NHS Providers

Browne Jacobson

PROVIDER COLLABORATION

A practical guide to lawful, well-governed collaboratives

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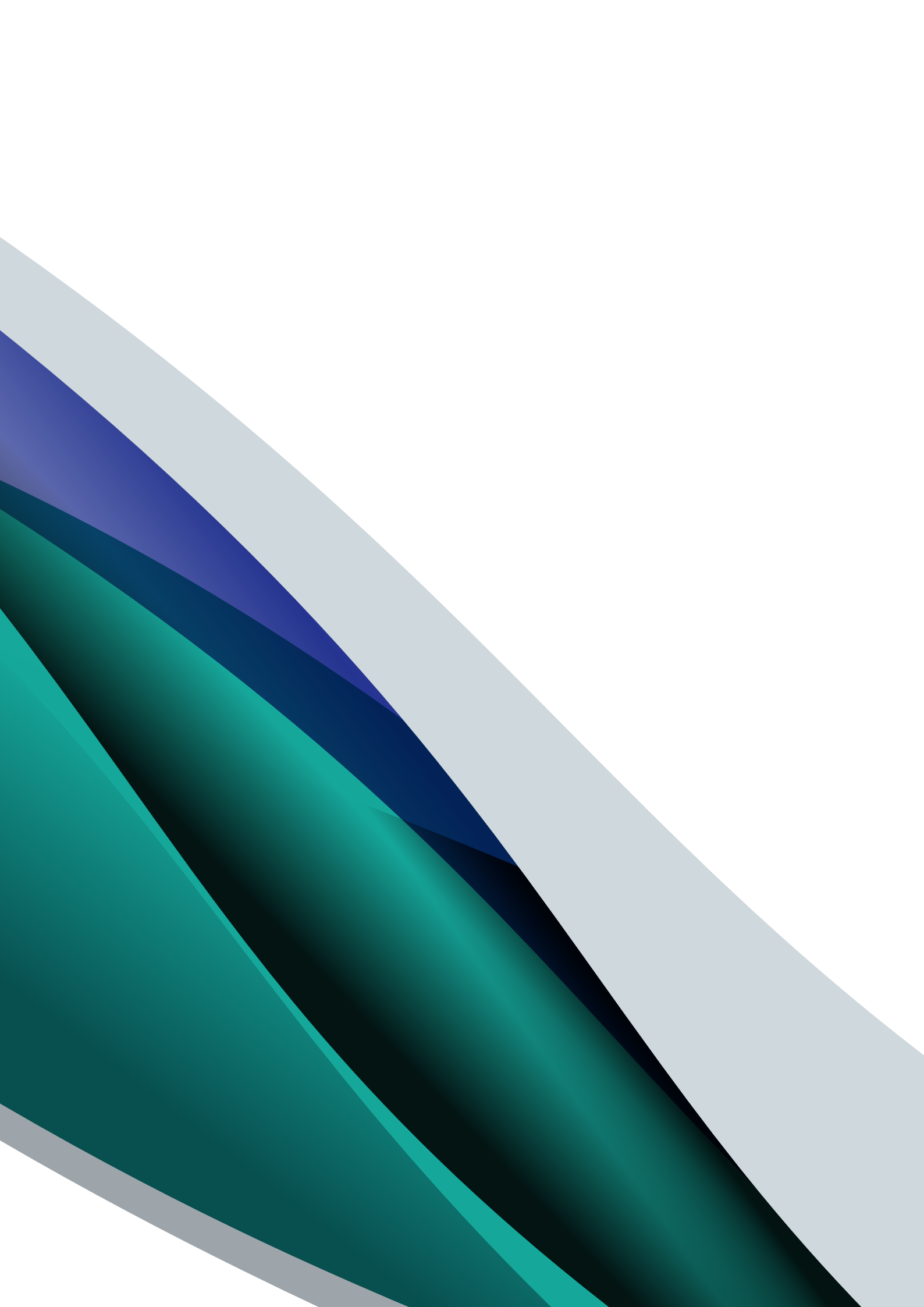

PROVIDER COLLABORATION

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FOREWORD

Trust leaders across all sectors – acute, mental health, specialist, community, and ambulance – are facing significant challenges. Increasing levels of demand, deteriorating finances, and rising operational pressures have created a difficult environment for trust boards to navigate. Trust leaders agree with national policy makers that we cannot meet these challenges acting as single organisations in isolation. Our leaders recognise the premium of partnership working, particularly through provider collaboration within the context of health and care systems.

Despite the challenging environment, the story of provider collaboration is one of optimism.

There are great examples of providers embracing the opportunity to build relationships and deliver better and more efficient services by working together both locally at place, and across systems. This includes standardisation to improve care and services, addressing unwarranted variation in care quality, bolstering service resilience, identifying approaches to support people experiencing inequalities and developing innovative ways of working with other local partners, such as social care providers and primary care services. Some collaborations are also exploring how they could, in time, take on a more formalised role within integrated care systems (ICSs) and lead on transformational change, allocating budgets, planning services, and redesigning pathways.

This guide recognises the local context of each collaboration, acknowledging that providers may also be involved in more than one partnership, across more than one system. It seeks to support and empower trust leaders to navigate key governance considerations, principles and legal models when establishing or reviewing collaborative arrangements.

Working with Browne Jacobson has been very fruitful and ensures we can provide our members with an authoritative legal viewpoint on the models that are available to providers. I'd like to thank them for acting as our partner to develop this resource, alongside colleagues from trusts who have contributed case studies.

Sir Julian Hartley
Chief Executive, NHS Providers

1 INTRODUCTION

We know that creating good governance can be challenging.

Working together, Browne Jacobson LLP and NHS Providers hope this guide will support NHS acute, mental health, community, specialist, and ambulance trust boards to focus on the considerations that enable well-governed provider collaboration. We know there is considerable enthusiasm to develop new collaborative arrangements at scale and at place-based partnership level. This guide includes considerations relevant to partnership at any level of population, although we have focused more on collaboration at scale.

This aims to be a practical guide – reflecting the legal framework for collaboration and NHS England (NHSE) policy, as well as building on the experiences of trusts.

Given that the Health and Care Act (2022) is relatively permissive legislation, we do not seek to suggest how providers should set up their collaborations but to describe the legal and governance considerations relevant to different forms of collaboration and collaboratives.

We hope the guide will support trust boards seeking to establish collaborative arrangements as well as those already involved in provider collaboration(s) and seeking to review and improve existing arrangements.

Further information and feedback from trust leaders involved in developing collaborative arrangements can be found in NHS Providers' survey (NHS Confederation et al, 2023) of provider collaboratives, case studies (NHS Providers, 2022), and feedback from NHS Providers' Provider Collaboration programme (NHS Providers).

How to use this resource

This resource sets out key governance considerations when establishing and sustaining provider collaborations and collaboratives.

Section one, provider collaboration: why focus on governance, discusses the statutory basis for collaboration and makes the case for an early and ongoing focus on good governance.

Section two, the fundamentals of governance in collaboration, identifies some key principles to bear in mind whatever partnership working you are considering or when thinking about governance in collaboration(s) you are already engaged in.

Section three, what are the options for collaborative arrangements, sets out the various organisational models and legal forms that can be used to ensure lawful and effective decision-making in your collaboration. It identifies some principles of good governance that might particularly apply to the model or form under discussion. This section includes examples of provider collaborative arrangements in practice, and links to five longer case studies included in the annex.

The annex comprises:

- An 'at a glance' summary of considerations.
- Considerations concerning councils of governors (specific to foundation trusts).
- In-depth case studies about current governance practice in five provider collaboratives.

Glossary

In this guide we refer to the following key legislation and guidance:

1990 Regulations	National Health Service Trusts (Membership and Procedure) Regulations 1990 (please note amendments to legislation on this website may not be kept up to date) (National Health Service Trusts (Membership and Procedure) Regulations, 1990)
2022 Act	Health and Care Act 2022 (Heath and Care Act, 2022)
Addendum to your statutory duties	Addendum to your statutory duties – reference guide for NHS foundation trust governors (NHS Engand, 2022a)
Code of governance	Code of Governance for NHS Provider Trusts (NHS England, 2022b)
Delegation guidance	Arrangements for delegation and joint exercise of statutory functions Guidance for integrated care boards, NHS trusts and foundation trusts (NB only available on the FutureNHS website which requires a login) (NHS England, 2023a)
Governance and collaboration guidance	Guidance on good governance and collaboration (NHS England, 2022c)
Governor guidance	Your statutory duties – reference guide for NHS foundation trust governors (Monitor, 2013)
NHSA	National Health Service Act 2006 (as amended) (National Health Service Act 2006)
Provider collaborative guidance	Working together at scale: guidance on provider collaboratives (NHS England, 2021a)
Provider licence	NHS Provider Licence Standard Conditions 31 March 2023 (NHS England, 2023b)
Transactions guidance	Assuring and supporting complex change Statutory transactions, including mergers and acquisitions (NHS England, 2022d)

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We refer to NHS trusts and foundation trusts collectively as 'trusts'. Where we need to differentiate between them, we refer to NHS trusts as such and NHS foundation trusts as FTs.

The terms provider collaborative and provider collaboration can often be used interchangeably. Here, we use the term provider collaborative primarily to refer to a formal partnership between providers and/or in relation to NHSE's guidance about establishing provider collaboratives. We refer to provider collaboration where we discuss working together as an activity.

Please note that although NHSE's guidance may be statutory or non-statutory, all trusts have relevant provider licence obligations (NHS England, 2023b) such that they must have regard to all NHSE (and secretary of state) guidance about co-operation and collaboration.

PROVIDER COLLABORATION
Why focus on governance?

2

What is provider collaboration?

Many of the challenges facing health and social care in England can only be solved by working across organisational boundaries and so by providers working together.

Provider collaboration is not new, but the NHSE requirement for most trusts (acute and mental health) to be part of a collaborative is new. As a result of this increased focus, organisations are jointly setting up new organisational models, and adapting or creating new governance arrangements and leadership structures to enable collaboration.

There is no legal definition of what constitutes a provider collaborative. NHSE's provider collaborative guidance (NHS England, 2021a) states:

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience.
- Improve resilience by, for example, providing mutual aid.
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Some provider collaboratives have been in place for a number of years, but they now form part of ICSs, placed on a statutory footing by the 2022 Act. The 2022 Act does not create any specific obligation to create provider collaboratives in a certain way and there are only limited restrictions to the functions they can undertake. Providers therefore have great flexibility and scope as to their aims and legal and governance arrangements. There is no blueprint for how to 'do' effective collaboration.

The statutory basis for collaboration

Trusts, alongside NHSE and integrated care boards (ICBs), are subject to the new 'triple aim' duty in the National Health Service Act (NHSA) (as amended by the 2022 Act) (National Health Service Act, 2006). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

1. Health and wellbeing for people, including its effects in relation to inequalities.
2. Quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services.
3. The sustainable use of NHS resources.

The 2022 Act also introduces into the NHSA the 'duty to cooperate' (National Health Service Act, 2006) on NHS organisations when exercising their functions and in its national guidance NHSE uses the terms cooperate and collaborate synonymously.

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The triple aim and duty to cooperate are reinforced within the new provider licence (NHS England, 2023c) for all trusts in England. NHSE's governance and collaboration guidance (NHS England, 2022e) further articulates expectations under the provider licence. This guidance sets expectations of provider collaboration in respect of three areas:

- Engaging consistently in shared planning and decision-making.
- Consistently taking collective responsibility with partners for delivery of high quality and sustainable services across the system.
- Consistently taking responsibility for delivery of agreed system improvements and decisions.

The guidance forms the basis of how NHSE will oversee providers' performance regarding collaboration and the governance needed to support it, using the NHS Oversight Framework (NHS England, 2022f).

In terms of provider collaboration, while system working is supported in law by the triple aim and duty to cooperate, the 2022 Act does not mandate the establishment of provider collaboratives. However, in its provider collaborative guidance (NHS England, 2021a), NHSE sets the expectation that all acute and mental health trusts should be part of at least one provider collaborative, while ambulance and community trusts may work with other providers where it is beneficial for patients and makes sense for those involved and their system(s).

The ICS design framework (NHS England, 2021b) sets out the expectation that *provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities*, with the provider collaborative establishing how this contribution will be made.

Why focus on governance?

Governance arrangements should be a vital enabler of effective collaboration, not a barrier to it. Providers investing in collaboration will want to give their partnerships the best chance of succeeding; good governance supports provider collaboratives to deliver their aims.

Governance is the way in which boards of directors lead and direct their organisations to ensure legal duties are met, be they under statute or common law, and that the exercise of their functions is done in an effective, lawful manner.

It is about leadership and direction and the mechanisms and processes used to run an organisation.

Governance arrangements should be proportionate to the risk to the partner organisations of the collaborative's activity and use of resources. So, they may well change as a collaborative's aims and functions change. For many informal collaborations there is no need for additional governance arrangements at all: existing mechanisms and processes can be used. Where the

collaboration's aims involve transfers of funds, people or services, partners will likely prefer more formal collaborative arrangements to ensure risk is managed, and to provide clarity and security for the partners as well as patients.

The governance professionals employed by trusts (such as company/trust secretaries and directors of corporate governance) can support trusts on governance matters when establishing collaborative arrangements. Legal advice is also recommended where formal contractual and/or legally-binding arrangements or changes of organisational form are being considered.

In this guide, we have set out some key principles of good governance as they relate to provider collaboration, but this is no substitute for speaking to the governance professional(s) in your organisation(s).

