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Partnerships in Primary & Social Care

Integrating services for vulnerable people

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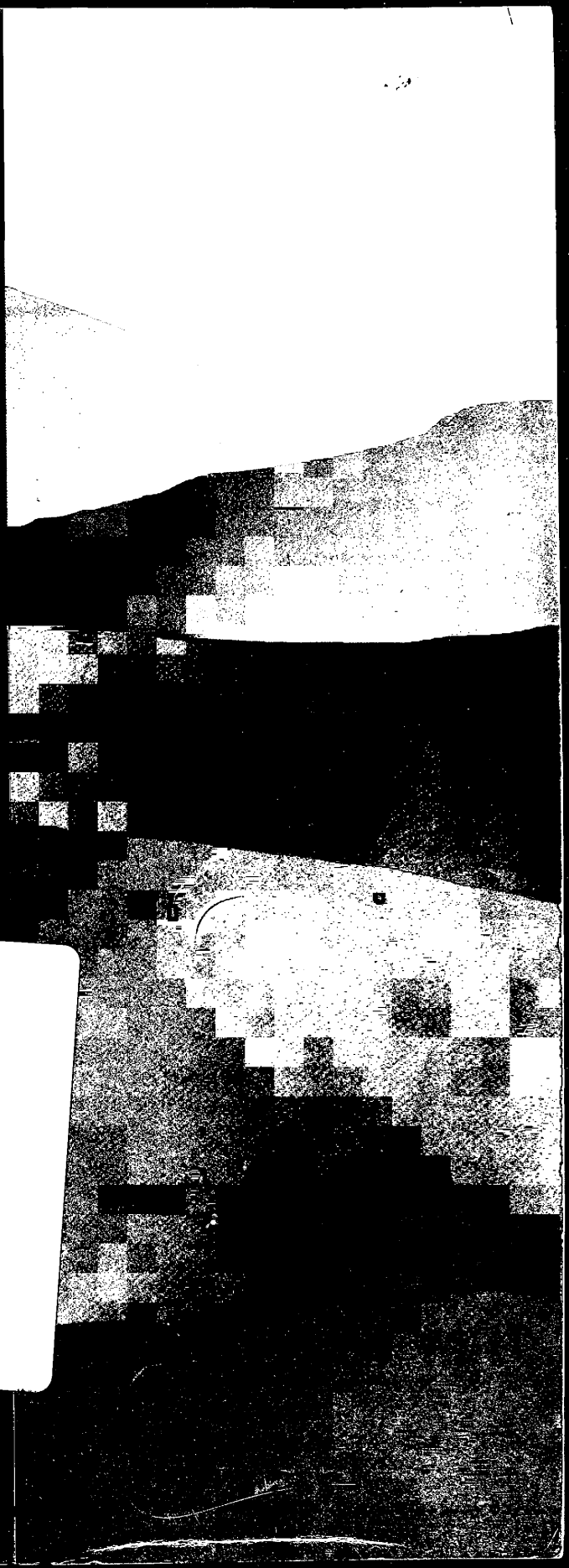

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Partnerships between health & social care – key messages for primary care groups

Experience from the King's Fund Joint Commissioning project provides topical learning about successful approaches to the development of primary health and social care partnerships, while also offering insights into problems that might hinder progress. Primary care groups can build on successes achieved to date but they will need to tackle the obstacles that have so far inhibited the achievement of better integrated care for vulnerable people.

Joint working

Most collaboration between primary and social care to date has taken the form of joint casework, co-locations (where social workers or care managers have been attached to general practices), practitioner alignments (where GPs and social workers have effectively merged their catchment areas) and integrated teams. These forms of joint working have improved communication between GPs, community nurses, care managers and other social care staff, and have resulted in better access to services for users and carers in some cases. However, joint working in primary care is by no means widespread, relying as it has on the inclinations of particular practitioners and being confined mostly to small-scale pilot schemes.

