



COLLABORATIVE PROVIDERS: Delivering transformation in care and support for Scotland

By Annabel Davidson Knight and Fanny Olsson

collaborate
for social change

ABOUT THE PARTNERS

About Collaborate CIC

Collaborate CIC is a social consultancy that supports cross-sector collaboration in order to tackle complex social challenges. Issues such as rising inequality, multiple needs, devolution and fairer economic growth require collaborative responses. We create partnerships that get beyond traditional silos to deliver credible change on the ground.

We are values-led, not for profit and driven by a belief in the power of collaborative services as a force for social and economic progress. Our clients and partners span local government, NHS, charitable funders, civil society and the private sector.

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About CCPS

CCPS is the Coalition of Care and Support Providers in Scotland. It exists to identify, represent, promote and safeguard the interests of third sector and not-for-profit social care and support providers in Scotland, so that they can maximise the impact they have on meeting social need.

CCPS aims to:

- Champion quality care and support provided by the third sector.
- Challenge policy and practice that inhibits or undermines the sector's ability to provide quality care and support.
- Prepare providers for future challenges and opportunities.
- Support providers to understand, negotiate and influence the complex policy and practice environment in which they operate.

For more information, see www.ccpscotland.org



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Distress Brief Intervention
Dundee City Council
Dundee Health and Social Care Partnership
Dundee Voluntary Action
Fair Deal
Glasgow City Council
Glasgow City Health and Social Care Partnership
Greenock United Football Club
Gibbs Hill Community Centre
Healthcare Improvement Scotland (iHub)

Key
Penumbra
Scottish Government (Third Sector, Self-directed Support and Adult Social Care Reform divisions)
Scottish Recovery Network
Simon Community Scotland
Support for Ordinary Living
The Advisory Group
The Marie Trust
Turning Point Scotland

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ABOUT THIS REPORT

Social care as a whole is facing significant challenges. Demand is increasing, resources are reducing and people are looking for more choice and control over the support they use to live their lives. Against this we are working with systems, processes and sets of relationships that don't always encourage organisations and people to do their best work.

In our 2014¹ report Collaborate found that meeting these challenges could only be done through working better together- harnessing the resources and innovation of the whole system. The report called on the sector to move away from competition towards collaboration.

Changes to legislation and policy have very much set the scene for collaborative relationships between commissioners; providers; supported people and communities, but the challenge remains - how do we actually do it?

In Part 1 we present a story of voluntary sector providers of social care collaborating to focus on person-centred care and support. We call these 'Provider Collaborations' and in this report we present what we have learned about how these work; what difference they make; and the conditions required for them to flourish. In studying this diverse set of projects we found that successful collaborations both changed their own practice and influenced the context they were working in.

More specifically they:

- Put people front and centre of planning and (re)designing support.
- Provided an effective route to delivering on wider public service transformation goals.

However often collaborations are working against system and process conditions that need to be changed if we're going to realise the potential of collaborative care and support. The projects studied identified the following approaches to making conditions more receptive to collaboration:

- **Valuing lived experience:** investing in peer support; neutral local brokerage and other approaches that put people in charge of their support.
- **Using learning from collaborations in local strategy and service design:** make the most of the opportunity for mutual support and learning between collaborations and wider systems of services. Invest in practical support to help make this happen.
- **Redesign commissioning and procurement:** highlight and spread pockets of innovation in commissioning and procurement making use of flexibilities in the legislation to shift practice and processes that can support collaboration.
- **Support staff through culture change:** invest in the skills that help staff collaborate effectively, focussing on the cultures and behaviours that drive innovative or person-centred service design and delivery.
- **Create the right capabilities locally:** invest in growing skills locally so changes to public services are owned and driven by the community. Building skills in collaborative and systems leadership is key.

In part 2 we present a practical tool for organisations looking to work together better 'The Collaborative Providers Index.'

METHOD

To explore the questions of what makes for effective collaboration between providers we took the following approach.



For more detail on our methods see 39

Part 1:

THE PROVIDER COLLABORATIONS

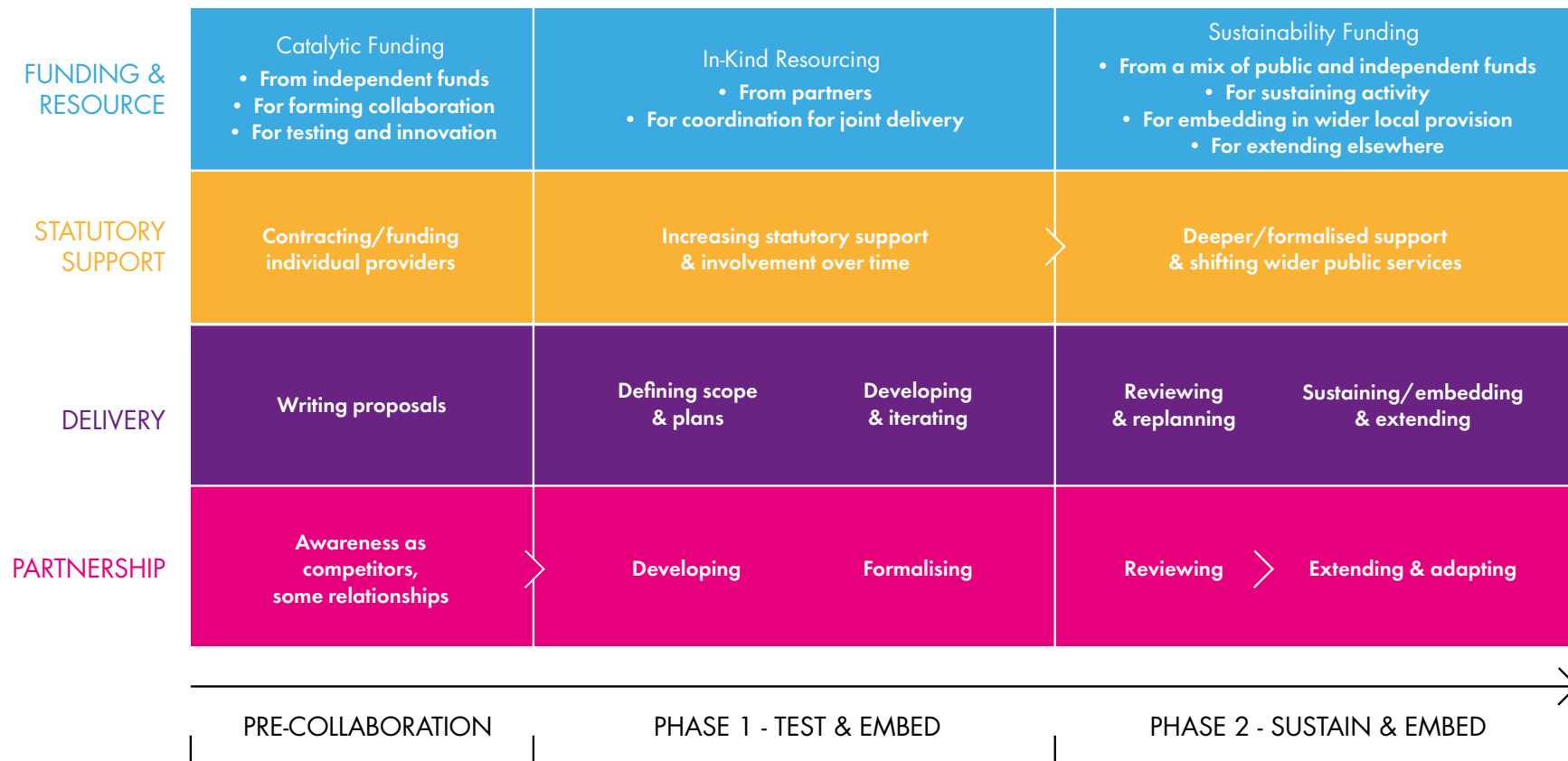
Through this project we worked with four Provider Collaborations delivering and facilitating vital care and support to people across Scotland. We sought a spread of models, localities, issues and partners to contribute as broad a perspective as possible. While there are many distinctions, a number of key features, strengths, challenges and principles emerged:

Common features of collaborations

- **Built on trusted relationships** – professional and personal relationships underpin collaborative efforts, both among staff and more personal relationships with supported people.
- **Strong shared vision, focused on people served** – coherence across partners as to ambitions, driven by central focus on best possible outcomes for people.
- **Aligned, not merged services and support** – partners within collaborations worked to make sure their supports and services were integrated and complementary while maintaining the distinct identity and offer of each partner.
- **Informal arrangements at outset** – some evolve towards more formal arrangements over time, but emphasised importance of keeping things loose initially and letting things develop over time.
- **Conscious broker into wider systems** – collaborations play an active role in strategic decision-making and planning fora, with some involving Statutory services as part of the partnership.
- **Share resource and in-kind support** – make better use of limited resources flexibly using assets. Much support was 'in kind' (i.e. not financial) but took the form of staff time etc.
- **Catalysed by independent funding** – crucial to the early development of collaboration, building relationships and testing ideas.

