Teneo
The Global CEO Advisory Firm

HILL DICKINSON

# A stepwise approach to designing provider collaboratives

February 2021

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# Introduction

This paper focusses on the role of providers of acute, specialist and mental health services acting through “provider collaboratives” in the emerging ICS landscape. Providers face a particular challenge because they will be expected to join up services both within places (for example, by collaborating with primary, community and social care providers through place-based partnerships) and across places on an ICS or wider footprint (for example by providing mutual aid for services at scale through formal collaborative arrangements in provider collaboratives). Our aim is to give providers clarity on the options available to them to meet the provider collaborative challenge.

# Integrated Care Systems

Integrating services continues to be at the heart of NHS policy.

## Latest guidance

Integrating services continues to be at the heart of NHS policy. From April 2021, all organisations within the NHS will be required to work together as Integrated Care Systems (ICSs), involving:

- Stronger partnerships in local 'places' between the NHS, local government and others with a more central role for primary care in providing joined-up care
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale

At present, collaboration is on a voluntary basis and ICSs themselves have no statutory status. However, the government's legislative proposals set out in the white paper Integration and Innovation: working to improve health and social care for all (February 2021) intends that ICSs become statutory organisations in 2022 through changes to primary legislation (see opposite).

If approved by Parliament, the new legislation will make participation in an ICS mandatory for all NHS organisations and strengthen the range of levers available for encouraging collaboration within a system. Existing ICS arrangements will form a strong basis for these changes, but each system will need to understand the implications of these changes (both collectively and individually) and consider how their current arrangements need to change or evolve. In particular, the role of providers in these systems will need to be informed by the earlier guidance issued by NHS England and Improvement Next steps to building strong and effective integrated care systems across England (November 2020) which makes recommendations regarding the role of provider collaboratives.

## Proposed legislation changes

Statutory ICSs will comprise an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The proposals for ICSs are designed to provide a core set of requirements for each system that the partners can then supplement with local arrangements. There is a recognition of the need to avoid a one-size-fits-all approach and enable flexibility for local areas to determine the best system arrangements for them.

The ICS NHS Body, which will include NHS provider representatives, will be responsible for developing a plan to meet the health needs of their population, developing a capital plan for NHS provision and securing the provision of health services to meet population needs. It will have a duty to meet the system financial objectives allocated to it by NHS England.

The reforms do not change the governance structures, statutory financial duties or CQC arrangements of NHS Trusts and Foundation Trusts. Further, the ICS NHS Body will not have the power to direct them. However, they will be subject to additional requirements for closer working with other providers and with commissioners, including through a new duty to collaborate, and the ICS NHS body will be able to compel them to have regard to system financial objectives to support achievement of financial control at system level.

ICSs and providers will also be able to make use of new powers to set up joint committees and new guidance on joint appointments.



# Designing provider collaboratives

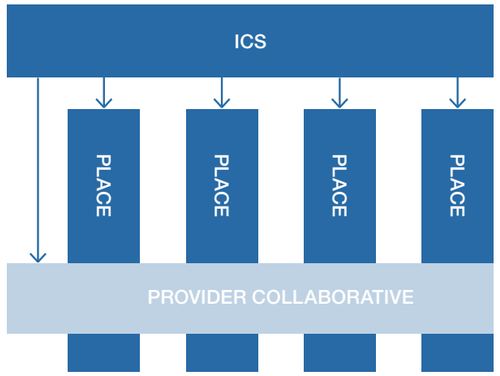
# What are provider collaboratives?

Provider organisations will play an active and strong leadership role in systems. Through their mandated representation in the leadership and decision-making of ICSs, they will help to set system priorities, allocate resources and hold each other to account.

The Next Steps guidance observes that “collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity”. This will require provider collaboration that operates at a whole-ICS footprint or more widely where required.

To achieve this, all providers are expected to be part of one or more ‘provider collaboratives’, depending on the systems they operate within. As a minimum, provider collaboratives will be responsible for:

- Delivering relevant programmes on behalf of all partners in the system
- Agreeing proposals developed by clinical and operational networks, and implementing resulting changes (such as implementing standard operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration)
- Challenging and holding each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning
- Enacting mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system




**Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.**

# What are the benefits of provider collaboratives?

Provider collaboratives can deliver tangible benefits, and many of these have been highlighted during the COVID-19 pandemic when Trusts and other partners have been working more closely together than ever before. It will be important to build on this momentum to tackle the health and care challenges facing the country when the pandemic starts to subside, in particular the elective backlog. We set out opposite five examples of how provider collaboratives may support this.

