King's Fund

Joint Approaches for a Better Old Age

Developing services through joint commissioning

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Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1996

ISBN 1 85717 114 4

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD
Tel: 0800 262260
Fax: 0800 262266

Printed and bound in Great Britain by Peter Powell Origination & Print

Cover photograph: Tony Stone Images

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Chapter 1

Introduction

Setting the scene

This book is about looking for better ways of meeting the health and social care needs of older people. Its concern is improving the quality of life of older people through the closer collaboration of statutory and other agencies. It focuses upon what has become known as 'joint commissioning', involving principally health and local authorities.

Increasingly, health authorities and social services departments are required by Government to work together to address particular problems; an obvious example is meeting the continuing (longer-term) care needs of older people. Perhaps more importantly, the interrelated nature of people's needs and the administrative division of responsibility for services demand a more collaborative approach. There has been a growing sense that by pulling together, in a more systematic way, the ways by which needs are assessed and responded to, health and local authorities will together become more effective in meeting their responsibilities, particularly those which appear to overlap in the policy and practice area of community care. Meeting these responsibilities is often achieved by means of contracts with other organisations whose role is to provide services: for older people, which services are available and how they are delivered are what matters. The essence of joint commissioning is translating strategy into action.

Securing fundamental change

Growing numbers of people living to advanced old age, shorter lengths of hospital stay and the requirements of the community care legislation (not to mention personal preferences) are all putting immense pressure on community health and social care services. The indications are that tinkering with the present ways of providing care will not be effective. But securing more fundamental change is far from easy: the complexities of the health and social care systems are great, as are the competing demands made upon the time and resources of managers and other decision-makers.

Because this is an account of joint commissioning in practice, it reflects those complexities as well as the frustrations associated with securing change. It examines the ways in which agencies are working together in five different places across the country, with a view to improving services for older people. In doing so, it may sometimes appear to be somewhat removed from the day-to-day problems facing older people. The challenge for all of us concerned with meeting the needs of older people is to ensure that, no matter how complex the solution may become, we should never lose track of the basic reason why this work is important.

A positive view of ageing

This analysis supports a more positive view of ageing being taken by the statutory agencies and, indeed, society generally. The problems being examined here are certainly not older people, nor indeed have they been created by older people. Increasingly, people well into what has traditionally been dubbed 'old age' can and do make a major contribution to the quality not only of their own but also of other people's lives. It is important to be able to acknowledge and address the existence of ageism in the way in which, for example, resources are allocated. There is an important argument emerging that notions of inclusivity need to be applied to older people in general in a way similar to how other disadvantaged groups are being incorporated into broader society.

Older people form by far the largest recognised group of people whose needs health and social care agencies (both purchasers and providers) have to address. And yet, despite the best efforts of many, there seems to be a lack of focus and perhaps of passion too in making progress on older people's services, compared to, say, the impetus behind obtaining a better quality of life for people with learning disabilities. In some ways the scale and complexity of the issues seem overwhelming. There is so much that joint commissioning could (in theory at least) be trying to address. There are growing numbers of older people, especially those of 85 years and over. Recent policies and practices emphasise the importance of older people being looked after in their own homes wherever this is possible and they themselves want it. There is unresolved confusion and controversy about the services to which older people are entitled, and about whether these are 'health' services and therefore at nil charge, or 'social' services and

therefore liable to a charge. Social services departments have to decide between concentrating exclusively upon those in greatest need and giving some attention to preventive services, often with diminishing financial resources.

Is joint commissioning working?

Increasingly, joint commissioning is becoming linked with the implementation of the community care legislation. 'Is joint commissioning working?' might be another way of asking whether community care is working. In both cases the actual evidence remains largely elusive.

This analysis does not set out to provide a comprehensive guide to the way forward; indeed, it is doubtful whether such a guide is possible. Much depends on local circumstances, local initiatives and the ability to make changes in the light of growing local experience. The intention is rather to pass on what has been learnt from work undertaken at the King's Fund with five places who have tried to improve services for older people through joint commissioning. Various approaches were adopted so no single blueprint was ever likely to emerge. Progress may sometimes be seen as slow – some would say with the risk of not being sustainable in the longer term. Some key ingredients for success can be identified but these have to be seen in the context of on-going work which has not yet come to fruition locally. It may be that other approaches have to be tried (as well as joint commissioning, rather than instead of it) if the necessary momentum for a spiral of development is to be obtained for the care of older people. While mindful of the difficulties involved and the largely unproved nature of its effectiveness in terms of major service change, this account nevertheless adopts a cautiously optimistic line in relation to joint commissioning for older people's services.

Chapter 2

The state of joint commissioning

This analysis of joint commissioning focuses upon five particular examples and identifies some important messages from that work. These examples are not put forward as models for others to follow. Indeed, if securing significant service change were seen as the benchmark for success, it is doubtful whether any of the places themselves would claim major progress. But there are nevertheless important lessons here. In effect, these analyses are of the two statutory agencies addressing new requirements brought about not just by legislation and regulation but also by a recognition that there should be no place for disruptive interorganisational rivalry. The emphasis has to be on addressing the needs of individuals rather than the needs of organisations. To do this the new-found enthusiasm for collaboration (which certainly exists) has to be converted into impact on services.

This book is essentially about the efforts, the achievements and the setbacks experienced. It does not provide a comprehensive account of what joint commissioning involves, nor why it is important, nor how it relates to earlier collaborative efforts or to organisational theory. Nor is it a step-by-step guide of the 'how to do it' variety, although the King's Fund work has produced one such detailed account of GP practice-based joint commissioning in Wiltshire.[1] However, it is useful here to place this work in context.

What is joint commissioning?

Joint commissioning has been variously described as a mechanism, an overarching activity, a problem-solving tool.[2] There is no precise agreement on what 'counts' as joint commissioning, although there is some consensus that what distinguishes it from earlier efforts at joint working is its position in mainstream decision-making rather than at the margin. In broad terms it is based upon an overall partnership approach to health and social care, and especially to those activities which take place on or around the boundaries between the two. In this version of joint commissioning, collaboration becomes the standard form of behaviour

where organisational needs take second place to those of people for whom the agencies have responsibilities. There is some attraction in a loose definition, not least because it encourages participants to concentrate upon meeting specific local needs and identifying strengths which can be built upon to achieve meaningful solutions.

The need for clarity

There is also a danger, however, that by aiming to embrace everything this catch-all approach ends up in confusion and with no progress being made. It will be argued that clarity is a key ingredient for any sort of success through joint commissioning. If it is not clear at or near the outset of any local initiative what is involved and what the desired outcomes are, then it is likely that joint commissioning will be consigned to the scrap heap of unfulfilled promises. This emphasis on striving for clarity does not negate the inevitability of tensions nor the existence of different ways forward. Searching for better outcomes for and with users and carers is itself an important means of gaining a greater clarity. Opportunism, commitment and energy are also crucial: the clarity required here is more than that of the neat planning model. Learning by experience is a basic necessary skill. Being able to combine these differing aspects is one of the tricks of successful joint commissioning.

Service change

Perhaps the most significant driving force behind joint commissioning has been the desire for 'seamless' (or joint) provision, i.e. services designed and delivered in a way which makes more sense and is more acceptable to users. However, in most cases it is very debatable whether there is sufficient clarity around what these new service responses might look like, including whether in practice 'seamless' should mean 'co-ordinated' (across boundaries), 'integrated' (through the effective removal of boundaries), or some other form of 'joint'.

For older people's services particularly there is some indication (not just from the King's Fund work) that as yet major service change is simply not receiving sufficient attention. There is a risk that joint commissioning becomes an end in itself, another item on the checklist of activities which

must be ticked off in order to avoid incurring the displeasure of the relevant inspector.

The evident lack of emphasis on change and lack of clarity on responsibilities suggest that commissioning itself is not working well enough, within as well as between agencies.

A number of major policy and practice 'distractions' for senior staff, together with seemingly endless organisational turbulence in the systems, have helped to keep joint commissioning largely in the wings so far as major decision-making around older people's services is concerned. However, this sort of comment itself confers on joint commissioning the same sort of status as, say, hospital discharge arrangements, i.e. another issue to be tackled. Unless the collaborative approach becomes an underpinning way of thinking and behaving, then joint commissioning will be confined to the margins of decision-making.

So where does that leave joint commissioning for older people's services?

The arguments for

The Department of Health has provided comprehensive guidance on some key aspects: the reasons for undertaking joint commissioning, the legal framework which both underpins and sets the parameters, different ways of getting going, what constitutes commissioning, possible gains to be achieved. Perhaps the most important parts of this useful material are those which both analyse and emphasise what is meant by commissioning (see Fig.1) and which clarify what the law presently allows (and, of course, what it prohibits).

The basic arguments why joint commissioning is seen as important are well documented: focusing on needs, addressing gaps and overlaps, promoting value for money, improving accessibility, involving users and carers in decision-making, etc. A relatively early contribution by Knapp and Wistow[3] remains one of the most persuasive, as well as providing a valuable analysis of some of the activities which make up joint commissioning.