Governance arrangements for provider collaboration should enable participating organisations to:

- Jointly develop and agree plans for collaboration, that can be jointly reviewed and adapted over time.
- Understand which statutory functions, if any, the collaboration will exercise, and which duties the directors of the partner organisations must meet.
- Exercise appropriate and effective lines of accountability, ensuring adequate assurance is provided to the partner organisations.
- Have confidence that effective and lawful decision-making is in place (including through jointly developing terms of reference, schemes of delegation or other arrangements to establish relevant delegated authority and the scope of decision-making where needed).
- Enable appropriate oversight of decision-making and activity to manage risk effectively.

3 THE FUNDAMENTALS OF GOVERNANCE IN COLLABORATION

Establishing effective governance in provider collaboration will give the partner organisations:

- Assurance that decisions are being made lawfully and risks are being managed.
- Adequate control over the activity and decision-making.
- Assurance about progress and impact through adequate oversight.

Here, we select some general principles that partners should consider, based on learning from trusts and recognising that good governance is ultimately about much more than systems and structures. Proportionate choices will seek to balance, for example, organisational control with collaborative freedom, and maximise board member capacity while ensuring effective oversight and risk management. Ultimately the governance arrangements for collaboration should strike the right balance for the partners.

Shared purpose and strategic alignment

For effective provider collaboration, a shared purpose, and a clear vision on what will be achieved by working together is crucial.

NHSE's guidance on provider collaboratives set out a range of benefits of working together at scale, which include:

- reductions in unwarranted variation in outcomes
- reductions in health inequalities, greater resilience across systems,
- better recruitment, retention, and development of staff
- consolidation of low-volume or specialised services
- efficiencies and economies of scale.

These benefits have guided many provider collaboratives in setting their priorities and objectives.

However, it is also the case that priorities for provider collaboration have been identified through alignment with system plans and strategies. Joint Forward Plans (NHS England, 2022g), published in early 2023, set out "how ICBs and partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs four core purposes and meet legal requirements"(NHS England, 2022g). Delivery objectives for provider collaboratives are included in many of these plans. Some of these objectives relate directly to system priorities, while others are a distinct set of priorities identified by trusts.

Potential partners may find they can deliver elements of their local corporate and clinical strategies more effectively through collaboration. Meanwhile, the purpose and shared objectives for many provider collaboratives are clear from the outset. For example, NHS-led

provider collaboratives for specialised mental health, learning disability and autism services have been established to arrange specific specialised services, and play a key system role.

The section, relationship with ICBs, sets out the principle of engaging with system partners when agreeing priorities for the collaborative.

Relationships and culture

Effective structures and processes are necessary to support good governance, but human factors such as the behaviours and relationships that contribute to organisational culture matter just as much.

Trust boards should be well aware of their duties in setting, modelling, and sustaining the culture they wish to see in their organisations. This is also true within partnerships, and care should be taken, as with articulating a shared vision or strategy, to articulate shared values and perhaps shared cultural attributes that the partners wish to see. The closer and more extensive the collaborative arrangements and ambitions, the more culture(s) will play a role in the success or otherwise of the collaboration.

Similarly, interpersonal relationships can be either the engine driving, or brake upon, successful provider collaboration. Positive relationships between partners tend to be described by them as open, transparent, trusting, and collegiate. Sharing values between partners can also provide a steady platform from which to build successful relationships and help prevent relationships and collaboration breaking down when personnel change.

Some collaboratives have deliberately taken the time to start with relationship-building. This might involve board-to-board activities and discussions, networking across roles and specialisms, or simply getting to work on relatively 'easy' wins i.e., starting with something simple to work on together and build relationships (and trust) while doing. This latter approach can help partners not only get to know one another but also see the benefits of collaboration and be more likely to buy-in and get involved.

Careful consideration should be given to:

- Acknowledging the value of relationships and establishing trust, transparency and an open approach to working together.
- Smoothing the transition of key personnel/partners into a collaborative system approach.
- The risks that personnel changes can bring.

3

Building in non-executive director challenge

The role of a non-executive director (NED) is to provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account (NHS England, 2022b). Crucially, NEDs are not employees of the NHS organisation in which they undertake their role but are contracted to provide their independent expertise and experience. NEDs provide a vital check and balance to the power of the executive.

In the private sector, numerous reviews into corporate failures from the Cadbury Report (1992) to date have highlighted the importance of strong NEDs. In provider collaboratives, as in providers, NEDs should be appropriately involved in decision-making to improve the chances of the executive being effectively challenged and supported, and of avoiding groupthink and cognitive bias.

In the NHS, recent Care Quality Commission (CQC) inspections of trusts operating a group model have also highlighted the risks that not having sufficient NED challenge can bring. Many of these risks could also apply to various models for leading provider collaboratives, wherever decision-making and oversight is devolved to committees, programme boards or similar. The CQC requires assurance that NEDs have effective line of sight to challenge the trust's governance, risk management, and performance.

Taking account of recent CQC reviews, our recommendations are:

1. Assurance committees must have NED input.
2. Trusts cannot rely on goodwill and NEDs using informal touch points to inform themselves about the operational risks of the trust.
3. Where operating a divisional structure, trusts should avoid variation between divisional units in the structure and scope of their assurance committees.
4. It needs to be clear how assurance committees in divisional (or collaborative) structures feed into the audit committee of the trust to ensure line of sight.

3

Authority and oversight

(Being clear about accountabilities, delegated authority, and oversight requirements of partners)

Trusts are used to delegating authority to committees of the board and through executive directors, setting out their assurance and oversight requirements in a way that enables the board to hold its delegates to account appropriately.

For the boards and individual directors of trusts it is crucial for accountability to be tied to the ability to take decisions and to act. The legal responsibility to decide, act, and the consequent liability of boards and individual directors is set out in statute as well as in common law. Trusts as bodies corporate and directors, collectively and as individuals, have legally defined powers and powers of delegation. They are rightly answerable and held to account for the exercise of those powers.

This is important when formalising advisory or decision-making arrangements for collaboration. This clarity is important for the legal reasons set out above and can help create a firm foundation supporting well-governed partnership activities.

If organisations share decision-making in their collaborative, then they are jointly and severally accountable for those shared decisions i.e., accountability is not apportioned between two partners in the sense that each is accountable for 50% of a decision – rather, the partners are 'in it together'. Both are together and individually accountable for 100% of any adverse outcomes. Contracts can be used to specifically apportion liabilities, and may provide welcome clarity for providers.

In governance arrangements without shared decision-making, individuals or committees will be accountable only to their parent organisations.

It is worth noting here that when/if ICB to provider or provider collaborative delegation under the 2022 Act begins, the Act specifies that liabilities arising from undertaking delegated functions move to the body undertaking the function (i.e., ICB passes any liability with the delegation). Collaboratives accepting such delegations would be wise to seek a contractual basis describing the limits of their liabilities.

The scope and extent of delegated authority (freedom to act and use resources within clear boundaries) can be established through the use of terms of reference for a decision-making forum or may simply rely on the individual's authority by virtue of their role within the employing organisation. Partner organisations should ensure they have adequate assurance in place to satisfy themselves that authority isn't being exceeded.

3

Managing risk

Effective risk management enables providers and provider collaboratives to achieve their objectives and minimise the likelihood of harm to both patients and the organisations involved.

At its core, much of risk management at collaborative level will likely use processes identical to those already in operation in individual trusts. The management and leadership body or bodies of a collaborative are responsible for identifying and managing risk to any service(s) and activities that the collaborative provides and undertakes, and for seeking adequate assurance that risk is managed properly.

Depending on the scope of the activities of the collaboration, risk may be managed simply using project/programme risk registers and escalation. Strategic risks may also be identified to the collaborative itself or risks that have escalated beyond the scope of any delegated authority the collaborative holds. Partner organisations should agree and establish processes and procedures through which risk can be escalated to individual trusts or all of the trusts within the collaborative. The cut off point at which risk is escalated beyond the collaborative will vary according to what has been agreed through negotiation between participants and the risk appetite of those participants.

In collaborations where there is formal shared decision-making, accountabilities and therefore any liabilities arising from any risk that actualises may be joint and several, as described in section being clear about accountabilities, delegated authority, and oversight requirements of partners.

Some provider collaboratives have been discussing 'risk/gain' arrangements involving financial transfers, i.e., should a provider agree to carry more risk for the benefit of the collaboration, they would also stand to accrue any financial benefit in proportion to the risk. At the time of publication, NHSE are working on guidance to support providers to manage and defensibly document decisions about transference of risk within systems and so we do not consider it further here. However, the principle that risks should continue to be managed pertains, and any such decision carefully documented.

Collaboratives should not try to contain risk that should be escalated. Robust assurance information plays a crucial role both within the collaborative but also for individual organisation's boards where they remain answerable for the outcomes of the collaborative's activity.

Both collaborative leadership and trust boards should periodically review the effectiveness of risk management arrangements. Such reviews need to be more frequent at the outset, reducing in frequency as arrangements become established.

Conflicts of interest

An FT director's duty to promote the success of their own organisation remains in place, as does their duty to avoid situations in which a director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of their organisation. NHS trust directors have implied equivalent duties because of their fiduciary obligations. As noted above, the 2022 Act creates the duty for all trusts to cooperate and to have regard to the triple aim, including taking account of the impact of decisions on a wider population.

While it is possible for these duties to create tensions for directors to manage, it is unlikely that true conflicts of interest will arise in provider collaboration, due to the duty to cooperate and where partners' interests – and those of the populations they serve – rare well aligned.

To ensure directors can fulfil their duties, providers (whether working collaboratively or not) ought to ensure their conflicts of interest policies and procedures are up to date post the 2022 Act, and ensure their directors and other employees are aware of the expectations of them.

Providers working collaboratively should have early discussions with their partner(s) about how to manage any conflicts or perceived conflicts that may arise and be clear about how and when the interests of participants will be recorded and shared, the mitigations that are available, and the approach that the collaborative wishes to take to managing any conflicts that arise. Doing so should mean that in practice, directors working across collaborative structures should not need to be excluded from undertaking their day-to-day activities.

Contractual arrangements

The type of contractual documents used when collaborating, if any, will depend upon the form the collaborative arrangements take. Alongside any 'contractual or partnering' documents, and depending on the model chosen, this may include terms of reference (of any committees formed) and a business plan / operational plan. Any contract will 'wrap around' and refer to such documents that already exist. The order that these documents are entered into will also be different depending upon the chosen model.

At the early stages of collaboration, partners may enter into a **Memorandum of Understanding (MOU)** which will set out the high-level principles and objectives of the partners in working together. This is not normally intended to be a legally binding document (although it can be if parties agree it should be) and will simply set broad intentions, outline principles of joint working and describe the goals and aims of the collaborative and perhaps next steps and proposed timelines for further actions.

The partners may then wish to progress from this document to a fuller **partnering agreement / collaboration agreement / joint-working agreement** (there are any number of names used but all have a similar intention). This document will go into more detail about the operational and practical aspects of working together including the objectives

of the partnership and agreed principles to work to. Key areas such an agreement may cover includes:

- objectives and partnership principles
- duration and review process
- governance and financial arrangements
- personnel and equipment
- arrangements at the end of the agreement, amongst others.

It may be that not all of these are included in an initial draft depending upon the remit of the collaborative and what it will be doing initially. For example, many provider collaboratives do not agree joint financial arrangements from the outset (even if partners contribute a fee towards the running costs of the collaborative).

If a corporate vehicle has been established, then the contractual arrangements between the partners will be quite different and will be covered in documents such as a members agreement or articles of association. However, the corporate joint venture is not a model that is often used for this sort of joint working arrangements.

Contracts for the provision of health services to patients

In terms of who holds the commissioning contract for the provision of health services to patients – initially this is likely to still be each partner separately and they will still be ultimately responsible to the commissioner for performing that contract.

Alongside this, the provider collaborative may be looking at ways of changing some service pathways which may affect how they are commissioned.

Over time, and depending upon the collaborative and contracting arrangements, how the various services within scope are commissioned may change. A lead provider model (lead provider contractual joint venture) may be used or contracts may be awarded to individual organisations who then have separate arrangements amongst themselves as to how those are performed between the partners.

3

Relationship with ICBs

Providers play a key role in ICSs. Recent NHSE guidance reinforces the expectation that provider collaboratives, along with place-based partnerships, will be key to enabling ICSs to deliver their core purpose and meet their triple aim.

In accordance with guidance, as well as the 2022 Act, providers can collaborate without the agreement of their local ICB(s). In practice, providers can work collaboratively on programmes or activities outside of more formalised collaborative arrangements and without involvement of the system. The same can be true for more formalised provider collaboratives, collaborating without involvement of the system, or without including all providers within the system.

However, there are many examples of provider collaboratives working in and through system-wide governance structures to deliver on system-wide, or cross-provider programmes. Provider collaboratives often sit as part of the delivery infrastructure of the ICS, alongside place-based partnerships. The ICS design framework (NHS England, 2021b) sets out the expectation that "provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities", with the provider collaborative establishing how this contribution will be made. It remains between the system and the provider collaborative to define the working relationship and the governance arrangements.

In some instances, 'responsibility agreements' are used to set out the specific areas of focus, work programmes and resourcing jointly agreed between the ICB and provider collaborative. It may be appropriate that the ICB supports the provider collaborative by contributing to the programmes resourcing either financially and/or through staffing. This is particularly the case when the collaborative is delivering against key system strategic objectives, or where there are links to programmes being delivered through a sub-committee of the ICB. An example of this is where systems have established mental health, learning disability and autism programmes or boards, coordinated by the ICB, with input from wider system partners, with services delivered through the provider collaborative.

