# JOINT COMMISSIONING
# THE STORY SO FAR

**Briefing No 1**
**from the Joint Community Care Commissioning Project**

KING'S FUND CENTRE

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**from the Joint Community Care Commissioning Project**

**Compiled by**
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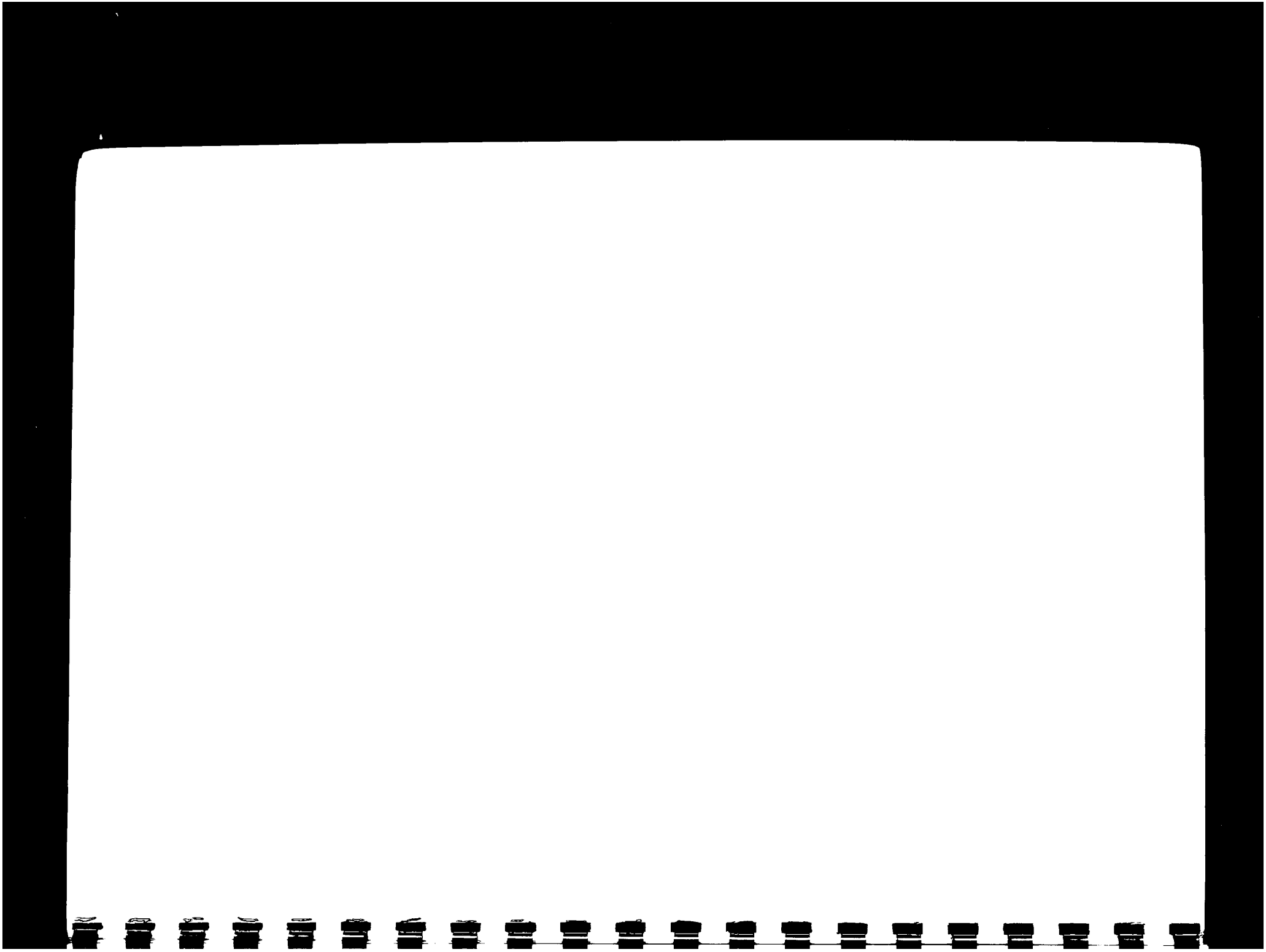
**February 1994**

The Project is funded by the Gatsby Charitable Foundation



# JOINT COMMISSIONING: The Story So Far

## INTRODUCTION

This report discusses progress and problems arising in the joint commissioning of community care services during 1993.

Particular attention is given to the commissioning of services for older people, which in terms of expenditure, size of population and potential for service change represent a major challenge in health and social care.

The report also concentrates on developments in joint commissioning at strategic level rather than at the operational level where care managers are purchasing for individuals. The relationship, however, should not be forgotten: joint commissioning makes more sense and is at its most powerful when it clearly operates as part of a broader community care planning process. It is proposed to develop this theme in future reports.

It is hoped that this brief account will contribute to the debate about the benefits and the limitations of collaborative commissioning, principally between health and local authorities, and the future directions in which it might be heading. It should be of interest to local health and social care commissioners working on a collaborative basis and also to those at national level who are interested in promoting innovation and good practice in this area.

