Beyond the Berlin Wall? Investigating joint commissioning and its various meanings using a Q methodology approach

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Abstract

Joint commissioning has been extensively alluded to in English health and social care policy as a way of improving services and outcomes. Yet there is a lack of specificity pertaining to what joint commissioning actually is and what success would look like. In this paper we adopt a Q methodology approach to understand the different meanings of joint commissioning that those involved in these arrangements hold. In doing so we get beyond the more orthodox interpretations of joint commissioning found in the literature although the appeal of joint commissioning as a 'good thing' is still prominent across these accounts.

Key words

Joint commissioning; Q methodology; collaboration; meaning.

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Introduction

The English welfare system is rooted on a distinction between health and social care services. Health services are for those who are sick and are free at the point of delivery by the NHS, whilst social care is for those who are 'frail' or 'disabled' and recipients who may have to pay some or all for these services to their local authority depending on their financial means. However, over time it has become apparent that this distinction is not meaningful and particularly for those with complex or chronic illness or disability there may be a significant overlap between these services. The New Labour government elected in 1997 declared itself committed to 'breaking down the Berlin Wall' that separated health and social care services (Department of Health, 1998). Since this time we have seen a range of different policies and incentives introduced to encourage health and social care agencies to work together more closely (Author A and Author D, 2008; Future Forum, 2012). Over a similar time period we have also seen 'commissioning' became an important lever in reform of the English public sector. Since the introduction of the NHS market in 1991, there has been a division within the NHS between the payers (initially referred to as 'purchasers' and now termed 'commissioners') and the providers.

Over time then, health and social care policy has placed growing emphasis on the importance of a *commissioning-led approach* and on the need for more effective *health and social care partnerships*. Combining these two agendas together, policy has increasingly started to focus on the need for greater **joint commissioning** of health and social care (see, for example, Department of Health, 2007; Secretary of State for Health, 2010). And yet, current policy rhetoric about the importance of joint commissioning often seems to lag behind the reality at ground level - despite the fact that aspirations for effective joint commissioning date back many years (see, for example, Department of Health, 1995). Many national policies and local partnerships appear to be based on the assumption that joint approaches are essentially a 'good thing' that must inevitably lead to improvements for local people but there is scant evidence of the impacts of joint working in practice (Author A and Author C, 2011). One of the difficulties in evidencing joint commissioning is that it is not always clear precisely what these ways of working are trying to achieve (Author A, 2008).

This paper reports on one component of a study which sought to map out the relationships between joint commissioning arrangements, services and outcomes and examine the degree to which joint

commissioning leads to better services and outcomes for service users. The research questions underpinning this project were as follows:

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

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

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

This paper specifically deals with one component of the research that sought to investigate the first of these research questions. Building on previous studies that have employed Q-methodology to investigate joint working (e.g. Sullivan *et al.*, 2012) we investigated joint commissioning in five localities, each of which has very different types of arrangements. In this paper we examine the ways in which a range of stakeholders view the concept of joint commissioning and what they believe it should (and should not) achieve in practice. Through this process we sought to articulate some of the "less heard voices" which transcend those that tend to dominate and which are set out in terms of the elite policy orthodoxy.

The paper is organised into three sections. The first sets out what the existing literature says about joint commissioning and what it should achieve in practice. The second sets out the methodology underpinning the paper. The last sets out the findings in terms of the different viewpoints of joint commissioning and analyses what this tells us in terms of ways of working at a local level. Ultimately we find that joint commissioning has a high degree of salience and is seen as something that can deliver better outcomes (across a variety of domains) and for less money. However, whilst optimism is important there is also a risk that joint commissioning is set up to fail by being seen as a way of being able to deliver too many different things to too many different people. We conclude by setting out the policy and practice implications of these findings as well as indicating areas for future research.

Joint Commissioning: the literature

In order to better understand the concept of joint commissioning we conducted a literature search at the start of the research project (early 2010). Two of the research team searched a number of databases covering health and social care including: HMIC; Medline; ASSIA; Pro-quest/ EBSCO; Social Care Online; Social Sciences Citation Index; Social Services Abstracts; and ISI Citation Index database. The search terms used for this exercise were (partnership* OR joint working OR integrated working OR inter-agency working) OR (commissioning OR joint commissioning) AND (good practice OR best practice OR innovation OR success). There were no date restrictions applied but papers needed to be written in English to be included. In total this search retrieved 512 abstracts which were read and the inclusion and exclusion criteria applied. Articles were included where they explored joint commissioning in its broadest sense (i.e. more than one organisation involved in needs analysis and subsequent purchasing of services) and based on an English context. Following this process, 399 items were rejected due to a lack of relevance and 105 items were retrieved in full. The majority of rejected items mentioned joint commissioning in passing, but this was not the central concern of the article. Two researchers read 10 items selected at random and used a standardised pro forma to extract relevant data. These proformas were compared for their inter-researcher reliability and the remainder of data extraction completed.

