Trusts IN SYSTEMS

PROVIDER COLLABORATION

Realising the benefits of provider collaboratives

NHS Providers

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PROVIDER

COLLABORATION

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REALISING THE BENEFITS OF PROVIDER COLLABORATIVES

CONTENTS

KEY MESSAGES

- Trust leaders see significant opportunities in working collaboratively to benefit patients and service users. They know that no single organisation can tackle the systemic challenges facing the health and care sector alone and want to build on the success of collaboration during the COVID-19 response to deliver high quality, joined up and more efficient care for local communities.
- Trusts and their system partners have been developing these collaborative ways of working for several years. However, national policy has only recently formalised them in the Health and Care Act 2022 and guidance, including on provider collaboratives and place-based partnerships.
- Trust leaders welcome the permissive national policy framework which enables them to develop collaborative arrangements based on their local contexts. This flexibility means that provider collaboratives vary in their purpose, membership, model and role within their system(s). As we recently highlighted in our report on **place-based partnerships**, there is no one-size-fits-all model for collaborative arrangements, and form must follow function.
- NHS England has identified several potential benefits of provider collaboration, including reducing unwarranted variation in outcomes and access, maximising economies of scale, and improving recruitment and retention of staff. In this briefing we illustrate how trusts plan to realise these benefits and summarise the different opportunities for acute, community, mental health, specialised and ambulance trusts.
- Many of the ambitions and priorities of integrated care systems (ICSs) will be delivered through trusts collaborating with each other and wider partners. In many systems, provider collaboratives – alongside place-based partnerships – will play a key role in leading service and pathway improvements, recovering backlogs of care, and delivering **NHS long-term plan** objectives and system-wide clinical strategies.
- Over time, integrated care board (ICB) budgets and functions could be delegated to provider collaboratives, with some already seeing potential to take on traditional commissioning functions, including redesigning services and allocating funding. Provider collaboratives will also help bring together and amplify the voice of providers in ICBs and integrated care partnerships (ICPs).
- Trust leaders have identified several key enablers that support provider collaboration at different stages of development. These include the importance of building trust between partner organisations, focusing on shared priorities and functions rather than models and form, and ensuring changes are led by clinicians and driven by realising benefits for local communities.
- The novel, complex nature of provider collaborative arrangements also creates risks for trust boards to manage. These include ensuring trust strategies align with those of provider collaboratives, ICB, ICP and places; avoiding recreating siloes and reinforcing a provider/commissioner dynamic; and understanding how collaborative arrangements could be assessed and how that will interact with trust boards' ongoing duties and liabilities. NHS Providers will continue to support trust boards to effectively manage these risks and realise the benefits of provider collaboration at scale through **our support offer**.

1 INTRODUCTION

The health and care system in England continues to grapple with significant challenges, including chronic staff shortages, constrained financial resources and insufficient capacity to meet growing demand. Trust leaders and national policymakers recognise that providers cannot tackle these systemic challenges alone. Provider collaboration has therefore risen up the national policy agenda, in part to capture the benefits seen when trusts and wider partners worked together in response to the COVID-19 pandemic.

Greater collaboration between NHS organisations is enshrined in the Health and Care Act 2022 (the Act), which placed ICSs on a statutory footing in July 2022. Trusts will play a critical role in delivering the key purposes of ICSs,[1] often through partnership arrangements that will act as delivery vehicles within ICSs including provider collaboratives, place-based partnerships and neighbourhood multi-disciplinary teams.

In this briefing, we:

- provide a brief overview of how provider collaboratives are developing across England
- illustrate some of the emerging benefits that collaboratives are working to realise
- explore how trust leaders see the role of provider collaboratives developing within ICSs
- identify some key enablers and risks trust boards need to consider.

To inform this briefing, we have drawn on insights collected through our regular engagement with trust leaders, our member support offer on provider collaboration (which includes a regular webinar series sharing collaboratives' progress and peer learning forums), and ongoing influencing work to shape the development and implementation of national policy.

What are provider collaboratives?

NHS England **defines provider collaboratives** as partnership arrangements that bring together two or more trusts to maximise economies of scale and improve care for their local populations. NHS England has required all trusts providing acute and/or mental health services, including specialist trusts, to join at least one provider collaborative from July 2022. Community trusts, ambulance trusts and non-NHS providers, such as voluntary sector organisations and social enterprises, are expected to participate in provider collaboratives where it makes sense locally and we know that many are actively exploring these opportunities. In this briefing, we also explore how some collaboratives are looking beyond the provider sector and including planning bodies like ICBs in their membership.

1 National guidance states that ICSs' four key purposes are to: 1) improve health and care outcomes; 2) tackle inequalities in outcomes, experience and access; 3) boost productivity and value for money; and 4) support broader social and economic development.

Place-based collaboration

Alongside working in provider collaboratives, trusts are collaborating across smaller footprints within systems known as 'places', which often align with local authority boundaries or patient flows into hospital services. You can read our recent place case study briefing **here**, in which we set out how place-based partnerships are developing and the role trusts are playing in them.

