Local Government Association

Integration and Better Care Fund

Strategic collaborative planning and commissioning

A guide

Contents

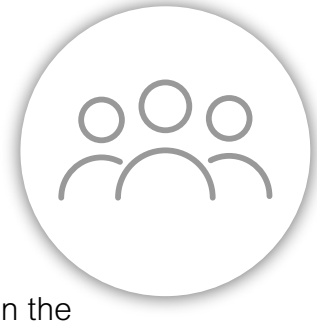
Executive summary

This guide aims to provide an overview of 4 key enablers that support health and social care systems to collaboratively plan and commission effective support, at a strategic level. The 4 key enablers are interdependent on each other, and all 4 will need to be achieved in order to put the best foot forward for strategic, collaborative planning and commissioning. Each key enabler is supported by high level, practical advice in the form of 'principles' and top tips.

Acknowledgements

The LGA and BCF programme team would like to offer their thanks to the Institute of Public Care, for their work leading the development of this guide. Thanks to colleagues who attended the two national stakeholder roundtables in 2022 for their input to shape the themes set out in this guide, and also to colleagues in Greater Manchester, Somerset, Nottingham and Nottinghamshire, Gloucestershire, and Hampshire, who kindly offered their time and shared their experience for the good practice examples.

Enabler 1: Collaborative strategic relationships



We:
Trust all partners represented in our health and care system to **act on each other's behalf**, to make timely decisions and to take actions that are in the benefit of the whole system.

Have a **shared vision** for all parts of and segments of the health and care system.

Have **effective governance arrangements** which simply and clearly outline our **shared responsibilities** for the health and wellbeing of our local people and communities.

Have **joint decision making and escalation processes** across all levels of our local health and care systems.

Have agreed our **local strategic shared outcomes** for our local system and place and **how we will measure** the success or achievement of these.

Share our local data with each other so we have a collaborative understanding of our local needs and develop a consensus on local priorities.

Collectively hold shared values and sustain **open, respectful and trusting working relationships**.

Have **collective accountability** and we **avoid a blame culture** in working collectively towards shared outcomes and objectives.

Have the **right people** in strategic positions that are able to drive forward effective **culture change, break down barriers and advocate for strategic, collective arrangements**.

Take the time to get this right, acknowledging forging true relationships between organisations can take **time and effort, with the right personalities and roles driving it forward**.

Put our local children, young people and adults at the **heart of everything we do**, leaning on the experience and guidance of all members of the system.

Collaboratively to anticipate and agree how we will resolve disagreements before they can escalate.

Top tips:

- focus on building transparency and trust
- right people, right time, right place
- take the time to get this right
- build on experience from the pandemic
- remove any 'us' and 'them' culture
- parity is key

Enabler 2: Collaborative co-production of support and interventions

We:
See people who use local support and those who deliver them as **equal partners** who are involved in any decisions regarding how to best meet people's needs.

Understand that co-production is not about giving up power, but **sharing power** and as a result the system becomes **more powerful as a collective**.

Acknowledge that co-production is **everyone's business** and must be embedded at all levels of a system or organisation. It cannot operate in isolation if genuine outcomes are to be met.

Our care and support approach is based on what is **best for our local people and communities**, rather than the internal needs of our organisations.

Actively listen to what our local people say and when adjustments or changes are needed, we consider how we can make these for the benefit of the whole system.

Ensure that any strategic action or decision we make (eg a design of support, care pathway or publication of a policy / strategy) has been completed with **meaningful input from internal and external stakeholders**.

Consider the **variety of options** for engaging and communicating with local people, providers of care and community organisations to best suit the needs of the audience so no group is underrepresented.

Have **strong relationships with our local care providers** ensuring we make full use of all assets available in our local area.

Top tips:

- acknowledging when we don't have it right
- make it formal
- balance anecdotal evidence with hard facts
- know your local area

Enabler 3: Collaborative sharing of both risks and achievements

We:
Have a culture whereby we **learn from each other** to improve the quality and access to the local care and support offer and we **do not incite blame** to a particular organisation or person when things do not go to plan.

Are **not afraid of innovation and change** and are **willing to test and adopt** new ways of working for the benefit of our local people.

Collectively agree and sign off a **risk assessment** as required, prior to an action, decision or commissioning activity which highlights potential risks, the likelihood and severity of such risks, and how these will be **collaboratively mitigated and managed by all partners**.

Make tough decisions in the interest of securing improved outcomes for local people and communities. This includes stopping, adjusting or introducing services and support.

Present, at the very least, **annual reviews of each commissioned service to the collaborative partnership** to recognise local achievements and outcomes are met, as well as identifying areas for improvement or adjustmen.t

Monitor the outcomes of our local arrangements together on a regular basis and collaboratively **agree how to address** any areas of underperformance, or if desired outcomes are not being delivered by the partnership.

Have **shared frameworks** in place for both the **commissioning and decommissioning of services**, and how we will manage this as a collaborative system.

Top tips:

- understand and plan for existing governance arrangements
- robust conversations and decisions are better in the long term
- work towards reducing ‘upstream’ activity
- unite around shared outcomes and objectives
- build and use risk frameworks together

Enabler 4: Collaborative and creative allocation of resources

We:

Consider the **benefits of a pooled budget** wherever possible, ensuring there is **a clear and agreed scope** for funding and **trust in each other** on how the budget will be used effectively and appropriately, **even if individual funding streams are used beyond traditional, statutory duties**.

Ensure that where funding streams are shared/split in commissioning activities, any tools or processes used to agreed funding contributions by each organisation are **designed, delivered and reviewed together, and never in isolation**.

Understand our **assets as a collective and formally agree** how these will be practically shared – these include skills, expertise, workforce and funding streams.

Provide training and awareness sessions to each other, where required, to **provide additional skills, knowledge and awareness of the individual challenges and operations of each system**.

Consider the **joint recruitment of planning and commissioning roles** across our system, who will have comprehensive experience and knowledge across the health and care system, and fully understand and drive the benefits of collaboration.

Work together to allocate our **combined resources and capacity to meet shared priorities** – to facilitate the realisation of the right resources, at the right time and in the right place.

Aware of the **potential governance arrangements available in order to support place-based budgets** (eg Section 75 agreements) and collectively agree which process, if any, would benefit the local area.

Top tips:

- flexibility on funding responsibilities – keep focused on the destination
- keep it simple and straight forward
- create joint posts and budgets
- coaching rather than instructing
- put agreements in writing
- bring finance directors / leads together

Introduction – why collaborate?

Context

Health and care systems, operating at both place/Health and Wellbeing Board (HWB)system level and Integrated Care System (ICS) level, are increasingly working closer together, although the extent of collaboration often varies according to local circumstances and context. The introduction of statutory Integrated Care Boards and the legacy of joined up working through the Better Care Fund (BCF) and most recently over the two years of the COVID-19 pandemic (2020-22), has shifted the scale and pace of collaboration across many systems.

These developments prompted the BCF programme[1] and Local Government Association (LGA) to commission the Institute of Public Care to develop this framework, to support local systems to successfully deliver the integration of health, housing and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers, a key BCF objective.

In this context, reference to health and care system in this guide may be different for different areas and might relate to an ICS or a local system / area in which the population of service users are grouped according to the HWB /local authority for that area or other locally determined footprints.

This guide is intended to support strategic health and care systems and leaders to consider the foundations for how to best collaborate and work together, drawing upon some of the lessons learnt so far – as well as exploring key enablers that underpin successful collaborative approaches.

1 The BCF programme supports local systems to successfully deliver the integration of health, housing and social care. It can often also be an effective enabler and catalyst to deliver and accelerate broader integrated working (for example across an Integrated Care System) across health, social care, housing, and voluntary sector

Defining collaboration:

Whilst collaboration takes different forms, the general features of a strategic collaborative health and care system can be described as:

Strategic collaborative planning and commissioning

The shaping, influence and support given to the local health and care sector by the commissioning system, which includes providers of care, local people and communities.

Achieving a system understanding of the root causes, nature of demand and local capacity / resources at a **place, population and locality level**.

Agreeing priority and **shared outcomes**, and the alignment of resources to meet these (eg workforce, funding envelopes, skill base etc.)

