

Provider collaboratives

Opportunities and challenges

Our members, the organisations that plan, commission and provide NHS services, are overwhelmingly supportive of the move towards statutory integrated care systems (ICSs). They recognise that many of the challenges faced in the healthcare sector can only be overcome by partners working more closely together.

Provider organisations have historically worked together to address mutual challenges, well before sustainability and transformation partnerships and ICSs were conceived. But the requirement for some providers to be part of a collaborative, and the formal role for provider collaboratives in the structure of ICSs, are new and need careful consideration.

This briefing sets out our view on provider collaboratives. It describes what they are, explores the background to provider collaborative models, details the experiences of our members and highlights the opportunities and challenges of this new requirement.

Key points

- The COVID-19 pandemic has shown the benefit of NHS providers working together to address challenges. Collaboration across NHS providers has existed for many years, with several of our members engaged in different forms of provider collaboration. However, provider collaboratives (one or more providers operating across places within an ICS) have been more formally recognised in policy terms over recent years and are expected to be a key element of ICS delivery.
- From April 2022, all health and care systems in England will be required to work together as integrated care systems. NHS England and NHS Improvement is developing guidance on the expectations of provider collaboratives. Early indications are that as a minimum all NHS trusts will be expected to be part of at least one provider collaborative.



- In reality, multiple collaboratives could operate locally, regionally and nationally, across one or more ICS footprint, as well as across several pathways and places within the ICS. This complexity creates opportunities to work differently but will not fit easily into a simple new architecture for the NHS and its partners. Our engagement with members points to opportunities to better join-up care for local communities.
- Although opportunities remain, members have identified six key challenges presented by the current drive for provider collaboratives. This includes lack of clarity on the overall purpose and aims of a provider collaborative; continuation of the provider-commissioner split; the need for inclusive representation, resources and investment; the balance between provider collaboratives at system and provider collaboration at place; and questions over the duty to collaborate and management of risks.
- While we support the direction of travel to enable and develop provider collaboration, there are several questions that remain unanswered. There is a risk that in making provider collaboratives a mandatory requirement, policymakers will remove the spirit of collaboration, forcing collaboratives to become focused on 'tick box' regulatory programmes rather than true innovation.
- We urge NHS England and NHS Improvement to avoid adopting overly simplistic models of collaboration, and instead embrace a flexible and permissive approach that considers a range of models that will work in varied geographies and contexts. However, we do believe it is imperative that the collaborative structures developed are inclusive of a range of providers, including community, ambulance and specialist trusts, as well as finding a method to genuinely listen to the voice of primary care.
- We have established a support offer for leaders developing or working in provider collaboratives. If you are interested in finding out more, please contact Kerry McQuade at Kerry.mcquade@nhsconfed.org

What is a provider collaborative?

Provider collaboration has existed in multiple forms for years. Collaboration can occur at several levels, including place, system, region and national, and can involve a varied range of partners.

A draft definition produced by NHS England and NHS Improvement defined provider collaboratives as focused on two or more NHS trusts/ foundation trusts working at an appropriate scale across places to join up services.

This definition of a provider collaborative more closely links provider collaboration to the strategic development of the ICS and its footprint of delivery. In contrast, provider collaboration is more fluid and organic, developing at multiple scales and geographies depending upon the case for collaboration and change.

A potted history

Our provider members have long remarked that most of the current challenges they face are unlikely to be resolved within their organisation alone. Instead, solutions to multifactorial 'wicked' issues are more often found in collaboration with a range of other partners, including other providers.

The ability of the provider sector to transform at pace has often been overlooked, with senior leaders in provider organisations frustrated by the continuation of centrally driven transformation programmes. Recent experiences during the COVID-19 pandemic have shown the benefits of providers working together to address challenges, from personal protective equipment supply to the elective waiting list.

Our members have been engaged in many forms of provider collaboration for several years.

These collaborations have included:

- 1. Organisations working together to address a challenging issue**, such as clinical quality, patient safety or workforce recruitment and retention. This might typically include, for example, two hospital trusts working together to improve fragile services in one or more speciality. It might also involve decisions at a system level about the centralisation of hyper acute stroke services to improve clinical outcomes.
- 2. Organisations working together to reduce the cost of back-office functions and/or drive efficiency savings**. This might include, for example, agreeing to employ a central procurement team to leverage the purchasing power of several hospitals, or to employ one team of executive directors to work across two organisations.
- 3. Organisations agreeing to form partnerships or committees across a defined geography to share experiences, influence local decision-making and make collective decisions** over issues of common interest, such as a regional urgent care strategy.
- 4. Organisations formally merging or agreeing to form a group structure** driven by financial and quality challenges, or by the requirement of the regulator.

Collaboration across NHS providers is therefore not something new, but provider collaboratives have been recognised more formally in policy terms over recent years.

