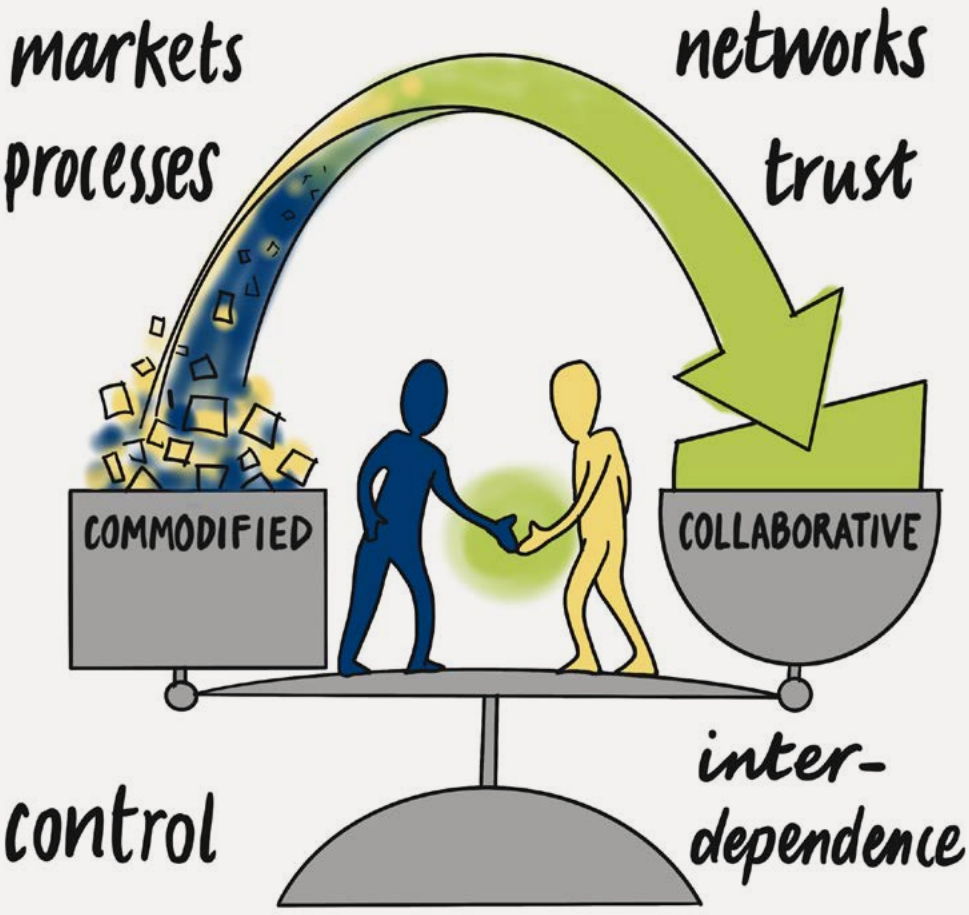
Towards collaboration: VCSE and health and care commissioning relationships



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Health and care commissioning and the VCSE sector

Research briefing no.1

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Key messages

- The growing focus on prevention and health inequalities means the statutory sector and the voluntary, community and social enterprise (VCSE) sector increasingly need to work together.
- There is a move towards more collaboration in commissioning, where sectors and organisations work together as partners and where knowledge and insights are shared to better address people's health and care needs. Some places and organisations are further along with this than others.
- The development of Integrated Care Systems (ICSs), which have partnership working at their core, provides a duty and opportunity for collaboration in commissioning. The wider context, however, can often feel like it works against collaboration.
- Our research, which included over 160 interviews across six areas of England, highlighted many challenges associated with commissioning, particularly when it is based on market-like approaches. However, it also revealed a number of enablers to collaboration between VCSEs and health and care commissioners at the local (system, place, neighbourhood) level, and it is those that we focus on here. We found that these enablers are important to building collaborative relationships but often these fundamental building blocks are missing, limiting what is possible.
- At the foundation is a shared agenda between commissioners and VCSEs, and organisational knowledge, skills, capabilities and cultures that help organisations and individuals to work together.
- Investment and resources, shared spaces for organisations and individuals to come together, and proportionate rules to help govern how money is spent and how risk is shared, all help to build webs of relationships and networks of organisations and individuals.
- Leadership that champions the role and value of VCSEs and partnership working is essential and runs throughout.
- Networks of organisations and individuals help to develop relationships based on trust, transparency, distributed power and interdependence, where commissioners and VCSEs recognise they need each other, to work together to plan and deliver better services.
- These relationships enable knowledge, learning, resources and decision-making to be shared, all of which can contribute to better health and care outcomes for all.