Producing a **system strategy** to deliver the desired outcomes and how these will be monitored, reviewed and acted upon as necessary.

Oversight of a commissioning strategy and/or framework and their implementation.

Assurance of delivering the system strategy.

Outcomes and collaboration

The below images illustrate two common commissioning experiences for health and care systems across two population groups (1. Providing coordinated support for children and young people, and 2. Reducing hospital admissions for older people). The images consider the agreement of shared strategic visions, desired individual outcomes for local people, and examples of the variety of support, interventions and public services that may be accessed at various points throughout an individual's level of need.

Each commissioning challenge has cross-cutting implications, importance and responsibilities for a range of strategic teams such as public health, social care, health, housing and other universal services including schools, community safety and more. An individual's level of need from universal support potentially up to specialist and/or more intensive care, support and treatment should not be seen in isolation. Instead, **partners should feel they are collectively responsible** for all the outcomes, focusing as much as possible on prevention and early intervention, and recognising that a number of factors influence and impact upon each other to safeguard, protect and support people to live well, and independently for as long as possible.

In addition to these specific examples, the images are complemented by a set of generic 'I' or 'We' statements illustrating the potential universal outcomes on a **people, population and place** level that are likely to result from effective collaboration, defined as the following:

People: These are improved outcomes for local individuals (and their carers) who may need care and support from the collaborative health and care system – supporting them as much as possible to live healthy and independent lives, in their local communities. These statements are taken from the The Making it Real Framework, Think Local Act Personal

Population: These describe potential improved outcomes for different targeted population groups within the local system - focused upon improving physical, mental health and wellbeing and hence reducing potential health inequalities.

Place: These describe the potential benefits to different health and care systems working together within a place to support its local people and populations.

A comprehensive outline on the definition and importance of strategic collaborative planning and commissioning can be found at **Appendix A**

Example 1: Coordinated support for children and young people

Strategic collaborative health and social care system

Shared vision an agreed population outcomes

All children and young people have a great and equitable start to life

All children and young people can fulfil their potential and prepare successfully for adulthood

All children and young people with additional needs, experience support that can be accessed quickly in a coordinated manner

Individual outcomes

(aligned with the population outcomes above)

My pre-school child has lots of places to go to play with other kids and have fun

As a child, I have good opportunities that will help me as I get older

I know who to talk to if things are hard for me

The support I get is great and I'm not passed back and forth between services

It's great to know that the support I need I can still get while staying at home

Strategic collaborative planning and commissioning of support across the 'system'

Play schemes

Schools

Health care

Leisure, libraries, play areas

Extracurricular activities – sport, music, etc

Safe communities and local areas

Carer support

Careers IAG. Vocational training, FE etc

Social care: disability and early support

Children's community nursing services

CAMHS, forensic CAMHS

Specialist schools and accommodation

Placements: fostering, shared lives etc

Example 2: Reducing hospital admissions for older people

Strategic collaborative health and social care system

Shared vision an agreed population outcomes

All older people are ageing well in our system, they experience good health and wellbeing

All older people can access support that helps prevent their loss of independence and wellbeing, where necessary through early intervention

All older people with additional needs, experience support that can help recover, improve, treat and maximise their independence

Individual outcomes

(aligned with the population outcomes above)

I keep fit and well

I don't feel isolated in my own home or community

I am kept safe in my own home

I have recovered from my operation and I now have a good level of mobility and independence

It's great to know that the support I need I can still get while staying at home

Strategic collaborative planning and commissioning of support across the 'system'

Accessible universal services

Safe pavements and accessible environment

Health care

Leisure and, libraries

Befriending services

Community based falls prevention services

Carer support

Handy person schemes

Therapy

Home care

Specialist equipment (including AI and tech)

Reablement

Hip operations

People: "I...

- can live the life I want and do the things that are important to me as independently as possible
- am treated with dignity and respect
- feel safe and am supported to understand and manage any risks
- have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals
- have care and support that is co-ordinated and everyone works well together and with me
- am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want
- have people in my life who care about me – family, friends, people in my community
- know what my rights are and can get information and advice on all the options for my health, care and housing
- am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health
- when I move between services, setting or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens".

Population: "We...

- are reducing health inequalities within our communities
- have effective care and support in place that are of high quality, providing the agreed desired outcomes and that has been share and influenced by our local community
- are assured that there is equitable access to all offers of support and care no matter where the person lives, their personal choices or what their needs are
- have a shared understanding on what is important for our local people, and consider together how to creatively support better health and wellbeing
- are not afraid to think innovatively and trail new ways of doing things that we believe will help our local people".

Place: "We...

- keep people in our local area safe and well
- maximise and share our resources and capacity together to meet the needs of local people make shared decisions based on the best interests of local people and communities
- avoid duplication and unnecessary use of public funds
- are assured that people in our local area, as much as possible, grow up well, live well and age well".

Strategic collaborative planning and commissioning guide

Introduction

The guide is not intended to be prescriptive, but rather describes **key enablers** that are the foundations to collaborative planning and commissioning that will aid health and care strategic systems and leaders work effectively together to better meet the needs of their local communities, strengthen independence, and improve accessibility, quality and efficiency of support being offered.

In addition to this guide, the LGA is developing complementary guidance to support health and care systems to develop and adopt the various 'operational' commissioning approaches to meet local circumstances and objectives, including more advice and support on how to embed or establish the environment for effective collaborative commissioning. This guide can be found here, and can be used to supplement this document.

The four key enablers for collaborative planning and commissioning are:

- **collaborative strategic relationships**
- **collaborative co-production of support and interventions**
- **collaborative sharing of both risks and successes**
- **collaborative and creative allocation of resources.**

Under each key enabler, a series of '**We statements**' have been set out to describe the characteristics and principles that systems are encouraged to adopt and develop to strengthen their collaborative approaches. These 'we statements' offer an opportunity to gauge progress towards having the right conditions and arrangements in place for effective collaboration.

In addition, each enabler is further supported by a summary of good practice from five areas across the UK that were interviewed to support this guide, as well as a number of 'top tips' identified from these interviews to provide some practical guidance on embedding such approaches to support strategic collaborative commissioning and planning arrangements.

Comprehensive detail on each case study, which considers what worked well and any learning or advice from each area, can be found in the appendices:

Appendix B: Greater Manchester Health and Care Partnership – transforming care and learning disabilities and autism

Appendix C: Somerset – community equipment and wheelchair service

Appendix D: Nottingham and Nottinghamshire – sexual violence Support Services

Appendix E: Gloucestershire – Collaborative Strategic Commissioning and Partnership Boards

Appendix F: Hampshire County Council – Short Term Stays Services for Older People

Key enabler 1: Collaborative strategic relationships

Health and care system leaders recognise the importance of good governance and trusting relationships when working across different and diverse organisational boundaries and interests.

Indeed, when consulting with health and care systems in the development of this guide, there was a clear message: achieving robust, transparent and trusting relationships between and within the health and care system is **paramount**. This forms the foundation of effective strategic collaborative planning and commissioning, and if it's missing or not undertaken in a truly genuine way, the mutual benefits will not be fully realised.

