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Joint Commissioning in Health and Social Care: An Exploration of Definitions, Processes, Services and Outcomes

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Glossary of terms/abbreviations

AN – Alyson Nicholds (member of research team)

CCG – Clinical Commissioning Group

GP – General Practitioner

HD – Helen Dickinson (member of research team)

LA – Local Authority

PCG – Primary Care Group

PCT – Primary Care Trust

POET – Partnership Outcome Evaluation Toolkit

POETQ – Updated version of POET which incorporates a Q methodology approach

SJ – Stephen Jeffares (member of research team)

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Contributions of authors

Helen Dickinson – research designer, lead author on the report, designer of POETQ and day to day oversight of the research.

Jon Glasby – principal investigator, research designer and report editor with focus on practice and policy implications of the research.

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Alyson Nicholds – research fellow on project dealing with day to day operation of project, conducted literature review, responsible for data collection at 4 of 5 sites, data coding, analysis and report preparation.

Stephen Jeffares – research designer, designer of POETQ interface and sample framework, Q methodology analysis, data collection at one site, data coding, report editing.

Suzanne Robinson – data collection at one site, and report editing.

Helen Sullivan – research designer, report editor with focus on wider implications of findings in context of inter-agency collaboration.

Executive Summary

Background

In recent years health and social care policy has placed growing emphasis on the importance of a *commissioning-led approach* and on the need for more effective *health and social care partnerships*. Combining these two agendas together, policy has increasingly started to focus on the need for greater **joint commissioning** of health and social care. Yet, current policy rhetoric about the importance of joint commissioning often seems to lag behind the reality at ground level - despite the fact that aspirations for effective joint commissioning date back many years.

Many national policies and local partnerships appear to be based on the assumption that joint approaches are essentially a 'good thing' that must inevitably lead to improvements for local people. Yet, although there is much talk at national and local levels about 'effective joint commissioning' there is often little specificity about what this actually looks like in practice. Furthermore, much of this literature has a tendency to be overly descriptive and largely atheoretical, often describing the process of partnership working and asserting it to be a positive development without actually exploring how or why this might be the case, or what outcomes are actually achieved in practice.

Aims

In contrast to the more established literature, this study seeks to provide a more theoretically and empirically robust understanding of the dynamic relationship between joint commissioning, services and outcomes, thereby addressing three main questions:

- How can the relationships between joint commissioning arrangements, services and outcomes be conceptualised?

- What does primary and secondary empirical data tell us about the veracity of the hypothesised relationships between joint commissioning, services and outcomes?

- What are the implications of this analysis for policy and practice in terms of health and social care partnerships?

Underpinning this study is a desire to explore a working hypothesis common in current policy and practice: that partnerships lead to better services and hence to better outcomes for service users and their carers.

Methods

This research project is broadly based within a theory-based approach to understanding joint commissioning in health and social care. What this means is that we have sought to map out the range of ways in which joint commissioning is understood across five case study sites which all have different types of joint commissioning arrangements in place. At these sites we have investigated the types of assumptions that underpin the relationships between the processes and practices of joint commissioning and its intended impacts. Having mapped out these programme theories it was intended that primary and secondary data would be sought to test the veracity of these intended relationships. The research is therefore structured into two phases.

In terms of the methods employed within the research, in the first phase POETQ was used which is an innovative online evaluation tool. POETQ asks a series of process-based questions relating to the effectiveness of the joint commissioning arrangements and then employs a Q methodology approach which asks participants to select between statements relating to what joint commissioning should achieve in practice. Nearly 100 Q sorts were collected across the five sites and by a process of factor analysis a number of viewpoints of joint commissioning are identified for each of the sites. In phase two these viewpoints are further investigated with staff and service users through focus groups and interviews (involving 105 individuals). The purpose of this qualitative investigation was to further test the viewpoints and what they suggest in terms of their 'theories' of joint commissioning so that we might understand the links between the processes, practices and impacts within these localities.

Results

Even though the case study sites engaged in the research had been selected as they were identified as sites of 'best practice' in terms of joint commissioning, many of the sites rejected this terminology. Sites instead spoke of simply "*integration*" or "*commissioning*" or "*integrated commissioning*". When we explored local data in more detail, we found that the five sites all had different ways of seeing joint commissioning and this tended to vary depending on the local context. Thus, there does not appear to be one definition or model, and each site interprets joint commissioning in a different way depending on local aims and priorities.

What the research did uncover is that the potential meanings of joint commissioning go way beyond those found in the existing literature. In the literature review we found that joint commissioning can be understood as something that can produce efficiencies, empowerment and productivity. In our research we found that these discourses existed alongside each other but also with other potential meanings. There was prevalence in both phases of the research for an 'ideal world' view of commissioning: a belief that joint commissioning is simply a 'no-brainer' and can deliver better outcomes for less money. There are limits to the conclusions we can draw from this given our focus on existing examples of good practice and the involvement of commissioners in the research, but it does seem that many local workers may have seen joint commissioning as inherently a 'good thing', with very aspirational aims associated with this way of working.

In terms of the processes of joint commissioning, many people talked about it in terms of the formal structures that had been put in place to facilitate this way of working – be this formally merged organisations or integrated management teams. Sometimes these gave the impression of being an end in themselves rather than a means to an end (of better services and better outcomes for local people). However, at other times, participants seemed to suggest that the focus on formal structures was a response to a turbulent policy context, with local areas feeling that they had to make their relationships more structural in order to protect against future disruption, reorganisation and loss of organisational memory.

None of the processes cited in any of the case study sites seemed to be particularly distinctive of joint commissioning. All of them were very much the sorts of processes that you would expect to encounter in exploring joint working in a very general sense. Moreover, there was no apparent pattern to the use of the different processes, with different sites using different aspects of these. Interestingly, there seemed to be a real paradox present in the sense that although a lot of the joint commissioning processes described to us were formalised and structural, people often recognised that joint working is essentially relational (based on informal conversations and interactions).

In practice, many sites struggled to cite specific examples of the impact of joint commissioning or to evidence their claims, thoughts and hopes. This may be due to a variety of reasons including: the difficulties of evidencing very broad, preventative outcomes; difficulties in attributing changes to joint commissioning initiatives; tensions between locality and strategic commissioning; and, the challenge of the counterfactual. What the findings do seem to suggest is that the value of joint commissioning might not simply be in terms of this as a rationalist model of improvement that can be introduced in sites to bring about particular outcomes.

Conclusions

There may not be anything that is specific about joint commissioning that is different to other ways of working and it is far from a coherent model with a set of clear organisational processes and practices. However, what joint commissioning does have is a degree of acceptance and a sense that it is a positive thing. In all of the cases it has been used as a "framing concept" to introduce a range of organisational, structural and in some cases cultural changes. The very value of joint commissioning may then be in its ambiguity and symbolism as a concept that is seen as inherently good and able to deliver against a range of the very sorts of pernicious issues that contemporary health and social care organisations struggle with (e.g. health inequalities, constrained budgets, involving the public and service users in the design and delivery of care services).

Ultimately what this research suggests is that we might need to ask very different questions of joint commissioning than those that we have traditionally asked, focusing on what collaboration means to a range of different stakeholders. This allows us to understand the notion of agency in joint commissioning in a different way, beyond just improving outcomes and offers us a chance to understand joint commissioning in a different way.

Looking to the future, it seems likely that the relationships built and the outcomes achieved through joint commissioning arrangements could come under threat as organisations are abolished and as clinical commissioning groups come into existence. A key ambition of joint commissioning is to achieve better outcomes for and with patients. This study confirms the findings of numerous previous studies of patient and public involvement; that it is difficult, time consuming and fragile in the face of radical organisational or policy change. Regardless of whether or not clinical commissioning can provide better or more responsive services for patients, the process of reform is disrupting existing relationships and focusing attention on internal organisational concerns rather than external user-professional relationships.

1 Introduction and background

Over time, health and social care policy has placed growing emphasis on the importance of a *commissioning-led approach* and on the need for more effective *health and social care partnerships*. Combining these two agendas together, policy has increasingly started to focus on the need for greater **joint commissioning** of health and social care (see, for example, 1;2). And yet, current policy rhetoric about the importance of joint commissioning often seems to lag behind the reality at ground level - despite the fact that aspirations for effective joint commissioning date back many years (see, for example, 3). At least part of the difficulty seems to lie in the fact that joint commissioning is, by definition, more complex than commissioning in single agency settings; joint commissioning almost inevitably brings additional challenges because of the need to develop effective partnerships between health, social care and beyond.

Although there has long been a recognition of the need for inter-agency collaboration to provide seamless services for users and carers (see, for example, 4;5), this has acquired increasing impetus following the commitment of the former New Labour government to achieving 'joined-up solutions' to 'joined-up problems' (6). Despite the focus on greater competition in some areas of the health service, this emphasis on the importance of collaboration (or 'integrated care') has continued under the current Coalition government (2;7;8), with an added need to respond to a difficult financial context by working together more effectively and using scarce resources to best effect.

Responding to these policy developments, a large number of different partnership arrangements have been developed in different parts of the country, including:

- Care Trusts and Children's Trusts

- Use of the Health Act flexibilities

- Joint appointments

- The use of staff secondments and joint management arrangements

- Joint commissioning units

- Joint Strategic Needs Assessments

Although there is a substantial and growing literature on partnership working (see, for example, 9;10;11;12), there are a number of limitations to our existing knowledge, including:

- A tendency in health and social care partnership research to focus on the perspectives of policy makers and managers without always adequately exploring the views and experiences of service users, carers and front-line staff;

- Much of the current literature is descriptive and 'faith-based', emphasising the virtues of partnership working without necessarily citing any evidence for the claims made (see for example, 13;14;15). Often, the focus is on the *processes* of partnership working (how well do we work together), rather than whether or not this improves *outcomes* for people using services; and,

- There is a tendency to focus on health and social care partnerships in isolation from broader joint working arrangements between the NHS and local government as a whole (including former Local Strategic Partnerships and Local Area Agreements, as well as more recent Health and Well-being Boards).

In exploring the processes, services and outcomes of joint commissioning arrangements, it is some of these limitations in the current evidence base that this study seeks to address.

1.1 Aims and objectives

Many national policies and local partnerships appear to be based on the assumption that joint approaches are essentially a 'good thing' that must inevitably lead to improvements for local people. Indeed, although there is much talk at national and local levels about 'effective joint commissioning' there is often little specificity of what this actually looks like in practice. Furthermore, much of this literature has a tendency to be overly descriptive and largely atheoretical, often describing the process of partnership working and asserting it to be a positive development without actually exploring how or why this might be the case, or what outcomes are actually achieved in practice. In contrast, this study seeks to provide a more theoretically and empirically robust understanding of the dynamic relationship between joint commissioning, services and outcomes, thereby addressing three main questions:

1. How can the relationships between joint commissioning arrangements, services and outcomes be conceptualised?

2. What does primary and secondary empirical data tell us about the veracity of the hypothesised relationships between joint commissioning, services and outcomes?

3. What are the implications of this analysis for policy and practice in terms of health and social care partnerships?

Underpinning this study is a desire to explore a working hypothesis common in current policy and practice: that partnerships lead to better services and hence to better outcomes for service users and their carers. Thus, this research seeks to investigate whether joint commissioning leads to improved services and subsequently improved outcomes for service users. In the following chapter we say more about the definition of joint commissioning and its relationship with the concept of 'partnership' or joint working more generally.

1.2 Theoretical insights

Evaluating joint working is extremely difficult (for an overview of some of these complexities see 15;16), and previous collaborative research tends to fall into one or two different approaches:

1. **Method-led approaches** suggest that many of the problems in evaluation result from methodological shortcomings; thus refinement of research methods alone will lead to the solution of any difficulties and problems. Different approaches are adopted – for example, randomised trials, case studies etc - but the assumption is often that one method is automatically better than another within a given context. Therefore getting the method 'right' will produce 'good' results. In reality, evaluating collaboration simply does not lend itself to a single 'robust' or 'right' research method. As such, mixed method approaches have become widespread within the field, with El Ansari and Weiss (17) suggesting that "a simultaneous multilevel multi-method (quantitative and qualitative) approach to research on partnerships is optimal, thus drawing on differing frameworks and seeking to embrace the perspective of all stakeholders and the complexity of the phenomena under study" (pg. 178).

2. **Theory-led approaches** do not reject the methods used in method-led approaches, but argue that they tend to maximise one type of validity at the expense of others. Rather than inferring causation from the input and outputs of a project, theory-led evaluation aims to map out the entire process, focusing more on "what works, for whom and under what circumstances" (18). Gambone (19) suggests that data collected without "theory" has the status of "information" and is limited to describing phenomena, while data collection guided by theory produces what can be called "knowledge". As commentators such as Weiss (20) and Patton (21) point out, the sorts of projects which today's evaluators are asked to work on tend to address 'wicked issues' which are multi-faceted and which joint commissioning is increasingly set up to tackle. In this context, the greatest strength of theory-led evaluations is their focus on the issue of attribution. As joint commissioning invariably tends to consist of a number of complex interventions taking place within a complex environment, evaluation requires an approach which is able to make distinct statements about

the nature of causal factors within that locale. This is precisely what theory-led approaches seek to achieve by mapping out and investigating the distinct theories underpinning programmes. Recent high profile examples include approaches such as 'realistic evaluation' and 'theories of change', and aspects of these approaches have been applied in national partnership evaluations (for example, of Health Action Zones, Local Strategic Partnerships and the Children's Fund - see 6;22;23;24;25).

Building on the above analysis, this study is broadly designed within a theory-led approach. Rather than assuming that interventions such as 'joint commissioning' lead to a series of clear and specified outcomes, we argue that the situation in practice is often a great deal more complex than this. We are not dealing with means-ends mechanisms here and different stakeholders might not hold the same types of beliefs about what such complex interventions are aiming to achieve. Indeed, in a study of health and social care collaboration, Dickinson (26) found that even partnerships that considered themselves to be high-performing and well-functioning comprised a range of actors who held very different notions of what success for that partnership would look like. Although stakeholders broadly agreed on the parameters of the collaborative endeavour and the types of activities that should be conducted, they held often quite different perspectives concerning what the partnership should achieve in practice.

Against this background, this research sought to map out the processes, practices and outcomes of joint commissioning within five quite different locality areas and then test the many different programme theories and assumptions that might be at work within these contexts. In undertaking this process we drew on two main theoretical/methodological insights:

1. The overall analytical frame for the research is one of interpretive analysis. In practice this means that rather than treating joint commissioning as a simple means-ends tool that seeks to deliver particular aims and then can be judged successful (or not) against these, we sought to unpack the meaning that joint commissioning provides, how it might provide symbolism in collaborative endeavours, support aspects of individual and group identity, and give meaning to the actions of professionals.

2. In the first phase of the research we incorporate a Q-methodology approach which aided in quickly surfacing a range of viewpoints concerning what joint commissioning is (and is not) and the types of impacts it should have (see methodology chapter for further detail on this approach).

By building on previous work from the fields of health and social care, this study seeks to develop and add to these theoretical and methodological debates, in addition to providing practical and useable data for local

organisations about the nature, processes and outcomes of joint commissioning.

1.3 Structure of the report

Building on this initial introduction, Chapter 2 explores insights from the previous literature on joint working, on commissioning and on joint commissioning. Next, Chapter 3 sets out the methods adopted, summarising the theoretical frameworks adopted during the study, methods of data collection, practical and ethical issues and the overall scope and focus of the research. After this, Chapters 4 and 5 present findings from our case study sites, including local perspectives and national trends. Finally, Chapter 6 draws the project together, with an overall summary and discussion as well as setting out the implications for research, policy and practice.

Ultimately we conclude from this research that joint commissioning is not a coherent or consistent entity and it is used in a number of ways depending on the local context. There are no clear set of processes or practices that we can argue are integral to joint commissioning and many of those identified are often associated with joint working in a more general sense or relate to other aspects of organisational development. Although we did find evidence of impacts at the case study sites, it was not clear whether these had been delivered as a result of joint commissioning specifically or due to the range of other activities that were taking place at these sites. However, one thing that is apparent is that the term joint commissioning is largely seen as positive and as innately a "good thing". Many of the case study sites had experienced challenges in recent times associated with the concept of joint commissioning but often believed that if they 'just got it right' then joint commissioning should deliver a range of impacts across a variety of domains.

2 Literature Review

2.1 Introduction

As a first phase of the research we conducted a literature search in order to produce an up to date review of this evidence base and also to help identify examples of effective joint commissioning in practice which would be used as case study sites within the research project (see Chapter 3 for more detail). This chapter sets out the detail of this literature review and is structured as follows: firstly we set out detail of the search strategy and the type of data generated; we then move on to define the term joint commissioning and the organisational processes and practices associated with it; and, finally we examine the types of claims that have been made for joint commissioning in terms of what it should achieve in practice.

2.2 Search Strategy

The purpose of the review was to provide an up to date account of the literature and also to aid in the selection of case study sites and to inform the outcome statements which would be used in the research process. The search of the literature was undertaken in early 2010 at the start of the research project. As we will explain in more detail in the methodology chapter, we aimed to surface examples of best practice in joint commissioning which might form the basis of potential case studies which could be used in the research and capture a range of outcomes associated with joint commissioning that would be used in the first phase of the research.

Two of the research team (HD & AN) searched a number of databases covering health and social care including: HMIC; Medline; ASSIA; Pro-quest/ EBSCO; Social Care Online; Social Sciences Citation Index; Social Services Abstracts; and ISI Citation Index database. The search terms used for this exercise were (partnership* OR joint working OR integrated working OR inter-agency working) OR (commissioning OR joint commissioning) AND (good practice OR best practice OR innovation OR success). There were no date restrictions applied but papers needed to be written in English to be included.

In total this search retrieved 512 abstracts which were read and the inclusion and exclusion criteria applied. Articles were included where they explored joint commissioning in its broadest sense (i.e. more than one organisation involved in needs analysis and subsequent purchasing of services) and based on an English context. Following this process, 399 items were rejected due to a lack of relevance. The majority of the items that were rejected mentioned joint commissioning in passing, but this was not the central concern of the article or an issue that was addressed in any real detail. Some of the items sought were not able to be obtained, others

proved irrelevant once the full item was obtained and in the process of reading full items others were collected through 'snowballing' sources (see Table 1). A final list of 105 items was constructed and these items were retrieved in full. Two researchers (HD & AN) then read 10 items selected at random and used a standardised pro forma to extract relevant data from these articles. These pro formas were compared for their inter-researcher reliability and then the remainder of data extraction completed.

Table 1. Numbers of items retrieved in literature search

Stages of Literature Review Process	Number
Abstracts identified from initial search of database	512
Abstracts discarded after application of inclusion and exclusion criteria	399
Duplicates	4
Items unable to obtain	7
Items discarded after reading in full due to lack of relevance	4
Additional items found through snowballing	7
Total number of items included in review	**105**

Many of the items identified through this search process derive not from the peer review literature, but instead from practice and policy literatures and this has implications in terms of the methodologies adopted in these pieces and the status of this evidence. We briefly reflect on this in the next section before moving on to set out what is known about joint commissioning from the literature.

2.3 The nature of the evidence base

Although attempts were made to uncover as many papers relating to joint commissioning as possible, it quickly became apparent that the joint commissioning literature is not terribly robust in the sense that there is not a good body of peer review literature underpinning this concept. Of the total papers selected, only a small number were peer-reviewed articles (27). Of the remainder, 42 were practice-based review articles, most of which formed the basis of commentaries and reflections on joint commissioning, eight were publications from think tanks and 26 papers were government documents describing policy initiatives (see Table 2). Thus, despite joint commissioning having been a key component of health and social care policy for some time, there appears to be little good quality (i.e. peer reviewed) evidence relating to this concept. What evidence does exist is predominantly in the form of governmental publications which often lacked a clear evidence base or a systematic approach to generating evidence about joint commissioning.

Table 2. Types of items retrieved in literature search

Type of article	Total Number found	Percentage of total items retrieved	Example of source type
Practice-based journals	42	40	Journal of Integrated Care, Tizard Learning disability review, The Mental Health Review, Managing Community Care, Health Service Journal, Community Care, Building Knowledge for Integrated Care, Commissioning News, Children Now, CCMP, Housing, Care & Support, Nursing Times, Journal of Integrated Care
Peer reviewed Journals	27	26	International Journal Integrated Care, Journal of Integrated Care, Health Service Management Research, Research Policy & Planning, Health & Social Care in the Community, Social Policy & Society, Journal of Inter-professional Care, Journal of Social Policy, Social Science & Medicine, British Medical Journal
Government documents (including central government department documents and government agencies)	26	25	Department of Heath, Department of Communities and Local Government, Office of the Deputy Prime Minister, Department of Work and Pensions, Association of Directors of Social Services, Care Services Improvement Partnership, Integrated Care Network, Healthcare Commission, National Drug Treatment Agency for Substance Misuse
Think Tank and independent policy advice	8	8	Kings Fund, Nuffield Trust, Office for Public Management, Turning Point
Book chapters	2	2	
TOTAL ITEMS RETRIEVED	105		

Our first conclusion about the extant joint commissioning literature is that there is a distinct lack of high quality research evidence, with much of the literature comprising opinion pieces or the voices of those who have been involved in leading these types of initiatives. To some extent we might expect this given that similar claims have been made about the commissioning literature more generally. For example, in a review of the evidence base of published generic social care commissioning guides, Huxley and colleagues (27) found that although these guides were accessible in terms of being clear and well written, the evidence was drawn mostly from government documents rather than research evidence. Similarly, Dickinson (15) and Bovaird *et al* (28) also observe that there is a lack of robust evidence pertaining to collaboration in health and social care and commissioning more generally.

On closer inspection of those articles that appear in peer reviewed journals, (see Table 3) not only do we see that the methods are largely qualitative (33%), but also the large majority comprise a case study approach (41%) which seeks to draw on practical examples of joint commissioning in situ. Often these were very descriptive accounts of activities at one site without theorisation or an attempt to extrapolate to a wider context. Where case study methods were used, there is rarely, if ever, any discussion about the methods used to gather data, or how the sample was drawn. Of the three studies reported which adopt a 'mixed methods approach' (11%) these are actually linked publications which all draw on the same bank of data involving quantitative survey and qualitative interviews to offer different perspectives of the process of joint commissioning. The remainder of the literature constitutes literature reviews and editorials which provide rigorous accounts of the data which already exists around partnership, but which lack any empirical contribution of their own.

Table 3.   Methods used in peer reviewed literature on joint commissioning

Methodology	Number	References
Mixed methods (qualitative & quantitative)	3	(29-31)
Qualitative	9	(32-40)
Quantitative	0	N/A
Literature reviews	2	(14;41)
Case study	11	(42-52)
Other	2	(53;54)
TOTALS	**27**	

What this overview of the literature so far reveals is that we lack a clear and robust evidence base about joint commissioning, both in terms of what this is, how it is practised in organisations and the impacts that this has in terms of outcomes. This is not made as a claim that we need to do away with qualitative approaches and simply engage in large-scale quantitative research. It is instead to highlight the nature of the extant knowledge around this topic. Yet this observation is not new. As Caroline Glendinning and colleagues (32) remarked over a decade ago:

> *'All these initiatives still require careful evaluation to determine whether, and which benefits claimed by primary health and social services staff are also shared by service users. Which model of joint commissioning delivers most for patients? How easy is it for them to find out about services? Are services better coordinated? To what extent are patients' preferences taken into account? What are the consequences for equity and citizenship?...it is vital that the lessons from today's experiences are taken into account' (pg. 124).*

However, this observation shows we have not significantly advanced our knowledge of joint commissioning, or arguably collaboration or commissioning in their widest sense. Having set out an account of the nature of the literature base, we now move on to reporting what the literature does say about joint commissioning. We start by attempting to define the concept of joint commissioning and in doing so we delve into the policy background to the concept in more detail.

2.4 Defining joint commissioning

On reading the joint commissioning literature the first thing that becomes immediately apparent is that definitions of this term are rather sparse. Joint commissioning is frequently referred to as though we all know what this term means and there is little need to define this in any further detail. On further investigation we see that joint commissioning is often conflated with other forms of joint working such as: partnership, integration or collaboration (39;55-57). Joint commissioning is often discussed in a similar way to these other terms with no clarification about if and how this differs to other forms of joint working. Given this observation, we go on in this section to set out an account of the policy context in order to try and tease out the meaning of joint commissioning in more detail.

2.4.1 Policy context

Joint commissioning emerges as an area of policy interest at the intersection between simultaneous interests in 'partnership working' (or a range of other synonyms used to indicate the presence of collaborative endeavor) and an increasing focus on the demand side (commissioning function) of welfare services (58). In this section we briefly reflect on the

growth of interest in partnership and commissioning and the policies that have sought to bring these agendas together in the form of joint commissioning.

The need for partnership between health and social care is rooted in the English welfare system's distinction between health needs (for those who are sick and is free at the point of delivery) and social care needs (for those who are 'frail' or 'disabled' and recipients who may have to pay some or all for these services depending on their financial means). As Glasby and Dickinson (11) argue, this distinction is not always meaningful in practice, and with increasing numbers of older people within the national population and with more individuals living for longer with impairments, this has often led to a lack of continuity of care and in some cases, individuals falling between services. The New Labour government elected in 1997 declared itself committed to 'breaking down the Berlin Wall' that separated health and social care services (59). This is a stark metaphor that stresses a sense of profound division between very different cultures, but it is also deeply structural; just as many of the reforms introduced to encourage joint working have proved. This suggests that the primary solution to the issue of joint working is structural in nature and many of the reform efforts since this time have focused on structure over agency. Over the New Labour governments we saw a range of different policies and incentives introduced to encourage health and social care agencies to work together more closely (11). Although with the election of the Coalition government the terminology changed from partnership to integration, this new government retains a focus on joint working between health and social care. This focus has become particularly pronounced through the work of the Future Forum and its focus on integration (7;8). The rationale often given for this interest in joint working is that it is seen as a driver of quality, efficiency and effectiveness of services, although the evidence base to support these types of assumptions is relatively weak as we will discuss in more detail below (15).

Over the last twenty years or so commissioning has also become an important lever in the reform of the English public sector although it has been rejected by the devolved nations of Scotland and Wales. Figure 1 provides an illustration of an example of a commissioning cycle and the range of activities that this is typically thought to encompass. However, as Bovaird et al (28) note, commissioning cycles are not always conceptualised in the same ways in health and social care. For example, the Department for Communities and Local Government do not separate out the commissioning and provision of services as different activities in quite the way that the Department of Health does. Therefore different departments have different understandings of what commissioning is and this may obviously pose difficulties for organisations seeking to jointly commission services.

Figure 1. The Commissioning Cycle
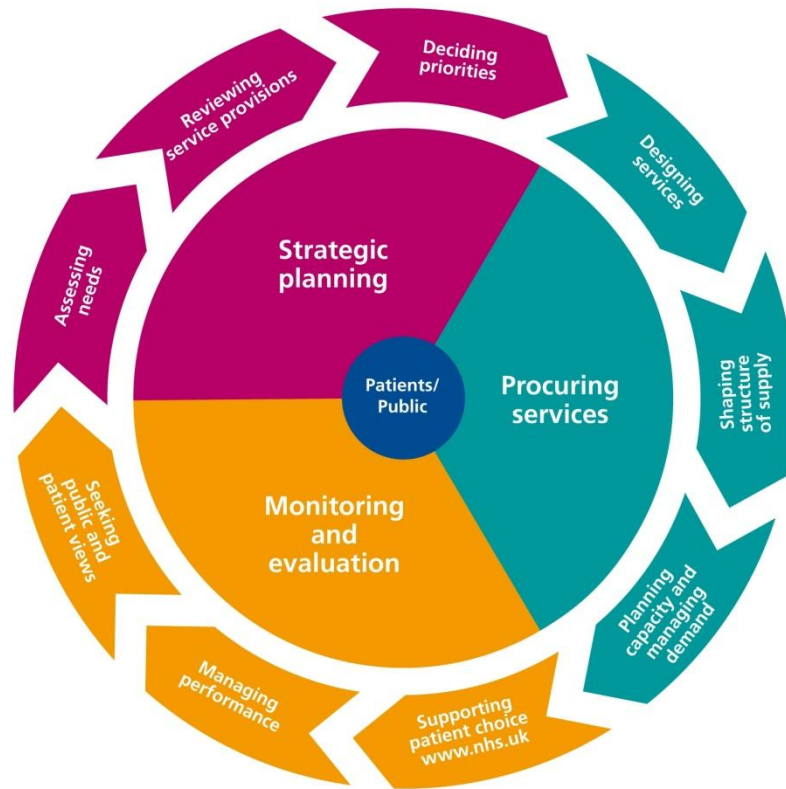
Since the introduction of the NHS market in 1991 (60), there has been a division within the NHS between the payers (initially referred to as 'purchasers' and now termed 'commissioners') and the providers. Allen *et al* (61) chart how there has been regular reform of the payer (or demand) side of the NHS, with major organisational reform taking place in 1991 (following the creation of Health Authorities and GP fund-holders); 1996 (following the merger of Family Health Service Authorities); 2002 (following the abolition of Health Authorities and creation of Strategic Health Authorities and PCTs); 2006 (following the mergers of SHAs, mergers of PCTs) and more recently with future plans to abolish PCTs and devolve commissioning further to Clinical Commissioning Groups (2). Some commentators have argued that there is little evidence that commissioning has delivered much in terms of the impacts promised of it (28), but one of the primary implications of this periodic organisational turmoil is that it makes it very difficult for NHS commissioners to prove effective (62;63). The lack of effectiveness surrounding NHS commissioning has, amongst

other things, been cited as due to the difficulties faced by PCTs (and their predecessors) in developing and sustaining necessary relationships with partners (64). Health and social care services today have a wider range of provider services across different sectors (public, private and third) than we have previously faced since the establishment of the welfare state. The impact of the Transforming Community Services programme and other changes has meant that commissioners are faced with a more fragmented system than ever before and joint commissioning may be seen as one way to address this, combining the reform agendas of joint working and commissioning.

Thinking specifically about joint commissioning now, although the terminology has changed over time, various means and mechanisms have been brought about under the guise of this concept. In the 1970s there were Joint Consultative Committees and Joint Planning Groups; then in the 1990s joint commissioning was brought into the public service lexicon by the Conservative government (3) and more recently these types of arrangements have been referred to under the guise of strategic – or 'place-based' commissioning. Although the need for joint commissioning has remained constant since the 1970s, the amount of interest paid to this agenda has also varied over time. Joint commissioning received a degree of attention in the mid-late nineties, but this faded away to a certain extent with the advent of Primary Care Groups (PCGs) and then Primary Care Trusts. In the last few years joint commissioning has arguably come to the forefront of policy again, particularly with the legal requirement that local areas produce a joint strategic needs assessment and the importance that has been placed on outcomes-based commissioning (65). The 2010 NHS White Paper (2) has since outlined new commissioning responsibilities again, but has not diluted the need for joint commissioning, with the Coalition government arguing:

> *"The arrangements for joint planning between the NHS and social care must remain…joint working and commissioning between PCTs and Local Authorities will be of increased importance to deliver better outcomes for patients, service users and their carers" (66: p. 6)*

Joint commissioning is therefore seen as an important component of local health and well-being services and is closely tied to notions of better outcomes for individuals. Yet it is not always clear what joint commissioning means, or how it should be operationalised in practice. To summarise in short, joint commissioning is concerned with the ways in which relevant organizations might work together and with their communities to make the best use of limited resources in the design and delivery of services and improve outcomes. However, given that this is potentially a wide aim, there is a lot of elasticity in terms of what joint commissioning actually is and discussions surrounding the meaning, purpose and impact of joint commissioning make for an increasingly complex and confusing debate (57;67). In attempting to define this

concept Rummery and Glendinning (68) state that "there is no universally agreed definition of joint commissioning; the term can cover a wide range of activities" (pg. 18). Williams and Sullivan (69) go further than this arguing that joint commissioning does not actually have a single meaning, but that several communities of meaning co-exist and each aims to deliver different types of outcomes.

