

Introducing Role and Service Changes in Health and Social Care: The Impact and Influence of User Involvement in England and Wales

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A key characteristic of the English and Welsh system of care provision is that the supply function is divided between two types of organisation: the National Health Service (NHS) and local authorities. These inter-organisational and the related inter-professional divides have long been recognised as problematic from a user and carer viewpoint; and various policy changes have attempted to address them. This paper draws on three different research projects to describe practical experiences of user and carer involvement in this context (a) the Evaluation of the 1999 Health Act Section 31 flexibilities encouraging more effective service delivery partnerships between the NHS and local authorities in England; (b) a Baseline Study of Partnership Working and Flexibilities Use in Wales; and (c) the Evaluation of the NHS Changing Workforce Programme, which implemented new ways of working to improve patient care across health and social care in England. In synthesising the studies' findings, the paper also begins to explore relationships between involvement effectiveness and different types of NHS–local authority partnership as they seek to introduce change and deliver more effective services.

Introduction

A key characteristic of the English and Welsh system of care provision is that the supply function is divided between two types of organisation: the taxation-funded National Health Service (NHS); and local authorities (which provide services responding to needs associated with advancing age, disability etc. as opposed to what are seen as more immediate medical/health problems) funded partly through local taxation. There are also distinctions within the NHS (e.g. between secondary, primary and community health care delivered by NHS Trusts and Primary Care Trusts (PCTs)) and local authority services (e.g. between social care and areas such as housing, education, sport and leisure etc.). These divides and the distinct organisational and professional boundaries that they generate have long been recognised as problematic from the viewpoint of those on the receiving end of care provision (Lewis, 2001; Means, Morbey and Smith, 2002). This is because of service fragmentation and duplication that in turn is associated with a lack of seamlessness and responsiveness to patient/user and carer needs (Hudson and Henwood, 2002). The situation is particularly pertinent for groups (e.g. older people, and those with learning difficulties or mental health problems) with service requirements that cut directly across entire sectors, for example health and social care; and those requiring smooth, effective shorter-term coordination between different parts of the system (e.g. on the journey from

hospital to community rehabilitation) (Glasby *et al.*, 2003; Older People's Steering Group, 2004). Many of the same patients/users, and other groups such as ethnic minorities, also experience gaps because they 'have needs [e.g. for more culturally sensitive provision and/or practical domestic support in addition to personal physical care] that fall beyond the current limits of . . . services' (Shaping Our Lives National User Network *et al.*, 2003: 3) (Evans and Banton, 2001; Raynes *et al.*, 2001).

There are several strands to the post-1997 New Labour Government's approach to addressing these issues. First, partnerships – from service planning, through commissioning to front-line provision – have been encouraged as a clear alternative to the adversarial relationships of former quasi-markets (DoH, 1998a; Health Committee, 1998; Paton, 1999). Mechanisms introduced to facilitate this include: the 1999 Health Act Section 31 (s31) flexibilities enabling the NHS and local authority services to pool budgets, delegate lead commissioning responsibility and integrate provision (Glendinning *et al.*, 2003); and subsequent Care and Children's Trust developments, which utilise the flexibilities as their legal underpinning (Glasby and Peck, 2003). The hope is that these changes – introduced from April 2000 in England and April 2001 in Wales – will have provided a concrete base upon which organisations and professionals can build more innovative, seamless and responsive services. In Wales, the flexibilities were also pump-primed by the Flexibilities Special Grant (worth £17 million between 2001 and 2004) (NAW, 2001).

A second complementary strand of the government's modernisation agenda directed attention towards workforce change. As the 'HR in the NHS plan' (DoH, 2002) stated, delivering quality services – in ways that are efficient for the organisation, fulfilling enough for staff to want to work in them, and responsive to patient/user and carer needs – depends both on there being more staff *per se* and on those 'staff, working differently'. This implies fundamentally re-examining professional (doctors, nurses, therapists) and support worker boundaries and working practices (Cameron and Masterson, 2003; Davies, 2003; Doyal and Cameron, 2000; Lissauer and Kendall, 2002; DH/RCN, 2003; Read *et al.*, 1999). Although most developments – known in NHS language as job reconfiguration or role redesign – are happening solely within health, where appropriate, as in rehabilitative or intermediate care, the NHS is joining with local authorities to modernise across the entire service system (DoH, 1998b). Hence the key initiative established to experiment with new ways of working – the NHS Changing Workforce Programme (CWP) – included various Pilots (e.g. older people's services, mental health, and the wider health team) exploring the potential to move tasks traditionally perceived as 'health-related', towards social care. Other Pilots (e.g. around Senior House Officer (SHO), Allied Health Professional (AHP) and Anaesthetist roles) were essentially partnerships between NHS organisations in primary and secondary care (NHS MA, 2003, 2004a).

Finally, the government has emphasised patient/user and carer involvement and empowerment *per se* (DoH, 2000). There is, however, longstanding evidence that this 'involvement' – effective involvement that is, with real, interactive discourse between users, organisations, and staff – is harder to achieve in practice than policy suggests (Croft and Beresford, 1990; Evans and Banton, 2001; Hoyes *et al.*, 1994). One view is that, without *tangible* issues that all parties can relate to, involvement can be perceived as 'for the sake of it' – rather than being a meaningful partnership *in its own right*. Unless managed properly, therefore, involvement attempts can even contribute to loss of change

management impetus in the same way as if other partnership relationships break down (Hardy *et al.*, 2000).

Although not directly required to undertake it, parallel developments like s31 and workforce redesign do provide *concrete vehicles* for involvement of the kind sometimes lacking generally. Moreover, patients/users and carers are clearly key if either are to achieve real improvement from the viewpoint of those receiving services – rather than repeating unsatisfactory experiences of past reforms (Henwood and Hudson, 2000; Nocon, 1994). But has it worked out this way in practice? Or are different forms of partnership (e.g. defined by client group, service area, professional group, organisation type etc.) better, or more willing, than others to encourage involvement and use wider policy vehicles to help?

Illustrative data from s31 flexibilities and CWP evaluations

In order to explore the above questions this paper draws on findings from various research projects including:

1. The Department of Health (DoH) funded National Evaluation of the 32 earliest sites using s31 flexibilities in England;
2. A Baseline Study of Partnership Working and s31 Flexibilities use across all NHS organisations and local authorities in Wales undertaken for the National Assembly; and
3. The DoH-funded Evaluation of the NHS Changing Workforce Programme's initial 13 English pilots of job redesign across primary, secondary and social care.

