion of the role and process of commissioning should now encompass both macro and micro levels.

Indeed, it would now be impossible to consider questions of public engagement in commissioning without identifying the substantially different and additional opportunities for direct involvement offered by personal budgets at the level of individuals alongside the more traditional forms of voice-based engagement in commissioning at the level of populations. The latter form of commissioning has also been subject to substantial development over the past decade, both generally and more particularly at the level of neighbourhoods. Much of the thinking about the commissioning cycle took it for granted that commissioning took place predominantly at the macro level. Although direct payments slowly expanded (Davey *et al.*, 2007a), numbers were low and the initiative was initially conceptualised more in terms of a rights-based approach to individual empowerment than as an aspect of commissioning per se.

The development of a small-area focus has, however, become a more explicit dimension of the commissioning agenda. In the NHS, this approach is exemplified by the encouragement of practice-based commissioning and the aggregation of practices into locality-based federations of practices. The underlying driver has not been located in a commitment to direct patient empowerment nor has it had a strong orientation to geography or place. Rather, it has been part of the strategy to shift influence over priority setting and resource allocation from acute to primary care. In this respect, PBC has been more about empowering different groups of professionals rather than the patient, though there has been an accompanying belief that primary care professionals will reflect the patient view more closely and holistically than hospital-based professionals.

In local government, on the other hand, the development of a small-area or neighbourhood focus has been associated with physical, economic and social regeneration. Neighbourhood renewal, the New Deal for Communities, participatory budgets and associated initiatives have all sought to target resources more effectively on the needs of small areas with high levels of deprivation. An additional aspect of these neighbourhood approaches has been their integration with initiatives to empower communities and renew democracy. Thus public engagement was to ensure that resources were better targeted on needs and priorities defined by local communities (Callaghan and Wistow, 2008). In addition, public engagement could itself contribute to local renewal strategies by helping to build individual self confidence and the social capital of local communities (Wistow and Callaghan, 2011). Such place-based initiatives have not always been described in the language of commissioning (HM Treasury and Communities and Local Government, 2010; New Local Government Network, 2010). Nonetheless, they have combined to create an intermediate level of commissioning between the individual and the local authority/PCT. As a result, it has become appropriate to think of commissioning taking place at three levels:

- the individual;
- the community or neighbourhood;
- the authority or strategic.

Identifying these three levels was an essential early step in developing a framework for the collection and analysis of our empirical data. An initial response to the research questions about the involvement of older people in commissioning is necessary to identify the components of the commissioning process, investigate the degree of engagement within each element and assess the impact on commissioning outcomes. However, it is clear from our analysis that somewhat different forms and purposes of commissioning exist at each of the three levels, perhaps with different opportunities to participate and different levels of impact by older people. Consequently, it was important to explore the

impact of older people along both dimensions: levels and components of commissioning (with the latter being helpfully organised by the IPC into the four principal categories of analyse, plan, do and review; CSIP, 2007a). By combining the two dimensions we produced a matrix which helped us to conceptualise how and where different opportunities for engagement might exist in our fieldwork sites and, thus, a framework which helped structure the collection and analysis of empirical data (see Chapter 3).

Summary and conclusion

This chapter has sought to provide an overview of one part of the context for the study we undertook of the nature and results of older people's engagement in commissioning. In particular, it has focused on the nature and purpose of commissioning, including the relationship between commissioning and public engagement. As our analysis demonstrates, the effective engagement of older people in commissioning is an essential route to enabling them to impact upon decisions about not only the shape of care and support where they live and local priorities for resource allocation, but also their opportunities as individuals to exercise choice and control over their own lives. Commissioning is not a merely a technical process of analysis, procurement and performance review. These activities are important to effective commissioning but are located within a set of more or less explicit values, principles and outcomes that shape who gets what, how, when and where. The shift from services to outcomes as the focus for commissioning helps to make this relationship more clear.

The apparent desire to include the public more fully in commissioning processes and also to commission more opportunities for choice underlines the importance of commissioning for the lives and opportunities of older citizens. The next chapter deals with the second part of our context: engagement by the public, including older people, and the extent of their influence on decision-making together with what is known about how to maximise that influence. This allows us to locate both the aspirations for engagement on commissioning as well as our empirical findings within a framework which is realistic and broadly based.

2 Involving older people in commissioning: recent evidence

(prepared by
Charlotte Darwin
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Introduction

The empirical work for this study was conducted in two localities. As with any qualitative study a key question is the extent to which our findings were specific to those locations or reflected wider trends. Consequently, we undertook a review of some literature on the involvement of older people in commissioning services at a strategic, community and individual level. Three limitations of this review should be noted.

- 1 First, older people may be involved in commissioning expressly as older people or more generally as citizens and service users, as they tend to have more time for involvement. Our interest here lies primarily in those efforts to involve older people per se, though we recognise the need to identify how those opportunities may be affected by the broader community empowerment and democratic renewal agendas.
- 2 Second, involvement in commissioning can refer to many different forms or levels of involvement, including formal committees or other bodies which make commissioning decisions: but they may equally be involved in more informal mechanisms which may or may not impact on commissioning decisions. Our review has, therefore, sought to acknowledge the potential contribution of such indirect routes to commissioning decisions.
- 3 Finally, because of the very extensive literature on user involvement at different levels of policy and practice and across different policy arenas, it would have proved impossible – and probably not very fruitful – to cover it comprehensively. It must be emphasised that no attempt was made to do so: given the interest in locating our own empirical work within current practice, a decision was made not to look at papers published before 2006. Although this meant that much material was immediately excluded, we were left with a surprising number of reports and papers.

What we offer, therefore, are insights into some of the problems, issues and tensions arising around the involvement of older people at all three levels of commissioning, as evidenced by recent research.

The involvement of older people at strategic and community level

Introduction

Numerous mechanisms have been established by public bodies and the voluntary sector to engage with older people at strategic and community levels. Many have been put in place at the behest of central

government, with the express purpose of discovering and addressing the unmet needs of older people, as well as tailoring policy to those needs. While older people are not a homogenous group, what they do have in common is that the services designed for their benefit will, with advancing years, become increasingly important to their continued wellbeing. However, their ability to influence the nature of these services may simultaneously decrease.

Means of engagement between older people and local authorities

One key review of formal means of engagement by older people sets out three models: the independent forum, the older citizens' panel and the supported group (Vegeris *et al.*, 2007). These are discussed with a few exemplars to aid understanding.

The *independent forum* is separate from any service and is run by and for older people. It is a popular and common means of giving older people a voice. Forums generally appoint a steering group to set the agenda and select the topics for discussion, question experts, and control the proceedings with the aid of a skilled facilitator. One example is the Senior Citizens' Forums in Shropshire, made up of six district forums with a membership of 8,000. The County Association of Forums is funded unconditionally by the council to maintain a website, give administrative support and publish newsletters. The forums are not simply discussion groups, but are formally consulted by the council on a range of matters, including some not exclusively focused on older people. Researchers have argued that they 'regularly provide input into Council department consultations' (Vegeris *et al.*, 2007).

The Older & Bolder Project in Haringey, London, provides another example. Established in 2003 as part of the New Deal for Communities, it provides opportunities for older people ('the forgotten minority'; Russell, 2008), to participate in neighbourhood life. The project includes a local forum held twice a month (Russell, 2008).

In Devon the County Council and PCT have provided some development monies to support the creation of a Senior Council. It is both a bottom-up approach to engagement, as it has its roots in 29 local groups, but also a county-wide strategic body, as each group elects two representatives to sit on the Devon Senior Council. The latter has been constituted as a company limited by guarantee with seven elected Directors. Whilst the county and PCT have committed a small amount of ongoing funding, this is linked to a set of 'deliverables' negotiated with the Senior Council (Halliday and Evans, 2008).

A second model, the *older citizens' panel*, does not have a physical entity since it is effectively a contacts database of older people who are 'potential volunteer participants' (Vegeris *et al.*, 2007) with different interests. An example is the I-Opener (Islington Older People Empowerment Network) database, which has 3,000 names and is maintained by the local PCT. Recruitment to the panel was originally through GP and Freedom Pass lists. Such panels can be engaged by councils in a variety of ways, including consultation on particular issues. The I-Opener database, for instance, has consulted panel members on social security benefits. It has been noted that, with no physical identity to provide a focus, such panels may be more useful to those who have access to it – council departments – than to the participant members (Vegeris *et al.*, 2007).

Finally, the *supported group* model is typically one in which engagement between older people and the local authority is overseen and organised by a third party from the voluntary sector, contracted for the purpose by the local authority. The Knowsley Old People's Voice (KPOV) has 300 members from 45 organisations, administered by staff from Age Concern. A steering committee liaises with statutory bodies and voluntary agencies. KOPV holds themed events for older people, for example on IT or housing, and, importantly, it also provides volunteers for council committees (Vegeris *et al.*, 2007).

Another such group, the Sutton User and Carer Involvement Group, run by the local Age Concern and part-funded by the local authority and the PCT, engages in a variety of activities that might influence decision making. For instance, it has evaluated hospital nutrition and hygiene and conducted surveys

on older people's experiences of receiving specific services. The User and Carer Group also represents older people's issues on local authority and other committees. Other activities include delivering training to professionals on older people's issues, and lobbying and campaigning. Their research activities have been seen as a valuable route to the 'seldom heard' (Age Concern Sutton Borough, 2008). All of these activities can, in principle, influence commissioning, through membership of council committees or less formal lobbying to change policy.

Many ad hoc systems for consulting older people also exist. For example, a Citizens Jury of older people held in Newcastle in 2002–3 focused on how to improve the lives of older people, with a particular focus on falls. It was described as 'DIY' because the participating older people identified the topic of enquiry, rather than a local authority or a drug company. The older people participating found it stimulating and some new ideas were raised, but it did not have much of an impact on service provision (Reed *et al.*, 2006).

Some examples from practice

Both formal and informal means of engaging older people in commissioning services or in activities leading to the commissioning of services are illustrated. Some are 'top down', i.e. initiated by statutory authorities, some are 'bottom up', i.e. initiated from within local communities, and yet others are a mixture, initiated or driven by the voluntary sector at community level, often in partnership with local authorities.

'Top down' initiatives

Hampshire County Council has an overall objective of ensuring that 'local communities and service users are at the centre of commissioning and actively involved in designing and delivering integrated health and social care services' (Turning Point, 2008). It recently developed a county-wide Wellbeing Strategy for older people following two 'listening event workshops', in which older people identified their priorities and issues. It now aims to work with older people, district councils, voluntary organisations and the NHS, 'providing opportunities to work together, highlighting older people's priorities and ensuring they influence planning' (Turning Point, 2008).

Bradford Metropolitan District Council set up a specific body as a means of consulting older people: the Bradford Older People's Focus Group (Moriarty *et al.*, 2006). Established in 1996, it has grown to 150 members and meets monthly, assisting with consultations and providing a resource for council services. For example, members serve on standing committees of the council, undertake consumer surveys and inspect care homes. It also offers a variety of training opportunities for older people, such as assertiveness training and meeting skills.

In the health sector, three Reference Groups in the Northwest provide networking and support for older people active in implementing the National Service Framework for Older People. Research on the Greater Manchester Reference Group reported lay members felt a considerable culture shift had taken place. More specifically, they had been able to influence commissioned services on occasion – for instance the serving of food in hospital – and Local Implementation Teams were an important mechanism for championing older people's involvement (Cornes *et al.*, 2008).

Some top-down initiatives are aimed at older people with specific needs. In Somerset, the PCT implemented an integrated community service for people with Chronic Obstructive Airway Disease (COPD) to reduce the number of avoidable emergency admissions to hospital. Through patient representatives from voluntary groups, and the Somerset Patient and Public Forum, the PCT ensured that COPD sufferers 'were fully engaged in the procurement procedure' (DH, 2008a), as well as its design and delivery. They learned about the tendering process for the provider of the new service, and COPD patients will be involved in ongoing evaluation of the service (DH, 2008a).

‘Bottom up’ initiatives

Two examples can be noted here. First, the North Tyneside Handyman scheme, set up by Age Concern in 1998, began at grass-roots level, when an individual realised how difficult it was for frail older people to manage some practical aspects of living at home (Reed *et al.*, 2006). The scheme provides older people with small repairs such as changing light bulbs, hanging curtains, installing bath rails and so forth, all free of charge. A committee directs the scheme, whose members include service users, volunteers, the coordinator of the handyman volunteers, and representatives from Age Concern, local churches and North Tyneside Council. The twelve volunteer ‘handypersons’, themselves mostly retired, were primarily recruited through Age Concern, selected in part for their friendliness, and proved able to reduce social isolation. The committee networked the service into other services. The scheme was felt to be a success because it had tangible outcomes, which encouraged people to become and remain involved with the scheme, and met older people’s needs in the way they wanted.

The mobilisation of the village of Belford, Northumberland, to save the local care home provides a second example of a grass-roots initiative. Belford, a village of 1,000 residents one-third of whom were elderly, had seen its services whittled away over several decades, including the railway station in the 1970s, the cattle market in the 1980s and the bank in 2000. They were seasoned campaigners, however, having succeeded in overturning the local authority’s decision to close their middle school. They united again against the proposed closure of their local residential home and day care centre, with respite care and other services, such as chiropody and Meals on Wheels, which enabled elderly villagers to remain in their own homes. The village raised funds to build a new Resource Centre to take the place of the old care home. Older people participated in both macro and micro decision making, and at all stages of the project’s protracted development. Some used their experience and contacts to penetrate officialdom, others organised fund-raising events and still others contributed ingredients from their gardens to chutney-making projects. An evaluation concluded that the new service model was developed ‘with, by, and for the community, with the involvement of older people throughout’ (Reed *et al.*, 2006).

Voluntary sector initiatives

The contribution of voluntary sector organisations to involving older service users in decisions about service delivery is illustrated in a report on community-led commissioning (Turning Point, 2008). Among the examples cited is an Older People’s Network in Cheshire, coordinated by Age Concern and built into the commissioning process through the Local Area Agreement (LAA). The network is judged to give ‘older people a greater influence over decision making and a greater role in public service delivery’ (*ibid.*).

Informal means of engagement

Such means may be particularly important in the case of hard-to-reach groups. One report (Robson *et al.*, 2008) describes how informal means of engagement proved a useful means of reaching people with dementia (among others). A group of people with dementia attending a specialised day care centre were asked what they wanted from the social services. They indicated that they wanted a measure of autonomy, to have a say, to feel valued and respected, and to be treated as a normal person. It was arranged for monthly meetings to be held at the centre, with a service user in the Chair, and the agenda set jointly with the members and the staff. Strongly supported by staff committed to giving them more control, this group was able to have an impact in various ways. They set up their own website for dementia sufferers. Two members also joined a demonstration in London against a NICE decision about treatment. It was said that the staff ensured that, if the local authority neglected their views, the centre would challenge their decisions.

The same report also studied a group of Greek, Asian and Afro-Caribbean pensioners at a day centre, who shared cultural experiences with each other (Robson *et al.*, 2008). Following parties to celebrate Eid, saints’ days and Diwali, sharing food and customs, as well as other activities of ‘everyday participation’, the group extended its focus to wider concerns. For example, they complained to the

council about transport services and to social services about home care standards. These activities enabled both groups to participate to a much greater extent in activities concerned with services commissioned on their behalf. The researchers concluded that 'seldom-heard users of social care can become engaged if practitioners and managers adopt an inclusive approach to participation'.

Barriers to involvement and methods of overcoming them

Motivations to participate

There is broad agreement among older people that getting involved yields personal benefits: camaraderie, mutual respect, confidence building and personal development, new skills and a sense of purpose. Research suggests older people may seek involvement for reasons particular to their circumstances, such as a need to go on working and be useful following retirement or to 'fill the gap' following a bereavement (Vegeris *et al.*, 2007). However, at a less personal level, great satisfaction can also be gained by achieving visible outcomes through joint effort. Some want to promote a service from which they have benefited (or from which they have *not* benefited), with a general desire to improve the lives of those in the local community through changes in policy, practice or attitudes. For example, members of Growing Older in Darlington sought to change the negative and stereotypical view of older people held by agency staff and the wider population, which itself 'limited the contribution older people made to their community' (Reed *et al.*, 2006).