What is implicit in the account we have set out so far is one of the primary functions of commissioning: how decisions are made in public services and how scare resources are rationed. One of the primary drivers of the separation of provision and commissioning (purchaser) functions alluded to in our policy account has been a desire to drive efficiencies through the uncoupling of these roles (70). Commissioners are charged with deciding what the needs of the local population are and then determining what services should be provided and by whom. The setting of priorities and rationing of scare resources is therefore a primary role of commissioners (71). One of the perceived benefits of joint commissioning is therefore the consolidation of health and social care commissioning into one approach. Pulling together health and social care commissioning over an area should bring not just an enlarged budget but also the skills and expertise of two sets of commissioners. As we see in the next section these functions may operate at a range of different levels, but ultimately the concern here will be with how to set priorities and ration health and social care resources for a particular geographical/service area.

2.5 Structures, practices and processes of joint commissioning

Given that joint commissioning lacks clarity in terms of a definition, in this section we set out some of the structures, practices and processes that have been associated with joint commissioning in order to demonstrate some of the types of activities that have been operationalised in relation to this concept. We start by exploring some of the scales that joint commissioning might operate on and then move on to cover some of the different structures, practices and processes that have been introduced under the banner of joint commissioning.

2.5.1 Scales of joint commissioning

Some of the items included in the literature review attempted to form some sort of typology of joint commissioning in order to differentiate the concept in some way. Greig (72) distinguishes between joint commissioning at a strategic and an operational level, where the former relates to planning and the latter to the everyday running of services and organisations. Rummery (34) goes slightly further in her differentiation, identifying three different levels of joint commissioning in primary care:

- *Locality based* – the commissioning of health and social care services in a particular area;

- *Practice-based* – the commissioning of some health and social care services in a practice or groups of practices; and,

- *Individual-based* – commissioning of services for individuals often through some sort of care manager.

Rummery explains that from her research it is the latter type of commissioning which appears to be most common in practice. This framework is somewhat similar to Hudson's (46) distinction between geographical, team and individual commissioning levels. Williams and Sullivan (69) similarly differentiate between different types of integrated arrangements (which involve joint commissioning) on the basis of scale including case studies at the levels of:

- *Specialised service integration* – for a particular user group;

- *Locality or community-based integration* – for a defined local community area; and,

- *Whole systems change* – redesign of health and social care services over a wide geographical area.

The Office for Public Management (73) however, goes further, citing five levels, suggesting 'the range of different levels of commissioning can be broadly categorised as national, regional, strategic, operational and individual' (pg. 18).

What is clear from these attempts to differentiate between different scales of joint commissioning in its broadest sense is that it can encompass the full range of activities from a strategic dimension through to more operational issues. Joint commissioning is not simply about the planning of a system and issues in relation to the procurement of services but also involves issues relating to their delivery. This image of the commissioning function resonates with Wade et al's (74) portrayal of commissioning as comprising the 'brain', 'conscience' and 'eyes and ears'. According to this analysis, the key roles for health and social care commissioners are:

- *Conscience* – setting out 'how things should be' – what the system aims to achieve and how;

- *Eyes and ears* – observing and reporting on 'how things are' – what the system is currently delivering; and,

- *Brain* (having processed information from both sources) identifying and implementing the optimal solutions for delivering stated objectives (pg.3).

This more nuanced account of commissioning suggests that it comprises a range of activities which may need to take place at different scales. What this also suggests is that it is difficult to differentiate what is meant by joint commissioning from more traditional or single-agency commissioning, given that this incorporates more strategic elements that will likely require input or collaboration from wider partners.

2.5.2 Structures of joint commissioning

Despite there being few items identified in the literature search that deal directly with the issue of the definition of joint commissioning, a burgeoning literature has emerged that focuses on the structures of joint commissioning. Typically such pieces describe how integrated structures have been created and the factors that have helped and hindered the process. Often the types of facilitators and barriers of these working relationships look very much like those associated with the more general literatures relating to joint working more broadly (e.g. professional identity, professional accountability, governance frameworks etc.). Within these accounts there is some debate concerning whether effective joint commissioning is as a result of the right kind of 'structures' being put in place, or whether it is more to do with the degree of human 'agency' that actors display in overcoming some of the barriers associated with its delivery (75). As we suggested earlier, many of the Labour government's efforts to encourage greater joint working in general across health and social care focused on introducing new and different types of structural arrangements in order to overcome the "Berlin Wall". Indeed, the history of joint commissioning (and joint working more generally) is one that has become increasingly formalised in terms of structures over time.

As Greig (55) outlines, the Joint Consultative Committees and Joint Planning Groups of the 1970s were statutory bodies largely driven by the need to plan for health and social care services in their area to overcome issues of organisational fragmentation. Following the election of New Labour there was an attempt to shift joint commissioning away from its earlier 'planning' focus through to a more active role where partnerships were involved in "agreeing a joint strategy through jointly agreed resources" (pg. 27). After this point, joint commissioning began to feel more action-oriented than the previous planning efforts, although in practice there was still little advice over *how* joint commissioning should be achieved in practice (76). Thus, arguably as central government's acceptance of the need for health and social care agencies to collaborate has increased over time and local areas have been compelled to work together more closely, increasing numbers of formalised structural types have emerged that might facilitate these types of working arrangements.

Probably the most formalised of all these types of structural arrangements is that of care trusts. Care trusts were originally proposed in *The NHS Plan* (77) as a vehicle for delivering and/or commissioning integrated health and

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social care. As NHS bodies, they would have delegated authority from local authorities for social care, and would have increased representation of local authority elected members on their boards to ensure democratic involvement in their governance (78). The NHS Plan generally envisaged their establishment in areas where there was joint agreement about care trusts as a beneficial organisational model. However, there was also a threat that they could be imposed in areas where effective partnership was not in evidence. The hope was that bringing together health and social care practitioners, managers and commissioners into a single organisation would lead to "tailored and integrated care, greater accessibility, and one stop shops for services that used to entail repeated conversations and a procession of different faces at times of illness, stress and vulnerability" (79: pg. 1). There would be better career opportunities for staff, and engagement with health and social care practitioners in developing and implementing care pathways that would enable people to be successfully transferred from acute care into the community. Single IT systems could also be developed with benefits both in relation to patient information and performance management. Whilst they could be introduced in any area, it was envisaged that they would lend themselves more readily to communities with co-terminous boundaries between the local authority and primary care trust and/or to services for people with mental health difficulties.

As this brief overview of care trusts suggests, it is not a coherent model of commissioning, or indeed provision, and as Greig and Poxton (72) note:

> "*The care trust term is to cover all possible combinations of commissioning providing for any or all client groups or service mixes. Thus a care trust in one place may be concerned solely with commissioning and purchasing older peoples' services, in another be a learning disability provider and in another cover all NHS and social services commissioning as well as social services provision and NHS provision in mental health, learning disability, older people and community health*" (pg. 37).

Therefore there is not one simple model of care trust and in practice they cover different types of client groups and functions (80). Similarly, there are a number of different types of Joint Commissioning Units and Health and Wellbeing Partnerships (52) that have been set up across England, that have some aspects of joint commissioning responsibilities although again these vary across the different types of arrangements in these localities. In summary then, evidence generated from the literature suggests that there is not a specific set of organisational structures that are associated with joint commissioning and these may vary at the local level depending on priorities, client group or population.

2.5.3 Practices and processes of joint commissioning

As we have seen in the previous section, although a number of structures have been introduced to facilitate joint commissioning there is no one particular model that exemplifies these types of arrangements. In this section we think about the types of practices and processes that have been used to make joint commissioning happen within health and social care organisations.

One of the major facilitators of joint commissioning was introduced in the Health Act of 1999. The legislative freedoms known as Section 31 and latterly Section 75 'flexibilities' were introduced as a means of overcoming some of the barriers to joint working. These flexibilities allowed health and social care organisations for the first time (legally at least) to pool budgets, appoint a lead commissioner and set up integrated provider services. Organisations could use one or all of these flexibilities in practice, and a national evaluation found that pooled budgets were the most popular option (81), albeit that a later study found that pooled budgets only accounted for about 3.4% of total health and social care expenditure (82). Given that one of the challenges associated with the fragmentation of services is the incentive to 'cost-shunt' between partners, much of the focus of joint commissioning has seemingly related to issues of finance. By pooling budgets across health and social care it is hoped that these types of debates should be consigned to the past; i.e. there will no longer be incentives for health and social care agencies to 'cost-shunt' to their partner and therefore make it difficult for service users to access care. It is also argued that single agency models of commissioning provide little incentive for social care or primary and community care to invest in services that they will see few returns on (58). As part of a joined-up approach to commissioning, partners might agree to invest in preventative low-level services that aim to save money on expensive acute medical services in the future. Whereas in the past, social care might traditionally commission and fund these activities, PCTs might agree to invest in these services as a way to prevent admissions to acute or institutional care settings. Similarly, local authorities might invest in PCT intermediate care services as a means to reintroduce individuals into the community after a hospital stay rather than having to access residential care (83).

Aside from the tendencies to use aspects of Section 75 flexibilities and an attempt to guard against cost-shunting between partners, there is little else in terms of the practices and process identified in the joint commissioning literature that is shared across a number of the examples of these types of arrangements. In Table 4 we have presented some of the array of examples of joint commissioning that we came across as part of the literature review process. These examples were selected purely as they illustrate the full range of scales, structures and processes of joint commissioning that appear within the literature. Thus, this table is intended to demonstrate the range of different types of joint commissioning

arrangements that are set out in the literature, but it is not exhaustive of the literature. It is important to note that not all of these projects exist today and many are a snapshot of policies from a particular point in time. Many of the types of processes and practices cited relate to issues such as encouraging staff from partner agencies to develop shared visions or cultures, helping professionals to better understand one another and their values, co-locating teams and finding more effective ways for professionals to communicate and share information. Again it is worth noting that none of these sorts of factors are specific to joint commissioning and are found in the more general literature on joint working (11).

2.6 What should joint commissioning achieve?

So far in this chapter we have tried to explore the range of ways in which joint commissioning has been defined and also the many different types of structures, practices and processes which have been subsumed under this label. We argue that these sorts of issues are broadly concerned with how partners work together in terms of joint commissioning, but say little about the difference that this makes in terms of services delivered or whether this impacts on service user outcomes. However, given the variety of different structures, practices and processes that exist to facilitate joint commissioning then it is difficult to be definitive about the impacts of joint commissioning as it is likely that these different types of arrangements are seeking to deliver different types of impacts. This challenge is compounded by the fact that the wider literature on health and social care collaboration is rather silent about the issue of the types of outcomes that it delivers and tends to focus much more on issues of process (15).

Table 4. Examples of joint commissioning processes and practices identified from literature review

Scale	Structure	Examples uncovered in review	Overview of arrangements and examples of processes and practices
Strategic	Joint Commissioning Board	Somerset Social Care Trust (84)	Integration of mental health service involving Somerset county council and Somerset health authority to form Somerset Partnership Health and Social Care Trust. Process involved creation of a Joint Commissioning Board which service users and carers were also a member of and establishing integrated provision. The aims of this initiative were: to introduce locality management arrangements; to integrate care management; and to co-locate staff.
	Joint Commissioning Unit	Oxfordshire County Council and PCT (52)	Resources pooled from county council and PCT budgets using section 31 agreement for a pooled budget and lead commissioning arrangements to purchase bed-based services for older people. Resources for adults with physical disability also included once fully operational. Agreement put in place where details of operational management, governance, performance management, exit strategies and reporting arrangements are all clearly defined. External support engaged to allow partners to identify any issues regarding joint working at various points in the process.
	Partnership	Southwark and Lambeth (85)	These London boroughs jointly commissioned a housing support service. Discussions centred on how commissioning process should be handled, i.e. through concurrent contracts or a sole contract and a service level agreement. Work done to think about how administrative costs supported and how

Locality	Partnership		
			performance managed. Tension between this sub-regional commissioning process and move towards local commissioning in health.
		Hartlepool Connected Care (86)	Partnership between residents, councillors, Turning Point and NHS to commission services for complex needs in deprived areas. Pilot based on one of most deprived wards in country where public services increasingly fragmented and perceived to have little impact. Aim of project to establish a ward-based budget which could be better spent. Work done in number of areas including: developing governance arrangements; audit of the difficulties and ambitions of local residents; audit of resources currently in use; evaluation; audit tool; and, development of service specification and commissioning new services.
		Easington (87)	Easington joint commissioning management group commissions all health and social care services for the locality. General Practice commissioning group elects senior GP who plans and commissions services in locality with community health council, social services and local advocacy group. Group joint financed pilot innovations that are then replicated across the locality.
		Bromsgrove Total Purchasing Pilot (87)	Four total purchasing practices collaborated with social services department to fund four care managers, and respite care services for their practice which covers the population of Bromsgrove. The care managers assess need and purchase social services for older people and also refer other client groups to relevant social work teams. Also purchased four respite beds that can be accessed by practice mangers and paid for by social services if need is "social" and not health.

			Social worker manager oversees social care budget and can resolve issues over funding of patients quickly.
		Sedgefield Integrated Team (47)	PCT came together with district and borough councils to establish five locality-based, co-located front line teams each comprising social workers, district nurses and housing officers. Resources between social services and PCTs pooled, single line management introduced in teams and local partnership boards introduced to oversee the new arrangements.
		Knowsley Borough Council and PCT (88)	Developed joint working by sharing objectives, targets, and performance indicators and co-location. Retain own staff terms and conditions and professional accountabilities but have shared responsibilities in meeting targets.
	Practice Based Commissioning	Arley (87)	Joint commissioning project between a GP Practice and Health Authority. GP practice commissions intensive home care and respite services (provided by a local trust) to prevent unnecessary hospital discharge and support early discharge. Services managed by nursing manager and can be accessed by anyone in the primary health care team (including a practice-attached social worker who is partly funded by joint finance).
Individual	Extended fundholding	Malmesbury (87)	GP Practice extended fundholding to mental health services. Integrated teams of social workers, occupational therapists and district nurses carry out assessment and care management for older people. Health members of team can assess needs and purchase services using social services budget and vice versa.

Given that joint commissioning is such a "broad and malleable concept that it can legitimately mean different things to different people" (89;cited in 90: pg. 18), rather than attempting to interrogate a rather limited literature which does not deal in any systematic way with the issue of outcomes, we adopt an interpretive approach to investigate the various claims that are made for joint commissioning, based on different understandings about what it means and what it should achieve in practice. Such an approach follows the previous work of Dickinson (26) and Williams and Sullivan (69) which both adopt an interpretive approach to understanding the concept of collaboration more generally. In doing so we move away from treating joint commissioning as an overly-rational tool of policy. What this means is that instead of treating joint commissioning as a simple means-ends tool, we seek to explore the additional work that this concept might do beyond those which are articulated by their makers (i.e. policy makers and senior leaders of health and social care agencies). In employing this process of analysis it is possible to surface three different ways in which joint commissioning is discussed in the literature: prevention, empowerment and efficiency.

2.6.1 Interpretive analysis: making sense of joint commissioning

Given that we have argued that joint commissioning is not a coherent entity within the peer-review or wider literatures, then a traditional approach to the analysis of this literature would arguably reveal little beyond the need for more research. As we set out in the previous chapter, through this research we sought to conceptualise the relationships between joint commissioning arrangements, services and outcomes and then seek empirical data that would tell us about the veracity of these hypothesised relationships. Therefore, through the literature review we sought to surface the range of ways in which the links between joint commissioning practices and processes operate and the impacts that this should have on services and service users. By extracting the different meanings given to joint commissioning within these literatures we could then start to construct some of the types of programme theories (91) (also known as programme logics 92; theory-of-action 93; intervention logics 94) which are essentially the causal links between inputs, activities and a chain of intended or observed outcomes. We say more about the specifics of the theory-based approach adopted in this research in the next chapter. Here we briefly reflect on the nature of interpretive analysis and its role in the field of policy.

The focus of mainstream policy analysis has arguably tended to be on generating rigorous quantitative data, objectively separating facts and values and searching for generalisable findings which have validity outside of the social context they were forged in (95). In this sense, policy analysis has often been seen as a 'rational model' that might inform decision-making - or as Stone (96) terms this, the "rationality project". Postpositivist approaches reject the notion of "traditional scientific principles" and the idea

that a unified understanding of scientific methodology can be applied to all research questions (97). Everyday life is understood as embedded in social and cultural meaning which is produced (and reproduced) by discursive practices which are outside of actors' choosing or making (98). An interpretive approach recognises that the social world is not fixed and objective but is framed through discourses of actors. Interpretive approaches argue that it is important that we consider socio-cultural processes with the analysis of policy and the way that individuals make sense of their every day lived experience. Fischer (98: p. 49) argues that 'rather than seeking proofs through formal logic and empirical examination, the investigation of social action requires the use of metaphoric processes that pull together and connect different experiences based on perceived similarities'. Through the literature review we therefore sought to identify a series of discourses which frame joint commissioning in slightly different ways in terms of the problem that joint commissioning is attempting to address, the types of activities that it seeks to do this through and the impacts that this should have in practice.

In conducting the analysis of the items identified through the literature review, a summary of each document was made using a standardised proforma to examine the aims and aspirations of joint commissioning and the activities engaged with in order to deliver this. Once all the items had been coded in this way we drew together the themes in order to identify the different "interpretive communities" (99: pg. 20). In keeping with the goals of an interpretive approach to surface implicit meaning, it is possible to see how despite a common reference that joint commissioning should lead to 'service improvement' in a general sense, there were differences in the language, objects and acts used to describe how joint commissioning is actually done. Through subsequent iterations of the consolidation of the various activities and themes, we identified three different ways that the literature frames joint commissioning, each of which is constituted by different uses of language, processes and practices used to implement and communicate policy (Table 5). This section now turns to describing each of these different discourses and their inherently different ways of seeing and doing joint commissioning in more detail.

Table 5. Discourses of joint commissioning identified through literature search

	Joint Commissioning as Prevention	Joint Commissioning as Empowerment	Joint Commissioning as Efficiency
What joint commissioning should achieve	Deliver preventative services through early intervention. This should in turn reduce inequalities, improve the quality of services and make services more accessible.	This should involve patients, service users and carers in the co-production of services. A user-led approach to care should be adopted that promotes self-care and in doing so transforms health and social care away from being professionally-led.	What is important is improving efficiency and reducing waste and duplication in health and social care services. In turn this should also improve access and performance of services.
Organisational processes to promote joint commissioning	Service re-design is important here and thinking about the needs of individuals and providing services around these. A key role for the alignment of strategies and budgets and the development of care pathways.	Personalisation of services plays an important role here with service users being given budgets with which to determine their own care. Fairness, inclusion and respect should be at the heart of all processes.	Increasing the number of providers that are available to health and social care commissioners will give more choice and competition. Greater freedoms and flexibilities for providers and the freedom to innovate should be supported by incentive-based reward, and quality will be assured through inspection.
Organisational practices that support joint commissioning	The focus here is around commissioning practices and making full use of the Joint Strategic Needs Assessment to identify gaps in need.	What is important is how we work with service users and carers and the management of complex relationships. Workforce development and training may help with this.	More effective management of information may help to identify waste. What is important is the relationship with providers of care and how these are contracted with and performance managed.

2.6.2 Joint Commissioning as prevention

The first discourse refers to joint commissioning in the context of prevention and early intervention. The purpose of joint commissioning then is around health improvement through the reduction of inequalities. Common to this way of seeing joint commissioning is a focus on improving the 'quality' of service provision as a basis for improving the health and well-being of populations (e.g. 1;100;101). The view that joint commissioning offers a means of prevention and early intervention is evident in policy documents which talk about organisations needing to work together to promote health and reduce inequalities by improving the quality and accessibility of services (1;100;102). For instance, in a service review of the joint commissioning of drug treatment services which noted a wide variation in quality, the former National Drug Treatment Agency talks about the need to "improve the health and well-being of service users and their families and…reduc[e] crime related to their substance misuse" (101: pg. 3). Similarly, in the *Commissioning framework for health and well-being* the focus is on "involving the community to provide services that meet their needs, beyond just treating them when they are ill but also keeping them healthy and independent" (1: pg. 7).

The use of the joint strategic needs assessment for the local area is crucial in informing where the gaps are in terms of local provision and needs, and care pathways can be designed to address these. Policy programmes which have the prevention of ill-health and early intervention at their heart tend to allude to the notion of 'service re-design' as a means of achieving policy goals. This is premised on a belief that inequalities in service provision can be addressed by finding ways of improving how services are delivered (1;102). In noting the tendency for "a small number of people to incur extremely high cost"' in health and social care provision, the Birmingham Total Place Pilot suggests that the total public expenditure could be re-aligned by moving away from separate strategies and financial plans towards financial planning with longer term investment in mind (103: pg. 7). Similarly, in the context of children's services, there is an emphasis on commissioners working together to commission children's services to "ensure that children and young people's services meet population requirements and address health inequalities" (104: pg. 12).

The focus on prevention and early intervention is driven by efforts to identify gaps in service provision through the better management of commissioning practices such as joint strategic needs assessment and the development of care pathways. The sorts of practices that are referred to include health needs assessment and performance management devices (i.e. self assessment toolkits). For instance, the National Treatment Agency for Substance Misuse, suggests that energy is invested *through improving the efforts of local drug partnerships* to improve their "commissioning management"; (that is how services are planned, procured and managed)

and harm reduction serviced (which reduces the risk of blood borne viruses) *and through health needs assessment* and the development of indicators to assess the effectiveness of commissioning (100: pg. 5). Implicit within these are commissioner practices to better understand the complexities of care pathways for their client group, in ensuring they are better able to pin-point where there might be gaps in needs so that resources can be focused on the needs of client groups.

2.6.3 Joint commissioning as empowerment

In contrast to the first discourse with its focus on organisation-led service change, the second sees the purpose of joint commissioning in the context of user-led service change based around the promotion of self care (85;88;105). Here, language tends to focus on meeting the needs of service users and carers through the co-production of their own care and the empowerment that this should bring. This involves a fundamental shift in power relationships from paternalistic services to ones truly driven by service users. Here, the language in policy documents appears to centre on adopting a more 'user-led' approach to joint commissioning based around involving patients, service users and carers' in the co-production of services (88;105). For instance, in the *Working Together for Change* policy (101) this is expressed in terms of transforming adult social care away from professionally-led service delivery towards a user-led model which involves the design, commissioning and evaluation of individual services. Such an approach is bound up in the core values of the personalisation agenda where "the services people use are based on their circumstances, need, preference and desired outcomes" (106: pg. 5).   The idea here is that "if service users are able to direct their support in a truly personalised way then joint commissioning is needed to effectively manage markets and provide the support that these micro commissioners need".

In reviewing the key activities in commissioning social care, the Care Services Improvement Partnership defines effective commissioning as "care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all sections of society" (107: pg. 11). This is also picked up in some of the earlier practice-based literature which notes how the advent of partnerships brought with it a focus on the inclusion of service users, carers and a much wider range of agency partners (43). This shift in focus towards service users/ carers also highlights the importance of the commissioning cycle as a policy tool in managing a mixed economy of care. Here, government documents highlight the importance of the commissioning cycle in responding flexibly to changes in the "demographic and epidemiological" service needs of a population over time (108: pg. 2). From the perspective of an empowerment approach then, an important policy object involves the commissioning cycle in 'driving service change' and ensuring that care packages are responsive to need (105). This is in stark contrast to the preventative discourse which relies on health

needs assessment as a means of assessing individual needs, resources, markets and services available.

In terms of the practices associated with this discourse there is a noticeable shift in emphasis towards the importance of partnerships in managing the "complex inter-relationships between the varying roles, responsibilities, resources and traditions of the many agencies involved in delivering health and social care services" (43: pg. 193). Gostick also talks about the value of partnerships in "managing a mixed economy of care" (43: pg. 196). But the emphasis here is on partnerships between agencies, service users and their carers "so that services fit around the service user and the transformation that needs to take place". This is most keenly expressed in the *Working to Put People First* strategy (88: pg. 1) which talks about "putting choice and control into the hands of people who use adult social care". This focus on partnership with service users implies a need to develop the capacity of the workforce in ensuring that staff have the right skills to work in a collaborative way. Hence, the focus of the *Working Together for Change* (105) policy highlights the need for effective leadership and workforce development in supporting staff from a range of backgrounds to adapt to a more complex and personalised joint commissioning environment.

2.6.4 Joint commissioning as efficiency

This third discourse frames joint commissioning in the context of efficiency. Here, language is rooted in a concern to meet the rising expectations from the public and improve access to health and social care services by increasing choice and control. There is a tendency here to focus on increasing the range of alternative providers to give service users choice and drive competition. Concern about reduced waiting times and high quality care centred on patients is premised on beliefs that in the past, hospitals and providers have taken for granted the funding they have received, irrespective of clinical performance or the quality of outcomes produced (109). Implicit within this way of seeing joint commissioning, is the need to provide patients and people with more choice and control over their health and care and clinical staff with the means to meet these rising expectations. For staff this is expressed in the notion of greater freedoms and flexibilities in an attempt to improve "clinical services and productivity" (109: pg. 6). Interestingly, such notions of 'efficiency' also express the full weight of the marketisation of health and social care provision by promoting the concept of 'choice', not in terms of patient choice, but in the context of seeking a 'wider range of providers', and their measurable performance in delivering outcomes. This is in direct contrast to the discourse of prevention (where choice refers to patient choice about service delivery) or empowerment (in ensuring services are more user-led). Here, increasing patient 'choice' appears to mean 'opening up the market' to a greater range of alternative providers.

The means of achieving such increased choice is perhaps most keenly reflected in the government document *Creating a patient-led NHS: Delivering the NHS Improvement Plan* (110). Here the means of improving such 'access' lies with a complete overhaul of the way in which health and social care services are expressed at the point of delivery. Such reform is a central component of the *NHS Plan* (77) and *NHS Reform* (109) which specifically, proposed four work-streams to implement demand side reforms; supply side reforms, transactional reforms and systems management. These four 'streams' of improvement are described as:

> *"more choice and a much stronger voice for patients (demand-side reforms); more diverse providers, with more freedom to innovate and improve services (supply-side reforms); money following the patients, rewarding the best and most efficient, giving others the incentive to improve (transactional reforms); system management and decision making to support quality, safety, fairness, equity and value for money (system management reforms)"* (109: pg. 5).

This linking of payments to patient experience and health outcomes is part of the drive to incentivise better clinical performance. Better management of information is also seen as key in ensuring that the goals of joint commissioning (in terms of integrating services, reducing duplication and waste and reducing waiting times) are all met in a satisfactory way (111;112).

2.7 Chapter Summary

In this chapter we have sought to set out an account of the literature underpinning the concept of joint commissioning. We have demonstrated that this is not based on clear and high quality research evidence, but instead largely a series of opinion pieces and government documents. The term joint commissioning itself is rarely defined or used in a way that might distinguish it from more general concepts of either commissioning or joint working. Further, we have illustrated the wide array of different structures, processes and activities that are associated with this concept. Joint commissioning, therefore, is not a simple or coherent model. Despite being frequently promulgated by central government and local organisations as a way of improving services and outcomes for service users there is little empirical evidence to support these assertions. In this chapter we have employed an interpretive approach to demonstrate that there are at least three different discourses of joint commissioning in the wider literature that outline an underlying theory or rationale of what this is and the types of practices that might be associated with this way of working.

Therefore this research project seeks to investigate the reality of joint commissioning in more detail and examine the degree to which the notions of joint commissioning set out in the wider literature are present within local practice. This should allow us both to map out the relationships between

joint commissioning arrangements, services and outcomes in the minds of key stakeholders at a local level, and identify data that we might use to test the veracity of these relationships. If multiple theories are identified at the case study sites then this allows the opportunity to test how comfortably these co-exist in practice. For example, there are likely to be tensions between the user focus of the empowerment discourse and the technical orientation of the prevention discourse. We suggest that in practice meanings of joint commissioning are likely to conflict and local conditions will result in one prevailing over others. Local conditions offer a very important counter to the direction of the discussion up to this point. As we have indicated, our analysis has concentrated on the discourses in operation amongst the policy elite. Not accounted for in this analysis so far is what happens to joint commissioning and how it is interpreted when local professionals, managers, practitioners and service users are engaged.   As we go on to set out in the next chapter, capturing these other voices is a key component of this research project.

3 Methodology

3.1 Introduction

In this chapter we set out an account of the methodology employed in this project for exploring joint commissioning in five localities. The purpose of this exploration was to gain a better understanding of the types of ways in which individuals and groups define joint commissioning, what sorts of organisational processes and practices are associated with this way of working and the types of impacts that are aspired to and demonstrated in practice. The broad approach we adopt to the research is theory-led in nature, seeking to surface the range of meanings and understandings of joint commissioning within a range of locales. As we outline in this chapter we adopted a two-phased approach to the research, employing the POETQ tool in the first phase and undertaking in-depth qualitative data collection with staff and service users in the second. In the first sections of this chapter we set out the approach to the research design in more detail, explaining the rationale for the phased approach to the research and how we went about selecting the case study sites for the research. We then go on to set out detail of the two phases of research and the specific activities undertaken at the case study sites.

3.2 Surfacing programme theories and meaning

As we noted in the introduction, researching joint working is not a straightforward task as a number of those who have attempted to do this have attested (10;15;16;113). If we are seeking to measure the effectiveness of joint working in its entirety then this involves being able to capture information about both the processes of collaboration and also the impacts that this produces in terms of changes to services and subsequently service user outcomes. This is a challenging process given that collaborative initiatives often take place in complex environments, involving a range of different stakeholders who, as we have seen in the previous chapter, may not always have the same opinions about what that joint endeavour is supposed to achieve in practice. A lack of clarity over what outcomes joint commissioning should achieve in practice makes it very difficult to research employing traditional method-led approaches; this in turn has led some to suggest that theory-led approaches may be more suited to researching collaborative endeavours (6;114;115).