See Table 1 for a description of the different studies, including types of partnership involved. The studies were not themselves commissioned to measure user/carer and service outcomes, but focused instead on different stakeholders' perceptions of the change management process and implementing that change through partnership working – one aspect of which was involvement. Realistic evaluation designs were, therefore, used because they ask questions such as what has been done and what works, for whom, in which circumstances and why? (Pawson and Tilley, 1997). In addition, a similar mixture of methods was employed, namely: documentary analysis, baseline and follow-up postal/interview surveys, and semi-structured interviews in local case studies (Yin, 1989) (Table 2). Full findings are available from the various project reports (Glendinning *et al.*, 2002; Hyde *et al.*, 2004; Young *et al.*, 2003). This paper provides a necessarily synoptic view of elements most relevant to involvement.

Timing and overall nature of involvement

s31 flexibilities partnerships

Both studies of the s31 partnership flexibilities (pooled budgets, lead commissioning and integrated provision) asked NHS and local authority participants about patient/user and carer involvement (broadly defined to include those actually receiving services, proxy representatives such as Community Health Councils (CHCs) and the general public) at different partnership development stages. In England, the question asked about: selecting the partnership project, developing the objectives, drafting proposal documents and

Table 1 Overview of s31 flexibilities and CWP study sites

| National evaluation of s31 flexibilities in England | Baseline of partnership working and s31 flexibilities in Wales | Evaluation of NHS Changing Workforce Programme in England | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--------------------------------|---------|--------------------------------|--------|--------------------------|--------|------------------|--------|---------------------|-------|---------------------------|-------|--|----------------------------|--------|--------------------------|-----------------------------|----------|---|-------------------------|---------|-------------------------------|---------|---------------------------|--------|----------------------------|--------|------------------------------|-------|------------------------|--------|---------------------|--------|-----------------------------|--------|--|---|--------|--------|---|
| <p>Type and number of partnerships studied 32 earliest partnerships that had notified the DH of their intention to use the s31 flexibilities from April 2000. Initially, local authority partners were all social services, plus one case involving education. Within the NHS, health authorities, Community and Mental Health Trusts predominated. By the follow-up survey, Primary Care Trusts had replaced other NHS partners and four partnerships included Police/Probation, private nursing home providers, the voluntary sector or user/carer organisations.</p> | <p>All 22 co-terminous local authority social services/local health group areas. Each area reported having partnerships using the s31 flexibilities. NHS Trusts were also significant partners, followed by LA housing, education and leisure services in a third-half of areas. Police/probation and LA transport services were also involved in two and one area(s) respectively.</p> | <p>13 Initial Pilots – either: redesigning roles/task bundles usually performed by particular professional groups – e.g. Senior House Officers (SHOs) and Allied Health Professionals (AHPs); or focused on work performed by several occupational groups but for a definable client group – e.g. older people and mental health. Each CWP pilot covered several NHS organisations (PCTs and/or NHS Acute and Mental Health Trusts), and in some cases entire regional health economies (including where relevant local authorities).</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Client groups covered No. (%) partnerships (N = 30)</p> <table border="0"> <tr><td>Older people (includes EMI)</td><td>14 (47)</td></tr> <tr><td>Adult learning disability (LD)</td><td>13 (43)</td></tr> <tr><td>Adult physical disability (PD)</td><td>5 (17)</td></tr> <tr><td>Adult mental health (MH)</td><td>4 (13)</td></tr> <tr><td>Child complex/PD</td><td>2 (7)</td></tr> <tr><td>Child/adolescent MH</td><td>1 (3)</td></tr> <tr><td>Child learning disability</td><td>1 (3)</td></tr> <tr><td>Sensory impaired</td><td>1 (3)</td></tr> <tr><td>Carers</td><td>3 (10)</td></tr> <tr><td>Acute/terminally ill people</td><td>3 (10)</td></tr> </table> | Older people (includes EMI) | 14 (47) | Adult learning disability (LD) | 13 (43) | Adult physical disability (PD) | 5 (17) | Adult mental health (MH) | 4 (13) | Child complex/PD | 2 (7) | Child/adolescent MH | 1 (3) | Child learning disability | 1 (3) | Sensory impaired | 1 (3) | Carers | 3 (10) | Acute/terminally ill people | 3 (10) | <p>No. (%) Respondents (N = 31)</p> <table border="0"> <tr><td>Older people</td><td>11 (35)</td></tr> <tr><td>Elderly mentally infirm (EMI)</td><td>6 (19)</td></tr> <tr><td>Adult learning disability</td><td>3 (10)</td></tr> <tr><td>Adult physical disability</td><td>1 (3)</td></tr> <tr><td>Adult mental health</td><td>2 (7)</td></tr> <tr><td>Child complex/PD</td><td>4 (13)</td></tr> <tr><td>Child/adolescent MH</td><td>4 (13)</td></tr> <tr><td>Child learning disability</td><td>3 (10)</td></tr> <tr><td>Sensory impaired</td><td>—</td></tr> <tr><td>Carers</td><td>3 (10)</td></tr> </table> | Older people | 11 (35) | Elderly mentally infirm (EMI) | 6 (19) | Adult learning disability | 3 (10) | Adult physical disability | 1 (3) | Adult mental health | 2 (7) | Child complex/PD | 4 (13) | Child/adolescent MH | 4 (13) | Child learning disability | 3 (10) | Sensory impaired | — | Carers | 3 (10) | <p>CWP pilots were principally distinguished by their service area, so covered all age groups and types of patients/users. Within that, however, three sites – mental health, older people's services, and stroke services – focused on particular client groups.</p> |
| Older people (includes EMI) | 14 (47) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult learning disability (LD) | 13 (43) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult physical disability (PD) | 5 (17) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult mental health (MH) | 4 (13) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child complex/PD | 2 (7) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child/adolescent MH | 1 (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child learning disability | 1 (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sensory impaired | 1 (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Carers | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Acute/terminally ill people | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Older people | 11 (35) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Elderly mentally infirm (EMI) | 6 (19) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult learning disability | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Child complex/PD | 4 (13) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child/adolescent MH | 4 (13) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child learning disability | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sensory impaired | — | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Carers | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Service areas covered No. (%) Partnerships (N = 21)</p> <table border="0"> <tr><td>Community/continuing care</td><td>8 (38)</td></tr> <tr><td>Home care/supported living</td><td>6 (29)</td></tr> <tr><td>Rapid response teams</td><td>4 (19)</td></tr> <tr><td>All MH services</td><td>4 (19)</td></tr> <tr><td>All LD services</td><td>3 (14)</td></tr> <tr><td>All PD services</td><td>1 (5)</td></tr> <tr><td>Integrated assessment</td><td>1 (5)</td></tr> </table> | Community/continuing care | 8 (38) | Home care/supported living | 6 (29) | Rapid response teams | 4 (19) | All MH services | 4 (19) | All LD services | 3 (14) | All PD services | 1 (5) | Integrated assessment | 1 (5) | <p>No. (%) Respondents (N = 31)</p> <table border="0"> <tr><td>Home care/supported living</td><td>8 (26)</td></tr> <tr><td>Residential/nursing care</td><td>6 (19)</td></tr> <tr><td>Day care</td><td>2 (7)</td></tr> <tr><td>Rehabilitation services</td><td>9 (29)</td></tr> <tr><td>Rapid response teams</td><td>10 (32)</td></tr> <tr><td>Joint equipment services</td><td>8 (26)</td></tr> <tr><td>Housing repair/adaptations</td><td>5 (16)</td></tr> <tr><td>Outreach/prevention services</td><td>2 (7)</td></tr> <tr><td>Work/education/leisure</td><td>1 (3)</td></tr> <tr><td>Welfare rights</td><td>3 (10)</td></tr> <tr><td>Other: joint discharge team</td><td>1 (3)</td></tr> </table> | Home care/supported living | 8 (26) | Residential/nursing care | 6 (19) | Day care | 2 (7) | Rehabilitation services | 9 (29) | Rapid response teams | 10 (32) | Joint equipment services | 8 (26) | Housing repair/adaptations | 5 (16) | Outreach/prevention services | 2 (7) | Work/education/leisure | 1 (3) | Welfare rights | 3 (10) | Other: joint discharge team | 1 (3) | <p>Access and diagnostic services – 7 roles Allied health professions – 8 roles Anaesthetics – 9 roles Diabetes care – 11 roles Emergency care – 10 roles Generalist and specialist care – 8 roles Mental health – 19 roles Older people's services – 12 roles Primary care – 11 roles Scientists and technician services – 15 roles Senior House Officer roles – 19 roles Stroke care – 8 roles Wider health team – 6 roles</p> | | | | |
| Community/continuing care | 8 (38) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home care/supported living | 6 (29) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rapid response teams | 4 (19) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All MH services | 4 (19) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All LD services | 3 (14) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All PD services | 1 (5) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Integrated assessment | 1 (5) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home care/supported living | 8 (26) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Housing repair/adaptations | 5 (16) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Outreach/prevention services | 2 (7) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work/education/leisure | 1 (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welfare rights | 3 (10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: joint discharge team | 1 (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Progress in implementation At baseline (N = 30), pooled budgets, lead commissioning and integrated provision were planned by 25 (83%), 12 (40%) and 13 (43%) of partnerships respectively. Two years later (n = 23), pooled budgets were in use by all partnerships, almost half had implemented lead commissioning, but only a third were using integrated provision (which proved more difficult given Human Resources implications).</p> | <p>Counting both current and planned use, integrated provision was the most popular flexibility overall (97% of respondents), followed by pooled budgets (80%) and lead commissioning (66%).</p> | <p>143 new roles were identified across the 13 pilots covering: advanced nurse/midwife/health visitor roles; advanced AHP, pharmacy/other clinical roles; AHP/other clinical assistants or technicians; health/social care support workers; administrative and domestic/porter/transport workers</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Table 2 Overview of the different study methods

