NHS Provider Collaboratives Event

Welcome

5 December 2023

Provider Collaboratives – Governance and Legal Arrangements

Stewart Duffy, Legal Director, Weightmans LLP

Weightmans

Weightmans

Provider Collaboratives

Governance and Legal Arrangements

05 December 2023

Stewart Duffy
Legal Director
0207 227 7418
stewart.duffy@weightmans.com

Provider Collaboratives

- NHS Act 2006
- NHS (Joint Working and Delegation Arrangements)(England) Regulations 2022
- Statutory Guidance

© Weightmans LLP

Provider Collaboratives

- 2 or more trusts working at scale – shared purpose and effective decision-making
- Maximise economies of scale
- Improve care for local populations
- NHS expects acute and mental health trusts to be part of at least one collaborative
- Consistency with ICS priorities
- Providers as key drivers of transformation

© Weightmans LLP

Provider Collaboratives – Types

- Sectoral
- ICS footprint
- Diversifying membership
- Spanning ICSs

© Weightmans LLP

Provider Collaboratives – Relationships

- Arrangements between NHSE and ICBs e.g commissioning
- Arrangements between ICBs
- Arrangements between NHS providers and with NHSE and ICBs
- Arrangements involving local and combined authority functions

© Weightmans LLP

Weightmans

Key Enablers

- Leadership – time, behaviours & culture
- Shared objectives/ambition
- Trust between parties
- Clinical Leadership
- Building Capacity
- Supporting staff

© Weightmans LLP

Core Capabilities (per NHSE/I)

- Partnership building
- Programme delivery
- Shared governance
- Peer support and mutual accountability
- Joined up working
- Quality improvement

© Weightmans LLP

Provider Collaboratives – Resourcing

- Efficiency savings
- ? Shifting staff
- Well resources project management
- Time budget for execs
- Support staff

© Weightmans LLP

Weightmans

Examples

- Pathology services
- Joint procurement
- Consolidation of clinical services to improve resilience

© Weightmans LLP

Governance

FORM FOLLOWS FUNCTION

© Weightmans LLP

Weightmans

Governance Issues

- Conflicts of Interest
- Proportionality – flows from shared purpose and objective – infrastructure and governance
- Reflects shared vision and commitment
- Support efficient/effective decision-making
- Reflect needs/voice of local communities
- Clarity re decision-making (**including dispute resolution**), funding and resources
- Streamline ways of working across systems

© Weightmans LLP

Strong decision-making (per NHSE/I)

- Agree only those impacted by decisions make the decisions
- Locked gateways – different stages in the decision-making process
- Majority rather than consensus – avoid gridlock
- Strong dispute resolution processes

© Weightmans LLP

Accountabilities and Oversight

- Constituent entities retain their own arrangements

BUT

- Mutual accountability e.g risk and gain share agreements
- Accountability to local community
- Providers in collaborative accountable for services commissioned from or delegated to participants

© Weightmans LLP

Decision-making structures

© Weightmans LLP

Committees

- Advisory
- Group of individuals with decision-making authority
- Committee in Common (statutory)
- Joint Committee (statutory)

© Weightmans LLP

Committees

- Non-statutory v Statutory

© Weightmans LLP

Committees in Common

- Multiple statutory committees – one for each participant
- Coincidence rather than combination
- Shared ToR, Agenda, venue (remote or real)

© Weightmans LLP

Weightmans

Joint Committees

- Single Committee
- Reps from constituent organisations
- Can have members who are not employees – flexibility/expertise
- Each constituent org determines make up of its representation
- FT Trust's Committee must be statutory voting Board members of the FT.
- NHS Trusts have more flexibility
- LAs and Combined Authorities cannot delegate functions to joint committee (section 75 arrangements remain important)

© Weightmans LLP

Delegation and Joint Exercise

© Weightmans LLP

Delegation – General

- **Internal** – to committee, sub-committee or employee
- **External** – delegation to another organisation e.g lead commissioner arrangement
- **Joint exercise of functions** – often overseen by joint committee

© Weightmans LLP

Delegating and joint exercise arrangements

- Power to delegate to committees re any function of the Trust (s65Z5)

BUT

- NHS FT committee cannot have non-directors
- UNLESS – a joint committee under s65Z6 of the NHSA 2022
- Power to pool funds

© Weightmans LLP

Weightmans

Pooled Funds

- (In addition to section 75 arrangements (which exclude some NHS services))
- Can be managed by Joint Committee, or led by a participating organisation
- Need to agree:
  - (i) What functions are covered by the fund
  - (ii) respective contributions and responsibilities for shortfalls/surplus
  - (iii) hosting arrangements
  - (iv) authorisation arrangements
  - (v) reporting
  - (vi) termination

© Weightmans LLP

Limitations on Delegation

- No joint Rem Comms
- No delegation of functions central to corporate governance of the organisation

  e.g preparation of consolidated accounts, audit committee
- List of functions not suitable for delegation – Regulation 2 – 40+ items identified

© Weightmans LLP

Risks

- Complexity including multiplicity of arrangements
- Recreating commissioner/provider split
- Oversight and regulatory arrangements
- Variation – high performing v poorly performing constituents
- Risks for Trust Boards

© Weightmans LLP

Risks

- Lack of alignment in understanding
- Mission Creep
- Enmeshing/blurring of boundaries
- Lack of sufficient NED involvement/challenge
- Lack of alignment with Schemes of Delegation
- Lack of alignment with constitution
- Decisions of Joint Committee binding on constituent orgs – even without specific delegation to members

© Weightmans LLP

Collaborative Forms/Models

- Lead Provider – collaboration agreement with management board – single provider holds contract and sub-contracts – possibility for delegated functions e.g joint committee
- Shared Leadership – Key leader(s) shared across organisations perhaps with Committee(s) in Common
- Provider Leadership Board
- Mergers/Acquisitions

© Weightmans LLP

Contractual Arrangements

- MoU
- Collaboration Agreement – aka partnering agreement

© Weightmans LLP

Joint Ventures

- Contractual Joint Ventures – partnership board with ToR
- Lead Provider
- Corporate Joint Ventures/jointly owned company

© Weightmans LLP

Powers to participate in companies

- NHS Trusts
- FT Trusts

© Weightmans LLP

Joint posts or Group posts

- Sharing leaders
- Constitutional requirements re-appointment and termination

© Weightmans LLP

Weightmans

Authority and Oversight

- Clarity
- Stress-testing arrangements
- Boundaries
- Reporting

© Weightmans LLP

Accountability

- Participating trusts remain sovereign
- Trust executives remain accountable to their own Trust Boards
- Trusts retain all duties and liabilities
- Clinical quality and performance – CQC

© Weightmans LLP

Council of Governors

- 2022 Act – Change of Context but NOT change of duties
- Represent wider public interest in context of system working
- Approving Transactions – statutory transactions or significant transactions
- Structural integration e.g mergers/acquisitions
- Whether FT has undertaken appropriate due diligence?
- Early and ongoing engagement

© Weightmans LLP

Fit and Proper Person

- Trusts retain liability
- Consider appointees to joint committees under FPP requirements
- Failings in oversight of shared decision-making arrangements could give rise to FPP issues for Trust Board members
- Disclosures re ‘directors’ to others within collaborative arrangements.

© Weightmans LLP

Individual Accountability

- Challenges in managing disciplinary processes where individual is in a shared role or seconded.

© Weightmans LLP

The Evolution of Provider Collaboratives

Emily Newton, Policy Advisor (Systems), NHS Providers

THE EVOLUTION OF PROVIDER COLLABORATION

Emily Newton
Policy Advisor (Systems)

5 December 2023

What will we cover?

- ‘Evolution of provider collaboration’ survey
- Survey results & analysis
- Insights from our members
- What’s working well

A brief history of system working

Health and Social Care Act (2012): Rooted in competition as the driver of improvement

NHS Long Term Plan (2019) focused on out of hospital care, digital infrastructure, personalised care and introduction of integrated care systems

