

Provider collaboratives: explaining their role in system working

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17-minute read

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This explainer looks at provider collaboratives in England, the opportunities they provide and the unresolved questions to consider when thinking about their role in the changing health and care landscape.

What are provider collaboratives?

Provider collaboratives (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>) are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way the health and care system is organised, moving from an emphasis on organisational autonomy and competition to collaboration and partnership working.

What is the rationale for provider collaboratives?

NHS providers face significant challenges including rising demand for services, severe workforce challenges and the legacy of a prolonged funding squeeze. NHS England has [argued](https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>) that the challenges facing providers after the Covid-19 pandemic are too much for a [single organisation to tackle](https://www.england.nhs.uk/wp-content/uploads/2018/01/acute-care-collaboration-learning.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2018/01/acute-care-collaboration-learning.pdf>). Formalising provider collaboratives is a culmination of a national policy focus on addressing these challenges through system working and exploring the potential of working at scale.

The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care.

The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care. Collaborative arrangements could see providers coming together to consolidate corporate services for greater efficiency, increase sustainability by making better use of a limited workforce and improve quality of care by standardising clinical practice to tackle variations in care across different sites.

NHS England believes that formalising provider collaboratives now will give providers the opportunity to combine resources to address the challenges they are facing. However, there is a limited evidence base (although anecdotal reports of the benefits of co-operation during Covid-19 added to this) and few evaluations of previous [initiatives](https://www.kingsfund.org.uk/publications/mental-health-new-care-models) (<https://www.kingsfund.org.uk/publications/mental-health-new-care-models>), to verify the success of provider collaboration in tackling these longstanding challenges.

The history of provider collaboration: policy and practice

Provider organisations have historically worked together to address mutual challenges, encouraged by a number of policy documents that have both made the case for collaboration and also identified ways to do this.

In 2014, the [NHS Five Year Forward View](https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view) (<https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view>) set out a number of new models of care with the aim of breaking down barriers between services and delivering integrated care. This was closely followed by the [Dalton review](https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care) (<https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care>), which explored organisational models to underpin this. In practice, these policy documents led to the creation of new models of care that, for example, brought together primary care, community, mental health and hospital services into [primary and acute care systems](https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/primary-acute-care-systems) (<https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/primary-acute-care-systems>) and hospital providers into [acute care collaborations](https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/viable-smaller-hospitals) (<https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/viable-smaller-hospitals>). Acute care collaborations demonstrated that organisations could take diverse approaches to collaboration, including providers working together on a range of clinical and non-clinical service areas (multi-specialty chains), hospital group models and trusts working on a specific service area (specialty-based franchises).

The Royal Free London was [an acute care collaboration vanguard site](https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/) (<https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/>), that worked as a hospital group, bringing Barnet Hospital, Chase Farm Hospital, and the Royal Free Hospital together into a single group structure with the aim of reducing variation in clinical services, such as pathology, and reducing costs through collaboration, including spend on agency staff. This group structure was underpinned by a single board and executive team for the group, management teams for each hospital in the group and clinical practice groups working across the different sites.

The 2015 [Carter review](https://www.gov.uk/government/publications/productivity-in-nhs-hospitals) (<https://www.gov.uk/government/publications/productivity-in-nhs-hospitals>) identified that efficiencies and quality improvements could be gained by acute hospitals either changing the way clinical services were delivered or sharing some supporting services. This review brought about changes in mental health services, with the [Five Year Forward View for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>), bringing together commissioning and provision of services and delegating budgets for some child and adolescent mental health services (CAMHS) and specialist adult mental health inpatient services to providers, who came together to refocus these pathways and improve the quality of care. This direction was then built on and expanded in the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) (<https://www.longtermplan.nhs.uk/>), with the emergence in April 2020 of [NHS-led provider collaboratives](https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/) (<https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/>), – groups of providers of specialised mental health, learning disability and autism services that agreed to work together to improve care pathways for their local population.

