JOINT COMMISSIONING

TALKING HEADS ON THE ROAD TO NOWHERE?

Briefing No 4

from the Joint Community Care Commissioning Project

King's Fund

HOHCC (Pox)

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by

Richard Poxton, Project Manager, King's Fund

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INTRODUCTION

This is the fourth in a series of Briefings from the King's Fund's Joint Community Care Commissioning Project. The earlier Briefings examined some of the issues involved in joint commissioning, progress then being made at the Project's five Development Sites, and how the establishment of a collaborative culture was an essential pre-condition for change affecting services and the quality of people's lives. The Sites are:

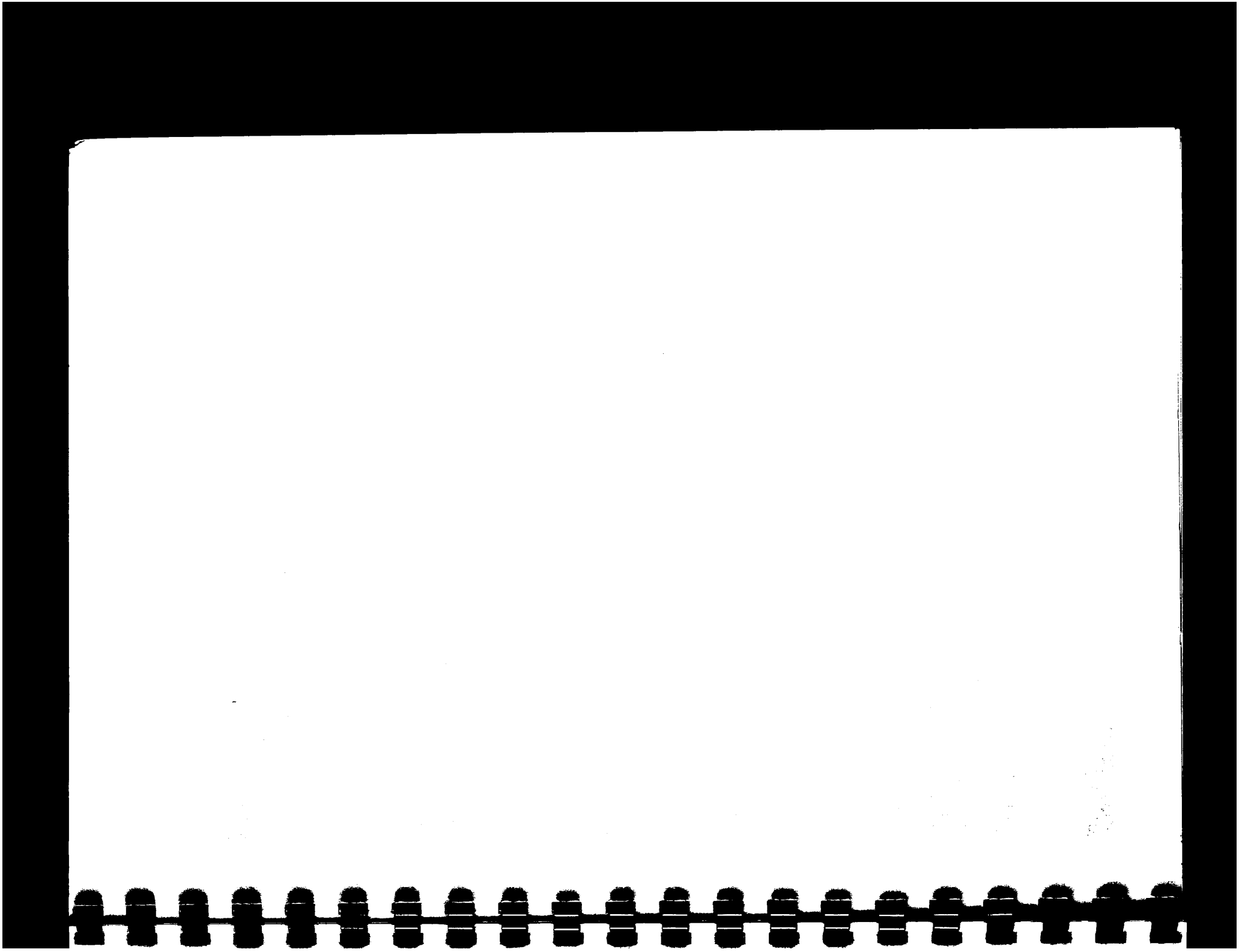
Easington
Hillingdon
Oxfordshire
Victoria (Westminster)
Wiltshire

This is the last Briefing before the Project's final report, which will be available later in the year. It continues the theme of achieving change through joint commissioning and questions whether it really can lead to a significant improvement in the quality of life for older people, which has been the specific focus of the Project. Establishing a culture of greater trust and understanding within and between the health and social care systems is not to be decried, but how valuable a gain is it when it remains largely an act of faith that joint commissioning can go on to make a major impact on older people's lives?

