# JOINT COMMISSIONING
# GEARING UP FOR ACTION

Briefing No 2

from the Joint Community Care Commissioning Project

KING'S FUND
CENTRE
FOR HEALTH
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DEVELOPMENT

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by

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July 1994

The project is funded by the Gatsby Charitable Foundation

## INTRODUCTION

Briefing No 1 (Joint Commissioning: The Story So Far) gave an indication of some of the major issues involved in joint commissioning services for older people. Many of those issues are also relevant to other user groups. It gave an introduction to the work taking place at the 5 King's Fund Development Sites, which are:

Easington
Hillingdon
Oxfordshire
Westminster
Wiltshire

This second Briefing concentrates on how these sites are getting on with their various joint commissioning activities. It gives an insight into what collaborative commissioning really means, the complexities, problems and achievements. It shows that, for older people's services at least, both strategic and local involvement is necessary.

Much of the work so far is concerned with mechanisms. But all of the sites are clear that these are a means to an end, the achievement of better services. Getting a clarity as to precisely what changes are required is part of the task. Doing this in a meaningful way but without re-inventing the wheel emerges as an important skill.

Nine months after their recruitment to the Project, the work with the Development Sites is gathering pace and some real change in services is predicted by those involved, certainly by the end of this Project's life at December 1995. Further Briefings will report on that progress. There will be opportunities to hear first hand from the Development Sites at future workshops.

It is useful to consider this practical information in conjunction with the analysis of issues provided by the Department of Health Working Group in its recent series of workshops and forthcoming guidance. Learning from others' experiences as well as understanding the more technical aspects of working together may be of major benefit to those setting out on the joint commissioning route.

Progress at each Development Site is examined in turn, focusing upon:

- aims and objectives: the importance of having a real clarity about what this (often difficult) work is trying to achieve by way of service outcome and different ways of working.
- achieving change: how the work is taking place, where did it start and what does it look like now.
- key players: the roles and responsibilities of those people responsible for ensuring joint commissioning achieves its aims, in different organisations and at different levels; the importance of senior managers' commitment.
- brief commentary: some very initial thoughts, which will be expanded in future Briefings.

No two places are the same: there is rich variety of activities and approaches dependent upon local circumstances and preferences. This account is inevitably a snapshot. Achieving sufficient momentum is an important component of successful joint commissioning and as you read this account activities have moved ahead.

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# Easington

## 1. AIMS AND OBJECTIVES

The Easington Joint Commissioning Board (JCB) was established following a review of health purchasing arrangements in 1992 by the Northern Regional Health Authority. At the root of its establishment were concerns about the extent of health problems in the area, the fragmentation of services and the complexities of joint working across health and social services.

Members of the JCB are County Durham Health Commission, County Durham Social Services, Easington District Council, the RHA and 2 local GPs; Easington District Council and North Durham CHC work closely with the JCB. Nine overall objectives have been identified:

i) To establish successful functioning local planning groups throughout the Easington District, through the Locality Director.

ii) To develop user/carer/consumer involvement and participation in planning and developing services through a variety of means.

iii) To develop methods of health and social care needs assessment, that take into account district-wide and local issues.

iv) To develop extended, strengthened and refocussed primary care teams.

v) To adjust the balance of activity, in favour of primary and social care.

vi) To produce and successfully implement integrated purchasing plans annually, which embrace all aspects of service provision, including community care.

vii) To purchase services which place a priority on providing an improved quality of life, whilst maintaining value for money.

viii) To raise the profile of 'health' in the community and other agencies, including the workplace.

ix) To ensure improved information is provided to the public and to ensure sharing of information between agencies with particular reference to management and shared patient/client information.

The Board is led by County Durham Health Commission's Locality Director for Easington and she is supported by a Deputy Director with special responsibilities for joint commissioning. County Durham Social Services' Group Manager for Easington is a key partner in the JCB and associated activities.

The JCB aims to involve local residents and health and social care practitioners in the assessment of needs and the determination of service response. To do this it has set up eight local planning groups (LPGs) to cover Easington District, which has a total population of some 97,000 mainly scattered across small former mining villages and towns (together with the former new town of Peterlee).

The LPGs are all now up and running. Their initial task is to undertake some local needs assessment which covers health and social care. They are geographically based and have a responsibility across all client groups, although for the purpose of this project the focus is of course on the needs of older people. Each group

comprises one or more local GPs, other health worker(s) and social services representative(s), together with a local user and/or carer and the Deputy Locality Director; other local people can be involved as appropriate. Developing the involvement of local people in real decision-making has been considered vital.

Fundamental to the collaborative approach being adopted in Easington is an understanding of its social and economic history, and the legacy of ill health and deprivation which has accompanied this. Traditionally, local communities were provided for, albeit in a limited way, when the mines were being worked. Little spirit of self-help was engendered outside the framework provided by the mining industry. The East Durham Community Development Initiative aims to address some of these problems, and community development workers are potentially a key resource for the work of the LPGs and the JCB. This initiative is supported through funding by the JCB.

The involvement of the LPGs in the commissioning of services is still in the early stages. Small budgets (in the order of £25,000) have been made available by the Regional Health Authority for each of the groups to undertake a very limited amount of purchasing. They have been asked to address particularly the eight priorities for service development for older people's services which were identified in the 1993/4 Easington Community Care Plan (these include home care, day care and night sitting services as well as improved co-ordination, developing user and carer involvement and improving needs assessment).

Both the health and social care systems in Easington operate with significant degrees of devolved responsibility. County Durham Health Commission's Locality Director and the Social Services Group Manager are very much the lead statutory commissioners. The joint commissioning mechanism which has been established seeks to ensure a powerful local voice in the way that issues are addressed and resources are allocated through the commissioning process. Work is proceeding on further clarifying respective roles and responsibilities (and ensuring the appropriate linkages are in place) now that the seeds have been sown and an important commitment obtained to collaborative working at strategic and local levels.

Further refinements of specific aims will need to take place. At its core joint commissioning in Easington is designed to impact upon the whole of the health and social care system, with the views of local people (users, carers and other residents) to the fore. The extent to which such ambitious goals are achieved may well depend upon the ability to identify achievable interim targets whilst not losing sight of the overall objectives.

