ROB GREIG & ASSOCIATES
Consultancy in Community Care

DISTILLING THE LESSONS

A Review of the King's Fund Joint Community Care Commissioning Project

2, Belgrave Road, Bath, Avon, BA1 6LU Tel. & Fax. 0225 482011
Registered VAT No. 627 1039 58

DISTILLING THE LESSONS

1. BACKGROUND AND INTRODUCTION

1.1 This report was commissioned from Rob Greig and Associates (RGA) by the Kings Fund as part of the process of evaluating the impact and effectiveness of their work in the five Development Sites of the Joint Community Care Commissioning Project. As this report is intended to be read alongside other materials, it does not describe in any detail the actual operation of the five sites.

1.2 In order to produce this report, a short piece of fieldwork and evaluation took place. This involved spending up to two days in and around each site, meeting with and talking to people involved in the projects. Some people were interviewed by telephone where mutually convenient meetings proved impossible. In addition, a short questionnaire was circulated to a wider number of people from each site. We wish to express our thanks to all the people who found the time to meet with us, and in particular to the key contacts used at each site who assisted with the arrangements for this evaluation.

1.3 This report does not purport to be a detailed evaluation of the effectiveness of the work undertaken by people at each site - to do so would be wrong from such a short series of visits. Rather, it seeks to draw out common themes and lessons for a reader who is already generally aware of the work both within the Kings Fund and at the five sites. It is intended that this report is made available to people from all five sites. All have had different objectives and approaches, made variable amounts of progress, and have been faced with differing obstacles. It would be wrong to try and directly compare them.

1.4 For these reasons, two versions of the report are being produced. Where observations are made about how the work hit problems or could have been done more successfully by other approaches, it is inappropriate that this information should be attributed, even on a limited circulation. Therefore, much of the content of this report is not identified to the site in question. In order to help the Kings Fund to learn from the process themselves, they have additionally received a version of the report, (only for their internal usage), which notes which sites the comments apply to. In all other respects, the two reports are the same.

2. THE SIMPLE QUESTION

2.1 The main brief for this work asked RGA to

> "Report on the extent to which the five Project Development Sites have met the service change targets they set themselves for joint commissioning activities. It will be important to reach a view on the likelihood of the activities in progress leading to significant and sustainable changes in services which, in turn, secure a better life for older people"

2.2 A secondary question was;

> "How useful and effective the Development sites have found the support received from the Project"

This question is addressed separately in Section 16

3. THE SIMPLE ANSWER

3.1 The simple answer to the main question is that very few of peoples own self imposed targets have been achieved. If there was one common theme across all sites it was that almost every single person was disappointed by the amount of progress made as a result of developing joint commissioning arrangements. Indeed, in many cases the targets that formed part of the submission to the Kings Fund have either been superseded by others, or forgotten completely. For example, in one location it was described that the current Health Authority senior officers (with the exception of those involved in the project) were "blissfully ignorant" of the original objectives.

3.2 To leave the simple answer here would, however, be doing a disservice to both the people in all five sites, and the process of joint commissioning. This apparently negative summary masks the following significant facts:

- Many of the original objectives/aims were dropped or changed because, as the joint commissioning work developed, it was discovered that they did not reflect the needs and wishes of users and carers
- There are a number of examples of practical progress and developments that have been made but which were not part of the original set of objectives
- There are many examples of the development of systems, infrastructures and relationships that could and should lead to improved services and lives for older people in the future
- Peoples expectations were probably uniformly unrealistic, either in terms of the potential scope of what they were embarking upon, or the timescale it would require to achieve changes.

3.3 In short, despite peoples' own disappointment about progress to date, there is substantial evidence that joint commissioning, as being developed in these five sites has led to changes that should improve the quality of lives of older people,

and that, perhaps more importantly at this stage, that a number of structural and organisational changes are being made that should lead to more significant improvements in the future.

4. THE MORE COMPLEX QUESTION

Given the above, this report focuses on two other phrases from the brief for the evaluation. It's title is **"Distilling the Lessons"** and the covering letter to the invitation to tender for the work asked for an emphasis on **"what has worked well and what has not"**. Thus the report concentrates on key themes, seeking to address their impact on the success or otherwise of the projects, and illustrating the points made by examples from the five sites.

5. SUMMARY OF SOME KEY ACHIEVEMENTS

Before discussing the more complex issues, it is worth just listing some of the advances and progress that has arisen from the joint commissioning activity on each site. The following are examples where there is general consent that the joint commissioning arrangements were a significant influence in them happening, although there is a valid debate about whether some of them would have happened anyway without the specific structures and inputs arising from the Kings Fund Project.