Commissioning capacity

Practitioners in primary health and social care frequently confuse the terms 'joint working' and 'joint commissioning'. This confusion reveals a widespread lack of understanding of the commissioning process, and limited knowledge of and skills in commissioning activities. Failure to distinguish joint commissioning from joint working has had the effect of inhibiting progress towards better integrated care for both individual users and carers and the wider population.

Joint commissioning & GP practices

Joint commissioning between primary health and social care has so far failed to flourish when based around a particular GP practice or group of practices. Some efforts jointly to assess individual need and fund individual care packages have taken place but have been relatively rare. Efforts to engage in collaborative commissioning for a practice population have achieved disappointing results.

Joint commissioning in locality groups

More progress has been made where primary health and social care agencies have worked together in locality groups, linking their activities to strategic priorities in commissioning and contracting set by health and local authorities. This has been particularly evident in mental health services. However, these developments have tended to be the result of agency directing or prompting rather than being led by primary care managers or practitioners.

Service outcomes

Insufficient attention has so far been paid to the specific service outcomes that the different partners wish to achieve by working together. This has resulted in a lack of momentum in joint commissioning and a tendency to see the process of working together as an end in itself. Progress in jointly commissioning services for older people within a designated locality has been slower than that achieved in mental health. This has reflected a lack of consensus about desired changes in services for older people.

Engagement of users and carers

Users and carers have played little part in the partnerships that have emerged between primary health and social care. There appears to have been a reluctance to involve them in discussions about the shape and performance of local services and about priorities for service development. Often the reasons cited are to do with the fragile nature of the professional partnerships. Where users and carers have participated, their involvement has been constructive and often illuminating.

Political process

Developing partnerships across primary health and social care is a political process, where powerful political, managerial and professional interests have to be accommodated, and where shared responsibilities have to be negotiated. Effective partnerships require strong but sensitive leadership with the vision to see the way forward, the determination and courage to handle inevitable risk and the skills to forge new working relationships. Evidence from joint commissioning pilots suggests that progress will be limited when the task of working across the health and social care divide is only seen as a set of technical processes concerned with the co-ordination of planning and budgetary cycles.

Decision-making

Weak vertical links between decisions made at practice, locality and strategic levels have been a feature in most joint commissioning pilots, causing difficulties in co-ordinating planning and provision within a coherent set of priorities. In order to achieve greater coherence a more effective exchange of information is required between different levels within the health and social care system. The joint policies of strategic authorities need to bear in mind individuals' needs, while service developments at more local levels need to take account of strategic vision and aspirations.

Budgets

Problems in aligning budgets at practice and locality levels have impeded agencies' capacity to achieve service improvements through joint commissioning. It has also proved difficult for agencies to co-ordinate decisions in the face of different planning cycles and financial planning regimes. Where resources have been pulled together for joint commissioning purposes, they have tended to be small scale rather than involving mainstream budgets. Failure to secure a breakthrough here has thwarted the efforts of even the most enthusiastic advocates of joint commissioning at primary care level.

Prospects for primary care groups

Partnership between health and social care agencies through primary care group boards seems set to become a statutory requirement. While this sends out welcome signals to stimulate and reinforce collaboration at local level, primary care groups and health and local authorities will need to address the barriers identified here if they are to make any difference in improving services for vulnerable people. They will need to be clear about desired outcomes and how partnerships can be developed and sustained so as to achieve these goals. Really effective partnership working cannot be treated as just another process issue to be ticked off.

Introduction

Primary care groups (PCGs) offer new opportunities for partnerships between health and social care. There is now widespread support for collaboration in order to achieve better integrated care for people with both short-term and continuing care needs. But there is also recognition that this is a complex task. As they embark on implementing the partnership arrangements set out in *The New NHS* White Paper, health and local authorities – together with their colleagues in primary care – will need to build on current knowledge and experience of health and social care collaboration.