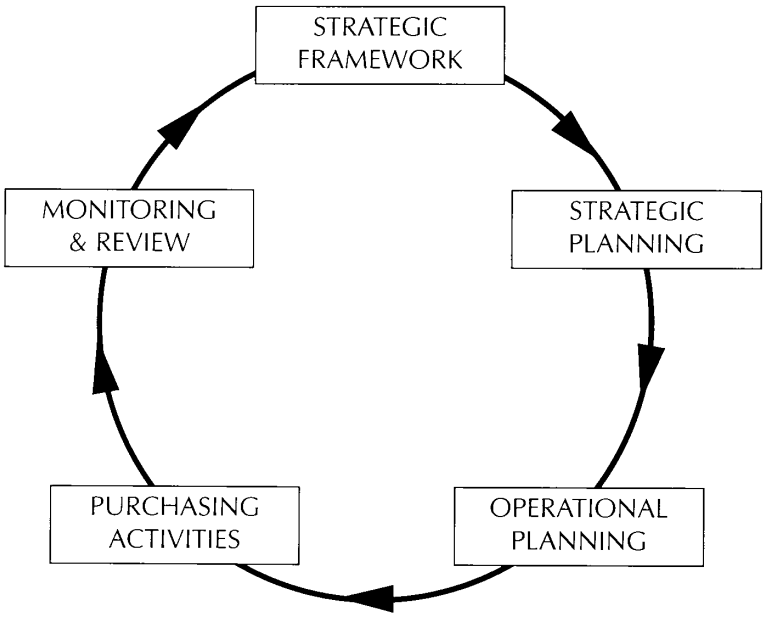

Figure 1 The commissioning cycle

Relating joint commissioning to organisational and collaborative theories may appear rather remote to most health and social care managers but there is merit in some study of successful examples of collaboration in other areas of decision making.[4]

Joint commissioning in practice

Less is known about the nuts and bolts of real world joint commissioning. There are interesting accounts of the experiences in Merseyside[5] and elsewhere as well as some less detailed reports[6] which provide a flavour of different versions of joint commissioning in practice. The Wiltshire guide[7] referred to above provides a step-by-step account of developing and implementing joint commissioning at a level involving GPs and social care teams. An earlier contribution offered more general guidance on how to get started on joint commissioning, based upon real life experiences.[8] The field of learning disabilities has probably provided more examples of important service change, driven by the requirement in many places to close down long-stay hospitals and make alternative accommodation and support arrangements based upon the principles of ordinary ways of living. Useful accounts[9,10] have been provided of progress made in this area which has implications for the development of older people's services.

Key features

Before examining the work of the five King's Fund development sites in more detail it is perhaps useful to offer some brief thoughts on the main features of joint commissioning. The basic thesis is that better services and thus a better quality of life will be achieved by the statutory agencies and their partners looking at and responding to health and social care needs together. There are four key features (shown in the boxes below) which, although in many ways obvious, distinguish joint commissioning from previous efforts at achieving change through collaboration.

Achieving a better quality of life: sharing aims, objectives and underpinning values

- Being clear about what really makes a difference to older people's lives
- Involving older people in decisions about their own lives and about more general developments
- Ensuring a better understanding by older people of the health and social care systems and so promoting a greater ownership

Obtaining better services: developing an agreed programme of service change and development

- Effectiveness: meeting needs clearly identified through user involvement
- Efficiency: avoiding duplication of effort, reducing costs associated with 'non-client contact' (e.g. overheads, travelling time)
- Accessibility: simplifying the ways in which people make use of the health and social care systems
- Innovative ways of meeting needs: beyond the traditional public sector way of thinking and responding
- Equity: adopting a systemswide approach to the allocation of resources

Jointness: being clear about the extent to which working together will influence decision-making

- 'Joint' or 'collaborative' commissioning: being clear about whether decisions are to be taken together (in the same place) or separately on an aligned basis, equally being clear about decisions still to be taken within agencies
- Resource implications: being clear about whether (or rather the extent to which) purchasing decisions made as a result of commissioning should make use of budgets which are clearly identified and aligned alongside one another
- Impacting upon services: co-ordination or integration – the importance of having a clear view of what is being sought in terms of service development

Commissioning: understanding what is involved and the extent of local application

- Involves decision-making ranging from needs assessment to determining appropriate responses, on an individual, locality or service basis (or some mix of all three)
- Including both strategic and operational elements
- On a rigorous and systematic basis with clear timescales and responsibilities
- Based upon the statutory responsibilities of health and social care commissioners
- But also involving providers, users, carers, advocates and others who can bring an 'added value' to the process
- With users, carers and other members of local communities having an important role in decision-making
- Having built in mechanisms for monitoring and review

These are the key components of joint commissioning. Those setting out as well as those already engaged should be aware of them and should also be able to determine their own stance in relation to them if they are to be purposeful in their approach.

Chapter 3

The five development sites

In 1993 the King's Fund obtained funding from the Gatsby Charitable Trust to undertake some work to determine how joint commissioning could lead to better community care services for older people. The principal method adopted was that of identifying a small number of development sites across the country in order to work with them and to learn from them. At the outset a deliberate effort was made to obtain a good cross-section in terms of geographical location, type of authority, political complexion, approach being adopted to joint commissioning and progress already made.

At about the same time the Department of Health was confirming its support for this collaborative approach to making progress on the community care agenda. The King's Fund project was thus able both to contribute to the work of the Department's national development group and to benefit from involvement in discussions at this level.

Five sites were chosen which, for much of 1994 and 1995, offered the opportunity to assist local leaders in their efforts and provided a rich source of material as they pursued their selected aims and objectives in their own ways. While there was a genuine commitment to working together, none could yet claim any significant progress on joint commissioning for older people's services. The role of the project was to support and to analyse what was happening locally. Support provided included consultancy to local leaders and large group facilitation as well as developing a network whereby representatives from the sites came together to consider issues. Some financial assistance was also provided, which proved especially useful in ensuring that developmental capacity was available.

Much of the work of the project has been recorded in a series of four briefing papers.[11–14] The analyses that follow draw on the main aspects of that work and will look at:

- the sites' background
- the joint commissioning focus: aims, structure, locations

- the leading players
- the outcomes for service shift and for working together
- the lessons for the future.

Obviously, strengths and weaknesses emerge. This account aims to pull out the key lessons (in the following chapter) rather than to offer judgement. However, the non-judgemental tone of this piece should not be mistaken for complacency. Although there is much to be admired in the achievements to date and in the way in which individuals are addressing complex issues, the real test, as stated before, lies in the extent to which the lives of older people are improved. It is important to distinguish between process changes (which are often impressive as well as essential) and service improvements themselves.

As the story of each local area unfolds, readers will become aware of linkages within as well as between agencies, the importance of leadership, problems and progress in user and carer involvement, and other issues, some of which are addressed in Chapter 4.

An early lesson was that to make significant change would take time, often longer than the project's involvement. This is important to bear in mind when reading the following commentaries. But also there has to be some limit to the time required to build up a momentum which is adequate in terms of both pace and volume of change. Getting this sort of balance about right is just one of the skills involved in joint commissioning on the ground.

OXFORDSHIRE

Background information

- A large county of 540,000 population comprising Oxford, Banbury, a number of smaller towns and the remainder largely rural.
- A mix of older people's needs, which reflects the urban and rural nature of the county.
- Joint commissioning developing from a strategic, top-down focus which seeks to take account of existing locality work and to initiate more.
- A county-wide joint elderly strategy which is developed and implemented by an inter-agency team, based upon three local plans (covering the whole of the county), which examine needs and determine priority proposals to be addressed through the corporate planning mechanisms of the statutory agencies.
- Overall aim of achieving integrated needs assessment and service planning for the whole range of health and social care services in the county, with six key areas identified as initial priorities.

Oxfordshire's approach to joint commissioning has been based upon a comprehensive, collaborative planning exercise which has the long-term aim of examining all expenditure on health and social care for older people, with a view to prioritising as appropriate. The impetus for this overall approach clearly came from the top of the statutory organisations: running through the work is the notion of achieving equity of some sort across the county, the desire to provide care for people in their own homes wherever appropriate, and the further development of a strategic vision which underpins these aims.

As the collaborative approach has developed, it has necessarily broadened its emphasis not only because of the requirement to move toward a primary care-led NHS but also in order to acknowledge that even a strategic-led approach relies upon local initiatives taking off so as to provide sufficient momentum and range of activity. The approach has been centred upon an annual comprehensive, collaborative planning exercise which identifies

health and social care spending on older people's services. The focus has been a small team of commissioners with some voluntary sector involvement, looking at 'elderly issues' from both the purchasers/commissioners' and the providers' viewpoints. This team has now been expanded slightly to include two GPs and senior managers from health and social services with overall commissioning responsibilities.

The detailed work which this group has led in producing plans for the health and social care of older people has in itself greatly assisted the development of a collaborative culture among those directly involved and has spilt over into the agencies as a whole.

The medium-term joint strategy produced by the team includes the following components:

- assessment of needs, demands, resources and investment
- improving the experience of users
- improving the experience of carers
- developing joint work at primary care team level
- developing multi-agency care management
- developing joint approaches at local level in respect of the major services for older people.

This has been an ambitious agenda for change and, inevitably, progress has been quicker in some areas than in others. This approach potentially involves a huge range of issues to be addressed, dependent upon priorities and resource availability at any one time. It also provides a framework by which others (notably providers) can be engaged in the joint commissioning process. The stated intention is to ensure that joint commissioning becomes the means by which these various activities are threaded onto a single string so that one is affected and influenced by another in order to provide better care for older people.