The creation of NHS-led and supported specialist mental health, learning disability and autism provider collaboratives in April 2020 signalled a shift in policy and delivery. Based on the learning from a series of pilot projects (called new care models/vanguards), providers were empowered and incentivised to address

historical challenges in patient outcomes and experiences in a range of specialist services, including adult secure, child and adult mental health services and eating disorders inpatient services.

Evaluation of the early pilots of collaboratives found the benefits of these models to include repatriating out-of-area patients, reducing bed days and reinvestment of efficiencies in local community mental health services.¹

From April 2022, all health and care systems in England will be required to work together as integrated care systems and all NHS provider trusts will be expected to be part of one or more provider collaborative. Integration and Innovation, the white paper setting out reforms to the NHS in England, indicates that as a minimum a provider collaborative should include every NHS trust/foundation trust within an ICS. In reality, multiple collaboratives could operate locally, regionally and nationally across one or more ICS footprint, as well as across several pathways (mental health, community, acute for example), and places within the ICS. This complexity creates opportunities to work differently, but will not fit easily into a simple new architecture for the NHS and its partners.

¹ NHS England and NHS Improvement (2020), NHS Operational Planning and Contracting Guidance 2020/21 – Annex G: Planning Guidance for NHS Led Provider Collaboratives. www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21-annex-g-planning-guidance-for-nhs-led-provider-collaboratives/

Opportunities and challenges

Our members have identified a number of key challenges presented by provider collaboratives:

1. The overall purpose of the collaborative

The white paper describes provider collaboratives as being clinically led, with improved patient experiences and outcomes at the heart of the model. However, our members have expressed concern about the overall purpose and function of provider collaboratives. Many of the successful existing provider collaboratives were driven by the need to address a clearly defined challenge or issue within a local system. The decision to work together to address this challenge was usually made locally by leaders. In the national drive to create specialist mental health provider collaboratives, for example, data indicated a clear need to address out-of-area placements. This need, and the significant financial incentivisation of cooperation, drove mental health providers to collaborate.

Comments from our members include:

“I am unclear what the problem is that the collaborative is trying to solve.” Chief Executive, Acute Trust

“I fear that we will be creating collaboratives to tick a box rather than address a genuine need.” Chair, Acute and Community Trust

“I am incredibly committed to provider collaboration; I think it’s the right thing to do. However, we need to define it for our own system needs, not look to the centre to tell us how to do things.”
Chair, Acute Trust

“What does success look like? What is it we are trying to achieve? We really need to be clear on the answer to these questions.”
Programme Director, Provider Collaborative

2. Duplication with the purpose of an ICS

We understand that the forthcoming guidance document on provider collaboration at system level will describe in high-level terms a range of outcomes expected to be delivered by provider collaboratives. These include reduction of health inequalities, uptake of successful innovation, alleviation of workforce pressures, and the integration of services with place-based partnership. There is a risk that too much is being asked of provider collaboratives and that they could lose their focus and become overwhelmed by a broad range of tasks.

As provider collaboratives and ICSs work out their roles and functions, it will be important that they do not duplicate one another. Many of the outcomes that ICSs might reasonably want to achieve could also be delivered by a provider collaborative. This leaves a question mark over who will ultimately be held accountable for delivering the outcomes. Feedback from both commissioner and provider leaders has indicated the importance of being clear on the scope of the collaborative from the outset.

“It is unclear to me where power and influence will sit in the new world. Where we have a strong provider collaborative, will it potentially challenge the role and purpose of the ICS?”

Chief Executive, Ambulance Trust

Some of our ICS members have also expressed concerns about the impact of provider collaboratives that span multiple ICS footprints.

“There is a risk that the creation of a pan-ICS provider collaborative distracts provider leaders from the work that needs to be done in individual ICS footprints. In effect, the leaders will become interested in the sub-regional or regional acute issues at the expense of the wider determinants of health that we need to address in our ICS.”

Chair, ICS

3. Continuation of the provider-commissioner split

The emphasis on providers rather than commissioners in collaboratives has raised important questions about how to retain the highly developed skills of commissioners in the system and avoid the re-creation of provider-commissioner splits. One member commented:

“We need whole-system solutions rather than artificial divides.”

Programme Director, ICS

“It is disappointing that we are referring to provider collaboratives. They are collaboratives across the system. Providers might take the lead, but commissioners are also involved.” Accountable Officer, CCG

Providers recognise the important role that clinical commissioning groups (CCGs) have played at a local level as independent organisations brokering relationships between two or more providers and supporting collaborative working. CCGs see these commissioning skills evolving at ICS level to continue integrated working at scale but also to incentivise cooperative behaviours and stimulate innovation.

The direction of travel is no doubt towards the transfer of many transactional commissioning responsibilities from CCGs to ICSs. However, what is not clear to our members is how these commissioning functions would then be divided between the ICS, system-level provider collaborative(s) and place-based partnerships.

