Integrated Commissioning for Older People

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ABSTRACT

The commissioning context for older people's services is changing rapidly. The integration of health and social care commissioning arrangements clearly has wide ramifications for the delivery of services for older people. While new structures and processes are becoming established, commissioning between health and social care agencies is in a state of flux, and likely to remain this way for some time. We addressed the questions of how the planning, prioritising and commissioning of non-acute health and social care services for older people are evolving between local authorities and primary care trusts (PCTs). In so doing we sought to gauge the readiness and capacity to integrate commissioning.

The findings reveal patterns of decision-making in joint commissioning; adaptation and response to the new policy directions; new structural and financial arrangements, and continued threats to joint commissioning which centre on political willingness, perceived financial viability, and general financial constraints further undermined by financial uncertainty. The opportunities of incentive structures and planning systems are examined.

Continued tensions surrounding perceived power, autonomy and accountability, control over processes, and concern with the logistics of joint commissioning are apparent. In terms of service developments to date there is little evidence that review and evaluation have informed developments, due to limited time and capacity given the required pace of change to meet national targets.

Six key words: joint commissioning, older people, primary care trusts, social services, strategic processes, integration

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INTRODUCTION

The National Service Framework for Older People and other key directives for social services (SSDs) and primary care trusts (PCTs) on joint commissioning of older people's services have required significant developments in services focused particularly on preventative intermediate care interventions. This requirement is combined with a wider emphasis on the promotion of healthy ageing and independence, aimed at reducing reliance on permanent long-term care (Office of the Deputy Prime Minister, 2003; Department of Health, 2002a). Government policy has indicated clearly, that fundamental strategic and/or organisational changes to the commissioning of non-acute health and social care services are required to provide the most appropriate and effective means of meeting both national imperatives and the 'locally determined priorities' that are expected to drive local service developments. A key dimension of this new vision is an emphasis on partnership, not just between PCTs and SSDs, but also with wider local authority responsibilities (notably housing) and other parts of the local health economy. Partnership has moved from being optional to increasingly mandated, as epitomised in the requirements to develop a 'Local Strategic Partnership'.

While partnership may be the preferred language, integrated commissioning is the expected behaviour. The Priorities and Planning Framework for 2003-2006 (Department of Health, 2002c) underlines this in specifying that SSDs and PCTs should plan together, sharing information and resources to ensure improvements in level and scope of activity, efficiency of services and the extent of choice in access to care for older people.

The expectation for new forms of integrated commissioning has been underpinned by the legal framework of the 1999 Health Act. This stressed the breadth of local authority and NHS functions that can be commissioned jointly (Greig and Poxton, 2001). The Section 31 Health Act Flexibilities (HAFs) introduced by the Act greatly

extended opportunities for joint funding and commissioning by allowing for the establishment of pooled budgets in which the pooled resource effectively loses its health or local authority identity (Dow, 2000). The potential benefits of such an arrangement are manifold. For example, it enables care managers to commit resources for a unified package of care and allows strategic managers freedom to manage jointly funded services without the transaction costs associated with separate accounting of resource flows.

The flexibilities also provide for lead commissioning arrangements where either the local authority or the PCT takes on a delegated lead in commissioning services on behalf of both organisations. A third option is that of integrated provision where local authority and health services can be merged (Henwood and Hudson, 2000). Together these three flexibilities have been presented as key opportunities for effectively bringing together the two organisations at all levels from strategic decisions to operational frontline arrangements.

Despite the apparent opportunities presented by the HAFs, these arrangements do not entirely remove long-standing barriers to integrated commissioning. These include, for example: different planning mechanisms, incongruent budgetary cycles, differing performance management frameworks and accountability mechanisms, not to mention an array of organisational and cultural disparities affecting operational approaches.

As major budget holders within a decentralised NHS, PCTs are key to implementation of the Health Act Flexibilities, and the development of new models of integrated commissioning between health and social care. In 2001 PCTs displayed reluctance in taking over commissioning responsibilities from health authorities, in some cases even handing back funds (Baxter, 2002; Glendinning et al., 2001a, 2001b; Rummery and Coleman, 2002; SSI, 2002a). This fuelled debate about the capacity of PCTs to fulfil commissioning expectations. In April 2002 PCTs assumed responsibility for the full range of services, and strategic health authorities emerged to support and performance-manage PCT commissioning. By late 2002 it was expected that PCTs would have developed their lead role in local strategic partnerships (LSPs) with respect to the National Service Framework for older people and wider Health Improvement Modernisation Programme strategies. As such it was expected that collaborative if not integrated commissioning structures, arrangements and expertise

between PCTs and SSDs would be emerging. The research set out to explore progress in strategic commissioning between PCTs and SSDs and the nature of strategic developments, including: use of HAFs, the extent and nature of jointly commissioned services, attitudes towards progress, and adaptations and responses to policy directions.

This paper comprises two sections. The first draws on respondents' descriptions of emerging infrastructure and expertise for integrated commissioning. Reflections and recognition of strengths and weaknesses are apparent. The depiction is enhanced by an analysis of the development of services within the framework of commissioning expertise. The changing institutional environment affecting these areas of expertise is described. The second section describes the latent threats to (and opportunities for) integrated planning, prioritising and commissioning of services for older people. Together these create a picture of the readiness for and the capacity to integrate commissioning locally, and ultimately the potential for improvements in the delivery of services to older people.

METHODS

Six areas were selected, comprising an inner and an outer London borough, two Shire counties and two unitary authorities. One site was chosen because of particular commendation of its Joint Investment Plan for older people. All other sites were selected non-purposively. The sample was derived to allow comparison of sites with similar characteristics. The study was exploratory in nature: given the methodological framework the sample was not designed principally for the application of generalisability (Miles and Huberman, 1994).