The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) (<https://www.longtermplan.nhs.uk/>), built on what had come before, describing collaborative arrangements as drivers of integration. This translated into a significant step forward in [Integrating care: next steps to building strong and effective integrated care systems across England](https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) (<https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/>), which introduced formal provider collaboratives and outlined them as one of the four interlocking elements, alongside place, integrated care systems (ICSs) and the national and regional bodies that would make up the future landscape of the NHS. The formalisation of provider collaboration in this form was then confirmed in the [Integration and innovation](https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version) (<https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version>), White Paper and [NHS England guidance](https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>), which cited the Covid-19 pandemic as bringing fresh impetus to this type of collaboration as existing collaborative arrangements often played a role in co-ordinating parts of the pandemic response.

The new approach to provider collaboratives

From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative.

From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, will be offered the opportunity to take part where this will benefit patients and makes sense for the providers. Individual providers may be involved in more than one collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England.

However, how these arrangements develop will vary significantly across the country. They may take different forms and will vary in their scale and scope: some will be 'vertical' collaboratives involving organisations that provide different services (eg, collaboratives bringing together primary care, community, local acute, mental health and social care providers); others will be 'horizontal' collaboratives that bring together providers that offer similar services (eg, a chain of acute hospitals or mental health services).

There is little evidence that one model of provider collaboration is more effective than another. Different [possible models and routes to bring providers together](https://www.kingsfund.org.uk/publications/new-care-models) (<https://www.kingsfund.org.uk/publications/new-care-models>), have been explored, with evidence showing flexibility is important to allow arrangements to fit with the specific local context. This flexibility is also evident in the [NHS England guidance](https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>), which focuses on 'the desired outcomes, rather than on the underpinning governance structure'.

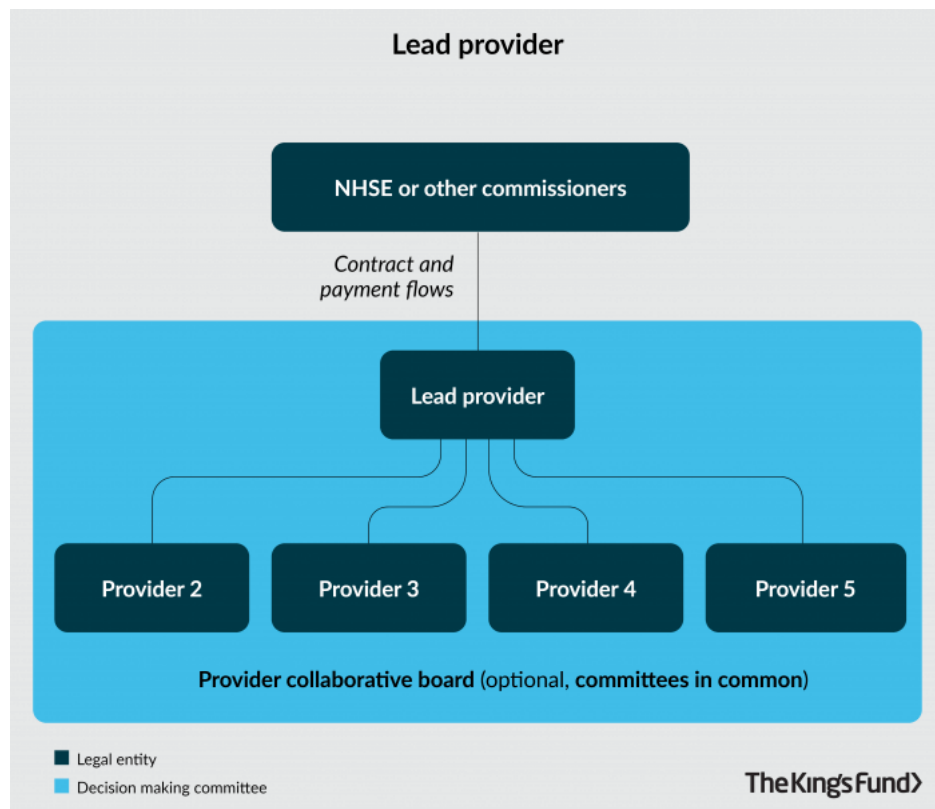
NHS England has set out a number of guiding principles that should underpin the chosen arrangement. These include:

- a shared vision and commitment to collaborate
- strong accountability mechanisms for members
- building on existing successful governance arrangements
- efficient decision-making
- embedding clinical and community voices
- streamlining ways of working.

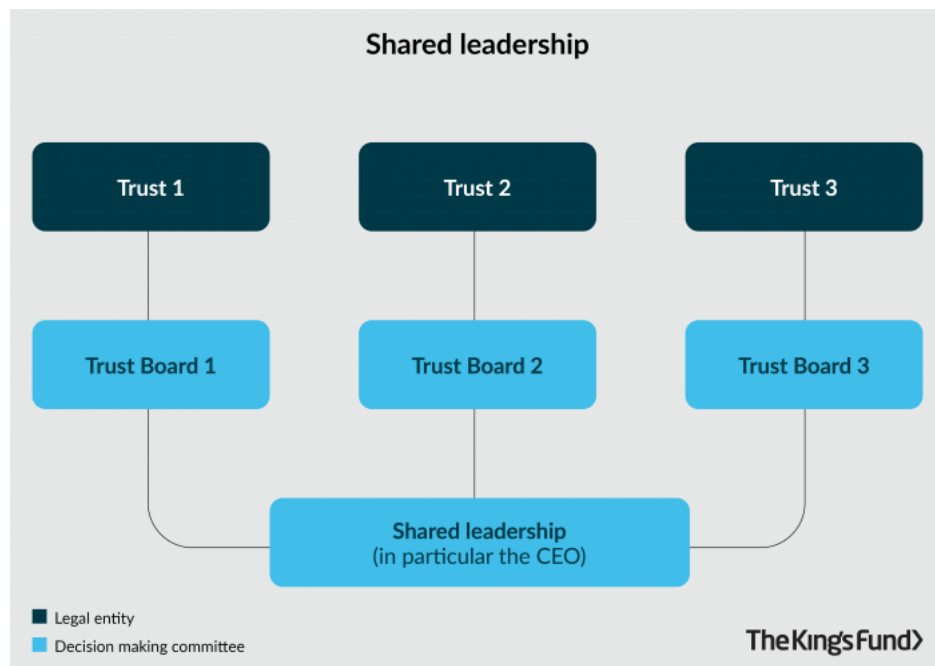
However, the guidance is also clear that it is up to members of the proposed collaborative to decide which arrangement will work best for them in the context of their 'shared purpose and objectives'. This permissive approach recognises that the form and function of the newly mandated provider collaboratives will in many ways be determined locally; influenced by the history of collaboration, the local provider context and the relationships in that area.

While there is no blueprint for developing a provider collaborative, the guidance suggests functions and forms that providers can consider. It highlights several potential models that are being used in different parts of the NHS.