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Background

The involvement of VCSEs in health and social care is extensive and highly varied. From community-based day-care to wellness support and from hospice care to advocacy, 38,000 VCSEs were active in the field in 2019/20[1]. Many of these services and activities are commissioned by local authorities, the NHS and the evolving integrated care boards. Recent studies, however, suggests that commissioners find it challenging to engage with the diversity of the sector and VCSEs can struggle to navigate unequal commissioning landscapes[2].

The importance of commissioners and VCSEs working together to address health priorities is being increasingly recognised. The pandemic highlighted what can be achieved when this happens. The development of Integrated Care Systems (ICSs) offers new opportunities for joined up working. Existing evidence suggests that this isn't always easy[3]. There is a need to learn more about working together on commissioning: what works, in what contexts, and why.

Our study looked to better understand experiences of VCSEs and health and care commissioners at the local (system, place and neighbourhood) level. We talked with over 160 people from commissioning and VCSE organisations, comparing and contrasting commissioning across six case study areas in England, focusing on services and activities in the fields of learning disabilities, social prescribing and end-of-life care.

This briefing is part of a series focusing on different aspects of the study especially written for commissioners and VCSEs. It looks specifically at collaboration in commissioning, what this looks like and the factors that enable this way of working, drawing on findings from the research. We deliberately focus on what our evidence has shown us is possible, rather than on the well-rehearsed challenges associated with more commodified approaches to commissioning which can make change feel impossible.

Key findings

What does collaboration in commissioning look like?

When exploring how commissioners and VCSEs work together, we found that approaches to commissioning happened along a spectrum. At one end of the spectrum is a commodified mode of commissioning, based on market-like practices and processes such as competition and contracts, and at the other end of the spectrum, collaboration, based on networking and partnership (figure 1).

Commodified commissioning centres on competition between health and care providers, where commissioning is driven by procurement, rules and processes. VCSEs are positioned as service providers rather than partners, with an unequal relationship between commissioners and VCSE organisations; the commissioner is in control and the power and potential of the VCSE sector is not fully realised. Hierarchy and bureaucracy are key features of commodified commissioning.

In contrast, collaboration centres around cooperation, networks and partnership. Commissioners are not just buyers of services or contract managers, but planners, facilitators and enablers. VCSEs are not positioned solely as providers but as strategic partners. Trust and shared knowledge are key elements of commissioning. This comes, in part, through a shared understanding that commissioners and VCSEs need to work together to meet the health and care needs of communities:

> *"Treating them [VCSEs] as equal players in the system. They are there as a strong alliance which could help us deliver our overall outcomes. We want the people of [this place] to live healthier lives and we want to reach the poorest the fastest and improve outcomes. I think by saying that to the [VCSE] sector and saying that you play a crucial role in that, listening to their issues and challenges, and then doing something about it and bringing them onboard alongside then that's ultimately how we do it."* (COMMISSIONER)