Documentary analysis was used to develop an understanding of the local context, and to compare plans with operational realities. Data were then collected through semi-structured interviews with key respondents from the local authority social services department and their PCT counterparts involved in planning, prioritising and/or commissioning of joint services for older people. Interviews took place between November 2002 and February 2003.

The emerging issues, approaches and strategies in the commissioning, prioritising and planning of health and social care services for older people were explored. Data were analysed using ATLASti. Three aspects pertinent to the readiness for and capacity to integrate commissioning of services for older people were identified:

- commissioning infrastructure and expertise;
- the extent, nature and objectives of integrated commissioning of health and social care services for older people;
- opportunities and threats to integrated commissioning.

Preliminary findings were validated through presentation to participants in a feedback workshop in June 2003. Views expressed in discussion were taken into account in subsequent analysis.

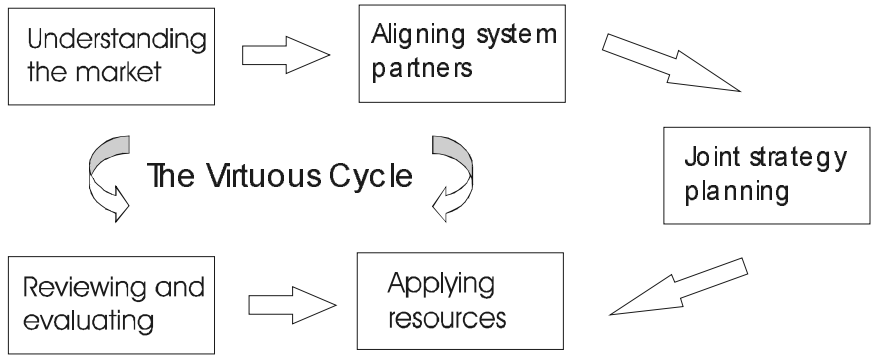
FINDINGS

Integrated commissioning – progress, infrastructure and expertise

Commissioning forms a multi-dimensional link between purchasers and providers; planning and activity; the identification and deployment of resources; and those resources and the achievement of outcomes (Knapp, Hardy and Forder, 2001). Commissioning infrastructure and expertise is therefore crucial to developing and improving services offered to older people.

LSPs are central to the 'commissioning cycle' (see Figure 1); partnerships are expected to plan together, sharing information about current activity to explore priorities, challenges and opportunities across the whole system. In exploring how to achieve service visions LSPs should determine the optimum role for each organisation and identify all opportunities for collaboration and co-ordination.

Figure 1. The commissioning cycle

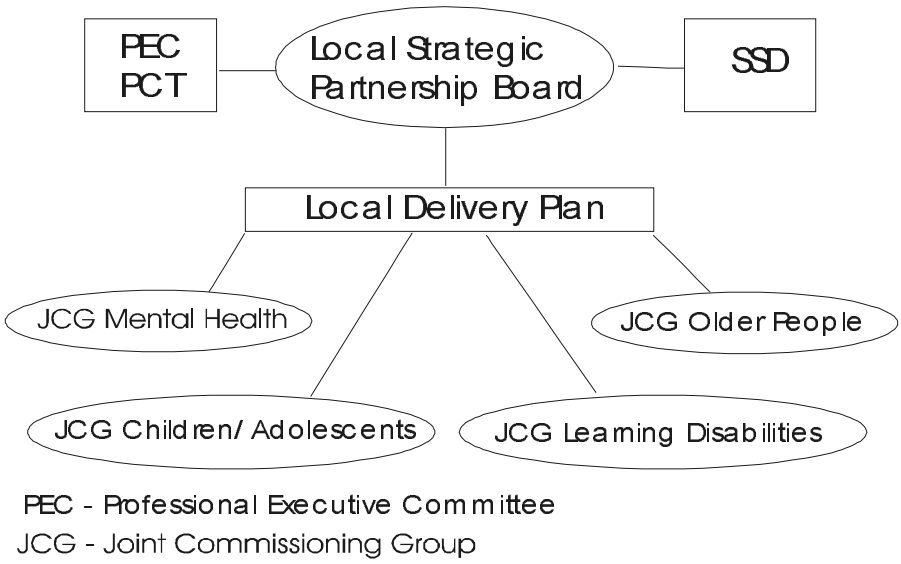


Source: Department of Health (2003)
A catalyst for change... Driving change in the commissioning of non-acute services for Older People.
Health and Social Care Change Agent Team

Recent mandatory financial planning requirements such as the Local Delivery Plan require PCTs and SSDs to jointly establish appropriate balances between service plans for different client groups and between community-based services and acute services, thus ensuring a whole-systems approach. As a response to this requirement, all sites were in the process of restructuring their planning and commissioning infrastructure (summarised in Figure 2). In our sites local strategic partnerships for older people were becoming the key forum for developing over-arching strategies for older people's services.

A significant part of this restructuring was the recognition that mechanisms for strengthening the relationship between strategy setting and budget allocation were required, although some sites were clearer about how to achieve this than others. County councils were also considering establishing locality groups that would feed into the Joint Commissioning Groups, to respond to the additional challenge of working with various district councils, and the need to manage their interface with multiple PCTs.