THE JOURNEY OF COLLABORATION

The diagram below illustrates some of the common milestones and phases observed in collaborative models, informed by our research with the four Provider Collaborations, and by our wider experience supporting practice and development of collaborative models of social change. It is not intended to be a precise representation of the journey for every collaboration; there are of course variations – for some, certain stages may be longer or shorter, or the involvement of statutory partners may be more or less embedded.



THE PROVIDER COLLABORATIONS

Inverclyde Connections

Inverclyde Connections was set up in 2015 with a focus on promoting creative use of people's social care budgets through a wide range of community-based alternatives and for people with disabilities. It is a collaborative project between several partners including The Advisory Group (TAG), KEY, Turning Point Scotland, Quarriers, the Inverclyde Health and Social Care Partnership (HSCP) and a range of community organisations (Greenock United, Community Centres, local college etc.).

The collaboration received funding from Scottish Government to support implementation of self-directed support as the mainstream approach to social care through a Community Connector model which seeks to connect and seed community-based activities to support people with learning disabilities. The aim is to increase awareness of self-directed support amongst the wider workforce and people with disabilities, to foster creative solutions to achieve the best outcomes for each person, as well as to explore how organisations and people can work together and utilise community resources more effectively.

Some of the activities undertaken include training for service users and carers to devise their support plans as well as training and some light touch mentoring for staff in partner organisations. It continues to focus on linking opportunities across a range of services and activities in Inverclyde and to help develop new opportunities for service users where they don't exist.

The project is collaborative in its design as well as delivery. It is managed by the Chairperson of TAG and KEY provide, HR, IT and payroll services (a portion has been included in the salary). Office space is provided by KEY, Turning Point Scotland and Inverclyde HSCP. The Steering group (Inverclyde

TAG) meets every two months to review the progress of the project. It is this group that set targets and agree milestones for the Community Worker. The group is made up of people with disabilities from across the collaboration. By having a lead partner (TAG) which is an independent non-provider and a service-user led organisation, the collaboration has been able to bring together providers without having to work with the politics of competition.

Making Recovery Real, Dundee

Making Recovery Real (MRR) brings public and third sector partners and Scottish Recovery Network (SRN) together with the intention of increasing the focus on recovery and improving the experience and outcomes for people living with mental health challenges. The work focuses on gathering and recording stories from people with lived experience to be shared with others, as well as training peer support workers to be embedded in mental health services locally.

In Dundee the Making Recovery Real, a non-commissioned initiative started as an initial expression of interest by seven organisations. At the beginning the partners invested a lot of time in developing the partnership before planning and deciding on what activities to undertake. Today the collaboration consists of eleven organisations including the council (CLD), NHS Tayside and a range of voluntary organisations, service providers (Penumbra, Richmond Fellowship, SAMH), lived experience led organisations and Dundee Voluntary Action.

SRN has contributed with resources in the form of staff time and some financial support for events materials and to bring people together. SRN has also supported key partners to secure some local funding in the beginning to support initial activities. There is now a part-time MRR project worker, employed by Dundee Voluntary Action, who undertakes specific activities and reports to the partners group. There are regular partner meetings which are chaired by Mental Health Networking coordinator with Dundee Voluntary Action.

Dundee Voluntary Action has a key role in the delivery of Making Recovery Real and its activities, and other partners are involved to varying extents in the activities of the initiative. This can include delivery of training, taking part in events, involvement in the planning and delivery of activities and events and supporting people using their services to participate in story sharing. Though the focus of collaboration is about empowering people to have a voice, they also work to target service redesign and to gain strategic influence.

City Ambition Network

CAN is a partnership of the Simon Community, Glasgow City Mission, The Marie Trust, Turning Point Scotland and Glasgow Health and Social Care Partnership. Their work is focused on helping some of the Glasgow's most vulnerable and excluded homeless people by working creatively to stick with people through the most challenging journeys. The Network was formed in 2015 with a common vision that no one in Glasgow should need to sleep rough. This meant finding ways of working with people who really struggled to accept the help that is on offer and just couldn't meet the expectations of services in Glasgow.

CAN uses a keyworker model, with staff drawn from across partner organisations working as a joint team to provide tailored support across a range of supports and services to adults with multiple and complex needs. To date the network has been able to support 37 people. A few of the third sector partners receive statutory funding, however the network itself does not, and is instead made possible by independent funders. The Oak Foundation has provided 3-year funding (March 2017 - 2020) which covers the coordinator's post, a new post of Bridgeworker as well as the costs of an evaluation. During the course of this funding the collaboration aims to work with 70 people.

The network is led by the third sector and they have a formal partnership agreement. Each of the 5 partners has its own distinct structures, operations and governance. Members of the five partner agencies are represented on the CAN Steering Group, CAN Operational Group and the CAN Keyworker Group. The Steering Group has agreed Terms of Reference and meet monthly. Their role is to oversee and take responsibility for the direction and management of the coordinated intervention. The Operational Group also meets monthly while the Keyworker Group meets every 2 weeks. The Operational Group includes a range of stakeholders to support the work of frontline staff, these are keyworkers for the 34 individuals who were identified from partner organisations. This group inclusion of the Council's Emergency Accommodation Coordinator and Homelessness Health Link worker brought a multi-disciplinary perspective to the front-line group.

This three-tier governance structure is an important feature of the network as it enabled rapid problem solving (thanks to frequency of meetings) particularly the coordinated frontline group which works as a team despite members all being from different organisations. The Steering Group and Operational Group focuses on responding and making possible what the frontline staff require to offer the best and most appropriate support.

Connecting Fair Deal and Support for Ordinary Living (SOL)

This is a newly formed collaboration between two charitable support providers, Fair Deal who are Glasgow based and SOL, operating in Central Scotland. The partners have devised a new approach to sleepover support for 4 people with complex needs, utilising SOL Connect technology in place of overnight staff support. Achieving successful outcomes for the partnership depends on the partners' passion and commitment to ensure staff teams and service offered are well integrated.

This approach involved supported people, their families, GCHSCP, Fair Deal staff and independent Advocacy to ensure that all views were heard. This included:

- Hosting a meeting involving the supported person, family, Fair Deal and SOL Connect staff and the GCHSCP representative
- Exploring concerns and fears
- Identifying solutions
- Trying out the equipment

- Setting up a trial period with SOL taking over the night time support
- Reviewing the statistics from the trial and updating support plans, risk assessments and
- Preparing for going live

The collaboration applied a thorough and robust process to identify creative solutions and achieve better outcomes for each of the 4 supported people, enabling them to explore how the organisations and staff might work together to minimise risk.

The outcome of the partnership to date has meant that the people involved have been able to spend time independently in their lives for the first time. It is hoped that this first step will give them the confidence to explore increased independence at other times of the day. The next steps for the partnership will be to offer this innovative approach to re-designing night time support to other provider organisations across Glasgow.

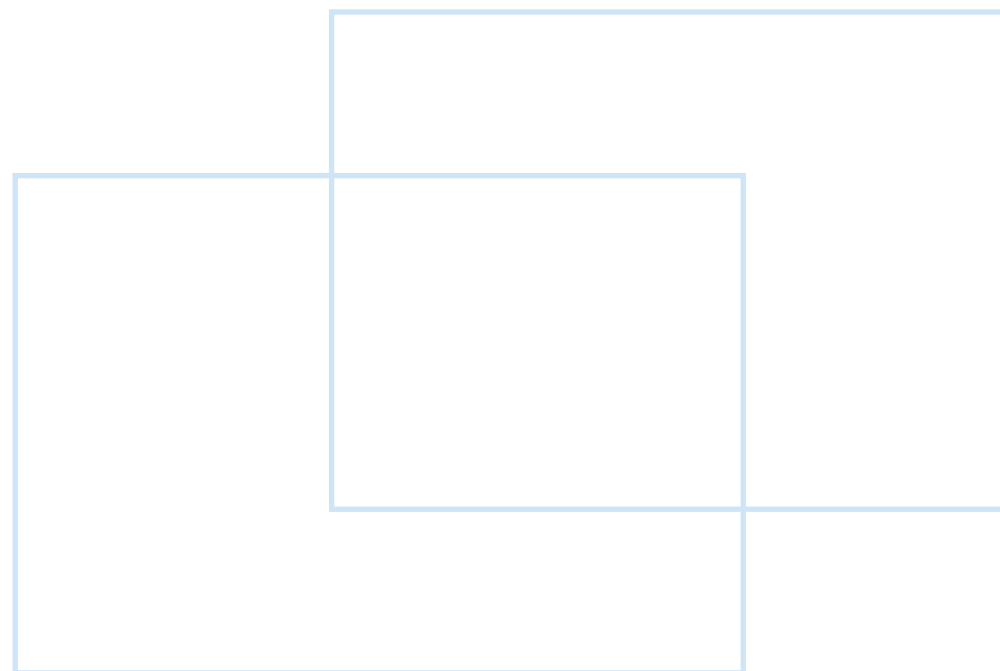
THE STATE OF COLLABORATION IN CARE AND SUPPORT

The care and support offered by third sector providers is critical to society – from support at points of crisis, to co-production of day to day activities that are fun and fulfilling. At a time when available resource is diminishing, and creative ways of managing well with less are sought by all, collaborative models of delivery offer an attractive alternative. While delivering efficiencies is of course key, it is improvements in the lives of people that must remain the core focus and driving principle of change and reform in services to the public. It is here, as our analysis indicates, that Provider Collaborations excel.