Although Oxfordshire has succeeded in involving in joint commissioning activities a significant number of people (commissioners, purchasers, voluntary sector representatives, providers), the impetus rests with the inter-agency group and, more particularly, with the development officer responsible for moving the work forward. This joint commissioning

development and co-ordination post has structural links with the health authority and social services department but sits slightly apart from both; although there have been some difficulties, this has generally been effective. Investment in a skilful resource has proved invaluable in terms of progress made in pulling the organisations together. The trick here has been to recognise that collaborative efforts need roots in the organisations themselves, if they are to succeed: initiatives too closely associated with one person or chiefly consigned to the margins of project status will be likely to fail. This important aspect is well recognised in Oxfordshire where chief officers have considered it important to proclaim their personal commitment to joint commissioning and to allow others the space to operate.

An important achievement has been the establishment of a culture of collaboration between the health and local authorities which has enabled, for example, the development of a mutually supportive continuing health care agreement (despite the problems of financial pressures). The work on the strategy for older people and the collaborative planning process have led to specific initiatives on, for example, the involvement of care managers in accident and emergency admissions, clarifying the role of primary health workers in nursing and residential care homes, and reviewing the role of community hospitals in relation to health and social care.

In addition, an important piece of work has been undertaken analysing the health and social care budgets allocated to older people's services. This has led to a pilot project being set up which aligns local budgets and analyses the use made of them by care managers and the primary health care team. The pilot represents an important development for Oxfordshire, as it involves a much more locally driven approach to needs assessment and response. This focus on individual and local needs will mean that the relatively underdeveloped involvement of users and carers will have to be addressed if the full potential of the collaborative effort is to be realised.

There are service improvements resultant from joint commissioning activities but to date these are small scale and not of a mainstream nature – for example, more co-ordinated information on services, more flexible use of community hospitals, user-sensitive continuing care agreement, better hospital discharge arrangements. These achievements demonstrate

the relative lack of visible outcome so far as service change is concerned. Oxfordshire has adopted a deliberately ambitious agenda but is aware that short-term gains are important if the momentum for longer-term change is to be maintained. This may require a greater involvement of service providers in the process, working with commissioners and as instruments of change. The strategic approach has not led to significant user involvement, which may partly explain why a lack of major service improvement to date has passed with relatively little criticism.

Perhaps more could have been done to engage users, GPs and providers; possibly more demonstration projects (on the lines of the local purchasing one) might have gained more pace to the process. In particular, a greater involvement of users and carers might bring with it more of a passion for service change, which in turn strengthens the joint commissioning momentum. But this ambitious agenda requires careful preparation and nurturing: 'fragile flowers' is a familiar Oxfordshire phrase. If the key players continue to commit time and effort to already expanding activities, there is every likelihood that Oxfordshire will be at the forefront of major service shift as a result of a comprehensive approach to the joint commissioning of services.

VICTORIA

Background information

- An inner-city area of London with a 40,000 population, with a significant number of older people living alone.
- A known shortage of resources compared to other parts of the borough.
- An important and developing collaborative culture at strategic level, with a commitment to replicate this in the locality, where relations between practitioners have historically been poor.
- Focus on the locality in order to achieve more locally based and responsive health and social care provision for older people, including moving toward integrated assessment and services and shifting from acute and residential to care in the community.
- An important emphasis on the involvement of local people in the commissioning of services through participation in the locality work.
- Commitment to developing effective means by which the locality project can impact upon the decision-making processes of the statutory agencies.

In Victoria, the City of Westminster Social Services and Kensington, Chelsea and Westminster Health Agency chose a locality focus for the development of their collaborative activities. There was already a culture at strategic and senior management level which placed an emphasis on working together, as shown, for example, by the parallel process for the Community Care Plan and Health Purchasing Intentions. The intention in Victoria was to identify local health and social care priority issues, involving local residents and practitioners. This would be followed by the establishment of a development programme to identify priority items and to work with strategic commissioners to secure the necessary service shifts. Although there was some devolved budget with the social services team and the possibility of being able to tap into some GP funds, the main approach was always through the strategic/locality linkages.

Victoria has a large number of older people, of whom many live alone, and a relatively small and diverse population of minority ethnic older people with significant problems of accessing services. The locality was considered to be less well resourced than other local areas, and there had been no real progress in joint working between local practitioners, as had happened elsewhere in the area.

From the outset an important emphasis was placed on a project management approach to the work. A project manager was appointed with the brief of completing the design and then implementing the activities involved: two people already working in the area (one in the health agency and the other in the voluntary sector) were recruited on a job share basis. A group of locality-based practitioners, users, carers and their representatives provided the focus for the project's activities; an important aspect of this group was the presence of service provider representatives (acute as well as community) alongside GPs and care managers with commissioning responsibilities. How this group operated proved to be an important part of the project's functioning, with the dynamics of the group for a while getting in the way of effective joint commissioning. It is worth noting that Victoria consistently referred to 'collaborative' commissioning, a term which in many ways more accurately reflected what was happening or being aimed for; as a term, it has received support from several commentators.[15]

The detailed development work (led by the project manager) has focused upon five priorities identified by the local group mentioned above and endorsed by the statutory agencies as acceptable to them as strategic commissioners.

Victoria's priorities for joint commissioning

1. Integration of services for dependent people in their own homes

Looking at four aspects of integration – interfaces between services, the overall range of provision, the experience of fragmentation, and the adaptability of services. Detailed work has been done on improving the information about local people whose needs would ordinarily require a multi-service response. Local providers are working together (with the project) to improve their co-ordination. Commissioners are considering

how to ensure better performance by providers and also how to obtain different configurations of service provision.

2. More effective respite care provision

Aiming for a more locally based response which involves both health and social care and which is more sensitive to carers' needs and wishes. An in-depth review has taken place of what currently exists and whether this meets the needs identified as priority. Work is proceeding on the design of appropriate responses.

3. Community rehabilitation

Testing the ability of the two statutory agencies to design and implement a joint programme of rehabilitative services involving a range of therapies, which will enable people to live in their own homes with prospects of an improved quality of life. A pilot is being evaluated with a view to commissioning a comprehensive service from a single provider.

4. Day care

Several local initiatives are being pursued involving health, social services and a local housing association. The specific intention is to make some inroad into the problems faced by older people living alone.

5. Integrated assessment

Developing a joint assessment tool to be used by primary health and social care workers, including GPs. It is envisaged that this will be used in a large number of cases but that joint assessments themselves will only be used as and when required. There has been a major improvement in general working relations as a result of this specific activity, which has included joint training, designated liaison points between teams, and reaching agreement on respective care roles (nursing and social care).

The above priorities represent the major part of the service development activity, although they are in fact only the most important among a wider programme. Of at least equal significance to date has been the progress brought about by the project in terms of inter-agency working and engaging

- with local people and other stakeholders. Apart from anything else, there is a good deal of organisational activity in Victoria which was not previously present. The project managers have successfully engaged with a whole range of participants and have facilitated some important developments in collaboration at both individual case and locality levels. Of course, this work has some way to go and by no means involves all Victoria practitioners: the involvement of GPs in particular has been on something of an opportunistic basis.

  There has been an important amount of work done to involve local people in the commissioning process. This has taken up a significant amount of developmental time, in part at least because of some early lack of clarity about what they were being asked to do. But undoubtedly, the project has succeeded in raising the profile of health and social care issues among a significant number of older people, so that there is now a fairly well-established pattern of public opportunities to consider important issues such as the changing nature of domiciliary care services. Older people in Victoria increasingly recognise that they have a right to be heard and the statutory agencies readily acknowledge that this adds value to both the process and outcome of decision-making.

  To a greater extent than at the other development sites, the Victoria work has been characterised by its project nature. It was set up by the two statutory agencies as a specific project and has been run as such. Internal evaluation has been on-going, designed to assist chief officers in determining lessons for the future in Victoria and, indeed, elsewhere. The work has been overseen by a steering group of senior officers and others. At the core of just about all of the project's activities has been the work of the joint commissioning project managers, supported by a strategic commissioner from each of the two agencies. Importantly, the project managers adopted a project management approach to all components of the work, each having aims and objectives broken down into key tasks, timescales and responsibilities for action. The general view is that this has helped significantly in making progress so far and in giving a real optimism that, for example, the five priorities identified above will lead to important outcomes.

Certainly, the Victoria project has yet to demonstrate that it offers a sustainable locality-focused model for service change. But it does present some important messages as well as a real prospect for local change. Crucially, it shows that joint commissioning at locality level depends upon the on-going involvement of strategic commissioners providing guidance and support on the parameters for change (the 'what') and on the operational developments required (the 'how'). The evidence here is that by themselves local players (practitioners and public) do not have the skills and resources to bring about major change, nor indeed do they have sufficient ambition and ideas for change. What they have been good at is the identification of individual and local needs. In addition, the emphasis on joint commissioning at locality level has greatly assisted the growth of better working relations between different practitioners, including the development of some joint systems. The establishment of the inter-agency group and particularly the involvement of local people has itself provided the basis for the further development of shared decision-making on health and social care matters. As in Oxfordshire, the developmental and catalytic role of the joint commissioning post has been crucial: the cross-boundary skills as well as the dedicated time have been invaluable.

EASINGTON

Background information

- A population of nearly 100,000, comprising Peterlee, Seaham and a number of former pit villages covering the area between Durham and the east coast.
- High incidences of health and social care needs, together with structural unemployment and environmental concerns.
- A stated commitment to collaborative effort to achieve a greater 'well-being' in the area; this was demonstrated by the establishment in 1993 of a joint commissioning board (JCB) of health commission, social services, district council and GP representatives.
- The setting-up of local groups across the district to assess local health and social care needs and to devise means of response.
- A significant devolution of responsibilities from county to district level for both health and social services.