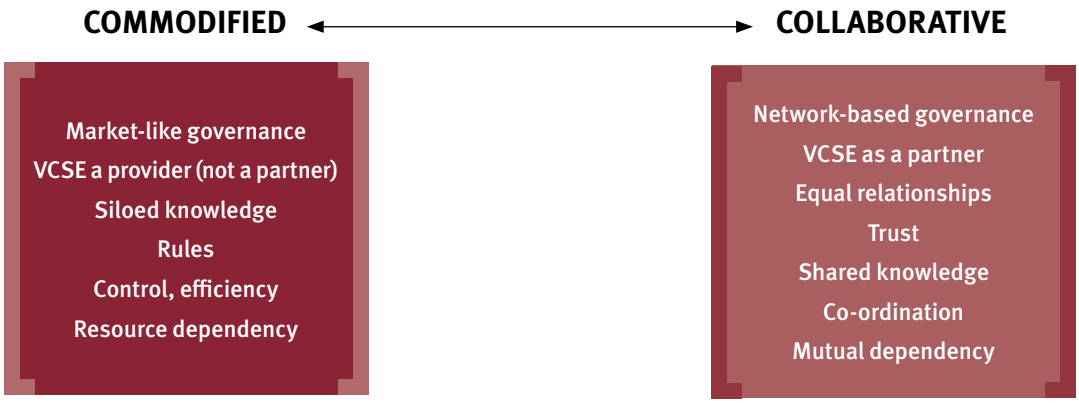
[1] NCVO (2022) UK Civil Society Almanac. NCVO

[2] Gilburt, H. and Ross, S. (2023) Actions to support partnership: addressing barriers to working with the VCSE sector in integrated care systems, The King's Fund; Paine, A. and Macmillan R. (2019). Telling tales of commissioning: insights from a qualitative longitudinal study of third sector organisations, TSRC

[3] Rees, J., Miller, R., & Buckingham, H. (2017) Commission incomplete: Exploring the new model for purchasing public services from the third sector. Journal of Social Policy, 46(1), 175-194

In our research, all areas operated across the spectrum, moving between commodified and collaborative approaches, often working in these ways simultaneously, which can be very challenging for all involved. We also saw, however, a general move towards working together and aspirations across all areas for more collaboration in commissioning, accelerated by the pandemic and move to ICSs, albeit often hindered by the everyday realities of squeezed resources. In some places, collaboration was becoming a more embedded way of working, with VCSEs positioned more as partners rather than simply providers in commissioning.

