working together for well-being:
from vision to reality

an implementation guide

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section 1: introduction

The Inter Agency Group on adult social care (IAG) commissioned this paper as part of a longer-term programme of work on adult social care and community well-being. The IAG was set up in January 2005 to bring together a range of lead agencies from the statutory, independent and voluntary sectors to influence the government agenda on health and adult social care.

It is the most recent in a number of papers prompted by the government's decision to follow *Every Child Matters* with a similar green paper on adult social care in 2005. Taken together, this series of publications has been developing a case for a partnership approach based on two fundamental principles:

1 **firstly**, that health and social care commissioning should be firmly located in a wider community well-being programme in which care and treatment promote health improvement, independent living, inclusive communities and reducing inequalities; and

2 **secondly**, that this agenda should be delivered through partnership arrangements based on the 'convening' role of local authorities, focussed through Local Area Agreements (LAAs). This agenda would embrace both central government and local agencies, while reinforcing public engagement and accountability.

From vision to reality is designed to build on those principles taking account of the vision set out in the health and adult social care white paper, *Our health, our care, our say*. It also analyses the potential contribution of the local government white paper *Strong and prosperous communities* to the implementation of that agenda. Finally, it identifies some practical next steps using examples from a range of settings in which relevant developments are already taking place. The full version is available on www.lga.gov.uk.

the government's vision for community services

Our health, our care, our say outlined 'a new direction for community services' based on the longer term aim of securing a 'sustained re-alignment' of the entire health and social care system. This new direction referred to all health and social care services provided in community settings. In essence, the government's vision was that:

"Far more services will be delivered – safely and

effectively – in settings closer to home; people will have real choices in both primary care and social care; and services will be integrated and built round the needs of individuals and not service providers".

The effect of providing more care locally is that less care will be provided through traditional hospital services as patients are offered more options within, for example, primary care or diagnostic and treatment centres.

The same whole systems approach is being applied to outcomes, objectives setting and performance management. This approach supports a greater local focus on health and well-being, together with the seven green paper outcomes on adult social care detailed by the Department of Health (DH) in *Independence, Well-being and Choice*:

- improved health and emotional well-being
- improved quality of life
- making a positive contribution
- choice and control
- freedom from discrimination
- economic well-being
- personal dignity.

These seven domains locate the *Our health, our care, our say* outcomes within the context of social inclusion, sustainable communities and citizenship pursued by local government and the Department for Communities and Local Government (DCLG). In other words, they are broader than, but also embrace, the more traditional understanding of health and well-being pursued by the National Health Service (NHS) and the DH.

understanding the vision

A sustained re-alignment of health and social care involves a range of interlocking and interdependent agendas potentially involving the entire NHS and local government. It implies fundamental shifts in relationships, responsibilities and resources within, and between, services. They can be summarised as shifts in:

- the NHS: from secondary to primary/community services and prevention;
- public health: from NHS leadership to community co-leadership;
- social care: from residential to home care, re-ablement and prevention;

- health and social care: from health care pathways to health and social care pathways, especially for long-term conditions;
- local government: from social care to universal services and social inclusion;
- local governance: from patients and clients to partners and citizens; and from individual targets to partnerships for well-being;
- commissioning processes: from separate services to outcomes focussed around individual and community well-being; and
- power: from professionals and services to individuals and communities.

moving the vision forward

Successful implementation depends, therefore, on dealing with a wide and often divergent range of interests operating within fragmented structures and systems. *Our health, our care, our say* looked towards the local government white paper *Strong and prosperous communities*, to complete the framework of governance arrangements capable of overcoming such barriers.

In practice, it is not yet clear whether *Strong and prosperous communities* will provide a sufficiently broad or robust framework. In particular, it appears to focus primarily on the social care and public health elements of those interlocking agendas.

As a result, the interdependencies between those parts of whole systems realignment and the reshaping of primary and acute care seem to have been insufficiently recognised. It is questionable, therefore, whether the scope of the white paper is sufficient in reach or grasp to rebalance local service systems away from their historic acute sector dominance.

Our health, our care, our say implies a major programme of cultural change, organisational development and the re-shaping of service delivery. In what follows, we identify components and examples of the changes that will be necessary.

future requirements

First, however, it is important to establish the baseline capacities and capabilities of local government, adult social care and the NHS against those implementation challenges.

A review of evidence about recent and current performance reveals a mixed picture of strengths and weaknesses:

- The former social services departments successfully managed the transition from demand-led social security funding to cash-limited local government budgets. In doing so, they successfully shifted the balance of care from residential to domiciliary services.
- Local authorities have been less successful to date in realising the more recent objectives of personalisation, self-directed care and user involvement in commissioning.
- Understanding and experience of commissioning and market development have evolved over the last decade and a half but significant weaknesses continue to exist, especially in relation to early intervention and more individualised services based on the principles of choice and control. Collaboration with service providers in re-shaping the system is patchy.
- Comprehensive support services for carers are urgently needed, not least to reduce admissions to care homes and hospital.
- Improved performance is evident in council infrastructures, processes and managerial systems which provide a foundation for the change management processes required by the health and social care white paper.
- An evidence-based governance framework for local strategic partnerships is emerging incrementally. Its capacity is still under-developed and the engagement of the NHS is limited.
- Financial and structural turbulence in the NHS has severely challenged continuity, certainty and trust in partnerships. Different organisational systems, cultures and patterns of central/local relationships have proved long-term barriers to more integrated working.
- Social care has received less generous financial settlements than health, but has had to cope with the challenges of growing demand and rising expectations. This has often resulted in raised eligibility criteria and increased charges being used to control costs.
- The NHS is meeting access targets in the acute and primary care sectors but it is too early to reach a judgement about the impact of the systems reforms on health status, commissioning or the Best Value regime.
- Reconfiguration of the acute sector is the inevitable consequence of the white paper and will be politically challenging unless local residents are confident that traditional acute services are being adequately replaced by safe and high quality services close to home.

As this analysis shows councils, the NHS and the

governance systems within which they work, cannot be described as fully fit for the purpose of achieving the white paper outcomes for individual and community well-being. Some of these inevitable gaps and shortcomings are matters for local development. Others lie in the province of central government.

central/local partnerships for better governance

The starting point for improved local capacities and capabilities is the role of central government in creating policy environments that enable local agencies to secure better outcomes. Substantial progress has been made in these respects but the Whitehall/Town Hall relationship is still lacking in mutual trust and understanding. Central government could now promote better working relationships between governance tiers by:

- reinforcing the message of *Our health, our care, our say*, that the well-being outcomes are the focus for organisational and system reform across the local policy system;
- ensuring that objectives setting, resource allocation, performance management systems and regulation are aligned to those outcomes and drive the necessary restructuring of service systems;
- securing whole-hearted engagement of local partners in this agenda rather than reinforcing silo working;
- guaranteeing compatibility between the vision for local government and system reform in the NHS;
- creating frameworks for local governance which are sufficiently comprehensive in scope and capability to deliver whole systems change;
- requiring costed plans for re-aligning service systems, enabling the appropriate redeployment of resources, and ensuring that funding levels are adequate;
- enabling the supply of a workforce compatible with the objectives and outcomes set out in *Our health, our care, our say*; and
- ensuring the implementation of Strong and prosperous communities is capable of delivering the full set of health and well-being outcomes from *Our health, our care, our say*.

local building blocks: outcomes, commissioning and service models

The case studies included below demonstrate that some local partnerships are making headway in addressing these issues, some building on past successes. However, progress nationally is patchy and the challenges are significant both for central government and local partners. The relationship between outcomes, whole system performance management, comprehensive needs assessment and mature supply-side structures needs to be made more explicit if the vision of *Our health, our care, our say* is to be realised.

making it happen and making it stick: next steps

How can the necessary strategic shift be made to happen and be made to stick? Three starting points suggest themselves from this study:

1 the shift towards empowerment, prevention and well-being is rooted in what people want in terms of health and well-being, independent living and having greater choice and control over their lives;
2 local agencies have already embarked on at least part of this agenda; and
3 change will not happen spontaneously or universally. Silo-based power structures constantly renew themselves and retrench in the face of challenge.

Some of the necessary changes require concerted central/local action to develop local policy environments which will promote and sustain strategic re-alignments towards community well-being.

section 2: local building blocks: outcomes, commissioning and service models

introduction

The organisational development task associated with implementing *Our health, our care, our say* is complex and demanding. While a fuller programme of development needs is outlined in section 3, this section concentrates on three basic building blocks which should form the core of local and national implementation strategies:

- outcomes
- commissioning
- service models to deliver the new agenda

In each case, we review the implementation challenges and provide case study examples from localities with relevant experience to share. Finally, we summarise some messages for central government and local agencies.

The IDeA has developed a whole system improvement framework which identifies a set of interlocking components needed to deliver better individual and community outcomes. In particular, they focus on three aspects of an integrated health and social care system that would need to change: governance and strategy; infrastructure and organisation; and delivery. This approach is summarised in Figure 2.