## JOINT COMMISSIONING AND THE COMMUNITY CARE REFORMS

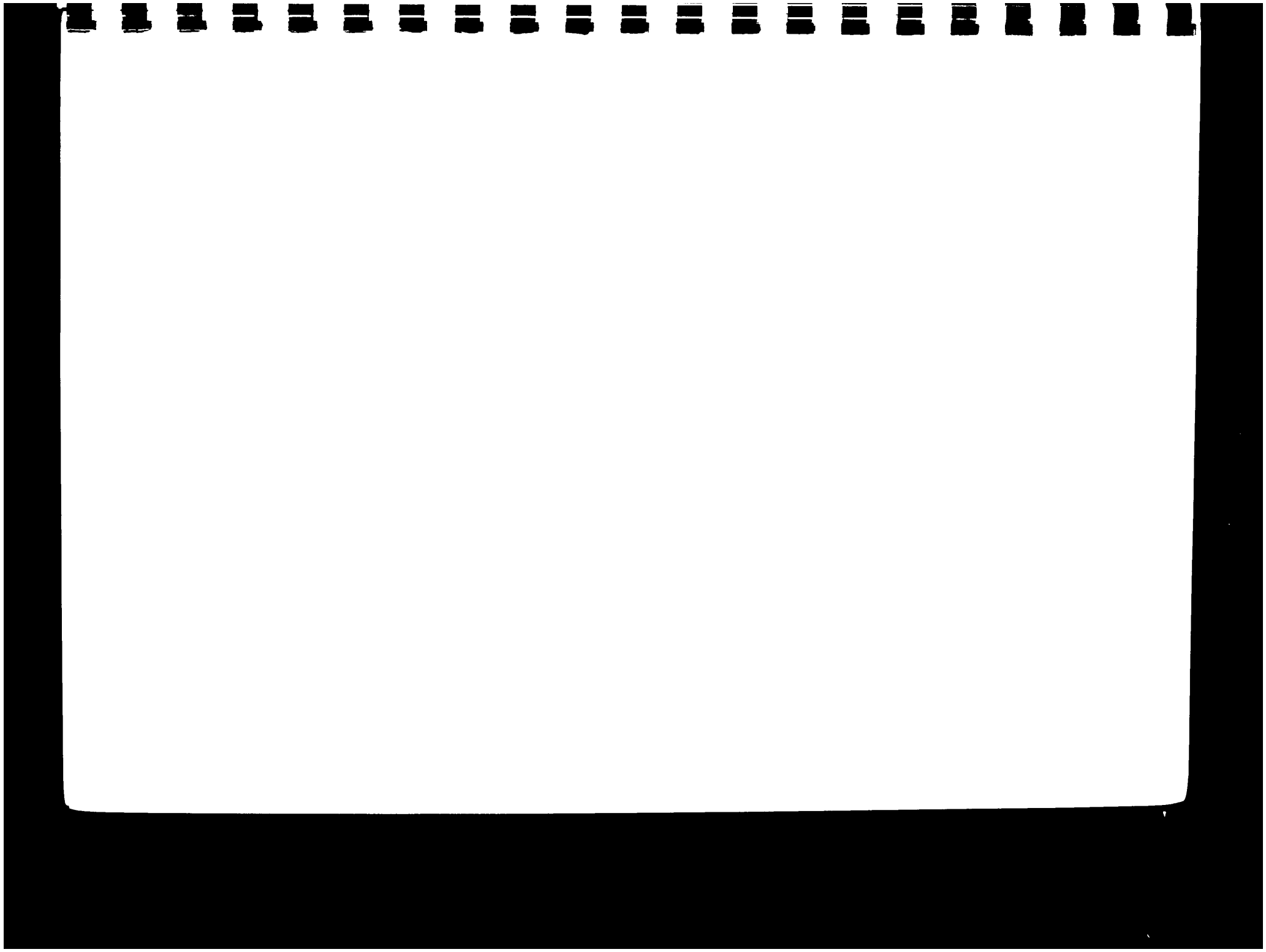
Joint commissioning has come to be regarded as an important component of the new era of community care. The reforms have separated certain responsibilities between health and local authorities and within those authorities through the distinction between purchaser/commissioner and provider roles. There remain real concerns about gaps in services, withdrawals of services, people falling through safety nets: the seamless service for older people is yet to be achieved.

Central Government policy attaches great importance to collaborative working in general and to joint commissioning activities in particular. It is seen as a way of improving services by pooling information, expertise and resources, in the search for a seamless service and by addressing the 'grey area' of the health and social care divide characterised by both gaps and overlaps.

Ministers have given their backing to joint commissioning. Dr Brian Mawhinney, Minister of State for Health, in a speech at a conference in July 1992 said;

> *'Community Care for users and carers should be one service. The seamlesness which this implies is the challenge for those who provide services. This policy is about people and meeting their needs, not primarily about structures and organisations'.*
>
> *'With the development of mutual trust and understanding the community care changes provide an impetus for all sorts of new ideas for joint working - in particular joint commissioning'.*
>
> *'At first glance joint commissioning may appear to mean a loss of control for individual authorities. Actually it is a question of sharing responsibilities between agencies in pursuit of a common goal of better services for users and carers....'*
>
> *'There is no obligation for either health authorities or local authorities to do what the other dictates. There is however, an obligation for both to work together in the best interests of those they serve. And that obligation requires dialogue, discussion, negotiation and when necessary compromise'.*

There has been no public pronouncement since then to suggest that the Minister's commitment to collaborative working as a means to achieve more effective services has diminished. Indeed this commitment was reinforced in Department of Health guidance titled 'Joint Commissioning for Community Care "A Slice Through Time"', issued in March 1993. This document contained information drawn from projects



operating at that time. It was intended to provide encouragement and practical guidance to those setting out on the joint commissioning route.