Barriers to involvement

Nonetheless, the participation of older people seems particularly problematic. Many researchers have commented on the obstacles to effective participation by older people (see, for instance, Barnes *et al.*, 2006; Branfield *et al.*, 2006; Maguire and Truscott, 2006; Moriarty *et al.*, 2006; Reed *et al.*, 2006; Skidmore *et al.*, 2006; Steel *et al.*, 2006; Clough *et al.*, 2007; Doel *et al.*, 2007; Vegeris *et al.*, 2007; Cornes *et al.*, 2008; Elbourne, 2008; Robson *et al.*, 2008; Russell, 2008). Instead of reporting on these reports individually, we incorporate their findings into a general discussion here.

A number of factors affect people's ability or willingness to attend meetings and constrain their ability to be effective once they are there. There are simple practical problems of attending a meeting, including transport, particularly in rural areas. Where older people have ill health or disabilities, these add to the problems of getting out of their house – especially where there are problems of mobility or sensory impairments. The timing of meetings can be an issue, as many older people do not want to go out at night, and unsuitable facilities at the site can raise major hindrances. Problems have been noted in refunding participants' expenses either quickly enough or at all.

There may be additional problems in joining a discussion, including the personal inhibition that anyone might experience in a new setting, especially where others seem much more familiar with issues. In some cases, where English is not the first language, language itself can be a barrier, as is also the case if jargon or even very formal terminology is used. Dominant personalities can be inhibiting. There can also be structural problems arising from how meetings are run if procedures are very formal. In addition, older people may have particular problems associated with their age, such as with their hearing or vision or mobility, affecting their ability to take part effectively. They may also have declining stamina.

A recurring theme in the literature is powerlessness and a sense of tokenism. Service users complain that they are not valued by the professionals and that they are patronised. Some feel that user involvement is no more than 'a cosmetic exercise' (Branfield *et al.*, 2006) or that their experiences are regarded as merely anecdotal. It is argued that the culture of organisations is not truly committed to the involvement of service users ('you know they're going to tick a box saying "have you consulted with service users?" when they've only talked to me') (Social Care Institute for Excellence [SCIE], 2006). Some feel that there is an inherent prejudice among many people, including the professionals involved in consultation exercises, against taking older people seriously, i.e. ageism. Many people may be

reluctant to take part – or to continue to do so – because of a scepticism about the likely effect of their involvement. Older people may be particularly doubtful of their ability to influence decisions; many tend to remain uninvolved in any local decision making, or even in networking with each other, despite the increasing efforts to reach them.

A number of researchers have commented on the tendency for there to be a small group of active individuals who become ‘insiders’ in participation exercises. Barnes and colleagues (2006) refer to the ‘forces of inclusion and exclusion’ at work beneath the rhetoric of community empowerment. In practice, they observed ‘a sharp divide between a small group of insiders involved in a disproportionate number of governance activities’ and a much larger group of outsiders, active in the community but unable to ‘translate their social capital into political leverage’. This is also noted by Russell (2008) in a discussion of the Older and Bolder project, with a concern that the views being put forward were those of ‘an unrepresentative few’. This is seen as a worrying issue for the decisions made and for the inherent messages given to those newly joining any consultation exercise.

Funding of user groups is also a common issue. Forums are independent and select their own agenda, but their sustainability is fragile without funding for basic expenses, such as room hire and refreshments. Funding is often seen as a major dilemma in user-controlled groups, with some concern that those supported by council funding may end up as reactive – rather than proactive – in what they take on. Indeed, some argue that ‘you have to adjust your ideas to meet funders’ criteria’ (Branfield *et al.*, 2006). Moreover, looking for funding wastes time and demotivates those involved, particularly if user-controlled groups are in the position of David against the Goliath of large established charities.

Barriers to effective involvement may equally be a concern for those keen to listen to their views. Primary Care Trusts experience many difficulties in their efforts to involve patients and public. Only 20 per cent of respondents of one survey thought Patients’ Forums were ‘highly influential’ in commissioning decisions. Even fewer thought their successors, the Local Involvement Networks (LINKs) would be able to affect commissioning decisions (Chisholm, 2007). Issues of recruitment and changing group membership can also inhibit continuity. Steel and colleagues (2006) report that the recruitment of active citizens was much more difficult for committees and meetings and governance than for time-limited specific tasks at the local level. One writer entitles a paper ‘how do we find the right patients to consult?’ (cited in Steel *et al.*, 2006).

A light-hearted effort to summarise some of the above constraints is provided by the Exeter Senior Voice’s guide to ‘How to Make Sure Marginalized People Stay Marginalized’ (quoted in Moriarty *et al.*, 2006). It sums up ‘the practices that prevent participation from become meaningful’ and includes the following advice:

- *Remember the ‘easy to reach’ are easier to reach. Exclude people who cannot complete your questionnaire. Only invite the usual suspects – they understand how meetings work.*
- *Make it clear who’s in charge here – they must appreciate they’re only here on sufferance.*
- *Never divulge how you’re going to use the information they give you.*
- *Make sure every letter comes from a different person, and don’t give out a contact number.*
- *Management terms, jargon and abbreviations should be used throughout.*
- *Choose a venue with only two lavatories, and they’re on another floor.*
- *Make people pay for the privilege of being consulted – do not reimburse expenses, or if you must, make them ask about it.*
- *Keep it simple – you only have to say you’ve tried. Limit your consultation to one public meeting, in the evening.*

No assumption should be made, however, that such barriers are the only cause for non-participation. Involvement with the wider community or with policy-making bodies does not suit all people. Some simply prefer to do other things with their time. Even if they do want to feel they are doing something for

their community, it may be via other routes, such as baking to assist fund-raising, rather than sitting on a committee.

Overcoming barriers

The SCIE has suggested that organisations take a ‘whole systems’ approach, examining their culture, structure, practice and review process (Moriarty *et al.*, 2006). The solutions to some barriers are self-evident, such as a careful choice of venue and the timing of meetings (not too late in the evening, but not coinciding with rush hour), immediate reimbursement of expenses, providing door-to-door transport and ensuring a named facilitator is available at an event. It has been noted that meeting and greeting participants demonstrates that their presence is valued. Providing materials in large print or Braille can be helpful, as can providing a hearing loop. Support and capacity building focused on enabling older people to understand agenda papers and prepare in advance for meetings can also help to make older people’s contributions more effective.

Help the Aged’s organisation SUFOA (Speaking up for our Age) advocates these and additional policies to support and encourage service users’ ongoing participation. Examples include ensuring that there is clear information about how to get to meetings, clearly written and informative newsletters, friendly staff, efficient updating of any database and the use of plain English in the proceedings. It has also been argued that organisations successful in engaging with service users ask themselves what they would want and expect if their roles were reversed, listen to the answers, change the service accordingly and feed back to the participants what the changes are and why they have occurred (see Moriarty *et al.*, 2006).

Some constraints on effective involvement, such as increasing ill health or decreasing mobility, require local authorities and others to find different ways to listen to older people’s concerns. Efforts can be made to consult ‘hard-to-reach’ people at home, or within the local community, churches and other religious bodies, or GPs’ surgeries. One report concludes that ‘the means of engagement delineates who is included and excluded’ and urges a mix of approaches to reach the greatest diversity of the older population (Vegeris *et al.*, 2007). The authors also suggest that less formal means of engagement than the meeting or committee format should be adopted.

One research team (Lowndes *et al.*, 2006) devised a framework called CLEAR for assessing the effectiveness of participation schemes. The initials stand for the argument that people take part when they can, when they like to do so, when they are enabled to do so by the infrastructure, when they are directly asked to do so and when they experience the system as responsive.

Some reflections on the participation of older people

While older people generally agree that they value their engagement in discussion groups, panels, local authority committees and other bodies, what is less clear is the extent to which their involvement has a real impact on the commissioning of services. In other words, there may be many intrinsic benefits but few extrinsic ones. Although we have set out some examples where it appears there was some effect from the involvement of older people, a number of reports conclude that little control is actually relinquished to the public, and there remains a gap between the rhetoric and the reality (Vegeris *et al.*, 2007). One research team suggest that while the user participation movement has ‘achieved much in terms of principle, it is less clear what changes have resulted in practice’ (Doel *et al.*, 2007).

Indeed, a recent report on older people’s engagement with government notes an impressive level of commitment among older people, but suggests that often local authorities do not view listening to them as a priority (Elbourne, 2008). It further argues that, while older people are sometimes influential and there is much good practice to build on, their voice could be greatly strengthened by more regular, structured contact with government. There is also a need for leadership and means of capturing the views expressed. It recommends that existing systems, such as older people’s forums and advisory

groups (OPAGs) should be built upon, rather than replaced, with greater support and funding. In addition, it recommends the establishment of a UK Advisory Forum for Older People, supported by regional forums, to be chaired by the lead government minister for older people.

An interesting question is the extent to which changes in services are proposed as a result of the involvement of older people, i.e. the extent to which the decisions made by them are the same as those made on their behalf. One research team compared the views of older people with mental health problems (and their carers) with those of GPs and mental health staff on service development priorities (Tucker *et al.*, 2007). Older people and their carers were more supportive of specialist services for younger people with dementia as well as increasing the provision of anti-dementia drugs than the other groups. There was, however, considerable variation in views among the older people and their carers, as well as among members of the other groups.

Finally, it is seen as important to build in systems for evaluation, preferably at an early stage. One research team contacted 1,599 social care organisations in England, Wales and Northern Ireland, but only 30 responded (Doel *et al.*, 2007). The researchers suggest that this response rate could be due to 'a gap between participation of service users and carers (considerable activity) and systematic evaluation of what difference this is making (relatively little)'. The authors suggest that evaluation processes tend to be introduced too late, lack clarity regarding what should be evaluated and how, and experience difficulties of objectivity; indeed, they propose there may be a fear of what evaluation may discover.

The involvement of older people at the individual level

Introduction

A person commissioning his or her own service is in a different position from one contributing to discussions about commissioning services more widely. The decisions taken must be highly concrete and relate to the individual's own particular circumstances. Older people, along with other people needing adult social care services, can be involved in commissioning their own services via two routes: direct payments and individual budgets (IBs).

Direct payments

Numbers and expenditure

Direct payments can be used solely for social services purposes. Local authorities have been formally required to offer direct payments to older people since 2003, alongside other groups (people with a physical disability or sensory impairment, people with learning disabilities and people with mental health problems) for whom they were required earlier.

The principal evaluation of direct payments was undertaken by three research teams covering five universities and two other bodies and published as two reports (Davey *et al.*, 2007a,b). This confirmed that take-up by older people has been notably low. The then most current data (2004–5) showed that only 0.7 per cent of older people (7,180 people) receiving community care services were in fact receiving such payments. This is in contrast to 6.2 per cent of people with a physical disability and 4.7 per cent of people with a sensory impairment. A few older people (161) also received a one-off direct payment.

The nature of the organisations providing support to people with direct payments was also explored. These were primarily small voluntary (or not-for-profit) organisations, set up for other purposes. Although most worked with all groups of people receiving direct payments, a substantial minority did not cover all groups. They provided information, training, accountancy and advocacy services to assist people in working with their personal assistants; some provided peer support, but rarely for older people.

Barriers to participation and ways of overcoming them

A review of some literature on direct payments for older people (Poole, 2006) explored barriers to take-up: the lack of clear information for older people; poor awareness of direct payments among social services staff; their reluctance to promote this option; a lack of administrative support for older people; concerns about criminal records checks and reliable references for personal assistants. However, take-up appeared to be substantially better where support services were available to assist people in managing a direct payment. This finding is consistent with older people's tendency to access social services in a time of crisis, when they are least able to cope with managing a direct payment. They may also have had little experience of employing other people in their working lives. Nonetheless, as the same review notes, older people using direct payments have found the experience positive and feel happier and more motivated, experienced an improved quality of life and reported positive impacts on their health and sense of social inclusion.

An evaluation of direct payment arrangements by the National Centre for Independent Living provided a wealth of examples of good practice (NCIL, 2006). One issue was identifying people who might be good candidates for this arrangement: the Hampshire 'Empowering older people with direct payments' project, run by Age Concern in cooperation with the Hampshire Centre for Independent Living, arranged for hospital care managers to look out for older people who would be likely to need community care services on discharge. Of 17 people in a three-month period, ten had direct payments (including a personal assistant) waiting for them on discharge. The Plymouth Direct Payment Support Service did outreach to day centres, older people's groups and residential homes, as well as a radio campaign, to publicise direct payments.

Providing support to people with direct payments is also essential. Some areas provided help with paperwork, such as Disablement Association Hillingdon (DASH), using volunteers to assist with this aspect of direct payment management. Some areas had registers of personal assistants, such as the Richmond Users Independent Living Scheme PA finder. Another source of support can come from Circles of Support, which can help to assist people with direct payments: the Norfolk Coalition of Disabled People developed Independent Living Trusts to support people with Alzheimer's disease to live independently using direct payments.

User involvement in management arrangements was felt to be crucial for publicising direct payments and supporting individuals. User networks helped to empower individuals to share their skills and ideas, extending the range of services for which direct payments might be used. They also provided a forum for consultation with users, enabling them to have an input into local policies and practices. It might be added that a lot of the barriers to the development of direct payments arise not around the problems of older people themselves but within the local authority, the support organisations and the voluntary sector: knowledge, culture and leadership were identified as important issues.

Individual budgets

At the time of this study, there has been relatively little research on IBs apart from the major evaluation of the 13 pilot projects (Glendinning *et al.*, 2008). A small number of other papers are drawn on here, including an overview of IBs for older people, based on discussions in 8 of the 13 pilot sites, which explores issues and cites numerous examples of good practice (CSIP, 2007b).

The evaluation of the pilots raised serious questions about the benefits of IBs for older people, compared with other groups. Satisfaction was found to be lowest among older people. There was less scope for an older person's IB to result in improvements in his or her wellbeing, as support plans tended to reflect high levels of need for personal care, compared to occupational or social participation activities. Older people also tended to receive smaller average levels of IBs, compared to younger adults, giving smaller scope for flexibility and innovation. Indeed, overall there was no difference in social care outcomes for older people, compared with those receiving standard care, but the latter remained slightly more cost effective and people receiving such care tended to feel happier.

The research also found lower levels of psychological wellbeing among older IB holders, compared with other groups. This appeared to arise because of concerns over managing their budget. The team suggested that there appeared to be three different responses to the availability of an IB on the part of older people who accepted one. Some had little interest in change, as they were happy with existing services, but ‘accepted’ an IB as recommended by their social worker despite little motivation concerning taking control over their services. In these cases, either nothing changed, as the social worker administered the budget, or the sole change was a shift in the responsibility of undertaking paperwork to the older person (or his or her carer). As one older person said:

Carers are all laid on for me at the moment and I haven't got the time and I haven't got the brain, really, to work out financial details or anything like that, and I'm quite happy with the arrangement I've got.

The second group, who did want changes in their care arrangements and therefore accepted an IB for this reason, nonetheless experienced the administrative element of an IB as stressful. They were concerned that they might overspend, fill in a form incorrectly, find problems in securing help or have their budget cut. As with direct payments, the direct employment of a carer was seen to require much more responsibility than using an agency, and there were also fears about what could happen if the relationship broke down. Although they could use an agency to manage the paperwork, some saw this as money wasted. However, this group did welcome the changes brought on by an IB and some seemed to find the paperwork less daunting over time.

A third group, in contrast to the above, were able to handle the financial and other management activities without stress, but these were relatively rare for older people. These tended to be people who had some relevant work experience or very competent adult children (‘my son is an accountant’). The heavier numerical weight of the former two groups led, it was argued, to a lower level of psychological wellbeing among older people with IBs.

It was also noted, however, that many older people were referred to services at a time of crisis, and therefore when they felt unwell, vulnerable and not able to make decisions easily. This group was quite large and led to a lower take-up of IBs among older people. Indeed, the research found that a ‘potentially substantial proportion’ of older people may view taking responsibility for their own support to be a burden (Glendinning *et al.*, 2008).

The services sought by older people

Discussions on this subject tend to stress that even small changes in arrangements could make a substantial difference. Many examples in the CSIP report centred on issues of getting out of the house, eating arrangements and keeping the house clean. One man (himself a carer to his wife) employed a personal assistant with his IB to do small DIY tasks and to take him out for a walk twice a week, giving him some male company as well as exercise. Another purchased a freezer, so his daughter could cook less frequently but in quantity, allowing her to spend the saved time going out with him. Yet another, who had refused meals on wheels, used his IB to pay someone to bring a meal in from his local pub. One woman paid a neighbour to provide her and a local man with a meal, enabling her to get out of the house and have some company. More imaginative ways of making shopping easier were also noted, including the purchase of a computer so that shopping could be done on line, and shared taxis to shopping areas. It was noted that IBs often benefited people who had refused or disliked previously offered conventional services.

