NHSProviders

Briefing

March 2020

CHAIRING MORE THAN ONE TRUST BOARD

Key messages

- The move towards system working, greater provider consolidation, and in some instances a drive to improve quality or become more efficient, has led a number of trusts to consider certain joint appointments including sharing a single chair for the medium or long term.

- While chairing more than one provider trust presents challenges and risks, none of these are insurmountable nor are there fundamental legal or governance impediments to such arrangements. The risks commonly identified include:
  - a need to manage potential conflicts of interest
  - time management and capacity
  - the need for clear governance arrangements including around appointment and removal of the chair.

- The benefits commonly identified include:
  - cross-fertilisation of cultures, learning and practice
  - supporting integration as organisations work towards merger/acquisition or where trusts have common strategic interests
  - mutual support
  - collaboration in service provision
  - building relationships across trusts and helping to stabilise leadership teams
  - more joined-up care, support for system working and a potential decrease in competition in the interests of patients.

- Based on those we spoke to, the pre-conditions for success are likely to include:
  - a clear, strategic rationale for the adoption of the model (rather than to force consolidation when this may not be the right strategic option) – this was seen to be strongest when it was locally led with the support of the boards concerned, rather than being seen to have been imposed by NHS England and Improvement
  - sufficient commonality of interest between the trusts concerned
  - ensuring that the joint chair role can be performed effectively not just by the incumbent but by a successor who may have less history with or experience of the trusts concerned
  - engagement and support of local stakeholders in the context of system working – and of regional and national regulators.

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Introduction

In recent years, the practice of individuals chairing the board of more than one trust has become more common alongside a general trend towards provider consolidation in different forms. There are a number of reasons that the number of chairs overseeing more than one trust has increased. It has long been the practice of Monitor and latterly NHS England and Improvement to ask chairs of successful foundation trusts to take on a dual role as chair of a struggling organisation to help the board of that organisation to improve its governance, and through that, organisational performance. Typically, these appointments have been for a relatively short period and have therefore involved minimal disruption at the chair's original trust.

More recently, the move towards system working, greater provider consolidation, and in some instances a drive to improve quality or become more efficient, has led a number of organisations to consider certain joint appointments including sharing a single chair for the medium or long term. In some instances, this is a prelude to a more formal merger of acquisition, but not in every case.

This briefing examines the potential benefits and risks of more than one trust sharing a chair and includes reflections from a number of colleagues who have adopted dual chairing roles for a range of different reasons. Some of these benefits and risks are specific to the chair role, but many will be applicable to joint appointments in general.

2 Legal considerations

There is no overriding or insurmountable legal impediment to an individual simultaneously being the chair of the board of more than one trust.

For foundation trusts paragraphs 8, 16 and 17 of Schedule 7 of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the amended Act) apply. These specify that a non-executive director (NED) and the chair must be eligible to be a member of the patient or public constituency of the membership and that the person must not be disqualified from being a director under the provisions of paragraph 8 of Schedule 7. The amended Act specifies that it is for the council of governors to appoint the chair.

NHS England and Improvement, in its role of Monitor, has the power to remove foundation trust directors including the chair where the trust is in breach of its licence and the circumstances warrant it. It also has the power to direct the appointment of an interim, but there is no power to impose a particular replacement on the foundation trust.

The directors of foundation trusts, including chairs, also have a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation (foundation trust) and a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity. Chairs of trusts and foundation trusts must also meet the requirements of the fit and proper person test.

For NHS trusts, the National Health Service Trusts (Membership and Procedure) Regulations 1990 apply. Until quite recently these regulations prevented NHS trust chairs from also chairing foundation trusts simultaneously, but the regulations were amended in 2014 to remove these impediments. These regulations empower the secretary of state to appoint and by implication remove the chair of NHS trusts, but this power is delegated to NHS Improvement.

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The role of the chair

Corporate governance in the UK is based on a separation of powers, with the chief executive leading the management and the chair leading the board. This briefing does not seek to provide a full role description for the chair but, in summary, it is the chair's responsibility to ensure that the membership of the board is equal to the task it faces and to ensure that the board is effective in carrying out its duties – from setting strategy, to overseeing the work of the executive, to triangulating information to confirm assurance. While the management team might make the greatest input into compilation of the board agenda it is the chair, with the help of the company secretary, who sets the agenda, ensures that it is comprehensive and then ensures sufficient debate and challenge on each item at board meetings. The chair has an ongoing interaction with the chief executive, both formal and informal, to ensure that board decisions result in positive action and to amend the agenda in the light of this. In foundation trusts the chair also leads the council of governors in examining the performance of the board of directors and in representing the interests of the public.