This Briefing reviews specific progress at the Development Sites, looks at whether or not this is satisfactory in terms of stated objectives and relates this to achieving a better quality of life for older people.

The five Development Sites (in their different approaches) continue to make genuine progress in cross organisational collaboration, sometimes in the face of budgetary and other problems. What is now clear, however, is that the complexities and scale of these are such that the achievement of significant and permanent change requires a longer period than the 18 months or so of effort so far expended. The overall impression from the Development Sites is that commissioning as a tool is being deployed only in a piecemeal way - lessons are still being learned. This reinforces a key message contained in the Department of Health Guidance on Joint Commissioning: understanding the key activities in the commissioning process is crucial.

The prospect for joint commissioning is encouraging in at least two respects. Firstly, the exhortations from Central Government remain strong: there are now several important examples (such as hospital discharge and continuing health care) where specific joint working between health and local authorities is monitored and used to assess performance. In addition, joint commissioning is part of the Department of Health's Draft Community Care Development Programme. But also there remains a real (and possibly growing) enthusiasm for joint working amongst local policymakers and practitioners. The enthusiasm evident at the Development Sites is an important factor behind the act of faith underpinning joint commissioning.



But some nagging doubts remain. Is joint commissioning, as we presently understand it, a sufficiently powerful tool as far as older people's services are concerned? Is sufficient known about the sorts of changes required and if so, do we continue as now and keep chipping away at the old ways of doing things? Or are some other sharper techniques also required which impact directly upon current and potential providers?

Alternatively, the possibility remains that joint commissioning is basically a managers `game' which flatters to deceive and takes us down a winding road which proves to be a cul-de-sac. This Briefing offers a more optimistic prospect, but a cautious one.

PROGRESS AT THE DEVELOPMENT SITES

There is no single blue-print for joint commissioning and so determining whether places are making adequate progress remains largely impressionistic. The five Development Sites are using different approaches to achieve different goals, although all of them have as an ultimate aim the most effective provision of health and social care on a systems-wide basis. Whilst many varied activities can properly be accommodated under the joint commissioning banner it is important to be clear that joint commissioning is more than `straightforward' collaboration. It involves both jointness and commissioning, and as such requires both strategic and operational components.

A brief re-cap is provided here of how the Development Sites are undertaking joint commissioning - some of which have developed since the detailed descriptions contained in Briefing No 2. To date service development achievements include a variety of reviews of specific services; agreements and plans for future change; and a range of pilot projects resulting in small-scale service changes.

Easington

Joint reviews of services for elderly mentally infirm people and of the need for home bathing are underway. These are probably the two major current activities affecting older people's services and in both cases the tasks have been tackled on a District-wide basis rather than via the eight Local Planning Groups originally envisaged as the focal points for joint commissioning. A recently appointed Joint Commissioning Development Officer is leading the work: this is a jointly funded and jointly accountable post established for a temporary period.

An important third activity near to achievement is the setting up of a `one stop shop' for information and certain health and social care services: this does represent a genuinely local project, designed and developed by one of the LPGs and supported by the Joint Commissioning Board.

The development of the warden alarm and meals-on-wheels services are two other specific activities which are also involving the District Council, so far focusing on incremental improvement and expansion.

A recent review of activities of the Local Planning Groups indicated the following efforts to improve older people's lives:

* lobbying about hospital bus service
* clarifying information from a GP practice

* collecting information on need for a local chiropody service
* improving physical access at a local clinic
* tackling dampness in privately rented properties
* better and more co-ordinated information on what services are available

Again, at District-wide level the close collaborative approach adopted by senior managers is shaping the way in which some familiar issues are being addressed, such as continuing health care and rehabilitation services.

The notion of `well being' remains at the core of Easington's joint commissioning aspirations. It follows, therefore, that the achievements to date are set against an ambitious agenda of change which takes a `whole systems' look at needs in the area (health, social, economic, environmental etc) and sees them as inextricably linked. Building upon what has been achieved to date in both service change and organisational development will be crucial. The leadership from the `District Centre' (ie Health and Social Services) will continue to be important: the collaborative culture in Easington has not yet rolled out fully across the systems. Developing collaborative working arrangements amongst practitioners is proceeding but unsurprisingly still has some way to go.