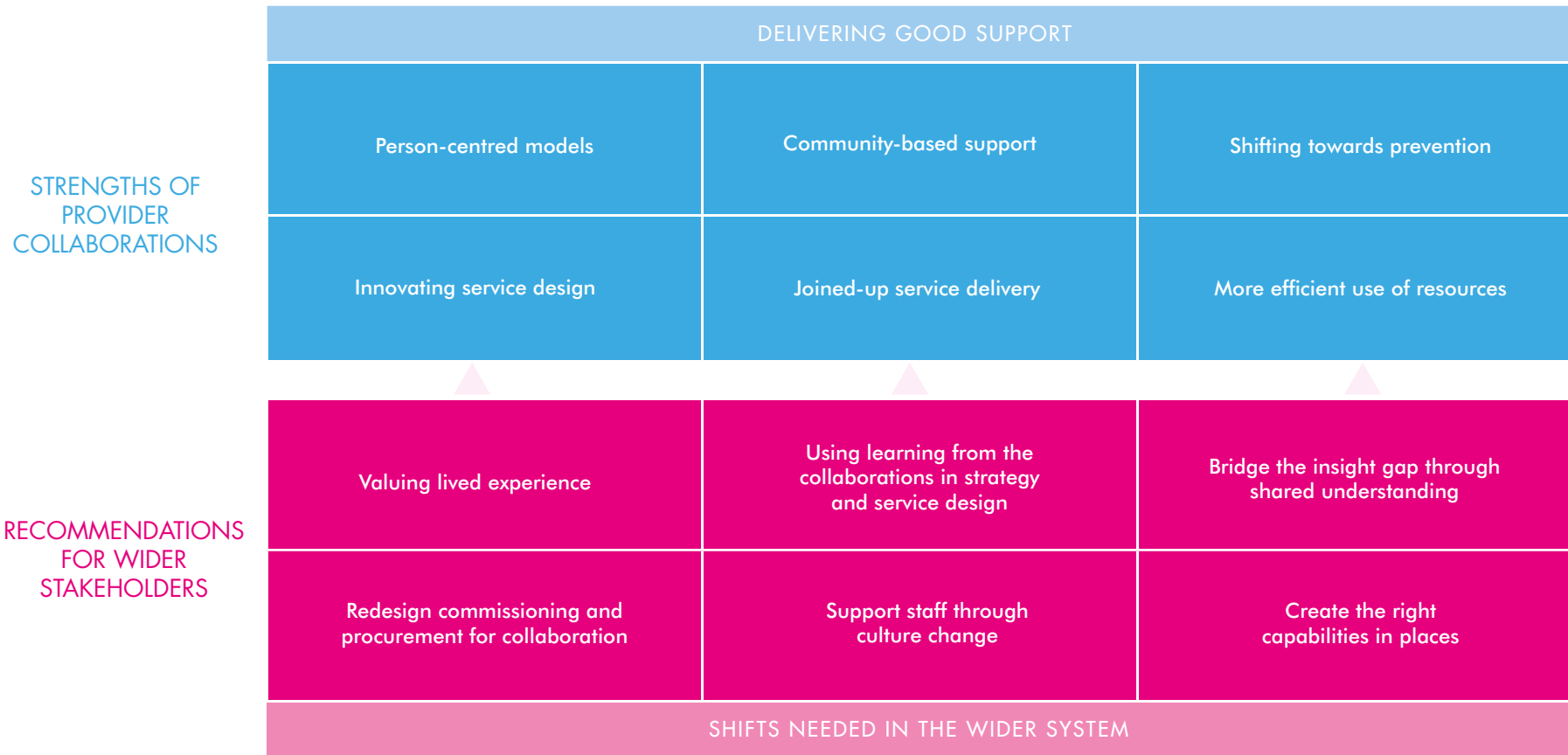
In section 1 below we outline how our research demonstrates how the Provider collaborations we studied are at one and the same time;

- successfully putting people front and centre of planning and redesigning services and support and
- providing an effective route to delivering on a wide range of public service transformation agendas (termed the “Scottish Approach”)

While this is true, there are too a number of key systems conditions which require further attention and investment if we are to realise the full potential of collaborative models of support in continuing to achieve these goals. These are explored in Section 2 within this chapter.



PROVIDER COLLABORATIONS



SECTION 1:

COLLABORATION IN PRACTICE

Person-centred models

"We set up with one vision in mind: to focus on the person - this is our purpose and vision."

Across the collaborations we spoke with, the feature that perhaps deserves greatest cause for celebration is how demonstrably person-centred the work is. Services and activities are designed around people's requests and needs in a way that only collaborative models of delivery can allow. This moves beyond selecting support from a list of registered providers, to greater choice in accessing a range of other forms of support or community activities from across partner organisations. It is the focus on the person that provides the basis for shared vision and collaborative working among partners.

A mix of co-production, the use of peer-support models, imaginative forms of engagement and 1-1 support provide the necessary insights to inform the work of the collaborations. Devolving decision-making to a well-coordinated frontline group allows support to be tailored to the person and underpins how the majority of collaborations deliver their work together.

"I think there is a real commitment now to embedding co-production at the heart of how we develop services. "

The impact on people accessing services and support is clear; a greater sense of agency, voice and happiness;

"There is real excitement among participants in having been part of the work"

"It's the first time I've been able to be open and honest about my experience and views ... Given me something that hadn't existed. I feel really empowered by that."

Community-based support

"Services aren't as important as people make them out to be – [they're] just one part of the jigsaw."

For two of the collaborations, there is an explicit focus to improve outcomes for people through broadening access to more community activities. This reduces use of formal and clinical services and support. It is clear there are a number of benefits for supported people. These include the opportunity to take part in activities never thought possible before as well as going to places where the person's condition does not define them. "where people can go; where they can be themselves and feel themselves".

"The Mum of one young guy said to me 'I said something tonight something I thought I would never say: "Frankie it's time for your football training.' "

The projects have increased connection with wider communities too, addressing stigma in natural, incremental ways;

"[It's] taken away stigma – the kids get to ask questions. They know Johnnie's a person, he knows them as his friends."

Shifting towards prevention

“These are folk that [before] would end up coming to a provider in moment of crisis”

Though each project is dealing with people facing different challenges and on quite different points in their respective journeys, all are providing some form of preventative support. This is either by diverting people away from crisis towards greater stability, or by working with people early on to build resilience for later challenges.

They do so by focusing variously on recovery, peer-support, community-based support and through more person-centred, tailored approaches (as above). Because of this, there is good alignment locally with local priorities and earlier strategies and some evidence these models are beginning to shift thinking and practice among local institutions.

“There’s more of a focus now on prevention, greater joining up, using Link workers, thinking about the role of primary care in putting in place good support... but it’s still in its infancy.”

Innovating service design

“[Before] services were expensive, unsustainable, not necessarily well attended...”

In every example, partners had chosen to work in collaboration to make significant changes to the support offered to the people they worked with. The collaborations are themselves examples of service innovation in action. Crucially, this is also leading to innovation in the core offer of participating organisations (outwith the work of the collaboration), and is seeding ideas for

new work together, extending their work to tackle different issues, or to new geographic areas.

An example in point is the Inverclyde Connections project which supports people with a range of Learning Disabilities and communication capabilities, who too often are not given the same opportunity as others to choose the support they receive. Partners in the project devised a pub quiz event run on a regular basis to identify activities people would like to access in the community, leading to the development of a project with local team Greenock United, among other community activities.

Partners are succeeding too in prompting innovation in wider services locally, some influencing local strategies and service redesign plans, with one having some impact on national policy.

An example of this is the City Ambition Network (CAN) who influenced the Scottish Government’s Homelessness and Rough Sleeping Action Group’s ³ approach to reducing rough sleeping during winter. The Action Group’s approach includes increasing multi-agency working; empowering frontline staff to do their work through giving them direct access to housing and other support services as well as making provision more flexible (particularly for people who are not able/willing to use night shelters).

Working in collaboration, having the opportunity to share ideas and insights and co-create solutions is a powerful prompt for innovation. Contrary to the dominant narrative, competition does not necessarily drive innovation.

Joined-up service delivery

The models studied are all third-sector initiated and still in the main led by third sector partners. Rather than integration of services, they are explicitly aligning existing activities and playing to specific strengths. This thereby retains the rich diversity on offer to maximise choice while reducing duplication and unnecessary competition. By working in partnership and providing discrete projects to test new approaches, over time, most have helped to improve joint working in statutory provision too, supporting wider integration priorities for Health and Social Care locally (though there are challenges here).

More efficient use of resources

A key benefit of collaborative models of delivery is greater efficiency and creativity in the use of resource at a time when it is becoming ever scarcer. Though it does not trump the drive to collaborate to improve outcomes for people, the incentive to find better ways by working together to manage reducing funds and assets is clear. All of the collaborations demonstrate a flexible and practical approach to resources needed to deliver the work, with a good deal contributed in-kind by partners (if not always equitably across all). Most had secured funding to provide a shared resource in the shape of a dedicated member of staff, taking a pragmatic approach to which organisation holds the funds and line manages the staff. Independent funding is clearly a critical catalyst, providing space to build relationships and test ideas which would not be possible without this crucial resource. Some felt it would not be possible to commission such activity through mainstream processes.



