



Gofal Cymdeithasol **Cymru**  
Social Care **Wales**



# The anatomy of resilience: **Toolkit**

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Noddir gan  
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# Using the voices of older people in Wales to improve the way we commission and deliver services



Identifying and building on the strengths of older people in a way that supports their wellbeing.

## Background to the research and this publication

Imogen Blood & Associates were commissioned by the Social Services Improvement Agency (SSIA) in 2015 to build an evidence base to inform preventative services, based on the lived experience of older people in Wales. Having reviewed the relevant literature to understand the factors which shape older people's wellbeing, we went out to five diverse areas in the North, South, East and West of Wales and interviewed 135 older people and family members caring for older people. We targeted those who might be 'on the cusp' of needing statutory services, to explore with them what helps to keep them strong and how they perceive services.

The evidence review and research report has been published by the SSIA, alongside a summary version and accompanying video at: <http://www.ssiacymru.org.uk/8885> In 2016, we were commissioned by SSIA to consider how our findings could be applied in practice – both with individual older people and at a strategic planning and commissioning level. We know that our research to date supports the principles and intentions of the Social Services and Wellbeing (Wales) Act. The purpose of this paper is to help focus ways of working with older people which identifies and build on their strengths and in a way that supports their wellbeing.

We recruited an advisory group of 14 professionals to help us to better understand the current landscape and to generate and test ideas for applying the research findings. This group included: Adult Social Services locality and service managers, commissioners, people working in the voluntary and housing sectors, researchers and policy officers. We interviewed members of the group by phone, then came together for a discussion.

This publication sets out the implications of the research findings for practitioners and commissioners and presents a series of prompts, reflective questions and practical examples intended to complement existing frameworks. The aim is to offer a selection of 'tools' which are intended to challenge, inspire and prompt a re-focusing on what older people tell us they want and need.





## Key findings from the research

Although each older person we interviewed had a unique story to tell, there was a clear consensus regarding the fundamental building blocks of a good life:

### **Being independent:**

People did not want to have to rely too much on other people; they valued being able to get out and about and being able to move around their homes without needing someone else to help them, or by accepting the minimum level of help necessary. Those we spoke to were very clear that they did not want to go into a care home.

### **Feeling good about yourself:**

'Being happy' often involved being able to continue to do 'your thing', 'keeping your mind', and maintaining a strong sense of who you are through a life story which brought meaning. Faith and spirituality played a big part in this for many.

### **Being connected to other people:**

Relationships were a key driver of wellbeing, however there was huge diversity in the relationships that mattered to people – friendships with younger people, neighbours who 'pass tomatoes over the garden fence', shopkeepers who say 'hello', as well as partners, family and long-standing friends. Some had a thriving and outgoing social life; some felt isolated and lonely; others just enjoyed their own company.

### **Being (mentally and/or physically) active:**

Being able to participate in interests and pleasures which give meaning to life; for some this involved formal classes or group activities; others were happy to get on with their individual hobbies but most people agreed it helped to have some kind of routine to structure their time.

### **Being well:**

Managing pain, and coping with changes to energy levels and memory were common themes here; maintaining confidence and managing worry was critical, and people also valued feeling safe and secure.



## What helps or hinders older people achieving wellbeing?

### **Transport:**

A little over half of those we spoke to still had access to a car – those in rural areas felt this was essential; although there were criticisms of bus services, the free bus pass was very popular and we got the impression that buses are key social hubs for older people.

### **Home environment:**

Being able to remain in your own home was central to maintaining control for many, though upkeep, utility costs and accessibility were often challenging. Some had already 'downsized'; others were considering it – a convenient location was the key factor here for most. However, the availability of appropriate housing stock was an issue for many who wanted to downsize.

### **Neighbourhood:**

The availability of local facilities; the sense of community safety (or the fear of crime); and the sorts of relationships they had within the local community all impacted on wellbeing. Many – especially those in longstanding and/or Welsh-speaking communities – felt that the profile and dynamics of their neighbourhoods had changed in ways that threatened their ability to remain independent.

### **Money:**

Some people told us that poverty was causing them to be anxious and isolated; others (particularly low income owner occupiers) were in the 'squeezed middle'. Others had a decent income and some savings and felt this enabled them to take steps to promote their own wellbeing without having to wait for services and to make the most of life.

