IMPROVED OUTCOMES THROUGH PARTNERSHIP WORKING: A VISION FOR SOCIAL CARE

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My Home Life England, City St George's, University of London - 2026

Funded by the Rayne Foundation

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INTRODUCTION

This report offers a timely and practical contribution to national conversations about the future of adult social care in England. It relates directly to the **Casey Review** and the Government's wider ambitions for a reformed, more integrated and localised health and care system, and the vision of collaborative leadership set out in the **Messenger Review**.

These developments invite all of us - providers, commissioners, system leaders and regulators - to reflect not only on how services are organised, but also on the quality of the relationships that sustain them.

The report brings together learning from a **two-year appreciative inquiry** led by **My Home Life England**, part of **City St George's, University of London**, and supported by the **Rayne Foundation**, drawing on conversations with **90 stakeholders** and the experiences of over **2,600 care leaders**.

It uses an 'appreciative lens' to explore what effective partnership looks like between adult social care providers and the wider health and care system - particularly when relationships are based on respect and equality, not hierarchy. It draws on the concept of **'adult-to-adult' relationships** between organisations and colleagues, as identified within Transactional Analysis.

In this context, we define adult-to-adult relationships as interactions based on mutual respect, shared responsibility, and objective dialogue. This approach helps to reduce defensiveness, blame, and hierarchical communication patterns, replacing them with collaboration and shared learning.

This report demonstrates how **cultural and relational change can strengthen integration across health and social care**, highlighting the transformative impact of shifting organisational relationships from unequal, parent-to-child approaches, to mutually respectful, adult-to-adult dynamics. It presents a **series of case studies and recommendations** that point to real improvements when trust, equality, and shared purpose are prioritised in partnerships across the system.

The report also acknowledges that care providers themselves need to be 'the change they want to see.' While they cannot always change the behaviours and attitudes of other organisations or sectors, they can change their own and influence relationship dynamics through their own actions.

Specifically, the report aims to:

- Present an evidence-based vision for more adult-to-adult partnership working between care providers and the wider health and care system.
- Support a national conversation about how relational and cultural reform can underpin the future of care.
- Summarise evidence and lessons learned from good practice in adult-to-adult partnership working.
- Set out challenges and reflections for all stakeholders to consider in improving partnership practice.
- Act as a live discussion paper to be developed further through ongoing engagement.

EXECUTIVE SUMMARY

This report focuses on what good, adult-to-adult partnerships look like between the social care sector and the wider health and care system, their impact, and the conditions required to enable and sustain them.

The report, written by My Home Life England, draws on a two-year appreciative inquiry supported by the Rayne Foundation, involving 90 stakeholders across the care, local government and health sectors (see Appendix 1), a literature review (see Appendix 2), case studies (see Appendix 3) and insights from working with over 2,600 care leaders.

This report comes at a time of **major change in England's health and social care system**. **The Health and Care Act 2022** created **Integrated Care Systems (ICSs)** to promote collaboration, yet **adult social care providers often remain on the margins of decision-making**.

Recent policy shifts - including the planned abolition of NHS England, cost-cutting and mergers of Integrated Care Boards - risk weakening local engagement and capacity. At the same time, national reviews and government plans, including the **Casey Review** (Department of Health and Social Care, 2025), the **Messenger Review** (Messenger & Pollard, 2022), and **Fit for the Future - The 10 Year Health Plan for England** (Department of Health and Social Care, 2025), call for culture change, stronger trust-based relationships, and genuine partnership working at local level to deliver shared outcomes and improve quality of life.

Our report sets out a vision for a future in which **care providers are respected and engaged as equal partners within the health and social care system** - working alongside statutory bodies to shape, deliver and improve services. It imagines a **shift in culture and behaviour** that moves beyond compliance, control and transactional relationships, towards mature, trusting, adult-to-adult ways of working.

We have learned how system outcomes are shaped not only by policies and structures, but by the **quality of relationships** - especially under pressure. Where those relationships are rooted in respect and shared purpose, the system becomes more effective, more human, and more sustainable.

The report identifies that where there is **mutual accountability, shared learning, and respect** for the professional knowledge and values each partner brings, **significant outcomes can be delivered**:

- Better design of initiatives that potentially can save money on both sides.
- A sector that feels trusted, valued and supported, with knock-on effects on the quality of the care that they provide and sector resilience.
- Better engagement of registered managers on initiatives that affect them and reduced duplication of initiatives.
- Reduced likelihood of unforeseen care service crises.
- Improved hospital discharges.
- Reduced pressure on council adult social care quality teams by enabling care associations to develop their role.

The case studies (Appendix 3) in this report show that when people are trusted, respected and engaged as equals, the benefits ripple outwards across the wider sector.

The challenges

While the ambition for more integrated working is widely shared, partnership between care providers and statutory bodies often remains limited by deep-rooted cultural and structural barriers.

Across the inquiry, care providers described **a persistent imbalance in power and voice**. Too often, they experience unequal dynamics - where decisions are imposed, expertise is disregarded, and compliance is prioritised over collaboration. These dynamics are reinforced by commissioning and procurement processes, safeguarding systems, regulatory approaches, and organisational behaviours.

To help understand these dynamics, the inquiry drew on **Transactional Analysis** (see Appendix 4) - a model that describes common patterns in human relationships. In this framework, many current interactions position statutory bodies in the parent role and care providers in the child role, leading to dependency, frustration, or disengagement. By contrast, **adult-to-adult relationships are built on mutual respect, openness and shared responsibility**.

Registered managers in particular often feel isolated and undervalued - responsible for care delivery but excluded from system-level decisions. Mistrust, fear of blame, and long-standing negative assumptions about social care further inhibit effective partnership. These patterns are widespread, and changing them requires courage, consistency and reflection from all involved.

What works

Despite the challenges, the inquiry uncovered many examples where **more relational ways of working** are already in place - and making a difference.

Through interviews, workshops, literature review and detailed case studies, the inquiry identified key behaviours, structures and mindsets that enable effective partnership.

These include:

- Respectful relationships grounded in trust and shared goals.
- Recognition of the leadership role of care providers, particularly registered managers.
- Transparent, inclusive systems that value care provider insight.
- Strong local and national forums and care associations acting as independent, strategic connectors.
- System leaders who model humility and suspend hierarchy.
- Investment in leadership development and relational skills across the care sector.

> The evidence suggests that where adult-to-adult dynamics are prioritised, the system becomes more responsive and resilient. Providers are more engaged, joint problem-solving improves, and people drawing on care benefit from more person-centred support.

Many reforms focus on redesigning systems, but lasting change depends on how people relate to each other.

The case studies in this report show that trust, respect and equal partnership unlock widespread benefits:

- Care becomes more connected.
- Outcomes improve for those drawing on care.
- Councils build stronger partnerships with providers.
- Commissioners co-design better services.
- The NHS sees fewer crises.
- Regulators work more supportively.
- Staff collaborate and grow.
- The care sector leads its own development.

Everyone gains when relationships are built on trust, mutual respect and shared responsibility.

Making it happen

The **shift to relational partnership** is already happening in some places. But to make it the norm, not the exception, we need **deliberate cultural change** across all parts of the system.

This report offers a series of **practical, relationship-focused recommendations**.

These include:

- Embed person-centred and relationship-centred care. Focus on what matters most to people and families and ensure that frontline relationships are supported by trust throughout the system.
- Embed mutually respectful, adult-to-adult dynamics as a guiding principle in system working.
- Enable the national care sector to reflect on how it might change its own governance, behaviours and practices, in order to challenge the myths and attitudes held by the health and social care system and the wider community.
- Recognise and resource the leadership of registered managers.
- Strengthen the role of local and national care associations and forums.
- Reflect on whether current processes reinforce hierarchy or foster trust.
- Invest in relational capability through training, coaching and peer support.

This work starts with each of us. Everyone involved in health and social care - commissioners, providers, regulators, policymakers - has a part to play in creating more equitable and effective relationships.

This report is a live document, intended to spark reflection and action. It includes reflective questions (Appendix 5) to support honest conversations across the system and invites continued dialogue about how we build a more collaborative, respectful and person-centred future for adult social care.

To be part of the ongoing discussion, contact mhl@citystgeorges.ac.uk.

TABLE OF CONTENTS

1. ADULT-TO-ADULT RELATIONSHIPS: A VISION FOR ADULT SOCIAL CARE PARTNERSHIPS

This report sets out a vision for a future in which care providers are respected and engaged as equal partners within the health and social care system - working alongside statutory bodies to shape, deliver and improve services. It imagines a shift in culture and behaviour that moves beyond compliance, control and transactional relationships, towards mature, trusting, adult-to-adult ways of working.

At the heart of this approach is mutual accountability, shared learning, and respect for the professional knowledge and values each partner brings. This vision is grounded in real experience and informed by the voices of registered managers, commissioners and system leaders.

1.1 The role of care providers in system transformation

Adult social care providers possess invaluable insights and expertise that can enhance system design and service delivery. However, their potential is often under-utilised due to hierarchical dynamics and limited involvement in strategic decision-making. This report advocates for:

- **Inclusive engagement**: Ensuring care providers are involved early and meaningfully in system planning and decision-making processes.
- **Recognition of leadership**: Valuing the leadership roles of care providers, particularly registered managers, and supporting their participation in system-level conversations.
- **Support for provider engagement**: Investing in care associations and provider forums as vital connectors between sectors, facilitating collaboration and shared learning.

By fostering relationships characterised by mutual respect, accountability, and collaboration, the health and care system can better leverage the strengths of all partners to improve outcomes for individuals and communities.

1.2 What could adult-to-adult partnership look like in practice?

Adult-to-adult partnership is a way of working. The vision described here draws on practical examples and collective insight to paint a picture of how the system could operate when care providers are treated as peers and collaborators.

1.2.1 Recognising and supporting care leadership

- **Care services and the individuals working within them are recognised as professionals** with valuable expertise and insight into how services can be improved and made more person-centred.
- **Registered managers have strategic engagement written into their job descriptions**, and time is protected to enable them to contribute to wider system development.
- **Support is in place to help registered managers stay resilient**, professionally confident, and able to participate in system-wide conversations.
- Registered managers understand how the ICS works, know who to go to for what, and are not left to navigate a complex system alone.

1.2.2 Embedding care voices in decision-making

- **Care providers are involved from the outset in strategic forums**, with their insights shaping thinking - not just consulted after decisions are made.
- **A culture of collaboration is fostered through communities of practice**, where registered managers and other system partners regularly come together to share issues and design solutions. Time is allocated and resourced for this engagement to be meaningful.
- **Joint training, buddying and shadowing opportunities are available**, helping colleagues across health and care better understand each other's roles and challenges. These are offered in both virtual and face-to-face formats.

1.2.3 Creating shared responsibility and accountability

- **Procurement processes are co-designed**, with care providers contributing to shaping contracts that support collaboration, flexibility and innovation.
- **Commissioning frameworks include two-way accountability**, so that councils and ICSs commit to behaviours and processes that mirror the expectations placed on providers.
- **Safeguarding becomes a shared responsibility**, grounded in learning, trust and proportionate responses. Where appropriate, those raising concerns first consider whether the issue can be resolved at an individual level.

1.2.4 Building trust and reducing unnecessary burden

- **Trust is the default**, not the exception. Registered managers are empowered to speak directly with hospitals, make their own assessments where needed, and act without unnecessary oversight.
- **Duplicative requests for paperwork and data are removed**, with system partners working together to streamline demands placed on care providers.
- **Regulation supports improvement**, not punishment. Inspectors and providers work together to build confidence and learning.

1.2.5 Elevating the professional status of the care sector

- **The care sector is recognised as a professional body**, on equal footing with other parts of health and social care. It has its own governance, standards, training and quality assurance mechanisms that support its development.
- **Language and communication are inclusive**, with registered managers actively supported to shape and interpret the terminology used in system discussions, avoiding exclusion through jargon.

1.3 What this enables

When adult-to-adult relationships are in place, care providers can be more engaged, responsive and empowered. As a result, they can contribute to problem solving and provide frontline insights that are otherwise unavailable to other parts of the care and health system. This in turn can make systems more agile, with the ability to identify and resolve issues faster. Ultimately, it can enable people who draw on care - and their families - to benefit from more person-centred support.

