

Working together at scale: guidance on provider collaboratives

Following the recent publication of the *Integrated Care System (ICS) design framework* (16 June), NHS England and NHS Improvement (NHSE/I) has published further guidance on provider collaboratives. This document *Working together at scale: guidance on provider collaboratives* sets out NHSE/I's expectations for how providers should work together in provider collaboratives, as well as the benefits, enablers, and possible governance arrangements. It positions provider collaboratives as one of several key components of system working and ICS delivery. For any questions on this briefing, please contact georgia.butterworth@nhsproviders.org.

Key points

- NHSE/I describes provider collaboratives as partnership arrangements involving at least two trusts working at scale, with a shared purpose and effective decision-making arrangements.
- NHSE/I expects acute and mental health trusts to be part of one or more provider collaboratives by April 2022. Other providers (such as community and ambulance trusts) should be part of a collaborative where it is beneficial for patients and makes sense for the providers and systems involved.
- This year, providers and their system partners, with the support of NHSE/I regions, will be expected to identify the shared goals, objectives, membership and governance of each collaborative. They will also be expected to define responsibilities and ways of working between the ICS, places, clinical networks, cancer alliances and other collaborations.
- The document covers the benefits of scale that can be delivered through provider collaboratives, including reductions in unwarranted variation and health inequalities. It also sets out key enablers for collaboration, and gives examples of programmes of work across clinical services, clinical support services and corporate services.
- The guidance proposes three models that trusts have typically used to form collaboratives: the provider leadership board, lead provider and shared leadership model. It also outlines several decision-making mechanisms and staff resources required.

- Trusts will maintain their current accountabilities, but they will be expected to support mutual accountability within the collaborative. Collaboratives may, in time, be looked to for support where poor performance or challenges are identified under the system oversight approach.
- While the Health and Care Bill is expected to create further opportunities for effective collaboration by providing new options for trusts to make joint decisions, NHSE/I says providers should not delay pursuing greater collaboration within existing legislation.

Summary of the guidance

Following successful collaboration and mutual aid before and during the COVID-19 pandemic, NHSE/I sees provider collaboratives as essential to recovering from the pandemic and tackling care backlogs.

NHSE/I describes provider collaboratives as partnership arrangements involving at least two trusts working at scale across multiple places. The guidance highlights some of the key benefits NHSE/I has identified for providers working together at scale, including reductions in unwarranted variation; reductions in health inequalities; greater resilience across systems, including system-wide capacity management; better recruitment, retention, and development of staff; consolidation of low-volume or specialised services; and economies of scale.

NHSE/I states that system partners will need to agree the areas of focus and delivery for each type of collaboration, ensure these are consistent with ICS priorities, and decide how these arrangements can work most efficiently in a local context to achieve benefits for people and communities. ICS partners will agree locally on the scale at which system objectives, activities and capabilities should operate.

The guidance acknowledges that the specific programmes of work to achieve the benefits of scale will vary in each ICS, but are often considered across three areas: clinical services (e.g. designing new models of care); clinical support services (e.g. sharing patient records); and corporate services (e.g. coordinating or consolidating procurement or HR).

Expectations of NHS providers, including capabilities and enablers

NHSE/I expects all trusts providing acute and mental health services, including specialist trusts, to be part of one or more provider collaborative by April 2022. Other providers including community trusts, ambulance trusts and non-NHS providers (including community interest companies) should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved. The specific arrangements should be driven by the purpose of collaboration.

By April 2022, ICS leaders, trusts and their system partners will be expected to identify the shared purpose of each collaborative, and develop and implement (or reflect on) their membership and governance (in line with ICS priorities) and the specific opportunities to deliver benefits of scale. They will be supported in this by NHSE/I regional teams. NHSE/I acknowledges that additional work programmes may fall outside of ICS-agreed objectives.