Figure 2, Integrated Commissioning Structures

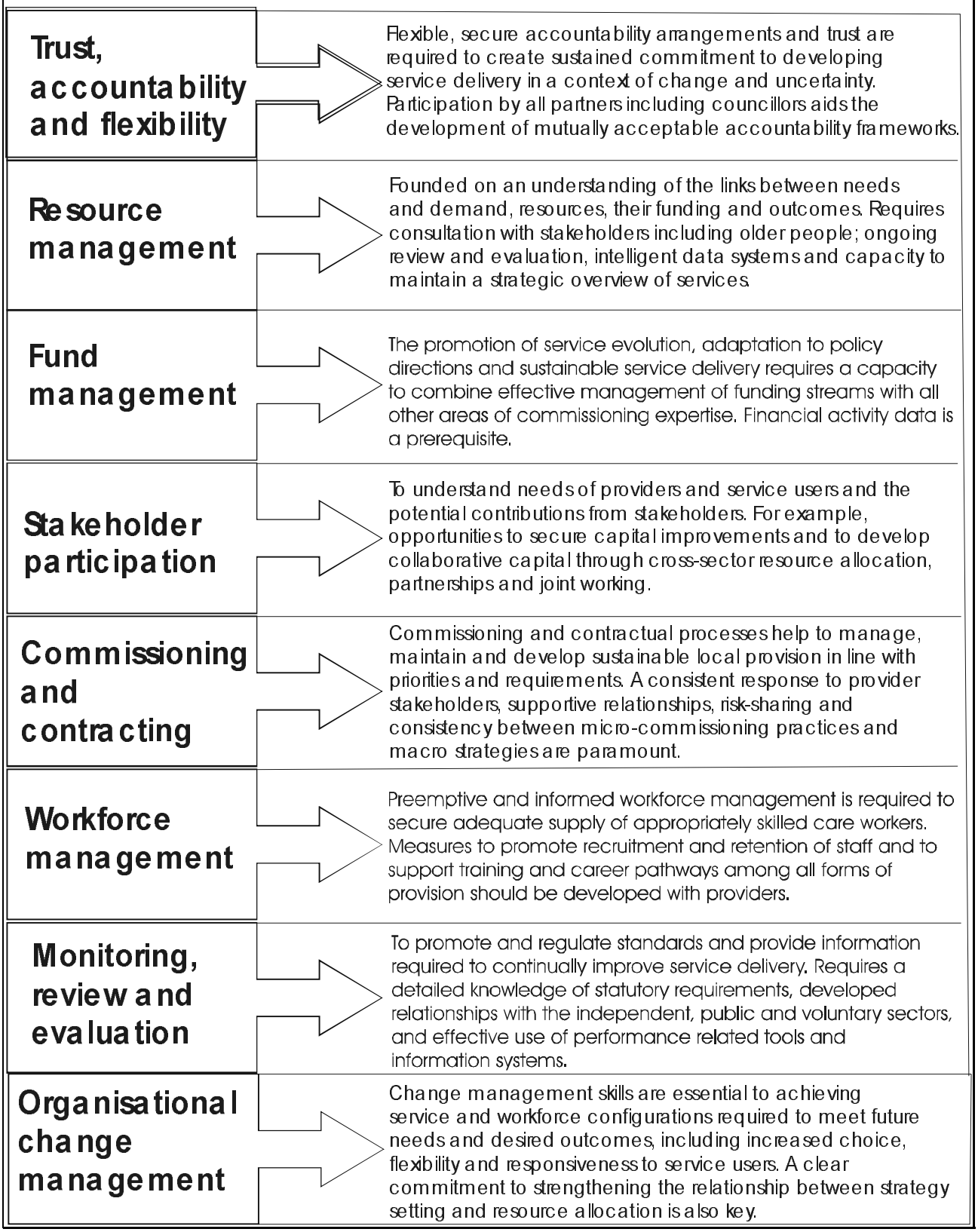


PEC - Professional Executive Committee
JCG - Joint Commissioning Group

Commissioning expertise may be conceived as comprising a number of elements. Our work in the six research sites suggested the eight dimensions summarised in Figure 3, which now provides the framework for the description of our findings. Given the primacy of commissioning expertise to the commissioning cycle, one 'test' of the capacity to improve services for older people is in the formation and application of commissioning approaches between PCTs and SSDs. As previously stated, it was expected that in early 2003 integrated commissioning structures, arrangements and expertise between PCTs and SSDs would be emerging.

Today's level of whole-systems planning requires PCTs to develop expertise in commissioning new types of services, necessitating a much wider understanding of local providers and new approaches to commissioning. New areas of expertise need to be developed jointly in all eight areas if the new frameworks for commissioning (see Figure 2) are to be successful.

Figure 3, Commissioning Expertise



Trust, accountability and flexibility

'Integrated services' were defined by respondents as those supported with joint funding, or designed specifically to operate at the interface between health and social care (theoretically being of mutual benefit). However it was acknowledged that none of the services in operation had been formally established on a truly integrated basis (using HAF). They were often were either predominantly PCT or SSD in origin. This loose definition given by respondents reflected the lack of progress and cohesiveness among existing integrated services. All sites acknowledged that expenditure on integrated services was marginal, and that these services were disjointed and poorly integrated with mainstream health and social care provision. Respondents explained that the reluctance to utilise HAFs reflected a view that satisfying the associated legal and bureaucratic requirements was onerous and likely to exceed managerial level capacity. Furthermore, existing agreements for so-called 'integrated services' based around joint operational appointments (registerable as HAF), were not necessarily considered to be a real marker of commitment, or of capacity to integrate at a wider strategic level. In the six study sites, *integrated commissioning* was identified as a necessity to overcome the limits of supply of integrated joint services and to develop a genuinely truly integrated approach to service delivery. The development of integrated commissioning thus featured as greatest priority in all sites.

The establishment of trust and the clarification of accountability were central to the development of services of a truly integrated nature and frameworks for integrated commissioning. The Section 31 Health Act Flexibilities (HAFs) provide the legal freedom for PCTs and social services to progress from collaboration and co-ordination to integration. In early 2003, none of the localities had made use of the Health Act Flexibilities. According to respondents, implementation of the flexibilities was restrained by a need to formalise organisational and financial roles and responsibilities. Despite this reticence, attitudes towards the flexibilities were positive. It was stated unanimously that effective and meaningful integrated commissioning *could not be* achieved in each of the six local areas *without* use of the flexibilities.