Figure 2 The IDeA Onion
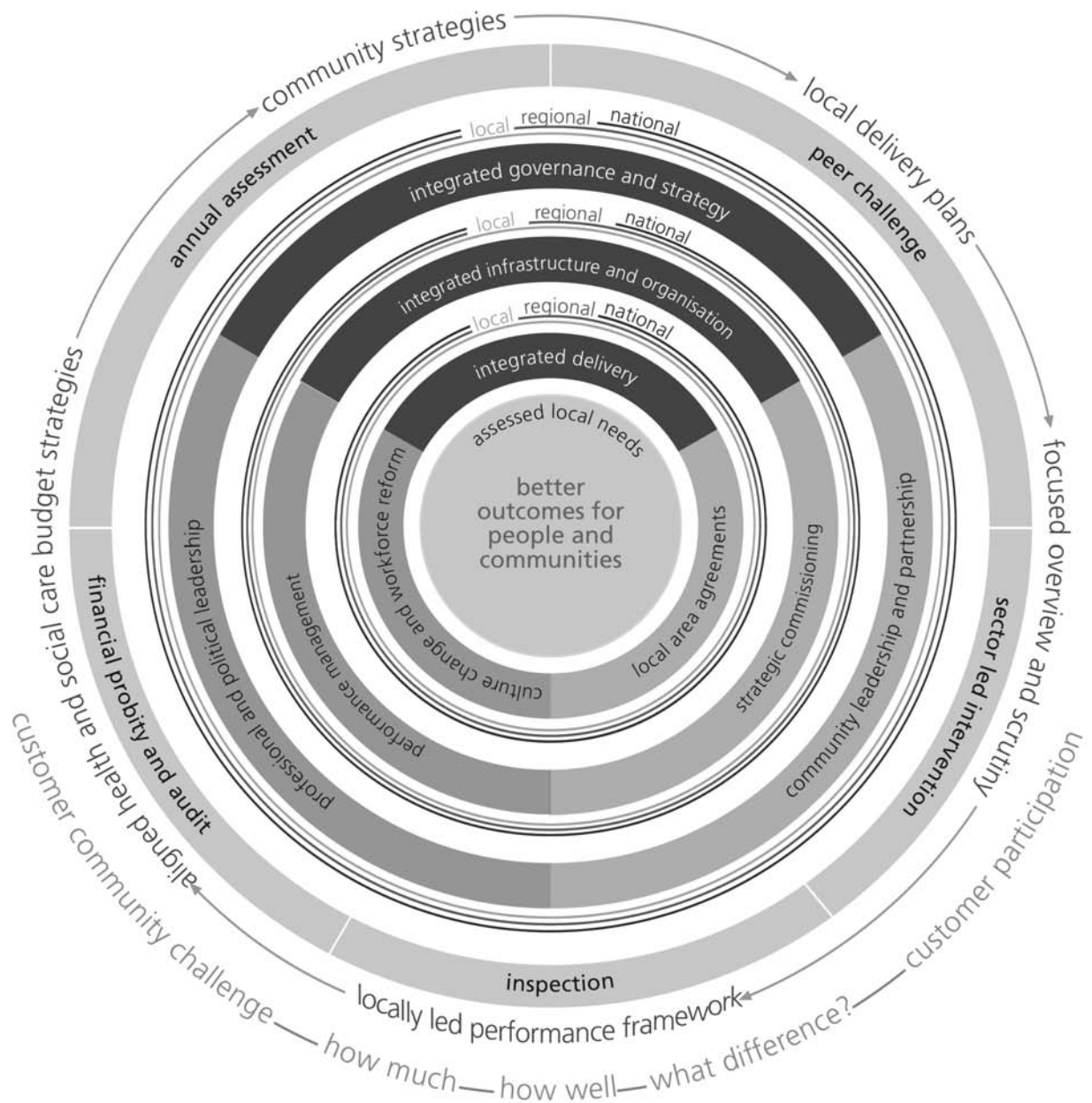
outcomes

The language of 'outcomes' is gradually becoming more commonly used in both policy and practice and is supported by a growing body of evidence from research – by the Audit Commission (2004), ODPM (2006) and Henwood and Waddington (2002) – into what is important to service users and members of communities more generally.

Our health, our care, our say explicitly seeks to improve outcomes for individuals and communities in respect of their independence, health and well-being. Their purpose is to structure objectives and performance assessment to help ensure that commissioning and service provision are firmly focussed on delivering the outcomes that matter to local residents. Moreover, they need to apply to all the relevant agencies so that the individual activity of each is geared to the same common ends. Alongside objective setting and performance assessment, therefore, they fulfil a third purpose of shaping and driving whole systems change through appropriate partnership working. As the white paper acknowledges:

"……for truly effective joint commissioning to occur, the performance management and assessment systems of health and social care need to be aligned. Having different performance measures and targets for PCTs and local authorities has not facilitated joint commissioning". (Department of Health 2006a, para 7.62)

Experience of developing and applying such a whole systems approach to outcomes, objectives and performance has been gained in the field of children and young people. In developing its implementation programme for *Every Child Matters*, the government worked with children, young people and their families to develop a set of five outcomes that are key to well-being in childhood and later life, namely; being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. These outcomes have been used to develop a shared understanding about how services can be better brought together around the child, young person and family.

Every Child Matters: Change for Children highlighted however that:

"if the outcomes are to be really effective in driving change, it is important to be clear what is meant in practice and how progress towards them will be measured". (ibid. page 8)

A national outcomes framework was produced; therefore, to act as, 'a basis for agreeing local priorities and planning local change'. It also provides the basis for monitoring progress.

 Our health, our care, our say envisaged the development of a single set of outcome indicators for health and social care based on the seven well-being outcomes. It highlights the importance of shared performance assessment arrangements across health and social care. It also recognises the need to secure consistency with the national outcomes framework for local government. These outcomes would be included in each locality's community strategy and the strategic plans of the major public sector organisations.

In its recent consultative document, CSCI begins this process by proposing a framework that apparently represents the first stage in this process. While dealing "mostly with social care [it] starts the journey of addressing the healthcare pathway as part of the step change towards an aligned social and health care outcome framework in 2009." (CSCI 2006)

Based on the seven outcomes in *Our health, our care, our say's* and a further two: leadership, and; commissioning and the use of resources, the framework provides a distinctive social care description to support the evidence to demonstrate delivery under each of the outcomes. The new self assessment framework will be used to map all relevant data including Performance Assessment Framework indicators, service inspection and regulatory data. See box 1 over the page.

box 1

a new outcomes framework for performance assessment: CSCI consultative document

- **Improved health**: enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long-term conditions independently. There are opportunities for physical activity.
  Services promote and facilitate the health and emotional well-being of people who use the services.

- **Improved quality of life**: access to leisure, social activities and life-long learning and to universal, public and commercial services, security at home, access to transport and confidence in safety outside the home.
  Services promote independence and support people to live a fulfilled life, making the most of their capacity and potential.

- **Making a positive contribution**: maintaining involvement in local activities and being involved in policy development and decision-making.
  Councils ensure that people who use their services are encouraged to participate fully in their community and that their contribution is valued equally with other people.

- **Exercise of choice and control**: through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life.
  People who use services, and their carers, have access to choice and control of good-quality services, which are responsive to individual needs and preferences.

- **Freedom from discrimination or harassment**: equality of access to services for all who need them.
  Those who need social care have equal access to services without hindrance from discrimination or prejudice; people feel safe and are safeguarded from harm.

- **Economic well-being**: access to income and resources sufficient for a good diet, accommodation and participation in family and community life. Ability to meet costs arising from specific individual needs.
  People are not disadvantaged financially and have access to economic opportunity and appropriate resources to achieve this.

- **Personal dignity and respect**: not being subject to abuse. Keeping clean and comfortable. Enjoying a clean and orderly environment. There is availability of appropriate personal care.
  Adult social care provides confidential and secure services, which respects the individual and preserves people's dignity.

The two additional measures are:

- **Leadership**: a council with adult social services responsibility (CASSR) will provide a key professional role for staff working in adult social care services. They will also have a key role in assuring accountability of services to local communities through consultation with local people and in particular people who use services.

- **Commissioning and use of resources**: adult social care leaders commission and deliver services to clear standards of both quality and cost, by the most effective, economic and efficient means available and so demonstrate value for money.

In the meantime, some local authorities and their partners have begun to use the white paper's seven outcomes to develop local priorities and action plans. They have found the outcomes framework valuable in providing a common language for defining quality of life in partnership with their local communities. For example, Knowsley (CS1) and Lancashire (CS2) have both developed approaches emanating from work with older people as members of their local communities to identify the characteristics of a good quality of life, and outwards to construct performance assessment indicators (see case studies). In effect, they centre on addressing the following series of questions:

- What do we want?
- How do we achieve it?
- What methods are most effective?
- How will we know when we are successful?

Some authorities are also developing quality of life measures to asses the impact of specific interventions on outcomes. Both Westminster (CS3) and Camden (CS4) provide examples of such work in their case studies.

CS1: Knowsley's Older Peoples Outcome Framework
'Go Integral' is a partnership approach to the health and social care of older people in Knowsley. It makes extensive use of Health Act flexibilities to create integrated locality teams, pooled budgets, jointly commissioned and managed services.

The outcomes framework is based on six high level outcomes;
- staying healthy
- staying independent
- staying safe
- lifelong learning and enjoyment
- being an active and involved citizen
- enjoying economic well-being.

Each of the outcomes is supported by a set of aims, targets and indicators. The framework also sets out what the partnership needs to achieve to enable improved well-being at: a personal level for older people; a departmental level for staff, and; an organisational level for senior managers. The framework will also be used to measure the impact and effectiveness of various ways of working.

Recent work has focussed on identifying gaps in services for people with long-term conditions with a view to preparing a joint business case across the PCT and local authority. A core component of the work has been identifying the preferred outcomes for patients and staff.

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CS2: A GOAL for Central and South Lancashire
The Growing Older Active Lives (GOAL) project in Central and South Lancashire represents a whole system approach focussed on improving and sustaining active later life.

The three elements of GOAL are;
Medicines active lifestyle service
Medicines management specialists will work with integrated community teams to move thinking from primarily drug based treatments, to solutions based on healthy living and self care.

Community based active lifestyle services
Partnerships between the county council, PCT, Third Sector and business will be developed to make available a wide range of community based mainstream health and well-being services.

Outreach active lifestyles service
Here the focus will be on engaging with people who are currently socially excluded to enable them to access health and well-being services. In order to assess the impact of these approaches, Lancashire is developing an outcomes framework using six high level outcomes based on those identified in *Our health, our care, our say*. Work is underway to develop three themed targets for each high level outcome and this is likely to include a 'hard' local indicator, a 'softer' quality of life local indicator, and a national indicator.