Method-led approaches aim to refine the use of particular methods in the aim that this should reveal insight into particular initiatives. Such a perspective suggests that if we use the right method to investigate an issue or policy then we should be able to get to the truth. Theory-led approaches instead aim to map out the series of assumptions (or programme theories)

underpinning a particular initiative and then to test different aspects of this. So, for example, in the context of partnership working, a theory-based approach would map out what is happening in terms of efforts to work jointly, what impacts this is thought to produce in terms of partner agencies, services and outcomes. Once this has been mapped out then different aspects of this would be tested using a range of approaches. Thus, this is an approach to research which is seen as reconciling processes and outcomes (116). There are a range of different types of theory-led approaches to research, with realistic evaluation (18) and theories of change (117) probably being the best known. Our research is not based on either of these more popular approaches but is influenced by programme-theory (e.g. 118;119) as will be described further below.

As a first stage of this research we therefore sought to search for the many different types of meanings and assumptions about joint commissioning. As illustrated in Table 3 in the previous chapter, joint commissioning has typically been researched through method-led approaches, although many of the studies were lacking in rigorous accounts of their methodology. The approach to research adopted in this project is rather different to these more traditional approaches in the sense that it is informed by a theory-led approach that sought to understand the assumptions held about joint commissioning and what it should achieve in practice.

Having set out the broader methodological considerations of the research we now move on to consider the methods that we might employ to collect data. We argue that although there is an array of different ways in which we might gather data on joint working we can ascribe them to two main categories of approaches – bespoke and rapid. Bespoke approaches typically involve an external team of researchers or evaluators involved in ethnographic engagement, interviews, focus groups, documentary analysis etc. What is good about this type of approach is the level of engagement and ability to empathise with those involved in the research. The systematicity and comparability of these many possible types of approaches depends on the specifics of the methods adopted (15) and these approaches can often be quite expensive.

The alternative is the rapid approach and there are three recognised types of approaches here: toolkits, audits and guides (120). Guides include instructions and examples to guide partnership formation, toolkits provide activities to develop and advance existing relationships and audits provide a means to assess the effectiveness of partnerships and help monitor progress. Markwell's (120) review of some 40 toolkits, audits and guides marks a highpoint for partnership evaluations. Whilst these take different forms, they characteristically differ from the bespoke approach outlined above. Many are designed to be self-administered with an evaluator present as a facilitator and tend to focus on the view of a lone voice in the partnership. For example, three of the most widely used rapid approaches

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are The Partnership Assessment Tool (121), The Working Partnership (122) and the Partnership Readiness Framework (72).

However, several authors have expressed criticisms of these rapid approaches. These generally fall into four types of criticism, namely that these approaches are:

- Superficial (17);

- Normative in the sense that all collaborations should conform to particular ideals or standards and which are often implicit rather than explicit (15);

- Focused on process to the detriment of outcomes (14); and,

- Overly narrowly focused on what is considered performance, or success of joint working (123).

Born out of this critique are what could be labelled a second generation of 'rapid' approaches to partnership evaluation. What distinguishes these approaches is in part technological, given a greater utilisation of online survey tools, but is also very much methodological. Online methods allow for a move away from single voices of the partnership to multiple voices. There is also a move to focus on outcomes, or at least the priorities which collaborations are trying to achieve. Examples of these include Dickinson's (26) POET approach or more recently Ball *et al's* tool (124).

The Partnership Outcomes Evaluation Toolkit (114) was designed in line with a programme-theory approach where individuals are asked for their views on how effectively the partners work together and their assumptions regarding the outcomes that the partnership is aiming to achieve via an online survey. This data in itself is not summative in the sense that it is then used in further group settings in order to prompt dialogue and discussion regarding the meaning and purpose of that collaborative endeavour. This is modelled on a *strategic assessment approach* ('assumptional analysis') (125) that emphasises dialogue, and requires involvement of a wide range of stakeholders in group-based discussions to surface programme assumptions, rating their importance and the degree of certainty with which they are held to be correct. Groups make the case for the programme, identifying the key assumptions, followed by open dialectical debate, focusing on the assumptions which differ between groups. An attempt at synthesis is made, but if synthesis cannot be achieved points of disagreement are noted and implications discussed. However, as Dickinson (26) reports one of the major challenges of this approach was that participants found it difficult to articulate the service user outcomes that joint working was attempting to achieve. Participants were asked which outcomes they thought the collaborative endeavour was aiming

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to achieve but without any options to choose from, which proved very challenging for individuals in practice.

Rather than a theory-led methodology, Ball *et al* (124) adapted the Partnership Assessment Tool of Hudson and Hardy (113). Their tool seeks to measure processes, outcome priorities, and performance in the form of progress towards such priorities. The respondents are asked to score a series of indicators based on 12 process principles (for example to what extent the partnership is consensual or inclusive), and also 11 outcome priorities and performance indicators (e.g. 'minimising delayed discharge') and to what extent this objective has been met. In a summative sense the scoring makes it possible to allocate an average score for the partnership and allows for comparison between partnerships.

While it cannot be overlooked that the Ball *et al* (124) tool has potential to offer an 'objective' means to compare process, priorities and performance across partnership types, it has two critical shortcomings, one methodological and one technological. In the absence of theory, the methodological shortcoming is founded on a normative and idealised view of the nature of partnership working and does so by employing large-n survey techniques to relatively small groups. It begs the question; if 10 of the 20 people taking the survey indicate that the partnership is 'giving a role to the voluntary sector' what can be deduced? The partnership is 'performing well?' The partnership is engaging flexible and innovative individuals? Or for that matter, the partnership is performing irresponsibly engaging essentially private sector partners free of democratic accountability? The major shortcoming here is that it constrains us into thinking that there is only one way to do partnership.

Ball *et al's* (124) approach also reveals a technological shortcoming, or at least constraint. Advances in technology present new opportunities for engaging research respondents online rather than face to face, but there are limitations. Ball *et al* report their respondents took an average of 90 minutes to complete the online survey. Research into response rate quality of online surveys show significantly higher response rates where surveys are between 10 and 20 minutes compared with those 30 to 60 minutes (126, 30% and 18% respectively), and respondents are more likely to be willing to complete a survey of 10 minutes compared with that of 30 minutes (127). That is not to say actors are unable to engage in an online task for 90 minutes, rather careful consideration is required to make this an engaging experience.

In the context of the confusion surrounding the meaning of joint commissioning and the implications of this in terms of achieving better outcomes for service users, the aim of this research was to engage professionals, service users and carers involved in different joint commissioning arrangements around the country in exploring the implications, consequences and 'outcomes' of this way of working. However, this is not the kind of everyday discussion that professionals

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naturally find easy to engage with. Indeed, as argued in previous chapters, despite much talk about the importance of outcomes in policy and practice literature, articulating what people actually mean by the outcomes of joint commissioning can be extraordinarily difficult. As such, this research made use of both rapid and bespoke approaches in an attempt to investigate joint commissioning and was structured into two phases of research.

Broadly speaking, the first phase was designed to surface assumptions about what it is that joint commissioning is aiming to achieve in each of the sites. This first phase is a rapid approach facilitated by the use of an online tool known as POETQ (which is a development of Dickinson's original POET tool). The second phase is bespoke and essentially tests these desired outcomes with people who use services (both to see if they are the 'right' outcomes and to see the extent to which they are being met). That is, having established the perspectives of a wide range of stakeholders in the first phase of research, the second phase checks with the users of these services whether these are the types of outcomes which they perceive should be delivered, the degree to which they are being delivered and the value of joint commissioning to deliver them. Analysing the data retrieved through these two phases then allows us to identify and link specific practices, processes and outcomes of joint commissioning within the case study sites and make links across these sites.

3.3 Case Study selection

Five case study sites in total were selected for study in this project and we aimed to choose sites on the basis of their reputation in the field of joint commissioning. As we suggested in the previous chapters, to date a number of authors have questioned whether there is the evidence to link partnership working and/or joint commissioning to improved outcomes for service users (e.g. 15). In this project we sought to identify those sites which have been cited for their good practice in these areas to give us the best possible chance of making links between the practices, processes and outcomes of joint commissioning.

The proforma used in the literature search had a section which recorded where examples of good joint commissioning and/or partnership working were cited. These examples were collated once the literature review had been completed and we sought to test these examples against four key criteria:

- *Peer review* (sites which are cited as good practice examples in publications such as *Community Care* or the *Health Services Journal*, or are recognised as leading examples of partnership working by bodies such as the Association of Directors of Adult Social Services and the NHS Confederation);

- *Government* (sites quoted as good practice examples in official documents such as inspections or guidance produced by bodies such as the Integrated Care Network);

- *Users and carers* (sites recognised as good practice examples by service user and voluntary sector representatives on our advisory group); and,

- *Academic* (sites quoted as good practice examples in academic literature on partnership working).

In the original research design we had intended that sites would be included where they met at least three of these four criteria. This approach was informed by Borins (128), who demonstrates that studies of good practice can be undertaken in methodologically rigorous ways. These reduce the problems of 'self-reporting' and other forms of bias that can occur, especially in a policy environment where 'success' is a normative requirement (129). Given that joint commissioning does not take place according to one particular model we also sought to include a range of different approaches to joint commissioning from areas with different histories and local contexts. However, as we have argued in the previous chapter, there is a dearth of robust evidence from the peer review literature and therefore it was often this factor that was lacking.

From the literature search and in conjunction with our advisory group we identified 32 sites in all, that had been seen as examples of good practice in joint commissioning/partnership. The above filtering process was applied along with collection of local knowledge about these sites to check that joint commissioning was still in operation within the areas and this list was ultimately reduced down to a possible list of nine sites. Each site was initially approached informally to check out which may be interested in the research, able to participate and provide the level of commitment that would be required for the project. Of the nine sites, eight were willing to commit to the research, but shortly after the NHS White Paper *Equity and Excellence* (2) was published which proposed significant changes to the commissioning landscape. These political changes compounded the financial pressures that many areas were experiencing and at this stage three sites withdrew from the process, leaving five remaining sites. These sites were agreed with the advisory group for their variation in terms of types of joint commissioning arrangements, locations and contexts and were formally invited to participate in the research. However, as we will discuss further in more detail, the sites finally selected to participate in the research found that changes to health and social care services meant that they often found it difficult to fully participate in the research at times.

We now move on to set out the detail of the two phases of the research and the activities that were undertaken within these.

3.4 Phase One: POETQ

Our starting point for this research was to focus on outcomes and outcome priorities. In the health and social care environment this is associated with a hypothesis that joint commissioning leads to better outcomes for service users. As we have described above, rather than base a tool on this realist measure of performance we became interested in developing a tool that uses outcomes as a means of enquiry. This was motivated out of previous work on the POET application where respondents were able to describe structures and practices but found it difficult to engage with aspiration, normative or vision oriented questions (e.g. 26).   In search of an engaging means to discuss outcome aspirations we chose Q methodology as a means of mapping inter-subjectivities and incorporated this into the existing approach. In addition to building on POET, this also builds on related work within the research team where Q methodology is applied to evaluate and understand collaboration (130;131).

POETQ is a web-based resource designed to recognise the importance of both process (i.e. how well do partners work together) and outcome (i.e. does the partnership make any difference to those who use services). In this way, POETQ is both:

- *Formative* - it evaluates how well partners are working together, helps people to understand and make sense of their current context, and highlights both areas for celebration within the partnership as well as areas where development work is needed.

- *Summative* – it is evaluative in that it encourages participants to articulate the desired outcomes they are aiming to achieve and then in a subsequent process check out the degree to which the partnership is successful in achieving these aims.

The POETQ approach uses an online application of Q methodology to surface understandings about the outcomes of joint commissioning in health and social care. By applying it to multiple cases, it also allows for a degree of comparison. Essentially, a Q sort presents a series of statements that are designed to represent the range of debate on a topic in question. POETQ is designed to elicit understanding around outcomes of joint commissioning and includes a set of statements drawn from previous research into joint commissioning. Participants are sent a link to an online survey which essentially asks participants to rank statements in terms of agreement. With this approach, we are essentially asking one question – that is – what do you think that joint commissioning should achieve? Often when we ask this question in an interview or in a questionnaire it is possible to come up

with a long list of possible reasons. But seldom do we explore whether a group of actors working in a particular context have the same situation in mind. In this research we provided a range of common statements about joint commissioning and what this should achieve and forced (in the nicest possible way) participants to decide which they agreed and disagreed with, and more than this, which they agreed with the most. From these individual sorts we were able to identify groupings of individuals who speak about joint commissioning and what it is aiming to achieve in similar manners. By understanding different meanings this gives us an insight into the many ways in which individuals theorise the contribution of joint commissioning. Before we move on to give an overview of how these statements were identified we set out a brief account of Q methodology

3.4.1 Q Methodology

Q methodology was first developed as 'Q-Technique' by British born psychologist and physicist William Stephenson (132). Stephenson was interested in how statistics could help understand subjectivity, that is, perspectives or viewpoints on a topic. He imagined that the communication and debate surrounding any topic had a structure to it but up until then there was no systematic means of revealing this 'scientifically'. Stephenson proposed using factor analysis, but applied in an unconventional way. Conventional R factor analysis is employed to reveal latent structures operating within a group of traits (such as relationship between shoe sizes, height, gender, length of forearm), instead Stephenson proposed a Q factor analysis to explore if there is a structure operating within a group of people (i.e. person A's view compared with person B, C etc). To do this he had to find a way of comparing the viewpoint of one person with that of another. He proposed the best way to compare people's view on a topic is to first gather together a set of statements or other stimuli that describe the many and varied ways in which the topic is discussed and then ask a group of people to sort this set of statements into order of preference. Because everybody is sorting the same set, it is possible to compare their preferences statistically. Stephenson called the debate surrounding a topic the 'concourse', the technique of an inverted or by-persons factor analysis, 'Q factor analysis' to distinguish it from the conventional R factor and the technique of ranking of statements or other stimuli on a topic he called the 'Q sort' or 'Q sorting'. In a nutshell, Q methodology, or 'Q-method' as it is known to some, is the combination of a theory of concourse and two techniques – Q factor analysis and Q sorting.

Q methodology has found applications across a broad range of sectors and academic disciplines. In the 1960s Q was notably instrumental in the development of new forms of marketing, that considered different market segments and the most effective means to communicate and brand products. Following this books were published in the social sciences (133;134) and there are now several thousand published studies in the Q bibliography. Q is particularly useful for exploring highly contested or

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complex issues (135). It is used to understand how people define their interests in a policy issue or problem, establish criteria for evaluating policy alternatives, to understand attitudes towards a policy, and to recognise the value and efficiency of policies (136: pg. 405).

The potential of Q to reveal the subjective structure of debate surrounding a policy issue or initiative makes it well suited to policy and programme evaluation (133;137-142) and importantly, to conceptualise aspects of partnership working such as questions of democracy (131) or leadership (143). When applied within an organisational setting, Q can reveal how many shared viewpoints on a policy initiative are operating at any one time. It reveals where and over what points these viewpoints overlap and suggest points of greatest contention. Used in evaluation, Q challenges the evaluators to put aside preconceptions and stereotypes about how a particular professional or pay grade might think about a policy initiative. When applied across multiple sites, Q offers the grounds for statistical as well as qualitative comparison. When applied multiple times, Q enables change to be mapped (144). When applied alongside a large scale survey it allows evaluators to not only understand the structure of the debate, but also its reach (145).

The process of designing, administering and analysing a Q study consists of five phases.

1. **Capturing the debate** through literature review, conducting interviews or observation, systematic search, or facilitating debate;

2. **Representing the debate**, in the form of a 30-80 item set of statements, symbols, pictures, objects, sounds, and usually limited to a 30-80 item set;

3. **Q sorting** the set of items, recruiting a group of individuals engaged in the topic, instructed to rank order the items in the set, to produce a series of sorts for analysis, 40-60 is preferred (135) but smaller numbers are sufficient;

4. **Analysis** of the sorts, first by correlating each sort, employing factor analysis and selecting and rotating typically between 2 and 7 synthetic sorts that exemplify a clustering of viewpoints; and,

5. **Interpretation** of the selected factors (viewpoints) through careful examination of characteristic items, distinguishing items and qualitative information provided by the respondents that 'load on' or exemplify this view.

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In applying Q as an evaluation tool to understand outcome priorities, the process of capturing the debate involves collecting short statements that describe the diversity of views of what joint commissioning arrangements can or should achieve. The next stage involves employing a suitable sampling grid to narrow these to a set of statements for sorting by partnership members. The Q sorting involves recruiting a diverse sample of individuals working in and around a partnership arrangement and instructing them to rank sort the statements according the same condition of instruction, such as 'most agree-least agree'. The analysis involves importing the sorts into a software package, correlating and exploring a number of possible 'solutions', essentially deciding how many different shared viewpoints are present in the partnership arrangement. The interpretation strives to examine the character and distinctiveness of each viewpoint and draws on additional qualitative information given by the Q sorters aligning with and informing that viewpoint. Additionally, when the same statements are applied across several sites, it offers the opportunity to compare the findings using what is known as a second-order Q factor analysis.

Q sorts are traditionally administered in the form of an interview, in meeting rooms or classrooms, occasionally through postal survey and increasingly online. Improvements in computing graphics and ownership, and faster network connections make Q sorting online an attractive proposition for partnership evaluation. Applying this online allows respondents to sort in their own time at their desk or wirelessly on laptops and tablet computers. While the shift to faster processors, cloud computing and quicker internet connections makes online Q sorts increasingly viable, it also introduces new challenges. Respondents now come to expect a certain standard of experience when responding to researchers. This includes an intuitive interface, ergonomic design, a platform compatible with their device's operating system, and assurances that their personal data are safe. The challenges these expectations pose require creative collaboration with computer scientists while ensuring for the researcher that these applications are reliable and configurable.

3.4.2 Selecting the Q statements

The final POETQ tool presents respondents with 40 carefully chosen statements about outcomes of joint commissioning. The statements were drawn from the literature review and also a pilot study.

For the purposes of developing POETQ we studied the concourse of debate around our area of enquiry - joint commissioning arrangements in local health and social care provision - and statements were generated from the literature review. There was a space on the literature review proforma where the aims, outcomes or impacts of joint commissioning were reported. This process generated a list of nearly 200 statements about joint commissioning. Two of the team (HD and SJ) sifted these statements

looking for those which were addressing similar issues and reduced the list of statements by over half. The team then engaged in a Delphi-type approach where through electronic circulation the 40 statements which seemed to represent the full breadth of possible impacts and aspirations for joint commissioning were selected. These 40 statements were then piloted to test the themes and also generate further discussion and potential statements.

As we argued in the last chapter, the joint commissioning literature is overwhelmingly positive and sees it as a good way of working. The piloting stage was therefore important in capturing alternative views of joint commissioning. The pilot engaged 31 members of a joint commissioning arrangement. The locality had in recent years structurally integrated health and social care into one organisation. Two locality teams were engaged in this process and those professionals who completed the tool came from health and social care backgrounds (e.g. social workers, nurses, occupational therapists, general managers and administrators), worked with a range of client groups (e.g. learning disability, physical disability) and comprised both commissioners and providers of care. Thus the sorts of professionals completing this survey were very similar to those that we then engaged in the joint commissioning project. The commissioners spent on average 20 minutes sorting the statements. They were asked to write why they had chosen the two most and two least agreeable statements. This yielded a rich set of responses which we were able to capture more possible statements from. The process of 'capturing statements' is in the main carefully recording arguments, opinions, prescriptions, definitions, and espoused logic.

Through the piloting process we discovered that giving simple statements generated meaningful and natural language. Our statements were simple short phrases from the literature. In responding to these phrases, our respondents elaborated on these short statements using professional vernacular. In turn these responses become the source of statements for our final set. The pilot also revealed three types of consensus – themes with widespread agreements, widespread disagreement and widespread indifference. Where there is agreement these are clearly themes that need further refinement to ensure potentially vague terms like 'leadership' or 'trust' are refined into their different meanings. Piloting themes allows for a refined and nuanced understanding of popular themes. As for the common disagreements, these too can be refined in a similar way. The third type of consensus, where there is broad indifference, should be treated in a different way. This indifference brings into question whether the theme should be retained for the final set of statements.

Combining original extracts from the literature review and the qualitative responses of our pilot case study yielded 212 potential statements in total. In line with other Q based studies(146) we drew on a sampling framework to ensure that we covered the range of debate and avoided duplication. We

sought a framework that ensured a balance across important sets of themes expressed in the literature and our pilot group, one that included reference to the themes around efficiency, empowerment, prevention that we found in the literature review and key empirical themes of enhancing collaboration, communication and professional awareness. We developed a '4Ps' outcome framework (where the Ps are - people, partnership, productivity, professional), a framework inspired by the influential work of Janet Newman and her work on theorising governance (147) which in turn was informed by the work of Robert Quinn (148). Each are described in turn below and an edited version of the statements appears in the coding framework set out in Figure 3.1:

- **People outcomes** – these statements tended to categorise the person focused aspects of joint commissioning outcomes in terms of 'improving real lives' and being pro-active about prevention on the basis of early intervention, offering high quality service, choice and equality of access and fairness in allocation. Here the implications are that where people outcomes are met, service delivery is less fragmented and has processes which are easier to navigate, understand and access, and based on holding service providers to account. People outcomes are ultimately about the degree to which service users feel they have an influence on the way that services are planned and delivered.
- **Partnership outcomes** – these statements tended to categorise the joint working aspects of joint commissioning, in terms of working together differently, aligning systems and sharing information, highlighting the consequences this might have for working conditions and morale. Taking this a little further, from the perspective of partnership, joint commissioning could be seen to assist in building professional empathy, sharing ideas, building informal relationships, creating a common language and building trust. Here, the implications are that where partnership outcomes are met, it can have a transformational impact on organisations, revolutionising how they work together synergistically, in the face of increasingly complex environments.
- **Professional outcomes** – these statements tend to categorise those aspects of joint commissioning associated with professional culture and professional identity that might be affected by bringing together different professional groups with potentially different professional values and subscribing to different models of care. Tied in with this is the extent to which joint commissioning assists in formalising a pre-existing culture of close collaboration, or merely provides a more 'symbolic function' in terms of demonstrating to others that 'we are working in partnership'. Thus, for some, the professional outcomes

generated by joint commissioning could either be about enhancing organisational influence through stronger alliances, standardising processes such as risk management, or for that matter, promoting insularity amongst professional groups. It could also be about offering increased opportunities for private and voluntary organisations.

- **Productivity outcomes** – these statements tended to categorise the productivity aspects of Joint Commissioning in terms of delivering more for less, reducing duplication, cost-shunting, speeding up referrals, investing now to save in the future or simply saving money in general. It could also be about reducing demand on services, working smarter and could have implications for management structures and systems too.

3.4.3 Coding Framework

Figure 2. Coding Framework

People				Partnership		
Fair	Personal Relationship	Co-production	End to blame	Common language	Quantum leap
Simple and clear	Quicker less wait	Personalised	Adaptable	Professional empathy	Trust
Choice	Preventative	Legitimacy	Improved systems	Face time	Integrated IT
Professional					**Productivity**
Celebrate previous efforts	Adjusting balance	Lots to do	Cost saving	Less management	Lean
Formalise collaboration	Language barrier	Partial integration	Reduced duplication	Not without sacrifices	Less red tape
Professional integrity	Different cultures/ Models	Jack of all trades	Firing line	Initial expense	Channel shift

Some examples of statements that reflect each of these four areas for outcomes are illustrated in Figure 2. Using our sampling framework the task was to narrow down our 212 to a manageable number that we could include in our web-based survey.   In searching for a manageable number, too few (e.g. less than 30) and the diversity of the debate is under-represented, conversely, too many (i.e. 60+) and respondents struggle to complete. Members of the project team have previously found between 36 and 45 to be an optimal size for a Q set administered online (130;131;146). The final set of statements for POETQ retained 40 statements in the Q set. The list of the final 40 used in the online survey can be found in Appendix One.

Figure 3. Example of statements on Joint Commissioning outcomes

People outcomes *Commissioning jointly is about delivering a* **seamless service** *for service users*	**Partnership outcomes** *Properly done Joint Commissioning can deliver a* **quantum leap** *in how organisations work together*
Professional outcomes *Joint Commissioning can feel like a* **battle of the models**: *a health approach verses a social care approach*	**Productivity outcomes** *Joint Commissioning is about delivering* **more for less**

Because we are essentially dealing with subjectivity, there is no hard and fast rule for categorising certain statements as belonging to a cell. Where it fits is not the issue, for it is the final respondents that ultimately give meaning to the statements, not the researchers. The interpreted meaning of a statement is not something the researcher can control for. However, what is important is that there is the greatest amount of diversity in the final sample. The final proposed set was approved by the wider research team and the advisory group with some statements being corrected and in some cases shorted to clarify their meaning.

3.4.4 The POETQ survey

The POETQ survey is a web-based application that health and social care professionals access through activating a unique code sent to them in an email format. Participants can exit the survey at any time and return to the step via the original link. The data is held on a password protected admin section on a secure server. After agreeing to participate each respondent navigates through a series of screens involving multiple choice, rating, and text entry. There are a series of short questions relating to their role, professional affiliation and understanding of joint commissioning

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arrangements before we come to the main section of the survey – the Q sort. The 40 statements appear in turn and the respondent decides whether they agree or disagree with each statement. If the respondent is indifferent about a statement, they can respond using a 'neutral category'. Once all 40 statements are categorised the next page displays all of the agreeable statements on a single screen. The respondent then selects their two most agreeable statements of those displayed.   Once selected, the selected statements vanish from the screen. They repeat the process, selecting and dispatching statements, following the onscreen instructions. This process is Q sorting, where the prioritisation of statements in this manner is a form of rank ordering. The process is repeated with disagreeable statements and any neutral statements.

In the background the application is allocating the selected statements and the desired order to a virtual sorting grid than resembles an upturned pyramid. The pyramid includes nine columns representing degrees of agreement from +4 on the right-hand side to -4 on the left. Respondents are encouraged to select just two in the +4 position, three in the +3, four in the +2 position. Some Q studies allow respondents to decide how many statements can be placed in each position. The end result makes little difference as this is little more than an heuristic to prompt people to make careful choices between statements. Many respondents find the process almost game-like and somewhat engaging. The respondent is presented with their preferences summarised in the sorting grid on screen and given the opportunity to review and if necessary swap statements around until they are satisfied their view is represented. The final page of the survey prompts respondents to reflect on four statements, placed at the -4 and +4 positions. These are their most and least agreeable statements and understanding why these were chosen above the rest is critical to the analysis. Once complete the survey is submitted by the respondent, who is then presented with a thank you acknowledgement and given details of how to ask further questions about the results or how the data will be used.

3.4.5 Data Analysis

The process of analysis starts by exporting the data into a Q methodology analysis application known as PQmethod. In Q methodology terms, each respondent provides 'a sort'. The analysis correlates and compares each sort for the purposes of factorisation, where any highly correlated sorts will be assumed as clustering or orbiting about a tacit shared viewpoint. It requires the placing of statements to be compared pair-wise, e.g. person A places statement 1 at -4 and person B places statement 1 at -3. A difference of 1, and repeat for statement 2 and so on to statement 40 and then summing the differences.   Comparing each pair of respondents pair-wise it requires several hundred thousand individual calculations but allows for a correlation matrix to be constructed, e.g. where person A's sort is 0.77

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correlated with person B, but only 0.22 with person C. Beyond this stage there is little or no focus on the placing of individual statements, what is compared is the correlation between whole sorts.

The first process of analysis is to arrive at a suitable factor 'solution' and by default the programme will extract 8 factors. The optimal factor solution is most often between 2 and 7 shared viewpoints. Although there may be 8 distinct viewpoints, viewpoints with 2 or less sorts informing the viewpoint will in most instances be rejected. In most cases the optimal factor solution is self-evident; however it might be necessary to consider two possible solutions (e.g. a 4 factor and a 5 factor) in more depth. In this hypothetical example the five factor solution might explain more of what is going on, but if two of the five factors are highly correlated a four factor solution with distinct factors might well be preferable. Factors are suggested mid-points between two or more correlated sorts. This allows for a factor array to be generated for each accepted factor. In other words it is possible to identify how this factor or viewpoint would sort the statements if it were a respondent completing the Q sort. So in the example of a four factor solution, the Q sort of factor 1 can then be compared with the Q sorts of factors 2,3 and 4. This reduction of the data means rather than attempting to analyse, interpret and compare the sorts of all respondents in a study, the task is now simpler as one of comparing a discrete number of idealised or synthetic factor sorts.

Once a set of factor arrays is identified it is then a process of interpreting the character of these factors. The analogy is one of putting flesh on the skeleton suggested by the factor analysis. There is no one standard means of interpreting a factor, however there are some processes that should be conducted and in the following order:

- Factor interpretation begins by exploring the characteristic statements for each factor. Each factor is interpreted in isolation. Starting with factor 1, the first step is to visualise the factor array for that factor by reproducing the sorting grid and focusing particularly on the top and bottom 5-6 statements;

- Next is to identify those statements that distinguish this factor, in other words statements that are favoured where others are indifferent or disagree, or statements that are disagreeable where others agree. It can also be interesting to look at what statements the factor is indifferent about when other factors have a stronger view. By now it is possible to start sketching a paragraph of text that paraphrases the characteristic statements and privileges the distinguishing statements. Possible names for the factor should be noted at this stage as an *aide memoire*; and,

- Next is to explore which sorts most closely resemble or correlate with the factor. There are usually 2 or 3 sorts that share upwards of a 0.70 correlation with the factor. These are known as exemplars for the factor. On closer inspection many of the top rated statements will resemble that of the factor. However, it is important to acknowledge every sort is unique and not all statements will correlate neatly. It is standard practice to extract the quotes and any additional free text comments from the exemplars and paste these into the working document.

Armed with character statements, distinguishing statements, working titles and respondent text it is then possible to start to identify the unique character of each factor in turn. Often in a policy context there is considerable consensus around certain statements, therefore identifying the unique and distinguishing character of a factor can be difficult in the first sitting. Some factors will be easily identifiable from the theory or previous research, whereas others will be novel and unfamiliar.

When applied in a single case study site it is possible to identify how many shared viewpoints are 'operating' (or operant) among the persons responding. This is not to say there are no other viewpoints, however because the process is to explore shared perspectives, if the person sample is drawn from a cross section of the organisation then additional shared viewpoints, although possible, are arguably improbable. That said, with most P samples in Q methodology numbering less than 50, there is no claim of widespread generalisablity. However, it can be argued that the most prevalent shared viewpoints are indefinable in this way because the statements are representative of the debate (note the inversion of the factor analysis means that representativeness is also inverted away from person sample to statement sample, thereby meaning careful and informed selection of statements is critical). Furthermore we can also argue these shared viewpoints are more than coincidence and will be operant beyond the sample taking part in the study. The differing size of factors is largely inconsequential and no indication of popularity. Some factors explained more of the variance and enjoy more participants loading on it, the differing weights of the factors help generate hypotheses for further research, rather than signal the popularity of a particular viewpoint. Q methodology does not deal with questions of popularity, only that of character. To be clear, the approach here is to understand the character of thinking about joint commissioning viewpoints in given parts of the country.

