Provider Collaboration: Governing provider collaboratives: Joint committees, decision-making and testing models

This briefing covers the key messages from our webinar on provider collaboration and governing provider collaboratives, featuring two provider collaborative case studies: the North East London Mental Health Learning Disability and Autism Provider Collaborative and the West Yorkshire Association of Acute Trusts (WYAAT).

North East London Mental Health and Learning Disability and Autism Provider Collaborative

Selina Douglas, the executive director of partnerships at North East London NHS Foundation Trust and Carys Esseen, programme director and deputy director of integrated care at East London NHS Foundation Trust shared their experience and key learnings on the evolution of governance of the North East London mental health learning disability and autism provider collaborative.

Background

The North East London Mental Health, Learning Disability and Autism Provider Collaborative was launched in early 2022 and is a partnership between North East London Integrated Care Board (ICB), East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) and seven place-based partnerships.

They aim to be an inclusive collaborative and work closely with local faith-based organisations and people with lived experience in their community as they plan their work. The committee includes representatives from local authority, voluntary sector and four seats for people with lived experience of the services.

Presently, the collaborative is governed via a sub-committee of the ICB which is chaired by the joint chair of ELFT and NELFT, but over the past two years they have looked at a number of different governance models and they have now settled on a joint committee of ELFT, NELFT and NEL ICB (exercising S65Z5 of the new Act).

Why a joint committee?

- The collaborative leadership team believe that the joint committee represents the best option for ‘earned autonomy’ in that it can facilitate an incremental delegation of responsibilities and functions from each of the members’ boards and become the legal decision-making body for those functions.
- As the statutory responsibility for ICB functions remain with the ICB in a joint committee arrangement (although they will be jointly exercised with trusts), the risks predominantly lie with

the ICB rather than the providers, which the collaborative leadership believe is preferable in a formal provider collaborative like theirs when the relationships are still relatively new.
- The joint committee option also enables the NELFT and ELFT Boards to delegate functions of their own to the joint committee. This would enable all three statutory bodies to participate equally, share in risks together, and move towards a genuine joint exercise arrangement.
- The joint committee could also act as a prototype for enabling NELFT and ELFT to work together around an external delegation, and enable the creation of a pooled fund.
- It would also be possible for the ICB to withdraw from the joint committee at a future date when all parties are comfortable, leaving the providers to manage their joint committee – and an external delegation – themselves.

Key points of learning / challenges

- They are determined that they want the work of the collaborative to be transparent and for the public to be aware of what they are doing and deciding.
- With this in mind they believe that lived experience perspectives within their sub-committee are extremely valuable. However, they acknowledge that they have to be willing to fundamentally adapt the way they conduct business and offer a great deal of support to make this meaningful.
- Defining the delegation from each of the three statutory boards is contentious, particularly as the two providers are foundation trusts, but it has helped that the executives meet every week to work through the challenges.
- The collaborative's design intentionally seeks to integrate vertically into places as well as across the system to deliver things at scale. This does however mean that there is a great deal of complexity in this and risks making governance ambiguous.
- They feel that they have a firm foundation which has been helped by many senior leaders being in the system in a range of roles for some time.
- They have been exploring what assurance, performance management and programme oversight could look like once the delegations have been made – however, it's easier to define what you don't want it to be like than to design something new.

Key thoughts from speakers:

"Having the voice of service users and carers from across North East London has fundamentally challenged the collaborative's leadership committee to think, act and do business differently in a really positive way."

"The key ingredients to making the collaborative work have been getting service user voice heard, senior leadership buy in and hearing the voice of clinicians from across North East London."

"We want to be as open and transparent as we possibly can without turning into a committee of thousands."

West Yorkshire Association of Acute Trusts (WYAAT)

Lucy Cole, director for WYAAT discussed the evolution of the collaborative, their current governance framework and how and why their current decision-making model works for them.

