# Provider collaboratives

Toolkit for setting up collaborative arrangements

NHS England and NHS Improvement

# What's in this toolkit?

In August 2021, NHS England and NHS Improvement published *Working together at scale: guidance on provider collaboratives*. The guidance sets out the expectations and principles for establishing provider collaborative arrangements.

In this toolkit, you'll find ideas, tools and case studies to help you **set up your collaborative**. You might also find the toolkit helpful to **strengthen an existing collaborative**. We worked with existing provider collaboratives across the country to develop these resources and share their experiences. While this toolkit focuses on setting up a collaborative, future work will focus on sharing learning about how provider collaboratives can work effectively as part of systems and with partners including place-based partnerships and clinical networks.

Here's what you'll find in this toolkit:

- **Setting up: information and ideas to help you set up provider collaboratives**
- **Form and governance models: core components, structures and questions to consider**
- **Tools library: tools, template examples and case studies**

Before using this toolkit, you should **read the provider collaborative guidance.**

This toolkit reflects the arrangements that provider collaboratives can put in place now. The Health and Care Bill, if enacted, will create new opportunities for providers and partners to work together in joint committees and other collaborative arrangements. We will update this toolkit soon to reflect changes enabled by the legislation.

### 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, along with place-based partnerships, are expected to be a **key component of ICSs**, enabling them 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.

Effective collaboratives can help streamline the relationships between ICSs, providers and wider partners to integrate care and respond to needs of local communities.

# The benefits of working together at scale

The guidance sets out benefits of scale that provider collaboratives can achieve, and some examples of what established provider collaboratives have delivered (see our case studies as well for examples of achievements).

Benefits of working together at scale include addressing **key immediate priorities to support pandemic response and recovery and Long Term Plan goals.**

## Benefits of scale

- **Reduction in unwarranted variation** in outcomes and access to services
- **Reductions in health inequalities**, including fairer and more equitable access to services across the footprint
- **Greater resilience across systems**, including mutual aid, better management of system-wide capacity and alleviation of workforce pressures
- **Better recruitment, retention, and development of staff and leadership talent**, enabling providers to collectively support national and local people plans
- **More efficient and effective corporate and clinical support services** providing better services and better able to manage demand and capacity
- **Rapid spread of successful innovation** across care pathways
- **Consolidating low-volume or specialised services** where this makes sense for populations to achieve better outcomes

## Key immediate priorities

- The immediate 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 continuing to respond to the pandemic and meeting the needs of patients whose care was disrupted or delayed, alongside 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.
- Provider collaboratives can help systems meet these challenges by working together to, for example:
  - get a better picture of patient needs across a system
  - share capacity where possible
  - redesign pathways where this will help address pressures
  - provide mutual aid where this is needed to improve services, and
  - share best practice.
- This work should be aligned with system priorities and programmes and the ambitions of partners at Place.

# The expectations for provider collaboratives

The guidance sets out expectations for provider collaboratives including working together to identify the benefits that can be achieved and putting in place the capabilities that provider collaboratives should have. This toolkit is designed to help you and your organisation work with partners to achieve these expectations.

**Supporting system working**

Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services.

**Identify shared goals, membership, governance and activities**

ICS leaders, trusts and their system partners, with support from NHS England and NHS Improvement regions, should work together to identify shared goals, appropriate collaborative membership and governance and ensure activities are well aligned to ICS priorities.

**Become part of one or more collaboratives**

- All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives.
- 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.

**Collaboratives should have certain capabilities**

**Partnership building**: Agree a common purpose aligned to the triple aim and agreed with ICSs and system partners to align with system priorities.

**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.

**Shared governance**: Work within proportionate shared governance arrangements that enable providers to efficiently take decisions together that speed up mutual aid, service improvements and transformation.

**Peer support and mutual accountability**: Challenge and hold each to account to ensure delivery of agreed objectives and mandated standards, through agreed systems, processes and ways of working.

**Joined up working**: Work with clinical networks, clinical support networks, Cancer Alliances and clinical leaders to develop strategies, agree proposals and implement changes.

**Quality improvement**: Drive shared definitions of best practice and the application of a common quality improvement methodology.

# Setting up

**This section covers:**

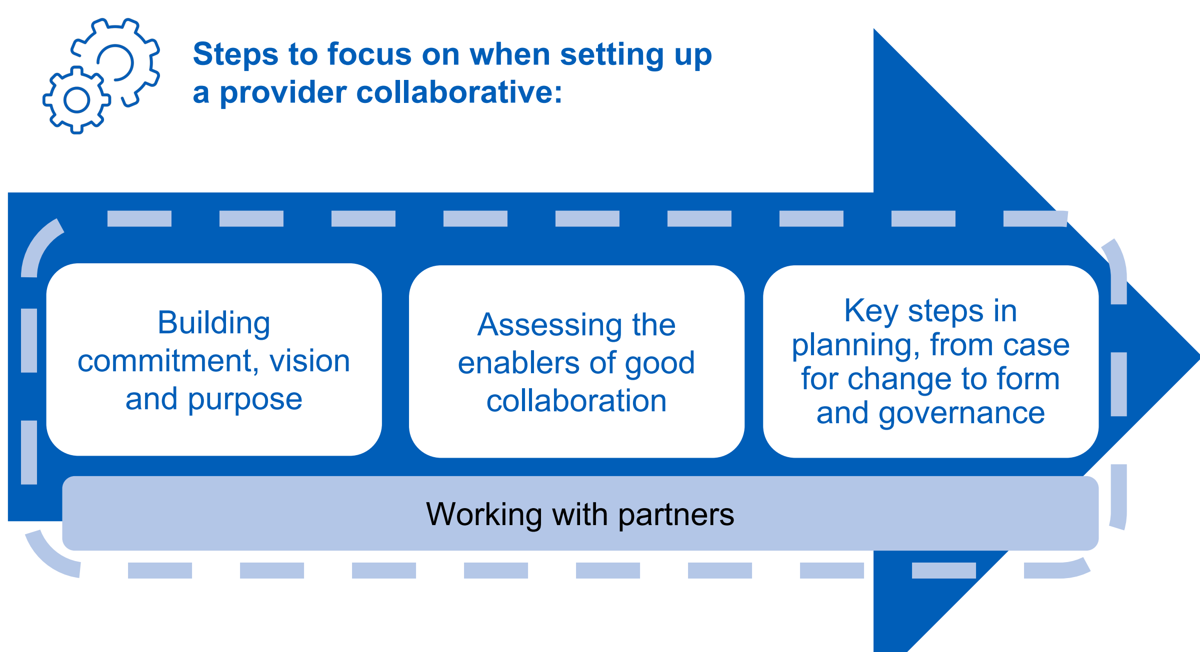
- Getting started
- Vision and purpose
- Assessing the enablers
- Key steps in planning
    - Developing the case for change
    - Mapping existing collaboration
    - Resourcing the collaborative's activities
    - Measuring success
    - Agreeing and implementing the form and governance

**Corresponding tools:**

- Setting up a provider collaborative worksheet
- Developing a case for change worksheets
- Example job description (included in a case study)
- Evaluation resources

# Important areas of focus when getting started include building a shared commitment, vision and purpose for the collaborative. This should come before considering the form and governance of the collaborative.

Emerging provider collaboratives should have identified a **shared purpose and the specific opportunities to deliver benefits of scale and mutual aid**, identifying a mix of quick wins and longer-term goals and prioritising programmes of work.