This briefing paper is intended to help in that task. It discusses the experiences of five development sites in England that took part in the King's Fund Joint Commissioning project during 1996–98 (see Box 1). It reviews their achievements and considers the problems that arose, drawing out implications for primary care groups.

Box 1 The five sites

	Dartford and Gravesham, Kent
LOCATION	North West Kent between London Borough of Bexley and Medway Towns
MAIN AGENCIES	West Kent Health Authority; Dartford & Gravesham Health Care Partnerships Project (health locality commissioning); Kent Social Services; Thameslink Healthcare Services NHS Trust
JOINT COMMISSIONING	**Primary Care Pilot Sites (older people); Locality Purchasing Board (mental health)**
	Dudley, West Midlands
LOCATION	Between Birmingham and Wolverhampton
MAIN AGENCIES	Dudley Health Authority; Dudley Social Services; Sedgley & Coseley GP Commissioning Group
JOINT COMMISSIONING	**GP practice as pilot site for locality commissioning group; stand-alone practice**
	Huyton, Merseyside
LOCATION	Knowsley Borough, east of Liverpool
MAIN AGENCIES	St Helens & Knowsley Health Authority; Knowsley Social Services, St Helens & Knowsley Community Health NHS Trust; St Helens & Knowsley Hospitals Trust; Huyton GP Forum
JOINT COMMISSIONING	**Primary Care Alignment of Staff Groups (older people); Locality Collaboration (mental health)**
	Sutton, Surrey
LOCATION	Southern edge of Greater London
MAIN AGENCIES	Merton, Sutton & Wandsworth Health Authority, Sutton Social Services; South West London Total Purchasing Project
JOINT COMMISSIONING	**GP Practice Pilots (older people)**
	Trowbridge, Wiltshire
LOCATION	Western Wiltshire
MAIN AGENCIES	Wiltshire Health Authority; Wiltshire Social Services; Trowbridge Total Purchasing Project; Trowbridge Health and Social Care Alliance
JOINT COMMISSIONING	**Lovemead Integrated Primary Care Team; Trowbridge Locality Commissioning Forum**

Beyond joint planning

Joint commissioning takes place when different agencies share information, pool expertise, make joint decisions on resource utilisation and agree on main programme priorities. Thus they act together to plan and purchase services. That emphasis on purchasing is important for, as the Department of Health's 1995 guidance emphasised, '... above all, joint commissioning is a process for translating plans into action, and not just for planning.'[1]

Joint commissioning represents a clear advance on joint planning, for it involves mainstream service programmes, major contracts and large budgets, which contrast with the relatively small budgets of joint finance and other 'funny monies'. Joint commissioning has been used for one- off projects promoting particular aspects of service change (e.g. home bathing), but this approach has gradually given way to agencies undertaking more thorough reviews of how health and social care systems can be reshaped to respond more effectively to the needs of service users.

The evolution of health and social care partnerships

The NHS and Community Care Act 1990 required health and local authorities to work together in planning and developing services for people with long-term illness or disability. But collaboration was not new. Its origins may be traced back to the reprovision of long-stay hospitals for people with mental health problems and people with learning difficulties, where mechanisms such as joint consultative committees and joint care planning teams were engaged. Joint finance was used to fund generally small-scale projects which, although of some value, were often short term and on the margins of mainstream services.

Since the implementation of the 1990 Act, there have been a number of important milestones emphasising collaboration between health and social care, notably continuing care agreements,[2] a policy statement on mental health,[3] guidance on *Better Services for Vulnerable People*[4] and, most recently, proposals for introducing pooled budgets, lead agency status and integrated care programmes.[5] Under the Labour Government, partnership has become a major theme, as reflected in health improvement programmes, health action zones and primary care groups.

During the 1990s, the growth of primary care commissioning presented new opportunities for collaboration. GP fundholding began, in some places, to embrace aspects of social care. And a renewed momentum grew for better joint working, with the focus on getting the basics right between primary health and social care practitioners in order to benefit patients and clients. On the evidence available,[6] it seems that there were marked differences across the country in the extent to which the collaborative agenda was addressed. This is not surprising, given the different local circumstances and the absence of any specific requirements to work together, beyond GPs contributing to social care assessments where considered appropriate. The relationship between GP and social worker has thus tended to dominate the story of primary and social care collaboration.