5.1 Easington

- Structures that involve users carers and providers on a locality basis, and a review of those structures to respond to user and carer concerns
- Greater understanding and more openness between senior officers
- The appointment of a project worker to focus on progressing specific initiatives and the LAG's and user/carer inputs
- A start to aligning care managers with GP practices, with some 'attachment', and plans for shared client held records
- The development of a multi-agency resource centre for the elderly
- Agreement to a pilot generic bathing service
- The use of health resources to funds aids and adaptations for elderly people to enable them to stay in their own homes
- The use of health money to extend the alarm system to all people over 85

5.2 Hillingdon

- The development of new central structures for joint working
- The existence of the project enabled relationships to be maintained between agencies at times of major organisational turbulence
- An effective consultation/Search conference with Asian elders
- Action by the Housing Department to respond to concerns by Asian elders
- A 'hospital discharge audit' as a tool for future planning
- The development of a night respite service that is being tendered for
- Engaging a GP practice in the north of the Borough in planning for services

5.3 Oxfordshire

- The development of a central and three locality plans for future services (which together covered the whole County), that have the support of the statutory agencies
- Positively viewed consultation around those plans, partly through the CHC
- A resource analysis of expenditure on elderly services across all agencies that provides a framework for future planning and contracting
- New arrangement for agreeing the use of DHA funding for long term care
- Developing plans for joint commissioning with devolved budgets around a GP practice/ Social Services District in Chipping Norton
- Plans to involve the Housing Department through a workshop in the near future
- A review of OT services across agencies taking place

5.4 Victoria

- The development of an inter-agency planning group that involved carers
- Local managers more empowered to deal with inter-agency disagreements
- The identification of key areas for future planning
- A well attended consultation meeting for elderly people
- Joint care manager/district nurse training days
- An influence over the future shape of a proposed day service
- Plans being developed, and funding identified, for a rehabilitation service
- A survey on health needs within a housing estate to inform future priorities
- A joint bathing service being developed and funded.

5.5 Wiltshire

- The development of two GP practice based projects with multi agency steering groups including users and carers
- Greater understanding and closer relationships between GP practices and care managers
- Users and carers listened to and their priorities taken on board
- A care management/district nurse training project developed involving users and carers
- Research into home care leading to commitment to change service by Social Services
- Therapeutic input to day services changed
- A voucher based respite care service being explored
- A handbook being developed for application across the rest of the County on 'how to do joint commissioning'

6 CLARITY OF VISION AND PURPOSE

6.1 The Department of Health guidance states that "Above all, joint commissioning is a process for translating plans into action, and not just for planning". Elsewhere, it has been written that "Joint commissioning is a vehicle for achieving significant service change that could not be achieved by organisations

acting independently". This implies that when embarking on joint commissioning, organisations should have in mind not just a belief that working together is a good thing per se, but also a vision of the types of changes that would be made. This theme has been central to the work of the King's Fund Project from the outset

Whilst the submissions to the Kings Fund did list such changes, as noted above these had generally been forgotten or changed. Individuals interviewed in this evaluation almost uniformly stated the purpose as being simply to get organisations to work together because that was **a good thing**. Where there were more specific objectives these tended to be organisational or systemic in nature. For example, Wiltshire had a very clear vision of allying primary care teams and care managers around GP practices and Easington of having locally driven planning groups with users and carers central to them. Where there were outcome or service specific aspirations these tended to come from users and carers, though these were sometimes beyond the scope or capacity of the project.

6.2 Where visions were articulated to us, it was not uncommon to find these were personal rather than shared within organisations, let alone across organisations. For example, one Chief Executive stated a long term vision of a single budgetary approach, but their next most senior colleague involved in the project denied any such intention. In another case there was significant variation between key stakeholders as to whether the projects objective was to instigate service changes or to develop more effective systems of working together.

6.3 The existence of such clearly articulated vision appeared important in keeping some of the work on track, whilst their absence appeared to be related to;

- More junior staff and users and carers 'drifting' and being unable to focus on clear objectives
- The process of joint commissioning appearing to become the raison d'être, rather than any defined outcome.

KEY LESSONS

- A vision of how joint commissioning will change both processes and life for service users is important

- This vision needs to be clearly articulated to and understood by all people involved at differing levels of the joint commissioning work

- The continuing understanding of the vision and the relationship of proposed actions to it needs to be monitored over time, in order to ensure that the processes do not take over from the vision.

7 CLARITY OF OBJECTIVES

7.1 There was a general consensus that the acceptance of and agreement to clearly agreed objectives was of great benefit in providing impetus and focus for the work. For example,

- almost everyone in Victoria reported that the concentration in the last six months on a number of task groups, with defined objectives, had renewed

peoples enthusiasm and provided a glimpse of what joint commissioning might achieve.

- the agreement to priority areas within each location has provided a focus for work and action
- the motivation arising from the decision to develop collaborative GP/Social Services/Health Commission arrangements in Chipping Norton
- the motivation arising from the agreement to develop the multi-agency resource centre at Wheatley Hill

7.2 In a number of places these objectives had arisen as a result of consultation with users and carers, and where this was the case, there was a resulting strong commitment to them from all concerned. Equally, the existence of objectives that were not owned and shared by the people involved appeared to lead to disillusionment with the joint commissioning process.

7.3 The process of identifying the objectives varied between localities, with some places relying on carer representatives on the groups, some employing short-term project workers to research and survey user and carer need, and others using group members to instigate a variety of consultative approaches. The latter two approaches appeared to have led to priorities that are more widely accepted, and where the joint commissioning groups themselves have established priorities, the time it has taken to do so, and the degree of acceptance of the result are not always in line with the managerial expectations of the statutory agencies.

KEY LESSONS

- Clear objectives for the project and any steering group lead to more focused work

- Where those objectives have been derived directly from user/carer needs, they appear to have greater validity amongst people

- Care needs to be taken that the process of establishing objectives and priorities has a time limit and does not distort other work.