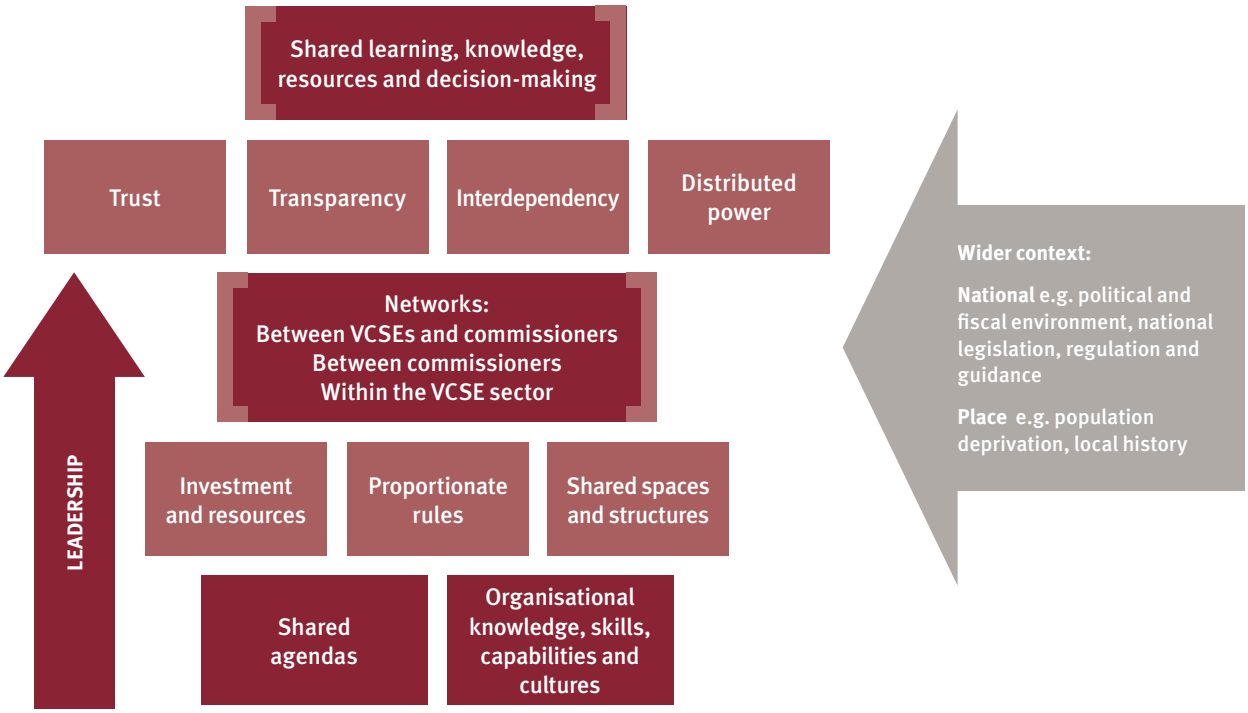
Figure 1: Key features of commissioning



What enables collaboration in commissioning?

The extent and nature of VCSEs and commissioners working together varied hugely within and across the different localities and health and care fields in our research. We identified 12 dimensions that are key to understanding these variations, influencing the extent and nature of collaboration in commissioning (see figure 2). It is helpful to think of this as a layering of different enablers; leadership runs throughout, with a shared agenda and organisational skills, knowledge and capabilities at the foundation, and other dimensions building from there. However, the dimensions of collaboration will also be influenced by wider contextual factors including national legislation, guidance and fiscal policy.

Figure 2: Enablers to collaboration in commissioning



Leadership

Our research found that individuals within commissioning organisations and VCSEs played a key role in promoting and supporting joined up working – providing leadership on collaboration in commissioning and driving the agenda forward. Identifying such individuals was recognised as an important foundation to build from, with leadership an essential element throughout. In some places, leaders in commissioning organisations were open to VCSE involvement and 'championed' their role and value. There were many examples of leaders in VCSE organisations focused not just on their own organisation, but on leading across the sector as a whole, and beyond. Some spoke of shared and 'distributed' leadership and the importance of shared ownership of commissioning decisions.

Leadership in other sites was weaker and more fragmented, although the development of ICSs was seen as an opportunity for improvement. It was highlighted that collaborative approaches need to be more fully embedded within commissioning, not dependent on one or two individuals. Some spoke of leaders championing collaboration at senior levels which failed to trickle down through organisations and systems. While in others, individual commissioners were leading the way, but they had yet to gain the full commitment of those at a senior level:

> *"The challenge is how we ingrain it so that everyone does it and it's normal... I suppose you need one person to be the one that's maybe innovating and trying to push the boundaries... how do you move people into that space behind me?... You can't have it all dependent on that person, because if that person goes, the relationships and things like that go."* (COMMISSIONER)

Shared agendas

Commitment to shared agendas, such as prevention and tackling health inequalities, were important to collaboration. Shared visions and values have also been identified elsewhere as key to partnership working between statutory and VCSE sectors within ICSs[4]. Where there was a commitment to shared agendas, there was a focus on meeting the needs of people rather than organisations; moving from 'what can they do for us', to 'what can we achieve together' and 'what can we learn together' as one person put it. It was important that shared agendas were reflected and formalised in policy commitments, for example, to addressing health inequalities. Such priorities, that required joint efforts, legitimised VCSE involvement in a way that was less obvious when health and care systems were dominated by agendas such as reducing waiting times which were more clearly focused on acute care providers. Developing shared agendas could take time and commitment, however both commissioners and VCSEs hoped ICSs could create opportunities to move this forward:

> *"You take something like the ICS, and the ICS principles are kind of on the basis of that distributed leadership and community-based approach, and starts to have a bit more of a shared problem feel than perhaps it would have been before."* (COMMISSIONER)

[4] NCVO (2020) Creating Partnerships for Success: The voluntary sector and health transformation, NCVO