NHSE/I defines several core capabilities that are essential for provider collaboratives:

1. **Partnership building:** Agree a common purpose aligned to the triple aim and agreed with ICSs and system partners to ensure alignment with system priorities.
2. **Programme delivery:** Agree a set of programmes that are delivered on behalf of collaborative members and their system(s) and are well informed by people and communities where there are service changes.
3. **Shared governance:** Work within proportionate shared governance arrangements that speed up decision-making.
4. **Peer support and mutual accountability:** Challenge and hold each other to account to ensure the delivery of agreed objectives and mandated standards, through agreed systems, processes, and ways of working, for example open-book accounting.
5. **Joined up working:** Work with clinical networks, Cancer Alliances, and clinical leaders to develop strategies, agree proposals and implement resulting changes.
6. **Quality improvement:** Drive shared definitions of best practice and apply a common quality improvement methodology.

The guidance also sets out five key enablers of collaboration, alongside having a common purpose. The enablers are: building and nurturing strong relationships; clinical leadership; taking into account what matters to people and communities; data sharing; and interoperable digital capabilities.

The role of provider collaboratives in health and care systems

The guidance reinforces the ambition in the *ICS design framework* that provider collaboratives will be a key vehicle in supporting systems to deliver some of their strategic priorities. NHSE/I will not prescribe the membership or footprint of individual provider collaboratives, with providers and system partners deciding local arrangements. NHSE/I suggests some principles to guide decisions about membership, including being purposeful, evolutionary and inclusive. The members of a collaborative will agree together how to achieve their objectives, including developing plans and programmes of delivery.

The roles of different organisations and services

- **Acute trusts** will be able to deliver benefits of working at scale. Areas of focus include addressing unwarranted variation in clinical outcomes, access and experience and consolidating specialist services or enabling greater specialisation across a system or systems.
- **Mental health providers** already have experience of lead provider collaborative models for specialised mental health, learning disability and autism services. Providers may also consider expanding this model across a wider range of mental health services or becoming part of other collaboratives (e.g. joining up with community providers to focus on integrating community, physical and mental health provision).
- **Specialist trusts** are well placed to help standardise pathways and ensure equity of access (e.g. setting up shared diagnostic hubs).
- Some **community providers** work across an ICS or straddle several ICSs. There may be opportunities to work with partners to find efficiencies of scale, standardise approaches to pathway design across places, ensure equity of access to community care, and provide a birds-eye view of system-wide population health. Community providers will provide an important link between collaborations as they work particularly closely with primary care networks and local authorities.
- **Ambulance trusts**, already working at scale and with local systems on care pathways, have a unique view across regions. They could lead relevant provider collaborative programmes (e.g. reducing variation in access to or quality of out of hospital urgent care).
- The participation of **independent sector providers** in provider collaboratives may be important to delivering benefits, depending on local priorities and provision.

The expertise of wider partners may be embedded into the work of provider collaboratives through place-based partnerships and, eventually, system-level integrated care partnerships (ICPs) with time. This includes working with the voluntary sector, primary care and social care partners, local authorities, and with clinical networks and Cancer Alliances.

Form and governance

NHSE/I emphasises that form and proportionate governance arrangements should flow from the shared purpose and objectives, and be decided by the collaborative, with help from NHSE/I regions and ICS leaders. NHSE/I outlines some guiding principles to help determine the appropriate form and governance, which:

- must be underpinned by a shared vision and commitment to collaborate;
- should build on and enable existing successful governance arrangements;

- should enable providers to efficiently reach decisions, which each organisation is committed to upholding;
- should provide strong mechanisms for providers to hold each other to account;
- should ensure the needs and voices of local communities are a key consideration in all decisions and clinical leadership is embedded in programme delivery;
- should make it clear how decisions are made, how disagreements are resolved, how funding flows to services within the collaborative's remit, and how the collaborative is resourced; and
- should help streamline ways of working within and across systems.

