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Considerations for system working

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Introduction

System working in the NHS recognises many of the challenges faced by trusts and other organisations are inter-related and best tackled collaboratively. The purpose of system working is to bring organisations and services together at a local level, in order to better focus on improving care, make best use of available resources and address health inequalities. However while system working is intended to foster a greater sense of co-ownership of local issues, it is also the case that provider boards still have specific responsibilities and liabilities. This section therefore focuses on supporting boards to maintain appropriate oversight and control of these.

As such, it offers a series of considerations for provider boards when working with, or considering working with, other organisations within the permissive framework of the Health and Care Act 2022. Ways of working are developing differently across the country – there really is no one size that fits all,

and so no off the shelf answers as to how to operate in the new landscape. The principles of good governance should continue to apply in all cases.

While there is guidance from NHS England (NHSE) adding detail to some of the bones of the Act, this is not the case for all areas the Act covers, and in general NHSE has so far sought to echo the permissiveness of the legislation and provide options and aspirational examples without being prescriptive: this is understandable given the success of system working ultimately depends on the quality and sustainability of the relationships underpinning it.

Our Guide to the Act remains a useful reference point for those seeking to understand the most salient parts for trusts in some detail.

Overview

Working in systems raises questions for provider board members seeking to maintain control over their organisations and fulfil their duties as directors, acting in the best interests of their organisation and its stakeholders.

Some of these questions will be entirely familiar to board members: are we clear about our strategy and our plans?, have we identified risks and are we managing them effectively?, are we clear about who has authority to decide what?, do we have sufficient capacity and capability?, do we have values and a culture conducive to achieving our aims?, do we have appropriate relationships with other players (providers, commissioners, regulators) to serve patients effectively?, how will we know how things are going, and can we change things if we need to?

The Health and Care Act 2022 introduces new duties on trusts and foundation trusts to contribute to achieving the objectives and financial plans of the systems they are part of. It also provides opportunities for trusts considering joint working arrangements and NHSE now requires mental health and acute trusts to be part of at least one such partnership arrangement (or provider collaborative). Partnership working and cooperation is nothing new to provider organisations. Boards have likely always kept an eye, at a minimum, on what other relevant providers, in any relevant sector, were doing. But the Act establishes new duties on provider organisations and, for some, working in systems introduces new dimensions to the considerations for boards in relation to issues such as: alignment with other players' priorities (and how you influence them), degrees of alignment and how to sustain fruitful relationships with partner organisations, and crucially whether new alliances and partnerships will better enable the delivery of good care. However, providers are now statutorily required to

contribute to the delivery of the objectives of the system(s) they are part of, as well as have regard to the wider effect of their decisions on health and wellbeing (including inequalities), the quality of services (and any inequalities in benefits), and efficiency and sustainability (the 'triple aim'). These questions are now more pertinent than ever.

Our annual governance survey 2023 highlights huge variation in providers' experience of governance in systems. This has informed our focus in this section. There are also some specific considerations for individual board members including proportionate management of conflicts of interest, 'bandwidth' challenges for executives and non-executives (NEDs), and the role of NEDs in system structures.

Boards in systems at a glance

Question	Considerations
Are your strategy and plans suitably aligned within your system?	• Have you discussed the annual update of the joint forward plan with your integrated care board(s) (ICB)? • How will plans be monitored and success measured? • Will the plans improve the health of your population? • Are the priorities justified by the data?
Does your board have oversight and control?	• Are there clear leadership arrangements and oversight by the trust board of activity/decisions taken elsewhere in the system? • Do you understand the governance and programme/project management infrastructure in the system and how that links to your own governance infrastructure? • Is system governance proportionate and not unduly complex? Are you able to influence it? • How does your board assure itself that any new decision-making arrangements are lawful?
Are you clear about the new regulatory environment?	• Have you discussed with your ICB(s) their approach to the 'day to day' oversight of providers? • Do you understand what is required to meet the provisions of the NHS Provider Licence (new for NHS trusts in April 2023)? How will the board gain assurance on this?
Do you have effective risk-management, including around system risks?	• Have you reviewed your risk appetite in the context of system working? • Does your board understand 'system risks', how they might impact on your organisation and how to influence system risk management?