Many of the items identified through this search process derive not from the peer review literature, but instead from practice and policy literatures and this has implications in terms of the methodologies adopted in these pieces and the status of this evidence (See Table 1). Thus, despite joint commissioning having been a key component of health and social care policy for some time, there appears to be little good quality (i.e. peer reviewed) evidence relating to this concept. Of those articles that appear in peer reviewed journals not only are the methods largely qualitative (33%), but also the majority comprise a case study approach (41%). Often these were very descriptive accounts of activities at one site without theorisation or an attempt to extrapolate to a wider context. Where case studies were used, there is rarely, if ever, any discussion about the methods used to gather data, or how the sample was drawn. The three studies which adopt a 'mixed methods approach' (11%) are actually linked publications which all draw on the same bank of data involving quantitative survey and qualitative interviews to offer different perspectives of the process of joint commissioning. The remainder of the literature constitutes literature reviews and editorials which lack any empirical contribution of their own.

Insert table 1 here

On reading the extant literature it quickly becomes apparent that joint commissioning is not a concept that is clearly defined or which has a distinct meaning. As Rummery and Glendinning (2000) state that "there is no universally agreed definition of joint commissioning; the term can cover a wide range of activities" (pg. 18). Williams and Sullivan (2009) argue that joint commissioning does not actually have a single meaning, but that several communities of meaning co-exist and each aims to deliver different types of outcomes. In this research we were interested in conceptualising the links between joint commissioning and outcomes and therefore sought to analyse the different ways it is conceptualised within the academic and policy literatures. To do this we adopted an interpretive approach to analysis, seeking to identify a series of discourses which frame joint commissioning in slightly different ways in terms of the problem that it is attempting to address, the types of activities that it seeks to do this through and the impacts that this should have in practice.

A summary of each document identified through the literature search was made using a standardised proforma to examine the aims and aspirations of joint commissioning and the activities engaged with in order to deliver this. Once all the items had been coded in this way we drew together the themes in order to identify the different "interpretive communities" (Yanow, 1996: pg. 20). In keeping with the goals of an interpretive approach to surface implicit meaning, it is possible to see how despite a common reference that joint commissioning should lead to 'service improvement' in a general sense, there were differences in the language, objects and acts used to describe how joint commissioning is actually done. Through subsequent iterations of the consolidation of the various activities and themes, we identified three different ways that the literature frames joint commissioning, each of which is constituted by different uses of language, processes and practices used to implement and communicate policy. Each of these discourses provides an inherently different way of seeing and doing joint commissioning. We do not argue that these viewpoints are exhaustive of the literature base or of the meanings that exist in practice. The three identified discourses as those which are most prominent in the literature accessed. We now provide a brief overview of each of these discourses.

Joint Commissioning as prevention

The first discourse refers to joint commissioning in the context of prevention and early intervention, seeing its purpose in terms of health improvement through the reduction of inequalities. Common to this way of seeing is a focus on improving the 'quality' of service provision as a basis for improving the health and well-being of populations (Commission for Healthcare Audit and Inspection, 2008;e.g.

Department of Health, 2007). Policy programmes which have the prevention of ill-health and early intervention at their heart tend to allude to the notion of 'service re-design' as a means of achieving policy goals (Department of Health, 2006;Commission for Healthcare Audit and Inspection, 2008) premised on a belief that inequalities in service provision can be addressed by finding ways of improving the ways that services are delivered (Department of Health, 2007). The focus on prevention and early intervention is driven by efforts to identify gaps in service provision through the better management of commissioning practices such as joint strategic needs assessment and the development of care pathways.

Joint commissioning as empowerment

In contrast to the first discourse with its focus on organisation-led service change, the second sees the purpose of joint commissioning in the context of user-led service change based around the promotion of self care (Department of Health, 2009;Department for Communities and Local Government, 2006). Here, language tends to focus on meeting the needs of service users and carers through the co-production of their own care and the empowerment that this should bring (Department of Health, 2009). Such an approach is bound up in the core values of the personalisation agenda and the idea that if service users are able to direct their support in a truly personalised way then joint commissioning is needed to effectively manage markets and provide the support to individuals.