| Study phase | National evaluation of s31 flexibilities in England | Baseline of partnership working and s31 flexibilities in Wales | Evaluation of NHS Changing Workforce Programme in England |
|------------------------|---|---|---|
| Baseline survey | Postal questionnaire of 32 sites notified to DH as using the s31 flexibilities at April 2000 – response rate 73% (<i>N</i> = 22). | Postal questionnaire of all 22 local authorities, 22 co-terminous local health groups, 14 NHS Trusts and five health authorities – response rate 56% (<i>N</i> = 35). Overall, information was provided by either/both social services and LHG in 18 of the 22 unitary areas. | Telephone interview survey of key stakeholders such as CWP team members, steering group chairs, clinical leads etc. (<i>N</i> = 30) across all 13 pilots. |
| Case studies | Semi-structured interviews with key stakeholders (local authority and NHS managers, user/carer representatives, voluntary sector etc.) in sub-sample of ten sites selected for maximum variability in terms of s31 flexibilities used, types of partner organisation, scheme size and scope, client groups and service areas covered, geographical location etc. Further semi-structured interviews following up experience in three of the ten case study sites (Manchester – mental health, Barnsley – extensive s31 use across six client groups, North Yorkshire – older people) selected to illustrate the widest possible potential impact of the s31 flexibilities. Documentary analysis (s31 flexibilities partnership notifications and proposals) | Semi-structured interviews with key stakeholders (local authority and NHS managers, user/carer representatives, voluntary sector etc.) (<i>N</i> = 23) in sub-sample of five sites selected to cover a range of partnership types (s31 flexibilities used, client groups, and service areas – e.g. integrated teams, hospital discharge, reablement etc.) and user and carer involvement activities. They were also chosen to achieve coverage of all five health regions in Wales. The LA/LHG areas were: Neath Port Talbot, Caerphilly, Powys, Rhondda Cynon Taff and Wrexham. Documentary analysis (s31 flexibilities partnership notifications and proposals) | Semi-structured interviews (<i>N</i> = 64) with NHS and local authority, and CWP managers, staff working in redesigned roles, clinical leads, user and carer representatives etc.) in four pilot sites and the CWP central team. Pilots were chosen to cover a range of different role redesign activities (for particular client and/or professional/worker groups), client groups and service areas, patient/user and carer involvement activities. The pilots studied were: North Derbyshire – older people’s services; Newcastle, North Tyneside, Northumberland and North Cumbria – Mental Health; senior house officers – Leicester; and Salford – allied health professionals. Documentary analysis (e.g. progress reports, steering group minutes), meeting attendance and shadowing role holders |
| Follow-up/wider survey | Follow-up postal questionnaire of the same 32 sites to assess progress in flexibilities implementation – response rate 73% (<i>N</i> = 22). | Not applicable | Postal survey of HR leads in all NHS Trusts and Primary Care Trusts (response rate 29%), plus people who had received training from the CWP Team nationally to use the role redesign workshop/toolkit for local change (response rate 37%). The aim was to assess the wider spread and sustainability of CWP approaches. |

Note: All quantitative survey results were coded and analysed using SPSS. Qualitative data for each of the studies (interview transcripts, and notes from documentary analysis, meeting attendance and staff observations was analysed thematically using standard techniques (cf. Dey, 1993). Case study summaries and interim reports were sent to the participants for comment/verification.

consultation on completed draft proposals. In Wales, it asked about: consultation and actual involvement in drafting proposals. Overall, involvement levels for user and carer groups and CHCs were encouraging, particularly in England (Table 3). If, however, we test the strength/inclusiveness of that involvement – i.e. if we say that involvement in all partnership stages means a strong or inclusive approach, and a weak or minimalist approach is where groups were consulted on a completed draft proposal, but not involved at any prior stage – then levels drop markedly. In addition, fewer partnerships had involved less well-established and definable groupings, such as local communities and the general public, compared with more easily accessible bodies like CHCs.