## 2. ACHIEVING CHANGE

Much of Easington's joint commissioning attention to date has been focussed on the establishment of the Local Planning Groups and the 'selling' of the collaborative approach by Easington's senior managers to those further down the respective organisations. The emphasis has been more on involvement and participation than on working with devolved budgets and obtaining specific service changes. So far whatever influence the LPGs have brought to bear on statutory decision-making has been because the key players have been keen to encourage and accommodate it (rather than the system demanding it).

The JCB itself is very much a health-focussed body, reflecting its origins in the development work of the (then) Northern RHA. Nevertheless, the Social Services and District Council involvement at this level is real and committed although the involvement of the District Council at LPG level is still at the early stages. In a recent exercise, individual members of the JCB had little difficulty in establishing more personal objectives for change which they were all prepared to support. These included:

- shared information/ better communications
- shared needs assessment
- shared budgetary committment
- shared strategy
- 'one stop shop' approach to services
- raising carers' profiles
- enhancing older people's expectations

Essentially, senior managers operating as the JCB and in their day-to-day dealings with one another can demonstrate a personal commitment to and leadership of collaboration. Without underestimating the hurdles which still exist, they are clearing the way and providing the guidance for change which the LPGs are required to address. When asked to identify some specific challenges JCB offered:

- agency protectiveness
- meaningful evaluation to be devised
- focus on pragmatic action
- importance of JCB 'letting go' to LPGs
- how to achieve real involvement of users and carers
- unscrambling the financial rules
- obtaining appropriate legal advice
- overcoming professionals' 'cultural differences'
- managing the process: keeping on course for desired outcomes
- ensuring effective publicity

An important stimulus to the initial work of the LPGs was the holding of a search conference early in 1994 to help in the achievement of a collective understanding of the needs of older people and then to work towards a shared view of the possible future. An important theme was that to a significant degree the well-being of older people was tied to that of younger people and to the general economic climate for the area. Unless significant improvements can also be made towards improving job prospects for younger people in particular and the economically active in general, the likelihood is that life will not improve for older people. This awareness of the relationship between economic, environmental and health and social care factors is a vital ingredient of Easington's joint commissioning activities.

The conference produced some key shifts which it was appropriate for those engaged in joint commissioning (at JCB and LPG levels) to address, including:

| MOVING AWAY FROM | MOVING TOWARD |
|---|---|
| Older people as burdens | Older people offering skills and experience |
| Older people as grateful | Older people assessing, planning and co-ordinating own services |
| Health and Social Services responding to specific 'episodes' | Integrated service supports, including Health, Social Services, Housing, Leisure etc. |

Various unmet needs were also identified as well as some common themes which it was considered the JCB and LPGs needed to emphasise:

- user and carer empowerment
- collaboration between agencies to include information exchange
- countering ageism
- personalised responses
- importance of personal security.

Subsequent to the conference and its confirmation of significant local support for the process, further attention has been given to the design of the joint commissioning system. This has sought to ensure that a realistic agenda is set within the comprehensive approach adopted.

Each LPG is now engaged upon an audit of local health and social care services, to be followed by a needs analysis exercise and then moving to specific proposals. As with other places, the LPGs have some small budgets for their own use but in the main the power devolved to them is an advisory one: how this will actually work out in practice will be important i.e. to what extent will the LPGs be heard? For the purposes of this project a local decision has been taken to concentrate for the time being on the work of one LPG on a pilot basis. As part of its deliberations, the LPG will need to 'call in' other assistance as necessary, acknowledging that one GP, one health worker, two social services staff and two local residents are unlikely to have sufficient expertise to be absolutely sure about the way forward. The whole issue of 'specialist advice' is one being looked at in relation to strategic commissioning as well as the local version practised by the LPGs.

Clarity of respective roles and responsibilities has also emerged as a crucial issue. This is relevant in relation to individual members of the JCB and the JCB itself as well as between the strategic (Easington locality wide) and local levels. Particularly relevant is the extent to which budgets will be further devolved, i.e. down from Locality (District) level for both Health and Social Services.

The intention is that the LPGs make an important impact on the Community Care Planning and Commissioning Intentions for 1995/6, with real service changes beginning to take place then.

## 3. KEY PLAYERS

Although its collaborative system emphasises determining and acting upon needs at local levels, the key players so far have been at District level. The origins of the system lie mainly with the then County Durham FHSA's enthusiasm for an across-the-board approach which would both address needs in a holistic way and

which would help deal with the organisational tangle which saw Easington largely by-passed in terms of health focus.

The Joint Commissioning Board was set up, with a reporting line to the Joint Consultative Committee, and the FHSA's Chief Executive as its Chair. A JCB locality director for Easington was appointed: he, together with the Social Services Group Manager for Easington, led the development work during 1993. The RHA had largely slipped into the background after an important initial role, although RHA support (including financial) remains extremely important. Senior managers from Social Services, County Durham FHSA and North Durham HA were prominent in their support during 1993, as were two Easington GPs and (importantly) the General Manager of Easington District Council.

The focus has increasingly been on those at Easington (as opposed to County Durham) level being responsible for the development and implementation of the system. Within Social Services, the Group Manager has a significant degree of devolved powers. The new County Durham Health Commission decided to operate on a locality basis and Easington now has a Health Locality Director responsible for commissioning services for the district. The JCB locality director now reports to her rather than to the FHSA Chief Executive as before.

The challenge now is to ensure that local key players are able to pick up the work of the LPGs: so far there is a real enthusiasm across the spectrum of local practitioners, users and other residents. The development of this is likely to depend upon early progress being made and the system continuing to make sense to them. The complexities of tieing in collaborative decision-making to that of the statutory agencies are as real here as elsewhere but such issues are of little substantive interest to local people.

A further challenge is the need to involve more District Council players in collaborative commissioning activities. District Council involvement is important because of the holistic approach taken to health and social care: housing, environmental health, leisure, education are all important players. The personal support and involvement of the General Manager at JCB level now has to be built upon within the district. Further work has to be done to ensure an appropriate involvement by District Councillors.