1.4 The work ahead

Realising this vision means **challenging long-standing dynamics**. Many relationships in the system remain transactional, hierarchical and compliance focused. These patterns can limit the care sector's ability to contribute fully to shared challenges.

As **The King's Fund** observes:

> *"After several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement."*
>
> THE KING'S FUND - INTEGRATED CARE SYSTEMS EXPLAINED

Delivering the shift to adult-to-adult working requires more than structural change. It requires cultural transformation - of attitudes, behaviours and expectations.

As the **Hewitt Review** puts it:

> *"Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part."*
>
> THE HEWITT REVIEW: AN INDEPENDENT REVIEW OF INTEGRATED CARE SYSTEMS, RT HON PATRICIA HEWITT, APRIL 2023

Transforming these relationships demands effort, courage and reflection at every level.

It also involves **care providers having the confidence and skills** to take the first step and change themselves in order to work more effectively with health and care system partners.

The prize is a more equitable, effective and human system - where all partners are respected, trusted and able to play their full role.

2. STRATEGIC & POLICY CONTEXT

This report is published at a time of **significant transformation and challenge** within England's health and social care system. It is intended for health and care leaders, local authority and NHS commissioners, and managers and owners of care services who are navigating these changes and seeking to foster more effective partnerships.

2.1 A shift towards integration and collaboration

For decades, integrating health and social care has been a policy ambition aimed at improving outcomes and efficiency. The **Health and Care Act 2022** (Health and Care Act c.31, 2022, UK) formalised this ambition by establishing **Integrated Care Systems (ICSs)** across England, marking a shift from competition to collaboration. ICSs are designed to bring together NHS organisations, local authorities, care providers, and the voluntary and community sector to plan and deliver services that improve population health and reduce inequalities.

However, the practical implementation of ICSs has revealed challenges, particularly in ensuring that adult social care providers are treated as equal partners in system design and decision-making.

2.2 Recent developments impacting ICSs and NHS England

In 2025, significant policy changes are impacting the health and care landscape:

- **Abolition of NHS England**: The government announced plans to abolish NHS England, integrating its functions into the Department of Health and Social Care. This move aims to reduce bureaucracy and bring the NHS under direct ministerial control. However, it has raised concerns about potential disruptions to service delivery and the loss of independent oversight.
- **ICB running cost reductions**: Integrated Care Boards (ICBs), the statutory bodies responsible for commissioning within ICSs, have been instructed to reduce their running costs by 50% by the end of the 2025/26 financial year. This directive is expected to lead to significant job losses and restructuring within ICBs, potentially affecting their capacity to engage with partners and communities effectively.
- **Mergers of ICBs**: In regions such as the East of England, plans are underway to merge existing ICBs to streamline operations and reduce costs. While intended to improve efficiency, these mergers may also impact local engagement and the ability to address specific community needs.

These developments underscore the importance of strong, trust-based relationships between care providers and system partners to navigate the evolving landscape effectively.

2.3 Aligning with national calls for culture change

This report aligns with recent national reviews and policy documents that emphasise the need for cultural transformation within the health and care system, with a stronger focus on integration at local and neighbourhood level.

- **The Casey Review**: Highlights the opportunity to redesign adult social care, not just in terms of funding and structure, but also in how people work together across sectoral boundaries. (Department of Health and Social Care, 2025)
- **The Hewitt Review**: Calls for a shift towards trust-based, collaborative cultures within ICSs, recognising that effective partnerships are essential for improving population health and system performance. (Hewitt, P. 2023).

- **The Messenger Review**: Highlights the importance of collaborative leadership across health and social care, calling for inclusive cultures, parity of esteem between sectors, and investment in people as the foundation for integration. (Messenger and Pollard, 2022)
- **Devolution White Paper**: Under the new plans, district councils may be eliminated in favour of unitary authorities, alongside more elected mayors given a wider remit across strategic planning decisions. Plans could have far-reaching implications for how social care is delivered and funded. (Ministry for Housing, Communities and Local Government, 2024)
- **Fit for the Future - The 10 Year Health Plan for England:** The Government's plan for the NHS focuses on three key shifts: from hospital to community; analogue to digital; and sickness to prevention. In particular, the proposals for a Neighbourhood Health Service requires genuine partnership working at a local level across all health and care professionals. (Department of Health and Social Care, 2025)

Co-production and partnership remain an important ambition for many national health and social care organisations, but this needs to be genuine, and **built on shared outcomes** that will ultimately support quality of life for people who draw on care and support.

3. METHODOLOGY

This report is the result of a two-year appreciative inquiry led by **My Home Life England (MHLE)**, supported by the **Rayne Foundation** and completed in Autumn 2025. The purpose of the inquiry was to explore **how adult social care providers and statutory partners can work together more effectively**, focusing on how to build adult-to-adult relationships rooted in mutual respect, trust, and shared accountability.

An **appreciative inquiry** approach was adopted to identify and **build on examples of what already works well in the system**, rather than starting with what is broken. This strengths-based approach aligned with MHLE's ethos and provided the best route to understanding how relationships can enable positive outcomes in care.

The inquiry drew on MHLE's longstanding experience of working with the adult social care sector, including its support for over **2,600 care leaders** across the UK over the past 19 years. These leaders' insights and lived experience helped inform the inquiry's design, focus, and analysis.

Between 2022 and early 2024, the inquiry engaged **90 stakeholders** across England (see Appendix 1). Participants included care home and home care leaders, local authority commissioners, ICS staff, provider association leads, and representatives from national bodies including the Care Quality Commission. These stakeholders brought diverse perspectives, including operational, strategic and policy-level insights.

A mixed-methods approach was used to build a rich and practice-informed evidence base:

- **38 discussions** were carried out with key stakeholders, exploring lived experience, relational dynamics and opportunities for change.
- **5 facilitated group workshops** brought together care providers and system partners to share examples of good practice and test emerging themes.
- **2 validation workshops** were held to review draft findings, check resonance with stakeholders, and refine the narrative.
- **Ongoing reflective field notes** were kept by the inquiry team to record learning and insights throughout.
- A review of over **40 documents** was conducted, including academic research, grey literature, policy papers, and sector reports, to place the inquiry within the wider policy and evidence landscape (see Appendix 2).

A further strand of evidence came from a set of **case studies** (see Appendix 3), developed in collaboration with local stakeholders. These case studies reflected:

- **Geographical variation**, drawing from different regions across England (and Northern Ireland), including urban and rural areas.
- **Thematic diversity**, addressing issues such as hospital discharge, collaborative safeguarding, quality monitoring, and system-level commissioning.

These case studies served to illustrate the practical application of adult-to-adult working and highlighted the factors that enable or inhibit such approaches.

The inquiry was delivered by colleagues from **City St George's, University of London** who contributed to the design and review of the inquiry process.

4. KEY THEMES: BARRIERS & ENABLERS

This section explores the core findings of the two-year inquiry, identifying the key barriers that prevent effective partnership between adult social care providers and statutory partners - and the enablers that support more relational, adult-to-adult working.

4.1 Barriers to adult-to-adult partnerships

4.1.1 Parent-to-child dynamics: a default system setting

Across the inquiry, a recurring theme was the persistence of hierarchical dynamics with care providers often seen as the 'child' to the statutory sector's 'parent'. Even though the case studies identified by this inquiry reveal there are encouraging signs of improvement, care providers are not yet consistently treated as equal partners 'from boardroom to bedside'.

This unequal parent-to-child dynamic undermines trust and limits innovation.

4.1.2 Registered managers: responsibility without power

Registered managers (RMs) of care services often perform highly demanding, multi-faceted roles, yet feel that the wider system fails to fully recognise this. Many reported feeling isolated, vulnerable, and undervalued.

While it is true that professionals across councils and health agencies face significant pressures, registered managers told us their challenges are distinct. These differences can undermine effective partnership working, both operationally and strategically. A core issue is the perceived power imbalance between registered managers and other health and social care agencies - registered managers frequently carry significant responsibility without the corresponding authority to effect change.

The opportunity cost of failing to empower this vital group within the care system is significant.

4.1.3 Negative myths shaping reality

Social care often brings people face-to-face with some of their deepest fears about ageing, frailty, illness, and death. In the face of such strong emotional responses - and enduring negative stereotypes - it can be difficult for people to fully acknowledge, let alone embrace, the positive contributions that social care can make to individual lives and communities.

The system in England is based on a mixed economy of care, with both not-for-profit and for-profit providers operating within the same system. This has resulted in several myths and narratives that are deeply embedded on all sides. Some individuals working within the system view care providers as 'overly profit driven', lacking in professionalism or values. Conversely, care providers themselves may hold negative assumptions about their colleagues in health and social care - seeing them as bureaucratic, wasteful, slow, or insincere.

Such attitudes steadily erode confidence in the care sector and in those who deliver care. Even among the most skilled and committed registered managers, there is a sense of being regularly mistrusted, their expertise and judgement too often dismissed. It can feel as though professionals from other parts of the system are looking for evidence to confirm their negative assumptions - searching out poor practice rather than recognising the good.

The most harmful consequence of these myths is their power to shape reality.

When registered managers or care providers are not trusted or valued, we risk creating a sector that

does not feel appreciated - and which may, in turn, begin to reflect those very assumptions. This dynamic mirrors the 'Critical Parent - Reactive Child' model of interaction, where one party's criticism leads to defensiveness in the other, ultimately undermining productive relationships.

4.1.4 Relationships embedded in a procurement model

Typically care services are part of procurement processes with adult social care teams within councils and sometimes with the Integrated Care System. Procurement rules and systems, by their nature, are very linear, and do not support co-creation or partnership and involve processes which exclude the need for relationships. Typical transactional tender processes can make it difficult to co-create with providers; co-design new services or indeed simply problem solve together. As one commissioner put it:

"You're the commissioner and they are the providers and there needs to be clear blue water".

This therefore leads to an inherent power imbalance between purchaser and provider. It also means that roles within the wider health and social care system can be predominantly about contract monitoring and compliance which can feel adversarial and lacking a spirit of cooperation and flexibility.

This approach to procurement means that registered managers are rarely genuinely involved in resolving shared issues.

4.1.5 Cultures of fear and blame, especially in safeguarding

A strong theme throughout this inquiry was the apparently inherent blame culture within health and social care. Many spoke of a system where responsibility is frequently deflected and where self-protection takes precedence over openness. It is, perhaps, the biggest barrier to good partnership working. The perception that there is a culture of 'passing the buck' and self-protection is very strongly held.

Safeguarding should be about working together, collaboratively and openly, for the benefit and safety of the vulnerable person. We were told that it can often be used as a weapon; an instrument of threat to control. This raises anxiety levels, reducing collaboration, and results in what can be an accusatory and demoralising situation.

Many care providers told us how too often they experienced an embedded culture of being 'told what to do' by the wider system rather than being listened to.

Overall, the culture of blame and mistrust, coupled with relationships being framed around procurement and compliance do not support good partnership-working or equal status between registered managers and their counterparts in councils and in health. This creates real inherent dangers. A culture that nurtures a lack of candour with key stakeholders hiding issues for fear of the consequences, is highly problematic.

4.1.6 Structural disconnects and low visibility of care leaders

Care services are often positioned outside the core structures of the wider health and social care system. They are frequently perceived as separate or 'other', making them more likely to be excluded from new initiatives and less likely to have a clear understanding of the system's key actors, their responsibilities, and the support available. This disconnect can be compounded by a broader lack of understanding of social care among commissioners, system leaders, and middle managers.

As a result, the perspectives of social care leaders are sometimes overlooked - particularly when decision-makers are under pressure and do not instinctively consider the sector.

Care services also tend to operate at the end of the care pathway. Individuals are discharged from hospital either to their homes or to care homes, with contractual arrangements in place for care providers to respond. However, discharge-related issues often arise, and providers can be left feeling isolated as they attempt to seek support from other agencies. It is at these points - when providers are managing complex situations with limited support - that care leaders can feel most alone, with few options for escalation or collaboration within the system.