In terms of more concrete involvement in partnership structures, no baseline survey respondents ($N = 30$) in Wales identified user/carer groups as full partners on s31 proposals, and only three identified CHCs. In England, just five baseline survey respondents ($N = 22$) identified user/carer groups as named partners ('non-signatory') and two said that CHCs were included. In the follow-up England survey, a distinction was made between formal *consultation* in the last 12 months and actual *representation* on partnership Boards. Involvement through representation would suggest the strongest, most inclusive approach. A weaker or more minimalist approach is where groups were either consulted only or, in particular, had still not been involved in any way. As Table 3 shows, users and carers (whether as individuals or groups) had been formally consulted or were now formally represented at Board level (though case studies showed they did not necessarily have voting rights).

Overall, at the most significant – ideas forming – early stages of s31 developments, there was at best variable, and at worst relatively little, real engagement with users/carers. This means that mainstream organisational partners were still 'in control' of partnership agendas, and potentially important views about focus and direction may be being missed. Moreover, the view that users/carers did not need to be consulted because the partnership had 'not yet made changes that affect them' could carry through to affect longer-term decision making (as it had in three of the ten English case studies).

Changing Workforce Programme

Centrally, the CWP intended that pilots would identify role redesigns through an exercise known as the 'Toolkit for Local Change/Role Redesign Workshop' (NHS MA, 2004b), which took local stakeholders (managers, front-line staff, patients/users) through a nationally prescribed set of tasks aimed at re-engineering staff inputs associated with a given patient pathway, or journey through a particular episode and/or on-going phase of care (e.g. within hospital, or via discharge to community services) (cf. McNulty and Ferlie, 2002; Parker and Wall, 1998). Staff subsequently tested changes for three months. During testing, service data and patient views were amongst the information collected to support further implementation. However, not all sites successfully employed this bottom-up approach. Nine used the Toolkit to generate ideas, but others employed it only to maintain momentum on role changes already in progress. Moreover, just two and one site(s) respectively included patients/users and carers in the Toolkit exercise, and only one included the CHC and voluntary sector (effectively as a proxy for users/carers) (Table 4). Even in the Mental Health Pilot, which had a high profile within the CWP nationally for

Table 3 Involvement at different stages of s31 partnership development

| User Grouping | | Baseline survey: England (N = 22) No (%) | | |
|--|---------|--|---|--|
| | | Not involved | Consulted on completed draft proposals only (weak/minimalist) | Involved in all activities (project selection; objectives development; drafting proposals; plus consulted on completed proposals) (strong/inclusive) |
| Service user groups | 5 (23) | 4 (18) | 3 (14) | |
| Carer groups | 8 (36) | 2 (9) | 3 (14) | |
| Community groups | 12 (55) | 3 (14) | 2 (9) | |
| Community Health Council | 6 (27) | 6 (27) | 5 (23) | |
| General public | 17 (77) | 3 (14) | – | |
| | | Baseline survey: Wales (N = 31) No (%) | | |
| | | Not involved | Consulted on completed draft proposals only (weak/minimalist) | Involved in drafting proposals only |
| Service user groups | 15 (48) | 13 (42) | 2 (7) | 1 (3) |
| Carer groups | 16 (52) | 10 (32) | 4 (13) | 1 (3) |
| Local community groups | 27 (87) | 4 (13) | – | – |
| Community Health Council | 15 (48) | 10 (32) | 4 (13) | 2 (7) |
| General public | 28 (90) | 2 (7) | 1 (3) | – |
| | | Follow-up survey: England (N = 21) No (%) | | |
| | | Not involved | Formally consulted in previous 12 months (weak/minimalist) | Formally represented on Partnership Board |
| Service user groups | 5 (24) | 6 (29) | 5 (24) | 5 (24) |
| Carer groups | 6 (29) | 4 (19) | 5 (24) | 6 (29) |
| Individual users/patients | 8 (38) | 7 (33) | 3 (14) | 3 (14) |
| Individual carers | 7 (33) | 6 (29) | 5 (24) | 3 (14) |
| Other [one each of: neighbourhood groups; and the CHC] | * | * | 2 (10) | * |

Note: *Since the England follow-up postal survey did not ask directly about the types of response listed under the category of other, it is not possible to ascertain the full level of the Neighbourhood Group and CHC relevance across the sample.

Table 4 Involvement and consultation methods: detail from baseline interviews across all 13 CWP pilots

| Method employed | Number of pilot sites ($N = 13$) | | | |
|---|------------------------------------|--------|-----------------------------|---------------------|
| | Patients/ Users | Carers | Community health council | Voluntary Sector |
| Toolkit workshops re. specific roles | 2 | 1 | 1 | 1 |
| Other workshops, conferences etc | 1 | | | |
| Patient Liaison Service (PALS) | 2 | | | |
| Other patient/user support groups | 3 | 1 | | |
| Wider fora, e.g. via social services | 1 | | | |
| Role testing, measuring outcomes, patient mapping etc. | 4 | | | |
| Questionnaire survey of views | 4 | | | |
| Independent evaluation/focus groups | 3 | | | |

Note: As the baseline CWP evaluation interviews were qualitative and exploratory, we did not systematically ask about each of the categories listed in the above table. What the table captures, therefore, is the *diversity* of involvement/consultation methods employed, but it may underestimate the complete picture across all sites.

its 'successful' user involvement:

The service user organisations were a bit miffed because they hadn't been invited. The project worker was invited, but not the rest of the service users. We then, after the project had started, had to try and think of a way to get them involved without being tokenistic. (CWP Team Member)

In terms of involvement in main decision-making structures (namely project steering groups), only seven pilots included user/patient representatives. This compared with much more consistent representation for organisational partners (NHS Trusts, local authorities, professional bodies), which meant groups could be perceived as 'top-heavy', 'dominated' by particular 'organisational interests'. In addition, only four sites included user/patient representatives on project/implementation groups, working with staff to 'see through' role changes. Where users/carers were not involved in steering/implementation groups, they had sometimes been consulted in other ways (Table 4). This meant that sites could make the general claim to have 'included' them, but it did not mean that involvement was consistent across all roles. As with the s31 flexibilities, therefore, involvement varied both across partnership sites and stages of development of new arrangements.