3.5 Use of POETQ as part of case study

When analysed in the way described above, the Q sort data allows us to identify the character of shared viewpoints in a given organisational setting. It is an efficient method in that it engages people in a debate they might well have tacit feelings towards and which would be difficult to ascertain systematically from interviewing or conventional survey techniques. Typically a relatively diverse P sample (person sample) of 20-50 people is more than adequate to identify the pattern of shared viewpoints and gain insights into the organisational, environmental and temporal elements underpinning this collective view. It allows researchers to gain a superior insight into what is taking place, particularly in a policy area fraught with nebulous and ill-defined professional language. The other metadata about job description, time served and perceived understanding are integrated into the case study qualitatively and allow additional insight, particularly from factor exemplars whose opinion matters, because their view is somehow reflective of what might turn out to be a wider group or 'school of thought'. It, too, allows us to go beyond preconceived ideas or prejudice about how particular groups think about integrated working, or age old professional differences such as the 'Berlin wall' between the working culture and outcome expectations of health and social care workers.

Using a standard set of statements across case study sites, it is possible to compare both qualitatively and quantitatively. The Q sort data can be compared in two distinct ways and used to inform the overall analysis.

The two ways of comparing the sites are either to aggregate the sorts into one factor solution or to retain individual factor solutions and compare these in the 'second order'. The aggregate approach works by entering the sorts as if they were all in the same site, but making note of the location of each participant. By running a factor solution it becomes clear that there are some factors informed by sorts from all five sites. This suggests that the factor viewpoint is universal, at least beyond local borders. The disadvantage of this is how it hides local nuances and distinct points of view. However, it is useful to get an overall snapshot of how joint commissioning is viewed across a range of localities in England.

The second approach to comparing factors is through what is known as a second order analysis. It starts by identifying local factor solutions for each locality. As we explain in chapter four, most of our localities had 3 factor solutions, one had 5. Next each of these factor solution arrays are entered into a new PQmethod study file as if each of these are individuals. So rather than having upwards of 100 actors compared in aggregate, it is a case of comparing 15 or 16 'actors'. Although it is interesting to run factor solutions, perhaps of most interest here is the correlation table where it is possible to see whether factor 1 in location A is indeed similar in form to factor 1 in location B or C. This process of second order reveals which factors are broadly shared across locations and those which are distinctive

to localities. We found several 'local' factors which would have been missed by performing an aggregate analysis alone

The POETQ survey was sent to as large a sample as possible at each of the case study sites so that we might gain insight at all levels of organisations and across different professional groups. As respondents were free to respond – or not – to the survey this process alone could not ensure representativeness in terms of the key partners. Therefore for each site we looked at the balance of responses to the survey and in the second phase of the research sought to engage others so as to gain an overall representative sample in terms of the case study data.

3.6 Phase 2: Site Visits and Interviews

Whilst phase 1 gave us a sense of the structure of joint commissioning and aspirations, Phase 2 presented an opportunity to engage in face to face conversation with policy actors and service users. Whereas phase 1 was conducted remotely, phase 2 involved site visits. The objective of phase 2 was fourfold:

- To test out our working definition of joint commissioning and explore aspirations of local staff and service users;

- To capture what processes are in place and the rationale for their development;

- To understand practices of joint commissioning; and,

- To capture examples of where joint commissioning has resulted in specific impacts for service users or organisations.

Specifically phase 2 used four forms of enquiry: documentary analysis, feedback workshops, focus groups and semi-structured interviews with key contacts in the organisation. Figure 4 sets out a flow chart which shows the ordering of activities planned for each site. As we will go on to explain, this did not always happen in practice at all sites due to some of the challenges that local organisations were facing at the time of the research. Feedback workshops essentially involved the presentation of the findings of phase 1 and then a facilitated discussion about the responses of those present to these groups. During these sessions detailed notes were taken and were later analysed along with other qualitative data. Some of these respondents will have been involved in phase 1, whereas others will be new to the research. This approach is based on a strategic assessment approach (125) that is present in the original POET tool. What is important here is the dialogue that goes on between a wide range of stakeholders.

The use of POETQ allows us to quickly reach a rather nuanced view concerning the various viewpoints regarding joint commissioning in the specific localities and these are presented to a variety of stakeholders who then discuss and deliberate between these. The staff focus groups were particularly helpful in terms of this process in facilitating dialectical debate and focusing on the assumptions which differ between groups.

In terms of research instruments, semi-structured interviews were deemed to be the most appropriate tools to surface evidence of the different ways in which joint commissioning had been implemented in practice and the difference it had made. The rationale for this was based on drawing on the experience of staff involved in delivering jointly commissioned services and service users who had experience of using jointly commissioned services. During the interview process, what was of prime concern here, was an emphasis on 'actual' real-life examples, not only of how jointly commissioned services had been implemented in practice (in terms of the processes and practices used), but also what difference they thought it had made in terms of productivity, partnership, professional and people outcomes.

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Figure 4. Flow chart showing process of research at case study sites