The two main focal points for joint commissioning in Easington have been the JCB and the close working relations between the lead health and social services managers responsible for the area coterminous with the district council. The origins lie in the regional health authority's recognition that the needs of the area were such that a co-ordinated approach by the statutory agencies was required; this was compounded by the need to bring Easington under the responsibility of a single health purchaser. The initial impetus was therefore a strategic one, but it also sought to build upon the commissioning powers newly devolved to district level by developing some form of joint commissioning with a village focus.

The aims of the JCB reflect the broad approach being adopted, with the emphasis more on health and social care generally than on community care itself. They include the following:

- to agree jointly on health and social care needs
- to agree jointly what services should be provided

- to ensure that the three statutory agencies work together effectively
- to ensure that users and carers have a bigger say in the planning and development of services.

In pursuing these aims the board committed itself to the achievement of greater integration between community-based health and social care services, better access to care, working with local people and improving the overall health and quality of life of local people.

The board has represented the public demonstration of joint commissioning in action, allowing GP and community health council representatives to have some involvement in decision-making around a selected number of items of joint interest. It has been a useful forum for discussion of matters of concern. By itself, however, it is doubtful whether it would have been sufficiently powerful to enable joint commissioning to develop in the way that it has.

The other key part of the mechanism has been the local groups. The aspiration was that these local planning groups would have a growing influence on decision-making within the statutory agencies, including resource allocation, but this has not proved sustainable. Following a review, a greater focus was given to the advisory role of the groups. This confusion about role has not helped the development of local involvement in the process, and it does reflect a very real dilemma which Easington had to face. Devolution to district level had not been without some criticism, at least on the health side. There were concerns about the continuing powerful position of providers in relation to commissioning. Pushing down further purchaser and commissioner powers ran the risk of exacerbating this situation. Relatively early on the decision was taken to change the planned role of the local groups to that of advising the board and the individual agencies. There was a risk that the process would otherwise become stalled. Trying to instil further momentum for change was almost certainly a wise move; but for local practitioners and residents it seemed to be a backward step and the indication of some confusion. There remained an important emphasis on the involvement of local people and the development of joint working between practitioners but in practice the main impetus lay elsewhere.

Of major importance has been the working relationship between the health and social care district level commissioners. This has developed largely because of the skills and attitudes of the individuals concerned, recognising that by discussing problems and ensuring a consistency between their activities, then a more effective addressing of needs would be likely to result. A deliberate decision was taken to locate the small health locality team in the same building as the social services district team. At the heart of this commitment to collaboration is the firm belief that the needs of the area have to be seen in the round, an outlook which also affects the other participants (district council, GPs, etc.), albeit – so far– to a lesser degree. Easington as a place inspires this approach but its problems of poor health, unemployment, housing stress, environmental decline and so on are in fact mirrored in any number of other places. What undoubtedly exists among strategic commissioners in Easington is a commitment to doing something about this situation, to some extent based upon traditional notions of public service but with very modern views about a collaborative way forward. The approach is reminiscent of (local authority) corporate planning of a few years ago but with a much greater emphasis on health and social care. Also important here is an attempt to re-invent community development as a contribution to the process of local needs assessment and response.

What Easington has perhaps lacked is the emphasis on project management which characterised, for example, Victoria's approach to collaboration between agencies. In Easington joint commissioning is very much considered to be 'the way we do things here'. More than anywhere else among the King's Fund development sites, joint commissioning has become almost a philosophical commitment. However, in order to make progress in terms of service improvement rather more tangible components are necessary. Progress on both specific service developments and on extending the collaborative basis has been greatly assisted by the appointment of a development worker involved solely with joint and inter-agency activities. This has built upon what had previously largely been co-ordinated developments involving two or more agencies driven by members of the JCB.

The service development outcomes so far only begin to do justice to both the commitment to change and the collaborative culture which underpins it.

As in most other places the major elements of mainstream expenditure (e.g. the home help service) remain largely unaffected. But change is certainly evident: in a recent external evaluation of the work of the JCB[16] there were 39 service and 17 process achievements ascribed to the JCB, the great majority of which related directly to older people's needs. Even developments which did not appear to have any direct relevance (e.g. Easington School project) could be linked back to an awareness that older people's needs cannot be seen in isolation from others', in this case those of younger people.

Some of the achievements have a clear local (village) focus, for example:

- the opening of an advice and resource centre involving inputs from health, social services and the district council
- the development of a local chiropody service
- improved information provision
- the provision of safety equipment in homes.

Other initiatives which are being developed with a districtwide perspective include:

- the development of a stroke rehabilitation programme
- a pilot 'hospital at home' scheme
- the expansion of the warden alarms scheme
- the development of a joint bathing service
- the development of day care for older people with a mental infirmity
- the transfer of health funds to the district council for targeted work on aids and adaptations for highly dependent older people.

These clearly are only the beginning of the greater integration of community health and social care services, which has been one of the JCB's main priorities. The further development of joint working arrangements is key to the board's continuing impact on health and social care main programmes, and in particular the further involvement of the district council in collaborative activities. Apart from at strategic (district) level the main progress has been with some care manager attachments to GP practices, the involvement of a variety of practitioners in the work of the eight local groups, and a growing general awareness by practitioners of the potential benefits of working together.

Easington's strengths then are to do with its vision for the future, the leadership by example and the commitment to change. Further progress is required in the 'operationalisation' of joint commissioning, which should include:

- identifying further priority areas for service change
- involving more players within the two main agencies (including GPs)
- having more emphasis on the use of joint budgets
- involving the district council more in both the assessment of needs and the responses
- ensuring a closer engagement with providers of services, especially the health trusts, which (because of their geographical location) do not see Easington as their major purchaser.

It is important to be able to make secure the progress already achieved, even (perhaps especially) when this means giving some formality or systemisation to previously informal arrangements. This should help to overcome continuing organisational and personnel upheaval, and to survive financial crises which can put relationships at risk. A greater clarity of role and responsibilities may help: being clearer about what is on the present and future agendas and what is not seen as within the remit of joint commissioning. So far as older people's needs are concerned there has to be a focus on the needs of individuals as well as on those of local areas so as to ensure that high dependency issues are addressed. Overall there is every reason to believe that progress will continue to be made and that some significant gains will be made for Easington.

HILLINGDON

Background information

- London borough on the western side of the conurbation with a population of some 240,000 mostly in an urban setting.
- A mixed population in terms of socio-economic and ethnic background.
- A reputation for good working relations between the health and local authorities (including transfer of management of learning disability services to the local authority).
- Taking a more positive and needs-focused approach to joint commissioning based upon a reinvigorated collaborative culture at strategic level.
- Creation of a series of more task-oriented joint commissioning activities, including two locality projects.

The story of joint commissioning at Hillingdon is not unlike many other places. It is one largely of aspirations for change and some real advances being made but progress largely being dogged by disruptions and a real difficulty in being able to develop sufficient momentum.

The foundations for joint commissioning were laid some years ago and led to some early advances, including the transfer to the local authority of learning disability services using Section 28a powers. But although the collaborative mechanisms remained in place, it seemed that there were few if any underpinning shared service change objectives in relation to older people. Having an array of groups with the right-sounding names was proving no substitute for the development of a local culture based upon real partnership with clear priorities and a shared commitment to invest in joint commissioning activities because they were acknowledged to be important.

A significant change of senior management personnel in both health and social services provided the opportunity to take stock and to try to breathe

fresh life into collaborative activities. As the King's Fund project began its involvement with Hillingdon, senior managers were already embarking upon an exercise to tighten up priorities for joint commissioning and to work out how these could be best achieved in practice. The intention was to build on what existed rather than to throw it out and so to recognise the commitment shown by middle managers and others in the organisations (which was seen as essential for future developments). However, it was recognised that the formal, client-based structure of joint commissioning groups was not working well and needed attention.

A review took place which identified what should shape the future development of what began to be referred to as 'collaborative' commissioning, so as to put some clear water between the new arrangements and what had gone before. The key changes identified were:

- the establishment of a more powerful executive group to provide inter-agency strategic direction, management and leadership
- the replacement of standing joint commissioning groups by task-based project groups working to agreed priorities and timescales
- a new emphasis on project management to be introduced throughout the process
- a re-examination of and commitment to commissioning as a process for achieving change
- the involvement of selected key people from the statutory and voluntary sectors in the commissioning process (i.e. additional to those with commissioning as a specific responsibility)
- a strengthening of the role of users and carers in the process
- a more systematic relationship between collaborative commissioning activities and the achievement of community care priority objectives
- a clearer appreciation of the areas in which collaborative commissioning might operate and equally where it was not appropriate
- a renewed emphasis on the securing of service change through collaborative commissioning, recognising that this is not an end in itself
- the introduction of a locality focus as one way of examining and responding to needs
- the need to ensure consistency in decision-making between the collaborative commissioning process and the processes of the individual agencies.

This review had been able to identify many important aspects of what elsewhere appeared to make up successful joint commissioning. New senior managers had arrived with the aim of stimulating strategic commissioning. An enthusiastic GP fundholder was recruited to be a full member of the executive group. Two small locality commissioning projects were designed in order to test out this different (for Hillingdon) way of working. An away day of several of the leading players was held to do some more detailed design work on how the revised process might operate and what could form some of the initial priority issues.