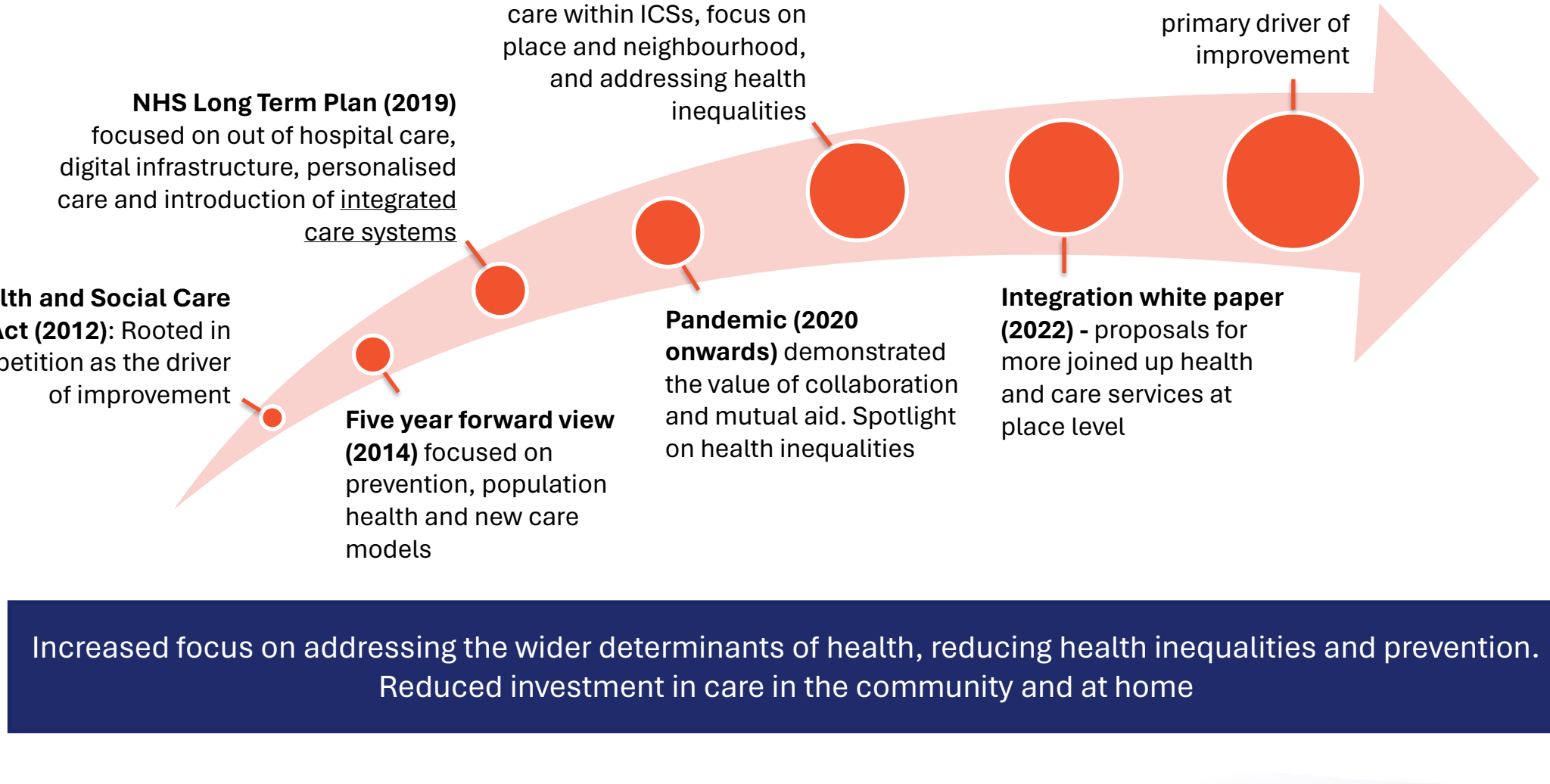
Five year forward view (2014) focused on prevention, population health and new care models

White paper (2021) set out collaboration and integrated care within ICSs, focus on place and neighbourhood, and addressing health inequalities

Pandemic (2020 onwards) demonstrated the value of collaboration and mutual aid. Spotlight on health inequalities

Integration white paper (2022) - proposals for more joined up health and care services at place level

Health and Care Act 2022 embeds collaboration as primary driver of improvement



Provider collaborative survey: The background

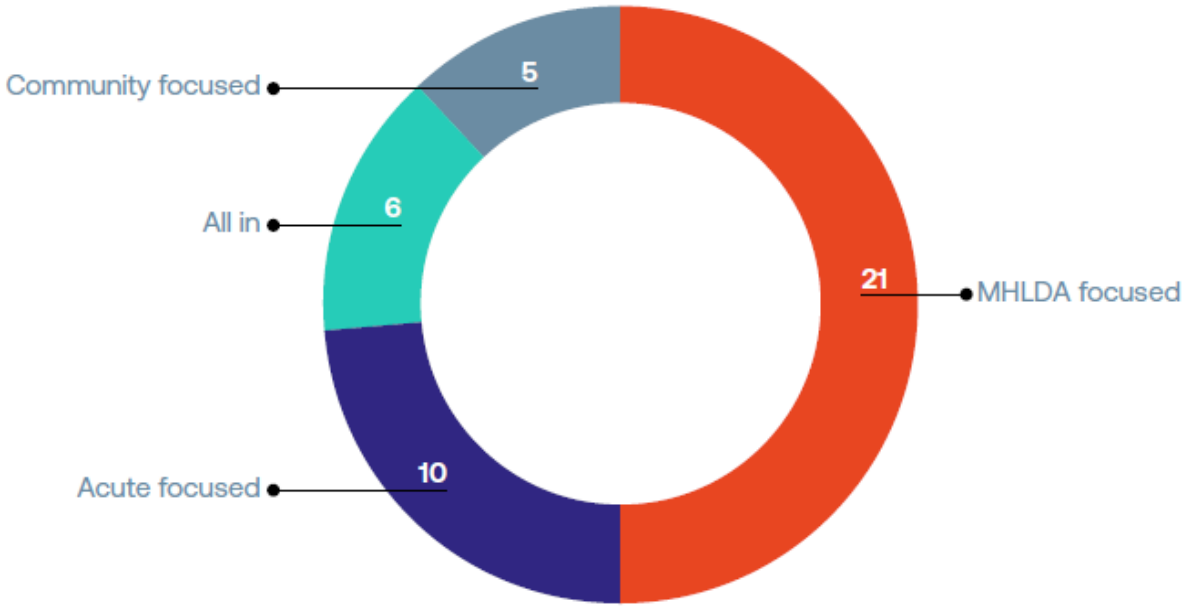
When?
- Survey took place in November 2022, report published in March 2023

Why?
- Lack of information/data across the country - first national picture of how they are progressing

How and who did we approach?
- Joined with NHS Confederation
- Targeted provider collaborative leaders
- One response per collaborative

Responses?
- 42 different provider collaboratives
- Across the country and sector

Figure 1: Composition of survey respondents

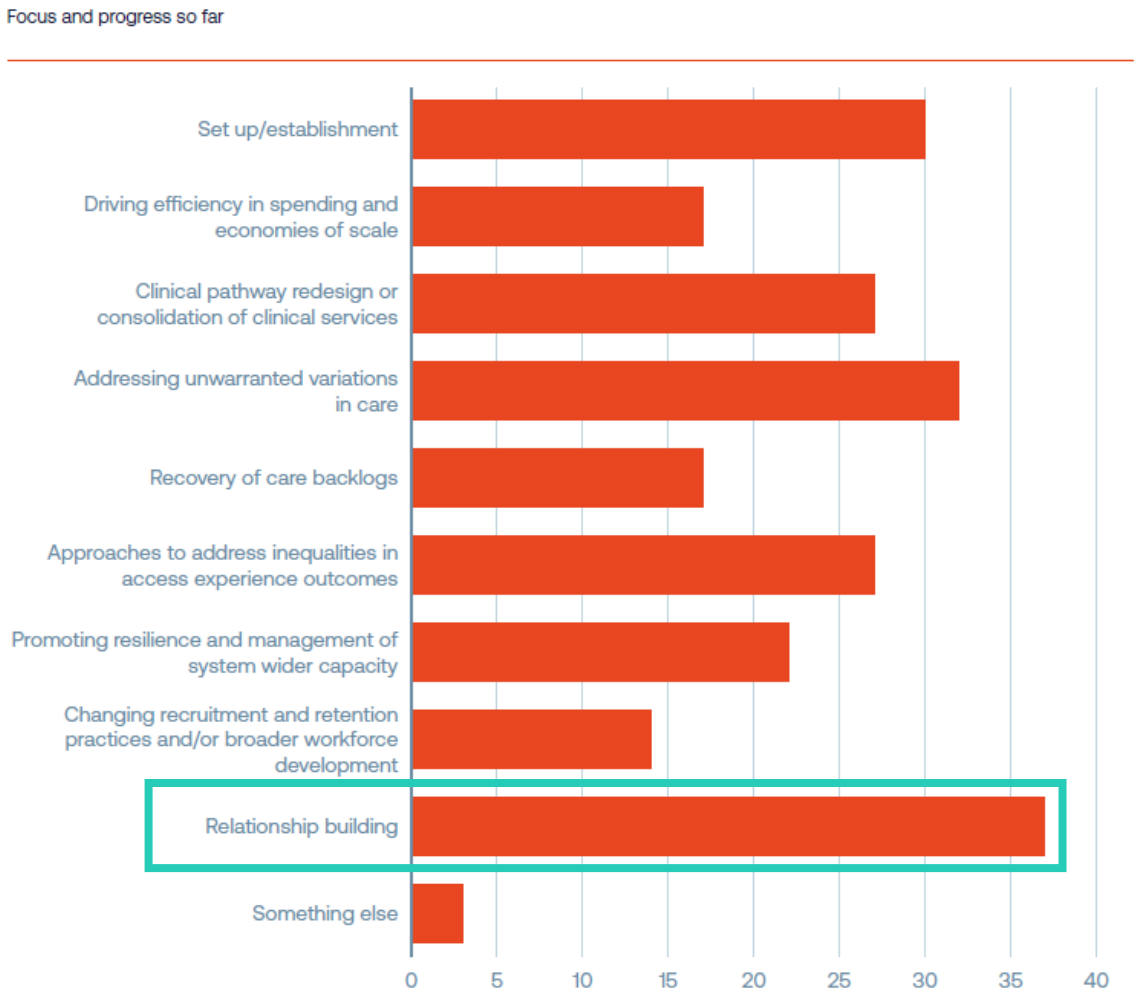


Key priorities over the previous 12 months

- 86% said relationship building
- 74% identified addressing unwarranted variations in care
- 72% prioritised set up/establishment

Differences in response:

- 90% of acute-focused collaboratives have been addressing care backlogs compared to 14% of MHLDA collabs
- MHLDA collaboratives were the least likely to identify relationship building as a key priority (many already established)



Key priorities over the subsequent 12 months

- Collaboratives looking to focus on improving clinical pathways and address variations in care
- This is where collaborative working can be of most value to patients

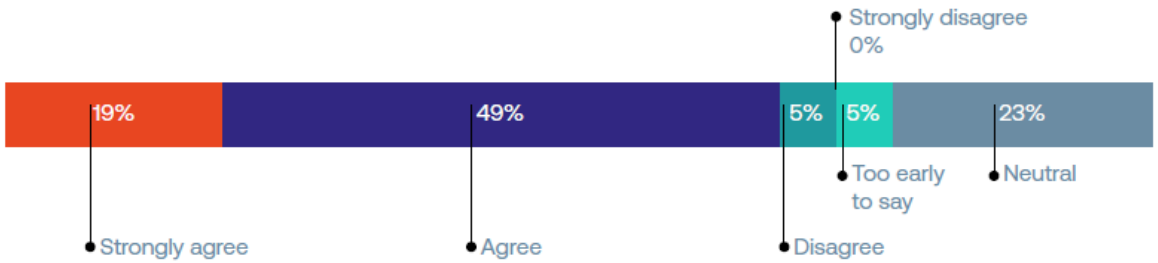
Desire among some collaboratives to take on delegated functions from the ICB, but not a majority:

- 40% currently considering using legal flexibilities
- 50% too early to say
- 10% something they are not considering

Relationships with ICB and partners

There is a positive early picture of collaboratives' engagement with ICBs and partners.

