COLLABORATING
for better care

NHS Providers

Providers Deliver
Collaborating for better care

Contents

Foreword

Welcome to *Providers Deliver: Collaborating for better care*. This publication marks the start of an important and exciting work programme for NHS Providers, supporting greater provider collaboration. It has been developed in response to our member trusts' desire for us to help them adapt and evolve as leading players in the fast-changing health and care landscape.

In the coming months we will continue to highlight the benefits of these partnerships, showcasing the breadth of existing practice, and sharing learning to help forge new initiatives and deepen cooperation. We will also continue our work to influence national policy and guidance on provider collaboration, which offers great opportunities for trusts to broaden and develop their contribution as partners working at place, system and pan-system levels.

This is the fourth report in the publication series in which we celebrate and promote the work of NHS trusts and foundation trusts in improving care for patients and service users. Our first *Providers Deliver* report explored the way trusts have responded to feedback from Care Quality Commission, encouraging great ideas that have improved care. The next in the series, published last summer, looked at new roles for trusts in prevention. Our third report focused on the resilience and resourcefulness that characterised the response of trusts and their staff to the challenges posed by the pandemic.

This time we are focusing on ways in which providers are collaborating to address common challenges, provide more integrated care pathways and deliver more sustainable services. The case studies in this report show how trusts are at the forefront of work to recognise and respond to the opportunities of joint working. They demonstrate once again how, in a time of unprecedented challenge for the NHS, providers are delivering for patients, service users and the communities they serve.

Saffron Cordery
Deputy Chief Executive
NHS Providers

Understanding the national policy context
The context

The health and care system is undergoing significant changes to the way it is structured, organised and delivered. In recent years, the national policy direction has shifted away from trusts and foundation trusts competing for contracts, as was envisaged in the Health and Social Care Act 2012, towards collaboration as the main driver of improvement. Integrated Care Systems (ICSs) have been established to plan and deliver better joined up care for patients and service users, and better health outcomes for local populations.

As part of these changes, providers have increasingly sought to work more closely together to address common challenges, provide more integrated care pathways, and deliver more sustainable services. This approach has been further accelerated during the COVID-19 pandemic, which saw providers, and wider system partners, supporting each other during an incredibly challenging time. Alongside this the scale and impact of provider collaboration is fundamental in tackling unwarranted variation in outcomes, access to services and experiences, as well as in tackling health inequalities.

The next year will be a key transition period for ICSs, with the government's legislative proposals aiming to place ICSs on a statutory footing by April 2022 (assuming the Health and Care Bill passes through the parliamentary process as planned). The associated policy frameworks will also change significantly, including the financial architecture, procurement model and regulatory frameworks, in response to this focus on system working and collaboration.

Trusts and the national NHS bodies have high aspirations for how provider collaboratives can operate and what they can achieve by working together. This report aims to identify key themes and share lessons learned from a wide range of provider collaborations spanning different functions, forms and geographic footprints, to support trusts to respond to national policy developments and embed collaborative arrangements within their local system(s).

National policy developments

Recent national policy documents have placed provider collaboration as a key pillar in the development of ICSs. NHS England and NHS Improvement's *Integrating Care* paper, published in November 2020, renewed the vision for ICSs, setting an expectation for all trusts to be part of one or more provider collaborative, which will vary in scale and scope. The paper also reaffirmed the shift to strategic commissioning at ICS level, with other commissioning activities moving to provider organisations, provider collaboratives and place-based partnerships.

The Department of Health and Social Care's White Paper, *Integration and innovation: working together to improve health and social care for all*, published in February 2021, confirmed that ICSs will be placed on a statutory footing from April 2022, but places and provider collaboratives will not have a statutory underpinning. However, there is an

expectation that decision making will increasingly be delegated to provider collaboratives and place-based partnerships. The **2021/22 planning guidance** (April 2021) also set the expectation that ICSs will firm up their governance and decision-making arrangements this year, with trusts working collaboratively to deliver the NHS' priorities, such as tackling waiting list backlogs.

The scale, scope and complexity of these proposed changes are significant, with trusts at different stages of developing their collaborative working arrangements. NHS England and NHS Improvement's new guidance on provider collaboratives will focus on supporting at-scale horizontal collaboration. It seems that NHS England and NHS Improvement intends to be flexible rather than directive, with the guidance expected to point to several potential models that are already working well in some areas, including: lead providers, shared leadership arrangements, and a provider leadership board.[1] However, it is important that the complexity, variety, and different levels of maturity of existing collaborative arrangements and functions are considered and built upon.

What does provider collaboration mean?
State of play in the provider sector

Many providers have already been working together, formally and informally, to deliver more joined up care in a complex network of collaborative arrangements. The level of formality can vary greatly depending on the local context, the size of the ICS(s) that providers are working within, the composition of providers within that footprint, and population needs. While some have been collaborating in this way for over a decade, others are building on new arrangements developed during the COVID-19 pandemic.

In this report we set out examples of a wide range of collaborations taking place across the country to show the complexity of arrangements, including:

● horizontal provider collaboratives at ICS (or multi-ICS) level, for example bringing together acute services, or community and primary care services, across a larger geographic footprint

● vertical integration in place-based partnerships across community services, mental health, primary care and local acute services, as well as other partners such as local authorities and the voluntary sector

● mental health provider collaboratives taking on responsibility for the budget and care pathway of a number of specialised services across an ICS or regional footprint

● group models bringing together several providers of the same type under the same leadership, sometimes (but not always) leading to mergers

● formal vertical integration, with trusts bringing together acute, mental health and community (and sometimes primary care) services into one provider.

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1   *NHS England to set three models for NHS provider groups*, Health Service Journal, 9 April 2021.
     https://www.hsj.co.uk/policy-and-regulation/nhs-england-to-set-three-models-for-nhs-provider-groups/7029864.article

The current myriad of provider collaboration arrangements in each ICS cannot be neatly defined. Some provider alliances or boards have different provider types represented on them and many of these arrangements will have been developed of providers' own volition. One type of provider collaboration does not preclude another, so there may be a group model or merger within a provider collaborative. Some providers are involved in place-based partnerships, at-scale provider collaboratives, regional networks and horizontal/vertical integration.

Sector-specific challenges will also need to be carefully thought through. For example, for providers working across several ICSs, places and neighbourhoods, such as ambulance services, collaboration becomes a complex task when it means contributing to a large array of different partnerships. Many mental health trusts have used the provider collaborative model for a number of years, so their previous experience, progress and challenges will vary to other sectors that have more recently set up collaborative arrangements. Additionally, there is a need to ensure that community providers have appropriate voice, input and opportunity to add value at all the different levels of the collaborative arrangements within local systems.

There are also complications for providers who deliver specialised services across much larger footprints than ICSs. NHS England and NHS Improvement's *Integrating Care* paper references an important role for clinical networks and provider collaborations in driving quality improvement, service change and transformation across specialised (and non-specialised) services. At the same time, there are plans to devolve strategic commissioning responsibilities for some specialised services to ICS or multi-ICS level, depending on patient flows. The interaction between providers of specialised services and ICSs needs careful thought. It is incumbent on everyone involved – including NHS England and NHS Improvement – to continue working through the detailed issues to understand and shape the implications of system working in this area.

The case for change

The trust leaders we interviewed are clear that there is a key leadership opportunity for providers to be the engine room for transformation within ICSs and places. National policy on system working has evolved over time, from the original high-level strategic plans to the current recognition that providers are the key delivery vehicle within ICSs. The interviewees highlight several benefits of horizontal collaboration at scale, including tackling unwarranted variation, supporting sustainable services, and accelerating improvements in quality of care. Trust leaders also emphasise the advantages of vertical integration at place, with a much stronger focus on improving population health, tackling health inequalities and engaging with local communities.

Collaboration can also alleviate workforce pressures. Providers are able to create more attractive job opportunities, staff passports and portfolio careers for the health and care workforce when organisational barriers are removed. This creates the potential for providers to improve access and better manage demand and capacity across the ICS, which will be

important for the recovery of elective care, meeting areas of under or unmet needs, and other services. It can also enable staff to focus more on delivering high quality care to the populations they serve.

However, the added responsibilities for trust leaders should not be overlooked, and support, time and investment will be needed to ensure there is capacity for them to service all these collaborations and continue leading their individual organisations.

Enablers and barriers to collaboration
Enablers

Our research has shown that there are several factors that enable effective collaboration. A common thread that runs throughout the case studies is the importance of developing strong relationships with partners. In many of these cases, COVID-19 has acted as a catalyst by providing a common purpose for providers and the wider system, bringing together senior leaders more regularly, and removing barriers to enable resources to be shared.

Buy in and alignment across senior leaders is also essential for successful collaboration. It requires leaders to take their organisations and staff with them. Senior leaders also need to have a strong commitment to modelling collaborative ways of working, which helps push forward proposals into action.

Having an unrelenting focus on patients, service users and local communities, including the NHS workforce, is also key, alongside a clear aim to address health inequalities. Trusts must ensure all voices are heard when developing collaborations, and the benefits for patients, staff, individual services and the wider care pathway are clear.

In systems where trusts have agreed to stop competing for contracts, this has opened up difficult conversations about who is best placed to deliver which services, with organisations prepared to "win some and lose some". Developing a memorandum of understanding between partners to provide clarity on the governance, responsibilities and risk-share of the collaboration can help, but it has to be underpinned by the right leadership, relationships and behaviours.

Barriers

While relationships are a key enabler of collaboration, managing competing priorities can be a significant challenge. Equally a lack of clarity around the governance arrangements and accountabilities can also stifle effective collaboration, particularly at ICS level.

Another challenge is working through the commissioning, resource and capacity issues within the system. Some of the case studies highlight the cultural shift required when it comes to risk-sharing and open-book accounting, particularly where there is variation between the performance of organisations within a collaboration (for example, better performing organisations within a poorer performing system). Historically fragmented

commissioning arrangements and funding inequities also create challenges, with provider collaboratives looking to address variation in service provision and historic underinvestment in particular providers and/or localities within the ICS. Working through these complexities will take time and will likely require partners within a collaboration to continuously develop and refine their approach. It will also be vital for the national bodies to provide necessary resources and support to ensure the ambitions for integrated care and collaboration have the intended impact.

What are the next steps for provider collaboration?

Much of the collaborative work that providers have undertaken so far has been informal, innovative, and responsive to local needs. Formalising some of these arrangements under a national framework, in a way that is sufficiently permissive and enabling for the range and scale of collaborations already in existence, is a significant challenge, as well as an important opportunity. Several case studies in this report highlight the importance of the new policy and legislative framework being enabling and reducing bureaucracy, rather than further complicating the system architecture. This is the challenge for NHS England and NHS Improvement: to strike the right balance between providing sufficient guidance and best practice to support the development of collaboration, while enabling the appropriate level of local flexibility on the right issues.

There needs to be absolute clarity on how the roles and responsibilities of the ICS NHS body, the Health and Care Partnership, health and wellbeing boards, provider collaboratives, place-based partnerships and their constituent organisations will fit together, without overlap or confusion. There are also details to be worked through to ensure providers across different sectors have their interests fully and properly represented when the ICS NHS body is making decisions. Further questions remain around how multiple provider collaboratives, place-based partnerships and other collaborations will work efficiently together within an ICS, how funding will be allocated and delegated, and how this will be decided particularly within the context of strained resources. There are also examples of collaboration at scale taking place over multiple ICS boundaries, which adds further complexity.

We hope the report supports trusts and their partners – across ICSs, CCGs, primary care, social care, the voluntary sector and local authorities – to consider how they develop collaborative arrangements in 2021/22 and beyond.

The view from Bill McCarthy

North West regional director,
NHS England and NHS Improvement

This has been an extraordinary last 12 months. The courage and compassion shown by teams across the NHS in responding to the pandemic has been remarkable. Stretching all the way from the earliest days to the exceptional roll out of the vaccination programme.

Many characteristics have contributed to NHS achievements including resilience, innovation, decisiveness, agility in the face of adversity. This report is celebrating another, and one of the most significant. Collaboration between providers across many settings has been at the heart of the NHS response and core to serving our communities and patients effectively during the pandemic.

My own region, the North West, has had a particularly hard time with COVID prevalence and hospitalisations consistently higher than national levels. We understood very quickly that collaboration was not a polite aspiration but was the only practical response in real time to the challenges we faced. And this meant collaboration at many levels: in our local places where community, primary care and social care teams worked together to identify and support shielding people and care homes, in each of our three system level hospital collaboratives to provide daily mutual aid and support for critical care teams, and across the region where our mental health trusts have been working together on a strategy to enable our most complex patients to experience better lives. All of this has required leadership focused on and committed to the shared responsibility to serve patients and communities in the best way possible and putting this ahead of narrow organisational interest. I could not be prouder of the response from chief executives and their teams across the North West. I know from my fellow regional directors that level of collaboration and sense of pride in the response is replicated across the country.

The November 2020 publication, *Integrating care: Next steps to building strong and effective integrated care systems across England*, has baked this experience into the vision for the future. As much as collaboration across providers has been an essential response to COVID, so too will it be at the heart of recovery so that we can make the very best use of capacity while tackling inequality of access and build on our understanding of population health management techniques to coordinate effort for the most vulnerable groups. It will be important for us to use the planned establishment of ICSs on a statutory footing as an opportunity to build on the examples of good practice that we have seen across the country and to maintain our focus on collaboration to tackle these future challenges. It is great to see the progress that has already been made by so many, and a number of examples are included in this report.

Key to groupings

In this report we set out examples of a wide range of collaborations taking place across the country to show the complexity of arrangements. They are grouped as follows:

Mental health provider collaboratives

Horizontal collaboration between acute providers at ICS level

Community and primary care collaboration at ICS level

Vertical integration at place level

The ambulance sector's role in provider collaboration

More formal vertical collaboration between trusts

More formal horizontal collaboration of trusts

Provider collaboration within the
South London Mental Health and Community Partnership

Partners involved in this provider collaborative

- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

Background

The South London Mental Health and Community Partnership (SLP) is made up of three mental health trusts. They have around 12,000 staff between them working across a population of 3.6 million, spanning two ICSs and 12 London boroughs.

Setting up the partnership

The three trusts collaborate in a variety of informal and formal ways, including through a lead provider collaborative model. They established a committee in common in 2020 with chief executive-led portfolio boards for each of the SLP's programmes and dedicated clinical directors for each provider collaborative programme.

One of the SLP's priority areas for collaboration is the delivery of services that are part of the national NHS-led mental health provider collaborative programme. The SLP also has locally developed collaborative programmes focused on nursing workforce development, complex care, acute care pathways, and corporate services. These programmes have their own programme and/or clinical directors from one of the trusts, and a chief executive lead from a different trust, to ensure a sense of balance across the partnership.

Matthew Trainer is the chief executive of Oxleas NHS Foundation Trust and the senior responsible officer for the partnership's forensic services provider collaborative programme.

There has always been a small central function that is dedicated to the running of the partnership. Matthew highlights that it was essential that this small team had enough capacity and seniority to push the partnership's work forward and to build relationships where needed. It now includes a commissioning hub in order to help the SLP best manage the £100m specialised care budget and £35m of CCG complex care budgets it has been delegated to manage to date.

The impact of the partnership so far

For Matthew, one of the most positive impacts of the SLP's work to date has been the improvements made in South London's children and young people's services. The trusts' use of children and young people's general adolescent beds has reduced by a third and the average distance of placements away from home has reduced on average from 73 miles to seven miles, thanks to the trusts working together.