Pooled budgets were the most favoured flexibility. These were thought to offer huge potential benefits for users and frontline staff who may otherwise suffer amidst

wrangles over funding responsibility. As noted, the level of development was limited by concerns regarding trust and accountability. Addressing these concerns dominated the agenda for integrated commissioning. Supportive policy guidance on developing accountability frameworks for integrated commissioning was felt to be lacking. Concerns had led to more circumscribed objectives being developed for the short-term, such that only certain elements of older people's services would be the focus for the pooled budget. These elements would include funds for nursing home placements, equipment services and intermediate care services.

Resource management

In addition to accountability concerns, the continued disparity between the two organisations in prescribed budgetary and planning cycles constrained visions of the 'flexibility' that pooled budgets would provide. Sites were therefore struggling to envisage how integrated strategic-level commissioning might function in practice, other than through existing mechanisms (such as transfers of funds under Section 28A/ 28BB of the 1977 National Health Service Act).

Prescribed models of integrated support have been most evident for intermediate care (Department of Health, 2002a, 2001b,c). Consistent with other research findings in this field (Coleman and Glendinning, 2002), resources for integrated services across the fieldwork sites had been aimed primarily towards preventing delayed transfers of care, with considerably less development of preventative services. Tensions were apparent between these objectives, with integrated efforts focused on high-intensity services (services with high levels of specialist nursing, therapy and social work input), in an attempt to meet central policy targets.

Intermediate care services in the sample were mainly provided in-house. Political reluctance to decommission high-cost in-house social services facilities had been a factor. Service reconfiguration was required and 'intermediate care' provided a strategy to retain facilities and develop practice models. In all cases these facilities were structurally not fit for purpose as 'enabling environments', although suitable environments were also largely unavailable in the independent sector. Where

independent care homes had been used, in-house health and social services generally provided the intermediate care inputs.

Many respondents were unsure whether they were using the right service models to achieve desired outcomes. Reflection and evaluation that is both cumulative and continuous (Waddington, 1995) should provide answers to these questions. However, the majority of the localities were overwhelmed by the requirements of the central policy agenda, and unable to attend to the need for evaluation.

A great deal of alignment was evident between PCTs and SSDs in visions for future services for older people. It was clear that PCTs and social services were prepared to explore new service options to improve the spectrum of services available, both to meet needs more effectively and to respond more flexibly to older people's service preferences, through engaging a wide range of stakeholders and potential providers. Both PCTs and SSDs stated that to achieve the extent and range of provision envisaged, commissions with the private and community and voluntary sectors were important. The community and voluntary sector was considered particularly effective at providing low-cost services, deemed to have a high-impact on well-being and promoting independence.

Targets for extra-care sheltered housing schemes (Department of Health, 2002e) had clearly influenced service visions. In response to 'Supporting People' (Office of the Deputy Prime Minister, 2002), partnerships with the wider corporate local authority were increasingly the focus of activity. A number of sites identified the potential for securing capital in partnership with housing.

Future service strategies centred around four areas: targeted prevention, Local Improvement Finance Trust (LIFT) schemes, partnerships with housing and alternatives to existing modes of delivery. Developing strategies would be contingent upon reconfiguring services. In all cases the emphasis would be on decommissioning low-level domiciliary care services, believed to be relatively ineffective in promoting independence or preventing the need for more intensive long-term care.

Some targeted prevention services were underway, for example a programme directed at the most frequent A&E attenders in one locality. This involved weekly visits by district nurses over a period of eight weeks and aimed to improve access to

appropriate services. All sites aimed to provide effective 'signposting' to services given locally identified areas of unmet need.

Half of the sites were jointly establishing LIFT bids to develop services in areas of shortfall such as nursing homes and EMI provision. Pooled budgets for nursing home placements were considered to have the potential to extend these financial gains. However, strategies were largely focused on developing multi-function units providing a single access point to services for older people. Here personnel could be co-located, providing greater compatibility in service provision, case-management and strategic-level working, an approach for which there is some evidence of success in promoting closer integration (Cameron and Lart, 2003).

Fund management

Historically, a breakdown on spending for older people has not been applied to primary care services (Abbott and Lewis, 2002). Despite new ways of working, PCTs in our study were perceived by SS to have difficulty in disaggregating their expenditure on services for older people. Information about service costs, patterns of expenditure and quality of services is required to make properly informed decisions on the basis of 'best value' (SSI, 2002a). Recent Social Services Inspectorate reports have found that social services increasingly hold such expertise. Poor awareness of spending patterns by either partner can reduce confidence to make major resource changes (Gillam, 2001).

The new financial flows system will revolutionise the manner in which PCTs commission. *Response to Reforming Financial Flows* (Department of Health, 2003: 22) asserts that, 'closer links between [PCTs'] use of resources and their funding [through the new financial flows system] will provide the incentive for PCTs to manage demand and make effective use of capacity which has in large part been missing until now.'

However, this vision is still some way off becoming a reality and it appeared from our study that PCTs required considerable learning to develop the necessary expertise to manage funds effectively in this increasingly complex environment.

Stakeholder participation

Engaging stakeholders effectively requires sustained approaches and investment in appropriate mechanisms. SSDs were concerned that their specific expertise and infrastructure in this area should be recognised by PCTs. SSDs in the study believed they had well developed relationships with the independent sectors both informally and formally (via consultation groups) and many examples of this were given. In addition, wider partnerships with the police, leisure, transport and the environment were focused upon developing broad strategies for promoting independence.

Despite the fact that both PCTs and SSDs recognised that responding more effectively and flexibly to older people's needs required increasing commissioning from the community and voluntary sector (C&VS), informal engagement with this sector needed more structure. PCTs reported that they were inundated with requests for funding for projects from the C&VS. Half of the sites were aiming to draw the C&VS sector into commissioning plans at an earlier stage in order to improve mutual understanding of each other's objectives, and enhance capacity to collaborate effectively.

In all sites, partnership with domiciliary care providers was focused on the development of skills to meet future requirements, and increasing high intensity support to reduce levels of admission to permanent long-term care, in line with performance indicator targets.