This guidance, together with papers produced by Knapp and Wistow in 1992(1), remain important references for anyone involved in joint commissioning (or for others who simply want to understand better the relationship between health and local authorities).

## JOINT COMMISSIONING: WHAT'S IT ALL ABOUT?

Joint commissioning is a loose term (also referred to as collaborative commissioning) which involves some or all of the following activities:

- pooling information
- combining expertise
- taking joint decisions on resources (which may involve pooling)
- agreeing main programme priorities
- acting jointly through the planning and purchasing of services

These activities can take place at one or more of various different levels in organisations' decision-making hierarchies.

There is generally more agreement about what joint commissioning is <u>not</u> rather than what it actually comprises. It is not joint planning, which operated on a project basis at the margins of the statutory agencies' activities. Whilst actual pooling of financial resources may or may not be on the agenda these resources are not limited to the relatively small joint finance monies which fuelled (to an extent at least) joint planning. It is not (necessarily) the vehicle for the creation of a single statutory commissioning agency (this issue is very real but has to be addressed elsewhere). And, of course, joint commissioning is not an end in itself - fascinating though the inter-agency structure and process issues might be.

There is not even agreement about who should be involved in joint commissioning. Key players are certainly the local authority (generally in the form of the Social Services Department) and the health authority (generally also involving the FHSA, whether as part of a commissioning agency or separately). For older people's services there is a general recognition that Housing should be involved (although this only happens to a limited degree) and a debate about whether (and if so, how) to involve voluntary organisations. There is a general commitment to somehow involve users and carers but variable clarity as to how to do this effectively.

Providers within both Health and Social Services are often reluctant to be excluded from the joint commissioning table: if they are included their role and status needs to be absolutely clear, if they are not included other means of drawing on their expertise should be considered.

There are certain important emphases of approach within joint commissioning, which can be found within single agency operations but which the collaborative effort specifically facilitates:

- provision of services based on identified needs rather than providers' views;
- development and refinement of services being driven initially at least) by commissioners and purchasers;
- involvement of users and carers (two distinctive groups) at various levels of decision-making;
- moving towards 'seamless' health and social care services.

In very broad terms what joint commissioning is really about is achieving change: what sort and the extent of change and how this can be brought about has to be sorted out locally. The major objectives are:

- a shift in services to more accurately reflect users' needs and wishes;
- user and carer involvement in the planning, purchasing and provision of care;
- a shift in power from providers to purchasers who act on behalf of users (and potential users);
- a mixed economy of care whereby private and voluntary organisations are encouraged to play a more important part in the care market;
- a shift toward redesigning services so that there is increased 'seamlessness' at the point of delivery so making services more efficient and more easily accessible for users;
- establishing a joint 'ownership' of services which are neither solely health nor solely social care, e.g respite services;
- ability to view the health and social care needs of a particular geographical area in the round (and indeed - potentially at least - in conjunction with other major programmes such as economic and environmental development).

As might be deduced from the above a precise definition of joint commissioning is difficult to achieve. Whilst there is no blueprint for how best to undertake collaborative activities it seems to me that the lack of a generally agreed definition is not a major problem.

On the other hand, some would argue that without a greater precision there is real risk of understating the complexities involved in achieving real change through greater collaboration. Certainly if joint commissioning does begin to deliver some of the successful outcomes which it appears to offer a greater rigour and clarity will then be beneficial. In the meantime enabling different models to emerge may be the best way forward.

A basic definition could be:

> *'Joint commissioning occurs when health and social care agencies, operating in a defined area, work in a collaborative way in order to ensure more effective and more efficient use of their available resources'.*

Slightly greater elaboration is usefully given in two definitions which are highlighted in 'A Slice Through Time'(2)

> *'....a means for bringing more and earlier attention to the identification of needs, the explication of outcomes and specification of services. It is the link between planning and activity.'* (Knapp and Wistow, my emphasis).

> *'a joint commitment at an inter agency level leading to shared responsibilities with an agreed cash sum for agreed levels of service delivery, meeting shared objectives'.*

Within joint commissioning, collaboration between health and social care agencies can create and sustain momentum in the process of improving services. As I turn now to look at some local developments to date it is clear that this momentum often requires a light and sensitive touch in order to get the initial movement and then to maintain pace and direction.

## JOINT COMMISSIONING IN PRACTICE

Diversity of Approach

There is great variation in the way localities are approaching joint commissioning developments. This was evident in presentations given at conferences organised by the NHSME and Nuffield Institute in Leeds and London in October 1993, these included

- a strategic, countywide approach which embraced (to some extent) all customer groups;
- a 'managing the market' initiative being undertaken across two Regional Health Authorities;
- a primary care led approach to purchasing.