SECTION 2:

CHANGING THE SYSTEM

There is a good deal to celebrate in the collaborative care space in Scotland. There is an increasingly supportive political vision and legislation, a strong history of community action and mutual support and a skilled care and support sector with a range of professional and co-production expertise to bring.

The building blocks are there but moving whole systems of support from being service and institution driven to a more collaborative, person-centred way of working is no mean feat. The operational and process challenges are difficult, time consuming and require considerable energy and focus to get right. The cultural and behavioural challenges are also considerable but are often deprioritised as people grapple with the technical issues.

Below we begin to chart the next stage in the journey towards this new way of working, outlining the challenges we witnessed which continue to hamper progress. Later on, we suggest a series of actions to respond to these challenges. Get these points right, and the conditions for delivering on the vision of person-led collaborative care and support will be strengthened.

Valuing Lived Experience

What works:

In the main the collaborations we spoke with are having real success in amplifying the voice of the people they work with to shape support and begin to influence services locally. A core delivery strand of the work of Making Recovery Real Dundee has been the collection of personal stories of recovery from those with lived experience of mental health issues; this method has provided a powerful platform for people to share their perspectives on what matters to them and reflections on services received. Schemes have used film

and social media to share the perspectives of people with lived experience more widely, both to advertise their work and broaden awareness of both professionals and the public alike.

“Through [this collaboration] we’ve exposed fantastic assets in the city in people with lived experience. [This was previously] hugely under-utilised.”

Needs work:

Too often however, people in receipt of services feel their views hold less weight than those of professionals, particularly those in formal services. They still struggle to gain real choice and feel there is “still very much a them and us mentality” predominating.

“People are having to shout to get what they want; most people don’t know their options or don’t have the skills to ‘shout loud enough’ ”

This is true too of peer workers who “are often not really given ‘professional’ gravitas – they’re seen as an add on. There’s a long way to go.”

In some collaborations, partners were concerned about the risk this posed to those they support. The work delivered by these collaborations feels fundamentally different to people and raises aspirations on what the future might hold for them and the support they receive. It invites people to share sometimes very personal accounts of their experiences, of service failure and more, and collaborations were acutely aware of the need to support people to share stories safely, and the critical importance of things visibly changing in response. If services fail to meet these aspirations or let them down in some other way, partners worry this could have a particularly negative impact, and staff were working hard to mitigate against this risk.

Another case in point is the implementation of Self-directed Support. The 2013 legislation aimed to make Self-directed Support the mainstream approach to social care through giving supported people more choice and control over their support. However local authorities are struggling to make this a reality.⁴ This was reflected in our research with supported people and often staff too not understanding what this means for them. We heard concerns that there remains fundamental misunderstanding about people's rights to choose between the four options - which is a requirement on authorities, not something they can choose to offer or not.⁵

"I've been at meetings where families have asked about SDS and Council have said 'No, we're doing this for you instead.'"

Using learning from the collaborations in strategy and service design

What works:

We can see that Provider Collaborations clearly align with a number of key priorities for Local Authorities and Health and Social Care Partnerships. Local statutory partners have varying degrees of involvement across the models, in one case as named partners in a formal agreement, but all receive some level of support and in all examples, collaborations felt that engagement with statutory partners had improved during the life of their work. Connections and relationships among staff from across statutory and third sectors are being strengthened too through contribution to partnership activities. A number of those we spoke with felt the advent of integration brought with it a culture more supportive of person-centred and collaborative approaches. In Dundee, a number of partners in the Making Recovery Real project were optimistic about the changes brought by Health and Social Care integration for the future of Community Mental Health. The focus on prevention and population health, on the importance of public and third sector collaboration and changes to Locality Managers remit which have become broader were all felt to be supportive of the aims of their work.

"We're moving towards working that way, [there's a] big need for partnership working – we need to get our act together. It's hard – the council is an institution, runs a certain way."

Needs work:

While the direction of travel was felt to be broadly positive, there remain some significant issues in how the work of collaborations is supported or otherwise by local statutory partners. Progress remains slow in embedding co-production and more person-centred services and support, and there was a strong sense that local authority and NHS staff were struggling with the internal processes and technical challenges of sizeable service transformation, leaving them little time for anything else.

On the whole we heard there were challenges in engaging Health partners, particularly in-patient services where risk-averse behaviours were creating barriers to progress for some activities. This was often exacerbated by inconsistent involvement from statutory partners or over reliance on a small number of key champions, without which support from the wider organisation would be impossible. Obtaining support from key decisionmakers was also difficult for some as those involved “don’t have power to bring about change – others who do have been inconsistent in their involvement”.

“Statutory views and commitment vary depending on who is involved and how personally committed they are.”

While collaborations were generally well aligned to local statutory priorities there was a sense that the work delivered by these collaborations was still viewed of peripheral importance and with limited influence. Some referred to the implicit power imbalance at play between public and third sector partners, particularly where the latter are in receipt of statutory funding. There were clearly fears of challenging established practice, within the NHS in particular. Some reported instances where formal complaints had been made by statutory services about the impact of new ways of working introduced by the collaboration. “NHS and Council ‘knocking on door’ to ask about peer support, but not shifting the core model, rather an add on ‘as it’s cheap’.”

Use evidence with shared purpose

Works well:

Evidence and data provide essential insights for those delivering support; building understanding of shifting outcomes for supported people and groups; and creating a picture of how services are being used across systems. All of this contributes critical learning to help shape practice and respond to individual need. The potential of data and insight shared across partners and the wider system (that is, the whole system of support in the locality including formal services through to community activities) has the power to drive improvements in a coordinated way ⁶. Three of the four projects were not yet using data and evidence as effectively as they could. City Ambition Network has a coordinated frontline team which has developed data and insight sharing related to supported people to help in planning the appropriate response. Though this has been effective, there remain challenges in accessing data on people from different service departments with no formal data sharing agreements in place. There are legitimate concerns around access to personal data, and the recent GDPR legislation has only raised fear of risk in this arena.

Needs work:

More widely, the practice of sharing data and evidence across partners, and particularly across public and third sector partners to inform service design on an ongoing basis, is not standard practice. Our previous work ⁷ has shown there is a fundamental misalignment on the value and purpose of evidence across commissioners/funders and providers, particularly those working in the third sector. This is driving sub-optimal use of evidence and makes effective sharing of data and insights high impossible.

The collaborations we spoke with placed high value on the perspective of people they worked with in shaping their practice. Decision-makers in public agencies, commissioners and funders however, often placed a higher value on forms of ‘hard’ evidence or reaching pre-defined ‘time-and-task’ targets. Furthermore, there was felt to be a hierarchy of evidence at play:

“The Clinician may say they notice reduction in symptoms, but it may not feel that way to the person - but that is the evidence used.”

Redesign commissioning and procurement for collaboration

What works:

A number spoke of innovation in commissioning within their localities with some areas exploring collaborative commissioning models in related service areas (and making good progress). In one area, there had been success in a collaboration between commissioners, providers and contract staff in developing a joint approach to commissioning care and housing packages for people being discharged from hospital;

"This avoided going to tender for 10 out of 14 (of support packages). [That's a] massive leap forward."

For all collaborations there was, in principle, good support and an understanding of the value of collaborative forms of delivery from at least some commissioning staff.

In our workshop with the projects, there was tentative optimism about possible changes to commissioning and procurement to offer better support to person-centred, collaborative models.

Needs works:

Nonetheless, it was felt the wider environment of commissioning and procurement practice does not encourage collaboration. Standard commissioning and particularly contracting and procurement processes are still driven by the principle of competition, creating perverse incentives and practical barriers for partners (for example, partnerships being disrupted by some parties not making it onto Council Framework agreements).

The long-held principle of competition within service procurement, with its attendant focus on neutrality and fairness relies on ostensibly objective processes to guide decision-making. All four collaborations identified that this can have the unintended consequence of removing commissioning and procurement staff from the realities of service provision and the effects of their decision-making. In an attempt to make the system 'fair' we have processes that don't encourage joined up models where person-centred support is the goal.

Wider policy and legislation encourage (and sometimes mandate) co-ordination and integration. Statutory partners are beginning to recognise the value of collaboration among providers but are not necessarily using procurement approaches that encourage this:

"Partnerships [are] often forced by commissioning tenders. If you didn't know about the ITT before it is online, you won't get it. If you haven't built a relationship with organisations before the tender comes out, [it's] not going to be a good partnership."

Support staff through culture change

Works well:

Moving towards person-centred, collaborative forms of support represents a significant change for services to the public and challenges staff to adapt. Collaborations are supporting improvements in staff capabilities in person-centred models, and better collaborative ways of working. These bring awareness of the range of other services and activities in their place supporting better signposting and coordination. This is having a positive impact on staff within the collaboration as well as some impact on wider public sector staff in the locality.