Methods employed to encourage and facilitate involvement

Table 4 has already given some indication of actual involvement methods. More detail is also provided by English s31 case studies (Table 5) (equivalent detail was not requested in Wales, but case studies did describe their overall approach to involvement, which is described below). This clearly shows the wide variety of mechanisms being used, but once again illustrates users and carers were more often consulted on what they might perceive as *existing* decisions. For instance, only four sites mentioned setting up task groups for them to influence overall priorities, governance structures etc. Even in the

CWP pilots, where it was an explicit policy within the context of the national programme that the widest possible range of stakeholders should be involved at an early stage, the general emphasis was on consultation 'after the event' through questionnaires, focus groups, PALS interviews etc. (and then it was most likely to be in pilots, such as older people's services and mental health where there was already a cultural commitment to involvement because of the client group concerned).

In addition, Table 5 illustrates the extent to which involvement was often in the context of other types of partnership and policy mechanisms (e.g. Health Action Zones; Joint Investment Plans; Citizens/Neighbourhood Panels; Advocacy Services; Health Improvement Programmes). At least two of our Welsh s31 case studies also reported consultation as feeding into a wider involvement projects under Better Government for Older People (Cabinet Office, 1998), as did CWP's Older People's pilot (see Table 6 for more detail).

The effectiveness of involvement

Impact on partnership processes and thinking

The comments in Table 7 illustrate the progress many s31 partnerships perceived: (a) in terms of involving users and carers *per se* and (b) in then being influenced to alter their general thinking and behaviour by having facilitated that involvement. Interviewees also noted the specific impact on Board agendas and working practices. As one Social Services Director commented, Boards could be 'slightly ethereal' to ordinary members of the public. Three of the ten English s31 case studies argued, however, that they now used more accessible language and minutes, varied written and oral presentation techniques, and/or flash card systems for people to intervene in discussions. Similar changes of attitude were reported in CWP sites that were most active in user involvement (Table 7). In some cases, it was felt that these effects were 'a bit of a shock' (Voluntary Sector Representative) for the statutory agencies. It was nevertheless important precisely because active user/carer participation was seen by many as a key measure of s31 and CWP success – i.e. part of what would make using the flexibilities and redesigned roles different from previous arrangements. As one s31 Board Chair argued: 'You have to be sort of prepared to have your agenda slightly diverted sometimes. But I still think it's a strength... you need to have people saying, "Look this is awful, this is what happened to me."'

Impact on services and patient/user and carer experiences

Whatever the impact on relationships and process, the real issue is whether involvement translates into front-line delivery improvements. Significantly, CWP interviewees did argue that bottom-up piloting (involving patients in the Toolkit, steering/implementation groups etc.) had led to improvements (e.g. in terms of timing, location, staff continuity, tasks carried out by the 'right' individuals, filling service gaps etc.) (Table 8). As one PCT manager commented: having an 'excellent user voice' was often key to Pilots' success in terms of creativity and really challenging the status quo. As just one example, in Salford 'only certain people were allowed to administer eye drops [until]... a patient rightly pointed out that they could put in eye drops themselves' (CWP Team Member). In addition the entirely new role of Education Health Worker evolved directly from a

Table 5 Involvement and consultation methods: detail from s31 flexibilities case studies in England

| Approaches employed in s31 case studies | No. case study sites (N = 10) |
|---|-------------------------------|
| Before s31 partnership notification or launch | |
| • Broad consultation exercises on future priorities, models of service provision, Best Value pilot status etc. | 4 |
| • Roadshows, stakeholder workshops and conferences etc. | 6 |
| Post-launch influence on shape of s31 partnership | |
| • General views on s31 partnership elicited from users and/or carers via existing involvement groups and processes | 5 |
| • Stakeholder/task groups set up specifically to help decide s31 partnership priorities, governance structures etc | 4 |
| Post-launch influence on partnership decision-making | |
| • Users and carers as actual members of Partnership Board (current or planned following capacity building) | 5 |
| • Partnership Board decision-making supported by dedicated user/carer advisory forums | 6 |
| • Feedback to Partnership Board from person centred planning, care planning and care management processes | 2 |
| Post-launch influence on the long-term service priorities and changes | |
| • Flexibilities-specific consultation with users and carers on plans for service developments/changes | 2 |
| • Flexibilities-specific consultation with users and carers on planned changes in charging arrangements | 1 |
| • Consultation on s31 partnership services as part of Joint Investment Plan (JIP) | 4 |
| • Consultation on s31 partnership services as part of Health Improvement Programme (HImP)/wider strategy development for specific client groups | 1 |
| • Consultation on s31 partnership services as part of developments around care pathways | 1 |
| Other general consultation methods used in relation to the s31 flexibilities | |
| • User focus groups/one-to-one interviews | 3 |
| • User (self) advocacy methods being developed | 3 |
| • User survey | 2 |
| • Carer/parent focus/discussion groups | 3 |
| • Carer/parent survey | 3 |
| • User/carer open day | 2 |
| • Local communities via Health Action Zone structures, Parish Councils etc. | 3 |
| • General public via citizens' panel/local newspaper/internet discussion forum | 1 |

Note: It is important to remember that interviewees were not systematically asked about each possible method of consultation/involvement. Table 4 may, therefore, underestimate levels of engagement in the case study sites.

parent's suggestion regarding school-based special needs support. Importantly, where patients/users had simply been consulted on existing organisational decisions rather than enabled genuinely to influence those decisions, interviewees admitted that potentially

Table 6 Section 31 flexibilities and CWP role redesign consultation in the context of wider partnerships: the example of older people's services

CWP role redesign: North Derbyshire case study

North Derbyshire – This CWP pilot had the overall aim of encouraging local organisations to explore ways of delivering the NSF for older people through role redesign. Much of the consultation around redesigned roles that are moving tasks across traditional health and social care boundaries (e.g. in intermediate care) has been via wider mechanisms such as the older people's conferences instigated by the CHC in Chesterfield, and the area-based congresses set up as a result of Better Government for Older People. The conferences, for example, bring together strategic and middle managers from health and social services, some front-line staff, and between 30–50 older people. They provide a forum in which users and carers have reportedly grown in confidence to express their views.