A stepwise approach to designing provider collaboratives


### Pace of decision making

Experience shows that providers do not reach conclusions rapidly for major service change. Years are wasted and populations are denied access to better care whilst providers negotiate change. Collaboratives can bypass the rivalry and competitive behaviour of multiple Trusts and they are often able to determine and implement new service configurations at pace.


### Performance

Operational excellence and standard operating provides resilience and improvement across a collaborative. Collaboratives can deploy resources across multiple organisations enabling improvements to access/waiting times. Best practice is rapidly implemented across multiple points of delivery to reduce unwarranted variation, with measurable achievements. New approaches to talent management and succession planning can be developed, enabling career opportunities and stability of leadership.

### Service Resilience

Scale enables pooling of workforce and/or mutual aid easier to achieve. Supporting fragile services or enabling smaller Trusts to make change is made possible by this scale. The ability for collaboratives to create flexible approaches to workforce deployment and/or flexible use of capacity enables the better provision and sustainability of services. Collaboratives make it possible to widen leadership and managerial bandwidth meaning that change and improvement can be pursued which otherwise would not have been possible.

### Adoption of new technologies and care models

Innovation, including that assisted by digital technologies, is spread quicker in a collaborative structure and reliable implementation and impact is more assured. This compares with the NHS' inability to secure adoption of best practices without mandation. Clinical reliability is being significantly improved in many collaboratives through standardised operating methods, for example in sepsis pathways; acute kidney injury; joint replacements; medicines reconciliation etc.

### Unit Cost Reduction

Economies of scale have been used to access value which might otherwise have remained locked-in separate organisations. Numerous examples are available: which include the rationalisation of pathology services and providing decontamination services at-scale, both of which are delivering significant efficiencies. Back office/corporate service costs can be reliably reduced with 10%+ savings realised.

# Can provider collaboratives support post-COVID recovery?

One example of where provider collaboratives could have a significant and immediate impact on provider recovery is in the reduction of waiting lists for elective care.

Provider collaboratives can help to address this issue by:

- Taking a more joined-up and systematic approach to elective recovery across a region
- Load balancing demand to ensure equity of access and best use of all available resources
- Facilitating more joined up pathways and PTL management across the entire pathway
- Making better use of workforce across the system
- Ring-fencing existing 'green' elective capacity for shared use across the system
- Accessing investment for new elective capacity across the system (e.g. diagnostic hubs)
- Accessing investment in technology that can reduce DNAs, drive increased throughput and support virtual out-patient models
- Making best use of the private sector and its resources

Accessing and sharing investment is something that collaboratives (particularly those at the 'tighter' end of the spectrum) can do more effectively than single, small, organisations who would struggle to provide a compelling return on investment.

This is one example of where provider collaboratives could support recovery. In general, wider scope, greater scale and pace of decision making will mean that provider collaboratives are able to play their part in addressing a multitude of short and long-term issues.

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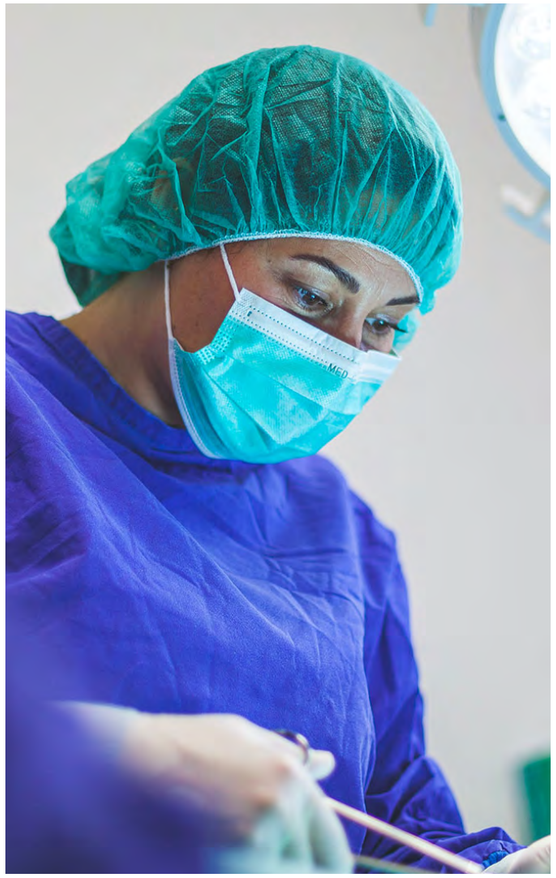
# What options exist?