**A good place to start setting up a provider collaborative is to focus on:**

- Providers working together to build a commitment to collaboration and agree a vision and purpose for the provider collaborative.
- Assessing and strengthening the enablers that will be important for the success of the collaborative; these include strong relationships, clinical leadership, involvement of patients, staff and communities, data sharing and digital capabilities.
- The key steps of planning: these include developing the case for change, mapping existing collaboratives, planning to measure success, resourcing and deciding the form.
- Working with partners to ensure the shared vision for the collaborative is aligned with system priorities and stakeholder views are taken into account in all steps of setting up.

# At the earliest stages of development, providers should work together to build their commitment to collaboration and develop a shared vision and purpose for the collaborative. This requires open and honest discussions about any concerns.

### Things to consider:

- **Relationship-building** and developing a shared vision might require some time upfront for to have honest discussions about what each member wants to achieve, and thinks can be achieved. *Each member needs to ensure their organisations, Boards and, where relevant, governors are committed to the collaboration*.
- Provider leadership teams will want to **openly discuss any concerns** they may have about working together and **reach consensus about the vision and purpose** for their collaborative**.**
- Providers should **work with partners** to ensure the vision and purpose of the collaborative is **aligned to system priorities and those of partners and stakeholders**.

### Working with partners:

When developing a shared vision, it will be important to work with partners to ensure that there is a shared understanding of aims, objectives and responsibilities across systems.

System leaders

Place-based leaders

Voluntary sector organisations

Primary care

Patients and communities

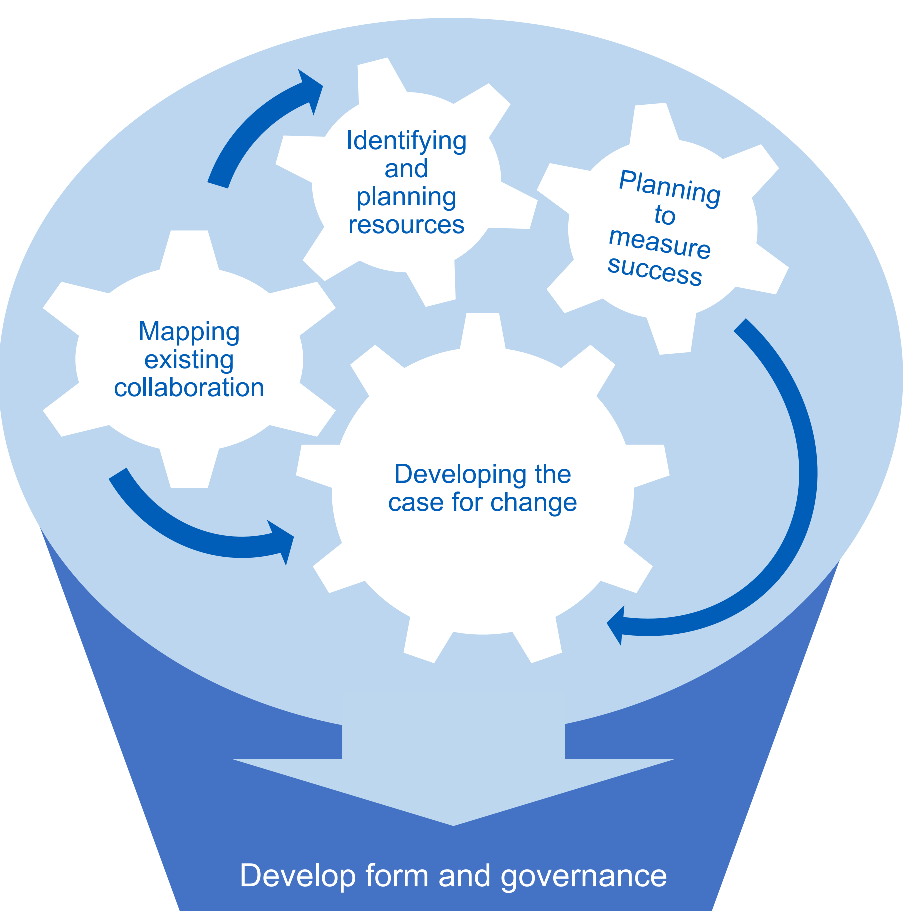
NHS

# A helpful early step in setting up a provider collaborative is to take stock of the strength of the cross-cutting enablers of good collaboration and plan how to address any gaps.

The extent of collaboration between providers varies across the country. Some areas have more developed arrangements, while others may be starting out. Established provider collaboratives described the elements below as key enablers to success. When starting out, a good step is to consider the extent to which these enablers exist or need to be strengthened. Collaboratives may need to develop some enablers, such as data and digital, overtime as part of or alongside other programmes of work.

| Enablers of good collaboration | |
|---|---|
| Relationships | Good relationships among providers and system partners will underpin effective provider collaboratives. It's necessary to build and nurture relationships and a collaborative culture at all levels, based on honesty and transparency. Expect that this will take time and involve trial and error. Some trusts used relationship-building 'kick-off' workshops aiming to begin with open and honest discussions about challenges and any concerns about working together. Ensuring that all members of the collaborative are represented on boards, committees and programme teams is another way to build trust. |
| Clinical leadership | Empowered and engaged clinicians accurately define problems and ensure the solution is evidence-based and meets patient needs. Provider collaborative boards will have membership which includes the chief executives or chairs of the member organisations. But service redesign needs to be clinically-led. The provider collaboratives in our case studies took steps to identify and tap into clinical leadership, for example, by allocating time of clinicians from systems or trusts and working with clinical reference groups or clinical senates to co-design services. |
| Patients, staff and communities | Providers will need to consider how they work with and rely on the expertise and experiences of patients, families, staff and communities to make sure that people are involved in service change. Sharing best practice around community engagement and working with patient groups, the voluntary sector, primary care, and place-based partnerships are just some of the ways that providers can ensure they connect with people and communities. Staff can play an important role in achieving change and leaders will want to promote a collaborative culture throughout their organisations. |
| Data | 'Open book' approach to sharing performance and population data and clinical strategies will help overcome siloes and maximise use of capacity. Population health data, performance and quality data will help to identify where change is needed and benefits that can be delivered and monitor progress and outcomes. Collaborative leaders will need to consider what data they have, where and how this is held, and how it can be shared to support delivery of collaborative programmes. |
| Digital | Investment in digital capabilities can support the need for sharing information and spreading innovative practice across the collaborative, as well as help improve work and patient flow. Digital solutions can enable working together, for example, by building a picture of shared capacity across a system or a shared pool of staff. |

# Key steps in planning the collaborative include developing an initial case for change and mapping existing collaborations; form and governance models should follow and should be proportionate to the objectives the collaborative aims to achieve.




| **Key steps**– these are iterative and are not always sequential, local circumstances should inform implementation. | |
|---|---|
| Case for change | Articulate shared challenges and ambitions and define specific objectives with programmes of work and risks. |
| Existing collaboration | Map existing collaborations, including clinical networks or other transformation programmes being delivered jointly in the collaborative's geography |
| Resourcing | Agree what resources are needed to deliver the objectives, using existing resources where possible to drive the collaborative. |
| Measuring success | Outline in advance how the collaborative will measure its success. |
| Form and governance | Select the form and governance that best supports delivery of shared objectives. |

**A worksheet on the key steps can be found in the Tools Library.**



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# When developing a case for change and defining a shared set of priorities, consider the potential benefits of working together across clinical services, clinical support services and corporate services.