S31 flexibilities: Wales case studies

Neath Port Talbot – This is an example of local partner organisations attempting to adopt an inclusive approach to service planning generally through their strategic planning process. A formal contract exists between the voluntary sector, LMC and local authority detailing the basis for joint working, consultation and engagement. In addition, the Older People's Forum is where a broad range of partners, including the Benefits Agency and transport providers, meet and talk with older people as citizens of their community rather than service users. The emphasis here is on prevention and promotion of independence. In both of these cases, it was envisaged that discussions about use of the s31 flexibilities will naturally develop in existing forums. They will simply be part of the process of operationalising agreed plans and priorities for particular client groups and services.

Rhondda Cynon Taff – Here, Better Government for Older People had enabled local organisations to improve consultation mechanisms and to engage older people more effectively in the process of setting priorities. It was followed by another initiative called Project CHAIN (Community Health Alliances through Integrated Networks), which has also been shaped by the views of older people as partners or 'citizens' rather than 'service users'. Part-funded by the National Assembly for Wales as a three-year demonstration project, Project CHAIN aimed to change organisational and professional cultures and sustain partnership alliances through integrated network governance. It is based on the understanding that, in order to meet the needs of older people effectively, commissioners and service providers must work in 'integrated multi-sector networks'. The project's priorities were identified by older people as: improved access to adequate income; improvement in health status; reduction in the fear of crime; and ensuring a comfortable and safe personal environment. A network has been established for each priority bringing together all relevant parties irrespective of whether their contribution is formal or informal, statutory or non-statutory. This was seen as providing a strong foundation for service and organisational changes introduced through the s31 flexibilities.

fruitful role/service reconfigurations had been overlooked. Of course, enabling the mainly qualitative perceptions of patients/users to be voiced did not obviate the need to collect 'hard' impact data (e.g. around waiting times, clinic throughput etc.), but 'giving patients the opportunity [simply] to say did they have a better experience, were they happy with the service?' (NHS Manager) was invaluable.

Table 7 The influence of involvement on partnership processes and thinking: views from s31 England and CWP case studies

S31 flexibilities in England

The great thing is that at least we are involved in the struggle. We are not sort of sitting there smirking from the outside. (User Representative – Mental Health)

[This local authority] has not been very good on [user] consultation, but to put that right the empowerment service will hopefully be the start . . . to gain people's views and bring it back so it's a two way communication thing . . . And obviously the Partnership Board's been important in that . . . I suspect it has been quite a shift. (Local Authority Partnership Manager – Learning Disabilities)

It is really proper involvement and I have to say they've done what they can to assure that there aren't any barriers there, which has made a difference. But the main thing to come out is the user voice has come out at the top. And that has really changed. (User Representative – Older People)

So the work that's going on at the moment . . . is to take the whole service and to think about 'Where do we want to be?'. And that is involving all stakeholders in quite a different way. It's only fairly recently . . . but there's some new people who've arrived on the disabilities scene who've really started to make a difference. (NHS Manager – Learning Disabilities)

CWP evaluation

Although CWP have finished in North Derbyshire and is being rolled out, it has brought people to think in different ways of doing things. It has changed their perceptions especially for older people, and I have seen the difference that makes. (User Representative – Older People)

It [the CWP Toolkit exercise] certainly allows people to understand what it is that we want to change . . . It helps people think differently . . . because it puts the patient at the centre. (CWP Team Member)

[The conference organised by the Alzheimers Society and CHC around the Nurse Consultant Early Dementia Care role was] a fantastic experience. And in terms of how you sustain or market and publicise roles and get them approved that was the big driver . . . to the commissioners to turn around really because I think they were seriously worried about the role and the funding implications of it . . . Having some of them there at the conference to listen to people [who have been through the new system], not to contribute but to listen to them . . . then we got the funding . . . That has been a tremendous force. (CWP Team Member)

Quite unlike some other boards where I have to fight for my voice to be heard, they actually explained some of the jargon in the papers and simplified it, put it in plain English. I was welcome straight off. (User Representative – Older People)

If you are going to involve service users you have to be very careful what you do. So you can't just land them in a meeting and start talking jargon. You can't give an agenda out. You have to facilitate people being involved as much as possible, not just invite them to keep the numbers up and not take any notice of what they are going to say. They might say something that is important. (NHS Manager – Mental Health)

Note: It was too early in the partnership development process to ask about concrete impacts in Wales, hence Table 7 focuses on English s31 and CWP case studies only.

The English and Welsh baseline surveys asked respondents what they hoped to achieve using s31 flexibilities. The majority specified improvements in service outputs and outcomes for users/carers. As one English NHS manager said: 'What's the point of

Table 8 Improvements relating to patient/user experiences – selected examples from CWP baseline interviews and case studies

| Case study sites | Perceived service improvement by role redesign type |
|--|---|
| Professional and support worker roles | |
| Senior house officers – Leicester | Skill-mix changes – i.e. substitution of other professionals into junior doctor roles. This led to: (a) reductions in drug errors and discharge delays, and the freeing up of beds and hence increased throughput through use of Pharmacists on medical wards; (b) more appropriate preparation of patients for theatre and fewer cancellations through the development of a trauma co-ordinator role; and (c) increased continuity of care between outpatients and ward, and reduced hand-offs through having a specialist sister in haematology and oncology. |
| Older people's services – North Derbyshire | Job widening and deepening – this included: (a) nurse consultant in early dementia care that improved clinic access and reduced patient waiting times between primary and secondary care; (b) stroke support workers providing on-going rehabilitation when AHPs are unavailable, which improved various aspects of continuity; (c) enhanced home help roles that saw LA staff taking over medication supervision from district nurses so that older people had fewer staff entering their homes; and (d) patient carer support nurses who (by liaising better with social services and taking patients home if necessary) smoothed the process of hospital discharge. |
| Mental health – Northern Region | Job widening and deepening – this included: (a) dispensing assistant dealing with medicines dispensing, stock control and requisitions on the mental health ward, which was linked to reductions in dispensing errors; (b) community psychiatric nurses providing open clinics within GP surgeries, which appeared to have speeded up access; and (c) expanded pharmacist roles, which were felt to have improved patients' experience of medications taking. As one pharmacist said: 'It is great on patient contact, and the patients feel we are more neutral because I am not the one who sectioned them so they can think about the medication.' New role creation – an example here is the associate psychologist role, which was divided between adult and children's services thereby improving communication and hence continuity across service boundaries. The role was also linked with reduced waiting times. |
| Allied health professionals – Salford | New role creation – this included: (a) consultant therapist for people with complex foot problems that was linked to reductions in orthopaedic waiting times; and (b) education support worker that improved continuity by reducing the number of hand offs between different professionals that users experienced. |
| Roles for patients/users themselves | |
| Diabetes care – Luton and Peterborough | New role creation – at its most developed, patient/user input centred on roles occupied by expert patients themselves, which freed-up professionals' time to deliver more clinical care and meant that service users received what they felt was more appropriate advice/support from people that truly understood their condition. |
| Primary care – Somerset | |
| Across all pilots | Other examples of service benefits reported by the CWP central team <ul style="list-style-type: none"> • Provision of a wider range of services (including to a more diverse community) • More efficient referrals between different staff groups • Improved access and shorter waiting lists (e.g. via reduced cancellations) • More appropriate needs assessment • Better continuity and more appropriate patient journey • More thorough testing and quicker test results • Quicker treatment and improved standards of care (e.g. via reduced errors and inappropriate procedures) • Quicker and smoother discharge • Better patient knowledge of particular conditions |