Hillingdon

Two locality-based pilots have respectively examined the needs of minority ethnic older people and the respite care needs of older people with a mental infirmity. At the same time there has been a refocus at strategic level of collaborative commissioning priorities and the means to achieve them.

There is a clearer agenda for what needs to be done and where the responsibilities lie for achieving change. This collaborative approach includes the more operational elements of community care, such as reaching agreement on responsibility for continuing health care needs of older people. Clearly this makes a good deal of sense. To be of real benefit joint commissioning has to inform the key issues of the day.

However, this important development has its negative side in that it stretches still further the limited joint commissioning development resource: this is true for Hillingdon as it is for other places. One result has been that the pilot projects have not progressed as far as had been anticipated. In fact it is probably true to say that one (for older people with a mental infirmity) has gone into temporary abeyance. The main reason for this is that a need which had been identified on a boroughwide basis and for which there was some local `support' from health and social care practitioners does not appear (so far at least) to be reflected in terms of assessments of real individuals by GPs and Social Care Managers. A new, flexible respite care response had been designed by health and social care commissioners, following a series of `locality panel' meetings involving managers, practitioners and carers. Specific funding had been provided for (a limited amount of) service provision to be bought in on an individualised basis. The closer working relationships in the locality will remain as a real gain from the pilot and should indeed form a good base for further collaborative activity. Further analysis will be undertaken on why no real gain has resulted so far for older people: this may well prove to be of real value for further activities.

The collaborative work looking at the needs of older Asian people is beginning to lead to some small-scale benefits for local people. This pilot is much more

open-ended than the one noted above: there was little if any pre-conception of what would emerge from a series of public locality meetings. Involvement has been encouraging, perhaps prompted by the absence of any `compartmentalisation' of need. People are encouraged to discuss needs and problems rather than, say, the relevance of the meals-on-wheels service. The active involvement of the Housing Department has been a major benefit. Apart from improving the availability of information and responding to individual problems, further specific collaborative commissioning is getting underway -including another look at respite care.

Pilot work in localities, together with priority operational and developmental tasks on a boroughwide basis, all forming part of and helping to shape a systems-wide review by commissioners: this remains the ambitious agenda by which Hillingdon commissioners are seeking to improve the quality of life for older people.