They have also been able to reduce the number of forensic patients being sent out of area by a third and bring down the number of readmissions to forensic inpatient services by two thirds. More broadly, Matthew tells us the partnership has enabled the sharing of best practice between the three trusts and facilitated more joined up care for patients and service users across inpatient and community services in South London.

The SLP's work has also had a significant impact on workforce challenges facing the trusts. Its nursing development programme has resulted in a 5% increase in nurse retention rates. The partnership has also worked to develop shared career development pathways and a staff passport so that it is easier for staff to move between organisations and work more flexibly across South London.

All of this progress has meant the partnership has been able to reinvest £9m into the creation and delivery of new local care models to date – for example specialist community forensic services across South London and a new dialectical behaviour therapy service for children and young people at one of the trusts.

Matthew stresses the importance of providers being able to reinvest the savings made through collaborative working into genuinely new and improved services. This gives "real-life" examples trusts can show to staff, patients and the local population more broadly in order to demonstrate the tangible difference this way of working is making.

Sharing lessons learned

Personal relationships between the chief executives of the three trusts, built on mutual trust and respect over several years, have inevitably been an important factor in the SLP's success to date. Strong leadership modelling from each of the three chief executives has also been vital, as they have made it clear to all staff that working collaboratively is important and needs to be prioritised.

The trusts' chief executives have also made a point of engaging with staff members' concerns about this new way of working – from the frontline right up to board level. For example, any rumours about mergers or politics stemming from new funding and commissioning responsibilities have been discussed openly and honestly. This approach has been equally important when it comes to engaging with key partners and stakeholders outside of the partnership. For example, the SLP had to work hard to allay concerns from some local authorities that the partnership's work might have undermined local NHS accountability and existing borough relationships.

Matthew also highlights the importance of the partnership's strong investment in staff, genuine clinical leadership from across the three trusts, and use of simple governance that "doesn't make life difficult for individual providers" and involves non-executive directors.

Being transparent about finances and resource allocation has been particularly important. Matthew explains that the SLP has a simple mechanism for reinvesting the surpluses it generates – the funding is split three ways, with an emphasis on "levelling up" any areas where this is needed between the three trusts first and foremost.

He also stresses that the three trusts working together and communicating more informally as "providers who collaborate" has been just as important as the work they do as a formal provider collaborative.

Challenges

The three trusts deliver services independently where that makes sense, and Matthew emphasises how important it has been for the SLP to focus only on "work that could be done better together than one trust could do alone". He also stresses the value of the partnership's work being guided by three simple principles: care closer to home, better patient experience and outcomes, and better value for the NHS.

Matthew reflects, in particular, on the SLP's attempt to use a collaborative model to deliver a single adult inpatient service across South London. They realised very quickly that it was the wrong scale and type of service for this collaborative model because it is less specialist and has more links at place level than a children and young people's eating disorder or forensic service for example. The trusts are therefore working together to standardise their adult crisis and home treatment service specifications and use a shared clinical model across their own services instead.

A key lesson learned by the SLP was that organisations and individual teams need to understand and work through any cultural differences and incompatibilities. Matthew shares an example of when the SLP had to "wind back" and spend time working on bringing the culture of certain teams from different organisations closer together in order to make the progress the partnership has been able to make to date.

Matthew also stresses the importance of each partner in a collaborative working arrangement being willing to compromise in order to make broader, strategic long-term progress that benefits the local population as a whole. For example, Oxleas has invested significant amounts of funding into an assessment area in one of their local acute hospital's emergency departments to reduce long waits for patients with mental health needs, which has improved collaborative working between frontline staff and also enabled other endeavours to progress.

Next steps

Looking to the future, Matthew tells us that working out how the two ICSs and multiple provider collaboratives and places within each will interact with the SLP and its three constituent trusts is a key area of focus and needs to be well thought through.

Discussions are also now taking place between the partnership and its ICSs about taking on more day-to-day commissioning. But Matthew is also keen to emphasise the importance of providers being given the time and support to consolidate the areas they have worked collaboratively on already, before expanding and taking on further opportunities.

National policy to support provider collaboration

Matthew has some concern about the number of different collaborative arrangements trusts could be involved in and the risk of complicated governance arrangements. Whilst the SLP's governance has become more developed now that it holds formal contracts, Matthew stresses the importance of avoiding overly complex arrangements as much as possible, so as not to stifle innovation and the pace of delivery.

He was also keen to highlight that, whilst the SLP has worked well together when it comes to finances and resource allocation, their focus on targeting new investment to underfunded areas should not be a substitute for addressing any fundamental underfunding of services. Matthew tells us, "some services in South London have a threefold difference in per patient funding depending on the borough, and you can see the impact of this on the time people have to wait to access the care and support they need, and their outcomes."

More broadly, he is concerned about the risks of imposing a lead provider collaborative model onto areas as a "one size fits all model" where it may not make sense or have the right ingredients in place.

West Yorkshire Mental Health, Learning Disability and Autism Services Provider Collaborative

Partners involved in this provider collaborative

- Bradford District Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust

Setting up the collaborative

The West Yorkshire Mental Health, Learning Disability and Autism Services (MHLDA) Collaborative was established in 2018 and is part of the West Yorkshire and Harrogate ICS. The boards of each trust involved in the collaborative approved the establishment of a committee in common that year, to help ensure that decisions are made together and in a streamlined way around a shared programme of work, such as service transformation.

The committee in common's membership is made up of the chief executives and chairs of the four trusts with delegated authority from their respective boards, operating together with an agreed memorandum of understanding and a rotational chair from each trust. The collaborative is currently chaired by Cathy Elliott, chair of Bradford District Care NHS Foundation Trust, and supported more broadly by Keir Shillaker, the ICS' programme director for mental health, learning disability and autism.

Cathy and Keir tell us the four providers decided to come together initially to improve the delivery of mental health services that were presenting the most significant challenges to all organisations within the collaborative. This includes those services that are part of the national NHS-led mental health provider collaboratives programme, as well as other areas where this made sense for West Yorkshire and Harrogate, for example: the delivery of complex rehabilitation services, services for people with a learning disability and autistic people, and psychiatric intensive care provision.

At the outset, the trusts worked together to understand their collective use of beds and capacity, workforce challenges and referral criteria across these different service areas. This information was used to assess the potential impact of improved, more collaborative working between the trusts – for example what benefits collaboration would have on reducing the number of people having to be sent out of area to receive the right level of care – as well as the extent to which West Yorkshire and Harrogate might also need additional capacity, and how and where this could be supported through commissioner commitments within the mental health investment standard.

The impact of the collaborative so far

Prior to the pandemic, the collaborative was able to demonstrate reductions in people's length of stay within tier four child and adolescent mental health services and adult eating disorder services, as well as the number of people in West Yorkshire and Harrogate having to be sent out of area to receive the right level of care.

They have improved working relationships across the system as a result of their work to date. However, the strength of relationships between the trusts really came to the fore during the COVID-19 pandemic, with the organisations able to share and learn from each others' approaches and responses to the new challenges COVID-19 posed for services and the patients in their care.

Keir and Cathy also feel working collaboratively has given more of a voice to the patient population that the trusts serve within their ICS more broadly, it has enabled partners to speak with one voice and help set ambitions for the whole ICS to reduce the gap in life expectancy for people with mental illness, learning disability and autism compared to the rest of the population by 2024.

Alongside service transformation, an example of successful attitudes to collaboration is the ongoing work to align the training that staff from each organisation receive in prevention and management of violence and aggression (PMVA). The co-production process undertaken has enabled the best examples of good practice from each trust to be shared, jointly reviewed and a more consistent way of working proposed across the collaborative for the benefit of patients and staff. This is now being stress-tested with teams and, if validated, will ultimately mean that staff can be more safely shared across the four trusts.

They are now building on their work to align PMVA training to develop a collaborative staff bank. A bank spanning the whole collaborative has already been put in place, in collaboration with West Yorkshire Association of Acute Trusts, for psychology staff to deliver the area's **new staff mental health and wellbeing hub**. Keir explains that "the wellbeing hub is a really good example of how, once you're in the mindset of collaborating, it's easier to choose to collaborate in order to tackle the next challenge".

The collaborative has also worked together to support all system partners to make best use of funding to transform the delivery of community mental health services. The MHLDA core team, working on behalf of the ICS, has brought together all place-based NHS, primary care and voluntary, community and social enterprise (VCSE) provision to agree how funds should be split amongst system and place. They have also worked together to agree a standard outcomes framework for the provision of community mental health services and which challenges – such as workforce and information governance – need tackling at scale. This has built upon the existing relationship of trust between collaborative partners and extended this ethos and way of working to others.

Sharing lessons learned

Keir and Cathy stress that the fundamental starting point for organisations coming together as a collaborative should be working on the relationships between them and building a willingness to collaborate through the creation of a sense of shared purpose, mutual respect and trust. Cathy reflects on the importance of these relationships and concludes that "what's particularly special about West Yorkshire and Harrogate ICS is that it's a coalition of the willing."

Cathy and Keir also stress the importance of recognising that collaboration is a journey and the organisations involved in other ICSs need to be prepared to redevelop and refine their approach as necessary over time. They have recently introduced a twice-yearly 'strategic session' as part of the cycle of collaborative meetings to give the trusts the opportunity to reflect, problem solve and reset where necessary in order to have foresight in their collective work.

Another key lesson Cathy and Keir highlight is the importance of 'taking everyone with you' and enabling the development of, and engagement with, 'critical friends' when it comes to delivering service transformations. One of the ways the collaborative does this is by holding a non-executive director, governor and lay member meeting twice a year to update and brief them on service transformations before they happen as well as take on board their feedback. Given the complexity of the work across numerous system partners – five CCGs, NHS England and NHS Improvement commissioners, four NHS providers of mental health, learning disability and autism services, five local authorities, multiple primary care organisations, and hundreds of possible VCSE organisations – there are still gaps in communication, understanding and agreement. Importantly though, the role of the collaborative is to learn and improve as it develops and as each piece of work comes to maturity, external communications is on their agenda for 2021/22.

Cathy and Keir also emphasise the importance of involving experts by experience and service users so that the transformation of services is truly co-designed and co-developed. As Cathy explains, "a provider collaborative can be quite hierarchical and it's made up of very senior leaders, but we have to keep bringing it back to what's the experience of service users to ensure person-centred care."

The collaborative has also recently introduced a template assurance report for each meeting of the committee in common, which goes to all four boards to ensure that they receive the same information about what the committee is assured on, alerted to and what further information it is seeking. Understanding the perspectives of different providers within the collaborative and respecting where their interests lie, which may mean not all need or want to be around the table for every particular agenda item, is also an important lesson learned.

Cathy and Keir also stress the importance of having a balance of formal and informal meetings taking place between leaders of each trust within the collaborative. For example, they have set up weekly meetings on a more informal basis between the chief operating officers of the trusts that provide adult mental health services, facilitated by the MHLDA

core team, which have proved to be really effective. The chairs of each trust also meet informally, before each committee in common meeting at least, to exchange practice and updates.

Cathy and Keir also emphasise the importance of provider collaboratives being clear about the scale they are working at and adjusting what they focus on doing together accordingly. For example, those collaborating on a smaller scale may find it most valuable to focus their efforts on the sharing of good practice.

Next steps for the collaborative

The collaborative is now evolving to look at how its members might be able to work together on broader areas, such as capital investment, workforce and recruitment, as well as equality, diversity and inclusion. Keir and Cathy highlight that working collectively should enable the trusts to give more opportunities to their staff to work in different ways and in more exciting roles in particular, such as roles with an element of focus on system transformation. They hope this will help overcome recruitment and retention challenges.

Cathy and Keir are also keen to build on the collaborative's work with experts by experience and service users, to ensure the voice of people living in West Yorkshire and Harrogate with mental health conditions is a regular part of everything it discusses and is truly embedded in its governance architecture going forward.

The collaborative is equally focused on the engagement and involvement of VCSE organisations in West Yorkshire and Harrogate at a system level. There are strong partnerships at a place level between the four trusts and the VCSE sector, and so they are now thinking about how they make sure that these partners are part of key conversations and discussions at a system level. Keir and Cathy highlight that this will be crucial to the delivery of the national programme to transform community mental health care at scale across West Yorkshire and Harrogate in particular.

The collaborative is also starting to think about how it gets the interface right between itself and the integration and collaboration happening at place level, as well as beyond the boundaries of their ICS.

National policy to support provider collaboration

Keir and Cathy tell us they would welcome support at a national level to develop further system leadership capabilities and collaboration skills across all disciplines, given the different skill set required for this compared to those historically necessary to lead a trust or deliver a service within one organisation. Cathy would also welcome the development of peer learning on a more systematic and coordinated basis so that collaboratives can learn from colleagues across the country as they move along the process of services transformation.

They stress that change management and transformation work requires genuine investment to deliver – that is investment in resources to enable trusts to dedicate existing staff time and energy to collaborate, as well as investment to create and sustain independent, strategic roles that act as a facilitator and 'an honest broker' for the collaborative. At the moment, the collaborative is reliant on a relatively small group of people, a number of whom are also service managers and clinical leaders delivering work locally at place level, alongside some ICS staff on fixed contracts, which does not feel wholly ideal and sustainable. The committee in common is currently considering more sustainable resource in future.

Keir also stresses the importance of ensuring their role as part of (not separate to) the ICS is not undermined as the policy around provider collaboratives develops at a national level. The ability for collaboratives to be able to focus on tackling the challenges that they decide are the right ones to focus on for their local populations is also crucial to maintain.

Cathy and Keir emphasise that the process of setting up, and the continuous development of, a provider collaborative needs to be driven by its constituent organisations based on what works best for their local communities, as opposed to a "one size fits all" model imposed nationally. However, Cathy and Keir are keen to stress that there are a number of "ingredients" that are key to provider collaboratives succeeding, as well as ICSs more broadly. Cathy shares that "it would be helpful for these common 'ingredients' of collaboratives to be set out for providers across the country so that local areas can 'pick and mix' from these fundamental elements based on what works for their local area specifically within their ICS."

Horizontal acute provider collaboration in the Greater Manchester ICS

Partners involved in this provider collaborative

- Bolton NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Pennine Acute Hospitals NHS Trust
- Pennine Care NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
- East Cheshire NHS Trust

Background

In April 2016, the Greater Manchester Health and Social Care Partnership was formed. Serving a population of 2.8 million, the partnership is the first devolved health and care system, in charge of the £6bn health and social care budget for the 10 boroughs in which it operates.[2]

The Greater Manchester Health and Care Board brings together all statutory bodies in the partnership (trusts, CCGs and local authorities) and representatives from primary care and the voluntary, community and social enterprise sector. The Greater Manchester partnership executive board is constituted to be the operational decision-making body for the partnership and includes representation from across the health and social care system. Provider trusts are represented on the board by three chief executives nominated by the Provider Federation Board (PFB).

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2   The 2015 Memorandum of Understanding between the government, NHS and Greater Manchester NHS statutory organisations and local authorities delegated certain decision-making responsibilities of NHS England to GM. NHS organisations in GM remain part of the NHS and are subject to the same statutory duties and constitutional standards as those in the rest of the NHS.