Positive relationships between system partners are considered key to effective provider collaboratives. But this experience, and the frequency of collaboratives' engagement with their ICB is likely to vary depending on a range of factors including the maturity of the ICB and the scope of the provider collaborative.

Greater complexity is likely to come for those provider collaboratives spanning multiple systems, this will come from balancing the relationship-building, potentially differing priorities, and engagement with system partners across a larger footprint.

ICB to provider delegation

The 2022 Act introduced new delegation powers. Sections 65Z5 and 65Z6 of the Act allow ICBs and trusts to delegate their functions to each other, jointly exercise functions and form joint committees. Delegatees are legally liable for the exercise of the specified functions, but delegators retain overall accountability.

The delegation guidance (NHS England, 2023a) published in September 2022, recommended that systems should not make use of ICB powers to delegate to trusts. At the time of publication, NHSE has continued the hold on the formal use of delegation, to ensure that the right processes and legal requirements are in place to safeguard standards, providers, and systems.

Notwithstanding the hold on delegation under the 2022 Act, ICBs and providers can establish collaborative working arrangements through a number of approaches which are able to achieve similar if not the same aims as can be achieved through formal delegation. These arrangements include:

- **Outcomes-based commissioning** where a contract sets out what the provider is expected to achieve (sometimes used in service redesign).
- **Lead provider model** (covered later in this guide) in which a single trust takes on contractual responsibility (on behalf of a provider collaborative) from the ICB for an agreed set of services, and subcontracts to other providers as required.
- **Conferral of discretions** in which providers are able to determine the services they deliver under a contract, and how they are delivered.
- **An ICB committee or sub-committee including providers** where an ICB arranges for its functions to be exercised through a committee or sub-committee which can include members who are not employees of the ICB (National Health Service Act, 2006).
- **A joint committee between ICB(s) and providers or solely between providers** which can exercise functions those bodies have agreed to exercise jointly through the committee, allowing binding shared decisions.

Once powers are made available for formal ICB delegation to take place, this could mean delegation of functions such as quality improvement, patient involvement or 'arranging' functions, which gives providers the ability to assess population needs, design services or decide what services are necessary. This enables providers to play the traditional role of commissioner in contracting with other providers for key system services on behalf of the system, while not directly providing any of these services.

4 WHAT ARE THE OPTIONS FOR COLLABORATIVE ARRANGEMENTS?

Governance arrangements for providers working in collaboration can encompass a range of options. As highlighted in Provider collaboration: why focus on governance, aligning on the key principles for collaboration is vital, and should support the process of agreeing the right governance model to support collaboration. In this section we've considered common approaches that we see in practice or that are discussed between providers looking to work more closely.

These options are not prescribed or otherwise fixed categories, rather they illustrate a spectrum of options ranging from informal arrangements, through formal agreements to group models. In categorising the wide range of collaborative forms into seven types of collaboration we are not implying that these are hard and fast models for collaboration that must be adopted. Rather, these are a categorisation of forms to help describe governance for collaborations within this spectrum:

Spectrum of collaboration

Informal arrangements		Formal agreements			Group model	
Informal collaboration	**Strategic collaboration**	**Committees**	**Joint ventures**	**Lead provider**	**Shared or joint leadership**	**Single provider/ merger**
• May have advisory group • May have non-binding memorandum of understanding • High level shared principles for working together / collaboration • No shared decision-making - advisory / recommendations only • May make use of existing authority of individuals to make decisions for their organisation • Can be a stepping stone towards strategic collaboration	• Advisory group or leadership board • Memorandum of understanding / partnering agreement • Terms of reference for leadership board • Advisory group only or decisions through individual exercise of delegated authority • Shared information to discuss relevant matters • Joint decisions by consensus • Aligned decision making but not shared decision making	• May be statutory committees in common or statutory joint committee • Memorandum of understanding / collaboration agreement • Terms of reference for committee(s) • Collective exercise of delegated functions • Shared information to discuss relevant matters • Committees in common aligned or virtual joint decision-making • Joint committee shared decision-making by unanimous or majority voting	• Contractual or corporate • Management board • Contractual joint venture agreement or company documents • Services agreement • Principally a mechanism for service delivery • Can permit joint decision making on management board for contracted out services • Note restricted NHS trust powers for companies	• Contractual joint venture • Main contract held by lead NHS provider • Alliance / consortium agreement • Sub-contracts between lead provider and other NHS / non-NHS providers • Principally a mechanism for service delivery • Can permit joint decision making on alliance / consortium management	• Same person or people lead each provider involved • Boards of NHS Trusts or FTs appoint same person to multiple posts • Enables aligned or virtual joint decision making • May enable actual joint decision-making if combined with a joint committee	• Governance and legal advice required to determine feasibility • Must comply with NHS England transactions guidance e.g., full business case and due diligence requirements • Internal and external approvals process • Statutory transfer document and legal agreements • Results in single board for organisation

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The seven types of collaboration we describe are not exhaustive or mutually exclusive and they should not be viewed as a 'progression'. For example, the various committee models can be applicable within contractual joint ventures and group models. Informal collaboration may continue to take place between providers which have also established more formal decision-making structures, and joint leadership posts may exist in a number of the arrangements.

The aim of this section is to illustrate the flexibility of approaches to governance for collaboration, as well as to set out the key considerations related to each 'type'. Providers may wish to consider which elements of governance are best suited to their local context.

It is useful to note that in the 2021 provider collaborative guidance NHSE defines provider collaboratives as "partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements."

The governance options covered in this section demonstrate a range of ways decision-making can occur, noting that providers may seek arrangements for shared decision-making at the level of the provider collaborative, while others may wish to retain decision-making at their trust boards.

Informal collaboration

What is informal collaboration?

Much collaboration happens informally in the NHS.

Nothing in this resource is intended to suggest that providers should not continue to work together in these informal ways or be compelled to put governance structures in place around current informal collaborations.

Informal collaborations can take a variety of forms as we use this term to describe providers working together with minimal governance around the arrangements. For example, the participating organisations may not have agreed a memorandum of understanding or similar governance document. The use of the term 'informal' does not indicate the level of commitment of the participants to the arrangements or longevity of the arrangements. On the contrary, informal arrangements may represent longstanding arrangements.

The range of informal collaboration is wide due to the variations in scope, scale, and extent of the collaboration that is possible. The work may be 'task and finish' in nature (such as reviewing and making changes to part of a care pathway) or may involve medium or longer-term programmes (like mutual aid). Another example is the formation of peer networks across two or more providers, such as a network of finance or HR directors. Peer networks create space for peers to come together to share best practice, provide support and problem solve mutual challenges. These networks are often fertile ground for further collaboration. Equally, informal collaboration can take place within and across particular services or role specialisms (such as collaboration between estates or workforce functions).

Decision making between providers working together in this way can happen simply through the delegated authority of line management: the individual employee's powers to make decisions and use resources. Any proposals that exceed an individual's delegated authority would be escalated through each organisations' existing decision-making processes and fora.

Collaboration on a joint project or programme might use paperwork such as project or programme plans, as well as light infrastructure to facilitate delivery, such as a programme board or partnership board which may be advisory in nature. As described, these boards would not involve shared decision-making, save through the delegated authority held by individuals already. The people involved in managing these shared programmes will be employed by one of the participating organisations. The activity may be funded jointly by the participating organisations.

What is an example of an informal collaboration?

Peer networking, one example of informal collaboration, is a component of the Lancashire and South Cumbria provider collaborative.

Considerations

- Informal collaborations are relatively quick and easy to establish, and can be relatively quick and easy to walk away from.
- There are no restrictions on the types of organisations that can be involved, allowing NHS providers, local authorities, and independent and voluntary sector organisations to collaborate under these arrangements.
- They provide an opportunity to develop relationships between organisations. This can make them a useful option for providers at the start of their collaborative journey, providing a stepping stone to more formal collaborative arrangements. Conversely, informal collaboration can happen regularly within established formal collaboratives, where relationships have been built and trust established so that joint activity is more likely to arise at all levels of the organisations.
- Informal collaboration can support delivery of joint programmes between providers without the need for additional formal governance structures. Those involved in such collaboration should be clear about the limits of their delegated authority, and any paperwork underpinning collaboration should be clear and well-understood by participating organisations, with appropriate oversight through existing governance where necessary.

Strategic collaboration

What is strategic collaboration?

Strategic collaborations are arrangements where the commitment of the parties is underpinned by some form of governance (for example a memorandum of understanding or partnership agreement which may be wholly or largely non-legally binding) but that governance does not require the use of statutory powers (as is the case in committees) or contracts that are wholly legally binding (for example in contractual joint ventures).

There is a wide range of collaboration from informal to formal. For example, there are relatively 'informal' collaborative arrangements where the participating organisations have a memorandum of understanding without any shared decision-making, but nevertheless they are based on shared principles, and also established with clear strategic intent.

Strategic collaborations would include exploratory collaborations such as longer-term buddying-type arrangements, which seek to encourage learning and interactions between peers across two or more organisations to identify opportunities for fruitful joint working. Equally, two or more providers may look to establish longer term strategic programmes,

such as bolstering diagnostic capacity, developing shared approaches to recruitment, or delivering on commitments as anchor organisations in their localities.

Decision-making may take place within existing structures and/or may have a more formalised structure for example an advisory group or group of individual decision-makers. Decision-making may also happen simply through an individual employee's delegated authority to make decisions and use resources. Any proposals that exceed an individual's delegated authority would be escalated through each organisation. There may be some personnel employed specifically (by any of the participating organisations) to support collaborative working and/or any programmes or projects that emerge from the exploration of opportunities.

Considerations

- Strategic collaborations are characterised by some formal governance arrangements and are harder to walk away from compared to informal collaborations. They will usually require organisations to give notice as set out in the governance document agreed between participating organisations (whatever form that may take).
- There are no restrictions on the types of organisations that can be involved, allowing NHS providers, local authorities, and independent and voluntary sector organisations to collaborate under these arrangements.
- They provide an opportunity to develop relationships between organisations. This can make them a useful option for providers at the start of their collaborative journey, providing a stepping stone to more formal collaborative arrangements.
- This type of collaboration can support delivery of joint strategic programmes between providers without the need for additional formal governance structures. Those involved in such collaboration should be clear about the limits of their delegated authority, and any paperwork underpinning a strategic collaboration should be clear and well-understood by participating organisations, with appropriate oversight through existing governance where necessary.
- A leadership group of some sort may be formed to oversee the work, which may be referred to as a partnership board, project board or programme board. The board may be advisory only or may allow decision-making by individual members of the board without the need for additional delegated authority, referring back up through their respective organisation if resources are required that exceed their limits of authority. Such decision-making must be by consensus.
- There may be documentation setting out the objectives and ways of working of the collaboration – such as terms of reference for an advisory group, or a project/programme work plan. Partners are free to set these up as they wish within the delegated authority of the individuals who are managing the activity. Alternatively, a memorandum of understanding might be used to set out the shared principles of collaboration and exploration encouraged between peers across the collaborating organisations.

Committees

A principal feature of provider collaborative governance is the establishment of a forum in which the participating organisations can discuss how the collaborative will operate. This can be advisory or decision-making and may have many different names such as programme board, partnership board, committees in common etc.

In this resource we use the following terms to refer to different legal structures, but we note that in practice a wide variety of nomenclature is used:

- **Advisory group** – a group comprising individuals from the participating organisations which oversees the operation of the collaborative in an advisory capacity. It has no delegated functions or decision-making powers. Any decisions must be referred back to the boards of the participating organisations. It may be described by those establishing such groups as a 'committee' or 'committees in common' but it is not a statutory committee of any of the participating organisations.
- **Group with individual decision-makers** – a group comprising individuals from the participating organisations which oversees the operation of the collaborative and where delegated functions or decision-making powers are exercised by an individual on behalf of each participating organisation. Decisions do not need to be referred back to the boards of the participating organisations but are made by consensus through authority delegated to those individuals by virtue of their role in the organisation. It may be described as a 'committee', but it is not a statutory committee of any of the participating organisations.
- **Committees in common** – an arrangement where each participating organisation uses its statutory powers to establish a statutory committee which has delegated functions or decision-making powers in respect of the parent organisation only. Decisions delegated to the committees do not need to be referred back to the boards of the participating organisations. Decisions are made by the committees collectively and all committees need to be in agreement for decisions to be binding. Terms of reference for each committee will be shared or aligned. Further detail on committees in common is provided below.
- **Joint committee** – an arrangement where the participating organisations use their statutory powers to establish a statutory joint committee. The committee has delegated functions or decision-making powers in respect of all the parent organisations collectively. Decisions do not need to be referred back to the boards of the participating organisations. Decisions are made by the committee collectively and it has a single terms of reference. Further detail on joint committees is provided below.

4

What is the difference between joint committees and committees in common?

We go into detail about both types of arrangement below, but by way of brief introduction:

Joint committees are a statutory arrangement where the NHS organisations involved set up a single committee usually made up of representatives of all members, in accordance with their statutory powers and delegate functions and/or decision-making to that committee. They can be used by NHS organisations when they are exercising their joint working and delegation powers (National Health Service Act, 2006).

Committees in common are an arrangement for which there is no standard definition (NHS or otherwise). They are a joint working arrangement by NHS organisations where each appoints its own statutory committee which then operates "in common" with the others. "In common" means the committees have shared or aligned terms of reference and levels of delegated authority, and meet together (physically or virtually), with the same agenda and paperwork for each meeting. In this way, each committee makes its own decisions or recommendations but can deliberate with the members of the other committee(s). Each committee may have its own delegated authority but together the committees do not have shared delegated authority ie, each committee comes to its decision independently, albeit through and following 'in common' discussion with the other committees. A decision is only made if all committees agree.