Lancashire has produced an A4 chart of how the outcomes, targets and indicators will fit together.

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The City of Westminster has been one of the pilot sites for developing the new Local Area Agreements. The local Health and Care Network, a sub-group of the LSP, has developed a set of stretch targets for prevention, carer's support and smoking cessation.

The prevention target seeks to "increase the rate of older people in receipt of preventive services who report an improved sense of well-being, confidence and reduced social isolation".

In assessing the extent to which this outcome is achieved, the Westminster Partnership will conduct surveys of older residents using Quality of Life in Later Life (QuiLL) indicators which are currently in development.

The surveys will seek to ascertain:
• the extent of social isolation people feel;
• how people feel about their own health and well-being;
• perceptions of control and influence that people have over their own life; and
• how people feel about their own safety.

Responses in year 1 to these quality of life indicators will provide a baseline and allow comparisons over future years.

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In 2002 Camden was one of the first local authorities to produce a strategy which concentrated on looking at what makes a difference to people's quality of life, their sense of independence, freedom and well-being. Since then agencies have been working with older people to ascertain what would improve their quality of life and how services can become more person-centered.

Part of the work has included a major survey to ascertain what older residents feel about their quality of life together with supporting focus groups to establish baseline information and ascertain older people's priorities.

The approach has involved collaboration across agencies and sectors within Camden and has had support from City University's Department of Sociology which has helped in the development of Quality of Life measures based on those developed as part of the ERC Growing Older longitudinal research.

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commissioning and market-shaping

A second set of local building blocks will be provided by strengthening the ability of individual organisations to commission for well-being outcomes as part of a whole system process under *Our health, our care, our say* guidelines. The latter is fundamental to an approach that demands the re-balancing of services and investment. Without whole system commissioning, the re-focussing on prevention, personalisation and empowerment would remain improbable. Even at the level of individual agencies, service re-profiling involves complex systems' interdependencies.

Health improvement and the reduction of health inequalities are not possible by the NHS or local government acting alone. The shift from hospitals to care closer to home, including the reduction in emergency admissions and bed days, similarly rests on a wide range of complementary contributions outside the NHS and, for that matter, the state. Similarly, prevention, early intervention and independent living in social care depend on support from the NHS, other 'universal services' and the community sector.

The introduction of practice-based commissioning offers opportunities for primary health and social to plan services around the needs of a defined population and to commission more collaboratively across agreed care pathways. Early experiences in Southwark (CS5), South West Staffordshire (CS6) and Torbay (CS7) demonstrate some of the benefits which are emerging.

In many cases, this re-shaping of the whole system towards health and community well-being implies new or reconfigured providers and provider interdependencies. However, the necessary supply-side change, in turn, will flow both from joint commissioning processes driven by the white paper's seven outcomes and also from the spread of individual budgets.

CS5: Pooled budgets and PBC for social care in Southwark

Partners have brought together all external provision commissioned by the PCT and SSD for older people and people with disabilities (around £50m). The aim is now for commissioned expenditure from this pool to be provided to the practice-based commissioning (PBC) consortia in order to aid understanding of the totality of commissioning in an area. Social care professionals are working towards commissioning within the consortia.

The consortia will be able to commission services that alter the length of an individual's stay in acute care and also support the ongoing viability of initiatives such as the local POPPS programme.

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CS6: Primary and community teams: South West Staffordshire PCT

A practice is using PBC to set up community teams to manage cases which require a mix of health and social care expertise. Consultants in mental health, geriatrics and several other specialities are now based in a primary care setting and a social worker is attached to the practice.

Care is initiated by the member of the team who best knows the person and that person takes responsibility for the subsequent management of the care plan.

Voluntary organisations have also been involved and established an 'eldercare' patients' charity called Living for the Future which facilitates befriending and peer support.

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CS7: Integrated commissioning and delivery: Torbay Care Trust

Torbay Council commissions adult social care from the care trust and the two organisations work closely together. Operational management in the trust is integrated under a Director and sub-divided into zones based on clusters of GP surgeries.

Budgets are devolved to zone managers and these zones are becoming the local commissioning groups involving all practices and led by a GP. Each zone will have at least one multi-disciplinary team with practitioner links to practices and two zones also manage a community hospital. All zones manage in-house social care provision.

clarity of definition and purpose

Commissioning is not a new activity for the NHS and local government. However, there is a strong belief that it has been poorly developed within and between agencies. It is this view, for example, that has driven the most recent round of NHS changes. The Third Sector has also been critical of the quality of commissioning by public services in the field of health and well-being. (DH 2006c)

Some of the people we interviewed for this publication pointed to a different problem: the lack of a shared definition of commissioning or an agreed vocabulary to discuss the topic. Commissioning, contracting and purchasing, for instance, could be used interchangeably or to cover a different mix of activities.

At the same time, experience and understanding have undoubtedly been building up within different organisations and, perhaps most especially within adult social care. Since the 1993 community care changes, adult social care has gained much experience in commissioning, contracting and market development for individuals and client groups. The partnership between Bradford District Council and Methodist Homes Housing Association (CS8) is a good example of commissioner and provider sharing risks to reshape the market.

Though patchy and incomplete, this experience of market management is more substantial than sometimes recognised and more extensive than the historically predominant NHS pattern of service level agreements (SLAs) and block contracting. In this sense, therefore, the post 1993 social services experience is a resource to be built on rather than criticised for its apparent lack of sophistication.

Some of the differences in language and approach can be illustrated by recent descriptions of commissioning

from social care and NHS sources. CSCI, for example, has recently described 'strategic commissioning' as being:

"at the heart of effective and efficient service development. It happens when councils use all the knowledge and local intelligence available to them to:
• *build up a comprehensive picture of need and of the cost and quality of available resources, and then to*
• *help to develop the local care market to ensure that services are there to meet needs". (CSCI 2005 para 10.4)*

This focus on comprehensive intelligence about needs and resources as a basis for developing markets to meet those needs is incomplete as an account of the commissioning process. However, David Behan, the former Chief Inspector of CSCI added the following description of the process linking needs identification and market management, in his definition of commissioning, as:

"The process of translating aspirations and need into timely and quality services for people which: meet their care needs; promote their independence; provide choice; are cost effective, and support the whole community.'

This process is about transforming and changing lives, it is not about commissioning commodities, or as one person said to me last week 'It isn't the same as arranging for 1,000 reams of photocopying paper'." (Behan 2006)

Recent NHS guidance on commissioning has given much attention to working with a greater plurality of providers in contestable markets (DH 2006d). This focus is legitimate given that most of the previous experience of commissioning in the NHS, unlike local government, has been within 'an internal market' and through a process based on SLAs in which service specifications were limited and agreements were not legally enforceable (with the recent exception of foundation hospitals).

The NHS guidance describes effective commissioning as being, "*about care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all sections of society … Good commissioners constantly seek to reinforce a virtuous circle of service redesign around the patient."* (DH 2006d para 2.13) The guidance also distinguishes 10 elements within a 'commissioning cycle for health services' (see Box 2) and emphasises that:

"Effective commissioning requires more than success on one element of commissioning. PCTs and their practices will need to work with their patients, local communities and local partners to ensure all the elements of commissioning...are delivered effectively". (ibid para. 2.14).

Box 2

Elements of a commissioning cycle for health services

1   Assessing needs
2   Reviewing provision
3   Deciding priorities
4   Designing services
5   Developing the PCT prospectus
6   Shaping the structure of supply
7   Managing demand and ensuring appropriate access to care
8   Clinical decision-making
9   Managing performance
10 Patient and public feedback

The differences between Behan's approach and that of the NHS guidance are instructive but they are not irreconcilable. The former focuses more on the overarching purposes of commissioning, whereas the latter concentrates on a technical description of commissioning as a set of interlocking activities. The absence of either would be a serious weakness in local capabilities for achieving the white paper's well-being outcomes.

For example, the shortcomings identified by CSCI reflect technical gaps and weaknesses in social care commissioning. Criticisms included in its findings were that:

• the views and aspirations of people who use services are not yet at the heart of commissioning;
• that councils lacked sufficient capacity to design services that that will meet people's needs in different ways; and
• that councils needed to understand better the complex dynamics of their local social care market.

Each of these shortcomings relates to activities covered by guidance in the NHS commissioning cycle, though not necessarily conceptualised in ways which correspond to CSCI's findings.

If improved health and well-being outcomes are to be the mainspring of the whole system, a whole systems commissioning framework would seem to be the prior condition. Any specific mechanisms for NHS, local government and other services' commissioning could then be nested within it.

The breadth of the *Our health, our care, our say* agenda also supports such an approach. A strategy for community health and well-being depends on harnessing and focussing all the relevant commissioning activities for specific people and places. The Greenwich (CS9) case study offers a valuable insight into one authority's approach to promoting the social inclusion of people with learning disabilities through delivering co-ordinated commissioning activities across a range of partners.

If the sustainable community plan and LAAs are to provide such a framework, the focus for commissioning development within individual agencies should logically be one of ensuring that their own commissioning objectives and mechanisms are fit for that wider purpose. In the past, the main concern has seemed to lie in the opposite direction: design silo-based systems and see how far they can subsequently be joined together. The almost inevitable consequence is that joint commissioning becomes something that takes place at the margins rather than in the mainstream of organisations.

In addition, and as has been argued above, a whole systems commissioning framework cannot operate and should not be developed in isolation. At root, it is 'merely' a set of processes ensuring that the 'right' interventions are available at the 'right' place and time for the 'right' people at an affordable cost. None of these objectives can be secured through a commissioning system alone, even a whole systems one. It must be driven by a whole system set of outcomes, secured by whole system performance management approaches, founded on sufficiently comprehensive information about needs and preferences and delivered through supply structures capable of meeting them.