## 4. BRIEF COMMENTARY

Easington's vision of what joint commissioning is all about is wide-ranging and progressive. Collaborative working was considered to be the most effective (perhaps the only?) means to address major issues of deprivation and ill-health which had been compounded by organisational arrangements which meant Easington received inadequate attention compared to neighbouring areas. This view was adopted at a senior level and significant support is still present. Senior managers across the board clearly have a real commitment to the area (not all are locals). There is a 'sense of place' in Easington associated with its past and its present which has helped develop a commitment to collaborative working and a determination to succeed. There is also a realism about the difficulties: this is no romantic notion of turning around decades of economic decline through cosy discussions but rather a considered attempt to use collaboration to make real progress.

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# Hillingdon

## 1. AIMS AND OBJECTIVES

Collaboration between Health and Social Services in Hillingdon has an impressive track record. In May 1985 the District General Manager and Director of Social Services agreed to proceed with the transfer of the management, staff and budgets of the DHA's learning disability services to the Social Services Department. The purpose of this arrangement, which came into effect in 1987, was to provide an integrated and balanced service with common principles, avoiding both gaps and duplications.

In 1991, a comprehensive structure of Joint Commissioning Groups was established following a review of how to improve further collaboration between the statutory agencies. The seven JCGs were charged with identifying existing resources, unmet needs and proposals for service change; for recommendation to the Chief Officers Group.

In 1993, Hillingdon Chief Officers became increasingly concerned to ensure that joint commissioning was performing as effectively as practicable, given the new emphasis on purchaser/provider separation in Social Services and the coming together of the DHA and FHSA in a Health Agency. A particular requirement was to determine whether by introducing a locality focus to the collaborative efforts more significant impact could be made on service change. This issue applied particularly to services for older people, where the 'across-the-board' approach was proving difficult to translate into action.

Essentially, therefore, the aim of the current work is to build upon the significant collaborative efforts to date and the existing arrangements for joint commissioning, through the incorporation of a locality approach with the existing boroughwide mechanisms.

Two local areas have been selected, one in the north of the borough and one in the south; with regard to both of these an important aspect of current activities is to design and implement the necessary mechanism which will link the new local players to the existing centrally-based systems. In the north the thesis being tested is that collaboration can lead to improved services for older people with a mental infirmity. In the south, the aim is to secure better services for ethnic elders.

## 2. ACHIEVING CHANGE

The development work in Hillingdon is slightly behind that of the other Development Sites, although important progress is now being made and the aim of some service change during the Project's life (i.e. before 1996) should be well within reach. In determining which service areas to focus upon, Hillingdon made use of a review of services for older people (including those with a mental infirmity) which it commissioned from the King's Fund College.

Design activity is currently nearing its conclusion on various identified key components of the enhanced joint commissioning system which will facilitate this work. These are set out below in summary form only at this stage. A more detailed account of the work in Hillingdon will be included in a future Briefing.

Issues currently being addressed are:

- definition of the two localities
- identification of key local players
- extent of devolved decision-making
- operational/locality mechanism
- links to strategic commissioners
- linkages to Health and Social Services decision-making processes
- involvement of users and carers, perhaps through a locality panel which will contribute to needs assessment and response
- voluntary sector involvement in commissioning
- role of 'project manager' and how to ensure adequate involvement by other key players.

## 3. KEY PLAYERS

The revitalisation of joint commissioning in Hillingdon has been very much a top-down approach, initially from Health and then picked up at 2nd tier level in both Health and Social Services. The amount of organisational change of late has been enormous, and in itself has been a major hindrance to further collaborative progress. Joint commissioning has to be robust enough to survive the inevitable comings and goings but there is a critical level beyond which this sort of work becomes difficult to sustain. With so much concentration of effort at the central and strategic (boroughwide) level, Hillingdon has been affected by the major organisational changes. Moving down to locality level offers an opportunity of building up an element of stability, although there can be no guarantees.

The recruitment of a middle manager in the Health Agency, an important part of whose work is to function as project manager, should further improve the agencies' ability to move matters onwards. An early priority is to identify key local managers and practitioners who will work on needs assessment and service response issues at locality level. It is intended that they should join with local people in assessing the needs of the locality and determining appropriate responses; further attention is being given to the creation of a Locality Panel.

The voluntary sector and both users and carers have played important roles in the history of joint commissioning so far in Hillingdon. As more emphasis has been placed on distinguishing between purchaser/commissioner and provider roles, and as both users and carers have properly insisted on speaking for themselves, it has been necessary to review how these players are best involved. The current task for Hillingdon is to ensure the system is efficient in terms of achieving service outcome (by making use, wherever possible, of inputs which give 'added value') whilst maintaining clarity of role and responsibility.

Most of all in this period of change, Hillingdon is seeking to ensure that skilled players are involved at all appropriate points in the system, with clear roles and the available time necessary in order to deliver.

## 4. BRIEF COMMENTARY

This brief description of activity at the Hillingdon Development Site indicates that progress to date is not as advanced as at the other Development Sites. The reasons for this are entirely understandable. The rate of recent design activity and the continuing hands-on commitment by senior managers in Health and Social Services should ensure that service changes begin to take place at about the same time as elsewhere.

The second stage of the Hillingdon work will involve the development of locality joint commissioning in respect of service for ethnic elders, and provides an important opportunity to test out whether collaborative work can begin to make some important gains in an area where the Community Care reforms as a whole are proving slow to take off.

This development and the continuation of work in the north of the borough will receive further attention in a future Briefing.

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## Oxfordshire

### 1. AIMS AND OBJECTIVES

The aims and objectives of Oxfordshire's joint commissioning initiative reflect the importance of both strategic and locality contributions to the development of services for older people. Activity centres around the Joint Elderly Strategy and is promoted through the Joint Elderly Commissioning Team (JECT). The aims are:

> To assess the health and social care needs of the elderly population.
>
> To integrate the planning of services to meet these needs.
>
> To improve the services available and promote new ones within existing resources.
>
> To involve users, their carers and providers of services from the statutory and independent sectors in the decision-making process for commissioning services.