- After the initial work to define a shared vision and purpose, specific objectives can be identified by developing a case for change looking at **opportunities to deliver benefits** across clinical services, clinical support services and corporate services. This work should align closely with the priorities of ICSs.
- When identifying benefits, providers should reflect on the membership of the collaborative and **ensure an inclusive approach** – the collaborative should involve all providers who are needed to deliver, or may be impacted by, delivery of the benefits, and this may include providers of a range of different services along pathways of care.
- Providers may want to start with simpler projects, gain proof of concept and identify areas where they can work better together, and then move to more extensive and complex projects. A separate, specific case for change can be developed for each programme that the collaborative will oversee.

| | Clinical services | Clinical support services | Corporate services |
|---|---|---|---|
| **Why should these services be prioritised?** | • Standardisation of protocols, policies and pathways may enable providers to reduce variation in access, experience or outcomes.<br>• Collaborative working can lead to new models of care, helping to address ongoing challenges for individual providers.<br>• Partnerships can help tackle inequality by improving representation in decision-making. | • Standardisation and consolidation of laboratory services can help deliver routine and direct access testing from fewer sites.<br>• Images and reports can be shared at point of care through common technical solutions.<br>• Clinicians can easily access patient records at whichever site they attend. | • Collaborative approaches to staffing increase retention and make recruitment easier, improving staff experience and reducing agency spend.<br>• Joint procurement helps providers leverage increased volume to obtain better prices and standardise products across collaboratives – resulting in savings and improved quality. |
| **Examples from provider collaboratives:** | • Standardised nursing practices including handovers, mid-shift huddles and training.<br>• Shared frameworks for standards of care, safety and hygiene.<br>• New pathways with joint bed management and single point of access referral processes.<br>• Creating hubs or networks with centres for lower volume or more specialised services where this is appropriate for local populations. | • Shared pathology services with laboratories moving to a 'hub and spoke' model.<br>• Demand and capacity modelling for CT and MRI scans across providers to understand demand.<br>• Implementation of a shared EPR system ensuring interoperability and information sharing across all sites. | • Platform through which vacant hospital shifts are broadcast to shared pool of qualified staff.<br>• Joint nursing development programme including 'employee passport', enabling nurses to move easily between trusts.<br>• Centralised recruitment hub and campaigns.<br>• Joint purchasing of surgeon gloves, film dressings, anti-embolism stockings and more. |

**Further support on developing a case for change can be found in the Tools Library.**



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# Mapping existing collaboration across regions and systems is a helpful step to align different partnership arrangements and build on existing collaboration where possible. This can also help to determine the necessary scale and focus of the provider collaborative.

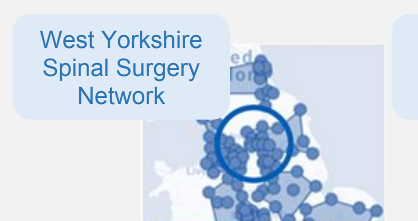
- Provider collaboratives should build on existing partnerships where possible, therefore it's important to know what's already in place. **Mapping existing levels of collaboration, characteristics of these collaborations** and **existing relationships between leadership teams** will help determine the scope of any future arrangements.
- Providers can consider whether and how a provider collaborative can support the work of clinical networks, for example, by hosting network activities or enabling providers to agree on network-led transformations across a range of services.

## 1. Mapping existing collaboration

**Potential types of existing collaboration:**

- Cancer alliances
- Clinical networks
- Leadership groups, eg, Chief Nurses network
- Clinical reference groups or clinical senates
- Networks providing clinical support services – for example, pathology networks and diagnostic imaging networks

**Example: some of the collaborations in West Yorkshire and Harrogate (see our case study to read more about West Yorkshire's collaborative)**



## 2. Mapping key characteristics of existing collaborations

**Potential characteristics:**

- What geography/footprint does the collaboration cover?
- What services or transformation programmes are they working on?
- What providers are involved and how do they work together?
- How do they align to or work with Places in the system or systems in which they operate?
- Are there gaps or areas of support needed to agree or drive implementation of their work?

## 3. Assessing relationships

**Mapping existing leader relationships:**

Linked to the enablers of good collaboration, existing relationships between leadership teams can provide a platform for building collaborative arrangements and programmes.

Relationships may be:

- Formal – may include group models or arrangements in which providers share a leadership team.
- Informal – may include groups in which leadership teams from across a system come together, for example, in Directors of Nursing, Strategy, Finance or Medical Director networks.

# Resourcing requirements will depend on the scope of activities carried out by the collaborative. Resourcing should be proportionate to the benefits the collaborative wants to achieve and should develop over time as the scope of activities grows.

Many established provider collaboratives have emphasised the importance of having dedicated resource, while recognising that collaborative working must also be built into existing roles. Typically, staff from individual providers are partly or wholly assigned to the work of the partnership, however, in some cases, roles were recruited to directly.

## Staff

**Roles to consider:**

| Role | Activities |
| --- | --- |
| **Leadership and management** | • Day-to-day leadership and direction of the collaborative<br>• Policy and strategy advice |
| **Secretariat and administration** | • Co-ordination of meetings<br>• Preparation of papers<br>• Briefing support |
| **Business intelligence and PMO** | • Data analysis, including population health intelligence, and production of dashboards/reports<br>• PMO and programme delivery teams to support transformation programmes |

**Examples from provider collaboratives:**

- Different governance models may impact resourcing decisions; for example, for collaboratives using lead provider arrangements, the lead's programme and clinical directors provide day-to-day leadership and management. In other collaborative arrangements, the functions may be shared across providers.
- Dedicated PMO function – to create a dedicated programme delivery function, some collaboratives have hired staff to run collaborative programmes; some collaboratives and their ICS share PMO resources, some may redeploy existing staff to collaborative activities.
- In some cases, new roles were developed for clinicians, enabling them to lead or co-design service changes on behalf of the collaborative.
- Regional clinical senates provide independent scrutiny of decision-making and priority development. They can help bridge provider collaborative strategy with ICS decision-making and the responsibilities of commissioners.

## Funding

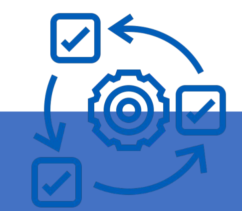
**Options that provider collaboratives have used or could consider:**

- Annual funding dedicated to collaborative from each provider (e.g. £2 million between 6 acute trusts).
- Funding collaborative activities through efficiency and joint procurement savings.
- Systems contribute to funding the provider collaborative; this may be a useful option to consider particularly where ICSs have asked provider collaboratives to lead delivery of certain system priorities or programmes.

**An example job description can be found in West Yorkshire Association of Acute Trusts case study on FutureNHS.**

# Collaboratives should build-in plans from the beginning of the project to measure their own progress and success. Measures may be drawn from existing data collections.

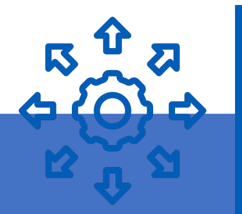
- Providers should use a mix of progress and outcome measures to understand whether the collaborative is achieving the benefits that providers set out to deliver. These measures can sit at either specific programme or overall collaborative levels. The appropriate measures of success should be based on system priorities and local circumstances, as reflected in the case for change.
- Measures can often be drawn from existing data collections, e.g. CQC ratings, population health data, staff experience surveys and should be embedded into programme management and reporting functions.