- 68% agreed/strongly agreed that 'the collaborative and ICB(s) are working well together to plan and set priorities'



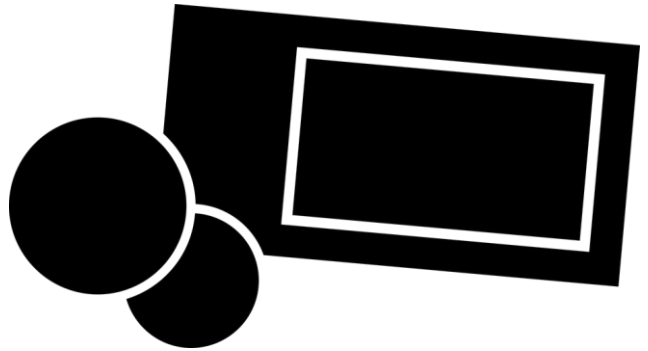
- 57% agreed/strongly agreed that 'the collaborative and ICB(s) are working well together to address operational pressures'

- 68% stated their collaborative was meeting with place-based partnership(s) very or quite regularly
- 58% indicated that their collaborative was meeting with local authorities very or quite regularly
- Engagement with PCNs, and to a lesser extent the VCSE sector, appeared less frequent – this is changing over time
- Likely to vary depending on factors such as the maturity of the ICB, the number of systems covered and the scope of different types of collaboratives

Key findings: Challenges

Workforce and resourcing were seen as a ‘significant challenge’ or ‘somewhat of a challenge’ by over three-quarters of the respondents (76%). Only one in ten (8%) saw it as no challenge at all.

Operational pressures were also of high concern to provider collaborative leaders, with seven in ten (71%) stating that this was a ‘significant challenge’ or ‘somewhat of a challenge’.



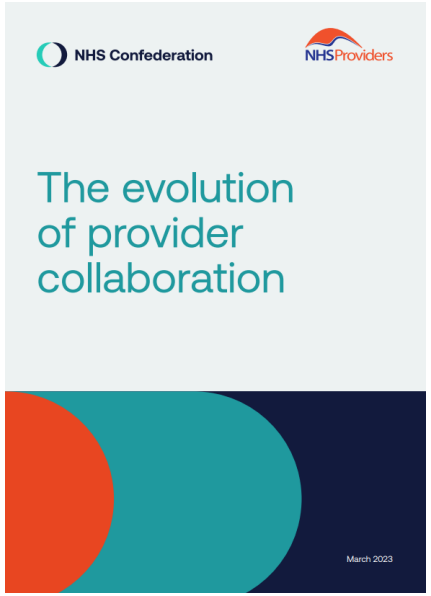
Funding was considered a ‘significant challenge’ or ‘somewhat of a challenge’ by three in five (59%).

Provider collaboratives are realising benefits

- *'Working collaboratively has improved patient outcomes through **reduction in out of area placements**' and 'reduced waiting times and lists.'*
- *'Our recruitment hub is helping **reduce vacancy levels** and reduce time to recruit.'*
- *'There' been an opportunity for long wait patients to **access quicker diagnostic and elective procedures** by working as a set of acute providers rather than individually.'*
- *'Our collaborative has been able to **invest savings** in strengthened community services that provide greater choice for patients and improved experience.'*
- *'An orthopaedic elective hub and has some of the **lowest orthopaedic waits** in the country.'*
- *'Moving forward culture of collaboration has been beneficial on many fronts. Key deliverables have included aseptics hub, elective recovery, diagnostics recovery, **estates strategy, agreement on key workforce issues.'***

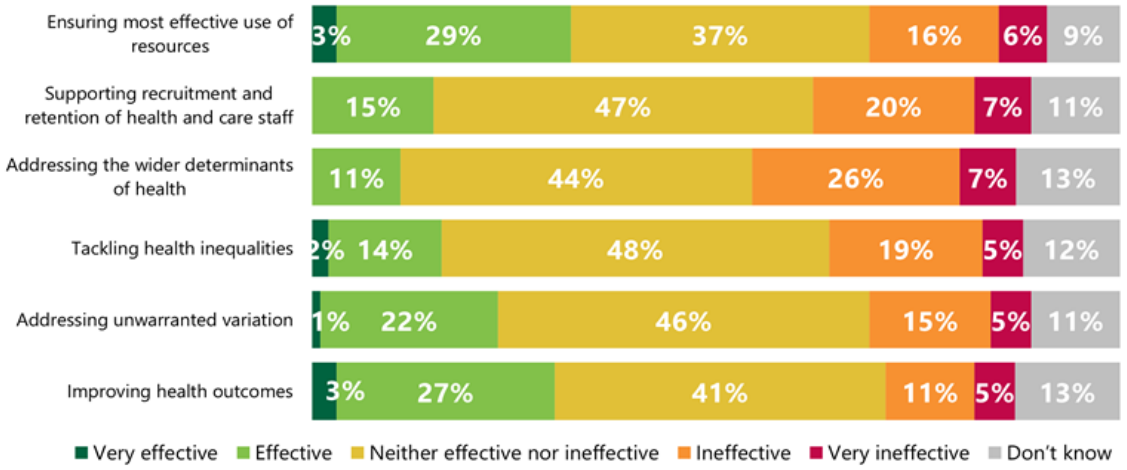
Analysis and reflections from the survey

- Provider collaboratives considered themselves in the **early stages of development**
- **Relationship building** was a key priority – but it will take time
- **Positive early picture** emerging of collaboratives' engagement with ICBs – but depends on maturity and size
- Collaboratives are already working to **make a difference** for the populations they serve
- Collaboratives **vary by sector and in maturity** - they are using the deliberately open statutory framework to take approaches that make sense in their local areas.
- Collaborations also need **staffing, resource and leadership capacity**
- The **permissive approach** should continue over the coming years to allow collaboratives to flourish
- Collaboratives are **developing and need support**. The ability to access the right support will help collaboratives realise their potential to make a transformational contribution to care in their systems.

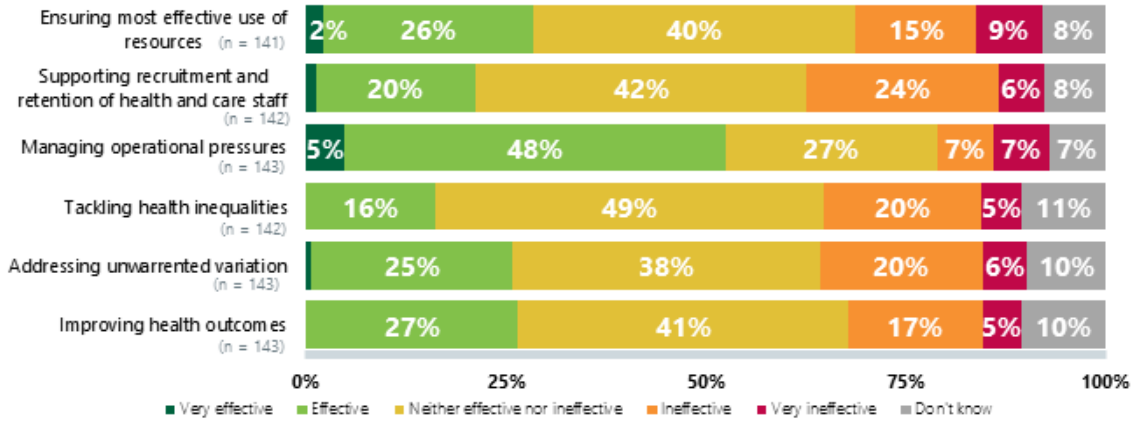


NHS Providers State of the Provider Sector survey

How effective has your provider collaboratives been in:



State of the Provider Sector survey 2022



State of the Provider Sector survey 2023

Our State of the Provider Sector survey (2022) of trust leaders found that provider collaboratives have been the most effective **in efficiencies and economies of scale** (32% saying it was effective or very effective), as well as in **improving health outcomes across the system** (30% saying it was effective or very effective).

When the survey was repeated in 2023, **managing operational pressures** was included as one of the options.

Overwhelmingly this was the area more trust leaders said their provider collaborative(s) have been effective in, **with over half (53%) saying it was effective (48%) or very effective (5%).**

What are our members telling us now?