### **Information Technology:**

Some people were using the internet to improve their wellbeing in a range of ways, from ordering food and other shopping to be delivered online; using Skype to keep in touch with dispersed family; or emailing fellow members of social groups. However, fear of scams was a key barrier here, along with knowledge, skills and confidence; cost; poor connectivity; and disability (especially arthritis and visual impairment).



## Common themes

Five themes came up repeatedly in our interviews with older people and their carers:

- Having choices and being in control (including having the right to take risks);
- Having a strong sense of identity, continuity and belonging;
- Coping with worry and uncertainty;
- Planning for change and transitions; and
- **Feeling socially connected: the key contribution of relationships to wellbeing.**

In the next section, we present some of the key messages from older people and carers regarding services and how they perceived or had experienced them.



# Starting with the voices of older people



Starting with the voices of older people..... gives so much more credibility, integrity and it comes up with far better solutions.”

Service Manager, Adult Social Care

What older people told us...	Example	What this means for services...
The help on offer is not always the help you need	We spoke to a woman who doesn't want home care workers to come to the house at set times to help her mother to get up/ go to bed, but would like an occasional day sitting service so she can sort out her mother's old house and put it up for sale. Another person told us: "I want someone to come and listen to me and understand the challenges I face and work out with me what I need to go about my day-to-day life, not just give me what they've got in the storecupboard!"	Start with what matters most to people, within the scope of their wellbeing, and what they would like to be different in their lives, rather than which services are available and whether or not they are eligible for them. We need to stop viewing an assessment, a referral, or the setting up of a service as an 'outcome'. The delivery of a service might be measured and recorded as a service outcome, but that differs from a personal outcome which is about the impact of activities or a service on an individual's life. What resources are available to this person, from their existing or local community networks? How can you mobilise and build on these? Could a personal budget help someone buy in the additional support they want and need?
Jargon can put people off asking for help or mean that they can't make informed decisions about what they want and need.	"Someone said I could get a carer assessment. I don't understand what that is" "I don't see myself as a carer, I just see myself as my father's daughter"	We need to have a different, more 'human' conversation with people about what matters to them. Frontline staff need permission to do things a bit differently and they need to speak and record in the older person's language, rather than in 'service speak'. Many councils are already replacing an 'assessment' with more of a conversation or chat about what is going on in an individual's life.
It can be difficult to find out what help you might be entitled to in future so you can plan ahead now – especially as a self-funder	An 85-year old man caring for his wife told us, "When I contacted our social services I said 'we're just about managing but if anything happened to me' They just asked me a series of questions: 'Can she dress herself?' And so on ... I'm trying to think ahead! They just said 'You don't have any needs'"	Advice and information about options and entitlement need to be offered early on, e.g. at the point of diagnosis of long term conditions such as dementia; through groups and third sector organisations. Knowing we have choices and options is critical.



What older people told us...	Example	What this means for services...
<p>Lack of clarity about different organisations' roles and responsibilities; how systems work; and what you might be entitled to can put people off seeking timely help.</p>	<p>We heard that basic preventative measures (such as alarm pendants and grab rails) were hard to access in some areas, and that there were varying charges and referral mechanisms in different areas. Some people confused 'Social Services' with 'Social Security'.</p>	<p>It is important to have people who understand the system playing a 'connecting' role, explaining who does what and when and how to ask for support. It is important that someone looking for support has a clear understanding of what the roles are of the people they may encounter along the way and what it is they can do. Understanding this will help them ask for the right support at the right time.</p>
<p>Professionals do not ask the right questions in assessments (or ask them in a way that means people have to 'admit' their limitations).</p>	<p>"We met with social services and my mother-in-law then answered the questions that were being asked: 'Are you ok?', 'Yes', 'Can you manage?', 'Yes, no problems at all', because people from that era are that proud they don't want anyone to know that they can't do this and that."</p>	<p>Assessment forms may require us to ask questions about what people are having difficulty doing – when these problems began and what impact they are having - but to understand the personal outcomes the individual wants to achieve and how they can be supported to achieve them, supplementing these with one or two of the sorts of questions that encourage people to express aspirations and open up possibilities and can take the conversation in a very different direction. Examples might include:</p> <p>"What would a good day look like for you?"</p> <p>"What has helped you stayed strong?"</p> <p>"Are there things you have thought of trying but haven't tried yet?"</p> <p>"What prompted you to pick up the phone today?"</p>
<p>Reluctance to approach (and be honest with) services, because of the fear that they will take over and you will lose control if you admit you are struggling.</p>	<p>"When they ask me how I am, half the time I'm telling lies – I've got this fear that if I tell them too much, they'll put me in a home – I want to die here."</p>	<p>It takes time to build relationships and trust. An empathic approach within conversation results in disclosure from a person, rather than hidden harm. Time spent up front (preventative agenda) should be viewed as 'spend to save' as it can offset the need for costly and unnecessary interventions. Additionally, third sector organisations and community 'hubs' (from places of worship to libraries) can be well-placed to act as independent intermediaries and sign-posters.</p>