Commissioning and contracting

To operate as equal partners in developing services for older people, PCTs have been required to develop expertise in commissioning new types of services. The research showed that differing approaches to commissioning and a lack of equivalent expertise remained an issue. As one social services respondent remarked:

> Their [The PCT's] ideas of commissioning were very different from some of ours, in developing strategic commissioning plans. They were very much more based on experience in big commissioning blocks with key hospitals.

A further demand for PCTs is to develop as micro commissioners. Micro commissioning undertaken by care managers includes assessments and individual spot placements. At the time of the research, PCTs were beginning to take on the role of funding nursing care for nursing home placements. As part of this they were newly required to assess nursing care needs. According to respondents, the lead role for PCTs in implementing the Single Assessment Process had underlined a need for them to develop micro-commissioning expertise. Locally engineered plans for health and social care professionals to work alongside each other, to undertake all assessments and individual (spot) placements, were being implemented. It was recognised that the new division of responsibility for funding personal care costs and nursing care costs between SSDs and PCTs could lead to greater interface-related delays, unless health and social care professionals co-ordinated and integrated assessment processes. Proposed local arrangements and adaptation to policy demands held the potential for improving local health and social care needs assessments and transfers of care.

It was understood that to implement such a change, PCTs and health personnel needed to develop a much better understanding of local providers as well as expertise for commissioning independent sector providers.

Effective strategies for older people require links between collaborative strategic-level commissioning and joint micro-level commissioning. There was considerable uncertainty regarding how this might be achieved. Social services respondents were keen to distinguish between micro and macro commissioning but unclear how to align the two processes. SSDs considered themselves best placed to lead macro-level commissioning and were especially keen to highlight their relevant skills. These skills were described as: market management expertise, a detailed knowledge of statutory responsibilities, contracting skills, and improved ability to maintain a strategic view of services and achieve greater clarity over commissioning priorities for older people's services. However, espoused expertise was not necessarily translated into best practice. For example, jointly commissioned services were typically financed via grants that were not quality-contingent or block contracts with minimal specification of service requirements. These arrangements were inconsistent with the pursuit of objectives associated with intermediate care. Such arrangements are less efficient and provide poorer value for money than, for example, block contracts with a price

differential between occupied and unoccupied beds (Forder et al., 2004). The effects were evident: one site referred to their residential intermediate care as inefficient in filling its beds.

Other challenges to commissioning and contracting expertise included: developing quality–contingent service specifications with providers (to include requirements for NVQ training, for the promotion of user independence, and for other desired outcomes) and the adoption of optimal strategy in implementing fee increases to retain independent residential and nursing home sector capacity.

Workforce management

Workforce management featured prominently on the agenda of both PCTs and SSDs. Staff shortages were a pervasive feature across sites, and posed a major risk of undermining service visions and aspirations (Alcock, 2003; Ware et al., 2001; Henwood, 2001). Efforts were being made to improve recruitment and retention through improved career pathways, although attention was focused primarily on in-house capacity despite the allocation of funds to local authorities, to resource training across *all* care sectors (Alcock, 2003).

Monitoring, review and evaluation

Whilst it was clear that shared learning and increased evaluation were required, it was also evident that some of the sites had sought mechanisms to achieve an integrated approach to monitoring, review and evaluation. Performance assessment models have become potentially useful tools in appraising developing systems and in understanding pressures on services. Although not many sites had been engaged in a Joint Best Value Review, it was remarked that the Best Value model was helpful in enabling PCTs to gain insight into social services' perspectives towards cost efficiency and market management. However, the separate performance assessment systems for health and social care, and the often divergent policy agenda confronting partners *were* seen to constitute some of the most fundamental barriers to whole systems working (Hudson et al., 2002; Smithies, 2001). The Priorities and Planning Framework 2003-2006 states that 'both NHS organisations and councils should

consider how joint activity will be reflected in local PSAs and contribute to meeting them' (Department of Health, 2002b: 7). Our sites had considered this but found few solutions to dealing with disaggregated performance indicators when trying to merge services or relinquish single ownership in order to create a seamless interface for users.

Furthermore, the disparities between the principles of Best Value versus clinical governance were seen to underline differences in organisational models. To caricature, social services were believed to be preoccupied with cost, while PCTs were seen to adhere to highly medicalised models of service quality. In reality the clinical governance model requires improvements in quality of services and high standards of care, while the Best Value regime requires continuous improvements in the combination of economy, efficiency and effectiveness.

Local Overview and Scrutiny Committees (OSCs) had yet to emerge in any meaningful sense at the time of the fieldwork. OSCs are a joint responsibility between elected members and health (Cook, 2003). A critical aspect of the OSC is to link into existing partnership working and expertise (Cook, 2003). OSCs hold the potential for reinforcing an integrated strategic approach to services by requiring partners to demonstrate maturity in critically examining areas of health and social care without organisational priorities and party politics coming to the fore (Jassat, 2003). OSCs are expected to utilise existing information and expertise such as Best Value appraisals. For older people's services a further impetus to shared critical review will come from the results of the audit of the NSF for older people begun by the SSI and Audit Commission teams in conjunction with the Commission for Health Improvement (taken over by the newly established Commission for Healthcare Audit and Inspection and the Commission for Social Care Inspection).

Related to review and evaluation of services, most sites had an undeveloped relationship with their Strategic Health Authority (StHA). The only manner in which StHAs had sought to fulfil their remit to maintain adequate mechanisms to ensure the quality and effectiveness of planning, prioritising and commissioning, had involved requests to the partner organisations to complete further performance-related activities. All sites hoped for a more supportive role from their StHA, ideally one as problem solver for forthcoming issues.

