Symbiotic relationships

The Department of Health and Social Care's White Paper, which sets out its legislative proposals for a new 2021 Health and Care Bill, proposes a new legal duty for all NHS providers, together with the new legal entity that is the Integrated Care System (ICS), to collaborate to address the needs of local populations. This builds on the existing expectation that all NHS providers are in some form of formal 'Provider Collaborative' by the time ICSs enter the Statute Book on 1 April, 2022.

Provider Collaboratives can be arrangements between NHS organisations with similar missions (e.g., an acute collaborative) or could they be organised around a 'Place', with acute, community and mental health providers forming one collaborative. NHS providers may be in several collaboratives.

Why have Provider Collaboratives?

- Improve service quality and sustainability
- Reduce unwarranted variation in practice and outcomes
- Reduce health inequalities
- Better workforce planning, including achieving clinical critical mass,
- Effective application of resources, particularly clinical support and corporate services
- Lean working, particularly the removal of duplication through consolidation

A 'Collaborative' could mean anything from a structural merger to a looser coalition of the willing to better manage common issues through sharing, mutual aid and joint working. Any kind of formal collaboration raises, naturally, a new set of organisational risks for provider boards and their partners to identify, manage and mitigate. For example, how should boards facilitate streamlined decision-making, while exercising proper oversight of their own corporate responsibilities? Each Provider Collaborative will need to have a means of taking decisions as a collaborative, alongside the already-codified decision-taking of each individual member trust concerned. And of course current plans are that each NHS trust will, in some way to be locally determined, be represented through to the ICS board itself. Some ICSs intend to do this directly by individual trust suffrage, whilst others are planning that this will be through Provider Collaboratives. So the relationship between each individual NHS provider board and the governing body of the Provider Collaborative will be an important, and perhaps complex, matter to determine.

In short, Provider collaboratives are arrangements that allow leaders and leadership teams from individual provider trusts to come together through agreed governance and decision-making arrangements which enable effective decisions to be made on behalf of the collaborative and its constituent members, in addition to individual trust decision-making processes.

For governance model of Provider Collaboratives there are really just four shows in town:

1. Provider leadership board
2. Lead provider
3. Shared leadership
4. Single organisation (merger)

The single organisation aside, in governance terms the options all pose some differential governance issues as at its heart good governance is an accountability system to locate unambiguous accountability for an organisation with a defined group of individuals (a board), who have been selected by qualification, skill and experience to be responsible for the organisation and it's conduct.

This table describes at a high level the four options:

Provider collaborative type	Brief description	Governance challenges
Provider leadership board	The Accountable Officers (Chief Executives) of all member organisations come together to take decisions on behalf of the all organisations under a formal delegation from each board	Decisions made by the Chief Executives, and reports received by them, may not benefit from rounded constructive challenge. The issues to watch for would be 'scope-creep' away from the delegation made by the individual boards, or repetition of decisions by needing to be re-endorsed by the individual member boards. These are the weaknesses of the current 'Committees in Common'.
Lead provider	One provider would take on a lead contractor role and pass on resources, under a contract, to other providers in expectation of agreed performance and quality	Similar to the system now being operated by mental health trusts under the New Models of Care. The board of the lead provider would need to develop a working pattern, and governance mechanisms, to be accountable for service performance undertaken by others. The risk pattern of the board would change and the BAF and board reporting should change to reflect this.

Provider collaborative type	Brief description	Governance challenges
Shared leadership	The managerial leaders from the different organisations, in particular the chief executive, are the same in each member of the Provider Collaborative, but the boards remain separate and distinct, often with different non-executives. Sometimes there is a hybrid mix – for example, a Chair in common. In some forms of this arrangement there may be a formal management arrangement and the management for one trust effectively 'take on' the leadership of another.	This can be a quick to execute approach and maintains the regulator ratings of each individual organisations, making higher-scoring organisations more willing to partner with other trusts that have regulator or financial issues. The need to maintain and service the different boards, however, remains. The arrangement has in some instances been a pragmatic prequel to an actual merger which can thus be timed to take place in a planned way to achieve the full benefits of consolidation.
Single organisation (merger or take-over)	Where two or more organisations become one, either through one acquiring the other, or by both parties being liquidated and a new organisation formed. This results on one clearly defined board with all the advantages of transparency over who is actually accountable.	Mergers have a mixed-track record in terms of being win-wins for both organisations. Recent examples where there has been shared leadership prior to merger show some signs of being less risky. Although the White Paper aims to make the route to merger simplified there are significant costs and sunk-time involved before benefits can be realistically achieved. However, the ultimate governance model is the most satisfactory in terms of simplicity and clear accountability.

The Good Governance Institute (GGI) has experience of working with all these models of arrangements between trusts and counsels Provider Collaboratives to work from the basis of anticipated gains from working together, then find the right partnership model and appropriate form of governance. Governance should always come last and simply be an enabler for achieving better value to all stakeholders.

Illuminations

- All forms of Provider Collaborative, other than full merger, inevitably involve some compromises to a 'pure' governance solution because they involve 'greyness' over who is accountable for each organisation, and how. This requires thoughtful attention to developing governance structures and systems, and a degree of sophistication in terms of board dynamics
- In thinking about Provider Collaborative governance, one yardstick would be to appreciate the benefits that governance should be bringing to the arrangement – the 'meaningful outcomes' of good governance identified in King IV that GGI endorses
- ICSs as they are currently planned will entail sophisticated governance solutions based on the principles of good governance to avoid the Byzantine models that multiplied whilst the 2012 Act remains on the statute books
- GGI will be developing further guidance on board working in the complex scenario that is an ICS, including non-executive contribution

If you have any questions or comments about this briefing, please call us on 07732 681120 or email **advice@good-governance.org.uk**