The terms of reference and scope of delegation to committees is open to almost infinite variation. This can range from limited scope and terms of reference for a specific project to responsibility for oversight of a wide range of projects with powers to make extensive and substantial decisions (including financial). In every case, parent boards will need to apply levels of oversight they consider prudent and proportionate to manage risk and the terms of reference should clearly set out when a decision is reserved to the boards of the organisations.

What are the powers of NHS providers to form committees?

NHS trusts have powers (The National Health Service Trusts (Membership and Procedure) Regulations, 1990) to appoint committees and delegate to them the exercise of any of their functions. NHS FTs can do likewise (National Health Service Act, 2006) but with restrictions on membership of the committee.

An NHS trust committee can consist of directors, people who are not directors, or a mixture, while an FT committee cannot include anyone who is not a director of the FT (National Health Service Act, 2006) (unless it is a joint committee under s.65Z6 of the NHSA). FTs cannot delegate to an individual who is not an executive director.

The 2022 Act introduced new flexibilities in the NHSA for FTs to make arrangements to carry out their functions jointly with other persons (National Health Service Act, 2006). Both FTs and NHS trusts may also now arrange for functions that are exercisable jointly with a relevant body (as defined by the NHSA), a local authority or a combined authority to be exercised by a joint committee (National Health Service Act, 2006).

When establishing **committees in common** which include at least one FT, then, membership of the FT's committees is restricted to voting directors of the FT only. Where a **joint committee** is established, membership can be more flexible.

What are committees in common?

Committees in common are a means by which two or more organisations can come together to make quasi-shared decisions.

Each organisation must form a statutory committee of its board of directors. The committees should have shared or aligned terms of reference. Each board should agree the same level of delegated authority to its committee.

These separate statutory committees can then meet in one meeting room or virtual space as committees in common to work to the same agenda and to discuss and agree on matters addressed on the agenda.

A common misconception about committees in common is that each committee must have identical or equivalent membership. There is no such requirement for the committees. One organisation might, for example, create a statutory committee of its chair, chief executive, medical director and one further NED, while the other organisation appoints its chair, chief executive, director of nursing and director of finance to its committee.

Equally, in some committees in common membership is aligned (appointees to each committee are holders of the same posts). It can also be identical (appointees to each committee are the same individuals – ie they are holders of joint posts in each organisation[1]). Identical membership of committees in common is most likely within a group model with joint directors of each trust. These committees can be considered a virtual-joint committee.

In FTs, such committees must consist of statutory voting board members, but NHS trusts have greater latitude and may appoint non-board members to their committees.

In provider collaboratives it may be that the members of each trust's committee include the chief executive and the chair. This provides senior executive and non-executive input and balances non-executive and executive representation. In some provider collaboratives membership is far more extensive and may include other executive and non-executive directors.

In short, committees in common can operate on a scale from having limited decision-making authority, perhaps to manage and oversee board-agreed priorities or programmes of work, through to quasi-boards with a large degree of latitude on managing budgets and the projects or services on which they are spent.

Historically, committees in common were a workaround arrangement for NHS organisations that did not have powers to form joint committees. Where NHS organisations can now use their powers to establish a joint committee, then they may prefer to do so. However, committees in common may still be useful, including in circumstances where joint committees are not possible, for example remuneration committees of trusts operating together in a multi-trust group model.

A note about language

Committees in common is terminology that is not always used to mean the same thing by those using it. In our view, committees in common are two or more separate committees that operate alongside each other with shared terms of reference, agendas, paperwork, and the same levels of delegated authority to make decisions. We know the term is sometimes used for advisory groups but here we reserve it for committees with some degree of decision-making authority, so as to set out relevant legal considerations.

When the committees in common come together to work through their shared agendas, they are often described as **a committee in common** (singular), which is simply shorthand for the multiple committees operating in concert.

1 An example: two boards each appoint to its statutory committee its joint chair, joint CEO, joint director of finance and joint strategy director. The committee in common is therefore four individuals strong but is made up of two committees, themselves each four strong.

Considerations

- As when setting up any committee, the committees' remit (mirroring the scope of the collaborative) and purview should be clearly established through the terms of reference. The assurance requirements of provider boards should be agreed and defined. Equally, any delegated powers should be clearly agreed and well-defined to avoid any misunderstanding or mission-creep.
- Provider boards will usually retain organisational autonomy and the freedom to form other collaboratives and partnerships outside the scope of the terms of reference. An exception to this is where a group model uses a combination of joint leadership and committees in common to operate as if a single entity with significant harmonisation across organisations. In this case it would be more difficult for a trust to exit the arrangement or form separate collaborations.
- The value of NED challenge, input, and scrutiny at the point of decision-making should be considered.
- Whatever the delegated authority of the committees in common, time spent building mutual trust and effective relationships between the members of the committees and/or between each of the provider boards will likely pay dividends. Each provider board must have trust in the judgement of the committee members to whom authority is delegated, and each committee will likely want to gauge their board's appetite in relation to significant decisions. They must also trust that decisions reached by all committees in common will be sound.
- Providers may need to amend their schemes of delegation.

What is an example of a committee in common arrangement?

West Yorkshire Association of Acute Trusts Leicestershire Partnership and Northamptonshire Healthcare Group.

What is a joint committee?

A joint committee is a statutory, reciprocal arrangement between two or more bodies, usually established for the purpose of joint decision-making. Under this arrangement, the participating organisations set up a formal committee which is a joint committee of all of them, to take responsibility for one or more of their statutory functions.

The new flexibilities introduced by the 2022 Act (National Health Service Act, 2006) allow FTs to participate in joint committees that include people who are not directors of the FT. The bodies which can form joint committees are NHS trusts, FTs, NHSE, ICBs, local authorities and combined authorities. Only the NHS bodies (ie, not the local authorities or combined authorities) may delegate functions to the joint committee.

The constituent organisations are bound by the decisions made by the committee, which is established by agreement between the participating organisations. Collaborating organisations decide who should be appointed to the joint committee and this is not restricted to employees of the participating organisations. The committee's terms of reference should clearly specify who the members of the committee are, but other persons may be permitted to attend meeting of the joint committee in a non-voting capacity.

While ICB and NHSE approval is not required under the NHSA for provider joint committees, ICB support can be useful in demonstrating their backing for such arrangements.

Considerations

- Joint committees can make decisions that are binding on the organisations involved without the need for delegation to individuals or groups of individuals on the committee. As when setting up any committee, the scope, responsibilities, and powers of the joint committee will need to be carefully agreed by the participating organisations, as will the provider boards' assurance requirements in relation to the activities of the committee.
- Not all functions of an NHS trust or FT can or should be delegated to a joint committee. The delegation guidance (NHS England, 2023a) gives examples of the types of functions that cannot or should not be delegated. Most relevant are "functions central to the corporate governance of individual organisations"(NHS England, 2023a). This includes the requirements to prepare consolidated annual accounts and to have an audit committee.
- Membership of joint committees with significant delegated functions and/or decision-making powers should be carefully considered. Appointing organisations should be confident that the committee has sufficient senior (likely board member) representation and adequate NED involvement to provide scrutiny and challenge. The ability to appoint individuals from outside participating organisations allows, for example, the appointment of specialist clinicians, patient representatives or independent NEDs from other organisations or sectors.

- Time spent building mutual trust and effective relationships between the members of the committee and each of the provider boards will likely pay dividends. Each provider must have trust in the judgement of the committee members as functions and decision-making authority is delegated, and those on the committee will likely want to gauge their board's appetite in relation to significant decisions.
- The participating organisations will need to amend their schemes of delegation to reflect the joint committee arrangements.

What is an example of a joint committee?

Lancashire and South Cumbria Provider Collaborative case study.

Joint ventures

Provider collaboration may be enabled via two types of joint venture, either a contractual joint venture or a corporate joint venture.

Contractual joint venture

What is a contractual joint venture?

A contractual joint venture is simply a collaboration of providers underpinned by a partnership or collaboration agreement. The key feature of a contractual joint venture is that the organisations will agree in a legal document how they are going to work together. There is no fixed legal form or prescribed documentation for a contractual joint venture, which can be used alongside many of the models outlined in this guide.

The governance of the arrangements is usually in the form of a partnership board (though other names may be used), with terms of reference set out within the contract. Such 'boards' are a contractual construct, and so there is no restriction on FTs' participation[2] as the scope of decision-making of this board is limited to matters under the contract. There is no formal delegation of functions or decision-making.

One of the providers will usually be designated as 'host' and provide legal personality[3] for the joint venture to eg employ staff and enter into contracts for services. The member organisations will often have a service level agreement with the host for the provision of services back to the members. Where the host holds a commissioning contract for the provision of services and subcontracts to the other members of the joint venture, this is also known as a lead provider arrangement. So, a lead provider arrangement is a type of contractual joint venture.

2 i.e. paragraph 15 of schedule 7 of the NHSA does not apply

3 A contractual joint venture creates a form of partnership and while that partnership may operate at arm's length from the participating organisations (often using a brand name) it is not recognised as a "person" in law.

Can new powers under the 2022 Act be used?

The new powers in section 47A of the NHSA allow an FT to enter into arrangements for the carrying out any of its functions jointly with any other person.

In the NHS at present, contractual joint ventures are often used for back-office services such as procurement and IT support, and successfully used by many pathology networks. The legislation enables greater scope however, such as in Mid and South Essex NHS Foundation Trust where the joint venture agreement is underpinned by quality concordats that enable, for example, the introduction of single points of access for different clinical services.

Considerations

- Membership of a contractual joint venture is not limited to NHS providers and can include independent health providers and the voluntary sector. This a key advantage of this approach.
- Providers and ICBs are accustomed to and understand contractual bases for service delivery: this is a familiar approach and as oversight and control methods are reasonably well-understood in contract delivery, governance arrangements can be relatively simple and aligned to delivery of activity.
- Formal delegation from boards to committees or individuals is not required, and existing programme and project management reporting lines can be used.
- Provider boards and organisations clearly remain autonomous and responsible for activity outside the contract specifications as well as managing the contract.
- The contractual basis lends itself well to definition of the scope and objectives of the collaboration, and also to adaptation over time as renegotiation of the terms of engagement or dissolution of the contract is relatively simple (as opposed to trying to reverse a merger or withdraw from joint ownership of a company, for example).
- Where services are transferred to a host organisation this may involve a transfer of staff under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (The Transfer of Undertakings (Protection of Employment) Regulations 2006). (TUPE) as well as separately negotiated asset transfers between the member organisations.

What is an example of contractual joint venture?

Mid and South Essex case study.

Lead provider model (lead provider contractual joint venture)

What is a lead provider model?

A lead provider model is where one organisation holds the contract with commissioners for all services and then subcontracts to the other providers within the collaborative.

Underpinning these arrangements, there needs to be a robust agreement between providers to ensure:

- Governance arrangements for overseeing the contracts and services are clear.
- The lead provider is insulated from the risks it is taking on under the commissioning contract.
- The subcontracted providers are protected if the lead provider breaches the terms of the commissioning contract.
- The subcontracting arrangements must remain in place so that the lead provider cannot choose to provide all services under the commissioning contract itself.

We consider the various available contractual arrangements in the Collaboratives and Contractual Arrangements section.

A lead provider model is usually underpinned by a collaboration agreement setting out the terms of engagement (which may be called a MOU or joint venture agreement, among other possibilities). Decisions about the contract can be made by a 'management board', which is a contractual construct with responsibility for overseeing the services. The management board can take binding decisions about the services but does not have any delegated functions. Depending on the remit of the management board set out in the collaboration agreement and/or contractual arrangements between the parties certain decisions may be reserved to the participating organisations' boards. The management board cannot exercise delegated functions unless it is also operating as committees in common or a joint committee.

The NHS Long Term Plan introduced NHS-led provider collaboratives for groups of providers of specialised mental health, learning disability and autism services, using the lead provider model. The ambition supported partnerships of providers to take on new responsibilities for pathway, commissioning, and budget management for specialised services. It also allowed providers from a range of backgrounds, including third sector providers, other NHS and independent sector providers to collaborate. The lead NHS provider remains accountable to NHSE for the commissioning of services.

Considerations

- Lead provider arrangements are reasonably well-understood having been used in the NHS for some time.
- This model is not limited to NHS providers and therefore allows for collaboration with independent and voluntary sector organisations.
- Many providers and ICBs are familiar with and understand contractual bases for service delivery. Likewise, oversight and control methods are reasonably well-understood in contract delivery.
- As in any structure, a collaboration agreement and relevant contracts will need to be clearly defined, accountabilities and liabilities clearly articulated, and risks effectively managed.
- Ideally, providers involved should have sufficiently mature relationships to successfully move to an arrangement where only one provider holds a contract with commissioners.
- Provider boards and organisations clearly remain autonomous and responsible for activity and their organisations outside the contract specifications.
- Putting services under a single commissioning contract with subcontracting arrangements between the lead provider and other partners can create shared responsibility between providers for the provision of services. There can be shared decision-making about the contract.

What is an example of a lead provider model?

South West Provider Collaborative.

Corporate joint venture

What is a corporate joint venture or jointly owned company?

A corporate joint venture is where the participating organisations form a company or limited liability partnership[4] (sometimes referred to as a special purpose vehicle). The legal language used to describe the relationship of the participating organisations to the company depends on the type of company formed. For a company limited by shares, the participating organisations are the shareholders. For a company limited by guarantee or a limited liability partnership, the participating organisations are known as members. In any case, the participating organisations control the company for legal purposes. The company can take on responsibility for the provision of a specific set of services by entering into contracts with the members (to subcontract services) or with commissioners.