Further examples of the kinds of services sought by older people are provided in a paper on experience in one pilot site, West Sussex (Goldingham, 2006). One married couple in their eighties, both with growing health problems, were able to draw up a much more flexible and comprehensive support

plan for their care. This involved the employment of personal assistants and a respite break together at a seaside hotel, instead of residential respite for the wife. In addition, they purchased the support of a local day centre, as well as some telecare equipment to help with the management of their medication, and a falls monitor. Their daughter, who was very involved in helping them to design their support plan, noted:

Having an individual budget has given us the opportunity to be really involved in planning and as a result, we have been able to come up with a much more creative package than otherwise might have been possible.

No single model of support was consistently preferred by older people and many, in any case, liked to 'mix and match' conventional and new service arrangements. The CSIP paper noted that an IB did enable older people to have more control over their circumstances, for instance negotiating with an agency as if they were self-funding, which was appreciated. This also meant they were often able to negotiate more flexible arrangements and be firmer as 'customers' than their local authority. It was said they were sometimes getting better value for money, for instance insisting on the full 30 minutes commissioned of an outsider's time. Some authorities were changing their arrangements with providers to facilitate this flexibility. In West Sussex, the authority paid providers who then negotiated the care directly with the service user and was exploring the possibility of transferring funding as an Individual Service Fund. In Bath and North East Somerset, older people could take their budget directly to a provider and roll over up to 10 per cent of the budget each month.

It was noted that there was better take-up of direct payments by older people in IB sites. They welcomed the opportunity to pay family, friends and neighbours for small services, gaining the kind of help they needed and not feeling they were displacing services for others as they would be if going through an agency. It also meant they could recompense people for their time and not feel beholden to them.

In some cases, service users had pooled their budgets to gain even greater flexibility and better value, sometimes limited to other elderly couples but sometimes extended to a wider group. In Barking and Dagenham, service users of a mix of ages in independent living flats pooled their IBs to buy in a service of a sizeable scale. In other cases, additional partners were brought in to discussions, such as Partnerships for Older People's Projects (POPPs) money in West Sussex, and Care and Repair and other agencies in Bath and North East Somerset. There was interest in working more closely with the NHS as well as transport to widen possible service improvements.

Browning (2007) stresses that commissioning is an increasingly important, but difficult, part of SDS. Increasingly, service suppliers will no longer be able to rely on contracts negotiated in bulk by authorities, but will need to please the individuals receiving care, as they are the effective commissioners. This may have a very destabilising effect on the market for service provision. It also means that there is a need to ensure that there is a range of high-quality options available at a reasonable price.

Conclusion

This overview of recent evidence about involving older people in commissioning has presented what can most generously be described as 'a mixed picture'. There are some examples showing practice to be well developed and resulting in identifiable change. More frequently, however, the literature notes a disconnection between involvement activities and impact on local commissioning decisions. Even where there is evidence of barriers to the establishment of involvement processes being removed, the subsequent results remain limited for the most part. It was against this background of recent evidence about the conduct and outcome of involvement by older people that we conducted our own fieldwork in two contrasting localities with reputations for successful involvement. The thinking behind their selection and our findings are summarised in the next chapter.

3 Involving older people in Dorset and Salford

The fieldwork commenced in the second half of 2007 and was completed in 2009. In all, it involved twelve focus group meetings (five in Dorset and seven in Salford), primarily covering older people, commissioners and providers. In both localities we met with older people and their representative organisations. In Dorset our group comprised representatives from local older people's forums as well as people involved in their POPPs steering group. In Salford we met separately with a small group of service users at a day centre as well a group of people from the Older People's Forum, representatives from some of the neighbourhood forums and people involved in the LinkAge Plus work. In addition we were able to meet with a group of 'enablers', staff from the voluntary and statutory sector whose role was to promote and support involvement by older people.

We also met commissioners in each of the sites. In Salford, this group included health as well as social care commissioners, and participants at both sites included individuals with responsibility for care management staff as well as those with a strategic commissioning brief. The Salford group also included representatives from the neighbourhood management section who commission more generic health and wellbeing services. We also organised focus groups of providers, which involved the voluntary, private and public sectors. In Salford, leisure services were represented in this group, reflecting the role of 'healthy living' services in the strategy for older people.

Our fieldwork took place in two stages. Initially we facilitated focus groups separately with older people, commissioners and providers and then produced an interim fieldwork report which summarised our findings from each site and the emerging themes from across both sites. We shared this interim report with our lead contacts in the sites as a basic check on its accuracy before undertaking the second phase of our local fieldwork. This stage involved return visits to test our interpretation of the material they had shared with us and to develop further our emerging conclusions. In order to support this process, we prepared a summary report on each site and a PowerPoint presentation based on it. Our strategy at this second stage of data collection was to facilitate mixed focus groups consisting of older people, commissioners and providers. However, we also held pre-meetings with older people some weeks before to provide them with an added opportunity to discuss and challenge our findings prior to meeting them in the company of commissioners and providers. In this way, we sought to ensure that older people had the opportunity to understand and challenge our emerging conclusions free from any possible influence from the commissioners and providers they were seeking to influence.

We present the findings from our work with the individual fieldwork sites below. These findings are grouped under two headings: first, the structures and processes for involvement (i.e. what arrangements were in place to engage older people in commissioning?); second, the focus and impact of engagement (i.e. what parts of commissioning have older people been involved in and what difference have they been able to make?).

Salford

What arrangements are in place to involve older people in commissioning in Salford?

Older people in Salford are engaged in extensive and long-established networks of formal arrangements which shape or influence commissioning decisions. These engagement processes have two distinct sets of origins, although there is a recognition that they now need to be brought together more fully:

- involvement as older people centred on developing a city-wide strategy for an ageing population, 'Growing Older in Salford';
- involvement as residents of their local (geographical) community and as members of a community of interest within those localities as part of the devolved structure for neighbourhood working across the city.

These patterns of involvement are not new, though the structures and processes continue to evolve.

'Growing Older in Salford' sought to place the voices and needs of older people at the centre of strategic commissioning. The final document (<http://www.salford.gov.uk/d/wellbeing-strategy-olderpeople.pdf>) was based on a number of building blocks, of which the first listed was involvement ('with us, not for us'). The strategy stressed it 'had been written in partnership with older people and reflected their priorities and their desire to be recognised as key contributors to Salford's communities'. Its seven priorities included 'increasing the involvement of older people' and their influence on decisions about policy and service provision. The Salford Forum for Older People was a partner in producing the strategy and has a key role in supporting its implementation. The forum is a city-wide body, established ten years ago, with a membership made up of organisations for older people.

In addition, older people had seats on the Older People's Partnership Board established by the council and PCT to plan and commission services for older people and to ensure their access to generic services. The preparation of the local wellbeing strategy coincided with the publication in March 2005 of the central government's 'Opportunity Age' report. Both documents endorsed a similar broad-based approach to the promotion of wellbeing through more joined-up working across services. Salford was subsequently selected as one of eight LinkAge Plus pilots. It is overseen by a city-wide Wellbeing Strategy/LinkAge Plus Development Board on which older people are represented and whose functions include:

- to bring together Salford people, service commissioners and providers to progress a common agenda;
- to support the development of scrutiny processes by and on behalf of people growing older in the city;
- to foster creative and effective use of resources by working in partnership.

Part of the project's funding was earmarked to develop the capacity of the Forum for Older People to provide a city-wide voice of older citizens.

The second strand of engagement, devolved neighbourhood management, has been in place for 14 years. More recently, it has been considerably strengthened as partners have recognised the benefits of neighbourhood working to the extent of deploying their staff within the same boundaries and teams. The city's current neighbourhood management structure is based on eight areas, each with its own political executive of local councillors, a team of officers headed by a neighbourhood manager, and

a 'community committee' made up of representatives from community and voluntary organisations in the area and ward councillors. The neighbourhood teams comprise a wide range of partners including the police, fire and public health services. Their role is to engage with local people both to prepare Community Action Plans and also to coordinate and improve local services to deliver those plans. The community committee's role is to produce the Action Plans, decide on the use of devolved budgets and scrutinise local services. Each committee also has budget and task groups which, respectively, recommend how the budgets should be spent and progress issues identified in the community action plans. Older people are significant participants in the work of these groups. People we met stressed to us the importance of the Chair of the neighbourhood committee being independent, and in some instances this was an older person.

At the same time, an increasing number of the community committees include an older persons' task group within their structures. On occasions the neighbourhood teams work with older people's groups which exist at an even more local level. Although these arrangements offered opportunities for older people's engagement, harder-to-reach groups (including those living in residential care) might not be able to make use of such opportunities. These concerns had provided the impetus for the development of a mentoring scheme providing training and support to volunteers and paid staffs that disseminate information to older people not engaged in the forums and committees. They were seen as a mechanism for engaging 'that audience who have not been consciously left out in the past but who feel they've been forgotten about because they're not the more able older person'.

These structures for involvement are supported by investment in a number of posts with a remit to promote engagement and provide practical assistance to older people engaged in the process. This includes recruiting new members to the networks and developing different methods of engagement and participation in recognition that:

not everyone would want to attend regular meetings of the partnership board or feel that they have the skills and would, indeed, find it quite intimidating to walk into a boardroom or a chamber, you know, within the civic centre.

In addition, these 'enablers' provide confidence-building support for those engaged in formal meetings.

What difference have older people been able to make in Salford?

Our discussions with the focus groups in Salford identified a considerable list of ways that older people had been able to influence commissioning priorities and particularly the quality of service planning and delivery.

Exerting influence at a strategic level

The major focus has been the work on the 'Growing Older in Salford' strategy. The document adopted a broad perspective and contained a strategy for community wellbeing based on seven priorities identified by older people: feeling safe and secure; combating ageism and enabling people to be involved in the life of the community; transport; being healthy and active; access to information; health, social care and housing; and having an adequate income. An action plan was drafted and the Forum for Older People was formally engaged in the implementation and monitoring process. The document is refreshed regularly and older people are key to the review process.

The LinkAge Plus pilot was also an important vehicle for delivering aspects of the strategy, particularly capacity-building work with the Salford Older People's Forum and the development of culture and leisure activities to improve older people's health and wellbeing.

Another role for the Forum for Older People has been to act as researchers on behalf of the PCT, which commissioned them to conduct a survey of awareness about 'Choose and Book'.

Scrutinising the quality of services

A more recent major involvement initiative was the scrutiny of domiciliary services conducted by older people with the support of LinkAge Plus. A scrutiny team of older citizens was appointed through the Forum of Older People to look at home care services commissioned by the council from the independent sector and also at the rapid response service provided directly by the council. Older people were described as having the lead role in identifying the topic, the issues to be addressed and the process by which the scrutiny was conducted. Older people were described as shifting the focus of the work to include direct contact with front line domiciliary care workers and care managers. For example, 'it was an older citizen who suggested that we try and facilitate the opportunity for scrutiny panel members to actually speak to home care workers and that ... shifted us perhaps ... from a direction that we were originally taking'.

The scrutiny report contained a number of recommendations about access to and the quality of care. It was particularly concerned about the impact of low pay and low status on the quality of care and recommended a meeting with local MPs to raise this issue. Locally it suggested that a statement of shared values should be agreed between older people and care providers, based on the strategy for wellbeing and used as a local care standard. Other recommendations included the possible appointment of a 'Home Care Champion', an annual conference between older people and independent sector providers and an extended role for older people in supporting service users to express their views about the quality of services they receive. It also recommended the promotion and funding of services which were not accessed solely through care management (such as befriending and carer support services) to provide service users with greater choice:

efforts should be made to promote services which complement home care. Existing services and helpful initiatives, including those from churches and voluntary organizations which might assist people growing older should be identified within each local community in Salford. There could be a role for community committees in supporting local developments and identifying a means to coordinate information at a local level.

The report and its recommendations were presented to lead officers and local MPs.

Redesigning services

We also heard about a pre-existing group of older people and their carers, called Reach Beyond, which had worked with commissioners and providers of older people's mental health services to redesign hospital and community services. As part of this process, information about current levels of investment was shared with the group so that it could take an active and informed part in discussions about the costs of different service models. The group also took an active role in implementation including participating in interviews and staff training. Significantly, one element of the approach adopted by the mental health services was to assist in extending the group's membership and further develop its capacity.

Problem solving together

A different focus for involvement was provided when older people raised the reduction in numbers of local pension service staff and the provision of face-to-face advice through the LinkAge Plus network. It was recognised that the national context meant that this decision would not be reversed and that an alternative approach to calling for the reinstatement of the service was necessary. This, in turn, prompted local agencies to consider how existing staff and resources could be used to fill the gap, a process which is still ongoing. However, it was seen as an example of lateral thinking and collaboration in problem solving.

Working at a neighbourhood level

The problem of social isolation had been identified in one local community action plan, especially among residents of sheltered housing schemes. A neighbourhood worker followed up the issue by setting up a public meeting at which a number of residents expressed an interest in supporting others who were not involved in community activities. The Irlam and Caddieshead Social Inclusion (ICSI) group was formed as a result of the meeting and now provides a visiting service and regular social activities such as coffee mornings and tea dances. The latter incorporate information-giving sessions, for example falls prevention, fire safety, bowel screening or direct payments. These events are seen as important ways of engaging 'the person on the ground, the person who doesn't want to go to older persons' forums or other meetings'.

A group in Little Hulton had performed a similar function and had also been successful in securing the siting of benches on the routes to post offices. This example was one of several in which action through the community committees had addressed older people's priorities for improving the general quality of life. Others included traffic light resiting, speeding controls and the disposal of industrial waste.

Dorset

What arrangements are in place to involve older people in commissioning in Dorset?

At the time of our fieldwork, Dorset was in the process of completing the creation of a comprehensive network of 18 forums for the over-50s across the county. Representatives from the local forums are brought together regularly through the Association of Dorset Forums, which enables information sharing and promotes joint working. A series of themed conferences have been organised by forum members on housing, transport and day care. While there is coordination across the forums, they are seen as having a key role in identifying local priorities and ways of responding to them. 'The whole idea of the forums is that they are autonomous and they actually develop according to local need'.

The network is also being constructed to have linkages with, including representation on, both district and county-level Local Strategic Partnership (LSP) mechanisms. The development of forums had been substantially facilitated by local authority investment in capacity building. The initial stages of the network formed the basis for a successful POPPS bid, which has provided funding not merely for low-level support but also for capacity building to enable older people to take a leadership role in managing the programme and developing new services. In addition, Dorset sends representatives to the South West Seniors' Forum, and further external and national linkage was provided by a local group which spanned the boundary into Devon and was affiliated to both the Devon Pensioners' Action Group and the National Pensioners' Forum.

The Dorset Strategic Partnership also has a theme group focusing primarily on issues affecting older people in communities in Dorset, which is called the Dorset Age Partnership. It has close links with the Older People's Forums and meets in the six District/Borough Councils on a quarterly basis. It has identified its priorities as to:

- engage older people in the commissioning of services;
- promote partnership working;
- review progress of services in relation to national and local priorities;
- promote health, wellbeing and active ageing of older people in Dorset.

The Dorset Age Partnership is also taking the lead in the development of the county's wellbeing strategy for older people. It has agreed a set of questions they want to ask of older people:

- What stops you ageing well?
- What *could* stop you from ageing well?
- What makes growing old hard?

It is then asking:

- What can you do about it?
- What can your community or neighbourhood do about it?
- What can organisations in Dorset do about it?

So as one older person told us 'it's virtually looking at it from an individual point of view, from a locality point of view and from a county-wide point of view.'

Older people also told us of their involvement in the Practicalities and Possibilities Programme, one of a number being run around the country. The focus locally is on improving practice through the development of person-centred planning, developing practice on safeguarding adults, and research into practice for adults in Dorset.

In discussing the engagement arrangements with older people, we encountered a variety of views, ranging from 'there is a huge overlap between all the sorts of things that are going on, duplication of effort but a lack of communication' to another emphasising the importance of getting:

the right structure in place ... I mean forums aren't everything and they don't claim to represent every older person in Dorset, for goodness sake, but by having those independent forums geographically spread across that are linked into the South West Seniors Network Forum ... then at least there's the structure and the opportunity building now and ... it's getting stronger ... they do have representatives on key planning groups throughout Dorset and you know they have got to improve that and how that operates but it is getting there.