# Introducing the 'Anatomy of Resilience' model



We developed this simple wheel from the findings of our research. The segments show the different resources which older people told us promote resilience, or help them to respond and adapt to the challenges of ageing.

## A note about 'internal resources'

By 'internal resources', we mean:

- Psychological resilience, coping strategies
- Beliefs – which may include faith or general outlook on life

## Work and Learning

Although older people have typically 'retired', we included this segment in the wheel because issues related to work and learning often came up in our conversations with people about what mattered most to them. For example:

- Many retired people had taken on unpaid work – as volunteers, as councillors or board members, or as carers for grandchildren, partners or older relatives;
- Some continued to practice their trade (one man in his seventies was still decorating for friends and family), or to mix with people they used to work with;
- A commitment to learn new things, 'keep busy' and make a contribution were critical to the identity of most of the older people we spoke to, even when they faced health challenges;
- For many people, it was important to talk about their earlier work and other roles: these are central to who they are;
- How retirement is managed and experienced can have a significant impact on finances, relationships and self-esteem in later life.

# Using the 'Anatomy of Resilience' model: practice with older people



## Who is this section for?

Practitioners who work directly with older people, including statutory, independent and third sector.

## What will it help you do?

Identify the strengths and assets older people have.

Help you understand what really matters for older people.

## How does this support the Social Services and Wellbeing Act?

Supports the shift towards outcomes focussed social work practice being adopted across Wales.

## Mapping a person's supportive resources

Where there is a challenge in one or more areas, you can look to the remaining segments to understand the supportive resources a person has. An older person may, for example, experience a challenge in relation to their physical health or the loss of a partner (relationships); but they may be supported to stay strong by a close-knit community or by their personal beliefs and sense of humour (internal resources).

You can support someone to map their resources in this way to identify the areas that could be strengthened to promote resilience, either during a crisis or, often equally effectively, preventatively or retrospectively. This can help a person reflect back on what they would do differently if things became difficult again, to avert a crisis.

Making sure that someone has information about benefits and how to access support; or facilitating them to build relationships with people in their community should mean that they are better equipped to adapt when their health condition flares up, or their partner's dementia worsens.

## Working positively with risk

Sometimes, different segments may be in conflict with each other: a beloved home may be worsening a person's physical health because of damp or inaccessibility; a beloved grandchild (relationships) may steal money (financial). Giving people the opportunity to express and explain these conflicts is a key first step in working positively with them around risk, since it highlights the positives that come from taking risks as well as the negatives and sets the risky scenario within the context of the whole of a person's life. Ideally, if we have helped an individual to identify the supportive resources they have, they will be in a much stronger position to manage the risks. People may from time to time have a 'wobble' but will be in a much better position to steady themselves when understanding their own capacity to manage risks.