**Progress measures measure the specific steps in a process that might lead to defined outcomes.**
*They are important as they provide an interim measure of progress towards longer term outcomes.*

### Some possible measures to consider:

- Greater workforce flexibility through use of workplace passport
- Agreed set of provider collaborative priorities aligned with system priorities
- Clear governance arrangements established
- Agreed data sharing and monitoring strategy in place
- Processes for joint procurement or other corporate activities established
- Streamlined or standardised protocols in place across defined clinical specialities
- Streamlined working with ICS and wider partners to facilitate integrated care



**Outcome measures are the high-level clinical or financial outcomes or benefits that the provider collaborative expects to achieve.**
*They will ultimately determine whether the collaborative has been successful.*

### Some possible measures to consider:

- Improved staff experience and retention
- Effective use of resources
- Greater uptake and spread of innovation
- Reduced unwarranted variation in health outcomes
- Improved patient experience

**An example logic model and links to further evaluation resources can be found in the Tools Library.**

# As described in the guidance, provider collaboratives should have some common capabilities, underpinned by a form and governance model that enables the collaborative to work together effectively to deliver benefits.



- There is no one form and governance model that all collaboratives must adopt; it will be up to members to decide which arrangements will work best for them to achieve the benefits that they have identified.
- It is important that governance arrangements enable leadership team members of each organisation to take decisions together at pace on behalf of their organisations, and enable them to quickly resolve differences about those decisions (for example, a committees in common model can facilitate this).
- Generally, less formal arrangements, in which there is no ability for individuals (eg CEOs) on the provider collaborative leadership board to take decisions on behalf of their organisations, are not likely to have the capabilities required of provider collaboratives. However, some provider collaboratives have maintained individual trust Board approval at key stages of decision-making and have found this works effectively when relationships are strong and Boards are fully supportive of the objectives of the collaborative.

The provider collaborative guidance sets out some guiding principles for deciding form and governance arrangements:

**Guiding principles: form and governance should…**

- **Be based on 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, with leadership teams encouraging and supporting collaborative culture throughout their organisations.
- **Build on and enables existing successful governance arrangements**; for some areas arrangements may need to be strengthened rather than created from scratch
- **Enable providers to efficiently reach decisions, which each member is committed to upholding**, on topics that are within the collaborative’s remit
- **Provide strong mechanisms for members to hold each other to account** to ensure that decisions are reached and carried out and benefits of scale are realised at pace
- **Ensure the needs and voices of local communities are a key consideration** in all decisions and clinical leadership is embedded in programme delivery
- **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
- **Help streamline ways of working within and across systems**; for example, by empowering members to engage in conversations about transformations on behalf of all members

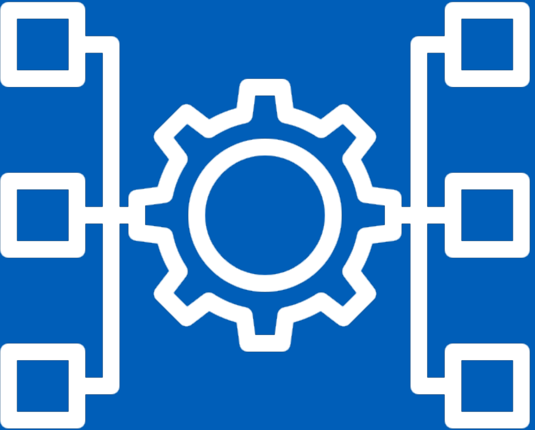
# Form and governance models

**This section covers:**

- Key questions
- Committees in common
- Examples of models
  - Provider leadership board
  - Lead provider
  - Shared leadership
- Contractual arrangements
- Next steps

**Corresponding tools:**

- Case studies



# Form and governance provides a framework for provider leadership teams to work together and make effective decisions about how to deliver benefits.

To develop the form and governance arrangements, providers should think about the 'building blocks' of a collaborative model and consider some key questions:

### What **boards, committees and links to partners** are needed to carry out the collaborative's work?

- What board structure and reporting structure is needed to ensure that leadership has appropriate oversight, assurance and challenge?
- What are the chairing arrangements and how often should the board meet?
- Should sub-groups be established to oversee specific programmes of work? Who will sit on and lead these?
- Should there be advisory committees, such as strategy or clinical advisors? Who will sit on and lead these? How often will they meet?
- How will the collaborative's governance structure link with those of the ICS and other partners to exchange input and ensure alignment of objectives?

### What **decision-making arrangements** will best support effective collaborative working?

- Under each trust's governance, can individual trust boards delegate decision-making to their representative on the collaborative? Or do decisions of the collaborative need to be ratified by the boards?
- How will decisions be taken? Will unanimity be required or will trusts agree that they will each provider take the decision that a majority of providers have agreed to take?
- Are there different types of decisions that may be taken and do all members need to be involved in all decisions?
- How will the collaborative resolve any disagreements among members? Or otherwise ensure that disagreements do not derail progress?

### What **written agreements** are necessary to underpin all of these arrangements?

- What MOUs, alliance agreements, or other contracts will providers enter into to record these arrangements and formalise their provider collaborative?

| Decision-making arrangements | Risks and benefits management |
| --- | --- |
| Boards, committees and links to partners | People, leadership and support roles |
| Written agreements | |

### How will **risks and benefits** be managed?

- How will risks to delivery be identified, reported and managed?
- How will financial risks be managed and shared across collaborative members?
- How will any financial savings be managed and/or reinvested? How will this be decided?

### What **people and roles** will be needed to achieve the vision and purpose?

- Do we have the right providers involved to deliver the benefits?
- Who will be part of the leadership of the collaborative?
- What support roles are necessary to deliver programmes and who will fill these roles?
- How will we incorporate clinical leadership and who will fill these roles?
- How will non-executive directors play a role?

# Committees in common can be used to facilitate collective decision-making in areas of delivery or transformation that the collaborative members have agreed to work on together.

- Provider collaboratives may make use of committees in common to support their form and governance models. Committees in common are a way for organisations to take aligned decisions about how to deliver benefits of scale.
- Providers should consider the role of non-executive directors (NEDs) in any governance model. NEDs have an important role to play in offering challenge and scrutiny to decisions taken by the collaborative.
- If the Health and Care Bill is enacted, NHS Foundation Trusts and NHS Trusts will be able to delegate decision-making functions to joint committees. This may mean that governance arrangements will look different from committees in common, but the results – taking decisions together – are the same.

*This toolkit will be updated to reflect any changes to governance arrangements that are enabled by the legislation.*

## How do they work?

- An **NHS foundation trust** board may delegate some or all its powers to a committee of its own directors (or one executive director) to exercise (take decisions) on behalf of the organisation. A wide range of responsibilities can be delegated, but they must be in line with a board's scheme of delegation. Committee members remain accountable to their respective trust boards.
- An **NHS trust** may 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.
- These committees with delegated authority meet at a common time and place where decisions can be taken on behalf of each participating trust.
- These committees in common should each work according to the same agenda and consider the same papers. A single discussion can take place, considering the matters of common concern to the trusts but also addressing issues of specific concern to one or more of the trusts involved.
- Commissioning contracts remain with the respective providers.
- Trust boards remain accountable for the decisions taken in committees in common and so often will want to maintain a monitoring role.