Setting up the collaborative

Providers in Greater Manchester have a long history of collaboration. Darren Banks, group director of strategy at Manchester University NHS Foundation Trust, tells us that acute provider chief executives originally began to meet on an informal, but regular, basis 20 years ago and that more recently, mental health and community providers, as well as the ambulance service, have joined the meetings. Darren explains, "that decision coincided with the initial discussions in Greater Manchester about devolution. As providers, we had already started talking about how we would move towards greater collaboration and system working and how we could formalise our collective decision-making approach". Providers were particularly keen to ensure their collective contribution to health improvement and delivery of high-quality care and constitutional standards was recognised in the new arrangements.

The PFB was set up as a membership organisation. In this equal share arrangement, each member pays a minimal subscription which covers the costs of a small secretariat, policy and programme support. "We already worked together in several different areas, but constructing PFB gave that collaboration a proper structure, a recognised voice for providers in the system and also ensured that our partners had a mechanism to engage with providers spanning community, acute and tertiary care across both physical and mental illness", Darren says. As such, the PFB has enabled both the system to benefit from provider expertise in those areas where it is needed, and providers to represent collective views to help shape policy and service delivery. This has facilitated more systematic co-design with partners, as well as greater clinical input, at a system level. The PFB member trusts also play a key role in place-based collaborations through the local care organisation approach across Greater Manchester.

The case for change

As well as enabling providers to have a voice in the Greater Manchester Health and Social Care Partnership, the PFB was established to enable collective decision-making across trusts, provide a strategic approach to transformation and address provider quality and efficiency against the backdrop of the financial challenge. In particular, the core rationale for the PFB is to facilitate solutions which go beyond the remit and scope of the individual organisations in the membership, such as managing cancer pathways across Greater Manchester and dealing with urgent care pressures.

The emergence of the devolved system subsequently brought these objectives into sharp focus. Ryan Donaghey from the PFB secretariat, tells us, "Greater Manchester introduced a strategic plan for the first five years of the devolution experiment. Along with our core issues, that plan drove our agenda to a certain extent because we needed a collective position on many of the issues discussed with partners, particularly commissioners and local authorities."

To help it achieve its objectives, the PFB has an agreed approach to making formal, collective decisions in those areas which are both within providers' remit and likely to have a significant impact on PFB members. The approach seeks to define which

member organisations need to be part of a specific decision (the eligible constituency) and then proceeds through stages from business case to decision. However, the overriding principle is for the PFB to work on a consensual basis and, importantly, the member trusts retain their statutory duties and accountabilities.

Having the full range of providers across physical health, mental health, ambulance providers, specialist services and community health services as members of the PFB has facilitated transformation conversations across a wide range of issues. Darren also points out that one type of provider collaboration does not exclude another, for example the mental health trusts are also part of the North West mental health provider collaborative and there are shared leadership teams and group models between some of the acute providers.

The impact of COVID-19

Increasingly, the PFB has put more resource and organisation around its supporting infrastructure, including the director-led sub-groups which meet regularly to carry out work commissioned by the PFB. All of that has been fast-tracked since the start of the COVID-19 pandemic, "We quickly established a Gold Command within the PFB arrangements with key representatives from all trusts and the broader system meeting daily to manage the pandemic response." Gold Command, which continues to operate, drew heavily on the director and multi-professional subgroups to deal with issues like personal protective equipment (PPE) or escalation protocols around critical care.

Darren explains, "We moved a significant number of critical care patients and ventilators between our hospitals to even out the pressure, and moved thousands of items of PPE, so that not a single site fell over."

At the start of the pandemic, system-wide COVID-19 dashboards were quickly developed by Gold Command so they could see what the relative pressure was across the organisations and prioritise resources according to which organisation needed them most. "I think it worked incredibly well," Darren explains, "We were definitely building on the fact that we already had the PFB. We all knew each other well, which allowed us to operate as a hospital system and manage the pressure at a system level." Darren adds, "the common purpose allowed us to overcome any of the institutional barriers that may have arisen in the very early stages…"

The PFB now has clinical reference groups for the five most challenging specialties during recovery and are developing common approaches to the system's biggest challenges, for example orthopaedics. An example of collaborative transformation is the PFB's work with the primary care sector around endoscopy which enabled transformation of the entire pathway which has reduced demand and increased the productivity of the process itself for patients.

Priorities for the collaborative

The key priorities for all the member organisations are to deliver high quality sustainable services, responsive to the needs of patients, and in line with statutory and constitutional standards. The PFB enables the sharing of best practice to help them all towards these goals.

In the immediate term, they want to restore services in a way that is fair and equitable for their population, while looking after staff who have just been through an extremely challenging time dealing with the pandemic.

They are also looking to develop their anchor roles within their localities, recognising that more could be done in this area to consistently capture the value added to the system, both in direct care provision and the economic contribution, and to seek further ways to support the Greater Manchester public service ambitions.

The PFB is also discussing its system leadership role, particularly in the areas of service transformation and improvement. These discussions are in the context of the collective approach with partners to the emerging Greater Manchester Health and Social Care Partnership and the opportunities set out in the recent White Paper, as well as the emerging guidance on collaboration. Darren says, "We consciously ask ourselves, is this something for us to do as a collaborative or as individual organisations? We've had a role to play in some service reconfiguration conversations, but this has been limited to clinical and operational advice because we're not the commissioner."

Sharing lessons learned

One of the key enablers for provider collaboration in Greater Manchester has been the quality and stability of senior leadership relationships. But it takes time to build these. The provider chief executives spend a lot of time making sure that all organisations have the opportunity to participate and to have a leading role on specific projects.

Ryan says "even though we've been collaborating for as long as we have, we still face pitfalls, and it is sometimes challenging trying to get everyone on the same page. Those conversations take time and resources, so I would say to colleagues that they shouldn't underestimate the resources you need in terms of the infrastructure to make it happen." The PFB had relatively little resource over previous years but this was augmented through the management of the pandemic, which certainly helped them to facilitate increased collaborative working.

Looking to the future, Darren says, "Post COVID, we need to recover in a way which seeks to address some of the inequalities which existed across Greater Manchester and have been amplified. That is quite a challenge. But we've got more standardised approaches, we've got more transparency around equity of access to services, and a real drive to work with partners to re-engineer whole pathways working as a system, so we are starting to make progress."

Horizontal acute collaboration between acute trusts in the Bath and North East Somerset, Swindon and Wiltshire ICS

Partners involved in this provider collaborative

- Bath and North East Somerset, Swindon and Wiltshire (BSW) ICS
- Great Western Hospitals NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust

Setting up the collaborative

The Acute Hospitals Alliance (AHA) was established in Spring 2018. This wasn't a pre-existing partnership, Kevin McNamara, chief executive of Great Western Hospitals NHS Foundation Trust tells us, saying "we didn't have a track record of working together on big, meaningful programmes". Historically, the trusts pointed in "three slightly different directions so it wasn't a natural geography" but this all changed when the trusts teamed up to provide community health services.

Cara Charles-Barks, chief executive at Royal United Hospitals Bath NHS Foundation Trust and chair of the AHA, agrees with this analysis, noting that the acute provider collaborative had evolved over several years before the chief executives were in their current posts. The starting point, Cara says, was "sharing the work that each organisation was doing, looking at whether there were opportunities for us to work together" for the benefit of staff and patients.

Reframing the AHA's priorities in April 2020 has been a gamechanger for the partnership, heralding a series of ambitious joint programmes that have been established over the past 12 months which focus on delivery and transformation across BSW ICS for the benefit of patients and staff alike. Cara recalls conversations in spring 2020 when all three chief executives sat down and had a "clear conversation about the things we felt we wanted to take forward over the next 12 months – that was the first time I think that we really sat down and committed to formal pieces of work together".

Building personal relationships

Relationships across the three partner trusts have gone from strength to strength with a real focus by the leadership team on building trust and developing mutual understanding. Kevin tells us that the leadership team was now having, "three or four conversations each week on different things that previously would have been quite alien to the individual organisations".

There is a real commitment to strengthening the leadership team, Cara says, explaining that she, Stacey Hunter, chief executive of Salisbury NHS Foundation Trust, and Kevin recognise

that, "the strength of what we want to deliver, the opportunities and our collective ambition will be strengthened by the way in which we work together". The three chief executives have, "proactively committed to having joint coaching together" to help take this collaborative way of working into the next phase.

Cara expresses her hope that the commitment of the three chief executives to work together in the AHA will enable them to "develop a framework so that we can have difficult conversations without it becoming personal or disrupting long-term relationships". Kevin adds that another key step forward has been the acute alliance conversations moving from just being a chair and chief executive level discussion to a wider executive-level conversation. This feels like a real gear shift when colleagues such as chief operating officers are engaging with this discussion.

The case for change

Cara highlights the value in playing to the strengths of each individual organisation, which has benefited the development of the AHA. "Salisbury is really strong on procurement so they will lead that on behalf of the three organisations... we're also looking at some work from a finance perspective where this is a particular strength at Great Western for example". This sense of equity across the three trusts has been important in terms of influencing ways of working across the alliance and within its constituent organisations, with an executive member of each organisation leading a specific programme of work across all three. The AHA is also looking at replicating the Royal United Hospitals Bath NHS Foundation Trust's quality improvement programme in the other two trusts, to support a common approach to transformational change across the alliance.

By playing to each other's strengths and working at scale, the AHA is delivering tangible benefits, with Stacey highlighting improvements for patients, finance, safety and quality and the workforce from this collaborative way of working. She highlights an example of the work the AHA has been doing on children's oral surgery. Waiting lists for this service had increased significantly because of the COVID-19 pandemic. Clinicians across the three trusts worked together to pool staff expertise while also looking at how best to secure access to theatres and other infrastructure. By working together, the clinicians were on track to tackle that waiting list much more quickly than they would have been if working as standalone organisations.

Working as part of the AHA also meant that clinical teams were given the right kind of executive support to allow them to make decisions, Stacey says, which meant that clinicians could do "something really different within two or three months rather than two or three years". This also included reassuring some teams that existing relationships across different hospital sites or tertiary centres were not going to be unpicked.

The collaborative working arrangements in the AHA were particularly helpful at the height of the COVID-19 pandemic whereby providing mutual aid allowed the AHA to deal with serious site, system and organisational pressures. Kevin says, "We were trying to support one another." The experience of the COVID-19 pandemic also unlocked innovation in how some clinical specialities could be better configured across the three organisations,

with Cara sharing the example of dermatology services which had long patient waiting lists and challenging workforce shortages. By working together and delivering some of this work virtually, the dermatology teams are now offering a much better service to patients, as well as a much stronger employment offer for staff with more opportunities for research and teaching.

Cara also highlights how being part of the AHA has enabled the trusts to quickly move towards setting up a collective elective recovery strategy and single waiting list. Doing so gives the AHA "visibility of the needs of all of our patients" Cara says, and helps the trusts "work out where we've got inequity of access" and what needs to be done to tackle that.

Cara also points out that collective working by the three acute trusts puts them in a stronger position to influence the ICS wide strategy, "We're then able to influence that into becoming a BSW-wide strategy that then creates a much better, collective and fair offer for patients but also importantly helps us start to address where we've got inequality because, particularly around elective pathways, the inequalities will be huge coming out of COVID".

All three trusts view the work through "both a horizontal and a vertical lens", Cara explains, which are both equally important in improving population health in their local communities and ensuring the sustainability of each individual organisation. There are many "layers of the onion", with each organisation focusing on neighbourhoods, place, the acute provider alliance and wider provider collaboration, and the ICS itself.

Challenges

It hasn't all been plain sailing though. Working as part of an alliance comes with challenges for individual organisations. Stacey explains, "how do I try and influence and support my board through a conversation that on the face of it, is not great from a Salisbury Hospital point of view but is absolutely the best thing for the Salisbury and South Wiltshire population. This is a whole different conversation".

The AHA has sought to tackle this challenge head on, with Kevin saying, "We've also been a bit more explicit about various red lines". He added that the coaching the three chief executives have committed to having would "help those difficult conversations further down the road". The chief executives hope this coaching will also help them realise the art of the possible through their collective leadership.

There is a real commitment to openness, transparency, and accountability, with the AHA placing a strong emphasis on accountabilities within the provider alliance and ensuring there is clarity over who is accountable for which specific pieces of work. The AHA is also starting to have some of the more challenging conversations around contracts, governance, equity of access to services and funding. One of the key lessons learned from the AHA is to invest in relationships and have honest conversations, so that you can then discuss the "really tricky" issues and gain momentum on tackling tangible programmes which will demonstrate benefits to each provider board. The challenge will now be, as Kevin put it, to navigate what is best for local communities and what is in the White Paper and national guidance.

Next steps

Kevin highlights the impacts of the policy shift in recent years to system working and how this has changed how organisations who were previously in competition with each other, now work collaboratively. Leadership changes are a key driver in pushing forward system working, Kevin says, with Stacey having "joined from a system that is further down the line on this" and Cara having "gone to a new trust in the same ICS bringing a different perspective and approach there – that leadership change has helped pull that part of the system together a bit more". All three chief executives agree that this shift in mindset was deliberate and crucial to the development of the AHA, as trusts move away from being organisationally focused and a culture of competition towards doing what is best for the local population.

There is now a concerted effort to recruit individuals who could contribute to system leadership rather than just organisational leadership. Stacey agrees with this perspective, saying there was a "deliberate strategy to recruit people who were partnership and population orientated, not just people who could run hospitals". This has embedded the approach that the partnership serves the populations – not its three chief executives.

Partnerships and population health

All three chief executives are mindful of the huge impact of COVID-19 on their patients and populations, particularly in exacerbating existing health inequalities. Stacey sees a role for the AHA in making sure "that our hospitals are organised around what our populations need rather than what we as individual hospitals determine needs to be done – there is a really big difference in those two things".

Having a "strong voice for acute hospitals in our broader ICS partnership" is also essential, Stacey says. There are also benefits for the ICS to not "always have three conversations" with each individual acute trust. All three chief executives agree that positioning within the ICS is key for the AHA, with a real focus, Stacey says, on "serving the partnership rather than trying to tell the partners what to do".

Cross-system provider collaboration across the Dorset ICS

Partners involved in this cross-system collaboration

- Bournemouth, Christchurch and Poole Council
- Dorset Council
- Dorset Clinical Commissioning Group
- Dorset County Hospital NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Dorset Primary Care Networks (PCNs)

Background

Health and care organisations across Dorset had a history of working collaboratively long before the national ICS programme was established. Conversations about the shape of health services in the county started as early as 2013, with the launch of 'The Big Ask' public engagement process. This contributed to the formulation of the Dorset NHS System Collaborative Agreement in 2017/18 and 2018/19, which set out shared performance goals and financial controls for Dorset as well as plans to deliver the agreement.

The Dorset ICS has a population of over 800,000 people and includes two acute hospitals, approximately 80 GP practices, 18 primary care networks (PCNs), a community and mental health trust, a single CCG and an ambulance trust as well as two county councils.

We spoke to Stephen Slough, chief information officer for Dorset County Hospital NHS Foundation Trust and Dorset CCG, about his experiences of leading a programme of digital transformation across the ICS. He shared his thoughts about why integration of health and care services across Dorset has progressed so well.

Setting up the collaborative

Stephen discusses the workstreams that have been set out in the ICS transformation programme and focuses on how this provider collaboration will come together. The ICS has identified two places of delivery, Bournemouth, Christchurch and Poole Council and University Hospitals Dorset in the east of the county and Dorset Council and Dorset County Hospital NHS Foundation Trust in the west. Community and mental health services and GP practices will span both.