Although the King's Fund project worked with Hillingdon on these strategic matters, there was a particular focus on the development of two pilot locality schemes. These were in effect testing out two important elements: working together at local, GP-practice level; and the development of new service responses. This work took place against the backcloth of change at strategic level which is described above.

The two proposed initiatives originated at strategic level in terms of both the service developments and the locations selected. At the time there seemed to be no alternative to this approach, since there was little if any local involvement in any sort of collaborative activities. As it turned out, both projects could have benefited from ensuring a greater ownership at local level from the outset. One was based in the north of the borough in an area covered by three GP practices, while the other was in the south with a recognised locality focus. The aim of the first project was to develop a new respite service for older people with a mental infirmity, while the aim of the second was to identify the priority needs of Asian elders and respond to those needs in an appropriate way. In both cases the notion being tested was that better services would result from local practitioners engaging with local people, including individual users and their carers, and having some funds of their own with which to commission services. The development of closer working relations between health and social care practitioners was also a clear aim.

The outcome in terms of service change of the first project has been disappointing to date, although the evident development of closer working relations holds some prospect of future improvement. There has resulted a closer understanding between the professionals involved (health and social care purchasers and providers) on what respite care actually entails.

The small-scale, very local focus did lead to a much greater shared understanding of the issues but it did not produce (certainly within the time envisaged) any meaningful demand for the newly commissioned service. Consequently, there was insufficient momentum to maintain the commitment of those local practitioners who had been involved, and the project came to an inconclusive halt.

The work with Asian elders has been more productive, particularly in the involvement of local people in the assessment of local and individual needs rather than in the redesign of services: responses have occurred but so far these have been of a small-scale, one-off nature. A series of local conferences has generated a real interest among the local community for the first time. The feeling is that this is possibly because previous efforts at consultation were less convincing as they did not cover both health and local authority matters. In fact the main concerns to emerge were to do with housing, transport, general information needs and the need for respite care – all of which are being pursued with the relevant agencies. The major hurdle to be crossed is that of ensuring that this work acquires more of a mainstream status in both health and local authorities.

The locality focus has proved difficult to develop in Hillingdon. Partly, at least, this is because the developmental resource required was underestimated. To make progress within a realistic timescale various aspects have to be tackled more or less simultaneously: the locality itself, joint working between local practitioners, service design and development, engaging with users, carers and other local people. No matter how skilful and resourceful the boundary worker may be, she (and it usually is a she) needs specialist support as well as the involvement of senior managers with overall strategic commissioning responsibilities. The real challenge with this sort of locality focus is to ensure that it achieves more than marginal significance in the statutory agencies, which for Hillingdon probably means a closer tie-up with the strategic collaborative commissioning activities.

Of course, to be of any use at all, joint commissioning has to be sufficiently robust to survive the various changes which seem to impact ceaselessly on health and social care. The experience in Hillingdon shows that at times the turbulence can become too great and despite the skills and knowledge

being present, there is simply too much else to do. This need not mean total abandonment but it does suggest that ambitions must be clearly linked to ability to resource. There probably needs to be a more hands-on style of leadership from the top of the statutory organisations if collaborative commissioning is to become the predominant way forward. This should then help to ensure that the contributions of individual joint commissioners are put to optimal effect.

WILTSHIRE

Background information

- Focus has been upon two towns in the west of the county, with a population of 28,000 and 12,000, respectively.
- Older people live in the towns and the neighbouring rural areas; transport can be a problem.
- Well-developed networks to support the involvement of users and carers in the activities of both health and local authorities.
- Strong emphasis on the development of joint commissioning based upon GP practices supported by the work of strategic commissioners.
- Pilot activities taking place across the county with a view to more general application.

Of the five development sites, Wiltshire is by far the most committed to a locally based approach to needs assessment and determining what responses should be made. The health authority had a policy to develop practice-based commissioning well in advance of the national move towards a primary care-led NHS. The director of social services responded by backing an approach which encouraged social care teams to build closer collaborative arrangements with their local GPs and other primary care colleagues. Four main reasons were identified to support this approach:

- primary care services provided by GP practices and health centres offer relatively easy, non-stigmatising access to health and social care services for local communities
- having one team improves relations and understanding between health and social care staff
- more effective service planning can take place when based upon small scale needs identification and local prioritisation
- 'cost shunting' is less likely to result while the move to 'seamless' services should be helped.

There was a clear acknowledgement that working together at local level with individual patients and clients relied upon an equally close relationship at strategic level, where senior staff were responsible for overall development of the joint commissioning process and for policy guidance on the parameters for service change. While the involvement of both local and strategic commissioners was indeed vital, it was not always easy to get the balance of this relationship right. The two components were both vital but deciding who provided the direction of change and the pace at which it should be achieved proved a delicate issue at times. Here, the contributions made by two skilled boundary operators working at middle-to-senior level in each agency were invaluable: working from mainstream positions these 'reticulists' operated at strategic and local levels, designing and negotiating, supporting and probing. The time and skills which they brought were matched by their knowledge of the decision-making systems – a key ingredient in joint commissioning.

Two previous developments significantly underpinned the growth of locally based joint commissioning. The first was the presence of social services linkworker posts in a number of GP practices across the county – these were SSD staff but from a variety of backgrounds, including nursing. Their role was to ensure smooth joint working around particular cases; where this worked well, it became the basis for a climate of mutual trust between the two teams. The other important development was the growth of (separate) users and carers networks across the county whose roles were to develop and support the involvement of users and carers in all aspects of decision-making. Both the statutory agencies had been consistent in their backing of this work, and local joint commissioning initiatives were able to involve user and carer representatives in a meaningful way.

The King's Fund project worked for two years with two selected local initiatives, in Malmesbury and Trowbridge. During that time steady progress was made, as elsewhere, on the ways in which practitioners worked together and in which users, carers and other local people became engaged in health and social care matters. Actual service change proved more difficult to develop in any major way. Although there was an initial emphasis on getting together to make some specific gains using project funds, this soon took second place to the various stakeholders, including users and carers, wanting to learn more about how each other operated.

Leading participants recognised this dilemma all too well: at one point an understandable desire to move things on more quickly led to disagreement and an abandonment of the work between two particular teams.

The use of needs surveys in the towns and the active participation of user and carer representatives meant that there was rather more emphasis on preventive aspects of care: in Trowbridge the steering group (of practitioners, users and carers) concentrated on the need for better and more comprehensive information on what was already available for older people, the development of affordable domestic help, and the need for more flexible local transport. Having adopted an approach which was heavily based on engaging with local people and finding out their views on priorities, the statutory commissioners were, of course, obliged to listen carefully. But it should be added that health and social care boundary issues were by no means neglected by this approach: in Malmesbury the priorities were the development of a local joint assessment and care management service; the setting-up of a community night-sitting service; and the more effective use of day care and day hospital facilities. Again, a local project group was established involving local users and carers. The service developments chosen are more dependent on strategic involvement because of the restrictions on devolved budgets. Social services have devolved the purchasing budgets for residential and nursing home care and for community care packages, and are intending to transfer budgets for home care services to the care management teams. The issue is more pertinent for health, where everything outside of the scope of fund-holding is dealt with through contracts and there are presently no mechanisms sufficiently sensitive for the local level to impact on these block contracts.

Crucial to the development of practice-based joint commissioning has been the gradual drawing together of the health and social care working arrangements. The relatively long-standing presence of a linkworker at Trowbridge certainly helped matters there but so too did the vision and commitment shown by the social care team manager and by the lead GP. Although they understandably did not always know the precise direction in which they were heading, these two shared a commitment to changing the way in which older people's health and social care needs were viewed. Given that the focus of the approach is the practice, there is much to

applaud in the forward-looking and non-defensive approach taken by social services, at strategic as well as local level. At Malmesbury, the personal involvement of the team manager and of the lead GP was crucial, but the practice manager also played a key part in co-ordinating the various activities, especially the involvement of users and carers. This may set an important example for inter-agency working at local level. Both practices insist that their community-oriented stance is clearly linked to their fundholder status.

Agreements have now been reached to develop joint teams in Trowbridge and Malmesbury so that specific health and social services staff will work together for the benefit of the practice population. This development represents a step on from linkworking and is a direct result of the local joint commissioning projects' progress.

The development of joint assessment systems is being addressed in both places. At Malmesbury a care management training programme is under way which will enable district and practice nurses to take on social care management responsibilities, particularly valuable since the social services office is ten miles away. At senior level this approach is seen in part to balance the amount of health-related work picked up by the SSD linkworkers. The development is deliberately at a considered pace. There is an understanding that some assessment and care management work will remain best done outside of a practice setting. What has real attractions for the needs of older people does not necessarily make sense for people with mental health problems. The way forward has been described as one of 'evolution with steam', making progress where possible with local partners who want to collaborate. A change programme is being created, supported by training and staff development. The King's Fund has sponsored and helped develop a detailed guide to practice-based joint commissioning which should prove useful in extending the approach across the county, based upon the achievements so far in Malmesbury and Trowbridge.

In their developmental phases the Malmesbury and Trowbridge sites relied upon special funding from the agencies and the project for small-scale purchases of services. Mainstream funding has not been accessed in any significant way: this is despite devolution of budget holding in the SSD

and the fundholding status of the practices. It does point to an area needing further development if joint commissioning is to make an impact on the traditional areas of expenditure. The continuing growth of the collaborative culture locally should help deal with the rather more challenging issues associated with decisions about money. A closer relationship is needed with the internal commissioning functions of both the health authority and the SSD. Part of the problem here is clearly that there are in reality very few opportunities for local managers with devolved budgets to undertake 'pooling', or more accurately 'aligning' activities because their ability to free up resources is limited. In part this may be due to the continuing importance of contracts managed centrally and also to the weak links with existing and new providers. In Wiltshire work is continuing on both of these aspects so as to maximise the opportunities offered by the collaboration at local level.