Organisational change management

At a strategic level the term 'integration' had become synonymous with a whole systems paradigm of service planning and delivery. At the time of the research fieldwork all sites had reached the point where they were seeking ways to move beyond historical organisational challenges to joint working. A period of change was underway in the manner in which both organisations committed jointly and collaborated in planning, purchasing and providing services for older people. This was described across all sites as far exceeding previous efforts.

Clearly sites had unique legacies of earlier approaches and attitudes to joint working. Nevertheless they displayed similarity in terms of current levels of integrated capacity. There was also a likeness between sites in: future service plans; attitudes towards expertise for integrated commissioning; and in opportunities and threats to integrated commissioning.

Respondents referred to rapid and radical transformations in systems thinking, since PCT and SSDs had begun working alongside each other in a commissioning role. Preoccupations over narrow sectoral responsibilities and boundaries were said to be diminishing generally across the organisations, and had been rejected by key commissioning stakeholders from PCTs and social services. Respondents stated that what they were intent on achieving was a 'zipping up' of capacity, resources and processes to enable an invisible interface for users between partner organisations. Clearly operational-level challenges to achieving this remained. For those that had better histories of joint working at operational level, strategic-level integration was felt to be the final measure required to enable development and improvement in services. For those with outstanding challenges in bringing together staff from health and social care at the operational level, strategic integration was felt to have kick-started a radical process of cultural change that they expected would trickle down. Levels of optimism were high.

Opportunities and threats

Challenges in the development of integrated commissioning structures, arrangements and expertise were to be expected. Unsurprisingly, meeting the challenges of change was constrained by demands on managerial-level staff, and reflected overloaded policy agenda, on-going staff recruitment and retention difficulties, and concentrated timeframes for achieving targets and delivering policy objectives. However there were other obstacles to operationalising service objectives that were also significant. These obstacles were only revealed through exploration of decisions and adaptations to policy directions, with respect to the experience of achieving stated aims for integrated commissioning and joint services.

Despite the diversity of local histories across the six sites there was a clear commonality in these hidden threats to (and opportunities for) integrated planning, prioritising and commissioning. These threats and opportunities can be arranged under seven heads: political willingness; perceived financial viability; control, trust, uncertainty and accountability; relationship with acute trusts; incentive structures; planning cycles and funding systems; information requirements and abilities to map systems.

Political willingness

Despite a willingness evident among PCT and SSD commissioners of older people's services to pursue integrated approaches, the centrality of local political willingness to accept integration cannot be over-estimated. The worst- case scenario could involve internal divisions between parties about whether local authority resources should be allowed to merge with health service resources as a pooled budget. The necessity of working with elected members, 'the art of positioning things politically' as one respondent described it, to pave the way for political acceptance of integration, was therefore paramount. As another respondent remarked on the prospect of pooled budgets:

> We may find it's not as easy to bring about as we would like – so we've got a lot of political ground-work to do.

Although none of the sites had established HAF partnerships for older people's services, all *had* made use of the HAF partnerships for learning disabilities, and for adult mental health services. In one locality the development of a mental health care trust, was viewed by local politicians as a testing ground for the more risky partnership with health:

> The members took the view that mental health is really predominantly a health service responsibility. Certainly the relative spend on mental health services, is hugely biased towards the health service with social services only spending a small amount of money (in our case about £2½ million of our base budget). But with older people … we're talking about large amounts of money.

Local political commitment could be more easily gained if key stakeholders - particularly chief executives within PCTs and acute trusts - were particularly proactive, as this signalled important ownership.

Perceived financial viability

Banks' exploration of partnerships between health and social services observed that 'financial clout is at the heart of relationships and the exercise of power between relationships' (2002: 9). The national evaluation of the use of the Health Act Flexibilities also highlighted the significance of financial equivalence between partners (Hudson et al., 2002).

Echoing these findings in the current study it was remarked,

> The idea, of course, is that it is much easier to pool budgets when you are in financial balance and you've achieved some sort of equilibrium. And we're fighting quite hard, both the PCT and ourselves, for a much more substantive share of the funding than we've had. ... My belief is that when … [the] budgets are set, we'll be in a much better position to share and pool our budgets with the health service ...

Control, trust, uncertainty and accountability

PCTs and social services had their own concerns. Within social services, the main concerns voiced were around how to maintain control from a strategic commissioning perspective, particularly in the eyes of the local authority. Social services generally

expressed some concerns that PCTs lack the required degree of understanding of local authority processes and were keen to help PCTs to understand these issues in order to provide a platform from which to base formal discussions of governance and accountability arrangements.

PCTs' concerns revolved around their financial interface with the whole health economy, namely the other PCTs within the area covered by their StHA. This reflected the requirement for PCTs within a health economy to share the risks for certain activities, such as high-cost low-volume health inputs. It was reported that this had previously been achieved informally through working relationships. PCT concerns were fuelled by uncertainty over the potential level of financial commitment that formal risk sharing would imply, and the extent to which PCTs might be expected to cover another PCT's overspend. Given this environment, it was difficult at the time for them to see how they could advance their negotiations on risk sharing with social services.

Nevertheless it was clear that efforts were underway to create strong PCT-social service ties at senior management levels, not only to create an environment where strategic decision making would be easier, but one where concerns around governance and accountability could be discussed in the context of good working relationships and a mutual understanding of goals, limitations and shortfalls. In two sites this had been formalised through the director of social services and staff at strategic management level becoming jointly accountable to the PCT Executive Board as well as the local authority, and vice versa.

The process of establishing formal trust seemed to be progressing even where working relations were historically poor. Progress was often fuelled by the necessity to address uncomfortable shared issues, such as reimbursement mechanisms for delayed discharges, and the development of pooled funds to manage NHS-funded nursing care from April 2003 in order to minimise cumbersome bureaucracy in passing funds from PCTs back to social services.

Nonetheless relationships of trust and reciprocity remained on shaky ground, as evidenced by remarks surrounding a limited willingness to share risk, or perhaps more accurately, another's overspend.