Principles for effective collaborative strategic relationships

We **trust** all partners represented in our health and care system to **act on each other's behalf**, to make timely decisions and to take actions that are in the benefit of the whole system

We have a **shared vision** for all parts and segments of the health and care system

We have agreed our **local strategic shared outcomes** for our local system and place and **how we will measure** the success or achievement of these

We have **effective governance arrangements** which simply and clearly outline our **shared responsibilities** for the health and wellbeing of our local people and communities

We have **joint decision making and escalation processes** across all levels of our local health and care systems

We collectively hold shared values and sustain **open, respectful and trusting working relationships**

We have the right people in strategic positions that are able to drive forward effective **culture change, break down barriers and advocate for strategic, collective arrangements**

We share our local data with each other, such as population level data, so we are able to have a collaborative understanding of our local needs and consensus on local priorities

We **take the time required to get this right**, acknowledging forging true relationships between organisations can take time and effort, **with the right personalities and roles driving it forward**

We work **collaboratively to anticipate and agree how we will resolve disagreements** before they can escalate

We put our local children, young people and adults at the **heart of everything we do**, leaning on the expertise and guidance of all members of the system

We have collective accountability and we **avoid a blame culture** in working together towards shared outcomes and objectives

Case study - Illustrations of collaborative strategic relationships

Collaborative strategic relationships		
System	**Service area**	**Illustration**
Greater Manchester Health and Care Partnership	Transforming care – learning disabilities and autism	**Subsidiarity**: individual directors given authority to act on behalf of other directors within the partnership.
Nottingham and Nottinghamshire ICS	Sexual violence services: (all ages)	**Leaders taking the lead**: the development of the new service was galvanised by individual system leaders advocating for change amongst their peers.
Somerset ICS	Community equipment and wheelchair services (all ages)	**Permission to innovate**: system leaders recognised and encouraged staff to innovate drawing upon front-line experience. This was backed up by clear governance arrangements and accountability.
Gloucestershire ICS	Collaborative strategic commissioning and partnership boards	**Listening to others**: the development of dedicated Partnership boards to engage people with lived experience was supported by system leaders to help inform service development and improvement.
Hampshire health and care system	Integrated short stay services for older people	**Empowering staff**: staff were supported to deputise for system leaders in strategic meetings- offering new perspectives in the decision-making process.

Top tips

- **Focus on building transparency and trust**: effective collaborative relationships require a high degree of honesty and transparency. Keep the communication channels open and be prepared to listen and to take counsel from others.
- **Right people, right time, right place**: having a core group of like-minded colleagues within the different parts of the local health and care system all working together can create the right conditions for innovation and change and be prepared to delegate authority (or offer options for subsidiarity) to colleagues and be willing to accept delegated responsibilities to support innovation and change.

- **Take the time to get this right**: all the case studies reported that collaborative approaches take at least 24 months for relationships to mature and new services and support to start to come on-stream.
- **Build on experience from the pandemic**: collaboration was reported as being easier during the pandemic period (2020-22) as systems leaders came together with shared priorities and funding. This culture of collaboration should be learnt from and continue even when funding streams and budgets change or revert back to being held by individual organisations.
- **Remove any 'us' and 'them' culture**: embed a culture where all members work as 'one team', with a full understanding that all are members are working towards a common aim.
- **Parity is key**: good strategic relationships are built upon a sense of parity between all partners. Each part brings added value to the strategic relationship.

Key enabler 2: Collaborative co-production of support and interventions

Many health and care systems have embraced co-production as the default position in how support is planned and organised. Co-production offers the opportunity for local people, as well as providers of care and support, to genuinely shape services and support around individual need and expectation, building individual and community resilience, reducing pressures on scarce resources and capacity, and tackling health inequalities. This goes beyond purely asking people what they think and using this to make decisions, but truly giving local communities an equal seat at the table to shape and define the current and future support offers.

Collaborative co-production should extend across the whole health and care system and include new meaningful relationships and partnerships with individuals with lived experience, local communities, community and voluntary organisations (VCSE) and care providers, as well as a broader range of services and support, such as housing providers for example.

Principles for collaborative co-production of support and interventions:

We see people who use local support and those who deliver them as **equal partners** who are involved in any decisions regarding how to best meet people's needs

We ensure that any strategic action or decision we make (eg, a design of support, care pathway or publication of a policy/strategy) has been completed with meaningful input from all internal and external stakeholders

We understand that co-production is not about giving up power, but **sharing power** and as a result the system becomes **more powerful as a collective**

We acknowledge that co-production is **everyone's business** and must be embedded at all levels of a system or organisation. It cannot operate in isolation if genuine outcomes are to be met

We **actively listen** to what our local people say and when adjustments or changes are needed, we consider how we can make these for the benefit of the whole system

We consider the **variety of options** for engaging and communicating with local people, providers of care and community organisations to best suit the needs of the audience so no group is underrepresented

Our care and support approach is based on what is **best for our local people and communities**, rather than the internal needs of our organisations

We have **strong relationships with our local care providers,** ensuring we make full use of all assets available in our local area

Case study - Illustrations of collaborative co-production of support and Interventions

Collaborative co-production of support and interventions		
System	**Service area**	**Illustration**
Greater Manchester Health and Care Partnership	Transforming care – learning disabilities and autism	**Wider engagement**: the partnership opened up its engagement approach beyond more traditional groups of stakeholders to develop holistic responses to transferring individuals into community settings – for example local housing associations contributed to development of new provision.
Nottingham and Nottinghamshire ICS	Sexual violence services (all ages):	**Detailed needs analysis**: as part of the development of the business case for investment an extensive needs analysis exercise was undertaken to include wide engagement with survivors to understand their needs and identify areas for improvement.
Somerset ICS	Community equipment and wheelchair services (all ages)	**Early engagement**: a key catalyst for change was early and meaningful engagement with people with lived experience to help inform the scope of proposed improvements to services.
Gloucestershire ICS	Collaborative strategic commissioning and partnership boards	**New service**: feedback from the co-production Partnership Boards informed the establishment of a new clinical programme to support people with neurological conditions to respond to previously unreported unmet need and poor access to services.
Hampshire health and care system	Integrated short stay services for older people	**On-line surveys**: As part of a programme to review services and plan ahead post-pandemic, an extensive online survey exercise was undertaken of people with lived experience to understand both what worked and what didn't in terms of meeting need. This survey is to be repeated to track progress.

Top tips

- **Acknowledging when we don't have it right:** whilst not always an easy thing to do, particularly within a partnership, having honest reflections with local people and community assets on approaches that have not worked is considered essential to move forward and to agree innovative and effective solutions.
- **Make it formal:** meaningful and successful collaboration requires partners to be treated and respected as equals. Co-production mechanisms should be afforded a formal place within the health and care system governance framework. Formal recognition provides gravitas in terms of valuing the contribution of stakeholders, as well as providing a mechanism for more meaningful and broader discussions, decision making and accountability.
- **Balance anecdotal evidence with hard facts:** personal stories are very powerful and persuasive in bringing about change and innovation and should be included within business cases and commissioning strategies.
- **Know your local area:** resource and asset mapping is essential to fully understand the offer and support available in the local community. This may open up additional co-production opportunities with community groups and services not directly commissioned by the partnership. Recent guidance by DHSC confirms Health and Wellbeing Boards will be responsible for Joint Strategic Needs Analysis to inform the Integrated Care Strategy,

Key enabler 3: Collaborative sharing of both risks and achievements

Fundamental to local health and care systems working well together is a shared approach to risks and failure, as well as success. A proactive and agile approach to local risks and achievements allows more scope for innovation, creativity and service development across the whole system.

Effective strategic collaborative planning and commissioning means that partners should be prepared to share the benefits of collective endeavours and learn together from their experiences. This includes taking a more long-term, system-wide perspective on investment alongside responding to immediate pressures across the system.

Principles for collaborative sharing of both risks and achievements

We have a culture whereby we **learn from each other** to improve the quality and access to the local care and support offer and we do not incite blame to a particular organisation or person when things do not go to plan

We **monitor the outcomes of our local arrangements** together on a regular basis and collaboratively **agree how to address** any areas of under performance, or if desired outcomes are not being delivered by the partnership

We are **not afraid of innovation and change** and we are **willing to test and adopt** new ways of working for the benefit of our local people

We present at the very least, **annual reviews of each commissioned service to the collaborative partnership** to recognise local achievements and outcomes are met, as well as identifying areas for improvement or adjustment

We collectively agree and sign off a **risk assessment** as required, prior to an action, decision or commissioning activity which highlights potential risks, the likelihood and severity of such risks, and how these will be collaboratively mitigated and managed by all partners

We **make tough decisions** in the interest of securing improved outcomes for local people and communities. This includes stopping, adjusting or introducing services and support

We have **shared frameworks** in place for both the **commissioning and decommissioning of services**, and how we will manage this as a collaborative system

Case study - Illustrations of collaborative sharing of both risks and achievements

Collaborative sharing of both risks and achievements		
System	**Service area**	**Illustration**
Greater Manchester Health and Care Partnership	Transforming care – adults with learning disabilities and /or autism	**Distributed leadership and learning**: working across 10 'places', individual directors took the lead for identified themes on behalf of others, which included sharing learning and experience to benefit the whole system.
Nottingham and Nottinghamshire ICS	Sexual violence services: (all ages)	**Learn from the past**: systems leaders were open to making positive changes to services to reflect past deficiencies.
Somerset ICS	Community equipment and wheelchair services (all ages)	**Ceding control over budgets**: whilst money for the new integrated service was predominately held by health, Somerset County Council took responsibility for managing a new contract (worth £57 million over seven years).
Gloucestershire ICS	Collaborative strategic commissioning and partnership boards	**Commissioners and Individuals learning together**: the partnership boards brought together commissioners and individuals into the same 'virtual' room to share experiences and work together on designing new services.
Hampshire health and care system	Integrated short stay services for older people	**Transparent governance**: In response to ensuring engagement and accountability across the whole system, a S75 Agreement is being put in place with its own governance framework.