While there might be some lack of coherence between these different arrangements, they nonetheless provided a growing range of opportunities for older people to be engaged at the locality and strategic, county-wide levels of commissioning. Although the implications of the choice and personalisation agendas were being increasingly acknowledged, the emphasis thus far had been on collective engagement rather than individualised commissioning. The forum arrangements encouraged participants to understand involvement in commissioning as collectively seeking to influence formal decision-making structures. In addition, the POPPs programme provided decision-making structures and budgets through which older people could directly commission services at locality level. However, there appeared to be little awareness among older people, at this relatively early stage in national policy implementation, of personal budgets as a different or complementary route to influencing commissioning outcomes for individuals. The number of direct payments was seen as relatively low but growing and Dorset has an LAA stretch target to drive the extension of direct payments. However, on our second visit to Dorset older people described their engagement in contributing to the new assessment processes and development and piloting of documentation. Older people were also beginning to ask whether they could contribute to the transformational training that was soon to be delivered.

The only example of the use of personal budgets to commission services discussed within the focus groups was advanced within the provider group:

you could ... where a day centre was closing, take that group of people, give them all an individual budget, ... club it all together and say 'Right, twelve of you, what would you like to do with your grand a week?' They're not going to buy bingo ... are they? They're going to do something really cool ... what older people are saying to us is actually we don't want to sign a petition saying save our day centre, we want to be given the money and we want to decide how we want to spend it, we might have cookery classes or ... save the building of the day centre and use it in different ways.

The forums primarily engaged with active older people whose interests were not confined to the more traditional health and social care agenda. Their focus on prevention and the promotion of wellbeing was reflected in the content of the POPP programme, which they had substantially influenced. Some of the forums were conscious of the need to extend opportunities for involvement to a wider range of older people and were seeking a variety of ways to do this. For instance in one forum POPP money had been used to purchase a projector to take presentations around residential care and sheltered housing; in another newsletters were distributed to people in care:

so that they're sort of being able to catch up with things that are going on outside of their domain if you like because if you've got a lot of needs your world tends to shrink, doesn't it, so you know you might not know about certain things that could benefit you so we make sure they get newsletters.

Commissioners were also concerned about the limitations of engagement based on forums for predominantly active older people. For example, in engaging older people in the preparation of a day care strategy they had found that 'people had difficulty relating to a strategy which was actually focussed on people who need our services'. Their experience was that:

people found it difficult to relate to the fact that they might at one time in their lives need to go to a Day Centre ... they were like saying, Day Centre, I'm not going to go to a Day Centre ... one woman said, you know when I'm 90 I'm going to go hang gliding. Well that's fine but you're not going to go hang gliding if you're somebody ... [with] the kind of level of frailty that we've got in our Day Centres. You are talking about people who need two people to sort of hoist them, who need help with feeding, who need help with going to the toilet. They couldn't relate to that really.

The commissioners recognised and sympathised with the participants' difficulties in anticipating their future needs and how they might wish them to be met: 'when you are more frail and older you want something different, something that you never believed, or dreaded you would want ten years ago'. They felt they might be asking people 'almost too early', or they were not:

accessing that really older group of people, when they're 80, when they're 85, perhaps when they're not getting what they need, that's when we need to be asking them in an ideal world, right now, right here, 'what do you need?' and it would be very different from what we are commissioning I think.

As noted above, this limitation in the extent and capacity of the local engagement processes was beginning to be addressed through some aspects of the POPPs programme.

Providers also identified some limitations to involvement and not least the existence of multiple user voices:

you're talking about a voice, there isn't one because some people want to be very involved in shaping the services and really are very active and others actually just want to receive the service when they need it and don't want any involvement in it.

In addition, they had to manage differences of view among those who wished to be involved. They also expressed some concern about the risk of professionalizing involvement: 'you have somebody, an older person who's incredibly able who goes everywhere and in a sense becomes another professional [and] then you've got the majority of older people, how will they understand this process?' In such circumstances the challenge was to ensure the maintenance of strong links with the wider constituency of older people. This issue was being actively considered at the time of our fieldwork.

What difference have older people been able to make in Dorset?

Our discussions with the focus groups in Dorset identified a considerable list of ways that older people had been able to influence commissioning priorities and particularly the quality of service planning and delivery, and also identified areas where experiences had been less positive.

Exerting influence at a strategic level

The examples which were discussed concern residential and housing services, day services, eligibility criteria and budgetary priorities. The older people's focus group saw the development of extra care housing as one of the major examples of positive engagement. The forums had identified housing when asked to specify the most important issue for them. A subsequent conference arranged for the forums was instrumental in changing the strategic approach to residential and housing services. Focus group members reported that:

a lot of people were saying quite clearly they did not want to go to care homes, they wanted to have their own front door, they wanted to have control of where they lived, over their lives. And that has meant much more focus on the building of extra care housing which I don't think we would have got if we hadn't had that housing conference. So it's been very influential.

Since then extra care housing schemes have been developed or planned in a number of localities across the county.

The conference was also seen to have kick started a continuing process of implementation and involvement. Three working groups were established, covering sheltered accommodation, extra care housing and Telecare. Each had representatives from the forums, which were perceived by the older people's focus group as being effective: 'they influenced what came out because the working groups actually worked through the setting out of strategy and [associated] financial plan'. For example, older people worked with professionals to develop a specification of extra care housing which incorporated older peoples' preferences for the size (a maximum of 45 units per scheme) and design of developments (two-bedroom flats rather than bedsits). Older people measured the effectiveness of this contribution by the fact that the County Council used this specification in deciding its support for future developments.

Another stream of work originating from the forum's housing conference was the development of a county-wide home improvement service, working to common standards and procedures, in place of three separate schemes about which forum members had been critical. They felt that the three service managers were now working 'absolutely collectively together and using best practice. They were also very much taking notice of what older people were saying'. A related development was the extension

of a pilot project which helped older people to decide whether they needed to move to other housing options or whether help could be provided to enable them to 'stay put'. Forum members wished the service to be provided county-wide and they perceived that their contribution had supported the manager in securing funding to extend the service. Both they and the provider group identified, as evidence of the effectiveness of involvement, a review process which took place after two years and involved the preparation of feedback forms from the extra care and sheltered housing groups saying, 'this is what's happened – you've said this and we've done this'.

The remaining examples of involvement at county level were perceived differently. A less extensive form of involvement was identified in the case of day services. It had been a very early area for engaging with older people and one in which, as noted above, commissioners described more active older people as having difficulty in relating to those with greater needs. The process had produced a strategy for modernising day services based on a tiered approach to meeting need. More recently, however, resource constraints had made that strategy unaffordable:

we're at a stage now where we're currently trying to get through committee some cuts that are actually based on reduced usage and then when we've got that through, which is going to be difficult enough, because, I mean, there's been, you know, people on the streets and things, protesting...

As a result, the issue had effectively moved into a different and more political arena. However, at a subsequent point it would move back to the more usual arrangements for engagement:

but phase 2 ... is like, OK, what are we going to do now, we are fully intending to involve service users in the localities as well as members, service users, third sectors ... obviously we will use the existing old people's forums and POPPs.

One of the reasons for the reduced use of day services was said to be the result of the raising of eligibility criteria. The older people's focus group identified the latter issue as one which forum members had little or no opportunity to influence: 'but they did give an explanation, they didn't consult us. The explanation was that they had no funds; they're so poorly funded by the government that they had to ... raise the eligibility criteria'. Forum members contrasted this approach unfavourably with the council's commitment to partnership working. They were similarly critical of the nature and level of consultation about the county's overall spending priorities, which they described as 'a total contrivance'. However, the commissioners' group described the process as involving both a local citizens' panel and more structured consultation events. These experiences with setting eligibility criteria and budget priorities led some forum members to conclude that 'yes, we are being consulted and yes, we certainly do have more power than we had but still find that both the health and the county council are fairly selective in what they ask us to consult about'. On the other hand, forum members were positive about the space they were given to structure their meeting agendas and the absence of an attempt by the council to prescribe what they should consider.

Working at a local level

In addition to such county-wide issues, an extensive range of more locality focused topics was identified as areas of involvement. They included:

- bus services;
- the use of libraries as resource centres;
- extending the availability of rapid response services;

- securing an alternative to a community hospital;
- developing a community centre;
- engaging GPs in forum meetings; and
- developing an outcomes framework.

From the older people's perspective, each of these examples, though at different stages of development, was considered to demonstrate at least some degree of successful engagement on their part. In addition, a number exemplified older people's desire to extend the coverage of local initiatives more widely across the county.

Older people as a resource in meeting local needs

Commissioners commented that the engagement of older people was part of the solution to the problem of meeting local needs. Not only did they have resources of skill, time and information which could be mobilised and deployed locally but such forms of engagement could make a positive contribution to their own wellbeing as well as to the sustainability of local communities. As it was described to us, the POPPs programme represented the fullest expression of this philosophy and approach. It provided:

- opportunities for leadership and service delivery roles for older people at county and the most local levels;
- a structure for effective partnership working between older people, the statutory and other sectors;
- a focus on the wider determinants of health and wellbeing;
- a direct commissioning role for older people, especially for developing lower level services and community resources; and
- a budget to make all this happen and an evaluation resource to assess its effectiveness.

We now move on to consider the common themes that ran through our work with the field sites.

What did we learn from all the focus groups?

All the focus groups in both localities provided evidence of substantial engagement of older people through structures and processes operating at strategic and locality levels. In addition, there was equal consensus within and between the sites that this engagement was producing identifiable results. Indeed, the level of impact was such that all stakeholders remained enthusiastic about the potential for older people to have an impact on commissioning decisions. They were also committed to finding opportunities for further developing their local arrangements. The major exception to this positive, overall assessment was the view in Dorset that the same processes of constructive dialogue had not extended to financial issues and priorities. We acknowledge this caveat here and return to the issue separately below. Despite this evidence of apparent success, there was little to report about individuals arranging and managing their own care. In both sites, at the time of our fieldwork, take-up of direct payments was low and early work was under way to introduce individual budgets. As neither site was an individual budget pilot, this finding is unremarkable. In both cases, preparatory work was under way and is likely to be reinforced by the subsequent 'Transforming Social Care' grant and guidance as well as stretch targets included in the LAA in Dorset.

The view of our local focus groups about the positive impact of engagement was fundamentally different from that described in the two national focus groups. Some participants in the latter questioned whether engagement structures and processes were generally successful in producing any concrete outcomes:

what is clear is that people feel very strongly, both in PCTs and local government, that they are engaging but that what actually seems to be missing is the quality of that engagement and the impact it has, and the few people I have spoken to, when you say to them 'So can you give me a really concrete example of how you'd redesign the service based upon the information given?' have been hard pushed to do so or at least where they have that seems fairly minor ... a fairly minor change which has been relatively easy to put in place.

On the basis of the focus group evidence, we are unable to make independent assessments of the relationship between the structures and processes for involvement, on the one hand, and the extent or quality of its impact on the other. It is significant, however, that the Dorset and Salford focus group participants, including older people themselves, were broadly satisfied with the outcome of their work. They recognised that they were on a development path which would produce further learning and results over time. At the same time, however, it should be emphasised that Dorset and Salford were both selected for their reputation as sites which were relatively advanced in promoting involvement by older people. Thus they were expected to be towards the forefront of developing engagement rather than representative of practice across the country as a whole.

Participants in the focus groups were invited to identify the factors which, from their perspective, had facilitated the development of involvement by older people in commissioning or which had acted as barriers to be surmounted. We have grouped our findings across both sites into three main categories:

- 1 *Context and culture*: what were the features of the authorities that influenced the approach to engagement?
- 2 *Structures and processes*: what was put in place that seemed to encourage or hinder progress?
- 3 *Focus of involvement*: what decisions were older people able to influence and where was their influence more limited?

Context and culture

Both sites felt that they had made considerable progress in the involvement of older people in service planning and delivery. The groups emphasised that this progress had not come easily but had been nurtured over a long period and had required high levels of commitment from the statutory agencies as well as older people and their organisations. The current structures and processes had matured over time, taking advantage of local and national opportunities as these arose. Dorset had been an early Better Government for Older People (BGOP) pilot and used its learning to inform the development of local older people's forums to secure county-wide coverage with roots in local communities. In Salford the Older People's Forum initially provided a more coordinated voice by bringing together local organisations and groups representing older people. Individuals were gradually invited into planning groups and became partners in developing the wellbeing strategy. Opportunities have been sought to coordinate this approach with the parallel developments in neighbourhood management so that older people have a voice in localities as well as city-wide.

These evolving arrangements were seen by both sites as being the product of a consistent and long-standing commitment on behalf of statutory partners to engage with older people in a variety of ways and to move towards a more formalised structure for engagement with them in decision-making

bodies. The realisation of this commitment was being demonstrated by seats on commissioning bodies such as Partnership Boards and resource allocation groups such as the POPPs steering group and Dorset Age Partnership.

Some particularly important ingredients for success were identified by participants:

- Senior managers were crucial in developing a culture that promoted the importance of the views of older people, making resources available to grow their voice and enabling and empowering front-line staff to work more closely with older people.
- Political leadership was an important ingredient in promoting the engagement culture by combating inherent ageism and recognising older people as valuable resources in their community.
- Joint commissioning structures were seen as offering older people the opportunity to engage more effectively with the health sector, which was generally viewed as having less well-developed structures for engaging older people.
- The transparency of the engagement process: older people felt more able and willing to contribute if they felt their views were really valued, information was shared openly with them and links were made between consultation, engagement and outcomes – as represented by the ‘You said, we did’ philosophy.
- Establishing a shared direction of travel between older people and statutory agencies, as summarised by Salford’s wellbeing strategy and Dorset’s Partnership for Older People Project.
- Engaging in wider learning opportunities: both sites were national pilot sites. Participating in these pilots has allowed them to develop their ideas and test out new and innovative approaches. It has also delivered additional resources which have facilitated the process of giving older people a more central role in allocating budgets. One of the tests of the learning will be whether this leads to a more fundamental shift in practice.

An important message from the focus groups was that the engagement agenda needed to be promoted throughout the organisation. As one commissioner emphasised:

My experience in doing participation is you can't empower or engage people in communities if you're trying to do it through people who themselves aren't empowered ... The whole culture has to percolate through the organisation so that the people at the front line who you're asking to have a frank discussion with an individual and their carers about the services ... they have to feel empowered; otherwise they are just doing a tick box exercise.

Structures and processes

We identified three main themes relating to the structures and processes by which involvement was being pursued:

- Comprehensiveness and inclusivity: who is being involved?
- Capacity building and budget holding: how are people supported and what resources can they deploy?
- Links between levels of commissioning: strategic, locality and individual.

Who is being involved?

All participants apparently supported the belief that involvement should be as comprehensive and inclusive as possible. However, they recognised the difficulties of making this a reality. The most common structures for involvement were forums for older people or local communities. In addition, older people were invited to be members of other formal groups established by the various agencies to carry out different aspects of their planning, development and decision-making functions. These forms of involvement were recognised to have limitations in terms of their ability to engage with the full range of older people's voices and the ability of lay people to make effective contributions in unfamiliar settings. In both sites, strategies had been deployed to promote inclusiveness, which were beginning to demonstrate some small successes. Whatever their potential weaknesses, however, these formal structures and processes promoted continuous dialogue rather than 'one-off' consultation. It was also recognised that only a minority of older people were either interested or skilled in formal meetings. As a result, initiatives were being taken to combine 'business with pleasure' in the content of meetings.

The development of formal structures and processes was generally recognised as an opportunity for continuing and meaningful dialogue. As indicated above, tangible products of this dialogue were readily identified. Less tangibly, but no less importantly, the opportunities for dialogue had built up mutual trust and confidence across the system. There was relatively little cynicism about motivations and intentions on any side. Understanding of how 'the system' worked seemed to be growing on the part of older people while commissioners were developing insights into older people's expectations and requirements as well as learning how to promote and support their involvement.

The focus groups provided suggestions about the improvements older people would like to see. For instance, in Dorset, older people felt that the NHS apparently had less commitment to engaging. They recognised some shifts in attitudes and behaviours but were critical of NHS cultures which did not seem to place the same value on working with them. A second comparison was between the experience of genuine partnership working through older people's forums with what was perceived to be tokenistic consultation on funding priorities and eligibility criteria that took place outside that established framework. This experience raises questions about the relationship between established forum networks and the routes taken by formal consultations about service changes. As one participant commented:

people don't mind losing the argument if there has been a level playing field and the arguments have been deployed, okay, so we lose, that's the nature of it but if you squeeze people out of that, then they get very, very frustrated, don't they? ... I suppose it's how you set processes that there is the dialogue but it moves on to another level that then says well how can we work on it.

How are people supported and what resources can they deploy?

