September 2024

NHS Providers

Joint/shared roles and shared decision-making

Based on interviews with leaders of trusts working in partnership using various shared leadership and/or shared decision-making arrangements (including groups and board in common approaches), this chapter aims to support leaders either considering or reviewing such arrangements.

Overview

Both joint appointments and shared decision-making arrangements will impact on trust governance – we set out risk-based considerations for board members in this chapter.

Provider collaboration has accelerated since the enactment of the Health and Social Care Act 2022. Trust leaders tell us that collaboration between trusts is essential to making real change and delivering on the ambitions of system working. Provider collaboration offers an opportunity for trusts to work together at scale to tackle some of the complex challenges they face, such as long waiting lists, demand for diagnostic tests and workforce shortages.

As collaboration between providers progresses, we are also seeing increased use of consolidated leadership models across the provider sector – the ambition to collaborate is changing the NHS provider landscape.

In July 2024, approximately a third of trusts shared their chief executive or chair with another trust (in some cases both posts were shared). Joint roles are no longer uncommon and may apply to any board role, including chair or CEO, as well as to more junior roles.

At the same time – and because the two are linked – multi-trust arrangements involving joint or shared decision-making forums with extensive delegated powers, including but not limited to those calling themselves groups, are being adopted between two or more trusts[1].

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[1] It is hard to put exact numbers on the increase in group-style models, because those partnerships calling themselves groups do not conform to a single set of arrangements, and because some partnerships have adopted group-style models but do not call themselves groups.

Other collaborative options are available, and involvement in one or more is 'expected[2]' of each provider by NHSE. Therefore both joint appointments and shared decision-making models raise questions: for example, what is the evidence that this will achieve the desired outcome, when other options will not, or what do these arrangements enable providers to achieve for patients and communities that would not be possible with other forms of collaboration?

With **shared leadership**, there are potential risks around the capacity of those leaders, their ability to oversee and control organisations effectively, and about leadership style, as well as challenges and opportunities related to succession planning.

Shared decision-making models where more than one trust is effectively governed by a single decision-making forum (such as 'boards in common' or group boards) raise their own risks, including where the buck stops when jointly-taken decisions affect trusts. There are also potential challenges for non-executive directors (NEDs) in terms of seeking and receiving adequate assurance, and ensuring that each trust is fulfilling their statutory obligations.

Definitions

Shared leadership roles are simply defined as leadership roles shared across two or more organisations, undertaken by the same postholder.

A **shared decision-making arrangement with extensive delegated powers** can involve a variety of arrangements, including group-style arrangements, boards in common or joint committees. We do not seek here to include shared decision-making arrangements where individual boards reserve the majority of decisions to themselves and the collaborative forum controls only specific programmes, projects or discreet efforts at integration.

Some trusts working in strategic partnership delegate broad powers over each organisation to a single shared decision-making forum and may call themselves groups. These trusts remain legally independent while collaborating on a range of corporate and/or clinical programmes, with a central leadership body (often with one or more shared leadership roles). However there is no tightly drawn definition of an **NHS group model**[3]: there is no legal definition and groups can take various

[2] See NHSE's Guidance on good governance and collaboration

[3] In the corporate sector, a group structure is reasonably well defined: a central parent board with overall strategic control of subsidiary companies, each led by its own board which has significant autonomy.

organisational forms. Some large individual trusts take a group-style approach to leading and managing across multiple sites since legislation does not allow them to establish subsidiary boards within their organisations.

This is why here we prefer to use 'shared decision-making arrangements' rather than the terminology of groups.