Top tips

- **Understand and plan for existing governance arrangements**: all members of the partnership should outline their internal governance arrangements at the beginning of a collaborative planning or commissioning arrangement which will need to be followed and built into the project timeline.
- **Robust conversations and decisions are better in the long term**: whilst it is important to nurture working relationships, partners must be prepared to give and receive honest and robust feedback to secure sustainable approaches over the longer term.
- **Invest in capacity and resource for long term strategic approaches**: the case for prevention and early intervention is generally well understood. As such, all partners should commit to taking a long-term system-wide approach to investing in early intervention and preventative solutions alongside responding to the immediate or crisis pressures on acute interventions and activity.
- **Unite around shared outcomes and objectives**: having a shared vision and set of shared objectives brings systems closer together. These objectives should concentrate on improved outcomes for individuals and communities that transcend local health and care systems. These should be articulated as a local outcome framework (aligned to the proposed national outcome framework) and supported by shared information systems and metrics.
- **Build and use risk frameworks together**: health and care system partners should collectively agree risk appetite and manage these risks through a shared framework. This approach will help to minimise disputes, delays or limited progress towards shared objectives as all partners can be confident that risks and mitigating actions are being shared and owned.

Key enabler 4: Collaborative and creative allocation of resources

The effectiveness of collaborative planning and commissioning is largely determined by the extent to which health and care systems are prepared, proactive and equitable in sharing resources (financial and non-financial, ie, capacity, skills, physical assets etc) for mutual benefit to support on-going activity and long-term sustainability of services.

A key feature of collaborative and creative allocation of resources is systems having both the awareness and commitment to collectively investing in preventative and early intervention approaches whilst recognising financial and non-financial benefits will accrue elsewhere in acute health and residential care settings. In addition, this way of working may result in more societal benefits (social value) as individuals live longer independently with good health and wellbeing outcomes.

Principles for collaborative and creative allocation of resources

We consider the **benefits of a pooled budget** wherever possible, ensuring there is a **clear and agreed scope** for the funding and **trust in each other** on how the budget will be used effectively and appropriately even if individual funding streams are used beyond traditional, statutory duties

We ensure that where funding streams are shared/split in commissioning activities, any tools or processes used to agree funding contributions by each organisation are **designed, delivered and reviewed together, and never in isolation**

We are aware of the **potential governance arrangements available in order to support place based budgets** (eg, Section 75 agreements) and collectively agree which process, if any, would benefit the local area

We understand our **assets as a collective and formally agree** how these will be practically shared - these include skills, expertise, workforce and funding streams

We work together to allocate our **combined resources and capacity to meet shared priorities** - to facilitate the release of the right resources, at the right time, and in the right place

We provide training and awareness sessions to each other, where required, to **provide additional skills, knowledge and awareness of the individual challenges and operations of each system**

We consider the **joint recruitment of planning and commissioning roles** across our system, who will have comprehensive experience and knowledge across the health and care system, and fully understand and drive the benefits of collaboration

Case study – Illustrations of collaborative and creative allocation of resources

Collaborative and creative allocation of resources		
System	**Service area**	**Illustration**
Greater Manchester Health and Care Partnership	Transforming care – adults with learning disabilities and autism	**Joint posts are critical**: key to progressing collaborative initiatives, the partnership has established a core team that works across organisations coordinating effort and building commitment.
Nottingham and Nottinghamshire ICS	Sexual violence services (all ages)	**Consolidated funding**: a new service was born out of combining small pots of funding allocated for distinct elements of service provision, to create investment mass for a system-wide approach.
Somerset ICS	Community equipment and wheelchair services (all ages)	**Long term commitment**: a seven-year contract for the new integrated service offers greater probability of stability and sustainability over the course of the contract and beyond.
Gloucestershire ICS	Collaborative strategic commissioning and partnership boards	**Creative use of community assets**: feedback from the partnership boards led to development of innovative solutions of matching community assets to support the wellbeing of individuals.
Hampshire health and care system	Integrated short stay services for older people	**Flexible use of national pandemic grants**: a new innovative short stay model within a traditional nursing home was introduced through creative uses of resources rather than being focused upon the output, often described in grant criteria.

Top tips

- **Flexibility on funding responsibilities − keep focused on the destination:** effective collaborative approaches look towards more creative interpretations of how funding streams can be used - focusing upon long-term shared outcomes that transcend organisational boundaries, alongside the management of more immediate and pressing challenges and opportunities.
- **Keep it simple and straight forward**: collaborative planning and commissioning processes can be complex. However, there are opportunities to minimise burden and simplify approaches − such as using the standard NHS Contract as opposed to more bespoke technical contracts, using a common language to describe services, or having shared information. systems for example, which in turn creates flexibility to work collaboratively.
- **Create joint posts and budgets:** dedicated joint posts can provide greater capacity to working collaboratively across local health and care systems, offering insights and access to both health and local authority perspectives aligning governance arrangements − and often management or oversight of joint /pooled budgets and resources.
- **Coaching rather than instructing:** collaboration is not a construct that can be imposed, but rather a culture and a set of behaviours that is to be encouraged and nurtured. The use of an independent facilitator to support partnerships to build formal collaborative agreements may be beneficial to support partnerships to build a consensus of sharing resources in a constructive and meaningful manner.
- Put agreements in writing: Section 75 Agreements and Memorandums of Understanding (MoU) are helpful tools for health and care system partners to clearly (and legally) set out how they will invest and share resources together to meet shared objectives and improved outcomes. Section 75 Agreements offer reassurances for clinical engagement and commitment.
- **Bring finance directors/ leads together :** collaborative agreements are more likely to succeed if relevant finance directors or leads from across the local health and care system have been engaged and proactive in making agreements and plans together about how resources will be deployed. This approach can minimise risks of budgets being allocated to other themes.

Conclusion

It is hoped this guide offers helpful examples and some practical pointers to support health and care strategic systems in creating the right conditions for effective collaboration for strategic planning and commissioning. These are described as four key enablers and each holds equal importance as well as being interdependent upon each other.

Health and care systems and leaders are encouraged to use this guide to determine areas for development and exploration together. Perhaps however, **the most important element to collaboration is a real sense of trust between organisations and individuals** particularly when it comes to difficult conversations about resources. This trust is a key foundation upon which all collaboration, innovation and change can truly flourish and be sustained.

Appendix A

Comprehensive context for strategic collaborative planning and commissioning – health and care

Context: Strategic collaborative planning and commissioning – health and care
It has been proposed for a number of years that in order to meet the holistic needs of individuals who require health and care support, effective collaboration between those responsible for health services, social care services, public health and wider public services is required, in close and meaningful partnership with providers of care, community organisations and with local people and communities.

Collaborative planning and commissioning is defined by the UK Government as "The government's vision for public services in the modern era is one of 'collaborative commissioning'. This means that in the future, local stakeholders will be involved in an equal and meaningful way in commissioning and all the resources of a community, including but not confined to public funding, will be deployed to tackle the community's challenges. People will be trusted to co-design the services they use."

This way of working observes a community of need as a 'system' of interconnected parts, each of which impacts and shapes the other. It has the ambition that people receive the right care, at the right time and in the right place. It supports individuals to be more resilient and independent, and to have all their health and care needs considered in a complimentary way, leading to improved outcomes and a reduction in health inequalities.