Joint commissioning as efficiency

This third discourse frames joint commissioning in the context of efficiency. Here, language is rooted in a concern to meet the rising expectations from the public and improve access to health and social care services by increasing choice and control. There is a tendency here to focus on increasing the range of alternative providers to give service users choice and drive competition. Implicit within this way of seeing, is the need to provide patients and people with more choice and control over their health and care and clinical staff with the means to meet these rising expectations. For staff this is expressed in the notion of greater freedoms and flexibilities (Department of Health, 2005). Interestingly, such notions of 'efficiency' also express the full weight of the marketisation of health and social care provision by promoting the concept of 'choice', not in terms of patient choice, but in the context of seeking a 'wider range of providers' and their measurable performance in delivering outcomes. This is in direct contrast to the discourse of prevention (where choice refers to patient choice about service delivery) or empowerment (in ensuring services are more user-led).

Methodology

Given that our analysis of the literature suggests that there are at least three different discourses concerning what joint commissioning is and what it should achieve in practice, in this research we sought to explore the degree to which these principles were operant amongst those *doing* joint commissioning. We engaged five case study sites in this research, each of which has quite different joint commissioning arrangements (see table 2). The sites have been anonymised for the purposes of reporting in line with the research governance approval conditions.

Insert table 2 here

The sites were identified as examples of best practice through a process which included insights from: academic publications, government documents, advice from the project's advisory group and service user and voluntary groups. Given that there is little evidence of the effectiveness of joint commissioning we sought to engage with sites that are recognised as being particularly developed in terms of their arrangements and cited as having impact in practice. If we were to identify evidence of impact then it would be in these sites. As we have described above, we also sought sites that have different types of structural arrangements and serving different client groups as a way of examining the full range of debates about what joint commissioning is and what impact it should produce. Clearly this has implications for the types of conclusions that we may draw from the study, in the sense that we have five quite different examples of joint commissioning arrangements.

Q methodology has been demonstrated to be an effective means of articulating different interpretations of joint working in previous research and the degree to which dominant views are operant across public managers engaged with such activities (Author B and colleague, 2011; Sullivan *et al.*, 2012). Based on previous research (Authors A and B) we sought to employ an online tool to gain understandings of joint commissioning from a range of stakeholders within the case study sites. The POETQ approach uses an on-line application of Q methodology to surface understandings about the outcomes of joint commissioning in health and social care. By applying it to multiple cases, it also allows for a degree of comparison.

Q methodology

POETQ includes a set of statements drawn from previous research into joint commissioning. With this approach, we are essentially asking one question – that is – what do you think joint

commissioning should achieve? We provided participants with a range of common statements about joint commissioning and what this should achieve and forced (in the nicest possible way) them to decide which they agreed and disagreed with, and more than this, which they agreed with the most. From these individual sorts we were able to identify groupings of individuals who speak about joint commissioning and what it is aiming to achieve in similar manners.

Q methodology (here on Q) differs from conventional R factor analysis as it seeks to explore if there is a structure operating within a group of people (i.e. person A's view compared with person B, C etc) rather than if there are latent structures operating within a group of measurable traits (such as relationship between shoe sizes, height, gender, length of forearm). To reveal the subjective structure of a debate Q research starts by considering the volume of communication surrounding a topic, known as the 'concourse' (Brown, 1980), and through a process of Q sampling this concourse is represented in a set of items (typically short statements), respondents are then asked to "Q sort" (essentially rank) the statements, these sorts are correlated by-person and factored. This potential of Q to reveal the subjective structure of debate surrounding a policy issue or initiative makes it well suited to policy and programme evaluation (Brown, 1980; de Graaf, 2010; Van Excel *et al.*, 2007; Steelman & Maguire, 1999; Ockwell, 2008; Mathur & Skelcher, 2007) and importantly to conceptualise aspects of collaborative working such as questions of democracy (Author B and colleague, 2011) or leadership (Sullivan *et al.*, 2011).

When applied within a discrete organisational setting, Q can reveal how many shared viewpoints on a policy initiative are operating at any one time. It reveals where and over what points these viewpoints overlap and suggest points of greatest contention. Q challenges the evaluators to put aside preconceptions and stereotypes about how a particular professional or pay grade might think about a policy initiative. When applied across multiple sites, Q offers the grounds for statistical (Baker *et al.*, 2010) as well as qualitative comparison (Dryzek & Holmes, 2002).