This statement does not imply the necessity for a single unitary system. It does imply, however, the existence of aligned systems of outcomes, performance management and the rest. At the risk of being over-simplistic, joint commissioning cannot compensate for performance management systems which are geared to delivering competing objectives based on conflicting definitions of needs and outcomes and the minimisation

of budgetary outlays by individual agencies. Just as the NHS commissioning guidance emphasises the integration of its 10 elements, so commissioning guidance for health and well-being must emphasise the integration of commissioning with these other processes.

In all of these respects, the direction of travel in *Our health, our care, our say* demands an approach that is broader than the historic concentration on integrating health and social care. Such a partnership is too restricted in scope and purpose to deliver the well-being outcomes it advocates. The commissioning role in relation to those outcomes, therefore, has to be understood and embedded within a more comprehensive framework of community governance.

At present, the risk is not only that commissioning will be developed in isolation from those wider governance processes. It is also that different areas of commissioning will be developed in isolation from each other, especially (but not exclusively) in the NHS, social care and local government more widely. IDeA made available to this study, a 'map' of commissioning initiatives produced by the Department of Health which extends to 28 pages. It is unclear how such activities are being co-ordinated. While its existence is not unhelpful, however, it does highlight the need for focus and alignment if commissioning is to be strengthened within a whole systems concentration on improved outcomes for health and well-being.

CS8: Commissioning in partnership: Bradford District Council and Methodist Homes Housing Association (MHA)

The development of extra care housing is identified as an important element in rebalancing Bradford's specialist accommodation system. As a result a partnership was formed across the council, PCT, voluntary sector, local community groups and MHA to develop a mixed tenure scheme, designed to be a Centre of Excellence for dementia care.

The partnership was developed through trust and agreement about a set of shared outcomes. An 'open book' approach was used to design the service and make best use of resources, knowledge and expertise.

As Jane Barker, MHA's Group Director - Strategic Partnerships concludes:

This new way of working has many benefits and can result in a successful scheme, built on strong relationships. Most importantly it can lead to further service provision that will meet identified requirements of older people in the local community, to meet their needs now and into the future

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CS9: Being valued in Greenwich

Greenwich Council has worked hard to ensure that meeting the needs of people with learning disabilities is the responsibility of the entire council not just social services. By working in this way the council has been able to break down the barriers people with learning disabilities face far more effectively.

Greenwich has achieved this by making sure there is strong political and senior officer engagement, and that the needs of people with learning disabilities are considered within wider corporate plans and strategies. Greenwich has also made sure that people with learning disabilities themselves are more engaged in local decision-making, through forums like local neighbourhood and housing panels.

Outcomes and improvements
Through a more joined up approach across the council and with its partners, Greenwich has been able to set up a range of initiatives that have improved the quality of the service people with learning disabilities receive locally. These include:
- supporting people to become more involved in local decision-making panels and making sure that meetings are made more accessible;
- producing the council's key plans in accessible formats;
- using Neighbourhood Renewal funding to support a project run by people with learning disabilities that looks at how accessible local services are and publishes the results on the Greenwich Finders accessible website;
- developing partnerships with local leisure centres so that people with learning disabilities are able to access mainstream leisure classes;
- working with Transport for London to develop the Out and About guides. This programme has helped people

to travel on public transport independently, which have led to getting a job or going to college; and
- modernising day services for people with complex needs, including producing individual communication profiles and using photos and simple language to show how a person likes to be supported.

Excellence and innovation
Greenwich has been able to achieve Beacon status through ensuring:
- strong political leadership and senior officer involvement;
- effective partnership working with people using services, family carers and other stakeholders;
- the needs of people with learning disabilities are considered and addressed across the whole authority;
- people are supported to access mainstream services, in addition to having specialist support available if required;
- people are involved in local decision-making.
- information about council services is produced in accessible formats; and
- that people with learning disabilities benefit from the opportunities that funding streams such as Neighbourhood Renewal and the European Social Fund present.

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needs identification

Effective commissioning depends on information. It has to be based on knowledge about the costs and outcomes of different service models, the structure of supply, the signals to which it responds and the management of contracts. More than anything, it depends on the quality of its information base about the people and places for which it is responsible, their needs, preferences and experiences of services and support. Such information bases would, therefore, combine statistical profiles and softer experientially-based data.

Paradoxically, this information is frequently both lacking and duplicated. Each commissioning organisation develops its own, rarely complete, information base. The NHS and local government may even be using different demographic data for planning purposes, as well as independently developing profiles of the same or broadly similar populations.

The case for 'doing it once' and, thereby, 'doing better' applies nowhere more strongly than in developing area profiles (and at multiple geographical levels). This argument does not mean that all local commissioners have identical information requirements but they do have substantial common ones, such as demography, socio-economic status, needs and aspirations, levels of well-being, existing supply or local variations in each of these.

They also have common requirements for certain generic skills, not only in respect of the above tasks but also, for example, aspects of: public engagement and capacity building; economic evaluation; research; service design; contract negotiation and monitoring; outcomes measurement and quality assessment; or performance monitoring and review. Such activities and skills can be

organised on different bases, including by service, skill or area. It is arguable that current practice is weighted too much towards individual services at the expense of area and skill.

Corporate units in local authorities provide something of a counterweight if they are not accompanied by duplication at departmental or service level. However, whole system commissioning to improve the health and well-being of given populations and places would benefit from sharing these activities and skills on an area basis. Such thinking is consistent with the earlier IAG (2005a) advocacy of Joint Commissioning Units to support local 'partnerships for well-being'. Figure 3 illustrates the scope and functions of such a unit in its role of commissioning for health and well-being.
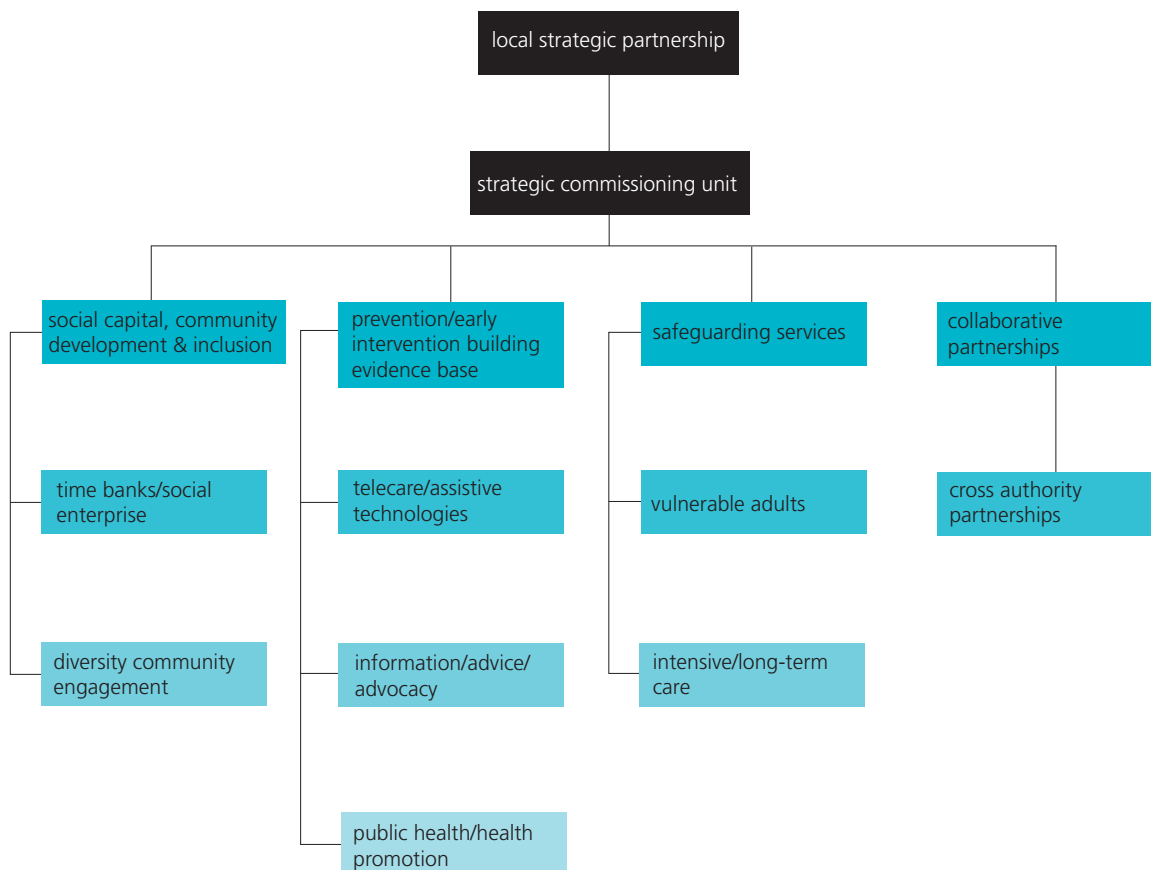
Figure 3: The Role and Function of a Joint Commissioning Unit
Source: Local Government Association, Association of Directors of Social Services and NHS Confederation (2004) *Our future in our hands: putting people at the centre of social care*. London: Local Government Association

This approach is also consistent with the concept of achieving efficiency savings through streamlining management costs.

Unfortunately, such savings have been set on a service rather than area basis. As a result; opportunities are not being encouraged for sharing costs and functions at levels which promote whole system working and commissioning. Rather, setting efficiency gains targets on a service level discourages local resource sharing and reinforces silo-working at a time when it needs to be broken down.

While the contradiction between this approach to savings and the promotion of community well-being appears to have been little noticed, a number of initiatives can be highlighted which could be valuable in strengthening local information bases for commissioning. These include the responsibility the white paper proposes should be adopted by the directors of adult, children's and public health services for strategic local needs assessment, with lead responsibility resting with the former. Providing this role is not confined to DH-related duties and is linked to the wider local authority well-being role, it could be an important development in establishing a single local data base on needs, preferences, gaps and resources.