Stephen is keen to ensure the current digital technology portfolio and solutions, such as the Dorset intelligence and insight Service (DiiS), do not get "watered down" when the new system is put in place amid concerns that two teams delivering two lots of services may start to pull apart. Ideally, Stephen tells us, he would like to see a single back-office function for digital rather than two separate ones.

Impact of COVID-19

Stephen says joint working between NHS organisations and local authorities in Dorset came into its own during the COVID-19 pandemic, and in particular with the roll out of the vaccination programme. He tells us more about DiiS, which was designed by clinicians and professionals – and the rapid speed with which they were able to use this to set up a COVID-19 dashboard.

The dashboard "has grown and expanded over the last 12 months" Stephen says, and now includes "everything from daily infection rates, COVID-19 test results, number of deaths, staff absences in both primary and secondary care settings, mortuary capacity, crematorium capacity, PPE stock… this single dashboard brings together all the information that trusts and primary care need to stay on top of what is happening across the ICS".

Stephen adds that the dashboard also includes "significant quantities of data from local authorities… including demographic data". This has been particularly important during the roll out of the COVID-19 vaccination programme, Stephen tells us, as the availability of local authority information on ethnicity and deprivation deciles allows the ICS to "map those factors against vaccine take up", alongside other information on areas which had high infection rates. Stephen adds that bringing this data together from across the system partners enabled them to address geographic pockets of the ICS and particular population groups where vaccine uptake was low. It also enabled them to address other factors and identify barriers, such as access to public transport and accessibility of vaccination centres. Recognising the impact the DiiS has on the population and to encourage others to realise the potential of following the example set in Dorset, Microsoft created a global case study to showcase the creative use of their products to power the DiiS.

Stephen tells us the pandemic has accelerated the use of data and digital platforms, which are "becoming central to everything now", and that this has led to local authorities and the local university getting involved as well. For example, joining data together has created "additional spin offs" including supporting population health management and discharge processes.

Sharing lessons learned

Stephen tells us about the importance of close relationships and collaborative working between NHS partners and colleagues in local authorities in both identifying and tackling deprivation and isolation. This collaboration has enabled measures to be put in place to address health inequalities and improve access to services. Stephen notes that they were able to build on the well-established relationships between primary and secondary care

in the Dorset ICS, which enabled patients to flow in and out of services without the usual barriers. He points out that while different organisations have their own culture and ways of working, it is vital that individuals can work together for the common good. "If you can't get on with each other, this will show up in the work you deliver and the results you achieve".

Stephen discusses how having a common foe, in this case COVID-19, acted as a catalyst for partners to put aside their organisational differences and focus on getting the job done. It was very much a case of "the NHS versus COVID" he says, which meant that any tensions, for example, in the provider-commissioner relationship, took a back seat while treating patients, re-allocating PPE via mutual aid and sharing staff across organisational boundaries took centre stage. The ICS is now "trying to work out how you keep the best elements of what we've gone through in the last 12 months and retain that as the way of working because it has made all our lives so much easier".

Thinking specifically about the ICS' digital journey, Stephen notes this is an uphill battle because it has been a back-office function for a long time and needs significant central investment to get it back onto a functioning, sustainable footing. However, as a first step, Stephen suggests finding advocates within individual organisations – such as chief clinical information officers, chief nursing information officers and digital midwives – to help build up and promote digital technology internally. Learning about the solutions they need to make their professional lives easier, and then fixing those things first, is key, Stephen says, because then these individuals will help "advocate for digital transformation and cultural change among their colleagues and teams".

Challenges

Despite the significant progress that has been made towards integrated working across Dorset, Stephen notes "it's definitely not all plain sailing". Compromise seems to be key: colleagues get together and have open conversations and are able to make collective decisions to move forwards.

Stephen adds that a lot of work has gone into convincing leaders and health professionals that data and digital is the way forward. He says, "from a technology perspective, we have done a lot of work to persuade people that our digital aims and products are actually possible and to explain why they should trust us when we say this data stuff really is the future. We have worked hard to convince colleagues that we need to move into modelling and artificial intelligence as well". Stephen is keen to ensure that the DiiS and Dorset care record do not get watered down and re-fragmented by the focus on place. To avoid this, together with system partners he is developing plans with funding from the digital aspirant fund to have a single patient administration solution across the ICS.

Reflecting on the lack of central investment in IT over successive years, Stephen expresses concern about the risks this now poses to patient safety. He says, "we're now at a point where either very old, or poorly implemented technology risks negatively impacting the quality and safety of patient care. For example, if the WiFi is not working in the hospital and you can't get access to your drugs administration system, you can't prescribe to patients

anywhere other than a fixed point in the pharmacy, this will slow down, or halt discharging the patient or disrupt the delivery of their continued care as an inpatient". Investment in this area will improve patient care both within the organisation and across the wider system.

Next steps

Looking to the future, Stephen is keen to expand the scope of the DiiS to help with demand and capacity management. The ICS is working with suppliers to explore whether it can turn historical information into a forward view which models demand and capacity. Linking this to smarter patient records could lead to more effective staff rostering and service preparedness ahead of major events, for example. Stephen tells us, "if you've got better intelligence, you can develop better plans, be better prepared, and afterwards you can review, evaluate and improve them".

Stephen also draws attention to the ICS' focus on its new 'Think Big' initiative, which aims to bring together "many of Dorset's outpatient services or procedures" in one place to help tackle elective care backlogs.

National policy to support provider collaboratives

Stephen is clear that a key source of support from national NHS leaders and the government would be additional funding for digital. Stephen suggests it would be helpful for a "guaranteed percentage of an ICS' budget to be made available for digital improvement every year so that the ICS can plan strategically and consistently". He adds "There needs to be a commitment to revenue based, not capital funding", as services are increasingly moving to cloud-based models. Long term funding predictability is key, he says, adding that this needs to be accompanied by "financial leadership in our systems becoming more entrepreneurial".

Community provider and primary care collaboration across the Sussex ICS

Partners involved in this provider collaborative

- ■ Sussex Community NHS Foundation Trust
- ■ East Sussex Healthcare NHS Trust
- ■ NHS Brighton and Hove CCG
- ■ NHS East Sussex CCG
- ■ NHS West Sussex CCG
- ■ Brighton and Hove PCN
- ■ East Sussex PCN
- ■ West Sussex PCN

Background

The **Sussex Health and Care Partnership** covers a population of over 1.7 million people across three local authorities including Brighton and Hove City Council, East Sussex County Council and West Sussex County Council.

There are currently three collaboratives operating at ICS level in Sussex, including the mental health collaborative, the acute collaborative network, and the most recently established primary and community care collaborative network. They all report into the ICS health and care partnership executive once a month.

Siobhan Melia, chief executive of Sussex Community NHS Foundation Trust, chairs the primary and community care collaborative network at ICS level, and her colleague Kate Pilcher, chief operating officer at the same trust, leads on work at place-level. The network was initially set up in summer 2020 and Siobhan says, "it's been difficult to think forward this year, but now is the right time for us to try and create some headspace".

The primary and community care collaborative network, as Siobhan tells us, has a number of different organisations around the table, including the chief executive at East Sussex Healthcare NHS Trust, executive managing directors from the three CCGs who are responsible for either community services or primary care, and clinical directors from the PCNs. The collaborative also has representation at ICS level, including the director of the ageing well programme and the director of long-term conditions programme. They are also looking to include representation from a director of public health.

Setting up the collaborative

Siobhan explains that the main purpose of the primary and community care collaborative is "to provide strategic leadership and a collaborative approach to the planning and delivery of primary and community care services across Sussex" in line with the ambitions of the NHS long term plan. They operate both at scale and at local level, as they are developing a high-level primary and community care strategy for Sussex, with a view to delivering integrated models of care at neighbourhood level.

The impact of COVID-19

While they had several pieces of work exploring how they could tackle health inequalities before the pandemic, Siobhan says "COVID-19 has undoubtedly shone a spotlight on inequalities on so many levels". Sussex Community NHS Foundation Trust employed a public health consultant for the first time a year ago, and this has enabled them to think more comprehensively about population health, prevention and inequalities. "We are now in a good place to think over the coming year, 'how do we go further and faster with what we've got in place and what we've learned?'".

Siobhan and Kate both highlight a number of positive changes that have taken place during the COVID-19 response that enhanced collaboration, including accelerating digital services, which has transformed how they deliver care to patients in the community. Smaller peer groups across providers and commissioners have been set up to discuss and test potential workstreams before jointly presenting them to the wider network, integrating COVID-19 discharge hubs in line with the government's hospital discharge service guidance, and now thinking about what recovery looks like for the primary and community care sectors.

Siobhan tells us the collaborative's discussions about recovery have largely focused on restoring wider access to primary care services, and for community health services the priority is to tackle the most challenging waiting lists, such as diagnostic services for autism, access to speech and language therapy, pain treatment and musculoskeletal conditions. All the partners in the collaborative want to ensure they effectively restore access to services and address the backlog for these life-changing and long-term conditions, among others.

She also discusses the positive impact of the COVID-19 vaccinations programme on primary care engagement with the ICS. She says, "we now have a weekly ICS programme board meeting to discuss strategy, tactics and delivery of the vaccination programme across Sussex, with a strong focus on addressing vaccine inequality. Representation is from a wide primary and community setting, with a clinical director from every PCN, or the federation representing them, the directors of public health from the three local government organisations, Healthwatch, myself and the ICS system leader". She notes that this may not necessarily be the governance structure that is "here to stay" as the vaccine programme continues to evolve, but the conversations that have taken place have been really balanced and collegiate and highlight the value of coming together.

Siobhan reflects on the impact of COVID-19 over the past year and concludes , "I think there's potential to get to the point where we can engage on a better footing off the back of how we've had to come together in adversity".

The case for change

Kate discusses work underway at place level in Brighton as an example of effective provider collaboration. They have developed a shared system discharge improvement plan, with a collective focus on delivering key success objectives in four domains, systems and processes, capacity modelling, ways of working and communication. The team is developing shared outcomes for patients rather than looking at organisational components as individual health and social care providers. Siobhan says they are in the early stages of looking at the metrics to determine the level of impact collaboration has had, such as on the referral pathways to a community bed or a patient's home. This will be something they will continue to monitor going forward and they will hopefully then be able to aggregate this work into West Sussex and then expand it to East Sussex as well.

Kate also notes that collaboration means they can share workforce more effectively in Brighton. She explains, "we've had memoranda of understanding in place to be able to share staff across providers throughout the pandemic". They have also looked at workforce in the context of business continuity for care home staff and how they can all support each other to deliver care to the population.

Sharing lessons learned

Relationships built around a shared purpose have played a huge part in strengthening collaborative working. Siobhan points to the partnership they have with acute and adult social care colleagues, and how the collaborative approach of bringing everyone together under a common purpose has really changed things. She also touched on setting up peer groups, including a chief medical officers' group and a chief nursing officers' group across providers that functions as a forum to discuss ideas before they are proposed to the collaborative network.

Siobhan also reflects on the COVID-19 vaccination programme and how it brought providers across primary, secondary and adult social care together in a way that the incident management response hadn't. She says the vaccine programme enabled a common purpose for delivery, and the recent decision to have frontline GPs 'at the table' of the collaborative has gone down very well.

"I've been a strong advocate since we set up the primary and community care collaborative network to have the frontline GPs, who are very visible in the community here, involved in these important discussions".

Challenges

Siobhan is clear there are challenges around deciding what happens at place, provider collaborative, and ICS level. She says, reflecting on the recently published white paper, "it seems place is going to have a bigger role than we first thought". She also shares some of her thinking around what happens at system level and at place level for community services, explaining that it would be beneficial to agree a best practice standard and funding for community health services across the Sussex ICS, and for places to hold responsibility for delivery, which can then be nuanced to meet the needs of their populations. Kate adds that the thinking around community care in its broadest sense, such as discussions around the number of community beds across the system, needs to be decided at ICS level.

The relationship between the provider collaborative at ICS level and the place based executive partnerships is also an area Siobhan and Kate highlight as a current challenge. Siobhan says there's an ambition at ICS level to be more collaborative and enable decisions to be made in partnership, but notes that there still seems to be a disconnect at place. Kate says, "I think at place level there is still a degree of variation in decision making across Sussex which is possibly a result of still having three CCGs". They both agree that the strategic direction in the NHS White Paper will improve alignment, as there will be one ICS NHS body across Sussex accountable for the commissioning of services.

Next steps

One of the core projects for the primary and community care collaborative network focuses on population health management, and Siobhan says, "I think we need to step into a space that says we can understand communities in ways that the acute providers can't" and show how we're making an impact to address health inequalities. She hopes to do this in partnership with primary care, the voluntary sector and local government partners.

Siobhan also highlights how it will be important to recognise pathways that interface with the acute collaborative network. She says "our provider chief executives acknowledge the need to remain close on some of the pathway developments within acute services as they will obviously pervade across acute, primary and community services. It is important that some of these pathways are starting to be articulated through the lens of primary and community care, and from the perspective of prevention, rather than just from the lens of hospital appointments, outpatient elective recovery, etc."

They are also looking to review their community bed model and think more creatively about the right place for patients to receive their total pathway of care. Siobhan says there is scope for them to think about the out of hospital model, which Kate agrees will be "absolutely critical for future investment in community services as the right thing for most people is to be at home rather than in a community bed". Siobhan welcomes the fact that collaboration at ICS level and the move to one commissioning organisation creates, for the first time, a Sussex-wide approach to community beds.

National policy to support provider collaboratives

Siobhan highlights that each ICS is very different from the rest, which means that provider collaboration also looks different within each system. She is concerned that the current national policy proposals focus narrowly and predominantly on inter-NHS collaboration, when non-NHS organisations, such as local government partners and a range of voluntary sector organisations including hospices, have a key role in the community sector.

She says, "I don't think all collaboratives need to be structural and to follow the same blueprint. One of my concerns about the white paper is that they will shoehorn structure and make it overly complex, which will get in the way of doing what is right for patients and populations, particularly for primary care". She adds that members of the primary and community care collaborative network have had really helpful discussions during the pandemic, for example planning the community long COVID service, and what this means for primary and community services in the context of projected demand, and she would like to continue in this spirit.

While Siobhan acknowledges that it might make sense for some smaller scale community providers to focus on place, there is a clear case in ICSs like Sussex to bring together primary and community care services at scale to have a strong voice at the ICS table where they can demonstrate their value and influence the overall ICS strategy.

Community provider and primary care collaboration across the North West London ICS

Partners involved in this provider collaborative

- Central London Community Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- West London NHS Trust
- Central and North West London NHS Foundation Trust

Background

North West London serves a population of 2.4 million people across eight boroughs including Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and City of Westminster.

Four providers within the North West London ICS footprint have operated an out-of-hospital community provider collaborative on an informal basis for at least two years, and conversations within the system are now underway to formalise the existing arrangements.

Andrew Ridley, chief executive of Central London Community Healthcare NHS Trust, and the local care senior responsible officer for the ICS, is leading a programme of work to standardise the community services 'offer' across the North West London ICS as part of this collaborative.

While the North West London ICS functions as the lead ICS for Andrew's trust, the organisation runs services across three other ICSs including Hertfordshire and West Essex ICS, South West London ICS, and North Central London ICS, adding a layer of complexity to managing collaboration across different systems and places.