Organisational knowledge, skills, capabilities and cultures

Key to collaboration were the knowledge, skills, and capabilities VCSEs and commissioning organisations had and the extent to which these could be drawn on. Particularly important were those at a senior level:

- Knowledge and expertise of communities, service users, and services within respective areas of commissioning
- Knowledge and understanding of each other, including ways of working and the constraints that each other were under
- Skills and capabilities in working across organisational and sectoral boundaries, in collaboration
- Ability to recognise the value of external information, assimilate it and use it (see briefing 2)

Individuals and organisations working across statutory and VCSE bodies, or who had moved from one sector to the other were particularly valuable. These acted as boundary spanners, helping to translate between sectors and promote cross sector understanding and knowledge:

> *"My role is really to act as an interface between the VCSE and the statutory health and care system [...] supporting the development and understanding of an intelligence base that connects community needs and the insights of organisations and the people those organisations support with the decision-making process in the statutory health and care system."* (VCSE RESPONDENT)

Organisational culture within commissioning organisations and VCSEs can also influence collaboration. Our research found that commissioning cultures that were more supportive of VCSEs and recognised their value leaned more towards collaboration. Organisational cultures and structures that gave commissioners more autonomy and space to make decisions and choices enabled collaboration in commissioning (see briefing 4).

With the above enablers in place – leadership, shared agendas and organisational knowledge, skills, capabilities and cultures – this lays the foundation for the following dimensions that make collaboration in commissioning possible:

- Investment and resources;
- Proportionate rules for commissioning; and
- Shared spaces and structures.

Investment and resources

Availability of, and access to, resources was fundamental to collaboration in commissioning. Across the case study areas commissioners highlighted tightening finances and fewer resources, including the staffing of commissioning activities, impacting their approach to commissioning (see briefing 4). It was also widely acknowledged that VCSE resources were often highly constrained and fragile, affecting their ability to engage in collaborative activities.

> *"There's so little new money to co-design anything around. And when we are co-designing we're co-designing with a view to cutting costs. So that makes it really difficult to be innovative."* (VCSE RESPONDENT)

However, some areas had fought to protect funding to VCSEs and commit resources, including time, to building and strengthening relationships with VCSEs. Financial 'investment' took many different forms from ongoing investment in local VCSE infrastructure, full-cost recovery and longer term multi-year contracts for VCSEs, to re-imbursing the costs of VCSEs participating in planning or co-commissioning activities. As discussed above, knowledge was also an important resource.

Proportionate rules

While the rules and regulations that surround commissioning, and procurement in particular, were generally thought to be constraining, our research highlighted how proportionate and flexible rules are an important enabler to collaboration in commissioning. These rules govern how much money is spent, help safeguard parties involved in commissioning and ensure risk is shared. Rules are important for commissioners accountable for the spending of public money and clarify commissioner expectations for VCSEs. In our research, rules supported collaboration when they were applied flexibly and proportionately. There were examples of commissioners minimising rules, such as allowing more flexibility in the delivery of services, when these presented barriers to collaboration, particularly important during the height of the Covid-19 pandemic:

> *"Removing some of the rules and regulations, allowing a little bit more freedom for commissioning organisations and providers to work together, and there being less of that wall between commissioners and providers."*
> (COMMISSIONER)

Shared spaces and structures

Central to collaboration in commissioning was the degree commissioners and VCSEs came together to share knowledge and insights through shared spaces and structures, and how these helped to build networks. These spaces included Partnership Boards, Health and Well-being Boards, ICSs and many other forums and networks. Local VCSE infrastructure organisations, such as Councils for Voluntary Services (CVSs), played an important role in creating and co-ordinating these spaces and networks. The coverage, strength and capacity of these organisations, however, varied between areas and this affected the opportunities commissioners and VCSEs had to connect. Where these spaces existed, concerns included whether VCSEs had an equal voice, which organisations were included, and who 'owned' the agenda. Where it worked well, there were shared spaces where VCSEs and commissioners came together to exchange information and knowledge, and subsequently to build trusting relationships, through which VCSEs felt they had a voice to influence the commissioning environment.