NHSE/I has identified three models that trusts have typically used to form provider collaboratives:

- **Provider leadership board model:** CEOs or other directors from participating trusts come together, with common delegated responsibilities from their respective boards. Trusts should consider the involvement of non-executive directors (NEDs) in providing scrutiny and challenge.
- **Lead provider model:** A single trust takes contractual responsibility for an agreed set of services, on behalf of the whole collaborative, and sub-contracts to other providers as required.
- **Shared leadership model:** Members share a defined leadership structure where the same person/people lead each of the providers involved, with at least a joint CEO.

Options for strengthening decision-making:

NHSE/I outlines a range of mechanisms used by collaboratives to strengthen their decision-making:

1. categorising decisions, whereby providers agree that only those impacted by decisions have binding votes;
2. locked gateways whereby providers agree to different stages in the decision-making process;
3. majority rather than consensus decision-making where each provider agrees to adopt the decision that is supported by the majority of trusts rather than a unanimous view; and
4. strong dispute resolution processes where providers agree to procedures for resolving disputes, including where a provider is unwilling to implement a majority decision.

The Health and Care Bill, if enacted in its current form, will enable trusts and foundation trusts to form joint committees and ICBs to delegate functions to trusts, for example devolving budgets to provider collaboratives. NHSE/I will set out more detail about this in due course. While the Bill will offer new ways for providers to work together within collaboratives, NHSE/I states that providers can already come together under the existing legislation and therefore should proceed to deliver the benefits of scale and mutual aid regardless of when the legislation is enacted.

Resourcing

Providers will need to consider how they resource the collaborative's activities and programmes. NHSE/I expects resources to be generated through efficiency savings as provider collaboratives evolve. Shifting staff and other resources from systems to provider collaboratives, where it makes sense and is proportionate to the benefits, could also be considered. NHSE/I outlines that a well-resourced independent project management office could be useful where a collaborative works on a wide range of complex programmes. There will be a need to build time for the collaborative's activities into existing roles, particularly in executive, clinical and operational leadership roles. Provider collaboratives should also consider having administrative and operational staff from collaborating trusts partly or wholly committed to support the work of the collaborative.

Accountabilities and system oversight

Trusts will maintain their current accountabilities, but they will be expected to support mutual accountability within the collaborative through informal and formal routes e.g. via risk and gain share agreements. Provider collaboratives will also need to consider themselves collectively accountable to the populations and communities they serve. NHSE/I intends to update governance guidance to help facilitate providers working together in a transparent and cooperative way, including new guidance under the NHS provider licence that includes a requirement to collaborate and updating the code of governance for NHS foundation trusts, which will also apply to NHS trusts.

NHSE/I, and in the future ICBs, may, over time, decide to look to provider collaboratives for support where poor performance or challenges are identified as part of the NHS system oversight approach. The guidance notes that, subject to the passage of the legislation, ICBs will hold provider collaboratives to account for delivering any services or functions that they have commissioned from or delegated to collaboratives under the terms of agreements and/or schemes of delegation.

NHS Providers view

We welcome the renewed emphasis on providers as the key driver of transformation within local health and care systems, following the success of collaboration before and during the COVID-19 response. We also welcome the flexibility for local systems and their constituent providers to lead the development of collaborative arrangements, including their membership, purpose and priorities. While trust leaders will broadly welcome this further clarity on the role of provider collaboratives within ICSs, NHSE/I will need to ensure the ambition of flexibility and permissiveness carries through into implementation. This is particularly important as systems are not starting from scratch and lots of

joint working arrangements (e.g. between clinical services and their teams) exist already and need to be strengthened, not disrupted.

We have been encouraging NHSE/I to recognise the benefits and opportunities for all trust types of working collaboratively at scale, beyond just acute and mental health trusts, and welcome NHSE/I directly reflecting this feedback in the guidance. We also welcome the principle of inclusivity when developing provider collaborative arrangements. Community providers have emphasised that there are similar opportunities to develop standardised service offers and clinical models at scale for community health services. While some benefits will be easily identifiable in some ICSs for all trust types, others may need careful consideration and a realistic expectation that collaboration will not provide a silver bullet for longstanding issues like workforce pressures. For example, trust leaders tell us that releasing efficiencies through jointly delivering back office functions is not always straightforward. Trusts need to be supported to develop robust business cases for new collaborative ways of working so that the benefits will be transparent, evidence-based and clear to all.