4.1.7 Short-termism and reactive culture

A clear theme in the literature review was that integration is not a short-term process (Erens et al., 2019), yet there is often an unwillingness to wait to see the impact, with pressure to respond to restructures and new initiatives.

Short-termism can not only undermine long-term planning, but also favour command-and-control approaches, particularly when under pressure.

4.1.8 Limited resources

When resources are tight, the finger-pointing between care professionals and wider agencies can escalate. Despite the need for even greater flexibility and collaboration during times of austerity and crisis, the opposite can occur. Pressure and stress results in practitioners and whole organisations retreating into themselves and, where they can, denying the collective reality.

According to the literature review, while integration is increasingly important, it cannot address major inadequacies in resources and structural inequalities: this has been termed the 'integration paradox' (Erens et al., 2019). The operational, regulatory and funding differences between health and social care systems pose significant challenges to effective collaboration and partnership working (Shand and Turner, 2019).

4.1.9 Limited data sharing

While progress has been made, it still remains difficult for digital and data systems across care providers, local authorities and the NHS to work together efficiently, consistently and safely.

Digital and data transformation is one of the best tools available for joining up care around people and supporting partners to work more efficiently together. Genuine partnership - including risk sharing across the whole system - is essential to effective data sharing.

4.2 Enablers of partnership and adult-to-adult working

4.2.1 Respectful relationships based on trust and shared goals

Where effective partnerships between providers and statutory partners were in place, they were consistently grounded in a sense of mutual respect, recognition of expertise, and a commitment to shared outcomes where both parties took responsibility for their role, listened actively, and worked together to solve problems rather than assign blame.

In these contexts, providers reported feeling trusted to act in the best interests of the people they support. Dialogue was frequent, transparent and not confined to moments of crisis. The inquiry found that shared purpose - such as improving outcomes for individuals leaving hospital - was a particularly strong foundation for collaborative behaviour.

The case studies described in this report indicate that where adult-to-adult dynamics begin to emerge, more constructive and effective joint working is possible. For example:

- Co-designing more flexible funding arrangements can support people with complex or fluctuating needs.
- Open cultures that draw on frontline insight may help anticipate issues and enable more responsive joint problem-solving.
- Consistency and trust in assessment roles may improve discharge planning and reduce readmissions.
- Commissioning approaches rooted in trust and collaboration may lead to better outcomes and greater value.

4.2.2 Confidence, voice and support for care provider leaders

The confidence and voice of individual care provider leaders - particularly registered managers - emerged as an enabler of effective partnership. Leaders who had access to peer support, mentoring, and professional development opportunities were more able to engage proactively and constructively with system partners.

My Home Life England's long-standing work with over 2,600 care leaders shows that investment in leadership development can shift how care services engage with external stakeholders. For example, in Sefton, the council's Director of Adult Social Services commissioned MHLE to deliver a Continuous Professional Development Programme for registered managers. This helped strengthen their confidence and voice as leaders and supported them to engage more meaningfully with commissioners. New relationships formed, grounded in mutual understanding. As one person put it:

"We began to see each other as just people, just trying to do our best."

Emerging and more isolated leaders particularly benefit from these kinds of enabling structures. Access to mentoring and peer networks helps them build confidence, find their voice, navigate the wider system, and see themselves as legitimate and valued participants in local planning and decision-making.

Other case studies indicate that opportunities to observe or take part in strategic roles also encouraged greater mutual understanding. Focusing on strengths, as well as challenges, appeared to help build confidence and participation.

4.2.3 Trusted and supported care provider representation

Care associations can play a vital role in representing the diverse range of provider organisations in key discussions with statutory agencies. This inquiry identified several positive case studies where care associations were able to support members collectively.

To be effective, however, these associations must have good governance arrangements, be independent from the influence of any one provider group and be able to engage with and represent a diverse range of care providers. They should also understand and represent the experience of registered managers in particular, and work in adult-to-adult ways. If they do not, they risk exacerbating unequal relationships with the wider sector or under-representing vital parts of the care provider market.

Effective care associations are also seen as valuable delivery partners, often taking on operational activities from councils or national programme - such as Better Security, Better Care where trade associations are funded to support care providers in their area on data protection and cyber security.

However, the inquiry found they often operated on insecure funding or volunteer capacity, limiting their sustainability.

4.2.4 Consistent engagement, communication and emotional safety

Partnerships appear to be more effective where there was sustained and consistent contact between providers and system leaders.

According to the literature review, co-location - either physical or virtual - can also enable informal problem-solving and helped demystify roles and responsibilities.

At national level, virtual networks - such as the 29 local support organisations and national team delivering the Better Security, Better Care programme - have proved effective.

The case studies indicate that regular communication and information sharing played a key role in supporting joint working. Examples included:

- Sharing timely or informal intelligence to support local decision-making.
- Conversations that highlighted strengths and good practice, as well as challenges, to build shared understanding.
- Ongoing dialogue - such as through regular meetings - that supported responsiveness.

Emotional safety also underpinned constructive relationships. Where care providers felt able to speak openly without fear of judgement or sanction, collaboration and shared learning became more feasible. In some instances, a neutral third party helped to create these safer spaces, including in interactions with regulators.

4.2.5 Leadership that suspends hierarchy

Both the literature review and case studies highlighted the value of leaders who recognise and respect the roles and contributions of others, actively involving all partners from the outset. Effective leadership was linked to a commitment to reciprocity, trust, and a shared vision, rather than reliance on formal hierarchies.

This review found several examples of system leaders who intentionally set aside hierarchical structures to foster collaboration. These leaders showed humility, curiosity, and a readiness to learn - qualities that helped model adult-to-adult ways of working across teams.

They used their influence to create space for difficult conversations, challenge defensiveness, and amplify voices that are often unheard.

For example, in the South West, the Director of Adult Social Services said:

"Of course there is sometimes frustration, but we deal with things head on, with a starting point of respect, acknowledging the value of the sector, the important role that they play, helping others better understand social care, and appreciation of what they do."

4.2.6 Transparency and accountability

Clear roles, responsibilities and expectations - whether within forums or partnership structures - seemed to support more transparent and effective collaboration. However, the behaviours and attitudes of those involved were often as important as formal arrangements. A willingness to listen, adapt, and collaborate made a noticeable difference.

Where providers were recognised and, in some cases, financially supported for their time and input, they were more able to engage meaningfully. Local systems that acknowledged the operational pressures providers face - such as staffing challenges - were often better placed to build sustainable relationships.

Collaboration requires transparency and being approachable, but also clarity about who has ultimate control and accountability.

Even in the absence of a fully integrated data sharing system, sharing information data and informal insights can enable all stakeholders to have a clearer picture of what is happening across an area. Care providers can bring insights from the frontline which reflect the experiences of people drawing on care, families, staff and the care provider.

4.2.7 Joint working and problem-solving

In some of the case studies, collaborative working between care providers and system partners contributed to more joined-up approaches. Reported benefits included:

- More effective use of local resources and improved service delivery.
- Timelier, person-centred responses - particularly in relation to hospital discharge.
- Shared exploration of system challenges and more aligned approaches to issues like workforce development.

Partnerships appeared to strengthen when participants focused on common goals and engaged in collective problem-solving.

4.2.8 Local delivery and decentralisation

Decentralised models, where national programmes are delivered through local partners, may offer a more flexible and cost-effective approach. Trusted local organisations have, in some areas, helped to reach and involve providers who might otherwise remain disengaged, and to tailor support in ways that reflect local priorities and capacity.

5. CASE STUDIES

5.1 Key themes

These case studies demonstrate current and potential good practice and lessons for other areas. The key themes and lessons from the detailed case studies are summarised below. Full case studies are available in Appendix 3.

Partnerships in adult social care work best when providers are treated as equal partners, with relationships built on trust, respect and collaboration. Where this happens, it supports flexible funding, better discharge planning and more responsive care.

Culture and leadership matter. Inclusive local leaders who listen and support provider involvement help shift away from hierarchy. Care associations can also play a key role - if they're independent, representative and well-resourced - by coordinating activities and maintaining neutrality.

Structures alone are not enough. Open behaviours, recognition of providers' time and shared problem-solving are essential. Regular communication, safe spaces and neutral facilitation help build trust.

Locally delivered approaches, shaped by trusted partners, can better engage providers and make national programmes more responsive, inclusive and cost-effective.

5.2 Summary of case studies

5.2.1 Sefton: How an emergency catalysed transformational change

During the Covid-19 pandemic, Sefton invested in developing and supporting registered managers of care homes and built their confidence to engage with commissioners via the Care Home Cell. Post-pandemic, they redesigned the care provider forum giving registered managers more influence and time for reflection.

Outcomes: A culture of more equal partnership working has become embedded. While it is difficult to prove a direct causation, over 80% of care homes have a Good our Outstanding CQC rating.

Lessons learned: Investing in registered managers' confidence and skills helped them become stronger leaders and more effective system partners. Redesigning care provider forums to be chaired by care managers, with time for peer support and shared agenda-setting, fostered genuine collaboration.

5.2.2 Midlands: Improving care quality and value for money

A nursing home in the Midlands, already working closely with the local NHS Continuing Healthcare (CHC) team, helped shape a more flexible approach to commissioning. The registered manager recognised that rigid staffing models were not responsive enough for someone with complex, fluctuating needs. By building trust and sharing insights from the front line, the provider and CHC team co-designed a more adaptable funding arrangement. The council's adult social care team also worked differently, responding to safeguarding concerns through dialogue rather than defaulting to compliance.

Outcomes: The individual received more personalised care, and the ICS saved approximately £50,000 per year, per person.

Lessons learned: Adult-to-adult partnerships are rooted in trust, mutual respect and flexibility - enabling joint problem-solving and a shared approach to risk.

5.2.3 South West: Better strategic and operational decisions at place level

In one South West county (who preferred to remain anonymous), the local care association is seen as a strategic partner. Council leaders, care providers, NHS partners and others invested time in building trust - through one-to-one discussions and a shared recognition of providers' limited capacity. Financial support was agreed to enable providers to participate fully. Leadership development, including system shadowing and board roles, created future care leaders who could contribute meaningfully to the ICS.

Outcomes: The care association now manages its own workforce strategy aligned with the ICS People Plan, leads the Trusted Assessor programme, supports health promotion, and provides early warnings on market risks.

Lessons learned: Strong adult-to-adult relationships are built on trust, financial fairness, inclusive leadership and clear roles - enabling more effective and sustainable system working.

5.2.4 Northeast London: Innovation, engagement and recruitment

Care Providers' Voice (CPV), a care association formed during the pandemic, has become a trusted partner to all seven Northeast London boroughs. From April 2024, local authorities agreed CPV would lead on several core programmes. This shift reflects a strong culture of mutual respect and shared purpose. CPV coordinates directly with councils to lead recruitment, provide sector intelligence, and support cost-effective training across the region.

Outcomes: CPV's leadership has improved recruitment outcomes, widened training access, and enabled better insight sharing. Their input has strengthened contract specifications and raised the profile of the provider voice in system decisions.

Lessons learned: Adult-to-adult partnerships flourish when care providers are trusted to lead. Delegating responsibility builds ownership, strengthens collaboration, and ensures real-time system insight.

5.2.5 Hertfordshire: Reducing pressure on councils whilst supporting care providers

Hertfordshire Care Providers Association (HCPA) is a well-established, independent association supporting over 760 providers. With more than 70 staff, it delivers training, mentoring, recruitment, inspection support, and a telephone helpline. Funded through a council contract but organisationally independent, HCPA facilitates inclusive engagement through forums, surveys and meetings. It gathers and shares insight across the whole sector - from homecare to residential - without favouring any provider group.

Outcomes: HCPA resolves issues early, reducing pressure on the council. It supports NHS-aligned training and shares intelligence from care staff, families and clients to inform faster, more responsive system decisions.

Lessons learned: Adult-to-adult working benefits from impartial representation, mutual trust, and clearly defined roles. Independence enables honest dialogue and helps align local authority and provider priorities.