The practice-based approach has some way to go before it can claim the sorts of successes in service improvement to which it aspires. As a way of working it is already making an impact: a Trowbridge user reported that it was becoming quite well known in the town that something was happening at the practice in question with social services, which meant that older people were getting a better service. The significance of this rather ill-defined comment should not be underestimated. Without making any major claims, the health and social care teams are in effect reworking the old medical and social models of primary care: the award of Department of Health funding has enabled the approach to be extended to the other three practices in the town.

In conclusion it is useful to recap (see boxes opposite) what has worked well in Wiltshire and what still remains to be addressed. The importance of this analysis at this point in the overall account is that it is also relevant for the other development sites. This is by no means an exhaustive list of indicators, even for the relatively small-scale work taking place in just one part of Wiltshire. It does, however, give a flavour of what seems to be some key ingredients for successful joint commissioning.

Success factors to date

- Leadership at both local and strategic levels
- Skilful 'boundary operators' who are comfortable in both sectors and at both levels
- Provision of development personnel with the necessary skills and capacity
- Long-term investment in user and carer involvement
- Making use of needs information collected at individual, locality and strategic levels
- Examining working practices
- Building upon local strengths, e.g. well-established linkworker scheme
- Taking time out to consider progress and work out next steps

Issues to be addressed/next steps

- Increasing the number of participants, within the 'demonstration' practices and elsewhere
- Building stronger models of ways of working together within the limits of available skills, resources and information
- Further design work at strategic level to liberate effective collaborative decision-making at local level
- Having a clearer vision about the ways in which needs of older people will be met, involving housing and other key areas
- Ensuring a greater linkage between agency-wide commissioning and joint commissioning at local level, including a more systematic involvement of providers
- Designing more effective links between practice and locality-based needs assessments
- Developing measures for evaluation of this approach

[redacted]

Chapter 4

Identifying the key ingredients

The five development sites have some way to go before securing the service changes which they are working towards. However, some worthwhile achievements have been made in the development of joint commissioning over the last two or three years and rather more in instances of joint working between agencies. These should be seen as intermediate outcomes which are valuable in themselves and which can form the basis for future success in service development. The signs are certainly encouraging and worthy of some attention; important achievements made to date include gains in knowledge and skills among commissioners. So, people working in the five sites have learned:

- more about how the health and social care systems operate, at both formal and informal levels
- practical ways of working together at strategic and local levels
- how to engage effectively with older people and how to put their needs before those of the organisations
- the importance of instilling a greater rigour and vigour into changes required so as to meet needs more effectively.

These are real achievements which can be seen to varying degrees and in different ways at each of the five sites. They add up to getting better at joint working – something that is of genuine worth in itself, which contributes to joint commissioning, and which provides a degree of optimism for the future development of community care services. Generally, the way in which health and social care agencies relate to one another has changed markedly over recent years. But it is difficult to stake any greater claim for joint commissioning at this stage at least. Therefore, any analysis of what its key ingredients are has to be subject to health warnings about its real significance.

How to obtain better joint working is worth examining, but it is important to see this as an early stage on the journey rather than the destination.

The experience to date from the development sites (and elsewhere) is that we know rather more about successful joint working than we do about successful joint commissioning.

In terms of major (systemswide) change, it remains largely an act of faith that joint commissioning can deliver. The five development sites show that there are a range of approaches which can be pursued, all of which offer some encouraging indicators. It is generally recognised that there is no single blueprint for joint commissioning, and certainly the sites' experiences are not being put forward as models, at least not at this stage.

It is possible to identify what has made a difference in the progress of the work at the sites. The significance of these ingredients for other areas will depend upon the similarity of approach being taken locally. The approach adopted will depend upon local priorities and also local strengths: building upon what has already been achieved generally makes sense.

In summary the key ingredients are seen to be:

- **creating partnerships**
- **having vision and leadership**
- **undertaking effective commissioning**
- **achieving pace and volume of change**
- **using resources effectively.**

Creating partnerships

When addressing needs across the health and social care boundary, there would appear to be an almost limitless number of partnerships which need to be forged in order to ensure optimal outcomes. The relationships of the various participants are often both complex and confused. A major challenge for joint commissioning is whether it can clarify responsibilities in general terms but especially for older people, who are often increasingly confused by the different (and changing) roles and responsibilities among purchasers and providers of health and social care.

The more agencies and other players involved, the greater is the potential for confusion and complexity. There is a pragmatic aspect to be considered

when determining how many local partners should be involved. These should be selected carefully: initial momentum can be obtained from those most clearly committed. But from an overall perspective whether or not a particular agency should be involved in joint commissioning ought to depend upon whether they bring an added value to that commissioning process.

For this analysis three different (but related) types of partnerships are examined:

- across organisations
- within organisations
- beyond organisations.

Across organisations

Partnerships across organisations are crucial for successful joint commissioning on a systemswide basis at four distinct levels.

- *At the top* organisational leaders need to act cohesively in order to provide both the shared vision and the leadership which are essential ingredients. These aspects are examined below (see 'Having vision and leadership', p. 47).

- *At strategic level* (below chief officers) collaboration is required to secure clear aims and objectives, putting the vision into some sort of tangible form. At this level the partnership should be part of mainstream work, if it is to be properly effective. An important part of the strategic commissioners' role is to ensure that the major planning and implementation systems of the agencies are effectively linked to the various activities happening as part of joint commissioning. While a project management approach is essential for the success of joint commissioning, this is best put into effect as part of main programme activities: pilot projects have their place but the learning and application as a result of their review are crucial. An important part of joint commissioning is obtaining a degree of alignment on the part of the respective decision-making systems of the organisations involved. This would seem to be a key role for strategic commissioners. It is not an

easy task, as anybody who has tried to align purchasing budgets at locality level will doubtless testify. Additionally, the personal leadership contribution of strategic commissioners can be of great value: it is often at this level that really skilled cross-boundary operators can be found, who also perform the role of 'product champion' for joint working. At the development sites the partnerships worked in different ways, as shown opposite.

- *At locality level.* In Victoria this was the main focus of joint commissioning activities, and a project manager was appointed to build up engagement of both managers and practitioners working locally. For the NHS this importantly involved providers, who are indeed often more evident than commissioners below strategic level. In Wiltshire the focus was on the GP practice, while in Easington it was on local small towns and villages. What makes up a locality is open to different interpretations. What is more clear is the opportunity provided for partners at this level to develop ways of working together, from needs assessment to service response.

- *At the individual service user or carer level,* and here there are close links to the previous (locality) level. Like many other places all of the sites were making progress on the implementation of joint needs assessments and other specific joint working arrangements which directly impact on users. Locality managers (which could include GPs) are again crucial in this respect. But so are nurses, home carers, social workers and other practitioners who now have more scope and encouragement to develop different ways of working. The extent to which this joint work is linked to resource allocation decisions in the agencies will determine how far it can be properly considered to be joint commissioning.

Within organisations

Perhaps less obviously, joint commissioning must also involve partnership within agencies. Although the emphasis may vary, the experience from the five sites is that each of the four levels outlined above must be engaged to ensure the sort of changes envisaged. The priority given to the role of health authorities in establishing a primary care-led NHS illustrates the point.

Oxfordshire

- Working of the joint elderly commissioning team
- Emphasis on organisational collaboration from the top
- Links through the collaborative planning process
- Bridges built by the joint commissioning co-ordinator

Victoria

- Joint commissioning project steering group
- Strategic commissioners providing joint support to the project managers
- Strategic commissioners playing a major role at meetings with users and carers
- Joint commissioning project managers linking across agencies at strategic and locality levels

Easington

- Significant devolution from county to district and locality
- High level of trust and mutual support between strategic commissioners at district level: informal aligned decision-making
- Joint commissioning board bringing in GPs, public health and district council
- Exploring ways of listening to local people and practitioners, e.g. search conference

Hillingdon

- Strategic review of well-established joint mechanisms
- Use of pilot schemes to influence future working arrangements
- Consciously pulling together joint commissioning and community care implementation
- Setting priorities and determining specific tasks for collaborative groups

Wiltshire

- Visible and hands-on leadership by organisational heads
- Clear shared policy direction of GP practice-based commissioning
- Regular reviews of progress involving listening to locality groups
- Joint commissioning development staff with close links to chief officers and local groups

New and more productive ways of relating are being devised up and down organisational lines. In some cases this involves a re-invention of management within a new framework of devolution and of commissioning and contracting. Elsewhere, it involves a new determination to create links where few previously existed: GPs have famously never been subject to the same hierarchical discipline as most other players and, unsurprisingly, are responding in a variety of different ways to the new requirements.

Being clear about respective roles and responsibilities is an essential requirement at a time when many changes are occurring:

- commissioning and contracting are replacing traditional management lines of accountability
- responsibilities for budgetary and other decisions are being pushed downwards

- both the health and social care systems are being fragmented as purchasers and providers become increasingly independent of each other
- the drive for a primary care-led NHS continues while the need for a strategic overview does not diminish.

