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Working together at scale: guidance on provider collaboratives

August 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- improve population health and healthcare
- tackle unequal access, experience and outcomes
- enhance productivity and value for money
- support broader social and economic development.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

This guidance outlines expectations for how providers should work together in provider collaboratives, offering principles to support local decision-making and suggesting the function and form that systems and providers may wish to consider.

Key points

- Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services.
- By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities.
- Significant scope to deliver these benefits already exists within current legislation and, subject to its passage through Parliament, we expect the Health and Care Bill will provide new options for trusts to make joint decisions.

Action required

- All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022.
- Community trusts, ambulance trusts and non-NHS providers should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved.
- ICS leaders, trusts and system partners, with support from NHS England and NHS Improvement regions, are expected to work to identify shared goals, appropriate membership and governance, and ensure activities are well aligned with ICS priorities.

Other guidance and resources

- ICS Design Framework

Introduction

We have a growing body of evidence pointing to the benefits that integrated care systems (ICSs) can achieve for patients and communities when providers work collaboratively. The response to the COVID-19 pandemic most clearly demonstrated how providers can work together effectively at scale and pace to achieve common objectives.

We now face the substantial challenge of meeting the needs of patients whose care was disrupted or delayed due to the pandemic, while continuing our work to meet NHS Long Term Plan commitments. No provider will be able to meet the challenges of recovering from the pandemic alone. Providers will need to build on the successful collaboration that they established in response to COVID-19.

On 16 June 2021, we published the ICS Design Framework, setting out how ICSs will be expected to operate by April 2022 when ICS partnerships and new statutory integrated care boards (ICBs) will be established, subject to the Health and Care Bill being enacted in the 2021/22 parliamentary session. The ICS Design Framework reinforces the expectation that **provider collaboratives**, along with **place-based partnerships**, will be a key component enabling ICSs to deliver their core purpose and meet the triple aim of better health for everyone, better care for all and efficient use of NHS resources.

This guidance sets out the minimum expectations for how providers should work together in provider collaboratives and provides some guiding principles to support local decision-making. ICSs and their constituent providers have flexibility to decide which arrangements will work best.

The guidance has been developed through substantial engagement with trusts (we use this term to refer to NHS trusts and foundation trusts throughout this guidance) involved in provider collaboratives and their system partners. Our engagement sought to obtain a diverse range of experiences, perspectives and expertise to ensure that the principles and lessons drawn are as widely applicable as possible.

The Health and Care Bill would create further opportunities for providers and their system partners to work together effectively by providing new options for trusts to make joint decisions. However, development of provider collaboratives is not dependent on the legislation; there is significant scope to deliver benefits of scale and support greater resilience within existing legislation and providers should not delay in pursuing this.

What are provider collaboratives?

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

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

Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, Cancer Alliances and clinical support service networks.

Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.

System partners will need to agree the areas of focus and delivery for each type of collaboration and decide how these arrangements can work most efficiently and coherently in a local context to achieve benefits for people and communities. The way in which providers might work in both provider collaboratives and place-based partnerships is discussed further below.

In some areas, provider collaboratives have already been established and have begun to deliver benefits of scale and mutual aid. For example:

- **The Greater Manchester Provider Federation Board (GM PFB)** has developed new models of care for patients needing breast, vascular and neuro-rehabilitation services. The GM PFB has provided mutual aid to members in urgent care and breast services, and joint system leadership with commissioners in cancer, elective reform and urgent and emergency care. The board was formed in 2015 to provide a structured provider voice into the Greater Manchester devolution partnership and a strategic approach to transformation, and to address provider quality and efficiency. The GM PFB

comprises all the acute, mental health and community trusts in the ICS and the region's ambulance trust. Members are bound by terms of reference, a risk–gain share agreement and agreed decision-making arrangements.

- **Foundation Group** began in 2016 with South Warwickshire NHS Foundation Trust (SWFT) providing buddying support to Wye Valley NHS Trust (WVT). The SWFT chair and chief executive were then appointed to corresponding roles at WVT. In 2017, the Foundation Group was created with SWFT and WVT as partners, and George Eliot Hospital NHS Trust joined in 2018. All three trusts operate under a group model, which is based on a common strategic vision to support sustainable local services and to lead integration at places by increasing the resilience of trust leadership and operations.

- **Humber Coast and Vale ICS** has three provider collaboratives: a mental health lead provider collaborative, a community health and care collaborative, and an acute provider collaborative. All three are joined up by a provider forum to ensure sharing across collaboratives. To date, among its programmes, the acute collaborative has agreed an elective recovery plan based on joint capacity, leads the community diagnostic hub programme, and has delivered significant investment into clinical support networks. The community health and care collaborative leads the implementation of the Ageing Well programme, including the two-hour urgent crisis response, and programmes related to hospital discharges and end-of-life care. The mental health collaborative leads the implementation of NHS Long Term Plan priorities and development of a lead provider arrangement for specialised services.

- **South Yorkshire and Bassetlaw Acute Federation** has redesigned stroke and children's services with commissioners, implemented some shared on-call rotas across a regional footprint, and realised significant efficiencies through, for example, joint procurement and establishing a common locum bank. The collaborative also has implemented managed clinical networks to co-ordinate and improve care in some smaller specialties and established each member as a host of a clinical network to support service redesign and improvement. The collaborative includes all acute and specialist trusts in the South Yorkshire and Bassetlaw ICS.