5.2.6 Dorset: Trusted assessor and hospital discharge

In 2023, Dorset Care Association launched an independent Trusted Assessor service with Dorset Council and the ICS. Assessors - often former care managers - work for providers, not the hospital discharge team. They review medical notes, attend ward rounds, coordinate welfare checks and discharge logistics, and ensure care providers are informed and confident before accepting people into their services. The service operates six days a week, with tailored support for people with complex needs.

Outcomes: More than 2,500 discharges have taken place with no failed placements or readmissions. The service is now seen as essential and is being rolled out in new areas.

Lessons learned: Clear roles, sector expertise and mutual trust underpin effective adult-to-adult partnerships. Independence and credibility ensure safe, timely, person-centred hospital discharges.

5.2.7 South Warwickshire NHS Trust: Enhanced Health in Care Homes Model

South Warwickshire NHS Trust reshaped its approach to care home engagement through the Enhanced Health in Care Homes Model. Previous working groups included only health system representatives, and early efforts to involve care homes failed. A second recruitment round, with a more positive tone, succeeded in engaging a few registered managers. One challenged the group to "talk about what's going well", prompting a shift toward sharing good practice.

Outcomes: A Collaborative Group now includes registered managers as co-leaders. This has improved understanding, engagement and shared solutions across the system.

Lessons learned: Adult-to-adult partnerships grow when care homes are treated as equal contributors. Highlighting strengths, not just problems, builds confidence and genuine collaboration.

5.2.8 West Midlands Care Association: Cult of personality

The West Midlands Care Association (WMCA) noted a stark contrast between local authorities - with one standing out for its consistently open, respectful and responsive engagement. A regular Strategic Providers Group created space for genuine dialogue, with senior, stable leadership from the council. The local authority was clear about its remit and honest about limitations. When concerns were raised, it followed up - often conducting deeper dives to understand harder-to-reach providers.

Outcomes: The result was a more confident, collaborative provider community. WMCA became a trusted intermediary between the sector and commissioners.

Lessons learned: Adult-to-adult relationships are built through consistent leadership, transparency, and trust in intermediary organisations to amplify provider voices safely and constructively.

5.2.9 Northern Ireland: Relationship with regulator

My Home Life Northern Ireland (MHL NI) worked with registered managers who, in the very early stages of the My Home Life NI programme (2014/2015), described their relationship with the regulator - RQIA - as formal and exclusively focused on the inspection process. MHL NI invited a senior inspector to a leadership support workshop, creating a non-inspection space for open conversation. This began an honest dialogue about confusion, myths and barriers. The regulator began attending regular MHL workshops and invited MHL NI to engage with a new initiative they were rolling out on Inspection Support Volunteers.

Outcomes: RQIA is now seen as a supportive partner and an important resource to support the work of care home staff. Registered managers feel more confident to speak openly, enabling earlier identification and resolution of issues.

Lessons learned: Adult-to-adult partnerships between regulators and providers depend on shared language, mutual respect and safe spaces for honest exchange - outside the context of judgement.

5.2.10 National: Better Security, Better Care (BSBC)

The Better Security, Better Care programme helps adult social care providers manage data securely and complete the Data Security and Protection Toolkit (DSPT). A decentralised model was adopted from 2021, working through local care associations, and in some instance NHS partners, as Local Support Organisations (LSOs) who used an adult-to-adult, peer-based approach.

Outcomes: By June 2025, over 76% of providers had published a DSPT, up from 15% in 2021. Engagement improved significantly, even among smaller and hard-to-reach providers.

Lessons learned: Adult-to-adult engagement, rooted in local relationships, builds trust and confidence. National initiatives succeed when local partners are involved and they lead, listen, and speak the same language as providers.

5.2.11 Lincolnshire: Enabling the homecare market to run itself

Lincolnshire redesigned its homecare model by appointing a lead provider in each of its 11 localities. These providers coordinate all care in their area and must subcontract at least 10% to others, sustaining a diverse market. Weekly virtual meetings bring providers and professionals together to focus on individual needs and safe discharges. Direct communication replaces intermediaries, enabling fast, collaborative responses.

Outcomes: Discharges are more timely and coordinated. Providers and health professionals work more closely, taking shared responsibility for managing risks and keeping people at home when possible.

Lessons learned: Trust, shared accountability, and direct dialogue are the foundation of adult-to-adult working. When professionals coordinate as equals, system responses become faster, fairer and more person-centred.

6. RECOMMENDATIONS

The insights and evidence provided in this appreciative inquiry corroborates the World Health Organisation view that:

> *"any integrated model development is strongly contextually-bound, nearly impossible to replicate and can only be successful if it does account for unique needs and characteristics of the population it aims to serve"*
>
> (THOMSON AND CHATTERJEE, 2024)

We also know that, as one strategic commissioner noted:

"We cannot afford not to engage care leaders...."

To this end, our primary recommendation is for national, regional and local systems to reflect upon their own behaviours, processes, practices and policies to consider how they can support improved partnerships with one another, building upon what works well and what can be even better.

Crucially, what can all parties charged with supporting those who draw on social care do to emphasise, promote and embed adult-to-adult relationships critical for effective partnership?

Our recommendations **reinforce the conclusions of the Messenger Review**, which highlighted the need for **consistent leadership standards** and **development opportunities across health and social care**. In particular, Messenger stressed that collaborative leadership should be institutionalised through induction, mid-career development and unified standards that build inclusivity and teamwork across boundaries. We see adult-to-adult partnership working as the practical expression of this agenda within social care, helping to turn those national recommendations into lived reality at local level.

Stakeholders could, for example:

- **Embed person-centred and relationship-centred care**. Focus on what matters most to people and families and ensure that frontline relationships are supported by trust throughout the system.
- **Adopt adult-to-adult dynamics as a guiding principle for partnership**. Relationships should be based on trust, mutual respect, accountability and openness-not control, compliance or blame.
- **Reflect on behaviours, processes and policies**. Ask whether they reinforce parent -child dynamics or create space for collaboration and trust.
- **Recognise and resource care provider leadership**. Enable registered managers and provider representatives to participate fully in system design and improvement work.
- **Strengthen the role of local care associations and forums**. Support them to act as independent, strategic connectors and delivery partners across the sector.
- **Invest in relational skills and cultures**. Training, leadership development and system design should reinforce adult-to-adult behaviours and values.
- **Develop the potential future care leaders who can lead on a new vision**. Identify and support future care leaders and enable them to develop and implement a new vision for the care sector.
- **Care providers need to be supported to change their own behaviours**. This can lead to changes in relationships with other system stakeholders.

6.1 Reflective questions

We have developed a series of reflective questions to support deeper thinking and action. Some of these are specific to stakeholder groups (See Appendix 5); others are shared across the system.

Common reflective questions include:

- In what ways are we involving people who draw on care, and their families, in shaping decisions and priorities?
- What patterns of relationship do I tend to adopt in high-pressure situations? Do these promote trust or control?
- How does my organisation respond to risk? Are we creating conditions for shared accountability, or defaulting to blame?
- What spaces do we create for honest, two-way feedback between providers and commissioners or regulators?
- Are we recognising the leadership and insight that care providers bring? What might we need to do differently to enable this?

These questions are intended to spark dialogue and reflection, not to assign blame. Change begins with awareness, and with a willingness to explore how our own behaviours and assumptions shape the wider system.

7. REFLECTIONS & NEXT STEPS

This report is not the end - it is an invitation to co-create a better, more human system. We have shared examples and insights that show what is possible when adult-to-adult relationships between care providers and the wider health and social care system are nurtured. At the heart of this work is a clear message: **structural reform without relational reform will fail**.

Many reviews, strategies and reforms have focused on redesigning systems and processes. While important, these efforts will fall short unless we also **invest in how people relate to each other**. As the Messenger Review made clear, leadership and collaboration need to be developed across the whole health and social care system if structural reform is to succeed. Our findings echo this national call: lasting improvement depends not only on new frameworks, but on the quality of relationships and the culture of leadership that sustains them.

The case studies in this report show that **when people are trusted, respected and engaged as equals, the benefits ripple outwards**:

- Care services can become a more central, connected part of the wider care and health system.
- Those drawing on care can have better outcomes.
- Local authorities gain more sustainable partnerships with care providers.
- Commissioners can codesign more efficient ways of commissioning services for outcomes.
- The NHS sees smoother discharges and less crisis-driven activity.
- Regulators can develop more supportive relationships with providers.
- Health and care staff can work collaboratively and support each other's development.
- The care sector takes responsibility and leads its own agenda for improvement and professional development.

Everyone stands to gain when relationships are rooted in trust, shared accountability and mutual respect.

We know that this shift isn't easy. Moving from hierarchical, parent-to-child, to adult-to-adult dynamics challenges long-held roles, behaviours and assumptions. But it is necessary - and it is already happening in pockets of promising practice across the country. This report shines a light on what's already working and asks what more is possible.

Change begins at home

My Home Life has worked with thousands of care leaders across the UK, supporting them to improve how they engage with external agencies. Through this work, we have seen care leaders shift from feelings of defensiveness, anger, and anxiety to becoming more confident, articulate, curious, collaborative, and open to compromise.

Any change in the relationship between the care sector and the wider system must begin with change within individual care leaders themselves - enabling them to influence how they are perceived by external stakeholders. This shift often involves moving from a hierarchical parent-to-child dynamic to a more equal adult-to-adult relationship.

Building on this insight, we are now exploring how the care sector as a whole might develop its culture and practice, in order to positively influence how it is viewed by wider society and statutory systems. We recognise that, as a sector, we may need to make an active and sustained effort to model the values and behaviours we wish others to see - helping to challenge longstanding myths and assumptions about care.

We have included **reflective questions** (Appendix 5) to support honest conversations across the system. We encourage you to engage with these - and to let us know what you think. What resonated? What challenged you? What do you plan to do differently as a result? What is missing?

This report is a living document. We, the authors, **commit to updating and refining it** based on your feedback. Our intention is to keep learning, keep challenging, and keep building a community of practice around these ideas.

We also invite you to take ownership of this work in your local context. Use the questions. Share the examples. Convene your own conversations. Invest in the relationships that underpin everything else. If we want a system where people feel safe, heard and supported - whether they are delivering care, drawing on it, or working alongside it - we need to start by relating differently.

The future we want is already emerging. Let's build it together - one respectful, adult-to-adult relationship at a time.

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APPENDICES

Appendix 1 - Stakeholder engagement

As of May 2025, 90 people contributed to the inquiry. In order to ensure complete openness and honesty on what can be a sensitive topic, we ensured that individuals would not be named and that insights would not reveal their identity.

Table 1: Sources

Meetings with individuals	35
Participants in workshops	55
Total	90

Additionally broad insights were informally captured from reports describing My Home Life's leadership support programmes delivered to 2,600 care leaders over the past 19 years.

Table 2: Roles

Roles	**Nos engaged**
Individual care leaders (registered managers, providers)	59
Representatives of local care associations	6
Representatives of national care associations	3
Local authority commissioners or Local ICB representatives	19
Other national/ regional stakeholders (CQC, ADASS, DHSC)	3
Total	**90**

Table 3: Geographical spread

Region	**Nos engaged**
South East and London	68 (predominantly care leaders in London)
North West	2
North East, Yorkshire and Humber	5
Eastern England	3
East and West Midlands	4
National/Regional/ UK	4
South West	2
South	2
Total	**90**

Themes

The discussions and workshops explored key themes around the roles and responsibilities of individuals in partnership working; the extent and appetite for strategic engagement with care providers; current good practices; barriers and opportunities for improvement; mutual benefits of collaboration; and the changes needed from both care providers and the wider health and social care system to strengthen partnership working.

APPENDIX 2 - LITERATURE REVIEW SUMMARY

The review identified 31 relevant papers and 10 conference abstracts. (See References). Key findings from the review are summarised below.