**They can be setup in different ways** depending on what they are for, ranging between:

- **Time-limited committees** set up to tackle a specific issue, in which case members may have delegated decision-making responsibility only until the decision has been reached, at which point the committees in common may cease to meet. This option is only viable in the context for provider collaboratives if it doesn't serve as the main form of the collaborative, as Provider Collaboratives need to have more long-standing way of taking decisions.
- **Ongoing committees** with maximum possible delegation of duties from trust boards. Aims to create, as far as possible, a joint board for member trusts.

**They can range in scope, between:**

- **Topic specific delegation**: where committees in common are delegated responsibility for the oversight and delivery of specific priority/topic
- **Maximum delegation**: where boards delegate to committees in common a wide scope of responsibility and functions, however, each individual trust board remains accountable for the board's functions and responsibilities, including those which have been delegated.

# There is no one-size-fits-all model of collaborative. Established provider collaboratives have used a variety of arrangements based on local objectives and context. These tended to fall within three broad types of collaborative.

- Pages 19 to 24 of this toolkit describe some of the form and governance models that we have seen provider collaboratives use to achieve benefits of scale. Even within these models, specific arrangements varied according to local circumstances and objectives.
- Larger groups of acute trusts, or mixed groups involving all of a system's trusts, often used the provider leadership board model. Mental health providers more often used lead provider models as many of these were established as part of the NHS-led Provider Collaboratives programme for specialist mental health services. Shared leadership models tended to involve two to three trusts and often had specific aims to improve the quality or sustainability of one or more trust involved.
- The models are not mutually exclusive; they can be combined or work in parallel and one may evolve into another. These models can be implemented within the current (2021) legislative framework, and this section will be updated to reflect changes that may be enabled by the Health and Care Bill if enacted.

## Provider leadership board

- 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. This enables them to tackle areas of common concern and deliver a shared agenda on behalf of the collaborative members and their system partners.
- This model can make use of **committees in common**, where committees of each organisation meet at the same time in the same place and take aligned decision.

## Lead provider

- A single 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

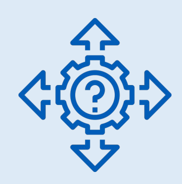
- Each collaborative member has a defined leadership structure in **which the same person or people lead** each of the trusts involved. Generally, this has been achieved with, at a minimum, the same person filling the chief executive posts at the trusts involved in the collaborative, and may also include chairs and other executive posts
- NHS trusts can also achieve shared leadership by having their board delegate certain responsibilities, within the remit of the provider collaborative, to a committee made up of members of another trust's leadership team. Under either approach, **each trust's board remains separately accountable** for the decisions it takes (even if aligned, for example, through use of committees in common).

**Case studies on each of these models can be found on FutureNHS.**

# **Provider leadership board**: Leaders from participating trusts come together with delegated responsibilities from their boards

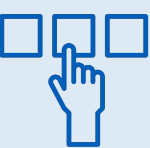
## What are the core components of a provider leadership board?

- An agreed shared vision that encourages and incentivises collaboration.
- At a minimum, each trust board delegates decision-making responsibility for agreed areas to the trust CEO (and optionally additional members of the leadership team). A wide range of decision-making responsibilities can be delegated, but they must be in line with the board's scheme of delegation and constitution. Some trusts may need to adjust their schemes to enable the work of the collaborative. Boards can change or revoke the authority delegated.
- CEOs do not need to return to their individual boards for approval of decisions within the remit of their delegated responsibility. Not requiring subsequent board approval can speed decisions and delivery of benefits and ensure that agreed actions go forward. However, established provider collaboratives have often had individual trust boards retain approval at certain stages of decision-making or for certain levels of decisions. Trusts will need ensure that whatever model they use enables effective collective decision-making and progress toward meeting objectives.



## What are the key decision-making arrangements?

- Members of the collaborative enter a **partnership agreement**, such as an MOU or alliance agreement, setting out their shared visions, terms of reference, how they will work together and take decisions, how they will hold each other to account, and any risk or gain sharing arrangements.
- CEOs and others with delegated responsibilities from each trust meet in common – at the same time and same place – to discuss issues within their agreed areas of concern and take decisions on behalf of their trusts; decisions for each trust reflect what the members have agreed.



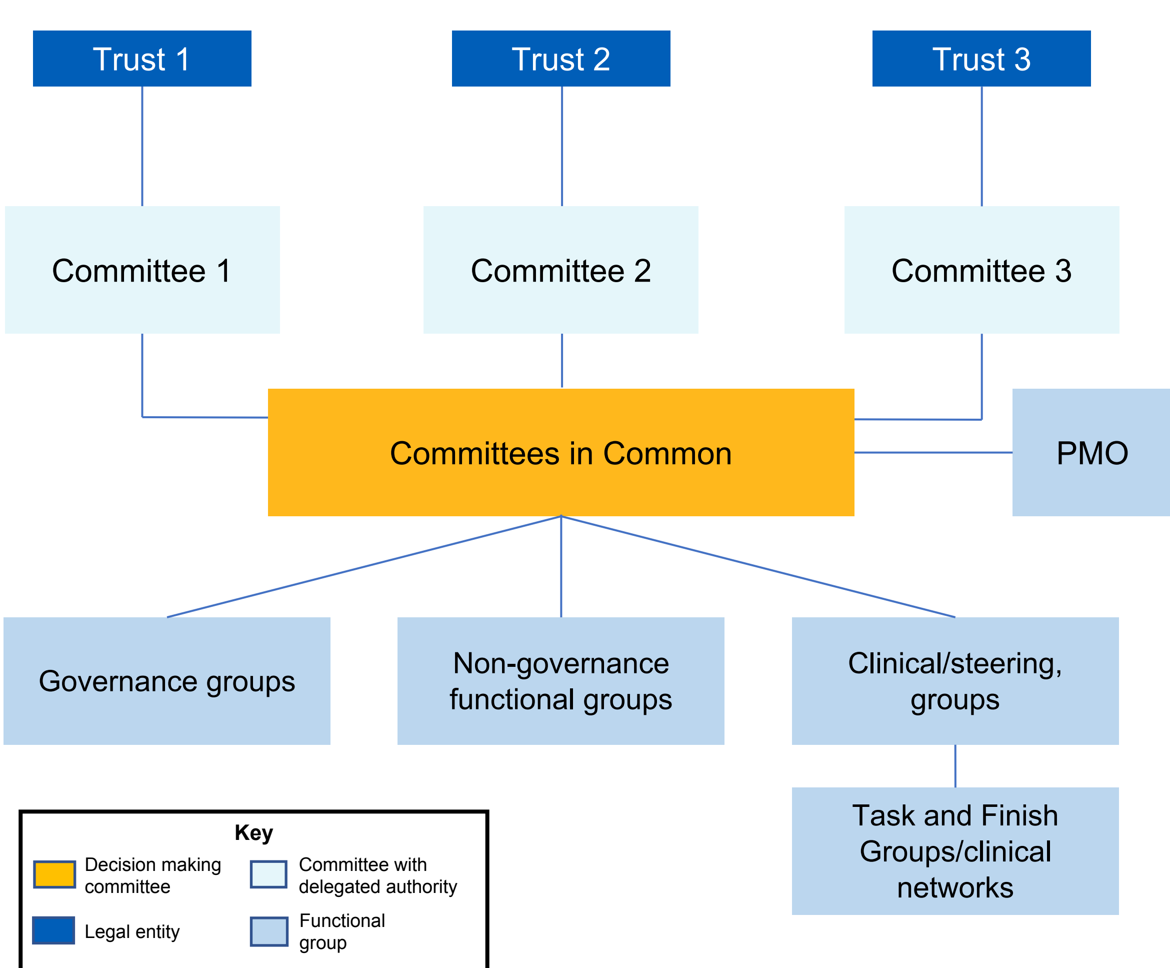
## When is this model most suitable?