While the chair may have an ambassadorial role, the core responsibilities of the chair go far wider, to encompass leadership, strategy, independent oversight and assurance. It can be a demanding and challenging role even in a small business, but more so in a large and complex organisation such as an NHS provider.

Where trusts are working together closely as part of a system there may be the opportunity for greater synergy created by sharing posts at a senior level. Nevertheless, sharing posts remains unconventional (when taken in the broad context of the application of corporate governance) and to be justified, realisable benefits for the organisations concerned and for those who use their services need to be identified. When deciding whether to proceed with an appointment, boards and councils of governors need to consider whether the benefits likely to accrue are outweighed by any disadvantages and obstacles to proceeding.

Chairing more than one trust – key considerations

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Benefits

There should be good and compelling reasons for an individual to chair two organisations with benefits being identified in advance. The identification of benefits is clearly of no use unless they are realised, so planning to realise benefits should be part of the process from the outset.

Trusts which have a shared chair, or are pursuing this model, commonly identified the following benefits:

- facilitates a cross-fertilisation of cultures, learning and practice
- assists in integration for organisations working towards merger/acquisition of trusts with common strategic interests
- helps to facilitate mutual support
- helps to facilitate collaboration in service provision, particularly specialised services
- assists in building relationships across trusts and can help in stabilising leadership teams
- facilitates more joined-up care and a decrease in trust competition
- aids system working and the creation of an integrated healthcare system – working with partners and sharing services.

Risks to be managed

There is risk involved in one person chairing more than one trust, so caution in identifying and managing those risks should be built into the process, and there should be a periodic review of how effectively the risks are being managed. If an arrangement is not working, organisations should not be afraid to say this and boards should engage in a frank dialogue on the way forward. Chairs rightly exercise significant influence over the board agenda and discussions. Moving to a joint chair model will also have a major impact on a chair's role. However strong their personal views, chairs need to ensure there is full board, foundation trust governor and wider stakeholder support for any move to a dual chair model. They also need to ensure that boards are able to have the rigorous and honest periodic review of how the arrangement is working outlined above.

All of the risks that arise from joint chair roles can be managed effectively with diligence and the commitment of the parties concerned. However, it is important that there is a rigorous assessment of risk and agreement on how they will be managed.

Below we set out the most common areas of risk identified by people in joint chair roles.

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Conflicts of interest

It is by no means certain that the public interest in one local area will coincide with the public interest in another. Where the interests do coincide there will be no conflict of interest and therefore no obstacle to an individual chairing two trust boards.

The test for a significant conflict of interest is whether a reasonable person equipped with the relevant facts would be more likely than not to believe the person's judgment of the public interest might be affected. Avoiding such conflicts is a legal requirement and the effect of ignoring any conflicts that come to light can be serious for both the individual and the organisations. The fact that there may be considerable external pressure on the individual will not offer any protection. Given that the test sets quite a low threshold, individuals would be prudent to exercise caution. Chairs of trusts are not exempt from the requirement to avoid conflicts of interest given that the statute was developed from common law, which applies to all directors.

It is likely that all conflicts of interest can be managed, but it would be advisable for all parties agree an explicit written statement on how conflicts will be identified and managed from the outset and to make the statement public, so that there is clarity and transparency about issues of probity and conduct.

Time commitment

The latest iteration of the UK governance code continues to stress the need for directors and chairs in particular to ensure that they have sufficient time to carry out their duties. This is likely to continue to be replicated in the new NHS code which is currently being revised. Time remains a major obstacle to chairing more than one organisation. Many chairs spend upwards of three days a week on trust business. For this reason, the foundation trust code states that no one should be substantive chair of two foundation trusts. The new UK code takes a softer line that the prior approval of the board should be sought before taking other significant appointments, with the reasons for permitting significant appointments explained in the annual report. Delegation to other board members may assist chairs in devoting enough time to each organisation that they chair, while the formation of committees in common, where appropriate, may mitigate some time pressures. Chairs will also want to keep under review the degree to which chairing more than one organisation is sustainable.