- **NHS-Led Mental Health, Learning Disabilities and Autism (MHLDA) provider collaboratives** are groups of providers of specialised mental health services. Led by an NHS lead provider, they work with families and

communities to develop a clinically-led approach to designing and delivering specialised mental health services across a wide footprint. The lead provider is responsible for subcontracting with other providers, including members of the collaborative, to deliver services. A two-year pilot phase at 15 pilot sites led to:

- over 550 people returned from out-of-area placement
- over 70% reduction in admissions to CAMHS units
- over £30 million savings for investment in new services.

The capabilities and achievements of these established provider collaboratives are described in this guidance and offer a road map for system partners who are starting now to implement their own arrangements.

Why do we need provider collaboratives?

By working effectively at scale providers can properly address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience in smaller trusts, and ensure that specialisation and consolidation occur where this will provide better outcomes and value. Meeting these challenges is essential to delivering recovery from the pandemic and can only be achieved by providers working together with a shared purpose.

The experiences of existing provider collaboratives and the successful ways that providers have worked together to respond to the pandemic have demonstrated the specific types of **benefits of scale** that can be delivered including:

- **Reductions in unwarranted variation in outcomes and access to services:** Providers can work together to develop new evidence-based models of care and standardise protocols to reduce unwarranted variation. Common processes and procedures ensure that staff can more easily move between sites. Members offer each other peer expertise, support and challenge to improve consistency where appropriate across a wider footprint.

- **Reductions in health inequalities:** Provider collaboratives have an opportunity to embed joint accountability, improve equity of access to appropriate and timely health services, and ensure the needs of underserved communities can be considered over whole pathways of care.

- **Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate**

workforce pressures: Members can support each other to implement improvements in quality of care, and can develop combined capacity and capability if a need for enhanced support arises. Strong leadership teams can help other providers stabilise and improve quality or navigate complex change. Staff may be able to work more flexibly between sites across a wider footprint through aligned contracts, processes and cultures. This could reduce agency spend, improve patient experience and make it easier to respond to demand changes in real time across the footprint.

- **Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans:** By working together, providers can form a more diverse pool from which to identify and develop future leaders and increase career opportunities, easing some of the recruitment and retention challenges that smaller providers face. Provider collaboratives can provide access to better training and leadership development through investments in shared programmes.

- **Consolidation of low-volume or specialised services**: Where clinically beneficial providers can improve outcomes and enable a greater degree of sub-specialisation by agreeing how and where to consolidate specialised services.

- **Efficiencies and economies of scale:** Members can find savings by joining up certain clinical support and corporate services, or leveraging joint purchasing power in procurement of, for example, clinically appropriate and safe medicines.

The specific programmes of work that provider collaboratives have developed to achieve these benefits vary, but clinical leaders and their teams across different providers often consider potential benefits across three areas:

- **Clinical services**, which may include:
  - standardising protocols, policies and pathways; for example, agreeing referral and assessment criteria to ensure patients are seen in the right place at the right time
  - expanding access to appropriate and timely health services to ensure that the needs of underserved groups are considered over whole care pathways

  - delivering service transformation in line with NHS Long Term Plan priorities
  - designing new models of care
  - jointly managing clinical demand and capacity
  - increasing staff flexibility to work between sites through aligned contracts, processes and cultures.

- **Clinical support services**, which may include:
  - sharing pharmacy, radiology or similar services
  - supporting pathology and imaging networks in sharing pathology and imaging services, as appropriate
  - sharing patient records to create a more seamless patient experience.

- **Corporate services**, which may include:
  - co-ordinating or consolidating, for example, HR, procurement or analytics
  - sharing data and informatics
  - deploying joint quality improvement and change management frameworks.

Table 1 provides examples of some of the benefits provider collaboratives have started to see across the country, as part of a range of programmes that they have undertaken.

Table 1: Examples of provider collaboratives' achievements

Achievement	Description
Clinical services	
Single service and standardised referral criteria and protocols (West Yorkshire Association of Acute Trusts, *North East and Yorkshire)*	To improve outcomes for patients, the collaborative established a single, shared West Yorkshire vascular service. This consolidated the number of arterial centres from three to two, creating unified protocols, regional clinical pathways, operational policies and evidence-based models of care. To ensure patients have more equal access to services, the trusts also standardised referral criteria and protocols for elective orthopaedics, which will be applied consistently across places.
Shared forensic pathways (South London Mental Health and Community Partnership, *London)*	Clinicians, with input from service users and their families, developed five new pathways including a new single point of access for referral across three trusts. This led to a 36% reduction in out-of-area patients, a 66% reduction in readmissions and 150+ patients

	repatriated to South London. Savings were reinvested in beds and new services.
Redesign of pathways across a region (South West Mental Health Provider Collaborative, *South West*)	More patients were able to receive treatment closer to home and in the least restrictive environment possible, reducing the number of inappropriate admissions. The eight collaborative partners redesigned secure services clinical pathways. In a pilot phase, the 2016/17 budget for secure care inpatient services was transferred to the eight-member collaborative, with improvements in services leading to financial savings which have been reinvested in four new community teams and enhancing the region's patient capacity.
Clinical support services	
Resilience support (Brighton and Sussex University Hospitals NHS Trust (BSUH) and Western Sussex Hospitals NHS Foundation Trust (WSH), *South East*)	BSUH exited special measures and improved its CQC rating to 'Good' in 2019 after WSH and BSUH established a shared leadership team with a substantially shared board, leading to leadership stability, the implementation of a continuous improvement methodology and alignment of governance, risk management and internal control processes.
Corporate services	
Centralised recruitment (South West London acute provider collaborative, *London)*	The SWL Recruitment Hub combines four acute trusts' recruitment teams into a single service. This has reduced time to recruit and vacancy rates, enabled the sharing of innovation and best practice, improved hiring managers' and candidates' experience, and led to cost savings. During COVID-19, the hub enabled rapid centralised recruitment to the South West London vaccination programme, managing high volumes of applications and offering candidates a single point of access to roles and a seamless journey into trusts across the ICS.
Joint procurement (West Yorkshire Association of Acute Trusts, *North East and Yorkshire)*	£1 million of savings were achieved by aggregating regional demand, standardising products and using the increased volume to obtain better prices.
Gold Command for rapid COVID-19 response (Greater Manchester Provider Federation Board, *North West)*	Greater Manchester's provider collaborative enabled providers to rapidly establish COVID-19 Gold Command. This included the ability to agree escalation levels and implement consistent escalation plans; rapidly appoint medical leads; develop a PPE dashboard showing demand and supply; and deploy mutual aid across organisations.