	• Is your board well sighted on who is responsible for system/collaborative risk management and who owns risks? • Do you have a clear board assurance process for system/collaborative risk? • Is the board satisfied that decisions about risk are evidence based and free from cognitive bias?
Will the culture of your board/organisation facilitate or hinder effective working with system partners?	• Is there a culture of openness and transparency – and is there commitment to build trust between partners? • How will you recognise and adapt to cultural differences between organisations that may be barriers to effective partnership? Do you have any 'red lines'? • Have you (and your partners/partnership) established a patient/user-centred approach as the norm, putting patients and the community you serve at the heart of decision-making? • Is there explicit shared understanding of NHS values and standards of conduct between partners? And agreement about how deviation from these will be managed? • Will those representing you with partners demonstrate your/NHS values through their interactions?
Do you have processes to consider opportunities for partnership/ collaboration and clarity about delegation and decision-making when working with others?	• Have you reviewed your stakeholder map/strategy in the new context? • Are you focused on solutions and outcomes when undertaking/considering working with partner(s)? When working in partnership/collaboratives have you considered: • How are decisions made – deliberative (with reference back to boards) vs majority (under delegated authority elsewhere)? • Whether committees in common are useful (committees of each board meeting together with same agenda to make decisions/seek assurance) to enable independent challenge from NEDs at the point of decision-making? • Whether to establish committee(s) to oversee collaboratives or oversee them through existing committee(s) to help your board obtain assurance?

	• Are you delegating to the right people? Can you devolve decision making to local managers and retain oversight? • Do those people understand the limit of any delegated authority? How do you know? • Do you have a means to settle disagreements? • How do you compensate for any lack of NED challenge at the point of decision making in collaboratives? • Do you understand the differences between local authority and NHS governance, culture and decision-making? If considering accepting delegations from others, have you considered: • Delegated functions bring associated liabilities – the Act is clear that the delegate is liable for anything that goes wrong. • Are there other ways to undertake functions, such as well-established contractual models where liabilities are distributed?
Considerations about executives	• Is executive capacity invested in systems proportionate to the outcomes/potential for improvement that are sought? • Do executives have any skills or other development needs related to the changing environment? • Does the board support your executives to be assertive in system discussions, with a clear view of your organisation's priorities and aims? • Are executives clear about their responsibilities in relation to conflicts of interest? Do they have clarity from the board about when they should withdraw from system discussions?
Considerations about NEDs	Have you explicitly discussed: • NEDs' comfort and understanding of the system working context? • The information NEDs need to assess whether they have assurance and how they can triangulate information? • Any skills or other development needs related to the changing environment? Are you clear that:

	• If you send a NED and an executive to represent you, you are sending a committee in all but name. • Foundation trusts cannot delegate to NEDs, but NHS trusts can. • System governance enables appropriate scope for independent scrutiny and challenge from NEDs.
For FTs, are you engaging your council of governors?	• Do you inform your council about system plans/alignment and any plans you have to work in partnership at early stages so they understand and buy-in? • Have you discussed with your council whether/how they might add value in systems (bearing in mind they have no statutory duties or role outside your trust)? • Are governors clear their role in representing the interests of the public now extends beyond trust boundaries and is instead across the ICB(s)? • Have governors had the chance to discuss nuances around decisions that may be in the best interests of the public at large, rather than your trust's patients?

Integrated Care Systems (ICSs)

The Health and Care Act 2022 made no change to the existence of NHS trusts and foundation trusts as bodies corporate, and so the trust board remains the statutory vehicle for control of the delivery of health care through these organisations. Board directors' functions, duties and liabilities with reference to their organisation remain as they were prior to the 2022 Act.

The 2022 Act introduced two statutory bodies (the ICB and integrated care partnership (ICP)) which together, and when including their partner organisations and any other structures set up by the ICB/ICP or their partners to deliver health and care, are now known as an integrated care system. ICBs took on the commissioning powers of clinical commissioning groups, which the Act abolished, while ICPs are joint committees of the ICB and local authorities within the system footprint. The formalisation of this structure is now familiar to those in the NHS and there are ample further explainers available should they be required (including this suite of resources from NHS Providers). There are, at the time of writing, 42 ICSs, each with a defined geography and population of between 500,000 and 3 million. However, it is worth noting ICSs do not exist as defined entities within the Act

2022. To the extent that they are described at all (the phrase only appears three times in headings), when there is reference to 'the system' it is defined as:
"the system for the provision of relevant health care, and adult social care, within the area of an integrated care board".

An ICS is not a body which has leaders, nor duties and liabilities, nor a role and responsibilities, except as further defined by NHSE in its guidance and statutory guidance. 'ICS' loosely describes the multitude of actors (including provider trusts, but also provider collaboratives and place-based partnerships) which plan and deliver health and social care in a specific geographical area covered by a specific ICB. This matters because reference to 'ICS leaders' is misleading (it is important to know who 'leaders' are). Similarly, an ICS does not itself have responsibilities or duties, because different parts of 'the system' have different responsibilities and duties, albeit they now share some.