Appointments and removal from office

If the person is already the chair of a foundation trust or NHS trust and the board (and council of governors for foundation trusts) agree that the chair can also be chair of another trust the appointment process is relatively simple in that the second trust can choose to appoint or not. If two trusts are seeking to make a joint appointment at the same time it is more complex. If both organisations are foundation trusts, both councils must make the appointment separately and the outcome that they both appoint the same person

is by no means guaranteed, and it must be stressed that there is no lawful way for that possibility to be avoided. If one of the trusts is a foundation trust and the other an NHS trust it makes sense that the foundation trust appoints the desired candidate first, assuming that their governors will do so, and then the NHS trust makes the appointment, thus guaranteeing a joint appointment. If both are NHS trusts there is no obstacle to the secretary of state appointing the same individual.

Finally, it should be remembered that councils of governors have the right to remove non-executive directors including chairs. While this rarely happens, it cannot be excluded from possible outcomes if a council decides that there are insurmountable issues with sharing a chair.

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Trust case studies

Hugh Taylor

Chair, Guy's and St Thomas' NHS Foundation Trust
and King's College Hospital NHS Foundation Trust

What was the original rationale for the arrangement and what were your reasons for agreeing to the approach?
The rationale for a move to a chair in common was for the two trusts to work in partnership (building on an academic partnership) and to collectively improve operational and financial performance. It also made sense to work together due to proximity and being in the same STP. A merger is not in prospect at the moment for a number of reasons including the need to overcome significant financial challenges.

What were the expected benefits of adopting this approach?
We expected this approach to support each other over time to improve position and provide more integrated services, as well as helping the development of the STP/ICS and collaborative working, including on specialised services. Ultimately, we thought this joint chair approach would also encourage building relationships across trusts at leadership level and throughout the organisations.

What unanticipated risks/issues have you experienced and how have you managed them?
A trust chair doesn't just chair meetings, they are held accountable by regulators which means taking on board a lot of responsibility, managing complex risk and managing a number of relationships – with the support of the team.

While chairing two different governing structures at two trusts is time-consuming and complex logistically – e.g. lots of meetings – there is also a need to rationalise and improve the effectiveness of the governance structures in this new arrangement. Additionally, wider changes within the executive leadership teams of both trusts have presented both an opportunity to develop and support people, and a risk to be managed in terms of loss of corporate memory and continuity. There are new players involved at NHS England and Improvement and also new board members all of whom need to form trusting relationships.

With the benefit of hindsight would you do it again and why?
We would do it again – despite the challenges, having a joint chair signals the potential of better, collaborative working. A clear benefit has been cultural alignment – there are similar values in both trusts with staff on the frontline also holding the same values. There are now two councils of governors, which works well and they hold the chair accountable. Each trust's council of governors is experienced and questions how they fit in the STP model. Going forward, a key concern is maintaining, and indeed improving, quality of care for both trusts. Structural groups, such as boards, will move further away from the operational line due to the workload of two trusts and will need a new regulatory model to manage.

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Joe Fielder

Chair, North East London NHS Foundation Trust (NELFT) and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

What was the original rationale for the arrangement and what were your reasons for agreeing to the approach?

The regulators approached Joe to consider being chair at BHRUT, as good progress was being made at NELFT and they saw opportunities for further progress. The rationale for there being a chair in common with BHRUT was to help develop the direction of the accountable care organisation where there would need to be more collaborative working between the trusts and wider stakeholders.

Joe was successful in becoming a chair in common, working to develop integration and improve healthcare for the local population, in an area where he grew up and still lives to this day.

For Joe, further personal motivation for becoming a joint chair was to influence the local community to improve patient outcomes, provide more holistic care and improve value for money for the taxpayer. It was also important to be more influential in the collaboration between health and social care and to be able to give back to the public sector, having previously worked in the private sector.

What were the expected benefits of adopting this approach?

It was expected that the benefits would largely be about bringing the organisations together, which would help develop the system – especially as there is so much crossover between the two who potentially needed to communicate and collaborate better in a number of areas. However, from the chair's personal perspective, Joe expected there to be an improvement in patient outcomes in the local population via collaborative working, for fragmented care to become more joined-up and a decrease in unhelpful inter-trust competition. There was also a hope to improve inpatient, outpatient, and mental health services, ICT and staff engagement.