Table 9 Service-related achievements in last 12 months – s31 follow-up survey in England

| Type of service improvement | No (%) respondents (N = 15) |
|---|-----------------------------|
| Improved service availability/appropriateness | 5 (33) |
| <ul style="list-style-type: none"> • Increase/greater geographical equity in service provision • Independent Living Centre established as equipment service base • Supported Housing set up • Reduced waiting times | |
| Improved efficiency and cost effectiveness of services | 6 (40) |
| <ul style="list-style-type: none"> • Better use made of existing resources generally (e.g. reduced duplication) • Pooled budget means gain in interest payments and more equitable charges • Significant savings in equipment supply due to ‘smarter’ purchasing • Lead commissioning means extension of local authority contracting rules to previous health-led agreements thereby improving value for money • Greater awareness of financial decisions affecting care plans | |
| Improved user outcomes and/or experiences | 5 (33) |
| <ul style="list-style-type: none"> • Increase in reported well-being of clients • Increased parenting capacity • Introduction of clearer user outcome measures • Reviews (of placements and equipment) now undertaken to suit user needs • Harmonisation of complaints procedures between health and social care | |
| Improved service outputs – defined | 9 (60) |
| <ul style="list-style-type: none"> • 414 hospital admissions prevented over specified timescale • Fewer long-term nursing care admissions than previous year • 246 high-risk elderly fallers supported over specified time period • Reduction of referral to Tier 3 from general practitioners • 200+ attended parenting education courses • Overall across all pooled budgets (rehabilitation beds, rapid response and rehabilitation at home) 66% of people returned home or were maintained at home and only 20% required long-term care | |

moving money around the system to duplicate poor practice?’ With the English follow-up survey, there was an opportunity to ask how far those objectives had been *achieved*. As with CWP, it is encouraging just how much progress partnerships felt they had made (Table 9). Obviously, this was not all accounted for by involvement *per se*. However, the flexibilities were (as suggested in the Introduction) seen as a *symbolic and practical vehicle* enabling organisations to develop a ‘whole systems approach’, focused more clearly on user/carer needs – and, supported by involvement, that vehicle was even more effective.

Some notes of caution

Although some user/carer representatives agreed with organisational interviewees about positive service impacts, others felt that process-level changes had not followed through

to the service experience. In other words, no matter how approachable individual s31 partnership and CWP managers were, questions remained about agencies' willingness to be influenced by users/carers. As one said: 'I don't think that at the commissioning level users are being involved'. Elsewhere, it was 'the Chief Execs who are meeting and the senior officers, but it hasn't come down to anybody else'. Importantly, Board representation did not mean voting rights. Hence, 'the weight' remains 'with the executive, which is the agencies rather than . . . users, carers and other parts of the system'. As another NHS manager tellingly stated: 'Consultation [in this case on charges for 'health' as well as 'social' elements of a s31-covered learning disability service] should not necessarily be seen as negotiation'.

Another difficult issue was how to balance user versus carer interests. One s31 site was concerned, for example, that although users' voices would be heard through the developing Learning Disability advocacy service, there were no carer groups organised. Elsewhere: 'You get the Carers' Council and they have a very strong view, but that may well not be the same as users'. Similarly, there were concerns about voluntary organisations being substituted for consulting individuals: 'There is an overlap . . . But the problem from our [NHS] point of view is we are used to dealing with organisations, that's our business. And dealing with individuals and this participation process is another matter altogether'. Finally, respondents recognised the importance of acknowledging diversity *within* user and carer constituencies, particularly in respect of cultural and ethnic diversity. As one Social Services Director said: 'Just saying, 'We'll have a service user on the Board or a carer, . . . that isn't the answer''.

Overall, whatever the *perceived* impact on process, services and user/carer experiences, partnerships also need to gauge the reality – especially where use of s31 flexibilities and CWP-inspired role redesign is leading to genuinely innovative ways of working. However, few CWP pilots had robust arrangements to monitor and review ongoing effects; and English s31 partnerships also admitted in the follow-up survey that monitoring and review arrangements were not necessarily effective. In Wales, none of the 26 postal survey respondents said that they had arrangements in place to measure impacts on users.

Factors that promote and hinder effective involvement

Unsurprisingly, many factors that appear to promote (or conversely by their absence to hinder) involvement were the same as for effective partnerships generally (Hardy *et al.*, 2000). Involvement was, for example, facilitated by there being real commitment to the s31 or CWP project at all levels (strategic, middle and front-line staff). Where there was such commitment, more organisational effort was invested in both partnership relationships *per se* and following that through to user/carer inclusion. An existing collaborative history, and hence mutual trust, was also helpful because it allowed partners to deal more effectively with challenging environments. Not only were stronger partnerships better able to deal with outside turbulence (e.g. changing government policy), they also had more confidence to let themselves *be challenged* internally on their service provision by users and carers. They were also less likely to be overwhelmed by competing agendas/targets, and the pressures of attempting change to tight timescales. Of course, it was stronger partnerships that, specifically in the context of s31 flexibilities, felt they had already established their strategic direction of travel – partly through previous consultation.

As the flexibilities were simply a further step on that road, these could, perversely, be the partnerships that involved users/carers less in early development of the new arrangements.