The Joint Elderly Commissioning Team has been responsible for developing and implementing an approach to joint commissioning of services which combines the strategic guidance of the participating statutory and other agencies with a locally-determined response to identified needs. Oxfordshire has a relatively sophisticated joint planning mechanism to which is being added the commissioning dimension. Understanding something of JECT's role is crucial to appreciating the aims and objectives of Oxfordshire's joint commissioning of services for older people.

The JECT reports to the chief officers of the Health Authority, FHSA and Social Services Department collectively known as the 3 GMs - a small, powerful, decision-making group which meets monthly. JECT comprises middle to senior managers from these agencies, a CHC representative and a voluntary representative. From the outset JECT has been committed to the involvement of providers through consultation, although they are not members of the Team.

Six Key Areas were identified for review:

- respite care
- day care
- care at home
- services for elderly mentally ill people
- acute care
- residential/longer term care

Together, they cover the range of services for older people. They were chosen to make the task of reviewing the vast web of services more manageable.

A Joint Elderly Strategy has been produced. It brings together the proposals for care in each of the service areas in a County Commissioning Framework. This represents the initial information upon which discussions will take place within localities across the county in order to achieve a refinement which will build up to local plans for service change.

It is recognised that some systems development is required to underpin these service objectives. Identified issues for current attention are:

- county and locality information
- costings of services and general financial information
- training support strategies
- establishing linkages and dialogues across agencies at various levels
- development of care management and use of needs assessment information
- effective user involvement

The emphasis in Oxfordshire is on general aims and objectives, reflecting what is essentially a strategic approach to joint commissioning which is to be informed by locality inputs. At this stage the aims and objectives are mostly expressed in systems terms although there is a clear recognition that service improvement is the real aim. Stated objectives are:

- a more equitable spread of services across Oxfordshire
- a shift from residential to community-based resources, and a better understanding of how to shift resources
- establishment of systems to implement commissioning intentions through the Social Services operational structures and Health purchasing mechanisms
- commissioning intentions to be built into service agreements and business plans
- information from needs assessment and from needs based planning to be fed into the joint commissioning information base and to influence planning decisions
- dialogue between commissioners of services and local provider groups
- development of costings analysis to enable effective comparisons to be made
- increased contractual links with independent providers
- more joint health/social care provision
- possible development of joint budgets for certain specific services.

Overall then the Oxfordshire aim is to improve the health and social well-being of older people by jointly assessing the population need and commissioning services to best meet these needs, to be achieved by a culture of 'joint working' which impacts upon every part of the health and social care systems. Appropriate service activity will vary according to the particular circumstances of different places in

the county, but within an overall commissioning framework shaped by the work of JECT.

## 2. ACHIEVING CHANGE

The challenge Oxfordshire faces is how to ensure that its comprehensive and ambitious programme for change develops sufficient early momentum to facilitate progress to actual service change. JECT has to make skilful judgements about the pace of this change, building upon the enthusiasm of commissioners and others but not in a way which antagonises other key players.

The existence of a culture which emphasises collaboration between health and local authorities undoubtedly assists. Oxfordshire has to some extent been at the forefront of joint commissioning services for people with learning disabilities. Although there are many differences when considering services for older people there are clearly 'knock on effects'. However, there is also evidence showing the importance of acknowledging distinctions between customer groups and of working through the steps necessary for change from the beginning.

A strategy has been agreed by the 3 General Managers which aims for joint local plans to be made for 1995/6. These will be incorporated in the 1995/8 Community Care Plan, with specific proposals for use of identified available funds. At this stage these are more marginal than mainstream monies but the intention is to move forward from this base. The local plans for 1995/6 will be based on 3 groupings of the Oxfordshire localities, which coincide with Social Services operational boundaries.

At the core of the activity in 1994/5 is a series of negotiation meetings between strategic commissioners and local purchasers and practitioners. Overall control by the centre will be maintained, but making best use of knowledge and ideas of people at local level. The 'negotiating teams' comprise strategic commissioners and purchasers from the Health Authority and Social Services with local key practitioners from Social Services and Primary Health Care Teams, with GPs and representatives of locality development groups, who will bring the views of users and carers.

A detailed process structure and guidance has been produced by JECT and endorsed by the 3 GMs: this covers both the county framework for services for older people and the process for negotiating locally on it. The timetable is tight and designed to fit in with the planning, budget and contracting cycles of the statutory agencies.

### Social Services Commissioning Framework:

Plans are to cover activity, cost and location of services within the 3 County Divisions to produce proposals to meet the needs of older people aged 75 years and above in the following areas:

- care at home (including evening and night care)
- more complex care when care at home is no longer possible
- services to provide respite to carers
- services to prevent acute social crises leading to inappropriate admission to hospital or to residential care
- transport services to enable local services to run smoothly

A specific concern for JECT is to monitor and develop the involvement of users and carers in all of this activity. This will require careful attention in order to ensure an effective involvement in decision-making activities, rather than a tokenistic and unproductive involvement. This issue is of course, by no means unique to Oxfordshire. In the main, this will occur through the Oxfordshire Locality Development Project, whereby 12 localities are being created across the country with stated objectives of:

- helping providers work better together
- giving purchasers a co-ordinated body to talk to
- enabling users, carers and the public to become better involved
- creating a climate in which new services and service providers can grow

The overall process will begin to yield changes in 1995/6 as commissioners put into effect the outcome of the negotiating process. Continuous refinement will be necessary to ensure that all of the relevant strands of activity (from individual assessments through service reviews to strategic overviews) are picked up and properly taken into account. Crucial to this will be the leadership and co-ordination provided by JECT.

## 3. THE KEY PLAYERS

It could be said that a joint commissioning approach as wide ranging as Oxfordshire is bound to have an array of Key Players, from chief officers down to those collecting and providing information on local needs. Certainly the personal 'hands on' leadership of the 3 GMs is a distinctive part of Oxfordshire's approach to joint commissioning: their close involvement in activity is shown in their monthly business meetings, where reports are received and decisions made. The 'middle to senior' managers who make up JECT are significant both for the work they do together (not only at meetings of the Team) and the leadership which they provide within their organisations.