Place-based partnerships bring together a range of organisations to improve and integrate care for communities at a more local level. Place-based partnerships can include trusts, commissioners, local authorities, primary care services, voluntary and community sector organisations, local residents and service users, and wider partners such as housing or education providers. Some trusts are also exploring new ways of working with primary and/or social care, such as developing new integrated delivery models which present opportunities to join up care (and bring some challenges).

Although not the main focus of this piece, trusts and their partners will need to work out how place and provider collaborative arrangements interface, especially given that ICBs will be able to delegate functions and budgets to both types of partnership arrangement. Provider collaboratives will need to both agree objectives with ICBs and align priorities with place-based partnerships, as well as develop a shared understanding of their respective roles.

How has provider collaboration developed?

Provider collaboration has been developing organically for many years, with trusts choosing to work together to address common problems. These collaborations have focused on various locally defined priorities, including:

- delivering shared clinical support services such as pathology
- making efficiency savings through joint procurement
- improving clinical quality and patient safety
- reducing unwarranted variation in quality and access
- improving resilience by consolidating clinical services.

National policy has also facilitated particular types of provider collaboration over the years, with mental health collaboratives now further ahead in exploring the benefits of taking responsibility for devolved specialised commissioning budgets. As provider collaboratives become more developed, we would expect to see a growing **evidence base** underpinning the different types of arrangements.

The response to COVID-19

Trusts have looked to build on the experience of the COVID-19 pandemic which united the health and care system against a common challenge and accelerated collaboration substantially. Mutual aid became widespread, with trusts sharing staff, capacity, equipment and other resources with each other and wider partners in primary and social care. The pandemic also shone a spotlight on – and exacerbated – stark health inequalities in England that long predated COVID-19. Trusts and their partners want to build on the lessons learned from the pandemic, such as the experience of delivering the COVID-19 vaccination campaign through an outreach model, which have opened up new ways of working with partners better able to reduce the impact of inequalities.

What does national policy and guidance say on provider collaboratives?

National guidance from NHS England (August 2021) sets out some minimum expectations for provider collaboratives but leaves scope for trusts to agree areas of focus and priorities for collaboration at scale, so it is likely that the roles and functions of provider collaboratives will vary between systems. Trust leaders welcome this permissive national framework, enabling them to develop collaboration based on local contexts, priorities and needs.

In addition to the original guidance on provider collaboratives, NHS England has published a supplementary **toolkit** which provides further support on setting up collaboratives, including potential governance models. It also points towards the new opportunities afforded to trusts by the Act to work together in joint committees and take on delegated budgets and functions from ICBs.

NHS Providers support offer on provider collaboration

Our Provider Collaboration programme focuses on sharing good practice through a range of events, peer learning forums and resources for boards. It covers the full spectrum of collaborative arrangements that providers are forging at scale and aims to support members to maximise the potential of greater provider collaboration to tackle care backlogs, reduce unwarranted variation, address health inequalities, and deliver more efficient and sustainable services.

Visit **nhsproviders.org/provider-collaboratives** for recordings of our webinars, blogs on provider collaboration, details of our forthcoming events and further resources. To find out more, contact Bobby Ancil, programme development manager (provider collaboration), **bobby.ancil@nhsproviders.org**

HOW ARE PROVIDER COLLABORATIVES BEING SET UP AND RESOURCED?

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Provider collaboratives are developing across the country. While some have existed for several years in a range of formal and informal arrangements, others have formed recently in the context of the national policy direction and the experience of mutual aid during the pandemic. Whether establishing new collaborative arrangements or evolving existing ones, trusts have needed to address some common tasks associated with developing and progressing a joint programme of work, including establishing their membership, scope and priorities; agreeing ways of working; and setting up governance and decision-making arrangements. Here we briefly outline some of the approaches that collaboratives are taking and illustrate some of the main ways they differ.

Membership and footprints

Some collaboratives bring together a group of trusts of the same sector. Examples of this approach include the Acute Hospitals Alliance (AHA), made up of the three acute trusts operating across the Bath and North East Somerset, Swindon and Wiltshire ICS. There are also well established collaboratives in mental health and learning disability services – for instance, the South London Mental Health and Community Partnership has supported collaboration between three mental health trusts in south London since it was established in 2016.

Other provider collaboratives bring together all the trusts within an ICS footprint – for instance North Central London ICS has an 'all in' collaborative, known as a provider alliance or the 'UCL Health Alliance'. Some at scale collaboratives have memberships which reach beyond the statutory trust sector, for instance including voluntary sector providers and social enterprises as formal delivery partners. An example is the West Yorkshire community provider collaborative, which includes Leeds Community Healthcare NHS Trust and two community interest companies: Locala Health & Wellbeing and Spectrum Community Health.