What are the powers of an NHS trust to participate in companies?

An NHS trust has limited powers to set up a corporate subsidiary. It may set up a company limited by shares for the purpose of additional (ie non-NHS derived) income generation but may not otherwise do so without a direction of the secretary of state for health and social Care. See HM Treasury (HM Treasury, 2010) and NHSE guidance (NHS England, 2018). It should also be noted that in accordance with NHSE guidance, all subsidiary transactions, including setting up a new company, are reportable under the Transactions Guidance. Where the joint venture company includes non-NHS participation the HM Treasury guidance will also need to be followed.

What are the powers of an FT to participate in companies?

An FT has a wide discretionary power to set up a subsidiary company for the purposes of or in connection with its functions (National Health Service Act 2006). It is not restricted to doing so for the purpose of additional income generation. It should be noted that in accordance with the Transactions Guidance, all subsidiary transactions, including setting up a new company are reportable. Where the joint venture company includes non-NHS participation the HM Treasury guidance (HM Treasury, 2010) and (NHS England, 2018) will also need to be followed.

Considerations

- A corporate joint venture is a separate legal entity to that of the participating organisations. In theory, it allows the company to employ staff, hold assets and enter into contracts, in practice, such apparent flexibility may not be realisable as transfers of staff and assets to the company would take them outside of the NHS and often meets significant opposition.
- The corporate joint venture can take on responsibility for the provision of a specific set of services through subcontracting arrangements with its parent organisations or directly contracting with commissioners. Depending on how the company is set up, it may be

4 For ease we use companies in this section to refer to all types of corporate bodies that can be used.

awarded contracts by the participating organisations without the need for a separate public procurement process.

- NHS providers are unable to delegate the exercise of NHS functions to the corporate joint venture.
- Corporate joint ventures are relatively complex to set up and to dissolve. For example, set-up requires clear articulation of its powers, an agreed overarching constitution (articles of association), a shareholder or members agreement setting out matters reserved to the participating organisations and decisions need to be made about funding, staffing etc. In addition, NHSE requires a trust-approved business case to be submitted detailing the nature of the proposal and its inherent risks for NHSE transaction review.
- Governance of the corporate joint venture is through its board of directors, who are accountable to its shareholders or members (i.e., the participating organisations). The board of directors do not need to be directors of the participating organisations and the directors can make decisions about the company and the services it provides. The shareholder or member organisations will need to pay careful attention to retaining oversight of the quality of company's outputs and establish suitable reporting and accountability mechanisms to do so.
- The powers of NHS trusts are insufficient to enable NHS trusts to participate in establishing a group structure by way of a corporate joint venture.
- Local authorities have acquired experience of establishing joint venture vehicles to deliver services and the Public Accounts Committee has highlighted governance concerns around:
  - conflicts of interest and confusion of roles and responsibilities (where the participating organisation may be simultaneously owner, funder and commissioner)
  - probity in relation to the control of public funds and awarding of any contracts
  - taking on commercial risk while experiencing financial challenges.
- Corporate joint ventures can have private sector participation (though this may impact on the treatment of the company for procurement purposes) and HM Treasury guidance will need to be followed when setting up companies between the public and private sector.
- NHS providers should always assess the potential impact of VAT when considering if companies are a suitable alternative vehicle for the provision of NHS services.

Group models

What is a group model?

Like provider collaboratives, a group is an organisational model which has no legal definition and can take various legal organisational forms. It isn't defined by NHSE in their collaborative guidance but is recognised as a way of governing a provider collaborative.

Nonetheless, groups do tend to share common characteristics, which include:

- A central leadership body responsible for the strategic direction, and governance, of the group.
- Discrete, locally managed 'units' which are responsible for operational leadership and management and may have varying degrees of autonomy from the central leadership.
- Some element of standardisation of systems, policies and procedures across the respective units and perhaps a shared set of values.

What are the options for group models?

The term 'group model' can be applied to a range of different organisational forms. It can be applied to a single provider that creates internal divisional or management units, for example to manage several sites or services, such as Barts Health NHS Trust operating a group model for its four major hospital sites. It can also be applied to two or more providers which are jointly governed but operationally led at individual trust level, for example recent joint working between Barts Health NHS Trust and neighbouring trust Barking, Havering and Redbridge University Hospitals NHS Trust establishing a group structure, utilising a group executive board to manage both trusts. Using Barts Health NHS Trust as an example demonstrates how the term group can apply to a number of different arrangements, whether they are uni-trust or multi-trust groups. In fact, many groups are also provider collaboratives, and equally provider collaboratives that don't currently call themselves groups could choose to do so.

Each group arrangement has its own merits and the 'best' model in one locality or organisation will not necessarily be right for another.

Group models can be achieved through the options for collaboration outlined in this section of the guide. Most commonly, group models involve joint leadership and some form of committee for strategic decision-making. In existing group models where the providers remain sovereign entities, this committee is usually advisory but the additional powers introduced by the 2022 Act enable a shift to joint committees with decision-making powers if group members so wish.

Considerations

- The governance considerations when setting up and maintaining a group model will depend on the specific arrangement and local circumstances and so we haven't included specific considerations here.
- Clearly the benefits and risks of operating at scale must be evaluated in forming the arrangement.
- It is worth noting that NED involvement in decision-making can sometimes be minimised where executive structures are the focus for 'managing' divisional units. Ensuring adequate independent scrutiny of decision making and the ability to effectively manage risk will remain key in groups.

What is an example of a group model (also described as a provider collaborative)?

The Foundation Group is a collaborative of four partner trusts: South Warwickshire University NHS Foundation Trust, Wye Valley NHS Trust, Worcestershire Acute Hospitals NHS Trust and George Eliot Hospital NHS Trust. These trusts share a chief executive and chair, and each trust has appointed a managing director to support the group chief executive.

The group uses an advisory committee approach, establishing a Foundation Group Strategy Sub-Committee which includes each medical director alongside the group chair and chief executive. Each trust retains its board and organisational distinctiveness. The group has invested in key leadership roles including a group financial advisor, group digital advisor and a group improvement lead.

Joint or group posts
(and leadership)

What are joint or group posts and leadership?

Group or joint posts and leadership is where a leadership position is held by one individual, but the role and postholder has powers and responsibilities across two or more organisations.

While the terms shared leadership and joint leadership are often used interchangeably, we prefer to use 'joint' here because shared leadership has other meanings (about devolving leadership within organisations) which could lead to confusion. It is also more commonly used terminology when such posts are created, such a joint chair or joint chief executive.

What are the options for joint posts and leadership?

In recent years there has been an increase in establishment of joint posts across NHS organisations and examples of joint leadership can be found across the NHS in England.

Commonly, joint leadership is in the form of a joint chair and/or chief executive, although as relationships between organisations deepen other board members, both executive and non-executive, may take on joint roles. Joint executive director roles are sometimes established to deliver on large scale strategic programmes between trusts, such as a joint chief digital officer across two organisations delivering a single electronic patient record.

What are the formalities for putting in place joint or group leadership?

For joint or group directors of NHS bodies the statutory requirements for board appointments will need to be followed.

For FTs:

- The chair and NEDs are appointed by the council of governors (National Health Service Act 2006).
- The chief executive is appointed by a committee of the chair and the non-executive directors (National Health Service Act 2006). The appointment of the chief executive must be approved by the council of governors (National Health Service Act 2006).
- The executive directors are appointed by a committee of the chair, chief executive, and NEDs (National Health Service Act 2006).

For NHS trusts:

- The chair and NEDs are appointed by NHSE (The National Health Service Trusts (Membership and Procedure) Regulations 1990).
- The chief executive is appointed by a committee of the chair and the NEDs (The National Health Service Trusts (Membership and Procedure) Regulations 1990).
- The executive directors are appointed by a committee of the chair, chief executive and NEDs (The National Health Service Trusts (Membership and Procedure) Regulations 1990).

Where you want to increase the number of board appointments to allow for joint posts you will need to consider the maximum number of directors for each organisation:

- For NHS trusts this may require an amendment to its establishment order, which would require a statutory instrument to be made by the Department of Health and Social Care. But note that in any event the maximum number of directors of an NHS trust

is 12 excluding the chair, with a maximum of five executive directors [5] (The National Health Service Trusts (Membership and Procedure) Regulations 1990).

- For FTs this may require an amendment to the trust's constitution to increase the number of directors, and the number of NEDs (excluding the chair) should equal the number of executives (NHS England, 2022b).

Considerations

- Joint leadership may increase strategic alignment between organisations and enable relatively simple joint decision-making as decisions can be delegated to an individual joint executive director or a committee of joint directors. Group posts may do the same across group structures.
- Capacity and bandwidth, and so support available, for joint and group postholders should be carefully considered. Depending on the degree of strategic, governance and operational alignment between the organisations or divisions, these individuals may be taking on a significant additional burden. Where there is not alignment, deputy directors may need to provide capacity for example, but care would need to be taken about their reduced delegated authority.
- Joint leadership is a flexible option for collaboration as it can range from one individual being shared to all board members being shared. As the number of joint director posts increase, the rationale for a full merger or moving to a group model might take on more weight.
- The statutory formalities for appointing joint directors should be carefully considered. Those making the appointments will need to be convinced of the benefits and that the postholder will have adequate capacity to fulfil their directors' duties in each organisation. It is also possible that the arrangements may be perceived to be 'merger by stealth'. For appointments in FTs made by the council of governors, it will be important to involve governors early and manage the appointment process to ensure that you take your governors with you.
- Individuals undertaking joint roles across organisations should be supported to understand their duties regarding managing conflicts of interest and the organisations should ensure their policies/procedures are explicitly updated to cover joint post holders, to inform and support transparency and decision-making that is free of bias, whether perceived or actual.
- The contractual employment arrangements for joint or group executive directors should be carefully considered (for example, whether separate contracts will be held with each employing organisation, or the employee enters into one contract with both organisations). Arrangements for holding the employee to account according to one or other organisations' policies and procedures (where these are not standardised) will also need to be clarified, as will arrangements for dismissing joint postholders, should that be required.

5 This is increased to a maximum of 14 directors, excluding the chair (and a maximum of seven executive directors) for approved mental health trusts and care trusts.

What is an example of joint leadership?

Examples of various joint posts are included in our Mid and South Essex and Leicestershire Partnership and Northamptonshire Healthcare Group case studies but there are numerous examples including: North West London Acute Provider Collaborative (which has a chair in common across four trusts), Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust (joint chief executive and joint chair), and Kings College Hospital NHS Foundation Trust and Guys' and St Thomas' NHS Foundation Trust (joint chair and joint chief digital information officer), amongst others.

Single provider

(mergers, acquisitions, dissolutions)

A defining feature of a provider collaborative is that it involves more than one trust. This excludes from the definition those provider collaborations, including group models, that have moved to a single provider structure (and indeed this is often the end point for a group model). However, this section is included here for completeness and because the move to a single provider by some combination of two or more providers can be seen as one end of the spectrum of collaborative forms. We don't say it is the culmination or apex of collaboration, since for many providers this is not considered a desirable outcome. But it is nonetheless worth considering briefly here.

What are the routes to creating a single provider?

There are several routes by which providers in a collaborative can come together to form a single organisation:

- Statutory merger (National Health Service Act 2006).
- Statutory acquisition (National Health Service Act 2006).
- Dissolution of an NHS trust (National Health Service Act 2006).
- Statutory transfer schemes (National Health Service Act 2006).
- Commercial transfers.

Each of these routes has advantages and disadvantages and should be considered in the context of the aims of the organisations involved. With the exception of statutory transfer schemes (section 69A, which was inserted into the NHSA by the 2022 Act) there are examples of all of these routes being used to create a single provider for services.

We have set out in the table below a summary of these routes:

Routes to create a single provider

	Summary	Legislative basis	Restrictions	Approvals	Example
Statutory merger	An FT (A) may apply with another FT or NHS trust (B) for both trusts to be dissolved and a new FT (C) to be established.	s.56 NHSA	Must involve at least one FT.	Application must be approved by NHS England and the Secretary of State. Each FT requires the approval of more than half of its Council of Governors.	Merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust to form Manchester University NHS Foundation Trust.
Statutory acquisition	An FT (D) may apply with another FT or NHS trust (E) for D to acquire E.	s.56A NHSA	D must be an FT.	Application must be approved by NHS England and the Secretary of State. Each FT requires the approval of more than half of its Council of Governors.	Acquisition of Royal Liverpool and Broadgreen Hospitals NHS Trust by Aintree University Hospital NHS Foundation Trust to form Liverpool University Hospitals NHS Foundation Trust.
Dissolution of an NHS trust	Where an NHS trust is dissolved its assets and liabilities may be transferred by order to another NHS body.	Schedule 4 NHSA	Only applies where an NHS trust is dissolved.	Order made by NHS England or Secretary of State.	Acquisition of Pennine Acute Hospitals NHS Trust by Salford Royal NHS Foundation Trust to form Northern Care Alliance NHS Foundation Trust.
Transfer schemes	NHS England can make a transfer scheme to transfer property, rights and liabilities from one NHS body (F) to another NHS body (G).	s.69A NHSA	Note that both F and G are continuing entities and therefore this option is better suited to transfers of individual services.	Order made by NHS England or Secretary of State.	N/A

	Summary	Legislative basis	Restrictions	Approvals	Example
Commercial transfers	Parties enter into a business transfer agreement to transfer the assets of one party (H) to the other party (I).	N/A	Liabilities of H cannot be transferred to I. Note that both H and I are continuing entities and therefore this option is better suited to transfers of individual services.	May be assessed as a material transaction by NHS England. May require council of governor approval for FTs where trust's definition of significant transaction is met.	Acquisition by Manchester University NHS Foundation Trust of North Manchester General Hospital from Pennine Acute Hospitals NHS Trust.