The sense of enjoyment and personal fulfilment staff gain from the new way of working brought by the collaboration cannot be overstated. This is an essential factor in supporting staff with change and the associated risks and losses. In terms of a sector struggling with recruitment it provides a potential route to better staff retention:

"[for the] individuals involved [it] has really motivated them; 'it's better than any CPD I've ever had'. [They] feel very positive, feel change is possible."

"Their worker said being involved in [the collaboration] had made her more ambitious, to try things differently, bravery to do this."

"We trust our staff! Collective risk management is shaped around the individual. The difference is we're willing to engage with risk rather than deny it or use it as a reason not to work with somebody."

This has required training in new models/approaches which have supported staff to work more collaboratively. These include a focus on person-centred support with delegated budget control (CAN) and the embedding of peer support models (MRR, Dundee)

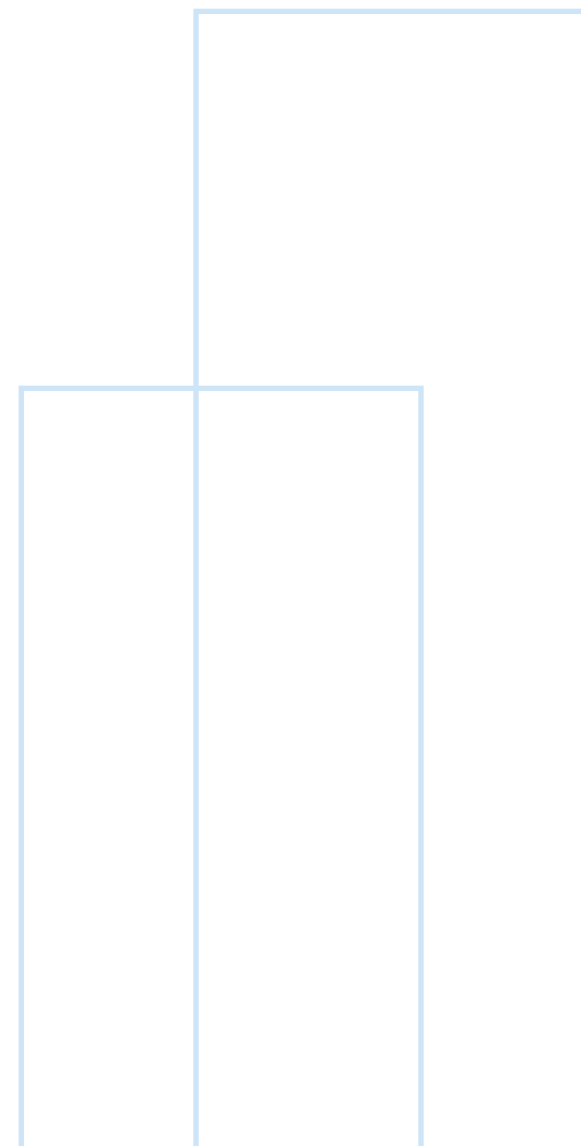
Needs work:

Nonetheless, the change in behaviours and cultures required to deliver person-centred, collaborative models of support is a key challenge for the future of social care. For individual staff members working in any organisation or sector, the change to their role, remit, professional expertise and sense of purpose needs careful support.

Further work needs to focus on supporting staff to work effectively with risk. It was clear from collaborations that some environments (e.g. in-patient services) encouraged risk averse behaviours. Disentangling perceived from actual risk and working comfortably with this in general is challenging- particularly for frontline staff.

Some collaborations noted that efforts should be focused on middle managers as they carry much of the weight of accountability and risk 'management' within organisations.

There was broad consensus that support to the workforce through training and continuous professional development requires a greater focus on developing behaviours and culture to sustain person-centred, collaborative work (over the technical implications).



FUTURE PRIORITIES

The research indicates we already have the foundations for a new, more collaborative way of working to deliver improved support to people. Provider collaborations are an important part of the mix, testing and demonstrating models which better deliver on the promise of more preventative, coordinated, person-centred approaches. For their value to be realised and to ensure the wholesale shift required across the wider system of social care and support, a series of actions are needed which draw on the talents and resources of many stakeholders.

ONE:

Valuing Lived Experience

The policy and practice space is well populated with efforts to improve agency, power and choice among citizens and communities in the services and support they receive, the Community Empowerment Act and related community planning requirements; the emphasis on co-production across service design and the advent of Self-directed Support are just some.

Realigning operational structures and organisational culture to put people's choice ahead of service logic however marks a fundamental shift in the role and purpose of public services and is far from easy to achieve.

While there is a range of good support, resource and legislation pushing for people to have more influence over their supports and services, the partners we spoke with felt there is still some way to go. Co-production and community choice still too often end up as peripheral activities, with core services and delivery models unchanged.

In Dundee, the Making Recovery Real project has focused on training a new cohort of peer support workers and has had early success with a team of Mental Health Officers through a co-design project considering the service's

response to the new Mental Health Strategy, opportunities to improve and ensure people's voice is front and centre of any changes. Organisations and initiatives which are user-led, like TAG Inverclyde, offer another valuable resource.

Learning from the Provider Collaborations, we suggest:

- + **Maximising potential for peer-support roles in public services** – planning for future workforce requirements and undertaking service redesign offer opportunities to think about embedding more paid peer-support roles within teams.
- + **Drawing more on user-led organisations** – not only for consultation and service redesign, but wider strategic planning too.
- + **Continue to embed choice and control in social work and social care.** Investing in local, collaborative facilitation to make Self-directed Support the mainstream approach to social care in practice.

TWO:

Using learning from Provider Collaborations in local strategy and service design

In many ways, Provider Collaborations are their own self-contained service innovations, testing in cost-efficient ways many of the tricky technical and cultural challenges facing wider Health and Social Care Partnerships. Key challenges include integrating workforces; finding ways to both tailor support and make it a reality; bringing different working cultures together; skill sharing; and aligning resources. For those leading strategy development or service design, local collaborations offer somewhere to test ideas and collect context-specific learning about how change works in practice. Because of their very nature and structure, collaborations offer a valuable insight into the health of the wider system, what is and isn't working in service delivery, leadership, culture and behaviour.

In nearly all of the collaborations, partners are playing an active role on partnership groups and boards affecting services in their local area; some too are receiving high-level support from local public services for their collaborative ventures. City Ambition Network, for example, has representation from the Glasgow Health and Social Care Partnership on their Governance Group and the support of their Chief Officer among other senior statutory leaders. This has been of significant support for their work in Glasgow and had an impact on wider services in the area.

Learning from these examples in other areas might look to:

- + **Reciprocate involvement with Provider Collaborations** – ensuring they are involved in key decision-making for a locality (e.g. involvement in UJB Strategic Planning Groups) and as far as possible receive consistency of support from senior decision makers in public services.
- + **Involve collaborations in service redesign and strategy development** – drawing on their 'systems insights' early in the process; particular opportunities highlighted by projects included the Carers Act and implementation of the Mental Health Strategy. As one interviewee put it, *"[we] need to get ahead of market driving forces of commissioning and procurement and build collaborative forms of service redesign ahead of re - contracting."*
- + **Provide resource for collaborations to strengthen practice** – making funds available to existing and developing collaborations to access bespoke support to help them work through challenges and strengthen their models would provide essential backbone support, without which these models could fall by the wayside.

THREE:

Bridge the 'insight gap' through shared understanding

In other publications⁸ Collaborate argued that the culture of New Performance Management has led to the widely-held assumption that the purpose of measurement is to demonstrate the delivery of targets and fails to support real learning and improvement. Many organisations we have engaged with delivering social support – in this and other projects – admit the prime (or only) reason they measure anything is to report to (often multiple) funders and commissioners. They argue that these requirements are so time consuming they have no time left to gather or use evidence for their own purposes of learning and improving what they do. Collaborations we spoke with felt there to be a considerable misalignment of perspective on the value and purpose of evidence and 'what good looks like' between those devising and funding initiatives and those delivering them; this in itself was felt to be creating barriers to effective use of evidence and data.

At our co-design workshop with the four collaborations, there were lengthy discussions on ways to make the most of shared data to drive collaborative models of change. Collaborations discussed the challenges of balancing different evidence forms; understanding and clarifying evidence 'value' and having a more honest conversation about the purpose of measurement.

Some of the ideas suggested by the collaborations include;

- + **For Provider Collaborations** – create the space to consider the purpose and value of measurement and how to improve practice to support learning and improvement through sharing insights and data across partners in a collaboration. This includes more time spent together on learning through workshops, training and using internal communications creatively. Opportunities for different collaborations to come together to learn from one another's practice were also desired.
- + **For Provider Collaborations and supporting partners/funders** – opening up the debate on measurement and learning with honesty and respect, creating a safe space for scrutiny of evidence for new and existing service delivery; building shared data agreements from this solid grounding and understanding.
- + **For funders, commissioners and other statutory partners** this might mean simplifying reporting requirements or enabling funded organisation(s) to take the lead in defining outcomes.⁹

FOUR:

Redesign commissioning and procurement for collaboration

The Christie Commission report set the course for public service reform across Scotland and the foundations for strategy and policy development. There has since been some important progress including of Public Social Partnerships,¹⁰ reforms to procurement legislation¹¹ alongside a number of initiatives including CCPS' *Coping with Complexity*¹² programme for commissioners and providers; and the emergence of organisations like LH Alliances providing technical support on alternative procurement processes.