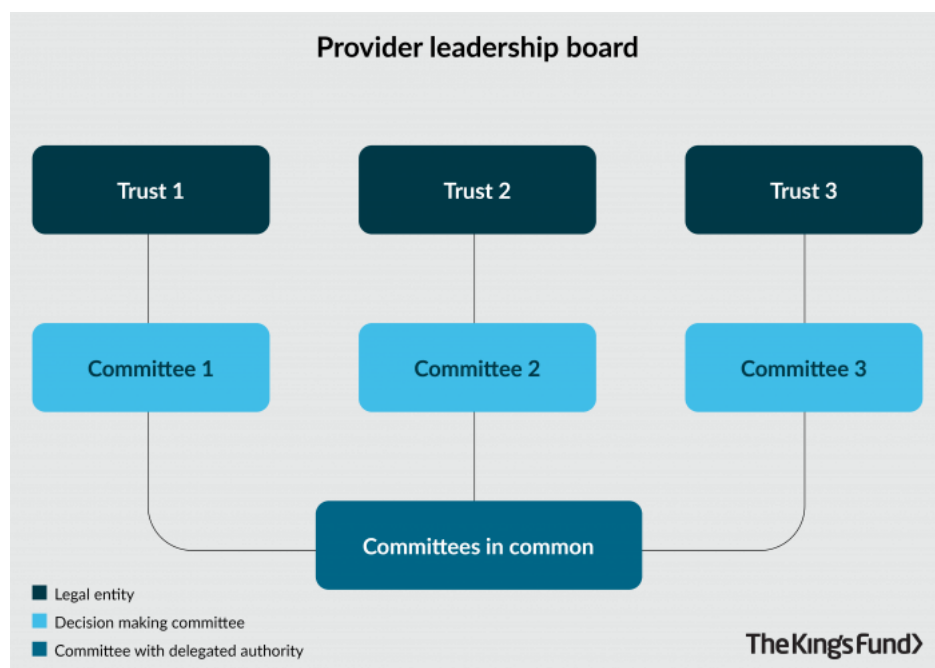
Lead provider – a single trust takes the responsibility, and contract, to deliver a set of services on behalf of the provider collaborative. This is underpinned by a partnership agreement between the collaborative members. This model means there is a single point of contact for the commissioner, but all members of the collaborative are contributing to the shared delivery of the service.



Shared leadership – the same person fills the chief executive posts at all the trusts involved in the collaborative, and sometimes this may also extend to the chairs and other executive posts. Alternatively, the boards of the individual providers can delegate responsibilities within the remit of the provider collaborative to a committee made up of members of another trust's leadership team.



Provider leadership board – with approval from their respective boards, the chief executives or other directors of participating trusts come together to tackle areas of common concern and deliver a shared agenda on behalf of the collaborative members and their system partners.



What are provider collaboratives expected to achieve?

Providers, as with other organisations in the health and care system, are expected to look beyond their organisational priorities to focus on system-wide aims and improving outcomes for the communities they serve. Working at scale, standardisation and sharing are three themes that encapsulate a number of the opportunities identified by NHS England for what provider collaboratives can offer as part of systems.

Working at scale

While the evidence on economies of scale is [contested](https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/) (<https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/>), NHS England believe the formalisation and roll-out of collaborative working offers the opportunity for NHS organisations to do things at scale. NHS England argues that scale can be deployed in several different ways, one example being through trusts working together to reduce the cost of back-office functions, for example, by employing a central procurement team, which then leverages the purchasing power of several hospitals and increases volume to drive costs down. This could potentially lead to financial savings across the collaborative but would also standardise the products used across an area, reducing variation and potential adverse events. The potential for efficiency savings could be particularly pertinent in the

context of the increased [cost improvement targets for 2022/23](https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/) (<https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/>), with trusts being asked to make savings as high as 5 per cent of their total costs.

Similarly on learning and development for staff, a collaborative has both a much larger pool of staff and greater resources to invest, which means that creating shared programmes could generate a better training and development offer. Scale also enables the specialisation and consolidation of services where appropriate. An example of which is dermatology services, a specialty where [workforce shortages](https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Dermatology-overview.pdf) (<https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Dermatology-overview.pdf>) are having an impact, where working as a collaborative offers an opportunity to change the model of delivery so that there is one service staffed by clinicians from across the providers, rather than each provider offering their own service.