Setting up the collaborative

Andrew explains that it all kicked off with a conversation between the provider chief executives within the ICS about the variation in non-elective admission rates across the eight boroughs. They began to discuss what they could do collaboratively to address this variation both within the acute trust setting and in the out-of-hospital space.

"It put a spotlight on the fact that there were different community based rapid response services in each of our eight boroughs, each commissioned by a different CCG". They operated to different specifications, and the fragmented commissioning model meant patients in one borough received different services to their neighbours.

It was also particularly challenging for other providers, like the London Ambulance Service NHS Trust, which sit in the middle of the patch and look after patients from different boroughs, to refer a patient to the most appropriate community based rapid response service because the landscape was so complex. Similar challenges were faced in the commissioning of community beds, whereby patients could only access the beds in a trust if they lived in one of the boroughs that commissioned those beds.

"So it was that conversation that kicked off a piece of work that started to look at harmonising our rapid response services, their specification and our capability for core community services across the ICS."

The impact of COVID-19

The COVID-19 pandemic accelerated work to harmonise rapid response services across the footprint – each borough now has consistent opening hours, referral pathways and clinical capability. The collaborative had been operating for about a year before the pandemic, but the COVID-19 response and emphasis on collaboration and mutual aid really catapulted community providers' joint working forwards. When the infection prevention control guidance was initially published, the community providers decided to take a unified approach to managing bed capacity across every borough during this period of operational intensity, rather than as individual trusts. Andrew says this has led them to now undertake a formal bed review across the system and to establish a pilot "community bed bureau" to ensure they have the right number of beds and there is consistency in length of stay across all units. "I think COVID has undoubtedly had an amazingly catalytic effect... it just put the finger on the fast forward button, so suddenly the theoretical conversations stopped being theoretical and the 'them and us' mentality ceased... It took away the friction that you normally get when you're trying to manage change."

The case for change

Despite the complexity of provider collaborative arrangements, Andrew highlights that "if you take it to its core principles of collaboration and transparency rather than competition it is discernibly much better." Throughout the duration of the pandemic, it was clear that trusts were communicating as one system, and Andrew believes this will play a significant role in the elective care recovery going forward.

He also emphasises some of the benefits the shift from competition to collaboration has had for NHS staff. "I think the melting away of competition is quite significant for them because it allows them to focus on delivering services to their populations, and not have to worry about losing their contracts" to another service. They still relate mostly to their immediate team rather than the wider ICS, however Andrew has noticed that his staff do feel a strong association at place level. He also emphasises how important the shift to digital has been in the past year in enabling frontline staff to feel more connected to their wider organisation and senior leadership team.

Sharing lessons learned

Andrew says the work they undertake as a collaborative is very much provider-driven and supported by the wider system, with an ICS local care team that supports change and improvement. All provider chief executives sit on the ICS board and are really engaged in the work of the ICS, as well as the borough-based teams.

He does also stress that the context in London is quite different and complex to other parts of the country. He says, "In North West London there are many trusts operating within a densely populated area, and so fragmentation drives inefficiency and inequity in a way that it potentially doesn't if you were talking about Dorset or Devon." He says, "I would give careful thought if I was running a trust in a different area of the country", and would consider the differences in population utilisation flow, the number of trusts and their catchment size when thinking about provider collaborative arrangements.

He also contrasts the collaboration taking place in the North West London ICS to arrangements in Hertfordshire and West Essex ICS, where the Central London Community Healthcare NHS Trust is the main community provider in the South and West Hertfordshire Integrated Care Partnership (ICP), with a population of over 600,000. In this context the provider landscape is simpler, with a majority of people receiving treatment at one acute trust, the West Hertfordshire Hospitals NHS Trust, and service collaboration mostly occurring at place level with the ICP in London patient flow is more complicated and requires ICS level collaboration.

Next steps

Discussions are under way to formalise the collaborative arrangements across the community providers in the North West London ICS, and questions have arisen around the scope of the collaborative: should it continue to include just community health services or should it extend to cover other local care services? How does it relate to the existing separate mental health collaborative? However, it is currently unclear how the community providers would have sufficient capacity and resource to deliver such a large scope.

Another challenge Andrew highlighted is around determining how the current at-scale community provider collaboration relates to the ICPs, and how duties and budgets are allocated, for example at place level or through the collaborative.

There may also be an opportunity to explore strategic commissioning functions and expand the collaborative's remit to address health and resource inequity across the ICS. Andrew pointed to the inequity across the eight boroughs, whereby the outer boroughs have significantly less service provision which is exacerbated by ongoing resource inequity, in comparison to the inner London boroughs.

Devolving budgets to ICPs could help address this inequity. The North West London ICS has eight 'place-based' boroughs, each with a quartet of directors covering primary care, mental health, community health, and the local authority to improve patient outcomes and service

delivery. A key challenge is how to strategically move resources and make funding more equitable and needs-based across the whole ICS.

National policy to support provider collaboratives

Andrew emphasises the need to keep national policy around provider collaboratives permissive and open to enable different ways of working collaboratively to take shape across different ICSs. He says the national thinking also needs to acknowledge the strategic role of community providers not just at place level but also within at-scale collaborative arrangements. He also says technical guidance could be helpful around governance and accountability, particularly as his collaborative could take on strategic commissioning functions in future and would need to be held accountable for delivering on this. Clarity on who they would be accountable to and for what will be needed if they do receive budget. Furthermore, there are questions around how a collaborative decides what work it would focus on and whether they would need to go through public engagement to prioritise work areas. Evidently, there are still very important questions that need to be answered by community providers and their partners, in a permissive, enabling environment.

Collaboration between at-scale primary care and secondary care: Modality Partnership

Partners involved in this provider collaboration

- Airedale, Wharfedale and Craven (10 GP practices)
- Sandwell and Birmingham (13 GP practices)
- East Surrey (3 GP practices)
- Lewisham (3 GP practices)
- Mid Sussex (4 GP practices)
- Walsall (10 GP practices)
- Wokingham (2 GP practices)

Background

Modality Partnership brings together 49 GP practices that operate primary health care and community health services across the country. It started with two GP practices in West Birmingham merging to create Modality Partnership in 2009. Modality now serves more than 400,000 people and has been at the forefront of at-scale development in primary care since they began.

Naresh Rati, a founding partner of Modality Partnership, tells us about the partnership and how they collaborate with secondary care providers – mostly focusing on Sandwell and Birmingham, where Modality was initially founded.

Setting up the partnership

Naresh says that "there was a like mindedness" among the two founding GP practices who began to see "there was something more to this than doing it on our own" back in 2009. It initially began with the intention to streamline processes and reduce duplication, for example they would share intelligence about meetings they attended to help manage their workloads and began to share back-office functions.

They started out by developing solutions to help struggling GP practices and over time, as their impact and benefits became more recognised, the partnership grew to what they have now. They became more innovative and proactive in their approach, which eventually led to them becoming one of the new care model vanguards in 2015. This enabled them to get further funding to build on their collaboration.

"So, progressively the partnership grew from two sites to five and then to six and so on. We started to be more innovative and eventually became a vanguard which propelled us to a whole different mindset."

The partnership also started to think about sustainability and diversifying their business model. Naresh says "we started to think about what else we could do to add value to the system. And that's when the outpatient business was born". Exploring the role of GPs in an outpatient setting, as part of the *GP plus* programme also provides more diversity to GPs' roles and is "breaking down the walls between primary and secondary care". Both primary and secondary care clinicians enjoy working across different settings, and these kind of portfolio careers provide a more attractive employment offer.

Naresh says the goal of the partnership now is to become more resilient and shift the focus towards population health and address challenges facing the primary and secondary care workforce.

The impact of COVID-19

Because they have been collaborating for a while, Modality practices were more prepared to manage the pressures and uncertainties brought about by the COVID-19 pandemic. The partnership was able to open specific practices up as COVID-19 hubs and produced uniform infection prevention and control guidance across all practices to streamline the process in a consistent approach. "Being an at-scale provider means we have a lot more Lego pieces to work with."

During the pandemic, they also modelled different scenarios to help them to forecast demand throughout its duration and beyond, and this prepared them to manage the second virus surge collaboratively. While waiting times have rapidly increased overall in the NHS, Naresh feels that collaboration has made this significantly more manageable and has made their services more "COVID proof". They continue to use modelling to predict future demand and account for potential new variants, future spikes and the potential increase in patients presenting with mental health issues.

He also notes that while they haven't been on the frontline dealing with the pandemic in the same way that hospitals have, the COVID-19 vaccination programme has helped them play an important part in the broader response.

The case for change

Naresh uses a case study example of Modality's community-based specialist cardiology service in Sandwell and Birmingham to explain the benefits of collaborative working during the first wave of the pandemic.

The inner-city population is known to have a high burden of cardiovascular disease, so it was important that they set up a COVID-19 secure environment to give patients the confidence to attend their appointments, receive the care they needed and reduce the number of patients presenting late.

The integrated cardiology care model delivered by Sandwell and West Birmingham Hospitals NHS Trust and Modality enabled them to maintain low outpatient waiting times

throughout the pandemic. While hospital consultants and other staff were redeployed to support the pandemic response, which meant backlogs were building up in outpatient services, they were able to increase capacity within community clinics so patients could continue to access the care they needed within four weeks of referral. Consultants, GPs with extended roles and other specialist staff such as echo technicians and cardiographers would run clinics, often at evenings and weekends to keep on top of the outpatient cardiology demand and prevent big backlogs from developing.

Naresh says, "there's no question that collaboration has eased the pressure, because we're on the same team, helping each other out". This partnership model has meant Sandwell and West Birmingham Hospitals NHS Trust has managed to maintain a low wait time throughout the pandemic as patients felt more confident attending a community-based clinic than going into the hospital environment during the pandemic, with 91% of patients saying they would recommend the service to their friends and family.

Sharing lessons learned

Naresh says that relationships and trust between partners is so important for developing effective partnerships, but this all takes time and effort to build. Having these good relationships makes it easier for partners to feel they can be open and transparent about sharing issues and challenges and "removes some of the worry about losing a service to another provider".

Naresh also notes that because of the history of competition within the NHS, it is difficult to shift to a culture of collaboration. He says, the new care models vanguard programme helped build trust between partners and shift to a more collaborative culture. "Setting ourselves up as a vanguard really helped pave the path because it really did bring people together... it was this little piece that connected us". As a vanguard in 2015/16 they started piloting services with a local trust who sub-contracted work to them, and this really helped pull them together and benefits have been realised for both parties.

Next steps and national policy to support provider collaboratives

Naresh touches on tensions that could arise as provider collaboration develops, particularly around collaborating at scale and having a seat at the table, so this will be something to work through. Naresh also hopes that the national policy changes to provider collaborative arrangements won't impact the successful collaboration already taking place within Modality Partnership and with their partners, as primary care's role at system, place and neighbourhood level is essential to achieving the ambitions of integrated care.

Vertical integration at place level in Bradford District and Craven ICP

Partners involved in this vertical integration

- Airedale NHS Foundation Trust
- Bradford Care Alliance Community Interest Company
- Bradford Care Association
- Bradford District Care NHS Foundation Trust
- Bradford District Voluntary and Community Sector Assembly
- Bradford Teaching Hospitals NHS Foundation Trust
- City of Bradford Metropolitan District Council
- NHS Bradford District and Craven CCG
- Primary care providers

Background

The seeds of today's partnership were sewn back in 2011 when local health and care organisations came together to create an 'integrated care for adults' programme. The partnership brought together the providers, local authority and commissioners at the time to implement this piece of work following the Health and Social Care Act 2012. They collaborated in their own way in response to local population needs, which did not always fit into the mould of national policies and programmes, such as the new models of care vanguards.

Helen Hirst is the chief officer for Bradford District and Craven CCG and the senior responsible officer for the ICP development work in West Yorkshire and Harrogate ICS. She tells us how "in our context, the CCG is seen as the collaborator pulling the partnership together, which is a bit different to how some other systems operate." In 2015, the CCG made a commissioning policy decision to not use competitive procurement as a first option, and instead work with their provider market. This evolved into a unified approach to funding and commissioning services across the partnership and influences their ICP today.

Setting up the collaboration

Helen tells us one of the early projects was their transforming diabetes programme. She says, "the programme has had its challenges, but it brought the providers across acute, community, primary care and mental health together – and that was the key objective." She says it also "brought commissioning into a different space where we were facilitating and supporting providers and their services." While the transforming diabetes programme did not achieve all its intended outcomes, it did demonstrate that collaboration was part of how the system and system partners worked.

In 2017/18, a strategic partnering agreement was in place between the providers, local authority, voluntary and community sector and the three CCGs at the time. Helen says, "we decided to close our financial year in a collaborative way, and from then on we didn't have individual contractual discussions." Helen also tells us how the CCG decided to use the system wide surplus to support providers as well as investing in projects such as the 'Reducing inequalities in communities' programme. Interestingly, this did have a negative impact on the CCG's rating from NHS England and NHS Improvement, but "it was the right thing to do because it enabled us to think more about wider population health."

In terms of the governance arrangements, James Drury, the programme director for the ICP board, tells us how partners across the whole system are part of the decision making process. The board includes representation from the chief executives of trusts, the local authority, social care providers, primary care and the chair for the voluntary sector assembly. The voice of PCN clinical directors is brought in through a clinical advisory board.

Andrew Copley, the system finance director for the ICP, adds that they now have a system finance committee with representation from across the whole partnership. This means there's a focus on collaboratively managing the total resource allocation for the place.

The impact of COVID-19

Helen tells us how the relationships they have developed over the years made it easier to respond to the COVID-19 pandemic. Out of this partnership approach a new *Act as one* programme was developed during COVID-19 to help them plan the recovery and restoration of services as well as preparing the ground for the future health and care landscape.

Kim Shutler, chair of the Bradford District Voluntary and Community Sector Assembly, tells us how partners from the ICP came together as part of the COVID-19 response in a different way to elsewhere in the country. There was a seat at the decision making table for voluntary and community sector representatives. She participated in the NHS Gold Command cell leading the operational response and tells us how "the role that voluntary organisations play in the health and care system is recognised here." This has now evolved into a strategic coordination group which has enabled them to mobilise interventions within their communities more effectively, such as thinking about "how we can get health messaging into neighbourhoods, schools and other local community settings."

Mel Pickup, the chief executive of Bradford Teaching Hospitals NHS Foundation Trust who started her role in early 2020, also highlights how "COVID-19 really short-circuited the normal period of time it would have taken to build relationships because we saw much more of each other virtually than we would have in normal times." She discusses how some of the lessons learned from the COVID-19 response around improving remote access to services is being used in the development of new programmes with primary care to keep people out of hospital as much as possible.

The case for change

The *Act as one* programme has enabled the development of a shared set of workforce principles and policies to allow staff to work together across organisational boundaries to deliver better joined up care, share population health data across partners, and set priorities based on shared data. For example, this enabled the ICP to collectively decide to increase resources to autism services and reduce the backlog in this area, as this was identified as a priority within their system.

Mel tells us how the shift to think more collegiately about population health has enabled them, as an acute trust, to think more about keeping people out of hospital. She uses an example of maternity services to explain the vertical integration with primary care, whereby "our obstetricians and our maternity staff now have a responsibility across the continuum of care to intervene earlier and reduce poor outcomes in maternity services."

Mel also discusses the horizontal integration between six acute trusts across West Yorkshire and Harrogate ICS, and how collaboration at this scale alongside place level enables them to explore areas, such as workforce and specialised equipment, and "to consolidate investments and make their services more resilient, cost effective and improve operational efficiency."