Both sites had explicitly invested significant sums to build the capacity of organisations and individuals to contribute to commissioning decisions at locality and authority-wide levels. Some of these 'facilitators' were employed by local government or the NHS. The majority were funded from statutory resources but employed by independent organisations such as Age Concern or authority-wide forums. It was such workers who led the initiatives to extend and refresh forum memberships and their coverage. In addition, they provided administrative and project management support to the formal structures and processes, provided or arranged training and supported individuals and groups to participate in partnership boards with the statutory services. As one of the groups remarked, the infrastructures that now existed did not happen spontaneously but depended on long-term commitment and investment. Apart from their contribution to more effective commissioning, these investments had begun to be repaid by the national resources and reputation they were also bringing to the sites.

Although preparations for introducing personal budgets were only beginning, both sites involved older people in allocating budgets. The Salford community forums allocated resources from devolved budgets through subgroups in which older people were influential in their role as citizens rather than

potential or actual users of health and care services. Similarly, in Dorset, the allocation of budgets to preventative and low-level services was specifically delegated to older people. For example the POPP steering group allocated funding to extend luncheon club options, develop arts and craft classes, toenail-cutting services, good neighbourhood schemes and tea dances. In Salford, neighbourhood committees have funded social visiting schemes, newsletters and projects to improve green space areas, benches and bus shelters. In both cases, control over budgets, however modest, gave older people the ability to exercise a degree of control over aspects of the commissioning process.

Links between levels of commissioning

The steps being taken to establish more comprehensive vertical and horizontal networks were designed to ensure more complete flows of information across and between geographical levels in service systems. Better communication and understanding among all parties is a precondition for older people's involvement in commissioning. In addition, there was evidence that network development was taking place as an instrument for changing the focus of commissioning. The strengthening of the neighbourhood/locality dimension was supporting a focus on community wellbeing as well as care. The locality approach to involvement was also influential in shaping strategic commissioning initiatives and their implementation. The development of commissioning strategies for older people in both sites illustrated this two-way relationship between commissioning levels, as did the design and implementation of the POPP and LinkAge Plus pilots.

The absence of individualised commissioning through SDS in the sites has already been noted and explained. Nor did we encounter any evidence of the involvement mechanisms being associated with demands to introduce SDS. Neither finding is particularly surprising given the national position at the time of our fieldwork. As national and local roll-out of SDS proceeds, however, it will be interesting to see what role these established networks play in local decision making and review. For the most part, the focus groups' consideration of involvement at the individual level concentrated on the role of user and carer involvement in assessment and care management processes. It was acknowledged that, however effective such involvement might have become, linkages between individual assessments and strategic commissioning tended to be less well developed. The developing interest of older people in both sites in eligibility criteria and the related operation of care management processes is a possible precursor to engagement around the issues of resource allocations at individual level. This focus may become more pronounced as SDS and its associated Resource Allocation System (RAS) produce greater transparency in the distribution of resources between individuals and client groups.

From one perspective, the introduction of individualised commissioning through SDS and a transparent RAS might suggest the redundancy of the collective engagement of older people in commissioning. If commissioning budgets are allocated to individuals to purchase services and support according to their own preferences, what purpose is to be served by older people engaging or being engaged collectively? This issue, in turn, raises questions about the purpose and structure of commissioning at strategic and locality levels in a future when all older people are offered their own budgets: how far will the market replace commissioning functions and processes; and to what extent will strategic commissioning be necessary to develop, regulate or otherwise intervene in the market? This is not the place even to begin to attempt a definitive response to such questions. The evidence from the focus groups does, however, begin to provide some glimpses into the scope for continuing collective contributions to some aspects of commissioning.

These include the most fundamental questions about the level and adequacy of resources allocated to particular levels of need and particular categories of older people (and other user groups) in relation to the structure of need, preferences and supply. While some of these issues had been addressed outside the structures and processes established for the engagement of older people, their continuing separation was beginning to be challenged, and such challenge seems more likely to grow than dissipate as older people's capacity for engagement continues to be developed. Second, the

engagement of older people is supporting a broadening out from a health and social care agenda to a more holistic concern for the wellbeing of individuals and communities. Again the local POPP and LinkAge Plus pilots provided evidence of this changing perspective towards commissioning strategies which embrace prevention, timely low-level support, social inclusion and citizenship. So long as access to personal budgets is determined by social care eligibility criteria, they will be relevant to only a tiny minority of older people (probably fewer than 10 per cent). Moreover, many of the concerns that older people identified in the sites related to collective goods rather than personal services and support (for example, community safety, social cohesion, environmental services, social networks, social deprivation, regeneration and public transport). The need to develop appropriate structures and processes for engaging older people in commissioning decisions affecting their quality of life and broader wellbeing seems unlikely to be displaced by the introduction of individual budgets for some aspects of personal care. In any case, and notwithstanding the interest in personal budgets for some aspects of health care, large elements of personal health services are likely to continue to be commissioned in more traditional ways.

Focus of involvement: what decisions were older people able to influence?

Two of the more fundamental questions about engaging older people are: who is being involved and about what issues? Equally important, however, is the relationship between those two dimensions of involvement: how does the response to the first impact on the latter, and vice versa? The more broadly based the population of older people engaged in commissioning, the less likely it seems to be that the agenda will be tightly focused on services specifically for older people (for example home care, residential services or services for older people with mental health needs). Rather, it will include the implications for older members of the population of more general or universal services (for example, transport, leisure, community safety, access to health services generally).

There were concerns in both sites about unintended consequences of involvement strategies based on population and place rather than service users, especially when combined with an emphasis on methods of engagement based on formal meetings. Both sites were conscious of, and seeking to counter, the potential exclusion of the voice of older people currently using services and especially those with the higher levels of need. There was a risk that those with the highest levels of need might be those least likely to be included in engagement processes; hence the emergence of outreach and other strategies to ensure that the voice of such groups could be expressed and heard. These strategies were not confined to those with high levels of need, however. As they also involved taking engagement to existing networks and leisure activities, there was recognition that more formal meetings-based engagement might have limited appeal to some groups. Consequently, it was necessary to find ways of engaging with harder-to-reach groups in the interests of equity and the more comprehensive coverage of all sources of diversity. All of these approaches to inclusion are essentially recognition that the selection of structures and methods for engagement is itself an important influence on the focus and outcomes of the involvement processes that are subsequently conducted.

Alongside such largely unintended agenda-setting processes, the focus for older people's involvement may also be shaped by adopting different routes and mechanisms for different issues which impact on them and their services. Formal consultation processes on financial and service reconfigurations are a case in point and there may be a case for bringing them within the scope of what are becoming 'mainstream' engagement processes where these exist. Otherwise, there is a risk that involvement is seen to be restricted to less important issues while different standards and 'rules of the game' apply to what are perceived to be the more important issues, which effectively set the strategic and financial frameworks for issues of an apparently lower order. Another aspect of this potential tension over the focus for involvement was provided by focus group members who questioned whether the agenda was structured around seeking to 'mend' what was actually a broken system. It was easier to gain consideration for incremental improvements to existing service structures than to discuss the need

for transformational change and how to achieve it. We do not have further evidence about how or if such more fundamental issues might be 'screened out' by existing processes or if, indeed, older people have sought to raise such a debate. Nonetheless, there is an apparent congruence between this concern and the absence of any obvious upwards pressure to address the personalisation agenda.

The dilemma is summed up by this comment from one older person:

we want a completely integrated service, we want a single point of access, we want a case worker and one person to work with, which isn't how things are currently set up. So for us we've got this sense in between do we focus on trying to get £10,000 here or £20,000 there to change this in this area or actually do we go and talk to the commissioners about 'can we have a discussion with you about completely reshaping Health & Social Care?' which is quite a challenge isn't it but it's what we're hearing people want.

The commissioning/involvement matrix

While it is important to establish variations in the extent of involvement at the three levels of commissioning identified here, it is no less important to recognise that our fieldwork has identified variations in relation to different components of the commissioning process. How we represent those variations depends on how we conceptualise that process. As we have noted in both the introduction and Chapter 1, it is commonplace to represent it as a continuous process, made up of interdependent steps or stages. The IPC model of the commissioning cycle (CSIP, 2006), for example, disaggregates commissioning into a number of elements, each contained within one of four principal categories of activity labelled *analyse, plan, do and review*. These categories can be combined with the three levels of commissioning (individual, locality and strategic) to construct a matrix onto which can be mapped the involvement activities reported in the focus groups.

The results of this mapping are represented in Tables 1 and 2. They show the expected concentration of current activities at the locality and strategic levels (though both sites had begun to develop personal budget initiatives and involve older people in those developments by our second round of visits). In addition, however, the matrices demonstrate that engagement is spread across many aspects of the commissioning process. In this respect, they support the suggestion that involvement in the sites can be characterised as a continuing process of dialogue and co-design across substantial parts of the commissioning process as a whole.

Alongside these similarities, our summary matrices also provide indications of some apparently significant differences between the two sites:

- Older people in Salford had played an influential role in the redefinition of a comprehensive strategy for older people which was wider than traditional health and social care services, also including, for example, an emphasis on citizenship, inclusion, prevention and early intervention. As a POPP site, older people in Dorset were helping to shape and deliver low-level preventative initiatives and influenced the shift from residential care to sheltered housing and the redesign of day services. However, they tended to be working within parameters set by the council and PCT, focused on specific services, and neither set the terms for nor participated in a more fundamental refocusing of the strategic vision for older people as was the case in Salford, although there were signs on the second visit that the Dorset Age Partnership may begin to address some of these issues.
- In Dorset, opportunities for involvement were principally as older people through a growing network of local forums established specifically for older people. By contrast, involvement at local level in Salford was through more generic community forums and, in some cases, older people's subgroups. However, the dominant form of engagement at the authority-wide, strategic level was through groups for older people and their services.

Table 1: Commissioning/involvement matrix: Dorset

| | Analyse | Plan | Do | Review |
|------------|--|---|---|---|
| Strategic | <ol style="list-style-type: none"> 1. DF 2. PSG 3. SWSF 4. DAP 5. Sheltered housing 6. Telecare 7. Home improvement | <ol style="list-style-type: none"> 1. DF 2. PSG 3. SWSF 4. DAP 5. Sheltered housing 5. Telecare 6. Home improvement 7. Day care services review | <ol style="list-style-type: none"> 1. DF 2. PSG 3. DAP 4. Day care strategy 5. Home improvement 6. Telecare 7. Sheltered housing | <ol style="list-style-type: none"> 1. PSG (review of programme) 2. DAP ? reviews planned |
| Locality | <ol style="list-style-type: none"> 1. DF 2. Inreach to residential homes 3. Sheltered housing | <ol style="list-style-type: none"> 1. DF 2. Sheltered housing 3. Community hospitals 4. Bus stops 5. Libraries as resource centres | <ol style="list-style-type: none"> 1. DF 2. Libraries as resource centres 3. Bus stops 4. Home improvement 5. Community hospitals | Generally see they are holding statutory partners to account |
| Individual | <ol style="list-style-type: none"> 1. DF and PSG input to assessment and care planning developments | <ol style="list-style-type: none"> 1. DF and PSG | <ol style="list-style-type: none"> 1. DF and individual representatives have input to piloting of changes | Not yet clear but contribution to be negotiated as part of personalisation implementation |

Key: DF, District Forums; PSG, POPPs Steering Group; DAP, Dorset Age Partnership; SWSF, South West Senior Forum.

- Salford had developed and implemented a concrete initiative involving older people in reviewing the nature and outcome of commissioning processes through user-led scrutiny enquiries. Dorset was beginning to consider opportunities for involvement in review processes but had yet to formalise its thinking and implement any initiatives.

While the two sites are almost certainly atypical of wider experience, as the views of our national focus groups suggested, they nonetheless point to the possibility of constructive and productive partnerships between older people and formal services. At the time of our fieldwork, this finding seemed the more significant given the emphasis in the circular *Social care transformation grant* (DH, 2008b) on its implementation through an innovative process of co-production, co-design and co-evaluation. Elements of each activity seemed to be becoming rooted in each of the sites. In the following chapter, we consider the implications of these findings for the promotion of involvement by older people more generally. In addition, we reflect on what our findings mean for the role and limitations of involvement as a means for older people to secure the services they want and the standards they expect.

Table 2: Commissioning/involvement matrix: Salford

| | Analyse | Plan | Do | Review |
|------------|--|---|--|---|
| Strategic | <ol style="list-style-type: none"> 1. Growing Older in Salford strategy 2. Reps on Partnership Board 3. SOPF 4. EMI strategy | <ol style="list-style-type: none"> 1. GOiS 2. Partnership Board 3. SOPF 4. EMI implementation plan 5. LinkAge Plus programme to strengthen SOPF/ cultural and activity programme 6. Representation on planning for intro of SDC | <ol style="list-style-type: none"> 1. GOiS 2. Partnership Board 3. SOPF 4. EMI implementation tasks 5. LinkAge Plus programme | <ol style="list-style-type: none"> 1. GOiS 2. Partnership Board 3. SOPF 4. EMI review of implementation (planned) 5. OP Scrutiny of Domiciliary Care 6. Review of Choose and Book |
| Locality | <ol style="list-style-type: none"> 1. Contribution to CAPs | <ol style="list-style-type: none"> 1. Older people's issues in CAPs | <ol style="list-style-type: none"> 1. Development of local services to combat isolation (e.g. ICSI) 2. Mentors for older people in residential care 3. Siting of benches 4. Resiting of traffic lights 5. Influence disposal of industrial waste 6. Having a say in how money is spent in neighbourhoods | <ol style="list-style-type: none"> 1. Review of CAPs |
| Individual | <ol style="list-style-type: none"> 1. Providing feedback on current assessment and care management arrangements 2. Analysis of Complaints and Compliments feedback | <ol style="list-style-type: none"> 1. SOPF representation on personalisation working groups | <ol style="list-style-type: none"> 1. SOPF involvement in piloting arrangements | <ol style="list-style-type: none"> Action Plan with review milestones built in |

Key: CAPs, Community Action Plans; EMI, elderly mentally ill; GOiS, Growing Older in Salford; OP, older people's; SDC, self-directed care; SOPF, Salford Older People's Forum.

4 Findings and conclusions

Introduction

This chapter reviews the findings from our fieldwork in the context of our literature reviews of commissioning and the involvement of older people. In addition, we seek to derive a number of conceptual and policy conclusions from the limitations on progress identified by our local focus groups. Members of these were already identifying and pursuing initiatives to improve the technical efficiency and effectiveness of older people's involvement in commissioning. However, we suggest below that this technocratic level of analysis was only one at which our findings should be examined. They should also be viewed through the lenses provided by the concepts of citizenship and consumerism, on the one hand, together with those of power and politics, on the other.

Our study was carried out in response to concern within the Joseph Rowntree Foundation that there were few examples where users have a real say in commissioning and more strategic approaches to service planning. We shared this view but did not wish to collect more evidence which merely endorsed what was already generally known. Rather, we wished to focus on what might be learned from that apparently small number of examples where involvement by older people was said to be more fully developed. Our aims were to describe possibilities for success rather than add to accounts of failure. We sought, therefore, to obtain better understandings of what different stakeholder groups perceived to be good practice locally, the factors they considered responsible and the results they thought could be achieved. While making no claims for the 'generalisability' of our findings, we hoped to provide a counterpoint to the picture of limited progress generally recorded in the literature. At the same time, by studying apparently 'successful' examples of involvement by older people in commissioning, we hoped to gain at least some understanding of its possibilities and limitations as a vehicle for better outcomes from their perspective.

This approach did not mean taking the apparently more successful sites at their own valuation, or that of the national policy and practice communities. We would need to establish how far their reputations could be justified. In broad terms, our purpose was to identify whether, and if so how, older people could achieve tangible results from their engagement in commissioning processes consistent with their own personal and collective objectives. We particularly wanted to establish if there was well-founded evidence in our two sites to suggest that older people were beginning to make a real and enduring contribution to commissioning decisions at different levels of policy and practice. If some really were making effective contributions in some parts of the country, our evidence might help others to understand and overcome some of the obstacles commonly reported in the literature.

We did not want to become apologists for poor performance but, equally, we considered it important to identify and acknowledge any gains that were genuinely being made. Accounts which continued to focus on the shortcomings of older people's involvement would become self-fulfilling prophecies if they demotivated local actors to the extent that they believed there was no point in trying to make progress.