There have been a number of benefits and lessons learned between the trusts, for example:

- there is a more developed volunteer scheme at BHRUT (hundreds of volunteers), something that NELFT needs especially since they are spread over more sites
- the trust charity at BHRUT is established and brings in £600-700,000 of income that is of great value and beneficial to patients, which is another aspect that NELFT could learn from
- BHRUT benefit from having more nurse associates which NELFT aspires to increase
- NELFT is a national leader in WRES and can assist BHRUT with its diversity agenda
- NELFT ICT is strong and well placed to assist BHRUT with the digital agenda.

What unanticipated risks/issues have you experienced and how have you managed them?
BHRUT faced unanticipated, early financial challenges during this process. Leadership challenges were also considerable and external investigations had to be commissioned, which led to some change in leadership. Time was another challenge – the joint chair role was supposed to be two days in each trust but has resulted in closer to a full-time role, while the NELFT council of governors were concerned about time commitments. The vice chair at NELFT was given more visiting responsibilities to engage with people across the trust as a result, which was then mirrored in BHRUT.

It is important for anyone hoping to become a joint chair to understand the rationale behind the regulator wanting a joint chair for the trusts and the challenges that they might expect. There is a need for the centre to be explicit about the rationale for a chair role and the combined objectives.

Have conflicts of interest arisen and if so, how have they been managed?
Where conflicts arose, the protocol established has been that the two vice chairs lead those discussions. They have been relatively few. In other cases where NELFT and BHRUT have been in direct competition, Joe would step out of that item during both board meetings.

With the benefit of hindsight would you do it again and why?
We would do it again as there is a need for improving patient outcomes and encouraging more joined-up care, and the need is becoming more apparent as time goes on. The vision is that we need to 'look after the whole person, for the whole of their health requirement for the whole of their life'. Having a joint chair also means the two trusts can make better use of vital resources like our staff, estates and IT and have a 'helicopter view' over two trusts allows for better visibility for patient care.

However, there is a need for more clarity from the regulators around system working and for space, time and support to make improvements rather than to encounter the real risk of continual further regulatory actions.

Kathy McLean

Chair, University Hospitals of Derby and Burton NHS Foundation Trust (formerly Derby Teaching Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust)

What was the original rationale for the arrangement and what were your reasons for agreeing to the approach?

We appointed a joint chair due to a merger – where the larger trust merged with the smaller trust.

What were the expected benefits of adopting this approach?

Two of the main benefits of the transaction were the improvement of patient care and recruitment, and a great deal of progress has been made, although there is still more to do in that area. Importantly, the larger organisation made working closely with partners and building relationships with them simpler.

Prior to the transaction, there were many unfilled vacancies at the one site, for example in radiology, but post-transaction the vacancies were filled. It has become easier to attract people with the right skillsets following the merger and increased the ability to recruit diverse NED and executive board members.

The transaction also made the new organisation more able to deal with the challenges it faced and made it more sustainable in the long term. There have been clinical service changes which have improved quality for patients which were not possible before the merger.

What unanticipated risks/issues have you experienced and how have you managed them?

The availability and use of capital at both sites was different, where Derby had a PFI building and Burton didn't. Different IT systems in both sites have also been challenging as integrated IT systems underpin easier communications. There were also, and still are, challenges in working across two STPs, not least the time commitment required.

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Marie Gabriel

Chair, Norfolk and Suffolk NHS Foundation Trust (NSFT) and East London NHS Foundation Trust (ELFT)

What was the original rationale for the arrangement and what were your reasons for agreeing to the approach?
This approach was originally agreed to support NSFT out of special measures. ELFT were already acting as a buddy helping NSFT improve. This wasn't a joint chair appointment with a future merger in mind but as a buddy arrangement to another trust.

What were the expected benefits of adopting this approach?
We anticipated this approach would provide the opportunity to improve and support the NSFT, as well as the opportunity to improve quality of care and to support others and help develop others in the trust. Being a joint chair also importantly means you can bring good things back to your old trust that you've learnt from the buddy trust.