8 ACHIEVING OUTCOMES

8.1 There was a clear and predictable relationship between elements of the five sites where service change was being achieved, and the people involved feeling positive about the process. Perhaps most stark of the examples was Easington, where the Local Advisory Groups where changes were happening (e.g. the Wheatley Hill/Thornley resource centre) were described positively whilst others that had yet to 'deliver the goods' were viewed as possibly not meriting the energy and time they took from people.

Other examples that had enthused people included;

- The Malmesbury care management/district nurse training project that involves user and carer input
- The Hillingdon Housing Department response to the criticism identified by Asian elders at the Search conference

- The Oxfordshire 'Band Three' process that agreed eligibility for jointly financed access to care
- The Victoria review of health needs on a housing estate

KEY LESSON

- Pick winners that will deliver a success early on - they will give the process credibility and enthuse people.

9 LEADERSHIP, PERSONAL COMMITMENT AND CONTINUITY

9.1 A common theme was the importance of leadership and personal commitment from key players. Related to this, was the importance of such key players remaining in place throughout the life of a project. Leadership can take many forms, and be located in varying parts of organisations, although leadership from 'the top' is obviously important. Examples if effective leadership we observed included:

- Despite having limited involvement in terms of actual time, the Wiltshire Director of Social Services sent appropriate messages and intervened on occasions that sent signals about the importance of joint commissioning and his interest in the Kings Fund project
- The Wiltshire Users network positively supporting users to engage in the joint commissioning process and support people to speak up in difficult situations
- Senior locality management from both the Health Authority and Social Services in Easington placing joint working relationships high on their agenda for committing work time
- An officer from Easington District Council demonstrating practical commitment to get things done
- The Oxfordshire Joint Commissioning Manager being seen by all concerned as an effective catalyst to joint working
- The Hillingdon project manager pushing the agenda forward despite the lack of commitment in the form of action from some agencies concerned
- A Hillingdon Housing officer taking responsibility for responding to issues raised by users and carers
- The Victoria Project Managers tackling the sometimes conflicting interests of different stakeholders

Whilst these examples of leadership come from differing levels within organisations, one of the key themes from all five sites is that leadership from the top of the statutory organisations is important is the work of others is to bear fruition.

9.2 Equally, organisations can (sometimes unintentionally) place obstacles in the way of effective leadership being developed. For example:

- The major re-organisations and key players departing in both Hillingdon Health Agency and then Hillingdon Social Services making it difficult for the two organisations to engage with each other
- The Victoria project managers having three different Health line managers during their employment

9.3 Having an identified person or post within the statutory organisations with responsibility for the joint commissioning work was widely acknowledged as being crucial. For most people, joint commissioning activity is marginal to their workload, and several examples were given of the impact of having someone who could focus on this activity. For example;

- The impetus initially given by the (now) Deputy Locality Manager in Easington, the loss of that impetus when his role was broadened, and the new impetus on the appointment of the Development Officer
- The impetus given by the appointment of the Service Development Manager in Hillingdon, and the loss of that when she needed to cover for the absence of a colleague
- The positive impact of the appointment of a part time Development Worker in Trowbridge
- The crucial and central role of the Joint Commissioning Manager in Oxfordshire
- The workload of the Project Managers in Victoria, although (whilst clearly not a criticism of the individuals concerned) several people raised concerns about the appropriateness of a job share in this type of role given its comparative isolation from the rest of the agencies activities.

Although this central person is often shown to be crucial to progress being made, it is important that their existence does not 'dis-empower' others 'part time' stakeholders who may gradually withdraw from active participation as they see someone else taking responsibility for action. there is a balancing act to perform, taking the initiative to ensure that progress takes place, whilst maintaining in active commitment of all those concerned with the work.

9.4 Equally, if those in positions of leadership are not genuinely committed to joint commissioning, have a limited vision of what its role might be or do not devote the time required to make the work of others a success, then joint commissioning will not fulfil its potential

KEY LESSONS

- Joint Commissioning will make greater progress if there is a 'product champion' who provides leadership

- Having a central 'project manager' provides increased focus and an important resource for work that otherwise might be marginal to most peoples work priorities

- Continuity is important, particularly at senior levels of the organisations concerned

10 FINANCIAL RESOURCES

10.1 The bringing of financial resources to the joint commissioning 'table' is a key element that separates joint commissioning from joint planning. Making this leap has been a difficulty in a number of the locations.

Nowhere, at this stage, has got beyond the margins of finance in terms of joint commissioning activity. As the Department of Health guidance points out, there

is a valid debate as to how broad the joint commissioning activity should be and in elderly services, as opposed (for example) to learning disability, there is an argument that it is inappropriate to try and view all specialist services to elderly people as part of the joint commissioning arena. This stems from a variety of arguments including;

- The complexity of health care contracts for elderly people and their integration with other services
- The sheer scale of services and contracts
- The proportion of specific services that are clearly health's responsibility or Social Services responsibility as opposed to potential joint responsibilities

10.2 Whether or not the aim is to jointly <u>purchase</u> all elderly services, a key element is the need for agreement over whether the <u>planning</u> elements of joint commissioning should cover all aspects of services. In Oxfordshire the aim is that they should, whereas in Hillingdon, the decision has been to focus on defined aspects of service and need. Agreement on which approach is being taken is not always clear across the five sites.

