

## **Health and social care: what future for joint planning?**

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### **Joint commissioning/joint planning – why bother?**

I want to explore the reasons why there is now a re-emphasis on agencies engaged in joint planning, reframed and enriched as it now is as joint commissioning. First, joint commissioning can be seen as the logical outcome of current requirements by central government for collaborative activity around:

- hospital discharge
- continuing care
- community care planning
- assessment of individuals' needs
- nursing home admissions

Joint commissioning should also help agencies tackle the grey areas at the health and social care boundary. Joint commissioning fosters a focus on needs rather than organisations; it also raises the profile of users and carers with the aim of improving access to services.

The work of the King's Fund project on joint commissioning by Richard Poxton has provided the basis for the analysis presented in the following sections.

### **Joint commissioning – what is it all about?**

Joint commissioning is seen as the activity with agencies focusing on:

- pooling information
- combining expertise
- agreeing main programme activities
- taking decisions collaboratively on resource development
- acting jointly through the planning and purchasing of services.

In Camden we are trying to move forward on all these fronts with colleagues across social services, health and housing. Progress sometimes feels slow in some areas but the occasional push forward in other areas more than compensates.

### **Joint planning: health and social care**

Joint planning officer groups range from the joint commissioning group taking a strategic commissioning overview across the housing investment plan, DHA purchasing intentions, community care plan and primary care development plan, through to client care groups which tackle both operational and planning issues. The member level of the JCC is refocusing around joint commissioning and starting to address some of the priority areas identified by the officer structures such as mental health, learning difficulties and continuing care. Cross-agency work is also being fostered with social services having a seat on the groups within the FHSA developing the primary care development plan. A range of other joint sub-groups were listed where specific issues were being tackled, for example the interface between district nursing and home care and implementing the action plan following the mental health task force visit review.

The consultation process described is extensive. It encompasses a flourishing independent sector forum for providers and full programmes of independently facilitated meetings between top managers and organisations, forums and groups who represent users, carers and advocates around the community care plan and the children's services plan.

Finally, there is a need to examine the joint operational working – as opposed to planning – in areas such as the eligibility panel. Joint operational working determines all residential and nursing home placements; the alignment of social workers/care managers with health colleagues; plans to integrate the NHS community mental health team with the specialist social services mental health workers; and the joint purchasing of complex packages of education, health and social care for children with special needs.

### **Reflections on the Camden experience**

Early on we made an honest assessment of Camden's position. This was summarised in terms of the joint planning and commissioning infrastructure 'not being a neat fit'! Recognition has always to be given, however, to the difficulties of integrating commissioning across sectors when each sector has a different perspective on the purchaser/provider separation as well as being at different stages in the development of the commissioning cycle.

One of the key tensions is that in the social care sector, commissioners and statutory providers are in the same organisation while in the health sector they are in different organisations. This inevitably leads to a different relationship between purchaser and provider within each of the sectors. The difference is revealed when the collaborative arrangements across the two sectors are examined. Notwithstanding the lack of a neat fit, Camden's style was described as using what we have got to create the change we want.

### **Lessons learned from joint commissioning and the *Caring for People who Live at Home Initiative***

A number of key lessons have been learnt. In particular, commissioning should be seen as a process rather than a set of functions. The Department of Health working group on joint commissioning and the King's Fund describe it as a circular flow of activities which each sector needed to go through – with collaboration brought in at every stage. Until organisations have firmly embedded the commissioning cycles within their culture, then the link between strategic and tactical commissioning remains a problem to be solved.

The *Caring for People who Live at Home Initiative* has highlighted the following:

- commissioners need detailed information upon which to make decisions, and therefore the use of the business planning support to the individual projects was commended by the joint commissioning group;
- new ideas should be tried and innovation is good if supported and piloted;
- diversity should and could be sustained amongst service providers with the principle being enshrined in the community care core values of 'a large number of small providers rather than a small number of large providers';
- preventative services are back on the agenda as tools to tackle the needs of clients.

In summary, Camden feels that the *Caring for People who Live at Home Initiative* has proved to be a vehicle bringing real learning to the Joint Commissioning process. We were striving to develop a collaborative culture across both health and social care organisations – statutory and independent, so that joint working becomes second nature.