The concept of provider collaboratives is not a new one – many NHS organisations are already working within collaborative arrangements, be they Hospital Groups, Alliances or Federations. These existing models may evolve into, be replaced by, or run alongside ICS provider collaboratives.

So, what are the options? The organisational form of ICS provider collaboratives is not yet prescribed, and we believe that subsequent guidance will outline several available options rather than a 'one size fits all' solution.

The available organisational forms can be broken down into several discrete options and choices. Like a menu, these options can be combined in different permutations to create a multitude of similar but subtly different models. The available menu is outlined in the figure below. This includes a range of options that are possible under the current legislation, as well as one option – a joint committee – which will be possible under the proposed legislation changes.

Each of these options come with certain advantages and disadvantages, making them more or less relevant for different situations. Over page are five example options with a description of when they might be useful. These examples are a mixture of legal, governance and leadership options. The proposed legislative changes will make it easier to set up joint committees , but this option will not be available until the legislation becomes law.

| Legal | Governance | Leadership | Resources |
|---|---|---|---|
| Collaboration Agreement[1] | Partnership Board | Separate leaders working together | Pooled / shared resources |
| Lead Provider contract[2] | Committees in Common | Distributed leadership[4] | Shared corporate leadership |
| Corporate JV[3] | Joint committee<br>Requires legislation change | Shared leadership | |
| Merger or acquisition | | New 'Group' leadership | |

1. Any form of written agreement outlining the terms of a collaborative arrangement such as an alliance agreement or partnership agreement
2. A specific type of contractual approach for the delivery of integrated services (see below)
3. A new corporate entity of which the organisations are shareholders or members (LLP)
   **Note:** The tax/pensions and liability issues associated with corporate JVs mean that they are unlikely to be seriously considered in the short term
4. Leaders are drawn from across providers to take the lead for specific workstreams

# Five example options and when they might be suitable

## Option

### Partnership Board

Governance

Provider organisations may create a 'Partnership Board' with representation from provider organisations within the system. The Board would have a clear remit, based on the opportunities it is trying to address. The Board would seek to take aligned decisions on those matters that fall within its remit as a forum rather than an actual decision making body.

In most cases this is combined with a Collaboration Agreement, which is the legal document used to establish the Partnership Board.

### Committees in Common

Governance

The boards of the provider organisations each create a board-level committee – these committees meet at the same time to discuss the same agenda and to take collective decisions. In essence this seeks to replicate a single 'joint committee' of the separate organisations. However, legally they remain two separate committees each taking their own decisions.

Committees in Common are often combined with an overlap in leadership positions (e.g. where one person is the CEO of multiple organisations), which further strengthens its ability to take binding decisions.

## Suitability

- As a first step toward greater collaboration and to build relationships
- Where relationships are already strong and there is a track record of aligned decision-making
- Where the collaboration will not need to address 'difficult' decisions such as service reconfiguration

- Where aligned decision making through a Partnership Board has proved ineffective
- Where the collaboration needs to address 'difficult' decisions such as service reconfiguration
- As a transitional stage on a path to merger (when combined with overlapping leadership)



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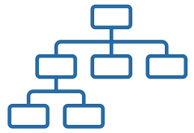
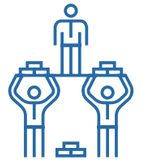




### Shared Leadership

Leadership

Organisations share key leadership positions – for example, one individual is the CEO of two different organisations. These arrangements are increasingly common, particularly for the role of Chair and CEO.

Many organisations combine this approach with a form of shared governance (either a Partnership Board or Committees in Common).

In many cases, a shared Chair or CEO is a precursor to merger further down the line.

### Lead Provider

Legal

Commissioners award a contract to a single provider who is then responsible for the provision of a package of services. Some services may be delivered through sub-contracting arrangements with other providers. In some cases, a number of different providers may each take the lead for certain services under the overall framework of a Collaborative Agreement which operates under the lead contract to integrate the services. This option enables joined-up decision making and the integration of services.