Definitions and limited evidence base

- **Integration is hard to define** and there are many different models and approaches, which further complicates evaluation (Malik et al., 2020; Miller, Glasby and Dickinson, 2021).
- **Integration is not a short-term process** (Erens et al., 2019), yet there is often an unwillingness to wait to see the impact, with pressure to respond to restructures and new initiatives.
- **Many interventions focus on healthcare outcomes** for individuals (Kaehne, 2019): this distorts the concept of genuine partnership between health and social care from the outset.
- **The evidence base is limited** (Miller, Glasby and Dickinson, 2021), particularly regarding 'what works for whom under what circumstances' (Kaehne, 2019). The evidence that it achieves successful outcomes does not appear to be strong (Billings and Davis, 2016).
- **There is a 'paucity of robust research' for evaluating interventions** involving health and social care services in partnership with community stakeholders. (Thomson and Chatterjee, 2024). Their rapid evidence review of the barriers and enablers to integrated care in the UK reinforces that there is no 'one size fits all' approach and the importance of identifying which elements of integrated care are linked to successful, meaningful and sustainable outcomes.

Barriers to partnership working

- **The system undermines partnership working** in many ways. Commonly cited infrastructure barriers include: incompatible IT systems, and difficulties in communication and data sharing across sector boundaries (Gudnadottir, Bjornsdottir and Jonsdottir, 2019; Cheng and Catallo, 2020; Lalani, Bussu and Marshall, 2020; Macinnes et al., 2020). An example given is a care home manager calling the ward for information about an admitted resident and being told: "You're not a relative, we can't tell you anything." (Cook et al., 2016).
- **There is a perceived disconnect between senior leaders and staff** working with the 'patient' or person, with different preoccupations or priorities creating tensions.
- **Organisational cultures** often hinder partnership working, even more so when several 'cultures' come together (Griffith and Glasby, 2015).
- **Different professional roles and perspectives** can create significant challenges. For example, insufficient knowledge of each other's roles can lead to misunderstandings or feelings of being "invaded" (Gudnadottir, Bjornsdottir and Jonsdottir, 2019).

Enablers of partnership working

- **Relationships were seen as crucial**, with communication, accessibility, information sharing and flexibility also being vital.
- **A clear understanding and appreciation of each other's roles and contribution** is a requirement for successful partnership working. This includes avoiding hierarchal patterns, and involving all partners from the start (Macinnes et al., 2020). Building reciprocity and trust are key, underpinned by a shared vision with strong leadership (Malik et al., 2020; Clifford, Squires and Wood, 2023).

> *"The quality of professional relationships is paramount in enabling organisations to move forward as one system"*
> JONES, 2020

- **Sharing a physical space** (co-location) builds relationships and supports information sharing and "corridor conversations" (Lalani, Bussu and Marshall, 2020).
- **Protected time to reflect together** (e.g. in workshops, and joint training/ reciprocal learning) can be a crucial part of the integration process (Jones, 2020, Park et al., 2024).
- **Language is important**: it can subtly delegitimise partnership working, or it can equally signal equality of status across different parts of the system (Thomas, 2015).
- **The scale and context** of an integrated project often contributes to its success (Macinnes et al., 2020), with many of the examples reported being on a small scale in a regional area – "keep it simple" and "less complex and smaller scale initially", with "a clarity of purpose and vision" (Round et al, 2018).

APPENDIX 3 - CASE STUDIES

These case studies spotlight where investment in adult-to-adult relationships has appeared to lead to improvements in collaboration and effective partnership working. Some have been examples of where My Home Life England (MHLE) has been engaged, but some are where other local initiatives have driven change.

Sefton - How an emergency forged more effective partnerships

BACKGROUND

This case study from Sefton, North West England, demonstrates that a crisis, combined with targeted support to registered managers, can drive change and better engagement between a local council and care services. It shows that **a truly relational commissioner and care provider forum can be transformative**.

THE ISSUE

Before the pandemic, **Sefton Council** described relations between care providers and the Council as 'challenging'. In March 2020, at the beginning of the Covid-19 pandemic, news reports were coming from Spain of abandoned care homes and residents found dead in their beds. The shock of these reports changed the way Sefton Council viewed their relationship with their care homes saying:

"If we fail care homes now, we have utterly failed as humans".

The crisis exposed both the vulnerability and the importance of care homes and particularly registered managers.

As in some other areas of the country, Sefton set up a **Care Home Cell**. This was a multidisciplinary group, including care home registered managers whose roles were to: ensure provision of PPE, share staff across the sector, coordinate hospital discharges and solve problems rapidly.

Initially the Care Home Cell was very prescriptive. Although the intention was always to help and support care homes, the meetings were often one-way – an example of a parent-to-child relationship in Transactional Analysis terminology. Council and NHS partners were often focused on information giving, presentations, and dissemination of national government guidance, and not on collaborative working.

As a result, care home managers did not have the space or confidence to fully contribute or problem solve collectively.

ACTIONS

The Council recognised that in order to **develop and sustain a genuine partnership approach** to the Care Home Cell, the care home managers needed **support to improve their own professional confidence and resilience** - and in turn, to improve the culture of the care within their services.

The Council **commissioned My Home Life England** to run a 9-month Professional Development Programme for a group of care home registered managers. The programme created a space for reflection, helped to build confidence and a sense of joint working - enabling care managers to consolidate their 'voice'. One participant said:

"I feel like I'm not JUST a care home manager now."

Another said:

"Before this I was just about to resign."

My Home Life England then supported these managers to engage effectively with commissioners and to work better together. After the first cohorts of the programme graduated, **two summits were held**.

The first focused on the learning from the programme - particularly around peer support, self-reliance, and navigating uncertainty during the pandemic. The second summit brought together registered managers who had graduated from the programme, along with care home leaders, council officers, and members of the South Sefton Enhanced Health in Care Homes team. The group reflected on what had worked well during the pandemic and considered how to sustain those relationships in the future.

OUTCOMES

Care home managers who graduated from the programme **developed their leadership skills and grew in confidence**. This enabled them to be viewed as more equal partners by the wider system, who recognised that they benefited from hearing the perspectives of these individuals.

Boundaries blurred while the focus on a common purpose sharpened: to deliver effective support to the staff and residents in local care homes. So developed a different set of relationships: People got to know, and crucially, to understand each other's problems and challenges. One person reported that:

"We began to see each other as just people, just trying to do our best."

One important outcome has been the **redesign of provider forums**. These were split into two: one focused on quality and collaboration, and another on finance and commissioning. This separation helped ensure that financial matters didn't dominate all discussions.

Registered managers were also given more control over forum agendas and structure. The meetings are now chaired by a registered manager, with the first half reserved for peer discussion among managers. Senior commissioners join only in the second half, allowing space for the managers to identify pressing issues and areas for joint working.

Managers are able to raise concerns early at the Forums before they reach a crisis point. This has improved council / provider relationships – and reduced strain on the care providers.

The Council believes that the Forum has also supported service innovation. Regular Forum participants are able to receive direct briefings and Q&A sessions on new tender, funding and pilot scheme opportunities. This in turn enables them to respond more effectively to funding, grant and pilot scheme opportunities.

Council staff also began visiting individual care home managers, enabling them to engage with managers who are less directly involved in the Forum.

Building on the pandemic response, the **new relationships have become embedded**. These changes have brought a lasting shift in the way Sefton works with care homes. A more relational and collaborative culture has taken root. Trust has grown, and there is a widespread sense that the old way of doing things won't be returning.

While it is difficult to prove a direct causation, more than one person shared the fact that **over 80% of care homes in Sefton have a Good or Outstanding CQC rating**.

LESSONS LEARNED

Crises can spark change - but only if power and vision are shared:

- Initial Council-led responses were top-down.
- Real partnership began when care home managers were empowered to contribute equally and shape decisions.

Leadership development unlocks confident collaboration:

- Investing in registered managers' confidence and skills helped them become stronger leaders and more effective system partners.

Co-designed forums create space for real dialogue:

- Redesigning forums to be chaired by care managers, with time for peer support and shared agenda-setting, fostered genuine collaboration.

Human connection builds trust across the system:

- When people saw each other beyond roles - as individuals doing their best-trust grew and working relationships improved.

Midlands – Improving care quality and value for money

This inquiry struggled to identify many examples of how individual care services or registered managers have successfully brought to the attention of commissioners where cost savings could be made or where quality could be improved. However, this case study demonstrates that when collaboration is possible, there are opportunities to improve quality of care and make savings.

BACKGROUND

The registered manager of **Julie Richardson Care Home** in the Midlands area had developed a close partnership with the local **NHS Continuing Healthcare team (CHC)**. This nursing home was one of only a few services that specialised in responding to individuals with high levels of complex care – the local CHC team prioritised these services in terms of developing strong working relationships.

THE ISSUE

The registered manager recognised that **the traditional commissioning model was not meeting the complex and fluctuating needs of an individual** receiving 24-hour, one-to-one support. Under the standard procurement approach, the package of care had been set up with little flexibility, meaning staffing levels could not easily be adjusted based on the person's changing requirements due to the prescriptive nature of the commissioning of one-to-one funding packages.

ACTIONS

The registered manager worked closely with the CHC team to build trust. Over time, they were able to demonstrate that **a more flexible, responsive approach to care** could both meet the individual's needs more effectively and make better use of resources.

Together, the care service and the CHC team co-designed **a new funding arrangement** that was less prescriptive. This allowed the nursing home to vary the level of support needed depending on the person's weekly or even daily needs. Importantly, there was an understanding that if the care team successfully reduced behaviours that challenge, this would not automatically trigger a cut in funding - a common concern among providers working with individuals with complex needs.

The Council's adult social care team also adopted a **more adult-to-adult relationship** with the provider, particularly in the handling of safeguarding concerns. Rather than defaulting to a compliance-driven stance, there was a shared commitment to work collaboratively to manage risks and find constructive solutions.

OUTCOMES

This more trusting and flexible way of working resulted in **a clear financial saving - approximately £50,000 per service user per year** to the Integrated Care System (ICS). More importantly, the **quality of support for the individual improved**, thanks to a care package that could be adapted in real time.

LESSONS LEARNED

Trusted relationships enable joint solutions:

- A strong, trust-based partnership between the provider and CHC team allowed honest conversations and co-designed care, showing the value of long-term collaboration.

Flexible models can improve care and efficiency:

- Working together to create a more adaptable funding approach helped meet the individual's changing needs while using resources more effectively.

Adult-to-adult approaches build shared accountability:

- A shift away from compliance towards open, respectful dialogue - especially around safeguarding - supported joint risk management and more constructive outcomes.

South West - Better strategic and operational decisions at place level

Local care associations typically represent care providers and registered managers at a place or county level. These associations are at different stages of their development and are not in every area of the country. There is a sense that care associations have generally developed their role over the past few years. This example illustrates that progression.

BACKGROUND

One **South West county council** (which preferred to remain anonymous) has developed a strong and trusting partnership with their local care association. The Director of Adult Social Services noted:

"I need them, not just as a trade association but as a strategic partner."

THE ISSUE

The Council recognised the importance of **supporting quality in the local care market** and wanted to explore this further.

ACTIONS

Leaders from the council, care provider trade association, hospital trust and other agencies **invested time in building trust**, including through one-to-one discussions rather than in wider or public meetings.

The council recognised that care providers' capacity is limited and precious. **Financial recognition was agreed** to support the time care providers spend on system improvements. This assists care providers to release the capacity to engage in high level meetings and take forward the actions that have been agreed.

All parties recognised that collaboration requires transparency and being approachable, but also clarity

about who has ultimate control and accountability.

Care provider leaders were supported to **shadow key systems meetings** in order to develop their confidence and ensure that there are future care leaders that can play this wider systems role.

The council and trade association also started to identify future talent from the care sector to hold non-executive roles within the ICS.

OUTCOMES

The care provider association manages their own workforce strategy but connects it to the ICS's People Plan to enable resources to be used effectively. For example, they are trying to align social care roles with Band 3 and 4 roles within the NHS in order to bring the workforce closer together and potentially improve recruitment and retention.

The care association is also **running the local Trusted Assessors programme** which has led to improved and speedier hospital discharge.

The association is also **supporting the ICP health promotion strategy** by engaging their workforce, the families of their workforce, service users and visitors to care services to engage in reducing blood pressure and smoking cessation programmes.

The care association has also been able to provide the council with 'early warning' insights about providers who might be at risk of failure or closure. This has enabled the council to act more quickly to manage that risk.

Regular dialogue and open sharing have enabled the council and care providers to tackle strained relationships and resolve issues together more quickly.