- There continues to be **enthusiasm and energy around provider collaboration** and the impact provider collaboratives can have in their systems.
- Experiences reinforce that there is **no 'one size fits all' approach to collaboration**.
- Building trusted relationships **takes time.**
- There is **variability in trust board engagement and involvement with provider collaboratives**.
- **Relationships with ICBs vary**.
- Provider collaboratives need to be clear about **how working at scale can add value rather than create additional complexity**.
- Some trusts have seen success through developing a **collective improvement methodology** to achieve transformation.

… and what do our members want to see?

- Continued permissive approach on the form and function of provider collaboratives.
- Time to build collaborative and trusted relationships.
- Clarity of roles within systems.
- Distinguishing between the role of provider collaboratives vs. the role of individual providers.
- Value for all types of collaboration (incl. with organisations sitting outside the NHS).

Examples of provider collaboratives delivering impact

Black Country Provider Collaborative

- Collaborative of 4 acute trusts have implemented a clinical improvement programme, driven by a recognition of health inequalities, cancer outcomes, fragile services and elective backlog.
- Delivered through 11 clinical networks, with clinical leads appointed to each network to enable cross-system working.
- Seeing improvements across access, quality and system resilience and transformation, as well as strong performance eliminating 104 & 78 week waits across the system.

Mid and South Essex Community Collaborative

- Contractual joint venture agreement which supports collaboration between 2 trusts providing community services and a community interest company.
- Focused on reducing variation in outcomes for patients, sharing clinical good practice and ensuring community services are fit for the future and delivered closer to home.
- Has seen the creation of 120 virtual ward beds, single service models across UCR, long covid and others, joint procurement and shared staffing arrangements and reduced use of agency and bank staff.

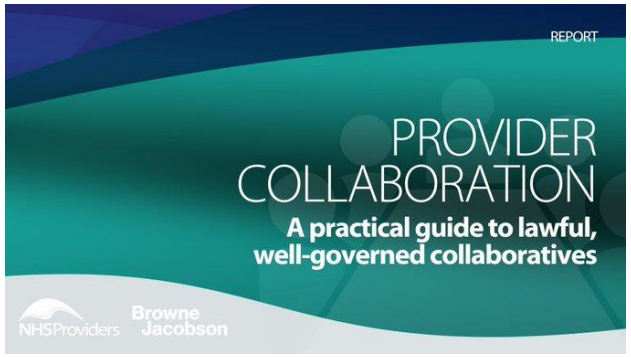
NHS South West Provider Collaborative

- Partnership of 5 NHS organisations, 1 community interest company and 2 independent sector organisations.
- Using a lead provider model to commission a wide range of specialised mental health, learning disability and autism services at scale to a population of 5 million people, across 6 ICSs.
- The collaborative has reduced average length of stay and out of area placements, as well as utilising inpatient capacity more effectively and allowing investment in community provision and services within its existing commissioning allocation.

Our work on provider collaboratives

Purpose: Supports boards to maximise the potential of greater provider collaboration to tackle care backlogs, reduce unwarranted variation, address health inequalities and deliver more efficient, sustainable services.

Activity: Webinars, peer learning events, case study briefings, regular bulletins, reports and resources



Most recently we have focused on:

- Providing members with a practical guide to provider collaborative governance
- Showcasing evolving relationships with place-based partners and collaboration with VCSE partners
- Influencing the upcoming NHS England policy and support update.

https://nhsproviders.org/provider-collaboratives

Thank you!

If you have any further questions, or would like to get in touch, you can contact me at:

emily.newton@nhsproviders.org

Next Steps for National Policy and Support for Provider Collaboratives

Zoe Bond, Senior Policy Manager, NHS England

Next steps on national policy and support for provider collaboratives

5 December 2023

Presented by:
Zoe Bond, Provider Development, NHS England

What I'll cover

- The current vision and landscape of provider collaboratives
- National work: our review of policy and support for provider collaboratives
- Current support in place
    - Guidance and toolkit
    - Maturity matrix
    - Directory
    - Innovators scheme
    - Existing learning forums across NHS England, NHS Providers and NHS Confederation

- Key takeaways for Board Members

The vision from 2021 – achieving the benefits of scale

Working together at scale: guidance on provider collaboratives, August 2021, set an expectation for trusts be part of one or more provider collaboratives of at least two trusts working at scale across multiple places.

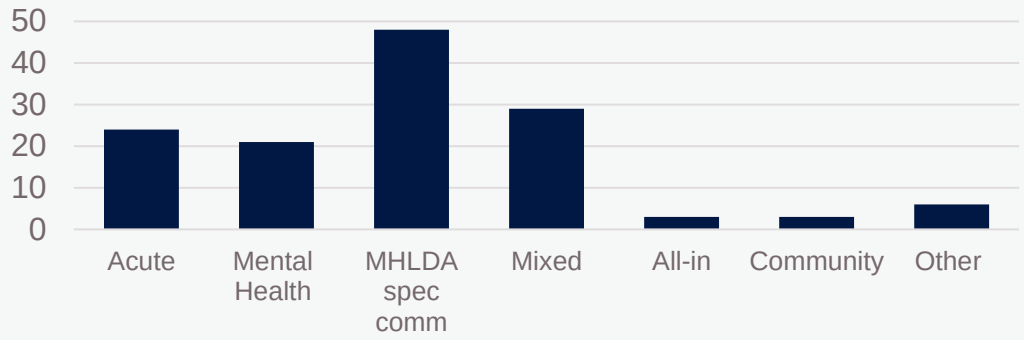
The guidance envisaged that provider collaboratives would deliver benefits of scale including:

- Reductions in unwarranted variation, including health inequalities
- Resilience
- Recruitment, retention, development of staff
- Consolidation of low-volume or specialised services
- Efficiencies and economies of scale

The guidance was deliberately permissive about the exact benefits to be achieved and the governance model of each collaborative, **leaving these be decided locally.**

The current provider collaborative landscape

- There are now over 100 provider collaboratives across England, most of which are sector specific. Around 50 of them are longer established specialised commissioning mental health, learning disability, and autism lead provider models *(see right).*
- There is considerable variation among collaboratives – self-reported maturity of relationships, the specific benefits which partnerships are working to deliver, governance models and ways of working, tangible impact for systems and patients.



Some of the barriers to provider collaborative development raised by providers, systems and regions include:

- Limited examples of best practice given most provider collaboratives are in an early stage of development
- Limited resource and capacity for the collaborative, including PMO resource, clinical time and executive capacity
- Uncertainty around what should be done at scale versus at place or neighbourhood level
- In some systems, uncertainty around the best ways for ICBs to work with provider collaboratives

Review of policy and support for provider collaboratives

Two years on from the publication of the Working together at Scale guidance NHS England are undertaking a review of policy and support for provider collaboratives as part of systems. Having engaged with various stakeholders over the past few months we are now taking forward three main workstreams.

1. Testing with provider and system leaders a refocused vision of the role of provider collaboratives and the expectations of them

This will re-emphasise the substantial benefits of scale, stay broadly permissive on what collaboratives work on while reaffirming that their focus should be on delivering ICS/national priorities.
We are not proposing a full re-write of existing guidance.

2. Enhancing national support and testing with the sector further options to accelerate progress

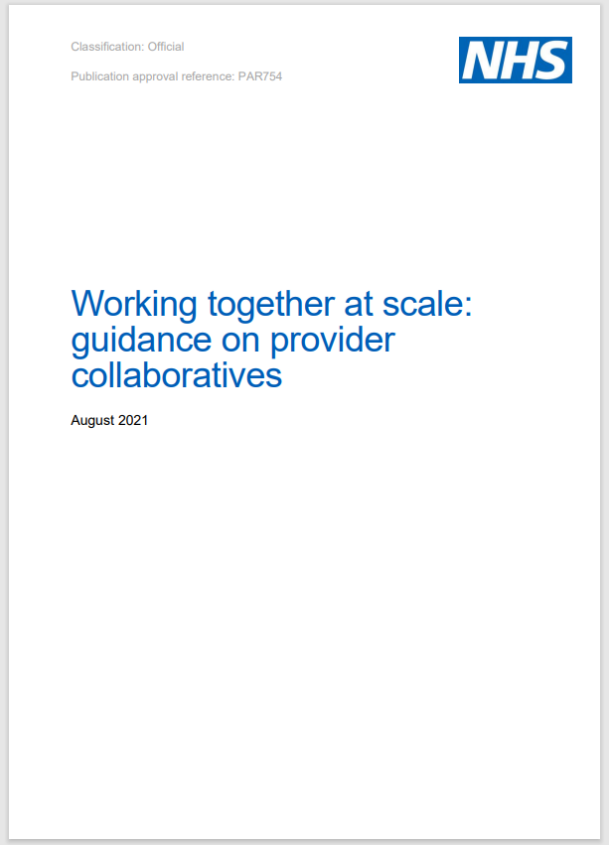
Based on initial feedback we are developing:
- *An accessible public directory of provider collaboratives this autumn*
- *New suite of practical case studies*

We will also scope and test other ways to drive progress, including a website and whether there is a case for a second innovators scheme wave from mid-24/25.

3. Embedding provider collaboratives into NHS England programmes and functions

We are working with teams across NHS England to embed provider collaboratives into key national programmes by sharing evidence, case studies, and identifying opportunities for national programmes to harness the potential of provider collaboratives to drive forward national priorities.