The expectation for NHS providers

All trusts providing acute and mental health services, including specialist trusts, are expected to be part of one or more provider collaboratives by April 2022, working together to agree plans and deliver benefits of scale. Community trusts, ambulance trusts and non-NHS providers (for example, community interest companies) should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved.

Systems and their constituent providers have flexibility to decide how best to arrange provider collaboratives, recognising that some providers, including community and ambulance trusts, may need to work across multiple collaborations and/or place-based partnerships and need to consider how best to devote their resources. The specific arrangements should be driven by the purpose – that is, individual providers should come together in provider collaboratives in ways which make sense to achieve benefits of scale, provide resilience and deliver system priorities. See further discussion below under Footprints and membership of provider collaboratives.

The Health and Care Bill will enable trusts to make joint decisions, offering new ways for providers to work together within collaboratives; nevertheless, providers can already come together in provider collaboratives under existing legislation. Providers should proceed with plans to deliver benefits of scale and mutual aid regardless of the timing of the enactment of the legislation.

We recognise that different regions, systems, providers and places are at different points in their journey to greater collaborative working and are preparing for ICSs to be placed on a statutory footing, as described in the ICS Design Framework. Whether provider collaboratives are well established or in the early stages of development, we expect that by April 2022, ICS leaders, trusts and their system partners, with support from NHS England and NHS Improvement regions, as appropriate, will:

- identify the shared purpose of each collaborative and the specific opportunities to deliver benefits of scale and mutual aid
- develop and implement appropriate membership, governance arrangements and programmes (or reflect on this where collaboratives are already in place)
- ensure purpose, benefits and activities are well aligned with ICS priorities.

Capabilities of provider collaboratives

Our engagement with provider collaboratives identified the core common capabilities (supported by the **enablers** in the next section) that are essential for them to deliver benefits of scale. Provider collaborative arrangements should be proportionate to the shared vision and objectives and should be sufficient for members to do the following:

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

Enablers of effective provider collaboratives

We know providers of health and care services have already made great strides in improving collaboration to better co-ordinate services. Among NHS trusts there is a growing spirit of openness and trust alongside a continuing focus on doing what is best for patients and communities.

To build on this momentum, trust leadership teams need to demonstrate a strong commitment to collaborative working and instil collaborative cultures and a common purpose within their organisations, from the frontline to the board and governors. These key enablers of collaboration need to be nurtured from within organisations to

facilitate effective provider collaboratives: relationships, clinical leadership, people and communities (including experts by experience), data sharing and digital capabilities (see Table 2). Trusts and their system partners should reflect on the extent to which these enablers are present or need to be developed.

Table 2: Enablers of effective provider collaboratives

	Description
Relationships	Building and nurturing strong relationships among trust leaders, clinical teams and with system partners at all levels, based on honesty and transparency, is critical. This is a continuous process, requires hard work and commitment, and even with these can be challenging at times.
Clinical leadership	Clinicians need to be empowered and engaged, as they are best placed to accurately define problems and ensure a solution is evidence-based and meets patient needs. Provider collaboratives should incorporate clinical leadership, which should be closely linked with clinical networks and the ICS clinical and care professional leadership models to be developed before April 2022.
People and communities	Provider collaboratives should always take into account what matters most to people who access or may access care and support, and people who work in services, communities and community partners. Collaboratives should share and build on the good practice that exists in their member organisations, such as co-production approaches and partnerships with experts by experience. They should draw on the community connections of foundation trust governors, and use insight and feedback from patient surveys, complaints data and partners like Healthwatch.
Data sharing	An ‘open book’ approach to sharing trust performance data is vital to overcome organisational siloes and to maximise use of capacity. In addition, systems will set strategies for developing population health data sharing and analysis capabilities. They will want to ensure that these capabilities are available to provider collaboratives and place-based partnerships; in some cases, provider collaboratives may have or develop advanced data capabilities that they can host on behalf of entire systems.
Digital	Advanced interoperable digital capabilities can support consistency across different providers in the collaborative, which allows for smoother working arrangements (for example, staff rota systems) and patient flows (for example via shared IT systems and patient records) in and out of settings.

The role of provider collaboratives in health and care systems

As provider collaboratives develop across the country, they will be an increasingly important vehicle through which systems will deliver some of their strategic priorities.

The most senior leaders of the member organisations should come together to agree objectives and priorities for their provider collaboratives, and these must be consistent with those of the ICS(s) they serve as well as the wider system, including place-based partnerships. To this end, we expect provider collaboratives to agree specific objectives with one or more ICSs, focusing on those priorities that require trusts to plan and arrange services at scale.

The members of a collaborative should agree how they will achieve their objectives and develop clearly defined plans and programmes of delivery using insights from partners, people, communities and data. While there may be additional work programmes agreed by members that fall outside ICS-agreed objectives, such as joining up corporate functions, such programmes should not cut across ICS objectives or distract resources needed to deliver them.