Joint commissioning of community care has had a relatively short history, during which it has been overshadowed by significant changes (real and proposed) in the NHS, social services departments and local government in general. In the mid-1990s, there were, nevertheless, high hopes that joint commissioning could achieve service improvements for people with both health and social care needs. However, various commentators[7,8,9] have expressed concern at the lack of progress made, noting the relative non-involvement of GPs, housing departments and other stakeholders in the process and a widespread inability to achieve major shifts in services.

While recognising the limitations of joint commissioning, it is nevertheless important to note that greater success has been achieved in services for people with learning disabilities or mental health problems than services for older people with long-term care needs. In both cases, the reprovision of long-stay hospitals provided the 'big issue' which

galvanised the NHS and social services departments into action. In the case of learning disability services, there was the added lever of health and social care bodies recognising that the services they each provided were broadly similar and that, in large part, most provision within the NHS could reasonably be interpreted as a social care function and thus best dealt with by local authorities as 'lead agencies'. In the case of mental health services, joint commissioning has also been employed by health and local authorities (and some GP fundholders) to improve the operation of community mental health teams and their links with primary health care teams and hospital specialist services over such issues as clarifying roles and priorities.

While joint commissioning may not have lived up to its early promise as a means of creating better services for people who have both health and social care needs, much has been learned through early efforts to forge health and social care partnerships. It is therefore crucial that, before joint commissioning gets written off as yesterday's news, the lessons learned are identified and applied to current thinking about partnership between primary care groups and social services, and more widely between health and local authorities.

Lessons from primary care joint commissioning

Five sites involved in the King's Fund Joint Commissioning project provide some useful insights into the development of primary health and social care partnerships, the nature of those relationships, the factors that contributed to success and those that inhibited progress.

Joint working

In all five areas, most collaboration between primary health and social care bodies consisted of joint working between practitioners rather than joint commissioning between agencies. Having practitioners located on the same site (usually within a GP practice) aided both understanding and communications in general. Generally, this was achieved by social workers making regular visits to the practices (weekly or more often) to discuss cases and sometimes to take part in broader discussions about practice issues. Lack of space often prevented the social worker having their own desk but this did not seem to be a barrier to the development of strong informal relationships nor prevent the social worker from feeling welcomed and valued by GPs and nurses based at the practice.

The relative informality of most liaison arrangements helped to foster the mutual trust and understanding which is now established as a cornerstone of sound partnership working. Opportunities to work together arose naturally, and were sometimes grasped quickly to discuss problems arising. Those who had been working together longest, not surprisingly, tended to communicate best. In Huyton, communication between the social worker and district (or practice) nurse was probably more important in terms of client/patient outcomes than was communication with GPs. In one arrangement, the costs of a home bath were shared.

In Trowbridge, Wiltshire, a move towards integrated team working improved communications between health and social care practitioners and led to effective joint working around individual cases. However, more systematic approaches to sharing information and record-keeping had yet to be developed.

More formal communication was evident in Sutton, with the introduction of a GP/social services agreement, on the lines of the PASS Agreement initially developed in Salford and elsewhere. This agreement seeks to shortcut the development time which informal relationships go through. It establishes protocols for dealing with referrals, assessments and emergencies and sets out times when practitioners can make contact with each other. Some previous examples elsewhere have proved difficult to keep going, perhaps because the formal communication tool has to be underpinned by informal communication, which continues to build trust and cement relations.