Current support – Guidance and toolkit



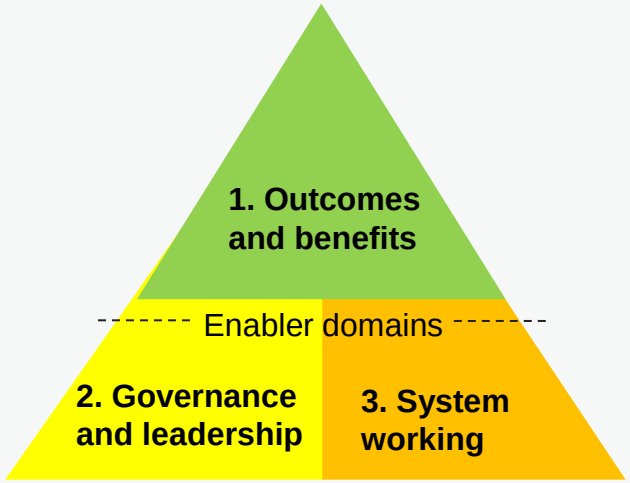
[B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk)]

[20220110 Provider collaboratives toolkit FINAL - ICS Guidance - Integrated Care (future.nhs.uk)]

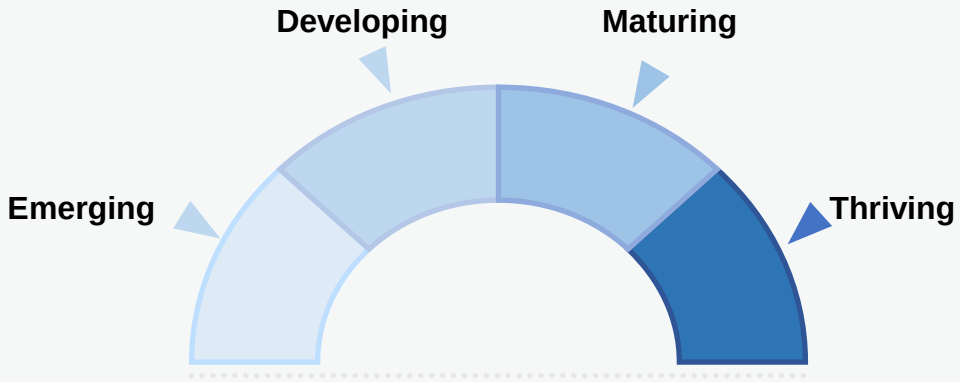
Current support – Maturity matrix

The provider collaborative maturity matrix is a self-development tool designed to support all types and sizes of collaboratives to accelerate the benefits they can deliver for their populations.

It provides **objectives** that collaboratives may want to work to across three different domains (and nine sub-domains):



Collaboratives can self-assess against these objectives across **four different maturity levels**



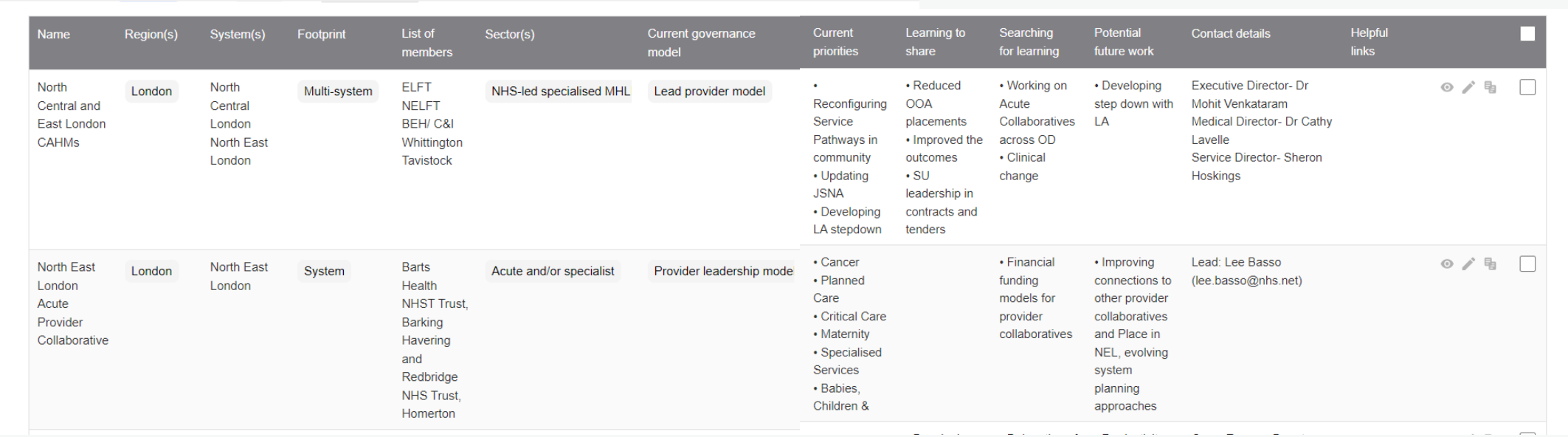
- The use of the matrix is **voluntary** and the objectives may be more or less applicable to different collaboratives as the matrix has been designed to be applicable to all types and sizes of collaboratives, operating across one or multiple systems with varied geographies.
- Collaboratives and their system(s) and partner(s) **should work locally to decide how best to use and apply it in their context.**
- **There is no requirement to work towards or assess against any/all of these objectives or generate an overall maturity rating.**
- Full detail of the matrix including an optional template is included in an **accompanying Excel document**.

Current support – Maturity matrix

Domains and objectives			Maturity levels				Optional template			
1	2	3	4				5			
Domain	**Sub-domain**	**Objectives**	**Emerging**	**Developing**	**Maturing**	**Thriving**	**Area of focus** (Y/N)	**Rating**	**Evidence / rationale**	**Actions**
The matrix fits into 3 domains	Each domain is separated into 3 sub-domains which cover the range of activities a collaborative may work on	For each sub-domain there are objectives that collaboratives may work towards	For each objective there are four maturity levels that a collaborative could assess themselves against				There is an optional template which collaboratives can complete to facilitate a self or peer-assessment			
1. Outcomes and benefits	**1.1 Reduce unwarranted variation and inequalities in patient outcomes, access and experience** **1.2 Improve resilience** **1.3 Enhance productivity and value for money**	*e.g. 1.1.a Reduce unwarranted variation*	*We envisage collaboratives may assess that they are at different stages of maturity for different attributes and domains. They may find that there is not a single, overall maturity level that fits best.* *The thriving level is ambitious and we recognise that few, if any, collaboratives will consider they have already reached this level across all objectives and it may take a number of years to reach this stage.*				*Based on feedback, we have developed an optional template for collaboratives to fill in to review their maturity and generate an action plan. Each included objective is weighted equally to calculate the overall and domain maturity level ratings. These scores are not designed for assurance processes.*			
2. Governance and Leadership	**2.1 Implement shared vision and governance** **2.2 Build a culture of mutual support and accountability** **2.3 Embed multi-professional clinical and care leadership**	*e.g. 2.1.a. Agree shared vision and objectives*								
3. System working	**3.1 Support ICSs to deliver priorities** **3.2 Build strong relationships with partners** **3.3 Engage and co-design with people and communities**	*e.g. 3.1.a. Form strong relationships with ICB(s)*								

Current support – Directory

- Launched recently, the national provider collaborative directory is a platform intended to assist networking and the sharing of best practise across the country on the FutureNHS Collaboration Platform.
- The directory covers all collaboratives as defined in the original *Working Together at Scale* guidance including acute, mental health and NHS-Led Provider Collaboratives: specialised mental health, learning disability and autism services, community and specialist collaboratives.
- The directory includes key information about each provider collaboratives listed as well as details on current priorities, previous work and learning they have to share or are searching for.
- The directory is open to be used by provider collaboratives, ICBs and trust leaders to foster a deeper understanding of what can be achieved with working at scale.