In this year of transition, provider collaboratives should work with ICS leaders, place-based partnerships, clinical networks, Cancer Alliances and others to define responsibilities and ways of working together. Provider collaboratives which are already established should ensure their plans and programmes are aligned to current and anticipated system priorities.

Following their establishment, ICBs will need to clearly articulate within their plans how the range of collaborations are working together. They will need to encourage and support arrangements that enable provider collaboratives to work effectively and cohesively with other collaborations.

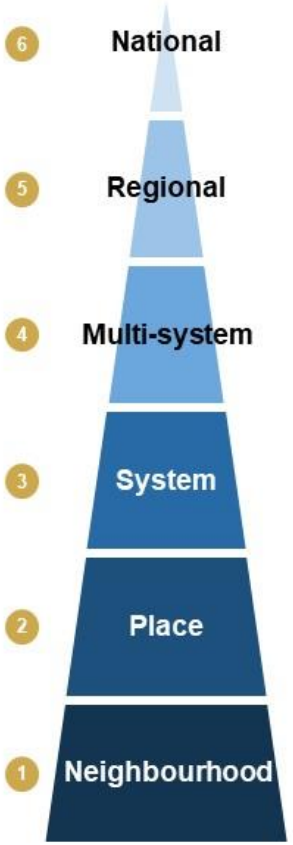
In the future, there will be greater opportunities and options for ICBs to empower providers to lead transformation and delivery of services. The Health and Care Bill, if enacted, will enable ICBs to delegate functions to providers including, for example, devolving budgets to provider collaboratives. See further discussion about delegation of functions below in Future opportunities: functions, form and governance. NHS England and NHS Improvement will set out more detail about delegating functions and devolving budgets in due course.

Footprints and membership of provider collaboratives

NHS trusts and other provider organisations operate over different scales and the scope of services they provide varies. Some providers operate only within places, whereas others have footprints that span multiple places, an entire system or multiple systems, or may be regional or national. The latter is particularly true for specialist and large tertiary centres, ambulance trusts, mental health and community providers.

Figure 1 below depicts typical levels of service planning and delivery and the different forms of collaboration that tend to align to them, although there will be local variation. We have observed that provider collaboratives largely fall into levels three to five. The figure is not exhaustive. At each level of service planning and delivery, there may be additional partners not listed here which should be consulted (for example, teaching universities, academia, or other public sector or private organisations).

Figure 1: Collaborations and activities that align with typical levels of service planning and delivery



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places. but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

NHS England and NHS Improvement will not prescribe the membership of individual provider collaboratives (which is what defines the collaborative footprint). It will be up to providers and their system partners to decide together which provider collaborative arrangements, including membership, create the best opportunities to deliver the full range of expected benefits of scale. They will be expected to work with our regional teams to ensure that each collaborative has agreed a membership that can deliver the benefits, supporting the delivery of system priorities.

For some ICSs, this might be achieved through providers of similar services working together on a system-wide or larger footprint; for others, a collaborative that includes all the NHS providers within a system may be more effective, with providers working in subgroups for different areas of focus. In some cases, as depicted in Figure 1, it may make sense for collaboratives to work at a supra-ICS or regional level, particularly when they are constituent members of smaller ICSs.

Some **guiding principles in determining the appropriate membership** of provider collaboratives should be:

- **Purposeful and benefit-driven:** Membership should be driven by the expected benefits for patients and communities. Trusts should allocate their resources across provider collaboratives and other collaborations according to the relative benefits expected for the populations they serve. Trust boards should be clear about – and signed up to – the purpose and scope of the provider collaborative(s) they become members of.

- **Evolutionary, building on successful collaborations:** In many areas, collaboratives will not be starting from scratch. The task is for systems and providers to reflect on their current priorities and membership and build on these if necessary, recognising that relationships, arrangements and functions will evolve and strengthen over time. Priority areas of work may change, but collaboratives should seek to have a membership that will be relatively stable over time. This will help strengthen relationships and embed a shared vision and approach to working together and solving problems.

- **Inclusive:** Membership should ensure that no provider is left less resilient or its population less able to share in the benefits of scale, and no provider whose involvement will be important for delivering the objectives of the provider collaborative should opt out, even if the direct benefit to the individual provider is marginal.

The roles of different organisations and services

Feedback from stakeholders emphasised the importance of carefully considering the role that providers of different services can and should play in provider collaboratives, noting that a broad membership can ensure a holistic approach to patient care and a diversity of perspectives. Additionally, some providers who work across places can provide an informed view of variation in outcomes and equity of access and how reconfigurations in one area may impact, or are impacting, on providers and patients in another.

Acute trusts have significant opportunities to deliver benefits of scale and ensure that acute trusts across a system are resilient. Areas of focus include addressing unwarranted variation in clinical outcomes, access and experience and consolidating specialist services or enabling greater specialisation across a system or systems where this will improve patient outcomes. Acute trusts will need to work closely with partners, including place-based partnerships, to ensure that their programmes meet the needs of people and communities across different places.

Mental health providers have led the way in the development of lead provider models of provider collaboratives. As noted above, under an NHS lead provider, the MHLDA collaboratives bring together NHS and large and small independent sector providers to redesign pathways of care and deliver specialised services. Some ICSs are considering ways to expand this model across a wider scope of mental health services. In addition to these arrangements, mental health providers may consider becoming part of other provider collaboratives; for example, joining up with community providers to focus on integrating community physical and mental health provision, where this makes sense for patients.