The arrangements may be wide (e.g. all mental health services) or narrow (e.g. children's surgery) in scope.

### Merger

Legal

Two organisations merge to create a new organisation, or one organisation acquires the other. This results in a single organisation with a single decision-making function (the Trust Board).

- To strengthen aligned decision making
- Two share leadership talent
- To repair historical relationship issues between two organisations
- Often pursued opportunistically as leadership vacancies naturally arise

- To join up fragmented services
- To address quality issues by drawing on the expertise of another provider
- To address unsustainable services (typically due to staffing pressures or low volume)
- To pass population risk from commissioners to providers

- Where one or more organisations are unsustainable in their current form
- Where one or more organisations would benefit from greater scale
- Where organisational protectionism is a significant barrier to necessary service change
- Where other routes (e.g. Committees in Common) have proved too complex or bureaucratic in the long-term

# Illustrative examples

The options outlined above are not mutually exclusive or sequential; they can be combined, and one may evolve into another over time. The illustrative examples below highlight how several options may be combined to create a collaboration, or series of collaborations, that address the specific needs of the system in question.

**5 places**

**4 acute provider FTs**

**2 mental health FTs**

**Models in play:**
Committees in common
Distributed Leadership
Pooled Resources
Shared Corporate Leadership

## System A

### Context

There is a strong track record of decision making, as evidenced by a number of successful service reconfigurations over the last four years. The main focus of the provider collaborative will be on post-COVID elective recovery, rolling out of new digital technologies and care models, and creating more sustainable system-wide staffing models.

### Design

System A establishes Committees in Common of the constituent provider boards with delegated decision-making powers and no organisational veto. Each provider CEO leads a workstream (e.g. for example one of the acute CEOs leads the 'elective recovery' workstream) on behalf of the system. The providers agree to pool their improvement and transformation resources and appoint a joint Director of System Transformation who attends the Committees in Common. The arrangements are underpinned by a written Collaboration Agreement.

**4 places**

**3 acute and community provider FTs**

**2 mental health FTs**

**Models in play:**
Merger
Lead Provider
Partnership Agreement

## System B

### Context

There is significant duplication of services across the acute providers and previous attempts to address this have been thwarted by organisational protectionism. If delivered, service change is likely to make one or two of the acute organisations financially unsustainable. The provider collaborative must address this if the system is to reach financial balance.

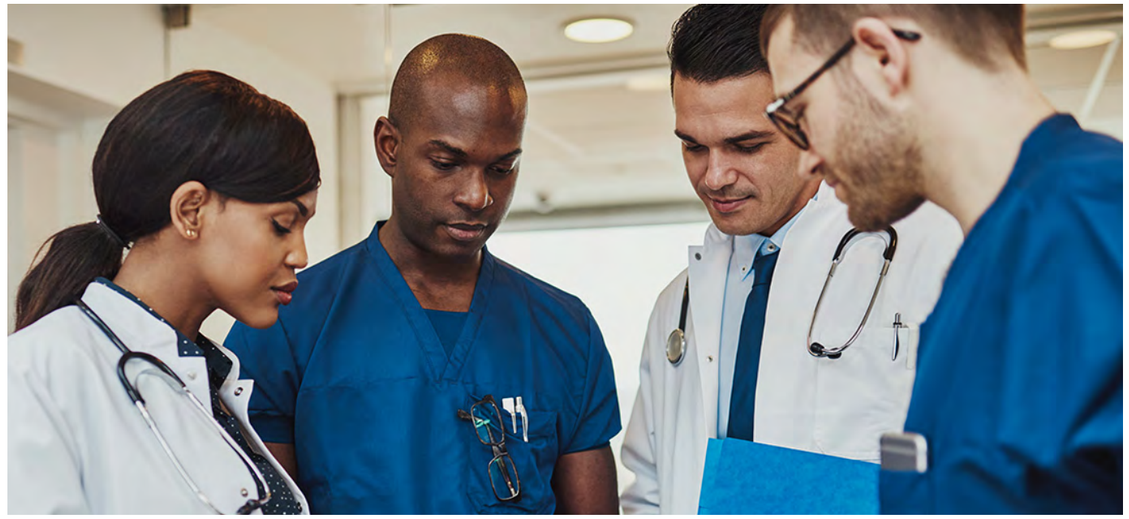
### Design

System B creates a single acute and community provider for the system through merger, allowing the necessary service change to move ahead. Scale enables the provider to host back-office support services on behalf of the whole system. The acute provider also enters into a multi-ICS collaborative with the providers of three neighbouring ICSs, focused on the design and delivery of specialist services across a region.