10.3 In terms of finances, Social Services have generally found it easier to 'bring their money to the table' The two main reason for this appear to be that:

- Social Services view the elderly as a 'client group' and construct their budgets accordingly, whereas the health services does not
- Social Services have had an element of growth money in the form of STG, and so have been able to identify a pot of money to consider jointly, whereas most of the health authorities have been in a position of financial contraction rather than growth.
- The increasing usage by Social Services Departments of 'spot' purchasing rather than a dependence upon block contracts.

10.4 A common theme was that turning joint commissioning intentions into reality was significantly hampered by the difficulty in getting health service money 'on the table' in a flexible manner. Obstacles identified were:

- The difficulty of extracting resources or instigating change from large cost and volume contracts with NHS Trusts
- The difficulty (in some places) of engaging NHS Trusts in discussions about using resources more flexibly
- The lack of financial systems that enabled the Health Authority to identify its level of spend on the services and/or locality concerned
- The difficulty in some places of engaging GP Fundholders in joint commissioning work (see below)
- GP fundholders not being willing to use their finances in a flexible way or 'put them on the table' (see below)

In short, the evidence is that other than for small one-off projects, the health service financial systems and processes mitigate against joint commissioning with the money following the plans.

10.5 There are some notable exceptions to this, perhaps the one with the greatest long-term potential is Oxfordshire, where a very impressive resource analysis

has been undertaken which identifies all the resources across the different agencies that are currently committed to services for elderly people. This provides a framework for future discussion and negotiations which is possibly unrivalled across the country.
Other examples are:

- The flexible attitude to resources displayed in Easington, with senior officers creatively identifying money once a project has been worked up
- The identification of a small amount of money from each agency in Victoria to develop a rehabilitation service

10.6 A further common theme was the expectation of many people embarking on these joint commissioning projects that they would be developing new services with new money. When this money has not then materialised those involved in the planning, particularly users and carers, have tended to become somewhat disillusioned. Although some places have dealt with this by identifying small pots of money for particular initiatives, (e.g. Victoria and Easington), others have used non-tapering joint finance (e.g. Easington and Wiltshire) and all have used the Kings Fund pump priming monies, all but the first of these leave open the debate as to whose financial responsibility a particular service will be in the future. The wider questions that this begs are:

- The capacity of joint commissioning to make inroads to mainstream contracts and budgets
- The willingness of organisations and people involved (particularly users and carers) to operate in a no-growth environment, where some services will have to be cut to develop others that have been identified as a joint priority.

Joint commissioning in a no-growth situation arguably requires a different mind-set to that when money is available for people to progress their 'pet-projects. The organisational ramifications of this could be significant, particularly in terms of securing the commitment of people and organisations outside the two main statutory agencies.

KEY LESSONS

- Clarity is needed from the outset about the extent to which financial resources are to be committed to the joint commissioning process
- Health Commissioning need to develop their financial systems is they are to effectively participate in locality based commissioning or client group based commissioning where budgets are not easily identifiable
- Block or cost and volume contracts with NHS Trusts must be flexible if joint commissioning is to deliver service change
- A resource audit is essential at an early stage of the work
- The availability of 'pots of money' to 'dip into' provides important flexibility
- Operating in a no-growth environment introduces additional pressures and difficulties, particularly in terms of securing participation and commitment.

11 G.P.'s AND PRIMARY HEALTH CARE TEAMS

11.1 Most of the five sites had working with GP's and primary health care teams as one of their key objectives. Where this was successful, such as in Wiltshire, there was near unanimous acknowledgement of the benefits of GP's working closely with care managers. Given the financial constraints outlined above, no site had yet aligned the purchasing functions of GP fundholders and care managers, but the more open relationships and understanding of each others functions and constraints was widely acknowledged.

11.2 Where GP's had been involved, they tended to have entered the process largely unaware of what they were embarking upon, and to an extent still did not share any overall visions that existed. This area of work is often fundamentally new for GP's. A prominent issue was that of whether GP fundholders see joint commissioning as a process that involves them sharing some of the decision making over how they commit their own resources. Answers varied from "certainly not", to surprise at the question as the idea had not really been considered, (although there is some indication that one of the Wiltshire practices has recently begun to consider this issue). Having only recently gained control over finances, GP's appear to be unwilling to immediately surrender any of that authority to a joint commissioning framework.

11.3 A practical difficulty in GP practices engaging in joint commissioning is the lack of clarity over the budgets they have been allocated and what they can do with them. This was compounded by areas that were identified as being a joint priority not falling within the scope of GP fundholding, such as terminal care. A belief was expressed that there needed to be a move to total fundholding before anything significant can be done.

11.4 Where the sites were particularly trying to develop GP focused commissioning, there was an understandable desire to allow local people to establish their own agenda and priorities. However, possibly given the newness of this work to all concerned, this did appear to lead to a lack of strategic direction, and certainly several people commented on the continuing need for the Health Authority to provide a strategic lead and a framework within which GP's should work. This approach is also in line with DoH Guidance on the accountability of GP fundholders.

11.5 Other members of the primary health care team were involved to varying extents. Some of the more positive experiences were where front line staff had engaged in dialogue and joint work with care managers. However, the involvement of their senior management was variable. Whilst Oxfordshire had significant middle management input from an enthusiastic person, others had experienced more difficulty, and in some cases there has been little thought given to engaging Trust management in the process. Whilst this reflects genuine concern about the Trust's primary role as a provider, it becomes more complex when staff such as District Nurses are effectively operating as care managers.