Our findings

We described in Chapter 3 how we structured the collection and analysis of data by developing a matrix in which one axis comprised the organisational levels at which commissioning took place and the other

covered different components of the commissioning cycle. We used the matrix to summarise our findings for Salford and Dorset including:

- 1 the extent to which local structures and processes for involving older people in commissioning had been developed;
- 2 the nature and extent of any continuing gaps in engagement activities, whether in respect of the different levels of commissioning or components of commissioning processes;
- 3 the extent to which involvement activities were genuinely impacting on commissioning decisions (an essential element of the study if we were to avoid the trap of equating activity with influence);
- 4 how far those engaged in the local involvement structures and processes felt they had travelled and whether they still faced barriers which prevented them from having a bigger impact on decision making.

Chapter 3 records the insights we gained into the evolution of older people's involvement in commissioning in Dorset and Salford. The evidence we summarised there demonstrated that the sites were making significant progress in developing patterns of co-working. Perhaps even more importantly, the older people and agencies concerned did not doubt that their local involvement structures and processes were worthwhile: the mechanisms were associated with identifiable results which, they felt, justified the inputs of time and other resources devoted to involvement. To that extent, the evidence reported in the previous chapter suggests that the sites' reputations were well founded.

Nonetheless, we continued to be mindful that the two areas were intended to be atypical of many other parts of the country. They were selected as sites for study not only because they were different from each other on a whole raft of socioeconomic, geographic and structural variables but also because they had acquired reputations for relatively well-developed engagement with older people (including through their participation in such national programmes as the Innovation Forum, POPP, LinkAge Plus and participatory budgets). As the evidence review in Chapter 2 demonstrated, areas with such a reputation were, by definition, unlikely to be representative of the more general pattern.

This view was confirmed by the responses of the focus groups made up of national policy and practice leaders which we organised as part of the study. Their members were clear that the style and impact of older people's engagement we described in Salford and Dorset meant the sites should, indeed, be seen as outliers in the national pattern. Mainstream practice was described as one of increasing activity but very little tangible outcome other than of the most cosmetic kind. Whereas older people and professional staff in Dorset and Salford experienced involvement processes positively, the national groups were generally sceptical about whether its outcomes justified the time and effort expended.

The Age Concern London study commissioned by the Joseph Rowntree Foundation alongside this research also provided a different perspective on practice from that in Dorset or Salford. That research was carried out in six London boroughs and, while its results were not wholly negative, the overall conclusion was that the involvement of older people in shaping services was in its infancy (Schehrer and Sexton 2010). One difficulty the Age Concern London study identified was that commissioners themselves were often poorly equipped to engage service users in planning and procurement processes. Their knowledge, skills and motivations were underdeveloped and associated with different interpretations of the purpose and methods of user involvement. Thus, the report argued that service users experienced three different approaches to involvement by services, which it categorised as:

- *Open and willing*
- *Ostensibly open but not actually willing*
- *Not open*

(*ibid.*, p. 22)

As a result, user involvement could range from a continuing process in which users felt they were equal partners in shaping local services to one which was a manipulative one-off consultation in which they gradually realised they were being given bad news. The study also reported that all three approaches might be in play at the same time, an experience which users found confusing. Although the service users in our own study generally commented favourably about the approach and motivations of statutory agencies in Salford and Dorset, those in the latter location also suggested that the local authority and NHS varied in their commitment to genuine engagement according to the nature of the issue.

In overall terms, therefore, our two sites lay towards the 'open and willing end' of the spectrum. However, that assessment needs to be caveated in two ways. First, some experiences in Dorset were described by older people and their supporters in terms which placed them towards or even at the 'not open' end. Second, leading local authority sources in Salford responded to reading the Dorset case study by reflecting that their own approach had not been subject to the same degree of challenge as we described there. While they hoped they would respond differently to a challenge about budget priorities, they could not be certain that they would pass such a test.

Stakeholders generally felt they were still learning about the skills and support mechanisms needed to initiate and sustain genuine dialogue. In addition, they were being proactive in identifying continuing problems or tensions in the involvement processes and were committed to addressing them (see below). Thus, they readily acknowledged that their collective efforts were imperfect and incomplete: they were contributing to works in progress rather than working with the finished article. They were becoming clearer about some of the local factors that had helped them move forward but were also conscious that a number of substantial issues still needed to be addressed. From our perspective, the sites were characterised by genuine enthusiasm for the journey on which they had collectively embarked, and stakeholders felt it was proving to be generally worthwhile. The local authorities, older people's support organisations and the older people themselves all felt they were engaged in activities which delivered benefits to their respective 'constituencies'.

We have also noted that the Age Concern London findings were not wholly negative. Its report identified examples of better practice where service users were involved in shaping solutions. However, it suggested these were more common in social care than in health. This difference between commitment and practice in local government and the NHS was also a perception of at least some older people and non-statutory providers in Dorset. The Age Concern London study reported that, 'even where good practice did not yet exist, there was often an honest acknowledgment of poor practice and a desire to improve' (Mauger *et al.*, 2010, p. 1). In such circumstances, we would hope our findings from Salford and Dorset might prove encouraging and helpful. It is in that light that we offer our final reflections on the experiences we studied, the journeys being travelled and their implications for policy and practice more widely.

Understanding 'unfinished business'

During the course of our fieldwork, we identified a number of issues or tensions which stakeholders in Dorset and Salford were still seeking to understand and manage. The focus group meetings helped us to understand the main problems and barriers local stakeholders had encountered, how far they were seen to have been overcome and what difficulties remained. At one level, their articulation of outstanding issues was simply as a list of continuing organisational development agendas: a series of issues they had encountered on their local journeys and had yet to resolve. At a different level, however, the same issues and tensions can be seen to represent some of the inherent limitations of two theoretically located methods and approaches which identify older people as citizens and consumers, respectively. Lastly, they can be related to more fundamental questions about involvement and underlying structures of power and politics. These three levels of interpretation become clearer as we set out below the agendas of unfinished business which were observed in both Dorset and Salford.

It was striking how often the various components of these agendas were presented as paired alternatives and we have followed that formulation here. Thus, stakeholders tended to express the issues with which they were dealing or had still to address in terms of whether involvement in commissioning was to be focused on one or other of the alternatives in Table 3.

We should emphasise that what we are describing as ‘an agenda of unfinished business’ is our own construct. It was not expressed in this systematic form in any of our focus group discussions. Rather, individual issues arose from the various first-round groups, which we consolidated into a single list and fed back in the second round of groups. Participants in the latter generally recognised our list as a set of key issues which had not been fully resolved. In effect, it was accepted as a valid way of summarising their emerging development agendas though they had not been explicitly formulated in such terms.

To the extent that these continuing difficulties were being identified and addressed, the methods adopted tended to be pragmatic and piecemeal rather than theoretically founded or systematic. Thus issues were being tackled individually and on their own terms with a view to establishing technically effective responses to the concerns raised by stakeholders. For example, hard-to-reach groups were being targeted in both sites for imaginative outreach work with a view to including the consideration of a fuller range of needs in decision making. On the other hand, there was less obvious concern to identify and address the underlying influences which might cause some individuals, needs or other issues to be systematically excluded from decision making (see below). In Dorset, for example, financial priority setting in the council and the reconfiguration of health services were recognised by older people as areas on which they had achieved minimal impact and from which they considered they had been largely excluded.

The representation of the sites’ unfinished business as pairs of alternatives (Table 3 above) reflects the way its components were predominantly described. However, its structure as an organised *agenda* for action is part of the construction we placed on it. We also construed it as representing two different approaches to involving older people in commissioning: one citizen focused and the other consumer focused (in each pair of alternatives at Table 3, the first is an element of the former approach and the second an element of the latter). This distinction has important implications for both the destination of the journeys on which local stakeholders embark and also the nature of their responses to the agenda we identified.

These differences in destination and purpose are summarised in Table 4 which separates out each of the paired alternatives in Table 3 and allocates them to either the citizen or consumer approach.

Table 3: Paired alternatives: issues to be addressed and resolved

| Focusing involvement on: | or: |
|---|---|
| all ‘older people’ (however defined) | older people who use services |
| those who find it ‘hard to anticipate’ their future needs because they are currently healthy and active | those who are ‘hard-to-reach’ partly because of their (high) level of current needs |
| older people in their role as citizens | older people in their role as consumers |
| services used by older people | older people’s services |
| securing better outcomes | providing better health and social services |
| greater independence and wellbeing | better health and social care |
| quality of life in a specific place | quality of life for specific populations of older people |
| service transformation (fundamental change) | service improvement (sticking plaster) |
| older people-led involvement processes and agenda setting | commissioner/provider-led involvement processes and agenda setting |

Table 4: Different agendas or different ideologies?

| Citizen focus | Consumer focus |
|---|--|
| all 'older people' (however defined) | older people who use services |
| those who find it 'hard to anticipate' their future needs because they are currently healthy and active | those who are 'hard-to-reach' partly because of their level of current needs |
| services used by older people | older people's services |
| securing better outcomes | providing better health and social services |
| promoting greater independence and wellbeing | improving health and social care |
| improving quality of life in a specific place | improving quality of life for specific populations of older people |
| service transformation agenda | service improvement agenda |
| older people-led involvement processes and agenda setting | commissioner/provider-led involvement processes and agenda setting |

Callaghan and Wistow (2006) highlight the importance of this distinction in identifying the nature of relationships between individuals and their services. In the case of consumers, they suggest that relationship is primarily characterised by rights of exit supported by limited rights of voice:

consumers speak with the authority of service users and, therefore, with a legitimate interest in provision on a personal basis. Apart from the right to be heard, consumers have the right to exit. The difficulties involved in exercising these rights in relation to welfare goods have long been recognized ... By contrast, the role of citizen is based on the legitimacy of legal, political and social membership of the community. Here, legitimacy implies involvement as part of a collective, defining priorities in the interests of the wider community. Citizen involvement is based on democratic principles and the aim of involvement stretches beyond consumerist notions of individual satisfaction to ensure responsiveness and accountability in the context of public funding.
(ibid., p. 585)

These different relationships with services bring to the fore different groups of older people and aspects of their lives. For example, an approach rooted primarily in citizenship will be concerned with the lifestyles of older people in the round, the quality of life in the places they live and their relationship to wider society. By definition, it is outcome oriented, geared towards maximising health and wellbeing, and concerned with responsibilities to balance the interests of all alongside the rights of individuals to shape how they live their lives and the communities in which they live them. The second approach, primarily rooted in the status of older people as older people, is more concerned with them as actual or potential users of health, social care and other services, most frequently those designed to meet the specific needs of such users. As a result, it focuses engagement on the social care and health needs of individuals, the design of services to meet them and improvements to the quality of service delivery. Place of residence is accordingly less important than the location of services, and the legitimacy of individual involvement is founded in current or future experiences of needing and/or using specific services.

When stakeholders were questioning the validity of framing service strategies around the views of younger and more active older people, they were effectively arguing for involvement to be focused on a relatively narrow range of existing service users. By contrast, a citizenship approach would by definition be inclusive of all older people, possible interventions to improve their quality of life and the interests of the wider community. Thus a citizenship model should ensure that no category of older person is excluded from consideration of their relative claims on resources. Paradoxically, the adoption of a service

user-centred approach itself tends to exclude systematically some interests (those who are not immediate users of the services in question) more than others and with it the interventions relevant to them. By the same token, however, processes dominated by potential or future users may exclude sufficient consideration of the needs of current users. Again, the adoption of a citizenship model with a universal rather than individualistic focus helps to provide a framework in which both sets of interests are given consideration and resource allocation choices are made in the light of their respective claims to priority. From this perspective, it becomes clear that our sites were identifying a series of interconnected issues which could be addressed primarily through the citizenship/service user lens and only secondarily through that of managerial efficiency and effectiveness. All choices are ultimately between values but only some choices are explicitly made between transparent sets of values.

Local stakeholders were not unaware of differences between citizenship and consumerist models and a small number of respondents referred to the objective of shifting towards the former approach (especially in Salford). What we did not find, however, was a fully formulated account of either approach or a proactive strategy to adopt a fully articulated version of one or other of them. Nonetheless, a more explicit recognition that older people were citizens as well as service users (actual or potential) was being encouraged by a number of national developments which aimed to engage older people as part of the general population and partners in modernising local democracy. These included:

- 1 The broadening out of the definition of older people as those aged 50 and above by the 'Better Governance for Older People' or BGOP initiative (Hayden and Boaz, 2000). This approach had extended the range of older people targeted by and involved in shaping services.
- 2 The foundations which BGOP laid for a citizenship model were built on by the Audit Commission (2004), and the government-wide strategy 'Opportunity Age' (HM Government, 2005). In addition, policy for social care and health began to emphasise commissioning wellbeing outcomes, especially choice and control, from a wider range of local authority and non-statutory services to support models of independent living (Strategy Unit, 2005; DH, 2007b; HM Government, 2007). The POPP programme provided an opportunity for putting into practice wellbeing and social inclusion initiatives based on older people's involvement (Windle *et al.*, 2009).
- 3 The BGOP focus on 'better governance' through the more structured involvement of older people in local and national decision making was an indication of the interdependence of policies for successful ageing and democratic engagement. With the Cabinet Office and DSS¹ leading the initiative, the governance dimension was perhaps less evident in the Department of Health's work on promoting health and wellbeing outcomes. Indeed, much of the initiative on local democratic renewal originated in the Department for Communities and Local Government's (CLG) promotion of citizen involvement in community and neighbourhood governance. Initially targeted in areas of high deprivation such as Neighbourhood Renewal and New Deal for Communities areas, such programmes were subsequently universalised (for example, Communities and Local Government, 2008), buttressed by David Miliband's (2005) earlier concept of 'double devolution' and reinforced by Gordon Brown's interest in democratising government at the outset of his administration (Ministry of Justice, 2007).

As these developments demonstrate, citizenship and the revitalisation of democracy were 'in the air' as part of the policy background with which our informants were working. However, it was less directly part of a health and wellbeing agenda (though such a connection can be made in relation to control, dignity and respect). Thus, the engagement of older people on the basis of their citizenship originated in concerns about better governance and democratic renewal as much as successful ageing and improved services for older people. This distinction is helpful in analysing differences between our two sites and understanding our findings in relation to different forms of governance.

Age and place

The Dorset model for a publicly funded network of Older People's Forums in each of its main centres was consistent with the recommendations of the national Elbourne Report (2008) that a hierarchy of consultative bodies should be established at local, regional and national levels to enable a structured and broadly based dialogue between older people's representatives and government. This mechanism may be valuable for consciousness raising and capacity building among older people, as well as providing a vehicle for raising the awareness of national and local politicians about issues of concern to older people. They can also be important symbols that older people expect to be both seen and heard. However, as age-based structures and processes, they risk reinforcing the otherness of older people in their own sense of identity and the perceptions of the wider community. It is as though specific age-based forums define them as older people first and citizens second.

To some extent, the Salford approach had different roots. Its authority-wide strategic dialogue was consistent with the substance and methods favoured by BGOP (and the DWP's [Department for Work and Pensions] similarly based LinkAge programme, for which Salford was a pilot). However, its more localised arrangements were part of a generic model for strengthening public involvement in neighbourhood governance rather than a model for universal older people's forums. Salford had been a pioneer of community governance through neighbourhood committees and management teams.

Participants in such mechanisms tended to include many older people but their involvement was defined and encouraged by virtue of their status as residents of a particular place and community and not primarily by their age. As a result, they had the opportunity to contribute alongside other local residents to debates about the overall quality of life where they lived as well as how the interests of different groups could be accommodated and balanced. Nonetheless, local stakeholders felt that the Salford structures needed revising to ensure that both comprehensive coverage at community level and a clear linkage between that level and the work of the authority-wide older people's forum. At the time of our fieldwork, therefore, the need for closer integration between age-related and place-based commissioning arrangements was becoming recognised.

Generally speaking, the Salford approach to involving older people reflected the influence of national policies to strengthen local democracy to a greater extent than Dorset's. By comparison, Dorset had developed a programme of user involvement in social care and to a lesser extent health. These different foci were reflected in the different national pilots and partnerships with central government departments developed by the sites. Thus, Salford worked closely with CLG, the DWP and their respective citizenship programmes for neighbourhoods and for older people. Its focus on neighbourhoods reflected its role as pilot site for such CLG initiatives and contributor to national thinking about them. Most recently, it had been selected as a pilot for the CLG participative budgeting scheme. In addition, its Member of Parliament was the Secretary of State for the CLG at the time of our fieldwork and was seen to have been an influence on the council's thinking about neighbourhood management and community involvement before this Cabinet appointment. It was also a pilot DWP for LinkAge Plus, a programme which built on the BGOP initiative in involving older people in community governance.