POETQ

To allow us to administer Q sorts across multiple sites we designed an online application called POETQ (Partnership Outcome Evaluation Tool with Q methodology). This contains the Qset (set of statements) which represent the range of debate about the topic. We developed the Qset from the literature review and then piloted the 40 statements (whittled down from 200 potential statements) with a separate joint commissioning team to test the themes and capture 'natural language'. As we argued above, the joint commissioning literature is overwhelmingly positive and the piloting stage was therefore important in capturing alternative views. In line with other Q based studies (Sullivan

et al., 2012) we drew on a sampling framework to ensure we covered the range of debate and avoid duplication. We developed a '4P' outcome framework, inspired by the influential work of Janet Newman (2001) and her work on theorising governance. Each are described in turn below and an edited version of the statements appears in the coding framework set out in Figure 1:

- **People outcomes** – are ultimately about the degree to which service users feel they have an influence on the way that services are planned and delivered. e.g. Statement 37. "*Joint commissioning changes the way service users can influence the services they receive".*

- **Partnership outcomes** – tend to focus on the organisational impacts of joint working so how systems are aligned and the consequences this might have for working conditions and morale. E.g. Statement 19. *"By commissioning with other colleagues you can share ideas, increase knowledge and be more creative in what you do".*

- **Professional outcomes** – categorise those aspects of joint commissioning associated with professional culture and professional identity that might be affected by bringing together different professional groups, values and models of care. E.g. Statement 12. *"Joint commissioning can feel like a battle of the models: A health approach verses a social care approach".*

- **Productivity outcomes** –tend to categorise the productivity aspects of joint commissioning in terms of delivering more for less, reducing duplication, cost-shunting etc. E.g. Statement 1 "*Joint commissioning is about delivering more for less*".

Insert Figure 1 here

The POETQ application includes a series of short questions relating to role, professional affiliation and understanding of joint commissioning arrangements before we come to the main section of the process – the Q sort. The statements appear in turn and the respondent decides whether they agree or disagree with each statement. In the background the application is allocating the selected statements and the desired order to a virtual sorting grid than resembles an upturned pyramid (see Figure 2). Participants sort all of the statements into the pyramid and the final page of the survey prompts respondents to reflect on four statements, placed at the -4 and +4 positions. These are

their most and least agreeable statements and understanding why these were chosen above the rest is critical to the analysis.

Insert Figure 2 here

Data Analysis

The Q sorts were correlated and factored using PQ-method 2.11 software. The analysis works by comparing respondents Q sorts pair-wise to produce a correlation matrix to be constructed. Factors are identified from the data which are suggested mid-points between two or more correlated sorts. Further analysis of identifying statements enables researchers to start sketching a paragraph of text that paraphrases the characteristic statements and privileges the distinguishing statements, extract any free text quotes and from this identify a unique character of each factor.

When applied in a single case study site it is possible to identify how many shared viewpoints are 'operating' (or operant) among the persons responding. This is not to say there are no other viewpoints, because the process is to explore shared perspectives if the person sample is drawn from a cross section of the organisation then additional shared viewpoints, although possible, are arguably improbable. We can also argue these shared viewpoints are more than coincidence and will be operant beyond the sample taking part in the study.

Five viewpoints of joint commissioning

Between 10 and 34 individuals completed the POETQ survey at each site, yielding a total of 93 completed sorts. Due to the size and scope of joint commissioning arrangements the number of respondents varies between sites. The average length of time that respondents spent completing the survey was somewhere between 32 and 37 minutes and the free text responses amounted to just over 18,000 words. In terms of who completed the survey, at each site we generated representation from across all of the partners involved in the local commissioning arrangements and in some cases beyond to wider partners from a variety of different professional backgrounds.

As a first phase in the process of analysis we aggregated the total number of responses and conducted a factor analysis on these sorts. As a result of this analysis we found that five distinct and shared viewpoints of joint commissioning emerged. We have named these viewpoints: ideal world commissioning; efficient commissioning; pluralist commissioning; personalised commissioning; and,

pragmatic commissioning. Table 3 illustrates the degree to which these viewpoints were operant at each of the case studies, illustrating how many of the completed surveys at each of the sites correlated to these aggregate viewpoints. The table shows that the ideal world commissioning viewpoint is far and away the one which is the most prevalent at each of the case study sites. At each of the sites there are also other viewpoints operant which may or may not be congruent with one another.

Insert table 3 here

We now move on to set out the aggregated viewpoints in more detail. In demonstrating these we draw on quotes given by respondents who illustrate these perspectives. In setting out these viewpoints we employ the '4P outcome' framework that we introduced earlier and consider collaborative working in relation to these different dimensions. In doing so we demonstrate the degree to which the different joint commissioning viewpoints are seen to be a function of these dimensions.