Leaders of provider and commissioning organisations have been working together more closely over recent years. More advanced provider collaboratives might be able to adopt most of the commissioning functions that currently sit with CCGs and many providers are already keen to transfer CCG staff to their payroll.

Losing commissioning skills in the new system risks creating 'self-managing provider clubs' that shift funding between a small number of providers without sufficient governance, oversight and accountability. It is currently unclear what the expectation is to collaborate with colleagues in the independent sector, for example.

Bringing together the different skills sets of commissioners and providers will be key to addressing this challenge, as well as creating the right checks and balances in the system.

4. Representation, resources and investment

The NHS white paper indicates that all providers will be expected to be part of at least one provider collaborative. The composition of provider collaboratives is likely to be open to local determination. For organisations such as community providers, ambulance services or specialist trusts, many of whom cover multiple ICS footprints, there is a question over whether they will get a seat at the table – a table which, most probably, will be dominated by the acute sector.

“There is a difference between being invited to the party because you are seen as an important partner, versus having to persuade and influence in order to get an invite.” Chair, Ambulance Service

Colleagues in community services and primary care are also keen to ensure that the emphasis on joined-up out-of-hospital services and primary care is not lost alongside a shift from expenditure in acute care into investment in community, mental health and preventative activities.

“There is a real risk that we just end up perpetuating the convention of talking about hospitals as if they are all that matters in the healthcare system. We need to ensure that the voice of community services remains strong.” Chief Executive, Community Health Services Provider

Some members are concerned about the resource that will be required to support and engage in multiple provider collaboratives. A mental health provider, ambulance service or specialist trust could, for example, be involved in multiple provider collaboratives at pan-system, system, pathway and place level. Each collaborative would have a slightly different focus, but the provider would need to be involved in each, fielding senior decision makers to engage fully in the collaborative. Individual organisations will need to develop their own strategies to address these complexities, but ICS management structures will also need to invest in lean, light and agile governance structures to support collaboration in the most efficient and dynamic way.

5. The balance between provider collaboration at system and place level

There is confusion in some quarters about the purpose of provider collaboratives at system level and those operating at place level.

Similarly, members are clear that place-based collaboratives should be equally as important as anything that operates at system or pan system level. Place is where engagement with local authorities, PCNs and voluntary and community sector colleagues will primarily be delivered. These relationships are key to addressing some of the key long-term challenges of health inequalities.

“The place-based collaborative is looking to introduce a lead provider model. The two are getting confused. We need to be clear about what models operate at what level.” Executive Director, Mental Health Trust

6. The duty to collaborate and management of risks

Finally, the white paper indicates a new ‘duty to collaborate’ for all organisations. We expect that for provider organisations this duty will include involvement in a provider collaborative. What then will be the sanctions imposed on an organisation if they are not actively participating in the collaborative? Who will determine what is genuine collaborative work? Provider collaboratives may look towards peer review/performance assessment models, but neither of these approaches could force an unwilling chief executive to genuinely come to the table and participate. Similarly, there remain unanswered questions about the management of risks – clinical, financial and quality – where multiple providers are involved.

NHS Confederation viewpoint

Many of our members have successfully worked in various collaboratives models to meet the needs of their organisations and local population, prior to the formalisation of provider collaboratives as models of delivery. They have also worked collaboratively with local CCGs or specialist commissioners in genuine partnerships to address complex challenges. Many of these collaboratives have been successful because they have been driven by a common understanding of the problem at hand.

While we support the direction of travel to create provider collaboratives, there are several questions that remain unanswered. There is a risk that making provider collaboration a mandatory requirement will remove the spirit of collaboration, forcing collaboratives to become focused on 'tick box' regulatory programmes rather than true innovation. We therefore suggest creating the right environment for collaboratives to grow organically to meet local needs, accepting a level of complexity in how they evolve. The governance mechanisms need to bring value and avoid unnecessary assurance or burden while also providing some clarity on the management of risks. However, we also urge providers to develop collaborative structures that are inclusive of a broad range of partners, including mental health, community, specialist and ambulance services.

Providers must have access to appropriate resources, guidance and decision-making capabilities to allow them to form effective provider collaboratives. As the needs of the population or place continue to change, providers also need the flexibility to be able to adapt to those needs, and this must be factored into any guidance by NHS England and NHS Improvement. The resource implication for provider organisations spanning multiple boundaries should not be underestimated. While this is clearly an internal challenge for organisations to manage, provider collaboratives will need to make sensible and pragmatic decisions about the expectations placed on their members. It is also imperative that the skills of clinical commissioning are not lost in the move towards a new, provider driven landscape.

Support offer

We have established a support offer for leaders developing or working in provider collaboratives. If you are interested in finding out more, please contact Kerry McQuade at kerry.mcquade@nhsconfed.org

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales.

We represent hospitals, community and mental health providers, ambulance trusts, primary care networks and federations, clinical commissioning groups and integrated care systems.

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