LESSONS LEARNED

Invest time in building trust and relationships:

- Strong partnerships depend on mutual trust, which can be developed through consistent formal and informal engagement.

Recognise and support care provider capacity:

- Providing financial support to enable care providers to participate in system-level work helps ensure their sustained and meaningful involvement.

Be clear about roles, responsibilities, and accountability:

- Effective collaboration needs transparency and approachability, but also clarity on decision-making authority.

Create opportunities for future leadership and integration:

- Supporting care leaders to shadow system meetings and take on governance roles (e.g. within Integrated Care Systems) builds confidence and ensures long-term sustainability of partnership working.

Align strategies and resources to maximise impact:

- When local care associations and system partners coordinate their efforts (e.g. aligning workforce strategies) they can make better use of limited resources and drive shared goals like recruitment and retention.

North East London - Innovation, engagement and recruitment

BACKGROUND

Care Providers' Voice (CPV) is a local care association in Northeast London that emerged during the Covid-19 pandemic. Since its formation, over half of social care providers across the region have become members.

CPV was created by several providers who felt isolated and unsupported during Covid. They observed that in Havering, the relationship between the local authority and providers was notably stronger than in other boroughs. Inspired by this, they aimed to replicate that collaborative model across the region and tackle system-wide issues.

In Havering, a membership organisation brought providers together and effectively communicated the challenges in the local care market. A key figure in this success was the Director of Adult Social Services (DASS), whose support - both verbal and practical - made a real impact. She regularly attended online provider meetings and proactively asked how the local authority could support providers, including through government funding.

THE ISSUE

CPV was initially formed without any resources, driven by a desire to offer peer-to-peer support. Provider feedback highlighted major concerns about recruitment, which worsened following the introduction of mandatory vaccinations. CPV Directors gained seats on the **Care Provider Oversight Group for North East London (NEL)**, where they voiced these challenges.

Although both the Integrated Care Board (ICB) and local authorities acknowledged the issues, they lacked solutions. However, the Barking, Havering and Redbridge (BHR) area agreed to **fund CPV to develop its own recruitment solutions**. This became CPV's second key focus: they recruited two job brokers to attract new workers into social care.

The third focus emerged from a challenge back to CPV: How can they build a unified, representative voice for social care across all of North East London - not just in BHR - given the sector's history of fragmented voices?

ACTIONS

From April 2024, **all seven North East London local authorities agreed to support CPV**. A trusting relationship began to flourish - especially in some boroughs - bringing care providers' perspectives to life and fostering a culture of collaboration between providers and local authorities "sitting at the table as equals."

Although initial trust was built through individual relationships and the wide-ranging experience of CPV Directors (both within and outside social care), the model gained further legitimacy as its impact became evident. Directors also held periodic meetings with all NEL DASSs to discuss the sector's journey, challenges, and opportunities to support local authority goals.

Timing also worked in CPV's favour. With Covid-related funding available, the development of the ICB, and the CQC gaining new powers to inspect local authorities, was both a willingness and a necessity for stronger provider engagement.

CPV now has four Directors, representing the original BHR boroughs. Each also acts as a borough lead, working closely with local authorities and the ICB.

As other boroughs joined CPV, paid borough leads were introduced in each new area. These leads are all current care providers working in their respective boroughs, ensuring they understand local dynamics. Each borough lead is also aligned to a CPV Director to support strategic coordination and share best practices.

Each borough tailors its approach based on local needs. Most hold monthly meetings to share feedback, ideas, and performance data. Additionally, there is a quarterly meeting bringing together all provider borough leads and local authorities to discuss lessons learned, progress, and priorities.

In several boroughs, CPV leads also represent providers on safeguarding boards and local borough partnerships.

OUTCOMES

Thanks to the trusted relationship between councils and CPV, they jointly agreed that CPV would lead on key activities - rather than the councils - bringing significant impact.

CPV now runs a highly effective recruitment programme for the care sector. Since job brokers were introduced, **938 job offers** have been made for social care roles. Feedback has been positive. One candidate who was struggling to find work until she met one of the job brokers at the Job Centre, said:

"I had an excellent experience with CPV. I felt supported throughout the process, and I credit CPV for my success in finding a fulfilling career in care."

CPV's job broker supported her through the job search, helping her secure interviews and ultimately a new role. When the first job proved unsuitable, the broker helped her transition to a better-fitting employer. The care worker is now thriving in a role where she enjoys supporting others.

She credits CPV - especially the job broker - for their responsiveness, kindness, and guidance throughout the journey.

CPV now delivers high-quality, low-cost training across all seven boroughs. The programme:

- Is used by 320 providers, covering over 12,500 staff.
- Offers 120+ training courses recognised by Skills for Care as excellent.
- Has reached 25% of the social care workforce in NEL with 242,000 courses completed.

CPV provides regular 'soft' intelligence to boroughs on the care sector, enabling improved problem-solving, early escalation of concerns, and better contract specifications for care providers. As a result, CPV is now seen as the go-to source for insight and engagement with the sector.

Feedback has been positive from key stakeholders:

> *"Since starting my role as Place Director in Havering, I've found CPV incredibly supportive. Mike, John and others have been central to shaping our partnerships and recognising the diverse care provided in Havering."*
>
> NHS NORTH EAST LONDON ICB

> *"Health used to see someone like me as representing the voice of care providers, but I've never run a provider organisation in my life... The ICB no longer comes to us with questions about social care - they go straight to CPV."*
>
> DIRECTOR OF ADULT SOCIAL SERVICES, NORTH EAST LONDON BOROUGH

LESSONS LEARNED

Trust builds effective partnerships:

- Mutual respect has shifted the culture from top-down to collaborative.

Delegated leadership drives success:

- Letting CPV lead on recruitment and training has delivered better outcomes.

Soft intelligence improves responsiveness:

- Regular insights from CPV help councils adapt quickly and improve contracting.

Cross-borough collaboration boosts engagement:

- Working together across all boroughs has maximised reach, training access, and representation.

Hertfordshire - Reducing pressure on councils whilst providing strong support to care providers

BACKGROUND

Hertfordshire Care Providers Association (HCPA) is a long-standing association which has developed a strong, trusting relationship with local care providers and statutory bodies.

HCPA has over 760 care provider members and over 70 directly employed, independent staff delivering a range of services. This includes: telephone helpline for care professionals, recruitment services, mentoring and training, business continuity planning, support on action plans for inspections, and the delivery of what they describe as an 'impartial assessor' role supporting discharges directly within the hospitals.

THE ISSUE

HCPA aims to **represent all care providers in the area**, regardless of service type or business model and it seeks to **create win-win solutions** for both the local authority and providers.

ACTIONS

HCPA has built trust with local care providers, the council and NHS system stakeholders by ensuring that it is representative of all provider types.

Its staffing and governance are completely independent from individual care providers. Member organisations pay a small membership fee which gives them access to HCPA services, many of which are delivered free at the point of delivery via the contract drawn up by the local authority which provides the funding to HCPA for the agreed services.

It facilitates a range of events, forums, surveys, face-to-face and virtual meetings to maximise engagement from all provider types and take the temperature of the overall market.

This ensures that no provider has a bigger voice and enables HCPA to listen, collate and distil all views while covering all provider types including residential and community services.

HCPA also delivers much of the training for care providers in the county, linking this training to regulations and working practices relevant to the Council's policies.

HCPA represents local care providers on a range of boards and commissioning groups, talks with various statutory teams and shares intelligence, without breaching individual care provider confidentiality.

OUTCOMES

The council adult social care team appears to trust HCPA with some operational aspects of improving quality, training and support to the sector, via very regular partnership working, compared perhaps to some other councils.

HCPA identified that through their activity they:

- **Reduce pressure on the local authority and improve care quality**: HCPA helps to identify and manage care service issues before they become major problems. The association also supports providers to remain at a high standard – often acting as a free consultant for a struggling care company. This is a major part of the contract drawn up between HCPA and the local authority. HCPA sees itself as a critical friend to care providers, while the local authority focuses monitoring. This keeps the roles separate while working together.
- **Improve joint training and understanding with NHS**: HCPA offers NHS training to social care professionals, where appropriate, and works closely with system partners to highlight both the similarities and differences between social care and the NHS.
- **Informs the wider system and enables faster, better responses**: By providing intelligence in a timely manner, HCPA helps the wider health and care system to identify, understand and respond to emerging issues. For example, they attend the safeguarding board and market shaping meetings. HCPA shares intelligence about issues facing care providers or care professionals which are often directly or indirectly about the issues that people drawing on care themselves are facing. For example, HCPA collects client and family insights via the Impartial Feedback Surveys which they carry out on behalf of care providers. HCPA also speaks directly to the care workers via its Care Professional Academy.

HCPA is well respected by the local council. There is a real sense that the association is an integral lead in supporting quality in the sector and in enabling care providers to contribute to wider system collaboration.

LESSONS LEARNED

Trust is built through inclusive and impartial representation:

- Independence from individual providers allows care associations to act as a 'critical friend' to the sector while supporting local authority aims.

Clear role boundaries support effective collaboration:

- Trade associations can focus on support and quality improvement, while the council can retain monitoring responsibilities. This clarity helps both parties contribute meaningfully to sector development without overlap.

Sharing timely intelligence strengthens system responses:

- Care provider, staff and client insights enable the wider health and care system to respond quickly and appropriately to emerging issues.

Dorset Care Association - Trusted assessor and hospital discharge

BACKGROUND

In 2023, the **Dorset Care Association, Dorset Council and the wider ICS** collaborated to improve discharge of patients from hospital to local care services. The independent **Trusted Assessor service** was created, recruited for and launched at Dorset County Hospital and associated community hospitals.

The Trusted Assessor service is delivered by Dorset Care Association and funded by Dorset Council to provide a **fully independent hospital discharge assessment service** for every care provider and any individual requiring care and support within the local authority area.

ACTIONS

Dorset Care Association appointed Trusted Assessors with knowledge of the care sector (e.g. former registered managers, nursing home managers) who understand the discharge process for providers and will not allow an unsafe discharge.

To maintain independence, the Trusted Assessors are not part of the Hospital Discharge team. They work specifically for and on behalf of care providers. Their decisions are accepted and respected across all parts of the Integrated Care System (ICS).

Trusted Assessors are responsible for reviewing medical notes, attending ward rounds, and managing all discharge support requirements. They also carry out welfare checks, track patients through community hospitals, and follow up with providers after discharge.

They provide a detailed, up-to-date report before discharge, including changes from baseline, equipment needs, medication updates, and required support. They arrange all necessary appointments and ensure end-of-life plans are in place if needed. Discharge only happens with full agreement from all parties, and ward staff cannot proceed without the Trusted Assessor's support. All documentation, medication checks, transport arrangements, and provider coordination are completed before discharge.

The service operates six days a week, with additional out-of-hours support available for providers supporting people with learning disabilities, forensic needs, mental health issues, and challenging behaviour. Dorset Partners in Care (PIC) fully supports the service and regularly invites the Trusted Assessors to attend all their meetings.

OUTCOMES

The Trusted Assessors have become so accepted by care providers that they are now **regularly completing assessments** for new referrals prior to accepting the individual into their service. This shows the success of the trust and confidence building. The Assessors now offer support 6 days per week, and weekend discharges are accepted by nearly all of the providers.

The Trusted Assessor service has recently been accepted as an Essential Service to the ICS in Dorset.

At the time of this enquiry, over **2,500 discharges** from acute hospital to care provider support had been made with **no failed discharges, readmissions or provider breakdown**.

The Trusted Assessor service is having wider influence. It is fully engaged with the improvement agenda encompassing collaboration, positive and safe community discharges, prevention of bed blocking, policy development, international recruitment and care sector support but, most importantly, the person they support.

The service has been so successful, that Bournemouth, Christchurch and Poole Local Authority commissioned Dorset Care Association to deliver the service in their area. Early indications are that this expanded service is delivering good outcomes.

LESSONS LEARNED

Focusing on one clear, shared issue can drive meaningful change:

- Concentrating collective efforts on a specific challenge - such as safe and timely hospital discharges - helps align partners and resources effectively.