Oxfordshire

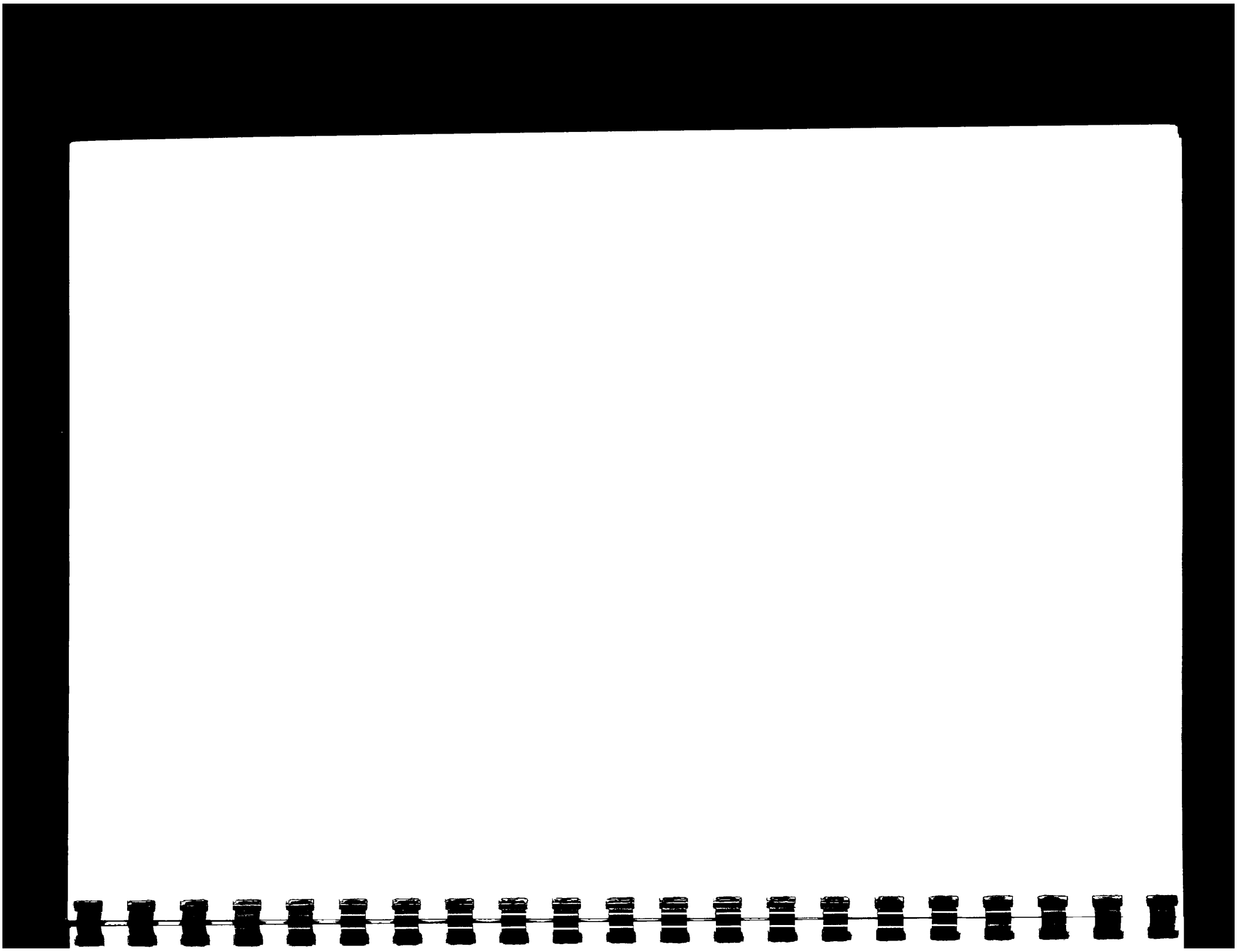
`Top down' meets `bottom up' is an over-simplfied description of Oxfordshire's approach to joint commissioning for older people's services. Perhaps with one eye on nearby spires their's is rather an intellectual approach to joint commsissioning on a systems-wide basis. An impressive, comprehensive, collaborative planning exercise has produced 3 local plans covering health and social care for older people across the county. These were just too late to affect significantly the 1995/6 planning round, although there may have been some impact on an important Health shift to the Community Sector.

These service improvements for older people are being put in place by the local community health trust. They can properly be seen as flowing from the established collaborative culture, and cover: an increase in community nurses, developing community hospitals into resource centres, improving the provision of various therapies and the development of a joint health/social services equipment centre.

For Social Services the financial climate is a more difficult one and spending plans for older people's services have been affected. The clear message here is that joint commissioning cannot simply be concerned with new or development monies. The notion of collaboration leading to greater impact applies when budgets are diminishing as much as when they are expanding, except that in the latter case the climate for working together usually seems more accommodating. Reducing expenditure does not generally lead to a better quality of life (certainly not in the short/medium term) but how the reductions are achieved can be affected by joint commissioning and the worst affects possibly avoided.

This argument re-emphasises the importance of the collaborative culture, and in Oxfordshire a range of activities have sprung from and contribute to this notion. Some of these could be said to have had a direct impact on older people's lives.

The monitoring and evaluation remains at an early stage but it is likely that direct benefits for older people can be linked with: the introduction of a care management function to an accident and emergency department; determining packages of care for highly dependent older people; jointly setting standards of care in nursing and residential care homes. Other activities will, it is believed lead to future gains including a joint locality purchasing pilot, reviewing night care services, evaluating a `rapid response' service,



determining the housing implications of community care for older people. These are a few of a wide range of current initiatives which are significantly influenced by a strong collaborative culture which is being developed by the Joint Elderly Commissioning Team.

Victoria

The stated aim in Victoria is to achieve locally-based and responsive health and social care provision for older people through creative commissioning of services and facilitating a shift from acute and residential care to primary and community care. This is to be achieved through working in partnership with users, carers, GPs, care managers and providers. There is a clear and visible emphasis on partnership both in the identification of local needs and the design and implementation of appropriate responses.

There has been a good deal of investment in the promotion of joint working between local health and social care practitioners and in the development of a locality forum by which local older people, their carers and representatives/advocates can take part in the beginnings of locality commissioning. This has resulted in both practitioners and local people being much better informed about each other's roles, priorities and problems: there has been a noticeable improvement in how workers in the health and social care systems relate to each other. The development of joint assessments is an important example of collaboration between practitioners.