It is encouraging to see the emphasis on function over form, and the importance of developing a shared purpose, which has been key to the success of collaboration thus far. Trusts will be supportive of the level of flexibility proposed in the guidance regarding the role, form and composition of provider collaborative arrangements, which will enable them to design a structure that works best within their system(s) and the populations they serve. It would be helpful to have an accompanying toolkit with practical examples of where progress has been made, and we will help to share case studies through our new NHSE/I funded [provider collaborative support programme](#).

While the guidance provides clarity around NHSE/I's expectations of provider collaboratives, trust leaders are navigating a complex policy and operational environment, particularly with regards to the ongoing pressure of the COVID-19 pandemic and legislative change proposed in the Health and Care Bill. Questions remain around what mutual accountability looks like in practice, how provider collaborative accountabilities, such as to the ICB and the ICP, will look in practice and how duplication will be avoided as trusts will retain their statutory roles and responsibilities. While it is positive that NHSE/I does not include a specific expectation for ICBs to sign off on a collaborative's priorities and objectives, how disagreements will be resolved, should they arise, in practice is not entirely clear. Servicing ICS, place and provider collaborative arrangements is a significant undertaking, and trusts will need sufficient time, staff and resources to do so.

We welcomed the opportunity to feed into the development of the provider collaboratives guidance and were pleased to see that our feedback - particularly around ensuring the guidance covers the

opportunities of at scale collaboration for all provider types, creating a flexible framework, and maintaining a focus on functions - has been heard. We have also been encouraging NHSE/I to reference the involvement of NEDs in governance arrangements to avoid a situation where executive directors with delegated responsibilities make decisions without challenge or scrutiny, so we welcome how this has been included within the guidance.

We look forward to continuing to work closely with NHSE/I to develop a clear support framework for trusts on provider collaboratives as they develop and increasingly become a key component for ICS delivery. We understand NHSE/I are still exploring delegated functions and resources in more detail, and we are keen to offer our support with this work. We will continue to engage with our members and ensure their views are fed back to NHSE/I.

NHS Providers press statement

New guidance on provider collaboratives welcome but outstanding questions remain

Responding to the publication of a new guidance document on provider collaboratives by NHS England and NHS Improvement (NHSE/I), the director of policy and strategy at NHS Providers Miriam Deakin said:

“Trust leaders will welcome today’s publication of new guidance on provider collaboratives, which offers further clarity on the role of collaboratives within ICSs.

“We particularly welcome the renewed emphasis on providers’ role in driving transformation and recovery within local health and care systems, following the success of mutual aid and other collaborative working arrangements before and during the COVID-19 response.

“The guidance offers much needed flexibility for providers to lead the development of collaborative arrangements, including their membership and shared goals.

“Looking to the future, we are calling on NHSE/I to ensure the ambition of flexibility carries through into implementation. This is vital to ensure existing joint working arrangements are not unnecessarily disrupted.

“While we should rightly be optimistic about what provider collaboratives can achieve, we must also be realistic in our expectations. We should not expect provider collaboratives to be a silver bullet for every challenge the health service is facing, such as longstanding financial and workforce pressures.

“We continue to encourage NHSE/I to recognise the benefits and opportunities for all trust types, including community providers, of working collaboratively at scale.

“Outstanding questions also remain over what mutual accountability between providers within each collaborative will look like in practice, how the relationship between the integrated care body and collaboratives will play out, and whether trusts will be sufficiently resourced so that they are able to service ICS, place and provider collaborative arrangements.

“We will continue to work closely with NHSE/I and our members to ensure trusts are appropriately supported as provider collaboratives develop”.