Across the different sites, co-locations of practitioners tended to result in what was considered to be more 'efficient' referrals between

GPs, community nurses and social workers, based on good quality information and leading, in many cases, to relevant and timely service responses. However, co-location was shown to be only one way of achieving good outcomes for users, as an evaluation of Wiltshire's integrated team approach showed, where there was no difference in either the speed of response or the type of care provided between referrals accessed through a joint point of contact and those accessed through the social services duty system.[10] What mattered more than the location of workers was sustainable approaches to identifying need and responding appropriately.

Co-location did, however, increase understanding of the role of key workers and care managers among primary care practitioners – a role that is crucial in the continuing care of older people where co-ordination of assessments and service inputs is required. Disappointingly, that understanding did not appear to have helped practitioners to instigate joint assessments, although some were planning to move in that direction.

Most GPs involved in the pilot sites valued having named social workers available at known times and often within easy reach. They identified real efficiency gains in joint working arrangements, as their jobs became easier. Some, but not all, social services staff felt similarly about having GPs and other health staff within easier reach. But, on balance, GPs benefited most, as other staff (community, health or social care) have regrouped around them and their practices.

Joint commissioning and GP practices

While there was a good deal of joint working going on at the sites, including some attempts at joint planning, engagement in the more ambitious arena of joint commissioning was rare. Health and social care partnerships based around particular GP practices experienced great difficulty in identifying resources that could be 'pooled' and in making effective links with mainstream decision-making at a more strategic level. This made it impossible to achieve any major service change – even in those partnerships able to demonstrate other key ingredients of successful joint commissioning,[7] such as shared values, strong leadership, dedicated support time, strong inter-personal relationships and mutual trust and understanding.

At the same time, cultural issues inhibited efforts to engage in assessing the needs of practice populations and in identifying priorities for service change. First, while GPs remained free of organisational constraints, social workers (and their district nursing colleagues) belonged to hierarchical organisations where they were subject to differing degrees of personal supervision and accountability. These differences in autonomy contributed to difficulties where there were GPs who tended to be more comfortable, with quick fire responses to presenting cases and where social care staff were attempting to engage in more wide ranging and sustainable needs assessment approaches.

Different ways of working presented real barriers to joint commissioning. Meetings had to be fitted into lunchtimes, or after surgery hours in the evenings. At best, meetings tended to be short and rushed; at worst, they revealed a certain amount of distraction as GPs tried to deal with their post or other matters during the discussions. There were even occasions where sheer disrespect on the part of GPs was shown towards social services staff in the course of meetings held to discuss joint business.

With all these factors combined, it is not surprising perhaps that joint commissioning failed to thrive at this level in the health and social care system.

Joint commissioning and locality groups

At two sites, attempts at joint commissioning for a locality were made by groups of GPs and social services managers but, at the time of writing, there was little to show in terms of redistributing resources and reshaping services. There were, however, indications that such change might occur in the longer term, once joint working arrangements have become more firmly established.

In Dartford and Gravesham, the locality group worked together to try to improve hospital discharge arrangements and to achieve greater co-ordination across the different occupational therapy

services operating in the locality. While there is still some way to go in achieving these objectives, action has been taken towards withdrawing social workers from their hospital bases and creating a single rehabilitation service covering health and social care – both moves have been prompted by primary care practitioners.

In Dudley, Knowsley and Trowbridge, locality groups made some progress in assessing the needs of their local population. In all sites, strategic authorities provided significant support for this work, with the health authorities playing an active developmental role in Dudley and Knowsley, and the district council and county social services department getting involved in Trowbridge.

However, generally, practitioners and operational managers in the locality groups were not looking beyond getting their working practices better co-ordinated, seeing how they might secure changes in the delivery of existing services or lobbying for new funds to secure 'a new project', such as a generic health and social care worker. Getting to this stage seemed to require a great deal of effort and it is perhaps not surprising that there was little push to move beyond that stage, at least for the time being. In any event, the locality groups involved were a long way from being able to obtain sufficient leverage to affect the main service configurations in their areas, including thorny questions related to the balance between residential and domiciliary care and between preventive and reactive services.