## Practical tips for using the wheel

There are a number of ways in which you might use the wheel:

- As a conversational prompt: look at the wheel together, and encourage the person to select the segments from it which they want to talk about – this allows them to prioritise the agenda rather than working through set assessment questions in order.
- You could do the strength mapping exercise outlined above in a number of different ways: writing notes in or by each segment; you could with a person give each segment a rating along a continuum (with high scores representing the strongest resources); or by drawing a line in the centre of the wheel, which is closer to the outer edge where resources feel strongest and closer to the centre where they feel less strong. You could do this:
  - Collaboratively with an older person, a family member, or both together;
  - You could leave a copy of the wheel and a key question (see below) with an individual or family to reflect on before you meet them again;
  - You could do this exercise on your own, soon after you leave the person (and before you start writing any formal notes);
  - You could do this about an individual in a meeting with colleagues and/or a case (or family group) conference type meeting: you may find you have very different views about someone's strengths and the challenges they face.

### Some suggested questions to ask people:

The key is to move away from asking about needs and areas in which someone is facing challenges and to instead ask questions like:

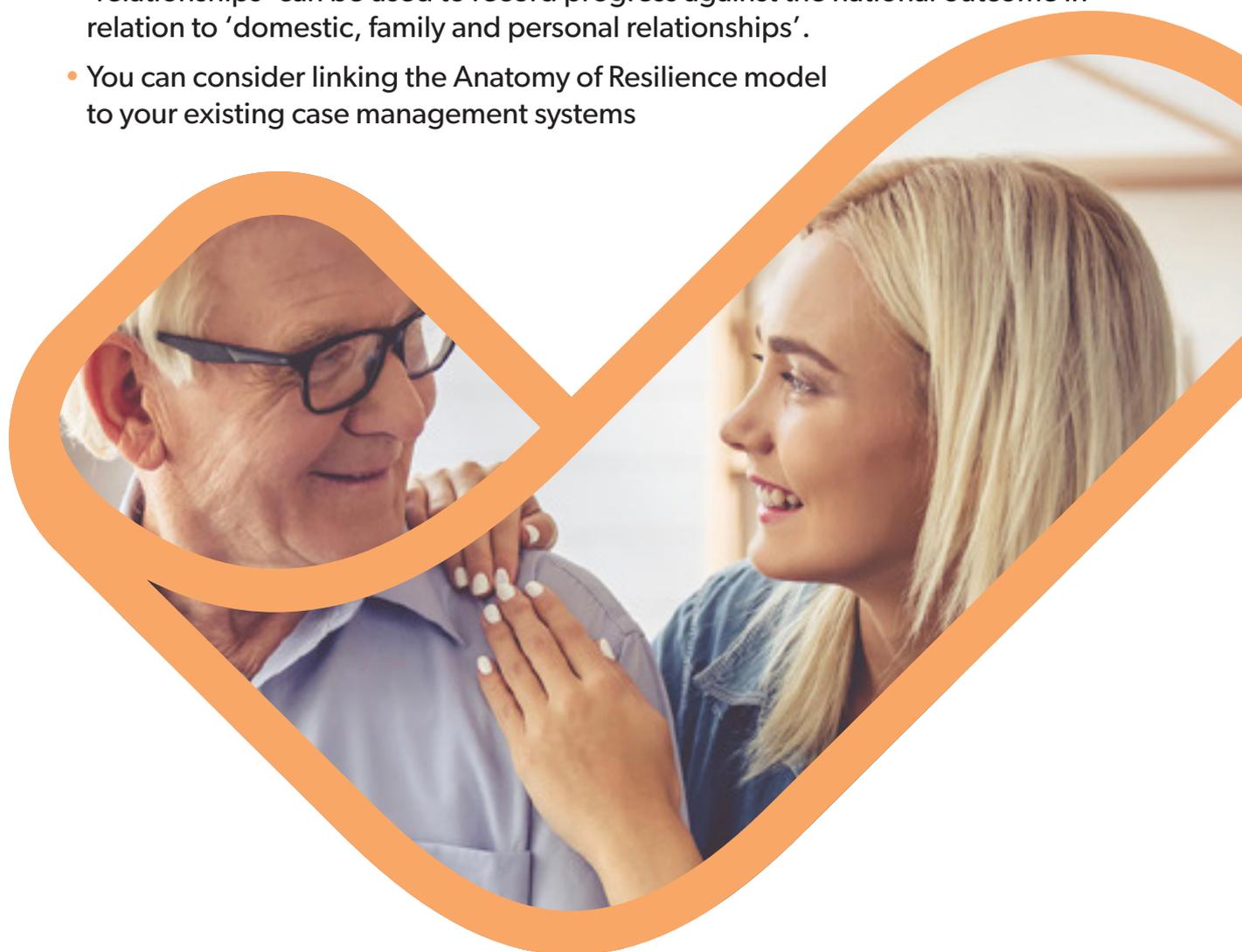
- What has helped you to stay strong so far?
- Are there areas here which you would like to build on or change to help you stay strong in future?