What unanticipated risks/issues have you experienced and how have you managed them?
Managing time between the two trusts is difficult, and can be unusual – particularly where you have to adapt to two different cultures and styles of leadership. As well as the issue of culture, maintaining an equal focus on both trusts can be demanding, especially as you have responsibility and accountability for both trusts which have contrasting geographies and challenges.

A joint chair can also stretch the other NEDS, which, if handled well, provide opportunities for them to develop their non-executive experience and insight into being a chair.

For those that chair two foundation trusts, extra focus must be invested in working with the council of governors who appoint the chair and inform the chair's appraisals. They must understand the benefit/impact for their particular trust, be kept informed and assured that patient and organisation benefits are secured.

Regulators need to think quite carefully about what having a joint chair for more than one trust means for the trusts, there needs to be a negotiation with the regulators on how much support can be provided by the chair and how much support they as regulators provide. Being a chair is about reflection, being seen in the trust and speaking to the frontline which is difficult at two trusts that are not in proximity.

Have conflicts of interest arisen and if so, how have they been managed?
There were conflicts of interests which were declared, for example ELFT had a role in supporting negotiations of buddy arrangements so we declared a conflict in setting those terms.

With the benefit of hindsight would you do it again and why?
We would do this again, but Marie would advise those looking to become a joint chair that they do their due diligence before they go in to the other trust to find out what needs to be done and what the purpose for having a joint chair is given this can vary considerably. The individual needs to gain a clear understanding of the local geography – the distance between the two trusts has often been a challenge. Being an experienced chair is helpful, but you also need to be clear about why you want to take the role of a joint chair.

Tackling chairing roles at trusts with difficulties will always be challenging and create work for the chair, but it also means you can make more impact. It is good for one part of the NHS to be helping another part, and for colleagues in different trusts to learn from each other.

Robin Talbot

Chair, North Cumbria Integrated Care NHS Foundation Trust (formerly Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust)

What was the original rationale for the arrangement and what were your reasons for agreeing to the approach?
As planned, these two trusts merged in October 2019. Before this point the board had already merged with joint executives and joint NEDs working across both trusts.

What were the expected benefits of adopting this approach?
We expected this approach to aid with the move towards an integrated healthcare system, particularly by creating a common agenda which aligned our objectives. Practically, we also expected there to be benefits with streamlining paperwork and the number of meetings, as well as economies of scale.

What unanticipated risks/issues have you experienced and how have you managed them?
Managing joint control totals was a challenge. In terms of the existing workforce, as the trusts work closer together, some staff might feel further away from what is actually happening in the trust. Similarly, it created visibility issues for senior staff, as the trusts merge and get bigger, staff such as senior managers cannot be everywhere all the time. The trusts are geographically isolated so there aren't many opportunities that exist to work outside.

The merger also highlighted workload issues. Workloads were already enormous within each trust – for example, agendas and meeting papers are incredibly long and it's hard to reduce these.

NEDs also understandably needed support to understand their roles in the run up and within a newly merged trust. There is also a need to bring governors on the journey such that they understand the objectives of the merger, and the challenge in improving committees and how they work.

Finally, there was a risk to parity of esteem with the community and mental health trust in particular to manage and a sense it was losing its individual identity.

Have conflicts of interest arisen and if so, how have they been managed?
As this was a merger rather than a chair in common, we didn't face this issue.

With the benefit of hindsight would you do it again and why?
Yes – there are many benefits in terms of shared learning and cross-fertilisation of ideas and practice and these outweigh the challenges posed by time constraints and managing conflicts of interest.

Paul Devlin

Chair, Lincolnshire Partnership NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust

What was the original rationale for the arrangement?
Paul has extensive experience as a chair, a NED and Care Quality Commission inspector and wished to use his experience to build on work to develop a positive culture at a new trust as his term in Lincolnshire began to draw to an end.

What were the expected benefits of adopting this approach?
We hoped Paul's experience in Lincolnshire would help bring about improvements in Nottinghamshire, but also bring back what is good in Nottinghamshire to Lincolnshire leading to a cross-fertilisation of good practice.

What unanticipated risks/issues have you experienced and how have you managed them?
The two systems that the trusts are part of are very different, so there was a considerable amount of learning. Time commitment is also an issue and it has been necessary to look carefully at what the chair needs to do at each trust and what can be delegated. The governance teams at the trusts are in contact with each other to co-ordinate work, ensure that there is no overlap and to ensure that Paul is available for key meetings at each trust. This has also had the benefit of shared learning across the two trusts.