Listed below are just some examples of the benefits local system leaders, commissioners, operational colleagues, those delivering front-line services and most importantly, those who may need care and support, should experience if local systems deliver on effective collaboration between health (including primary care, community health, acute, mental health), social care services, public health and wider well-being community support:

Sharing of resources and expertise	Effective coordination across the local support offer	Reduction of duplication across the support offer, and for individuals
Better outcomes for local people are achieved when the whole person is taken into account	Increased wellbeing ad long term health for populations in a local area	Sustainable and long term arrangements that prevent or delay, where possible, the escalation of need across health and social care

Defining collaborative strategic planning and commissioning

A key part of ensuring **effective collaborative planning and commissioning** is achieved is to understand the variety of terms used to define the different 'levels' of commissioning.

The LGA describes (integrated) commissioning taking a number of forms:

- **Strategic** involving the complete integration of the processes and governance of the member organisations.
- **Geographic** covering all services with a certain place or for a group of people; this can involve virtual arrangements where activity is aligned but not under single management.
- Commissioning can take place at **system, place or neighbourhood / locality level, or at the level of the individual.**
- It can involve a combination of commissioners across health and social care, public health, police, commissioners of universal services, independent care providers, community groups and individuals **working together**.

To compliment this perspective, we define '**Strategic collaborative commissioning**' as being:

1. **The shaping, influence and support** given to the local health and care sector by the commissioning system.
2. Achieving a system understanding of the root causes, nature of demand and local capacity / resources at a **place and population level**.
3. Agreeing priority and **shared outcomes**, and the alignment of resources to meet these (eg workforce, funding envelopes etc, skill base etc.)
4. Producing a **system strategy** to deliver the desired outcomes and how these will be monitored, reviewed and acted upon as necessary.
5. Oversight of a **commissioning strategy** and/or framework and their implementation.
6. Assurance against the system strategy delivery.

Once the above is embedded, a local health and care system can be confident that they hold a strategic basis for collaborative planning and commissioning. This will allow the system to work better together to plan or commission an intervention or service that will have benefits across the partnership and its wider community.

Operationally, there remains a variety of commissioning options for a strategic system to consider in determining how services and support are organised to meet specific needs, circumstances and priorities for local places or population groups.

'**Collaborative operational commissioning**' is defined below:

Collaborative operational commissioning approaches

A partnership approach to agreed single, parallel, collaborative or integrated commissioning activities for specific client groups or pathways:

1. **Single commissioning approach:** Objectives, plans, decisions and actions are arrived at independently without coordination.
2. **Parallel commissioning approach:** Objectives, plans, decisions and actions are arrived at with reference to other agencies.
3. **Joint commissioning approach:** Objectives, plans, decisions and actions are arrived at in partnership with separate agencies.
4. **Integrated commissioning approach:** Objectives, plans, decision and actions are arrived at through a single organisation or network, represented by a number of partners and agencies who share accountability.

The key here is for the strategic collaborative system to have agreement as to the approach that is to be taken for each planning and commissioning activity, and the rationale for this.

The table in **Appendix 1** aims to aid strategic leaders and commissioning partners to consider how to apply the different approaches to commissioning across all areas of the commissioning cycle, highlighting the differences in approaches for single, parallel, joint and integrated commissioning. Please note the joint commissioning approach is most closely aligned to the definition of collaborative commissioning.

In addition, the LGA has published complementary guidance and case study material to assist health and care systems to evaluate, develop and adopt **a variety of different** 'operational' commissioning approaches to meet local circumstances and objectives. However, the key message is that these decisions are dependent upon health and care systems collaboratively working at a strategic level in terms of planning and commissioning in order to decide which commissioning approach best meets the needs of the local area.

Why are effective collaborative strategic planning and commissioning arrangements between health and care needed?

Collaboration between health and care is not a new concept. It is recognised that in the majority of cases, an individual's needs are often complex and interacting, and therefore organisation boundaries or unnecessary bureaucracy will only cause further problems in the long term. In acknowledgement of the outcomes that can be achieved by effective partnership working, there have been arrangements in place for some time across the NHS and local authorities that aim to support integration:

Health and Wellbeing Boards	Better Care Fund	Integrated Care Systems (ICS)	Provider collaboratives	Primary care networks

But, the legislative landscape is changing. The Health and Social Care Act (2022) will formalise ICSs (comprised of an Integrated Care Board and an Integrated Care Partnership) with a statutory responsibility whilst disbanding all Clinical Commissioning Groups (CCGs). It is hoped this will achieve more effective joined up services as well as promoting a focus on preventative and early intervention which maintains and improves well-being over time, reducing individual's reliance on health and care services wherever possible.

This Act is also complemented by the White Paper 'Joining up care for people, places and populations' which outlines the government's proposals for health and care integration.

In summary, the White Paper proposes:

- The development of shared outcomes across health and care systems in order to deliver person centred care, improved population health and reduced health inequalities.
- A focus on **Place Based Commissioning** which is hoped to be the vehicle for the delivery of suitable services for a defined geographical area.
- Suitable leadership and roles are required to be accountable for health and care services which are well designed, effectively delivered and achieve the agreed shared outcomes.
- Requirements for integration – to include data sharing and simplifying financial alignment.

In addition to the above, this reform places additional responsibilities on the Care Quality Commission (CQC) to review ICSs and assess their effectiveness for health and care integration at a **place** level. The proposed themes, at the time of writing, which CQC will be assessing ICSs (and may be subject to change following further testing in 2022/23) are outlined in **Appendix 2**

A further White Paper ('People at the Heart of Care; Adult Social Care Reform') outlines plans for the CQC to independently review and assess local authorities and their ability and effectiveness to deliver their social care function. These reviews will include an assessment of local authorities' effectiveness in a number of areas, including managing transition between children and adult services, commissioning and contracting responsibilities, effective leadership arrangements and a focus on early intervention and prevention. All of which will be supported if effective strategic collaborative relationships are nurtured and promoted.

Finally, the benefit of collaborative working between health and care systems has never been more evident than throughout the COVID-19 pandemic. NHS bodies and GP surgeries, local authorities and social care providers and community organisations worked tirelessly and effectively together in the most challenging of circumstances to ensure that local people received the care and support they required in an ever changing landscape of lockdowns, isolation and the closure or reduction of face-to-face support.

Appendix 1 - Potential commissioning approaches for strategic collaborative arrangements

Commissioning cycle	Separate approaches	Parallel approaches	Joint approaches	Integrated approaches
Analyse – an ability to collate, analyse and report on evidence and the root causes of demand for services from quantitative and qualitative sources. Including: **Commissioning** Population Service provision Resources **Contracting/Implementation** Individual needs and outcomes Providers	Needs analysis is undertaken independently. Public meetings, conferences, and feedback are designed and delivered independently. The financial impact of services and policies on other organisations is not considered.	Separate needs analysis shared by organisations. Separate cost, benchmarking and general market intelligence shared by organisations. Organisations allocate some resources to address issues of common concern.	**Jointly designed population needs analysis informs commissioning priorities.** **Organisations jointly design and manage consultation and feedback activities.**	Single integrated projects undertaking needs analysis and using these to inform common commissioning and contracting priorities. Single research, analysis, or public health teams.
Plan – a whole system approach to commissioning decision-making including an understanding of impact and risks across all sectors. Including: **Commissioning** Gap analysis Commissioning Strategy Service design **Contracting/Implementation** Specification /contract development Purchasing plan	Organisations develop services to meet their own priorities. Single agency planning documents do not include key partner's priorities and drivers. Single agency commissioning strategies.	Systematic analysis of partner agency perspectives, issues and concerns. Liaison in the production of separate strategies. Strategies and plans reference and address partners' issues.	**Shared commitment to improve outcomes (across client group) clearly outlined in the health and wellbeing strategy.** **Joint strategy development teams producing common commissioning strategies and documents.** **Organisations identify pooled budgets for particular areas, and a joint approach to decision making on budget allocation to meet common objectives.**	Inclusive planning and decision process as an integral partner. Pooled budgets within a single agency or network, to meet combined needs identified for the population via the population assessment A transparent relationship between integrated bodies.