## Reflections on how this can best fit with your current ways of working and recording:

- This will help you to meet the national outcomes framework for people who need care and support<sup>1</sup>. For example, the segment called 'health' will support the national outcome in relation to 'physical and mental health and emotional well-being'; the segment called 'home' will support the national outcome in relation to 'suitability of living accommodation'.
- This will help you to work through your assessment to find an appropriate solution for an individual, based on what matters to them  
<http://www.ccwales.org.uk/national-assessment-and-eligibility-tool/>
- It will help you to engage with older people in order to identify and record progress against personal outcomes for example, the segment called 'relationships' can be used to record progress against the national outcome in relation to 'domestic, family and personal relationships'.
- You can consider linking the Anatomy of Resilience model to your existing case management systems



<sup>1</sup> <http://gov.wales/docs/dhss/publications/161117outcomesen.pdf>

# Applying the Anatomy of Resilience research: planning for care and support



## **Who is this section for?**

Staff from local authorities and health boards with responsibility for planning for social care.

## **What will it help you do?**

Identify what intelligence you are looking for in understanding the care and support needs, including the preventative needs of older people.

Developing Area Plans that set out how each region in Wales will address the care and support needs within their area.

## **How does this support the Social Services and Wellbeing Act?**

Planning for services that will promote the prevention of escalating need.

Putting what matters to older people at the heart of the service planning process.

## **Service planning and development**

Every five years, local authorities and local health boards are required to undertake an assessment of the care and support needs of their population. They will then respond to what they have identified within that assessment with an Area Plan, setting out how each region in Wales will address the care and support needs within their area.

As part of the assessment, each region needs to look at the strengths and assets of their community. There is also a requirement that each region builds a picture of what prevention looks like for their area and what is being done to move towards a more preventative way of working.

The assessment and plan must identify the care and support needs for older people and how they will be met.



## How does the work link to planning?

The guiding principle from the research is that we need to build on positive ability, capability and capacity to identify problems and activate solutions which promote the self-esteem of individuals and communities. By building resilience in this way, we can lessen the need for expensive professionally driven services.

When designing your process for assessing the care and support needs of your population, you may want to consider the following;

### Population Assessment

Use the wheel to:

- **Map the assets of older people in your community**
- **Frame your engagement activity with older people**

When designing your process for assessing the care and support needs of your population, you may want to consider the following;

- **What is our regional vision for preventative services for older people and does it link to the model? How is our approach to joint commissioning and pooled budgets influenced by the Anatomy of Resilience model?**
- **Have we understood the 'causes of the causes' and has this been built into our response to our assessment?**
- **Has the provision of information, advice and assistance been developed with and by people and communities?**
- **How have we understood the data and intelligence through the eyes of an older person?**

The Anatomy of Resilience model (page 7) can be used as a prompt when you analyse the data, research and intelligence you have gathered through the assessment. For example:

**HOME:** How well do you understand the housing needs of older people in your area and the options – across tenure – for meeting these? How does the planning and commissioning of housing for older people focus on what is important about 'home'?

**COMMUNITY:** How well do you understand loneliness and social isolation in your area? How can we strengthen and support the natural community hubs and connectors?

The key principles here are:

- **To use the evidence to help understand the nature of local problems and existing assets;**
- **To use community engagement not just to find out about people's 'needs' and experiences of services, but also to understand the landscape outside of 'serviceland' and explore people's aspirations and ideas for solutions;**



## Practice Example

Carmarthenshire County Council undertook work in which they mapped their existing services against the segments of the Anatomy of Resilience model and it showed that a more joined approach was needed that didn't predominantly focus on physical health.