Local priorities for service improvement have been identified and endorsed by strategic commissioners for further development work. The working out of effective linkages between locality and strategic commissioners is one of several interesting ingredients in the Victoria work: with relatively small budgets devolved so far, the scope for service change will largely depend upon the locality's powers of persuasion. Ensuring that these linkages are clear and work efficiently is vital for the development of locality commissioning.

Work is proceeding on five issues identified initially by the locality forum to bring about demonstrable demonstrable changes to services, with a timetable mapped out to May 1996. A key aim is to improve the integration of services to dependent people living in their own homes through making care packages more sustainable, increasing the ability of services to cope with increases in dependency and commissioning services not currently available to local people. Improvements in user satisfaction and value for money are both targeted. By May 1996, the position is expected to be:

* detailed work programme with current providers addressing specific requirements of integrated working, following consultation with users and others

* analysis of current spending patterns compared to identified needs to be completed

* recommendations to strategic commissioners on reconfiguration of expenditure.

It is also proposed to improve health and social care rehabilitation services to maintain or improve the functioning of older people living at home or returning from hospital. This is being done through a multi-agency and multi-disciplinary pilot project addressing a small number of specific areas of functioning. This may progress to a jointly commissioned service from a single provider.

Respite and day care are the other two areas of specific service improvement targeted: aiming for more flexible, locally-based respite provision across health and social care with carers heavily involved in the commissioning, and for a multi-disciplinary approach to the reprovision of day services at a local facility including involvement of local people in the detailed specification.

Integration of assessment is the final specific area for change, involving the mutual acceptance of assessments between district nurses and care managers. Again a detailed programme of preparation is laid down leading to integrated assessments for certain single services by May 1996.

An impressive amount of other work is also underway in Victoria including examination of older people's housing needs and the specific needs of minority ethnic older people, and the further development of users' and carers' involvement in commissioning.

Wiltshire

A review was recently held of progress at the two pilot sites in Wiltshire and how this work was helping shape developments of joint commissioning at primary care level across the county.

Overall there was a shared view that the collaborative effort was proving worthwhile. The tangible outcomes to date were confined to "process" ones such as a greater shared understanding and closer working relationships. There was an optimism that this would lead to a better quality of life for older people; not everybody felt that the pace of this change was sufficient.

In Town A there was a strong view that the new ways of working were in themselves major achievements. There was also a recognition that some of this still needed welding together.

Specific achievements included:

* listening to users and carers
* having user and carer involvement in the local commissioning group
* establishing an agenda based upon users' and carers' needs and wishes
* a local commissioning group, which now has a degree of cohesiveness, was grappling with real issues and was achieving a consensus approach

A major locality needs assessment exercise had been undertaken. This had provided a good deal of information but it was possible that in reality this had caused something of a distraction. Information is, of course, a key ingredient but determining the right time to act on what is to hand is crucial.

The changes in working practices and outlooks that had taken place were largely confined to project participants: influencing other practitioners was a key issue.

The imminent appointment of a Social Services Linkworker was eagerly anticipated because of the perceived significance in both building up and cementing relationships between health and social care.

In town B there was a similar balance of achievement and lack of progress. Two specific comments were:

> *"In some ways, we've made a lot of progress, in others none at all".*
>
> *"We're trying to get things nearer to the user but there's a danger of creating more bureaucracy".*

Positive aspects included a greater mutual understanding between the GPs and Social Services staff who were involved, the creation of a town focus through two "older people's workshops", the beginnings of discussions on bringing budgets together, and the roles played by users and carers in helping with a "bottom-up" approach to identifying and responding to needs.

The previous and continuing work of the Social Services Linkworker was considered to be a vital underpinning factor. In a similar way, it was expected that the new Development Worker would take forward the identified service priorities and work on the developing linkages between different parts of the system.

But there were also perceived weaknesses. There was a sense that too much rested upon key individuals: it was not certain that the time and effort required to continue this work was sustainable. There was an uncertainty about finances - how to unlock development monies and how were the local budgets to be identified and brought together?

Most participants (the user representative apart) accepted that a lengthy lead-in before service change was unavoidable, but there remained a frustration about this.

For both local areas the emphasis now was on ensuring that existing work was both sustained and developed in order to secure real improvements for older people.

There was general agreement that the models of local joint commissioning had to become stronger. The key components were people/skills, resources and information: the bricks and mortar of joint commissioning.

Some service change was seen to be within reach but to achieve major shifts further (and more detailed) work on the decision-making systems would be required, and this would involve strategic commissioners at the Health Commission and at County Hall.