In some systems, collaboratives – particularly NHS-led mental health provider collaboratives – have a wider membership beyond the provider sector, including commissioning/planning bodies (such as ICBs) and they are starting to move away from the provider collaborative terminology to reflect this. For example, Northamptonshire ICS is working through four collaboratives, each of which has a thematic focus either on a cohort of service users (e.g. children and young people) or a group of services (e.g. mental health, learning disability and autism). Provider collaboratives are also looking to develop relationships with wider system partners, including local authorities, primary care and place-based partnerships, to ensure priorities and delivery are aligned, and developed with people and communities.

There are some collaboratives which span several ICSs or regions. Some of these focus on services which benefit from being planned on larger footprints and delivered to larger populations, such as specialised services and ambulance care. For example, the East of England specialised services provider collaborative spans six ICSs and includes seven acute and specialist trusts across the region. Provider collaboratives will also need to work closely with ICS- and multi-ICS level clinical networks, building on established relationships and forums to develop clinical strategies and support service redesign and improvement.

Collaborative form or model

There is flexibility in the national policy framework for trusts to develop collaborative arrangements that make sense in their local context, and as a result collaboratives vary in the form they take. Trust leaders have been concentrating on shared priorities, which will then shape the structural and governance arrangements underpinning the collaborative.

National guidance highlights three main governance models for collaboratives:

- **Lead provider**. This model involves a single trust holding a contract with a commissioner and sub-contracting with other trusts in the collaborative to coordinate service delivery and improvement. In some cases, a lead provider may use its existing governance arrangements to support decision-making within a collaborative. For example, Devon Partnership NHS Trust is the lead provider for the South West Provider Collaborative, a mental health partnership including several trusts, independent sector partners and community interest companies to improve specialised mental health care.
- **Shared leadership**. This model involves multiple trusts appointing a single person (or group of people) to fulfil key leadership roles across the collaborative – particularly the chief executive role – while maintaining specific leadership capabilities for each member trust within the group. This approach is used in the **Foundation Group** in the West Midlands where three trusts – South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust, and George Elliot Hospitals NHS Trust – operate with a shared chief executive and chair and have a committee in common governance arrangement.
- **Provider leadership board**. This model involves senior leaders from participating trusts establishing a joint forum to shape a collaborative agenda. The joint forum may operate with delegated authority to take decisions for the member trusts. West Yorkshire Association of Acute Trusts is an example of a collaborative operating in this way.

These three models are not mutually exclusive; a trust could be part of more than one provider collaborative arrangement each with different priorities or delivering its own programmes. Additionally, some trusts are deepening their collaboration through other approaches based on what makes sense in their local geographies. For instance, in Somerset ICS the trusts have opted to pursue a full merger to maximise opportunities to bring their services and capabilities together.

Looking ahead, the ambition is for provider collaboratives to play a central role in delivering service change and improvement within ICSs. National bodies have suggested that to play this role, it will be important for collaboratives to have certain capabilities. For example, the Act enables collaboratives to take on functions and budgets from ICBs via delegation, where appropriate (although NHSE does not expect ICBs to implement delegations in 2022/23). The Act also allows trusts to come together via a joint committee to make legally binding decisions which some provider collaboratives are considering adopting. We understand that NHSE plans to set out some more information on how provider collaboratives could relate to ICBs in the future, including via delegations.

Resources

There is no additional funding from national bodies to set up and run provider collaboratives, so trusts have drawn on existing budgets, clinical staff and leadership teams to resource their establishment and programmes, in some instances seconding staff to do the 'set up' or sharing the costs of a shared programme management or director role to oversee the development of a collaborative. In some systems this involves establishing a programme management function to provide operational support to senior leaders and coordinate joint activities. The scale of programme management functions depends on the ambitions of the collaborative, with some using only a small number of staff and others creating substantial teams.

WHAT ARE PROVIDER COLLABORATIVES AIMING TO ACHIEVE?

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As part of this drive towards greater collaboration, NHS England guidance identifies a number of key benefits of working at scale. Over the last year, our provider collaboration support programme has shared examples of how provider collaboratives are committed to working together to realise these benefits and maximise the opportunities of closer partnerships across a single or multiple ICS footprint. A selection of these illustrative examples of their work in progress is set out below.

Reductions in unwarranted variation in outcomes and access to services

Many provider collaboratives aim to improve quality of care and access by standardising service offers. By collaborating across a wider footprint, trusts can pool their insight and data on local populations, develop a common improvement methodology and build on national programmes like *Getting it right first time* (GIRFT) to address unwarranted variation.

University Hospitals of Northamptonshire NHS Group

The **University Hospitals of Northamptonshire NHS Group** was formed in 2021, bringing together two acute trusts: Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust. They have a shared leadership model, with a joint chief executive and chair, and have brought together corporate functions to support clinical collaboration.

The group has an agreed clinical strategy which includes creating centres of excellence for cardiology at Kettering General Hospital and cancer at Northampton General Hospital. Their ambition is to transform cancer and cardiac services, and improve surgical outcomes, by bringing together best practice from across the two hospitals, with plans for specialist treatment hubs, single integrated advanced diagnostic services, joint multi-disciplinary teams and investing in new technology to establish single shared patient records.