Planning in the past tended to be very service-driven – what is the need for services – not what are the needs of people. In response to this Carmarthenshire developed a community prevention framework that worked with older people about what assets could be used in communities. They focused on three main areas of work; help to help yourself, help when you need it and ongoing support. The Council recognised that it needed to be starting with what matters to people and asking themselves which parts of the 'jigsaw' they offer which support these things – and how they can facilitate others (third sector, communities, peer support) to provide some of these things. As a result, they have now developed a public-facing prevention strategy which focuses on engaging with people and developing strong kind communities rather than starting with services.

## From Assessment to Planning

Following the assessments, it is the responsibility of the Regional Partnership Boards to produce a plan of how they will address care and support needs. As with the population assessments, the plan will set out how the region will meet the needs of older people.

- **What do we want to achieve for older people and is it clearly stated as a priority? Do our regional priorities link to the outcomes set out in the Anatomy of Resilience model?**

Are there opportunities for the development of social enterprises / co-ops / third sector organisations in response to older people needs? How do they link to what matters according to the Anatomy of Resilience model?





# Applying the Anatomy of Resilience research: commissioning for 'wellbeing'

## Who is this section for?

Staff from local authorities and health boards with responsibility for commissioning health and social care services.

## What will it help you do?

To move towards an approach to commissioning that is grounded in the perspectives of older people and their families..

## How does this support the Social Services and Wellbeing Act?

By commissioning in ways that:

- Support people who have care and support needs to achieve well-being.
- Foster partnership and co-operation as a means to drive service delivery.

If we are to enable these more 'human' conversations to happen and to shape service provision which builds on existing assets, we need a different approach to commissioning. The Social Services and Wellbeing Act (Wales) requires local authorities to promote the overall 'wellbeing' of those who need (and provide) care and support.

The evidence from our research suggests commissioning for 'wellbeing' means moving away from passive, service-based, solutions and instead focussing on the assets of communities in order to foster innovation and appropriate solutions that are relevant to older people. It is underpinned by a transition to individuals and communities being in control of solutions to their own assessment of 'problems'.

To achieve this requires a fundamental transformation of culture and practice. The key messages from the research necessitate rethinking and redesigning approaches to commissioning that are guided by:

- The factors which promote resilience – e.g. where people live, whether they enjoy supportive relationships.
- The extent to which opportunities for prevention are taken or missed, particularly through collaboration with voluntary and community groups.
- Co-production as a starting point not an added extra.
- Recognition that communities and the older people living in them have and are assets that are part of the 'solution' rather than a problem to be 'fixed'.



## What does planning and commissioning for 'wellbeing' mean?

The following table summarises how commissioning for 'wellbeing' might be different from more traditional, procurement-driven approaches.

Traditional approaches to commissioning have tended to...	Commissioning for wellbeing needs instead to...
Focus on the process of procurement and the outputs/ costs of delivery	Focus on the outcomes and longer term cost effectiveness
Respond to crisis and fund targeted services with immediate impact	Fund preventative and/or universal activities which take a longer term, 'spend to save' approach
Focus only on those eligible for state-funded care or those living in social housing	Look at the entire neighbourhood and plan actions across the whole population
Limit the offer to existing services and develop criteria to ration access	Start with what people actually want and their definition of 'problems' and broker creative responses which bring together and build on existing resources
Look only at the care and support which the local authority funds and/or provides	See local authority funded/provided support as only part of the jigsaw.
Work within departmental, service and client group 'silos', focusing on statutory responsibilities such as social care	Consider how to influence mainstream community resources, facilitate other partners and drawing together statutory, charitable and private funding.
Identify and service people's needs	Facilitate people's aspirations
Promote solutions which are developed by specialists and professionals for older people	Co-produce solutions with older people and their families and communities: transferring choice and control to them
Monitor compliance with contract specifications	Support older people and their families to determine what 'success' looks like

## Understanding the triggers of 'crisis': preventative commissioning and practice

From our conversations with older people and our review of the existing research evidence, we developed the following wheel. It shows the different factors which can contribute to a crisis, and which can often result in an unplanned move to a care home. Often it is the combination of two or more of these issues, especially where the supportive resources (identified through the anatomy of resilience) are lacking, which makes the status quo unsustainable.