It was acknowledged that the model(s) being created had to be dynamic: the worlds of health and social care are changing quickly. The emphasis (especially within health) on a primary care-led approach is in some ways encouraging but does not of itself reduce the complexity of work required.

Listed below are some specific issues identified for further development (some of which are already being worked upon):

* bringing together client/patient databases
* identifying specific budgets to be brought together

* working out (with strategic commissioners/purchasers) how to make an impact on Health Trusts, Social Services and other big providers

* creating a meaningful vision for the local collaborative work - being clearer about overall objectives and how to achieve them perhaps on the basis of what was described as a "jointly and severally liable" model

* extending the activity to others in the Practice and Team

* developing and being clear about linkages across the systems at all levels

* being clearer about the relationship between this work and the Locality Planning proposals of both the Social Services Department and the Health Commission

* improving information on services etc available to older people by pulling together existing sources, and by improving ways of passing on the information; specific issue identified of information on financial matters, including charging

The future for joint commissioning in both towns was significantly affected by the strategic, county-wide position and by the aspirations of those leading the whole collaborative exercise. What was now required was further dialogue between those with ideas of where this might be leading and those who now had some direct experience of putting local joint commissioning into action.

AN ASSESSMENT OF PROGRESS TO DATE

It requires fine judgement to determine whether the sort of progress being made at the Development Sites and elsewhere is adequate in terms of the laid down objectives. It may be helpful here to examine some of the strengths and weaknesses which have become apparent. This section draws heavily on the experience to date at the Development Sites but not exclusively so. Consequently it offers some relatively generalised views.

Progress on what?

In this analysis a very broad view is taken of what constitutes joint commissioning. It has been described as a process, an activity, a tool, a mechanism. Above all else it should be seen as a particular way of viewing the health and social care world: one which takes a broad scenario rather than a narrow one and which sees collaboration and partnership as the only effective means of making real inroads into unmet needs. In Easington they talk as much about `well-bring' as `health and social care needs'. In this analysis, therefore, all sorts of different collaborative activities can `count' as joint commissioning. *`We've been doing that for years'* is a common enough and justifiable response to a description of what activities are involved in joint commissioning. However, it is important to remember that joint commissioning is more than collaboration. Any assessment of progress has to take account of the essential systems-wide nature of both the process and the changes envisaged.

It is true that specific, usually small-scale service changes have for some time been the products of joint working. The success or otherwise of these activities needs to be assessed by measuring the impact made on the objectives which had been set out. However, joint commissioning should be seen as rather more than a series of largely unlinked small-scale activities, however worthwhile they may be: Wiltshire has a group responsible for regularly reviewing an array of initiatives spread across the county. Joint commissioning is about how organisations behave as well as the people within them. It is about commissioning which involves both strategy and operational components. It is about pilot projects which are co-ordinated and monitored in order to influence how the rest of the organisation conducts its business. It is about mainstream activity which seeks to impact upon core issues affecting the health and social care of older people.

The previous Briefing indicated the importance of establishing a collaborative culture as a pre-condition for change and analysed how to achieve this. It is also possible to indicate some specific real strengths emerging from joint commissioning in action, which should further consolidate progression to significant service change.

Some Positive Signs: Engaging with Local People in Commissioning

Commissioners are realising that effective engagement with users, carers and other members of the public can greatly strengthen their role. Various of the Development Sites are trying out different ways of surveying local needs and listening to local voices. Elsewhere in the King's Fund, experiments are being undertaken with `whole systems events', gathering together a cross-section of local people and other stakeholders to examine needs of older people. There is some evidence to suggest that local people respond better to a wider agenda than they do a narrower focus. In addition, they can bring real insight to issues which might well otherwise have been overlooked. In one very local user involvement exercise in Easington a clear view emerged that a significant benefit could be obtained for older people by providing more diversions for young people. Potentially the user/commissioner alliance is a powerful one: by looking at consultation and other involvement in a collaborative way different and perhaps more effective means are being tried. Developing a momentum is important: after a small-scale beginning the most recent public meeting in Victoria had to swiftly move rooms as over 50 older people turned up (most of whom had something to say!).

Challenging traditional models

Clearly linked to that development is a greater willingness to challenge traditional models of service response and to develop new models which are much more needs focussed. Despite many efforts the focus remains all too often on services rather than needs: at one locality meeting, a practitioner made three attempts before the users' advocate present agreed that she was indeed addressing the need rather than the service response. Commissioners need these opportunities to develop their own ideas which can then be built upon in discussion with existing and new providers: more challenges are required to traditional ways of responding to needs.