Ideal World Commissioning

This viewpoint stresses people outcomes more prominently than those associated with the other dimensions of joint working. As one respondent describes, "Joint Commissioning has produced fantastic outcomes for our patients, particularly those with most complex needs" (site D). For those who match to an ideal world viewpoint, joint commissioning is a "no-brainer" in the sense that it seems like a natural way of working that should lead to synergies between partners. As such, joint commissioning, "takes a wide-lens view of care which is only possible with an integrated workforce - shared knowledge of the local demographic, pooled budgets, reduced bureaucracy, targeted resources according to complexity of need, shared care planning" (site C). This viewpoint recognises that long standing differences exist between different professions, but believes that by coming together they might work for the benefit of service users. This viewpoint also believes joint commissioning can have pay-offs in relation to productivity**,** as working in this way can assure good value for money and help reduce demand and undue pressure on the system; "a multi-professional workforce is working in harmony to bring their knowledge and skills to reduce risk, inequality and manage limited resources" (site C).

Efficient Commissioning

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

one respondent told us, “It may be a cynical view but I feel that the commissioning arrangements [here] are more about the best use of scarce resources rather than promoting fairness and inclusion… to meet statutory obligations rather than to provide choice for service users (site B)”. Again, those that match with this viewpoint recognise that different professions often have quite different perspectives on the delivery of care, but see joint commissioning as a means to improve relations across agencies. In terms of outcomes for people, joint commissioning is viewed as delivering the same for less and therefore efficient commissioning offers little difference in the user experience or potential for improving life outcomes. “I believe that the main imperative in commissioning decisions is to make the best use of scarce resources” (site B).

Pluralist Commissioning

As with the ideal world commissioning viewpoint, pluralist commissioning also believes that joint commissioning is concerned with improving outcomes for people. Whilst ideal world commissioning sees joint commissioning as an attempt to improve service user outcomes in a general sense, pluralist commissioning is fundamentally concerned with issues such as fairer access, inclusion and respect. As one respondent described: “joint commissioning can provide a blueprint for how services look now and how they need to develop in the future. It takes into account the opinions of those who use the service and keep these as the central focus to service design. I believe that an organisation that can evidence its development as being based on the needs of the population will have a more content workforce, shared aims and objectives and more engaged users” (site D). An important component of the pluralist commissioning viewpoint is that service users have a say in terms of what services should be delivered and how. This viewpoint believes that professional barriers are fundamentally harmful and sees joint commissioning as a way to break these down and to dispel myths about joint working. Joint commissioning should reduce competition between professionals and allow them to focus on service users. This viewpoint sees debates about productivity as dangerous and believes that the current agenda around cuts and savings is hijacking the real purpose of joint commissioning which should be about addressing peoples’ needs rather than saving money.

Personalised Commissioning

This viewpoint suggests that the primary focus of joint commissioning should be about offering the highest quality and a seamless service to users; “The public do not want to be concerned with whose responsibility it is they just want to receive a high quality of service and not be bounced between organisations” (site D). How this viewpoint differs to the others is that it is more sceptical about the

mechanism of joint commissioning. "Although integrated it can still be administratively cumbersome due to the merging of large organisations and the resulting learning it is quite difficult at times to align processes" (site C). Joint commissioning can be cumbersome and costly and some professions seem to benefit more than others do. Joint commissioning is one way to work, but it is not the only way to achieving better outcomes for people and in this sense it's also about keeping an eye out for alternative models if they seem to offer a superior way of doing things. "Sometimes things will not always integrate and we need to recognise this. This is not a negative thing but it is about recognising skills and knowledge in the right places with the right people at the right time" (site C).

Pragmatic commissioning

The pragmatic commissioning viewpoint is concerned with being able to see beyond the rhetoric. Whilst this viewpoint does see joint commissioning as a way to achieve better outcomes, it also sees this in a more negative way in terms of the ways in which professionals engage with one another; "Where joint commissioning has taken part between health and social care then benefits have been seen. However…many teams now see us as a way of getting us to take on their work" (site C). There is also a need to acknowledge the costs and effort involved in joint commissioning. In professional terms there is an acknowledgement that there is a need for specialisation, but that this can mean that there is still a degree of buck-passing in the process of working in partnership. "The traditional approach of working in silos was never the optimal way of benefiting the client.... [But]...There are some areas where I feel specialist knowledge should be just that, after all I would not expect a social worker to carry out a simple let alone complex nursing task" (Site C). In productivity terms, this viewpoint believes that joint commissioning can make savings in some areas but costs can also increase elsewhere. This view concludes that joint commissioning is good in theory but difficult to achieve in practice, and it also comes at a price.

What does success mean for these viewpoints?