Andrew adds, "it's been an eye opener in terms of how much, as an acute provider, you were focused on your silo mentality rather than wider health inequalities. Now we're thinking more about our total resource and responsibility and looking at how resources can be moved across the system to address wider issues. This is the right thing to do and simultaneously supports our work as an ICP."

Sharing lessons learned

Everyone we spoke to in the ICP discussed the importance of relationships on a personal level, with an emphasis on building trust and having a shared purpose. James adds, "when you start with governance you end up working together within a set of rules rather than a shared purpose and that's why investing in relationships and unifying our purpose is so important."

However, relationships are not without their challenges. Helen tells us how in the early stages of their transforming diabetes programme, "it was easy to see how collaboration might work in theory, but in practice it was difficult for partners to let go of their money to support the development of this programme." These relationships take time and effort before gaining traction.

Mel adds, "the delegation of money will always bring with it the challenges of how we distribute it in a fair and equitable way. The hope is that we have done enough of the groundwork to enable us to work through these challenges in a mature way."

Strong leadership is vital and Kim says, "there are some leaders who will understand the important contribution that voluntary organisations bring to the table, and create a space and opportunity to be inclusive, and this is being filtered down." She adds, "if you really want to address health inequalities and look at making sustainable change, you need voluntary and community sector organisations around the table."

Brendan Brown, chief executive for Airedale NHS Foundation Trust and partnership lead for Airedale, Wharfedale and Craven Partnership, said "We are an incredibly diverse area not just in terms of our population but also our geography and the communities we serve. This means we have to consider the needs of all our people stretching from Airedale and Craven through to Wharfedale and into Bradford. For example, we work across more than one local authority area, so this can be challenging but also offers us a real opportunity to develop those relationships across our place and learn from each other."

Next steps

One way the ICP utilises its leaders to enable collaboration is by taking a distributed leadership approach across its programmes. Mel explains, "we take responsibility to lead a programme focused on specific population needs and addressing unwarranted variation. We cover areas that aren't necessarily within the scope of our day job and we identify touchpoints along the continuum of the programme where working together with our partners across the ICP enables us to be more impactful."

Brendan and Kim discuss some of the key priorities for the ICP going forward, including tackling health inequalities, COVID-19 recovery, and a strong focus on the workforce. From the perspective of voluntary and community sector organisations, Kim mentions that "one of the big challenges for the sector when participating in an ICP to address these priorities is the resource, capacity and time it takes to realistically mobilise quite a diverse spectrum of organisations." She also highlights how the sector is vulnerable in terms of financial sustainability which makes participation in ICPs and ICSs more challenging.

National policy to support provider collaborations

The senior leaders in the Bradford District and Craven ICP are keen to make sure that they continue to build on what they have developed, strengthen the partnership, and deliver benefits for patients and the wider populations they serve. As a mature partnership, they all highlight their concerns around having to change their approach or pause development in areas if it does not align with national policy changes.

Mel notes, "we're quite a mature system and there's a risk that national policy will result in us being shoehorned into a different structure and we will have to reframe the way we work, even though our current arrangements are working well for us and our communities." Andrew adds, "I think we've got momentum to get on with it, and what's stifling our collaboration is some of the national policy changes taking place."

Vertical integration at place level within the Surrey Downs ICP

Partners involved in this vertical integration

- Surrey Heartlands Health and Care Partnership
- Surrey County Council
- Epsom and St Helier University Hospitals NHS Trust
- GP Health Partners Limited
- Dorking Healthcare Limited
- Surrey Medical Network in the East Elmbridge area
- Central Surrey Health
- Surrey Medical Network Limited
- Princess Alice Hospice

Background

The Surrey Downs ICP is one of four place level partnerships within the Surrey Heartlands ICS and covers a population size of approximately 300,000. It brings together the acute trust, community providers, GP federations, the county council, districts and boroughs and the local voluntary sector to tackle health inequalities, empower the local population to lead healthy lives, and support their physical and mental wellbeing.

Setting up the partnership

The origins of Surrey Downs ICP stretch back to 2016 when providers started coming together to address shared challenges. The biggest concern across providers was that local hospitals were admitting an increasing number of older people who would have better outcomes receiving treatment closer to home.

Under the leadership of Daniel Elkeles, chief executive of Epsom and St Helier University Hospitals NHS Trust and Surrey Downs ICP leader, the *@home* project was set up. The partnership started on this relatively small-scale project, with the dual aim of admitting fewer people into hospital and discharging those who had been admitted more swiftly into the care of partners in the community. The *@home* service has been a great success and now provides joined up care to people at risk of admission, resulting in an 8% reduction in overnight stays at Epsom General Hospital for over 65s.

The partnership took another step forward in 2018 when it was awarded an integrated secondary, community and primary care contract. All three GP federations were included within the scope of the arrangement and Surrey Downs Health and Care was established soon afterwards as a joint venture to help deliver the contract. The scope of the partnership has expanded in recent years to include integrated stroke and acute frailty services.

Progress has been made rapidly since then, with the ICP board being established in 2019 with a shared vision and objectives agreed by all partners. This was closely followed by a delegated local commissioning model being developed with the CCG, alongside the first joint financial recovery plan.

Individual integrated services have developed rapidly too – a good example of that is Chirag Patel, general manager for 'Home First' (the service which supports patients' discharge home from hospital sooner by facilitating their on-going social and therapy assessments at home) and integrated stroke services across Sutton and Surrey Downs. When he joined the partnership four years ago he had six people in his team – now he has 400. This illustrates how the ICP is shifting resources away from hospitals into community settings to provide more proactive, preventative care.

Over the past year, the focus of the partnership has increasingly turned to population health, with radical service changes being introduced in response to the COVID-19 pandemic. The ICP has established a series of committees in common with local partners, which form the alliance at the ICP board.

The case for change

Thirza Sawtell, executive director of integrated care at Epsom and St Helier University Hospitals NHS Trust identifies the partnership's focus on delivery and commitment to achieving change for patients and service users as its unique selling point. She says, "We're really proud of the fact that we have the person and their care at the centre of what we do.

"When people see us working, it is not possible to tell who works for what organisation in our teams, indeed it is irrelevant. What people see is a large group of professionals whose passion is delivering outstanding care to their patients. This ethos applies across our Home First services, our frailty units, our integrated stroke services and our PCNs."

Dr Robin Gupta, the PCN clinical director in Dorking, highlights the value of multi-disciplinary team (MDT) working, and closer collaboration between primary and community care. The community medical team has grown significantly in recent years, with GPs working alongside district nurses, community matrons, physiotherapists, and occupational therapists to support patients with complex needs in the community. He reflects on how this directly benefits patients and tells us, "The MDT is a fully integrated service across the community health teams, the council, volunteers, and the mental health team, so it's a huge wraparound service that Surrey Downs Health and Care have been able to implement. It's better for patients, better for primary care, and better for community care".

Dr Russell Hills, GP and clinical chair of Surrey Downs ICP, agrees with this assessment and tells us, "We're trying to think about what's it like to be a resident of Surrey, and what we can do to make sure they can access the best health and social care."

This steady shift of focus has changed the configuration of health services locally. Daniel Elkeles reflects on how this shift towards community care has impacted on his trust, "There's been this huge shift of pressure away from our acute hospitals – I'm really proud we have the fewest number of acute beds we've ever had, even with COVID-19, because these guys are looking after so many people in community hospital beds, and community settings."

Great effort has also been put into improving communication between organisations for the benefit of patients in Surrey Downs. Emma Alderman, operations manager at Surrey Downs Health and Care, notes that the roll out of SystmOne and EMIS Web to community services has been pivotal in this respect. Additional funding has also meant the ICP has been able to invest in laptops for local care homes, improving communication and supporting MDT working with GPs.

All this collaboration and partnership working has ensured that the ICP has seen a 6% reduction in emergency admissions into Epsom Hospital for over 80s for three years in a row.

Impact of COVID-19

"Throughout the last year our COVID-19 response has demonstrated at pace what you can do around the integration agenda," says Dr Hills. Weekly co-ordination meetings were put in place for community and GP partners to allow the teams to respond rapidly to COVID-19, with care homes being brought into the fold as the pressures on the sector became increasingly apparent. Staff worked incredibly flexibly, with school nurses working on wards, podiatrists working in district nursing teams – working outside the traditional boundaries of their roles to ensure patients were provided with the best service.

Susan Sharkey, senior manager of adult social care for Surrey County Council, also reflects on COVID-19 and the significant challenges this brought about for the ICP, "As soon as COVID-19 came in, the world kind of flipped on its axis and we had to match our teams to what was happening."

Susan notes that the "collegiate approach" of the teams working in the partnership was key in shaping the ICP's approach and shares her pride that "they rallied around, rose to the challenges and just got on with it."

Simon Littlefield, director of nursing and quality for Sutton Health and Care and Surrey Health and Care, also praises the way colleagues came together during the pandemic, sharing an example of how teams across community services and hospices worked to support end of life care and to share information on infection prevention and control. He praises the willingness and commitment of all partners to share knowledge and to "really deliver the best care" for patients during an incredibly challenging time.

Nicki Shaw, chief executive of Princess Alice Hospice, reflects on how the demand for end of life care increased significantly at the start of the pandemic. She recalls receiving a call

from Daniel Elkeles when he was looking into creating a Nightingale-type hospital in the local area. Nikki says the ICP was able to mobilise provision for end of life care relatively quickly because "the relationships are there, the trust is there, but also because we know where each other's strengths are, and so we know we can contribute that added value, which has been really important". Nicki's hospice also provided education and psycho-social support to care home staff.

Dr Hilary Floyd, the medical director for a GP federation of 20 practices across the Epsom locality, discusses the establishment of the NHS Seacole Centre which provided rehabilitation for COVID-19 patients after discharge from hospital. In just 35 days, with teams across the ICP and the local resilience forum working together, the centre was transformed from a disused and derelict military hospital (which had been empty for years) to a working rehabilitation centre. This meant that those recovering from COVID-19 and in need of rehabilitation could be moved out of local hospitals to give them more capacity for the sickest patients. Dr Floyd welcomes the collaborative spirit within the ICP saying "it's really nice to be part of a team, a team that supports each other".

For Dr Floyd the ICP's realisation that processes didn't need to be perfect, was important. There was value in "learning and working together, delivering programmes of work quite quickly and constantly changing."

As the pandemic progressed, new challenges arose for the ICP, but these were also overcome by the ICP's willingness to put aside organisational and professional roles and work collaboratively.

Dr Gupta shares how cross team working across the ICP meant that they were able to roll out the vaccination programme to vulnerable housebound patients, "The rollout of the COVID-19 vaccination programme has worked really well because we decided as GP practices that we could deliver the vaccines for housebound patients more efficiently in Dorking because of the huge geography and this would enable our district nurses to keep working in the community medical team rather than taking out that capacity".

Challenges

The challenges facing the ICP have changed as the partnership has evolved. Thirza Sawtell tells us about the effort that went into building relationships locally. She says, "We started quite small, but small wasn't easy, it involved all of the partners, including Surrey County Council, community services, primary care services, mental health services and acute services working together.

"Where we are as an ICP hasn't just come about because we put a structure in place. We have those good relationships and that's taken real leadership and disagreements, as well as agreements, about how things work... there wasn't always agreement, but partners always came from the place of trying to get it right for patients."

Dr Hills agrees with this assessment and tells us, "While we haven't always necessarily agreed on everything, that's usually just because we're trying to work out a new way of doing something and we're all coming at it from a different perspective".

As partnership working has matured, Thirza tells us about the ongoing challenges around developing the right governance within the ICP "that is safe, appropriate and works effectively, but also delivers what the right thing to do is". Thirza notes Daniel's 'mantra' of "we need to make the right thing to do the easiest thing to do" and adds, "it's impossible to understand how often the system prevents that happening, so our governance from the beginning has always been about shared decision making".

Next steps

Looking to the future, Daniel Elkeles sees a "huge opportunity in planned care. There's a massive opportunity to join up our pathways so that there are a lot fewer outpatient referrals, by sharing the expertise from within the hospital with the PCNs. And there is a lot of scope to deliver joined up care at an MDT level within the PCN. This is particularly successful across chronic conditions, with the MDT focused on looking after a whole person". Each PCN already has a lead GP, lead manager and lead nurse or therapist working as a leadership trio.

The ICP also plans to implement its health inequalities reduction plan this year, as well as pressing ahead with proposals to roll out its population health management approach to all localities. For Daniel, the focus is on "how you turn the NHS into a proactive care system." He reflects on the need to tackle health inequalities in each locality, a concern which Dr Hills also shares. He says, "The health inequalities space is really important and we've decided to think about population health in the context of place."

National policy to support provider collaboration

Daniel outlines the ICP's hope that a "bigger share of the health budget" will be "delegated from the ICS to our place" through contractual mechanisms. He acknowledges that this will bring new challenges such as "how we allocate resources between ourselves and our partners who are part of the ICP." Potential issues around fairness and transparency would have to be addressed.

Dr Hills agrees with this and discusses the preparations that have been put in place to ensure the ICP would be ready to manage a delegated budget. The ICP is actively working through the governance issues, Dr Hills says, but he is confident that the collaborative approach which underpins the partnership would mean that any issues could be worked through.

Collaboration from the perspective of Yorkshire Ambulance Service NHS Trust

Partners involved in this provider collaboration

- West Yorkshire and Harrogate ICS
- Humber Coast and Vale ICS
- South Yorkshire and Bassetlaw ICS
- Yorkshire Ambulance Service NHS Trust

Background

Yorkshire Ambulance Service NHS Trust provides urgent and emergency care services to 5.5 million people across three ICSs: West Yorkshire and Harrogate ICS, Humber Coast and Vale ICS, and South Yorkshire and Bassetlaw ICS. The trust also works at a sub-system level, in each ICS' place-based partnerships and neighbourhood level arrangements, as well as being part of the Northern Ambulance Alliance (NAA), formed in 2016, which brings together four ambulance providers to address common challenges through collaboration, and share best practice.

Setting up the collaborative

The trust has a strong track record of collaboration with other ambulance services and wider partners. The work with the NAA provides an invaluable opportunity to support innovations that need to take place across a wider footprint than ICSs, but below national level. The chief executive of Yorkshire Ambulance Service NHS Trust, Rod Barnes, says it has been particularly helpful in developing the digital agenda. One example here is a joint computer aided dispatch system for emergency and non-emergency ambulances.

The NAA is pushing ahead with its digital agenda, which has led to the implementation of a common fleet management system, including ambulance maintenance schedules and collaborative procurement. This investment in digital is having positive knock on effects across the wider system through facilitating greater collaboration between regional ambulance services, reducing unwarranted variation between different services while also building "better resilience across the different services".

Recent changes to the commissioning landscape are also significant. There is now an integrated strategic partnership across the three ICSs to plan priorities for the urgent and emergency care sector. This includes a clinical forum of lead clinicians from primary care, secondary care, and the ambulance sector, which considers access to a range of services including mental health crisis response, frailty, and respiratory pathways.

At a system level, the trust is looking to embed integrated leadership teams within all three ICSs to ensure there is equal knowledge about 999, 111 integrated urgent care and non-emergency patient transport. When these teams are in place, anyone in the ICS who needs information about urgent and emergency care services should find "there'll be one individual that they'll be able to contact" who understands all these areas.