Development of Services for Older People

Although these events provided little evidence of progress on older people's services 46 localities had earlier submitted proposals in response to the King's Fund Centre's invitation to participate in its joint commissioning project. There was a degree of commitment to making real progress in a variety of ways. The general flavour was one of determination to address an area of service provision where the stakes were higher than for other customer groups because of the size of budgets involved, the potential for service improvement and the urgency of making progress before growing needs further outstripped service response. There was a realism that this was a major challenge which required real leadership and a steady, systematic approach: those involved had to weigh up how to be realistic without being unambitious.

Amongst the 46 submissions localities were planning to or already working on the following service issues:

- meeting the needs of older people with a mental illness;
- providing joint health and social care assessment and care management support;
- development of respite/short stay services;
- addressing the 'grey area' between health and social care provision in people's own homes and increasing the range of support available;
- nursing support in residential care homes;
- developing services which properly meet needs and wishes of ethnic elders;
- facilitating discharges from hospital;
- developing alternatives to continuing care beds;
- providing a flexible support service for carers;
- incorporating housing needs of older people into the community care 'system';
- providing a flexible support service for carers.

Organisation: how joint commissioning is taking place

In very broad terms there are three varying approaches to the joint commissioning of services: a customer/client group focus, one which looks at geographical areas and one which addresses specific service issues. These are not mutually exclusive, and indeed it might well be that elements of all these should be present in successful joint commissioning.

The strategic approach is generally led from the top of the organisations and is concerned with across the board provision for one or more user groups. It often involves the setting up of joint commissioning groups (co-ordinating, customer groups, specific issues eg. involvement of Housing). Sometimes a specific post is created to coordinate the work and to have an important role in determining the nature and pace of the identified change. Whilst this approach can engage with major policies and practices the evidence so far in older people's services is that to make real progress in service change smaller scale activities have to be undertaken: this means ensuring specific activities involving geographical localities or specific service issues.

Nonetheless having a strategic component is important: it can determine policy parameters, pace at which change should occur, quality thresholds; a key issue is the extent to which decision-making powers have been devolved through organisations and the extent to which these are understood and accepted. The strategic approach - from the top of the organisations - becomes more important the more significant are the changes sought.

In terms of bringing about those changes, older people's services are so large and diverse that a strategic-only approach can easily flounder because of the difficulties in actually making change happen. By focusing on localities or on specific issues (eg. equipment in the home provision) the task becomes more tangible, although still retaining enough complexity for most players!

Increasingly it seems that attention to specific localities is providing the key focal point for joint commissioning activities, this certainly being the case for the majority of the five development sites with which the King's Fund is currently working. Although there are important roles for key decision-makers at the top of the respective organisations it is local players - GPs, Care Managers and so on - who are then best placed to identify needs and determine the most appropriate responses across the health and social care system. This is, of course, much more easily said than done. A good deal of time and effort has to be put into building up and cementing relationships, agreeing on principles and priorities, setting up the basic mechanisms to underpin the activities of assessing needs, determining priorities, and working out how to proceed. Much attention has to be given to the linkages between strategic and locality aspects: clarity of roles and responsibilities is crucial in order to ensure that these two key components support and enhance one another.

Either as an alternative to or as part of a locality focus joint commissioning can be used to 'solve' a particular needs issue which spans the health and social care divide. Although this can be seen as a less ambitious and very pragmatic way forward it can in fact address some crucial service provision issues which have dogged health and social care for years to the dismay of those in need who are the losers: who provides the bathing services is the classic example here.

In future briefings more information will be provided on how joint commissioning is actually taking place in the King's Fund five development sites.

The Joint Commissioning Context

In trying to understand what is currently helping and hindering joint commissioning in action it is important to know something about the backcloth against which it is operating:

- gaps and overlaps in services: a variety of care providers working in an unco-ordinated and hence non user friendly way;
- services which are often old fashioned and not focusing on today's needs;
- static or declining resources leading to the prospect of service cutbacks at a time of increasing needs (amongst older people) due to demographic changes and an increasing awareness of those needs;
- continuation of inefficient working practices, eg. people at home being visited by a number of 'domiciliary providers' each of whom spend a significant amount of time travelling;
- major organisational uncertainities (eg. Local Government Boundary Review, DHA/FHSA 'mergers') which can give rise to a degree of 'protectionism';
- more vocal customer groups and growth of the citizens' charter movement;
- the dilemma of how increasingly larger commissioner/purchaser organisations can effectively address the specific needs of individuals and small localities;
- increase in the number of GP fundholding practices and growing pressure to ensure that all GPs are incorporated within commissioning and other aspects of community care;
- increasing awareness by commissioners and purchasers of the need for them to 'manage' the health and social care market.

Challenges and Problems for Commissioners

An awareness of the hurdles to be overcome is crucial for commissioners and purchasers whether acting within their own or (especially) when acting collaboratively. Nigel Jones of the NHSME's Community Care Unit has usefully identified:

- how to create effective purchasing strategies when providers are often well-established and have little inclination to diversify;

- the 'charge/no charge issue': how to address the apparent inequity that some services are free at the point of delivery whilst others are increasingly the subject of charge;

- continuing care provision (ie after hospitalisation): what sort, whose responsibility?