> We had an informal pooling of the Cash for Change money ... and [our] SAF money. ... Social services have [now] said, they've overspent on their element and they want us to contribute towards that overspend. ... We've said, sorry ... this is not a pooled budget, it was just an informal arrangement ...

This was not the only example of PCTs having been asked belatedly to 'risk-share' by social services. Two further sites mentioned similar experiences. In one the PCT had been asked to assist with a local authority overspend for long-term care, which had occurred, it was said, because of cost pressures related to a shrinking market in residential and nursing home care providers, and to rising home care costs associated with staff shortages and forced reliance on agency staff. Another PCT described how social services had announced that overspends forced them to rethink their commitments to their joint strategy for older people. At the time of the research, the consequences of this stance had not been finalised but it appeared that social services were hoping the PCT would make a greater financial contribution.

Relationships with acute trusts

Relationships with acute trusts featured as a further factor in integration capacity. Certainly some SSD members were concerned about the ability of PCTs to protect and meet their commitments to integrated services due to potential financial pressures bound up with the financial viability of their local acute trusts.

> The challenge for PCTs is to make primary care commissioning about primary care and not about acute care. The local hospital trusts are well known for their overspends and the PCTs need to think about how they are going to manage that in their commissioning of acute care so they can protect their focus on primary care.

PCTs themselves acknowledged these fears, talking of uncertainty over future resource commitments to acute services, particularly in one case with a new PFI hospital opening. Gillam (2001) observed that DH priority overloads were ensuring that PCG/T money for primary care was instead being soaked up by the acute sector. Waddington and Filby (2001) similarly asserted that 'funds for developing primary care services feel thinner in the context of continuing acute care cost pressures'. The NPCRDC's tracker survey of PCG/Ts also found that PCG/T commissioners perceived their degree of leverage over NHS providers to be low (Dowling et al.,

2002). The context of secondary care commissioning continues to change rapidly: The introduction of new financial flow mechanisms (Department of Health, 2002f) and the prospect of the establishment of foundation trusts (House of Commons Health Select Committee, 2003) are increasing uncertainty at this interface. Concerns have been raised in *Response to Reforming NHS Financial Flows* that PCTs may not have sufficient funds to invest in service developments or peripheral services. It has also been argued that payment by results may provide a disincentive to re-designing services, particularly in moving patients from secondary care to primary care and in establishing patient pathways. The Department of Health has responded with plans to ensure that sufficient incentives will be in place to encourage the continuation of recent service developments, such as intermediate care, that have shifted care from the acute sector to community settings (*cf* Department of Health, 2003: 4).

Incentive structures

New performance assessment targets and modest funding allocations have created some important incentives to strategic collaboration between health and social care. These are not without problems. Performance targets have arguably provided disincentives to manage the system strategically as new initiatives are opportunistically cobbled together locally in order to secure time-limited funding streams, featuring as the main instrument being used to develop alternative services to meet both national and local policy imperatives. Uplifts and 'must do's' were nevertheless considered to have greatest leverage over decision makers in securing agreement over proposed service developments for obvious reasons. Dependency on non-recurrent funds creates a vicious cycle. New services had most often been developed using non-recurring uplifts. Typically these were sustained by the new monies that came along,, although increasingly sites were making efforts to move services to the mainstream. Government expectations of growth in capacity following release of such funds was therefore generally not being matched, since the funds disappeared into retaining existing capacity. The cycle of uncertainty also created a disincentive to invest in service review.

Planning cycles and funding systems

Overloaded policy and planning agenda have now been accepted as capable of undermining strategic management skills development rather than promoting them (Department of Health, 2001d). Planning systems and funding streams are now changing (Department of Health, 2002b), aimed at decreasing reliance on short-term funds and increasing long-term strategic planning and greater local autonomy. Nevertheless, there was still ambivalence about local abilities to use this change to secure better outcomes since target-orientated planning has limited the development of strategic management skills to date. Paradoxically, SSDs were at the same time concerned about the likely consequences of local authority funds being subject to less ring-fencing in the future due to the decrease of short-term funds (typically specific to achieving certain objectives). There is also potential for an increase in new forms of cross-sector resource allocation through the strategic partnership arrangements where services may be commissioned to create improvements for all client groups (such as healthy neighbourhood schemes). Some social services respondents felt that all adult services funds needed to be ring-fenced for real freedom to achieve strategic change since proposed developments for older people were perceived as continuing to compete against the developments to meet needs of other client groups.

There was also a sense that strategic planning was becoming more and more difficult to grasp, with engagement in wider and wider strategies cutting through social services, PCTs, acute trusts and housing.

> The Local Delivery Plan… is *that* big. And there are hundreds of priorities in it. Every single thing's a priority. How do you prioritise priorities?

Information requirements and abilities to map systems

Most sites mapped needs via standard systems using public health and census data, typically supplemented with incremental examination of different parts of the system. Further input came from information collected as part of performance assessment. Ability to really understand the links between needs, resources and outcomes was marred by disparate information systems, which at present provide only snap-shots.

One PCT representative stated that to counterbalance the strong leverage of the acute trust, PCT commissioners of older people' services would need to:

> …look at the outcomes we are going to require and also to look to see if, okay, we're spending this many thousands but what's it really going to produce?

Ability to achieve this was questionable: sites desperately required the ability to track an individual's pathway through the system, and to use data that would allow interrogation of precipitating factors and care inputs along the way.

An ambitious Information Strategy for Older People has been issued (Department of Health, 2002c), promoting the establishment of local information strategy task forces. Local Implementation Strategies have produced some integration of health and social care data systems. However, progress has been slow and fragmented (Staton and Drury, 2003) due to the scale of the endeavour, and the significant financial implications. All sites complained of a mismatch between respective IT funding allocations to health and social care and a perceived lack of implementation support.