Considerations

- Where strategic and organisational alignment is significant, the delivery of shared objectives may in some cases be furthered by closer still alignment within a single organisation. Except in the case of mandated dissolutions or statutory transfer schemes, it will be for the provider organisations to discuss and decide. Potential advantages for already-substantially aligned organisations include reduction of duplication, economies of scale and ease of implementation of decisions.
- Structural integrations require considerable internal and external approvals processes, including approval by NHSE, the secretary of state, and the councils of governors of any FTs involved in the process. Such transaction processes therefore tend to be slow and complex to implement.
- NHSE's transactions guidance (NHS England, 2022h) was updated in 2022.

CONCLUSION
What next for provider collaboration?

5

NHS Providers view
(November 2023)

While collaboration between NHS providers is not new, the flexibilities introduced by the 2022 Act (and NHSE's expectation that acute and mental health providers will be part of collaborative arrangements) both reflect and are driving considerable energy behind collaborative working.

Our members tell us that they support the principle of working together at scale, and at place, and are optimistic about the benefits to patients and health and care systems. They are also clear that collaboration won't be a panacea for all of the longstanding issues that NHS providers, and the wider sector, are grappling with.

We hope this resource will help providers to make lawful, deliberate decisions about the type of collaboration(s) that might suit them and give provider boards confidence that their arrangements are sound; allowing them to navigate opportunities, manage risk and monitor performance. Proportionate governance doesn't have to be onerous; it should be viewed as a key enabler that embeds change and creates the right environment for successful collaboration.

This resource also seeks to demonstrate that there is no one-size-fits-all model for provider collaboration. Arrangements should be based on local objectives, relationships, context, and the benefits to be delivered. At the time of writing, many systems are in the process of reviewing their operating models to clarify and confirm the roles, responsibilities and priorities of system partners and associated delivery structures, including provider collaboratives. As system-working further beds in, local context and population need will increasingly influence the ways partners work together to achieve the triple aim of system working. This is likely to be reflected in the structures and arrangements providers and system partners put in place to deliver on these priorities. Flexibility to determine the right governance arrangements for the task remains crucial to support this.

As history dictates, NHS organisations will need to be responsive to a changing political and policy context. Revised NHSE guidance for provider collaboration should be with us in early 2024, and we might see the green light on new responsibilities and functions that may be delegated to providers from ICBs. We are also expecting a general election.

Although the context changes, the principles of good governance, based on decades of learning from corporate missteps, are relatively constant. Providers keen to exploit the benefits of collaboration will find good governance a firm foundation.

5

Browne Jacobson view

(November 2023)

The legal framework for collaboration is highly flexible. NHS England has put in place some policy constraints but nevertheless providers have huge freedoms in how they work together. With that freedom comes a responsibility to get the governance right.

The legislative changes that enable collaboration follow the white paper Integration and Innovation: working together to improve health and social care for all (February 2021) which identified the complexity and bureaucracy of existing arrangements. The disparity in delegation powers between different NHS bodies led to complex workaround arrangements in the form of committees in common, often with partners becoming frustrated by the lack of decision-making ability.

The aim of introducing new legislation was to reduce bureaucracy and remove barriers to integration and collaboration. But in many ways collaboration remains as complex as ever. The scale, complexity and number of collaboration arrangements that providers will be involved in makes non-executive director (NED) oversight more challenging than it has ever been. NEDs will have to focus on core responsibilities and be able to step back to see the bigger picture.

Provider collaboratives looking to take on responsibility for the arranging of services in the absence of a formal delegation from integrated care boards (ICBs), face a further challenge of navigating the requirements of the new Provider Selection Regime (PSR) expected to come into force in January 2014. While the PSR should make it easier for provider collaboratives to work with commissioners to change existing contractual arrangements, a new regime always brings with it uncertainty and we understand that there is variation in the understanding of the new arrangements between NHS bodies and local authorities.

While legal support is essential to setting up effective governance within provider collaborations the legal framework should not be viewed as a barrier to overcome but rather an opportunity to further develop relationships for effective decision-making.

6

ANNEX

Considerations summary

- Have you openly discussed and agreed with partners the extent of your ambitions for collaboration now, and with a view to partners' appetite for the future?
- Have you agreed how to begin to develop and continue to work on establishing fruitful relationships between participating organisations' boards and wherever else relevant between employees?
- Have you discussed organisational risk profiles as partners and how risks to achieving the collaboration's objectives will be managed?
- Are your decisions about governance arrangements proportionate to risk and does 'form follow function'?
- Is any paperwork, whether legally binding or not, underpinning your collaboration clear and well-understood, where considered useful?
- Have you ensured any committees or groups formed are lawful?
- Are there clear terms of reference for any collaborative committees or groups and are all partners in agreement?
- Are partners clear about which functions and decisions are reserved to provider boards? Are those with delegated authority clear about its limits?
- Are partner boards clear about their oversight and assurance reporting requirements?
- Have you made risk-proportionate decisions about involving adequate NED representation to provide independent challenge and scrutiny at the point of decision-making?
- Are roles and responsibilities well understood?
- Are partners clear about each provider's individual and/or shared accountabilities and their liabilities?
- Are conflicts of interests managed effectively?
- Have partners' schemes of delegation been updated if necessary?

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Councils of Governors

What is the council's role in provider collaboration?

The councils' general duties remain unchanged by the 2022 Act, however the context in which they undertake their duties has clearly changed. The Addendum to your statutory duties clearly articulates the change of context and explores its implications for councils of governors.

Holding to account

In relation to provider collaboration, as part of their general duty to hold the NEDs individually and collectively to account for the performance of the board, councils will expect to receive assurance around:

- The benefits of collaboration and its contribution to the organisation's strategic objectives and priorities.
- Their board's effective oversight and control of the collaborative(s).
- Board members' capacity and bandwidth to engage in collaboration while maintaining control of their own FT.

Councils should do this conscious of their duty to represent the interests of the wider public beyond the footprint of their own FT, which has clear bearing on their understanding of the rationale for provider collaboration.

The Addendum to your statutory duties from NHSE emphasises the role of the council of governors in representing the wider public and the need to make decisions in the context of system working. This may require a shift in mindset from governors, which should be supported by your interactions with them, who may tend to seek to represent the view of the specific constituency of which they are a member and have been elected. Councils should be reminded that while they have a legitimate interest in the activities of any collaborative their FT is part of or proposing to be part of, they have no powers to hold to account the board members of partner organisations and should not seek to do so.

Approving transactions

Also pertinent, depending on how collaborative working evolves, is that councils retain their role in approving applications for statutory transactions and significant transactions. Where trusts are seeking to put in place group models involving structural integration i.e., mergers or acquisitions such approvals will be relevant. The Addendum to your statutory duties is particularly helpful in highlighting the requirement for governors to consider the transaction in the context of the system as a whole:

"Councils of governors may well be expected to consent to decisions that benefit the broader public interest while not being of immediate advantage to or creating some level of risk for their NHS foundation trust. Consent should not be given for decisions that benefit the NHS foundation trust without regard to the effect on other NHS organisations, or the overall position of a wider footprint such as an ICS."

The Addendum to your statutory duties also helpfully reminds Councils that their approval role only requires them to assure themselves that the FT has undertaken due diligence when making the recommendation to NHSE to undertake such a transaction. They should not be revisiting the decision itself:

"Councils of governors are responsible for assuring themselves that the board of directors has been thorough and comprehensive in reaching its decision to undertake a transaction (that is, has undertaken due diligence), and that it has appropriately considered the interests of members and the public as part of the decision-making process (Monitor, 2013). As long as they are appropriately assured of this, governors should not unreasonably withhold their consent for a proposal to go ahead (Monitor, 2013). They should consider the implications of withholding consent in terms of the key risks the transaction was designed to address."

As such, it is important to ensure councils understand and are engaged early and on an ongoing basis around collaborations the board is either planning or is part of, and again engaged early and fully in relation to any potential transactions under discussion. This understanding and involvement will at a minimum help smooth the path through to approval and gives governors the chance to contribute useful insight and challenge to the board as plans are considered.

6

Lancashire and South Cumbria Provider Collaborative

Overview

The Lancashire and South Cumbria Provider Collaboration Board (PCB) is a formal joint working and delegation arrangement between the five NHS providers of acute, mental health, community, and specialist services in the Lancashire and South Cumbria ICS[6].

Following mutual aid arrangements in response to the Covid-19 pandemic, the leaders of the five trusts began to discuss mechanisms to enable greater collaboration. Following extensive engagement with the individual trust boards, staff and stakeholders, all the trusts agreed to form a joint committee structure to formalise the collaborative working arrangements and to commit to collective decision-making. The formation of the joint committee and the delegation of powers was then ratified by the ICB in December 2022.

The vision of the PCB is to "work together as one with a culture of continuous improvement", with the aim of "driving up quality by sharing skills and best practice, pooling resources and standardising ways of working to reduce variation and duplication".

One of the key drivers for collaboration was the commitment to making decision-making more streamlined and faster to enable better patient outcomes and quality of care.

The PCB seeks to provide NHS Lancashire and South Cumbria ICB, NHS England, local authorities, and the wider ICS with a single, collective trust view on proposals for service change. It also exists to develop shared clinical and other services, support financial stability and sustainability through reduced duplication and better use of existing resources, and to implement, manage and oversee shared corporate services.

The PCB has agreed to seven principles which guide the work of the collaborative:

- Work together as one structured system to achieve excellence.
- Have a trusting, transparent and open approach.
- Share data and best practice, learning together when things go wrong.
- Build a positive, aspirational culture based on continuous improvement.
- Encourage staff to be creative, innovative, and aspirational in what they want to achieve for the population and for each other.
- Be inclusive, ensuring joint working between the NHS, local authorities, the voluntary, community, faith, and social enterprise (VCFSE) sector, and private providers.
- Work as part of the Lancashire and South Cumbria system.

6 Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire and South Cumbria NHS Foundation Trust and University Hospitals Morecambe Bay NHS Trust.

6

The joint committee allows the PCB to make decisions on key programmes of work as agreed with trust boards. These key programmes each have a board or group which reports into the PCB. These are:

- **The Clinical Programme Board,** which leads the delivery of the joint clinical strategy. It also develops new models of care, for example the implementation of a system-wide networked service model for cardiology, the establishment of the Lancashire and South Cumbria (LSC) vascular network with a single inpatient unit, as well as the development of networked services in urology, and musculoskeletal trauma and orthopaedics.
- **The Central Services Portfolio Group**, which oversees the move to bring together operational services into one 'umbrella' service hosted by one of the partners in the PCB. Good progress has already been made in bringing together staff bank and agency, delivering savings from procurement, which the PCB is anticipating delivering a financial benefit to the system this financial year.
- **The Elective Recovery Programme Group**, which is responsible for six transformation programmes, all supporting the ambition of managing waiting lists and capacity 'as one'. The group also oversees the expansion of surgical hub capacity.
- **The Pathology Network Board** is overseeing the development of the Lancashire and South Cumbria Pathology service.

A PCB coordination group oversees and manages the PCB work programme. The group consists of executive directors and senior colleagues from all five trusts, each representing a profession (eg nursing, HR and finance). The role of these executive directors is to be a senior responsible officer (SRO) on behalf of their professional peers from across the collaborative, ensure clear communications between each trust and the group, and to be the SRO for the priorities falling within their professional remit. Director professional groups exist to allow discussion between the executive directors from across the trusts, ensuring the SRO is representing the views of their colleagues.

How are decisions made?

The PCB joint committee is made up of the chief executive and chair of each of the trusts. It is currently chaired by the chair of University Hospitals of Morecambe Bay NHS trust and the lead chief executive was until end of September 2023 the chief executive of Lancashire Teaching Hospitals, and is now the chief executive of University Hospitals of Morecambe Bay NHS trust. These positions are appointed for fixed terms by the members of the PCB by consensus.

Each trust board has delegated decision making authority to the PCB, so the PCB may make collective decisions that bind the trusts in relation to its delegated duties and responsibilities. This includes the delegation of decisions which support strategic service transformation priorities (as defined by the ICS and commissioners), priorities for provider productivity improvement, opportunities for developing standardised approaches to service change and delivery, some shared clinical services, and shared corporate services.

In exercising these delegated functions, the PCB has agreed to provide a single, collective view of the partner trusts and agree an annual work programme that promotes the best interests of the whole population. The individual trust boards and related sub-committees are engaged with matters presented to the PCB joint committee for decision.

When making decisions, all PCB members have the right to vote regardless of whether the service or issue is 'relevant' to them. Once decisions are made, all members have a collective responsibility to support the PCB in achieving its objectives and delivery of the work programme.

The first major decision made by the PCB was to develop a collaborative bank for nurses, midwives, health care assistants, allied health professionals and administrators. The ICS-wide bank is intended to improve patient care by boosting the temporary workforce and reducing reliance on agency staff.

Building on this first success, the PCB made the next priority to develop a vision for collaborative corporate services, with the aim of standardising the approach across all providers to reduce variation and duplication, and to meet a quadruple aim of 'ensuring the best health and wellbeing of the population, high quality services, a happy and resilient workforce and sustainability'. The providers agreed that collaborating across corporate services would allow them to meet these aims, agree joint priorities for these services and deliver against them by sharing best practice, skills and support, pool resources to support fragile services, provide flexible career pathways across organisational boundaries, and support the local economy.