KEY LESSONS

- GP involvement requires substantially more preparation time than for some other 'players' in the process.
- Health Authorities have an important role to provide in giving a strategic steer to GP's in joint commissioning
- the role of GP fundholding needs to be agreed early on
- The role on NHS Trusts, both front line staff and senior management needs resolution

12 THE ROLE OF USERS AND CARERS

12.1 The role and involvement of users and carers is perhaps the single issue that has used most time and energy across the five sites. With the exception of Oxfordshire, each site intended their involvement to be central to the joint commissioning work. The approaches taken to achieve this have varied, as have the degrees of success. With the possible exception of Wiltshire, the users and carers involved were dissatisfied both with the outcomes of the joint commissioning work, and the extent to which they felt they had been listened to by professionals. This dissatisfaction was much greater amongst the 'professional' carers and users, i.e. those paid staff who were employed by or worked for user and carer organisations, than by the users and carers themselves.

The major stated causes of dissatisfaction were that the health and social services 'professionals' on the group did not listen to users and carers and that they talk in language that users and carers could not understand. It is interesting to note that the more positive feedback from users and carers tended to come where those people themselves came from a past 'professional' working environment. Despite this, the statutory sector at all four sites that had actively engaged users and carers had a different perception, reporting one of the successes of joint commissioning as being that the user/carer voice had both been listened to and had led to changes being made. Some users and carers agreed with this. There were certainly examples given to us of actions that appeared to support this claim, such as;

- The resource centre in Easington
- The impact of the consultation meeting with Asian elders in Hillingdon
- The role and specification of a new day service in Victoria
- The users/carer involvement in care manager/district nurse training in Wiltshire

Additionally, authorities regularly stated that the work to date had taught them a great deal about how to involve (and how not to involve) users and carers effectively.

The comparative success in involving users and carers in Wiltshire appears to be, at least in part, attributable to past investment in user and carer networks, that had created an infrastructure with which the statutory organisations could work.

12.2 This leads to a debate about the role of users and carers and their representatives in the joint commissioning process. Underpinning this debate is a question of what joint commissioning is about. Arguably, if a joint commissioning process is concerned with taking decisions about planning and service priorities and then committing resources to those plans, users and carers can only have a limited role. Certainly the legal framework requires decisions that commit resources to be taken by officers and Members of the statutory authorities and not by representatives of external organisations who have been involved in the processes. Despite this, to varying extents, the structures in Easington, Hillingdon, Victoria and Wiltshire sought to involve users and carers in a way that created expectations amongst those users and carers that they were to be a central part of the decision making process.

12.3 A brief outline of Easington is particularly instructive. Local Planning Groups involving users, carers and providers were established and initially allocated an indicative budget that related to some of their joint commissioning activity. Subsequent Health Services management changes led to the indicative budget being removed and, because it was acknowledged that the local groups could not technically have control of the resources, their title was changed to Local Advisory Groups. This change in name, and the loss of budget, rancoured with the user and carer representatives met in this evaluation. This is not to say that the users and carers necessarily wanted control of the resources. A paid professional met whose role was to support and develop user and carer initiatives clearly stated that the users and carers he worked with wanted to have their own forum, without professionals from the statutory services where they could decide on their own priorities, then tell the relevant authorities what they wanted to be done and then expect the relevant officers to go away and do it. It was not possible to check out whether this view was shared by the actual users and carers concerned, but it does raise some fundamental questions about the role of users and carers in commissioning:

- Whether users and carers want to be involved directly in difficult decisions about resources and priorities
- The impact on the users and carers themselves of being then perceived as being 'part of the system'
- Whether users and carers want a full partnership, or whether they prefer to remain on the outside of decision making
- What should be the most effective way for statutory agencies to obtain a user and carer perspectives

12.4 Although Easington has been used as an illustration, similar issues arose elsewhere. These included

- Users and carers initially understanding that they were to be a part of the decision making around committing new plans and resources
- Calls to have a user/carer forum that did not involve statutory sector professionals
- A joint commissioning group that most participants felt to have some decision making authority being referred to be senior health and social services managers as a consultative forum.

12.5 There is unlikely to be a common answer to the issues raised above. Factors such as the culture of the area, the state of development of the user and carer networks and the type of input that is being sought by the statutory sector will all influence approaches that are made. Perhaps the key lesson is to be flexible, and not just assume that representation by one or two users and carers on a working group is the answer to consultation. Several of the sites have recognised this and sought to develop alternative approaches. For example, the consultation meeting with Asian elders in Hillingdon was positively reported, at least in part because considerable thought and preparation went into setting up and structuring the day and preparing the participants to be able to contribute.

12.6 Finally several people, both from the statutory organisations and users/carers themselves, raised the issue of how user and carer representatives were selected. There was a general feeling that the tendency to rely on the usual contacts/volunteers was not very helpful, but one place that had sought to find new and different people had come in for Political criticism that the 'wrong' people were on the groups. Wiltshire's approach of working with an established users network to identify local people for the two practice based projects appears to have been comparatively successful. There was also considerable evidence that, because of the difficult in users and carers being 'representatives' they were understandably concentrating on their own particular areas of interest. In some places this skewed discussion and debate away from what others might have considered the key issues.