The absence of robust information matching needs, inputs and outcomes clearly limits leverage over decision-makers:

> The problem [then] is in finding resources for it and you know it goes back to knowing… If I knew I could spend, you know, an extra £½ million on this provision next year and that would resolve the delayed transfers of care or improve the flow of the system, I could do that. But we're some way away from that.

DISCUSSION

The integration of commissioning arrangements by health and social services for older people is likely to have wide ramifications for the delivery of services. Commissioning forms the key interface in managing the mixed economy. The performance of a local social care system may be affected by commissioning practices particularly as they influence the distribution of relevant information, the allocation of risk, the nature of incentives and relationships and the level of competition (Knapp et al., 2001). Until recently, commissioning of social care services for older people has

primarily been the responsibility of local authorities. Former health authorities' contributions to commissioning joint services had tended to be tightly bounded endeavours. The combination of new local strategic partnership arrangements, Health Act Flexibility freedoms and the position of PCTs as major budget holders has created much wider opportunities for joint commissioning and ultimately integration. However commissioning in partnership clearly increases the number of players and potential complexity. Central to this complexity are the dimensions of PCTs' limited expertise in commissioning non-acute services, drawing on a variety of local providers to achieve objectives that focus on prevention, well-being and rehabilitation.

This exploratory study has demonstrated the limited extent to which joint commissioning has taken place, although commitment to the goals of integrated strategic planning and commissioning appears high.

Huxham's (1996) discussion of 'collaborative capacity' described collaboration as inherently more time-consuming and hence resource-consuming and costly than non-collaborative activities. He argued that collaboration demands actual time invested in achieving mutual understanding, gaining goodwill, negotiating bases for action and co-ordination (all of which create trust), as well as lapsed time to cope with accountability issues and other organisational priorities (Huxham, 1996) Waddington and Filby (2001) have observed that approaches to organisational development in the NHS tend to focus on issues of structure, accountability and task management. This study has shown that these so called 'customary exhibitions' continue to take place given the observed level of preoccupation with structural developments.

However, the central difference between earlier joint commissioning initiatives and today's agenda for whole system working is that current developments crucially need to involve every level of each organisation. Tensions surrounding perceived power, autonomy and accountability, and control over processes and concern with the logistics of joint commissioning are understandable, particularly given conflicting pressures on social services and PCTs. For example, the use of pooled budgets for jointly commissioning services, which are effectively ring-fenced, requires SSDs to be more focused than previously in their budgeting and resource allocation for older people as a client group. To-date resources have frequently been shifted across a

wider range of services and between client groups. PCTs on the other hand, perceive increasing financial uncertainty related to the introduction of financial flows, foundation trusts and the development of risk-sharing agreements with neighbouring PCTs.

Wider evidence on organisational mergers suggests that weak planning is often a key reason for disappointing outcomes since partners have failed to realise how operations should be integrated to achieve maximum efficiency, or to identify problems that may interfere with attaining the desired results (McEntire and Bentley, 1996). Waddington's early work supporting joint commissioning similarly identified that 'time consuming and essential initial tasks of reviewing current services, agreeing overlaps and gaps between agencies and producing a transparent audit of final commitments on both sides were essential preliminaries to the process' (1995: 6). While all sites were working extensively at these activities, to date there was little evidence that review and evaluation had informed developments. Given the required pace of change to meet national targets, limited time and staff capacities were major features. Incrementalism is a response that reflects the reality of scarce managerial skills and resources, as well as the unachievable 'rational deductive ideal' of amassing and evaluating all possible information on all possible alternatives (Hickson, 1987). However, the development of wider organisational decision-making structures and arrangements may also be viewed as key to the effectiveness, efficiency and equity of new service developments (Glendinning, 2002).

This study has shown that local responses to the joint commissioning agenda have been shaped by a number of both opportunities and threats. The significance of political willingness is an often unrecognised, element in joint commissioning (Peck, Gulliver and Towell, 2002). Weaknesses in capacity to operate strategically have also previously been highlighted (Jones and Lewis, 1999).

Perceived financial viability and financial constraints featured heavily alongside financial uncertainty. During the past decade, budgets for local authorities have not kept pace with growth in demand, causing tighter targeting of resources by local authorities and restricting expenditure to the most complex levels of needs (Parker, 2002). This has recently been recognised centrally with a substantial increase in funding to social services (6 per cent per annum in real terms from April 2003), and

an imperative to provide rehabilitative and preventive care across health and social services. This is underpinned by the Fair Access to Care policy requiring change at local authority level in the categorisation of need and subsequent provision

In a context of competing priorities and ongoing reform, the impact of financial pressure is likely to lead to decreased trust. Trust is generally considered a central pillar of collaborative negotiation, although Vangen and Huxham (2003) argue that since trust is rarely present from the outset, it needs to be developed via a trust-building loop. A key example of this was evident in plans to pool budgets for nursing home placements. Clearly, all parties were committed to smoothing the interface between health and social care responsibilities for both staff and users, and recognised the mutual benefits in pooling resources. However, neither organisation could currently envisage relinquishing the means of monitoring respective spending, thus ensuring clear lines of accountability in the event of an overspend. It was hoped that progress would occur over time given the opportunities to further test commitments, develop trust and whole system understanding.

Given the scope of current proposed collaborative arrangements between PCTs and social services, and the expertise this demands, Waddington's (1995) vision of the central importance of accumulated build-up of knowledge, experience, trust and reciprocity is still highly relevant. Additionally, attention to supporting commissioning expertise is required, as institutional arrangements and responsibilities among and between PCTs and local authorities evolve. Guidance on commissioning highlights the complex considerations and expertise required to commission flexibly, responsively and jointly to meet complex needs (Department of Health, 2002d). A highly rational approach is advocated (Hill and Laurence, 2003). This study demonstrated that relational and behavioural factors are equally important in governing commissioning and must also be considered if future policy imperatives are to harness integration potential successfully.

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