How do you engage with other system partners?

The PCB connects with other system partners through the Lancashire and South Cumbria ICB. The objectives of the PCB link to the system strategy and will continue to be guided by supporting the health and wellbeing of all of Lancashire and South Cumbria.

In parallel, to help deliver on its aims, the collaborative is considering how to increase involvement of place leaders, acknowledging the role of place-based partnerships as the engine room for delivery in localities.

The PCB is starting to engage with local authorities and is working with ICB partners to navigate this and develop more collaborative working. A major opportunity underway is the Lancashire and South Cumbria New Hospitals Programme. Two of the trusts in the collaborative, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust have been successful in securing investment from the national New Hospitals Programme to build two new hospitals. The programme involves all NHS organisations and wider partners, including local authorities and universities in the system. As a key strategic opportunity and major infrastructure programme, the PCB has an important oversight role and will be involved in extensive engagement with local politicians, local authorities, the public and other partners to develop the plans and agree locations for

the new hospitals. It's hoped that this opportunity for Lancashire and South Cumbria will promote positive system-working.

What's next for the collaborative?

To date the joint committee structure has supported more effective and efficient decision-making. However, the PCB will continue to keep the arrangement under review, through an annual performance review.

Aaron Cummins, PCB lead chief executive commented: "Going forward, our aim is to build on benefits of the PCB working 'as one' in responses to surges in demand and in planning for industrial action and develop those relationships further to really understand what the art of the possible is and co-designing what that could look like in practice with our colleagues, public, and patients."

One piece of governance advice that you would share with others

Angela Bosnjak-Szekeres, the senior responsible officer for governance and legal services for the PCB shared that 'good engagement leads to good decisions'. She also reflected that implementing decisions and holding each other to account for delivery is still a work in progress. While the PCB joint committee has facilitated the decision-making process, the collaborative is now looking to build on this to make the delivery of these decisions more efficient.

6

Leicestershire Partnership and Northamptonshire Healthcare Group

Overview

Leicestershire Partnership and Northamptonshire Healthcare Group is a collaboration between Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) providing community, mental health and learning disability services. The trusts are part of Leicester, Leicestershire and Rutland Integrated Care System (ICS) and Northamptonshire ICS, respectively.

The group was created in 2021, although the two trusts began working together in 2019 when NHFT was appointed to buddy LPT. The trusts' respective boards agreed they did not want to lose the benefits of collaboration at scale when the formal buddying arrangement ended. But there was no appetite for a merger, which they felt meant losing a sense of identity at place and may have created issues for the organisations' existing partners. Hence the decision to explore opportunities for joint working under the banner of a 'group'.

To develop the relationships and culture across the organisations, before moving to the group model, time was invested in board-to-board development and joint topical discussions. Tasks arising from these discussions were given to pairs of directors to lead and in doing so develop mutual understanding and communication channels (before the creation of several joint posts).

The trusts work in partnership where it will bring additional benefits, as reflected in their eight shared priorities: innovation and research, together against racism, talent management, leadership and organisational development, strong governance, strategic finance, strategic estates, and quality improvement.

To date the group has:

- Jointly committed to work together against racism with every board member making their own personal pledge.
- Developed a non-competitive relationship with the local university medical school for encouraging talent into the organisations.
- Improved and shared on-boarding and corporate induction arrangements.
- Instituted joint Gold Command incident control during the Covid-19 pandemic to share learning and improve resilience.
- Identified joint procurement opportunities for cost savings, delivering social value and achieving net zero.

In February 2023 they were selected as part of NHS England's (NHSE) innovators scheme for provider collaboration.

How are decisions made?

The group's non-legally-binding structure is underpinned by a memorandum of understanding (MOU) which sets out agreed priorities for joint activity.

The group's collaborative work is governed by each trust board through two (non-decision making) committees in common that meet together as a 'joint working group' (JWG) and are accountable to their respective board.

Each committee comprises:

- Chair, chief executive, chief finance officer, director of strategy and partnerships, (each of which are joint posts across both organisations).
- Plus the deputy chair, deputy chief executive, director of HR and operating director, and the director of governance and risk.

The JWG meets once every two months and is responsible for the group's eight shared priorities, which have been approved by each trust board. It operates 'like a programme board' overseeing the delivery of the programme of joint priorities. Whilst it has no powers to exercise authority on behalf of LPT or NHFT itself, matters are easily progressed via the authority vested in its individual members.

In addition to its role in overseeing the delivery of the group's existing shared priorities, providing strategic oversight and direction and a forum for collaboration, performance reporting, and accountability, the JWG can also make recommendations to each trust board for further opportunities for joint working.

A group highlight report from the JWG, including levels of assurance against the delivery of the group model and its eight shared priorities, goes to each trust's board meeting. Programme management offices are in place in both trusts, and support group work between them.

It had been important to engage NHFT's governors on the group's journey to ensure they understood and were bought into the collaborative work.

How do you engage with other system partners?

Each trust retains its own strategy (which reflects the priorities for the group as set out in its MOU). The group priorities are focused on effective enablers for both organisations while the trust's strategies focus on their system delivery and local population issues such as children's health and frailty, so it makes sense for the trusts to retain their own strategies and relationships with their relevant integrated care board (ICB) rather than approach both ICBs as a group.

For similar reasons, the trusts have their own relationships with place partners and stakeholders, and undertake their own public and patient engagement.

As noted above, the group has engaged with the local university medical school and would likewise engage with other partners as required to seek benefits at scale.

What's next for the collaborative?

The group priorities and the progress of the model remains under regular review. The terms of the MOU gives either party the ability to leave the group by giving 12 months' notice at the end of a financial year.

There are ongoing conversations about the potential to extend the group model further through additional shared priorities. Both trusts are involved in many other partnerships. For example both are part of a six-trust East Midlands mental health and learning disability and autism alliance. NHFT were also involved in learning disability and autism collaborative work in Northamptonshire and LPT have led a learning disability and autism collaborative with local authorities in Leicester, Leicestershire and Rutland.

The two trusts believe that the way the strategic priorities for the group are formulated allows them to be fleet of foot in terms of delivery. They can use subsidiarity as a principle and work with partners and stakeholders as appropriate, using existing delivery arrangements such as the group or mental health collaborative, or establish new ones.

The group would consider accepting any delegated functions from the ICB once that becomes possible, or either trust might consider taking delegated functions through one of their other collaborations. Contract variations are possible now without the need for formal delegation from the ICB. The providers' focus is on ensuring the ICBs trust them to deliver now without formal delegation being necessary.

Colleagues from both trusts have found NHSE's existing guidance for collaboratives useful but feel their conversations were most important in enabling change and building mutual trust.

What's the one piece of governance advice that you would share with others?

David Williams, group director of strategy and transformation, and Richard Smith, director of corporate governance at NHFT, said:

"Create the culture for effective collaboration: find the benefits of working together, and tell the stories that demonstrate those benefits. So, whether it's simply a manager of one trust can now use meeting space in their partner trust, or two heads of services can now pick up the phone to each other and share ideas, frustrations or hold joint team meetings, promoting the benefits of collaboration demonstrates the possibilities to others and helps to build organisational cultures where collaboration can thrive."

6

Mid and South Essex Community Collaborative

Overview

The Mid and South Essex Community Collaborative (MSECC) was formed in September 2020. Collaborative working began when the five clinical commissioning groups, now re-established as the Mid and South Essex Integrated Care Board (MSE ICB), contracted the commissioning and delivery of all community services to the three providers in mid and South Essex. Each provider had and still holds a separate contract for the same broad range of community services. The initial work on establishing the strategic relationships between the organisations dates back to 2019 and the collaboration was formalised via a contractual joint venture agreement in spring 2020.

MSECC describes itself as a partnership and is notable for including a community interest company (CIC). The providers forming the collaborative are:

- Essex Partnership University NHS Foundation Trust (EPUT).
- North East London NHS Foundation Trust (NELFT).
- Provide Community Interest Company (Provide CIC).

Their focus is on reducing variation in outcomes for patients, sharing clinical good practice, and ensuring community services are fit for the future and delivered closer to home.

Their work is structured around six outcome areas:

- Higher quality sustainable services.
- Reduction in variation and duplication.
- Effective use of resources.
- Unified provider voice.
- Health equality and equitable access.
- Improved staff experience and retention.

Three years into their collaborative arrangements, the partnership's notable achievements include:

- Creation of 120 virtual ward beds, reducing patient deconditioning and acquired infection rates in hospital settings.
- A single service model for Urgent Community Response Team, community beds, virtual wards, and respiratory and long Covid services.
- Joint procurement and shared staffing, creating efficiencies.
- Development of a single inequalities plan and joint participation in the East of England anti racism strategy.
- Reduced use of agency and bank staff, and a reduction in the vacancy rate for community nursing.

- Joint roles reducing duplication and offering more attractive career pathways.
- The collaborative was chosen to be part of the NHS England innovator scheme in early 2023.

How are decisions made?

The providers established a community collaborative board, leadership team, and a joint operations group and a clinical reference group to enable effective joint delivery of their separate contracts.

The partners sought legal assistance to think through the options around the form and governance of the collaboration. They considered and discarded the creation of a new organisation, for simplicity's sake and to avoid costly restructuring when finances were tight.

The remaining choices were restricted by the involvement of a community interest company provider (since delegation to joint committees and decision-making committees in common is not permitted to non-NHS organisations). The choice of a joint venture model was therefore mainly driven by practicalities as it allows the integrated care board (ICB) to hold 'one joined up conversation' with its three community care providers and offers flexibility to adopt a different structure later if appropriate.

Underpinning the joint venture agreement are a series of quality concordats, which function as standard operating procedures.

The MSECC board is made up of the chair and chief executive of each of the NHS organisations, and the group chief executive of Provide CIC. Each partner organisation has delegated authority to make decisions at the MSECC board.

The MSECC does not have any employees: it has a lead director with a team of four partnership directors and a children and young people (CYP) operations director, who are employed by the three partner organisations (one of the partnership directors was already a joint post with Thurrock Council local authority).

The leadership team operates like an executive team and includes a lead director, the chief operating officers of all three organisations, a quality lead, nursing lead, governance lead, finance lead and communications lead. The leads are nominated from one of the three partner organisations and liaise with their counterparts in the other two organisations to undertake their role on the team effectively.

The four partnership directors and CYP operations director act as a single operational leadership team. They have shared the different service portfolios between them, each with oversight of cross cutting services that span the whole geography: for example, wheelchair provision and local services (such as district nursing) in each of the four places.

The governance challenge is to join up discussions and decision-making to avoid duplication while keeping everyone informed, and to enable the relevant provider boards to have effective oversight of decisions and services for which they are accountable. Relationships, mutual respect and understanding are seen as key drivers in overcoming any challenges to successful collaboration.

Work is allocated on a consensual basis based on capacity or expertise. The relationships have been established such that open and honest conversations can take place wherever there may be differences of opinion.

Risk management is undertaken within MSECC but with a focus on collaborative rather than organisational risks. This seeks to complement the oversight undertaken by the partner's own boards.

How do you engage with other system partners?

Members of the collaborative are driven by the need for services to be high quality and joined up – and to 'make sense' patients.

Since the very start, the collaborative has employed a director of workforce and engagement to help support working relationships between partners to help achieve this.

Over the past few years, the collaborative has therefore slowly been blurring the boundaries between commissioning and provision, taking the lead role for community services on behalf of the system. Working together has also allowed the three organisations to engage more effectively with other partners, allowing for single strategic conversations.

The approach is set out in a Memorandum of Understanding (MOU) with all system partners. Having partnership directors across four places, and the support of engagement teams, has also enabled more interaction with local partners and this in turn has influenced the collaborative's planning and decision-making.

What's next for the collaboration?

They are keen to strengthen delegation from the provider boards to the collaborative leadership through a revised scheme of delegation and are receiving support from NHSE's innovators programme to create an accountability framework to support this shift. The partners believe that the trust and relationships are in place to enable delegation and more flexible decision-making in future.

The collaborative is also working on how to effectively enable clinical and care staff to move between organisations. This involves standardising procedures, for example, around infection prevention and control. Colleagues in the NHS organisations are also keen to learn from colleagues within the community interest company about ways to streamline policies and procedures, to become more nimble.

6

What's the one piece of governance advice that you would share with others?

Simon Evans-Evans, director of corporate affairs at NELFT told us:

"Do the groundwork. It was important to establish the shared vision, mission and purpose, and agree the principles behind the collaboration, including clear accountabilities and dispute mechanisms (recognising that a backstop is required for when things go wrong, because even with the best will in the world, it's a question of 'when' not 'if' in the longer term).

Governance should facilitate operational delivery. It should be kept simple and provide assurance, utilising existing structures where possible to avoid introducing additional, unfamiliar processes or being seen as a block instead of an important enabler of effective service delivery. Don't over-engineer it."

6

South West Provider Collaborative

The South West Provider Collaborative (SWPC) is a partnership of five NHS organisations, one community interest company and two independent sector organisations[7]. This collaborative commissions a wide range of specialised mental health, learning disability and autism services at scale, to a population of five million people across six integrated care systems, with a focus on ensuring people receive high quality care as close to home as possible. The SWPC commenced in shadow form as a New Care Model in late 2016, and then became a fast-track provider collaborative with full commissioning responsibility for Adult Secure services in October 2020.

The collaborative uses a lead provider model, with Devon Partnership NHS Trust (DPT) acting as the lead provider. DPT therefore holds the contract with NHS England and has established governance arrangements locally to manage oversight of these commissioning responsibilities through an executive-led commissioning board known as the Oversight Executive Group.