Having the right people with the right skills is essential:

- Individuals with relevant sector experience and understanding of the context can build trust and carry out tasks with confidence and credibility.

Independence, paired with clearly defined roles and strong connections, supports effective partnership working:

- Being seen as impartial yet integrated into the wider system helps ensure decisions are respected and acted on.

Partnerships are strongest when they meet the mutual needs of everyone involved:

- Solutions that work well for individuals, families, care providers and hospitals are more likely to be supported, sustained and successful.

South Warwickshire NHS Trust – Enhanced Health in Care Homes Model

BACKGROUND

South Warwickshire University NHS Foundation Trust (SWFT), guided by the principles of the **Enhanced Health in Care Homes (EHCH) model** and aligned with the **Ageing Well Programme**, set out to strengthen engagement with care homes across their locality. This effort reflects the NHS England vision for EHCH:

> *"This model moves away from traditional reactive models of care delivery towards proactive care which is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach."*
>
> NHS ENGLAND, 2023

THE ISSUE

Initial work to implement EHCH focused on bringing together NHS primary care, community services, the Coventry and Warwickshire Integrated Care Board, and local authority colleagues. However, a key voice was missing - there was **no direct representation from care homes themselves**. This led to conversations and decisions being made without the full picture.

ACTIONS

To address this, the team made a **strategic decision to actively involve care home managers**. An initial presentation was taken to existing local forums to invite participation, but no volunteers came forward. Undeterred, the team returned to those forums, and on the second attempt, a number of care home managers agreed to be involved.

Their impact was immediate. The managers offered grounded insight into what works in practice, helping to shape more realistic and effective plans. A turning point came during one meeting, when a manager asked, *"When are we going to talk about what's going well?"* This simple question shifted the group's approach.

From that point, the focus moved away from problems alone and towards highlighting successful practices, promoting what works, and building on shared strengths. A series of engagement sessions co-hosted by a care home manager marked the beginning of a more collaborative, equal partnership.

Key focus areas emerged, including:

- End of life care
- Falls management
- Personalisation of care
- Skin and wound care

As the group matured, one of the care home managers took on the role of deputy chair, working alongside a chair from the Coventry and Warwickshire Integrated Care Board. This deliberate move positioned care homes as equal partners in shaping local health and care services.

OUTCOMES

Through persistent and targeted engagement, the Warwickshire health and care system has developed a deeper appreciation for the care home sector and its vital role in supporting residents' health and wellbeing.

Recruiting more managers and sharing good practice remains an ongoing effort, but those already involved are strong advocates for the value of participation. The group remains open to new ideas and contributors, with regular updates shared through other care home forums. These forums serve both to keep others informed and to invite broader input, helping to co-create future priorities and improvements.

LESSONS LEARNED

- **Focusing on one clear issue** - such as engaging care homes in line with the Enhanced Health in Care Homes Model - helped bring partners together with a shared purpose.
- **Having the right people involved**, such as registered managers with direct experience of care delivery, was essential to shaping relevant and practical discussions.
- **An independent but collaborative structure**, with shared leadership between the system and care home representatives, created space for trust to grow and voices to be heard.
- **Shifting the conversation to highlight what is working well** encouraged care home staff to engage more fully, helping to build confidence, participation and a more balanced understanding across the system.

West Midlands Care Association - Cult of personality

BACKGROUND

West Midlands Care Association (WMCA) works with a number of local authorities across the region. This broad engagement has given them insight into how relationships between care providers and commissioners differ from place to place.

THE ISSUE

WMCA noticed **a marked difference in its experience with one local authority** in particular. While working relationships with some authorities could be mixed, this local authority stood out for having **particularly positive and productive engagement** with the care sector. As WMCA put it: *"They are always willing to engage and never offer 'lip service'."*

ACTIONS

A regular **Strategic Providers Group** was set up in this local area and became **a trusted and effective space for partnership working**. The local authority's approach was grounded in clarity and professionalism. They were open about what they could influence and took responsibility for the areas within their remit, while being clear and honest about where their influence ended. Their representatives were consistent in their attendance, reliably turning up and holding senior roles within the organisation - something that helped build trust and credibility over time.

When issues were raised by providers, the local authority didn't simply acknowledge them; they actively followed up, sometimes undertaking more detailed 'deep dive' engagement to better understand the root causes. This was particularly valuable for surfacing the experiences of harder-to-reach providers who might otherwise remain unheard. WMCA noted that this wasn't about following a specific methodology, but rather about a way of working that had grown over time, supported by the long-term stability of the senior team within the local authority. As WMCA observed, the individuals involved had "skin in the game," and this personal investment helped to foster a culture where adult-to-adult engagement could take hold.

OUTCOMES

The relationship between the local authority and care providers became one of mutual respect and effective collaboration. WMCA's experience showed that trust and consistent engagement made a real difference in encouraging providers to speak up. Importantly, WMCA highlighted their own role as a valued intermediary:

> *"I think some local authorities undervalue what their local care association can bring to the table. We deal with a large number of authorities compared to some of our colleagues so can easily see the differences. I think it particularly needs to be recognised that many providers are reluctant to voice issues to commissioners in case they are then perceived to be victimised for speaking out of turn, and having an independent body who is trusted by both sides is invaluable."*

LESSONS LEARNED

- **Personal investment and continuity** in local authority leadership can help foster a genuine culture of adult-to-adult partnership.
- **Effective engagement** is often less about formal structures and more about the attitudes and behaviours of those involved.
- **Trust, clarity, and responsiveness** - combined with the stabilising role of an independent care association - can create the conditions where partnership working becomes the norm.

Northern Ireland - Relationship with regulator

BACKGROUND

My Home Life Northern Ireland (MHL NI) works with a wide group of registered managers across the province to support leadership and quality of life in care homes. Over the past decade, MHL NI has built strong relationships with managers and other stakeholders, creating space for reflection, peer support and collaborative problem solving.

THE ISSUE

In the very early stages of the MHL NI programme (2014/2015), registered managers described their **relationship with the regulator - Regulation and Quality Improvement Authority (RQIA) - as formal and exclusively focused on the inspection process**. Historically, the roles of 'inspector' and 'inspected' were perceived as clearly separated, with interactions often feeling adversarial. As a result, many managers were hesitant to engage with RQIA beyond inspections, or to seek clarification and support.

While the RQIA's primary role is regulation and inspection, they also view their function as supportive and advisory. However, the lack of meaningful dialogue with care providers limited their ability to fulfil this wider role.

ACTIONS

To address this, MHL NI began **facilitating opportunities for constructive engagement** between registered managers and RQIA. This started with **inviting a senior inspector to a leadership support workshop** attended by one MHL cohort. This meeting was neither an inspection nor an awareness-raising presentation - the usual formats in which the two groups interacted.

Instead, it was an **open forum** where managers could raise questions and concerns - including queries about reporting mechanisms and processes. Some of these questions reflected misunderstandings or long-standing myths about what needed to be reported, regardless of what legislation or standards required.

The initial meeting led to an honest and open exchange. Both sides had the opportunity to understand each other's perspectives and experiences, fostering mutual respect. Encouraged by this outcome, MHL NI and RQIA continued to collaborate, with the regulator now regularly participating in all MHL NI leadership support workshops.

RQIA also invited the MHL NI team to provide training for all their inspectors, covering appreciative inquiry, the My Home Life themes, and some of the tools introduced to care home managers. In addition, MHL NI contributed to the review of several aspects of the inspection process.

OUTCOMES

Feedback on RQIA's involvement in the workshops has been overwhelmingly positive. Managers appreciate the opportunity for open conversations outside of the formal inspection environment. **RQIA is now viewed by many as an ally** - a source of support and a helpful resource. The workshops have created a safe and empowering space for registered managers to be open and transparent about problems, concerns and even failures. This enables both providers and the regulator to address issues earlier and more effectively.

MHL NI believes this much-improved relationship has made **a significant difference in how the sector works** and collaborates. RQIA is now actively advocating on behalf of care homes, which has been a huge boost to confidence within the sector.

As the Chief Executive of RQIA said:

> *"Supporting care home staff in developing their leadership skills and confidence will undoubtedly contribute to continuous quality improvement and benefit residents and staff across the whole service. RQIA actively support the My Home Life programme."*

RQIA has also invited MHL NI to engage with a new initiative they were rolling out on Inspection Support Volunteers.

LESSONS LEARNED

- **Creating neutral, non-judgemental spaces** for dialogue helps shift relationships from adversarial to collaborative.
- **Building trust takes time** but can lead to significant changes in how regulators and providers work together.
- **Mutual respect and understanding** are strengthened when all parties are given space to voice their perspectives.
- **Training and co-designed approaches** build shared language and values between providers and regulators.

National Digital Social Care programme - Better Security, Better Care (BSBC)

BACKGROUND

Better Security, Better Care is a national and local support programme designed to help adult social care providers store and share information safely. Managed by **Digital Care Hub**, it covers both paper and digital records, with a particular focus on supporting providers to complete the **Data Security and Protection Toolkit (DSPT)** – an annual, online self-assessment.

THE ISSUE

Before the programme began, **engagement with social care providers around data security and the DSPT was limited**. Many providers – especially small, hard-to-reach domiciliary care agencies – were not aware of the importance of data protection or lacked the support needed to complete the toolkit. Only **15%** of care providers had a DSPT in place in 2021.

ACTIONS

Since 2021, the programme has **implemented a decentralised model**, working through care associations, and in some instances NHS bodies, as Local Support Organisations (LSOs) to reach providers directly. The national Better Security, Better Care team takes an adult-to-adult approach – building skills and confidence of the LSOs to deliver support and identify challenges locally. The LSOs in turn foster peer-level collaboration and offer practical support tailored to the needs of local providers. This approach has **helped to build relationships and trust**, and it **significantly improved take-up of the DSPT**.

OUTCOMES

The evaluation of the programme (Cordis Bright, November 2024) shows that **this decentralised model was highly effective and delivered strong outcomes at relatively low cost**.

- LSOs made contact with a significant proportion of the 27,000 social care locations in England.
- These efforts helped improve understanding of data security and protection across the sector, for the benefit of both service users and businesses.
- By June 2025, **76%** of providers had published a completed DSPT, up from just 15% in April 2021.
- The programme also brought wider benefits, with local authorities and Integrated Care Systems (ICSs) recognising the value of working through trusted local delivery partners.

LESSONS LEARNED

Local support works:

- Partnering with care associations enables effective, targeted engagement with social care providers.

Relationships matter:

- The adult-to-adult approach fostered trust and collaboration, in contrast to top-down, parent–child models that had previously failed to engage providers.

Decentralisation is effective:

- A national programme can succeed through local delivery, especially when local partners understand the landscape and speak the same language as providers.

Persistence pays off:

- Even the hardest-to-reach providers can be engaged with the right support, relationships, and methods.

Lincolnshire – Enabling the homecare market to run itself

BACKGROUND

Lincolnshire has adopted a model for delivering homecare by **designating one lead homecare agency in each of the county's 11 localities**. These lead providers take responsibility for coordinating all homecare support in their area. They are required to subcontract at least 10% of the work to other local homecare providers, supporting the wider market. If homecare cannot be delivered, they must also cover the cost of any short-term residential care placements.

This approach is intended to simplify coordination and build stronger relationships across the system. With only 11 lead agencies, collaboration with other parts of the health and care system becomes more manageable.

THE ISSUE

Previously, fragmented provision and poor communication often led to delays, duplicated efforts, and risk-averse decision-making. It was difficult to coordinate timely hospital discharges and ensure consistent support for people with complex needs, especially when **no single agency had an overview or clear responsibility for outcomes**.

ACTIONS

To strengthen the local homecare market and improve coordination, Lincolnshire introduced a model where **a single homecare agency acts as the lead provider in each of the county's 11 localities**. These lead agencies oversee all homecare support in their area and are required to subcontract at least 10% of the work to other providers in their locality. This helps sustain a more diverse and resilient provider base while encouraging collaboration and mutual support within the market.