Specialist trusts are expected to become part of one or more collaboratives, as they are well placed to help standardise pathways and ensure equity of access; for example, by working with partners to build shared diagnostic hubs, referral protocols and/or a single patient treatment list. They offer an opportunity to share innovation in their specialties across members of the collaborative.

Community providers sometimes work across an ICS or may straddle ICS boundaries (as larger standalone trusts or social enterprises, or as part of a wider integrated care organisation). Provider collaboratives may offer them an opportunity to work with partners to find efficiencies of scale or flexibilities for staff; standardise approaches to pathway design across places where this works better for patients; ensure equity of access to step-down community care; and provide a birds-eye view of system-wide population health. Also, as community providers will likely work

closely with primary care networks (PCNs), local authorities and GP practices in place-based partnerships, they can provide an important link between collaborations.

Ambulance trusts, which already work at scale and with local care systems on care pathways, have a unique view across regions. They have rich localised experience and knowledge, and in some areas have a history of working closely with partners in places to develop local pathways for patients needing urgent and emergency or out-of-hospital care. Ambulance trusts and their system partners will need to consider what objectives ambulance trusts need to be involved in and agree how their involvement can best be facilitated. For example, ambulance trusts will have an important role in and could lead relevant programmes on behalf of a provider collaborative where systems have identified the need to reduce variation across places in access to or quality of out-of-hospital urgent care, mental health response and same-day emergency care services.

Independent sector providers may include, for example, small and large mental health organisations working with NHS lead providers, social enterprises providing community services (as noted above in community providers) or independent sector providers of elective care. Their participation in provider collaboratives may be important to delivering benefits, depending on local priorities and provision. The extent to which independent sector providers can participate in decisions of a provider collaborative may depend on the specific collaborative arrangements and responsibilities; this will need to be considered locally. This is discussed further in Form and governance below.

Working with the voluntary sector, primary care and social care partners

Working as part of a system gives trusts opportunities to connect with partners across the spectrum of care in ways that may not have been possible previously. Collaborative arrangements will help system partners to inform and support each other's objectives and work programmes.

For provider collaboratives, this means considering how to involve and embed the expertise of the voluntary sector, primary care and local authorities. Place-based partnerships and, if the legislation is enacted, ICS partnerships may provide a regular forum for linking the work of provider collaboratives with wider system priorities and gathering input from system partners.

Voluntary sector organisations can uniquely support provider collaboratives with expertise and links to people and communities to support co-design and delivery of

health and care services. The voluntary sector works with some of the most disadvantaged communities and understands health and care issues of the population, both at a local and national level. In some cases, it may be appropriate for voluntary sector organisations to support the work of collaboratives through subcontracting arrangements.

Primary care professionals have a fundamental role in ICSs. Provider collaboratives will need to consider how to work best with primary care. Collaboratives also offer an opportunity for trusts to consider how they can better support primary care, including working with PCNs, to support priorities relating to prevention, access to urgent and emergency care and whole pathway developments.

Local authorities and social care providers will be able to work with provider collaboratives to share knowledge and engage in dialogue to better understand the impact that service transformations will have across all services, communities and populations.

Working with place-based partnerships

The variation in the size of ICSs as well as their geography and provider landscapes means that it is important for ICS partners to agree locally on the scale at which system objectives, activities and capabilities should sit. Some responsibilities will best be delivered by provider collaboratives working across places (or across multiple ICSs) and some will sit with place-based partnerships in line with the principle of subsidiarity.

While systems have flexibility to decide how responsibilities are delivered at different scales by mutual agreement, each system should ensure there is internal coherence in how it operates and that this is widely recognised among partners.

Provider collaboratives and place-based partnerships will support and complement each other's work. Each NHS provider who is a member of a provider collaborative will be involved in a place-based partnership in the place or places in which it is geographically based. Areas of mutual support might include provider collaboratives working with place-based partnerships to understand population health indicators in local contexts and using patient insight and feedback collected at place and neighbourhood levels more consistently across different providers. Providers working across both collaboratives and place-based partnerships will be able to build joint engagement programmes, avoid duplication and help ensure alignment with ICS priorities.

Case study 1: Foundation Group (South Warwickshire NHS FT, Wye Valley NHS Trust and George Eliot Hospital NHS Trust)

Each of the three trusts who form the Foundation Group are the lead providers for integrated care working at each of the places where they are located. They work with PCNs, other providers and local authorities at place, and support the delivery of more care out of hospital across a wider geography. The collaborative members are part of two ICSs: Coventry and Warwickshire and Hereford and Worcestershire.

Working with clinical and clinical support networks and Cancer Alliances

Many collaborative arrangements including Cancer Alliances, clinical networks or networks providing clinical support services such as pathology networks have existed for several years. These tend to focus on single specialties or clinical support services, to ensure dedicated commitment, focus and resource for those services, and to lead delivery of the NHS Long Term Plan commitments or other national or local strategy, transformation and improvement plans.

To deliver the priorities of one or more ICSs, provider collaboratives, clinical networks and clinical support networks will work together to identify common areas of focus and shape and support delivery. NHS providers who are members of both collaboratives and networks will play an important role in aligning activities between both arrangements. It will be important for networks and collaboratives to agree how they can best support each other's work, clearly defining their relationship and how their arrangements intersect, while avoiding duplication and complexity. For example, through their membership and scope spanning multiple places or multiple ICSs, provider collaboratives can:

- help to co-ordinate and enable the work of clinical networks and clinical support networks
- facilitate agreement of provider leadership teams to network plans across a range of clinical specialties or clinical support services
- provide a multi-speciality view of interdependencies and cross-cutting issues.

Clinical networks and clinical support networks will contribute valuable clinical leadership, expertise and best practice to provider collaborative programmes.