Shared leadership – at a glance

Making the strategic case	• Do you know why you are adopting these arrangements and how they will benefit patients? • Have you considered other options that might achieve the same ends? • Are you clear what success would look like and how you will know whether you're achieving your aims?
Maintaining good governance	• Will your chosen arrangements enable you to meet the governance requirements of the provider licence, code of governance, and well-led? • Have you reserved the relevant corporate governance and regulatory functions to each trust board? • Will directors be able to fulfil their legal duties under these arrangements? • Are responsibilities and accountabilities clear and well-defined, and any delegated powers clear and well-understood? • Will there be sufficient NED challenge and scrutiny at the point of decision-making? • Are there suitable risk management arrangements? • Is there clarity about how conflicts of interest will be reported and managed? • Is there due separation of powers between the executive and non-executive, for example, has care been taken to avoid non-executives stepping into the executive space?
Director appointments and succession planning	• Will directors have sufficient time to fulfil their role(s) and responsibilities effectively? • Have you considered the roles and responsibilities of any deputies to ensure they are not acting in the capacity of a director? • Is your appointments process open, fair and made on merit, and has due consideration been given to the benefits of diversity? • Are you confident that you could withstand leadership changes and have planned for succession?
Public accountability	• Have you designed arrangements so as to build in public accountability?
Involving the council of governors (for FTs)	• Is your council of governors engaged and supportive of the arrangements? • Have you clarified roles and responsibilities between the council and NHSE during any shared appointment process between an FT and non-FT, and planned ahead in case either body seeks a dismissal or does not wish to reappoint?

	• Are you (and any non-FT partners) clear how the council will be supported to continue to undertake its statutory role under the arrangements?
Changing your mind	• Are partners clear about how you would change the arrangement(s) if it becomes sub-optimal? • Is there an agreed exit strategy for partners?

Considerations

Making the strategic case

Where collaborative arrangements are in use or being sought the benefits of the approach should be able to be articulated:

- Are you clear why you are doing this, and have other options have been carefully considered?
- Is there a realistic, evidence-based expectation that the proposed changes to arrangements will realise your objectives?
- Are there defined realisable patient benefits that can be measured over time?

There are several models for collaboration and no one size fits all. Our Practical guide to lawful, well-governed collaboratives sets out the options.

Meeting required governance standards

Good governance is about leadership and direction and is therefore necessary if organisations are to provide effective patient care, including through partnership working and collaboration. Good governance is also vital when seeking to integrate functions and/or services.

Where NHS organisations use arrangements that conform less to well-established board governance, risk is heightened, and this should be recognised and managed. Partners would be well-advised to seek the early support of governance professionals when considering integrated governance and/or shared leadership across organisations.

Both shared/joint appointments and shared leadership arrangements should therefore enable trust(s) to comply with the recognised governance standards, and specifically the requirements of well-led, the provider licence and the provider code of governance. The following sections of the provider licence apply and are not set out here because they are mirrored in the provisions of the code: G5 Systems for compliance with licence conditions and related obligations, NHS2 Governance

arrangements and CoS3 Standards of corporate governance, financial management and quality governance.

Table 1 – the requirements of the well-led framework and the code

Source	Reference	What good looks like
Well-led framework	Shared direction and culture	The trust transparently monitors and reviews how it delivers its objectives. This is supported by effective governance structures and clear systems of accountability at all levels. These structures support multidisciplinary, integrated working and effective risk mitigation and management.
	Capable, compassionate, inclusive leaders	The board has an appropriate mix of skills and experience to enable its members to exercise effective and visible leadership, including clinical leadership, across the trust.
		The trust transparently monitors and reviews how it delivers its objectives. This is supported by effective governance structures and clear systems of accountability at all levels. These structures support multidisciplinary, integrated working and effective risk mitigation and management.
	Freedom to speak up	Leaders are seen to promote Freedom to Speak Up through actively demonstrating positive behaviours.
	Governance, management and sustainability	The trust has clear governance, assurance, risk and accountability structures. These interact well with each other and support effective decision making. They provide robust assurance that risks are effectively and sustainably mitigated, and the quality of care is consistently sustained.
		The trust's governance and management of partnerships, joint-working arrangements and third parties is effective and supported by effective and robust assurance systems.
	Partnerships and communities	The governance and management of partnerships, joint working arrangements and third parties is effective, accessible, transparent and supported by effective assurance systems and data sharing arrangements.
Code of governance	A1.1	Every trust should be led by an effective and diverse board that is innovative and flexible.
	A1.4	All board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions
	B1.1	The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective

		judgement throughout their tenure and promote a culture of honesty, openness, trust and debate.
	B1.1	The chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.
	B1.2	Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.
	B1.3	Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.
	B1.4	The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically
	B 1.5	The board is collectively responsible for the performance of the trust
	B1.7	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.
	C1.1	Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management
	C1.1	Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths
	C1.2	The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy.