Each of the viewpoints aligns in different ways in terms of the four dimensions of joint working and these are summarised in Table 4. Given that these viewpoints hold different perspectives in terms of what joint commissioning is, they also hold different notions of what success might look like. The ideal world commissioning view of success is perhaps the most ambitious. It envisions a situation where people are working together in shared spaces, achieving more than they could before where there is a blending of professional cultures and there is no longer reference to "us and them". For

the service user the service fits their needs, exceeds their expectations, they feel engaged and efficiencies mean it costs less for the exchequer too.

The efficient commissioning view of success is to get to a stage where professional groups are able to work together in the complex task of commissioning health and social care. It is about overcoming the upheaval of reorganisation and the practicalities of office moves and office administration. Success is also about ensuring that cuts to budgets are not felt by the service user. This is not to say that those who relate to this viewpoint do not want to see services improved, but that their notion of success is more realistic in the sense of thinking about what can be achieved within current constraints. In contrast, the pluralist commissioning view of success is where the service moves beyond historical professional divides and invests energy in finding means to engage service users in the coproduction of their service. Service users and carers should not be passive recipients of services. They have a right to know how decisions that affect their service are reached and how providers are selected. More than economic performance, a pluralist commissioning view of success focuses on a democratic performance.

The personalised commissioning view of success starts with the experience and the quality of the service for the end user and works backwards. As long as the service delivered is of the highest quality, it takes a pragmatic view of how or by whom the services are delivered. Whereas other viewpoints value increased partnership working, this view argues that working in partnership is one, but not the only, way of organising the commissioning of services in health and social care. Finally, the pragmatic commissioning view of success see professionals working together to offer service users choices that meet their needs as being crucial. However, this viewpoint acknowledges that this end point will need financial investment and a sense of empathy fostered between professionals so that they acknowledge the specialist skills of their colleagues. This viewpoint recognises the length of time that it takes to build effective integrated services and does not think that success is achieved over night.

Insert Table 4 here

Discussion and conclusions

What this research shows is that despite a range of different types of joint commissioning arrangements being in place in the case study sites we can identify five viewpoints of joint commissioning that are shared across these sites; suggesting that these viewpoints are not tied to specific joint commissioning arrangements. What this means is that even though the types of joint commissioning arrangements are quite different across the five sites there are shared perspectives

about what joint commissioning is and what it is supposed to achieve in practice. We might therefore argue that joint commissioning is a 'framing concept' rather than a coherent model that is set out in the policy and practice literatures and which local organisations implement to specific and shared ends. The value of joint commissioning may actually lie in its and ambiguity and symbolism and the consequent capacity to attach people to it. In this sense we might think of joint commissioning as a 'boundary object': it is plastic enough to adapt to local needs but robust enough to maintain common identity (Star & Griesemer, 1989). Joint commissioning has sufficient power to be recognised as a 'generally good thing' but is also able to be moulded and shaped to fit with local contexts.

The sites engaged in this research were a small proportion of the total number of joint commissioning arrangements across the country and so we are not able to make major claims to generalisability across all sites. However, given the numbers of respondents we are able to suggest that these viewpoints will also be shared across other sites to some degree. The ideal-world viewpoint is the most prevalent which sees joint commissioning as simply a 'no-brainer' and can deliver better outcomes for less money. While this is not surprising given our focus on existing examples of good practice and the involvement of commissioners in research, what this does suggest is many of those who completed the survey see joint commissioning as inherently a 'good thing', with very aspirational aims associated with this way of working. This is common to the more general partnership literature (see, for example, Authors A and D, 2008) and also to the commissioning literature (Author D et al). While optimism for the future seems an important attribute (particularly in a difficult financial and policy context), there may also be a risk that joint commissioning can be set up to fail by being seen as a way of being able to deliver too many different things to too many different people (see Authors for a more detailed discussion of these issues). Although the power and positivity of joint commissioning may be helpful in engaging people with reform agendas and ambiguity at the outset may also help people buy into the agenda, as we have seen from the research a number of different viewpoints of joint commissioning exist at individual sites. Without being clear about what it is that joint commissioning is aiming to achieve there is a risk that in the future tensions will arise as competing claims over the intentions of joint commissioning emerge or that joint commissioning fails as it is able to only deliver one of these agendas. Local leaders need to therefore help professionals and citizens within an area to make sense of specific policy agendas and to help understand the implications of these for local contexts and therefore shape expectations of particular reform initiatives (Author A and colleague, 2008).