At the centre of joint commissioning for older people's services is the Strategy Coordinator, a joint post now funded from Social Services STG monies (previously from Joint Finance). She is located at DHA headquarters (but with a desk in Social Services). Basically her role is to develop and hold together the various strands relating to joint commissioning, as described above, for which she is accountable to the 3 GMs. The role requires a good knowledge of the workings of both Health and Social Services as well as a keen ability to effectively manage what is by any account a complex series of activities. Without such a role it is difficult to see any real progress being attained. Paradoxically it is also important that the Strategy Coordinator does not become overly associated with the process and its objectives to the exclusion of those others who have to achieve changes within their agencies. Tact as well as expertise have to be to the fore. The post is presently funded to April 1995.

During 1994/5 the Divisional negotiating bodies are a major focus of activity bringing together strategic commissioners and local practitioners, some of whom at least will have both purchasing and providing roles. How these individuals are able to inter-relate will be important: crucial to this will be the need for a clarity of respective roles and responsibilities in the development of better services for older people. The Strategy Coordinator and other JECT

members will be fully occupied in their various roles of advising, influencing decision-makers, as guardians of the process, giving publicity and being a lobby group for older people's resources.

## 4. BRIEF COMMENTARY

The comprehensive and relatively sophisticated approach to joint commissioning in Oxfordshire requires a solid commitment throughout the participating organisations. It also requires the skills necessary to ensure that real progress is made (as opposed to merely holding meetings). Keeping the overall aims of service change continually within vision is not made any easier by having a sophisticated model; in some ways it becomes more difficult and requires careful checks. There is a commitment to succeed as well as an impressive array of skills and expertise.

Of particular interest is the way in which a basically strategic approach to commissioning is being merged with a locality development model which is based around providers of services. The extent to which users' and carers' views will be heard in the midst of this conjunction will be of importance. Ensuring that the outcomes of this process are then translated via the statutory agencies planning systems into action is also likely to require supportive attention. Inevitably the issue of resources and responsibility for decision-making on resource allocation is crucial. Oxfordshire is committed to further devolution of such responsibility and as this happens will need to ensure that the necessary joint commissioning mechanism is in place.

Although Oxfordshire is very familiar with the issues of combining budgets in joint commissioning (because of work on learning disabilities services in particular) this important area of activity has not yet impacted upon older people's services to any significant extent. How this will be tackled is important in determining the degree of jointness which will ultimately emerge from the comprehensive commissioning model adopted. It is likely that it will be significantly affected by the more complex and wide-ranging nature of services for older people, presenting management challenges whether separate, aligned or pooled budgets are involved.

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# Westminster

## 1. AIMS AND OBJECTIVES

These have been explicitly stated and communicated to local users and carers as well as Health and Local Authority staff who are actively involved:

> To achieve a more locally based and locally responsive health and social care provision for the elderly population in Victoria through needs assessments, creative commissioning of services and facilitating the shift from acute and residential to community care.

In a slightly different form the Westminster Project Steering Group has formally adopted this as its mission statement, under the title of Collaborative Commissioning for Older People in Victoria. The statement goes on to indicate in relatively simple terms what this means:

- locally based provisions
- provisions that meet the needs of users and carers
- integrated health and social care provisions
- shifting from acute and residential care to care in the community
- working in partnership with users and carers
- working in partnership with GPs and Care Managers
- working in partnership with Providers

These statements clearly show some of the important underpinning principles of joint commissioning in action. It is a means to an end: there is a good deal of emphasis on provision of services as the main outcome. Needs assessment and 'creative commissioning' are identified as key means to achieve this end. A partnership approach is to be adopted involving Providers as well as local assessors of need (who also have developing, commissioning and purchasing roles) and users of services and their carers.

There is a stated emphasis on services being 'locally based' which to some extent address local concerns about the recent closure of hospital facilities within the locality. The new provisions must be aimed at meeting identified needs, which means that there has to be a local clarity of what these are and how they should be addressed. And there is specific reference to the importance of integration of health and social care provisions, looking for a tangible expression of 'jointness' as an outcome of collaborative commissioning. In addition, there is a particular interest by the Social Services Department in using a locality-based service development model in contrast to the usual customer group one.

Westminster has also identified the main reasons why it chose to base this work in the Victoria Locality (which comprises six local authority wards). Relatively well developed consultation processes informed the health and local authorities; the fact that those processes, and indeed the planning processes as a whole, run closely together added to the weight of the message. The main difficulties identified were:

- shortage of local GPs
- general hospital is difficult to travel to
- lack of facilities (and poor co-ordination) for older mentally ill people
- out-patient waiting times too long
- local community health facility not providing what local people want

There were other reasons too why Victoria was chosen:

- it has a higher than average number of older people and older people living alone
- there are strong local voices
- it is a well-defined area with a relatively stable and settled population of older people
- there is an identified shortage of health and social care resources

As a basis for taking collaborative action the two statutory agencies had identified certain key ways of working. Although these were explicitly stated in relation to the work in Victoria their origins lie with a general 'closeness' between the Commissioning Agency and the Social Services Department, as seen in how Community Care Planning and Health Commissioning Intentions now run on adjacent parallel tracks. A public commitment has been given to

- improving services
- closer working relationships
- user and carer involvement
- GP and Care Manager involvement in purchasing decisions
- working in partnership with Providers
- a strategic shift from acute and residential care to care in the community
- the development of locality purchasing
- joint commissioning of services

## 2. ACHIEVING CHANGE

The more ambitious the programme of change the more likely it is that new pieces of collaborative mechanism will be required. Westminster's aims for the Victoria Project certainly come under that heading. The population of the locality is some 42,000 of whom 7,000 are 65 years or older: the entire health and social care needs of this group are under review. Clearly this project is playing for high stakes.

It is well known that the process of joint commissioning is both complicated and of interest in its own right. Elsewhere this has led to over attention on this aspect and a losing sight of the main aims, ie service change. Westminster has sought to avoid that trap ensuring what new machinery it has established has clear linkages to the established joint and single-agency planning arrangements. A Project Steering Group meets roughly every 4 months; it is chaired by the Chief Executive of the Commissioning Agency and comprises senior officers from Health and Social Services as well as a Victoria GP. The bulk of the work will be overseen by a Project Management Group, chaired by the newly-appointed job sharing Project Managers and comprising almost entirely local purchasers, providers, users and carers.