Service outcomes

It was relatively easy to identify the outcomes of collaboration between primary care and social care practitioners where they worked together around individual users. In one example, a district nurse located in the Lovemead practice in Trowbridge was able to quickly secure social services agreement to provide some 'sitting hours' to a patient, enabling him to die at home with his wife rather than be admitted to a nursing home. In examples like this, having a permanent social services presence in a primary health care setting came close to resembling a one-stop shop, with the added advantage of offering a less stigmatising point of access for those people who might otherwise be put off from approaching social services directly.

However, little or no service change was apparent as a result of the work undertaken by locality groups. To a large degree, this was to be expected, given the time it takes to achieve discernible change in the overall shape and operation of health and social services. Health and social care involvement in the locality groups had, after all, only existed for periods of between six months and two years. At the same time, while the groups could fairly readily identify problems in the service system, they appeared to find it harder to specify the outcomes that they wished to achieve by working together. This lack of direction was especially evident where groups were focusing on services for older people, where there was little sign of any vision about the future balance of services.

Political process

Across the sites, a range of different stakeholders engaged in collaborative work, including those who operated at strategic levels (in health and local authorities) and those who were practitioners and team managers working in locality groups or around GP practices. There was evidence of leadership, vision and a capacity for negotiation which facilitated partnership working. This understanding of partnership as an essentially political process was evident in the following examples:

- the director of social services who spoke publicly about the merits of engaging with primary care and who spent time with his local teams and probably understood primary health care as well as the health authority
- the health authority director of commissioning with an outgoing and friendly style, combined with a project management approach which senior GPs readily acknowledged and respected
- the GP whose personal vision and commitment were crucial both to the (health) locality commissioning group that he chaired and to his own practice's joint working pilot
- the social services planning and development manager designing ways forward, negotiating with health authority and trust colleagues,

persuading GPs, social workers, district nurses and others, as well as ensuring his senior managers continued to support the move toward alignment

- the joint commissioning manager negotiating across boundaries at both operational and strategic levels, and facilitating communications between practices, locality groups and authorities – at the same time as leading on various other key initiatives involving health and social services.

The weaknesses associated with leadership and support at the sites were mostly to do with competing pressures and being able to devote sufficient time and effort required to sustain progress. Working in partnership is invariably complex and time-consuming. It does not happen by itself and, paradoxically, the more emphasis was placed on 'sorting out boundary issues', the more time-consuming the work became, as more and more problems were highlighted which had previously been hidden away.

Efforts to tackle these problems by concentrating on tasks and timescales and on performance measures did not appear to be helpful in cutting through the difficulties. In the absence of people providing leadership and development support across the health and social care boundary, working processes tended to become locked into ever-widening rounds of problem-solving.

Providing leadership and development support across the health and social care boundary requires particular skills, experience and probably personal outlook. It has to be based on a real understanding of the differing and shared interests of key stakeholders, skills in helping the various partners to find common ground, a capacity to solve problems arising and the determination and stamina to keep the work moving forward with a clear sense of direction. The sites that had a number of people with those attributes involved in collaborative activity made more progress than others where one or two isolated individuals struggled to bridge the health and social care boundary.

Engaging users and carers

The King's Fund project had a specific brief to investigate how user and carer involvement in primary care joint commissioning could be secured. Only in Wiltshire, where there was already a history of supporting such engagement, was there anything approaching an acceptable level of involvement. In some places, there was a surprising reluctance, at least at first, to move in this direction. Generally, the reason given was that the agency and professional partnerships had to be made secure before any wider engagement could be made. Of course, this is an understandable position but all the evidence suggests that it is important to engage users and carers from the outset if real partnership and genuine engagement are to be created.

Involving users and carers (and indeed other members of the public) from the start should help to ensure that the focus is on responding to needs rather than just on working practices. Certainly, in Wiltshire, it provided a discipline that demanded a more outward-looking approach, thus sparing professionals from criticism of any tendency to concentrate on their own professional preoccupations.