In terms of the relationship between types of partnership and involvement, some interesting observations can be made. As a general rule, in s31 and CWP sites, certain client groups (e.g. mental health, learning disability and older people) were both more likely to see effective NHS–local authority partnerships and to have effective involvement. It seems no coincidence that these are groups with existing, long-standing histories of consultation and participation for new partnerships to build on. As the user representative in CWP's Older People's pilot commented, involvement was in the context of local organisations being 'very receptive' to the views of older people compared with other areas. Partnerships focused on other groups (e.g. substance misuse or children's services) that have not traditionally been known for strong collaboration were both less likely to be employing s31 or role redesign approaches, and, when they were employing them, had yet to achieve strong involvement.

Another issue was the scale and scope of activities being undertaken. It is, quite simply, easier to achieve client legitimacy when you have a well-defined user population, relatively small, ring-fenced budgets, and simple (e.g. coterminous in a small local area) NHS–local authority relationships. As one English s31 manager argued:

Learning disability is quite a coherent service and quite a coherent body of people . . . We only have about 800 people using the service so I'm like the headmaster of a medium sized school; I know everyone by name and it's much easier to take people's views on board in that context.

By comparison, where partnerships were geographically and financially larger scale, and most importantly were serving less-defined populations (e.g. generally dispersed patients or the general public), organisations were less practically able to access user and carer views. They also perceived themselves as less able to respond to those views – because of the greater risk of knock-on effects for budgets and other 'competing' services and client groups.

There was also an organisational and professional cultural aspect to involvement. The view that users and carers were 'not particularly bothered' about being involved in important (e.g. commissioning) decisions 'as long as they get a high standard of service' was present in local authorities as well as the NHS. However, it was more noticeable in the NHS, particularly in the 'more medicalised' acute sector (e.g. the SHO and Anaesthetics CWP pilots) compared with community-based disciplines such as intermediate care and some AHP services. Similarly, culture affected awareness of potential pitfalls to involvement described above, such as the need to balance user and carer interests and ensure that voices of established groups (e.g. professionals themselves and voluntary organisations) do not predominate over those of ordinary patients/users. Interestingly, the very fact that involvement was in the context of partnerships meant that organisations and professional groups without a strong culture and history of such activity (e.g. the NHS acute sector compared with local authorities in CWP's Older People pilot; or PCTs as entirely new organisational partners at the time the s31 flexibilities were introduced) were much better placed than they would previously have been – because they now had access to mechanisms set up by partners.

Another observation is that involvement was facilitated by 'piggy backing' on to existing participation devices (Tables 5 and 6). On the one hand, this could be problematic because mechanisms were not tailored to flexibilities and CWP needs. On the other, it was helpful because of the perceived quality and timeliness of feedback from groups already accustomed to giving their views. It also meant organisations did not spend time duplicating arrangements, but were able to see s31 and CWP simply as a further 'building block', reinforcing relationships with local stakeholders – particularly around client groups such as the older people example described earlier where there was a wider government/policy-driven empowerment agenda (Cabinet Office, 1998). Overall, as Welsh interviewees argued, explicitly *not* viewing changes in isolation from other local partnership mechanisms was key to achieving wider ownership, and hence long-term sustainability of new arrangements.

Conclusions

Although there was still some way to go in achieving really *effective* involvement and empowerment, most s31 and CWP study participants felt partnerships had made considerable progress. There was also a sense that initial experiences, and lessons learnt (e.g. about which methods worked better than others) would prove useful when the s31 flexibilities and CWP-inspired role redesigns were rolled out to other client groups and/or service areas. To answer the questions posed in the introduction, interviewees did feel there was a stronger incentive for agencies to improve involvement than under previous arrangements. This was because underneath the relatively abstract concepts of s31 flexibilities and role redesign *per se*, organisations using the flexibilities and taking part in CWP pilots were focusing on 'concrete service delivery issues', making it easier for the relevant stakeholders to relate to what was being discussed. They also, in their own ways, removed the excuses organisations had when collaboration – and by follow-through the production of conditions that facilitate effective involvement – became too difficult. There were, however, two over-riding lessons to emerge. The first is about the real depth and breadth of the user involvement process in practice and the second about expectations and timeframes.

Consultation: ex-ante or ex-post?

In normal political discourse the word *consultation* is one with a known capacity to create fundamentally different interpretations between those proposing an action from a powerful position and those to be subject to that decision once it is taken. The key to this tends to be whether the consultation is to be *ex-ante* or *ex-post* – influencing the process leading up to the decision; or taking it as read and being asked to confirm or critique it. In the sphere of user involvement, as the paper has shown, this remains a critical issue. In the case of s31 partnerships and CWP pilots, a range of variance in practice is revealed. But there is an undoubted bias toward the *ex post* proposition. Users and carers appear to be more often consulted on what they themselves might perceive as *existing* decisions and some professionals seem still reluctant to be seriously influenced by those they serve. Interestingly, however, (which shows this can be about profile and empowerment among user groups in addition to management style and practice) the evidence indicates that certain client groups are taken more seriously than others. What makes the difference with these groups is that they are organised, have a history of engagement and have a certain

level of empowerment derived from their other activities within civic society in general. It follows from this that the 'reluctance' of professionals to take up *ex ante* consultation is more likely to be influenced by the relative power of the groups they engage with than by rulebook prescriptions that they should 'do more consultation'. This tells us more about the need to build more empowering partnerships in general – so that they can be good and effective clients for all sorts of public services – than about user and carer involvement in health and social care matters *per se*.

Having patience with partnerships

A second major lesson to come from the three studies was that real involvement takes a long time to achieve. 'The progress is extremely slow'; 'It's the time issue amongst everything else' were typical comments. This is, of course, the case not just for patient/user and carer involvement but also for partnership working generally. Effective and innovative partnerships need a sound infrastructure of trusting relationships (organisational, managerial, with front-line staff, and those on the receiving end of services) that grow up over time. The danger with this, in an era where bottom-up forms of empowerment have been widely promoted for almost a decade, is that over time frustrations tend to emerge on all sides – managers because the transaction costs are high and the results are hard to measure; service users or local groups because they too have opportunity costs on their time and they cannot see better services quickly enough. Tokenism, *ex post* consultation and partnership fatigue are ever present dangers in this situation and it will need serious political will to stick to the task long enough for the parallel benefits of *ex ante* consultation and service user/carer and community empowerment to arrive. Overwhelmingly, however, it has to be said that at this stage study participants, including users and carers, thought the effort would be worth it to achieve at least some real change and long-term service improvements.

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