- When accommodating collaborations that involve large numbers of providers or larger geographies.
- To enable collaborative working while maintaining full organisational independence.
- When seeking flexibility and ease that will allow the collaborative to scale up in future with new members or new programmes.

## How are system partners typically involved?

- Priorities set jointly with the ICS; collaborative can also deliver cases for change to commissioners/ICSs to agree; providers will continue to hold individual contracts with commissioners.
- Non-NHS providers may be represented on committees in common; however, legal advice should be sought on whether a particular non-NHS provider's board can delegate decisions and on what collaborative decisions the provider can be involved in.

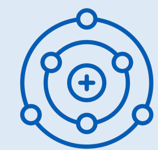
# **Provider leadership board:** an example of governance




## Governance structure

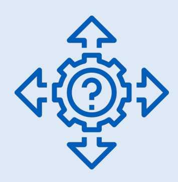
- The provider collaboratives in our case studies use **delegation** to take decisions together.
- The board of each trust in the collaborative delegates authority to an individual or committee within their organisation. These individuals or **committees then meet in common at the same time and place** where aligned decisions can be taken on behalf each participating trust.
- Typically, there is a **rotating chair** of the committees in common **or an independent chair** is elected.
- Typically, a **clinical advisory or steering group** supports the committees in common to help consider best practice and how services can be improved.
- Provider leadership board collaboratives established an **independent PMO function** to progress their work programmes and ensure effective operation of the collaborative.
- The collaborative can establish **functional groups or standing groups** to develop proposals and take agreed actions and/or task and finish groups to take forward agreed priorities and then disband. These are often sponsored by an executive-level Senior Responsible Officer.

# **Lead provider:** A single NHS trust or foundation trust takes contractual responsibility for delivering an agreed set of services on behalf of the provider collaborative



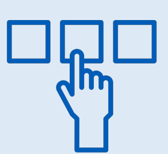
## What are the core components of a lead provider model?

- NHS England and NHS Improvement has used this model to achieve benefits for patients of specialised mental health services. A single trust is a lead provider, who then subcontracts, as appropriate, with the other members of the collaborative to deliver a defined set of services.
- The commissioner has a role in determining who the lead provider is through a provider selection decision, as well as consenting to sub-contractors.
- Funding for in-scope services flows to the lead provider, who takes responsibility for designing pathways that meet the needs to patients and communities, and meet the terms of the contract; members of the collaborative agree how services will be designed and delivered.



## What are the key decision-making arrangements?

- The lead provider and other members of the collaborative enter into a **partnership agreement**, such as an MOU or alliance agreement, setting out their shared visions, terms of reference, how they will work together and take decisions, how they will hold each other to account, and any risk or gain sharing arrangements.
- The role of the lead provider and their responsibilities are clearly established. Collaborative members may agree that some of the lead provider's decision-making powers will be exercised collaboratively with partners.



## When is this model most suitable?

- When there is an agreed and trusted local leader or organisation.
- Where systems have determined that integration and quality of care can be improved by having a lead provider take responsibility for designing services and managing the budget for the services, with senior clinical leadership closely involved.
- When systems are seeking to address fragmented or unstainable services through pathway redesign or by creating a network of providers.

## How are system partners typically involved?

- Providers in the collaborative work closely with commissioners and other system partners, including local places, to plan whole pathways of care across historical boundaries of primary, secondary and tertiary care. Clinical leadership should drive the design of new models of care.

# **Lead provider:** an example of governance

*Contract and payment flows*

NHSE or other commissioners

Lead provider

Provider 2 | Provider 3 | Provider 4 | Provider 5

Provider collaborative board (optional, committees in common)

*Optional operational elements*

PMO

Governance groups

Non-governance functional groups

Clinical/steering groups

Task and Finish Groups/clinical networks

**Key**

Decision making committee

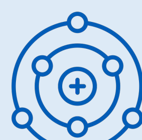
Functional group

Legal entity

## Governance structure

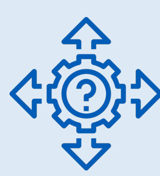
- The lead provider must have the **capabilities and capacity** to plan and procure the services they are responsible for delivering. The lead provider's role in arranging provision of services should be clearly split from the provider's operational functions.
- The **NHS-led mental health provider collaboratives** have in some cases organised a model in which the functions of arranging services are carried out by the collaborative as a whole; others have created a separate team instructed by the lead provider to carry out these functions.
- A **PMO function** should be established to ensure the smooth functioning of the collaborative.
- The governance structure can vary **depending on whether strategic decisions rest with the lead provider or are exercised in collaboration with other partners**. The diagram illustrates an example where strategic decisions are exercised through a partnership board where each provider is represented. This board can be advised by clinical groups or establish functional groups/task-and-finish groups to take forward agreed actions.

# **Shared leadership:** the same person or people lead the providers involved in the collaborative



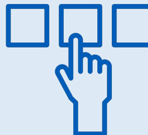
## What are the core components of a shared leadership model?

- Leadership, in particular the CEO but potentially the full leadership team, are the same for each of the providers involved. Alignment between trusts' decisions and actions is achieved because the decisions are made by the same people.
- Each provider's board remains accountable for all decisions. For example, each provider board retains the power to change or revoke the authority delegated to its committees in common if this is established.
- Examples of how shared leadership can be achieved include:
  - through a management support agreement (for example, one trust supporting management of another, with a joint CEO and Chair)
  - through forming a contractual joint venture (trusts come together to create a new contractual organisation) or a corporate joint venture (FTs only)
  - trusts enter into an MOU with terms of reference and the same person or people are appointed to lead two or more trusts in the collaborative
  - where the benefits and strategic case for doing so are clear, a group operating model can be established involving a dual-tier leadership structure; the group leadership makes strategic decisions for all trusts involved, while operating unit leadership focuses on the operational activities of each site.



## What are the key decision-making arrangements?

- Provider leadership board and lead provider models will make decisions across a range of benefits and programmes that participating providers have agreed to deliver jointly, whereas a shared leadership model will result in all decisions being aligned through joint leadership.
- Committees in common can be used, for example, where a joint CEO takes certain decisions with committees made up of other leadership team members of each trust, sitting in common at the same time and place.