Challenges

Rod tells us that one of the key challenges facing Yorkshire Ambulance Service NHS Trust is the number of different 'places' within each ICS that they need to engage with, and the likelihood that each of these will identify an independent set of local priorities. While recognising the importance of tailoring care to local patient and population needs, Rod says, there is a risk that the ambulance service is "going to get pulled in too many different directions".

To remedy this, the trust is working hard to reach a "balance" between a common agenda across the three ICS footprints and "responding to priorities at an ICS level as well as to local priorities at place level" and is looking to create advanced clinical roles that align with the new place-based decision making structures, so that ambulance teams can play into strategic conversations.

The impact of COVID-19

The COVID-19 pandemic was a catalyst for "far closer collaboration within the ICSs... and broke down some of the barriers that previously existed". Partners within the ICSs came together to resolve shortages of PPE and to support each other through mutual aid. For the ambulance sector, significant challenges around social distancing rules have meant reducing capacity in non-emergency patient transport services, so ambulances can only carry one patient as opposed to the usual three or four. The pace at which these can be relaxed will be heavily dependent upon how the virus evolves.

Rod also tells us that while there was a reduction in patients going into hospital for planned care, "hospitals had an increased requirement to discharge patients on the day or move patients between facilities according to whether they were treating COVID patients or not". Transfers between hospitals or for other services are going to carry on being a "real challenge" for the foreseeable future because of social distancing and other issues, Rod says, adding that the ambulance service has increased its surge capacity within patient transport to cope with these additional demands.

He welcomes the increased collaboration brought about by the pandemic with acute colleagues working with the ambulance sector on activity planning and managing demand, as well as closer working between non-emergency patient transport providers to coordinate capacity, share PPE and understanding of infection prevention and control guidance.

Sharing lessons learned

Rod describes a shift in mindset over the past couple of years from colleagues who are now recognising the role of the ambulance service in proactively tackling health inequalities as an integrated system partner, rather than just seeing it as an emergency response service. This has largely come about through partnership working in ICSs and a clear focus and commitment amongst those involved to develop strategic priorities, including tackling the inequalities agenda. He shares an example of specific recruitment campaigns and community engagement activities to give people in disadvantaged areas opportunities through volunteering to get into the job market. Rod says there are more conversations now about which interventions have the best impact and welcomes "partnership leadership arrangements involving the voluntary sector and local authorities".

Collaborating with West Yorkshire Police and West Yorkshire Fire has led to innovative policies to tackle knife crime and violence reduction in Leeds and Huddersfield. He says, "the best partnerships are those that are developed in local communities... collaborating with local community groups and local schools".

Next steps

In terms of next steps, Rod highlights several key priorities for the ambulance service over the next few years. The first is the need to build on the 111 first initiative with local partners to mobilise pathways and services that avoid patients going into the emergency department if they do not need to be there.

The second is making sure that the new roles in PCNs, which go live later this year, do not exacerbate workforce shortages for the wider health and care system. This is a "real risk" to the ambulance paramedic workforce, Rod tells us, identifying a "massive workforce challenge, bigger than anything we've seen in the last decade". Rod's trust is looking at whether it will be possible to rotate specialist paramedics across both the ambulance trust and primary care, given the significant mismatch between the number of experienced trained staff currently available and the demand from PCNs. He adds it is vital there is an "agreed rollout timetable": failure to do so could lead to a "massive bidding war for trained paramedics or potentially the ambulance service could be destabilised both on a regional and national level."

Rod says that, "we are still finding our feet" in terms of what facilitates greater collaboration, but he highlights a focus on empowering local teams and clinicians, having the right culture and mechanisms in place to support decision-making and resourcing teams at ICS and/or place level to carry out the transformation work.

Rod is clear about the value and pivotal role the ambulance service brings to ICSs and the health and care system more broadly. He says, "our teams have a huge impact on patient care and the wider system... we see well over three million patients a year. That's an awful lot of the patient contacts that go on within any one ICS, and we influence where those patients go in the system".

National policy to support provider collaboratives

Rod highlights how the planned changes to procurement rules will encourage further integration across urgent and emergency care services both within and across providers. Historically, both 111 and patient transport services were subject to competitive tendering every three to five years. Rod says the uncertainty this created led to variation in service delivery and hindered greater integration of patient transport service, 111 and 999 services. He explains, "if you think you will soon be going through the huge turmoil of unpicked systems and leadership teams, you're more inclined to leave them as separate services operating with a degree of independence". Rod is convinced that a more collaborative approach will improve the care the service is able to offer patients, and will encourage better information sharing between system partners to better meet health needs of local populations.

Collaboration from the perspective of West Midlands Ambulance Service University NHS Foundation Trust

Partners involved in this provider collaboration

- Birmingham and Solihull ICS
- Black Country and West Birmingham ICS
- Coventry and Warwickshire ICS
- Herefordshire and Worcestershire ICS
- Shropshire, Telford and Wrekin ICS
- Staffordshire and Stoke-on-Trent ICS
- West Midlands Ambulance Service University NHS Foundation Trust

Background

The **West Midlands Ambulance Service University NHS Foundation Trust** serves a population of 5.6 million people covering an area of more than 5,000 square miles and work across six systems. While they are a regional ambulance service, they currently have a lead ICS, Black Country and West Birmingham ICS, that works on behalf of the 22 CCGs within the six ICS regions.

The trust employs approximately 7,000 staff and operates from 15 new fleet preparation hubs across the region through a programme called *Make Ready* – an approach that led to improved efficiency and productivity and less variation in care and infrastructure. The trust took over provision of the NHS 111 service in the West Midlands (except Staffordshire) in November 2019 and provides non-emergency patient transport services across some parts of the region for patients who are unable to travel unaided because of their medical condition or clinical need.

Vivek Khashu, director of strategy and engagement at West Midlands Ambulance Service University NHS Foundation Trust, tells us that one of the key challenges for ambulance trusts is getting the partnership engagement piece right, particularly at place level. This includes managing the benefits of being a regional service with no borders but making sure they are also plugged in at a local level so that they can better connect with people and communities. He emphasises some of the complexities that exist around being an ambulance service across a particularly wide geographic footprint.

The impact of COVID-19

Vivek tells us the COVID-19 pandemic has brought provider leadership at system level to the fore and made partners much more aware of the NHS' role in tackling health inequalities and improving public health services, particularly as public health responsibilities sit with local authorities.

Restoration of elective care and other services is an important conversation taking place at the moment across all six ICSs. While recovering services isn't necessarily applicable to ambulance services as they never stopped, they have been plugged into the wider system recovery and transformation planning, which is focused around waiting times. However, Vivek highlights that there are important related issues for the ambulance sector particularly around managing handover performance and eliminating long delays outside hospitals.

He also discusses what financial recovery will look like given changes to contracting. "I think capital will be an interesting issue for ambulance services, and this is where system working may start to collide with organisational interest... there may be a need for some arbitration or independent review to mitigate any tensions".

The context for ambulance services

Vivek highlights how all ten ambulance trusts work within different contexts, so for example while the West Midlands Ambulance Service University NHS Foundation Trust operates across six ICSs, the North East Ambulance Service NHS Foundation Trust works within one ICS. Vivek says having a 'forum' in the form of the Association of Ambulance Chief Executives and its subgroups to share learning and discuss challenges is useful and will continue to be as collaborative working arrangements evolve.

Ambulance services work within a slightly different hybrid context of emergency services, including fire and rescue and the police, so they don't see their function as "purely NHS". This makes the world of system working quite complex for ambulance services, although there are opportunities to drive further integration across the system.

The case for change

In terms of integrated care, he stresses that most of the work they do as an ambulance service is supporting people with exacerbations of long-term conditions, frailty, or chronic diseases, and so from an integrated care perspective they have an opportunity "to integrate patients into a continuum of care".

Vivek says he feels that working in collaboration also provides more opportunities for better population health management and reducing health inequalities. He says the ambulance service has some valuable population health data about the people who call them and integrating this across the system could help address some wider health issues in their

patch. "Ambulance services can act as a real integrator of care because, like primary care, we are often the first port of call, and it's about how we plug people into the right parts of the health and social care system. I think we have a big responsibility as we move closer towards integrated care, not just from a public health perspective but also with regards to addressing health inequalities".

He also notes the importance of strengthening the delivery of local people plans, equality, diversity and inclusion, and the important role ambulance services have in addressing some of these challenges. He says, "we have thousands of contacts, many in person with our clinicians every day". That is a lot of contact where we can influence health and well-being within the communities we serve and ask things like 'Have you had your flu jab?' You can start to see how we could make a difference". The trust will be refreshing its organisational strategy to consider strategic priorities in these areas. He also notes, for example, how "ambulance services could potentially work alongside and virtually with integrated care teams to assess the needs of our patients and deliver the right outcomes first time".

Vivek also illustrates some of the shared benefits that could be realised by sharing the population health data they have with local trusts to help prevent patients needing to be admitted into hospital. So, for example, they could provide an individual, who would otherwise call the ambulance service on a regular basis, with necessary equipment and adaptations to their property so that they are not as vulnerable as they previously were. Vivek says, "we're going to increasingly have be more involved in helping people live independently, live longer with more dignity and contribute to reducing demand on the healthcare system".

Over the next year, the trust will also be thinking about the potential dividend for integrating care in this way. They will be thinking about opportunities to support greater productivity and efficiencies in healthcare across the region and the need to adapt commissioning arrangements to achieve this. He says, ultimately "the principle of ICS working is to remove boundaries and barriers and to support each other to achieve a collective goal".

While there are opportunities with regards to population health management there are also some associated risks. Vivek questions, "How will we be commissioned? How will we have a seat at every ICS table? How will we have a say, and a voice?".

Sharing lessons learned

One thing that has worked well for the West Midlands Ambulance Service and its patients is having a lead commissioner who works on behalf of the 22 CCGs that exist within the six ICS boundaries. They are also hosted by one ICS on behalf of the six, and this simplifies the planning and commissioning arrangements. Vivek has some concerns about how this will change as the national policy around ICSs develops, preferring a regional commissioning board model with a lead ICS, or potentially a specialised commissioning approach.

Another challenge they've had to navigate is balancing at-scale collaboration with place. "One of the biggest challenges, I don't think is at system level, but actually at place level, particularly as a regional ambulance service trying to make sure we're still plugged in locally". He says one way they've been building relationships at this local level is by getting the collaborative's senior operational managers involved in projects, such as rebuilding emergency departments at place within their patch.

He also discusses the role PCNs will have in employing paramedics in primary care, which has been particularly challenging as there are 110 PCNs within the six ICSs. He explains how the ICSs have had an important role in bringing together voices from appropriate partners to streamline this process. "ICS workforce leads set up a forum with us to exchange views and are now working on our behalf with PCNs within their patch, which has been very helpful."

Next steps

Regarding his concerns about the future role of ICSs in terms of resources and planning for the ambulance sector, Vivek sees value in maintaining a single lead commissioner role in some form or shape.

Vivek also touches on some of the challenges associated with moving towards shared accountability, particularly for systems where performance at an organisation level is variable. "At the moment we're achieving all of our objectives as we're measured as a standalone trust, and that gives us a lot of pride, but we don't know how it will play out as we move closer towards collaborative working arrangements and collective accountability...". There is a need to ensure everybody has the necessary influence over decisions at system level, including ambulance trusts.

However, the benefit of "a collective accountability arrangement means we are of course bound together with the obvious requirement to support one another" to address system wide challenges. Vivek says the trust is now thinking about how they can re-orientate themselves and continue delivering an outstanding service with a shared responsibility on a much greater level across their partners.

National policy to support provider collaboratives

Vivek agrees that putting ICSs on a statutory footing is absolutely the right thing to do when it comes to clear accountability and decisions about resources. But this is not without its challenges, as his trust recently had to work through, when it wanted to use its own capital to replace some aging fleet vehicles reaching the end of their five-year lifespan, when the ICS itself was resolving a challenging financial position. Working with partners the matter was resolved, however previously the trust wouldn't have had to go outside of the organisation to even discuss the matter. "There may always be this issue of organisational interest versus collective good, and with organisations still being held accountable for the care and welfare of their patients and staff, there will inherently continue to be tension".

Vertical collaboration between trusts in the Somerset ICS

Partners involved in this vertical collaboration

- Somerset Clinical Commissioning Group
- Somerset County Council
- Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Background

Somerset NHS Foundation Trust is one of the first trusts in England to provide community, mental health, learning disability services and acute hospital services. The trust was formed in April 2020 when Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merged.

Before they merged, they established a joint executive team in 2017 that oversaw all aspects of both trusts' operations and worked to a single set of strategic objectives covering hospital, community and mental health services. They decided to merge to remove the barriers that added unnecessary delay and cost to the care they provide, and to better integrate community, mental health and hospital services. The merger was built on the trusts' clinical strategy that was formulated as a result of significant engagement with staff in a wide variety of different services, who saw the improvements that could be made if services worked differently together.

They are now working towards a merger between Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust to bring together services across the system. Yeovil also has a history of developing integrated care models as a result of its work as one of the primary and acute care vanguard sites. This resulted in an innovative partnership with primary care and the development of an 'at-scale' primary care subsidiary, Symphony Healthcare Services. Jonathan Higman, the chief executive of Yeovil District Hospital NHS Foundation Trust, says, "we are about to submit our strategic case for a merger between the two foundation trusts to NHS England and NHS Improvement, and this would bring together the two acute sites with all mental health and community health services in Somerset. Between the two trusts we have integrated 20 GP practices as well".

Jonathan also reflects on the simplicity of the provider landscape in the Somerset ICS that has enabled this more formal collaboration to take place. He says, "we're a relatively simple system. We have one CCG, two foundation trusts, around 65 primary care practices, and one local authority." Commenting on the context in Somerset, he adds that their 'place' footprint is also defined as Somerset, "but actually within that there are four distinct localities and 13 neighbourhoods".

Setting up the collaboration

Peter Lewis, chief executive of Somerset NHS Foundation Trust, tells us that the partnership between the legacy organisations in the original merger, Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust, was initiated by conversations about how they could work more closely together as two trusts.

He explains that they did not initially intend to merge the trusts, but that "once we had set up the alliance, it quickly became apparent that there was a great opportunity here. We had people solving problems together rather than blaming the other party. We realised that if we really wanted to integrate our services, we probably needed to be one organisation".

There were conversations at the time to merge with Yeovil District Hospital NHS Foundation Trust as well, but they were focused on their work as one of the new care model vanguards. Jonathan says, "when Somerset NHS Foundation Trust was formed it felt like the natural next step to bring the learning that we have at Yeovil between hospital and primary care together with the work they have been doing between acute, mental health and community services."

The impact of COVID-19

Peter and Jonathan both discuss how COVID-19 has enabled them to deliver changes at pace in a way they hadn't previously been able to, using an example of their intermediate care service. Peter says, "our work on intermediate care really took off during the COVID-19 response because we urgently needed to create capacity in hospital and improve patient flow".

He also notes that, "when the system bureaucracy stopped, it enabled providers to collaborate better. It really helped that the commissioner gave providers permission to act and empowered them to get on and do things. We mustn't lose this."

The case for change

Peter discusses how moving towards greater collaboration will have benefits for patients in Somerset and the staff who serve them. He feels there is a real opportunity to improve the interface between the two trusts and standardise the quality of, and access to, services.