The [Northern Care Alliance](https://www.northernalliance.nhs.uk/) (<https://www.northernalliance.nhs.uk/>), brings together two NHS trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust. The alliance has operated as a group since 2016, with decision-making devolved to committees in common. The Northern Care Alliance [10-year vision](https://www.northernalliance.nhs.uk/about-us/corporate-priorities-values/vision-10) (<https://www.northernalliance.nhs.uk/about-us/corporate-priorities-values/vision-10>) describes financial sustainability as priority for the group. To date, this has involved centralising procurement into one team across the group, which looks to deliver savings for the trust with a focus on strategic sourcing, supply chain and purchase to pay.

Standardisation

A key driver of NHS England's support for provider collaboratives centres around their role in working at scale to reduce unwarranted variation in outcomes and access to services, including a focus on reducing health inequalities. This is where standardisation of pathways, protocols and policies can be leveraged to improve outcomes and patient experience. Standardisation through collaboratives can be clinician led, as seen in [mental health](https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/) (<https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/>), and focused on addressing ongoing challenges with new models of care across an area and standardising protocols to reduce variation.

Sharing

Sharing between providers underpins NHS England's concept of collaboratives and the benefits of working at scale. This means that capacity is viewed in a combined sense rather than on an organisational footprint. The opportunities this presents can be illustrated by the example of 'passporting' staff between NHS trusts, an initiative pursued by more [mature collaboratives](https://www.wyaat.wyhpартnership.co.uk/our-priorities/workforce) (<https://www.wyaat.wyhpартnership.co.uk/our-priorities/workforce>), which allows more flexible working for staff and can address gaps in staffing. Working in this way is also becoming increasingly important as providers tackle the [backlog of care](https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/) (<https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/>), with [Humber Coast and Vale acute provider collaborative](https://humbercoastandvale.org.uk/) (<https://humbercoastandvale.org.uk/>) agreeing an elective recovery plan based on joint capacity and [managing patient lists](https://humbercoastandvale.org.uk/2021/03/15/elective-care-programme-pandemic/) (<https://humbercoastandvale.org.uk/2021/03/15/elective-care-programme-pandemic/>) across the area, rather than on an organisational basis.

What does this mean for patients?

Collaborative partnerships can organise around the needs of people living in the area, rather than planning at individual organisational level, enabling them to deliver more joined-up, high-quality care for patients. This type of collaboration could deliver the ability to change models of care for patients, which could mean more effective use of resources for providers and better outcomes for patients through improved staffing and concentrated expertise.

[West Yorkshire Association of Acute Trusts](https://wyaat.wyhpартnership.co.uk/our-priorities/west-yorkshire-vascular-services) (<https://wyaat.wyhpартnership.co.uk/our-priorities/west-yorkshire-vascular-services>) provides an example of what collaborating in this way can mean for patients. This is a partnership arrangement with a committee in common that was established between the NHS trusts that deliver acute hospital services across West Yorkshire and Harrogate. The partnership has created a [single, shared vascular service](https://wyaat.wyhpартnership.co.uk/our-priorities/west-yorkshire-vascular-services) (<https://wyaat.wyhpартnership.co.uk/our-priorities/west-yorkshire-vascular-services>). In order to improve outcomes for patients, following the recommendations of the Getting it Right First Time (GIRFT) [vascular surgery report](https://www.gettingitrightfirsttime.co.uk/surgical-specialty/vascular-surgery/) (<https://www.gettingitrightfirsttime.co.uk/surgical-specialty/vascular-surgery/>). This entailed consolidating all specialised vascular surgery that requires an overnight stay in two centres, Leeds General Infirmary and Bradford Teaching Hospitals NHS Foundation Trust, while vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services still take place in local hospitals throughout West Yorkshire.

How do provider collaboratives fit in with the rest of the health and care landscape?

Provider collaboratives are one of many vehicles for collaboration that sit within the context of legislative changes to the delivery and organisation of health services in England through the Health and Care Bill. The Bill looks to establish a [legislative framework](https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained) (<https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained>) that promotes better joined-up

services. This includes a duty for all health and care organisations, including providers, to collaborate to rebalance the system away from competition and towards integration.