One mental health provider is awarded an outcomes-based Lead Provider contract with responsibility for managing a budget and supply chain of other providers, with a focus on reducing out of area placements. All providers whose services fall within the Lead Provider's remit work together under the terms of a Collaboration Agreement.







**6 places**

**5 acute provider FTs**

**3 mental health FTs**

**Models in play:**
Partnership Agreement
Lead Provider
Partnership Board

## System C

### Context

Some of the more specialist services are proving unsustainable due to low patient numbers and a regional shortage of certain skills (both professional and leadership). This is causing a number of quality concerns across the system. One of the acute FTs is a teaching trust with significantly greater patient numbers and a better track record of recruiting and retaining staff. Two of the FTs are small district general hospitals, which are financially and clinically unsustainable in their current form.

### Design

System C signs a Collaboration Agreement, which acts as an umbrella agreement for a number of Lead Provider contracts held by each of the providers. The Lead Provider contracts enable the local teaching trust to take on the design and delivery of some elective services across he system, while other providers assume responsibility for certain other services. The Collaboration Agreement also establishes and sets out the terms of a Partnership Board, including a process for how collective decisions will be taken.

To support this, the two small district general hospitals agree to appoint a shared Executive Team and to create Committees in Common, to effectively take on many of the duties of the two Boards. This arrangement allows them to benefit from scale without a merger.

The illustrative examples set out above demonstrate just a fraction of the complexity of a real system – real systems have much more complex politics, in addition to structural issues such as organisations that sit on the boundary of two systems. These examples are included to highlight that several different models may be required to create an effective working solution for a system.

# What does the Next Steps guidance say?

"Each system should define provider collaborative leadership arrangements for providers of more specialist services in acute and mental health care.

### These should consistently involve:

- Every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision making arrangements for defined functions;
- Provider collaboratives represented on the appropriate ICS board(s). **Note:** the White Paper only references providers (not collaboratives) being represented.

### It is for the providers to flexibly define:

- The scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;
- The precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);
- The precise governance and decision-making arrangements that exist within each collaborative; and their voting arrangements on the ICS board.

The guidance advises that “governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS”.

It also highlights the importance of clinical leadership and describes a role for existing clinical networks in “advising on the most appropriate models and standards of care” and “making decisions about clinical pathways and clinically-led service change.”

NHS England and NHS Improvement have committed to “set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.”



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# Are these arrangements enough?

In our previous report – NHS Collaborations; Part 1 – we discussed the challenges to collaboration within the NHS and the difficulties that often arise when organisations need to take joint decisions that will improve care for patients but may have detrimental financial implications for individual organisations. Organisational protectionism causes endless frustration within systems when change is thwarted by organisations exercising their ‘power of veto’.

Some of the models outlined above address these issues head-on – for example, Merger and Lead Provider contracts put one organisation in the decision-making seat and a joint committee (if introduced through legislation) would allow FTs to formally delegate decisions. Other models seek to circumvent the issues through organisations sharing leadership or governance – these ‘work arounds’ have had mixed success and looser collaborations, such as Partnership Boards and Collaboration Agreements, are often insufficient to overcome these barriers.

# Selecting the right option for your system

Provider collaboratives may take a number of different forms and the right model for a particular system will depend on the idiosyncrasies of the system in question. For example, it will depend on system size and structure, number and type of providers, and local politics and relationships. As a case in point, London has its own unique complexities due to the transient nature of its population, the relatively porous geographical boundaries and the magnitude of regional and national specialist services.

Opposite is a stepwise approach that providers can follow to design their provider collaborative(s), followed by a number of 'hints and tips' for any organisation involved in, or leading, a design process.

## Designing provider collaboratives

### 1. Define the objectives

First, organisations must be clear on what they are trying to achieve and why. This may involve creating a robust case for change. All organisations who will be part of the future collaboration must buy in to this before design work begins.