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┌──────────────────────┐        ┌──────────────────────┐
│ Site agrees to be     │        │ Meeting with         │
│ part of the research  │───────▶│ representatives of    │
│ project and research  │        │ the site to agree     │
│ governance approved   │        │ details of approach   │
│ and documentary       │        │                       │
│ analysis              │        │                       │
└──────────────────────┘        └──────────────────────┘
                                            │
        ┌──────────────────────┐            ▼
        │ Invites sent to       │   ┌──────────────────────┐
        │ individuals asking if │◀──│ Launch event with     │
        │ they want to          │   │ staff to explain      │
        │ participate in POETQ  │   │ POETQ approach and    │
        │ survey                │   │ next steps            │
        └──────────────────────┘   └──────────────────────┘
               │
               ▼
┌──────────────────┐  ┌──────────────────┐  ┌──────────────────────┐
│ POETQ survey     │  │ Local viewpoints │  │ Viewpoints and       │
│ completed and    │─▶│ fed back to site │─▶│ impacts discussed    │
│ data analysed    │  │ via feedback     │  │ with staff in focus  │
│                  │  │ workshops        │  │ groups and           │
│                  │  │                  │  │ interviews. Data     │
│                  │  │                  │  │ coded                │
└──────────────────┘  └──────────────────┘  └──────────────────────┘
                                                       │
┌──────────────────┐  ┌──────────────────┐  ┌──────────────────────┐
│ Local report     │  │ Local data       │  │ Aspirations and      │
│ written          │◀─│ sought to test   │◀─│ outcomes tested with │
│ summarising      │  │ hypothesised     │  │ services users and   │
│ findings for     │  │ relationships    │  │ carers in focus      │
│ that site        │  │                  │  │ groups and           │
│                  │  │                  │  │ interviews           │
└──────────────────┘  └──────────────────┘  └──────────────────────┘
```

Focus groups and individual interviews with service users and carers were also convened to provide an insight into the impacts that joint commissioning might have on those who received services. Typically, focus groups with service users constituted between 8 and 11 participants and

were again sourced using snowballing techniques via our lead contacts in each site. Depending on the nature of the jointly commissioned structure, service users were drawn from service user and carer forums known to each organisation, and constituted people from a wide range of ages, backgrounds and health and social care needs. However, as this table shows at some sites we were unable to recruit service users and carers. In the case of site D this was because the site did not want us to conduct this phase of the work and we reflect on this further in the limitations section.

Thus, in contrast to the sample recruited in Phase 1, which were predominantly based on the attitudes of commissioning managers (see chapter four for more detail), Phase 2 sought to recruit a wider range of staff involved in the delivery of jointly commissioned services including service managers (inc. operations, business); clinical leads (inc. general, community and specialist nurses, social workers and Health Visitors); private and third sector providers; and users and carers who had experience of using services from across the full range of integrated providers (inc. acute care, intermediate care; primary care and community care services). A summary of the research activities undertaken at each can be seen in table 6.

Table 6.   Showing main methods of data collection used in each case study site

Mode of data collection	A	B	C	D	E
Feedback workshop	11	7	0	3	3
Focus group (staff)	6	7	0	0	3
Focus group (service user / carer)	11	14	14	0	0
Individual interview (staff)	4	0	6	11	3
Individual interview (service user / carer)	2	0	0	0	0
TOTAL	34	28	20	14	9

Based on the above, a schedule of focus groups and interviews were planned with staff and service users from each site.   Interviews were broadly structured around joint commissioning and its meanings, experiences of the processes of joint commissioning, the types of outcomes that joint commissioning is attempting to deliver and whether there is any evidence about the outcomes of joint commissioning. Samples of the research tools from this phase can be found in appendix 2. Data collection

took place during a series of 2-3 day site visits at each of the 5 sites with the aim of immersing the research team in the field by meeting with a wide range of strategic, operational and clinical commissioning staff in addition to service users and carers. Where appropriate, visits were also arranged to observe the various jointly commissioned services in operation, in an attempt to observe how they worked in practice, for instance where two or more services had been co-located, or a partnership of organisations had been involved in building new integrated provision.

In practice the second phase of the research was much more challenging to arrange than the first. Following the publication of the *Equity and Excellence* White Paper (2) many of the joint commissioning arrangements came under question as to whether they would continue to exist (in the case of two of the sites who were care trusts) or the new form they would take with the introduction of clinical commissioning groups.   The context was one of confusion and frantic activity for many of those based in PCTs and local authority staff were often similarly engaged in programmes of change with many individuals at some of the sites involved in the research being made redundant or moved to other roles. This meant that in many of the sites the numbers engaged with the research were not as high as we had originally anticipated as we encountered various cancellations of data collection visits, individuals pulling out of the research and difficulty in getting time with many stakeholders. Further, given the changes taking place, site D did not feel comfortable with us collecting data with service users and carers and therefore data collection at this site remained limited to staff members.

3.6.1 Analysis: Phase Two

All individual interviews and focus groups were recorded with a digital audio recorder. Recordings were professionally transcribed and electronically coded using NVIVO 9. In order to ensure consistency in coding across the research team we developed a codebook based on the suggestion of MacQueen *et al* (149). In order to develop the codebooks we inductively coded data developing a series of freecodes. As a research group we met and discussed the freecodes and how these aligned with our overall research questions. We then used the research questions to introduce 5 topline codes and a series of subcodes, based on our analysis of the text within the data.

Table 7. Summary of the Codebook

1. Joint commissioning definition - focuses on ways in which agencies might work together in their commissioning and provision of services. This can involve public and private agencies alongside health and social care organisations.	**Efficiency**- this includes reducing duplication and waste, streamlining complex systems of care and the pooling of budgets.
	Value for money – this relates to spending wisely to achieve quality services that meet local priorities.
	Empowerment- this includes increased access to services and independent living, along with service user and carer influence on commissioning and service provision.
	Prevention- this is where joint commissioning is defined as a mechanism to reduce burden on service users and carers and reduce inequalities.
	Strategic commissioning – this relates to the inclusion of a number of organisations from across the local economy in the commissioning of services (e.g. housing, police etc) often defining joint commissioning as a fully integrated approach to commissioning and provision of services.
2. Processes – A series of actions to achieve a particular end – such as formal agreements, decisions to co-locate staff, integrating budgets, or commissioning process, integrating governance, or frontline teams, it could be about specific investment.	**Agreements** - these include contracts and memorandums of agreement between parties. e.g. Annual strategic agreement.
	Co-locating staff and facilities - include moving staff from different service areas into one office facility, purposive introduction of agile or flexible working, open plan offices, hot-desking or guest-desking. This should also include reference to integration of staff facilities such as a refreshment provision or fund e.g. Coffee club.
	Integrated budgets - this includes delegating budgets into a new commissioning vehicle (e.g. Care trust) or pooling budgets.
	Integrated governance or structures - these include the establishment of specific governance arrangements such as partnership boards or integrated boards to make or scrutinise decisions. It also refers to the establishment of common storage facilities.
	Integrated teams - this refers more to frontline integration - such as the establishment of areas teams, or joint management of services.

	Public engagement processes - these include any specific mechanisms that are specifically aimed at engaging users, carers or members of the general public in the integrated commissioning of services - such as commissioning road shows, engagement panels, user panels, groups or the maintenance of data on such activities.
	Sharing data - the establishment of shared databases for the purposes of integrating health and social care.
	Pro-integration process - this includes any specific posts or procedures that are aimed at explicitly promoting integration between organisations or activities.
3. Practices - the day to day interactions that go on with organisations between professionals, service users and carers and which facilitate service design and delivery.	**Challenge** – this includes challenging a range of stakeholders (Elected members, GPs etc) about processes or practices.
	Relationships – this includes any issues raised in relation to informal aspects of relations between professionals.
	Evidence – this includes the search for appropriate forms of evidence and the ways in which evidence is used in every day organisational interactions.
	Involving – this relates to the inclusion of service user and staff perspectives in discussions about services and service delivery design.
	Top down – this is where involvement of the public is avoided and professionals believe they know best about a particular situation.
	Co-ordination – this relates to changes in organisational practices to provide continuity in care and the coordination of a range of services.
	Prevention – investing in low level services in order to protect against particular situations occurring downstream.
	Role enactment – this refers to the slight changes in terms of who undertakes what activities in an organisational setting – these are not significant enough to change processes and happen at the margins

	Creativity – this refers to professionals thinking in different ways about services and producing quite different perspectives on care.
	Holistic perspective – this involves professionals taking a wider view of individuals and their lives beyond traditional health and social care services.
	Informing – giving service users knowledge through leaflets, information giving meetings or websites.
4. Outcomes – the result of process and practices**.**	**Organisational efficiency** –this refers to any reduction that results from the streamlining of processes such the reduction of red tape, bureaucracy, improving accountability (including democratic accountability), and the whole being greater than the sum of its parts.
	Improved access to services - ensuring that a wide range of provision is available, speedier access.
	Improvements in inter-professional working – any activity which results in reduction in barriers to partnership working to achieve a common goal (i.e. sharing information, reducing the 'them and us' mindset', developing a shared vision or common language).
	Improved quality of service delivery – refers to any improvements in the range or types of services which result in quicker referrals from primary care to social care'; more appropriate referrals from primary care to say the acute trust; or by ensuring proper services are in place following discharge from acute care into the community.
	Improved quality of life – refers to any improvements to the 'real-lives' of services users or their carers, such as by preventing unnecessary hospital admissions or transfers or by delivering wider goals pertaining to social inclusion.

The codebooks (Table 7) defined the nature of each code and included examples of when to code and when not to code. To develop each codebook we iteratively coded within each of our central guiding themes – definitions, processes, practices and outcomes. For each we generated four lists of freecodes, numbering between 15 and 25 codes in each list. We then collapsed each list of free codes into a manageable number of around five or six for each of the four main codes. The final codebook gave examples of each of the codes and examples of when and when not to use the code. Once the final codebook had been agreed each individual transcript was then coded using this guide. As we analysed each case study we compared coding and reviewed the utility of codes to ensure reliability and validity of the method. Table 7 shows a detailed description of each code within its associated codebook.

3.7 Ethical considerations

Given the 'joint' nature of this research and its situation across both health and social care, there was a requirement to follow several different ethical and research governance procedures in ensuring that the planned research met with the requirements of the different Adult Social Services Departments (ADASS) involved and the NHS. Because the research took place in two phases, both were independently considered. Following a formal enquiry to NRES at the start of the project, the research was considered to be exempt from full ethical review, and subsequently deemed 'service evaluation', subject to review by local research governance institutions at each case study site. An application was made to ADASS for research governance approval for the five sites and individual applications were also made to the PCTs involved in the research.

Since the research sought only to surface the attitudes and experience of human subjects (i.e. staff, service users and carers) rather than engage them in any clinical research or experimentation, the risks of participating in either phase 1 or phase 2 of the research were very small. However, in keeping with the need to assure staff and service users and carers of confidentiality and anonymity, a comprehensive participant information sheet was developed which detailed the background and purpose of the research; what taking part would involve; the benefits and risks involved and how these were intended to be managed. Prior to taking part in any research, formal consent was sought from all participants (including staff, service users and carers) on the basis of informed consent and their freedom to withdraw from the study at any time (up until the final report was being prepared) with assurance that all contributions were to be removed and destroyed. Staff, service users and carers were asked to complete and sign separate consent forms each designed with each client group in mind. All research instruments were subject to full ethical review by the University of Birmingham Ethics Committee who oversaw the design of all materials intended for use in the recruitment of staff and service

users, as well as the collection of personal data during individual or group interviews. Lead contacts were provided with all the necessary materials prior to any research taking part and handouts were provided on the day, with a participant information sheet, consent form and a copy of the questions to be used during interview.

3.8 Limitations

There are a range of limitations to any research project and this is no exception. Whilst POETQ is a useful way to gather a large amount of data relatively quickly and easily, one key limitation is a question of whether the degrees of engagement enjoyed in a face to face Q sort can be replicated online. There have been several attempts at developing online Q sorting software, of variable degrees of success. Most recently the software developed by Hackert and Brahler known as 'flashQ' has been used by Q methodology researchers, where the respondent drags the statements in what resembles an online game of solitaire or freecell.   POETQ was designed to minimise this limitation but we accept that the anonymity of the sorters reduced our potential to engage with individuals on a one to one level.

A second limitation is around what claims can be made. The respondents are not representative of a wider population, therefore claims cannot be made even if there seems to be a pattern emerging; for example all the people loading on one group are all male and under 30. More tempting in this example of inter-organisational partnership is perhaps the finding that all people in one group are from one organisation. Some choose to probe these patterns further through the use of what is known as a Q block technique (145).

In the original design of this project we had intended to include eight case study sites rather than the five which are presented here. As we have previously described, the publication of the *Equity and Excellence* White Paper (2) in early 2010 caused us difficulties in engaging sites. Some of those sites that had agreed to be involved in the research dropped out at this point as the White Paper indicated that there would be substantial changes made to the commissioning landscape once more. As such the decision was taken to study five sites, but in more depth. However, this shifting and uncertain policy context meant that recruitment issues remained a challenge throughout the project, particularly as commissioning staff from the NHS started to be made redundant or move to other posts in anticipation of this next round of organisational change.

The final limitation relates to the level of data saturation we were able to achieve at each site and the numbers we were able to engage in the research. As we have explained, changes within the external environment meant that we did not engage as many individuals in the research as we would have liked to. One of the sites (D) also was not supportive of us

engaging service users and carers meaning that this group is absent in this analysis. However, we did use a variety of different means across all of the case study sites so that we could generate as much data as possible about the joint commissioning arrangements within these localities.

One of the challenges of service user and carer engagement is in linking the notion of outcomes to joint commissioning. Service users and carers often found it very difficult to relate services to joint commissioning arrangements in a specific way and spoke very broadly about the services that they received. To some degree this may not be surprising given that staff encountered the same challenge. Therefore the degree to which we are able to make statements about service user and carer perspectives on the joint commissioning are limited and are worthy of further investigation.

3.9 Chapter summary

In this chapter we have set out the methodology adopted in this research. As we have described, this was broadly based within a theory-led framework where we sought to understand the range of meanings attached to joint commissioning and their interplay in practice. The research took place in two phases, with the first employing the POETQ tool of data collection and the second involving more 'bespoke' approaches to data collection with staff, service users and carers. Through these phases of the research we sought to gain a detailed understanding of the different viewpoints relating to what joint commissioning is, what processes are in place in the various localities to facilitate this, what organisational practices are operated under the banner of joint commissioning, and the types of impacts this has had in practice.

4 Phase One Findings: Meanings of Joint Commissioning

4.1 Introduction

In this chapter we set out the findings derived from the first phase of the research, where the POETQ tool was used to explore what it is that joint commissioning is perceived to mean and what individuals believe joint commissioning is aiming to achieve at the different case study sites. In the first section we provide an introduction to the case study sites setting out the key features of the organisations involved in the research and a sense of how we might differentiate between these different interpretations of joint commissioning. We then move on to set out the response rate garnered through the use of POETQ and analyse the data collected at both aggregate and local levels. Through the research we uncovered a range of different perspectives relating to what joint commissioning is and what it should achieve. Overall the most prominent viewpoint across all the sites is one which is most positive in terms of the possibilities for joint commissioning and is incredibly aspirational about what it might achieve. However, there are other less positive viewpoints operant and we reflect on these here too. One of the key observations about the data is that the viewpoints do not align with particular professional or organisational boundaries as we might expect from the more established literature.

4.2 Overview of case study sites

In this section we seek to provide the reader with an overview of the key and distinctive features of the case study sites involved in the research and a sense of how we might differentiate these from one another. The sites have been anonymised for the purposes of reporting in line with the research governance approval conditions. Table 8 provides an overview of the key characteristics and contexts of the five different joint commissioning arrangements. As this table demonstrates the sites vary in size from a rather small-scale joint project in the case of site E to much larger arrangements covering whole areas and multiple partners (site B). The sample includes formally integrated arrangements in the form of a care trust (site C) and a care trust plus (site D), an integrated management team (site A), a large pooled budget (site B) and a more informal project (site E). The sites have been in place for differing lengths of time with some being more established and others more recent and cover a range of different client groups.

Table 8. Key features of case study sites

Case study site	Case Study A	Case Study B	Case Study C	Case Study D	Case Study E
Joint commissioning arrangement	Joint Commissioning Unit	Joint Commissioning Unit	Care Trust	Care Trust Plus	Partnership between Urban Authority and Third sector organisation
Pooled budget	Single LA and PCT with section 75 pooled budget.	Single LA and multiple PCTs with large section 75 pooled budget	Integrated commissioning and provision	Integrated commissioning and provision	None
Background	Long history of joint working, integrated management arrangements and integrated teams; and a strong commitment to public engagement. The focus here was on older people's services.	Joint commissioning for people with mental health problems and for people with learning difficulties with one LA and multiple PCTs. Was formed in the face of significant previous overspends and a history of difficult relationships. It has since won national recognition for its joint working.	Integrated commissioning and service delivery. Formed between a single LA and PCT and has a strong reputation for its efficient use of hospital bed days for older people.	Includes integrated approaches to children's services and to public health. Formed between one LA and one PCT, alongside an integrated social enterprise for service provision.	Joint project to develop more community commissioning on two public housing estates. Also pursuing strategic collaboration with other nearby local authorities.
Year established	2002	March 2010	May 2003	2009	2009
Region	North West	Midlands	South West	North West	South East
Population served	150,800	1,036,900 of which around 18,000 adults have a learning disability and around 91,467 are expected to access mental health services.	140,000	170,000	2 public housing estates
Client group served	Older people	Learning disability and mental health	General population – all health and adult social care	General population	Estate Residents

4.3 Survey response rate

As Table 9 illustrates, between 10 and 34 individuals completed the POETQ survey at each site meaning that we gained significant coverage across each of the sites. Due to the size and scope of joint commissioning arrangements the number of respondents varies between sites. Table 9 also shows respondents spent nearly 52 hours in total completing these sorts, and the average lengths of time that respondents spent completing the survey was somewhere between 32 and 37 minutes.

Table 9.   Numbers of completed surveys and time spent sorting statements

Site	Number completed survey	Range sort times (minutes)	Mean sort time (minutes)	Total time spent sorting
A	10	15-90	37	6 hours 10 mins
B	14	17-85	35	7 hours 23 mins
C	34	14-78	37	18 hours 20 mins
D	22	12-59	33	11 hours 59 mins
E	13	7-68	32	7 hours 34 mins
TOTAL	**93**	7-90	35	51 hours 53 mins

In terms of who completed the survey at each site we generated representation from across all of the partners involved in the local commissioning arrangements and in some cases beyond to wider partners from a variety of different professional backgrounds. Table 10 sets out an illustration of which types of partners and professionals completed the survey at each site. The numbers at each site will not equal the total that completed as in some cases we had more than one individual with that title from that partner who completed the survey.

Table 10. Partners and professionals who completed POETQ

Site	Examples of partners and professionals that completed POETQ
A	Director (PCT) Partnership Manager (PCT) Director (PCT) Clinical Director (Health and Wellbeing group) Commissioning Manger (local authority) Commissioning Manager (PCT)
B	Director (local authority) Commissioning Manager (mental health trust) Chief Executive (third sector provider) Project Manager (third sector provider) Care Business Manager (mental health trust) Clinical Lead (mental health trust) Clinical Director (third sector provider) Commissioner (mental health trust) Manager (local authority) Volunteer (mental health trust)
C	Business Manager (care trust) Programme lead (care trust) Clinical lead (care trust) General Practitioner (care trust) Commissioning Manager (care trust) Assistant Director (care trust) Clinical Director (care trust) Service Manager (care trust)
D	Director (borough council) Service Head (borough council)

	Strategic Director (borough council)
	Service Transformation Head (care trust)
	Public Health Manager (care trust)
	Performance Manager (care trust)
	Strategic and Finance Manager (care trust)
	Director (care trust)
E	Commissioning Officer (Housing)
	Commissioning Director (local authority)
	Joint Commissioning Manager (local authority)
	Board Member Residents Association
	Business Manager (housing)
	Director (PCT)
	Director (mental health trust)
	Manager (third sector organisation)
	Community Researcher

4.4 The Aggregate picture

The POETQ process generated extremely rich data and this is reflected both in the length of time that respondents spent engaging with the survey and also the amount of free text comments that this generated. As a first phase in the process of analysis we aggregated the total number of responses (n=93) and conducted the factor analysis on these sorts (see chapter three for detail on this analytical process). As a result of this analysis we found that five distinct and shared viewpoints of joint commissioning emerged. We have named these viewpoints: ideal world commissioning; efficient commissioning; pluralist commissioning; personalised commissioning; and, pragmatic commissioning. Table 11 illustrates the degree to which these viewpoints were operant at each of the case studies, illustrating how many of the completed surveys at each of the sites correlated to these national viewpoints. The table shows that the ideal world commissioning viewpoint is far and away the one which is the most prevalent at each of the case study sites. We cannot say that this is dominant across all the sites as we only received completed surveys from a small percentage of the whole organisations. Further, many of those who completed these surveys were commissioners so to some degree it is unsurprising that they are optimistic about commissioning. However, at each of the sites there are also other viewpoints operant which may or may not be congruent with one another.

Table 11. Prevalence of aggregated viewpoints across local sites

Case Study Site	Number of survey responses that match to national viewpoint	Ideal World Commissioning	Efficient Commissioning	Pluralist Commissioning	Personalised Commissioning	Pragmatic Commissioning
A	8 of 10	5	0	2	0	1
B	12 of 14	5	4	3	0	0
C	20 of 34	11	0	1	5	2
D	17 of 22	11	6	0	0	0
E	10 of 13	5	1	2	0	2
TOTALS	67 of 93	37	11	8	5	5

We now move on to set out the aggregated national viewpoints in more detail and, in demonstrating these, we draw on quotes given by respondents in the survey who are identified as illustrating these perspectives. For the purposes of clarification, these are not five personality types or groups, but viewpoints on joint commissioning. In the same sense that there is no 'one' person who epitomises any view completely, there are several people who come close to it (in terms of a 75-80%) match and it is these individuals' words that we quote in the sections that follow. In setting out these viewpoints we employ the '4P outcome' framework that we introduced in the methodology and consider collaborative working in relation to the different dimensions of Partnership, Professionals, Productivity and People. In doing so we demonstrate the degree to which the different joint commissioning viewpoints are seen to be a function of these dimensions. As we described in the previous chapter, in the free text spaces of POETQ, respondents had the opportunity to justify why it was they had agreed and disagreed with the statements on joint commissioning that they had sorted. We utilise the words of those who matched to these different perspectives where appropriate to illustrate these viewpoints.

4.4.1 Ideal World Commissioning

This viewpoint stresses people outcomes more prominently than those associated with the other dimensions of joint working. As one respondent describes:

> *"Joint Commissioning has produced fantastic outcomes for our patients, particularly those with most complex needs"* (site D).

For those who match to an ideal world viewpoint, joint commissioning is a "*no-brainer*" in the sense that it seems like a natural way of working that should lead to synergies between partners. As such, joint commissioning:

> *"takes a wide-lens view of care which is only possible with an integrated workforce - shared knowledge of the local demographic, pooled budgets, reduced bureaucracy, targeted resources according to complexity of need, shared care planning"* (site C).

This viewpoint recognises that long standing differences exist between different professions, but believes that by coming together they might work for the benefit of service users. As one respondent suggests:

> *"All disciplines can share their knowledge and expertise about a patient to come up with the best solution for that person"* (site E).

The ideal world Commissioning viewpoint also believes joint commissioning can have pay-offs in relation to productivity, as working in this way can assure good value for money and help reduce demand and undue pressure on the system:

"A multi-professional workforce is working in harmony to bring their knowledge and skills to reduce risk, inequality and manage limited resources" (site C).

4.4.2 Efficient Commissioning

As its name might suggest, the efficient commissioning viewpoint aligns most strongly with the productivity dimension and sees joint commissioning as the best way to use limited resources. As one respondent told us:

"It may be a cynical view but I feel that the commissioning arrangements [here] are more about the best use of scarce resources rather than promoting fairness and inclusion… to meet statutory obligations rather than to provide choice for service users (site B)".

Again, those that match with the efficient commissioning viewpoint recognise that different professions often have quite different perspectives on the delivery of care, but see joint commissioning as a means to improve relations across agencies:

"Because we have to work together to achieve joint commissioning of services hopefully we will better understand each others' roles and that will lead to improved partnership working (site B)".

In terms of outcomes for people, joint commissioning is viewed as delivering the same for less and therefore efficient commissioning offers little difference in the user experience or potential for improving life outcomes:

"I believe that the main imperative in commissioning decisions is to make the best use of scarce resources" (site B).

4.4.3 Pluralist Commissioning

As with the ideal world commissioning viewpoint, pluralist commissioning also believes that joint commissioning is concerned with improving outcomes for people. Whilst ideal world commissioning sees joint commissioning as an attempt to improve service user outcomes in a general sense, pluralist commissioning is fundamentally concerned with issues such as fairer access, inclusion and respect. As one respondent described:

"Joint commissioning can provide a blueprint for how services look now and how they need to develop in the future. It takes into account the opinions of those who use the service and keep these as the central focus to service design. I believe that an organisation that can evidence its development as being based on the needs of the population will have a more content workforce, shared aims and objectives and more engaged users" (site E).

As this quote illustrates, an important component of the pluralist commissioning viewpoint is that service users have a say in terms of what

services should be delivered and how. This viewpoint believes that professional barriers are fundamentally harmful and sees joint commissioning as a way to break these down and to dispel myths about joint working:

> *"Working in this way helps to dispel the 'us and them' culture/thought - working together rather than in competition"* (site C).

One of the implications of keeping health and social care separate is that the possibilities for innovation and creation are reduced and there is a tendency to focus on organisational imperatives, rather than the end user:

> *"The traditional separate entities of health and social care has meant that creativity has been compromised and service user/citizen engagement ... it is holistic in its approach"* (site D).

Joint commissioning should therefore reduce competition between professionals and allow them to focus on service users. This viewpoint sees debates about productivity as dangerous and believes that the current agenda around cuts and savings is hijacking the real purpose of joint commissioning which should be about addressing peoples' needs rather than saving money:

> *"I feel this statement [about joint commissioning being about more for less] insinuates that cost-cutting is practised purely because health and social care are integrated. I don't believe this is what happens in practice or was ever intended"* (site C).

4.4.4 Personalised Commissioning

The personalised commissioning viewpoint suggests that the primary focus of joint commissioning should be about offering the highest quality service and a seamless service to users:

> *"The public do not want to be concerned with whose responsibility it is they just want to receive a high quality of service and not be bounced between organisations"* (site C).

How this viewpoint differs to the others is that it is more sceptical about the mechanism of joint commissioning.

> *"Although integrated it can still be administratively cumbersome due to the merging of large organisations and the resulting learning it is quite difficult at times to align processes"* (site C).

Joint commissioning can be cumbersome and costly and some professions seem to benefit more than others do. For this reason the personalised commissioning perspective does not believe that joint commissioning requires integrated budgets. In this sense, joint commissioning is one way to work, but it is not the only way to achieve better outcomes for people and in this sense it's also about keeping an eye out for alternative models if they seem to offer a superior way of doing things.

> *"Sometimes things will not always integrate and we need to recognise this. This is not a negative thing but it is about recognising skills and knowledge in the right places with the right people at the right time"* (site C).

4.4.5 Pragmatic commissioning

The pragmatic commissioning viewpoint is concerned with being able to see beyond the rhetoric. Whilst this viewpoint does see joint commissioning as a way to achieve better outcomes, it also see this in a more negative way in terms of the ways in which professionals engage with one another. As one respondent illustrates:

> *"Where joint commissioning has taken part between health and social care then benefits have been seen. However…many teams now see us as a way of getting us to take on their work"* (site C).

In 'getting real' about joint commissioning there is also a need to acknowledge the costs and effort involved. In professional terms there is an acknowledgement that there is a need for specialisation, but that this can mean that there is still a degree of buck-passing in the process of working in partnership.

> *"The traditional approach of working in silos was never the optimal way of benefiting the client.... [But]...There are some areas where I feel specialist knowledge should be just that, after all I would not expect a social worker to carry out a simple let alone complex nursing task"* (Site C).

In productivity terms, this viewpoint believes that joint commissioning can make savings in some areas but costs can also increase elsewhere. This view concludes that joint commissioning is good in theory but difficult to achieve in practice, and it also comes at a price.

4.5 What does success mean for these viewpoints?

As demonstrated in the previous section, each of these viewpoints aligns in different ways in terms of the four dimensions of joint working and these are summarised in Table 12. Given that these viewpoints hold different perspectives in terms of what joint commissioning is, they also hold different notions of what success might look like. If we accept that there are different perspectives on joint commissioning in terms of its definition and what it should do in practice, then there will be differing perspectives of what it should achieve.

Table 12. The five national viewpoints mapped against different outcome dimensions

Viewpoint	People outcomes	Partnership outcomes	Professional outcomes	Productivity outcomes
Ideal world Commissioning	Joint commissioning produces better outcomes for service users.	Joint commissioning leads to synergies between partners.	There are differences between professional groups, but joint commissioning can help alleviate these.	Joint commissioning can lead to better value for money.
Efficient Commissioning	Joint commissioning makes little difference in terms of service user outcomes.	What joint commissioning symbolises is more important than what it does.	Professionals having competing agendas can make joint working difficult.	Joint commissioning is about making commissioning more efficient.
Pluralist Commissioning	Joint commissioning is about providing fairer access, inclusion and respect for service users.	Joint commissioning can provide an holistic perspective, but doesn't necessarily deliver synergies.	Differences between professionals have been overstated; joint commissioning offers an opportunity to dispel myths of 'us and them'.	Joint commissioning is not about saving money.
Personalised Commissioning	The highest quality of service should be offered and service users should experience seamless services.	Joint commissioning can help build empathy between professionals.	Some professionals benefit more than others and joint commissioning can lead to buck-passing.	Joint commissioning can be cumbersome and costly.
Pragmatic Commissioning	It is important to address the needs of "real people".	Joint commissioning involves a lot of cost and effort.	Joint commissioning can exacerbate the difficulties of joint working.	Joint commissioning is good in theory, but in practice it is difficult to achieve and comes at a price.

The ideal world commissioning view of success is perhaps the most ambitious. It envisions a situation where people are working together in shared spaces, achieving more than they could before where there is a blending of professional cultures and there is no longer reference to "*us and them*". For the service user the service fits their needs, exceeds their expectations, they feel engaged and efficiencies mean it costs less for the exchequer too.

The efficient commissioning view of success is to get to a stage where professional groups are able to work together in the complex task of commissioning health and social care. It is about overcoming the upheaval of reorganisation and the practicalities of office moves and office administration. Success is also in ensuring that cuts to budgets are not felt by the service user. This is not to say that those who relate to this viewpoint do not want to see services improved, but that their notion of success is more realistic in the sense of thinking about what can be achieved within current constraints.

The pluralist commissioning view of success is where the service moves beyond historical professional divides and invests energy in finding means to engage service users in the coproduction of their service. Service users and carers should not be passive recipients of services. They have a right to know how decisions that affect their service are reached and how providers are selected. More than economic performance, a pluralist commissioning view of success focuses on a democratic performance.

The personalised commissioning view of success starts with the experience and the quality of the service for the end user and works backwards. So long as the service delivered is of the highest quality, it takes a pragmatic view of how or by whom the services are delivered. Whereas other viewpoints value increased partnership working, this view argues that working in partnership is one way but not the only way of organising the commissioning of services in health and social care.

Finally, the pragmatic commissioning view of success see professionals working together to offer service users choices that meet their needs as being crucial. However, this viewpoint acknowledges that this end point will need financial investment and a sense of empathy fostered between professionals so that they acknowledge the specialist skills of their colleagues. This viewpoint recognises the length of time that it takes to build effective integrated services and does not think that success is achieved over night.

Given that these viewpoints each visualise the success of joint commissioning in different ways we could argue that we might set these perspectives up in comparison to one another, which we have done in Table 13. This Table sets out the main line of argument put forward by the viewpoints and how this might be viewed by the other perspectives. As an example of this, an ideal world commissioning view could be construed as

optimistic, ambitious but equally unrealistic or impatient in the sense that it seeks to deliver everything and now. Similarly, pluralist commissioning could be viewed as important in opening up the policy process, but by others as unnecessary, self-righteous or pushing for the wrong things.

Table 13. How the different viewpoints view one another

Viewpoint	Main argument	Viewed by others
Ideal World Commissioning	Let's be optimistic	Lacking perspective
Efficient Commissioning	Let's improve the system	Lacking ambition
Pluralist Commissioning	Let's open this up	Lacking control
Personalised Commissioning	Let's look at this in a different way	Naive
Pragmatic Commissioning	Let's be realistic	Too cynical

Finally, it is also worth emphasising that the five shared viewpoints outlined here were found not within one case study but across the five sites. What this means is that even though the types of joint commissioning arrangements are quite different across the five sites there are shared perspectives about what joint commissioning is and what it is supposed to achieve in practice and these viewpoints are not necessarily tied to specific joint commissioning arrangements.

4.6 Viewpoints and professional groupings

In addition to the viewpoints not being tied to specific joint commissioning arrangements, they also extend across the many professions of those who took part in the survey. Examples of these are demonstrated in Table 14 with some of the professional groupings of individuals at the different sites are set out in relation to the viewpoints they match to. As Table 14 illustrates, these viewpoints do not necessarily align with professional groupings to the extent that, for example, all nurses align with a pragmatic commissioning viewpoint. Instead there is real variation in terms of the types of professionals that align with the different viewpoints.

Table 14. Professionals from case study sites matched against national viewpoints

Case Study Site	Ideal World Commissioning	Efficient Commissioning	Pluralist Commissioning	Personalised Commissioning	Pragmatic Commissioning
A	Director of Commissioning, Assistant Director Public Health		Partnership Manager		Commissioning Manager
B	Chief Executive, Project Manager	Care Manager	Mental Health Commissioner		
C	General Practitioner, Assistant Director Finance, Operations Director		Occupational Therapist	Community Matron, Occupational Therapist	District Nurse, Physiotherapist
D	Performance Manager, Head of Medicines Management	Performance Manager, Safeguarding Nurse, Finance Manager			
E	Director of Public Health	Director Local Authority	Community Researcher		Community Commissioner

However, there are limits to the types of conclusions which can be drawn from this data. Firstly, by asking people to describe their job description in the survey, this in no way reflects the views of any particular professional group. Secondly, whilst it is tempting to remark upon gaps in terms of missing viewpoints, the sample was drawn on an 'opportunist' basis and so merely reflects the viewpoints at a particular time and space and in no way suggests that it is fixed in terms of the full range of viewpoints which might be present in the case study localities. The third and final point pertains to the fact that in some localities, a number of the respondents' sorts did not contribute to any of the five groups. As we can see from Table 11 there are 26 individuals who do not match against these nationally aggregated viewpoints. In order to investigate this in more detail we further conducted analyses of the data for the specific case study sites. As we set out in the next section, when we analyse the data by the individual case study sites we find that there are some different viewpoints that emerge and which pertain to the individual sites. This suggests that there is something specific about the way that joint commissioning is organised in that local context which generates different viewpoints to the other sites.

4.7 The local picture

As outlined in the previous section, there are a number of individual Q sorts that do not match to the five national viewpoints that were identified. Therefore we repeated the analysis process at a local level - in effect producing a further five individual sorts. We then employed a statistical test to examine the sorts and see whether there is a mutual relationship between the national and local viewpoints. As we explain below, when this process was conducted we identified six more local viewpoints in relation to the case study sites. One advantage of this type of approach is that in performing such a test, unlike traditional research, using POETQ allows us to surface these more local nuances amongst the different viewpoints which could hold the key to understanding any differences in local determination. These findings would have gone unchecked unless we had explored these patterns in more detail and performed a separate second order analysis.

4.7.1 Case Study A

In analysing the local data from Case Study A we find that three viewpoints emerge. When we correlate these against the national viewpoints, we find that two of these match against the ideal world and personalised commissioning viewpoints. However, there is also another viewpoint which does not correlate with the national picture. The findings of this process are illustrated in the correlation matrix presented in Table 15. What we have done in producing these tables is analyse the degree to which the three viewpoints identified at this site correlate with the national viewpoints.

Here a score of 1 is a perfect correlation with a viewpoint. Table 15 shows that whilst the first and second viewpoints are highly correlated to two of the national viewpoints (ideal world commissioning with a correlation of 0.87 and personalised commissioning with a correlation of 0.94); the third viewpoint bears little correlation to any of the national viewpoints, and as such represents a more nuanced view of joint commissioning which is specific to that area. We now go on to provide an overview of the viewpoint that is specific to Case Study A, known as realistic commissioning.

Table 15. Correlation Matrix Site A

Case Study Site A Viewpoints identified	Ideal World	Efficient	Pluralist	Personalised	Pragmatic
A1	**0.87**	0.03	0.04	0.16	0.15
A2	0.01	0.03	0.01	**0.94**	0.01
A3	0.03	0.01	0.03	0.02	0.01

Similar to the pluralist commissioning viewpoint, **realistic commissioning** is concerned with delivering a high quality service and improving outcomes for people in terms of fairer access, inclusion and respect:

"In my opinion the service user is at the heart of any service or process we commission and the experience and interaction a service user has with any of these services should be as seamless an experience as possible. This will help promote confidence in the services we provide and promote quicker recovery and or rehabilitation".

But there is also an additional aim of joint commissioning that is concerned with achieving primary prevention and improved early intervention. As one respondent illustrates:

"Reducing pressure on acute services is important, but in my opinion should not be the sole driver. In my opinion joint commissioning is about working closely with health and social care teams to ensure the best possible outcomes for service users. If we commission these services correctly in the beginning the benefits of this should indirectly reduce pressure on acute services as a consequence".

Yet despite being concerned with prevention there is a question about whether joint commissioning does really manage to reduce pressure on acute services. This viewpoint suggests a commitment to joint working and professionals being engaged because they want to rather than because they have to;

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"My team are not driven by [government] requirements [to collaborate] or by ticking boxes".

Yet, in practice, joint commissioning does little to address the amount of red tape and bureaucracy which colleagues have to manage, nor does it lead to better working conditions for colleagues. In summary then realistic commissioning is about delivering better outcomes for people and professions but not in terms of productivity or partnership.

4.7.2 Case Study B

When we analysed case study B individually we found that four perspectives emerged. When correlated against the national viewpoints we find a high degree of match with the ideal world and efficient commissioning viewpoints (See Table 16). What stood out here are two further profiles that are broadly unrepresented in the national picture. Table 16 shows that the third viewpoint identified at this locality is 0.43 correlated with pluralist commissioning, but in the main, the third viewpoint is something distinct and seemingly unique to this case study. We have called this systems based commissioning on the grounds that it is linked to, but different from, a pluralist commissioning approach. There is a fourth and final view point present at this site which has little or no resemblance to the five national-level viewpoints. We have called this cuts commissioning.

Table 16. Correlation matrix site B