A key feature of the approach is reducing bureaucracy and enabling more direct communication. As Melanie Weatherley of Walnut Care explains, *"The trick here is to remove any middle person so that homecare providers can talk directly to other professionals."* This streamlining builds trust and makes it easier to resolve issues quickly. Relationships develop over time, so that if a provider cannot respond to a hospital's discharge request, a senior individual within the hospital can directly inform the wards that discharges requiring homecare cannot go ahead that day.

Weekly meetings held via Teams are central to this model. They bring together providers and partners to coordinate discharges and strengthen joint working with GPs, pharmacies, and mental health teams. The group collectively focuses on the safety and wellbeing of the person receiving care, rather than shifting responsibility between services. When a person's needs appear to require a care home placement, but the individual prefers to remain at home, all agencies work together to "give homecare a go." This shared approach allows for risks to be taken in a supported way, always prioritising the wishes and interests of the person.

OUTCOMES

This new model has led to **more timely hospital discharges** and **better integrated working across health and care services**. The reduced reliance on intermediaries and the focus on building direct relationships have improved trust and responsiveness within the system. Agencies now work together to manage risk and support each other in delivering person-centred care.

Instead of working in isolation, **homecare providers are in regular contact with GPs, pharmacists, and mental health professionals**, leading to more joined-up planning and decision-making. When capacity is stretched, the strength of these relationships allows the system to pause discharges and adjust quickly, avoiding rushed or unsafe transitions.

By sharing responsibility and plans as they develop, partners can act more flexibly and creatively. The local Director of Adult Social Services sees this approach as the start of a journey, giving them and the care association a foundation for future innovation. There is still scope to go further - such as using care homes more proactively for short-term support and encouraging community health teams to share specific concerns with homecare staff - but the foundation is now in place for more collaborative and confident care delivery.

LESSONS LEARNED

- **Trust and shared responsibility are essential**.
- **Reducing intermediaries** and enabling direct communication builds stronger relationships and better outcomes.
- **Weekly communication** helps everyone stay aligned and responsive to emerging issues.

APPENDIX 4 - THEORETICAL LENS

Understanding the relational dynamics between adult social care providers and statutory partners is central to this report. While policies, procedures and contracts shape structures, it is the way people interact - particularly in moments of pressure - that ultimately defines how partnerships work and what they can achieve.

The report was informed by three interlinked perspectives: **Transactional Analysis, Relationship-Centred Care**, and the **lived leadership role** of the registered manager.

Relationship-Centred Care and registered managers

Over the past 19 years, My Home Life England (MHLE) has supported more than 2,600 registered managers, deputy managers, and team leaders across the adult social care sector.

Through a nine-month professional development programme, MHLE helps participants build confidence, resilience, and leadership skills. With participants' ethical consent, the insights gained through this work have also informed research into leadership and partnership working in care.

A **core framework** underpinning MHLE's approach is **Relationship-Centred Care**. This model recognises that high-quality care is rooted in relationships that foster a sense of significance, security, purpose, achievement, continuity and belonging for everyone involved: people drawing on care, their families, staff and care leaders. Registered managers play a central role in creating the conditions for these relationships to flourish. Their wellbeing is closely linked to the wellbeing of care teams and people who use services.

However, the ability of registered managers to sustain this relational leadership depends not only on what happens within their service, but also on how they are supported by the wider health and social care system. Ideally, registered managers are surrounded by people who understand the complexity of their role and who work alongside them as supportive partners. In reality though, many registered managers describe feeling isolated, with their confidence gradually eroded by the attitudes and behaviours of others in the system.

Transactional Analysis: a framework for understanding relationships

One tool that MHLE-supported managers have found particularly valuable in making sense of their relationships - both inside their organisations and with external partners - is **Transactional Analysis (TA)**, a model developed by **Eric Berne** in the 1960s (Berne, 1961 and Berne, 1963). Originally applied in therapeutic and clinical settings, TA is now widely used in organisational and leadership development.

TA helps individuals understand how communication and relationships operate. It is based on two key ideas:

- Each person operates from three main ego states: *parent, adult* and *child*.
- In interactions or transactions, the ego state we adopt is likely to influence the ego state of the other person.

Parent-to-child transactions

Many relationships between external organisations and care services tend to follow parent-child patterns.

These dynamics often position one party as the authority figure (*parent*), while the other adopts a more submissive or dependent role (*child*).

In turn, the child ego state may show up as helplessness, passivity, or a reluctance to take responsibility. These parent-to-child patterns are often reflected in relationships between:

- Registered managers (*parent*) toward care teams (*child*)
- Regulators (*parent*) toward regulated services (*child*)
- Commissioners (*parent*) toward commissioned providers (*child*)

And sometimes:

- External professionals (*parent*) toward care professionals (*child*)

These dynamics can create a culture of blame and defensiveness, leading to withdrawal, inefficiency, and poor outcomes across the system.

Moving towards adult-to-adult relationships

There are times when a parent-to-child dynamic may be appropriate - for instance, when offering support to new staff or enforcing safety regulations. However, in the long term, this style of interaction can stifle collaboration, limit accountability, and weaken trust.

We argue that building adult-to-adult relationships based on mutual respect, clear communication, and shared responsibility is essential for sustainable improvement across the sector.

> Registered managers working with MHLE have demonstrated that when they consciously support adult-to-adult dynamics within their teams and with external partners, there is a noticeable shift in workplace culture. Staff feel more respected, morale improves, and people are more likely to take ownership of their roles and responsibilities.

Challenges in shifting from parent-to-child to adult-to-adult

Despite the benefits, moving away from parent-to-child interactions is not always easy. We often hear from registered managers, commissioners and local authority adult social care quality teams that letting go of the parent role can feel risky - especially when there's fear that something might go wrong. It's easy to slide into the 'controlling parent' stance under pressure.

On the other side, adopting the child role can also offer comfort. When someone or an organisation positions themselves as powerless or dependent, they can avoid taking responsibility by deferring to those seen as being 'in charge'. This tendency can be found at all levels of the care system.

Yet, good partnership working requires a conscious shift toward adult-to-adult relationships across organisations and roles. These relationships enable:

- Greater collaboration
- More open and honest dialogue
- A shared understanding of the challenges we all face
- Collective problem-solving, even within limited resources

When individuals and organisations feel valued and accountable, they are more likely to contribute actively and constructively to the system.

Why adult-to-adult dynamics matter

Adult-to-adult relationships promote responsibility, agency, and shared ownership - what's often called 'skin in the game.' When people feel trusted and invested, they're more likely to act with integrity, speak up, and pursue shared goals. These dynamics are key to building creative, resilient partnerships in health and social care.

Using Transactional Analysis, we explored how these relationships play out between registered managers, care associations, and wider systems. The model helps us understand and improve the relational foundations of good care and collaboration.

Across the case studies where adult-to-adult dynamics were strong, everyone seemed to benefit with smoother hospital discharges, fewer readmissions, quicker joint solutions, and more honest communication. Registered managers felt valued; partners gained new insights. These outcomes were no accident - they came from deliberate shifts in tone, process, and leadership.

APPENDIX 5 - REFLECTIVE QUESTIONS

What follows is a series of reflective questions that can be adopted to support dialogue, improve relationships across the system and, through this, deliver better outcomes.

Individual care services and local care associations

- How can we, as care professionals, develop our confidence, skills and leadership to engage in 'adult-to-adult' relationships with the wider system more often and more effectively?
- What investment and support from partners in the system might be required?
- How can local care associations strengthen their role - in relation to sector leadership quality standards, recruitment, training, amongst other things - to ensure that true ownership over the agenda for improvement is embedded in the local care sector, rather than held by partners that surround them? What could this look like at its best?
- How can local care associations demonstrate that they are fit for purpose with appropriate governance and structures, in order that they are:
  - Sustainable and not necessarily reliant solely on the goodwill of the local Director of Adult Social Services?
  - Transparent in terms of decision-making and clear about whose voices, interests they are representing?
  - Able to communicate in an 'adult-to-adult' manner with their members and their partners, with an emphasis on envisaging and supporting solutions for the whole health and social care system as well as those whom they represent?
- What other models of 'self-governing' professional bodies can we learn from within the sector? What might help to raise the confidence and esteem of registered managers and care leaders? For example, what could be learned from the Royal College of General Practitioners, as the professional membership body and guardian of standards for over 53,000 GPs in the UK?

ICSs and place level

- How can ICSs support the development of collaborative leadership skills and organisational values across the health and care system, in line with the Messenger Review, 2022?
- How might ICSs actively identify the skills, expertise and capacity within the care sector and work with them as part of the solution to local challenges?
- How can ICSs and place level systems enable, encourage and partner the care sector to develop its own agenda for quality improvement?
- What needs to happen to support greater partnership and trust across commissioners, social workers, acute and community health professionals with the care sector that enables strong collaboration on an 'adult to adult' basis in forging a shared vision?
- How can we enable local forums that bring the care sector together with commissioners and wider practitioners to truly demonstrate and embed equal partnership?
- How can we codesign local commissioning and procurement processes to enable and not hinder true partnership working and collaboration between commissioners and care leaders?
- What might support greater opportunities for joint-working on projects, shadowing or secondments?
- What information may need to be provided to the care sector to support it to better understand how to engage effectively with the NHS, ICS, and vice versa, and have the capacity/ resources to do so?

National care sector bodies

- What needs to be put in place to ensure that the care sector as a whole is recognised as a professional body akin to other health and social care professionals, and has the structure, governance, training and quality assurance processes in place that support this?
- What might be the cultural transformation required across the care sector to help the wider health community feel more confident and more likely to work with the sector, in an adult-to-adult manner, as equal partners?
- How might the care sector develop its own 5- or 10-year plan in order to transparently articulate its vision for the future.
- How might it develop itself professionally, to ensure that the sector owns the agenda for quality, in response to the changing needs of the population and need for reform and redesign. What might need to happen?
- As part of this, how might the status of professionals/ practitioners working in the care sector be developed so that can play a more effective role in working in partnership with others to identify solutions at a local, regional and national level?
- What might be a better governance arrangement that ensures that decision-making is more transparent in terms of whose voices it represents?
- What structures could be further developed to ensure that decisions are informed by local care services and agreed actions at a national level feed effectively down to action at the local level?

National government and national health organisations

- How might national government and other national agencies (including Department of Health and Social Care, Ministry of Housing, Communities and Local Government, Care Quality Commission, NHS England, ADASS and others) support the care sector to develop its governance, structures, professional status and skills, to ensure that it is not only fit for purpose but can play a stronger, more effective, equal partner role in meeting the many challenges that the NHS and the country at large face?
- How might national government assess the pros and cons of investing in quasi-governmental bodies that support care sector improvements rather than investing directly into a sector-led structure?
- What might true transformation look like for the governance of the care sector? How can we learn from what works well in other sectors? What value might be realised by supporting the development of a separate body for care professionals and practitioners?
- How could national bodies encourage greater mobility, secondments etc across health and social care sectors?

AUTHORS & FUNDERS

My Home Life England (MHLE)

My Home Life England (MHLE) is an evidence-led initiative improving quality of life for those receiving care and those who support them, by empowering confident care leaders and creating sustainable care systems. Founded in 2006, My Home Life England is part of City St George's, University of London, as well as the international My Home Life movement.

MHLE supports leadership and quality in care settings across England, through professional support and development for care leaders, as well as conducting innovative research projects shaping a better future for adult social care. Four key frameworks underpin My Home Life – working together, building good relationships, being positive, and having open and caring conversations – values that help My Home Life England bring people together to create lasting, positive change in the way that care is delivered.

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Tom Owen is Co-Founder of My Home Life and Director of My Home Life England at City St George's, University of London. With a background in social care and a degree from the University of Oxford, he leads initiatives aimed at enhancing quality of life in care settings. Tom's work focuses on fostering positive relationships between care providers, people who access care services, and their families to promote compassionate care practices.

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Funded by the Rayne Foundation

The Rayne Foundation is a charity that helps create positive social change by funding projects that tackle difficult issues in new and collaborative ways. Set up in 1962 by Lord Rayne, it supports work across the UK, with a focus on improving mental health for children and young people, supporting refugees and asylum seekers, and helping people in later life and their carers. The Foundation looks for ideas that can be shared and used more widely, and it aims to support leaders and organisations to make a lasting difference.

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