12.7 Most of the above has not referred to the work in Oxfordshire. This is a much more 'top-down' approach, and with the exception of the CHC and a voluntary agency, there is no formal involvement of users and carers in structures. However, consultation with users and carers on work undertaken has been undertaken by the CHC, at the request of the statutory organisations. This more centralised approach was justified to us by one person on the grounds that "If the senior people in organisations are not fully involved in and committed to joint commissioning, users and carers will get nothing out of it and their involvement would be a waste of time". There is clearly some truth in this, as witnessed by the frustration shown to us by a number of users and carers elsewhere about their efforts apparently coming to little as the statutory authorities were experiencing difficulties in working together at a senior level.

KEY LESSONS

- It is important to be clear about expectations of users and carers before seeking their involvement

- It is equally important to understand what users and carers expect of the statutory organisations before involving them and designing structures

- The more effective user/carer input appears to have been where actual users and carers were supported by user/carer organisations

- User and carer participation cannot be found out of nowhere - past investment in consultation and infrastructures greatly increases the chance of successful joint working

- Consider using a variety of structures and approaches

13 STRUCTURES AND PROCESSES

13.1 All the sites utilised some form of working group/committee structure that involved people from a range of organisations and backgrounds. As outlined above, some worked better than others, and some influencing factors have already been noted, such as clarity of objectives, understanding and acceptance of the overall vision and the way in which users and carers were engaged in the process.

13.2 Most sites had a two tier structure (at least), with a senior level group establishing strategy and a more 'front-line' group looking at needs and implementation. The dynamics between these groups were often difficult, with problems over communication, respective roles and levels of authority. The reasons for this were complex, but appeared to essentially be around the need for clarity around those points listed above, together with people entering the process with common expectations. Interestingly, where there was no strategic group, the local groups tended to complain about the lack of strategic direction being provided.

13.3 A tool to resolve these difficulties might be the 'commissioning cycle' found in the DoH Joint Commissioning Guidance. This identifies commissioning as having five stages, namely;

- Establishing the Strategic Framework
- Strategic Planning
- Operational Planning
- Purchasing Activities
- Monitoring and Review

Each group should have a clear role in this process, and the stages at which it is involved will be significantly informed by the level of authority it is given over finances and resources. The key decision in many ways is whether the various groups are consultation forums to inform stages of commissioning, or whether they are formally have the authority to undertake the work. Asking a group to undertake operational planning without clear routes into the necessary resources was a common cause of disillusion.

13.4 At least as important as these formal structures is the nature of informal working relationships. Where people had regular informal contact (such as Easington) or had begun to maintain informal contact outside the formal structures of the meetings (such as Oxfordshire and Wiltshire), then there was significant evidence that this led to more effective joint working. The danger of this was that it could be perceived by others that joint decisions were being taken outside the formal structures without reference to other people who felt they had a legitimate stake in the discussions. Where this informal trust has not been developed, progress appeared to be constrained to work transacted during the formal meetings.

KEY LESSONS

- Clear roles and remits for groups and committees leads to improved performance

- Asking people to undertake functions without the authority to put them into action leads to disillusionment

14 TIMESCALES

14.1 A general point was that all people felt that the changes were taking longer than they had anticipated. Part of this may have been something to do with unrealistic expectations to start with, particularly amongst user and carer representatives who tended to be anticipating fundamental change in a short period of time. This was at least in part a result of what they had been told when they was asked to become involved in the work. There is a dilemma here for the statutory agencies for, as one Chief Executive said, "If you are asking someone to join in a marathon run, you don't tell them how long it will take them or how painful it is going to be".

14.2 From a Kings Fund angle, some of the comments made raise the following questions;

- Whether there needed to be a greater lead in time for the projects. Where the work was not already underway, there was some suggestion that the structures and processes that were set up might have been more effective if more time had been taken. Similarly, the selection of user and carer representatives (see above) was on the basis of who was available at comparatively short notice, rather than necessarily who could most effectively represent a community voice
- The phasing of the Kings Fund money for developments was also felt to be too early on in the process. Most locations had difficulty in identifying projects/uses for the money in the first year, and would have preferred the money to be phased in at a later stage.

KEY LESSONS

- Sufficient time is needed in the set up phase of the project to ensure that the structures and priorities of the work are fully worked through

15 OTHER ISSUES

15.1 Communication

15.1 A key theme, particularly amongst users and carers was the importance of communication. Where users and carers were involved in progressing work outside the formal meeting structures there appeared to be a greater level of commitment than where people only interfaced with joint commissioning at the meetings. One impact of this was that people often appeared to be unaware of initiatives that were taking place as a result of discussions that they had been party to, or else did not get to hear of the outcome of workshops or conferences, or were even unaware of developments taking place in their immediate location.

KEY LESSON

- Communisation between those centrally involved in joint commissioning and those involved in local projects is important if people are to understand the full impact of their work.

15.2 Housing Involvement

One of the main thrusts of the DoH Guidance on Joint Commissioning, is that Housing Authorities should be fully engaged in the process. It is disappointing to note the very limited extent to which this had been achieved. There is senior officer input from the District Council in the Easington work, and housing representation on the Victoria Project, but this tended to be because of the commitment of particular officers rather than because the Authority itself had committed itself to joint commissioning.