There are wider plans to consolidate elective services based on this centre of excellence model, including the two hospitals' elective care teams working as one to minimise unwarranted clinical variation and standardise best practice, such as by maximising day surgery and one stop pathways.

Reductions in health inequalities

Provider collaboratives have a key role to play in reducing deep-rooted health inequalities. This includes using population health data to segment waiting lists to prioritise treatment for those facing the most severe health inequalities, and ensuring more equitable access and provision is at the heart of plans to redesign care pathways and reconfigure services. We know from our provider collaboration support offer that a number of provider collaboratives are laying the groundwork for a concerted focus on health inequalities and are focusing particularly on how they share population health data and encourage providers to use it in the same way to generate a set of agreed priorities.

Over the coming months we will share examples of the impact that these initiatives are having through our **provider collaboration** and **health inequalities** support programmes.

Efficiencies and economies of scale

Collaborative working offers trusts the opportunity to maximise economies of scale and make the best use of collective resources across several providers. These efficiencies can be released in different ways, including by consolidating corporate support functions or undertaking joint procurement to leverage the benefits of collective purchasing power.

The Acute Hospitals Alliance in Bath and North East Somerset, Swindon and Wiltshire ICS

The **Acute Hospitals Alliance** was formed in 2018, bringing together three acute trusts: Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust, and Royal United Hospitals Bath NHS Foundation Trust.

Greater collaboration during the pandemic catalysed a focus on sharing back-office functions, which will support the sustainability of services. The trusts now have one shared procurement team which has established joint contracts for specific medical devices and clinical consumables. This has several benefits, including making supply lines more resilient, and saving money. It proved extremely beneficial during the early stages of the pandemic when PPE availability was very challenging and is expected to save £4.6m in 2022-23 and £4.9m in 2023-24.

Consolidation of specialised services

Providers are hopeful that they can improve outcomes by agreeing how and where to consolidate low-volume or specialised services. Delivering services across fewer sites can also enable providers to improve clinical care and make best use of limited staff resources.

South London Mental Health and Community Partnership

The South London Mental Health and Community Partnership was formed in 2016, bringing together three mental health trusts: Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust. In 2017 the collaborative introduced a new pathway for forensic care including all medium secure, low secure and community outreach services across south London. Key aspects of the model include a commissioning hub to manage contracts across the network, a single point of access for service users, and a shared capacity strategy and quality improvement programme.

There has been a 36% reduction in out of area patients and a 66% reduction in readmissions since the new pathway was implemented. This has saved money which the collaborative has been able to reinvest in expanding its community services and creating additional adult low secure inpatient beds.

Separately, the collaborative now manages children and young people's mental health beds in a centralised way across the three trusts. By managing referrals and monitoring occupancy across the system, the collaborative has seen a 32% reduction in the number of children and young people accessing mental health beds, and a 93% reduction in out of area bed use, with an **average distance from home falling from 73 to seven miles** for inpatients since the collaborative was established.

Greater resilience across systems and better management of system-wide capacity pressures

Trusts can help each other to stabilise services and manage capacity across a wider footprint than that served by their organisation. This might include trusts collaborating to tackle waiting lists across the system or enabling staff to work more flexibly across trusts through aligned contracts, processes and staff passporting arrangements.

Black Country Provider Collaborative

The Black Country Provider Collaborative was formed in 2020, bringing together four acute trusts: Sandwell and West Birmingham NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. Their initial focus was to **deliver some priority services through clinical networks** using a hub and spoke model.

A lead orthopaedic surgeon was appointed from Dudley Group NHS Foundation Trust to bring together the orthopaedic teams from each provider to review their orthopaedic provision. The clinicians decided to create two elective hubs for the system (north and south) to deliver almost all the elective orthopaedic activity across the Black Country to make better use of existing capacity so they can tackle their elective backlog more quickly.

There are long waiting lists for breast cancer services across the Black Country. A newly appointed clinical lead is developing a model with two centres providing oncoplastic reconstructive surgery services and two other sites providing more routine services. Using one site for lower volume specialised services and the other sites for higher volume, more routine care will enable the trusts to tackle backlogs quicker. The trusts expect that this network approach will also help attract the additional specialists and trainees they need to stabilise these services.

Better recruitment, retention and development of staff

Collaborative working at scale can help providers tackle pressing workforce challenges, with joint initiatives to improve staff recruitment and retention such as shared training opportunities, leadership development programmes and additional support for staff health and wellbeing.

Humber and North Yorkshire Mental Health, Learning Disability and Autism Collaborative

The Humber and North Yorkshire Mental Health, Learning Disability and Autism Collaborative was formally established in 2021 (having operated informally for several years prior) bringing together a range of NHS, independent sector and social care enterprise care providers, with Humber Teaching NHS Foundation Trust as the lead provider for commissioning specialised services.

The **Humber and North Yorkshire resilience hub** was set up in response to the COVID-19 pandemic to support health and care staff across the members of the collaborative. The hub was launched in February 2021 and has supported more than 2,000 staff to date. It provides a range of services, including support for staff experiencing long COVID. The outcomes have been very positive, with excellent feedback from service users: 99% say they are satisfied or very satisfied with the service they have received. This hub model has now been widely shared, including through the national learning community for staff mental health and wellbeing hubs.