Commissioning cycle	Separate approaches	Parallel approaches	Joint approaches	Integrated approaches
Do – stronger relationships with and levels of understanding of all providers and markets. Including: **Commissioning** Market / provider development Capacity building Managing provider development **Contracting/Implementation** Arrange support and services Contract management	A fragmented approach to use of providers and resources. Market facilitation sited in separate organisations.	Organisations inform each other of purchasing intentions. Market development information shared across organisations when clearly relevant.	**Organisations develop joint service specifications and contracts or share contract risk.** **Joint appointments of commissioning staff.** **Jointly researched and produced a market position statement.**	Integrated commissioning function, eg a single manager with responsibility for managing commissioning and contracting within a single organisation or network.
Review – systematic whole system performance monitoring of intelligence and data across services demonstrating performance against outcomes. Including: **Commissioning** Review strategy and market performance Review strategic objectives **Contracting/Implementation** Review individual outcomes Contract monitoring **System assurance**	Contract compliance information is used independently of other sources and solely within the organisation. Provider performance information not shared between organisations.	Organisations share information about contracts and intelligence about performance where relevant. Organisations inform each other of performance improvement needs. Information from patients/ service users or service providers is shared when clearly relevant.	**Multi-agency review groups ensure robust joint arrangements for the collection and interpretation of performance information.** **Organisations jointly design monitoring frameworks.**	Integrated monitoring and review arrangements that result in a shared understanding of the effectiveness of current services and the evidence for changes in the future. A single function is responsible for managing and monitoring contracts to meet a single commissioning agenda.

Appendix 2 - Proposed Themes for CQC Assessment of Integrated Care Systems

Leadership	Integration	Quality and Safety
• Shared direction and culture • Capable, compassionate and inclusive leaders • Governance and assurance • Partnership and communities • Learning, improvement and innovation • Environmental sustainability • Workforce equality, diversity and inclusion	• Safe systems, pathways and transitions • Care provision, integration and continuity • How staff, teams and services work together	• Learning culture • Supporting people to live healthier lives • Safe and effective staffing • Safeguarding • Equity in access • Equity in experience and outcomes

Appendix B

Case study Greater Manchester Health and Care Partnership – transforming care and learning disabilities and autism

Like most health and care systems, the challenge of moving individuals with learning disabilities and/or autism from long-stay hospital settings to live in the local community has persisted for several years. Across the devolved Greater Manchester Authority, each of the 10 localities had a number of people with a learning disability and/or autism diagnosis whose options were limited due to lack of suitable local provision in the community. In response, the newly formed Greater Manchester Health and Social Care Partnership (GMHSCP) launched a plan in 2018 to support more people to move out of these long-stay hospital settings.

The approach required significant levels of collaboration across multiple partners to include, not just the local authorities and health partners, but also care providers, housing associations and importantly people with learning disabilities and/or autism to develop a new approach. Due to the significant levels of complexity in securing sustainable funding and managing potential risks, a Memorandum of Understanding (MoU) was established to support implementing the plan across the GMHSCP. This MoU was developed as a legal document and has the potential to be applied to other collaborative initiatives.

A key feature to this collaborative approach was a commitment between the partners, and a willingness to work beyond organisational boundaries (and barriers) towards a shared vision of improved outcomes for people with learning disabilities and/or autism. This required individual partners to make a commitment across the region to developing new community provision in each local authority area and agree a shared placement approach

To date, this collaborative approach has begun to see new provision developed in local communities and more placements being made locally with long-stay hospital settings gradually reducing. This is ongoing and will take time and persistence, but the foundations are firmly in place to support more people in the local community – and ultimately to improve health and wellbeing outcomes.

Collaborative strategic relationships – Greater Manchester is relatively unique in terms of the number of different partners involved, and a key feature was a distributed leadership model to support the development of services. This required a high degree of trust as well as significant commitment by the 'delegated lead' to establish and negotiate effective working relationships across the partnership. To support this approach, a Steering Group was established to provide a governance structure in making decisions and holding different partners to account in progressing the agreed Complex Needs Project plan.

Collaborative co-production of support and interventions –A key theme throughout the agreed Complex Needs Project plan was a strong emphasis upon co-production with individuals with learning disabilities and/or autism and their families, as well as with care and housing providers in designing the care pathway from long-stay hospitals to community settings. This engagement occurred in a timely way so partners were able to contribute to the design phase of the new service. This co-production was critical in ensuring new provision was fit for purpose and contributed to improved outcomes.

Collaborative sharing of both risks and successes – The range of complexity when working across several partners and differing delivery imperatives was significant. To help make early progress, the approach built upon the core principles described in the Greater Manchester Health and Social Care Devolution MoU to support collective decisions, manage risks and establish areas of responsibility and accountability. To ensure transparency, the Complex Need Project MoU was developed with legal advice (Queen's Counsel) included and all parties have signed up this MoU as a binding agreement.

Collaborative and creative allocation of resources – The Complex Needs Project Plan describes a pooled budget of £6.25 million across the partnership to support the planned reduction of long-stay hospital placements and expansion of corresponding community placements. To support the allocation of this resource, the partnership established a GM LD Fast Track Delivery Group as a collaborative commissioning team with additional case management team resources integrated with local CHC and Joint Funding Panel arrangements.

Any identified challenges and how these were mitigated

Being clear on risks and roles: Working across multiple partners and responding to long-standing complexity of transferring individuals with learning disabilities and/or autism from long-stay hospital settings required extensive detailed conversations and agreements to understand and mitigate shared risks, as well as to secure commitment and investment.

This process has taken around 24 months before potential transfers started.

Key factors to support this approach included leadership commitment to collaboration and the development of an MoU setting out and clarifying roles and responsibilities across the partnership. This MOU is designed to sustain the approach going forwards by offering a pragmatic framework to anticipate and deal with potential risks as they arise.

Appendix C

Case study Somerset – community equipment and wheelchair service

Historically community equipment and wheelchair services for all age groups across Somerset were run as separate services funded by the county council and Somerset CCG respectively. This approach followed traditional models of service delivery and was considered to be disjointed from the perspective of the person requiring and accessing support. This was recognised by leaders in both the county council and the CCG as a key risk and the increasing emphasis upon collaboration presented an opportunity to design a new collective approach that addressed improved outcomes for local people through an integrated and stream-lined service.

The county council and the CCG formed a joint Board to help steer progress towards establishing an integrated service, and after extensive engagement with providers and people who use community equipment and wheelchairs, a tender was issued for the new service. This was for a long term arrangement (up to seven years) and a NHS contract format was used, with 75 per cent of the funding coming from the CCG and the remaining 25 per cent from the council to a value of £57 million.

The new service is now up and running and early indicators indicate that local people are experiencing a more cohesive one-stop service to support them to remain independent in their own homes and local community.

Collaborative strategic relationships – The starting point for an integrated approach was driven by senior leaders in the county council and the CCG being open to a new way of working that transcended traditional operational boundaries and placing an emphasis upon shared objectives to improve outcomes for local people. This shift was part of a wider permissive approach being taken across the county towards bolder collaborative working and a recognition that silo approaches were not delivering improved outcomes. To help make progress, a Board was set up to monitor and steer the approach (chaired by the CCG, to include senior leaders from county council and Health Watch representation), as well as to provide a governance structure that facilitated both collective decisions and accountability across multiple partners.

Collaborative co-production of support and interventions – The active involvement of local providers and people with lived experience of using community equipment / wheelchair services was considered critical in ensuring the new service was designed around the shared objective to improve outcomes. Early and meaningful engagement with local providers in the design and preparation of a new contract (facilitated through workshops) and the establishment of a 'user sub-group' to inform the work of the Board helped to provide expertise, insight and importantly stimulated shared commitment to more collaborative approaches.

Collaborative sharing of both risks and successes – Whilst majority of the funding for the new integrated service is from the CCG budget (75 per cent), the new contract is managed by the county council and agreement was made to share risks of any potential overspends on an equal basis. This approach required the CCG to cede an element of risk in trusting the county council to manage the contract (total value of £57 million over seven years), although it is noted that the CCG had previously agreed for the county council to run the community equipment service on its behalf. To support the approach, the county council provides monthly reports to the CCG.