The ICB is the NHS commissioning body with a defined geography, and responsibility for the provision of most NHS health care within that geography (unless retained by NHSE). In arranging this provision it has a number of specific duties, such as reducing inequalities, improving quality, involving patients, and promoting integration 'where it would improve quality or reduce inequalities'.

The Act confers joint responsibilities on the 'integrated care board and its partner NHS trusts and foundation trusts' in relation to planning 'how they will exercise their functions' and use of capital resources, as well as delivering other financial objectives and duties. It remains the case (as set out in prior legislation) that provider trusts are responsible for the exercise of their functions, and trust directors retain their duties to strive for the success of their organisation and create value for their stakeholders. As we shall see, this embeds tensions between a trust director's duties to their organisation and to the ICB (or ICBs) they partner with in their system(s).

The ICP, a joint committee of the ICB and local authorities in the geographical area, is responsible for preparing an integrated care strategy 'setting out how the assessed needs in relation to its area are to be met by the exercise of functions of' the ICB, NHSE or local authorities in the area. The ICB must have regard to this strategy in exercising its functions. The ICP was intended to ensure the NHS and authorities responsible for related services, particularly social care, and agencies that influence the wider determinants of health, are pulling in the same direction to provide better care and improve the health of their populations. The ICS concept therefore has an inherent tension at its heart: it aspires to improve population health by integrating NHS decision making and care with services – particularly social care – which affect population health but which are outside the NHS in governance and funding terms. However the divisions between different sectors, with their own accountability,

regulation and funding regimes remain: local authorities are independent of NHS governance, while ICBs as NHS bodies, which are responsible for local NHS services only, are subject to NHS lines of accountability, and control NHS budgets.

Collaboration at scale and place

Under the Act providers now have duties to work with the ICB and other system partners within the geography of an ICS to agree joint forward plans (JFP), and providers must then contribute to delivery of their agreed part in them. Providers also have a duty to work with the ICB and system partners to agree and deliver their financial plans. ICBs have also been asked to prepare and publish a joint capital resource use plan before the start of each financial year, which should align with JFPs and ICS infrastructure strategies. The aim of the plans is to provide transparency to local residents, patients and other stakeholders on the use of capital funding to achieve the ICB's strategic aims.

The duty to cooperate existed in the 2006 Act, however the 2022 Act sought to strengthen this duty by allowing the secretary of state for health and social care to publish guidance on the discharge of the duty in practice. NHSE has since done so (in its Guidance on good governance and collaboration of October 2022), preferring the word collaboration to cooperation and sometimes using them synonymously. The Provider licence also sets out providers' duty to cooperate.

'Cooperation' and 'collaboration', while similar, imply different levels of ownership and participation: collaboration implies closer team-working in a coordinated way towards shared goals, while cooperation implies a division of labour between those working together, retaining individual endeavour and responsibility. The Act did not enshrine coordinated joint working, but NHSE's guidance seeks to.

NHSE's guidance also qualifies collaboration, saying it should be effective and consistent. Discussion about the way such relationships and outcomes should, or indeed could, be assessed – and provider boards held to account for delivery of them – is ongoing (in particular, does 'consistent' mean 'always' or 'always amenable to, if likely to get results'?) but the guidance referenced above describes 'illustrative minimum behaviours' in relation to three requirements:

- Providers will engage consistently in shared planning and decision-making.
- Providers will consistently take responsibility with partners for delivery of services across various footprints including system and place.

- Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other relevant forums.

As a requirement in statutory guidance, acute and mental health trusts must be part of a provider collaborative, while ambulance and community trusts need only be part of a collaborative where it makes sense for patients or the system. Our annual governance survey 2023 found that, of the responding trusts, 30% are part of two or more provider collaboratives at scale (with 10% part of four or more), and 60% are part of two or more place-based partnerships (with 13% part of five or more). Earlier in the year, another survey (undertaken with the NHS Confederation) of organisations in provider collaboratives (*The evolution of provider collaboration*) established that 'governance' was an issue of concern.

To support those in or considering appropriate collaborative forms to support their aims, NHS Providers worked with legal firm Browne Jacobson to produce *Provider collaboration: a practical guide to lawful, well-governed collaboratives*. This sets out the key legal and other governance considerations for effective provider collaboration. It details various collaborative options and also sets out five 'characteristics of governance arrangements' for collaboration with partners (whether horizontally between providers or vertically at place).

NHSE continue to seek to further define and articulate what good looks like in terms of provider collaboration, producing a 'maturity matrix' (FutureNHS site log-in required) to support collaboratives in assessing their own progress, and recent engagement to consider the policy and support to provider collaboratives, building on their *Guidance on good governance and collaboration*, and *Working together at scale: guidance for provider collaboratives*, as well as learning from the 2023/24 provider collaborative Innovators scheme.