The Audit Commission's initiative on Local Area Profiles (CS10), including its toolkit, should provide invaluable supports for this work on needs analysis.

An area profile brings together a number of components to help map the quality of life and services in a local area. It can provide a valuable resource for local strategic partnerships to address the issues that matter in their locality.

The experience of the Thurrock (CS11) pilot shows how it can be applied in the case of older people.

A further potentially useful approach is illustrated by Warwickshire County Council's regular publication of Quality of Life indicators (CS12) and how they change over time. This initiative is part of the Audit Commission's work on promoting sustainable communities. It demonstrates how the appraisal of needs and outcomes can combine statistical profiling and qualitative assessments. In addition, it seeks to strengthen commissioning by providing data for user groups and the general public to monitor developments in performance.

Public engagement in identifying needs, aspirations and experiences of services is a further development of commissioning information and its democratic roots. The case study of the Hartlepool Connected Care (CS13) pilot shows how residents of an estate with high levels of need conducted a community 'audit'. The process contributed to individual and community capacity building, while also highlighting the interconnected nature of social, environmental and economic well-being. In addition, it developed a set of quality characteristics residents expected all services to possess.

Thus, the Hartlepool case study provides an example of how public engagement in needs assessment and service design can strengthen local voices. Indeed, the experience suggests that public involvement strengthens locality commissioning and is, in turn, strengthened by it.

Three further case studies illustrate the contribution of housing to whole systems commissioning. The Supporting People Health Pilots (CS14) demonstrate the impact of commissioning housing services in a way that makes explicit links with health and well-being outcomes. The Leicester City example of commissioning an Extra Care scheme (CS15) makes the more general point about commissioners working in partnership with providers, in this instance Hanover Housing; as well as highlighting the need for the commissioning of new services to be more explicitly linked to local needs assessment work. The Extra Care Housing Toolkit (CS16) provides practical guidance on reshaping housing and care provision.

CS10: Audit Commission area profiles

An area profile places strong emphasis on people and places and on issues that cut across traditional service boundaries – for example, a complete picture of the needs of specific sectors of the community, such as children or older people.

Area profiles are created using a variety of tools. Each tool helps the user explore and understand the quality of life and local services with regard to an aspect of the local community. A good area profile involves analysis of the following aspects:

- indicators of local quality of life and context statistics;
- public funding into, and spending patterns within, a local area;
- local residents' and service users' views on quality of life;

- the LSP partners' views on quality of life and services;
- inspectorate judgements about local services;
- the community and voluntary sector's capacity and contribution to local quality of life and services; and
- the business and private sectors' capacity and contributions to local quality of life and services.

The profiles produced by each of these seven components are then brought together to form a synthesis of the findings.

The result of this synthesis is an area profile that can be used in different ways:

1 To provide a summary for the public of all the data and assessments for the local area. For example, key findings could be published online, in a leaflet, or in a local newspaper article. This will help local people to hold public services to account and empower them to take decisions about priorities and services in their local area.
2 LSP partners (council, police, health, voluntary and private sectors) could apply the information to highlight problem areas where improvement is most needed and to inform future commissioning.
3 The government, national agencies, and regulators could draw on area profiles to identify strengths, weaknesses and trends in local areas. This will help them to agree on how best to target their support and regulatory activities.

To support users in area profiling the Audit Commission is developing a web-based 'one stop shop', comprising data and information about local public services, including the views of service users, other residents and the assessments of regulators.

Contact: area-profiles@audit-commission.gov.uk
Or visit www.audit-commission.gov.uk/areaprofiles

CS11: "Nothing about us without us"

Thurrock, a unitary council was involved in Phase 1 of Area Profiles and produced a report on their 50+ population as part of the development of a joint strategy for meeting the needs of an ageing population. They brought together a considerable amount of quantitative and qualitative data including developing ward-based data. Building on this work, part of their joint commissioning agenda has focused on understanding and engaging with BME older citizens in line with their partnership approach 'Nothing about us without us'. In addition 'Active Thurrock' has brought

together the council and the PCT in a programme of targeted work on sports and physical activity for older people.

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CS12: Warwickshire: Using Quality of Life Indicators

Warwickshire County Council has produced an annual Quality of Life report for the past five years. The report provides a comprehensive source of information on economic, social and environmental performance across the county and helps gauge how successful the various local agencies and organisations are at meeting the aims detailed in community and strategic plans. The report continues to be used across a wide range of organisations and is now firmly embedded as a vital component of the local decision-making process.

Recently, the authority has placed an increasing emphasis on its web pages and now updates the indicators on an ongoing basis, rather than just once per year.

The most recent report was also published in a poster format to help publicise the information in libraries, schools, GP surgeries and other community venues and encourage users to obtain further, and more current, details via the website.

A further innovation to appear during the past 12 months is a reorganisation of the indicators. They now appear within one of four headings – economic, social, environmental and natural resources – to align with the authority's increased emphasis on sustainable development. The annual report offers a 'snapshot' of performance, but users are now in a position to see how indicators are changing on a much more frequent basis via the website.

Contact: www.warwickshire.gov.uk/qualityoflife
Source Audit Commission; *Local Quality of Life Indicators-supporting local communities to become sustainable*; Aug 2005

CS13: Connected Care in Hartlepool

Central to developing a 'locally owned' service is to ensure that services are easy to access, meet people's

needs and are delivered in a way which makes sense to the people that use them. Connected Care in Hartlepool is addressing these issues through a partnership between Turning Point, Hartlepool Council, the PCT and a range of community groups

The starting point for developing a Connected Care service is a community audit to give local residents an opportunity to talk about what they feel is important. The audit in Hartlepool was conducted by locally recruited auditors and included the following findings:

- Better **information**, proactively provided at the right time and place, would help residents both to make better use of the options available and take more responsibility for their health and social care.
- Connected care should support and empower people to make choices for themselves. A lack of choice can lead to low aspirations and acceptance of poor quality services. Connected care needs, therefore, to operate strategically as well as operationally to identify and fill gaps.
- Difficulties in **accessing services** reflected gaps in provision as well as poor information, the absence of a single point of entry to all service and lack of outreach. Residents looked for more services closer to home,

rather than in hospitals, and integrated, high quality out-of-hours services.

- **Continuity and Co-ordination** were frequently identified as problematic. Services were complex, complicated and sometimes alienating. A dedicated connected care workforce would focus on people's whole needs, support them to find their way through the care system and help them to obtain integrated, personalised care and support.
- The **workforce** would be responsive, flexible, well trained and treat people holistically, individually and with respect and dignity.
- Choice, access and empowerment are often restricted by economic status and connected care must be embedded in the wider social and economic contexts in which people live their lives. It needs to be delivered within the wider context of social inclusion and regeneration initiatives that tackle poverty and create employment and prosperity.
- Crime and fear of crime can restrict access to services and a good quality of life. Tackling **community safety and anti-social behaviour** is part of the Connected Care package.

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CS14: Supporting People Health Pilots

The Supporting People Health Pilots were designed to explore the extent to which the Supporting People framework for policy, planning and commissioning can be used to benefit the physical and mental health of the community. The six health pilots represented a wide range of people who use services and agencies from the statutory, independent and voluntary sectors.

Authority	Project Title	Focus
Doncaster West PCT	'On Track'	Young people with a dual diagnosis
Northampton PCT	'Swan Nest'	Women wanting to exit the sex trade
London Borough of Waltham Forrest	'Place to Live'	Supported living for people with learning disabilities
City of Salford Housing	'Sure footed in Salford'	Integrated falls service
London Borough of Southwark and Lambeth	'Housing support outreach and referral for hard to reach individuals living with HIV'	Hard to reach individuals with HIV
North Lincolnshire County Council	'Spiders'	Older people

Evidence from the pilots suggest that *Supporting People* services can be deployed to benefit people's physical and mental health; agencies and professionals can work across organisational boundaries, but that difficulties in doing so should not be underestimated.

The findings from the pilots are now available together with *Supporting People for Better Health: A Guide to Partnership Working* www.cat.csip.org.uk/_library/docs/Housing/supportingpeople/SPeoplebetterhealth.pdf
Contact: www.cat.csip.org.uk/housing (click on Supporting People in the A-Z index)

CS15: Commissioning an extra care scheme in Leicester City – from needs analysis to start on site

Although within Leicester, there was not a capacity problem in meeting the needs of the older population through existing services, the lack of night time care, and the absence of an Extra Care option meant that a quarter of older people who moved on from sheltered housing had no alternative but to move into residential care. Furthermore, it was clear that there was a strong need for services that met the diverse needs of people from black and minority ethnic communities.

Taking the work forward required the development of strong partnerships within the council (between Councillors and Cabinet, Adult Services, Supporting People, Housing, Planning and Property Services); with health (including the local NHS Trust, NHS Estates and Leicester PCT), and: Hanover Housing, as the housing provider. Support from the Housing Corporation and Department of Health was also required.

Many important lessons were learned about developing effective needs assessment information, engaging with communities and constructing effective partnerships.

Building work is currently underway on 57 apartments and 12 flats, with opportunities for shared ownership.

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CS16: Extra Care Housing Toolkit

This new toolkit from the Housing Learning and Improvement Network (LIN) is designed to assist in the development of extra care housing in the context of the wider accommodation and service needs of older people. It offers a structured approach to developing policy and locally based initiatives and a variety of tools designed to facilitate thinking about extra care.

The Extra Care Housing Toolkit explores how this form of provision may be developed, designed and delivered across the state, voluntary and independent sectors. It examines the range of options for extra care from small local schemes to retirement villages, from rented accommodation to purchased properties and, from services to people with intensive care needs to no needs at all. Just as importantly the toolkit also discusses the

principles and ethos underpinning the development of extra care and explores how the concept may be used for groups other than older people.