Organisational development is being tackled with a growing determination, based upon a realisation that whilst a distinction between commissioning and purchasing (on the one hand) and providing has some clear merits it is more likely to secure service improvement through partnership than competition. New skills and outlooks are required by organisations, perhaps with a premium

placed on those who are comfortable operating across the health and social care boundary. In Hillingdon, the successful launch of a locality forum for Asian Elders was significantly due to the ability of one manager to address both health and social care matters raised. There is more emphasis on the achievement of change through collaboration and developing both structures and styles which facilitate rather than hinder. Being clear about respective roles within organisations but not clinging rigidly to a hierarchical approach is a theme which runs through most of the Development Sites.

Developing linkages

Building alliances across the systems is also clearly taking off. Each Development Site has very particular examples of this, often creating a powerful momentum for change. These alliances often operate at more or less the same `level' in the system - between chief officers, between GPs and Social Care Team Managers, between commissioning managers. But they can also have a major impact when they cut across more expected alliances: the rapport between the Chief Officer and the User Advocate is an important ingredient at one of the Development Sites. Engaging and obtaining the involvement of GPs is being furthered at all of the development sites.

Links between strategic and local/locality commissioning are developing, which is of crucial importance for older people's needs. A recognition of the importance of clarity in decision-making (what is devolved to where, and what is not) is an important step forward. Through the development of greater mutual trust and understanding and having specific pilot activities on which to work, the interdependency between commissioning at strategic, locality, practice/team and individual levels is becoming more accepted. It may be that it is in fact the `jointness' which is helping to bring about this greater cohesiveness: the complexities, the focus on needs, the greater clarity of roles - all help to emphasise the essential mutual dependency of the different levels of commissioning.

Room for Improvement: Financial implications

None of these Briefings has given much emphasis to the financial aspects of joint commissioning. And yet how resources are spent is a key factor in bringing about change. In the Project's work with the Development Sites, the approach to budgeting alignment is relatively unsophisticated. There is only one example of what could be termed a joint purchasing project, although this is an ambitious pilot (in Oxfordshire) involving identification and devolution of comprehensive budgets to a GP Practice and Social Care Team. Elsewhere relatively small sums are being put `on the table' for joint decisions or the financial implications are simply being being addressed within each agency in much the same way as previously.

Listening to Older People

In the main users' voices are not very prominent in the commissioning process in spite of an increasing amount of engagement through local public meetings, membership of planning groups and so on. There now exist various sources of guidance of good practice on user involvement (for example, **`Having a Say in Change: Older People and Community Care'** by Patricia Thornton and Rosemary Tozer) although it has to be stated that involving very frail and dependent older people is never going to be straightforward. Of course, stronger user voices alone will not bring about better services. But combined with effective listening skills on the part of commissioners and the ability of

commissioners and providers to respond positively and often imaginatively, user voices can make a big impact on making joint commissioning a success.

Developing a passion for change

Possibly linked to this weakness is a perceived lack of passion for the creation of better lives for older people together with future visions which are either unclear or inadequately expressed. Of course there are champions for change in older people's services just as there are for, say, learning disabilities. But is the passion and vision often found amongst proponents at national level sufficiently replicated amongst local stakeholders? At times it appears that what is required is a greater sense of outrage at the way in which many older people are expected to live their final years in unhappiness, confusion and often much worse. Greater clarity continues to be required around the respective roles of health and social services in caring for older people in their own homes, including a greater rigour about what precisely are the needs which are being addressed rather than determining suitability for available services. A stronger Social Services emphasis on rehabilitation of older people may be important here.

Need for effective leadership

The issue of leadership is relevant too. It is clear that the Providers retain a powerful position in determining the future direction of older people's services. Their experience and expertise is invariably too valuable for them not to be integral to service development. But, the future success of commissioning depends upon commissioners and purchasers being able to draw in this Provider expertise rather than be pulled along behind it. In the meantime, there is potential at least for a limbo situation where both parties effectively opt out of leadership on the assumption that the other party either already is or in future will be picking up the reins. There remains some suspicion that professional interests are getting in the way of a better deal for older people: it is ironic that as health agencies seemingly become comfortable with local authorities taking the lead role in continuing care, the professional groupings across the range of health and social care are sometimes reluctant to yield an inch of ground in terms of lead roles. Potentially, the development of commissioning will ensure that the main focus is on needs of individuals and communities rather than on any lower priority concerns.