Jonathan also discusses the one organisation approach and says, "we can see the benefit to having a population budget with clear outcomes and being able to plan and move resources across boundaries into prevention and early intervention services".

Peter adds, "it really does give us an opportunity to focus more on addressing inequalities, prevention, and population health because now the incentives are aligned in a way where we can be proactive in our care. I think now we've got the scale and reach at our disposal to really put that at the centre of what we do."

Jonathan also highlights that, "having a 'one Somerset' service is actually much more attractive for staff, which has helped with workforce sustainability. We have already seen that having a single urology or stroke service, for example, gives staff more opportunity for research and pursuing specialist interests".

Sharing lessons learned

Peter and Jonathan both tell us that relationships and culture are key to collaboration, but it takes time to develop and get this right. Jonathan says, "I think culture is the bit that you can't just change overnight and, actually, it might not be about changing it but instead embracing and supporting the evolution over time, as both organisations have strong and distinct cultures".

Peter and Jonathan both highlight that while a formal merger was the right model for the people of Somerset, it may not work everywhere. Jonathan says, "this is only one way of doing things, it's not necessarily right for every system". Peter adds, "other systems are more complex, which highlights the need to make sure there is flexibility in national policy and guidance. We need a permissive approach to ICSs rather than a rules-driven approach".

Peter also discusses the importance of bringing everyone on the journey. He says, "people were concerned that mental health would get lost in the new integrated organisation and the acute services would take all the money. So, we set out some very clear objectives, one of which was to prevent that and invest more in mental health than in the acute services. That got people in mental health services on board". He notes that there has been some "fantastic transformation" in their mental health services as a result.

Jonathan also notes the importance of bringing people with you and says, "we need to engage with primary care across the whole county and build on the work we have already done with Somerset County Council who are also going through a change process to move to a unitary authority model".

Next steps

Peter notes that during the pandemic, there was a positive change in the provider-commissioner relationship. He says the question is now, "how do we ensure the ICS enables the level of collaboration that took place during the pandemic?" Jonathan highlights, "it's a difficult time to engage with staff about this level of change, as many people are just focused on coming out of the pandemic".

Jonathan also discusses next steps for the operating model within Somerset and engaging with different localities. He says, "We're thinking about how we make sure that we take the best county-wide approach, recognising that there are distinct geographies within Somerset, to address population health needs and health inequalities. We are also thinking about how we engage with the voluntary sector, who can potentially provide resource in a different way. So, it's about both the horizontal and the vertical integration, and bringing all organisations together within our provider collaborative".

National policy to support provider collaboratives

Peter and Jonathan both highlight the need for legislation and guidance to be permissive and flexible enough so that they can continue to build on their simple model for collaboration. Jonathan says, "our focus is on how we can maintain simplicity, within the minimum standards set by national guidance".

Peter also notes that, "there is a danger that if you try and force change in a certain way without getting the important principles right, like aligned leadership and objectives, then you won't achieve the right outcomes. What we've done at Somerset NHS Foundation Trust to integrate community, mental health and acute hospital services has involved colleagues from services spread across the county and was possible because we developed a shared vision about what we could achieve together and had flexibility to do that." He adds, "we don't want there to be unnecessary layers of bureaucracy, especially as we've got a relatively simple health and care system. I understand that with the bigger ICSs, there will be a need for something different to coordinate across a wider geography and population, with more partners, but we aren't in this position".

Jonathan concludes, "I think collaboration is about bringing people together to make the services better for the population and recognising there's a mutual benefit in doing it".

Horizontal collaboration of trusts across Herefordshire and Worcestershire ICS and Coventry and Warwickshire ICS

Partners involved in this provider collaborative

- South Warwickshire NHS Foundation Trust
- Wye Valley NHS Trust and
- George Eliot Hospital NHS Trust

Setting up the collaborative

The Foundation Group was set up as a partnership in 2017 initially between South Warwickshire NHS Foundation Trust and Wye Valley NHS Trust. George Eliot Hospital NHS Trust joined the Foundation Group a year later in 2018.

Glen Burley had been chief executive at South Warwickshire since 2006 and successfully helped turn around Wye Valley in 2016, which had been placed in quality special measures. Wye Valley then appointed Glen as their chief executive and the two trusts moved to a shared leadership model. Faced with similar sustainability challenges, George Eliot Hospital – which was also in special measures – asked to join the Foundation Group under Glen's leadership. Each individual organisation has a managing director in post, reporting directly to the chief executive.

The Foundation Group originally aimed to be a sustainability model for three small to medium-sized trusts. Over time, each organisation has become the leader of integrated care in their 'place' within the two ICSs covered by the trusts in the group. Reflecting on the progress of the group and how this has aligned with national objectives in recent months, Glen tells us, "the national strategy is very consistent with the strategy of the group. Our strategy has been around a little longer".

Each year, all three trusts set their organisational level objectives, as well as collectively setting some group objectives. The Foundation Group has a committee in common governance arrangement which binds the interests of all three organisations together. The group strategy committee drives the collective activity. For example, all three trusts see staff wellbeing as a top priority, so they tackle this together and share their learning to help each other improve.

The case for change

Working within the Foundation Group offers a range of benefits for its members that they wouldn't necessarily be able to achieve on their own. Glen shares an example of how the combined turnover of £750m between the three trusts enabled them to invest in key leadership roles including a group financial advisor, a group digital advisor and a group improvement lead. By sharing data, the Foundation Group is also seeking to improve productivity and performance across the three trusts.

Crucially, group working has delivered significant benefits for both patients and the workforce. Glen welcomes the significant progress that had been made in completely changing urgent care at both Wye Valley and George Eliot by adopting the patient flow models used by South Warwickshire.

Glen was delighted about Wye Valley's recently received 'Good' rating from CQC for urgent care alongside it being the trust with the most significant improvement in mortality rates in 2019. This was driven by the trust's work to ensure people got the right care at the right time across the system. Similarly, improvements in George Eliot Hospital's urgent care has had a positive impact on recruitment, with the A&E team recently expanding from two to eight consultants. All three trusts within the Foundation Group are among the best in the region in terms of meeting the four hour A&E standard and they recently received plaudits from the West Midlands Ambulance Service University NHS Foundation Trust for their turnaround times during winter, which was a major safety benefit for patients.

Glen values the staff survey results and there have been significant improvements across the Foundation Group. He says, "the big one for me will be the staff survey, which drives all the quality that patients experienced. Focusing on empowering the frontline and giving people opportunities to improve the way that services function for patients". This evidence, combined with improvements in recruitment and retention, bottom line finances and the quality of services, all indicate the benefits of working in the group structure.

On staffing at a more senior level, Glen also highlights how having managing directors in post at each of the three trusts creates an excellent leadership pipeline for future chief executives.

Challenges

It hasn't all been plain sailing though. The Foundation Group spans two ICSs (Herefordshire and Worcester ICS and Coventry and Warwickshire ICS) and Glen is mindful that there is a "challenge about the number of layers in which we have to operate these days".

The Foundation Group is also grappling with different local government arrangements across the two ICSs. Glen says he welcomed the 'one Herefordshire' approach which meant that significant progress was being made on integration. However, other areas like Warwickshire, which has a series of district councils and a county council, are more complicated. Glen highlights the joint posts the Foundation Group has set up with

Warwickshire County Council. One particularly successful example has been the public health doctor who is now part of the Foundation Group's leadership team. This role, Glen says, is "helping us look at things differently".

The impact of COVID-19

Glen is clear that the existence of the Foundation Group and system working has been a key factor in shaping their response to the COVID-19 pandemic over the past year. The pandemic has been a "single unifying purpose" Glen says, sharing his pride at the way different parts of the health and care system have come together to manage the impacts and challenges of the COVID-19 pandemic. In particular, he singles out the local response to support care homes saying, "we wrapped ourselves around them and helped them to function during that period". He also reflects positively on the integrated trust model, which really came into its own in the discharge to assess process.

Working with partners to improve population health

Significant work is being done by the Foundation Group to collaborate with primary care. Glen acknowledges the, "very real risk that we could disengage primary care" in the current conversations about the ICS structure and lead provider models at place, but highlights primary care's pivotal role in supporting population health. He says, "I will always say the building blocks of population health should be the PCNs. So rather than looking at what the priorities are from an ICS, or even a place, we should look at those neighbourhood arrangements and say what are the big public health issues?"

Glen particularly welcomes the "significant progress" that had been made on embedding out of hospital care. He notes that when he first joined Wye Valley, the trust was on the verge of letting their community service contracts go. He made sure the trust continued to provide these community health services because of the long term need to invest in population health and focus on the wider determinants of health. He also ensured that resources that were in the trust's contract for acute services were redirected to expand primary and community services.

Glen highlights the group's commitment to "involving primary care in leadership" as well as the group's willingness to take on the system's financial risk and consulting their primary care colleagues every step of the way. To make the lead provider model work, he reflects that you need to show partners that you will invest in the system priorities to demonstrate the true nature of the partnership.

Sharing lessons learned

Glen offers this advice for those looking to move to more collaborative ways of working, "Don't try and design an end game situation... because everything keeps changing. The key enabler is to focus on incremental improvements." The group model has enabled Glen and colleagues to move forward quickly and realise benefits for patients sooner, without needing to go down the more formal route of mergers or acquisitions.

Glen notes that he personally didn't want to get distracted by a "huge load of governance and reorganisation. It was about connecting three organisations as simply as we could and supporting the frontline to get on and do things". In particular, he highlights the need to maintain the individual identities of the organisations involved, and the importance of co-producing strategic and operational plans tailored to each organisation, which were key to keeping staff on board.

National policy to support collaboration across providers and their partners

Glen expresses his hope that budgets and decision making will be delegated down to place. He saw this role evolving over time, with a narrow range of decisions being taken by the place-based partnership initially, with the scope to take on more as they demonstrated their credentials. This shouldn't be a one-way, irreversible process though, Glen warns, "ICSs should have the ability to reverse it if goes wrong as well as ensure that those place-based leads do a good job".

He also highlights the difficulties the two NHS trusts in the Foundation Group faced in accessing capital, compared to the process for the foundation trust. He hopes that being part of a high-performing group will allow non-foundation trusts greater autonomy in accessing capital investment. This would be a great way of incentivising more trusts to join a group.

The long quest for closer health and care integration has taken on a new momentum. As this report shows, NHS trusts and foundation trusts are at the heart of this process. They are harnessing a spirit of collaboration, propelled by the pandemic, to find better ways of working. They are joining forces with partners to plan and provide for the needs of their communities, improving care for patients and service users. There is growing awareness and recognition at the centre – from government and national bodies – that providers are the 'engine room' for transformation, with a key role to play as leaders and co-leaders in this fast-changing landscape, and as the point of delivery for services. While important questions remain around the statutory role and remit of ICSs, how they're comprised, and what their governance, accountability and funding will look like, the collaborative arrangements developing within and across ICSs have shown they can operate in a range of functions, forms and footprints that deliver success.

It is because of this variety of approaches – and the different purposes they serve – that we have focused on provider collaboration in its broadest sense: exploring the characteristics of acute 'horizontal' provider collaboratives in the Greater Manchester ICS alongside 'vertical' integration at place in the local partnerships in Bradford and Craven, and Surrey Downs, highlighting perspectives from an ICS level community and primary care collaborative in Sussex, and the increasingly important partnerships between at-scale primary care providers and secondary care – exemplified by the work of the Modality Partnership, showcasing the mental health provider collaboratives such as in South London, and considering the role of ambulance services in Yorkshire and the West Midlands.

A key lesson from these case studies is the importance of leadership in driving the transition from competitive to collaborative ways of working, and the way relationships based on trust and shared objectives can transcend institutional barriers of governance, form or structure. The Acute Hospitals Alliance within the Bath and North East Somerset, Swindon and Wiltshire ICS highlights the shared commitment of three chief executives to deliver benefits for patients and staff by developing mutual understanding and playing to the strengths of each organisation. The importance of building trust across leadership teams is also a key theme of the South London Mental Health and Community Partnership in resolving new funding and commissioning responsibilities, and in the Dorset ICS where close working between NHS partners and colleagues in local authorities has been important in identifying and tackling deprivation and isolation.

While some of the relationships behind provider collaboration go back many years, there is no question that the imperatives presented by the pandemic provided a powerful catalyst to develop these partnerships. The effect was neatly summarised by Andrew Ridley, speaking as the local care senior responsible officer for the North West London ICS, who said, "it put the finger on the fast forward button, so suddenly the theoretical questions stopped being theoretical and the 'them and us' mentality ceased."

Pandemic pressures forged closer collaboration over workforce, PPE and other equipment, it spurred progress on digital and clinical partnerships, and work to address inequalities. In the community provider collaborative across the Sussex ICS, work on the vaccination programme consolidated relationships across primary, secondary and social care, fostering a common purpose for delivery. And in the West Yorkshire and Harrogate Mental Health,

Learning Disability and Autism Services Collaborative, the pandemic provided a powerful stimulus for organisations to share and learn from each others' approaches to improve services for patients in their care.

Another key ingredient for successful provider collaboration is an unrelenting focus on a shared vision, with organisations working in a way that is right for their local patients and populations. Provider collaboration leaders in the Somerset ICS describe how coming together has allowed them to plan and move resources into prevention and early intervention services. And in the Bradford and Craven ICP, the *Act as One* programme has delivered better joined up care, with a more collegiate approach to population health exemplified by work "across the continuum of care" to improve outcomes in maternity services.

One of the features of provider collaboration is the way in which it has brought together different parts of the provider sector: hospitals, mental health, community and ambulance trusts, along with other partners to deliver better care, closer to home, for patients and populations. They bring their own pressures, priorities and expertise to these collaborations, as evidenced by these case studies. The ambulance perspectives – as seen here from West Midlands and Yorkshire – highlight the challenges of working across multiple footprints, including at region, ICS, place and neighbourhood levels. The West Midlands example highlights the opportunities for population health management and reducing health inequalities, acting as an integrator across the system. The Yorkshire case study also points to the way collaboration has helped to focus attention on the inequalities agenda.

Provider collaboration – in its many manifestations – is driving integration and delivering benefits for patients. But as we have seen, it requires commitment, strong leadership and a clear shared vision. It takes time and patience to build the right relationships, to develop and embed collaborative ways of working, and deliver improvements. Glen Burley, chief executive of the Foundation Group of South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust and George Eliot Hospital NHS Trust, has this advice for those looking to move to more collaborative ways of working, "Don't try and design an end game situation, because everything keeps changing. The key enabler is to focus on incremental improvements."

So what needs to happen now? It is clear that providers want a flexible and enabling national policy and legislative framework that will build on, rather than disrupt, existing arrangements, while providing clarity on how accountabilities will sit alongside those of the statutory ICS, and trusts and foundation trusts. The recent White Paper indicated that decision-making would be devolved increasingly to provider collaboratives and place-based partnerships, but the timing and nature of this needs to be worked out locally. For providers to come together as collaboratives and partnerships, acting as the engine room of transformation within ICSs in the way envisaged, they will need to be appropriately resourced.

They will also require ongoing support to share best practice and learning from peers. For this they can count on NHS Providers to play its full part as its provider collaboratives support programme takes shape in the coming months.

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Interactive version

This report is also available in a digitally interactive format at:
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PROVIDERS DELIVER

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NHSProviders

One Birdcage Walk, London SW1H 9JJ
020 7304 6977
enquiries@nhsproviders.org
www.nhsproviders.org
@NHSProviders