The established literature argues that health and social care organisations are fundamentally different and this causes problems in joint working (Authors A and D, 2008). Those on the health "side" are often characterised in the mould of a biomedical model of health and well-being, interested in curing things with the use of advanced technologies and medicines. Whilst on the social care side, individuals and organisations take a more holistic account of an individual's life and links with their community (Leathard, 2003). Indeed the concept of "Berlin Wall" separating health and social care vividly illustrates these divides. However, analysing the viewpoints by the professionals who completed the survey shows that they do not necessarily align with professional groupings to the extent that, for example, all nurses align with a pragmatic commissioning viewpoint (Table 5). Instead there is real variation in terms of the types of professionals that align with the different viewpoints. This suggests that in practice joint working may be far more complex than the simple dualism of being employed by a health or a social care organisation. Rather than individuals aligning with the organisation that they belong to or acting along the lines of their other professionals it seems that understandings of joint commissioning instead run across these divides. The sorts of identities that professionals create and are held are crucial as they will inevitably be related to the kinds of values that they hold and therefore in practice the sorts of reform agendas that they will respond to in practice. In this study we have found that a particular policy agenda (joint commissioning) not only has some common elements that are shared irrespective of context, but also that the ways that these agendas are seen also transcends professional boundaries. Taken together, this has profound implications for the way we think about and conceptualise joint working based on the divides that exist within this context.

Insert table 5 here

What is apparent from the research is that the potential meanings of joint commissioning go way beyond those found in the existing literature. The literature focuses on joint commissioning as a way to produce efficiencies, empowerment and productivity, but in this research we found that these factors sit alongside a range of other meanings. Although the literature sets out a number of possibilities in relation to the notion of joint commissioning, at a local level it has been used to understand it in relation to an even wider potential array of challenges. This suggests that there is something about the underlying values of actors that shape whatever "new" initiative that comes their way into an established local way of doing things. As Williams and Sullivan (2009) explain, "conceptual ambiguity creates opportunities for agency, for actors to interpret and understand the nature and value of integration and apply it in different contexts" (pg. 3).

Reference List

Baker R.M., Van Excel J., Mason H., & Stricklin M. (2010) Connecting Q and surveys: a test of three methods to explore factor membership in a large sample. Institute for Applied Health Research, Paper 44.

Brown S. (1980) *Political subjectivity: applications of Q methodology in political science*. Yale University Press, New Haven, CT.

Commission for Healthcare Audit and Inspection (2008) Improving services for substance misuse: commissioning drug treatment and harm reduction services. CHAI, London.

de Graaf,G. (2010) The loyalties of top public administrators. *Journal of Public Administration Research and Theory* **21**, 285-306.

Department for Communities and Local Government (2006) Supporting people for better health: a guide to partnership working. Department for Communities and Local Government, London.

Department of Health (1995) An introduction to joint commissioning. Department of Health, London.

Department of Health (1998) Partnership in Action (New opportunities for joint working between Health and Social Services). HSMO, London.

Department of Health (2005) Health reform in England: update and next steps. London.

Department of Health (2006) Our health, our care, our community: investing in the future of community hospitals and services. Department of Health, London.

Department of Health (2007) Commissioning framework for health and wellbeing. Department of Health, London.

Department of Health (2009) Working to put people first: the strategy for the adult social care workforce in England. Department of Health, London.

Dryzek J.S. & Holmes L. (2002) *Post-Communist democratization: political discourse across 13 countries*. Cambridge University Press, Cambridge.

Future Forum (2012) Integration: A report from the Future Forum. Department of Health, London.

Leathard A. (2003) Models for interprofessional collaboration. In A.Leathard (Ed) *Interprofessional collaboration: From policy to practice in health and social care*. Brunner-Routledge, Hove.

Mathur,N. & Skelcher,C. (2007) Evaluating democratic performance: methodologies for assessing the relationship between network governance and citizens. *Public Administration Review* **67**, 228-237.

Newman J. (2001) *Modernising governance: New Labour, policy and society*. Sage, London.

Ockwell,D. (2008) "Opening Up" policy to reflexive appraisal: a role for Q methodology? A case study of fire management in Cape York, Australia. *Policy Sciences* **41**, 263-292.

Rummery K. & Glendinning C. (2000) *Primary care and social services: developing new partnerships for older people*. Radcliffe Medical Press, Oxford.

Secretary of State for Health (2010) Equity and excellence: Liberating the NHS. HSMO, London.

Star,S.L. & Griesemer,J.R. (1989) Institutional ecology, 'translations' and boundary objects: amateurs and professionals in Berkeley's Museum of Verterbrate Zoology. *Social Studies in Science* **19**, 387-420.

Steelman,T. & Maguire,L. (1999) Understanding participant perspectives: Q-methodology in the National Forest Management. *Journal of Policy Analysis and Management* **18**, 361-388.

Sullivan,H., Williams,P., & Jeffares,S. (2011) Leadership for collaboration: situated agency in practice. *Public Management Review* **14**, 41-66.