The Bill also formalises ICSs (<https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#icss-operating>), partnerships that bring providers and commissioners of NHS services across a wide geographical area together with local authorities and other local partners to collectively plan health and care services to meet the needs of their local population.

...provider collaboratives, along with [place-based partnerships](#) (<https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems>), are badged as 'a key component of ICSs' enabling them to deliver their core purpose...

Provider collaboratives lie largely outside these legislative changes, with the formal duties and accountabilities of trusts unaffected by them. However, provider collaboratives, along with [place-based partnerships](#) (<https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems>), are badged as 'a key component of ICSs' enabling them to deliver their core purpose and meet the [triple aim](#) (<https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained>) of improving health and wellbeing of the population, improving quality of care and efficient use of resources – which is now also underpinned by a need to take action on [health inequalities](#) (<https://www.hsj.co.uk/policy-and-regulation/the-health-and-care-bill-must-require-action-on-health-inequalities/7031282.article>).

Providers will play a key role in ICSs, being asked to contribute not just as individual organisations but also to participate in their collaborative form, as the traditional commissioner/provider split is intentionally blurred. This participation could take the form of a provider collaborative taking on some of the functions that were formerly those of the commissioner, such as changing a model of care. This is intended to support the desired shift from a transactional approach to planning services towards organisations working together to do this. Provider collaboratives are intended to work with the ICS to determine how best the collaborative can contribute to the delivery of shared priorities.

Provider collaboratives will also interact with more than one ICS in many cases. Collaboratives are being encouraged to think about how they can be part of partnerships at a multi-ICS level where this scale is necessary to work effectively. They will also interact and interface with other bodies, including those focused on single specialties or clinical support services (such as [cancer alliances and clinical support networks](#) (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>)) which can work with one or more ICS, although how this will work in practice is currently unclear.

Providers will need to identify how they will work at place, a smaller geography within an ICS and the level at which [ICS policy](#) (<https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#systems>) states that much of the activity to integrate care and improve population health will happen. The [integration White Paper](#) (<https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations>) strengthened the role of place, with ICSs expected to delegate significant responsibilities and budgets to this level, and provider collaboratives will need to engage at this level. This will take place through individual members of the provider collaborative working as part of place-based partnerships, but also with the provider collaborative, in its collective form, working together with these partnerships at place.

The exact form of collaboratives' engagement with the new structures in the health and care system is still uncertain but is likely to vary considerably to reflect local priorities. The role provider collaboratives, and place-based partnerships, play going forward should be determined by the improvement or outcome needed, which will determine which collaborative function would be best place to achieve this and shape how these different groupings interact with each other.

What could provider collaboratives look like?

What unresolved questions do provider collaboratives face?

There are a number of unresolved questions remaining that may have an impact on how provider collaboratives develop.

Purpose

Previous collaboration between providers was often spurred by the need to address a clearly defined challenge or issue, such as [out-of-area placements in mental health](#) (<https://www.kingsfund.org.uk/publications/mental-health-new-care-models>), or by trusts coming together voluntarily because they saw the benefits of collaboration. However, provider collaboratives have already been mandated and are *then* being asked to define what they will achieve. As such, it is unclear what specific problem or challenge they have been designed to address.

There is also a question about what these provider collaboratives will add, given the number of collaborative bodies, including ICSs and place-based partnerships, that may have similar or potentially overlapping purposes.

Balancing permissiveness and pace

There is a tension between the opportunities presented by the flexibility and permissiveness on form and function of provider collaboratives and the need for them to be in place by July 2022. While the emphasis on local flexibility is welcome, it should be acknowledged that it takes time to arrive at a meaningful shared purpose, and that time is already limited.

Similarly, the wide variation in proposed approaches for scope and governance also require time to think through to reach the right choice for a collaborative. The absence of community, ambulance and non-NHS providers, such as VCSE sector organisations, as part of mandatory arrangements also raises a question about what impact this exclusion will have on the membership of provider collaboratives. The unintended consequences of this could lead to more providers adopting tried-and-tested models that bring the same type of providers together, rather than encouraging diversity.