Networks

Investment and resources for collaboration, shared spaces and structures to come together and rules to govern money and relationships, help make the development of relationships and networks of organisations and individuals possible. This is key to collaboration in commissioning.

Our research found that there were three forms of networks:

- Horizontal networks through which different commissioners collaborated
- Horizontal networks through which VCSEs collaborated
- Vertical networks linking groups of commissioners with VCSEs

While these networks facilitated dialogue, information exchange and collaboration, there were also issues around who is included and excluded and who is in control. Our research highlighted the need to ensure that networks and collaboration are open to the involvement of other VCSE organisations and commissioners and don't become closed networks that exclude and marginalise.

Our study found that, when built on the firm foundations identified above, networks amongst and between VCSE organisations and commissioners could help to develop relationships based on:

- Trust;
- Transparency;
- Interdependence; and
- Distributed power.

Trust

Trust between individuals, organisations and institutions was identified as a key ingredient and enabler to collaboration. This has also been extensively highlighted in other studies on commissioning and partnership working[5]. Some spoke of the inherent mistrust between VCSE organisations and statutory organisations and how this has been exacerbated by poor commissioning practices. They also spoke of how trust can be built through networks when enough time and effort is put into building mutual understanding and respect. VCSEs spoke of the value of commissioners trusting in the experiences and knowledge of VCSEs and the importance of flexibility to enable them to adapt their approach when needed:

> *"A different experience that I've had more recently is working on a project where it seems that the commissioners or the project leads there are very trusting in us and bringing in our real lived experience in what we're trying to deliver... And to me I think that's real true coproduction."* (VCSE RESPONDENT)

Transparency

Alongside trust, transparency and openness were seen as key features of collaboration in commissioning. VCSEs highlighted the need to be honest about the challenges and constraints they faced and commissioners noted how there is room for a "better, honest and open space" to promote collaboration.

> *"From my experience as an operational manager, sometimes our relationships with commissioners weren't constructive and, actually, I think we spent our time sometimes sort of masking things and trying to make sure that the commissioners didn't find out about certain things. I don't want people using their energy or their time to do that, so my view is I will take an approach which is I'll be open, I'll be transparent with the providers, and I'll give them the benefit of the doubt. But I expect certain behaviours in return."* (COMMISSIONER)

[5] Baird, B., Cream, J. and Weaks, L. (2018) Commissioner perspectives on working with the voluntary, community and social enterprise sector, The King's Fund

VCSEs and commissioners spoke of the importance of being open to two-way challenge and different ideas. This ability to challenge and to be open to challenge was particularly important for those VCSE organisations which combined service delivery and advocacy roles: they needed to be able to challenge commissioners on aspects of health and care that were failing their communities, and remain confident that it would not affect their contracts or wider relationships. It was recognised that the challenge could come both ways.

Interdependency

Our research found that there is a growing recognition of the contribution that the VCSE sector can play in addressing health inequalities and reaching into communities and how much statutory organisations need the VCSE to address health and care needs. Whilst the dependence of VCSE organisations on commissioners for financial resources is often reflected upon; the dependence of commissioners on VCSEs for their distinctive services, approaches to tackling inequalities, knowledge of service users, reach into communities, and ability to flex and respond to changing circumstances was less frequently acknowledged. Where relationships between commissioners and the VCSE were more collaborative, there tended to be recognition of a mutual interdependency, where commissioners and VCSEs recognised that they needed one another to meet community needs.