Case Study Site B Viewpoints identified	Ideal World	Efficient	Pluralist	Personalised	Pragmatic
B1	**0.84**	0.09	0.51	0.21	0.61
B2	0.36	**0.89**	0.53	0.30	0.42
B3	0.18	0.34	0.43	-0.16	0.20
B4	0.17	0.21	-0.28	0.08	0. 17

The **systems commissioning** viewpoint is linked to the national pluralist commissioning viewpoint, although it emphasises professional outcomes more than service user outcomes. Systems commissioning is about joint commissioners being professional and effective so that there are clear processes for holding individuals to account for risk management. Therefore unlike some of the other viewpoints, standardisation is not a negative but a positive thing:

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> *"Since we are all wanting the same thing...better outcome for service users using our particular frame of reference, using the same guidance and policy outlines"*.

Joint commissioning is also seen as a way of enhancing organisational survival in tough times and reduces the opportunities for cost-shunting and passing the buck. Respondents told us:

> *"There has to be cashable benefit for partners to enter such a partnership given the Comprehensive Spending Review".*

According to this viewpoint, joint commissioning can be seen rather cynically as demonstrating to government, that agencies are aligned and "*working together in partnership*", but that isn't to say that red-tape and bureaucracy have disappeared. In terms of the motivation to work in partnership, systems commissioners argue that in addition to offering some consistency around 'how we do things', joint commissioning is also mostly driven by a need to fulfil government requirements to collaborate.

The second viewpoint specific to case study B is that of **cuts commissioning**. This viewpoint believes that joint commissioning is about trying to make real improvements to the lives of service users. However this viewpoint also believes that any attempt to involve users in processes of joint commissioning is tokenistic.

> *"Sometimes I feel that service user involvement is viewed as a tick box exercise rather than a genuine attempt to have the people who use services shape services".*

This viewpoint recognises challenges in the current context in relation to an ageing population and constrained finances and sees joint commissioning as playing a part in dealing with these challenges:

> *"We live in an ageing society; money is scarce and there are many increasing priorities. Therefore joint commissioning should come into its own if there is a strategic approach to planning and service delivery".*

This viewpoint is also aware of the impacts of the financial context in terms of restrictions on what services people can access and the range of choices they might be offered. In summary then, whilst cuts commissioning acknowledges the potential of joint commissioning to offer a strategic approach to tackling the challenge of improving lives, there is a healthy scepticism about the possibilities this will ultimately bring in terms of outcomes for service users.

4.7.3 Case Study C

In studying the results from case study site C, three viewpoints emerge for this site. As we can see in Table 17, the first correlates highly with the ideal world commissioner profile (0.93); the second correlates highly with

personalised commissioning (0.94); and the third correlates although to a lesser degree with the pragmatic commissioning profile (0.76). What this means is that there were not any viewpoints that were specific to Case Study C and these strongly aligned with the results we derived at the national aggregate level.

Table 17. Correlation matrix site C

	Ideal World	Efficient	Pluralist	Personalised	Pragmatic
C1	**0.93**	0.31	0.57	0.61	0.52
C2	0.46	0.35	0.32	**0.94**	0.43
C3	0.77	0.23	0.47	0.46	**0.76**

4.7.4 Case Study D

For Case Study D, when analysed at the local level we found that three viewpoints emerged.   Two of these viewpoints match to the national aggregated data in terms of the ideal world and efficient commissioning viewpoints, whilst one appears to be local to Case Study D. We have called this preventative commissioning.

Table 18. Correlation matrix Site D

	Ideal World	Efficient	Pluralist	Personalised	Pragmatic
D1	**0.90**	0.41	0.38	0.45	0.65
D2	0.40	**0.75**	0.27	0.45	0.58
D3	0.51	0.21	0.30	0.11	0.32

In terms of the **preventative commissioning** viewpoint what matters most is the partnership potential for joint commissioning to enable informal relationships so that they might be able to deliver better preventative services. Prevention is better than cure according to this viewpoint and can be achieved through a learning process and the acknowledgement that actors are quite different and working together effectively will take time. Sharing an office space and working face to face in the same building should provide the opportunity to share ideas and be creative. This matters because the nature and the complexity of the challenges mean professionals

need to understand the nature of each others' roles so it makes it less confusing for users of services.

> "*Our service users shouldn't even know the system behind delivery of their service*".

This view of joint commissioning recognises that to tackle the most entrenched social problems working jointly is needed so that early intervention and preventative services might be provided.

> "*Because if we don't [prevent or intervene early] then we will never achieve improved outcomes for our population. It's also how [by] jointly working we can achieve everyone's agenda*".

There is a sense in this viewpoint that joint commissioning should significantly alter the way that services are delivered. This will involve a fundamental change and will not simple produce the same outcomes at slightly less cost:

> "*Because this [idea of delivering same for less] isn't true joint commissioning if this happens. We need to deliver more for less - and being innovative and creative in what we do, i.e. not the same!*"

However, this viewpoint does recognise that joint commissioning comes with costs and that it may be damaging to team morale:

> "*Morale hasn't been boosted and duplicate reporting to different meetings doesn't help*".

4.7.5 Case Study E

Finally, examining Case Study E's local data identifies three viewpoints. As we see in Table 19, the first of these correlates to the national Ideal World commissioning viewpoint and there are also two other viewpoints which did not appear to correlate with that of the national picture. We call these perspectives accountable commissioning and influential commissioning.

Table 19. Correlation matrix site E

	Ideal World	Efficient	Pluralist	Personalised	Pragmatic
E1	**0.87**	0.29	0.06	0.14	0.28
E2	0.12	0.01	0.21	0.13	0.16
E3	0.15	0.08	0.18	0.03	0.07

The **accountable commissioning** viewpoint has a strong belief in the notion of meaningful co-production. In keeping with a pluralist commissioning approach, accountable commissioning is primarily about

investing in the people and productivity outcomes of joint commissioning to ensure fairer access, inclusion and respect, but also a means of engaging service users in the co-production of services by holding commissioners to account.

> *"It's about making sure there's a long term change and it's not just a one off event. There needs to be choice but which meets people's tailored needs. It's no use providing services people don't want".*

As with an ideal world commissioning approach, accountable commissioning is about acknowledging the benefits that partnership brings through increased information sharing but in terms of its holistic approach rather than its synergistic effect:

> *"Commissioners need to be humble enough to understand the community's way of thinking about things and match it up with their own expertise. No one should be snobbish about [the way that] local people see things".*

Indeed, joint commissioning is about how that information can benefit service users in terms of increased communication.

> *"People need to be educated that even if services aren't perfect and on their doorsteps, they need to know where to go for alternatives and raise awareness about service provision".*

In productivity terms accountable commissioning means delivering pretty much the same level and standard of service but organised in a different way. In some ways, it's also about investing now to save in the future but it is certainly not about delivering more for less and neither is it the only way to deal with the most complex social situations.

The **influential commissioning** viewpoint is similar to the pluralist and pragmatic viewpoints in the sense that it recognises the potential of joint commissioning to address the needs of 'real people' in terms of reducing inequalities in access for service users but only if it's by improving the way that service users can influence the services they receive*.*

> *"If it works it'll mean improved services for local people which make a difference".*

As one respondent described:

> *"The old way isn't working so [we] need a new way to address most complex problems that means bringing the community in".*

There is a degree of scepticism in this viewpoint about the extent to which joint commissioning will lead to increases in productivity or will help sharing ideas across organisations. In short, whilst there is recognition of the capacity of joint commissioning to improve outcomes for people, influential commissioning suggests that this is more likely to come about through investing in the way that service users can influence the services they

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receive, rather than through formal partnerships or attempts to increase productivity.

4.7.6 Bringing the viewpoints together

Analysing the local data against the national picture demonstrates that some viewpoints are more prevalent than the others. As Table 20 shows, there is one viewpoint, that of ideal world commissioning, which is operant across all local sites and appears as a strongly held way of thinking about joint commissioning. Of all of the viewpoints this is probably the most optimistic and aspirational of all, believing that joint commissioning should lead to better outcomes for service users, will help in working relationships between professionals and can also lead to better value for money. The efficiency viewpoint arises in two of the five local sites, as does the personalised commissioning perspective. Meanwhile, the pluralist commissioning viewpoint is not operant within any of the local sites and only emerges once we aggregate the data. The local viewpoints are often linked to national ones but with a slightly different flavour in terms of the local nuance of the debate around joint commissioning. As such their difference to the national perspectives and to one another is subtle rather than being significantly diverse.

Table 20. Summary of viewpoints identified through local analysis of data

Case Study	Ideal World commissioning	Efficient commissioning	Pluralist commissioning	Personalised commissioning	Pragmatic commissioning	Additional local viewpoints
A	X			x		*Realistic commissioning*
B	X	X				*Systems Based Commissioning* *Cuts Commissioning*
C	X			x	x	*No*
D	X	X				*Preventative Commissioning*
E	X					*Accountable Commissioning* *Influential Commissioning*

4.8 Chapter Summary

In this chapter we have set out the findings which were derived from the use of the POETQ tool in each of the case study sites. Firstly we set out the key features of the case study sites and demonstrated the array of joint commissioning arrangements that we have studied in this research. We received a rich set of data with 93 completed POETQ surveys from across the five case study sites and we analysed this at two different levels. Firstly we aggregated the data and identified five different viewpoints of joint commissioning. We illustrated the key features of these different viewpoints and argued that these all demonstrated slightly different expectations of what successful joint commissioning would look like in practice. Following this we conducted a second order analysis on the data so that we extracted the viewpoints gathered at a local level. From this we gathered some more local viewpoints of joint commissioning, again which hold different expectations for joint commissioning. Table 21 sets out an overview of both the national and local viewpoints that we identified through the use of POETQ.

What this process of data collection suggests is that when we analyse the understandings of people working in and within a range of different types of joint commissioning arrangements we find that the perspectives on what joint commissioning is and what it should achieve are rather more nuanced than those within the wider literature. We do find the theme of efficiency within the aggregate analysis and this is one theory of joint commissioning that carries through right from the wider literature to the local analysis of the data. However, at the aggregate levels the themes of empowerment and prevention are diluted somewhat across the pluralist, personalised and pragmatic viewpoints. None of these viewpoints deal directly with these issues. Although all three are concerned with various aspects of service user experience and quality of service, all are more circumspect about the capacity of joint commissioning to deliver these agendas in practice. These aggregate viewpoints are also all a great deal more negative about some of the potential impacts of joint commissioning than the literature tends to be.

Focusing the data in even further to the local level, we find that with the exception of the pluralist viewpoint, the aggregate viewpoints persist at this level. What we also find are even more nuanced accounts of joint commissioning and the introduction of even more competing interests in relation to this agenda. Many of these local viewpoints are related to the aggregate ones but slightly accentuate the roles of particular groups. For example, the systems viewpoint at site B emphasises the importance of the process aspects of joint commissioning and the impacts that this has on professionals working within these arrangements. This sits alongside the cuts commissioning viewpoint which takes the efficiency discourse of joint commissioning identified in the literature review but takes this to a more extreme edge suggesting that it is about saving money predominantly and

is not concerned with involving service users. Site D has a local viewpoint that does bring the focus back specifically to the prevention agenda, linking back to the discourse identified in the literature review.

What these findings show is that there are clearly shared theories concerning what joint commissioning is and what it is attempting to achieve in practice. The closer to the site that the analysis was conducted the greater the nuance introduced into the theories generated in terms of what joint commissioning is and how it operates locally. In the following chapter we go on to conduct deeper analysis in order to find out more about how these theories co-exist in practice and what data there is to support these theories.

Table 21. National viewpoints of Joint Commissioning

Viewpoint	Description	Main Argument	Viewed by others
Ideal world commissioning	Delivering better services for less money	Let's be optimistic	Lacking perspective
Efficient commissioning	Saving money but not necessarily impacting on users	Let's do what we can	Lacking ambition
Pluralist commissioning	An opportunity to get beyond the myths of "us and them" to offer users greater choice and a fairer system	Let's open this up	Lacking control
Personalised commissioning	Less about choice and more about giving the user what they want – a decent service	Let's get the job done	Lacking principles
Pragmatic commissioning	Acknowledges the difference between rhetoric and reality whilst also recognising that successful joint commissioning is difficult to achieve and often comes at a price	Let's be realistic	Lacking pace

5 Phase Two: Joint Commissioning in Practice

5.1 Introduction

In this chapter we set out the findings derived through the second phase of the research programme. This phase of the research was designed to investigate the meanings of joint commissioning at the local level in more detail and tease out precisely what the case studies understand by joint commissioning and the impacts which this had in these localities. The data presented in this chapter is set out according to four major themes:

- How do people talk about joint commissioning?

- What organisational processes are in place to facilitate joint commissioning?

- What are people doing when they say they are 'jointly commissioning'?

- What impact (if any) has joint commissioning had?

What we aim to do through this is to map out the theories underpinning joint commissioning within the five localities. In doing so we aim to address the first research question where we seek to explore the relationships between joint commissioning arrangements, services and outcomes. In investigating the sorts of impacts that joint commissioning has had we also seek to test the veracity of the hypothesised relationships between joint commissioning, services and outcomes.

5.2 How do people talk about joint commissioning?

As phase one of the research illustrated, there are a range of different viewpoints concerning what joint commissioning is and what it should achieve. In the second phase of the research we further sought to comprehend what stakeholders understood in terms of joint commissioning. As we described in the methodology chapter, in many of the sites we held feedback workshops where we presented the phase one findings back to the sites. Where it was not logistically possible to hold these sorts of events we provided participants with copies of the findings from phase one so that they could familiarise themselves with the viewpoints, or held one to one debriefs at the start of interviews (in the case of site D). In phase two we then sought to check out with a wider audience the degree to which

these viewpoints resonated and to explain some of the reasons why it is that these findings might have emerged in relation to these local areas.

As we illustrated from the phase one findings, the viewpoint that resonated most widely was that of ideal world commissioning which is probably the most aspirational amongst the group and sees joint commissioning as something that can produce better outcomes, synergies between partners and professionals and save money. This viewpoint is arguably also the most impatient in the sense that it believes that everybody wants the same thing and is therefore fairly optimistic in this sense. At each of the sites we found groups of individuals who told us that they fundamentally believed in joint commissioning and saw it as important in delivering a range of different organisational and service user outcomes. This suggests that the notion of joint commissioning as being a generally "good thing" was well embedded in the case study sites. This may not be entirely surprising given that those who completed the survey were largely commissioners themselves. Yet, in all of the sites these individuals were joined by groups of others who see joint commissioning as focused on particular factors, be they organisational efficiency, giving service users choice and control, or making it easier for professionals to work together. In this phase we sought to understand how these different perspectives co-existed in practice and which were perceived to be the most dominant.

On closer investigation it appears that each of the sites understands joint commissioning in a slightly different way, with these nuanced perspectives linked closely to the specific contexts of that locale. In the remainder of this section we briefly set out an understanding of joint commissioning within each of the sites and make links between these where possible. Where we use verbatim quotes from the case study sites we have illustrated where these data sources came from (e.g. focus group, interview etc).

5.2.1 Case Study A

Case Study A is the most established of all the joint commissioning arrangements with the initial partnership coming together just over a decade ago. As we discovered through the first phase of the research, the ideal world perspective on joint commissioning is strongly operant in this site and the subsequent qualitative investigation found that staff in this locality are very wedded to the idea of joint working and believe that this is crucial if better outcomes for service users are to be achieved. As one Director explained:

> *"I do think integrated commissioning works really well. That doesn't mean to say we've got it right... We need to refine the model more"* (Director, Focus Group Joint Commissioning Team).

Thus, there was a strong sense that ultimately joint commissioning is a good thing that should bring about better outcomes, although participants

did not always feel that this was fully operational at present.   As the previous quote also illustrates, the terminology used at this case study was more often that of "integrated commissioning" rather than joint commissioning. This was seen as important because integrated commissioning was viewed to represent a greater degree of "closeness" than joint commissioning and is therefore preferable.

The area that case study A is based in is one of the most disadvantaged areas in the country, with a 15 year gap in life expectancy between the most deprived and affluent wards.   The vision set out in the documentation for the joint commissioning team suggests that it aims to "adopt a strong partnership approach to tackling the causes of ill health" and many of the stakeholders involved in the research suggested that this is the key driver of integrated commissioning. As one respondent told us:

> *"Health inequalities...are so huge that the only way you can tackle them and really improve people's lives...is if you tackle it across Health and the Council"* (Director, Focus Group Joint Commissioning Team).

 The need to address significant health inequalities then is the driving force for integrated commissioning in this locality, although this has the added effect of providing better efficiencies through investing in preventative services for example. There was a strong theme relating to the need to "*invest to save*" through joint commissioning. The locality where this case study site is based has a very strong sense of place and this came through in interviews and focus groups as the need to spend what public money there is in the most efficient way on behalf of the local population:

> *"So, it's about tackling the wider determinants of health and that includes unemployment, housing, you know, they're the biggest...so it's looking at those and it's about investing the [place] pound, you know, it's not a PCT pound, it's not a Council pound, it's the people's pound and that's investing it to achieve better outcomes for people in the borough"* (Director, Focus Group Joint Commissioning Team).

Bringing together a range of partners in this way should also offer a wider range of services for the local population and reduce duplication across partners. One of the themes that also recurred at this site related to an attempt to provide more seamless services and single points of access for service users so that they are not required to join up services for themselves. As one commissioner reflected:

> *"I've not met a service user yet that is interested in which department is responsible for what, or which organisation is responsible for what, or which commissioner is responsible for what. They just want to know how to access the services holistically and it's about us achieving that so that the service users don't need to be asking those questions"* (Commissioner, Focus Group Joint Commissioning Team).

This was seen as particularly important given that the primary client group that these integrated commissioning arrangements were concerned with are older people and there was a sense that this group values continuity of care and care givers as an important component of high quality care. As one commissioning manager explained:

> "The whole point of integrated commissioning is to create something like the Centre for Independent Living, where somebody's got one point of access, or only needs to be visited by one professional to perform a range of functions, or where services and providers can join up, to make sure that they can offer the best, most effective service for somebody at the end of that. So maybe they see three or four people who can come and help them with a whole range of issues. Instead of that happening, they see one person who can help them with that whole range of issues, so for me, that's one of the main purposes about **integration**, there's lots of other things that you can get from that, but that's one of the main reasons why I think it works and it's a good idea" [emphasis added] (Commissioning Manager, Focus Group Joint Commissioning Team).

What this quote illustrates is not only the importance placed on the notion of seamless services and having fewer people delivering care but also one of the difficulties that respondents had in thinking about the distinction between commissioning and provision. The kinds of changes that this respondent is referring to are arguably those which are more likely to have been produced through providers, as opposed to commissioners. This is illustrated in the previous quote through the use of the term integration rather than integrated commissioning. A strong theme of the research with all of the sites was the inability to separate out provider and commissioner-related changes and a tendency to conflate these in practice.

At the heart of the rationale for integrated commissioning at site A is a sense that some sort of mechanism is needed in order to join up the complexity of the range of public service organisations that exist in deprived areas such as this. Many of the respondents reflected that service users are not interested who provides services to them just as long as they get the support they require. Therefore the purpose of joint commissioning is to think about the types of outcomes that need to be achieved and design a system that should deliver this. As one commissioning manager described:

> "Commissioning is actually how you try to make a very complex situation, a very complex interaction of resources, people, themes, government policy, local policy, ethics, morals and actually put them into some sort of meaningful plan that lets you actually get to where the actual person doesn't see all the work and all the stuff that's gone before and just actually received the support they actually need. ..it actually provides a process and a model you can...use to get through...the many hazards and trips you have to go through to

actually achieve these services from very complex processes"
(Commissioning Manager, Focus Group Joint Commissioning Team).

Figure 5 is one of several figures set out in this chapter to illustrate how respondents from the sites spoke about joint commissioning in their locality.

Figure 5. Example of joint commissioning project site A

"If you go back probably five, six years ago now, we have handy person services within the borough and you had the PCT, the Health, Falls and Well Being service and if they identified someone who was at risk of falls, they employed a small handy person that did hand rails up the stairs and some very minor things, had a budget for that. They also then had a separate contract with a building company that did some more major sort of rails, hand rails outside properties, that type of thing, that would reduce falls. Then on our community occupational therapist team within the local authority, we were also identifying people that needed assistance and quite often they were handy person type services and we had the contract as well for that type of work. We then had the Home Improvement Agency, that was initially looking at core service of helping people get rewires, new roofs, that type of thing, but didn't do a huge amount on actual handy person services. That was the smaller part of what they did then and what we did is we brought all of those budgets and integrated them together and brought the Housing budget that was there for the Home Improvement Agency, we brought the Primary Care Trust and we brought the Council budget and they all came together as one pot of money that actually changed our Home Improvement Agency into a really large Care and Repair service that now has trusted assessors...one person goes out to a home owner or resident in the borough that will actually assess them for those items and if those are the items that they need or are going to make a difference, they will actually fit them there and then... they can look at my holistic needs in my property in terms of minor adaptations and repairs and they can give me the whole service. They didn't have to go to them, to them, to them and be seen by maybe three assessors and then be seen by three different handy persons, contractors. They now get one person assessing and the same person will actually do that work for them as well and I would say that's quite a good experience of how things are done differently now to probably four or five years ago" (Focus Group Joint Commissioning Team).

5.2.2 Case Study B

In comparison to case study A, site B offered some very different perspectives on the drivers for joint commissioning. As was detected through the first phase of the research there is a strong efficiency viewpoint expressed in this locality and similar themes were also picked up through the local cuts viewpoint. To some extent this might be seen as unsurprising given that the joint commissioning team was set up with the aim that it would

> *"Eliminate duplicate services and allow them to make the best use of public funds"* (Commissioner, Focus Group Commissioners*).*

This involved pooling the budgets of three PCTs and the city council, establishing the largest pooled budget in the country of approximately £300 million. A lot of the focus of joint commissioning at this site then was around establishing a single commissioning strategy that cut across the boundaries of at least four organisations within a context that the budget for these services had not been balanced in a significant number of years. With further impending cuts to spending across both health and social care these changes were predicated on the basis that they should help to shield services from these further cuts.

Against this background, much of the interest in joint commissioning was in terms of the efficiency gains that it might bring. Just the sheer size of the budget was seen as something that had been helpful locally and had allowed the site to manage more effectively:

> *"In joint commissioning, you kind of take the hit in both sides, [be]cause you're taking a hit from the Adults and Community side having to save a certain amount of money because of Government direction and you've then got it double barrelled from the Health side having to save money, you know, it's just the fact of having joint commissioning helps that because you can manage things"* (Officer, Focus Group Commissioners)*.*

The process of joint commissioning was understood as providing a way to redesign services across the newly designated (larger) geographical area, remove duplication and also ensure that the same sorts of patient pathways were offered across the patch. Joint commissioning was also seen as a vehicle through which to think about early intervention services which would also in the longer term save money. However, stakeholders were keen to note that this was not just to generate efficiency savings just for the sake of it and also believed this would in the process provide better services:

> *"We've made some great inroads with regard to the pooled budget and actually joint funding packages for people, so actually people are getting a better service. It's not about upgrading people's assessments...so they meet continued care so that health has to*

> *pay...we can use both parts of the budget to actually get them a better service"* (Officer, Focus Group Commissioners).

There was a feeling locally that partners have sometimes in the past had conflicting agendas and that joint commissioning could provide a way of getting over the longstanding differences which had sometimes posed difficulties when working together:

> *"I know you feel that you've got two different agendas between Health and Social Care...but it is about pushing...the issue here is about where you feel it doesn't merge...it cascades through the top down, so we've got one agenda for joint commissioning"* (Officer, Focus Group Commissioners).

Ultimately joint commissioning was seen as a way in which case study B could:

> *"Get people together from all the different sectors, Health, voluntary sector, local authority, supporting people and trying to map out what everybody was doing and get some commonalities and get them working together"* (Officer, Focus Group Commissioners).

On the issue of terminology the commissioning team at this locality were not keen on the term joint commissioning and believed what they were doing was simply commissioning. This was not a reflection of some division between commissioners but instead was a sign of how well the commissioners felt they worked together across health, social care and other partners. To call this a joint commissioning arrangement might signal that it could in the future be pulled apart back into its separate components:

> *"I think we've gone way past that now and we are a commissioning function...we've moved beyond a joint commissioning team"* (Manager, Focus Group Commissioners).

So whereas site A talked about integrated commissioning to signal their togetherness, site B instead simply referred to commissioning in order to signify the same thing.

One commissioner described how a major project at this site had been in relation to revisiting the contracts that commissioners have with providers and this is set out in Figure 6.

Figure 6. Example joint commissioning project site B

> "We're looking at...some of these contracts with the major providers have been pretty flabby and there's been a lot of wastage in them and a lot of overcharging for things what haven't been delivered and all of a sudden, because of where we are at this moment, we've got a strategy and we've all come together and the economic situation, we're starting to look at everything that's going on and look where there's duplications and it can be improved and we've got loads of work stream agendas on and they are going to deliver savings and we believe the services will be better for people. They'll be fairer, more accessible and all those sort of like social agendas are there as well. So I find it quite exciting at the moment, I think we're at a real zenith of it and there's going to be like a lot of results in the next year probably coming through. I mean, we might slow down, I think we might get to a stage where we've cut it so much that there's not much you can squeeze out of it..." (Focus Group Commissioners).

5.2.3 Case Study C

Of all of the case studies, C and A are the most similar in a number of respects. Site C is a well established care trust, formed in 2005 and which provided and commissioned services at the time of the research. As with Site A, the language used by stakeholders was not that of joint commissioning. Perhaps reflecting the nature of the organisation as a care trust there was often little distinction made between commissioning and provision and respondents simply referred to "*integration*". The vision for this organisation is about providing "*the right care, the right place, at the right time*" and integration was seen as a way to put service users and carers at the centre of service design.

The main driver for integration at this site is to put the individual at the centre and to design services around them. This echoes the key points of the personalised and pragmatic viewpoints which both point to the importance of providing seamless services that deal with the needs of "real" people. As one senior manager explained:

> *"If you're passed from pillar to post...that's a bug bear, so the cleanest thing is...one point of contact, knowing then it doesn't matter whether it's health or social care, you're going to get the service that you need and somebody else is going to do all that co-ordinating for you. I don't have to do it as the patient or carer of the patient or the service user, somebody else will take that away from me. I think that's absolutely fundamental in all of this"* (Senior Manager, Interview).

Site C had done a lot of local organisational development work using a fictionalised person and her family as the central narrative of this process. This individual is aged over 80 and is a user of both health and social care services. A story was constructed around this individual in terms of the services she required and the difficulties she faced in trying to navigate the health and social care system. The Trust vision centred on improving access to services for this character and individual staff across the organisation were able to connect with her as many of them recognised this person and the challenges she faced. This character became a symbol of the organisation and was present in most presentations and service delivery discussions.

Again, in line with case study A, joint commissioning was seen as a way in which to drive efficiencies, to identify duplication and provide better value for money:

> "I work in the real world, I know that the budgets are going to be cut, I know that we're going to work with less and less and we have to do more and more...it is incumbent on us to look at where we can cut things out, where we look at waste, where we look at lean processes" (Social Worker, Interview).

Having pooled budgets was seen to facilitate better care for patients and facilitate a patient-centred approach which should lead to fewer debates over boundaries:

> "If I'm spending money, whether it's health money, whether it's social care money, it doesn't matter. If my patient is at the heart of what I'm doing and I'm putting in the service to do that I haven't got to worry about, I've got to go to Joe Bloggs for a bit of health money, I've got to go to X Bloggs for a bit of social care money. Then you're at a discord, whereas actually, you're in control of the pot and you do the right thing...take the boundaries out and just concentrate on the service user or the patient, 'cause it makes you do the right thing" (Manager, Interview).

Figure 7. Example joint commissioning site C

> We did have a combined commissioning department so it meant that we had NHS commissioners and social care commissioners all in one location and we were all in one location and we were able to sort of share what we were doing, understand what each person was doing and I remember one example where one of the commissioning managers responsible for the contract with [Place] Hospital and we were talking about a service which was a preventative service and we were trying to see, well, could we disconnect some money from the hospital, to move it into this preventative service and it was working together to try and trigger a mechanism, to enable us to do that. So, for instance, this home improvement service, can you dismantle some of the funding from that contract and because the person is the same team who was responsible for that contact, we're able to look at the mechanisms in the contacts, to extract the money, to move it around the system" (Interview).

5.2.4 Case Study D

Of all the sites the phase two research with case study D probably unearthed a much more different perspective to joint commissioning than we might have expected from the first phase of research.   From this early phase the ideal world and efficient national viewpoints were operant locally alongside a local viewpoint called shared commissioning. Therefore we could be of the impression that joint commissioning was seen as a way to drive informal relationships between agencies and deliver better services for users. Although generally those we spoke to in the second phase of the research knew the term joint commissioning and had a view on what this meant, most felt that the term had meant more in the period running up to the establishment of the Care Trust:

> *"We used it...before we were a care trust...because it was what we were aspiring to...And now that we are joint...it just became the way things were. So you didn't use the term ...it was just what you did"* (Senior Manager, Interview).

The town which case study D is based in has a strong identity and has a national reputation for cultivating strong political leaders, a willingness to innovate and a long tradition of partnership. All of these factors had played an important part in deciding to set up a care trust plus:

> *"I think there's just always been very strong political drive and then some pretty strong characters and then the fact that it is a place where although it's very small, that kind of punches above its weight,*

attracts people who are interested in the challenge of working in an area where there's lots to be done" (Senior Manager, Interview).

Joint commissioning was recognised as a dynamic term and it had been an important term in the formation of the care trust. Once established though it was not recognised to the same degree because a full organisational merger has been achieved and so it did not make as much sense to talk about "joint" commissioning as it is more than this:

> *"So it is more than a partnership. It is a formal integration and merger...this is actually a full integration"* (Director, Interview).

Many described joint commissioning as having being a helpful vehicle that was able to engage a range of stakeholders in the process of creating the care trust. Given that a number of those who matched to an ideal-world viewpoint in the first phase this suggests that many people in the locality see joint commissioning as being a positive initiative and this was utilised in linking joint commissioning so closely with the care trust.

Although the term was not in common currency, respondents argued there was a widely recognised set of principles and a rationale behind joint commissioning and this underscored their processes and practices. In Site D joint commissioning was driven in part by necessity and in part by opportunity. The necessity came from a sense that the population of the locality were amongst some of the poorest, most disadvantaged communities with complex health and social care needs. The opportunity comes from the co-terminosity of PCT and Council, as this respondent put it:

> *"So intractable and in such a concentrated area that if you've got a unitary authority set up and you've got a PCT on the same footprint, then it's sort of seemed daft not to be doing the jointness"* (Senior Manager, Interview).

Beyond these rather pragmatic drivers, ultimately the aim of joint commissioning was about making sure individuals receive high quality services regardless of which agency might provide this:

> *"[Providing] improved outcomes for the people we deliver services to is most important. At the end of the day users need to receive good services - it should not matter who delivers and how quality and appropriateness is crucial"* (Council Officer, Interview).

Joint commissioning was also seen as offering 'economies of scale', particularly in the current era where working jointly might enable savings. However a common theme in discussing joint commissioning was less about joining resources and more about joining forces.

> *"So it's really more of a pooling of resources to get the greatest amount of...resource...So there's economies of scale ...but ...primarily, it was a case of joining forces"* (Senior Manager, Interview).

> *"Jointly working, we can achieve everyone's agenda. Rather than more elaborate management it should be about reducing duplication and expanding on expertise..delivering [same for less] isn't true joint commissioning if this happens. We need to deliver more for less - and being innovative and creative in what we do, i.e. not the same!...it's about organisational cultures coming together and sharing expertise and knowledge and not silo working in organisations"* (Public Health Consultant, Interview).

Crucial in being able to join forces is to have a shared vision and this was also something that joint commissioning was seen as being able to achieve:

> *"If you've got a vision that everybody buys into... that everybody feels as though they have some sort of involvement and buy-in"* (Senior Manager, Interview).

Although the Care Trust Plus was well established, respondents made clear that a true joint commissioning approach was about taking this to its full extension; they spoke of the potential of:

> *"Shared databases that we can all update...a single assessment process...the authority to micro commission services across the boundaries of health and social care. ...seeing the whole picture...integrated teams ...working on a county or a neighbourhood basis linked in with primary care all with an opportunity to add value to an assessment process and perhaps having a lead professional dependent on the needs of the individual, to me is as obvious as the nose on my face"* (Director, Interview).

Figure 8. Example joint commissioning site D

"There was some local authority money that was offered from the centre for stroke services improvement. It was a 3 year budget and I worked alongside our borough, now it was really the first time we had joint meetings I think before the care trust plus was born if you like, just before. Whereas I met colleagues that had no idea we were working on stroke services. So for example, you know the social care element of stroke and they were doing quite a lot of work and I had never even considered what they were doing. We got together with them and sport and leisure and our stroke rehabilitation nursing team and all got together to define how we could utilise this funding because...the funding stipulation was it had to be delivered across the pathway. You know so they held it but it had to deliver certain elements and we came up with some really...innovative pieces of work that we delivered locally over the 3 years. And for me that was something that I can sort of step back to now and think actually what have we missed over the years? That we haven't you know obviously we needed that incentive to do that, but from people in the health perspective I presume people similar to me have been in the health service a long time, I wasn't aware of the opportunities" (Interview).

5.2.5 Case Study E

The case study sites we have looked at so far have primarily involved relationships between health and social care agencies and this final case study site is slightly different in nature. This joint commissioning relationship is between a local authority and the residents of two local "sink estates" who face a range of significant economic and social challenges. This relationship is facilitated by a third sector organisation who is experienced in working with communities to help set commissioning priorities. We might then expect that joint commissioning was largely seen in this locality as a way of empowering individuals:

> *"The nice thing for me about [the project] was it really reflected our engagement approach. What we wanted to deliver around the [project] was very much how you empower local residents. Not just to actually take responsibility for their health and wellbeing, but how do you empower them so that they can shape and influence how local services are designed and delivered"* (Public Health Manager, Focus Group).

In addition to empowering local people this project was also intended to inform commissioning priorities;

> *"I was very interested in trying to do something with local people that properly understood what their views were around how we should be joining up services, improving services, designing services for the future that would actually make some in roads"* (Community Commissioner, Focus Group).

As we have suggested the two estates where the project centred face a range of challenges such as significant health inequalities, a mix of deprivation issues and one of the estates had always been perceived as a desert because of its location spatially between two administrative boroughs:

> *"one of the sites...is on the border with another borough so had particular issues and I think [we were] very interested in finding out how we might be able to bring the local people in that area so that they felt more part of the Borough"* (Manager, Interview).

It was perceived that the high levels of investment in these estates in the past had not always resulted in the anticipated outcomes and that this might be due to lack of engagement with these services. One manager described the process of joint commissioning as crucial to understanding what various public sector agencies are doing in that locality and why people are not accessing these:

> *"You can put all the services in that you want, but if they don't work together and the right people don't know about them then there are barriers to people accessing them"* (Manager, Focus Group).

The process of joint commissioning might therefore design more appropriate services and also deliver efficiencies through these redesigned services and the implementation of preventative services. One of the aims of the project was to get to the heart of issues faced by residents and really understand the broader determinants of health and well being. The power of these community-generated priorities can then be used to pull in a range of partners and really make a difference to the local residents through more coordinated services:

> *"I've had a much more realistic understanding of service delivery, so that was definitely a key thing for me and the whole thing was about seamless service...because as I say, with housing and with the kind of social improvements and the social impact that residents have...what they want is...improvements across the board. They don't necessarily see that their health condition that's exacerbated because of the damp in their properties is the responsibility of the housing team...if we can do that in a more coordinated, collective way, then that can only be a good thing"* (Manager, Focus Group).

Figure 9. Example joint commissioning project site E

> "One of the more recent things...was an estate action day. So we had a blitz on one of our kind of key problem estates, whereby we had first the health service, the police service, anti-social behaviour team, housing service and various elements of housing, have an open day and opportunity for residents with particular problems kind of working collectively and offer an opportunity or a forum in which residents with whatever problems that may have can come to this action day and speak to professionals in that particular field where they have concerns and hopefully get their problems, well, certainly if not addressed immediately, certainly followed up, to feel like we were doing something collectively. That was just kind of like the platform and as a result of that we, on a monthly basis, had briefings with residents and representatives from these various organisations, as I say the health care, police service come onto the estate. They have almost like a surgery, giving residents an opportunity to come and again, just continue to raise their concerns and potentially for us to develop initiatives" (Focus Group).

5.2.6 Bringing these perspectives together

What these accounts suggest is that there are some common themes across all of the case study sites in terms of the sorts of things that joint commissioning should achieve, although each of the sites puts a different emphasis on what they mean by joint commissioning and what they are trying to achieve through this process. Table 22 summarises these aims and in the next sections we go on to examine how these localities have attempted to make a reality of joint commissioning through their organisational processes and practices. What this table suggests is that a range of drivers are present across each of the sites although there is one primary narrative that tends to frame all of these issues.

Table 22. Primary and secondary aims of joint commissioning

Case study	Primary aim	Secondary impacts
A	Tackle health inequalities	Preventative services Efficiencies Wider range of services for users Create one stop shops and easy access Empowerment
B	Productivity – bang for buck	Efficiencies Redesign services over larger area Consistency of services Streamline services Early intervention
C	Service user at centre of service design	Seamlessness Single contact points Keyworkers Value for money Choice
D	Kick-start merger process into care trust plus	Focus on health inequalities and preventative services Economies of scale Innovative services
E	Empowerment of community	More appropriate services Efficiencies Reduce waste Preventative services

5.3 What organisational processes are in place to facilitate joint commissioning?