These and other pressures emphasise the need for the development of new partnerships within systems and organisations as well as between them. In particular the need for a new relationship between strategic and local/locality commissioners is essential, if fundamental and sustainable changes are to be secured. Judging by the experience of the development sites, such changes will require attention at local level to needs assessment and determination of response, and then at strategic level to systemswide analysis and then implementation of necessary changes in how resources are allocated. A further complication is that the relationships are significantly different within the NHS and social services: while both have elements of commissioner/purchaser and provider separation, this is more clearly demarcated for the NHS – although here the developing role of GPs serves to muddy the organisational waters.

Beyond organisations

Essentially, this phrase seeks to capture the potentially wide range of 'external' partnerships which strategic and local commissioners can build up in order to enhance their own effectiveness. There are no rules about who are essential partners and who are optional, much depends upon knowing who the local agencies are and which individuals might make a difference.

Users and carers might be seen as essential, given the intrinsic importance of their (separately) becoming more involved in decision-making, but how this happens will need careful consideration. Of the five sites, probably the most successful at involving users and carers is the one which has been at it longest. Sound advice is available from other sources[17] on how to approach this issue at different levels of decision-making. The partnership between statutory commissioners and users and carers remains potentially a really powerful one which is ripe for exploitation so as to develop more effective ways of viewing both needs and how to respond to them. The experience to date from the development sites suggests that involvement on specific issues (e.g. the development of a 'new' respite care service) works less well than on a wider agenda where users and carers have more

opportunity to set the priorities. This may simply mean that users and carers prefer to get involved on issues which they consider important and on which they are confident that they can make a contribution.

Four of the five development sites experimented with the involvement of **local communities** in needs assessment and service development, which constitutes locality commissioning of sorts. In all cases it is too early to be clear about the effectiveness or otherwise in terms of impacting upon needs. But the indications are that there is a real public support for looking at health and social care issues across the board and for this also to embrace other issues such as transport which clearly have an important influence on the overall well-being of older people. In Trowbridge this work was undertaken through local surveys and through a series of public meetings based on the GP practice. In Easington village focus groups were set up which also had the function of bringing together local practitioners with local residents. In Victoria local older people are represented at the locality commissioning forum but also can take part in an ongoing series of public meetings which examine their concerns about health and social care, including issues such as whether or not older people should be treated on separate wards in hospital. In Hillingdon there has been an important success in engaging with local Asian older people on a wide-ranging agenda which prominently includes housing. Important basic learning is to be clear about what roles etc. are being offered and to ensure a regular flow of reporting back.

There is an understandable debate about where (if at all) both of **the voluntary and private sectors** fit in the new world of commissioning. For voluntary organisations much depends upon how they see their role locally: provider, advocate, 'alternative voice', partner to the statutory agencies – or any combination of these. It is clear that they should no longer see themselves or be seen as proxies for direct links with users, carers or other local people. The traditional richness of the voluntary sector in the UK suggests that exclusion from joint commissioning will be at a cost but it is important that the precise nature of the added value from their involvement is carefully worked out locally. The involvement of the private sector (distinguished by its 'for profit' position) is less clear-cut but if representational aspects can be resolved then again the 'added value' test could be the one to apply. The involvement of potential competitors in commissioning services does, of course, apply also to some voluntary organisations: much will depend on the maturity of the relationships.

Increasingly, statutory **providers of services** are being regarded as important players in the commissioning process. This includes NHS trusts as well as social services providers. The experience and expertise of providers cannot be ignored: indeed, service development is seen by some as more appropriately a provider-led activity. But it is important to ensure that respective responsibilities are understood and respected. As relationships develop (or 'mature') and a collaborative culture takes root, the evidence suggests that real needs of older people and others may begin to take precedence over organisations' 'need' to maintain primacy of some form (e.g. status, financial position): the Continuing Care Agreements reached at some of the development sites are good examples. The partnership between statutory commissioners and purchasers on the one hand and providers on the other hand has to develop on a day-to-day basis around ongoing policy and practice issues. While its reflection in provider membership of joint commissioning groups is generally helpful, by itself this may be of little more than symbolic value.

If a wide definition is taken of health and social care (as with 'well-being' in Easington) there is almost no limit to the number of **other potential partners**. Clearly, the need to make some real progress means that there has to be some practical limit to the breadth of such involvement. Only so much partnership development work is possible at any one time. It is helpful if the 'core partners' come to a view about the optimal pace by which new partners will be involved. A major issue for the development sites as elsewhere is the need to make more significant progress on incorporating housing needs into that joint commissioning core, certainly so far as older people are concerned. The evidence from the development sites is that some progress can be made on a piecemeal basis but a strategic approach is again necessary. Income maintenance, transport, leisure, security, environmental protection are just some of the other issues which make up a more comprehensive picture of older people's health and social care.

Having vision and leadership

The importance of vision was stressed by Knapp and Wistow[18] in their early analysis. This was certainly born out by the experience of the development sites. The existence of a shared vision about the quality of life sought for older people greatly helped to give a focus and a meaning to the activities of joint commissioning. Also the development of that vision

was itself an effective means of drawing together the senior managers of the organisations. When local people were also involved (for example in Easington) a potentially powerful vehicle was created.

In Easington the vision is one of achieving greater 'well-being' for local people – clearly stating that needs should not be looked at in isolation from one another and that only through collaboration will the statutory agencies and their partners make a real impact on their area. In Wiltshire the vision (although 'guiding principle' may be a more accurate term) is one of local health and social care practitioners getting closer to their local populations and in this way getting a more accurate picture of needs and determining together how to address them.

Leadership is fundamental to joint commissioning. At the top of organisations it involves personal commitment and the ability to enthuse others to collaborate rather than remain within the old agency boundaries. There is also clear evidence that by being personally involved (i.e. over and above allowing the space for others) chief officers in particular can make a powerful contribution. Such is the significance and complexity of older people's services that this kind of involvement may appear to be inevitable but it does not happen everywhere. The progress made by the development sites on their ambitious agendas for change was significantly assisted by senior level involvement. Key decisions have to be taken on the extent to which agencies are committing themselves to working together, the speed at which it is planned to make progress on this joint agenda, and the emphasis to be given to working together at different points in the systems (e.g. locality, primary care teams, services, client/patient groups). When some key process issues are also thrown in (e.g. the extent of devolved budgets, the flexibility to be incorporated in contracts) then it is clearer that this is top of the organisation material.

Undertaking effective commissioning

It is worth drawing attention to the importance of commissioning in its own right. This applies as much to single agency commissioning as it does to joint or collaborative. The Department of Health Guidance[19] gave a good deal of prominence to this issue, detailing five stages to the cycle of commissioning (see Fig. 1, p. 8):

- setting the strategic framework
- strategic planning
- operational planning
- purchasing activity
- monitoring and review.

The development of successful single agency commissioning is an important pre-condition, together with a shared understanding of the process (as the Guidance points out). For older people's services in particular the sheer breadth and complexity involved in making a significant impact demands both a clarity of aims and objectives, roles and responsibilities, and timescales as well as a rigour in ensuring the meeting of deadlines and so on.

The experience of the development sites suggests that commissioning, as a tool for service improvement, still requires some fine-tuning. Adopting a project management approach to the whole exercise of joint commissioning is as important on a systemswide basis as it is on an individual issue basis. The movement in the NHS towards multi-year contracts between purchasers and providers is to be welcomed but there remains a concern that both health and social services agencies remain too immersed in the detail of activity and financial measurements, at the expense of the strategic view which encompasses reviewing how well needs are being met. Commissioning within and especially between agencies provides the opportunity for instilling a new rigour and vigour into meeting the needs of older people. But the picture from the development sites is that if it is not afforded 'status' within the respective agencies, in other words if it is not properly resourced and applied to the big (mainstream) issues as well as to the pilot ones, then it remains relatively feeble.

Achieving pace and volume of change

Joint commissioning is a dynamic process, both for how things get done and for the outcomes it seeks to achieve. A key aspect of successful commissioning is gauging the right pace at which change should occur. This requires a special skill when a number of partners are involved: it means the deployment of the vision and leadership referred to above. If the preparation is inadequate, the partnerships will be vulnerable to collapse (as happened at one site) or to diversion from the main agenda,

which to some extent happened at all the sites. There is a delicate balance between making some real and discernible early progress (which encourages both participants and recipients) and the need for a solid base in terms of understanding and respect between the partners (the 'collaborative culture').

Lessons can be learnt by being aware of what has happened elsewhere: the typical insular approach of the statutory agencies is open to criticism. But judgements will be needed on both the size of the joint commissioning agenda and the pace at which it should be achieved. Compromises will be necessary as not all the identified participants are willing or able to become involved. Proceeding at the pace of the slowest might turn out to be stuck in reverse.

Each of the development sites produced its expert at cajoling and encouraging, developing the art of shuttle diplomacy at strategic and local levels, so as to ensure that what happened was part of systemswide activity rather than a number of floating pilots with little or no impact on mainstream decision-making. Determining the appropriate pace of change was often crucial and to do this close working relations with organisational leaders were invariably essential. An important part of the King's Fund's support to the sites was concerned with identifying where progress was required, who needed to be engaged in the process and how this could be brought about. A key attribute for those involved in joint commissioning is simply being able to keep going.

For many participants it was important that the joint commissioning work was clearly related to existing priorities or offered the prospect of some quick returns: an important part of the dynamics was creating a 'win-win' situation. Working out how to bring this about is an area where external assistance can be especially helpful. Taking some regular time out to review and reflect also proved to be a valuable tool: joint commissioning across and within agencies is a complex business and cannot be done successfully without careful and continuing consideration. These periods of review and forward-planning are, of course, also important means to cement further the collaborative culture between joint commissioning partners.