WHAT ARE THE OPPORTUNITIES OF COLLABORATION FOR DIFFERENT TRUST TYPES?

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Building on the nationally identified benefits of provider collaboration at scale, trusts of all sectors see opportunities in this way of working and are involved in multiple collaborative arrangements of different types – some horizontal and others vertical – at place, ICS and multi-ICS level. Consequently, the blend of opportunities that collaboratives can seek to realise will depend on the local context.

In this section we highlight trust leaders' experience of collaboration at scale depending on their sector and draw out some – although far from all – of the opportunities for each sector, based on trust leaders' views. We also share trust leaders' reflections on what this suggests about the roles that provider collaboratives will play in the future NHS operating model as statutory ICSs become embedded.

Mental health providers

For several years, mental health trusts have been working collaboratively to redesign care pathways and improve services. NHS England's New Care Models programme, established in 2015, brought mental health and learning disability trusts together with wider partners, often using a lead provider model, to improve care for local communities. These arrangements evolved in April 2020 into NHS-led provider collaboratives for specialised mental health, learning disability and autism services, which aimed to provide **specialist care in the community** and reduce the length of stay in inpatient settings where appropriate. These collaboratives took on responsibility for some specialised budgets and have been able to realise benefits, such as the **West Yorkshire and Harrogate mental health provider collaborative** reducing length of stay in specialised inpatient care (prior to COVID-19).

The mental health sector therefore has expertise and experience in implementing a collaborative approach, and now aims to build on this to improve outcomes and standardise care; reduce health inequalities; improve use of capacity across providers; reinvest efficiency savings into community services; and shift to a population perspective when designing services. Mental health provider collaboratives will also have an important role to play in ensuring mental health is embedded as a priority in system decision-making.

Some more established mental health collaboratives have already expanded their membership across a wider range of organisations, while others are looking beyond service delivery and considering how they can consolidate back-office functions and provide collective staff training programmes. For example, the **South London Mental Health and Community Partnership** has taken this collective approach to retention, and its nursing development programme has resulted in a 5% increase in nurse retention rates.

Acute providers

As the national policy direction has shifted away from competition to collaboration, acute trusts have increasingly sought to work more closely together to improve care for local populations. While some acute provider collaboratives were well established prior to COVID-19, and have developed robust collective decision-making arrangements, others have evolved through the major incident response structures that brought trust leadership teams together locally during the pandemic. Their aims tend to centre on planning services at population rather than organisational level to deliver better integrated, high quality and more cost-effective care for patients.

Acute trust leaders tell us they see a clear opportunity to take a system-wide approach to sharing best practice and driving improvements in quality of care and access. As explored earlier, clinicians are working together to develop shared clinical strategies with an emphasis on improvement and standardisation, while some acute collaboratives are already delivering specific priorities for the ICS. Many acute provider collaboratives are also considering how to improve equity of access to timely, high-quality services for their whole population.

Trusts are building on each other's capabilities, understanding that, by playing to each other's strengths and working at scale, they are better able to deliver tangible improvements in efficiency, safety and quality for patients.

Specialist providers

For specialist trusts and providers delivering cutting-edge specialised services to often relatively small numbers of patients across large geographic footprints, collaboration offers a number of opportunities.

Firstly, there is an opportunity to create communities of clinicians operating in individual trusts and support them to share practice in a systematic way that drives up standards and quality of care and foster a professional environment which supports clinical research and innovation.

Secondly, there is potential to explore new approaches to deploying highly skilled staff across larger geographies, thereby improving patients' access to specialist care.

Thirdly, the **planned delegation** of much of specialised commissioning to ICBs, expected to take place from April 2023 onwards, will initiate localised decisions about how substantial specialised services funds are used. Bringing together trusts delivering specialised services could support a collective discussion of needs and priorities, alongside ICBs, including how best to allocate specialised services funding in light of local needs and service capabilities.

Finally, there is scope for collaboratives focused on specialised services to take on a more strategic leadership role, similar to that of NHS-led mental health provider collaboratives,

redesigning clinical services, transforming whole pathways of care, and driving education and research across regional footprints, and potentially taking on some functions which previously sat within commissioning organisations.

Community providers

Although national policy only mandates acute, specialist and/or mental health trusts must be part of a provider collaborative, community provider leaders see similar opportunities to deliver economies of scale and standardise services and pathways. For example, provider collaboratives could have a key role in **tackling community care backlogs** of over one million patients and working with social care partners to address delayed discharges. Collaboration between community providers has therefore been developing with similar aims to other sectors; to reduce unwarranted variation across services, share best clinical practice and support transformation of services. In many areas, a patchwork of service offers exists, and collaboration at scale presents an opportunity to address the variation in community service provision that can result.