Have conflicts of interest arisen and if so, how have they been managed?
Paul anticipated that conflicts of interest might arise from the outset and put in place open and transparent processes so that conflicts can be identified, declared and managed. The governance teams are in touch with each other and this facilitates the avoidance or management of conflicts.

With the benefit of hindsight would you do it again and why?
There are many benefits in terms of shared learning and cross-fertilisation of ideas and practice and these outweigh the challenges posed by time constraints and managing conflicts of interest.

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Conclusion

While chairing more than one provider trust presents challenges and risks, none of these are insurmountable nor are there fundamental legal or governance impediments to such arrangements.

However, there are a number of issues that the involved parties will need to consider and deal with:

- the need for identification and delivery of benefits associated with the joint chair arrangement from the outset onwards
- the need for a rigorous assessment of risk and agreement on how key risks will be managed
- the need for an explicit written statement on how conflicts will be identified and managed
- periodic reviews over time of the degree to which chairing more than one organisation is effective and sustainable
- for arrangements involving one or more foundation trusts, the need to keep governors informed and on-board with arrangements;
- where *Code of governance* requirements are not complied with, the need for real consideration of an explanation to stakeholders.

Given the development of joint appointments within the NHS, and of the joint chairing role is becoming increasingly common, NHS Providers will follow these developments with interest – and ensure our support and influencing activities remain responsive to trust boards' needs.

Appendix

Governance provisions – summary

The relevant provisions of the foundation trust *Code of governance* and the UK corporate governance code are set out below.

Code of governance

The *Code of governance* does not have the force of law and is based on the principle of 'comply or explain', whereby organisations that do not comply with the code must explain to relevant stakeholders their reasons for not doing so.

The foundation trust *Code of governance* stipulates that there should be a clear division of responsibilities at the head the organisation between the chair and the executive which is responsible for the management of the trust. The code makes it clear that no one individual should have unfettered powers of decision-making. It confirms the chair as being responsible for leadership of the board of directors and the council of governors and ensuring their effectiveness on all aspects of their role. It also confirms the chair's role leading on agenda setting, ensuring the provision of accurate timely information and ensuring that adequate debate. The code acknowledges the central role of the chair in promoting a culture of openness and facilitating constructive but challenging relations between executive and non-executive directors.

However, the code warns against appointments made for reasons of convenience emphasising that search for candidates should be conducted, and appointments made, on merit, against objective criteria with due regard for the benefits of diversity on the board and the requirements of the trust. The code asserts that on appointment the chair should meet the criteria for independence. The factors that may be taken into account in determining independence include whether the candidate:

- has been an employee of the NHS foundation trust within the last five years
- has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust
- has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme
- has close family ties with any of the NHS foundation trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies
- has served on the board of the NHS foundation trust for more than six years from the date of their first appointment
- is an appointed representative of the NHS foundation trust's university medical or dental school.

The UK corporate governance code

While there have been significant revisions to the UK code in producing the 2018 iteration the provisions regarding the role of the chair remain clear consistent with the foundation trust code:

- the chair leads the board and is responsible for its overall effectiveness in directing the company
- they should demonstrate objective judgement throughout their tenure and promote a culture of openness and debate – in addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors receive accurate, timely and clear information
- the responsibilities of the chair, chief executive, senior independent director, board and committees should be clear, set out in writing, agreed by the board and made publicly available
- the chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board
- the chair should hold meetings with the non-executive directors without the executive directors present
- when making new appointments, the board should take into account other demands on directors' time
- prior to appointment, significant commitments should be disclosed with an indication of the time involved
- additional external appointments should not be undertaken without prior approval of the board, with the reasons for permitting significant appointments explained in the annual report.

Foundation trust chairs are appointed by governors and the code is clear that a prospective chair's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.

Finally, and perhaps most importantly, although it is not legally binding, the code states that no individual, simultaneously while being a chair of an NHS foundation trust, should be the substantive chair of another NHS foundation trust.

Your feedback on this briefing is very welcome. For any comments or questions please contact john.coutts@nhsproviders.org

For more information:
www.nhsproviders.org/chairing-more-than-one-trust-board

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