Developing an ICS Provider Collaborative at Scale

March/April 2022

1. Purpose

1.1. This paper provides an update on the work progressing to establish an ICS Provider Collaborative at scale between Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (NHT), Nottingham University Hospitals NHS Trust (NUH) and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH).

1.2. The paper focusses on:

- Feedback from the recent joint Non-Executive Director engagement events
- Governance
- Establishment of a Provider Collaborative Office
- Next Steps, and
- Progress against the actions set out in the last Provider Collaborative update provided to the ICS Board.

2. Background

2.1. There is a requirement in the current legislative proposals that all statutory NHS providers are involved in at least one provider collaborative. National guidance and a national toolkit for the development of Provider Collaboratives at Scale have been made available by NHS E/I and this work programme has been based on those documents.

2.2. The last update provided to the ICS Board on the development of the Provider Collaborative at Scale, reflected the existing collaboratives already in place across our system, an update on the collective position about what our Provider Collaborative is and isn't and set out some next steps.

2.3. Since that update, there has been a national decision to delay the timeline to implement the legislative changes from 1 April 2022 to 1 July 2022. With that, the formal establishment of the ICS Provider Collaborative at Scale will also be delayed. Although work is continuing to develop our collaborative, the formal establishment date is now planned to be 1 July 2022. This date remains as a step in our journey of collaboration, not an end point.

2.4. There continues to be some oversight of the development of the Provider Collaborative through the ICS Transition & Risk committee to ensure alignment with other developing system plans / architecture.

2.5. As it has been determined that Bassetlaw will join the Nottingham and Nottinghamshire ICS, DBH are also becoming more involved in the Nottingham and Nottinghamshire Provider Collaborative at Scale. There is further work to do in relation to clarifying the specifics of individual partner organisation's roles

within these arrangements, including the role and relationship that the Provider Collaborative will have with other providers, including East Midlands Ambulance Service, CityCare, Primary Care and the Place Based Partnerships.

3. Joint Non-Executive Director (NED) Engagement Events

3.1. In February 2022, two joint NED engagement events were held virtually, with invitations extended across organisations. The purpose of these sessions was:

- To jointly build a common understanding of the work underway to develop a Provider Collaborative at scale

- To harness the experience of the NEDs and consider the opportunities and challenges that the Provider Collaborative may create

- To give NEDs the opportunity to help influence and shape this work programme and the areas of focus for collaboration.

3.2. Two identical sessions were run on separate days to maximise possible attendance. Over twenty NEDs from SFH, NHT, NUH or DBH were able to join one of the sessions.

3.3. Examples of provider collaborations were shared with the groups and then opportunities were explored in relation to both the function and the form of our local provider collaborative.

3.4. The feedback from the sessions was extremely positive. There were a number of key points arising from the discussions, which are detailed below:

- There was collective agreement that this is the right direction of travel and that it presents opportunities for the people of Nottingham and Nottinghamshire, as well as the providers

- It will be important to start by focussing on a small number of things and doing them well

- A clear purpose is vital for this work to be successful – we need to be able to clearly articulate ‘why’ we are doing something

- The collaboration needs to be underpinned with strong governance and agreements, detailing that sovereign organisations remain accountable for delivery, whilst also providing clarity around how decisions are made that may not benefit sovereign organisations and what happens when partners don’t agree

- Culture will drive the collaboration forward. Trusted relationships will be key but developing those will take time

- The work programme and priorities for the collaborative need to be clinically informed/driven

- The geographical location of the offices may want to be separate to one of the key providers, as this may be an important step to demonstrate impartiality
- The added value of the collaborative needs to be evidenced throughout the work

- Learning should be generated from what works well, as well as what doesn't work as well.

3.5. It has been agreed that future joint NED events will be arranged as the Provider Collaborative at Scale develops and a NED network will be established across the four organisations, in order to further build relationships and develop shared understanding between providers.

4. Governance

4.1. Board members will be aware from previous discussions, that the development of the provider collaborative will be iterative, non-linear and will be required to go through different stages of maturity. As a starting point, it is proposed that a Provider Leadership Board (PLB) is established and reviewed every 6 months. National guidance describes a PLB as:

> *'chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners.'*

4.2. Extracts from NHS England/Improvement guidance on possible governance forms is detailed in Appendix A, and further information about Provider Leadership Boards is detailed at Appendix B.

4.3. In order to support the agreed PLB approach, an initial governance structure for the developing Provider Collaborative at Scale in Nottingham and Nottinghamshire has been developed and is detailed in Figure One. This structure will evolve as the functions of the collaborative become clearer. On the right hand side of Figure One, there is a description of the function of each level, which should ensure clarity of discussions and clear mechanisms of accountability.

4.4. The PLB is to be chaired by a nominated CEO from one of the Provider Collaborative organisations. At this moment in time, Dr. John Brewin, Chief Executive of NHT, is currently chairing the shadow Provider Leadership Board.

4.5. It is proposed that there is a partner Director seat around the Integrated Care Board that is for NHS Trusts and Foundation Trusts. Early thinking would be that provider organisations would support the Chair of the PLB also representing NHS Trusts and NHS Foundation Trusts on the ICB, but more work is needed to confirm this.