As well as collaborating horizontally, community providers also have a significant role to play in vertical collaboratives with wider system partners across primary care, acute and mental health. Some ICSs, such as **Sussex ICS**, are setting up community and primary care collaboratives at system level to provide a coherent voice for 'care in the community' and ensuring services are sufficiently prioritised in planning and funding discussions. During the pandemic, some systems consolidated relationships across primary, secondary and social care to work on the vaccination programme, fostering a common purpose for delivery. These relationships have continued to build as the community sector supports the system in recovering from the pandemic.

Community providers' involvement in these different types of collaboratives also speaks to their importance in delivering the strategic ambitions of the *NHS long-term plan* at all levels of the ICS as well as how they can act as an interface between at scale and place-based collaboration. Community provider collaboratives are often leading on the delivery of the **Ageing Well programme** across the system, including the two-hour urgent crisis response and programmes related to hospital discharges.

Ambulance providers

Ambulance trusts already operate across several ICS footprints, giving them a unique region-spanning viewpoint. Ambulance trusts are well placed to participate in, and lead, some provider collaborative programmes where it makes sense to do so, such as reducing unwarranted variation in access and quality. In particular, in the urgent and emergency care pathway there are potential improvements which will provide a more integrated experience for patients, which will require collaboration between acute, ambulance and community trusts as well as wider system partners such as social and primary care. For example, **Yorkshire Ambulance Service NHS Trust** is working as part of the Northern Ambulance

Alliance to embed integrated leadership teams within all three ICSs it works across to ensure there is shared knowledge about 999, 111 and other urgency and emergency care protocols.

National guidance suggests that ambulance trusts have a role to play in provider collaboratives because of their rich knowledge of local populations, and their experience of working closely with partners. Trust leaders are keen to realise the full value of their contribution in facilitating integrated provision across services and population health management. **West Midlands Ambulance Service University NHS Foundation Trust** is looking to realise the benefits of sharing population health data with partner trusts to help prevent patients needing to be admitted to hospital.

Emerging and developing roles of provider collaboratives in systems

National policy has positioned provider collaboratives as central to delivering the aims of ICSs, while leaving scope for trusts and their system partners to define what this means in practice. Looking across the experiences of trust leaders developing collaboratives – and recognising that the roles of provider collaboratives in ICSs are still emerging – trust leaders see provider collaboratives playing an integral part in the future NHS operating model:

- delivering key system priorities, including the forward-looking objectives outlined in the *NHS long-term plan* (to be refreshed in autumn 2022) and short-term deliverables set out in regular operational planning guidance, as well as contributing to the broader set of objectives focused on improving population health, addressing health inequalities and promoting social and economic development
- providing functions that merit being done once across the ICS, such as leading on digital and data infrastructure, or standardising outcomes/processes which can support local delivery approaches
- amplifying the voice of different parts of the provider sector within ICSs to influence system decision-making – this is potentially particularly important for mental health and community trusts, whose priorities will need to be strongly expressed at ICS level
- taking on traditional commissioning functions, such as service planning, improvement and redesign, service monitoring and some resource allocation decisions, to improve outcomes for local communities – provider collaborative arrangements will likely need to evolve over time to enable them to take on more responsibilities.

Finally, the Act facilitates provider collaboratives to take on more formal responsibilities from ICBs, including budgets and functions, via delegation agreements – further recasting the traditional provider/commissioner dynamic. Work to move in this direction is at a relatively early stage, with implementation to begin in 2023/24. Trusts want to explore how collaboratives could evolve, in many cases, from operating through informal arrangements and delivering collaborative programmes of work into more formal entities holding and allocating NHS funding to improve care for communities.

WHAT ARE THE KEY ENABLERS FOR PROVIDER COLLABORATIVES?

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Trust leaders have identified several key enablers that support provider collaboration at different stages of development.

Modelling collaborative leadership behaviours

The role of trust leadership teams is vital in embedding a culture of collaboration. Their contribution should be maximised within provider collaborative governance arrangements, while taking into account their limited capacity. Trust leaders need to bring their organisations and staff along with them by modelling new ways of working from the top.

"The commitment of the organisations to work together have been liberating for clinicians. Getting out and meeting people to discuss clinical services, identify where the challenges are and to then look at ways to develop solutions has been overwhelmingly rewarding."

Dr Jonathan Odum, chief medical officer, Royal Wolverhampton NHS Trust

Aligning around shared ambitions

Investing time at the outset to develop a shared purpose is essential. Trust leaders tell us that engaging with clinicians and service users to co-produce the collaborative's priorities is valuable. Working closely with wider partners such as local authorities is also key to success. These discussions will ideally be anchored in the health needs, strengths and aspirations of local communities, and will be convened to empower participants with strategic influence.

"Agreeing a purpose early on and our shared ambitions is probably one of the most important things we did. "

Siobhan Melia, interim chief executive, South East Coast Ambulance Service NHS Foundation Trust (on secondment from her role as chief executive, Sussex Community NHS Foundation Trust)

Building trust

It is essential to build and retain trust at board level across the organisations involved in the provider collaborative. Understanding the history of partner organisations and their previous relationships can help to unlock more collaborative ways of working. Being open about organisational 'red lines' and having 'open book' finances are key. Service users and staff need to be assured of trust boards' commitment and intentions. Bringing people together at conferences and meetings helps develop buy-in and strengthen a culture of collaboration and co-production.