Both the Commissioning Agency and Social Services Department work to a system of devolved decision-making. Before the appointment of the Project Manager the two prime 'movers' were two 3rd tier managers in Health and Social Services operating with the support and knowledge of their senior managers but largely 'getting on with

it'. In this situation it is, of course, essential to have clearly laid down guidelines from the two agencies.

As with the other Development Sites, Westminster has drawn up a project plan, which identifies key tasks and responsibilities. Much will depend on the Project Management Group swiftly developing a cohesive and shared clarity of purpose, including GPs and other Practice members. The following is a summarised version of the network of activities:

Agree shared values and objectives between the statutory agencies;

Agree shared values and objectives amongst users, carers, GPs, care managers, providers

Mapping of resources for older people in Victoria;

Identify base-line budgets;

Identify and develop quality standards and evaluation measures;

Develop and implement system for joint assessments between care managers, GPs and district nurses across the Locality;

Ensure linkages between Locality and Strategic Commissioning intentions;

Identify priority services for development and commissioning;

Develop contracts for new services as part of Community Care Plan and Commissioning Intentions.

The timescale for these activities extends beyond the life of the King's Fund project, with the major focus for service change beginning in 1995/6 and gathering pace from then onwards. The length of time this sort of work takes can be a problem: it has to allow sufficient time to ensure a proper understanding and ownership by all players but it also has to show a fairly quick return in order to retain any credibility.

As for resources available it is clear that apart from small amounts of infrastructure support and pump-priming finding these is no 'new money' over and above what is currently to hand. This, of course, includes the Social Services STG allocation which offers some scope for service improvement, at least to 1995/6: hence the importance of trying to bring the timescale forward.

Further work is required on exactly how decisions will be taken on the deployment of resources in Victoria, whether GPs and care managers will be sole purchasers and the extent to which they will also be responsible for commissioning and contracting. The 'technicalities' of aligning budgets will apply here as elsewhere.

## 3. THE KEY PLAYERS

In common with other Development Sites the early running on the development of this project came from Health, but it has long been acknowledged that to have any chance of success a true partnership approach has to be taken with Social Services. The driving forces for the various activities have been 3rd tier managers encouraged and supported by their respective (2nd tier) line managers and by the Director of Social Services and Chief Executive of the Commissioning Agency.

The basis of the Victoria Project is an overarching firm commitment to collaborative working by the two Chief Officers, who meet regularly and have a mutual agreement

to 'put time into these sessions', ie they are seen as a priority. With other senior officers they have monthly meetings described as 'agenda'd but free flowing' where confidential sessions play an important part in sorting out issues. This setting the collaborative scene and having sufficient on-going knowledge of what is happening locally may well prove significant. The tight/loose approach to joint commissioning by senior managers is one which calls for wisdom and understanding.

In the Commissioning Agency it is the Community Care Development Manager (in the Purchasing Directorate) who has been instrumental in the design and development of the Project to date, supported and advised by the Social Services Department's Head of Assessment. Effectively the Development Manager's role is now taken over by the newly appointed Project Manager (as the former is leaving). How quickly the Project Manager settles in (both job sharers know the project) and establishes a rapport with the Project Management Group will influence whether the pace of development can be maintained.

Increasingly it is staff and others at Locality level who are becoming crucial to the project's success, and getting these people 'on board' is a current major task. Several local GPs have expressed their enthusiasm for the Project (but not all!), one of whom is a member of both Steering Group and Management Group. Local users and their carers have also shown their interest by attending introductory meetings: their ongoing involvement is crucial. Providers, too, have responded to the invitation to become involved: it would be foolish to pretend that their interests are entirely selfless but they do have local knowledge and expertise to contribute. Developing further enthusiasm and willingness to participate amongst GPs and care managers remains a vital next step.

Local politicians remain a largely unknown element as the recent Local Government Elections effectively postponed their involvement for a short while. Again, ensuring their support and appropriate involvement will need to be addressed.

## 4. BRIEF COMMENTARY

The work in Victoria has undoubtedly benefited from overall commitment to collaborative working which can already be seen in practice in other aspects of health and social care in Westminster. The Commissioning Agency in particular has been able to devote management time to the design and development of the Victoria project. This has been carefully undertaken with a blend of project development/management work (indicating roles, responsibilities, timescales etc) and 'hands on' activity in the Locality, informing and enthusing. The emphasis has been on establishing a different way of working in order to bring changes which previously proved elusive. The devolved management systems of the two statutory agencies are important: 3rd tier staff really do have the confidence and support to move forward. The 'systems' issues of how to make actual achievements will require further attention, and assistance may well need to be provided to the Project Manager in determining how local aspirations become service provision activities: in this context work is beginning on how to construct 'synchronised budgets' at locality level.

# Wiltshire

## 1. AIMS AND OBJECTIVES

In Wiltshire the Social Services Department and the Health Authorities can point to a well-established history of collaboration at both strategic and local levels. This has given rise to various joint initiatives across the county, At county level, senior and other managers have generally friendly and purposeful relationships. At local level the joint funding of Social Services linkworker posts based in GP practices has provided an important basis for taking forward collaborative working.

A key underpinning principle in the development of joint commissioning for older people's services is the shared belief that this will be undertaken most effectively at very local levels, ie centred around individual GP Practices, Primary Health Care and Social Care Teams, The challenge for the strategic commissioners developing this model is to be clear about aims and objectives to ensure that these are understood at all levels, and to gauge correctly the appropriate pace of change.

The overall objectives of this work have been identified as

> To improve the health and social care of older people and their carers who are served by the 3 Practices identified to take part in the Project.
>
> To maximise the integration of primary and social care services at Practice level.
>
> To maximise the care in the community potential of integrated approaches to commissioning.
>
> To achieve a better understanding of how joint commissioning can secure objectives of service improvement.

The Wiltshire approach has been to base the work in 2 small towns in the west of the county, and to concentrate on three main aspects:

- population needs assessment
- joint working arrangements between the local teams
- development of jointly provided services

Discussions with senior managers have gleaned further desired outcomes of this work:

- to facilitate a shift in emphasis to primary care of health and social care provision
- to bring two organisational cultures closer together
- to determine new ways of assessing need worked out locally, with more emphasis on prevention
- to move towards a 'one stop shop' approach to local health and social care
- to determine the way forward following a review of health services currently provided in the west of the county.