Provider collaboratives also will work with Cancer Alliances. Cancer Alliances will continue to lead whole-system planning and delivery of cancer care on behalf of their

constituent ICSs, as well as providing clinical leadership and advice on commissioning. Cancer Alliances will use their expertise and funding to deliver a single plan for cancer across systems, supporting provider collaboratives to deliver on their cancer objectives. Working with provider collaboratives will also create opportunities for Cancer Alliances to go further and faster, enabling plans for cancer to be implemented in a more co-ordinated and systematic way.

As a first step, it will be important for regions and systems to map existing collaborations and begin to agree ways of working between provider collaboratives, clinical networks and clinical support networks, Cancer Alliances and other forms of provider networks.

Case study 2: West Yorkshire Association of Acute Trusts (WYAAT) and their work with clinical networks

WYAAT is a provider collaborative composed of the six acute trusts in West Yorkshire and Harrogate ICS. Among its achievements, the collaborative has created a single vascular service for the region; reconfigured hyper acute stroke services; and established both a radiology and pathology network.

WYAAT works with clinical networks to bring clinicians together to share best practice, standardise processes and support one another. For example, a common clinical model and set of standard pathways for vascular services have been developed. In radiology, the paediatric special interest group has agreed standard protocols and provided support across trusts to cover staff leave or sickness.

WYAAT has also worked with the operational delivery networks (ODNs), particularly during COVID-19. For example, through organising regular meetings, WYAAT helped improve communication between the Adult Critical Care ODN and the ICS. This increased the visibility of the network and of critical care, reassuring the ODN that the issues and concerns of this pivotal service were being heard.

Case study 3: Cheshire and Merseyside Cancer Alliance and Provider Collaborative

Cancer Alliances have been central to maintaining care during the pandemic. Cheshire and Merseyside Cancer Alliance worked with the nascent provider collaborative to develop a regional cancer surgical hub, which co-ordinates mutual aid between providers to ensure that patients are prioritised and not disadvantaged by any local capacity constraints. It also created a shared patient list between cancer care providers and produces a monthly system-wide performance report and a highlight report for all providers and CCGs. The Cancer Alliance will continue to do this for Cheshire and Merseyside's provider collaborative, which is evolving from the hospital and community cells which the Cancer Alliance has reported into throughout the pandemic.

The Cancer Alliance will continue to provide whole-system leadership and planning for cancer. The provider collaborative will provide a more formal vehicle for the delivery of these plans, as well as the forum to reach a consensus between providers on any issues relevant to cancer.

Form and governance

Providers should determine and agree the form and governance of their collaborative, with help from ICS leaders and NHS England and NHS Improvement regions. There is no one model that all collaboratives must adopt; it will be up to members to decide which arrangements will work best for them.

The 'right' form and governance arrangements should flow from the shared purpose and objectives of the provider collaborative. Providers will need to identify the functions and core capabilities necessary to deliver the expected benefits of scale and use governance arrangements that are proportionate.

Some **guiding principles** in determining the appropriate form and governance are that the arrangements:

- must be underpinned by a **shared vision and commitment to collaborate** to deliver benefits of scale and mutual aid, doing what is best for people and populations across places
- should **build on and enable existing successful governance arrangements**; for some areas, arrangements may need to be strengthened rather than creating new arrangements from scratch
- should enable providers to **efficiently reach decisions, which each organisation is committed to upholding**, on topics that are within the collaborative's remit
- should provide **strong mechanisms for provider members to hold each other to account** to ensure that decisions are reached and carried out and benefits of scale are realised at pace
- should **ensure the needs and voices of local communities are a key consideration** in all decisions and **clinical leadership is embedded** in programme delivery
- should **make it clear** how decisions are made, how disagreements are resolved, how funding flows to services within the collaborative's remit, and how the collaborative is resourced
- should help **streamline ways of working within and across systems**; for instance, representatives of provider collaboratives are empowered to engage in conversations about services and transformations that are to be delivered at scale, rather than each individual provider needing to be consulted.

Provider collaborative models

While the Health and Care Bill, if enacted, will enable NHS trusts and foundation trusts to form joint committees and take joint decisions, trusts can currently come together through agreed governance arrangements to make effective aligned decisions. Through engagement with provider collaboratives, we identified three models that NHS providers have typically used to form collaboratives under existing legislation. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another.

- **Provider leadership board model:** chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners.[1] This model can make use of committees in common, where committees of each organisation meet at the same time in the same place and can take aligned decisions. To ensure effective oversight of the provider leadership board, trusts should consider how to involve their non-executive directors in providing scrutiny and challenge.

- **Lead provider model:** A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required. Alongside the contract between the commissioner and NHS lead provider, the NHS lead provider enters into a partnership agreement with other collaborative members who contribute to the shared delivery of services.

- **Shared leadership model:** Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. In the case of NHS trusts, this model can also be achieved by the board of one trust delegating certain responsibilities, consistent with the remit of the provider collaborative, to a committee which is made up of members of another trust's leadership team. Under either of the above approaches each

[1] The way that functions are delegated, and decisions taken, will depend partly on the type of provider. Under current legislation, each NHS foundation trust delegates to a committee of its own directors, and the committee considers issues together with committees of other collaborative members to take aligned decisions and achieve consistency – often called committees in common. NHS trusts take a similar approach, but an NHS trust can delegate functions to non-directors who can exercise those functions on committees that include others who are not employees of the NHS trust.

provider's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common).

See Table 3 below for an example of each of these models.