### Question for reflection:

By 'internal resources', we mean:

- How are we reflecting the components of the crisis 'wheel'?
- Do contract specifications and market management of providers focus on preventing, for example:
  - Collaboratively with an older person, a family member, or both together;
  - Fostering community connections to reduce the risk of isolation and loneliness;
  - Nurturing community and voluntary networks that help to create places that are 'friendly' for people living with dementia?

### Making the case for prevention

It can be difficult to make the case for commissioning that is preventative, and supports and fosters wellbeing, at time of significant financial constraint. There is a strong and understandable drive to focus on cost and short term savings vs investment in preventative activity that may deliver benefits over a longer timeframe and have less tangible and 'cashable' outcomes. However, focusing on 'prevention' by taking an asset-based approach to supporting individuals and communities can build resilience and lessen the need for expensive, professionally driven services.



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Develop a 'Theory of Change' which spells out how you expect your preventative work to impact on one or more of these segments of the wheel by working through the following questions:

- 1. What is it you are trying to prevent?** Use the wheel as a prompt here: e.g. falls, older people being victims of doorstep crime, older people becoming isolated, carer breakdown, etc.
- 2. Which groups are you trying to target and why?** Are there particular groups of people you are trying to target because you know they are at greater risk? This might, for example, include older people living alone, those with long-term conditions, those living in certain neighbourhoods or types of housing, or older carers for people with dementia.
- 3. How do you connect with the target group?** E.g. following diagnosis, by encouraging a range of other services to identify and refer; through outreach to places where people go, etc.
- 4. How do your activities help to prevent crisis by building resilience?** It might be helpful to look at the Anatomy of Resilience wheel to prompt you here, for example, you may be giving people information, trying to strengthen their relationships, maximise their income or make their homes safer and more accessible.
- 5. Can you evidence this increased resilience?** This might be a combination of:
  - A.** 'Hard' outcomes, like someone (re-)connecting with a friend, a hobby, a volunteering opportunity; making a successful claim for Attendance Allowance; reducing their cholesterol levels; or having a modification made to their home. Link these outcomes directly to the segments on the Anatomy of Resilience wheel, not to service outcomes: it's about someone making new friends/ doing activities, not about referring them to a befriending service.
  - B.** 'Soft' outcomes, like someone describing an improvement in the quality of their relationships, how they feel about their community or their sense of being able to cope. Don't dismiss these as 'anecdotal' – the key difference between 'anecdotal evidence' and 'qualitative data' is writing it down!
- 6. Can you (reasonably) conclude that you have been able to prevent something from the 'Anatomy of Crisis' wheel from happening as a result of your activities?** It is always tricky to prove that you have prevented something from happening but if someone who used to fall regularly (or was felt to be at high risk of doing so) has not fallen (or fallen less or with less impact), or if a carer who was feeling stressed and exhausted is now feeling more supported, or if someone with a long term condition is noticing improvements in their physical, cognitive or mental health then this seems to be a reasonable conclusion.
- 7. Is there any data estimating the costs to social care, health or other public sector agencies of these (prevented) events to which you can compare the costs of your activity?** For example, if you were aiming to prevent falls, the data suggests that women, those over 85 and people with dementia are most at risk and that, in the 12 months following a hospital admission for falls, health and social care costs were 70 per cent higher than in the 12 months before the fall (The Kings' Fund 2013<sup>2</sup>).

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<sup>2</sup> [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/exploring-system-wide-costs-of-falls-in-tor-bay-kingsfund-aug13.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/exploring-system-wide-costs-of-falls-in-tor-bay-kingsfund-aug13.pdf)



The following practical examples of prevention (or missed opportunities for prevention) emerged from our research:

### **Missed opportunity for prevention?**

“The pathway between the properties at our sheltered housing scheme is a real worry – it is very uneven and has resulted in three people falling over already. Yet the housing association keep saying it complies with their regulations and so they don’t fix it ...”

### **Missed opportunity for prevention?**

“The district nurse came to the house because of his incontinence, she saw the handrail and got us a stronger banister.”

### **Question for reflection:**

- How do you train staff – across agencies and settings – to spot and respond to preventative opportunities, even if they fall outside of their professional remit?
- Can do you incentivise this to happen?
- How do you proportionately record it, fund it and evaluate it?