Within the SWPC, there are two main oversight groups, the South West Mental Health Chief Executives Group, and the Oversight Executive Group from which it takes assurance. Executive members form part of the Oversight Executive Group, and are drawn from each provider partner, their function being to oversee the strategic plan and act as the senior liaison person within each provider partner and key link to their local ICS. They also peer assure delivery of the collaborative's service lines across quality, activity, and financial performance, seeking collective assurance on risk and delivery of the agreed strategic aims. The commissioning team of the SWPC provide routine performance reporting to the group for this purpose.

These structures are underpinned by a Clinical Senate for each service line, with senior clinical leadership drawn from across the region, and a Finance and Activity Group supported by senior finance leads from across the region. A programme director and a medical director are the responsible officers for the collaborative, appointed by the lead provider chief executive. The responsible officers are executive members of both the Oversight Executive Group and the executive team of the lead provider and are supported by a team of around 20 people with skills in commissioning, finance, and programme management.

The SWPC has collectively agreed a shared set of strategic aims that enable all provider partners to unite around a common vision for improving patient services across the South West. These strategic aims enable the SWPC to monitor delivery through aligned reporting and oversight, providing a clear, considered, and consistent view of overall operational performance to all provider partners, whilst developing a shared understanding of progress, successes, and key challenges. It also supports comprehensive assurance to the lead provider that the collaborative is discharging its roles and responsibilities effectively.

7 Devon Partnership NHS Trust, Cornwall Partnership NHS Foundation Trust, Somerset NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Gloucestershire Health and Care NHS Foundation Trust, Elysium Healthcare, Priory and Livewell South West (Community Interest Company).

6

West Yorkshire Association of Acute Trusts (WYAAT)

Overview

West Yorkshire Association of Acute Trusts (WYAAT) was formed in 2016 by the six acute hospital trusts, foundation trusts (FTs) and NHS trusts, working across West Yorkshire and Harrogate[8]. As such, WYAAT is an established collaborative, keen to share their experiences and learning with others. It is part of West Yorkshire Health and Care Partnership Integrated Care System.

The road to its formation started with exploratory conversations between the chief executives of the six trusts, who asked their respective company secretaries to consider the opportunities and options for formally working together. The company secretaries sought legal support and drafted a Memorandum of Understanding (MOU) setting out the terms of their collaboration – the original of which remains in use (with only a few minor wording tweaks), having been regularly reviewed.

Each of WYAAT's members contributes an annual fee to fund WYAAT's management, staff and activities. The contribution is proportionate to the turnover of each trust.

Initially, WYAAT explicitly decided to focus on what they term 'soft' projects and programmes, such as developing shared procurement to derive savings from bulk buying (which has more recently evolved to include all providers across the integrated care system (ICS)). This work enabled relationships to form and for people below board level to see the benefits of collaboration. This laid the groundwork before WYAAT began to tackle more difficult areas, and gave time to establish mutual trust, respect and candour.

WYAAT's first 'big difficult decision' recommended to its members was a reconfiguration of vascular services, moving from three arterial centres to two. This was a success, further cementing the relationships and ethos of collective accountability for doing the best for patients across the footprint, ahead of the interests of individual organisations.

Some notable achievements so far include:

- A workforce portability agreement, allowing staff to move between trusts to deliver clinical services.
- Shared and coordinated international recruitment, training, and apprenticeship management.
- Creation of cross-WYAAT posts such as anaesthetic associates, and clinical practice educators in radiology.

8 Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, Mid Yorkshire Teaching NHS Trust.

- Securing funding for educational grants, shared digital solutions, transformation of aseptic services and endoscopy training.
- An elective recovery programme, supporting trusts to transfer over 500 patients in 2022-23 to an alternative hospital to receive earlier treatment.
- Establishing numerous clinical networks and non-clinical networks of subject-matter experts and planning to deliver seven community diagnostic centres across the area.

WYAAT's members pride themselves on their collaborative ways of working and they set an expectation that leaders new to the trusts will actively sustain this ethos. When recruiting to senior posts in WYAAT or its members, it's made clear to applicants that they are applying for a role in a system, and need to be on board with working with partners at place, the ICB and others.

How are decisions made?

WYAAT is governed by committees in common with each organisations' statutory committee consisting of its chair and chief executive. Committees in common meetings are three hours, held quarterly with a formal agenda and reports. The six trusts opt into projects or programmes of work, and output of the discussion requiring formal support is presented to the relevant trust boards for governance and approval. The committees in common hold no delegated authority from respective boards, but do oversee and control programmes and priority activities underway, underpinned by a risk framework.

Company secretaries of each trust are involved to ensure consistency of approach, and paperwork, between WYAAT meetings and the flow to board meetings in their own organisations for appropriate decisions as required. For governance purposes, identical paperwork goes to trust boards after being reviewed by the committees in common. A log of 'previously asked questions' appended to paperwork helps reduce the need to repeat discussions that have already taken place. The company secretary from the trust of the chair of the meeting is in attendance along with a second company secretary from another member trust to support the minute taker. The company secretaries hold a short meeting within a week of the committees in common meeting to ensure the flow of information for approval to respective trusts' board meetings, for governance.

WYAAT has its own director. The director is supported by a small team: a medical lead, finance lead, analyst, communications manager, and programme management support. The director and their team are employed by one of the participating organisations. A chair of one of the members chairs the meeting on a rotational basis, as defined in the MOU.

Below the committees in common sit a programme executive, made up of the six chief executives, which meets monthly to oversee and steer work across each of WYAAT's priority programmes. Both the committees in common and programme executive are decision-making groups in relation to existing programmes and priorities, but proposals for new work or changes of direction go back to each organisation's board for approval following recommendation at the committees in common.

Four advisory sub-groups sit beneath this, feeding into the programme executive:

- Strategy and operations group.
- Directors of finance group.
- Clinical reference group.
- Chief digital and information officers.

Informal networks of all executive peer groups have been established to enable relationship building, discussion and identification of opportunities for collaborative working. There are also established clinical and non-clinical networks below executive level. Together, these arrangements enable suggestions and queries about joint working to reach the committees in common.

Each of WYAAT's 12 agreed priority programmes – spanning corporate services, clinical support, and clinical services – has a programme board with people and resources allocated as required. Programme boards are each chaired by a provider chief executive and include employees from other organisations within the ICS where relevant. These programmes are run using standard programme management processes and report up through the WYAAT structure. Updates, for example on progress and risk management are shared back to the provider boards; any feedback or challenge from those boards fed back into the WYAAT structures as required.

It remains of great importance to each of the trusts within WYAAT that they retain organisational autonomy. The trusts have no plans for closer structural integration, though they continue to review that the structure and approach is still fit for purpose to deliver shared objectives. The flexibility and focus that the structure enables, as well as retaining the local control and incorporating non-executive oversight and challenge via trust boards throughout decision-making is supported by the six trusts.

Retaining the autonomy of the organisational boards strengthens buy-in to the collaborative and its priorities, because each are explicitly and freely chosen as priorities for each organisation. The structure allows individual trusts to opt out of particular programmes if that makes sense for them – however no recommendation has failed to be approved by member boards to date.

Each chair's integral involvement in the WYAAT governing committees in common is intended to give the organisation's non-executive directors (NED) confidence in any proposals, as well as enabling board discussion and NED buy-in before proposals are fully formed. The director of WYAAT attends each member's board from time to time to engage with the full board, including NEDs, on WYAAT's activities, progress and plans.

Their approach enables careful communication, consensus building and development of ideas between members before a proposal formally reaches the trust boards for approval. Proposals are often initiated by the sub-groups of directors from each organisation, other advisory groups, or programme boards, before being refined into recommendations by the committees in common.

So, by the time the committees in common make a recommendation to members, the trust boards are usually well aware of the rationale behind any proposal.

WYAAT does not itself seek to engage with governors from its FT members. This happened through those FTs' own interactions with their councils.

How do you engage with other system partners?

WYAAT is one of a number of collaboratives in the ICS, alongside a mental health collaborative, community collaborative and a hospice collaborative all of which, along with the West Yorkshire Combined Authority, engage with the integrated care board (ICB) and integrated care provider (ICP). WYAAT has a partner member representative on the ICB, and each trust is a partner within the ICP. Strategically, WYAAT has worked closely with the ICB on its five-year joint forward plan.

WYAAT acknowledges its strong relationship with the ICB, whilst remaining independent of it. Much of WYAAT's business can be conducted within the collaborative, for example decisions relating to workforce portability or digital deployments, while keeping system partners informed and engaged where relevant. WYAAT will also make recommendations to the ICB where appropriate - for example about their vascular services programme or Community Diagnostic Centre investment.

There has been a change of approach since the ICB has been put on a statutory footing and NHS England (NHSE) has sought to devolve more to the ICB and hold it accountable for system level, and trusts' performance. In a complex landscape, the operating model requires further development to clarify responsibilities and accountabilities between the ICB, NHSE, places, trusts and WYAAT.

Each trust is a partner member in its local place and therefore most place engagement is through this route. Alignment of WYAAT with places is an area for further development as the ICB operating model evolves further in the future.

What's next for the collaboration?

The trusts within WYAAT are satisfied with the form of collaboration they have selected and have no plans to change it. The respective trust boards have considered and discounted setting the collaborative up as a wholly owned company, or pursuing a group model, or merger. They prefer to focus on deriving benefits from their relationships and networks, retaining organisational autonomy, and avoiding the transaction costs of a focus on structures at the expense of delivering their priorities.

WYAAT's director has been liaising with all trust boards around WYAAT's strategy for the next five years: seeking both input and buy-in, approaching boards directly seeks to ensure members' NEDs and all executives are properly engaged in its development. This was timed to incorporate, and where relevant reflect, the ICB's strategy.

WYAAT is also looking more closely at how risks are managed within and across the association, with a view to being joined-up with any system risk management framework in the future. Risks affecting all members are those linked closely to the delivery of quality and cost-effective acute services in West Yorkshire: for example delivery of elective targets and oncology capacity, as well risks such as those due to Reinforced Autoclaved Aerated Concrete (RAAC) and the impact of climate change, alongside the risks of delivering projects or programmes of WYAAT work. WYAAT is planning to bring the company secretaries of each of its member trusts together to lead a new piece of work assessing risk appetite, and adopting common risk language for a risk management framework for WYAAT committees in common. This may support the ICB in risk management across the system if they were able to establish a sound way of doing this across the association.

Interactions at place continue to need attention and more needed to be done to ensure WYAAT's programmes were aligned with work at place, and understood by place leaders.

What's the one piece of governance advice that you would share with others?

Lucy Cole, director of WYAAT, and Jo Bray, company secretary of Leeds Teaching Hospitals NHS Trust told us: "The success of WYAAT is based on a desire to work together for defined outcomes, which is the primary driver and can be underpinned by an appropriate governance model. Define the desire and outcome and don't get lost in the governance and delegation. WYAAT holds no delegated authority from its six respective trust boards."

RESOURCES AND ORGANISATIONS

Resources

NHS Providers

NHS Providers runs a Provider Collaboration programme which aims to support trusts to maximise the potential of provider collaboration. It focuses on sharing practice and peer learning through a range of events and resources for boards.
https://nhsproviders.org/provider-collaboratives

NHS Providers also runs a peer learning programme to share improvement approaches through provider collaboration aimed at tackling inequalities in outcomes, experience and access, Provider Collaboratives: Improving Equitably.
https://nhsproviders.org/development-offer/improvement/provider-collaboratives-improving-equitably

Various case studies, blogs and briefings on provider collaboration are available on the NHS Providers website, https://nhsproviders.org

Browne Jacobson

Browne Jacobson is at the forefront of supporting the NHS to develop clear and transparent governance systems which meet the legislative framework. Our expert health and care lawyers understand the issues you face and provide effective advice that is helpful, pragmatic and written in plain English.

Browne Jacobson is running a series of events on the procurement reforms as well as offering bespoke training packages for clients on the Provider Selection Regime.
https://www.brownejacobson.com/insights/provider-selection-regime-change-is-coming-what-does-it-mean-for-you

Shared Insights is a monthly, one hour forum (via MS Teams) which connects leaders and professionals from across the health and care sector to discuss the challenges you face and share learning, ideas and best practice.
https://www.brownejacobson.com/shared-insights

Gov.UK

Integration and innovation: working together to improve health and social care for all.
https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

Organisations

Airedale NHS Foundation Trust
https://www.airedale-trust.nhs.uk

Bradford Teaching Hospitals NHS Foundation Trust
https://www.bradfordhospitals.nhs.uk

Calderdale and Huddersfield NHS Foundation Trust
https://www.cht.nhs.uk/home

Dorset HealthCare University NHS Foundation Trust
https://www.dchft.nhs.uk/about-us/trust-board

Guy's and St Thomas' NHS Foundation Trust
https://www.guysandstthomas.nhs.uk

Harrogate and District NHS Foundation Trust
https://www.hdft.nhs.uk

King's College Hospital NHS Foundation Trust
https://www.kch.nhs.uk

Lancashire and South Cumbria Provider Collaborative
https://lscprovidercollaborative.nhs.uk

Mid Yorkshire Teaching NHS Trust
https://www.midyorks.nhs.uk

North West London Acute Provider Collaborative
https://www.nwl-acute-provider-collaborative.nhs.uk/about-us/board-in-common

The Leeds Teaching Hospitals NHS Trust
https://www.leedsth.nhs.uk

West Yorkshire Association of Acute Trusts and West Yorkshire Health and Care Partnership
https://wyaat.wyhpartnership.co.uk

West Yorkshire Health and Care Partnership
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