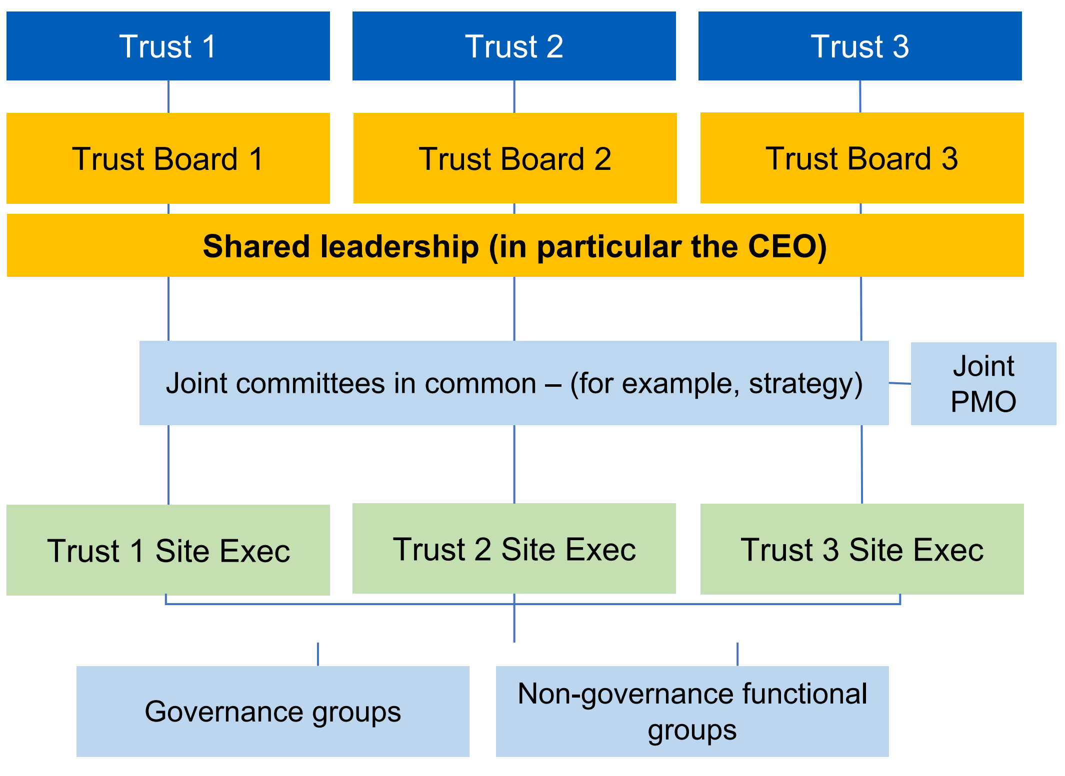
## When is this model most suitable?

- Where there is a strong leader or leadership team with capacity to act across multiple sites.
- To strengthen joint decision-making arrangements where they have not been effective previously.
- To repair poor historical relationships or to build common positive cultures across multiple organisations.

## How are system partners typically involved?

- Each trust or site that is operating under shared leadership will also likely be a member or leader of a place based partnership in their local area and will need to work with partners to ensure their priorities are aligned across a system or systems.

# **Shared leadership:** an example of governance




## Governance structure

- The **governance structure can vary** in shared leadership models depending on how many leadership posts are appointed with the same person and whether the trusts choose to have committees in common to further align leadership decision-making.
- The structure opposite illustrates an arrangement in which the **same person has been appointed to key leadership posts** at each trust, and the **trusts have created committees in common** to take decisions jointly across certain areas, such as strategic direction.
- Where the trusts establish committees in common, the boards of each trust will delegate **decision-making authority** to the joint CEO and other leadership team members who will sit in the committees in common (see provider leadership board structure for more information about committees in common).

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# Contractual arrangements: written agreements between partners will provide the foundation for any provider collaborative model.

Some options for written agreements are below. Legal advice may be required. If the agreements result in changes to a major service contract or meet relevant thresholds for scale, monetary value and risk, this may trigger an NHS England and Improvement review.

Depth of collaborative relationship

| | |
|---|---|
| **Memorandum of Understanding (MoU) / Alliance / Partnership agreement** | MoU / alliance / partnership agreement captures the objectives of the collaborative, terms of reference, agreed ways of working, agreed principles and behaviours, governance and decision-making and how resources (financial and non-financial) will be shared and deployed. All member organisations will need to agree to these terms.<br>• Some partnership agreements, or portions of them, can be legally binding on the organisations involved.<br>• An alliance agreement may include commissioners and overlays and relates to – but does not replace – the service contracts that each provider holds. |
| **Risk/gain share** | A contract can be agreed between partner organisations to distribute among them any savings, or losses, from a change that involves the member trusts. This arrangement may exist separately or feature as part of wider MOU/agreement. |
| **Contractual joint venture** | This is an agreement that does not establish a new organisation but can create legally binding rights and responsibilities. Examples include contractual joint ventures for pathology or radiology services. Providers make legally binding agreements between themselves about how to manage financial flows, make decisions jointly, and share staff and other services. This may be suitable to use when an NHS FT wants to tightly integrate some aspects of its work with other partners and/or it is not possible or desirable to undertake a formal merger. |
| **Lead provider sub-contracting** | A lead provider model will involve a contract between a commissioner and the lead provider in which the lead provider takes responsibility for redesigning services to meet patient's needs, delivering services and managing the budget for the services. The lead provider will enter sub-contracts with other collaborative members. This type of subcontracting agreement can take several forms:<br>• It can be the subcontracting of an entire service or of delivery of part of a care pathway.<br>• It can be the sub-contracting to one sub-contractor or to multiple subcontractors.<br>**Under this arrangement, the Lead Provider retains overall responsibility for the management and delivery of all the contracted requirements under the contract with the commissioner.** In some cases, the commissioner may seek to have a Contract Manager overseeing the Prime Contractor's management of the services.<br>The purpose of the NHS Standard Sub-Contract for the Provision of Clinical Services is to save time and effort for NHS providers and to reduce their risk, and that of commissioners, by ensuring consistency of the Standard Sub-Contract with the NHS Standard Contract.<br>Providers and commissioners using this model may need to engage with the NHSEI Integrated Support and Assurance Process |
| **Management support agreement** | A contract that sets out the arrangements involved in a trust providing leadership support to another trust. The agreement is likely to set out what the trusts will give and get as part of the agreement, conditions for termination (for instance handover arrangements) and any payment associated with the support. NHS England and NHS Improvement, or other bodies, may also be party to the agreement. The management support agreement can support the provider leadership board, lead provider and shared leadership models. These agreements have most often been put in place in response to concerns at one of the trusts involved. |



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# Systems and providers have highlighted some challenging issues that need further exploration. NHSEI is working with stakeholders to develop and share insights about these key issues.

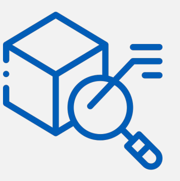
**Example key issues**

### How do provider collaboratives work with Places and other system partners?

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, including addressing health inequalities. Provider collaboratives need to agree objectives and priorities, and these must be consistent with those of the ICS(s) which they serve.

### How do provider collaboratives work with clinical networks and Cancer Alliances?

Through their membership and scope spanning multiple places or ICSs, provider collaboratives will work closely with other collaborations including clinical networks, Cancer Alliances and clinical-support service networks where there are mutual benefits in doing so, without creating further complexity or duplication.



### How do provider collaboratives manage provider dynamics, support each other, and hold each other to account?

Provider members may have different individual features and challenges; they may be large or small, rural or urban, high or low performing, with weak or strong cultures of collaboration. We want to explore how this dynamic works, how small remote hospitals will be supported, how providers hold each other to account and resolve differences.