> *"[VCSEs] provide a huge support to the NHS in terms of facilitating discharge from hospital, which is a huge problem for us nationally at the moment. So I think we are mindful of the contribution that these organisations make, and sort of reflect that in the way that we work with them."* (COMMISSIONER)

Distributed power

Within a commodified mode of commissioning, power and control is heavily skewed towards the commissioner. More collaborative commissioner-VCSE relationships, built on the above dimensions, typically had a more even distribution of power. Our study showed that a recognition of the interdependency between commissioners and VCSEs shifted power relations. Sometimes this required VCSEs to "be brave" (as one respondent put it) in entering into new spaces, evidencing their value, and realising their power. Often it required VCSEs to work together (see briefing 3). Many areas were striving for more equal partnerships, rather than VCSEs being positioned only as providers of services. However, where agendas were not aligned, and where VCSEs were financially dependent on commissioners and the dependence of commissioners on VCSEs was not recognised, VCSEs had less room to influence.

> *"There's something around, I think, the power shift as well, and rather than having a traditional commissioner/contractor-provider relationship, where it's about specifying deliverables and performance management, actually the shift is that we'll be working to set very long-term population outcomes."* (COMMISSIONER)

Wider influencing factors

Having in place all the above dimensions makes collaboration in commissioning more likely. In many cases, however, whilst some of the dimensions were in development, others were missing. Often, for example, shared agendas had not been established, or the spaces which brought commissioners and VCSE organisations together were exclusive and dominated by one party or the other, affecting the ability of networks to lead to trust and transparency. Leadership might be lacking, or procurement rules enforced in an overly prescriptive way. This may be affected by wider contextual factors, that impact on what is possible at the local level. These include:

National-level factors such as the political and fiscal environment, regulation, legislation, directives and guidance can get in the way of collaborative approaches. Commissioners and VCSEs highlighted, for example, how NHS formal contracting systems limited the autonomy of commissioners and their space to work collaboratively (see briefing 4). The requirement to compete in the context of regulation can create mistrust and restrict collaboration. The current financial environment was seen as particularly challenging. However, national legislation and guidance may also promote collaboration, for example, the ICS implementation guidance for ICS leaders to work with the VCSE sector[6].

System and place-based factors such as levels of deprivation and history may also affect the extent and scope of collaboration. We found, for example, that high levels of deprivation could motivate commissioners and VCSEs to work together and they more commonly recognised how dependent they were on each other to address needs in communities. Local histories were also important. Some places had a long history of partnership working, with the role of VCSEs recognised and reflected in policy. In some areas, VCSEs had been 'fundamental' to the policy agenda for some time, less so in others.

Conclusion and implications

This research has highlighted how a complex combination of factors can enable or constrain collaboration in commissioning between VCSE and health and care commissioners. We have identified 12 dimensions that, cumulatively, influence the nature and extent of collaboration. Thinking about what systems, organisations and individuals can do to support collaboration is more relevant than ever given the emphasis of ICSs on working together, combined with the scale of health and care challenges we are currently facing. Below we revisit six of the factors at the foundation of building collaboration and the implications of this for practice: leadership, shared agendas, capabilities/skills/knowledge, resources and investment, proportionate rules and shared spaces. If these are in place, then our research suggests that networks can be built amongst and between VCSE and health and care commissioning organisations which act as mechanisms for more collaboration in commissioning through the development of transparency, trust, interdependency and distributed power. Together these enable shared learning, resource and decisions, and ultimately better health and care outcomes for all.

Figure 3: Implications for practice

Leadership	Leadership is key to building and maintaining collaborative relationships in health and care commissioning. This should drive agendas forward that recognise the value of the VCSE sector, championing collaboration and partnership working. Collaboration can be fragile when built and sustained by a small number of organisational leaders and when collaborative working is not fully embedded within organisations and systems. It is expected that ICSs will accelerate 'systems' leadership with leaders working across health and care systems and organisational boundaries. There has been a shift to more distributed and 'generous' leadership in some areas. Research suggests that this distributed approach will need leaders at every level of the system to work across boundaries and drive shared agendas[7]. Ongoing learning and development of leaders, including peer learning will be important to sustaining systems leadership.
Shared agendas	Central to collaboration in commissioning is having in place a shared vision and common agendas. These need to be based on a mutual understanding of need and priorities, clarity on why relationships are being entered into and how working together will lead to a meeting of those goals. The focus here needs to be on putting people and shared goals before individual organisations. VCSEs bring deep understanding of community needs and they should play a key role in developing shared agendas at a systems level. This will help to promote commitment to achieving goals and health and care outcomes for communities.