### **How can we co-produce commissioning?**

Commissioning for wellbeing is underpinned by adopting a co-produced approach; this means transferring control and the exercise of choice to older people (and other people who may require care and support). Co-produced commissioning is a significant challenge to ‘traditional’ approaches to commissioning care, support and housing services. Our research suggests the need to understand where and how commissioning decisions can and should be delegated to citizens and where they are best left at a strategic level.

Some key questions to ‘check’ for this approach might include:

- How do you involve citizens and communities in commissioning as the co-producers of health and well-being rather than the recipients of services?
- How do you involve people who have been characterised as ‘service users’ and the wider community, in shaping the strategic direction and decisions made throughout the process?
- How have you incorporated co-production across the entire commissioning framework? Co-producing commissioning requires a shared role in: -identifying and recognising local assets as well as needs; deciding what ‘services’ or responses are needed, how they are shaped and the role people will play in delivering them; and interpreting the results of those services.



- What mechanisms have you put in place that support the transfer of control and resources to older people and other people who may require care and support, including removing barriers to the use of direct payments and individual service funds as well as innovations such as community budgets?
- How have you incentivised providers to be innovative and flexible about achieving outcomes? To what extent is co-production with older people specified as an approach that providers must develop as part of any contract? This involves changing the shape of provision through signalling co-production as a desired approach to the provider market, setting the approach as an expected way of working, and outlining clear quality standards that providers and commissioners can use to judge the depth of co-production.



# Commissioning for wellbeing: some practical examples



## Relationship-based care and support

As part of the research, we interviewed the daughter of an older woman with dementia:

“They’ve got 15 minutes to shower someone with dementia! I wrote it on a sheet for them to show them what I do when I shower mum. For example, if you turn the shower on, she will wet herself under the shower. Then if you soap the flannel, she’ll wash herself ... and so on, for example if you put the toothpaste on the toothbrush she’ll brush her teeth herself ... but they ignore all that because that would take more than 15 minutes. The risk now is that she’ll refuse because they will go too quickly, and you can’t do that with someone with dementia - or she will go downhill more quickly, because they are doing it in her place, instead of helping her to maintain her autonomy and capacity and choice and wellbeing by going at her rhythm”.

The Raglan Project in Monmouthshire supports people living with dementia in a small rural community and provides an alternative to traditionally commissioned domiciliary care in which sets tasks are carried out at set times. Instead, staff are full-time and salaried and they have a lot of autonomy about how they spend their time day-to-day working to support those on their caseload. The project recognises that people’s emotional and social needs are as important as physical needs and that care cannot be effectively provided – especially where a person has dementia – if it is not based on a relationship.

## Community networks which support the wider wellbeing of older people

A key message from the research is that opportunities to learn, to stay active and connected are crucial to helping older people stay independent and well.

For example, one man told us:

After I lost my dear wife I thought well I’ve got to do something so I joined a Welsh male voice choir and never looked back since – even sung at the Albert Hall in London. So we are out three or four weekends with that; odd times in the week as well; we rehearse every Monday. I’m not saying I’m lazy but it’s easier not to cook, I go and have lunch most days down at the Cambrian Arms which is about two miles down the road from me, where they provide a very good meal every lunch time and I meet three or four chaps down there and we have a good chat and pull everybody to pieces. And because I go there, they persuaded me to join the Dominoes’ team, so we play Dominoes once a week”.



The Leeds Neighbourhood Network contract is delivered by 37 locally based schemes, run by committees that are representative of the communities they serve, with the aim of enabling older people to feel included in their local community and to have choice and control over their lives.

The five-year contract with 35 different third sector organisations specified four key outcomes for the Neighbourhood Network Schemes:

- **increasing contribution and involvement**
- **improving wellbeing and healthier life choices**
- **improving choice and control**
- **reducing social isolation.**

## Emotional and social needs are as important as physical needs.

Each of the 37 schemes delivers a range of services, shaped by local people to meet these outcomes, including health related activities, digital inclusion, social groups, outings and trips, information and advice and practical support. These services are largely delivered by volunteers, many of whom are older people.



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