# Tools library

**Tools included:**

- Setting up a provider collaborative worksheet
- Example job descriptions (as part of WYAAT case study)
- Developing a case for change worksheets
- Logic model
- Evaluation resources
- Case studies

# Setting up a provider collaborative

*Have all steps been considered? (Note: this may be iterative and not in the order below)*

| Key steps | | Considerations for each step | Completed? Y/N |
|---|---|---|---|
| | Case for change | ✔ Identified benefits, shared objectives and priorities, considering broad areas of clinical, clinical support and corporate services and the benefits you can achieve in these areas across clinical care, workforce, and financial benefits.<br>✔ Prioritised areas or programmes which are most important for populations and local communities.<br>✔ Aligned priorities and benefits with plans of ICS, system partners and other collaborations. | |
| | Existing collaboration | ✔ Mapped existing collaborations including cancer alliances and clinical networks.<br>✔ Mapped key characteristics of providers and system.<br>✔ Assessed leadership relationships including formal and informal ones. | |
| | Resourcing | ✔ Agreed a fair, appropriate and proportionate plan for resourcing and funding.<br>✔ Determined the correct skills mix necessary for successful implementation, including any data/analytics capabilities that are required. | |
| | Existing collaboration | ✔ Mapped existing collaborations including cancer alliances and clinical networks.<br>✔ Mapped key characteristics of providers and system.<br>✔ Assessed leadership relationships including formal and informal ones. | |
| | Form and governance | ✔ Considering which model of form and governance is proportionate and can best achieve the benefits.<br>✔ Considering the building blocks of form and governance. | |
| | Measuring success | ✔ Agreed progress measures of success to help evaluate plans, structures and mechanisms.<br>✔ Agreed outcome measures of success to help track achievements and areas of challenge. | |

# Developing a case for change

## 1 WHAT SHOULD BE INCLUDED IN THE STRATEGIC CASE?

Strategic cases should be **actionable, realistic and relevant,** therefore plans should be put into the context of:

**National priorities**
*e.g. objectives set out in the Long Term Plan*

**System characteristics**
*e.g. needs specific to system population*

**Local relationships**
*e.g. provider collaboration and other arrangements*

**Restoration**
*e.g. COVID-19 and elective recovery*

**Clinical services** | **Clinical support services** | **Corporate services**

**Example cases to consider within each of these broad areas, including key questions:**

### Clinical case

- What are the clinical needs and priorities of your footprint? Population health management data will help inform this.
- How can system-wide collaboration address provider challenges? E.g. unwarranted variation.
- How can delivery of care become more integrated and sustainable?
- How can clinical excellence be delivered through digital solutions?

### Workforce case

- Are there any opportunities to improve recruitment and retention?
- How can collaboration impact system efficiency? This may include streamlining protocols, processes or governance.
- How can collaboration lead to innovation?
- How can leaders motivate staff to become more collaborative and encourage future leaders to continue these behaviours?

### Financial case

- What are the major factors affecting financial sustainability?
- What is the impact of COVID-19 on your system cashflow?
- How can provider collaboration address the existing financial pressures?

Continuous communication and engagement with various stakeholders is needed to build the case for change

# Developing a case for change

## 2 WHAT SHOULD BE INCLUDED IN PROGRAMME PLANS?

Strategic case
- *linking back to national and local priorities*

Programme 1 identified | Programme 2 identified | Programme 3 identified

The number of programmes will differ depending on the objectives and maturity of the collaborative. For each programme, it is helpful to determine:

The desirable outcomes you want to see for patients, communities, staff and your systems

The inputs (resources) required to generate the outcomes e.g. workforce, funding, technology, data

The specific activities and outputs generated

Use the outcomes, inputs and outputs to establish and agree the following with the provider collaborative board or other leadership:

1. The vision of the programme
2. The governance of the programme; what collaborative bodies it will be accountable to, in line with the overall collaborative governance structure
3. The approach to embedding clinical leadership, oversight and engagement with clinical staff
4. Intelligence, insights and the approach to engaging with patients, communities, partners at place
5. Create a risk register to outline all risks of the project and agree with board.

**Board approval and implementation**

1. Approve governance, plans and resources
2. Detailed planning with leads
3. Agree vision and next steps

Continuous communication and engagement with various stakeholders is needed to build the case for change

Using the logic model template can help you to structure these inputs, activities, outputs and outcomes and provide an overall framework for measuring the benefits of the programme.

NHS

# Providers should consider developing a logic model to describe the collaborative's programme of work and how it will generate a set of expected benefits.

A logic model is a useful tool for defining a programme and corresponding outcomes. It is a graphic depiction of how a programme of work generates a set of outcomes. Once set out in the logic model, the next step is to define a set of metrics by which to measure the outputs, outcomes and ultimately impacts of the programme.

| **Inputs**<br>*The resources used to produce outcomes, e.g. staff, funding* | **Activities**<br>*Collaboratives will undertake a set of activities…* | **Outputs**<br>*That will generate a set out outputs…* | **Outcomes**<br>*That will lead to a set of outcomes…* | **Impacts**<br>*And ultimately a set of longer term impacts.* |
|---|---|---|---|---|
| | | Greater workforce flexibility (e.g. through use of workplace passport to share staff across PC footprint) | Improved staff retention and experience | (Contributes to) financially sustainable systems |
| | | Joint procurement processes established | Greater uptake and spread of innovation | Improved patient outcomes and ultimately population health |
| | | Agreed set of priorities aligned with system level priorities | Reduced unwarranted variation | |

| Logic model component | Measure(s) |
|---|---|
| **Outputs** | |
| Greater workforce flexibility through use of workplace passport | Number of staff (i) with workplace passport and (ii) working across different providers |
| **Outcomes** | |
| Improved staff retention and experience | Proportion of staff reporting being satisfied (as reported in provider staff survey) |



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# Evaluation

Evaluation is an essential process that can identify critical issues, help inform decision making and ultimately assess the impact of an intervention. The following is a list of resources that provide guidance for systems on the different types of evaluations as well as the practical considerations of designing them.

| Guidance for systems | |
|---|---|
| Evaluation Framework: A set of principles, processes and resources<br>NHS North East & North Cumbria | This framework has been developed by the Mental Health Evidence and Evaluation Group with inputs from other groups. It aims to: ' *support health and social care commissioners and provider services (including clinical teams and service managers) to work collaboratively with service users, carers and wider stakeholders to embed the process of evaluation into routine practice.* ' |
| Evaluation: what to consider<br>The Health Foundation | Guidance that details the theory, rationale, and the different types of evaluation. It compares and considers the differences between different type of evaluations e.g. external vs internally commissioned evaluations. A list of resources on various aspects of evaluation is also available. |
| Magenta Book<br>HM Treasury | Comprehensive government guidance on what to consider when designing an evaluation, including purpose and timing of the assessment |
| Guide to Evaluation Design, Principles and Practice NHS Midlands Decision Support Centre (DSC) | Guide developed by the NHS Midlands Decision Support Unit (DSU) Network that outlines the steps of designing and conducting evaluation – including required governance, infrastructure and risk considerations. |
| Better Monitoring draft framework, Better Evaluation | This initiative, funded by UNICEF, focuses on monitoring functions, relevant activities and resources to aid within that monitoring process. |

Collaboratives may have their own unique metrics and frameworks to measure their progress and success. The following list contains examples of additional tools and templates that can assist collaboratives in developing their own tailored evaluation models.

| Tools | |
|---|---|
| Evaluation cycle<br>National Institute for Health Research, & NHS Bristol, North Somerset and South Gloucestershire CCG | Toolkit listing several resources at each of the identified stages of evaluation. Includes a checklist. |
| Cambridgeshire Full Evaluation Toolkit, NHS Cambridgeshire | 10 step evaluation checklist with relevant factors to build an evaluation framework e.g. stakeholder analysis |
| Evaluation Tool<br>Evaluation Support Scotland | Provides an interactive logic model (PDF template) for designing an evaluation |