- reprovision diversification, which in plain English means how to ensure that a range of new, different and flexible services are on hand as 'old' services are closed down;

- primary care: increasingly emerging as one of the most significant issues to be addressed - the extent to which the commissioning and provision of health and social care services should have a primary care focus, a particular issue given GPs' prominence in the lives of older people;

- accountability: an important process issue which questions the extent to which statutory responsibilities can be subject to joint arrangements.

To this list can usefully be added:

- user and carer involvement in the commissioning process is invariably acknowledged but with few places able to evidence significant progress;

- need to involve Housing in the commissioning process in a meaningful way;

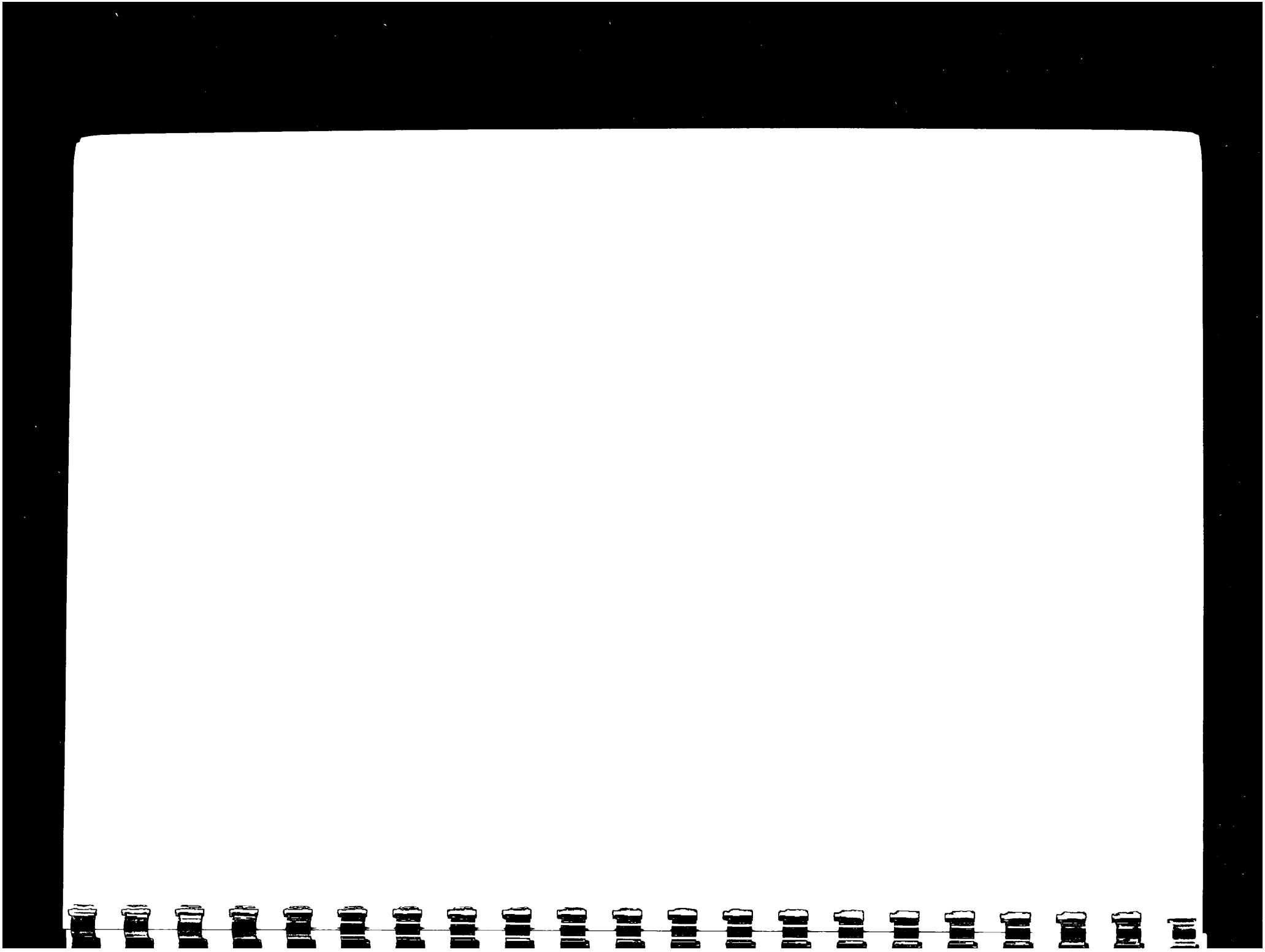
- similarly the need to determine an appropriate role for the voluntary sector which recognises that agencies here are rarely purchasers of services but can bring an 'added value';

- determining which boundaries to adopt when following a locality planning approach, significantly how to overcome the 'fluid' nature of GP practice catchment areas and their non-coterminosity with (for example) Social Services boundaries.

<u>The Financial Implications of Joint Commissioning</u>

To many people the issue of finance is at the core of joint commissioning. A not uncommon view is that joint commissioning can only really be said to exist if pooled budgets are used, i.e. health and local authorities putting money into 'a pot' for use according to decisions taken collaboratively. Certainly the use of financial (and indeed other) resources oils the wheels of the joint commissioning machine: such are the particular complexities that it needs attention as a special challenge.