[6] NHS (2021) ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector

[7] Fillingham, D. and Weir, B. (2014) System Leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities, The King's Fund

Skills, knowledge, capabilities and culture	Health and care commissioning relationships and practices are shaped by the skills, knowledge, capabilities and cultures within organisations, networks and systems. Key to collaboration is knowledge and understanding between partners; commissioners need understanding of VCSE organisations and what makes them distinctive, whilst VCSEs need understanding of how commissioning works and the constraints commissioners are under. Shared spaces and networks for individuals and organisations to come together are key to building this understanding. Freedom and space for commissioners and VCSEs to use their skills and knowledge to work together in new and different ways is important (see briefing 4). Skills in working in partnership across organisational boundaries will be key to collaboration within ICSs. The capacity to share and use knowledge and evidence between individuals and organisations and within systems is important. Commitment to a common vision and agendas, shared learning spaces and intermediaries such as local VCSE infrastructure organisations that can translate across boundaries are key to building this capacity (see briefing 2).
Resources and investment	Resources – money, time and knowledge – need to be invested to support collaboration in health and care commissioning. Constraints on resources at a local level and the wider external context including the challenging fiscal environment are creating barriers to collaboration, limiting what is possible at a local and systems level. Collaboration requires long term and sustained commitment of resources. Time needs to be invested to develop meaningful and trusting relationships between commissioners and VCSEs. Knowledge needs to be shared across sectors so it can be used to plan and develop services. Financial resources, including sustained investment for VCSE local infrastructure and covering the costs for VCSEs to participate and collaborate in health and social care commissioning are important.
Proportionate rules	Rules are important in commissioning relationships and are needed to safeguard all parties, reduce uncertainties, ensure risk is shared, and outcomes evidenced. These rules need to be underpinned by principles of how individuals and organisations will work together, co-developed and understood by all. Rules can act to constrain and create tensions in commissioning relationships. They can also enable collaboration when they are applied flexibly, proportionately and appropriately. At the systems level, rules will help to govern commissioning relationships, particularly when it comes to directly procuring services, but they also need to be flexible and responsive to changing needs and priorities.
Shared spaces and structures	Spaces and structures for individuals and organisations to come together are key to building commissioning connections and relationships. These spaces provide horizontal and vertical opportunities to network and share knowledge by connecting VCSEs together as well as commissioners and VCSEs. It is important to strive for shared ownership and leadership of these spaces to ensure agendas and discussions are not dominated by individual people and organisations. To ensure organisations are not isolated from the commissioning system these spaces and structures need to be as inclusive as possible, with knowledge and learning shared beyond these spaces. Local VCSE infrastructure organisations play an important role in creating and facilitating these spaces, helping to translate between sectors and promoting the flow of information within and across organisational and sector boundaries.

Reading and resources

Gilburt, H. and Ross, S. (2023) *Actions to Support Partnership: Addressing barriers to working with the VCSE sector in integrated care systems*, The King's Fund.

Fillingham, D. and Weir, B. (2014) *System Leadership: Lessons and learning from AQuA's Integrated Care Discovery Communities*, The King's Fund.

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About this research

The Universities of Plymouth and Birmingham and the London School of Hygiene and Tropical Medicine have worked together on a research project funded by the National Institute for Health Research (NIHR) that explores in more depth the VCSE sector and health and care commissioning relationship and identifies where improvements could be made. The project is based on analysis of Clinicial Commissioning Group spend on VCSEs, and six local cases studies. It focuses on services provided in the fields of learning disabilities, social prescribing and end of life care. The research was undertaken by the authors of this briefing, alongside Alex Gibson, Pauline Allen, Jonathan Clark, Russell Mannion, Sheena Asthana, Rebecca Hardwick and Chris Smith.

This is one of four briefings so far produced from the research. Other briefings, articles and reports will be published in due course. See see the website for further details.

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