Taking decisions together

The lack of synchronism both within and across the decision-making systems continues to hamper joint commissioning and collaborative arrangements generally. Clarity of decision-making at different levels within both Health and Local Authorities is not always as precise as it could be. When it is clear it can all too often emphasise the difficulties in developing linkages between commissioners (and especially purchasers). If there is no local GP fundholder who is eager to consider joint commissioning and even aligned purchasing where does the Social Care Team Manager turn to work out how to spend her/his devolved budget in a properly collaborative way? Progress in these circumstances is possible but it requires skilful and often time-consuming negotiations by joint commissioning operatives whose expertise straddles the health and social care boundary. If anything the reforms of recent years have increased the differences in how health and local authorities take decisions on allocation of resources, reflected in the contrast between the large block contract (on the one hand) and a series of small devolved budgets on the other.

Commissioning skills

The lack of commissioning skills and the space to put those into effect are also relevant. The Department of Health Guidance rightly emphasised the importance of this element. The experience of the Development Sites is that leadership and involvement by senior managers is crucial to enable commissioning itself to take off: this is necessarily a complex and systems-wide issue which requires the allocation or achievement of time and space in order to succeed. All too often, of course, the same people charged with moving forward the complexities of joint commissioning also have to sort out agreements on continuing health care and hospital discharge arrangements, as well as a myriad of other issues - often against a backcloth of an ever diminishing investment in development resource as financial pressures continue.

How to evaluate?

And finally, where joint commissioning activities are beginning to take root monitoring and evaluation often remain at best embryonic. Measuring effectiveness is invariably difficult in both community health and social care: joint commissioning needs to provide more rigour with aims, objectives, outcomes as well as specific inputs.

LOOKING AHEAD TO A BETTER DEAL FOR OLDER PEOPLE

The general tone of this Briefing has been one of limited progress amidst an array of complexities and competing demands. But there are some positive signs that joint commissioning can lever some important changes for the better, affecting the health and social care of older people. If not joint commissioning, then what? Unless a better route can be found then this does still offer the best prospects for change.

Realistically, the pace of change is likely to remain slow. Whilst this is understandable given the complexities, it may no longer be acceptable as conditions on the health and social care boundary appear to worsen. Whilst being able to cope with change (and indeed leading and managing it) will remain an important attribute, too much turbulence in the system does not benefit users. Possibly this is the situation already and joint commissioning should be seen as a force for clarity and accessibility. However, it understandably requires a good deal of skill and effort to create changes in working arrangements across the health and social care boundary.

The present framework of needs assessment and service response means that there have to be both shorter and longer term agendas for change. This framework is largely determined by legislative requirements (and constraints) and the ways in which commissioning and purchasing (on the one hand) and provision of health and social care services have developed differently across the boundary. The shorter term agenda should seek to address the efficiency and flexibility of services. These will mostly be of the sort with which we are familiar, e.g. home care available in the evening, respite care in a variety of settings. But pilot projects to test out new ways of working are also important and possible in this shorter term. As has been mentioned, pilot projects as part of joint commissioning should be part of the mainstream - properly managed and evaluated for possible expansion across the system. In the short term, local areas should make progress where they can, building

upon strengths and addressing weaknesses - making optimal use of skilful boundary operators and of already effective partnerships across the systems.

The longer term agenda for joint commissioning has to include some of the fundamental issues which affect the health and social care boundary. These issues have themselves become more transparent of late but have actually been in existence for some years. Problems about defining health and social care lie at the root, leading to unclear responsibilities, insufficient focus on meeting needs and a conservative approach to designing and implementing effective responses. Of course, real progress can be made in the interim but continuing efforts must be made to address the big issues of:

* new skill mixes amongst deliverers of health and social care

* joint assessments and joint packages, including GPs in these developments

* addressing the charging anomaly between health and social care services

* the impact of a Primary Care led NHS on opportunities (and requirements) for joint working especially at local level

* securing more cohesive strategic commissioning arrangements (at organisational level) which involve Housing as well as health and social care

* addressing the increased isolation of older people due to diminishing family and community networks and some reluctance on the part of carers to pick up further responsibilities.

These are major national issues which are already being discussed but where joint commissioning effectively calls for more clarification. The potential for making real progress so far as quality of life for older people is concerned, within the current scenario, should not be understated. However it has to be said that this assertion remains largely an act of faith. Whilst some concrete service changes and evaluated user outcomes in the short-term would undoubtedly support the case for joint commissioning, ultimately unless some of the longer term issues are addressed, it may well be that joint commissioning for older people's services will lead down a road to nowhere.

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