Collaborative and creative allocation of resources – The agreement between the CCG and the county council to pool resources (under S.75 agreements) and create an integrated community equipment and wheelchair service was based upon a shared ambition to improve outcomes for local people rather than to make savings or efficiencies (although in the long-term some savings may accrue as local people are supported to be more independent). The trust between the two systems was important and decisions to place the contract management element with the county council was based upon a recognition that the county council had existing strong links to the local provider market and community well-being sector, critical to the success of the integrated service.

Any identified challenges and how these were mitigated

Building trust: The pathway to an integrated service took over two years to establish. There were multiple partners and a large number of VCSE organisations historically working independently from each other towards the same or similar objectives.

The collaborative approach shaped the development of a commissioning alliance arrangement across these various VCSE organisations, steered, coordinated and championed by like-minded leaders and commissioners working towards shared outcomes, but this required both patience, the ability to listen to others and a sense of persistence and focus. Collaboration is a long-term project.

Appendix D

Case study Nottingham and Nottinghamshire – sexual violence support services (all age)

Following the 'Independent Inquiry into Childhood Sexual Abuse' in 2018/19, which explored the extent of any institutional failings to protect children in the care of Nottingham City and Nottinghamshire County Councils from sexual abuse or exploitation, both councils, the Nottinghamshire Police and Crime Commissioner (PCC) and clinical commissioning groups reported and recognised there was insufficient specialist support for survivors of sexual violence. This included significant waiting periods for statutory mental health services, an inflexible therapy support offer that could not meet the multiple needs of survivors (eg a short term, time limited offer that did not provide practical support or advice on other areas such as housing, financial support childcare etc.) and fragmented services across the local area that often required survivors who are experiencing significant trauma to present at a number of different services for different needs.

The PCC, Nottingham City Council, Nottingham County Council, Bassetlaw CCG and Nottingham and Nottinghamshire CCG agreed to take a collaborative commissioning approach in order to improve their support for survivors of sexual violence, including child sexual abuse. This was led by a Sexual Violence / Child Sexual Abuse Task and Finish Group with the aim to jointly develop a new service model and provide a single, consistent and high quality service for survivors.

A 'coordination hub', linked to the therapeutic support service was created which offered a single point of access for survivors to receive therapeutic support, as well as other support services which offer emotional and practical help commissioned by the collaborative partnership.

Since opening its doors in January 2021, the coordination hub has received over 800 referrals, with around 500 individuals being supported by therapy. Anyone waiting for therapy has access to a helpline, email and drop-in support, as well as online courses. Following support from the service, 85 per cent of survivors identified a reduction in clinical need.

Collaborative strategic relationships –The success of the redesign and delivery of the coordination hub was driven by the collaborative relationships between the PCC, the local authorities and the CCGs. There was a shared agreement that something urgently had to be done, and success would be achieved if all partners worked together to provide a service that considered survivors as a whole person, rather than managing each need in isolated and uncoordinated ways.

Collaborative co-production of support and interventions – A comprehensive needs assessment was completed as part of the redesign of the support offer, where a significant consultation exercise was completed with survivors of sexual abuse, as well as other key stakeholders. Survivors were invited to explain what they needed from such a service, and co-produced the design, procurement and award of the coordination hub contract. The acknowledgement of the multiple needs and support requests from those consulted provided the clear rationale that a joint and collaborative approach to commissioning was needed across a number of services, commissioned by different partners, to make a real difference.

Collaborative sharing of both risks and successes – The urgent need for change was clear and unambiguous, galvanising senior colleagues and leaders across the partnership to take a more proactive approach to risk taking in supporting and directing colleagues to think and do something new that will have meaningful outcomes for survivors. The partnership was able to acknowledge that the current provision was inadequate and agreed in collaboration that something more innovative was urgently needed. It was also essential for the partnership members to recognise their own level of expertise and listen / trust in those that were experts in this field when making decisions / driving a decision forward.

Collaborative and creative allocation of resources – The partnership agreed a pragmatic approach to the funding of the coordination hub by splitting this proportionately between the organisations. It was recognised this was a shared inter-connected issue, and therefore a shared responsibility.

In addition, there are shared roles within the coordination hub, with NHS employed health practitioners seconded to support the outcomes of the service.

Any identified challenges and how these were mitigated

Acknowledging that we don't have it right: Through meaningful and collaborative discussions and engagement, the partnership was able to acknowledge the current commissioning arrangements were not meeting the needs of survivors. This is not always an easy thing to do, especially across a number of organisations, and with providers, however this honest reflection was essential to move forward and to agree innovative solutions.

Business case for additional (and shared) investment in a challenging financial climate: This was mitigated by the clear justification for an urgent collective change in approach – supported by significant evidence such as the independent Inquiry, the internal needs assessment and powerful, real life examples of how the current siloed arrangements were failing those who needed help.

Governance arrangements of local organisations: Whilst collaboration between the organisations was agreed and successful, a key challenge was outlining the pre-existing governance arrangements that individual organisations are still required to honour for decision making. It is recommended that all members of the partnership outline their internal governance arrangements at the beginning of a collaborative commissioning arrangement which will need to be followed and built into the project timeline.

Appendix E

Case study Gloucestershire – collaborative strategic commissioning and partnership boards

Co-production is a key feature in how the Gloucestershire Health and Care System has developed its strategic collaborative planning and commissioning approach. Gloucestershire Integrated Care System has had partnership boards for local people for many years helping to shape and influence services and highlighting the experiences of people with 'lived experience' in setting shared objectives around improved outcomes. There are five separate boards established to cover:

- learning disabilities
- Autism Spectrum Conditions (ASC)
- mental health and wellbeing
- physical disabilities and sensory impairments
- carers.

Each board meets several times a year, bringing together people with lived experience alongside professionals (commissioners and social workers) within the statutory services and the voluntary sector as a working collaboration to effect positive change in how services are designed and commissioned. Over the course of the pandemic, the five partnership boards were brought together as a 'Collaborative Board' to meet regularly (online weekly) to provide insight and intelligence as to how local people and services were coping with the consequences of the pandemic.

Gloucestershire is reviewing its approach to co-production to include extending the approach to older people (ageing well), and the immediate findings comment that "in summary, working together via the collaboration of the five partnership boards has been a tremendously positive experience. There has been significant learning which will shape the way we develop services in future. By combining the partnership boards, it has strengthened the voice of people with 'lived experience', brought VCS organisations together and acted as a valuable resource to the statutory services".

As a consequence of this proactive approach to co-production, combined with a progressive leadership culture of collaboration and innovation, there are examples of new services being creatively developed to meet identified individual need that use resources in a more 'fluid' way. For example, the partnership used NHS grants for annual health checks for people with learning disabilities to commission user led organisations support individuals rather than more traditional 'clinical' responses.

Collaborative strategic relationships – Strong and enduring relationships are a key feature in how Gloucestershire Integrated Care System functions. The establishment of an integrated commissioning function across health and social care, to support integration and transformation, aided by coterminous boundaries, senior leadership endorsement, and the legacy of working closely with people with lived experience over the course of the pandemic – has created the right conditions for meaningful co-production in designing services and support to meet improved outcomes.

Collaborative co-production of support and interventions – Gloucestershire's approach to co-production builds from established partnerships boards that draw together a wide range of perspectives from people with lived experience, as well as from care providers and community organisations. These boards provide early, meaningful insight and influence in strategic collaborative planning and commissioning activities to include for example the establishment of a clinical pathway for neurological conditions to respond to unmet need and lack of established pathways or specialist services.

Collaborative sharing of both risks and successes – Meaningful co-production has required commissioners and other professionals to take a more positive approach to listening and acting upon feedback and contributions from people with lived experience and from providers and community organisations. This has opened the door to the system being more innovative and less risk averse to change in the pursuit of improved outcomes.