To flow funding to provider collaboratives, commissioning bodies could:

- contract and pay providers individually, and the providers working in collaboratives can pool funds to achieve their shared objectives
- for lead provider models, and similar to the existing mental health provider collaboratives, commissioning bodies could contract with and pay an NHS lead provider acting on behalf of a provider collaborative (whole budget for in-scope services); the lead provider would agree subcontracting and payment arrangements across the collaborative.

Independent sector providers can be members of a provider collaborative, but the extent of their participation may depend on the specific form and governance arrangements and the nature of a particular decision being taken by the collaborative. This needs to be considered locally to determine the best arrangements to support participation by independent sector providers.

Table 3: Examples of three provider collaborative models

	Provider leadership board	Lead provider	Shared leadership
	The West Yorkshire Association of Acute Trusts (WYAAT) is a partnership of six acute trusts in West Yorkshire and Harrogate ICS.	**South London Mental Health and Community Partnership (SLP)** is an NHS-led mental health provider collaborative with a lead provider for three of its programmes that involve managing the budget for specialist services (other programmes use a provider leadership board).	**The Foundation Group** is a group in which the South Warwickshire NHS Foundation Trust Chair and CEO have corresponding roles at Wye Valley NHS Trust and George Eliot Hospital NHS Trust.
People and roles	The collaborative is led by the chairs and CEOs of the trusts, supported by the collaborative	Delegated authority to the CEO and a non-executive director for each trust. A jointly appointed director co-	One CEO and one chair with each trust having a managing director and its own board. The trust

	director. Trust executive directors lead programmes supported by PMO programme teams.	ordinates the work of the partnership alongside clinical directors for each pathway. Chair is appointed from one of the member trusts, rotating every six months.	site executive includes a managing director, medical director, nursing director, chief operating officer and finance director.
Governance	Overseen by a committees in common established under a scheme of delegation. It consists of the trust chairs and CEOs, supported by the collaborative director, and takes aligned decisions (within delegated authority) or makes aligned recommendations to the trust boards.	A partnership board of the three CEOs and non-executive directors from each trust oversees the partnership. There is potential to establish ad-hoc committees in common for major decisions. Each trust holds a lead provider contract for different services (adult secure, CAMHS and adult eating disorders).	Committees in common (topic-specific delegation), a group strategy subcommittee (committees in common) with purely advisory role to each board for operational and financial strategy and a small number of specialist advisory roles across the group.
Decision-making	Decision-making is by consensus; there are no majority decisions. Two types of decisions (and programmes) are mandatory participation (which all WYAAT members must support or be part of) or voluntary participation (all participating members must support).	Unanimity, risk–gain share, dispute resolution.	Each trust board has devolved decision-making to the trust site executive. The site executive report into their relevant trust board

Options for strengthening decision-making

A key function for a collaborative will be to make collective decisions. Decisions need to be made efficiently and be binding. We have observed collaboratives using a range of mechanisms to strengthen their decision-making function. These include:

1. **Categorising decisions:** Providers agree that only those impacted by decisions (such as service transformations that require operational changes at their organisation) have binding votes; for example:

- Category 1 – decisions affect and will be binding on all providers
- Category 2 – decisions affect and will be binding on a subset of providers.

2. **Locked gateways:** Providers agree to different stages in the decision-making process, and at each stage once a decision is made it will not be reopened unless this in the best interest of the public. Usually there are four stages: initiation, case for change, options, options appraisal.

3. **Majority versus consensus decision-making:** Each provider agrees to adopt the decision that is supported by a majority of trusts, rather than a unanimous view; this could prevent a single trust blocking a decision in the best interest of systems.

4. **Strong dispute resolution processes:** Providers agree to clear procedures for resolving disputes, including where a provider is unwilling to implement a majority decision.

Future opportunities: functions, form and governance

The Health and Care Bill, if enacted as currently drafted, will give NHS trusts and foundation trusts new ways to jointly exercise their functions and, subject to future regulations and guidance, enable ICBs to delegate functions to trusts.

The legislation, if enacted, will allow NHS foundation trusts to jointly exercise their functions with other trusts (as NHS trusts can do now) and/or NHS trusts and foundation trusts to form joint committees that could exercise functions and jointly take decisions that have been delegated by their individual organisations, in line with their schemes of delegation. This means some of the current legal requirements necessitating the use of committees in common to make aligned (rather than joint) decisions will no longer be applicable.

ICBs (and potentially NHS England where commissioning functions are retained) will commission the delivery of services from NHS providers, contracting with NHS trusts and foundation trusts using the NHS Standard Contract. As they do now, members of a collaborative could pool their individual funds to deliver the objectives of the collaborative or, in a lead provider model, the NHS lead provider would agree subcontracting and payment arrangements across the collaborative.

The contract between the ICBs and the individual members of the collaborative will allow the ICB to hold each member to account for delivering the services they agree to deliver through the provider collaborative.

In addition, the legislation will empower NHS England and ICBs to go a step further, and delegate functions to NHS providers, where this is appropriate and better enables ICSs to meet their core purpose.

In practice, these approaches will allow NHS providers, working in collaboratives, to play a fuller role in the design and planning of services, as well as their delivery. ICBs will need to carefully consider these arrangements, the risks and accountabilities, and how to ensure that collaboratives meet their objectives aligned to the triple aim of better health for everyone, better care for all and efficient use of NHS resources. More guidance on joint committees and delegation of functions will be made available in due course.

Resourcing

An important consideration for provider collaboratives will be how to resource their activities, including the day-to-day running of the collaborative and delivery of programmes. Trusts may need to recognise the increasing role of collaboration (and reduced role of competition) in decisions about the allocation of their resources, including management time, and in resourcing the skills they need to operate successfully in the future and shift resources accordingly. We expect that as provider collaboratives evolve and begin to deliver benefits, resources may be generated through efficiency savings. Systems may also want to consider whether it makes sense to shift staff or other resources to provider collaboratives, and this may depend on the objectives and responsibilities that will sit with the collaboratives.