Sullivan,H., Williams,P., & Jeffares,S. (2012) Leadership for collaboration. *Public Management Review* **14**, 41-66.

Van Excel,J., de Graaf,G., & Brouwer,W. (2007) An investigation for informal caregivers' attitudes toward respite care using Q-methodology. *Health Policy* **83**, 332-342.

Williams,P. & Sullivan,H. (2009) Faces of integration. *International Journal of Integrated Care* **9**, 1-13.

Yanow D. (1996) *How does a policy mean? Interpreting policy and organisational actions*. Georgetown University Press, Washington D.C.

Table 1. Items retrieved in literature search

Type of article	Total Number found	Percentage of total items retrieved
Practice-based journals	42	40
Peer reviewed Journals	27	26
Government documents (including central government department documents and government agencies)	26	25
Think Tank and independent policy advice	8	8
Book chapters	2	2
TOTAL ITEMS RETRIEVED	105	

Table 2: Key features of case study sites

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

Figure 1: Coding Framework

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

Figure 2: Q sort grid

-4 "Agree Least" 2 cards	***-3*** 3 cards	***-2*** 5 cards	***-1*** 6 cards	***0*** 8 cards	***1*** 6 cards	***2*** 5 cards	***3*** 3 cards	***4*** "Agree Most" 2 cards

Rather than something completely new, this integration of care just formalises an existing culture of	Only by integrating can we address the most complex social situations	Integration of care is about improving choice for users	Integrating care signals to others that we are in partnership	Properly done, integration of care can deliver a quantum leap in how organisations work together	Integrating leads to better working conditions for colleagues and helps boost morale	Integration of care can feel like a battle of the models: A health approach verses a social care approach	Integration of care does little to address the amount of red tape and bureaucracy colleagues have	Integration of care preserves our marked differences in professional cultures
Integrating care makes it clearer who can be held to account for actions	Integration of care enables better risk management	At the end of the day, integration of care is all about realising improvements to real people's lives	Integration of care has had a minimal impact on users	Integration of care results in synergies, where we are greater than the sum of our parts	Integrating means fewer inappropriate referrals	Integration of care facilitates the development of a new common language	Integrating can lead to individual teams becoming more insular	Integration of care reduces inequalities of access to services
	Integration of care helps build the necessary trust between us	Integration of care seems to be speeding up referral	Integration of care is reducing opportunity for cost-shunting and passing the buck	Integrating is about delivering a seamless service for service users	By integrating with other colleagues you can share ideas, increase knowledge and be more creative in what you do	Integration of care means delivering pretty much the same level and standard of service but organised in	Integration of care enables greater information sharing.	
		Integration of care is about investing now to save in the future	Integration of care is mostly about fulfilling government requirements to collaborate	Integration of care is about delivering more for less	Where we are co-located, it benefits professional discussion through the development of informal relationships	Integration of care is about users knowing what to do and where to seek help		
		Integration of care is all about delivering the same for less	Integration of care is about delivering a system that promotes fairness inclusion and respect towards all sections of	Integration of care is about reducing duplication	Integration of care is about improved primary prevention and early intervention	Integration of care is opening up opportunities for the private and third sectors		
			Integration of care helps us enhance our own organisational influence by allying ourselves with others	Integration of care changes the way service users can influence the services they receive	Integration of care means that we better understand one another's roles and duties			
				Integration of care requires larger management structures				
				Integrating should be about reducing pressure on acute services				

Table 3: Prevalence of aggregate viewpoints across local sites

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

Table 4: The five aggregate viewpoints mapped against different outcome dimensions

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

	should experience seamless services.	professionals.		
Pragmatic Commissioning	It is important to address the needs of “real people”.	Joint commissioning involves a lot of cost and effort.	Joint commissioning can exacerbate the difficulties of joint working.	Joint commissioning is good in theory, but in practice it is difficult to achieve and comes at a price.

Table 5: Professionals from case study sites matched against aggregate viewpoints

Case Study Site	Ideal World Commissioning	Efficient Commissioning	Pluralist Commissioning	Personalised Commissioning	Pragmatic Commissioning
A	*Director of Commissioning, Assistant Director Public Health*		*Partnership manager*		*Commissioning manager*
B	*Chief Executive, Project manager*	*Care manager*	*Mental health commissioner*		
C	*General practitioner, Assistant Director Finance, Operations Director*		*Occupational Therapist*	*Community matron, occupational therapist*	*District nurse, physiotherapist*
D	*Performance manager, Head of medicines management*	*Performance manager, Safeguarding nurse, finance manager*			
E	*Director of Public Health*	*Director local authority*	*Community Researcher*		*Community Commissioner*