Department of Health guidance expected in the Spring of this year will clarify what can be done and what cannot: it will doubtless refer to advice already available on how to arrive at unit costs for different services; it will address the thorny issue of the extent to which



health authorities can fund local authorities' statutory responsibilities, and vice-versa; it will examine the issue of charging and how this affects jointly commissioned services.

Although finance is a crucial issue it should not be seen as a deterrent to setting off along the joint commissioning route. The reality is that much can be achieved before arriving at some of the particularly thorny hurdles mentioned above. The key advice may well be to keep matters as simple as possible, for example by using parallel budgets rather than pooled ones unless there is some good service outcome reason.

Financial issues lie ahead for each of the five development sites. At the moment these are not seen as getting in the way of determining the shape to be taken by collaborative working: how the issues are addressed will be noted in future briefings.

## SOME KEY FACTORS FOR SUCCESS IN JOINT COMMISSIONING

Some factors are already emerging from those involved in undertaking joint commissioning in terms of what makes for successful outcomes.

(i) Linkages with community care and other planning processes: although real achievements can be made through discreet small-scale tasks (on a relatively informal basis) (e.g. providing a co-ordinated respite care service) joint commissioning maximises its impact when it operates within the larger health and community care planning mechanisms. Just as commissioning should drive changes in the way services are planned and purchased so in turn it should be informed by information gained through individual assessments, local population needs analyses, specific reviews, and so on.

(ii) Support by senior managers: although collaboration to achieve significant service shift is unlikely to occur . without at least passive support from the top this does not mean it is necessarily preferable to adopt a strategic approach led by the authorities' chief officers. Much depends upon local conditions. The extent of devolved responsibility (and the extent to which those at the top are prepared to respect this in practice!) can be crucial. Clarity of roles and responsibilities is as important here as in other areas of organisational decision-making. Flow of information up and down organisations is also vital: at the very least chief officers need to be kept in touch to ensure a 'good enough' ownership should a problem-solving intervention be required.

(iii) Incremental approach: 'organisational inertia' remains a significant barrier to the radical changes which some are beginning to seek. By seeking small changes at the outset there is a greater likelihood of success and the important feeling of achievement to 'reward' the effort which various

people will have put in. This will also have the effect of developing a momentum around collaborative working which will help to smooth paths ahead and strengthen the motivation to press on.

(iv) Good relations between Health and Social Services: where these already exist they can be built upon, where they do not it is well worth putting some effort into establishing a firm basis. It is important that there is a coming together of principles and objectives and that managers do not allow petty squabbles to get in the way of a sound working relationship.

(v) Staffing time: collaborative working does inevitably require some resourcing of its own, the more ambitious are the objectives the more important it is to ensure that there are people in place with the necessary skills and space to make this happen.

(vi) Clarity of objectives: joint commissioning demands a clearly thought out project management approach. It should state aims, targets en route, specific responsibilities and timescales. There are a welter of process issues around how joint commissioning takes place which can become all-consuming to the extent that service outcomes are neglected. Joint commissioning needs to be led rather than simply allowed to happen. Issues such as which working groups are required and where are the user group demarcation boundaries need to be resolved swiftly and decisively: having a clarity throughout will mean any amendments which become necessary can be readily introduced.

## THE KING'S FUND'S CONTRIBUTION TO JOINT COMMISSIONING

Direct support is being given to the five development sites participating in a two and a half year service development project funded by the Gatsby Charitable Foundation. In addition support is being given to the creation of support networks for other local areas. The sites were chosen to provide something of a cross-section of joint commissioning work with older people's services, details are given in the Appendix.

One contrast which was sought was between 'advanced' and 'less advanced' sites. This became increasingly problematic as a site which may appear well forward (collaborative groups in place and so on) may well not have achieved as much by way of service change as another area operating in an informal but very focused way.

There are examples within the development sites of both 'top down' and 'bottom up' approaches, of countywide and small locality approaches. Emerging as an important focal point is the involvement of GP practices and other Primary Care team members. The GP practice as the

basis both for assessment and service provision developments is being tested out in different ways. Of course problems abound but where this approach is being tried it can be seen that it is indeed possible to collaborate at this level, based upon establishing common goals for the locality, sharing problems and skills, seeking out new working arrangements of mutual benefit, and by concentrating on those areas (in terms of providers and participants) where there is a likelihood of achievement. Without this sort of progress it is difficult to be optimistic about the scale of service improvement resulting from joint commissioning.

The project's involvement is scheduled to the second half of 1995, whilst work in the areas will continue so long as is necessary. The current project activity is concentrating on diagnosing what is in place, mapping ways forward, determining objectives and how to get there, providing consultancy advice as the work proceeds and evaluation designs, this in conjunction with colleagues from the King's Fund College. The identification and achievement of service improvement through collaborative working is, of course, at the core of activities with the development sites.

This report is made at the start of work with the sites. Further briefings will indicate progress made as well as covering developments in joint commissioning elsewhere. As with this initial contribution they will very much operate alongside other important initiatives. The DOH Working Group will provide further guidance and workshops in the Spring.

## CONCLUSION

So far as older people's services are concerned joint commissioning is still in its infancy. The potential benefits in terms of service effectiveness and efficiency are recognised as significant but in many ways are less straightforward to identify and achieve then for other user groups e.g. people with learning disabilities.