The resources devoted to running provider collaboratives should be proportionate to the benefits that will be delivered. For example, where collaboratives intend to work on a wide range of complex programmes, it may make sense to have a well-resourced independent project management office (PMO), as well as steering groups or task and finish groups, to support the work of the collaborative.

Existing provider collaboratives emphasised the need to build time for the collaborative's activities into existing roles; in particular, in executive, clinical and operational leadership roles. Collaboratives often use 'distributed leadership'; for example, having different trust chief executives responsible for driving each priority area. To support cross-organisation working each programme might be led by a chief executive, medical director or chief operating officer, each from a different trust.

Typically, administrative and operational staff from collaborating trusts are partly or wholly assigned to support the work of the collaborative. Administrative roles can

support co-ordinating meetings and preparing papers and briefs, and business intelligence roles may be needed to provide population health and other data analysis.

In some cases, provider collaboratives recruited to the provider collaborative directly (for example, for the lead PMO role) and members paid for this jointly. This cost is often offset by returns on investment, with a proportion reinvested to fund the administration of the collaborative and to grow the collaborative's capacity over time. In some cases, PMO resources are shared with the ICS, recruited from across members or directly to the collaborative.

Accountabilities

Individual NHS trusts and foundation trusts are and will continue to be accountable for the quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements. While accountability will remain with statutory bodies, we will continue to work with the CQC to ensure that the regulatory system reflects the ways in which providers are now working together.

Executives of NHS trusts and foundation trusts are accountable to their boards. These accountabilities do not change with the establishment of provider collaboratives or following the enactment of the proposed legislation.

Several mechanisms, set out below, are available now and after the enactment of the legislation to ensure that provider collaboratives are accountable to deliver their agreed shared objectives.

Accountability of provider members to each other and to their populations

Accountability between members is a key feature of a collaborative, and an important means of ensuring progress on shared objectives. Members will be expected to support and contribute to transparency and mutual accountability.

Mutual accountability, peer support and challenge may take different forms and will be most effective where providers build on a foundation of good relationships and trust. Mutual accountability may take the form of informal discussion and support between individual members and should also be explored in more formal terms. For example:

- agreements on decision-making arrangements to ensure binding decisions, dispute resolution and escalation mechanisms
- agreements to ensure sharing of data and intelligence, including trust strategies, across collaborative members
- risk and gain share agreements to ensure fair impact and benefit of collaborative activities for all members.

Members of a provider collaborative also will need to consider themselves collectively accountable to the populations and communities they serve and maintain openness as a way of working with all system partners.

Expectation for providers to collaborate effectively

Trusts currently have a statutory duty to co-operate with each other. NHS England and NHS Improvement are updating governance guidance to support providers to work collaboratively as part of systems. In the context of providers coming together in collaboratives, these changes to guidance (which are not dependent on the legislation being enacted) will facilitate providers working in a transparent and co-operative way to achieve their common purpose and objectives.

Subject to formal consultation, we will publish new guidance under the NHS provider licence that explains that good governance for trusts includes a requirement to collaborate. The guidance will set clear expectations for collaboration in key areas, such as engaging consistently in shared planning and decision-making, and the good governance that provider trusts must have in place to support this.

We also will update the Code of Governance for NHS foundation trusts, which will also apply to NHS trusts, and will publish an addendum to the reference guide for foundation trust governors, also subject to formal consultation. We are also making changes to the memoranda for accounting officers of foundation trusts and accountable officers of NHS trusts to support greater collaboration.

System oversight

NHS England and NHS Improvement and, in the future, ICBs may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for example, include looking to a provider collaborative (and the partners involved) for support where poor performance or challenges are identified, or assessing the effectiveness of collaborative working arrangements when considering whether systems and providers have an effective plan for improvement or recovery.

In line with the principles set out in the ICS Design Framework, NHS England and NHS Improvement will work with and through ICSs, wherever possible, to provide support and tackle problems, including if collaboratives are not making progress in delivering their agreed objectives or there are concerns about the extent or effectiveness of collaborative arrangements.

It is expected that providers will take necessary action to improve delivery on shared priorities through strengthening provider collaboratives where required.

A limited number of collaborative arrangements may require a transaction review under proposed changes to the transaction guidance. Although these arrangements may be reportable, we anticipate that a detailed review would only be required in limited cases. We are considering the specific thresholds and reporting requirements for reviewing collaborative arrangements and expect to consult on these and other proposed changes to the transaction guidance.

Subject to the passage of the legislation, ICBs will hold provider collaboratives to account for delivering any services or functions that they have commissioned from or delegated to provider collaboratives under the terms of agreements and/or schemes of delegation.

Next steps

The months leading to April 2022 will be a time of transition as ICSs continue to deliver recovery and their core purpose, while system leaders and partners prepare for the anticipated establishment of statutory ICBs (subject to the enactment of the legislation). NHS trusts and foundation trusts will play an important role in this transition period as constituent members of their systems. They will help lay the foundation for ICBs to take on their specific functions. System development plans should include setting out existing or developing provider collaboratives, and the role they will play in systems.

Providers will also work with NHS England and NHS Improvement regions and ICS leaders to map existing arrangements and build and strengthen provider collaborative arrangements.

We will continue to provide support for providers to work in provider collaboratives including by providing practical tools and sharing case studies.

For more information on integrated care systems visit: www.england.nhs.uk/integratedcare/

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