5. Establishment of a Provider Collaborative Office

5.1. Within its guidance to NHS Trusts, NHS England places a significant emphasis on the importance of having dedicated leadership resource to support the work of the collaborative, while also recognising that collaborative working must be built into existing roles – in particular for clinical and operational leadership roles.

5.2. NHS England case studies of existing provider collaboratives found that typically, administrative and operational staff from collaborating trusts are partly or wholly assigned to support the work of the collaborative. In some cases, roles are recruited to directly and paid for jointly among members.

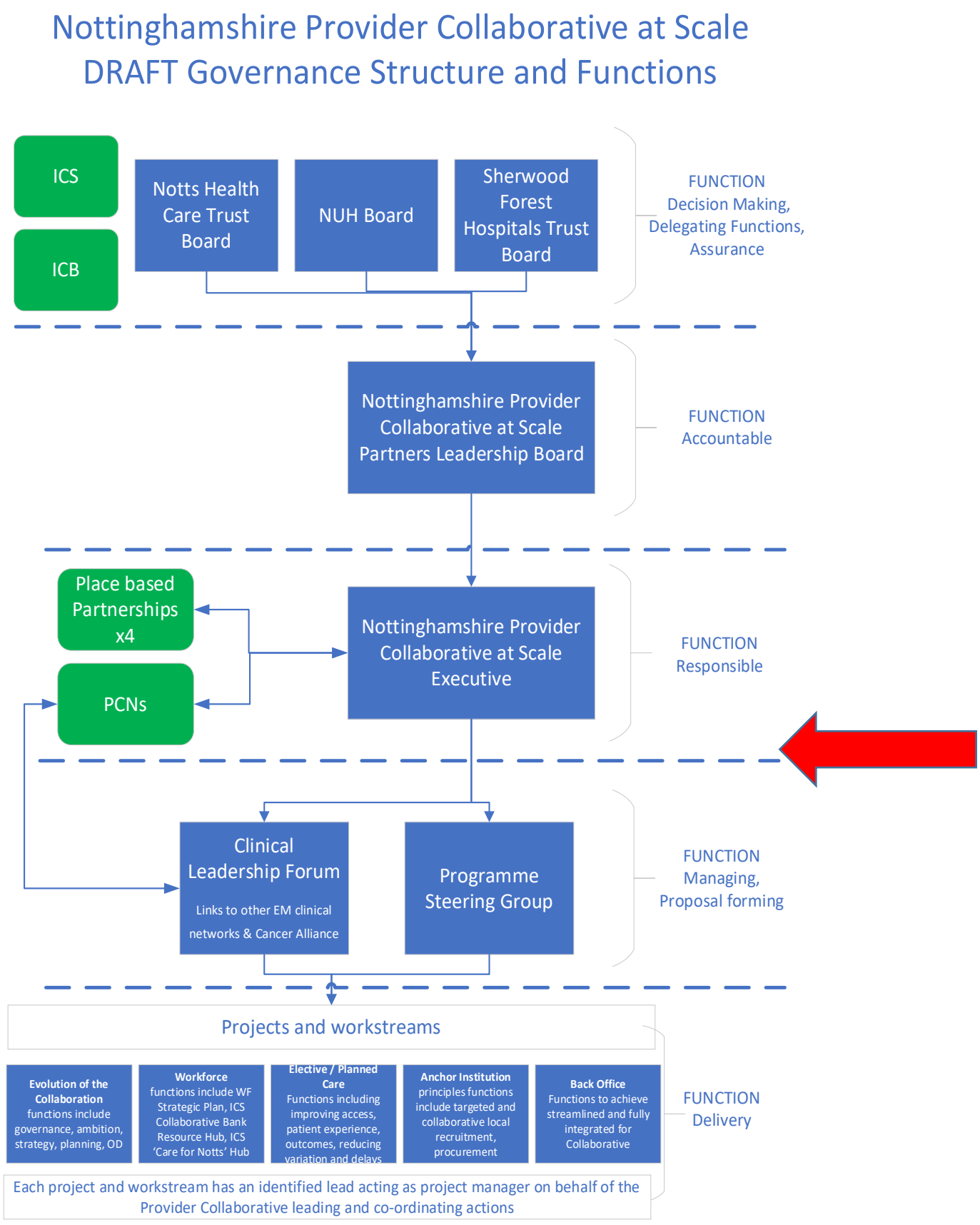
5.3. In order to support the development of a Provider Collaborative at Scale and to co-ordinate and drive forward the work of the collaborative, discussions about whether a Director for the Provider Collaborative should be appointed and a Provider Collaborative Office, established.

5.4. The initial thinking is that the Provider Leadership Board could hold the Director and other Provider Collaborative Executives to account to deliver the agreed priorities. The details of this are still being worked through and will have to be agreed by partner organisations.

5.5. The Executive would be made up of nominated Trust Executives, e.g. Medical Directors, Directors of Strategy, along with other attendees such as Place based Partnership representatives and representatives from other providers, e.g. CityCare.