The policy context within which this work is taking place has been spelt out in Health and Social Services planning statements for 1994/5. These strategic objectives are

of the 'basic principle' variety promulgated in the community care legislation, eg choice for service users, support for carers, partnership approach, more care for people in their own homes, etc.

The service review referred to above paid particular attention to the desirability of providing certain services outside a community hospital setting, in particular respite care, nursing/medical/geriatric assessments, terminal care and post-operative care. Joint commissioning is seen as a potential way forward to provide some of these services in alternative ways.

A further important factor in Wiltshire is the Practice Based Commissioning (PBC) initiative of the Health Commission for Wiltshire and Bath. This involves the notional allocation of Commission funds to general practices who can then determine services, within an indicative financial resource, to best meet the needs of their patients. Individual practice requirements can then be aggregated to form major contracts for services which remain the responsibility of the Commission. PBC aims to combine scarce commissioning and purchasing skills with more locally sensitive assessment and provision mechanisms: it is considered very much a 'bottom up' approach. The Commission view their joint commissioning work with Social Services as needing to fit with this overall approach to the determination of services to be provided. Assessing needs and determining how to respond at very local level (general practice/primary care team/social care team) within strategic parameters and using strategic mechanisms to actually achieve change: this is what joint commissioning of services for older people means in Wiltshire.

## 2. ACHIEVING CHANGE

Increasingly the linkages between strategic commissioners and their local counterparts is emerging as one of the main elements of joint commissioning. This is perhaps especially so for meeting the needs of older people, where the local dimension is so important in terms of both needs assessment and service response. In their submission to participate in the Joint Commissioning Project Wiltshire identified this aspect as being of particular relevance to their identified way forward.

The culture of collaboration across the county is well-established, although it is important to be clear that this represents a starting point only. There is a well-established scheme whereby Social Services link workers are placed with local primary health care teams: there is a consistent report that these individual workers (not all of whom have a Social Services background) are not only doing useful work themselves but also contributing to a developing general perception that collaboration is an effort worth making. At a recent meeting nineteen 'practice-focused joint projects' across the county were identified, and although some of these are fairly basic in concept they demonstrate a breadth of commitment to collaboration at local level.

Although there are various definitions of joint commissioning around at the moment it is clear that it represents rather more than a series of loosely connected local joint projects. In Wiltshire the development of joint commissioning of services for older people is (as elsewhere) very much a centrally-led initiative, albeit with a strong local focus. A major challenge has been to define and sell the 'product' in a manner which local practitioners can be enthusiastic about. The bulk of the development work and co-ordination of implementation activities is being undertaken by 3rd tier managers in Health and Social Services. The senior management of both the Commission and the Social Services Department is both knowledgeable about and personally committed to the development of collaborative practices, and consistently supports a devolution of responsibility to achieve change.

The challenge of developing joint commissioning at local level has been the focus of activity to date. At the outset of the Project's involvement three specific geographical locations were identified based upon three general practices and their 'partner' local

Social Services teams (two in one town, one covering the whole of another small town). Several individual visits and meetings were held to explain the purpose of the joint commissioning work, including a half day workshop involving all three local teams and other proposed participants. It has been crucially important to emphasise to local practitioners that joint commissioning is about ways of working and securing service changes for the longer term rather than quick fixes to currently identified problems, This emphasis on working out priorities for future development of services has at times led to some tension between those with strategic, longer term perspectives and those eager to spend the immediately available small amount of money on a one-off item. A key measure of success will be the extent to which the door is opened to greater integration and a recognition of the advantages to service users of a more collaborative approach.

Early attention has been given to building upon existing collaborative arrangements to achieve a more systematic and clearly stated account of how to proceed. Local needs analyses and service audits have been set in motion, these seeking to find the right balance between obtaining fresh, hard evidence and making appropriate use of existing (local, county and national) information on needs of older people. Gathering together such information can itself be a useful exercise in the team collaboration which will be important throughout this work. Building up programmes of activity (work plans) has been a useful means of mapping out tasks and roles, and how the strategic commissioners can assist the local practitioners in their development and implementation work. An important issue still to be finalised is how will the outcome of the current local activity be translated into service development activity, beyond the scope of the financial resources available to the local teams for purchase of services. Convincing local teams that these issues are being addressed is vital if they are to be sufficiently enthused to consider the whole range of health and social care provision for older people (without their being put off that they will also need to sort out these mechanism issues!).

The half day workshop referred to above sought to spell out these components, as well as enabling the three local teams to put forward their initial thoughts on how they wanted to proceed. Although it successfully did this the workshop also revealed some tensions which are very symptomatic of this type of collaboration. Chiefly these are between the local and strategic perspectives of what this collaborative work should achieve, and (related to this) the question of how much time and attention has to be given to the process issues rather than to the service provision issues themselves. This latter aspect is crucial to joint commissioning: it is a means to an end but that means is actually quite a complex one - how to do justice to those process and systems requirements without taking too much attention away from the goal of service improvement? Wiltshire has gone for a pragmatic approach, using the basis of collaborative experience to date in order to achieve quick, real progress leading to a much more systematic approach to change through collaboration.

Involving users and carers has so far proved easier to state in principle then to put into effect, this despite the existence of a well-established users involvement network. Attention is being given to making this more meaningful in ways which are also of interest to users and carers. Involvement in local needs collection exercises and public meetings to consider priorities for collaborative action are being implemented in one of the localities.

Strategic and local commissioners in Wiltshire are very much learning as they go along, and are open (and brave!) enough to pursue this model of practice. Difficulties are being encountered, most significantly the recent need to transfer from two of the original General Practices to work with a new Practice, albeit in the same town. Lessons are being learnt which will be of benefit elsewhere in the county when the work is sufficiently well-established to be modelled for replication. It is intended to produce a manual of good practice as a future guide on joint commissioning for local practitioners.