Recognition that a new approach to funding and commissioning across the board is needed is gaining increasing traction.¹³ For Provider Collaborations, we learnt that there are promising pockets of innovation in commissioning and procurement but that there remain significant procedural barriers to collaborative working - particularly the use of framework agreements.

Those we spoke with felt there was a need for investment in translating innovations across the system, including through developing the skills of professionals working in commissioning, procurement and legal services.

Ideas from our discussions with the collaborations include:

- + **Maximising potential for peer-support roles in public services** – planning for future workforce requirements and undertaking service redesign offer opportunities to think about embedding more paid peer-support roles within teams.
- + **Training and learning for commissioners** – to both improve insight into the perspective of people accessing support, as well as provide space to learn and trial new ways of approaching commissioning, procurement and legal services. A new 'Collaborative Commissioning Academy', where the focus is on action learning and technical support provided to professionals working through changes to their commissioning practice, is just one idea.
- + **Investment to upskill advisors** in alliancing and collaborative commissioning processes, who can support local areas in designing, testing and implementing new systems and approaches with skills to involve local communities in the process.

FIVE:

Support staff through culture change

It is well accepted that the move towards more collaborative forms of delivery centred around people's needs and aspirations (rather than organisational logic) requires a significant shake up of delivery models. We have seen in our practice that in order to deliver more personalised, flexible support, this often means staff are required to call on new skills, work outwith their organisational boundaries and increasingly put their professional expertise to one side in order to meet the person where they are. There are fears that with new approaches and skills (collaboration, co-production...) increasing in value, others will be devalued, particularly the professional expertise which forms a strong part of individual identity. The challenge is particularly prominent in public sector teams and while there is a wealth of training offered for professional development across the sector, still not enough is dedicated to developing collaborative working practices. As one interviewee notes, *"Change from command and control to systemic/non-positional leadership very difficult for local authority staff."*

In many areas collaborations reported that training for staff is increasingly delivered cross-departmentally and cross-sectorally on a range of subjects, following through on one of the original Christie Commission recommendations. This was felt to improve connections between staff across

organisations and represented a step in the right direction. Nonetheless, wider professional development, including line management and appraisal processes, could benefit from focusing more on the cultural and behavioural change required among staff, to ensure they are held and supported through this significant shift to working practice.

Delivering this support with care might entail:

- + **Maximising potential for peer-support roles in public services** – planning for future workforce requirements and undertaking service redesign offer opportunities to think about embedding more paid peer-support roles within teams.
- + **Placing greater value in professional development and appraisal processes** on collaborative behaviours and coproduction skills, drawing inspiration from the Collective Leadership programme¹⁴ led by Workforce Scotland.
- + **Ensuring line managers are well equipped to support staff 1-1**, trained in collaborative and person-centred approaches, and with skills to support staff in safe, non-judgemental space.

SIX:

Create the right capabilities in places

Third sector providers over the many years of framework agreements and contracts have come to view one another as competitors rather than potential collaborators. This represents a key stumbling block in delivering on the vision of joined-up, person-centred delivery of services and often a 'neutral bridge', an independent party is needed to bring people around the table. In Inverclyde, The Advisory Group (TAG) was well-placed to play that role, and crucially has the depth of understanding of the needs and desires of the people receiving support;

"As TAG wasn't a support provider we found it easy to make contact with other providers – we weren't a threat. We were able to act as catalyst to get those organisations working together".

Our research has pointed to concerns around the capacity in local areas for facilitating coordinated and collaborative transformation to public services. At present a range of national agencies and consultancies – from the Improvement Service, What Works Scotland to large consultancies and freelancers – provide support and facilitation of transformation agendas. There is however a need for greater capability among local players for brokering across strategic leaders to ensure joined up service redesign, while connecting this directly to co-production and the voice of people in receipt of services. This

requires a range of specialist skills, some of which need external input. To hold the thread on long-term change however needs local ownership. Any external support – by national organisations and agencies or external consultancies – must increasingly have a strong focus on embedding skills locally for the long term.

What's needed now:

- + **Build better insight into effective 'transformation brokers'** – a discrete piece of research is needed to uncover the value and impact of different forms of facilitative organisations who are helping places through public sector transformation. What impact are they having? How do they maintain independence in the conversation? How is local ownership best achieved?
- + **Support for existing 'transformation brokers'** – small pots of funding to support independent local brokers who are already acting as a 'neutral bridge' across sectoral and organisational barriers to facilitate person-centred service change.

WHERE NEXT?

The story told here is one of real promise: recognition across the board of the need for new ways of delivering support; ever improving relationships between public and third sector staff, communities and individuals; and grit and determination among a wide set of stakeholders to work through tricky technical and cultural barriers to drive change. A recurring theme in our conversations was one of a common-sense approach – a solid focus on improving outcomes for people being the *only thing that matters* and the reason for collaborating in the first place. It was this point that helped partners cut through the complexity at play (in people's lives, the services they access, and wider systems of support), providing clarity of purpose and action in an environment which can feel overcomplicated by requirements to monitor the numerous targets.

The success of the collaborations described here relies on a formidable mix of staying power, ingenuity, hard-earned trust and unshakable vision. We are already witnessing the value such models produce – and receive – by connecting in with wider stakeholders: local public sector strategy and service design, local community facilities, national policy and more. The challenge now is to help the emergence of more such models across the country, and to continue to support and deepen the impact of established Provider Collaborations. In the coming months we will look for opportunities to develop the calls to action described above – to continue to support and deepen the invaluable work of Provider Collaborations, and to improve the wider system conditions that can help them realise the vision of person-centred, coordinated support.

We are pleased to be able to prototype bespoke support to up to two of the collaborations presented in this research over the next few months and will use that learning to help devise greater clarity in the forms of support needed by the sector – results of which will be published in Autumn 2018.

Part 2:

THE COLLABORATIVE PROVIDERS INDEX

Introducing the index

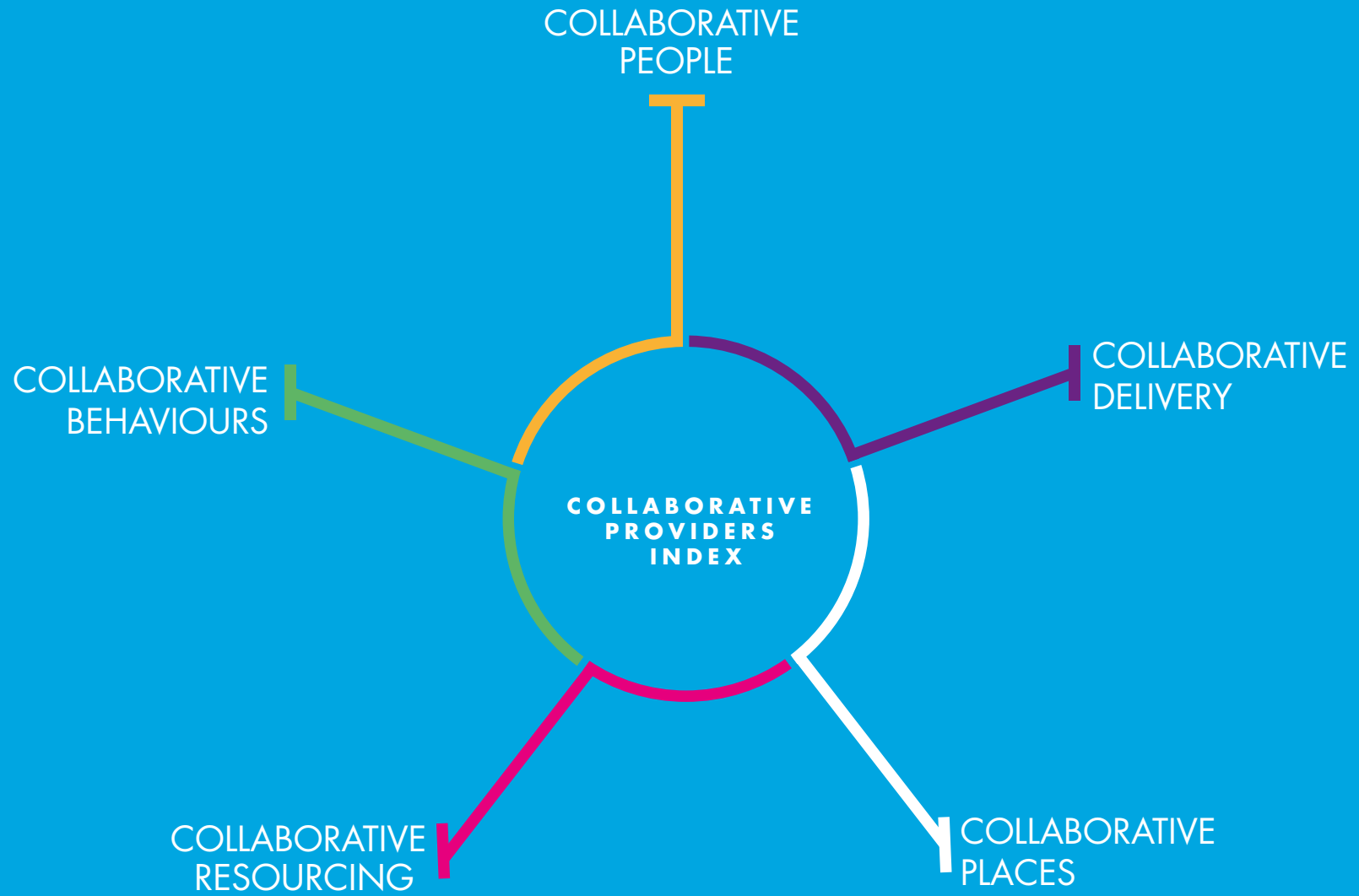
The aim of the index is to guide provider collaborations (and the people who work in them) in analysing and strengthening their collaborative efforts to help them thrive in a complex operating environment and provide better services.