The Extra Care Housing Toolkit covers six distinct topics:

• What is Extra Care Housing?
• Planning the development of Extra Care
• Undertaking a needs analysis and forecasting the demand for Extra Care
• Analysing the current and potential supply of accommodation and services
• Implementing successful Extra Care schemes
• Monitoring and evaluating the success of Extra Care.

Contact: www.cat.csip.org.uk/housing

market-shaping

Appropriate services and support are delivered in England through a mixed economy of supply: mixed not only as between market sectors (state, private and 'Third' sectors) but also as between service sectors (health, social care, housing and regeneration, for example). In most respects, working with and through the market is relatively new territory for the NHS. GPs and many other primary care staff are predominantly self-employed but operate on a scale which bears no comparison to the hospital sector. The NHS will have to further develop the independent sector as a significant element in a pluralistic system of acute and community hospital supply.

A major purpose of the NHS commissioning framework referred to above is to assist PCTs to commission and procure such services through market relationships with the independent sector, NHS and foundation trusts. Whether this mixed economy will assist the re-configuration of hospital services or provide further layers of complexity remains to be seen. However, the evolution and operation of these new markets will be of profound significance to the implementation of *Our health, our care, our say*.

By contrast, with around 75 per cent of formal services now outsourced, adult social care has some considerable experience of working with markets. However, the level of outsourcing varies between authorities, as does market structure and contestability. Most crucially, as CSCI has emphasised, councils' understanding of, and skill in, working with markets to achieve user defined

outcomes is also a problematic area. The current structure of supply too often creates or reinforces dependence rather than promotes re-ablement and independence. Too few options are designed and commissioned. In Coventry they have been exploring value for money in social care (CS17) from the perspective of the overall shape of the service rather than individual unit costs.

The Third Sector and independent providers alike outline ineffective commissioning capabilities and behaviours. There is considerable scope, therefore, for restructuring supply and improving commissioning inputs and outputs. The Leicester Extra Care housing case study provided one example of a local authority working with providers to develop a wider range of service options.

At a strategic level, the Manchester service delivery partnership (CS18) shows how social care, health and housing commissioners can work together with independent sector providers to reconfigure supply and develop a wider range of services for people with intensive needs. By contrast, the Shropshire partnership for well-being (CS19) is a useful example of partnership working between the council and community sectors to stimulate the provision of an extensive range of relatively low level services to promote well-being.

CS17: Value for money in social care in coventry

In Coventry work has been underway to reshape older person's services. Occupational therapists have an important role in the assessment of older people's needs and the promotion of their independence. as the experience of Mrs Y demonstrates.

Mrs Y is discharged from hospital with a fractured wrist. She has lost a lot of confidence as well as the use of her wrist. She used to use a walking aid to get about, now she has retired into a wheelchair. A social worker gets out to her to undertake an assessment for her care needs. She is identified as needing four calls a day for half an hour. To get her up, dressed, fed, checked on in the day, supported to eat her lunch (meals on wheels delivered) and put to bed. This was an appropriate assessment for her needs at the time. An OT also visited Mrs Y and she started a six-week programme of enablement - showing her how with the help of some equipment she could do more for herself. They worked together intensively for six weeks on an agreed

contract. By the end of six weeks Mrs Y was back cooking again for herself, walking with the aid of a stick, able to both dress and undress herself and was restoring her self confidence. The social worker re-assessed the package of care and reduced the visits to twice a day and this was probably over cautious to ensure that Mrs Y continued to make progress. It is possible that this can be further reduced in time. Mrs Y's daughter who also had become increasingly worried about her mum had been calling in more often and cooking some meals for her found that she could relax and return to her previous pattern of regular but not daily (or twice daily) visits. Mrs Y has nothing but praise for the OT Assistant who did most of the direct work with her and the OT who supervised her progress.

This case example raises several issues for social care. First if this case were replicated across social care there could be a significant impact on efficiencies. In this case the cost of home care visits and Meals on Wheels daily (the original social work assessment) would have been £106.65 per week or £5,545.80 per year. The actual cost of this intervention with the delivery of aids £174.69 plus OT and OTA time estimated at £500 plus half of weekly costs £53.33 equals £3,447.85. This case shows a potential saving of £2,000 on a year's service. Evidence in Coventry is that this approach has saved almost half a million pounds each year and we are now developing this further with the launch of our Enablement Community Support Services.

However, alongside the good news there is a risk to the council. The result of this approach has a negative impact on the current measures of performance used by the Commission for Social Care Inspection (CSCI).

As John Bolton, Director of Community services commented:

"If we continue to be successful as we roll out our enablement approach I would expect to be helping less people to live at home (as the evidence suggests that up to 50 per cent of older people will not require a further service after the enablement service has made its impact). This might also impact on our intensive home care indicator (where we have been a top performer) as the interventions can lower the level of care packages. In addition the interventions might increase our unit costs. All of this could count against us. Fortunately CSCI understand the benefits of the intervention and therefore the possible 'drop' in performance that may ensue.

In Coventry we have an approach, which focuses on the total shape of the service area rather than individual indicators. We are positive that we achieve good outcomes and value for money for older people which are demonstrated by few admissions to residential care, more people helped to live independently (or at least with less dependency on social care services) through enablement and more people living in their own home with the additional option of extra-care housing (where we have more tenancies than any other authority)."

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CS18: Manchester Strategic Service Delivery Partnership

Manchester City Council is establishing a Strategic Service Delivery Partnership to deliver care and support services for older people with high levels of need. The commissioning strategy had identified a lack of options for older people with very high needs, with the alternatives being an intensive home care package or a care home placement. As a result it was decided to develop a range of services under the 'Prospectus for Change' initiative.

Adult social care services, in conjunction with partners from the Primary Care Trusts and Housing, selected a range of private sector providers to work with to develop:

• a neighbourhood services model – this contains Extra Care housing and a community 'hub' along with specialist outreach services to support people with dementia and other needs; and

• an outcomes based approach to the service specification and subsequent monitoring of quality and delivery.

The views of older people were also actively sought, utilising the City's Valuing Older People forum.

The Strategic Service Delivery Model was selected as it provided a procurement process that enabled all partners to work collectively to design and implement new services. Funding was released to support the initiative through the planned reduction in purchasing of care home places. In addition a small amount of capital grant has been made available to providers to enable new service models to be built.

The partners are now at the final stage of the procurement process and will shortly be establishing the partnership. This will not be a legal entity in its own right and will be hosted by the city council. The underpinning framework agreement forms part of the contract.

Services to be developed are likely to include:

• a small neighbourhood model for people with high level of dementia, including respite provision, outreach, crisis support and day care;

• an assistive technology pilot, working with care managers to think differently about how home support can be delivered; and

• an extension of Extra Care provision, with community support and outreach services in several localities of the city. Various models are being considered but these are likely to be advice, day care and outreach support.

It has been a challenging process and taken longer than envisaged to set up. There are some clear lessons learnt around the change in culture required by all parties to develop a collaborative model, and the need to invest in the resources upfront to drive the project forward. However it is felt that the benefits that will be achieved in terms of choice, quality and value for money which will make the initiative worth while.

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CS19: Partnerships for Well-being in Shropshire

Shropshire County Council faces particular challenges due to the rural nature of the authority. As a large county with one main centre of population and five market towns, delivering services to the remaining dispersed population calls for different approaches including '*museum on the move*' '*art in a box*' and '*roving reminiscence*'.

There is a strong history of partnership working between the authority and the voluntary sector and work with the Community Council of Shropshire has led to the creation of a Care Development Team to which the authority delegates a prevention grant to develop a whole range of initiatives. These include exercise classes, good neighbour schemes and health awareness days. Activities are developed in response to local needs and

priorities. The needs of carers are also given a high priority as Shropshire has a very high number of older carers. Pamper days, respite care and outings to the council-owned farm museum are popular activities.

Providing support to older men is often a challenge but the local Age Concern initiative to develop pub lunch clubs now has a popular following from both sexes! Age Concern receives modest funding from the authority. To manage the scheme, they recruit local volunteer co-ordinators, often older people themselves, and the lunch clubs are self funding. Shropshire has been evaluating the impact of these and other initiatives and a report is due out in the autumn.

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new service models

As we demonstrated earlier, the existing service system is not 'fit for purpose' in relation to delivering the *Our health, our care, our say* outcomes. Hence, the argument for a strategic re-alignment towards prevention and empowerment based on providing services closer to home. In social care, this shift has been conceptualised as one of 'inverting the triangle of care'. Policy development in the NHS around long-term conditions has been structured around a similar, but not identical, concept as expressed through the 'Kaiser pyramid of care' and the development of integrated care pathways. Despite their similarities, they have however remained distinct social and health care models.

Both services have also adopted initiatives which are presented as supporting the personalisation and empowerment agendas of public service reform. In the case of social care, these agendas are reflected in the concept of independent living and, more especially, self-directed support demonstrated by the renewed emphasis on direct payments, the rapid spread of the 'In Control' programme, and the 'Individual Budget' pilot programme. They have also influenced the changing role of housing services and the development of low level support through the voluntary and community sectors. Similar initiatives have been developing in Scotland such as the local area co-ordinator scheme (CS20).

In the NHS, these objectives are seen to be expressed through 'Choose and Book' practice-based

commissioning, the expert patient programme and the long-term conditions strategy, more generally. Although emergency admissions have continued to rise, emergency bed days have begun to fall nationally. In the nine Innovation Forum localities, the initial evidence is that local authorities can for the first time promote a focus on reducing hospital stays through effective local partnership working (though some aspects of the national environment have proved unhelpful.)