5.6. Through distributed leadership, the Office would deliver the functions below the red arrow shown on the right in Figure One.

Figure One: Initial Governance Structure



6. Next Steps

6.1. There is a significant amount of work to do to progress the development of the Provider Collaborative at Scale. Conversations continue about the establishment of the office in order to drive and govern this work, which will be one of our key next steps but we are also progressing with securing some external support to help us with the others.

6.2. As a system, we have received £39,000 from NHS England/Improvement, in order to support the development of the Provider Collaborative at Scale. This amount has been supplemented with local funds to allow us to procure some external support to help us on this journey.

6.3. A procurement process for an external partner was initiated in February 2022 and will support us to develop and embed a shared vision, confirm priorities, develop a draft operating model and build collaborative relationships and leadership to meet population health needs, aligning behaviours, values and ways of working.

6.4. This work is expected to include:

- A workshop with leaders to develop a vision, principles and values
- Use of activity data and population health management data to consider a long list of opportunities
- Stakeholder engagement on the long list to help identify some potential priorities (considering which will be the best opportunities to build engagement and some quick wins to build momentum)
- A further workshop with leaders on priority opportunities, informed by work from the above
- Work with leaders to develop governance, including Terms of Reference for the PLB, a draft operating model for the Provider Collaborative at Scale, a decision making framework to provide clarity of roles and ownership of actions, functions mapped across the Provider Collaborative at Scale and aligned to decision making framework
- Actively bringing intelligence from across the country and from the centre to ensure the provider collaborative is set up to achieve the required aims and objectives and drive real change for the population
- A deep dive into one priority service to map and identify root causes of current performance and present at an appropriate forum.

6.5. There is also a need for us to consider how we are communicating the work to develop the Provider Collaborative and this will be an area to progress alongside the external support work.

7. Progress Against Actions Committed in ICS Board Update

7.1. In the Provider Collaborative update paper that last went to the ICS Board, a number of next steps were set out. Given the amendment to timescales nationally and more recent thinking about our approach, some of these have

been superseded or have needed to be amended. However, in order to ensure we are tracking progress, they are detailed below, along with a position statement against each.

Action Committed	Update
Communication plan to be used to engage with different audiences both internal and external	This action is not yet complete and a communications plan will need developing as part of our next steps.
Tripartite Board meetings to coproduce plans and agree priorities	Since the Chairs and CEO meetings have now been scheduled monthly, along with the shadow Provider Leadership Board and the NED events, we believe we have good Board level engagement across organisations. This joint Board paper is also part of our ongoing engagement with Boards. In terms of development of plans and priorities, the external support work will allow us to refine and develop our priorities and plans and this will be done with the engagement of Board members across our organisations.
Setting up the PLB to be in shadow form by January 2022	The January date is no longer relevant given national timeline slippage. A regular meeting of the CEOs and Lead Directors for the Provider Collaborative is now in place, which is taking the form of the shadow Provider Leadership Board. There is still further work to do to confirm Terms of Reference etc. which will be linked to the external support referenced within the next steps section.
Establishing a development plan that is in line with national provider collaborative guidance	A development plan will be created as part of the external support work and alongside the development of the Provider Collaborative Office. National guidance currently only specifies that a Provider Collaborative must be in place by 1 July 2022 and considers some of the things that we should consider, not details of those at this stage.
Progressing focused work on elective care and anchor organisations	Discussions across organisations continue in relation to our role as Anchor Organisations but there is further work to do to establish what we do already and look for synergies and alignment across organisations.

	In relation to elective care, discussions across the system have given this an even higher profile in relation to the development of proposals for hubs. This work will be considered as part of the work to determine priorities but work will also continue outside of the provider collaborative at this time.
Engaging with other partners to ensure clarity on how the provider collaborative interfaces and works alongside other system governance. This will include discussions with colleagues in Bassetlaw	More work is needed on this as part of the development of the operating model. Having said that, some conversations have progressed and DBH are now actively engaged in the Provider Collaborative work. Conversations are continuing with the Chair and Chief Executive Designates of the Integrated Care Board and with Place Based Partnerships.

8. Conclusion

8.1. This paper provides an update on the work to develop the ICS Provider Collaborative at Scale across Nottingham and Nottinghamshire.

8.2. The Board is asked to acknowledge the update and provide any feedback on the programme of work and approach.

Appendix A: Extract from Provider Collaborative toolkit - Potential governance models

Potential governance models

Provider leadership board

- Chief executives or other directors from participating trusts come together, **with common delegated responsibilities from their respective boards**, in line with their schemes of delegation. This enables them to tackle areas of common concern and deliver a shared agenda on behalf of the collaborative members and their system partners.
- This model can make use of **committees in common**, where committees of each organisation meet at the same time in the same place and take aligned decision.

Lead provider

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

Shared leadership

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

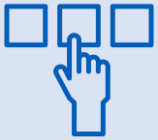
Appendix B: Provider leadership board: Leaders from participating trusts come together with delegated responsibilities from their boards

What are the core components of a provider leadership board?

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

What are the key decision-making arrangements?

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



When is this model most suitable?

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

How are system partners typically involved?

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