By contrast, the Dorset approach was founded on two Department of Health (DH) initiatives which had included older people's involvement and capacity-building streams as part of approaches to redesign services for older people. The 'Innovation Forum' and 'POPP' (Wistow and Henderson 2010; Windle *et al.* 2009) had a starting point, therefore, in promoting older people's involvement in health and social care services, though the language of citizenship and a focus on other services developed over time. There was, however, as far as we could see, little if any attempt to bring together or compare the results of these different national programmes and their different citizen/user emphases.

To some extent, the differences between the sites can be seen as different approaches to the same challenge of managing across a matrix in which one axis is formed by 'place' and the other by

'people'. Whereas the former provided the primary organising principle in Salford, it was the latter in Dorset (though in both cases it was a matter of the relative emphasis between approaches rather than the total absence of one or the other). Significantly, both sites shared concerns that their infrastructures for involving older people were insufficiently integrated with strategic decision making: in Dorset with more generic processes and in Salford with the strategic partnership for older people. The alignment of structures and processes to cover strategies for both people and places was therefore an ongoing issue for both sites.

Nor was this merely a matter of administrative tidiness or ease of communication (though such interpretations existed at a surface level). Rather, the concerns reflected two underlying issues: first, whether older people were primarily defined by their age or place of residence and everything which accompanied those primary sources of identity; and, second, how to ensure that the mechanisms adopted on both sides of the matrix were appropriately 'wired in' to local centres with the political power and authority to make the relevant decisions. Both approaches could be seen to carry risks for older people in terms of involvement outcomes: one that age-specific needs are insufficiently recognised or met (through place-based initiatives); and the other that community cohesion, intergenerational solidarity and other place-based interests are weakened by the emphasis on age.

The state and the market

Debates about the respective roles of citizenship and consumerism are, in effect, proxies for debates about the respective roles of the state and market: about the extent of collective political power and personal purchasing power in particular contexts. By framing our sites' agendas of unfinished business in terms of citizen- and consumer-centred approaches to engagement, we have located their work along one of the most fundamental fault lines of modern governance. The role of the state reached its apogee in the quarter of a century after the end of the Second World War. Since then we have seen both growing restrictions on the scale and scope of state action and also its 'hollowing out' (Beck, 1992; Rhodes, 1997) within those narrowing boundaries as market and quasi-market mechanisms have funded independent providers to deliver services that had previously operated wholly within the public sphere. At the same time, the related redrawing of the boundary between the state and civil society on the one hand and between public and private funding on the other has reinforced the focus on individuals as users/consumers exercising choice in welfare markets rather than citizens exercising their rights of access to public services to meet specified needs and holding services to account for their performance.

We do not seek to debate the merits or demerits of this broad secular development. Our point about this trend in the governance of 'Western democracies' is more limited. In particular, it has buttressed the engagement of the public as customers consuming welfare services, providing feedback about their experiences of contact with services and their satisfaction with consuming them but with few opportunities to hold them to account. From this perspective our agenda of unfinished business derives from the inherent limitations of a service user paradigm whose characteristics include:

- a focus on existing users of existing services;
- services designed primarily to meet established needs as predominantly defined by the services themselves;
- performance criteria based on the production of outputs as opposed to the attainment of outcomes;
- service recipients as providers of feedback on their individual experiences rather than agents of collective accountability and control.

As this discussion suggests, there is only so far that local stakeholders can go in making progress within the service user paradigm. To achieve more, they need to operate deliberately and self-consciously within a different – citizenship – paradigm. This was effectively the dilemma presented to them through their agendas of unfinished business: but the relative absence of explicit, theory-driven understandings of the contexts and tools with which they were working tended to cloak this dilemma as a more fragmented set of ‘practical’ initiatives or options.

The limitations of the service user approach do not mean it has little or nothing of value to offer; nor does it mean that its limits cannot be stretched further than might initially seem possible. The service user model may also be the most acceptable or feasible starting point depending on local circumstances. Limitations are just that: they need to be explicitly understood for what they are and how they compare with other approaches for achieving given outcomes. Moreover, there is a paradox in the debate about the relative merits of user and citizenship paradigms that we would do well to recognise: just as market mechanisms have been introduced into public services with the aim of overcoming perceived weaknesses and inflexibilities of state welfare, so user participation can be seen as being designed to compensate for the weaknesses of public governance flowing from disenchantment with and disengagement from the democratic process (Byrne, 2011).

Further issues arising from the distinction between citizen- and consumer-focused engagement concern the extent to which they are separate or overlapping categories and the implications of their conceptually distinct legitimacies for relationships with professionals. On the one hand, terms such as citizen, consumer, user, public and patient are not always well distinguished in policy documents and may be used interchangeably (see Callaghan and Wistow, 2006). On the other, however, it is perhaps less frequently recognised that individuals may occupy more than one status simultaneously, and certainly at different points in time. We have been seeking to deal with the implications for older people of becoming involved in commissioning decisions as consumers or citizens. In practice, they may not only be involved in both capacities but also draw on their experience as one to enrich their contribution as the other. The difficulty arises in balancing personal experiences of services and individualised perspectives on needs with those of the community as a whole.

This perspective is a basis for citizen involvement in the democratic processes of government. When older people engage in such debates on those terms, they are less open to accusations that they lack the legitimacy of managers and professionals who are necessarily adopting a wider, more detached perspective. Indeed, it is as citizens that older people can claim the right to exercise power over decisions about the nature, funding and delivery of services. It is also as citizens that older people can hold commissioners and professionals to account for their use of public resources and the outcomes (individual as well as collective) that are achieved. By adopting such perspectives, older people become empowered in relation to managers, professionals and politicians, who are no longer able to claim that only they can legitimately continue to retain control of decision making (Callaghan and Wistow, 2006).

Politics and power

This reflection introduces the third level at which we think our findings can be understood: the implications of seeking to involve older people in commissioning for the operation of local and national structures of power and politics. We can illustrate this dimension with two examples from our agenda of unfinished business: first, the perceived need to be more inclusive of people who were ‘hard-to-reach’ or whose voices might be ‘unheard’; and, second, the perception that some agendas were manipulated to exclude issues public agencies wished to reserve to themselves. As part of this discussion, we also consider how far power has zero-sum or variable properties. This distinction sees power as, respectively, either a finite resource, gained by one group at the expense of another, or a resource which varies in volume so that an increase in the power held by some is not necessarily at the expense of that held by others. That is, by pooling resources, all parties may benefit by an increase in the stocks of power they are able to deploy collectively.

The first of our two examples in this section highlights how 'older people', far from being a homogeneous group, actually have diverse and potentially conflicting interests. We saw this in the concerns expressed that, by dominating engagement processes, younger and more active people were potentially excluding the interests of more frail people from service design and resource allocation processes. In other words, this tension actually represented a clash of interests among older people which, left to itself, might lead to the systematic exclusion of certain interests from participation in engagement processes and influence over their outcomes. It could also be argued, however, that providers and commissioners who highlighted the risk of excluding such interests were at least partially seeking to protect their own interests and those of colleagues engaged in traditional services such as residential and day care. Special pleading in defence of particular interests is not confined to older people pursuing individualised agendas.

What might appear at first sight as a practical issue of how to ensure that the views of 'hard-to-reach' old people are articulated and heard within engagement processes can also be interpreted, therefore, as at least a latent clash of interests and influence, not only within the older population but also between some of its members and commissioners/providers. Nor is this the only insight into competition for power and influence provided by this example from our list of 'unfinished business'. It would be possible to 'solve' the problem of 'unheard voices' through a range of initiatives to promote and sustain their participation while seeking to ensure their interests and priorities were given appropriate weight alongside those of others. It might require imagination and a willingness among the more proactive older population to make space for interests that had hitherto been only weakly articulated, but, in principle, it could be done.

However, this apparently 'successful' extension in the involvement of older people would be meaningless if, in effect, it merely extended the range of voices that were ignored in public decision-making processes. There is a real risk, therefore, that older people find themselves playing in a zero-sum game where 'unheard voices' combine with 'usual suspects' merely to add greater numbers of those to whom commissioners and professionals do not or will not listen. In other words, tackling the division of power and interests within the older population is no substitute for tackling the distribution of power and influence between older people and those who provide and commission services. It is possible to make any number of technical improvements to involvement structures and processes without those who hold power being more willing to share it.

Nonetheless, there are genuine issues about the mix of older people able and willing to participate in standard meetings-based engagement processes. Hence the development of initiatives in Dorset and Salford designed to attract a fuller range of voices and to combine involvement with other activities such as tea dances, fun days and the like. It was remarked more than once that the behaviour of older people who attended meetings to discuss health and social care was fundamentally unrepresentative and atypical of behaviour by older people in general. In this respect, they could be thought of as the 'anoraks' of their generation, whether that be of 'young' or 'old' older people. Concerns among stakeholders about the potentially narrow base of involvement were also reflected in such terms as 'usual suspects' and 'professional users'. The danger of group membership becoming ossified, unwelcoming or exclusionary needs to be recognised openly and honestly if challenges to the legitimacy of those involved are not to become an easy target or self-inflicted wound.

In principle, of course, groups that are unrepresentative of the wider population in their interests and allocation of time are not necessarily incapable of organising opportunities for a more broadly based expression of views or championing the aspirations of others. The fundamental issue is whether they and the statutory services conceive of their role in such terms and whether they are open to renewal and the inclusion of new perspectives. To some extent, therefore, this issue is less about representativeness as a dimension of politics and more about the sociology of small groups including tendencies to be inward looking and exclusionary.

Charges that those engaged in user involvement are unrepresentative of specific subgroups or the older people's population more generally may also be a tactic to blame the messenger and thereby

undermine the message. In other words, it is possible for the debate about usual suspects and unheard voices to be part of the fog of war in which apparent concerns about the status of those expressing the voice(s) of older people are put forward to cast doubt on the legitimacy of the case being advanced by those voices. We are not arguing that criticisms of representativeness are always unjustified. However, we would argue that care is needed to establish whether allegations of unrepresentativeness are cloaks for refusing to engage in the substance of the case being advanced. In the politics of involvement, criticisms about the exclusion of some views and voices should not be allowed to exclude the voice of older people more generally. Indeed, older people and their supporters should do all they can to avoid being seen as representative of narrow interests and be proactive in being seen to practise inclusivity.

The final item on our list of unfinished business was whether engagement processes and agendas were to be led by the interests of older people or public services. This concern is closely linked to the question of whether involvement aimed to improve services or be transformative of them and their impact. From a citizenship perspective, involvement in commissioning decisions can be seen as integral to personal and collective capacity building. Confident citizens in confident communities building the so called 'big society' are part of the prize for policymakers in both the current and previous governments (HM Government, 2007; DH, 2010). This vision raises, in perhaps its starkest form, the question of the relative degree of power which older people will be able to exercise through engagement in commissioning. As we have previously observed in this chapter, the extension of structures and processes for involvement is not to be confused with the extension of power and influence. Indeed, the one may distract attention from the other as much as provide the infrastructure for exercising it.

The most fundamental questions underlying our lists and agendas of unfinished business are, therefore, about the ability of older people to shift commissioning decisions to support better outcomes where they can make a case that such shifts are necessary and will be effective. The key issue is whether more pluralistic structures and processes produce different outcomes or continue to reproduce existing ones because underlying power structures remain unchanged and the same interests determine who gains and who loses from public service interventions. The argument advanced in our national focus groups suggested that a semblance of increased activity concealed the durability of multiple road blocks and little evidence of changed outcomes.

We have demonstrated that Dorset and Salford were characterised by better-focused activity and evidence that such activity produced service changes valued by those involved. The analysis in this chapter, however, suggests that, though these experiences differed significantly from the reported norm, no one suggested that they were transformative of power relationships. The weakness of individualised commissioning was a particular indication that relationships between individuals and services were little changed. The adoption of a more explicit citizenship focus, if that was the route they decided to travel, might expose how little power relationships had changed, but that was still for the future at the time of our fieldwork.

Whether commissioners are ready to accept such shifts in power and influence towards older people is another matter and may depend on complex patterns of history, relationships and opportunity. The policy of demanding double devolution (from central government to councils to communities) is itself a recognition that the local state cannot be relied on to share power with its citizens (Communities and Local Government, 2008). Nonetheless, in a multi-level and multi-silo system of governance and state welfare in which authority and accountability are both fragmented between silos and centralised within them, power can also possess apparently positive and zero-sum properties according to context.

If older people have more power, it does not necessarily follow that public services or servants have less at local level. What matters most is how and if they can exercise power together. The pooling of interests, perspectives and expertise by service and user participants may empower all parties to improve outcomes directly for service recipients and providers alike or to extend their collective reach and influence within wider service systems. Similarly partnerships between older people and commissioners can create sufficient momentum to strengthen their collective ability to reshape services where commissioners alone might have encountered too much resistance.

One example of the success of such a strategy was the Dorset partnership between older people and adult social services to create a new accommodation strategy based on sheltered housing rather than traditional residential services. In this case, both parties seem to have secured benefits from pooling power, though this is not to say that they were not operating within finite boundaries set by others (the council's cabinet or central government, for example). The example suggests the need to avoid oversimplistic views of how power is distributed and exploited. Greater power for older people did not necessarily imply less for social services; rather, support to develop the voice of the former assisted the latter to secure a policy shift both parties desired and neither might have been able to secure alone. Arguably providers of traditional services 'lost', though that is to assume that investment resources would have been available to them and older people would have chosen their services. Since neither condition would necessarily have been met, the outcome for such providers would not necessarily have been different. Then again it might, since it is impossible to demonstrate either unambiguously.

The point here is not to trawl through a host of counterfactuals to establish whether an example like this 'proves' power has indisputable zero-sum or variable qualities. Rather, it is to focus on the understandings of those properties for behaviours. If either older people or social services had understood and behaved as though more power for the one implied less for the other, it is improbable that the outcome of their relationship would have been to agree and secure an objective valued by both. The more likely outcome would have been for social services to pull up the drawbridge, leaving older people 'outside the pale' feeling disheartened and impotent. The point of partnerships is that they have the potential to enhance the resources of partners. If relationships are perceived as necessarily zero-sum, all kinds of possibilities for better outcomes may be missed.

Equally, of course, there are genuine differences of interest between users, managers and professionals which require a redistribution of power to resolve. In other words, it may be most realistic and productive for user groups to treat power as possessing both variable and fixed properties. This implies recognising that stocks of power may move and be moved between interests in fluid and complex ways over time. Even if power is *ultimately* a finite resource, to regard it as such in all circumstances may become a self-fulfilling prophecy. Equally, to behave as though there were always shared gains to be secured may be unrealistic if not naïve. The skill is in exploiting joint resources of power as fully as possible, not lightly taking on battles that cannot be won but equally not avoiding conflicts that have to be fought. Both tilting at windmills and appeasement are best avoided. Managing power relationships calls, therefore, for sophisticated understandings on the part of both users and commissioners if they are to make the most of whatever space they occupy separately and together. In a sense, it is the essence of successful user involvement and one where appropriate skills and competencies really are relevant. It is, however, a long way from an agenda limited to managing meetings and agendas per se.

Local and national politics

We have reported that older people in Dorset felt their success was limited to agendas where the council was prepared to allow them influence. The clearest example cited was the consultation on spending priorities. We would not dispute this perception but would argue that the example suggests a more complex distribution of power and influence at work in a multi-level system. Older people and their supporters repeatedly emphasised that Dorset was the lowest-spending authority in England, per capita of both the total population and that of older people. Some seemed to imply that this state of affairs was a local political choice and the reason for councillors' resisting older people's having an influence on resource allocation decisions. Others, however, suggested that their unwillingness to open up such decision making was largely immaterial. The low spending figures were the outcome of national resource allocation formulae to a greater extent than local decision making. Nothing would or could change until there was a change of national policy, which, in all likelihood, would require the election of a different national government.

From our perspective, aspects of the relationship between older people and local political processes in Dorset seemed to have an adversarial element in relation to spending decisions. It was also interesting to note that, in Salford, the portfolio holder for social care (who was also an older person) attended one of our focus groups for older people. On face value, the relationship with other members of the group was one of informality, familiarity, openness and mutual respect. Our impression was that the portfolio holder's presence was welcomed and seen as part of the ongoing relationship between older people and local political processes. In other words, it was a ('small p') political asset to local groups and an indicator of their potential for exerting influence upwards. It is equally conceivable that support from older people was a political asset to the portfolio holder to be called in aid as necessary in the working out of local power politics within the cabinet and ruling group.