"It feels like there is an opportunity for provider collaboratives to do more and we at WYAAT are keen to take on more programmes of work… I think that a lot of the energy and commitment comes from the sense that we are entering into this in a voluntary way and we all want it to work."

Julian Hartley, chief executive, Leeds Teaching Hospitals NHS Trust

Clinical leadership

Clinical leadership should be at the heart of provider collaboration, with improving services and outcomes for local populations as the driving force behind the collaborative's programmes. Early engagement is vital to securing buy-in from clinicians who will lead much of the service improvement and redesign work.

"Clinical summits have played a big part in getting people to buy into working differently, as has working through lots of the old challenges through mutual aid. Working collaboratively gets you much further, much faster, and it's much more pleasant than competing with each other."

Diane Wake, chief executive, The Dudley Group NHS Foundation Trust

Ensuring form follows function

Progress is enabled by remaining focused on the purpose and aims of collaboration. Discussions about the form or model of the collaborative should flow from a clear articulation of strategic direction. Trust leaders say a lean management approach can evolve iteratively as the potential of the collaborative develops.

"The experience of developing the provider collaborative has felt like being on a water slide, going at varying speeds, fast and smooth, bumpy and scary... but people are glad we are where we are now."

Alan Burns, chair, Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust

Building capacity

Committing and mobilising sufficient capacity to develop and deliver the collaborative's work programmes is critical, including the roles of programme directors and programme management offices. Many collaborative arrangements rely on the input of senior executives and board members; there needs to be sufficient support, delivery, and organisational development capacity in place to move programmes forward.

"It's really helped that we started small with high-risk and high-cost patients and built out from there. We're now keen to engage with other collaboratives to avoid the risk of developing sector siloes."

Melanie Walker, chief executive, Devon Partnership NHS Trust

Supporting staff through change

Successfully embedding provider collaboration involves paying attention to the human and emotional factors that can accompany change, including fear and resistance. If collaboration may lead to exploring major service changes, such as consolidation of services across sites, leaders need to give careful thought to how communities and staff will be involved in co-designing and implementing those changes.

"Getting clinicians and service users together to look at the outcome data to see where there is variability across the patch or where outcomes are below the national average is a great way to galvanise support around improving a service collaboratively."

Melanie Walker, chief executive, Devon Partnership NHS Trust

WHAT ARE THE EMERGING RISKS FOR BOARDS TO MANAGE?

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Provider collaboration offers a range of opportunities to improve care and make better use of resources. But – like any change programme – as the ambition and depth of trusts' collaborative arrangements grow and statutory ICSs develop their ways of working, there will be risks for trust boards to identify and manage appropriately.

Complexity of collaborative arrangements within systems

Trusts in systems are likely to have multiple collaborative arrangements with other trusts and wider partners, which will perform different functions and operate over a range of geographic footprints including place, neighbourhood, ICS and multi-ICS levels. Many trusts will also be part of pre-existing multi-agency collaborations like cancer alliances and other networks, at the same time as also developing collaborations with wider partners such as local primary care services in their place(s). National policy has rightly left scope for ICSs to develop these arrangements based on local needs. However, the complexity and variety of different partnership models within any single system could make aligning priorities in each tier challenging. For trusts and collaboratives operating across multiple systems – and in some cases spanning a boundary between NHSE regions – this potential complexity is magnified. Without thoughtful coordination across collaborative vehicles, there may be a risk that trusts are asked to respond to multiple misaligned priorities that make incoherent asks of their leadership teams, clinical services and operational teams.

Recreating a commissioner/provider split

For several years, a national policy focus on collaboration and integration has seen local commissioners and providers increasingly working together across organisational boundaries – gradually blurring traditional notions of functionally separate commissioners and providers – and using their capabilities to collectively plan and improve care. Some stakeholders highlight a risk that the creation of sector-specific provider collaboratives could reverse this development and less collaborative, transactional relationships could re-emerge between trusts and commissioners. Leaders' behaviours and mindsets, and the extent to which they maintain a population and system focus when working through collaboratives, will be key in mitigating this risk.

It is also worth noting that provider collaboratives are a varied set of arrangements with some collaboratives, for example some mental health collaboratives, embedding ICBs within their membership and collectively delivering commissioning functions and provision. Some trusts also highlight a need for integration with primary care colleagues, and with social care, which the current national policy focus on provider collaboratives does not seem to facilitate.

Finally, while providers remain keen to work with ICB colleagues to ensure that functions and funding is delegated appropriately to provider collaboratives, this is a complex change programme in itself requiring risk management. Provider collaboratives, and the boards of

their component providers, will wish to assure themselves that appropriate resource (and in some instances commissioning expertise) is being delegated along with the functions they agree to lead on behalf of their populations.