Those health and local authorities which have made inroads are in effect tackling some of the most important problems which have dogged the health and social care system: 'seamlessness' of provision in people's homes, involvement of GPs in collaborative planning and provision of services, developing needs-sensitive services, how to effectively involve users and carers in decision-making.

Of course technical problems (legal, financial, organisational) remain to be resolved: these are being worked upon and progress can reasonably be expected. Whilst radical change can be achieved (and is often desirable) in due course, smaller-scale incremental change may be more realistic for most: local conditions are vital in determining the pace and, of course, the nature of change.

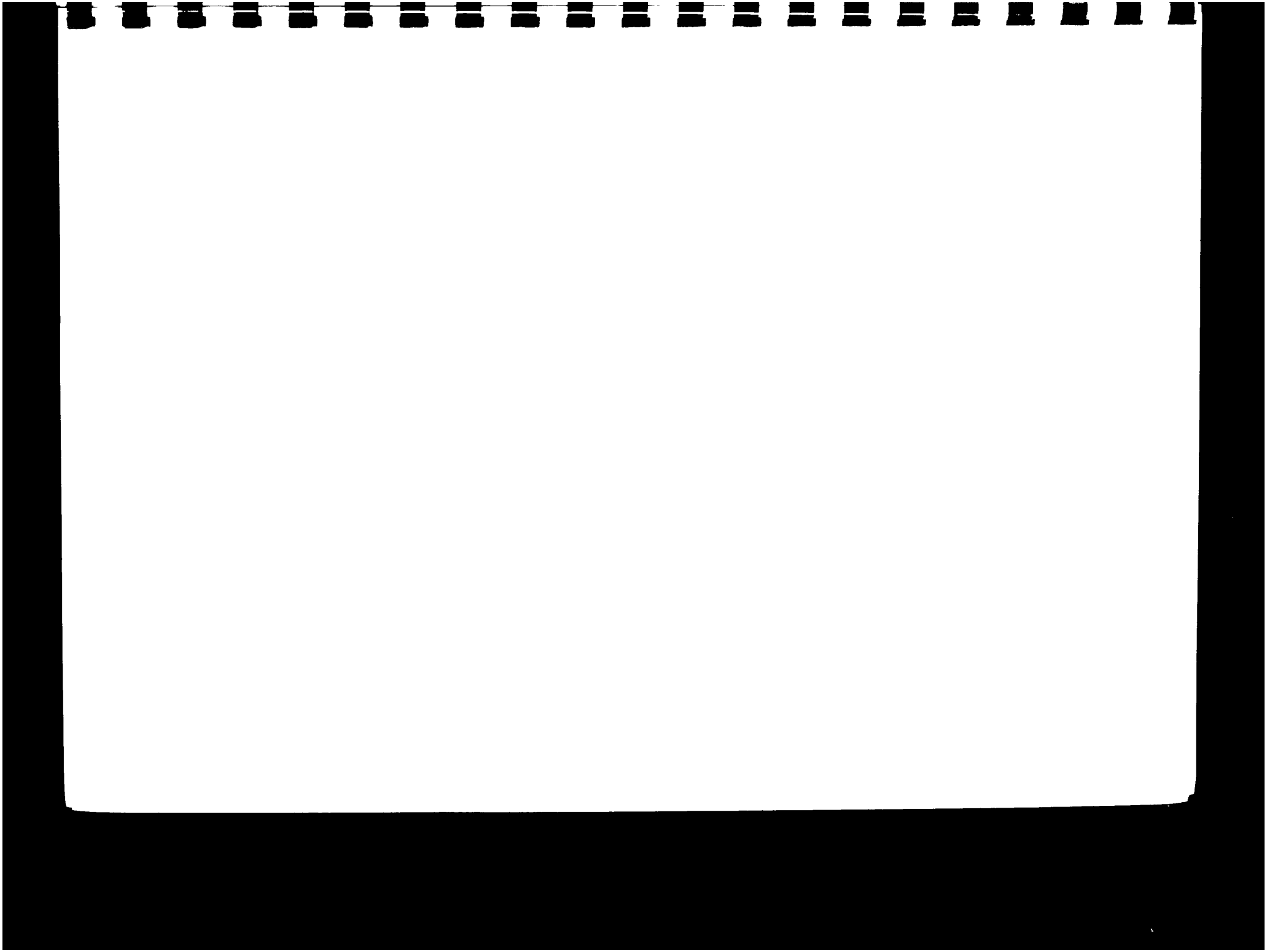
If the attitude of the Project's five development sites is anything to go by there is a real enthusiasm for tackling issues and learning from others, this in spite of all the surrounding pressures which beset health and local authority managers. The King's Fund Centre will help

with the development of this work over the next 18 months and is interested to hear of any particular joint commissioning issues which might be presenting special concerns.