Generally, local authorities have had more experience of and commitment to engaging local people than has been evident in the NHS. There is currently much interest in exploring new ways of establishing local governance and in generally opening up decision-making to public scrutiny. As yet, the evidence from these relatively progressive sites suggests that low priority is given to involving local people in developments at primary care level.

While the active participation of users and carers was on the whole disappointing, it was possible to see better communication taking place with service users. Health staff reported that being able to mention a named social worker was received positively by their patients, and sometimes helped to overcome a reluctance to accept social services help. Having a consistent message coming from health and social care staff was also appreciated, giving users more confidence in a service system that was seen to be working cohesively rather than disjointedly.

Budgets

The identification of an agreed resource pool has been put forward as an important ingredient of joint commissioning.[7] This has proved to be a problem at primary care level. Part of the difficulty is that the purchasing systems of health and social services are so different from each other and often difficult to understand. They are not designed to be matched up. Furthermore, while GP fundholding (in various forms) passed decisions regarding resource allocation down to primary care, in practice, there has been little 'spare' resource to put into a joint pot with social services. And, while some social services departments have devolved budgets to local levels, there have been restrictions on the ability of budget-holders to release resources: existing commitments have had to be met and in-house services have had to be supported.

Very little joint purchasing took place at the development sites despite the progress made in other aspects of collaboration. Consequently, it was difficult to secure service changes. This weakness again emphasises the importance of vertical linkages. It is only at the level of health and local authorities that sufficient resource can be created to enable real joint purchasing to take place from a primary care base. Strategic authorities need to design ways of achieving any sort of budgetary alignment, and this did not take place in any of the five sites.

The issue of pooling and aligning resources was an example of where development sites found it too difficult to keep all the plates spinning at the same time. As a consequence, the collaboration that did take place often looked as though it involved a great deal of effort for limited returns.

Decision-making

Decisions and how they are taken lie at the core of joint commissioning. The basic premise is that by taking decisions together health and social care partners will secure better outcomes for individuals and communities. These decisions can relate to policies, resources, practices or any combination. Unfortunately, in the development sites, it was not always clear that decisions were being taken jointly, or at the very least, taking account of partners' decision-making powers. Examples of this have already been identified in weaknesses involving spending powers and needs assessment. One of the reasons for this lack of jointness in decision-making lies in the fundamental differences between health and social care systems.

At practitioner level in the development sites, it was not always clear that the respective roles of various practitioners had been sufficiently thought through. How referrals were dealt with, assessments were made and care was managed varied considerably between practices. Thus, district nurses featured prominently in these activities in Dartford and Gravesham and in Knowsley but less so elsewhere. These variations contrasted markedly with the roles of social care practitioners, where practice tended to be driven more by policies and procedures laid down by social services departments. At agency level, there were similar problems in identifying and relating the different decision-making processes of health and local authorities – difficulties that were intensified by almost constant changes in departmental structures, policies and working procedures.

These differences made it more difficult to link decision-making across practitioners and agencies, although such linkages were easier to make when specific outcomes were being sought. It also became apparent that partners from outside primary health and social care would have to be brought in, as when the hospital-based geriatrician was invited to help with thinking about older people's needs in Dartford and Gravesham, and the local housing department was enlisted to help promote independent living in Trowbridge. More partners, of course, meant more decision-making processes to relate to, and an even greater imperative for all concerned to understand who was doing what.

Implications for primary care groups

Primary care groups are now part of the 'new' NHS, soon to be followed by primary care trusts, health improvement programmes and the introduction of new flexibilities intended to strengthen partnership between health and social care. There is a renewed interest in how agencies can work together more effectively, and how a primary care perspective can

be incorporated into the more effective commissioning and provision of services. How health and social care practitioners work together continues to be important in terms of better outcomes for patients and clients.

