PRUComm

Research note exploring the potential role of Provider Collaboratives

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Introduction

Despite the current loose definition of the aims of provider collaboratives, and the forms they might take, the recent *Integrated Care Systems: Design Framework* makes clear that provider collaboratives will be an important part of the collaborative landscape, alongside ICSs, place based partnerships and primary care networks. Although new guidance is expected, indications to date are that provider collaboratives' function and aims will be largely a matter for local determination.

This note is based upon our reading of the relevant policy documents and upon our ongoing research exploring the development and operation of Integrated Care Systems. We focus on the potential forms and aims which may be adopted by provider collaboratives, identify potential concerns arising the lack of specificity regarding form, role, responsibilities, accountability and governance of provider collaboratives and explore how these might be addressed.

Provider Collaboratives – potential forms and aims

Provider collaboratives are partnership arrangements involving two or more trusts. Participation is mandated for trusts providing acute and/or mental health services, who are expected to be part of one or more provider collaboratives, with discretionary participation of other providers. Provider collaboratives may form at supra-ICS level, may partially cover multiple ICSs, and may cover multiple places. Additionally, providers may be members of multiple overlapping collaboratives. Provider collaboratives may contain acute or mental health members only or may also include wider membership, such as community providers and primary care.

The stated purposes of provider collaboratives is wide ranging. Collaboratives should continuously improve quality, efficiency and outcomes, including unwarranted variation and inequalities in access and experience across different providers, acting as vehicles for the transformation of services, and restoration and recovery post COVID. It is anticipated that they will deliver systems' strategic priorities, and The White Paper *Integration and Innovation*: *working together to improve health and social care for all* indicates that 'significant' delegation to both place level and provider collaboratives from ICSs is expected. It is also suggested that in time provider collaboratives may play a role in oversight.

The form of provider collaboratives is anticipated to range significantly, and it is for the members of the collaborative to agree together the model and governance arrangements through which their contribution will be achieved. It is anticipated that provider collaboratives either alongside or instead of place-based partnerships will be the conduits for the flow of money from the ICS NHS body to providers, and that provider collaboratives may take further responsibility for use of resources to deliver population health outcomes. Where services are delivered through

collaborative networks, it is suggested that one vehicle would be a lead provider contractual arrangement.

Considerations

The emerging provider collaboratives raise a number of potential issues for consideration which relate to their fit with the emerging collaborative landscape, in particular their interaction with place-based partnerships.

1. *It is not clear what degree of oversight will be exerted over the formation of these arrangements, and by whom.*

   The formation of provider collaboratives may differ greatly across the country. Configurations agreed between provider collaborative members may have no alignment with configurations of place-based collaborations or ICSs. Provider collaboratives are potentially powerful networks, and some may become dominant decision-making forums, curtailing the role of place-based collaborations, and risking the retreat of acute/mental health providers from place-based decision making.

   If multiple overlapping provider collaboratives are allowed to form, these may become competitive rather than collaborative.

2. *The lack of clarity regarding accountability arrangements for provider collaboratives has potentially serious implications*.

   Provider collaboratives may be contracted with using a lead provider arrangement for a long term outcomes based contract. Previous PRUComm research has indicated that these contracts are difficult to monitor, and outcomes are difficult to specify. Lead provider contracts adopt a 'black box' approach, and may lead to strained relationships between lead and sub contractors, the possibility of opportunistic behaviour, and degradation of commissioner expertise (Sanderson et al., 2017).

   If a lead provider contract is in place, or if providers agree how to spend their respective resources as a provider collaborative, it is not clear who would oversee this arrangement, and where accountability would lie for the delivery of outcomes or poor performance. Additionally, provider collaboratives cannot be relied upon to undertake the complex brokering role required to ensure that local service provision is equitable and aligned with overall system strategic objectives.

   The establishment of provider collaboratives as key actors in delivering services and fulfilling ICS objectives introduces an additional actor to an already complex, congested space, and may add distance to the regulatory relationship between NHSE and NHS providers.

3. *It is not clear how it will be ensured that the work of provider collaboratives will take into account the interests, aims and work of the wider health and social care community.*

The involvement of other parties (such as community and primary care providers) in the work of provider collaboratives appears to be a matter for local discretion. Depending on the nature of locally agreed arrangements, provider collaboratives may encourage a silo'd approach and discourage collaborative working with wider partners. Provider collaboratives may amplify the voice of acute providers while decreasing the opportunity for the voice of other providers to be heard. Provider's goals and responsibilities differ, and what is right for one type of service may be detrimental to another. Since the formation of the NHS there has always been an organisation independent of providers with responsibility for adjudicating between the needs of the different types of services across geographical areas and for allocating resources between them (Lorne et al, 2019); the lack of such a body in the current proposals is concerning.

If provider collaboratives are to be responsible for decisions regarding the allocation of funds, with the possibility of adopting commissioning responsibilities, it is not clear how alignment with place-based partnerships will be assured. Issues of central concern to collaboratives such as the improvement of quality, efficiency and outcomes, may at times be more beneficially addressed in collaboration with wider partners at place level. At present a collaborative approach to decision making is not hard wired into the governance of provider collaboratives.

There is a risk that a lack of oversight of provider collaborative decision making may result in actions which run contrary to ICS plans. For example, it has been reported that in Greater Manchester a provider collaborative has decided to drop plans for the consolidation of high-risk general surgery which had previously been agreed by system members.

4. *Transparency*

The *Design Framework* makes clear that the involvement of patients, unpaid carers and the public is expected at place and system levels, with requirements for public meetings and published minutes in both the Partnership and NHS Board. It is not specified how provider collaboratives, where significant decisions regarding the planning and provision of services may be made, will be publicly accountable. Responsibility in this regard sits with the ICS NHS board and chief executive to put in place 'proportionate' measures to provide assurance on the spending of public money.

Potential solutions

The current loose specification of governance, oversight and accountability appears at odds with the potential significant power and influence of provider collaboratives. While local arrangements may well address the risks inherent in these arrangements, placing trust in the establishment of robust local arrangements carries risk.

Potential mitigating actions:

- Allowing provider collaboratives to take on large delegated budgets and effectively act as 'commissioners' potentially cuts across and undermines the role of place-based entities in planning services for their geographical population. To mitigate this risk, the role of provider collaboratives could be constrained to focus upon quality improvement, efficiency and

outcomes, leaving place-based entities to plan and oversee integrated services for their population.

- ICSs should be required to agree the configuration and governance arrangements of provider collaboratives (Currently the Design Framework states *It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives*). This is important because, if Provider Collaboratives are able to take on large delegated budgets it is important that there is external scrutiny and oversight of their governance arrangements
- Provider collaboratives should be required to participate in place-based forums/committees and be subject to their decisions.
- The requirements for public transparency of provider collaboratives should be strengthened, possibly through requiring minutes of provider collaborative meetings to be included with ICS public papers and for such meetings to be held in public

Finally, there is currently somewhat more clarity over the role of Provider Collaboratives than there is over Place-based arrangements. This is problematic, because it risks leaving Places undeveloped & lacking a voice in the new system, potentially limiting their scope to develop services specific for the needs of their population. It is not axiomatic that decisions made by large Provider Collaboratives will be in the best interests of local populations.

Moreover, the separation of Acute (and potentially mental health) services out from other services and allowing Provider Collaboratives to oversee their commissioning/provision separate to and across different footprints from the commissioning of community and primary care services risks a new system in which services are less integrated than previously, when CCGs acted as a single commissioner.

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