The spread of 'social prescribing' is evidence of primary care beginning to extend the range of options for those with long-term conditions. It is also an example, along with the expansion of housing options, of the wider local authority becoming engaged in promoting independent living. Leisure, libraries, art, sport, education, employment and transport are all contributing the opportunities for user groups historically seen as the responsibility of social services.

Two points are worth emphasising here. First, independent living means participating in mainstream, universal activities rather than segregated services. Second, access to such provision is one of the ways in which new models of care and support can be funded and provided. Using universal services more flexibly and 'mainstreaming' social care wherever possible, therefore makes sense in terms of needs, resources and outcomes. Wigan (CS21) is one of the government's Partnerships for Older People Projects (POPP) pilots and through this has developed a single point of access for older people who need practical help, advice and signposting to other services.

The implementation of the *Choosing Health* white paper and the cross-sector review of health inequalities have also led to an increase in locally based development projects between the NHS and local government. The emphasis on social inclusion and sustainable communities has helped promote greater commitment to public health in local government. In addition, the centre has initiated an array of pilots including Extra Care housing, POPP (CS22), Link Age Plus, self assessment as well as individual budgets. There is no shortage of developmental activity in relation to new service models. In addition, a significant amount of information will become available from the evaluations currently being conducted on these and other initiatives. The Northumberland and Dorset examples in particular offer experiences of the value of proactive information sharing across agencies.

Nonetheless, the shortcomings of the present service system in relation to *Our health, our care, our say* outcomes pose major development challenges. There is still too little choice, too few options to make independent living a reality and too much emphasis on responding to crises and dependency, whether created by life styles or services. The above analysis and supporting case studies illustrate what is possible and they are indicative of much creativity and commitment. They should not, however, be equated with everyday experiences of health or social care. A large scale service development programme task remains.

This development agenda will need to be heavily influenced by the voice of potential users of services both as individual procurers of care but also as part of a supported programme of engagement with citizens in their communities. It is encouraging to see the range of developments that are taking place to give people a voice in their communities. We have already highlighted the Connected Care initiative in Hartlepool and there is an increasing number of Senior or Elders Councils around the country including Brighton, Newcastle, Gloucestershire and Shropshire. Within the learning disability field similar examples can be found of individuals and groups having a voice in defining priorities and reshaping services, as shown by the Greenwich case study. The following examples from Manchester, Newcastle and Salford provide information about the range of approaches being developed (CS23).

CS20: Local Area Co-ordinators in Scotland

As part of the Scottish Executive programme for people with learning disabilities, 'The Same as You', a model of local area co-ordinators (LACs) has been introduced, building on work developed in Western Australia in the late 1980s.

LAC is a role, not a task. The co-ordinator will have an office where people can drop in for information or a chat. When an individual wants to change or develop something in their life the local area co-ordinator can work with them in an individualised and person-centred way to identify strategies and support. The local area co-ordinator can also advocate and negotiate access to services, where needed. They will therefore need to liaise closely with social workers and others eg if they identify an unmet need for a short break. They can help people to access Direct Payments and arrange their own

services. The co-ordinator is able to get to know the individual and family; help them to identify their own needs, develop their confidence and make links within their communities. More information is available on the Scottish Consortium for Learning Disability including a publication *Making Connections: stories of local area co-ordination in Scotland*.

Contact: www.scld.org.uk

CS21: Starting Point in Wigan

For each of the 15 POPP services available in Wigan there is one central referral point. Starting Point is a single point of telephone access designed to meet the low and moderate level needs of older people across the Wigan Borough. Besides being a referral route for people who are not able to access direct packages of care from the Adult Services Department, Starting Point is available and widely used by people who choose to self refer.

The Starting Point Service acts as a brokerage system to promote and market a range of advice, information, services and practical help. It is managed by Age Concern Wigan and ensures that effective communication and appropriate referrals are made within the statutory, private and voluntary sector.

Through the development of the POPP services in Wigan the Starting Point Service has grown, in terms of the variety of accessible support and the number of people aware of, and using, the referral route. More than 15,000 POPP promotional booklets have been distributed throughout the borough and as a result, the number of people making telephone enquiries and referrals to Starting Point has increased from 457 to 720 per month between April 2006 and the end of July 2006.

Each member of the Starting Point team and all operational staff working within the POPP schemes have received information and training around the wide range of services and are able to signpost individuals to the most appropriate pathway of care and support. The Primary Care Trust, Wigan Council's Department of Adult Services and a range of voluntary and community organisations are working in partnership and using this new and innovative telephone service to identify the support needs of older people in Wigan.

Referrals and information are now being exchanged through a central point that is efficient and effective. The 12 partner organisations are working co-operatively and communicating between themselves and the Starting Point service. The POPP scheme has certainly been proactive in developing the single point of access for services and ensuring that the PCT, the council and a wide range of CVS organisations are working collaboratively to identify and meet older peoples' needs.

"The single point of access ensures that older people in Wigan are better equipped to navigate and access the most appropriate services."

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CS22: Sharing information and identifying people at risk - some examples from the POPP programme

In Northumberland:
Through the data collection systems set up to support the evaluation of the POPPs work in Northumberland an opportunity has arisen for ambulance service callout data to be used to identify individuals who have fallen. This data has been analysed and disseminated to operational teams/ frontline staff working within the locality, and has allowed interventions to be put in place to reduce the risk of these individuals falling in the future. This has included referral to the new falls services, and sign posting onto the handyperson schemes, physical activity and Telecare services, which were all part of the Fishnets project.

North East Ambulance Services are also engaged as a referral route directly to the falls service through their use of the 1st line falls assessment (Cryer Tool) which is completed by the crews and faxed into a central access point. This allows the falls pathway to commence for the patient and appropriate and timely interventions to be put in place.

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In Dorset:
Within the GP practices based within the POPP areas, effective systems have been put into place to ensure information sharing and also to identify patients at risk who would benefit from POPP intervention. Each of the

nine GP practices has a whiteboard where they record information relevant to patients in the POPP areas who are at risk for various reasons. The POPP workers have specific practices that they support and work with and visit on a daily basis. Information recorded on the whiteboard is used to begin case finding and case management approaches. The patients are followed up and appropriate interventions and strategies done jointly between the practice and the POPP workers ensuring a joined up health and social care approach. This has been successful and in turn has resulted in reduced admissions and improved health and well-being for the individuals seen. Each GP practice also has a POPP tray where information is passed and shared with workers.

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CS23: Examples of ways of engaging with older people as partners

In Manchester:
"The pursuit of sustainable development in cities is entirely consistent with efforts to address the needs of older people in those cities; and vice versa. In this sense, there are clearly a variety of 'win-win' possibilities"
Office of Deputy Prime Minister, 2004

Three years after its launch, the Valuing Older People (VOP) programme has made significant progress. The VOP partnership has organised, delivered and supported a wide range of innovative projects and initiatives. The partnership's work has raised the profile of the older people's, or 'third age' sector, and set about the process of mainstreaming the age agenda. The initiative has created a community of interest – a network of agencies, organisations and individuals – working together to develop 'third age' policies, improve services for the city's older population and to plan for the challenges that lie ahead.

Workshops held with a cross section of older people and officers from across the city identified these themes as priorities for the next stage of VOP's development:

- **improving services** for older people;
- **neighbourhoods of choice** for older people;
- planning for the '**new old**';
- **tackling discrimination** against older people; and
- **involving** older people.

These themes have a close alignment with the Manchester's 10-year Community Strategy plan 'spines', which are: reaching full potential, mutual respect and neighbourhoods of choice.

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In Newcastle:
The Elders Council is taking a lead role in giving older people the opportunity to have a voice in the city. The Elders Council was established by older people in 2001 in response to a need for older people themselves to be involved in working with agencies to improve the quality of life of older people in the city.

The Elders Council is a membership organisation open to individual older people aged over 50 and older people's organisations in Newcastle upon Tyne. By October 2006 it had a membership of more than 1,000 older people. The issues identified by older people also influence the types of new services that are commissioned. For example, there has been a focus on information and low level practical services which can benefit the older population as a whole, as well as services for more vulnerable older people.

In addition new approaches to developing and commissioning services are emerging. For example, the Quality of Life Partnership, which receives core funding from Newcastle City Council and Newcastle PCT, has directly commissioned the information service 'Information Now' through Newcastle Age Concern, and a Trades Register through Anchor Staying Put. The Quality of Life Partnership has also acted as a catalyst in bringing the City Council, the Newcastle Partnership, the ALMO Your Homes Newcastle, Nexus PTE, the PCT and the Third Sector together to submit an Invest to Save bid to the Treasury.

Titled *Older People Mean Business* the objectives for the bid are:
• provision of practical help services;
• enabling older people's contribution;
• building capacity in the system;
• creating a sustainable model;
• assisting the modernisation agenda;
• strong and effective cross agency working; and
• employment and the local economy.

Older People Mean Business aims to stimulate and link Third Sector delivery of practical help services

(gardening, cleaning, shopping, handyperson) to older people in Newcastle thereby reducing demand on statutory social care and health services, promoting independence, health and well-being and contributing to the community safety of older people.

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In Salford:
Older people are now members of the Partnership Board which is the joint commissioning body for older people's services across the council and PCT. As one of the Link Age Plus pilots, Salford is investing resources in developing the capacity of the Third Sector, building on existing community groups in the city. Plans are underway to involve older people in the health and care scrutiny process as part of a wider programme to "age proof services" across the council.

Partnership working with older people is part of a much wider partnership agenda in the city, where the PCT and council make extensive use of Health Act flexibilities to pool budgets and establish lead commissioning arrangements. Integrated teams are currently being established on a geographical basis linking with clusters of GP practices, and some initial discussions are taking place regarding the opportunities offered by practice-based commissioning. Plans are also underway to explore the options for the delivery of PCT and council services in the future.