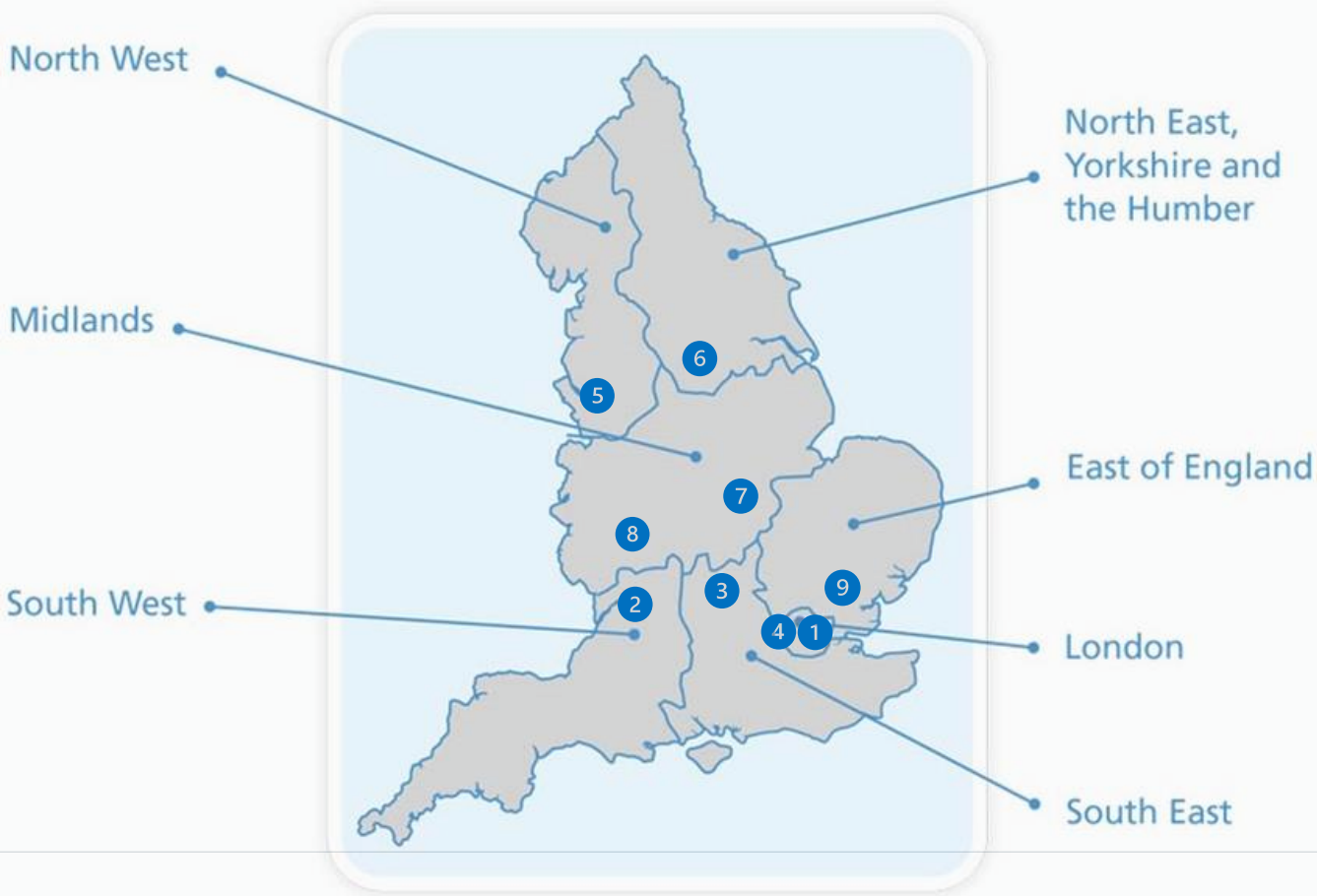


Name	Region(s)	System(s)	Footprint	List of members	Sector(s)	Current governance model	Current priorities	Learning to share	Searching for learning	Potential future work	Contact details	Helpful links
North Central and East London CAHMs	London	North Central London North East London	Multi-system	ELFT NELFT BEH/ C&I Whittington Tavistock	NHS-led specialised MHL	Lead provider model	• Reconfiguring Service Pathways in community • Updating JSNA • Developing LA stepdown	• Reduced OOA placements • Improved the outcomes • SU leadership in contracts and tenders	• Working on Acute Collaboratives across OD • Clinical change	• Developing step down with LA	Executive Director- Dr Mohit Venkataram Medical Director- Dr Cathy Lavelle Service Director- Sheron Hoskings	
North East London Acute Provider Collaborative	London	North East London	System	Barts Health NHST Trust, Barking Havering and Redbridge NHS Trust, Homerton	Acute and/or specialist	Provider leadership mode	• Cancer • Planned Care • Critical Care • Maternity • Specialised Services • Babies, Children &		• Financial funding models for provider collaboratives	• Improving connections to other provider collaboratives and Place in NEL, evolving system planning approaches	Lead: Lee Basso (lee.basso@nhs.net)	

Current support – Innovators Scheme

In April 2023 we launched the provider collaborative innovator scheme to help address key challenges by working with nine diverse collaboratives and their systems to:

- Share what we learn together over the coming year to help collaboratives improve care across the country
- Build on the progress already achieved and accelerate benefits for patients and service users
- Inform future national policy developments



1. UCL Health Alliance (UCLHA)
2. Bath and North East Somerset, Swindon and Wiltshire Acute Hospital Alliance (BSW)
3. Buckinghamshire, Oxfordshire, Berkshire West Mental Health Provider Collaborative (BOB)
4. North East London mental health learning disability and autism provider collaborative (NEL)
5. The Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST)
6. South Yorkshire and Bassetlaw Acute Federation (SY&B)
7. Leicestershire Partnership and Northamptonshire Healthcare Group (L&N)
8. Foundation Group provider collaborative (FG)
9. Mid and South Essex Community Collaborative (MSECC)

Current support – Existing learning forums

NHS England

NHS Providers

NHS Confederation

Regional forums
Learning shared within regions

Mental health ICS development community of practice
Discussion of mental health, learning disability and autism provider collaboratives in context of ICS development.

FutureNHS Collaboration Platform
An online forum to share resources and facilitate discussion. This includes the provider collaborative toolkit and maturity matrix.

Webinars
Share good practice of collaborative arrangements

Peer learning network
Connect managing/strategic directors working on similar issues

Quarterly email bulletins
Share insights on collaboratives with links to resources

Monthly thought sessions
Showcase work and discuss thematic issues and share the latest thinking

Action learning sets
Held every 8 weeks for a group of provider collaborative leaders
- Comms and engagement

Ad-hoc sessions
One-off sessions linked to topical issues.

Provider collaboration newsletter

Takeaways for Board members

- **NHS England is fully committed to the development of collaboratives**, and we believe significant improvements can be delivered by providers continuing to work together to **realise the benefits of scale –** including r**eductions unwarranted variation, improvements in resilience and productivity, addressing key workforce challenges, and opportunities to consolidate and support fragile services across systems**.

- We want to work with providers and ICBs to **rapidly accelerate** the **development of provider collaboratives**, with our ambition that **every system has mature provider collaboratives that lead on the delivery of core system and national priorities, realising in full the benefits of scale**.

- There is a **range of support available** for providers, provider collaboratives and ICBs - please reach out if you'd like to hear more or have any questions

Annex

Annex: Provider collaboratives – links to guidance and support

NHS England

Working together at scale: guidance on provider collaboratives, August 2021 – the core guidance setting out expectations for provider collaboratives as part of systems

Provider collaboratives toolkit, January 2022 – practical idea, tools, and examples, particularly focused on setting up a new provider collaborative but can be helpful if looking to strengthen an existing provider collaborative

Accelerating the benefits of collaboration for patients and communities, Feb 2023 – blog setting out the nine provider collaboratives selected to be part of the provider collaboratives innovators scheme and why NHSE has set up the scheme

Maturity matrix for provider collaboratives, April 2023 – a self-development tool designed to support all types and sizes of collaboratives to accelerate the benefits they can deliver for their populations

NHS Futures Provider collaboratives hub – where NHSE puts makes available all guidance and resources relating to provider collaboratives, including learning generated through the innovators scheme

NHS Providers

Provider collaboration webpage – where NHS Providers promotes events and peer learning sessions, and collates resources as part of the programme of learning opportunities for provider collaboratives which NHS Providers delivers under contract from NHSE

NHS Confederation

Provider collaboration forum – information about a forum convened by the NHS Confederation, along with resource including Aug 2023 report on the role of VCSEs as part of provider collaboratives

Children and Young People Mental Health Inpatient Services Provider Collaborative

Sarah Sams, Head of Commissioning

West Yorkshire Specialised MHLDA Provider Collaborative

Provider Collaboratives

- Partnerships
- Efficiencies and economies of scale & consolidating specialised services
- Tackling health inequalities
- Reducing unwarranted variation
- System(s) resilience
- Local response to local population (health need)
- Facilitating shared learning

Aims and ambitions WY CYPS PC

- Reduce the number of Young People admitted into inpatient beds *(least restrictive principles)*
- When admission is necessary;
  - Children should be cared for closer to home
  - Length of hospital stay to be as short as possible
- Reinvestment of efficiencies to increase community offer for young people experiencing mental ill health/ crisis

Where we are

- Commissioning Hub establishment
- Dynamic Support Oversight Group
- Standardised Operating procedures
- Consistent commissioning decisions
- Quality Surveillance
- Finance and Contracting schedule
- Facilitating shared learning
- Reduction in CYPS T4 admissions overall
- Less children are cared for far from home
- Children are in hospital for shorter periods

Where we are going

- Business as usual
- Continuous ambition and quality improvement
- Maximising WY capacity
- Systems appreciation
- Hospital avoidance and/ or least restriction
- Facilitated discharge/ transition
- Pathway enhancement (CLiPs)

How we will get there

- Strengthening relationships with ICB and LA colleagues
- - Complex cases and high cost community packages
- - System quality group
- - Inpatient Oversight Group
- Knitting together existing process(es)
- Forming new processes through cross system forums
- System thinking event(s) to inform strategy
- Health Intelligence

The role of the

Commissioning Hub

- Delineation from provider collaborative(s).
- Quality Assurance
- Commissioning - *including bespoke packages of care*
- Case Management
- Care and Safety
- Family liaison
- Facilitated hospital avoidance/ hospital discharge
- Complex care pathways

Lessons we've learned along the way

Consistency and clarity surrounding objectives, purpose and expectations of the PC:

- Members of the PC were unsure about the PC ambitions, and this has led to lack of engagement in capacity management, ownership of the identified cohort and some uncertainty about how the new way of working would benefit the system.
- The business cases were lengthy documents. An exec summary or "plan on a page" comms might have helped the wider understanding of provider collaboratives (from ward to board).

Role of the Commissioning Hub

- Providers had limited experience of local commissioning, and reported to be unfamiliar with the role of commissioners. This primarily surrounded scrutiny and quality assurance.

- The hub is developing an infographic which might help to represent the role of the commissioning hub. It will set out expectations and minimise misinformation/ miscommunication and broadly will cover the elements of collaborative commissioning cycle.

The softer, less tangible, aspect of collaborative working is difficult to implement; particular at times of system-wide pressure.

- We have facilitated a co-produced escalation/ dispute resolution SOP, and this took time to develop and implement. I wonder if, during the planning phase, there is dedicated time to think through:
  - What are the anticipated flash points within the system(s)
  - How to keep in mind collaboration at times of stress/ pressure
  - What would a supportive procedure for dispute resolution looks like

Understanding warranted vs unwarranted (local) variation

- National service specifications do/ will help. There is something about this being mapped/ drawn out; particularly surrounding the placed based services which support the PC. It's old fashioned – but a directory of service can be helpful – and something the live PCs are pulling together to identify any gaps in patient pathway and can set the scene for strategy./ commissioning intentions.