### 2. Describe the function of the collaboration

Organisations must then describe the way they want to work together in the future. Describing this from the perspective of function (rather than form) will help to ensure that the end design is fit for purpose. For example, this may require organisations to describe:

- The outcomes they would like to achieve
- The types of decisions they want to be able to make collectively
- The nature of the relationship they want to have
- Challenges or opportunities they would like to address together

### 3. Perform an options appraisal

Once everyone is agreed on the function of the collaboration, an appraisal can be performed to understand the options that are available. Each option should be assessed on its ability to meet the functional specification versus the consequences for the sovereign organisations.

### 4. Undertake detailed design

Once an option is chosen, organisations must then spend time working through the specifics of how the model will work and how it will be implemented. We recommend that this stage includes a period of rigorous scenario-based stress testing, to ensure that all potential issues are ironed out in plenty of time. This process may have implications for organisations and individuals and requires careful handling as well as a clear communications strategy.



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## Hints and Tips

### Be specific about your objectives

Any organisational design process should start with clear objectives. In many cases, the more specific organisations can be about their objectives, the more likely they are to create a model that meets their needs. Leaders often (openly or inadvertently) disagree on purpose or objectives, so being clear on this from the start can save time further down the line.

### Function before form

Describing the function of the provider collaborative should be done in conjunction with the wider ICS design process to ensure the right division of responsibilities between system and place, based on the principle of subsidiarity. Systems often jump straight to 'form', focusing more on what might be palatable for organisations or individual leaders, rather than spending time on describing the function of the collaboration.

### Alignment with place

In designing and creating provider collaboratives, Trusts will need to consider carefully how a collaborative arrangement will align with, and support, place-based models such as Integrated Care Partnerships. A key issue will be the alignment of place and provider collaborative leadership arrangements and governance structures, particularly given the involvement in place-based models of other partners such as Local Authorities and Primary Care Networks. It will be important to ensure that the leadership arrangements and governance structures establish a clear and robust framework for clinical and financial accountability, which recognises the sovereignty and statutory duties of individual Trusts. We recommend building a number of 'tests' into your options appraisal – one of which should be, "how well does this option support local place-based integrated care models?". Some of the models outlined above may be more or less suitable depending on the nature of the place-based arrangements that are in play.

### Minimise duplication

Organisations should perform a stock-take of existing collaborations as part of the design process. The model that is ultimately proposed may represent an evolution of existing arrangements, may replace existing arrangements entirely or, most likely, a mixture of the two. To ensure clarity and simplicity and to avoid a proliferation of duplicate meetings, we recommend that only those arrangements that are clearly distinct (for example, the role of regional clinical networks) are maintained in addition to the proposed provider collaborative(s).

# How we can help

We believe that all systems will need to consider how to respond to the developments discussed in this paper. Many systems have already formed a provider collaborative of some sort, but every provider will need to consider whether these arrangements are really delivering on their ambitions/goals. Much like the ICS development framework, we anticipate providers being asked to evidence where their collaborative sits on a spectrum from 'emerging' to 'thriving', and to demonstrate how and when progression will take place. We are unique in having the experience to support you in this.

Many systems will need help to navigate the myriad of available options, and the right independent support can be particularly helpful in navigating the sensitive politics that often surround the development of provider collaboratives.

We understand that the skills required to support these projects are many and varied, and that any single service organisation is unlikely to be able to fulfil this brief. The combination of Teneo, Hill Dickinson and Dalton Consulting bring unrivalled expertise to the table to help organisations and systems explore and deliver new ways of working.


**Lucy Thorp**
Lucy Thorp is an experienced consultant specialising in organisation and system design. Having delivered a multitude of org. design engagements for a diverse set of clients, Lucy brings strong project know-how and technical and analytical expertise. She is an expert in designing and delivering projects that help organisations to choose and implement the right model for them.

**Sir David Dalton**
Sir David Dalton is the former CEO of Salford Royal, where he led the development of the Northern Care Alliance across the north of Greater Manchester: one of the first NHS Groups to be established, which covers a population of c.1.2million, has a workforce of c.18,000 people, and a turnover of £1.3bn. David has since turned his considerable experience and leadership skills to helping others explore and implement different provider collaboratives.

**Jamie Foster**
Jamie Foster is an experienced commercial lawyer, providing advice to NHS organisations on collaboration models for integrating health and care services. Jamie's expert knowledge helps organisations to navigate the NHS legislative and regulatory frameworks. Jamie also helps organisations to implement their collaborative and place-based arrangements including for partnerships, lead provider models and mergers.



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