The Collaborative Providers Index has been adapted from our earlier Collaboration Readiness Index, deriving insights from our in-depth research with provider collaborations delivering a range of care and support across Scotland.

The index is designed to support collaborations of providers, particularly those in the third sector. While the primary audience is provider collaborations, it is intended to be instructive for Commissioners, Service Managers, Senior Leaders and others with responsibility for delivering social care support across public and third sectors.

The index comprises five categories which our research suggests are essential considerations for those delivering or looking to develop collaborations. Within each category there are a number of guiding principles which we saw had been catalytic in helping collaborations realise their aspirations. An Index tool with accompanying questions can be found at the end of this section and is offered to help collaborations assess their own approach to these considerations and, once established, their progress against these markers.

In introducing the Index below, we reflect on learning from our research with Provider Collaborations on the benefits and challenges of delivering to these principles through collaborative models.



THE CATEGORIES:

1. People

This category focuses on the impact of the collaboration on the people using their services by offering real choice, power and influence for the citizen in the services available to them. Also of importance is how well the culture and behaviour of co-production is embedded in the DNA of the collaboration, from leaders to frontline, with support and training for staff in skills which enable genuine co-production and choice in the services offered.

The extent to which the collaboration has a positive impact on citizens demonstrating;

- + Citizen agency
- + Embedded co-production

Benefits to people...

- **Enabling a more person-centred approach** – a fundamental feature in provider collaborations (people ahead of service and organisational priorities delivered through:
 - + Peer support
 - + Supporting voice and the power of storytelling
 - + Tailoring support, by empowering frontline staff to flex offer
- **An imaginative approach to engagement** – through unusual communication, consultation and co-production activities.

Benefits to staff...

- **Improvements in staff capabilities and knowledge** – by learning from other partners and sharing ideas, including skills such as:
 - + Co-design and service user engagement
 - + Community-based support
 - + Peer support
 - + Recovery
- **Enabling equitable relationships between staff and people** – providing the opportunity for a new sense of enjoyment and fulfilment and real friendships.

Challenges

- **Fear of change** – for staff, for families/carers of risks associated with moving away from recognised, formal support.
- **Differences in engagement skills across services** – collaborations support development of skills among partner organisations, but harder to influence staff outside the collaboration (for example among public service professionals) causing discontinuity for supported people.
- **Voice of supported people not always well-recognised by formal services** – causing misalignment across provision.

2. Delivery

This is about understanding the importance of clear, shared vision and outcomes within the collaboration, which is supported by an ability to use insights to innovate the service offer and a willingness to take risks and try new approaches, while ensuring accountability is evenly felt across partners. The ways in which the collaboration aligns its work around core functions (governance, workforce, communications and engagement, and data and insight) taking into account these principles is explored here.

Benefits

- **Creates greater coherence across service offer** – driven by common vision and outcomes among partners.
- **More space to take risks together** – underpinned by healthy attitude and collective bravery offered by working in collaboration.
- **Greater innovation and enriched service offer** – within partner and collaboration activities, and in seeding new, jointly devised initiatives.
- **Empowered frontline and enabling leadership underpins good practice** – as a good model for governance and delivery of collaborative models.

The extent to which the collaboration successfully delivers its work through;

- + Shared vision and outcomes
- + Healthy attitude to risk and accountability
- + Understanding demand to shape service offer

Which are reflected in aligning delivery of its functions;

- + Governance
- + Workforce
- + Communications and engagement
- + Data and insight

Challenges

- **Risk of not delivering to people's expectations** – fears of sustaining beneficial impact of new approaches, with wider adoption outwith collaboration's control.
- **Misalignment in attitudes to risk with wider, formal services** – creating barriers to progress.
- **Sharing of data and insights across organisational boundaries problematic** – with misalignment on view between third sector and funders/ commissioners on what constitutes good evidence; and problems in accessing data.
- **Uneven contribution across partners not uncommon.**

3. Places

This category is about understanding the ability of the collaboration to support place-based models of integrated and preventative health and social care which involve public and third sector stakeholders and communities, and how far local decisionmakers are supportive of the collaboration's work. The extent to which local strategic priorities and wider service context impacts on the collaboration and the level of influence the collaboration has on these is considered here.

Benefits

- **Collaboration provides greater knowledge of the local ecosystem and opportunities to move people towards preventative activity** – partners have a wider range of support to signpost people from primary prevention to acute services.
- **Collective impact of collaboration influences local priorities** – often through bottom-up demonstration of impact, shifting services and strategy development.
- **Good alignment with public sector priorities (integration, prevention, person-centred, efficiency)** – so in principle support for collaboration is often strong from public service partners.

Understanding the wider context of (services to the public in) the place, how well the collaboration is helping to shape service design, and is in turn supported in its work by local decisionmakers;

- + Influencing strategy and service design
- + Shifting towards prevention
- + Supporting (Health & Social Care) integration

Challenges

- **Health and Social Care Integration taking time and energy** – diverting focus away from other things and progress is slow.
- **Commitment from public service partners can be inconsistent** – requires different input from traditional provider/commissioner relationship; not always the same people attending meetings, or with the power to make decisions.
- **SDS implementation and uptake still slow** – Councils still struggling to implement and the promise of greater choice for individuals not yet realised.

4. Resourcing

This category explores how well provider collaborations are supported by commissioning and procurement practice and wider independent funding, and the extent to which collaborations are able to influence commissioning and funding practice. It is also concerned with how the collaboration is able to effectively use the resources (financial and non-financial) at their disposal most effectively, including in-kind support, use of staff time and physical assets.

How far the collaboration is able to effectively share resources, supported by an enabling commissioning and independent funding environment;

- + Collaborative commissioning
- + Effective sharing of resources among partners

Benefits

- **Greater efficiency and effective use of resource** – with partners across collaborations sharing and drawing on a wide set of in-kind resources, and through pooling of modest funds to make things happen.
- **Collaborations can act as inspiration for innovation in commissioning** – with new approaches trialled to adapt and allow for more collaborative forms of delivery.
- **Independent funding is key catalyst** – to developing relationships and testing new, collaborative ways of working.

Challenges

- **Processes of commissioning and procurement still (in the main) not conducive to collaboration** – there is distance to travel to work through the contradictory principles of competition and collaboration at play to find technical solutions in commissioning/procurement practice; still causing barriers to collaborative practice.

5. Behaviours

This category explores the strength of collaborative culture and behaviours within the collaboration, and whether there is awareness of difference and any mitigating actions to manage this. Understanding behaviours and cultures of key external stakeholders which impact on provider collaborations is important here too; there is need for awareness of the wider system drivers and incentives which may be affecting culture and behaviours of local and national policy, commissioning and delivery structures. For the collaboration to thrive, collaborative behaviours and culture should be reflected by wider system players (for example aligning with and supportive of in the collaboration's vision and attitude to risk). Ingenuity and flexibility are key to resilience and progress in the face of cultural misalignment with wider systems.