Using resources effectively

The key resources of joint commissioning can be seen as people, money

and information. More precisely these concern skills, time, purchase from mainstream service budgets as well as development monies, and information both on needs themselves and on different ways of meeting them.
This part of the analysis of key ingredients acknowledges the contribution of Rob Greig and Associates, who undertook a review of the work of the joint commissioning project.

It can be argued that the key distinction between joint commissioning and joint planning is that for the former the utilisation of main programme resources is fundamental, while joint planning is generally at the margin of decision-making. However, there are some real limits to the extent to which budgets can (and indeed should) be brought together. The complexity and size of contracts are clear restraints, as is the proportion of specific services which are clearly health or social services' responsibility (but not both). However, if much service provision is to be purchased jointly, there is need for agreement on the extent to which they will be planned together. It was clear in Oxfordshire, for example, that planning should cover all aspects of services. Three levels of resource utilisation can be identified which shape the nature of joint commissioning to be undertaken, and vice-versa:

- systemswide alignment of services
- development of services on the health and social care boundary
- pilot projects to test different ways of working.

Generally, social services departments find it easier (in theory, at least) to identify finance which can be used for joint commissioning purposes. For health authorities the situation seems to be more difficult for several reasons:

- resources locked into large contracts
- need to engage trusts in discussions on more flexible use of resources
- lack of focus on service or locality expenditure
- some difficulty in engaging GP fundholders
- real limitations to the flexibility of use of fundholders' resources.

Oxfordshire had made the most progress towards a systemswide analysis of what expenditure on older people's services was actually taking place. In Easington senior managers developed an informal arrangement which effectively meant that all resource redeployment decisions were taken

jointly. Elsewhere the reliance on relatively small pots of special funds tended to dominate. Overall, the difficulties found in accessing the large main programme budgets (especially for older people's services) have been a key factor in the achievement of only limited progress to date. As yet, no one approach (e.g. strategic or locality-focused) has emerged as having clear advantages over another.

This view is taken in the light of joint commissioning's main goal being significant (rather than small-scale) service improvement. To reach this goal major changes also need to take place in connection with people and information. What service providers actually do is, of course, at the heart of community care: as yet, the services on offer are mostly those which have been in place for some time. Innovative pilot projects are happening but their impact is still relatively marginal. Service provision for older people looks much as it has done for years, in spite of changing needs, legislation and societal expectations. Commissioning as a tool (joint or single agency) is not exerting the leverage expected of it. Information on needs and how these might be addressed has to be exchanged on a much more rigorous basis between agencies to help put some momentum into commissioning. This applies at both policy and practice levels.

The experience of the development sites confirms that while major progress can be made in developing joint working practices and that these can readily lead to small-scale gain, the major prizes remain unclaimed because main programme budgets are not being accessed. There is a view that the current legal restrictions on pooling budgets will inevitably limit the impact that joint commissioning can make on service change, and that charging policies severely affect the extent to which joint provision can be developed. In reality much can be achieved before these very real hurdles come into play: the work with the five sites lasted over two years without these being problems in practice. But it is possible that they present psychological barriers which affect joint commissioners' perceptions about the achievable volume and pace of change. These hurdles do not exist (at least not in the same way) in Northern Ireland, where there is a view that organisational union between commissioners and between providers helps the momentum for change. There is a real need for more considered exploration of whether or not this system merits pilot activity on the mainland.

Chapter 5

In conclusion

This account has shown that at the five development sites (as elsewhere) skill, effort and no little imagination are being demonstrated as statutory agencies and their partners strive to make a success of joint commissioning. But how is that success to be measured? Discernible improvements in services for older people are as yet thin on the ground. Fundamental weaknesses in measuring the effectiveness of different service interventions continue to pose serious difficulties in working out the nature and extent of service change required.

Some older people (relatively small in number) have benefited from the changes that have been made: more security alarms in Easington; better access to services for Asian elders in Hillingdon; a care management service in A&E departments in Oxfordshire; an integrated rehabilitation project in Victoria; and the setting-up of a local community night-sitting service in Wiltshire. These are not untypical examples of the small-scale service changes emerging so far. It will be seen that the bulk of provision for older people remains much as before – home care and district nursing, day care and day hospitals, residential care homes and nursing homes. In these and other areas of health and social care provision there remain real concerns about effectiveness in meeting needs and whether resources are being deployed efficiently. The continuing separation of housing from health and social care in terms of needs assessment and service response remains a major weakness.

Does this matter? It does if the thinking behind the inception of joint commissioning was correct, namely that some (largely undefined) fundamental changes are required in the way that health and social care services are both planned and delivered if the twin problems of gaps in provision and duplication of effort are to be resolved. For older people's services there is simply not enough happening as yet involving the mainstream services to be fully confident that joint commissioning really does offer the way forward. There is an image of joint commissioners

rolling a ball up a hill towards a summit shrouded in clouds and really not sure what further peaks lie beyond. The firm belief is that this labour has a purpose and is building a momentum which will keep the ball moving forward, although whether sufficient energy is being engaged remains to be seen.

More optimistically, there is no shortage of examples of better ways of working together. That these do not always strictly correspond to what is required for joint commissioning (as shown by the commissioning circle, see Fig. 1, p. 8) does not matter so much, if they are of real benefit in themselves and (particularly) if they are contributing to a growing collaborative culture whose main achievements lie ahead. The significance for older people themselves of these process changes can be underestimated, as the earlier Trowbridge example showed. Elsewhere continuing care agreements were being drawn up which acknowledged that it was more important to address older people's needs than it was for the respective organisations to maximise their financial positions. Again this can be seen as a genuine gain for older people and can be traced (at least at the development sites) to the collaborative culture associated with joint commissioning.

Responding to the needs of older people remains probably the biggest challenge facing health and social care. It is not clear that there is sufficient passion for change among policy-makers and practitioners to address the issues outlined in Chapter 1. There are some vocal and articulate advocates in the statutory sectors but more often than not it is the voluntary sector which provides the real leaders in championing the cause of older people. An important challenge for the new millennium is to reassess what we regard as an acceptable basic standard of life in old age, and to consider new ways of ensuring that public and other services maximise their impact on that quality of life. Being clearer about this issue would help to put some flesh on the bones of service developments being sought, where at present there is a real lack of substance.

Perhaps the sheer size of the task is proving too daunting for statutory sector policy-makers: in reality there are at least three distinctive customer groups – older people who are generally fit and well, those who are vulnerable to a breakdown in their health and well-being, and those

experiencing significant health and social care difficulties. A greater recognition of these (or similar) distinctions is required before real progress can be made.

If the development sites are typical then joint commissioning of older people's services is being driven by considerations other than issues of quality of life and service improvement. These include the development of a locality focus, primary care as the basis for needs assessment and strategic planning as the vehicle for major change. There is a lack of vision for a different service configuration: champions of older people's service development are required as well as champions of joint commissioning. More effective involvement of users and carers might help identify this gap more visibly. Greater involvement by providers in joint commissioning (and in service development generally) might help to fill that gap and bring the commitment, creativity and expertise which are often lacking.

Other important challenges remain before a more definitive judgement of joint commissioning can be attempted. There has to be a greater focus on mainstream activities rather than the present largely project approach. More attention has to be paid to the use of existing budgets rather than seeking new ones: the inability fully to pool resources may turn out to be a difficulty but in reality most places have much to do before reaching that stage. Involving providers has already been identified as important: service development is in some danger of slipping between the respective responsibilities of purchaser/commissioners and providers. The development of primary care as the driving force for collaborative effort generally remains at a relatively primitive stage: for this to happen strategic commissioners and other organisational leaders will have to play an important part. Commissioning as a tool is often underdeveloped: a greater focus is required within agencies as well as between them. As part of this process particular attention should be given to the part which users and carers can play in all aspects of the commissioning process.

But will it work and who is responsible for determining what counts as success? These are important and complex issues which get to the core of what sort of society we want to create. Collaboration between health and social care (in developmental, policy and practice terms) now seems firmly established. There are many interpretations of what this involves but

certainly joint commissioning should bring a disciplined and systematic approach which distinguishes it from joint working, although there are now well-documented examples of how joint working can bring significant improvements. Further experiment and evaluation is needed in order to test new opportunities and to assess the impact on services and the people using them.

At the same time some consideration might usefully be given to alternative means of achieving greater coherence in services on the health and social care boundary of community care. The difficulties experienced in obtaining real momentum for change suggest that these alternatives will need to include the creation of new types of organisation, sharing power and resources. For instance, much more needs to be known about the effectiveness (or otherwise) of different systems of combined health and social care commissioning; perhaps it is time for some imaginative experiments.

Such structural alternatives merit serious consideration but in the meantime renewed efforts are needed to make further progress within the existing framework. In terms of securing better services for older people the question is, if not joint commissioning then what?

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18. See 3.
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Services for older people can be improved when effective joint commissioning between health and local authorities takes place. Working across health and social care boundaries, however, is difficult to do when working cultures are different, budgets are separate and partnerships need to be forged.

Joint Approaches for a Better Old Age looks at how older people can benefit when joint commissioning of services takes place. It outlines the work already under way in King's Fund projects around the country and identifies the key factors which can bring success within reach.

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ISBN 1-85717-114-4

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