Collaborative and creative allocation of resources – Co-production has been instrumental in providing new perspectives in how funding is allocated and used. This includes examples of creatively using grant funding to build and support community assets in meeting improved outcomes rather than investing in traditional approaches and interventions. For example, the partnership boards shaped an innovative approach of matching community resources to individuals to offer wellbeing support (rather than just looking to meet care needs)

Co-producing plans and priorities means that Gloucestershire partners can spot opportunities and bid for funding supporting innovation.

Any identified challenges and how these were mitigated

Responses to shared objectives often result in very constrained solutions determined by narrow funding and organisational objectives and interests, and often restricted by accounting rules (the ability to carry forward budgets). Local authorities generally operated on a three year planning cycle (reflecting the Government's Spending Review period) whereas NHS organisations operate on an annual business plan cycle (reflecting priorities in the Annual NHS Plan).

Gloucestershire took a more progressive approach to how funding flowed across the partnership, building upon shared trust between organisations and accommodating the shorter-term goals of the NHS into more long-term objectives (informed in part by feedback from the partnership boards) through creative use of formal Section 256 Agreements.

Appendix F

Case study Hampshire County Council – integrated short services for older people

Hampshire County Council is aligned with two Integrated Care Systems, and until 2021 worked with five CCGs within its boundaries. Despite this complexity, Hampshire has pursued and developed strong collaborative approaches in planning and commissioning services to support local people and communities. Much of this progress was made during the pandemic (2020-22) – when systems came closer together with a defined shared purpose and budgets, but with the return to separate funding streams, this progress is being tested.

The national pandemic response placed a strong emphasis upon accelerated hospital transfers and local system leaders looked to rapidly develop innovative collaborative community-based solutions to manage this volume of transfers. Hampshire focused upon its short stay services (to include rehabilitation, intermediate care and step up /down services), and drawing upon flexible 'pandemic' funding streams and a permissive environment for rapid change over the course of 2020-22, developed new integrated services to support local people to be independent in their own communities. This collaborative approach has resulted in new models of care being offered to include discharge to assess beds within traditional nursing homes, and expansion of community-based services with much valued NHS and clinician support and endorsement. Over 5,000 older people were transferred from hospital to community settings over this period.

As Hampshire approaches Integrated Care System status, it is looking to consolidate upon collaborative progress made over the pandemic (2020-22) to include establishing formal Section 75 (S.75) Agreements for its newly formed integrated services and looking to the potential of S.75 in other areas of service. These agreements are being structured around sustaining shared commitment to long-term investment, shared objectives and plans and establishing a transparent and inclusive governance framework to further expand collaborative solutions and approaches.

Collaborative strategic relationships – Local system leaders offered support for front line and commissioning staff to work and to test new ideas together (based on examples from elsewhere and more expansive thinking). This approach included staff making new connections across organisations, positive risk management including new staffing structures and roles deputising (and therefore bringing front-line experience to strategic decisions and considerations) and importantly, holding a variety of regular multi-disciplinary cross-system weekly meetings (known as Community Partners). These online meetings helped to create a sense of shared ownership and transparency through regular unbiased dialogue around solving 'problems together' from front-line perspectives and seeing these challenges and opportunities through the lens of 'one system' working to improve outcomes for local people. This element of transparency allowed for robust dialogue between partners in managing risks and taking a more long-term system-wide perspective

Collaborative co-production of interventions and services – Key to Hampshire's approach was a focus upon working with a wide range of stakeholders to include local CCGs, Foundation Trusts, GPs, independent residential and homecare providers, social workers, in-house services, NHS and private therapy services, and community organisations as equal partners to develop and then commission integrated short stay services to support people to live independently. Further, the system also undertook a far- ranging extensive online survey of people who had experienced the short stay services in 2021 to inform development of these services going forwards. This approach included asking individuals "what worked and what didn't" and then incorporating this feedback and learning into improving services.

Whilst this experience required multiple discussions and interdependent agreements, the sense of a shared focus upon improved outcomes, regular and transparent dialogue, and a permissive environment for innovation and change released organisations and individuals to being even more proactive in seeking and encouraging meaningful co-production approaches, resulting in improved services and outcomes.

This focus on co-production is being extended as Hampshire moves forward as an Integrated Care System to include further structured surveys of local people and potential inclusion within emerging governance arrangements.

Collaborative sharing of both risks and successes – This sense of permissive collaboration was underpinned through a shared governance framework (built around an integrated care board for Hampshire) and consolidated through developing a model that could underpin a S.75 agreement for Short Term services, and potentially CHC services. These agreements are not yet signed but would offer legal assurances (to include shared risk frameworks) around risks and investments, built in governance frameworks and importantly, through the structure of S.75 agreements, support clinical engagement and commitment. This is often considered a significant risk to collaboration- where innovation is largely shaped around the social model of care and can be seen as potentially comprising clinical outcomes and perspectives.

Collaborative and creative allocation of resources – Pandemic funding (through 2020-22) offered local systems significant flexibility in how resources were deployed and shared. However, the return to more traditional approaches to grant funding and organisational budget targets is considered a risk to sustaining collaborative relationships and ways of working. Hampshire is looking to build upon well-established collaborative relationships through more formal agreements going forwards.

Any identified challenges and how these were mitigated

Keeping momentum and not going backwards: There is a real risk of systems reverting to 'tribal behaviours and cultures' in the post COVID environment as funding streams return to arrangements that were in place pre-2020 and additional COVID funding schemes end.

The (flexible) COVID funding arrangements allowed for less risk averse and more creative approaches to collaboration and Hampshire is looking to **consolidate upon these good relationships going forward** by establishing a S.75 Agreement across its partnership. This agreement is set to formalise how health and care systems continue to work together to include the sharing of risks and investments. This approach also compensates for the movement of staff in and out of the partnership and the risks to some relationships not being maintained as a consequence.

Appendix G

Glossary

The key features of strategic collaborative planning and commissioning are often open to different interpretations and hence different approaches. To help support health and care systems cohere around shared concepts, the following definitions are presented as the underlying foundations for collaborative approaches.

Commissioning

The UK Cabinet Office and the Commissioning Academy give the following explanation of commissioning: 'We 'commission' in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.'

Commissioning presents an opportunity for commissioners to work with partners, providers and people with lived experience to ensure that gaps in services are addressed and improved experiences and outcomes for individuals and communities are promoted.

Commissioning can take several forms:

- **strategic** involving the complete integration of the processes and governance of the member organisations (across the Integrated Care System)
- **place based** – covering all services with a certain place or for a group of people; this can involve virtual arrangements where activity is aligned but not under single management
- **operational** – can take place at system, team or locality level, or at the level of the individual accessing services and support.

Collaborative planning and commissioning

The UK Government defines collaborative commissioning as: "The government's vision for public services in the modern era is one of 'collaborative commissioning'. This means that in the future, local stakeholders will be involved in an equal and meaningful way in commissioning and all the resources of community, including but not confined to public funding, will be deployed to tackle the community's challenges. People will be trusted to co-design the services they use. Rather than being seen as a place of distinct policy priorities – health or crime or educational underachievement – a community will be seen as a 'system' of interconnected parts, each of which impacts the others.

Co-production

The Social Care Institute for Excellence (SCIE) notes that whilst there is no single formula for co-production, there are some key features that are present in co-production initiatives. They:

- define people who use services as assets with skills
- break down the barriers between people who use services and professionals
- build on people's existing capabilities
- include reciprocity (where people get something back for having done something for others) and mutuality (people working together to achieve their shared interests)
- work with peer and personal support networks alongside professional networks
- facilitate services by helping organisations to become agents for change rather than just being service providers.

Further reading

DHSC guidance Adult Social Care Principles for Integrated Care Partnerships

This guidance describes the principles supporting how integrated care partnerships and adult social care providers are expected to collaboratively work together.

DHSC draft guidance Health and Wellbeing Boards July 2022

This draft guidance for engagement sets out the role of health and wellbeing boards following publication of the Health and Care Act 2022 –to include its collaborative relationships with integrated care partnerships.

DHSC guidance Preparing Integrated Care Strategies July 2022

Guidance for integrated care partnerships on integrated care strategies to include co-production across local health and care systems.

NHSE guidance Working in Partnership with People and Communities July 2022

This guidance is for Integrated Care Boards. It supports effective collaborative partnership working with people and communities to improve services.

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