15.4 Member Participation

Similarly, the DoH Guidance stresses the important of involving Members. The was strong participation from Health Authority non-Executive Members in Victoria, but elsewhere there was little if any engagement of Members. There were some real obstacles to this happening such as difficulties created by the internal politics of the local authority and hostility from elected Members of the District Council towards both the Health Authority and the County Council, but even allowing for this the opportunity to promote the concept of joint working with Members had generally not been taken.

15.3 Geographical Boundaries

Another aspect of the DoH Guidance refers to joint commissioning being easier where there are geographical boundaries to the process that facilitate working together. Where this was the case, it clearly helped matters, such as in Easington (with the delegated authority that local managers in both agencies enjoyed, together with the opportunity to work with the District Council), or in one of the Wiltshire sites where the GP practices covered the entire town and so population needs could be considered in their entirety. Where boundaries were created for the purpose of the joint commissioning, the lack of existing working relationships was a significant obstacle.

KEY LESSONS

- Senior officers with delegated authority in respect of the area in question will be empowered to take joint commissioning forward more effectively
- Endeavouring to jointly commissioning services around boundaries that are not recognised by either agencies or people involved will create problems

16 THE IMPACT OF THE KINGS FUND

16.1 The second question given to this evaluation related to the impact and effectiveness of the Kings Fund itself in the five sites. Before addressing this, it is worth noting the differing stages of development that the five sites were in at

the time of their applications to the Kings Fund. Oxfordshire and Wiltshire had senior level commitment to joint commissioning and elements of work already underway. In both cases, the Kings Fund appears to have been seen primarily as a way of backing up what was already being done. In Easington, the concept of locality based joint commissioning was already being developed, and the Kings Fund was seen as a way of helping to steer and develop that work. In Hillingdon, joint working had taken place in other client groups, and the Kings Fund's earlier consultancy had identified some priorities for joint working on elderly services - the application was seen primarily as a way to implement those priorities. In Victoria, whilst there had been joint working in other areas, Victoria was chosen because of its poor inter-agency working and community infrastructure and as such was very much starting from scratch. The Kings Fund might well reflect back on these starting points when considering the progress made in each site. Some important lessons could be learnt for any similar work in the future.

16.2 One key conclusion of this, backed up by peoples comments during the evaluation, is that without this Project, the Hillingdon and Victoria initiatives almost certainly would not have taken place - the most optimistic response being that something much more limited might have occurred. On the other three sites, the Kings Fund was stated to have made work significantly more effective, primarily because of the additional financial resources it brought to bear. Generally, there was limited perception of the Kings Fund amongst people involved in the 'local' groups, and high perception of them amongst people with a central or strategic role.

16.3 Feedback about the Kings Fund's input and impact was generally positive. For example:

- The input of Richard Poxton, the Project Manager was described positively across all five sites.
- The input of Nan Carle, Kings Fund Fellow, was described in enthusiastic terms by those she had worked with.
- The cross site meetings were generally described in a positive manner, especially when they focused on addressing common concerns or problems
- Time spent with the Kings Fund provided an opportunity for people to 'look up from the grindstone' of daily work and think more strategically and creatively
- The letters that the Project manager sent after each visit were often felt to be particularly helpful
- Where 'Search Conferences' had taken place, they were described in a positive manner and appeared top have often been the catalyst to further action
- There were several examples given of the sites learning from one another, often by pursing links outside the formal opportunities created by the Kings Fund, for example Easington acknowledged learning from Victoria over a joint bathing service and Wiltshire over aligning care managers and Primary Health Care Teams.
- Where input had been sought over structural and strategic approaches, this was described in positive terms

- Where personal support had been provided to individuals, this was described in positive terms
- Where projects were struggling, it was felt that the Kings Fund's emphasis on being focused and requiring practical outcomes helped to re-orientate the work more effectively
- The Kings Fund's 'name' gave the individual projects added status amongst those who had heard of the Kings Fund and, in particular, was felt to lead to increased interest and commitment from senior officers
- The actual money was obviously viewed in a positive manner, and all five sites were able to state several aspects of work/service development, that would not have happened without the money. **There can be little doubt that the availability of hard cash either to fund the infrastructures or stimulate new service developments was a key component in both maintaining momentum at all five sites and to ensuring that some service change began to occur.**

16.4 Within this overwhelmingly positive feedback, there were a number of comments as to how the Kings Fund might have improved its effectiveness. In stating these, it must be noted that some points are arguably of a 'no-win' variety, others are differing views on some of the above positive points, whilst others are made with the benefit of hindsight.