- There's something about existing quality improvement work/ projects and the investment from place, expected outcomes or risks which might effect the PC approach

Quality Surveillance and/ or Assurance

- NHSE quality surveillance approach no longer meets the needs of PCs (in terms of collaboration/ transparency and standardisation). The WY quality surveillance SOP is something that can be shared and sets out how the commissioning hub determine the surveillance level of a provider and the 2 way approach to improve quality. This is now linked with IBC System Quality Group/ Quality Committee.

- NHSE will be considering a contract variation which explicitly supports commissioners to request and scrutinise information and/ or requests from providers.

- Shared understanding of Patient Safety Incident Reporting Framework – in the context of PCs

Finance and Contract Meetings

- If finance and contract meetings are established prior to go live, it might afford opportunities to explore any historic deficits, areas of (perceived) inequity and set out an agreed work plan for consideration

Investment Fund

- We have developed a SOP for an investment funds, but I think it might have been good to describe to partners of the PC how savings might be realised, and the benefits of an investment fund and approach which would benefit the population and the PC, and providers equally.

Governance Structures

- Thinking through governance structures, assurance forums, and decision making groups is worth thinking through to avoid duplication or gap(s)

- There is benefit from having a service development group, to monitor progress pre and post “go live”. This is something that WY have “re-established” for phase 1.

- Thinking through collaborative decision making and mutual appreciation, particularly where funding is split between component parts of 1 pathway

Supporting milestones

- The use of the pre-existing quality maturity framework was a helping matrix, to achieve progress through levels from forming to established (6 monthly check points)
- An MoU between the PC and NHSE might be considered as a transition toward delegation.
- After “Go Live”, WY had the opportunity to utilise a policy and strategy trainee, who proved invaluable in project management
- Each of our phase 1 PCs matured in different ways. Embrace the opportunity to set your own collaborative goals and milestones

A Case Review

Poppy*

- 15 years old
- History of mild anxiety, treated in the community
- August 2022; admitted to ICU Leeds and latterly to Calderdale.
- Detained under Section 2 MHA
- Request for admission to T4 CYPS bed

Presentation

- Very rare; malignant catatonia
- Fluctuating relapse/ recovery
- Requiring high dose/ off-licence psychotropic meds (IV)
- Mortality rate
- Requirement for specialist advice
- *High levels of professional anxiety*
- *Family distress*

September 9th 2022

- PC commissioning Hub (Coordinator and Chair)
- Regional specialist mood disorders (Newcastle)
- Neuro-psychiatry
- Immuno-neurology (Oxford)
- Paediatric team
- CAMHS
- ICB

Principles

- Shared decision making
- Specialist advise; agreed we would “pull” specialists as required
- Consistent communication – including to OOH/ On call
- To do as much as we could, with minimal transfer
- Consistent staffing team

Outcomes

- Flexible response to changing clinical picture
- **Bespoke care** (ECT and plasmapheresis)
- Parental support
- **Extra care MH staffing team** (virtual CYPS T4)
- Legal (MHA) involvement
- Medications review
- Continued matrix approach to MDT working

23rd November 2022

- Poppy stabilised and recovered, with week on week improvement
- Eventually extubated, high dose medications were gradually reduced
- ECT was withdrawn and full course plasmapheresis administered.
- Family engaged and involved*
- Section 17 leave to discharge
- Sec 117 aftercare planning to include specialisms
- **All without moving Poppy**

Lessons we learned

Common purpose

- Clinical *(difference of)* opinion was respected AND we agreed common purpose
- Keeping the purpose simple:
    - *Poppy's best interest*
    - *Legal Framework*
    - *Can it be done from here and what do we need?*
    - *Who needs to do?*
    - *Who needs to know?*
- Contingency planning

Translating learning to action

MDT approach to complex care pathways (hub and spoke SOP)

- Standard Operating Procedure
- 1 dedicated chair of the MDTs (frequency varies)*
- Key & consistent core team
- Reaching out for expertise
- Clear communication with point of contacts
- Timely commissioning decisions
- “Pull in” on demand, withdraw when appropriate

Nottingham and Nottinghamshire Provider Collaborative at Scale

Anthony May, CEO, Nottingham University Hospitals NHS Trust and Claire Culverhouse, Managing Director

NHS
Nottingham and Nottinghamshire

PROVIDER COLLABORATIVE AT SCALE

Anthony May OBE DL:
Chief Executive, Nottingham University Hospitals NHS Trust
and CEO Lead for the Nottingham(shire) Provider Collaborative at Scale

Claire Culverhouse:
Managing Director, Nottingham(shire) Provider Collaborative at Scale

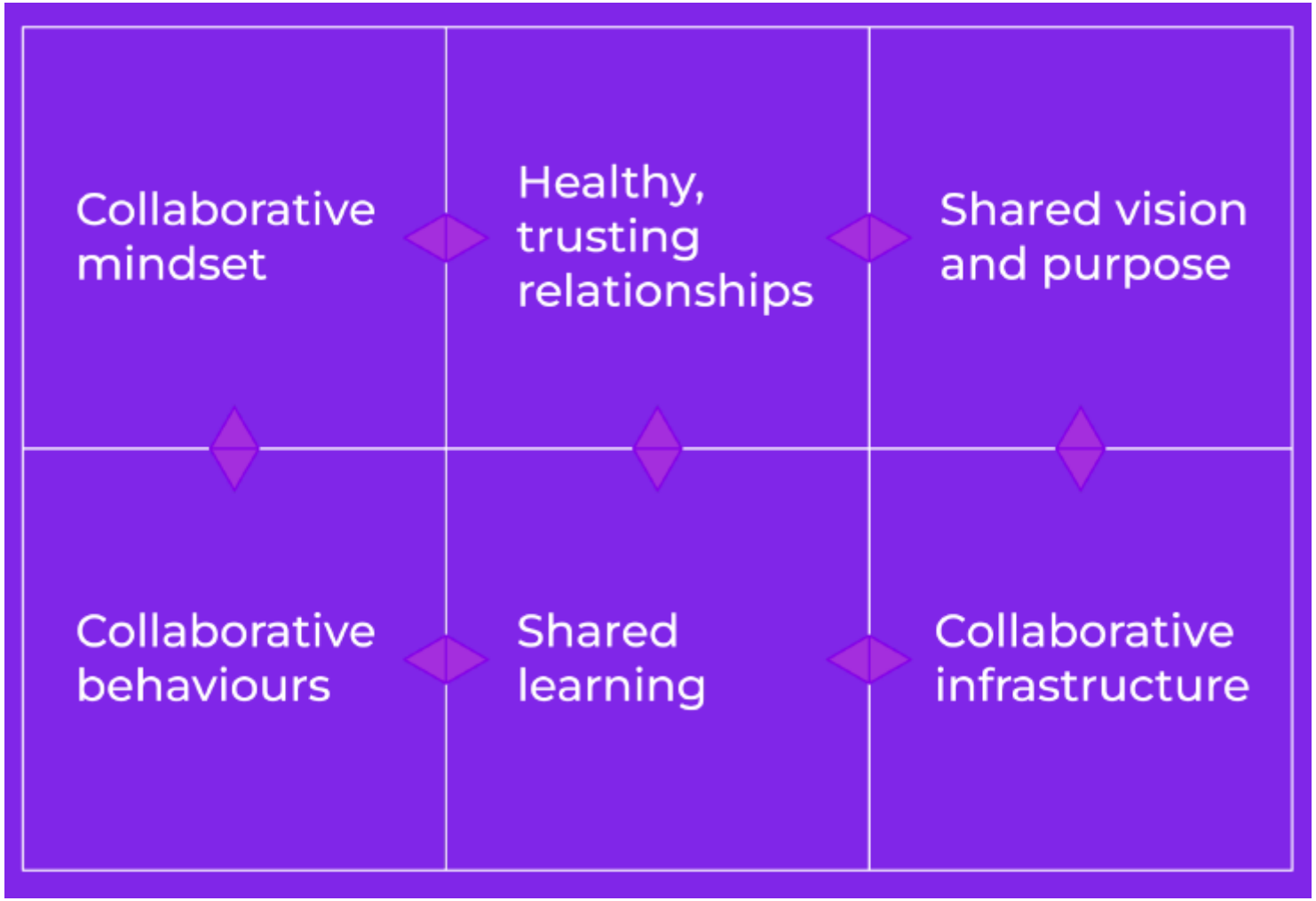
Today's Session

- Why collaboration?
- Our approach
- Our evolution journey
- Governance
- Areas of focus
- Moving forwards

‘Collaboration is what happens when people, teams, or organisations create value by working together towards shared goals’

A Guide to Collaboration Final (collaboratecic.com)

Six Foundations of Collaboration



A Guide to Collaboration Final (collaboratecic.com)

What are we?

- A collaboration of the NHS Trusts/Foundation Trusts in Nottingham and Nottinghamshire
- Work in both clinical and non-clinical areas
- We are not an organisation

Our Five Member Organisations:

- Nottinghamshire Healthcare NHS FT
- Sherwood Forest Hospitals NHS FT
- Nottingham University Hospitals NHS Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS FT
- East Midlands Ambulance Services NHS Trust.