Understanding how far collaborative culture and behaviour is embedded within the collaboration and wider system stakeholders, and the awareness and ability to manage wider system behaviours;

- + Collaborative culture
- + Systems awareness and ingenuity

Benefits

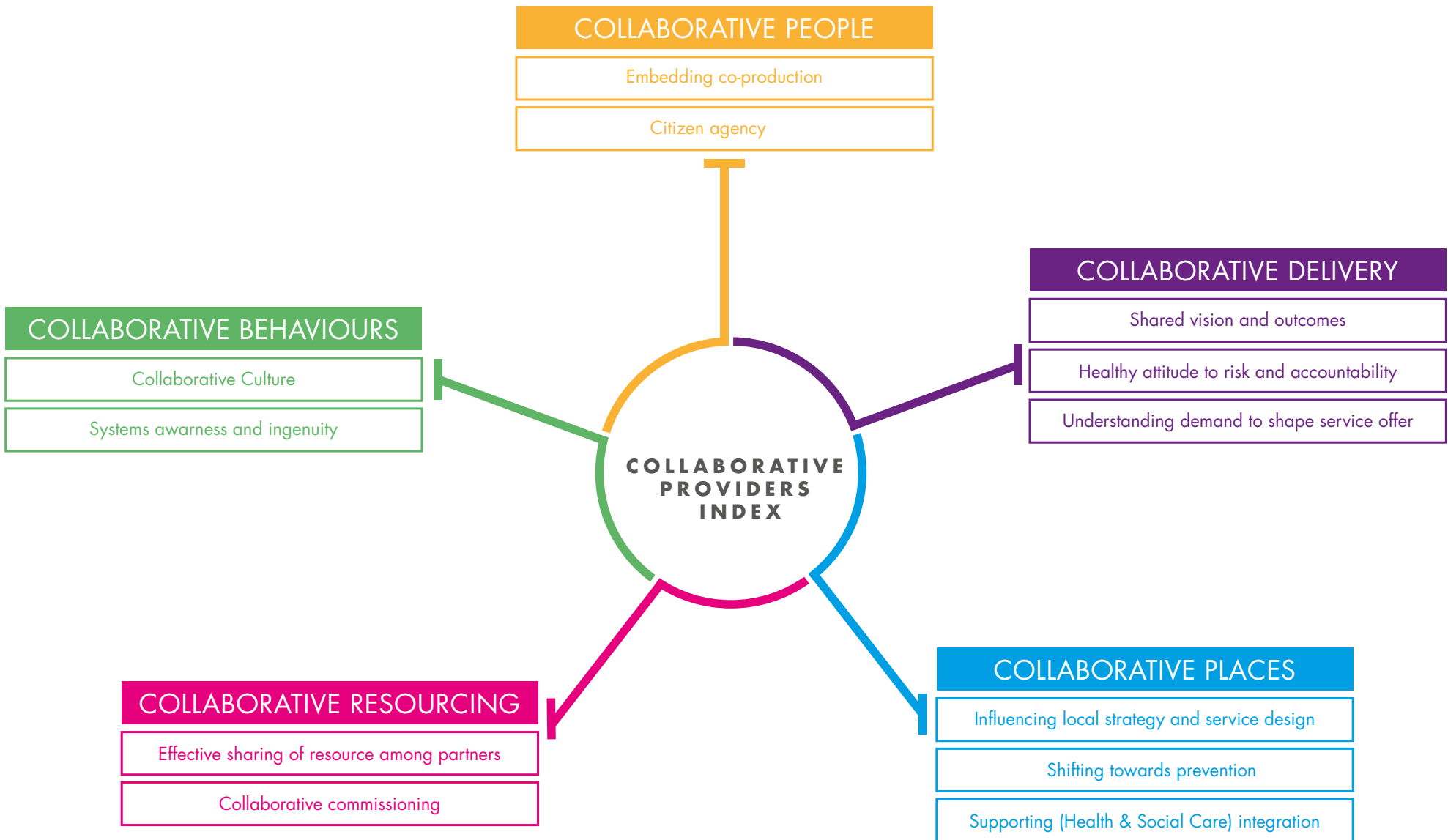
- **Clear benefit of collaborative ways of working** – to individual organisations (improved service offer, new business), and to individual staff.
- **Regular and informal communications** – helping to underpin a strong collaborative culture from leadership to frontline.
- **Improves engagement with statutory partners** – working as a collective can start to shift culture in wider services.
- **Strengthens 'systems awareness'** – through collective insights across partners of drivers and pressures in wider system (of place, of services) and helps strengthen resilience to change/challenge from that system.

Challenges

- **Culture in formal services can create barriers to change** – siloed ways of working still hold influence from leadership to frontline.
- **Shifting towards collaborative forms of support challenges staff role, remit and sense of purpose** – staff across all agencies need support through this transformation, middle managers, and in-patient services particularly.

CATEGORY	PRINCIPLES	QUESTIONS
People	Citizen agency	How can we ensure we put citizen interests ahead of organisational priorities?
		How can we support choice and power for individuals in the service(s) offered? (Through support, training, advice...)
	Embedding co-production	How well have we embedded co-production in the development of our support?
		Are our staff supported to develop the right capabilities and behaviours to enable citizens to have influence and choice over support received?
		How well embedded is co-production in wider systems and services, and what impact might that have on our collaboration?
Delivery	Shared vision and outcomes	Is there a shared vision for the collaboration and a common view of the desired outcomes across all partners?
	Healthy attitude to risk and accountability	Is the attitude to risk managed appropriately across the collaboration (i.e. responsible but flexible)?
		Who holds accountability for delivering outcomes? Is there a coherent view of this across the collaboration and wider stakeholders?
	Understanding demand to shape service offer	What data and insight do we need, across the collaboration and from wider stakeholders to effectively design and deliver our work?
		How can we best use evidence and insights to learn and improve together?
		What is our opportunity to innovate the service offer? (Internally, within the collaboration or more widely)
	Functions: Governance, Workforce, Communications and engagement; Data and Insight	What arrangements will help us build positive collaborative working across partners when considering key functions?
		What level of formalisation of the collaboration is needed to effectively deliver our work, at this point in our journey?
		How can we ensure key people in the collaboration are supported but not overly relied upon?

CATEGORY	PRINCIPLES	QUESTIONS
Places	Influencing local strategy and service design	What are the opportunities to influence local strategy and service design for us as a collaboration?
		What is the wider context of public service transformation locally (e.g. HSCP; SDS...) and what impact is this having on the collaboration?
	Shifting towards prevention	How well does our model assist towards early intervention and prevention?
		What do we need from local stakeholders to support shift toward delivering preventative services?
	Supporting (Health & Social Care) integration	How do we design our work to support alignment and integration of services?
	Resourcing	Effective sharing of resource among partners
Collaborative commissioning/funding		How well is commissioning and procurement practice enabling/preventing collaborative working?
		To what extent can we collectively use our insights to shape commissioning and procurement practice and the wider development of the sector?
		Where might independent funding provide particular value to our work?
Behaviours	Collaborative Culture	Is the collaboration understood and valued by all partners? At both leadership and frontline levels?
		Is there an alignment of cultures and behaviours across our organisations?
		If not, what sorts of challenges does this pose, and what might we do?
	Systems awareness and ingenuity	How well does the wider system support the vision and work of the collaboration?
		How can we find ways to work around challenges as they arise, and build resilience to do so?



APPENDICES

Appendix 1: Method

Scoping

This phase focused on refining criteria for selected collaborations and key aims for the project and included interviews with 7 Senior stakeholders across third sector providers and Scottish Government, and initial conversations with shortlisted projects. The Collaboration Readiness Framework¹⁵ was redesigned to create the 'Collaborative Providers Index' during this phase and informed research design.

Diagnostic interviews

After selecting 4 Provider Collaborations, we spoke with 24 participants through in-depth interviews, using the categories and principles of the Collaborative Providers Index to assess strengths and challenges at play within collaborations and wider associated stakeholders, often in the locality.

Analysis and feedback to Collaborations

Findings were written up into a bespoke analysis for each project to support their work. Cross-project analysis was then done to identify key challenges and opportunities for the projects, overarching analysis in the social care sector and the wider system (Local Public Services, Commissioners, Scottish Government and others).

Co-design of support and developing recommendations

A workshop brought partners from the four Provider Collaborations together to stress test findings and develop recommendations and to identify individual, collective and wider sectoral support needs to strengthen collaborative practice. This session provided time for projects to identify their own support needs and begin planning their next steps.

Reporting

Completed findings and process were written up and presented in this report.

Prototype support to Collaborations

This phase will follow in summer 2018. Prototyping support will be offered to two of the four projects. These projects will receive support tailored to their needs and findings from this phase will be published in Autumn 2018.

Appendix 2: Endnotes

1. Kippin and Reid (2014) From Providers to Partners what will it take? <http://www.ccpscotland.org/wp-content/uploads/2014/12/FromProviderstoPartners.pdf>
2. All names have been changed for anonymity.
3. <https://beta.gov.scot/groups/homelessness-and-rough-sleeping-action-group/>
4. http://www.auditscotland.gov.uk/uploads/docs/report/2017/nr_170824_self_directed_support.pdf
5. There are very limited circumstances in which the authority may withdraw or not offer Option 1 (Direct Payment.) These primarily relate to risk to themselves or others. This is covered in section 4 of the Self-directed Support (Direct Payments) (Scotland) Regulations 2014 <http://www.legislation.gov.uk/ssi/2014/25/part/5/made>
6. See following for examples of projects using a shared data approach: <http://www.theamapproach.org.uk/the-meam-approach/measurement-of-success/>
7. Davidson Knight; Lowe; Brossard and Wilson (2017) " A Whole New World: commissioning and funding in complexity. " Collaborate/ Newcastle University
8. <http://wordpress.collaboratei.com/wp-content/uploads/A-Whole-New-World-Funding-Commissioning-in-Complexity.pdf>
9. <http://www.evaluationsupportscotland.org.uk/how-can-we-help/harmonising-reporting/>
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11. The Procurement Reform (Scotland) Act, 2014
12. <http://www.ccpscotland.org/hot-topics/complexity/>
13. <https://collaborateic.com/the-future-of-funding-and-commissioning-1227a35cb329>
14. <https://workforcescotland.com/workstream/collective-leadership/>
15. Kippin and Billiald, 2015, Collaboration Readiness
16. <http://wordpress.collaboratei.com/wp-content/uploads/Collaboration-Readiness-Digital.pdf>

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