As collaboratives develop, the current flexibility and latitude given to providers to design their own arrangements must carry through into implementation so trusts can take forward what works best in their local context and for the populations they serve. NHS England will need to support this through its approach and behaviour, providing sufficient guidance and highlighting best practice without being too directive.

Footprints

There is potential for footprints to be an issue given that the boundaries of a provider collaborative that spans multiple ICSs will fit poorly with a single ICS's objectives and commissioning arrangements. Provider collaboratives will also be working across multiple places within an ICSs, as well as across several pathways and interacting with different bodies such as cancer alliances or clinical support networks. Navigating this complexity to work efficiently together is likely to take some time.

Capacity and capability

Provider collaboratives need resource – both in terms of funding and people – to deliver their objectives. The guidance is clear that this is something providers must source themselves which may present an issue with strained capacity. Support, time and investment will be needed to ensure that leaders have the capability to step into complex leadership roles and capacity to participate in collaborations and continue leading their individual organisation. These issues are magnified by the number of different collaborative initiatives leaders will be expected to engage with. [Clinical and professional leadership capacity](https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership) (<https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership>), in particular will need attention and a national, regional and local support and training offer would help those in these roles. It is unclear if the capability and capacity exists for providers to generate, engage with and participate in the numerous different collaborative entities.

Culture

There is a cultural component to consider too, with a legacy of competition and autonomy meaning that building relationships will be fundamental to a successful collaborative and developing these will take time. It will require [collaborative and compassionate leadership styles](https://www.kingsfund.org.uk/publications/what-is-compassionate-leadership) (<https://www.kingsfund.org.uk/publications/what-is-compassionate-leadership>), that enable leaders to commit to a shared vision, working together and buy-in from staff across the providers.

This is crucial as these relationships will be tested, with potential for tension between shared accountability and organisational responsibilities especially when it comes to risk pooling, money, and service models. There will also need to be a cultural shift to ensure that the collaboratives [empower clinical and professional leadership](https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership) (<https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership>), as harnessing this is key to improving services and identifying ways to alter the delivery of care to benefit patients.

Clearly, provider collaboratives will play an important role in the new health and care system, so it is essential that they embrace population health and a system-first approach. The importance of the cultural shift away from organisational autonomy and self-interest to prioritising collaboration and common purpose cannot be underestimated.

What next?

Collaboration is the foundation of the new health and care system and provider collaboratives represent one of a number of ways for working together to use all the clinical and managerial power available to a system to address its priorities. While there are opportunities to be found with providers collaborating in this way, there are still some unresolved questions that could limit the impact, or at least the pace, of implementation.

The next year will be a critical period for the development of provider collaboratives, and for the structures around them, including ICSs and place-based partnerships. However, these arrangements will be implemented at a time of great change for the system and with the prospect of further change to follow as a result of the [integration White Paper](https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) (<https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations>) and other potential reforms. The Secretary of State has referred to existing provider collaboratives, such as [South West London Elective Orthopaedic Centre](https://www.eoc.nhs.uk/) (<https://www.eoc.nhs.uk/>), as key '[partnerships for reform](https://www.gov.uk/government/speeches/health-and-social-care-secretary-speech-on-health-reform)' (<https://www.gov.uk/government/speeches/health-and-social-care-secretary-speech-on-health-reform>), and signalled that he wants to see

what trusts working in these partnerships could do with 'greater freedoms'. This suggests that providers will continue to be a focus of national policy, which is still evolving, and we can expect further developments in this area.

The work for this project was funded by [HealthTrust Europe \(https://www.healthtrusteurope.com/\)](https://www.healthtrusteurope.com/). This output was developed and written by The King's Fund and is editorially independent.

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