References


1. Martin Knapp and Gerald Wistow. Joint Commissioning for Community Care (in 'A Slice Through Time' DOH 1993)

2. Department of Health Joint Commissioning for Community Care 'A Slice Through Time'.



APPENDIX

## KING'S FUND CENTRE

## JOINT COMMUNITY CARE COMMISSIONING PROJECT

## THE FIVE DEVELOPMENT SITES

### Easington

In Easington eight local planning groups have been set up across the District, with the task of creating and implementing a joint strategy for health and social care. The groups have also been asked (by the Joint Commissioning Board) to produce model joint service specifications (e.g. for day care for elderly mentally infirm people), as well as ensuring firm links with users and carers, who will be represented on the groups. All of the groups have been established; together they cover the whole of this District of County Durham.

The Easington Community Care Plan for 1993/4 indicates certain priorities for service development: home care, day care, respite care, night sitting service, improved meals on wheels. The precise service changes will flow from the work of the groups but they are expected to include some or all of: independent sector day care, respite care voucher scheme, generic domiciliary care support workers, meals enhancements, mobile wardens and alarm systems, improved information provision, solidarity between generations through community development projects, sitting and befriending schemes, impact of changing family structures (e.g men as carers).

As with other places much of the financial resource required for such service development will need to come from shifting out of existing services and erasing duplicatory working through collaborative effort. There is a significant (and growing) amount of delegated responsibility to District level managers to assist with this process of change.

Because of its high levels of deprivation Easington receives some favourable national and EEC funding consideration. Possibly because of the scale of the problems to be tackled the area does seem to instil a real sense of common purpose amongst the different agencies.

### Hillingdon

In Hillingdon the project is linking up with some existing King's Fund activity reviewing services for older people, including older mentally infirm people. So far the review has thrown up the following provider issues for active consideration through the well established joint commissioning mechanism: establishment of a single system of respite care, a convergence of residential care and nursing homes through an increase in the residential nursing service, a move to joint assessments, development of linked alarm systems in older people's own homes, more investment in support for carers and users themselves. Pilot work is already underway in respect of generic care workers and flexible domiciliary care. It is considered that the project can provide key assistance as Hillingdon moves to service developments driven by its firmly based collaborative working arrangements.

Oxfordshire

Oxfordshire is also adopting a strategic approach to joint commissioning of older people's services, with similar significant gains to be made. The aim here is for a more equitable spread of services across the county, a shift from residential to community-based care and the creation of a quality information base (including financial costings).

The Social Services Department, District Health Authority, FHSA, Voluntary Sector and CHC have already come together to produce draft Commissioning Intentions in respect of: Respite/Short Stay Care, Care at Home, Day Care, Residential and Longer-term Care, Acute Care, Services for Elderly Mentally Infirm people. These have been consulted upon widely.

The outcome of the present consultation exercise will guide the development of specific services but initial areas for service development are: joint/multi-disciplinary night sitting service, sheltered housing as resource centres, EMI resource centre at an independent sector home, direct access for carers to respite/short stay beds.

A Joint Elderly Commissioning Team was set up in 0xfordshire in Autumn 1992, with representation from Social Services, District Health Authority, FHSA, Voluntary Sector, Regional Health Authority, Community Health Council, and GP Fundholders Consortium. The team reports directly to the 3 General Managers of Social Services, DHA and FHSA.

Westminster

In Westminster the aim is to develop joint assessment and purchasing arrangements for the local health and social care service for older people in Victoria. Three specific concerns have been put forward (as well as an overall lack of services): a shortage of GPs, a lack of provision for ethnic elders, and the need to achieve more timely and safe hospital discharges. At strategic level the Local Authority's Community Care Plan and the Health Agency's Purchasing Intentions run so closely together they may soon be merged.

The development of a new health and social care service in Victoria is one focal point, with joint commissioning and joint purchasing maximising the opportunity provided by a Tomlinson-funded capital scheme. The development of a variety of health and social care services linked to GP practices is the basic Westminster model, resourced by a move away from acute care (although this remains a sensitive local issue).

Service developments are likely to include: joint health and social care assessments (which are a service in their own right), generic health/social domiciliary care service, outreach service for ethnic elders, GP/Primary Care Team development, meeting the needs of two transient populations: homeless people and refugees.

How assessments will be carried out by Care Managers, GPs and other Primary Care workers is considered extremely important: integrated assessments should lead to a congruence of GPs' and Care Managers' purchasing intentions, even if these continue to take place as separate events in practice.

Wiltshire

The principal aim in Wiltshire is to put into effect the strategic intentions of the Health Commission and Social Services Department at a local level, through joint commissioning and locality purchasing.

The overall objectives are: to improve the health and social care of older people and their carers who are served by the three General Practices identified to take part in the project; to maximise the integration of primary and social care services at practice level; to maximise the potential of integrated approaches to commissioning; to achieve a better understanding of how joint commissioning can achieve service improvement.

The intention is to develop joint care management based in primary care settings, with GPs and Care Managers coming together to purchase individual packages of care; as part of this focus particular attention is being given to the role of GP Fundholders. There will be three areas of attention: population needs assessment; joint working; joint service provision.

One impetus for service change is the apparent over-provision of continuing care beds in the west of the county. The focus of the project will be two small towns; it will build upon an analysis of possible options which has already been undertaken. The main potential areas for service development are seen as: respite care, multi-disciplinary assessments (nursing, medical, geriatric), terminal care, post operative care, day care, although to a significant extent these will need to be checked against the outcome of individual assessments and views of other users and carers.

RP/KFC