Additional considerations about joint appointments

Making the right appointment

Many leaders undertaking the most senior joint leadership roles are long-standing and well-respected NHS leaders. This is only natural given the scope and scale of some of these roles. However, each improvement challenge should be considered on its merits and so it is important to recognise that appointing a well known leader to a shared leadership position is not a panacea for improvement.

This applies not only to providers making their own appointments but also to NHSE when appointing to NHS trusts.

Capacity

Leaders in joint positions will need to carefully manage their time and focus their attention: capacity is an issue that many leaders have raised with us. Some trusts have supported shared CEOs by creating additional deputy posts, or roles responsible for running hospitals or sites – sometimes called site managing directors or 'site CEOs'[4]. In some cases, these appointments have helped support board members, but this can change the nature of both the director and deputy roles and responsibilities. This should be acknowledged and regularly discussed to ensure arrangements are working, and that directors have the capacity and remain able to fulfil their duties. Remember that those acting in the capacity of directors – whether called directors or not – can assume director's liabilities[5].

In foundation trusts (FTs), adequate time for engagement with the council of governors must be factored in, particularly for chairs and other NEDs in joint positions.

Succession planning

Creating additional or new deputy positions can provide a good grounding for aspirant directors and may support succession planning. Trusts will want to ensure there are effective opportunities for talent management with the proliferation of below-board level directors and site leaders.

Equally, creating joint roles can create succession challenges. Organisations need to be able to withstand a change in leadership, be mindful of their succession needs, and plan accordingly – while being mindful of the need for open and fair competition for roles, with appointments made on merit.

The benefits of board diversity are articulated in the NHS EDI improvement plan, which links diverse leadership with better performance: more diverse boards (in terms of representation of people with diverse protected characteristics but also of thought and experience) are likely to make better decisions and avoid biases such a groupthink. Opportunities to improve diversity at the board and at very senior level should be considered when succession planning.

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[4] As set out in Schedule 7 of the NHS Act 2006 (as amended) for foundation trusts and Group Accounting Manual for NHS trusts, the chief executive of a provider board is its accounting officer (AO). Providers may wish to ensure terminology does not lead to confusion about who is the AO.

[5] If a person's acts in relation to the organisation are directorial in nature, that person may be a deemed a *de facto* director, and the duties and liabilities of the Companies Act 2006 have been established in case law to potentially apply.

Influence and division of powers

The greater influence one individual has over multiple organisations, the higher the risk of adverse impacts if they make mistakes (and everyone makes mistakes). This makes effective challenge and scrutiny, by the whole board but perhaps especially by independent NEDs, even more vital.
It is also important that there is due balance and distinction between executive and non-executive roles and responsibilities. Where there is a joint chair working with several CEOs for example, or vice versa, any risk of power imbalance should be carefully monitored. NHSE's expectation (set out in Our Leadership Way) that all leaders in the NHS demonstrate compassionate, inclusive and collaborative behaviours, may go some way to mitigating the risk of power imbalances.

For joint chairs and NEDs, it will also be important to avoid stepping into an executive role – something to pay careful attention to not only internally but also if representing the organisations at partner, system, regional and/or national forums. Joint executive directors should remain mindful of their delegated authority in such circumstances: it may well suit partners to speak to an individual to make a decision, but if the trust board(s) or a shared decision-making forum has responsibility for that decision, the individual must go through the necessary steps to secure agreement.

Conflicts of interest

Considerations related to managing conflicts of interest in collaboration are explored in our Guide to lawful, well-governed collaboratives and our advice for directors sitting on ICBs (kindly provided by law firm McDermott, Will & Emery) may also be useful.