Background

WYAAT has been established since 2016 and is made up of the following six acute trusts across West Yorkshire and Harrogate:

- Airedale NHS Foundation Trust
- Harrogate & District NHS Foundation Trust

- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Teaching NHS Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale & Huddersfield NHS Foundation Trust

WYAAT facilitates clinical and operational collaboration, transformation, and mutual aid across its six acute trusts and provides a forum for decision making for the system, including the planning and prioritisation of system investment.

The collaborative began with a small number of shared transformation programmes which initially brought people together and demonstrated the impact of collaboration. A larger piece of work around reconfiguration of vascular services was then initiated and began to move the collaborative forward, requiring mature discussions and decision making from the leadership across the organisations.

Covid-19 accelerated the evolution of the collaborative in 2020, and their existing collaborative structures supported them to work through the challenges of the pandemic, and they are now moving toward shared operational networks.

Why Committee in Common?

- A Committee in Common model has been in place since the collaborative's inception and is underpinned by a memorandum of understanding. This arrangement works for their current context and they are keen to ensure that they do not use resources to change what works well.
- The committee is made up of the chairs and chief executives of the six participating organisations and its role is to oversee and direct the collaborative work and support business cases, investments, and key decisions, however it is the trust boards that have the ultimate decision-making power.
- Retaining the sovereignty of each individual organisation has allowed the development of a sense of ownership within the trusts, as trust executives and non-executive directors (NEDs) are equally integral to the collaborative's decision-making.
- All papers and updates from the decision-making groups of the collaborative are shared with and discussed by trust boards on a monthly basis, which enables trusts to feel engaged with the collaborative and invested in its work.
- The assurance process ensures that business cases are thoroughly reviewed through the advisory groups (e.g., directors of finance, chief information officers, directors of strategy and operations, clinical reference group) before they reach the Committee in Common, and the trust boards.
- This process can be labour intensive, but it is effective in making sure that all business cases that reach the committee and ultimately the trusts' boards are successful in approval and implementation.
- Crucially, all of this work is underpinned by a shared vision and a common purpose. It is the long-standing relationships that have been built since the collaborative's inception in 2016 that allows this governance structure to work.

Key learnings around decision making and challenges

- It can be slow working through their current governance approach, but they feel that it is important to make sure that everyone is onboard and understands the work and reasoning of the collaborative. The relationships are being built as the process is worked through, and this can take time but is fundamental.
- Transparency around how and where decisions are being made is key. For significant decisions or large systems investments, there needs to be clarity around how the committee in common model

is playing into the existing decision-making structures of individual organisations as well as the ICB and its committees.

- This means there needs to be an awareness that where appropriate, the existing and successful infrastructure of the collaborative is being used only to support recommendations which can then be taken forward with the appropriate assurance into the broader system, where decisions may then formally be taken.
- They are still working through the risk management for the system and how and where this will be held and owned, and the governance arrangements may change as the impact of this comes to light.

Key thoughts from speakers:

"We are not an organisation; we are only what we do together. We are not doing things to the trusts; the trusts are WYAAT. Most importantly we are about peer support, we are not about performance management."

"All of the challenges we've had have been a learning point for success in the future, so whatever you set up in your local system, you will go through those challenges, and you need to go through them to get it right."

An introduction to upcoming publication: *Good governance in provider collaboration?*

Christian Dingwall and Carly Caton, partners at legal firm Browne Jacobson, gave a brief introduction to a publication being developed in partnership with NHS Providers on governing provider collaboratives, and what the publication will cover. The publication aims to bring together information and advice on collaborative governance to help simplify the process for colleagues and will be published in Autumn 2023. The publication will include the following topics:

1. Why provider collaboration?
2. Models / options for collaboration
3. Contracts and companies
4. Making decisions stick
5. Building in NED challenge
6. Lead provider accountability
7. Shared provider accountability
8. Group models
9. Managing collaboration risks
10. Aligning strategy
11. Role of Councils of Governors
12. Regulatory oversight and approvals

Further Information

The Provider Collaboration programme focuses on sharing good practice and peer learning through a range of events 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 www.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 - Bobby.Ancil@nhsproviders.org