As partnership continues to dominate the public service landscape, it is important to ensure that existing knowledge and experience of primary health and social care collaboration is not overlooked. Joint commissioning may have run its course as a useful concept or label, and primary care may not be the most effective setting from which to achieve service improvements; however, the experiences so far are still relevant, not least in understanding more about how working in partnership can make a difference.

The context in which joint commissioning development sites operated during the life of the King's Fund project was different from that in which primary care groups will grow and take root. There was no statutory requirement for partnership between health and social care; no established mechanism such as primary care boards within which joint decisions could be taken; no terms of reference laid down, and no relationship between locality-based groups and strategic health and local authorities specified. The people who worked in the King's Fund development sites had to find their own way of working together, depending on their own initiative, good will and ideas. They tended to be 'movers and shakers'; almost invariably, they had little support or direction from the centre for their efforts. Nevertheless, lessons emerging from these development sites have implications for the health and social partnerships that will emerge as *The New NHS* is implemented. These are discussed below.

- Primary health and social care practitioners by themselves cannot be expected to bring about systems-wide changes that are necessary to improve services for older people and other vulnerable groups. However, as assessors of need and providers of treatment, care and support, they remain crucial in securing better outcomes for individuals, and capable of contributing (through their representatives) to the development of better care at the more strategic level of the primary care group.

  Joint commissioning needs to be located at strategic and locality levels, and not at the level of GP practices. However, all of the different players working at different levels in the health and social care system – either as individual practitioners in primary and social care teams, in locality groups or in strategic authorities – will need to operate within a framework which specifies the service outcomes that the different partners have agreed that they wish to achieve, and which connects decision-making processes within and between agencies.

- Wherever partnerships are being fostered, it is important that there should be some shared vision of how things could be better, some shared agreement about problems to be tackled and the direction of travel needed to make progress.

- Collaborative processes and joint outcomes have to evolve together. This is not a linear relationship but one where successive players are engaged and work in different ways to achieve common ends. Thus, the goal of better outcomes for vulnerable people cannot be properly addressed without involving users and carers, so that they can play their part in identifying the service changes that need to be made. Similarly, joint strategies cannot continue to be designed and developed in the town hall (or its equivalent), leaving practitioners and sometimes their operational managers uninvolved and in ignorance of decisions being made. Different approaches are needed, as shown by Dartford and Gravesham, where it was recognised that for any success in improving mental health services, connections would be required between the activities of locality groups and contracting decisions made by strategic authorities.

Much is known about what gets in the way of effective joint working. The complexities involved are such that some combination of 'stick and carrot' is necessary to achieve more significant change. Even the most enthusiastic participants can flag

from time to time, and some incentives would help to sustain their efforts. It has also been suggested that some sanction such as the threat of loss of income might have some beneficial effect. However, experience in the joint commissioning development sites suggests that the development of an effective partnership culture may not be assisted by this. What may be much more helpful is having the resources to invest in partnership working, where support is provided for the different partners to learn to work together, building trust and confidence and the skills necessary to achieve change in mainstream services. For partnership is not achieved by political or administrative dictate; it has to grow and develop over time. And, as has been evident in this exploration of primary health and social care partnerships, many places will be starting from a very low base.

Health improvement programmes now require partnerships that go beyond health and social services. A range of local authority departments are expected to get involved, including housing, leisure, environmental health, education and planning, together with other partners concerned with employment, social security, police and so forth. Primary care groups will become the new focus for the further development of collaboration across the health and social services interface. As such, they will inherit the challenges that confronted the joint commissioning initiatives discussed above, but can also benefit from the learning that has taken place.

The partnership agenda is now larger and more ambitious than ever before, offering the prospect of significant change in public services throughout the country. Meanwhile, more effective partnerships between health and social care remain as important as ever if there is to be any prospect of achieving better integrated care and support for vulnerable people. While the development of these partnerships is undoubtedly complex, early experiments in joint commissioning show that no service improvements can be expected without greater cohesion in the way practitioners and agencies work together to achieve desired changes. For partnerships can only make headway if they have a common purpose.

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