Additional considerations about shared decision-making arrangements with extensive delegated powers

Reserving to the board

The board of each organisation must ensure that the organisation's statutory corporate governance functions are maintained, with adequate meeting frequency and time allotted at their board to undertake them effectively. Boards may wish to delegate some of the functions usually reserved to the board to a shared decision-making body in order to lead a group-style or 'board in common'

arrangement: NHSE guidance[6] sets out those corporate governance and regulatory functions which cannot be delegated.

Organisations should also be mindful of directors' duties[7] and ensure arrangements enable them to fulfil their duties to the organisation as well as their duty to cooperate to achieve system objectives.

NED challenge

Large decision-making bodies such as boards in common and joint committees may increase the risk that NED challenge will be diluted and less effective. The size of such forums can mitigate against probing questioning, as can the size and scope of some agendas. The code of governance for provider trusts expects boards to have independent NEDs in the majority, to provide crucial independent challenge and scrutiny at the point of decision-making[8]. In our view, where significant decisions are made in shared forums without recourse to individual provider boards, NEDs should remain in the majority. Their voice and challenge should be supported when making decisions for which provider boards remain responsible and liable. Of course, recourse to individual boards holds the least risk.

Public accountability

Public accountability and scrutiny are part and parcel of good NHS governance. As set out in the Health and Care Act 2006 (as amended), meeting in public is compulsory for provider boards for this reason. Collaborative models should seek to maintain public accountability and scrutiny in line with the expectations on individual organisations. Group boards and multi-trust boards in common should aspire to the same standard.

The council of governors

For foundation trusts, appropriate and early consideration should be given to the needs and expectations of the council of governors of any FT that is proposing to establish a multi-trust collaborative arrangement using a forum with significant shared decision-making powers. One of the council's statutory duties is to hold the board to account for its performance, via the NEDs, and so governors will continue to need appropriate access to the board and NEDs to fulfil their

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[6] Arrangements for delegation and the joint exercise of statutory functions, Annex F sets out those functions which can, and cannot, be delegated and gives the statutory reference and reason why.

[7] Directors of NHS providers have legal duties under the Companies Act 2006 including: act within their powers; exercise independent judgement; exercise reasonable care, skill and diligence; avoid conflicts of interest.

[8] More on the rationale for NED involvement is set out in our Guide to lawful, well-governed provider collaboratives.

responsibilities. They will also want to take an appropriate interest in the performance of the partnership, and therefore its decision-making forum. NHS trusts sharing a leadership forum with one or more FTs should be aware that governors will need to understand and have the chance to scrutinise the performance of the shared forum, since that is where the FT's board is making many decisions and receiving assurance about matters affecting the FT.

Accountabilities

Participation in shared-decision making can blur accountabilities and make it hard to identify where the buck stops. The extent of directors' and shared decision-making forums' delegated powers should be clearly established, articulated and communicated through each organisation's scheme of delegation and the forum's terms of reference. Where directors in shared leadership positions participate in shared decision-making this may compound the challenge.

What happens next?

A number of those we have spoken to have described a snowball effect where shared leadership precipitates a move to board in common arrangements. As the number of shared roles across partner organisations increases, or ambitions for the collaboration grows, a logic emerges for reducing the meeting burden and potential duplication of reporting and scrutiny. Providers should carefully weigh up the potential advantages and disadvantages of effectively reducing the time allocated to board activity, mindful of the requirements of the code of governance and well-led. We hope the considerations set out above will support them in this. It will also be important to enter into arrangements mindful that partners may change their mind – and to have regular touch points where partners assess how the arrangements are working, as well as acknowledging there may be a need to unpick the arrangements in the future.

Mergers and acquisitions

Finally, when we spoke to members about group-style arrangements the subject of mergers or acquisitions was naturally discussed. In some cases, this had been explicitly considered as an option and discarded as it was believed too complex or it did not suit the partners, for example because of the strong identity of each partner organisation. In other cases, the possibility of merger remained under review. For partners entering into boards in common arrangements and working increasingly closely strategically, clinically and corporately, a merger may prove a less complex and more transparent option in the longer term when compared with establishing and sustaining good governance as two or more sovereign organisations.