Misaligned oversight arrangements and regulatory frameworks

Trusts retain all their statutory duties and liabilities under the Health and Care Act 2022. The development of provider collaboratives does not change this, but it raises new questions about how service performance and care quality can be effectively understood, assessed and overseen. In particular, the oversight mechanisms used by NHS England and the regulatory framework used by the Care Quality Commission (CQC) will require refinement. Both NHS England and the CQC are adapting their approaches to gather more nuanced insights into how effectively services are meeting people's needs. For trust boards, there are important questions about how collaborative arrangements will be assessed and how that will interact with boards' ongoing organisational accountabilities. Relatedly, trust boards want to understand how the regulatory framework can support trusts to fulfil the Triple Aim and take decisions in the best interests of the system and its population, even if there are potentially negative consequences for their organisation.

Supporting both high-performing and more challenged trusts

As the provider collaboration agenda develops, there are questions about the role of collaboratives in supporting more challenged trusts. Recent statements from political leaders, including Sajid Javid during his tenure as secretary of state for health and social care, emphasised collaboratives' capacity to help organisations encountering performance challenges. This builds on experience over the last decade, following the 2013 Keogh review into trusts with unusually high mortality rates, of 'buddying' challenged trusts with a high-performing peer to support learning and sharing of good practice. Trust boards may embrace driving up quality and access in their ICS(s) by supporting partner trusts. However, it will raise long-standing questions about how their organisational performance will be assessed and contextualised if, through a collaborative, they devote resources to supporting a struggling neighbour. The oversight and regulatory regime will need to support them to make these choices and have the necessary nuance to assess and recognise improvement where it occurs.

Risk management and oversight for trust boards

Trust boards play a vital role in the NHS, providing robust organisational governance and risk management. The development of system working – with trusts collaborating in multiple vehicles and potentially on multiple footprints – is raising new questions for boards

about how they can perform their functions and meet their statutory duties and liabilities effectively in this context. For NHS foundation trusts, there are some specific questions regarding how best to involve councils of governors.

Trust board members retain legal liability for decisions made by collaboratives and in turn need to maintain a line of sight to the collaborative(s) of which their trust is part. At the strategic level, trust boards will have a particular interest in some key dimensions of collaborative working – including how the provider collaborative's strategic priorities are developed; how decisions will be taken within collaborative arrangements; how joint programmes will be resourced; how any disagreements will be settled; and how ICS/collaborative risks will be identified, owned, monitored and managed. Based on conversations with trust company secretaries, we have developed a set of key questions for trust boards to consider in relation to collaboratives. These are intended to support with constructive challenge and meaningful oversight of collaborative arrangements (see box).

High-level questions for trust boards to consider when a trust is working as part of a provider collaborative(s)

- Is the strategic direction of the trust aligned to the collaborative strategy?
- Is the collaborative infrastructure appropriate and proportionate?
- Are collaborative arrangements appropriately resourced to deliver?
- Is there a mature (maturing) risk management system?
- What options will a trust have if serious performance challenges occur?

Without careful calibration of trust boards' involvement in, and oversight of, provider collaborative decision-making – including robust scrutiny and challenge from non-executive directors – there is a risk that boards' ability to effectively manage risk is eroded as the operating environment for trusts becomes more complex. This reinforces the need for trusts to identify and monitor these risks, and to ensure the governance arrangements they work through, to which trust boards are integral, are strengthened – and not eroded or confused – as statutory system working develops. Governance arrangements must also be proportionate and not unduly complex. Trust boards are adjusting their ways of working to strike a constructive balance in how they operate to support their trusts to realise opportunities stemming from provider collaboration, while also proactively managing the questions and risks which arise through emerging collaborative arrangements. NHS Providers will continue to support trust boards as they navigate this process and support them to share learning.

7 CONCLUSION

While many trusts have developed successful collaborative arrangements in recent years, the formalisation of provider collaboratives in national policy has cemented their importance alongside place-based partnerships as key delivery vehicles in the new context of system working. As statutory ICSs establish themselves and the role of provider collaboratives and place-based partnerships evolves, we urge the government and national NHS bodies to maintain the current flexible national policy framework.

There remain some unanswered questions and risks for trust boards to navigate when exploring the opportunities of collaboration at scale. Managing risk and performance in this new context, as well as deciding what responsibilities and functions ICBs might delegate where in the system, are important considerations for trust boards.

Trust leaders across all sectors – acute, mental health, specialist, community, and ambulance – have a range of views about the benefits that can be realised in their local contexts, but they share a common sense of opportunity to use this new policy framework to drive change and deliver benefits for local communities. They see potential to improve care and services through driving standardisation, addressing unwarranted variation, bolstering service resilience, identifying approaches to better support people experiencing inequalities, and developing innovative ways of working with other local partners such as social care providers and primary care services. Some collaboratives are also exploring how they could, in time, take on a more formalised role within statutory ICSs and lead on transformational change, allocating budgets, planning services and redesigning pathways.

NHS Providers will continue to **support the NHS provider sector** to share learning about realising the benefits and managing the risks of greater collaboration.

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Trusts IN SYSTEMS

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

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