Although these two examples from Dorset and Salford are not directly comparable, they can be seen as two sides of the same coin. We have noted that older people did not challenge Salford Council's resource allocation decisions as their peers did in Dorset. However, senior officers in Salford told us they hoped that in similar circumstances their response would have been consistent with their commitment to genuine partnership working rather than tokenistic consultation. That view remained untested, of course. In Dorset, there was also a culture of partnership working, especially about services for older people, but an apparent resistance to extending it to priority setting. There was more than a hint that, in this context if not in others, opening up decision making to the direct influence of older people was seen as a zero-sum game. Unable to satisfy public expectations in the face of a uniquely difficult financial settlement, senior politicians might well have felt it better to keep at arm's length 'special pleading' from any group and retain what limited areas of discretion they possessed to themselves.

Where older people's engagement seemed an asset to politicians in Salford, therefore, it could easily have been seen as a threat in Dorset, especially to the coherence of decision making within the leadership of the majority group. Opportunities for power sharing with older people were perhaps more safely focused externally on local MPs and other national political processes. In principle, this external focus had two dimensions: first, partnerships between older people and services to bring in additional resources through special programmes such as POPPs; and, second, lobbying national bodies and the county's national elected representatives. Both provided possibilities for greater involvement by older people to take on the characteristics of a positive-sum game if they could succeed in influencing the resource allocation decisions of current and/or future governments. In the event, it is interesting to note that Dorset was the only local authority, following the change of government in May 2010, to secure an increase in spending. Although it amounted to less than 2 per cent over three years, it was secured in the context of the biggest spending reductions (around 25 per cent on average) in more than half a century.

Whether this outcome in Dorset owed anything to the impact of older people's growing involvement in commissioning on political awareness and voting behaviours or was part of a more complex swing of the electoral pendulum is not something we can reflect on given the timing of our fieldwork. However, this vignette does point to the importance of national as well as local politics in mediating the power and influence of older people's interests. In addition, it demonstrates the potential for national lobbying to become a zero-sum game for older people. The other side of the coin from Dorset's more favourable financial settlement is Salford's significantly less favourable settlement as national resources have been broadly shifted southwards and to rural or suburban settings (though Salford was perceived to have benefited from shifts in the reverse direction under the previous government).

Again, we do not have evidence on the impact of this switch in national funding on the more recent nature of involvement in Salford. In addition, several key individuals are no longer there and it would not be straightforward to attribute any changes to the relative influence of resource and other factors. However, we do have evidence to show that some of the older people and their supporters in Salford were clear that it was necessary to engage with both local and national political processes in order to secure the outcomes they wanted. The best example of this recognition is the scrutiny process

run by and for older people, in which its recommendations were explicitly categorised as requiring either local or national political action. Those involved in the scrutiny then put these recommendations to local cabinet members and local MPs, respectively. As our fieldwork ended, they were intending to produce a follow-up report on the extent to which the politicians had been able to secure the implementation of their recommendations.

What we can conclude is that local and national politics are critical parts of the context for local involvement. First, they are major influences shaping both the nature of local spaces for involvement by older people in commissioning decisions and also the power relationships within those spaces. While involvement by older people in commissioning cannot have an overtly party political association, it does need to understand and engage with political processes if it is to maximise its impact. Sensitivity and caution must be the order of the day, however, in a terrain littered with eggshells and 'heffalump traps' for the unwary or unworlly.

Second, the balance between people- and place-based interests is complex to achieve but critical to outcomes. The more that older people wish to see themselves as ageing well within healthy and supportive communities, the more this requires an increase in the power and resources of interests and interventions focused on improving quality of life and health and wellbeing. However, this requires political support to switch the distribution of power and resources within existing services while also to some extent creating risks that age-based needs will be less well met if, for example, wellbeing services do not prevent or reduce demand for more intensive health and social care services. Finally, the extent of political support and degree of resistance to change is likely to be determined, as we suggested above, by the extent to which power is perceived to be a zero- or positive-sum game. The best way of squaring this circle is probably by national political processes which demand evidence of improved outcomes rather than new operational processes, whether they are processes of care or processes of involvement.

Both sites were grappling with unfinished business which, we have sought to show, was associated with shifts from a primarily user-focused approach to one which also incorporated a citizen focus on both successful ageing and improved governance. These shifts were encouraged by a changing policy context in respect of both the substance of commissioning strategies for later life and the promotion of public involvement in commissioning processes and more generally. It was perhaps predictable, therefore, that our sites should find themselves identifying tensions between the two approaches and, indeed, running up against the limits of a user-oriented approach to commissioning in a policy context emphasising outcomes, prevention and universal services as well as strengthening local democracy. The different elements of that policy context are effectively mutually reinforcing; they lead to a different destination from user-centred involvement but depend on power being exercised differently rather than greater involvement.

Summary of findings

This discussion began by noting that the involvement of older people in Dorset and Salford was relatively well developed and well regarded by its participants compared with the more general picture revealed by recent research and the experience of our national focus group members. However, we had found no inclination at either site to rest on their laurels and/or believe they had reached the end of a difficult journey. In fact, our local focus groups had identified a number of issues and choices which had emerged in the course of their journeys and which they had still to address fully. We suggested that the issues identified could be understood at three levels:

- 1 At face validity as their 'to do' list: a series of issues, some obviously linked and others apparently not, which added up to a schedule of unfinished business. The list was primarily understood pragmatically as a set of largely separate issues emerging from the experiences of the various local stakeholders. It

was characterised by a relative absence of theory-based frameworks to interpret that experience or drive the achievement of improved outcomes from the involvement of older people in commissioning.

- 2 As a somewhat more structured and theoretically informed agenda rather than random experiences requiring individual pragmatic responses. At this second level of analysis, we interpreted our findings as reflecting two relatively coherent approaches to involvement based on different theories about the purpose and role of public engagement depending on whether older people were primarily conceived as citizens or consumers. While references were made in both sites to the possibility of shifting towards 'a citizenship model', we were not presented with a coherent, agreed definition of such a model or an agreed strategy for implementing such an approach. Progress towards such an approach was, therefore, likely to be disjointed and uneven.
- 3 As more fundamental choices about the respective roles of politics and economics, on the one hand, and the power relationships between people who need services and those who commission or provide them, on the other. From this perspective, the critical issue is how far the power of older people to influence commissioning decisions is being recognised and reinforced rather than the degree to which they are being involved in more or less relevant structures and processes. To the extent that the latter activities are important it is as means to influence the outcome of commissioning decisions and not as ends in themselves. Again, although coherent positions had not been mapped out in the sites, some stakeholders were recognising that the possibilities of better outcomes from involvement lay in different power relationships which could only be agreed in the arenas of local and national politics rather than within the framework of local involvement structures.

The foundations of the user- and citizen-focused approaches to involvement lie in different sets of power relationships: between users and professionals,² on the one hand, and between citizens and the state, on the other. The values underpinning the current policy priorities of independent living and personalisation imply significant shifts in the balance of power towards the person using services while those underlying localisation and democratic renewal seek to make a similar shift towards citizens. Our analysis suggests that attempts to strengthen the ability of older people to influence commissioning decisions are operating in the interstices of both these policies to shift power relations (or at least the rhetoric surrounding them). Ultimately, both are concerned with the extent to which different stakeholders have control over priority setting and the allocation of resources: the user and professional; the citizen and the state. In neither site were these foundational purposes stated explicitly. The language of empowerment was not uncommon and we might speculate about how far this terminology is adopted because it appears relatively unspecific and, therefore, unchallenging compared with that of 'transferring power'.

It was, of course, a central tenet of New Labour that service users across the public sector should have greater choice and control over their access to public resources. It is arguable that this formulation confuses, or at least fails to make the necessary distinction between, economic and political relationships. The interdependence of these relationships is complex. Each sets boundaries for the other and creates spaces in which the other operates. Thus the limits of market relationships may be set by political decision making and vice versa. Self-directed support and personal budgets may give service users greater control over how they use public resources but, as citizens in the political domain in principle, they influence the limits of those resources and their allocation between services. That was effectively the lesson older people in Dorset were learning when they found they were unable to influence resource allocation decisions nationally or locally.

On the basis of this study therefore, we would argue that user involvement needs to adopt a much more explicit concern with power relationships but that stronger user involvement cannot at the end of the day compensate for moribund democratic processes. Ultimately the influence of older people on the

shaping and commissioning of services depends upon the effectiveness of their contribution to wider processes of governance rather than to service improvement agendas alone.

Our third level of analysis also helps to explain the paradox to which our national focus groups pointed, namely the existence of growing levels of involvement activity but without tangible differences in experiences and outcomes for older people. One of the enduring features of public management is its apparent preoccupation with means and neglect of ends (Stewart, 1971; Seddon, 2008). At the end of a period of sustained investment in public services and apparently ever higher standards in public services (as measured by national targets), many of the 'old' problems remain, whether they are inadequate standards of care in hospital and residential homes or failures to manage the interface between health and social care such as discharge from hospital.

As we have revised the final draft of our study, a number of reports have re-emphasised these shortcomings (for example, Patients Association, 2010; Age Scotland, 2011; Bloxham, 2011; Care Quality Commission, 2011; Hough, 2011; King, 2011; Parliamentary and Health Service Ombudsman, 2011) and the inquiry into the Mid Staffordshire Trust has been ongoing. Against this background of apparently enduring poor performance and substandard care, it would be hard to argue either that power is in the right places or that greater involvement in commissioning has provided a full and proper remedy for long-standing deficiencies in quality. Perhaps we should not be surprised. Commissioning is widely seen to be weak and to have had limited impact on outcomes over the 20 years or so of its operation in the UK (House of Commons Health Committee, 2010). The general tenor of these reports is conveyed by the following overview from the Patients Association:

In the 21st century, in one of the most developed countries and health systems in the world, patients should not be left starving or thirsty, they shouldn't be left in pain and they shouldn't be forced to urinate or defecate in their bed because the nurse designated to them says it's easier for them to change the sheets later than to help them to the toilet now. Yet this is what is happening around the country every day.

(2011, p. 7)

Against that background, it would be unrealistic to expect even the most empowered older people to achieve significant impacts on service design and quality through commissioning processes at any level. As has repeatedly been argued, commissioning is not fully fit for purpose and engagement processes are unlikely to be able to compensate fully for such underlying weaknesses.

In principle, older people's involvement can help define outcomes and strengthen the focus of commissioning processes on securing them. Whether, however, it can make a significant contribution to shifting power towards commissioners is not clear from the experiences reported here. Our findings also suggest that involving older people in commissioning can lead to service change and improvement but within relatively narrow limits, and it remains dependent on democratic processes for the authoritative exercise of power and accountability. Thus, we see participation as more of a complement to such processes than a substitute for them or even for their revitalisation (though involvement may contribute to the latter goal).

New futures for involvement?

So where does this lead us in terms of continuing to promote the involvement of older people in commissioning? We can envisage two possible futures which are not necessarily mutually exclusive and could, indeed, be mutually reinforcing. But first it leads to some final reflections on our fieldwork. We have no wish to subtract from our conclusions about what Salford and Dorset both attempted and achieved within the terms of their objectives and those of public policy. As we have noted, more than once, our findings justify their reputation as leaders in securing the involvement of older people in different kinds of

commissioning activities and producing tangible results from that involvement. Our subsequent reflections were not intended to diminish that assessment but to use their experience to reflect on some of the limitations of that approach and whether a greater impact might be achieved.

We have come to the conclusion that two strategies might be explored. The first is to strengthen commissioning and especially its focus on outcomes. By commissioning we are thinking specifically of those mainstream processes used for needs assessment, service specification, priority setting, resource allocation and accountability. Unless such processes are conducted competently and capably within the relevant public authorities, it is improbable that the involvement (however well developed) of older people will be capable of improving service experiences and outcomes to the standards defined by the public. Involving older people, especially as citizens, should help commissioners to focus on securing those standards and outcomes but it is not a substitute for effective commissioning. In fact, there is a strong case for older people to insist that local commissioning be on track to demonstrate its fitness for purpose before they agree to become too heavily involved in it. To summarise this first possible strategy, then, we are suggesting:

- 1 a fundamental switch in the focus and objectives of involvement so that it concentrates on improving individual and collective outcomes through effective commissioning;
- 2 a commitment by public services to developing effective commissioning capacities and capabilities as part of the terms on which older people agree to participate in commissioning.

Our second possible strategy, which might be pursued alongside the first, nonetheless starts from questioning whether older people (or other groups) should seek to become integral parts of commissioning processes at all. This question revisits previous debates about the extent to which community and voluntary interests should stand apart from public services and retain their independence as campaigners and advocates on behalf of people who (potentially) need to access services and support. One side of this coin is whether detachment is necessary for such interests to 'keep themselves honest' and avoid being drawn into collusive relationships with commissioners and providers. The other side is whether growing involvement dilutes their proper focus and absorbs resources which might be better deployed in scrutiny and 'campaigning' activities.

What might these activities be? We have seen that older people's (and other groups') involvement has been advocated to serve multiple objectives: to compensate for potential market failures, to substitute for failing democratic processes, to improve services and to improve governance, among others. It is understandable that there might be a lack of certainty about its purpose and methods in such circumstances. Against a background of continuingly poor outcomes and experiences for people who use services, the most necessary role is arguably that of 'eternal vigilance' on behalf of the public. This role might include such functions as those of independent monitor, publicist of good and bad outcomes, and advocate for service and outcome improvement; and ultimately power to secure the operation of proper accountabilities. In short, the core purpose of public involvement should be to ensure that public services fulfil their core purpose of serving the public.

Substantial resources are currently devoted to public involvement and some may argue that these functions are already covered. If so, the persistence of poor standards does not provide confidence that they are adequately or effectively fulfilled. Certainly, it has yet to be demonstrated that involvement within commissioning processes can be effective as a vehicle for guaranteeing fundamentally better outcomes. Part of the problem may be a lack of clarity about how the objectives of different approaches to involvement are defined and the extent to which different central government initiatives are coherent or conflicting, competing and duplicated. We would propose, therefore, a root and branch review of all this activity as it relates to the health and wellbeing field in order to define the core role and purposes of public involvement and how it might be organised to secure better outcomes for the public. As one of

the pioneers in this field, the Joseph Rowntree Foundation might wish to consider how such a task could best be addressed and implemented.

Finally, there is a need to consider, as part of such a root and branch review, how far the weaknesses of involvement derive from the relatively low value we place on older people themselves, the services provided for them and the people employed to deliver such services. As with commissioning, improved involvement techniques and activities cannot compensate for more fundamental deficiencies. To the extent that the underlying problem is one of ageist power structures, it needs to be exposed as such rather than concealed by higher levels of engagement activities which flatter to deceive.

Notes

4 Findings and conclusions

- 1 The Department of Social Security (DSS) was the lead department in Whitehall for older people's policy, as is its successor, the Department for Work and Pensions (DWP).
- 2 We are using this term in a broad sense to cover all those paid staff in commissioning or providing organisations across statutory and non-statutory sectors.

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Acknowledgements

In the course of this work, we accumulated many debts to people along the way. We are first and foremost grateful to the older people in Dorset and Salford who agreed to talk to us and share their experiences with us so openly and frankly. We are similarly grateful to local authority, independent sector and NHS staff for their participation in the study in the demanding contexts of their own work programmes. We greatly appreciate all of their contributions and particularly those of Andrew Archibald and Tom MacDonald in Dorset and Salford, respectively, who opened the necessary doors and made the organisational arrangements to involve everyone locally in the study. In addition, a number of experts in the national policy and practice communities, including voluntary and user organisations, participated in focus groups at the LSE that generated stimulating conversations and enabled us to locate our local field sites in a broader national context.

We should also like to thank Charlotte Darwin and Ann Richardson for so effectively picking up the literature review of older people's involvement during Vanessa's maternity leave. Ultimately, of course, none of the work would have been possible without the funding from the Joseph Rowntree Foundation and we are extremely grateful to its Trustees, Officers and Advisory Group for commissioning and supporting our research. We are especially grateful to Alex O'Neill of the Foundation for his encouragement, support and thought-provoking discussion of our emerging findings as well as his understanding during a period of serious illness in the team. Needless to say, however, we remain responsible for any remaining errors, gaps and misinterpretations.

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The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of JRF.

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First published in 2011 by the Joseph Rowntree Foundation

ISBN: 9781859358818 (pdf)

Original design by Draught Associates
Typeset by [Prepress Projects Ltd](#), Perth, UK

Joseph Rowntree Foundation
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40 Water End
York YO30 6WP
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