## 3. THE KEY PLAYERS

Key players are required at both straetgic and more local (operational) levels. There is a strong interest in the project from Health and Social Services senior managers who at the same time, provide quiet, behind-the-scenes leadership. This is part of a culture of devolved responsibility where managers 'down the line' are encouraged to develop initiatives. There is said to be a supportive culture, and this is certainly the impression given.

The direct leadership for the work on this aspect of joint commissioning comes from a Social Services middle manager whose main responsibility is in the area of joint planning. His ability to ensure the desired pieces of activity (both within his own department and within Health) depend as much on his skills of negotiation as his position in the organisation. The importance of informal as well as formal roles in joint commissioning should not be overlooked. The leadership from the Health Commission is shared between a number of people, to some extent reflecting the involvement of its different Directorates.

At local level the Social Care Team Managers, GP Practice/Business Managers and 'lead' (for this project) GPs have all played key parts to date, and will continue to do so as the participating teams get down to real collaborative commissioning. An important element of the Wiltshire collaborative culture has been the role within the GP Practices played by the Social Services linkworkers: further attention may need to be given to developing their role within joint commissioning. The availability of one of the Health Commission's Community Care Planners to work on the project has meant having somebody knowledgeable about and well known to both systems and the local participants.

The single most central issue highlighted in Wiltshire to date has been the extent to which GP Practices can be held to account for their involvement in collaborative work: this is, of course, of national relevance and the experience in Wiltshire may yet produce some valuable indicators.

## 4. BRIEF COMMENTARY

Joint commissioning is being developed in Wiltshire within a strategic framework which emphasises the very local level (the GP Practice/Primary Care Team) as the basis for both commissioning and collaboration. The Health Commission and Social Services Department are both committed to a significant degree of devolved decision-making (including budgetary decisions) and identifying the most effective relationship between the strategic centre(s) and the local operational bases.

Devolved decision-making is a key aspect in the introduction of successful joint commissioning. Those at the strategic centre have to show the right balance between clear leadership and knowing when to 'let go', (the classic 'tight/loose' mix). When two different working cultures are involved this can become a tricky issue, as Wiltshire discovered in relation to a GP Practice and a Social Care Team. An important lesson learnt is that certain basic preparation and signing up work has to be undertaken before local collaborative work is likely to succeed: short cuts are fine so long as the travellers remain on the right route and nobody falls off at a tight corner!

In Wiltshire there is also significant devolution in terms of the leadership of joint commissioning of older people's services. In many ways skilful operators at 'middle to senior' manager level are well-placed to undertake this sort of work but it is important that help is available when required. Wiltshire would seem to be aware of this issue. There is, too, a good emphasis on project management (detailing tasks, timescales, critical paths etc) to take account of the depth and breadth of functions involved.

The importance of having an opportunity and stimulus for change can be seen in Wiltshire. The work of the Project picks up from an earlier review of services in the west of the county which made certain recommendations for service change. Inevitably (perhaps) this change has not come about as quickly as anticipated (does it ever?) but it does mean that a climate for change is present, which is ready for exploitation by collaborative effort.

With its focus on collaboration at local level and important relationship to the Health Commission's Practice Based Commissioning initiative it remains likely that the work in Wiltshire will have some important things to say about GP involvement in joint commissioning -so important but often so elusive a part of joint commissioning for older people's services. Having an approach which enables risk-taking and learns from mistakes is a real strength in this work.

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## Some Concluding Thoughts

The preceding accounts of joint commissioning life at the Development Sites have emphasised what is distinctive about their approaches. This concluding section briefly looks at some common issues.

Of course, problems abound in this sort of work - particularly for those with ambitious agendas. Learning from setbacks can be as important as recognising difficulties which lie ahead and setting up strategies to deal with them.

In the main, joint commissioning is a fragile flower requiring careful nurturing. To have any chance of success it has to be adequately resourced, which is not always easy when Health and Local Authorities are cutting back on developmental capacity to protect front-line services. However, to achieve change there must be a recognition that an investment of time and effort is required.

Although this aspect is well-recognised at the Development Sites, they are not immune to the problems which may arise when key personnel move on: joint commissioning can be very dependent on the contribution of a very small number of people. Ensuring that this activity is not simply 'another interesting project' but rather the way the organisations as a whole operate is a significant step.

None of the Development Sites would yet claim to have got right the issue of user and carer involvement: all continue to make some progress, including recognising that these are two different groups with often different issues and that involvement of the general public may well be a further factor to consider. Involvement in what and how requires a rigorous analysis and some lateral thinking in the response. Similarly, there is little evidence to date of a successful involvement of Housing in collaborative commissioning, certainly a vital ingredient so far as older people (and indeed other users) are concerned. The forthcoming DoH guidance will offer some assistance here, as it will with involvement of GPs where the individual accounts probably understate the small but significant successes achieved by the Development Sites.

It is certainly the case that the emphasis so far as been on getting the processes right at the Development Sites, usually involving both strategic and local or locality aspects. Undoubtedly preparation is important in ensuring progress is made. The importance of achieving a 'momentum for change' and early identifiable successes are also crucial. Getting the balance right is the trick which the Development Sites are addressing. Viewed from outside the systems (by a carer, for example) the two bureaucracies often seem lumbering and self-satisfied: overcoming organisational inertia and cutting through to real service improvements is at the core of this Project.

These concluding remarks do not attempt to provide an at-a-glance guide to the key elements of joint commissioning. But from the experience to date certain points do stand out:

- clarity about objectives and adoption of a rigorous project management-style approach to their achievement; with attention given to the role of 'project manager' with sufficient dedicated time;
- the significance of both strategic and local/locality elements, and the vertical relationship between these;
- the requirement for needs assessment information which is 'good enough' for the purpose to which it will be used, and for this to include the outcomes of individual assessments;

- the importance of linkages between the 'joint commissioning machinery' and the mainstream decision-making mechanisms of Health, Social Services and others;
- achieving systematic change in how services are commissioned and provided but using quick, relatively straight-forward successes as part of the approach;
- the importance of mutual trust between the statutory agencies, reflected in the working relationships of key staff at various levels.

The next Briefing will look in more detail at how the Development Sites are working at the achievement of change, especially the securing of more effective services by a joint commissioning route.

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