Having set out how the different sites defined joint commissioning and what it aspires to deliver, this section moves on to set out findings in relation to the kinds of organisational processes that are used to help support joint commissioning. As we will illustrate in this section none of these seem to be specifically confined to joint commissioning processes and many of these link to the types of processes that we would associate with joint working in a more general sense.   Having set out these processes in the following section we then go on to assess the degree to which these seem to have changed the behaviours – or practices – of those within these joint commissioning arrangements.

5.3.1 Formalised structures

What is apparent in the majority of the case study sites is that their joint commissioning initiatives are primarily facilitated through formalised *structures;* be they formally merged organisations in the form of care trusts (Sites C & D) or integrated management structures (Sites A & B).   The exception to this is site E which had the status of a project and so had no formalised structures built up around it. This project relied on an informal partnership between agencies and as such did not involve any formalised agreements in terms of budgets or administrative systems.

The integrated management structures for sites A and B tended to encompass a wide range of different professionals who are managed under a single line manager. The kinds of professionals managed in these teams included traditional health and social care staff such as nurses and social workers, but also included allied professionals such as occupational therapists, pharmacists, physiotherapists and even surveyors. This would often mean that professionals were being line managed by someone who was not necessarily of the same profession but this does give one line of accountability for that service:

> *"Having a director of joint commissioning means that you can make pragmatic decisions"* (Officer, Case Study B, Focus Group Commissioners).

Some of those we spoke to at case study C found it difficult to be line managed by another profession as they still felt allegiance to their primary employer and professional values:

> *"Well, I think you've got more than one master and I think that's hugely challenging to have more than one master because natural instinct is if you're employed by a particular organisation, then you are going to stick to that culture"* (Manager, Case Study C, Interview).

Respondents at site B saw the structures that they had created around joint commissioning as important, and considerable time and effort had been expended in creating these;

> *"I think...we've seen joint commissioning as an outcome in its own right and we've focused on governance and structure in the process of coming together"* (Officer, Case Study B, Focus Group Commissioners).

Some of the other sites reflected on the need to formalise joint arrangements through structures, or at least written agreements, as a way of protecting their work. These sorts of arrangements were seen as important because without these, in the event of key people leaving the organisation or changes in political priority:

> *"You find a service that was fairly robust starts to unravel"* (Director, case study D, Interview).

So whilst staff in this locality suggested that "*we didn't need to be part of the same management structure to work in an integrated way*" in order to safeguard the long term viability of these joint working arrangements, in practice setting up some formalised linkages were the best way to protect these relationships. This was also a message that was reflected through the other sites to greater or lesser extents.

5.3.2 Pooled budgets

As we indicated in the previous section, *pooled budgets* were widely employed across the four case study sites. Pooled budgets based on section 75 agreements are seen as a way of gaining "more bang for the buck" and a platform through which health and social care funding can be shared and maximised. As a Director from site A described, pooled budgets

> "*offered a much better chance of spending that money in a way that's going to achieve the outcome sensibly rather than...three or four...different approaches of different people...trying to tackle it in a different way*" (Director, Site A, Interview).

Having pooled budgets allows commissioners to use money to meet need, rather than having to define whether this is a health need or a social care need and removes the incentive to shunt responsibility for meeting needs from one partner to the other:

> "*unless its pooled budgets you're going to run out of money pretty quickly, certainly in social care, because at the moment what you'll find is overlap is actually a health need*" (Manager, Case Study C, Interview).

Pooling budgets is therefore thought to remove "artificial" health and social care barriers and provide what people want and need.

Although some of the sites had large pooled budgets (e.g. case study B), others shared budgets but these were often linked to particular projects or initiatives. One example of this from Site D was an initiative to provide a programme of universal free access to sport and leisure facilities which both the PCT and local authority each contributed £3 million to. Similarly site A had a number of projects around particular client groups or service areas, for example the entire Alcohol service pathway. Staff often found it difficult to identify the types of processes and practices that related specifically to joint commissioning and where they did give examples these were often in relation to specific projects such as this, rather than joint commissioning in its entirety.

5.3.3 Lead commissioning

Linked to pooled budgets many of the sites operated lead commissioning arrangements where one of the partners would take the primary lead on commissioning particular services with the support of their other partner(s).

Case study A has lead commissioning arrangements around a number of different areas such as wheelchair services where one partner would have overall control for commissioning on behalf of other partners so that a coherent integrated service was established, rather than having three separate commissioning processes for different aspects of wheelchair services. Lead commissioning arrangements were also seen to be a helpful way to identify waste or duplication in particular service areas where an entire pathway would be examined across a range of partners.

5.3.4 Co-location

In addition to creating integrated teams, most of the sites had some form of co-location of health and social care within the same office space. Essentially this involved linking staff from different partner organisations either within the same office space or else within the same building. Site A went beyond just assigning different teams to the same office space and had a hot-desking policy whereby professionals from a range of backgrounds could work alongside different colleagues on different days. This sort of approach was not always favoured by all and staff sometimes felt that they lacked a natural "home" or had been moved a lot and found this disruptive. One interviewee likened it to a sense of creative discomfort like that you might get in a supermarket. According this analogy supermarkets regularly move aisles so that people do not simply end up sticking to only one or a few areas of the store and have to move around to find the things they want. This individual felt that the rationale here was:

> *"Let's move everybody so they've got to know each other, now we'll move them all again"* (Manager, case study A, Focus Group Joint Commissioning Team).

5.3.5 Integrated assessment

Where integrated teams existed, joint commissioners had been keen to see the use of integrated assessments, rather than service users having to be assessed a number of times by different professionals. These were seen as a way to help coordinate and streamline care pathways. For example, case study A uses a single assessment process and then streamlines service user enquiries to a single point of contact known as 'customer access teams'. These then use a prioritisation process to categorise requests into need. Those with low level needs are referred to a generic worker (e.g. occupational therapy assistant or assessor) and specialist staff deal with more complex cases. However, not all sites had managed to get to this stage and assessment was generally seen as a rather tricky issue. At site B for example, although some progress had been made, one commissioning manager told us:

> *"Even though we've moved towards joint commissioning locally, I'm sure nurses still assess and I'm sure social workers still do their own*

assessment and I'm sure housing do their own assessment"
(Commissioning manager, Site B, Focus Group Commissioners).

So even where a seemingly joint assessment was being worked towards, in practice different professionals still assessed on an individual basis. Site D was yet to introduce integrated assessment across all client groups but saw that there was value in doing so:

"*I think we could be a lot more efficient and a lot more effective with our smaller resources if we did like joint needs assessment and then did priority and focuses*" (Manger, Site D, Interview).

5.3.6 Service user and carer involvement

Service user involvement was a significant component of a number of the sites and fulfilled a range of different functions. Given the nature of the project it was certainly a key feature of site E, but site A also spoke of the ways in which they involved older people through a local forum in order to set priorities for commissioners. Staff at case study A described how the older people's forum acted as a conduit and repository of information for members, but also enabled "expert older people" who have learned to speak up:

"*if you want to have integration, you want to have a joint commissioning process that's open and transparent and involves people*" (Manager, Site A, Interview).

Site C also had processes in place to engage carers on the basis that they have a great deal of knowledge about the barriers and facilitators of high quality services:

"*I think the key is to get the people involved...carers and the families that will be those people receiving the service, in designing what that might look like in the future, so they feel part of it*" (Director, Site C, Interview).

Site E ran a range of different engagement initiatives designed to reach out to the local community, such as having large scale events and the use of community researchers. The community researchers were trained by a third sector organisation and would visit places such as GP waiting rooms and speak to people within the community about what their service priorities are and what the best ways of meeting these might be. We expand on the issue of service user and carer involvement in more detail below.

5.3.7 Hybrid roles

So far, many of the processes we have discussed have been ways to bring teams together or to provide responsibility to a lead partner; this final process was more about creating jobs that span across the divide. Case study D referred to the creation of "hybrid bureaucrats" who span both

health and social care. However, this site also highlighted the difficulty of these roles not just in a practical sense of having "two lanyards" and working two systems but also of gaining the respect of those in both organisations and this was cited as particularly crucial for those in leadership roles.   This had been an issue at this site where they had a shared chief executive across the PCT and Local Authority. At lower levels within the organisation these types of hybrid roles had at times led to individuals having rather "opaque" job descriptions which had caused difficulties for people in practice.

5.4 What are people doing when they say they are 'jointly commissioning'?

Having established the types of organisational processes that have been introduced in the sites to facilitate joint commissioning, we were also interested in whether these had an impact on the practices of professionals. Here, practices are defined as the day to day interactions that go on within organisations between professionals, service users and carers and which facilitate service design and delivery. As we suggested in the previous section a range of joint structures, budgets, and management systems had been created, and health and social care staff were being located within the same offices and we were interested in whether this had an impact on what professionals did and how they described 'doing' joint commissioning.

Those whom we spoke to, by and large found it difficult to identify the sorts of practices that are associated with joint commissioning and that are different to other ways of working – be they in terms of more general joint working or commissioning. On the whole, there were few practices that individuals could identify that related specifically to joint commissioning. However, the themes of *relationships* and *creativity* and *risk* were ones that did run through discussions and we reflect on these briefly before moving on to examining the types of impacts that joint commissioning has demonstrated.

5.4.1 Relationships

Although many of the processes introduced in relation to joint commissioning are rather structural and formalised, in practice many across the sites told us that it was not these structures that facilitated joint commissioning but instead the relationships between individuals and teams. As one manager at site B explained:

> *"You don't actually need structures or pooled budgets...panels can work outside of that and I don't think we've concentrated enough on the culture of working together and it was processes and structures. It's the culture...where we've made improvements is where we've been co-located...we've just spoken to each other and work though solutions...and I don't think there's the same investment around the*

culture of two different models" (Manager, Site B, Focus Group Commissioners).

Indeed the notion of a *culture* of joint working was prominent in focus groups and interviews. The Director of one of the key partners for locality B however suggested that they had invested in structures over relationships and cultures primarily because the area that the joint commissioning arrangements cover is so vast that this would take a considerable amount of work and that because the turnover of staff in this locality is also relatively high compared to other areas. Attempts at joint working over many years had struggled due to these factors and it was felt that the locality needed strong governance structures in order to stabilise it.

Having good relationships with professionals from partner organisations was seen as important as it:

> *"Drives natural efficiencies, it stops people being defensive of their bit and you can just see over time, they've all come together"* (Manager, case study A, Focus Group Joint Commissioning Team).

Co-location had been a facilitator of forging better relationships in a number of places as it has meant that professionals have come into *contact* with each other more often on an *informal* basis. As one manager described:

> *"That's one of the benefits of co-location...you can have informal conversations on a daily basis...you get a lot more done than having to set everything up through a formal process. Ultimately, things have to go through a governance process but you can get so much done by these ad hoc conversations, unplanned conversations most of the time and you're suddenly, oh wow and we can do this"* (Manager, Case Study A, Focus Group, Joint Commissioning Team).

Some suggested that co-location can lead to confusion for staff and service users, particularly if staff are moved frequently. One manager at site A also reflected that they felt this is an overly structural response that has tended to be used around joint working in a blanket way when actually the crux of the issue is a more relational issue. What they were suggesting here is that there are other mechanisms to encourage professionals to have more contact with one another that go beyond having to move people into one office, particularly given that other interventions to encourage interaction could also be lacking after the move.

 Similarly, at site B officers were sceptical of the capacity of co-location to impact on deeply engrained differences between health and social care and saw the value as potentially being more symbolic in demonstrating to others the relationships between teams:

> *"Well, we are moving in one base...next year and I think that will really symbolically help, all being on one floor"* (Officer, Site B, Focus Group Commissioners).

This symbolic value was also felt at site D who co-located 350 health and social care staff in total and as one director described,

> *"All the staff saw it as you know, wow something's going to happen now"* (Director, Site D, Interview).

This site recognised that not all people like co-location but as one Director explained:

> *"Once they're forced together in the same building and starting to sit together around the table to work on projects...like it or not they start doing it"* (Director, Site D, Interview).

Site D has experienced much uncertainty in recent times with the national policy context having the potential to make a significant impact on the rather newly formed care trust. At this site a number of people mentioned that this uncertainty had led to staff "reverting to type" and retrenching back into their silos.

Site D had experienced somewhat of an unwillingness for staff to *speak honestly* with their newly co-located colleagues at this site which might reflect the immaturity of the collaboration here. The seldom used staff/common room was cited as an example of an immature collaborative culture. One interviewee put it as colleagues were avoiding conflict and "keeping the fish under the table". Others defended the idea that the Care Trust's immaturity was dysfunctional, rather it was to be expected:

> *"We haven't been a Care Trust Plus that long and I think it takes time to start to establish your relationships"*(Officer, Case Study D, Interview).

Site A spoke of the importance of being able to challenge one another. The relationships here were relatively well established and they spoke of feeling:

> *"Comfortable to challenge each other and go why are you doing that? Or you'll come up with an idea and go no...that's not going to work. You still have arguments"*(Commissioning Manager, Site A, Interview).

This sort of interchange was seen as an important in driving creativity and producing the "best of both". Language was an important theme in many of the focus group discussions with stakeholders indicating that different professionals and partners do not always "speak the same language". One respondent in site C explained that in a lot of communication they needed to go back to first principles and establish terms as, for example:

> *"My definition of a lead was different from her definition of a lead"* (Manager, Site C, Interview).

Site E recognised the importance of the ways in which professionals and residents interacted through some of their events in terms of delivering real engagement. In the more open space events there were explicit practices such as, no more than five people per table (mixture of service users and professionals) to allow people to input into the event. When introductions were made people used first names only and did not talk about their professional roles so that residents might be tempted to, for example, defer to GPs or social workers on particular topics. The events were described as a bit chaotic at first as they were relatively unstructured, but once the event started to move often the types of barriers associated with status were broken down. As one manager described:

> *"It doesn't matter if you are a chief exec or a service user"* (Officer, Site E, Focus Group).

The end result was often a reciprocal exchange instead of "the one-way conversation where they just present for an hour and they are bored".

5.4.2 Creativity and risk

The ability to be creative and manage risk more effectively are often cited as drivers for joint commissioning. In this section we reflect on the degree to which these factors have been promoted in practice. Although in the previous section we suggested that respondents felt like they sometimes had an "us and them" culture, in practice this was cited as being helpful in the sense that it meant that the care trust plus was perceived to be more innovative and creative than simply an NHS or local authority:

> *"I think that has probably led to a bit more creativity within the care trust than would have been if it was just an NHS organisation. But it's hard to pin that down really"* (Manager, Site A, Focus Group Joint Commissioning Team).

Another manager went on to explain this in more detail:

> *" Local authority culture is more kind of innovative, creative, there's freedom to express yourself, whereas with health ... a lot of rigidity, you're tied down to a way of doing things, so I think what the two did was you can't have too much of a laisser faire approach because then there's a danger that you lose track of what your objective...you might lose focus and if you're too rigid, you lose that innovation, so I think what the two coming together...you've got the innovation and the creativity coming together with rigidity"* (Manager, Site C, Interview).

At this site participants spoke about taking the "best from both" and using the fact that they had two sets of organisations to their advantage. As an example of this, the PCT was seen as being able to put out press releases quicker than the Council, and the Council allows people to make small purchases easier than the PCT. Working within the Care Trust framework,

public managers are able to navigate around issues by drawing on the strengths of both:

> *"We took the best of both. So for example the Falls Collaborative it was alright for health and fitness to go and order ....20 metres of ribbon to do some chair based exercises or some music to dance for a launch event.... And then we'd be quite sneaky in terms of things like press releases. We didn't jump through the council hoops in terms of you've got to go to a member and you've got to get this approved and that approved. We used the PCT at the time because that was not more relaxed but didn't have all the rules and regulations"* (Manager, Site C, Interview).

Site B was probably the site which was the most pessimistic in terms of whether anything had actually changed for staff as a result of joint commissioning. Although much had been done in organisational terms, it was suggested that often people still felt like activities were taking place in silos. As one officer explained:

> *"So, I just think that we do things, both politically and strategically, [but] I'm not sure we do things around a table with one piece of paper satisfying a joint agenda. I still think we are very much a 'them and us'"* (Officer, Site B, Focus Group Commissioners).

As another manager also described, despite joint budgets being established this did not necessarily mean that people behaved differently to before:

> *"You have to keep reminding them, actually we're in a Section 75, we're joint commissioning, you can't just do that or demand that because the local authority will have something to say about that"* (Manager, Site B, Focus Group Commissioners).

One of the problems here seemed to be that commissioners still did not always understand each other and so this had led to disagreements sometimes:

> *"We don't really understand the parameters of our colleagues and where they're coming from, what the direction is strategically or operationally"* (Officer, Site B, Focus Group Commissioners).

This could have difficulties in setting a strategic direction for commissioning as the "*base lines are a little bit skewed*".

Site C also struggled in some parts to change practice through their pooled budget and this was explained on the basis of both internal and external reasons. Externally the changes being made by national government which will mean that clinical commissioning groups take on responsibility for commissioning health care mean that this care trust will become a provider only over the coming months. This had led to some difficulties with pooling budgets locally:

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"Tight financial position that we're in and having to make significant cuts and difficulties in finding it and...the Government changes and dismantling some of the NHS commissioning from the Social Care commissioning, we weren't able as a Care Trust to pool budgets and to try and move money around, so it restricts our ability to, say, move money into Adult Social Care, which is a preventative step" (Manager, Site C, Interview).

In practice professionals did not feel that they had been able to fully leverage the pooled budget to meet need in the way that they had anticipated. One manager explained how he had entirely understood the good intentions behind the decision to pool budgets but did not necessarily think that this had fully developed:

"I think the vision was, Ok, we'll put this in social care and health. We can identify a health need, that money will follow the individual from hospital. That hasn't happened" (Manager, Site C, Interview).

Although the care trust had created integrated commissioning, difficulties arose with the fact that the local authority was also still commissioning some aspects of services:

"For me, the commissioning bit is the bit that hasn't felt jelled enough because you've got council still...I don't think there was enough thought and I know commissioning is a new concept really for local government but I said, "Well, why have we got commissioning in the Care Trust when the council are commissioning the adult social care?" So they built this whole commissioning team and then they've got … I could see why they had the health care, that wasn't an issue but then I think waters got muddied around not who had what budget but how the budgets were going to be" (Manager, Site C, Interview).

Some took this council-creative idea further to argue that through the merger into a care trust, they brought with them creative and flexible working practices. Some stakeholders reported that as a result of having more opportunities to interact they were able to produce more creative solutions:

"It could be that you end up doing something that you wouldn't necessarily have thought about had it just been you working in isolation" (Manager, Site C, Interview).

Site A also cited creative practice around the institution of a centre for independent living which had originally been planned but which had been scaled up under their Section 75 agreement. As the reason for the success of this initiative was explained:

"It's interesting, a colleague was asking in an interview recently, she had to sum up a factor of how we'd achieved integration in [case study A], what would it be and she said, it was leadership and risk taking and being solution focussed, because for some of us, all of us

around the table, it does sometimes involve a degree of risk, 'cause you're going out of your comfort zone or your historical routes...if we hadn't had an integrated approach, we would never have achieved that... so you've got to believe in it and sort of embrace it and be prepared to take some personal and organisational risk along the way, in order to achieve what you believe in" (Commissioning Manager, Site A, Interview).

What was important in producing this creativity was communication and not only between different professionals, but also between professionals, service users and carers. Professionals were clear at this site that service users could be very helpful in helping them to manage risk and understand the lives of individuals and families in a much more comprehensive manner.

5.5 What impact has joint commissioning had?

The final area that we present data in relation to, is that of the types of impacts that joint commissioning has been seen to deliver locally. This is different to the ways that people talk about joint commissioning which we outlined in the first section in the sense that this relates to actual evidence of impact that joint commissioning has had, rather than being the aspirations for joint commissioning. Given that many individuals struggled to be clear about what joint commissioning is and what it should achieve participants often found it hard to evidence the impacts that this had in practice. However, we also involved service users and carers from all but one of the sites (case study D) and we also sought their opinion on what (if anything) had changed in terms of local organisational services. We draw on the data gathered from both staff and service users in this section.

5.5.1 Difficulties in evidencing impact

As we have suggested, respondents often found it difficult to identify the impacts that joint commissioning had in practice. Whilst there were many examples of projects and different aspects of joint working, what people struggled with was thinking about how (and if) this was related to joint commissioning or some other kind of agenda. In focus groups and interviews individuals often reflected on the difficulties of evidencing the impact of joint commissioning in explaining why they were finding it difficult to evidence. We investigate some of the reasons offered in this section.

Despite staff in site A having a strong commitment to integrated commissioning and a firm belief that "it works" they found it more difficult to evidence the impacts that this was making in practice. As one commissioner reflected this is in part due to a lack of appropriate data:

"I think we've not always been as focussed on demonstrating the outcomes that it's achieved and some of that's to do with data information systems...not being...robust enough to sort of come up

with what we want really" (Manager, Site A, Focus Group Joint Commissioning Team).

Another commissioner responded to this stating:

"If you were designing integrated commissioning now, you'd maybe give much more thought to some of the support functions that needed to be there, to give some of the evidence" (Manager, Site A, Focus Group Joint Commissioning Team).

Some of the difficulties cited with demonstrating impact at this site were that a lot of the focus of integrated commissioning had been in preventative services which were difficult to demonstrate the impact of. So although staff felt that there was some evidence that people were more able to access a wider range of services through a single point of access and integrated assessment process, concern was expressed about the long term difference that had been made in terms of say hip fractures. Part of this problem lay not only with the time-lag between the intervention and any eventual impact, but also in terms of finding a suitable benchmark which allows a realistic comparison of 'like-with-like':

"How do we prove that all of those people we saw, we've actually reduced hip fractures?, because we've mentioned benchmarking before, but the trouble is...you could take a benchmark from five or six years ago and do the same now. You could actually be having a very positive effect on reducing the number of falls, but because the demographics are changing so rapidly as well, you're not really taking a true picture from five or six years ago" (Manager, Site A, Focus Group Joint Commissioning Team).

As another colleague described:

"If we've got 100 rails and 100 falls packages in you're guaranteed that you will have saved one hip fracture or one fall with a broken leg...something like £28,000 average price for a hip...but it is very difficult to prove what you've prevented" (Manager, Site A, Focus Group Joint Commissioning Team).

A large challenge here was also in terms of where an outcome might be achieved. As one manager described:

"If you take an example of supported living, some of the outcomes that are achieved aren't realised in supported living, they're realised in the acute [sector], but how do you say, that handrail that was put in or that scheme manager reduced an admission? It's difficult to pin it back and identify it was that intervention" (Manager, Site A, Interview).

This issue of attribution was also mentioned at site E where there were concerns over the number of variables that are present at the same time:

"I think joint commissioning integration, whatever you want to call it... we face [problems] because we tend to do lots of things at the same time. So we implement new interventions, commission new services at the same time all with similar benefits against them that we want to achieve. It is quite difficult to unpick which variable is impacting on which" (Manager, Site E, Focus Group).

Site A had tried to develop different types of indicators of success by incorporating a greater focus on service user and carer experience:

"So we're gathering information along the lines of [what's] important to people, which is to say 'it meant I wasn't scared', 'it meant that it changed my life" (Manager, Site A, Interview).

However, external to the integrated arrangements it was felt that these measures do not have the degree of legitimacy that they might.

One officer at site B believed that too much focus was put on setting up joint commissioning arrangements at that site and therefore not sufficient attention had been placed on measuring outcomes. This individual believed that there was nothing specific about joint commissioning that could not be achieved through other mechanisms:

"I don't think joint commissioning is an outcome in its own right, but people focus on that. In a previous life, I was a social worker in an integrated team and there was aligned commissioning strategy and you didn't know who was a social worker, who was a nurse. There was an interchangeable budget holder from Health and from the local authority at the time and that worked really, really well and it was about a better integrated approach to assessment, so it was at the micro-commissioning level and that's where we were really innovative and delivered outcomes that we would still dream of locally"(officer, Site B, Focus Group Commissioners).

5.5.2 Better joint working

One of the impacts of joint commissioning that was identified by many of the sites was that joint working was now "better" or "stronger" than it had been previously. One of the main impacts of joint commissioning was effectively better inter-professional, or inter-organisational, working. In the context of the '4P' framework these would be the partnership outcomes. Site D described that prior to the establishment of the care trust plus, their joint initiatives were mostly through big, flagship projects. Essentially joint working took place within particular projects rather than being a thing that was done all the time. Since the establishment of the care trust plus, joint working had become more normal and expected:

"Leading up to becoming a care trust...partly to do with you know organisations anxiety about being taken over by the other or ...the...PCT being scared of councils getting involved... So quite a lot

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of blockages beforehand. I think once we actually became a care trust, I've not been so aware of the blockages. It comes back to the thing of the jointness just becomes what we do and so it's not necessarily big projects that people are trying to shoehorn through to make a big impact, it's just daily work" (Senior Manager, Site D, Interview).

One participant likened this to a marriage;

"before we were a care trust, those big projects really mattered because they were the headline banner things we put in our application when we wanted to be a care trust and once we become a care trust, maybe it's a bit like getting married, I don't know, but it's gets a bit more mundane" (Senior Manager, Site D, Interview).

Another described that since working together as a more central part of their daily work they had begun to empathise and understand their colleagues more.

"I think it's just having a different mindset [from] that you've been educated around and you start to believe... That... health is not the be all and the end all...I'm sort of NHS blue all the way through, but I'm not quite as "that" now, you know, I'm a bit more "oh, actually" you know" (Manager, Site D, Interview).

Better joint working was also seen as a positive impact in case study E between a broad range of partners such as the local authority, PCTs, children's services, housing agencies and third sector organisations. Often the involvement of these partners had been rather peripheral in the past but through this project they were seen to have become more established. Indeed it was suggested that by involving a third sector organisation the involvement of wider agencies had somehow been legitimised. Staff taking part in the focus group noted how this had been instrumental in kick starting the initial involvement of certain partners in commissioning at this more local level.

Many of the staff and service users from case study A felt that one of the greatest achievements of joint commissioning was that it had managed to encourage providers to work together more closely. As one senior manager described:

"I think the way that joint commissioning has been carried out, it has ensured, by a variety of means, that providers have to work together closely to achieve outcomes. I think it's made a difference for people, in terms of outcomes for individual services" (Senior Manager, Site A, Interview).

Here joint commissioning was seen as having an impact because providers now just have one group to interface with, rather than having to go to two sets as they had in the past.

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5.5.3 Efficiency

As we have already seen in this chapter the aspiration for efficiency was a driver of joint commissioning at many of the sites and some found it easier to evidence this than others. In the context of the '4P' framework these would be the outcomes associated with productivity. For example, case study B was clear that much of its approach to joint commissioning was predicated on the basis that it should produce efficiencies through the operation of the pooled budget. Indeed, by the end of 2010/11 the budget was balanced for the first time in a number of years through "zero budgeting". Moreover the joint commissioning team were also able to find efficiency savings of £4 million per year. One example of where savings had been made was in relation to delayed discharge of care. Funds had been earmarked for the employment of a dedicated social work and nursing staff whose job it was to specifically target patients as soon as they were deemed medically fit to go home. The discharge staff would investigate reasons for delays such as failure to get into a care home, their housing not being ready or because someone had not done the relevant paperwork and would take each case to a weekly panel to consider the options. As a result of this investment the length of hospital stay had been reduced from an average of 108 days to around 40 days:

> *"We used to spend an average of about £2.4 million a year on delayed transfer of care beds and then £1.5 million on overspill beds for people out of area, so you know, there was sort of £4 million sat in the system that never necessarily needed to be there. We now sit at probably of an average of about 12 a week and their average length of stay is around about 40 days, so there's still work to be done"*(Commissioner, Site B, Focus Group Commissioners).

In locality B the percentage of the overall budget spent on residential care had also fallen, with more people receiving support through different types of housing options. One commissioner also reflected that since doing joint commissioning this had reduced duplication:

> *"we found out since coming together...we've both commissioned...the same services with the same providers and haven't known about it"* "(Commissioner, Site B, Focus Group Commissioners).

However these efficiency achievements were not seen as positive by all. As one officer explained efficiencies were being made but not to re-invest into other service areas but simply to make savings;

> *"A lot of the schemes that you see them going through are taking money out of the system and not reinvesting"*(Office, Site B, Focus Group Commissioners).

Whilst a manager from a PCT partner felt that although the new arrangements help to better manage the budget, in practice service users still were not getting a high quality service:

> *"I don't think there's integration at every level, so okay it helps us administer the money better and we've got some efficiencies, but in terms of outcomes for service users, they're probably still going through three or four assessments to the service at the end of the day..."* (Manager, Site B, Focus Group Commissioners)

Site C also spoke about the efficiency gains that it had made through integration, although these were often in relation to other initiatives that were not necessarily directly related to joint commissioning such as the use of individualised budgets. As one manager explained:

> *"With the personal health budgets, where we've been able to truly engage with our social care staff, we've come out with some very good results and in a number of cases, we've actually reduced the total amount of money we're spending"* (Manager, Site C, Interview).

Service users at site C did not always view efficiency savings in a positive light though and many had received cuts to services recently:

> *"They said they had to cut everything down. I mean, I was going out during the day and stuff, 'cause of lack of funding, I had to be really ill before people would listen"* (Service User, Site C, Focus Group Service Users and Carers).

As a result some service users expressed a loss of trust in the system being able to meet their needs all of the time, although in practice these cuts in budgets were predominantly related to drivers from the external world, rather than being driven by joint commissioning.

Site D believed that just by bringing commissioners together they had probably saved money as it makes it more difficult for providers to

> *"Play off against the other. They can't play any tricks....all the commissioners are together in one place"* (Senior Manager, Site D, Interview).

Interviewees spoke of 'driving a tight deal' but again did not have the data to demonstrate that this was directly related to joint commissioning. This was a very similar case to site A who suggested that although they generally thought that integrated commissioning had delivered efficiences that they would find it difficult to evidence this:

> *"I think we have struggled to necessarily measure that effectiveness in terms of productivity. It's not been easy to, if you like, quantify it...I think we've felt that we have to look at proxy measures around it...and we have got a number of areas that you could identify as being a proxy measure of effectiveness or efficiency, so we have very low, immensely low delayed discharge rates in [place] and we believe that's linked to the fact that our teams are very integrated, so things happen more quickly"* (Manager, Site A, Focus Group Joint Commissioning Team).

Site E had a slightly different take on their joint commissioning exercise in the sense that most of the staff recognised that in itself the process was more expensive that single agency commissioning.

> *"It is easy for me to sit in my office and write a specification, send it out, have a few focus groups and then commission a borough-wide service that is going to meet everyone's needs and it is tailored at the individual level. It is much easier to do that, it is more cost-effective, it doesn't take so much time. To do things like on this level is far more time consuming"* (Manager, Site E, Interview).

However, the value of such an approach is that commissioners can ensure that the types of services that they deliver are more appropriate to that particular locality through commissioning processes:

> *"I have commissioned services that talk about locality focus, making sure that they are meeting the needs of local people. You can say that, but what does it actually mean. In reality what you get are providers going out on a borough-wide basis and good care workers or good support workers will get to know the local community. They will engage and link their service users into the local community and start pulling on resources. But you are kind of reliant on those...skills of a particular provider...rather than the way that we commission services and the way we monitor them"* (Manager, Site E, Focus Group).

This manager went on to reflect that through this project they had found a way to better understand the locality and therefore are able to do more local commissioning around this area.

5.5.4 Ease of access

We heard a lot about access in terms of the impacts of joint commissioning. At case study A the co-location of providers in a Centre for Independent Living gave service users a single point of access to occupational therapy, surveyors, equipment, wheelchair maintenance and advocacy services. This new service had also assisted with the length of time it took for service users to access services:

> *"our OTAs, our therapy assistants, were struggling to keep up with the amount and suddenly we cleared a five, six month backlog in about four weeks, because suddenly we didn't have all these referrals coming in any more that were low level"* (Manager, Site A, Interview).

Many of the service users we spoke to suggested co-location had made services easier to access although sometimes felt that they only got access to services because they had heard about them by chance and felt that not everyone has the same chance of being able to access services. This highlights a common thread running through all of the interviews with service users about the onus placed on service users having to be savvy in

order to access any care they might need, but also the reliance on informal care through family networks in the form of transport or advocacy.

At site B service users did not feel that much had changed in terms of their ease of access. Interviews with service users highlighted some perceived differences in the quality of care depending on whether they had experienced an acute episode of mental ill-health as opposed to continuing care. Some carers noted the lack of a care plan, which they felt their friend or family member should have in place. For mental health service users, part of the problem here was with the potential time-lag that might occur between being mentally well and an acute episode which required them to access services. For many, the GP was the first port of call and service users and carers alike had mixed experiences of accessing services effectively through their GP. Linked to this was a variable experience of communication with other professionals where decisions were sometimes taken without the carers' knowledge. One carer reported his/ her family member being taken off his medication without the carers' knowledge.

There were other cases where carers felt they had to "convince" professionals, such as psychiatrists about the severity of service users' illness, in the face of "*one off assessments in which the service user seemed ok*". Service users and carers reported a sense of "*professionals knowing best*". One carer reported having been excluded from discussions about their family member because of "patient confidentiality". There was a sense of frustration here in not being listened to, when they felt they spent the most time with service users and were, as a consequence, more likely to pick up on potential changes in behaviour which might signal a decline in their mental well-being. Some staff were felt to hold misconceptions about the role played by families in the cause of service users' mental illness. The joint commissioning unit had recently invested in staff training in an attempt to challenge assumptions about 'toxic families' although the impacts of this was yet to be felt by those we spoke to.

5.5.5 What service users want

Although a number of impacts had been identified in relation to joint commissioning some of those we spoke to did not necessarily believe that they had addressed the sorts of impacts that service users wanted. For example, stakeholders at case study A suggested that some of the sorts of joint initiatives that had been introduced as a result of integrated commissioning may not be entirely what service users actually wanted:

> "*we all put these efforts into these joined up websites and these joined up structures and I'm not sure we've actually asked people if that's what they want*" (Manager, Site A, Focus Group Joint Commissioning Team).

This individual explained how an integrated website had been invested in but only something like 20% of the local population had internet access and

therefore it was going unused by the population. One of the issues raised by service users was that although some services were felt to have been improved they could not actually reach them due to the poor public transport infrastructure:

> *"I think one of the major things is, not the actual provision of the services, it's when they're planning, say to move services or integrate them, they don't look at the transport consequence"* (Service user, Site A, Focus Group Service Users and Carers).

To some extent the integration of provision had compounded this situation for some as there were now fewer entry points for services and some service users found they had further to travel to access them.

Although site B had introduced a programme focussed around early intervention, families of service users argued that this intervention could take place even earlier if they worked with families and carers in a different way. Current services are perceived as being very individualised so service users receive their services, but this does not always take into account their families. If a carer then gets into difficulty and needs support, they are often referred to a care and support worker separate from the service user,

> *"Whereas actually families should be having family support together to achieve common goals"* (Carer, Site B, Focus Group Service Users).

At site C service users were broadly happy although cited frustrations at the constant change that occurred around service provision and the impact this had on not only their own life but that of their family's life too:

> *"What's more frustrating is they put everything in place and everything's working really well and then they pull the rug from under your feet"* (Service User, Site C, Focus Group Service Users and Carers).

Site E felt that they now had a much better idea of what the local community want. The commissioning project had acted as a springboard to more regular meetings on a monthly basis;

> *"Giving residents an opportunity to come...and raise their concerns and for us to develop initiatives"* (Manager, Site E, Interview).

They explained how previously, surgeries would be held that were specific to the agency concerned and in the case of housing, might involve, repairs, caretaking and other issues relating to housing. What the estate action days had provided was a means of attending to a much wider remit involving police, physical health as well as employment through a much more strategic approach to commissioning. Beyond this, it was felt that the valuable work undertaken by the project to ascertain residents' needs had also resulted in the generation of some useful service specifications which provided a useful focus on which to base future service planning. However, despite the benefits, there was a sense that outreach work could inadvertently raise expectations without recourse. Here, there was much

discussion about the benefits that such locality type commissioning could bring, in being able to listen directly to local people about their needs, but recognition that the process did little to resolve the bureaucratic decision making structures involved in council governance such as planning or 'getting sign off'. One example was a 'collaborative care centre' which had been in the pipeline for many years, and one participant joked they would probably be retired by the time it was built.

Although the project described at case study E set out to better understand the locality and commission more appropriate services there were some warnings that came with this process in terms of feeding back to the community. One manager was concerned that processes such as this

> *"Raise expectations...and...I worry a bit about actually how well we have done in implementing the recommendations that came out...I am sure it is a common thing, but we are always not as good at giving feedback to the public and our services users about actually what has happened. And they don't know the subtleties of kind of how that is shaping the way of our thinking about commissioning"* (Manager, Site E, Focus Group).

An example of a priority that was identified by the community was an Astroturf football pitch that had run into disrepair and the local community wanted this replacing. This had not yet been achieved and these commissioning managers were concerned that given that this was one of the community's priorities then they could be seen to lose legitimacy for not delivering. The reasons given for not having actioned this were that the local authority's processes could not achieve this within short timescales and there was also a discussion within the council about whether to use this land for a different purpose:

> *"You know what would have been fantastic. We could have done it within six months. People would have said 'wow, they listened to us'...but no, there is a whole project going on behind it to change the use of the site...whether there is going to be Astroturf actually in the future or not, I don't know. We would have had to go through a whole process that would probably take a minimum of two years before you ever saw any improvement...that is what I mean by the kind of bureaucracy and the grand plans....so I think there are all of those things that go on behind the scenes that are frustrating"* (Manager, Site E, Focus Group).

The implications of not responding to what these communities want when they have engaged is that:

> *"You sort of disenfranchise them and it comes to the point next time when you go around trying to get their views...they are not going to bother"* (Manager, Site E, Focus Group).

5.6 Chapter Summary

In this chapter we have set out the in-depth qualitative data that we generated at each of the sites where we sought to understand the operation of joint commissioning within the specific contexts of the case study sites. As we have illustrated, each of the sites had a different understanding of what joint commissioning is, different languages associated with its operation and different expectations of what it should deliver. Most of the organisational processes used to facilitate joint commissioning were either structural or related to the formalised sharing of budgets and office spaces. Those involved in joint commissioning found it difficult to identify a clear set of practices that they associate with joint commissioning. There did not seem to be anything specific about joint commissioning that respondents would not do in other efforts at either joint working or commissioning in a single agency setting. Most of the respondents did however suggest that the success of joint commissioning is ultimately reliant on the creation of relationships between individuals, agencies and institutions. On the whole people found it difficult to identify what sorts of impacts joint commissioning has had. This is partly due to problems in data collection and attribution but also because it was not always clear what joint commissioning was trying to deliver.   The sorts of impacts identified related to productivity outcomes and partnership outcomes in the sense of better joint working, but these did not always closely map onto the expectations for joint commissioning in that locality.

6 Discussion and Conclusions

6.1 Introduction

As the introduction to this report suggested, there has been longstanding policy interest in both 'commissioning' and in 'joint working' (or, more recently, 'integrated care'). In both cases, different stakeholders might use the same terms to mean potentially very different things, and the formal evidence that either concept leads to better outcomes is often lacking (see, for example, 11;70). Arguably, this is even more the case when it comes to a topic like 'joint commissioning' – and a key aim of this study has been to explore in further detail what local sites mean by joint commissioning, what they are doing when they say they are commissioning jointly, how this differs from other ways of working and what outcomes it achieves for local people and organisations. Against this background, this discussion summarises the contribution and limitations of the study before moving on to focus on five main issues:

- The meaning of joint commissioning;

- Processes of joint commissioning;

- Practices of joint commissioning;

- The impact of joint commissioning; and,

- Looking to the future.

6.2 The contribution and limitations of the study

As we have argued throughout this report, although joint commissioning has often been seen as a solution to a number of difficulties in policy and practice spheres, we actually know relatively little about this. The existing literature is predominantly based on descriptive and observational pieces of writing, rather than on a robust evidence base. This research adopts a theoretically-informed approach to examining the nature of joint commissioning across a number of localities. The contribution it makes then is the first of its kind to examine the meaning afforded to joint commissioning across a series of localities. We have sought to theorise the types of relationships between joint commissioning arrangements, services and to a more limited extent outcomes and then explore these from a

range of different staff and service user perspectives and settings. By focusing on meaning we have been able to gain a sense of the sort of work that joint commissioning does for people beyond simply its impacts on organisational processes. We have been able to understand how joint commissioning shapes what actors do and what meaning joint commissioning gives them on an individual level.

There is also a methodological contribution in this study with the introduction of Q methodology to the POET approach to researching joint working. This is facilitated by the technological advancements provided through the hosting of this in an online survey format. By incorporating Q methodology into the project we were able to very quickly gather a nuanced picture of the different perspectives of joint commissioning across the range of sites and then use these to prompt further discussion and exploration in the second phase of the work. This approach enabled us to gain access to the sorts of insights into personal and organisational meanings of joint commissioning.

The limitations of the study relate to the numbers we were able to involve at the different sites and the time we were able to spend with the different joint commissioning arrangements due to the changes that these local arrangements were experiencing. Having greater involvement at the sites would have meant we could have gained a more detailed insight into the dynamic interplay between various joint commissioning agendas within the localities. At site D this also meant we were unable to involve service users in the data collection process and so have a clear idea on the degree to which they believed that they had felt the impacts of joint commissioning.

6.3 The meaning of joint commissioning

Although our initial literature review found little robust evidence, the literature that does exist tends to conflate joint commissioning with other forms of 'joint working', 'partnerships', 'integration' and 'collaboration.' Often there is no clear statement of what authors (including policy makers) mean by 'joint commissioning' or how it differs from other ways of working, and a general sense that we all know what joint commissioning is. In one sense this is not surprising, and a similar critique might also be applied to the more general partnership and commissioning literatures. What we did observe was the way that actors adopt or adapt 'new' language as a way of both representing themselves as 'new' or 'nimble' to policy makers, whilst actually carrying on doing what they have been doing for a good while in their localities.

New policy languages were often adopted for initiatives without a significant amount of change to the trajectory of those endeavours. Further, people were often not unduly concerned with these linguistic inconsistencies and the overlap between concepts. This may, in part, relate to what Bauman terms "liquid modernity" (150). Bauman argues in the passage of society from "solid" to "liquid" modernity we have created new numbers of

challenges which we have not previously encountered. The types of social groups and institutions change frequently and as such cannot provide a frame of reference for individuals in the same way. Individual actors therefore create a series of short term projects in an attempt to sequence "career" or "progress"; "the once cumulative and long-term nature of progress is giving way to demands addressed to every successive episode separately: the merit of each episode must be revealed and consumed in full before it is finished and a next episode starts. In a life ruled by the precept of flexibility, life strategies and plans can be but short term" (150: pg. 137-138).

What we were observing in some of these cases then was local actors creating a narrative around the progression of health and social care services in their area. This may explain why many of our sites – which had all been chosen as examples of good practice in terms of their joint commissioning – rejected this term, and tended to use another phrase to describe what they were doing locally. Examples of this included terms such as 'integrated commissioning' or simply 'integration' and 'commissioning'. For some this may have been because their organisations and work locally were so fully integrated that they did not see themselves as two or more parties doing something 'joint' in between health and social care. For others, this may be more of a conscious or subconscious reflection that joint working and commissioning can mean different things to different people (as evidenced by our subsequent findings about different viewpoints). When we explored local data in more detail, we found that the five sites all had different ways of seeing joint commissioning and this tended to vary depending on the local context. Elsewhere – particularly in sites that included both providers and commissioners – it was very difficult to tell where one activity ended and the other started. Thus, there does not appear to be one definition or model, and each site interprets joint commissioning in a different way depending on local aims and priorities. This flexibility of interpretation is often associated with national policy initiatives that require local ownership to be effective, for example the national evaluations of Health Action Zones and Local Area Agreements both found that local interpretations were important in determining whether the policy had local traction or not (151;152).

What we did find through our research is that the potential meanings of joint commissioning go way beyond those that we found in the existing literature. In the literature review we found that joint commissioning can be understood as something that can produce efficiencies, empowerment and productivity. In our research we found that these discourses existed alongside each other but also with other potential meanings. Although the literature sets out a number of possibilities in relation to the notion of joint commissioning, at a local level it has been used to understand it in relation to an even wider potential array of challenges. This suggests that there is something about the underlying values of actors that shape whatever "new" initiative that comes their way into an established local way of doing things.

As Williams and Sullivan (69) explain, "conceptual ambiguity creates opportunities for agency, for actors to interpret and understand the nature and value of integration and apply it in different contexts" (pg. 3).

In some areas, moreover, there was an underlying sense that whatever you join up inevitably leaves out other bits. Case study A, for example, recognises the importance of a strong relationship between the PCT, social care and housing, but had less developed relationships with local GPs or with local hospitals. They also had well integrated adult health and social care, but were experiencing problems with transitions from children's services. This seems similar to Miller *et al*'s (153) review of Care Trusts (which found that integrating health and social care could sometimes lead to a less well developed relationship with the broader local authority) and echoes Leutz's (154) reflection that 'your integration is my fragmentation.' Overall, perhaps the common claim that we can create 'seamless services' is more complex than it may first appear, as wherever you situate your boundaries you will create others. Taking this a stage further, perhaps the key issue is how we try to work across the boundaries that exist at any given point in time, rather than necessarily trying to get rid of these boundaries altogether.

Having completed the POETQ process, there was prevalence in both phases of the research for an 'ideal world' view of commissioning: a belief that joint commissioning is simply a 'no-brainer' and can deliver better outcomes for less money. While this is not surprising given our focus on existing examples of good practice and the involvement of commissioners in research, the section below on 'outcomes' explores the extent to which joint commissioning was actually able to deliver these outcomes in practice. Viewed against this background, our sense is that many local workers may have seen joint commissioning as inherently a 'good thing', with very aspirational aims associated with this way of working. Again, this is common in the more general partnership literature (see, for example, 11). While optimism for the future seems an important attribute (particularly in a difficult financial and policy context), there may also be a risk that joint commissioning can be set up to fail by being seen as a way of being able to deliver too many different things to too many different people (see, 155 for a more detailed discussion of these issues).

6.4 The process of joint commissioning

When asked about the process of joint commissioning, many people talked about it in terms of the formal structures that had been put in place to facilitate this way of working – be this formally merged organisations or integrated management teams. Sometimes these gave the impression of being an end in themselves rather than a means to an end (of better services and better outcomes for local people). Arguably, this is a tendency that may also apply across public services more generally, and the broader partnership literature is critical of a tendency to focus on process and

structures over outcomes (see, for example, 13;14;156;157;158). However, at other times, participants seemed to suggest that the focus on formal structures was a response to a turbulent policy context, with local areas feeling that they had to make their relationships more structural in order to protect against future disruption, reorganisation and loss of organisational memory. This might therefore suggest that there is something distinct that formal (structural) integration offers as distinct from collaboration more generally. What structural integration offers are both stability and a degree of protection against change (although this is not always the case as the two care trusts are having to make significant changes at present). Potentially more importantly, what formal integration offers over collaboration is the symbol that the partners are truly committed to this agenda, so much so that they have made structural changes.

Taking a step back from the data collected, none of the processes cited in any of the case study sites seemed to be particularly distinctive features of joint commissioning. All of them were very much the sorts of processes that you would expect to encounter in exploring joint working in a very general sense – pooled budgets, co-location, single assessment, single line management, joint posts and so on. Overall, this tended to reinforce the sense that 'joint commissioning' might be difficult to disentangle from more general joint working (or even that a distinctive entity called 'joint commissioning' might not necessarily exist in the real world of day-to-day practice). Moreover, there was no apparent pattern to the use of the different processes, with different sites using different aspects of these.

Interestingly, there seemed to be a real paradox present in the sense that although a lot of the joint commissioning processes described to us were formalised and structural, people often recognised that joint working is essentially relational (based on informal conversations and interactions). This has clear implications in the current financial and policy context, when reductions in the workforce and major national reorganisations are leading to substantial turnover and disruption to previous relationships. At the same time, the advent of clinical commissioning will introduce new potential partners, and the process of building trusted relationships at local level may need to begin again. Yet, this is not a new issue and is a longstanding concern for health and social care organisations. There has long been a tension concerning whether integration is formed by structures to support this or if it is due to the agency of actors operating within these systems (69).

6.5 The practice of joint commissioning

As suggested above, many participants talked about the organisational processes put in place to facilitate joint commissioning. However, the research was full of stories of these processes not always working as they might (where for example, co-location had caused difficulties in working

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relationships or where pooled budgets were not quite as fully shared at they might be). Ultimately, the overriding sense was that successful joint working depends not on systems, but on local and personal relationships to resolve – and these take time to develop. This might be particularly difficult in small health and social care communities: while it can sometimes be easier to develop close working relationships and integrate services in a small, co-terminous area, such localities often have to work with much larger providers that cover a bigger patch, and sometimes struggle to ensure a more locally tailored response (159).

Despite the importance of strong relationships, our data suggested a number of arguments and disagreements behind the scenes – including a reluctance in site D for colleagues to speak honestly and openly to partners from a different professional background. Site B also spoke of a 'them and us' culture persisting, while other participants talked of uncertainty in the broader policy context causing people to 'revert to type' and to retreat back to previous silos. Quite how to interpret these findings is open to debate. On the one hand, these sites were specifically chosen for their acknowledged good practice, and if anywhere could overcome such tensions then one would hope that these five areas could. At the same time, if even these five sites found negatives as well as positives, it might suggest that joint working is fundamentally difficult, that relationships need ongoing care and attention and that tensions are just as much a feature of working together as some of the potential benefits and synergies. Indeed, one interpretation would be to see the willingness to acknowledge and talk about problems as a sign of maturity – and that this might be preferable to areas that seem to claim that their relationships are always harmonious. Indeed, there is evidence to suggest that strong relationships are those that can accommodate conflict without necessarily being derailed by it (160).

6.6 The impact of joint commissioning

As suggested above and in the main body of this report, different staff had different viewpoints as to the nature, purpose and outcomes of joint commissioning. However, one of the more common perspectives was the 'ideal world' view of commissioning – with some participants very positive about the potential of joint commissioning and very aspirational in terms of what they thought it could achieve. In practice, many sites struggled to cite specific examples of the impact of joint commissioning or to evidence their claims, thoughts and hopes. This seems to be the result of a number of inter-linked issues:

1. As with all evidence of impact, the more specific that sites were about what they were trying to achieve and the more narrow these aims were, the easier they were to evidence. For example, sites A and C found it difficult in some respects to evidence the preventative,

holistic, patient-centred aspects of joint commissioning, whilst it was much easier to find evidence for site B (who had as a key aim to balance the budget and make savings). As with other forms of joint working, being clear in advance what success would look like – and being realistic about what joint working can actually achieve in practice seems crucial. To some extent this is the sort of challenge that theory-based approaches are often confronted with; whilst they are designed to deal with complexity they may end up being used to account for simpler things (6;25).

2. Several sites talked of ways in which they had been able to make efficiency savings through joint commissioning. However, these often seemed to derive from one-off actions or initial changes (such as removing longstanding duplication, revisiting contracts etc), and there was little evidence of scope for recurring savings. Making efficiencies in itself may also not lead to better user outcomes (although making savings in a difficult financial context might be a good outcome in its own right).

3. Even though sites found it difficult to evidence the impact that they were having, participants in interviews and focus groups would often end by reaffirming their belief in joint commissioning. On the one hand, it might suggest that joint commissioning is an important way of bringing people together and that it might be able to deliver in spite of all the barriers. As one manager at site C explained; *"it's a joint voice isn't it? So if health and social care which are two quite big agencies are joined together in certain areas, then other agencies are more likely to be influenced by that aren't they?"* On the other hand, this could be a rather touching statement that joint commissioning might be able to deliver if only we could get it right (it's just that we haven't ever managed this yet) – a case of the language of joint commissioning so infiltrating policy that participants continue to believe in it even if it has not yet been perceived to 'work'. There is a question about the extent to which sites knew what they were actually doing beyond a level of generality. There seemed to be a lack of detailed collective thinking at the sites in terms of what their theories of joint commissioning were. In the absence of such theories it is to some extent not surprising that they could not easily evidence their impact.

4. Many of the changes which participants described were often more related to more integrated service *provision* than they were to joint

commissioning. For example, in site A, one of the main pieces of evidence cited as an example of the impact of joint commissioning was a new Centre for Independent Living (CIL) (which was actually a form of service provision that offered more integrated care). Whether this was commissioning- or provider-driven was difficult to tease out, as was whether local stakeholders most valued the joint commissioning that may have helped create the CIL or the integrated provision it actually delivered on the ground. At the same time, case study A also gave a sense that the added value of joint commissioning was not just in the end product delivered or the outcome achieved – but in the process through which partners went together to reach this point. Perhaps this suggests a view of joint commissioning not just as an activity that should lead to different services, but also as a journey that local partners embark upon together (where there is benefit in the journey itself, not just in arriving at a particular destination). To some extent this is not necessarily a problem given that we have suggested throughout this report that joint commissioning is a malleable term.   However, within the context of the current policy agenda it does have some salience given that there is an ongoing push for the separation of provision and commissioning functions. What this means is that we are not clear whether these changes have been caused by joint working generally or whether this is something that has been instigated by commissioner or providers.

5. Building on this, many of the sites were able to talk in detail about projects or new care pathways where joint commissioning had been used as an initial starting point to bring together providers and redesign services. In this sense, joint commissioning might be seen as a glue that can hold other parts of the system together or as a trigger that can encourage future joint work elsewhere.

6. If joint commissioning is primarily relational, then stability and time (both of which seem lacking in the current context) should lead to better working relationships and allow sites to do more together and address new issues. Yet, this may be somewhat of an aspiration, rather than something that will be a reality; certainly history suggests that the policy context is rarely stable (6). In the case study sites involved in this research they definitely struggled to find these factors. For example, some of the difficulties sites A, C and D experienced in identifying outcomes or being clear about what joint commissioning means may derive from the fact that these relationships have been in place for a while and are more mature (with a range of different

stakeholders over time arriving, developing new approaches and moving on). In contrast, joint arrangements were newer in sites B and E and the introduction of these new ways of working may have given greater initial clarity and secured broader buy-in (at least in principle). Again, this is difficult to interpret. At first glance, sites with longstanding relationships that struggle to be clear about what joint commissioning means may seem less advanced than newer partnerships with greater clarity. At the same time, the ability to carry on working together in spite of different interpretations of what joint commissioning is, may actually be a sign of maturity – and some of the newer arrangements might become more contested and less clearer over time as they bed in.

7. Where changes had been identified locally, it was often unclear whether this was the result of joint commissioning *per se* – or whether similar outcomes could have been achieved through different means (for example, through an organisational development programme to encourage joint working, through a more general partnership approach or through informal working relationships). What this suggests is that the power of joint commissioning may not therefore be in terms of it as a clear model of improvement but in its role in helping to frame improvement programmes in a broad sense, which has also been noted elsewhere in relation to partnership working more generally (26)

8. There appeared to be tension between commissioning for a larger geographical area which may provide consistency and deliver efficiencies (for example, site B), and commissioning at a locality level which may be more expensive but might deliver more appropriate services (for example, site E). Resolving these issues may be crucial given current financial pressures and given the opportunity created by the current reforms to think through which services might be best commissioned at which level (of the individual patient, the practice, the CCG, the local authority and so on). Although to some extent this quandary is one which is classic in terms of the devolution field; how low do you allow services to be devolved to and for what reason? The issue of what is the ideal sized population-level or geographical area, is also one that has been debated more widely within the commissioning literature (63;64;161).

9. Sometimes a closer working relationship between health and social care could be undermined by a failure to work together across the

whole system. For example, site A had made some real progress in delivering new services, but some service users found these difficult to access due to problems with public transport. This to some extent supports the notion of place-based outcomes, rather than those which are set for individual services (152;162;163). Without these sorts of place-based objectives there is a risk that improvements in one service area are undercut by limits elsewhere and the positive impacts go unnoticed (164;165)

10. Above all, it remains unclear whether some of the changes described locally would have happened anyway without joint commissioning. A good example here is in site D, where many of the positives (falls prevention, integrated telecare/telehealth etc) cited in support of the integrated organisation that had been set up actually seemed to pre-date the creation of this new entity. Most of these were also developed at a time when money was more plentiful than at present and when there was a strong willingness to innovate and to collaborate locally. Whether the same contextual factors will exist in future in an era of austerity and with financial pressures placing increased strain on existing relationships remains to be seen. There is a question which is, as yet, unanswered about the degree to which austerity will stimulate joint commissioning in order to generate more efficiencies or whether it will prove its death knell given that there may not be the resources in order to enable it to happen.

What these findings do seem to suggest is that the value of joint commissioning might not simply be in terms of this as a rationalist model of improvement that can be introduced in sites to bring about particular outcomes. As we have demonstrated, there may not be anything that is specific about joint commissioning that is different to other ways of working and it is far from a coherent model with a set of clear organisational processes and practices. However, what joint commissioning does have is a degree of acceptance and a sense that it is a positive thing. In all of the cases we have studied here it has been used as a "framing concept" to introduce a range of organisational, structural and in some cases cultural changes. The very value of joint commissioning may then be in its ambiguity and symbolism as a concept that is seen as inherently good and able to deliver against a range of the very sorts of pernicious issues that contemporary health and social care organisations struggle with (e.g. health inequalities, constrained budgets, involving the public and service users in the design and delivery of care services).

This is an important observation and one which has been made elsewhere in relation to the notion of joint working more generally (26). It has long been argued that studies of collaboration have predominantly focused on

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the process of how partners work together and not on the outcomes that the collaboration achieves (15). Here we are able to theorise why partners might find the collaborative processes of joint working to be as important as the intended outcomes, and why, in some cases the enactment of a "joint" way of working becomes the core concern with outcomes perhaps neglected. If joint commissioning is an inherently good thing then enacting this should help deal with addressing the issues of health inequalities (sites A, B and to some extent D), dealing with the challenges of understanding excluded communities (site E) or dealing with a financial deficit (site B).

On a personal level the notion of joint commissioning might be seen as "right" or "good" for reasons of faith, rather than evidence, in the sense that this is a "right" way to work. Joint commissioning might provide work fulfilment in a system that otherwise tends to prioritise technocratic responses and performance management regimes that dominate public organisations (166). The very challenges associated with joint commissioning such as negotiating diversity and interdependence, the possibilities for creativity and the inevitability of conflict, stretch individuals and require them to make use of skills such as judgement that cannot be read off a performance chart but instead need to be honed through experience. For local organisations and professionals there is currently no alternative to collaboration. Given that this is seen to be such an inherently good thing then engaging with collaborative endeavours offers a narrative around the impact that individuals and organisations are seeking to deliver. Until there is a better alternative, actors are still going to keep going at collaboration in the absence of other options.

6.7 Looking to the future

As discussed above, this project has adopted an innovative approach to an under-researched area. Despite a number of limitations and caveats set out above, this has potential implications for future research. At the same time, the study is being published in mid-2012 in a very difficult financial context and at a time when significant reforms are taking place in both health and social care. With both these issues in mind, this report finishes with brief reflections on implications for future research and for future policy and practice. In the context of a detailed research report and a rapidly evolving policy context, these are inevitably brief and tentative – but will hopefully spark further reflection and debate.

6.7.1 Implications for research

There are two main avenues of future research that this project might suggest. The first is to do more detailed exploratory work into joint commissioning within a rational-empiricist model. An early intention of this project was to use primary and secondary data to test the veracity of the claims being made for joint commissioning. In practice this did not happen as we were unable in most of the sites to get to a clear sense of what the

sites were attempting to achieve in terms of outcomes. However, research that attempted to compare different types of joint commissioning arrangements (different professional make up, partners, structural forms etc) and performance indicators, may be able to reveal patterns about joint commissioning. Similarly research into many of the aspects we have illuminated here such as the challenges of evidencing outcomes, the difficulties in separating commissioning and provision, and the challenges of impacting on and evidencing long term outcomes in complex adaptive systems may also be fruitful avenues of research.

Going beyond this and working in a more interpretive vein – and one which we would argue is potentially more helpful within the current context - would suggest that we might need to ask very different questions of joint commissioning than those that we have traditionally asked. Sullivan (167) describes the new Labour government's valorisation of evaluation as a search for the "truth" within their evidence-based policy agenda. Sullivan concludes that "despite the considerable financial and human investment made in policy evaluation in the UK between 1997 and 2010, the attachment to the idea of 'truth' disconnected 'evidence' from 'argument', impaired the exercise of evaluator judgement and fragmented the contribution of evaluation to the policy process" (pg. 500). Similarly, we might argue that a huge amount of investment has been made in joint commissioning and on the basis of the evidence from "best practice" case study sites we have presented here there does not seem to be a clear link between joint commissioning and better outcomes. Sullivan points to the importance of theory-led approaches to evaluation in understanding the various different rationalities that are at play within any given context. What Sullivan is arguing here is that within any situation there are multiple truths operating and a range of reasons why actors might behave in a particular way. What is important here then are the situated realities of individuals and how they experience joint commissioning within the complex contexts of everyday organisational practice. What this suggests is that we need to ask different questions of joint commissioning and the actors involved in it, focusing on what collaboration means to a range of different stakeholders. This allows us to understand the notion of agency in joint commissioning in a different way, beyond just improving outcomes and offers us a chance to understand joint commissioning as an instrument of control and liberation, creativity and conflict.

6.7.2 Implications for policy and practice

Although joint commissioning has long been promoted by policy makers, it seems even more crucial in the current context as the Coalition government seeks to promote more 'integrated care' (8). The current reforms are also creating new fora for joint commissioning via Health and Well-being Boards (168) and via the move of some public health functions to local government. Single agency working will also be insufficient to tackle many of the issues we face in an era of long-term conditions and in challenging

financial circumstances. Faced with less money, but also with an ageing population, rising need and demand and higher public expectations, health and social care will have to work together more than in the past.

Despite this, the risk is that joint commissioning and joint working more generally could become even harder in the current context. Many of our case study sites have been trying to work together for many years, and have built significant expertise and trust over time. However, as financial pressures increase there is a danger that some agencies could retreat back into their own organisational and professional identities, and that joint working could suffer. As structures change, moreover, there is a real risk that previous relationships and organisational memory will be lost. Fully integrated commissioning organisations such as PCT-based care trusts may also cease to exist in their current form, and it would be ironic in the extreme if broader policy began to emphasise the importance of integrated care at exactly the same time that clinical commissioning led to the breakup of some of our most integrated structures and systems.

In addition, many previous joint commissioning arrangements have been between the local authority and the PCT(s) – and GPs are relatively new players perceived locally as not having been very involved in joint commissioning to date. Elsewhere, we have described the advent of clinical commissioning as having the potential to encourage 'new conversations between new players' and to develop a more place-based approach to health and well-being (169). However, there seems a real risk of throwing the baby out with the bath water, and a key test of the current reforms will be their ability to build on what is already working well rather than undermining existing joint work.

At these times, boundary spanning individuals may be more important than ever. Such individuals "cross, weave and permeate many traditional boundary types, including organisational, sectoral, professional and policy" (170: pg. 1). Arguably within the type of context that we have set out above where austerity is the norm and there is a degree of competition between organisations, "the default position of organisational self-interest may well prevail. This presents a huge challenge for boundary spanners to provide compelling reasons for collaboration, to provide a business case where benefits outweigh costs and to balance the protection of organisational interests and identities within an overall collaborative framework" (170: pg. 149). Organisations should invest in the various types of boundary spanning roles in order to overcome the complexity caused by the present context.

Also crucial are ongoing debates about the best balance to be struck between competition and collaboration – and joint commissioning might be one way of trying to jointly understand the nature of the problems to be solved and develop a joined-up response (whilst still ensuring that the services provided have been through a competitive process). Elsewhere, commissioning has been defined in terms of an analogy with the human

body – with commissioning being the conscience, the brain and the eyes and the ears of the system (74). Building on this comparison, joint commissioners will need to develop a shared understanding of what they are trying to achieve on behalf of local people and be a steward for scare public resources ('conscience'); assess current and future need and demand and allocate joint resources accordingly ('brain'); and understand how patients experience current services and what these achieve on their behalf ('eyes and ears'). Even if the policy context or the language used changes over time, these tasks still seem crucial whether or not we use terms such as 'joint commissioning' to describe them.

Figure 10.   The 'conscience', 'eyes and ears' and 'brain' of NHS commissioning

Responsibilities of the conscience include:			Responsibilities of the eyes and ears include:			Responsibilities of the brain include:		
Likely to be undertaken fully or partly at a national/regional level	Indicates activities to be undertaken by PCTs	Likely to be assumed either fully or in part by practice based commissioners	Likely to be undertaken fully or partly at a national/regional level	Indicates activities to be undertaken by PCTs	Likely to be assumed either fully or in part by practice based commissioners	Likely to be undertaken fully or partly at a national/regional level	Indicates activities to be undertaken by PCTs	Likely to be assumed either fully or in part by practice based commissioners
Establishing the overall objectives of and desired outputs from the system Setting minimum standards for services Evaluating and weighting the costs and benefits of different market models Assuring the quality of services commissioned Influencing patterns of demand at a macro level through public	Ensuring that health system objectives dovetail with those of other local commissioners (e.g. those who are part of Local Strategic Partnerships) Ensuring appropriate and mature partnerships with other health and social care organisations and agencies are in place, and proactively managed Stewardships of public resources (including reporting and accounting for	Establishing health objectives for individual patients and practice populations Supporting individuals in making choices	National collation of data and statistics for benchmarking (e.g. QOF data) External audit of local processes (e.g. Audit Commission 'spot-checks' of coding and reporting under PBR) Inspection of providers and commissioners against national standards (e.g. by Healthcare Commission, Monitor etc.)	Assessing needs of population and modelling demand for services (current and future) Monitoring and validating activity levels, costs and service outcomes Benchmarking need, demand, activity and outcomes Horizon scanning – identifying trends/technologies/evidence (e.g. as endorsed by NICE), /policies etc. Likely to impact on patterns of need, demand and costs Designing and	Assessing and reporting on current capacity of system to meet needs and achieve objectives (including availability of services, and patients' experiences of health and satisfaction with health services)	Establishing structures, processes and incentives required to ensure system objectives are achieved Supporting local application of processes (e.g. through designing 'templates' for contracts, PBC budgets, information packs etc.)	Deciding what services will be commissioned at which level of the system Allocating purchasing budgets to individuals, commissioners and networks Designing incentive and payment systems that encourage providers to enter market and deliver desired service models and pathways (market development and management) Procuring, contracting with and allocating resources to	Translating patient experience data into information to be used in commissioning Translating patient activity data from primary and secondary care into information to be used in commissioning Planning and designing efficient and effective protocols service models, and clinical pathways (and ensuring appropriate clinical advice and service user involvement in this process) Micro-level demand management Provision of

health activities Setting and regulating the 'rules of engagement' to assure the probity and 'acceptability' of the system (including developing nationally specified 'core contracts') Ensuring that the rules of engagement allow for sufficient contestability and choice with the local system Registering, regulating and arbitrating in conflicts of interest within the local health market	outcomes) Ensuring that there are robust and appropriate methods in place for making decisions about funding priorities, and on action to be taken when brain cannot reconcile demands of national priorities with available resource Ensuring the system operates in a way that does not create or increase inequalities (e.g. ensuring Patient Choice does not threaten access for vulnerable individuals)			implementing processes to ensure patients are effectively 'tracked' through the health care system.			providers Managing the performance of providers Removing resources from providers if service levels and standards are not achieved Designing and implementing local arrangements to assure patient choice, including designing and distributing information for patients and PBCs	extended primary care services Supporting individuals in making choices

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Building on this, while national policy promotes the concept of integrated care, there seems less clarity about what this actually means in practice or what it is designed to achieve in terms of outcomes for local people and organisations. This ambiguity is evidenced in abundance in the present study, where different people define joint commissioning in different ways and see it as trying to achieve very different things. If current policy is going to be more successful than previous attempts at encouraging more joined-up services, it will need to be clear about the outcomes to be achieved – what services would look like – for different stakeholders. Different forms of joint working (including joint commissioning) might then be chosen as a locally appropriate way of trying to deliver such outcomes – but with the centre holding local areas to account for what they achieve rather than what they actually do or the structures they develop. Put a different way: if joint commissioning (or joint working more generally) is perceived to be part of the answer, what is the question?

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Appendix 1 List of statements

1. Joint commissioning is about delivering more for less.
2. Joint commissioning is about reducing duplication.
3. Joint commissioning seems to be speed up referral
4. Joint commissioning is about investing now to save in the future.
5. Joint commissioning is all about delivering the same for less.
6. Joint commissioning requires larger management structures.
7. Commissioning jointly means fewer inappropriate referrals.
8. Commissioning jointly should be about reducing pressure on acute services.
9. Joint commissioning is reducing opportunity for cost-shunting and passing the buck.
10. Joint commissioning helps us enhance our own organisational influence by allying ourselves with others.
11. Joint commissioning is mostly about fulfilling government requirements to collaborate.
12. Joint commissioning can feel like a battle of the models: A health approach verses a social care approach.
13. Joint commissioning does little to address the amount of red tape and bureaucracy colleagues have to manage.
14. Rather than something completely new, this joint commissioning just formalises an existing culture of collaboration and partnership.
15. Joint commissioning preserves our marked differences in professional cultures.
16. Commissioning jointly makes it clearer who can be held to account for actions.
17. Commissioning jointly signals to others that we are in partnership.
18. Joint commissioning enables better risk management.
19. By commissioning with other colleagues you can share ideas, increase knowledge and be more creative in what you do.
20. Where we are co-located, it benefits professional discussion through the development of informal relationships.
21. Properly done, joint commissioning can deliver a quantum leap in how organisations work together.
22. Commissioning jointly can lead to individual teams becoming more insular.
23. Joint commissioning enables greater information sharing.
24. Joint commissioning helps build the necessary trust between us.
25. Joint commissioning facilitates the development of a new common language.

26. Joint commissioning means delivering pretty much the same level and standard of service but organised in different way.
27. Joint commissioning means that we better understand one another's roles and duties.
28. Only by commissioning jointly can we address the most complex social situations.
29. Joint commissioning results in synergies, where we are greater than the sum of our parts.
30. Commissioning jointly leads to better working conditions for colleagues and helps boost morale.
31. Commissioning jointly is about delivering a seamless service for service users.
32. At the end of the day, joint commissioning is all about realising improvements to real people's lives.
33. Joint commissioning is about delivering a system that promotes fairness inclusion and respect towards all sections of society.
34. Joint commissioning is about users knowing what to do and where to seek help.
35. Joint commissioning is about improving choice for users.
36. Joint commissioning, has had a minimal impact on users.
37. Joint commissioning changes the way service users can influence the services they receive.
38. Joint commissioning is opening up opportunities for the private and third sectors.
39. Joint commissioning reduces inequalities of access to services.
40. Joint commissioning is about improved primary prevention and early intervention.

Appendix 2 Phase 2 research tools

Example staff interview schedule

Section one: Your experience of joint commissioning

1. Can you tell me about your current role and how it links to joint commissioning?

2. What's your understanding of what your organisation is trying to achieve through joint commissioning?

3. What's been your experience of delivering joint commissioning locally?

Section two: How joint commissioning works in practice

4. Based on your experience of joint commissioning

    a. can you briefly describe an activity you've been involved in and how things were done differently?

    b. what would you say worked well in this instance and why?

    c. what would you say didn't work so well and why?

Section three: the difference joint commissioning makes to service users

5. One of the things we're particularly interested in is the difference that joint commissioning makes to service users and carers. What in your opinion helps most in the delivery of service user outcomes?

6. What in your experience hinders (prevents) the delivery of outcomes for service users/ carers?

7. What in your opinion would work better to achieve better outcomes for service users/carers?

Example staff focus group schedule

1. About you…

Can you tell me a bit about each of your roles and how they link to joint commissioning?

Do any of the viewpoints to emerge about joint commissioning particularly resonate with you and why?

2. About your experience…

Based on your experience of joint commissioning, can you describe an activity you've been involved with and how things were done differently? What would you say worked well and not so well and why?

3. About the difference this makes to service users and carers?

What difference do you think the activity made to service users and carers in terms of outcomes? To what extent do you think these are the right outcomes to be striving for? What in your opinion would work better to achieve better outcomes for service users and carers in the future?

Example service user interview schedule

Section one: About your experience of using services...

Can you tell me a bit about how you have come to use health and social care services locally?

How would you describe your particular needs? What is it specifically, that you require help/ assistance with?

Which services have you used to help you with meeting your needs and on what basis? i.e. how often and for how long?

Section two: About the difference that using services has had on your life...

What's been your experience of using health and social care services locally?

What, in your eyes has been good about the service? In what way has the service helped you to meet your particular needs?

Has there been anything about the service that was 'not so good'? Has this affected you in any way? and if so, how?

Section three: About your view of what an 'ideal service' looks like...

Based on the list of outcomes in front of you, what would you say are most important 'outcomes' to you in terms of meeting your needs?

Which would you say are least important 'outcomes' to you in terms of meeting your needs?

Of the 'outcomes' you have chosen as important to you, which would you say are your top three and why?

Section four: About improving the future delivery of services...

When you think about the services you currently use, to what extent do you think these 'ideal' outcomes are already being met? What is missing in your opinion?

What prevents these outcomes from being met, do you think?

What would you say needs to happen in order for services to be improved and for service user/ carer needs to be better met fully?