- The cross site meetings that were concerned with descriptions of work rather than analysis of issues were felt less helpful. On a couple of occasions, a couple of people felt that they were giving more to the Kings Fund than they were receiving
- The impetus from the Kings Fund was felt to have reduced in recent months
- Some people wanted more direction from the Kings Fund, with the Project manager playing the role of 'expert' more often (see below)
- People generally found it difficult to spend the available money in the first year, as the preparatory work had yet to be undertaken
- When sites were experiencing difficulty and making little progress, it was suggested that the Kings Fund could have used "more stick and less carrot" On the one occasion that the Kings Fund did 'wield the stick', there was (probably predictable) disagreement as to whether it had any impact, and whether it was necessary to have done so in the first place.
- The Kings Fund College days were not always felt to be used effectively and there was some dissatisfaction as to how they were accounted for. e.g. Two people turning up rather than one as expected and both days being counted against the allocation
- A greater focus on training and supporting local project managers could have helped.
- A small number of users and carers said they felt as though they were 'being watched in a laboratory'

16.5 Perhaps the most important of these for future Kings Fund work is the degree of intervention made by the Kings Fund, particularly when things are not working well. The criticisms of lack of intervention came largely from places that had struggled more, or around periods when the going got tough. The veracity of these comments was not clear, as in at least one place where it was

suggested that the Kings Fund had allowed local people to drift, we also saw evidence if substantial Kings Fund effort with senior people to establish a work programme and priorities. Other places were happy with low levels of interventions. However, there does seem to be a tension between the Kings Fund having a desire to allow local people to develop their own approach, and the Kings Fund using its wider knowledge to steer people away from approaches that are likely to fail. This is exacerbated by the nature of the Project being about learning from new ways of working.

16.6 With hindsight, it can be seen that some of the approaches, structures and aspirations were likely to lead to difficulties. Suggestions in these situations that the Kings Fund should have "approved the project design" or "say when things wouldn't work" are arguably either only possible to do with hindsight or else place a degree of expertise on individuals within the Kings Fund than may be inappropriate in an 'action research' type of project. Perceptions also vary. In one location, a decision for the 'centre' to be hands off to the local work was described as such because of Kings Fund requirements, whereas the local people described their structures as having been Kings Fund imposed! However, there is possibly some mileage in the fairly widespread request that the Kings Fund should have "played the expert" more often.

17 SUMMARY

To summarise such complex work across five different sites is almost certain to do it an injustice. All five sites have been faced with different agendas, and different obstacles, yet each has made progress in instigating change of some description. A common response to the question of "does joint commissioning lead to improved services for older people" was that "the jury is still out". Whilst to an extent that is true, people often undervalued the progress they had made to date. Although the practical changes on the ground may be limited in most places, there was a demonstrable increase in mutual understanding between organisations, a clearer perception of the service changes that need to be made and several processes and structures amended that will increase the chances of those changes occurring.

If the gains outlined above can be consolidated, and, by establishing clear objectives, the process of joint commissioning is not allowed to take over, then these five sites indicate that joint commissioning does indeed hold out the opportunity for significant and sustainable changes in services which, in turn, secure a better life for older people.

However, joint commissioning is still viewed, and operated, as an activity on the margins at most of the five development sites. Making the quantitative and qualitative leap to it addressing mainstream issues is the challenge facing all those who have been involved in the Community Care Commissioning Project.

Appendix I

SUMMARY OF KEY LESSONS

- A vision of how joint commissioning will change both processes and life for service users is important
- This vision needs to be clearly articulated to and understood by all people involved at differing levels of the joint commissioning work
- The continuing understanding of the vision and the relationship of proposed actions to it needs to be monitored over time, in order to ensure that the processes do not take over from the vision.
- Clear objectives for the project and any steering group lead to more focused work
- Where those objectives have been derived directly from user/carer needs, they appear to have greater validity amongst people
- Care needs to be taken that the process of establishing objectives and priorities has a time limit and does not distort other work.
- Pick winners that will deliver a success early on - they will give the process credibility and enthuse people.
- Joint Commissioning will make greater progress if there is a 'product champion' who provides leadership
- Having a central 'project manager' provides increased focus and an important resource for work that otherwise might be marginal to most peoples work priorities
- Continuity is important, particularly at senior levels of the organisations concerned
- Clarity is needed from the outset about the extent to which financial resources are to be committed to the joint commissioning process
- Health Commissioning need to develop their financial systems is they are to effectively participate in locality based commissioning or client group based commissioning where budgets are not easily identifiable
- Block or cost and volume contracts with NHS Trusts must be flexible if joint commissioning is to deliver service change
- A resource audit is essential at an early stage of the work
- The availability of 'pots of money' to 'dip into' provides important flexibility
- Operating in a no-growth environment introduces additional pressures and difficulties, particularly in terms of securing participation and commitment.
- GP involvement requires substantially more preparation time than for some other 'players' in the process.
- Health Authorities have an important role to provide in giving a strategic steer to GP's in joint commissioning
- The role of GP fundholding needs to be agreed early on
- The role on NHS Trusts, both front line staff and senior management needs resolution
- It is important to be clear about expectations of users and carers before seeking their involvement

- It is equally important to understand what users and carers expect of the statutory organisations before involving them and designing structures
- The more effective user/carer input appears to have been where actual users and carers were supported by user/carer organisations
- User and carer participation cannot be found out of nowhere - past investment in consultation and infrastructures greatly increases the chance of successful joint working
- Consider using a variety of structures and approaches
- Clear roles and remits for groups and committees leads to improved performance
- Asking people to undertake functions without the authority to put them into action leads to disillusionment
- Sufficient time is needed in the set up phase of the project to ensure that the structures and priorities of the work are fully worked through
- Communisation between those centrally involved in joint commissioning and those involved in local projects is important if people are to understand the full impact of their work.
- Senior officers with delegated authority in respect of the area in question will be empowered to take joint commissioning forward more effectively
- Endeavouring to jointly commissioning services around boundaries that are not recognised by either agencies or people involved will create problems