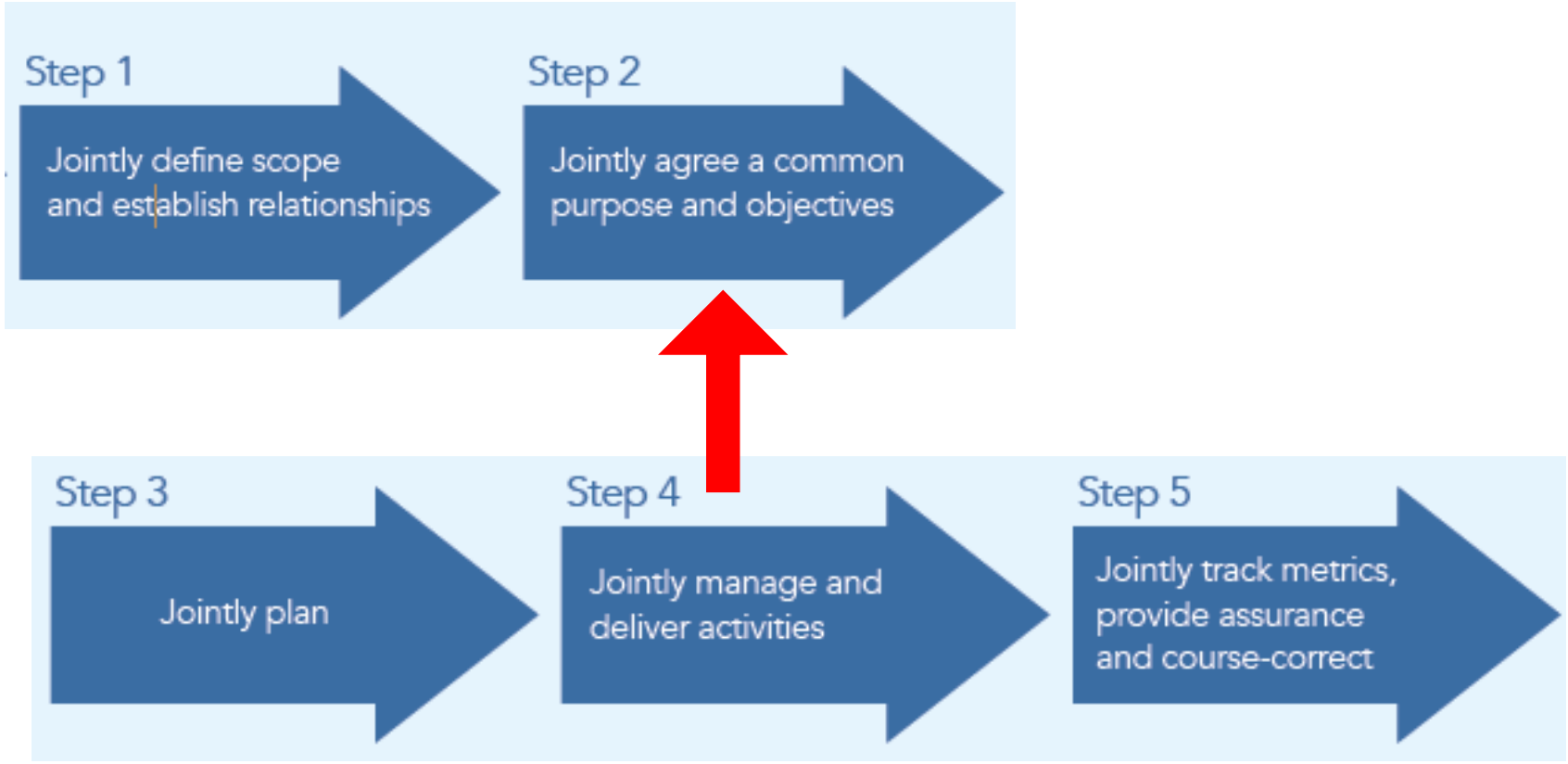
Our Context

- History of competition and even merger discussions
- Bilateral partnerships operating for some time at both corporate and clinical service level
- Partnerships dependent on individuals, not holistic and at times, bypass infrastructure, not facilitated by it
- Turnover in senior leadership posts – 3 of our 5 CEOs took up post in 2022
- Huge financial and operational pressure, alongside many other systems!

Our Mission Statement

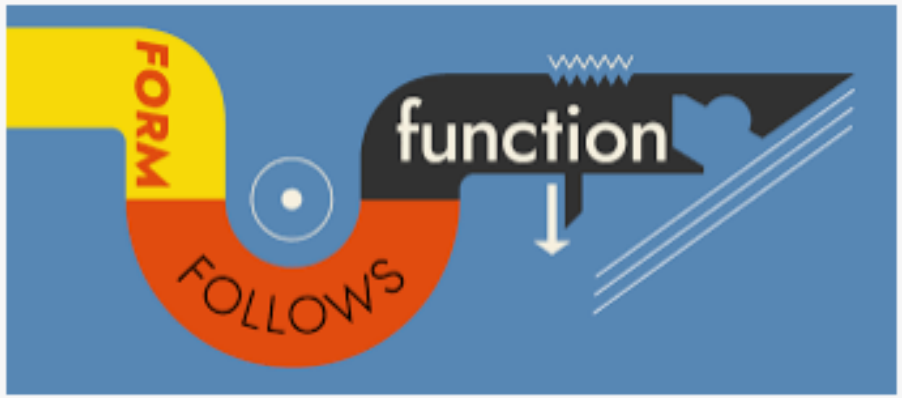
'We will work together, as relevant, for the benefit of our patients, our colleagues and teams and our communities'

Where are we now?



*Content from the Good Governance Institute – The Essential Guide to Provider Collaboratives, 2021.

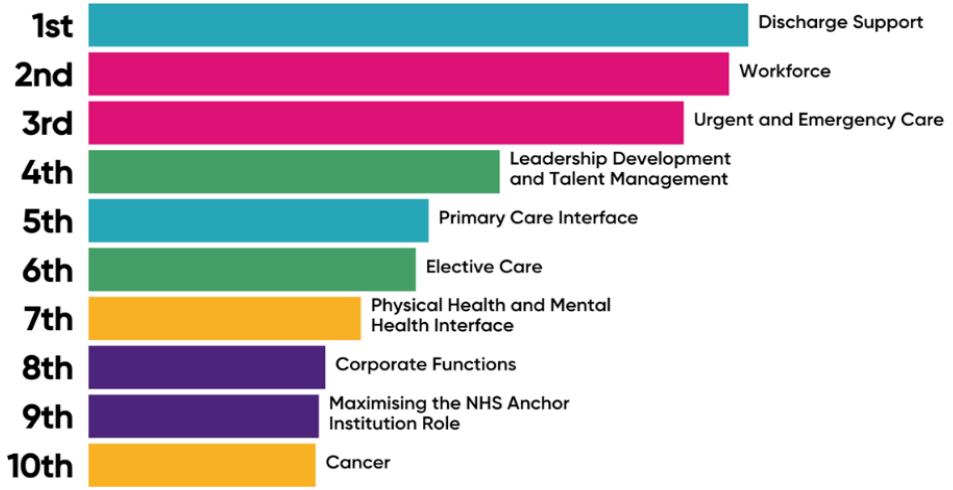
Our Approach



Governance

- Form follows function BUT governance is vital to bind us
- Distributed Leadership model
- Leadership - Lead CEO identified and shared Director post
- Documenting your model e.g. MOU
- Three levels of overarching meetings: Chair led, CEO led, Exec led
- Evolution of governance – what is right for now
- Currently not focussing on delegation
- Robust programme governance for work-streams
- External support/advice/challenge and learning from others
- Alignment with other local collaborations e.g. East Midlands Acute Provider, East Midlands Alliance (Mental Health)

Priorities



People and Culture

- Talent Management
- Passporting / Portability
- Collaborative Bank
- Scaling Up People Services

Urgent Care

- One of our biggest risk areas ‘we must be able to do something here’
- Busy arena and stakeholders broader than collaborative membership
- Acceptance that ‘lifting and shifting’ with no value added is pointless
- Agreed not the right space for this work.

What else?

- Primary Care, Corporate Services, Shared problem solving through Distributed Exec, Joint Forward Plan delivery and Prospectus development.

Next Steps

- Confirming our Priorities and delivering our work programmes
- Developing our Distributed Executive – shared problem solving
- Stepping into our role as system leaders, connecting with other system components e.g. ICB, Place
- Ongoing joint development with our Boards
- Finalising our prospectus and developing the provider collaborative identity.

Challenges and Reflections

- Take people with you – takes time but pays off
- Engage your Boards and NEDs
- Distributed leadership still requires capacity
- Not everything should be done in collaboration
- Complexity of working in systems can make this feel overwhelming – we can’t solve everything initially, so what is within our gift?

Panel Discussion

Stewart Duffy, Legal Director, Weightmans LLP
Kawan Patel, Deputy Director, Provider Policy, NHS England
Sarah Sams, Head of Commissioning, WY MHLDA PC
Anthony May, CEO, Nottingham University Hospitals NHS Trust
Claire Culverhouse, Manging Director, Nottinghamshire Provider Collaborative at Scale

Future Events

Quality Committee
Focus on: **Hearing the Patient Voice**
11th March 1pm-4.30pm

People Committee
Focus on: **Hearing the Staff Voice**
13th June 9am-12.30pm

Finance Committee
Focus on: **Planning at a System Level**
12th September 1pm-4.30pm

Audit Committee
Focus on:
Governance/Risk
10th December 9am-12.30pm

Can all be booked now at: https://www.360assurance.co.uk/events/ or by emailing Kirstie.anderson1@nhs.net

www.360assurance.co.uk @360Assurance
www.audityorkshire.nhs.uk @AuditYorkshire