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summary

We have identified in this section a set of building blocks which will have a key role in facilitating the implementation of *Our health, our care, our say*. The case examples demonstrate that some local partnerships are making progress in addressing these issues, some building on past successes. However, progress nationally is patchy and the challenges are significant both for central government and local partners. The relationship between outcomes, whole system performance management, comprehensive needs assessment and mature supply side structures needs to be made more explicit if the vision of *Our health, our care, our say* is to be realised.

Some of the emerging messages from these initiatives can be summarised as follows:

moving forward on outcomes

For central government
- The emphasis in the white paper on improving outcomes for individuals and communities is welcomed.
- The outcomes framework introduced in the green paper and further developed in *Our health, our care, our say* should be applied across health and local authorities so that commissioning and provision is focused on delivering what matters to individuals.
- The outcomes framework should form the basis of the new joint assessment arrangements and the proposed CSCI approach is welcomed as starting to shift the emphasis to shared outcomes being the driver of whole system change.

For local partners
- The outcomes framework needs to underpin each locality's community strategy and the strategic documents of the public sector organisations.
- Using the framework to develop a set of local indicators and agreed joint actions is proving beneficial in localities particularly where members of communities, service users and carers are involved in the development process and own the desired outcomes.
- Moving towards a more outcomes focused approach to commissioning requires further development and will characterise mature commissioning and contracting relationships.

commissioning for well-being

For central government
- Developing a shared understanding of, and vocabulary for, commissioning across local government and the NHS is a pre-requisite for whole systems commissioning. Opportunities need to be found to bridge the current divides in order to integrate commissioning approaches.
- Commissioning for well-being needs to be reinforced as a core role for the NHS. Joint commissioning should not be seen as an additional set of mechanisms which are expected to bridge the separate systems.

For local partners
- Effective commissioning depends on good quality information which combines both statistical profiles and softer qualitative data. It is about developing information about individual need within the context of

the broader community need. Joint commissioning units offer a model for 'doing it once and doing it right'.
- The work by the Audit Commission on Local Area Profiles offers practical support to local partnerships to map the quality of life and services in local areas. When put along side the new partnerships between Directors of Public Health and Directors of Adult Social Services and their counterparts in children's services, it provides a powerful impetus to improving strategic needs assessment to underpin whole system commissioning.
- Reshaping services and managing markets are most effectively done in partnership with providers.

new service models

For central government
- The information generated by the wide range of nationally sponsored pilots is likely to provide a significant body of evidence about the effectiveness of new systems, processes and service models. The challenge will be to disseminate findings in an accessible and timely way to inform policy implementation.

For local partners
- Increasingly, the wider local authority is becoming engaged in promoting well-being and independence as evidenced by the growth in 'social prescribing' (such as GPs contracting with leisure services to provide exercise on prescription as an alternative to more traditional drug based responses) and engagement with individuals who have historically been seen as the responsibility of social services. Engagement of individuals as members of their communities rather than as 'service users' has highlighted the importance of universal services in promoting well-being and social inclusion.
- However, there is still too little choice, too few options to make independent living a reality and too much emphasis on responding to crises. The change agenda will need to be heavily influenced by the voice of potential service users, both as individual procurers of care and as part of a more systematic programme of citizenship engagement.

section 3: making it happen and making it stick

next steps

Our health, our care, our say emphasises that its new direction for community services referred 'to all health and social care services provided in community settings'. The focus has now shifted to how and whether such ambitious goals can be delivered? Are the NHS and local government up for this challenge? Do they have the full range of capabilities and resources needed to move from vision to reality? To the extent that they are not ready, how can they, and their partners, be supported to make the changes necessary?

The progress made in re-profiling services over the last decade and a half should generate some confidence in the ability of services to manage change. In addition, this study has identified large numbers of promising local initiatives in governance, service modelling, commissioning and market-shaping. They have the potential to support implementation more widely. Central government departments have similarly launched a range of relevant pilot projects and implementation support. National representative bodies, development and regulatory bodies are similarly engaged in this agenda. The development programme in the South East of England (CS 24) is one such example.

However, this document has also shown that local organisations are not fully capable of implementing this agenda at present. Nor is the current framework of central/local relations and local governance sufficient for the road ahead. *Our health, our care, our say* poses a series of strategic challenges based on multiple, and not always mutually reinforcing, objectives. Some of the values underlying its new direction for community services fundamentally challenge the welfare dependency model which has historically characterised health and social care and its underlying power structures.

The resulting change management task is, therefore, one which centres on changes of power and ownership. It may be described as one of achieving cultural and behavioural change: but, at its heart are some basic shifts in power relationships between the public and its professionally delivered services as well as between services and levels of governance. It is a change agenda that will require high quality leadership within services and communities as well as among politicians, managers and professionals.

CS24: Local/National Development Partnership

In the South East a number of partners have come together to agree a joint programme of action focusing on the implementation of *Our health, our care, our say*. The Care Services Improvement Partnership (CSIP) and Care Services Efficiency Delivery (CSED) programme brings together the policy delivery role of the centre – the delivery role of local authorities is represented by the local branch of ADSS and the south east Regional Centre for Excellence (RCE), which acts as a pooled resource of LAs. The programme will be jointly funded by RCE and CSIP and will be supported by IDeA. The programme will be comprised of a number of focused work streams all with a White Paper/Gershon component.

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making it happen

The question to be addressed, therefore, is how are these challenges to be met and the changes to be made? How can the necessary strategic shift be made to happen and be made to stick? Three starting points suggest themselves from the work on which *From vision to reality* has been based:

1 The shift towards empowerment, prevention and well-being is rooted in what people want. The green and white papers were both founded on substantial evidence about the public's preferred options for promoting health and well-being, independent living and having greater choice and control over their lives.

2 Local agencies have already embarked on at least parts of this agenda. This paper contains a number of examples from a range of settings in which relevant developments are already taking place. However, these examples do not even begin to scratch the surface of the wealth of developments recorded in the relevant web sites and knowledge communities.

3 However, change will not happen spontaneously or universally across the system as a whole. Silo-based power structures constantly renew themselves and retrench in the face of challenge. In addition, some of the changes needed require concerted central/local

action to structure local policy environments which will promote and sustain strategic realignments towards community well-being.

From vision to reality concludes, therefore, by outlining some of the more strategic initiatives that need to be undertaken to make change happen and stick at national level and local levels, that these tasks are not the province of central government alone. They depend on effective national and central/local partnerships if they are to be well informed, appropriately designed and mutually owned. Ultimately, however, central government is constitutionally responsible for shaping the policy, organisational and financial contexts within which local agencies operate.

This responsibility was more obvious in respect of *Every Child Matters*, which required legislation before being put into effect. *Our health, our care, our say* is not being supported by a similarly comprehensive framework of legislation and subsequent guidance from the Department of Health. As a result, implementation preparations may lack the sustained and comprehensive focus provided by the legislative process.

The analysis conducted here of *Strong and prosperous communities* suggests that its approach to the health and well-being agenda is also potentially incomplete. Its discussion of the health and well-being policy area suggests that the principal focus of the local government white paper is on public health rather than the wider NHS agenda. If this remains the case after consultation, it is difficult to see how it will support and deliver a realignment of the health and social care system of the kind previously envisaged by the IAG or, indeed, by *Our health, our care, our say*.

and making it stick

The vision set out in *Our health, our care, our say* embraces not a single agenda but a range of overlapping and interdependent agendas. Like the IAG, it recognised that both the demand and supply of care and treatment are shaped by and shape decisions to promote health improvement, independent living, inclusive communities and greater equalities in health. Each implies different balances in relationships, responsibilities and resources across the whole system of NHS and local government services. Consequently, they need to be managed within an overarching implementation and development

framework capable of securing the necessary cultural change, organisational development, service transformation and resource realignment.

It is by conceptualising and managing implementation as a whole system programme which corresponds to the local implementation task that existing power structures will be more successfully challenged. Strategies of dilution, diversion and obstruction will be more readily apparent and more readily addressed within a national, transparent programme of implementation. It is also relevant that the community care changes were accompanied by a major national development programme which successfully supported local processes of managed transition. If such an approach were to be adopted now, it would need to have at least the following functions:

1 **Making the case and winning the argument** advanced in *Our health, our care, our say* for the sustained re-alignment of the NHS and local government towards prevention, empowerment and community well-being;
2 **Broadening the definition of health and well-being** in the implementation of *Strong and prosperous communities*;
3 **Embedding a whole system governance framework** focussed on outcomes, accountabilities and coherent central/local relationships, supported by appropriate performance frameworks;
4 **Developing whole systems capacities** for public engagement, commissioning, service design, market development and regulation;
5 **Securing resource adequacy** and flows based on costed plans for the necessary resource shifts between tertiary, secondary and primary healthcare, as well as the NHS and other providers, and between health and social care;
6 **Developing the workforce** to provide the necessary leadership and service delivery skills while also dealing with current difficulties around recruitment, retention and rewards;
7 **Managing knowledge systematically** so that the substantial existing resources of knowledge and skill can be harnessed to support *Our health, our care, our say* and be deployed at national, regional and local levels;
8 **Managing and monitoring an implementation timetable** to ensure that the relevant changes take place and are sustained.

From vision to reality focusses on identifying implementation support tasks rather than structures.

However, the above functions would need to be driven and delivered through some form of governance arrangements. Arguably, they should, themselves, be part of the new pattern of central/local relationships, local place-making and accountability. This suggests a structure which engages at least DH, DCLG, DWP and the Treasury from central government. Local interests would need to be drawn from the national organisations representing local government and health services interests. In this respect, there may be an opportunity for the LGA to exercise the convening and leadership roles nationally which it endorses for local government locally.

More generally, a national implementation programme which embraces the whole system of national stakeholders would be an opportunity for modelling the partnerships, cultural and behavioural changes expected locally. This would constitute an essential first step for any serious commitment to re-align the NHS and social care towards health, well-being and independence.

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promoting better local government