There is a more permissive framework around place-based partnerships than provider collaboratives: 2021's *Thriving Places* guidance from NHSE and the Local Government Association remains the key document setting out guiding principles for place-based partnership working.

In the context of systems, 'place' refers to a smaller geographic footprint which often aligns with a local authority area or with patient flows for acute care and it is for local partners to define the geography, role and purpose of place-based partnerships, as well as to establish suitable and proportionate governance arrangements. The guidance's section on governance and decision-making sets out the various options available to partners, ranging from informal consultative forums,

through delegation to individual executives or other staff, to the use of more formal structures such as statutory committees and joint committees, all of which are also explored in detail in *Provider collaboration: a practical guide to lawful, well-governed collaboratives* (albeit in relation to provider collaboration but the principles are the same and the Act enables the use of more formal options). At the time of writing, where information was publicly available, 12% of place-based partnerships were led by a trust employee: usually the chief executive but sometimes a more junior staff member. The considerations in terms of good governance for board members leading and participating in decision-making at place are similar to those within provider collaboration.

The key lines of enquiry that NHSE are likely to use in discussion with an ICB to indicate whether a provider is acting in line with its duty to cooperate are set out in its *Guidance on good governance and collaboration*. In practice this assessment (and indeed working together effectively and consistently) can only be a matter of ongoing negotiation, achieved through mutually-respectful relationships. The indicators of compliance are very process and activity focused – do providers engage meaningfully?, for example. One might ask what this means in practice, and what evidence might support compliance, and in our view boards would do well to keep in mind the intended outcomes sought as it is easy to get caught up in these process measures and forget that the purpose of cooperation, or collaboration, should be to improve population health and wellbeing, improve the quality of services (and reduce inequalities while doing both), and make efficient use of resources (as per the triple aim referenced in the overview). Collaboration is not an end in itself. For trust and FT boards, oversight and control of partnerships and collaboratives will be important, as decision-making may increasingly be devolved to board members and/or more junior colleagues operating in external fora. This is discussed in the section below.

Regulation

While NHSE and the Care Quality Commission (CQC) remain the regulators of providers, NHSE and CQC have new powers to regulate systems. NHSE's remit relates to ICBs, while CQC's relates to ICSs. NHS trusts are now required to comply with the provisions of the NHS Provider Licence (from 1 April 2023) while FTs have been subject to the licence since 2013. NHS trust boards will want to ensure that processes are in place to seek assurance around compliance. In FTs, such assurance-seeking is commonly part of the Audit Committee's remit.

The licence was revised and updated in 2023 to reflect the provisions of the Act 2022. It serves as the legal mechanism for any formal regulatory intervention and underpins mandated support for the most challenged providers. The changes to the licence reflect the Act's requirements around

cooperation in system-working, digital maturity and climate change. They remove a redundant competition condition and reflect the triple aim of integrated care systems. The licence also establishes a positive obligation on providers to integrate service delivery where this will benefit patients or reduce health inequalities. The *Code of Governance for NHS provider trusts* was also updated and trusts as well as FTs must now comply with its provisions or explain how alternative arrangements have been put in place to comply with its governance principles.

The NHS *Oversight Framework* 2022/23 sets out NHSE's intention to delegate 'day to day' oversight and performance management of NHS providers to ICBs. This is also reflected in NHSE's Operating Framework. The intention is to devolve more power to systems to work together and reduce the regulatory burden on trusts (and on NHSE), which is welcome. There is a fundamental tension created by NHSE's delegation of oversight and performance management, however: if ICBs are intended to be partners in systems, can they also be performance managers? Is the ICB chief executive a provider chief executive's equal partner, or overseer?

Trusts tell us[1] there remains a lack of clarity about roles and responsibilities between providers and ICBs, which can lead to confusion and duplication, and create challenges for provider board members' time management. There is no silver bullet, and representatives of your board will wish to remain in dialogue about ways of working, roles, and decision-making with your ICB(s). Your board will also want to be content that any Memorandum of Understanding established between ICBs and trusts (as suggested in the oversight framework) is well-defined, and that a shared understanding of its provisions is in place between your board and the ICB, with open channels of communication around the effectiveness of the ways of working.

CQC is also revising its ways of working in the new system context by introducing a single assessment framework for providers, ICSs and local authorities. The new approach promises to focus on building a more up-to-date picture of quality, enabling benchmarking between providers, and making information more accessible to enable them to share good practice and to drive improvement. Again, changes have not been fully realised at the time of writing, with a small number of trusts and systems piloting the new approach to inspection in late 2023/24.

The Act does not explicitly require CQC to issue ratings for ICSs, and the regulator has confirmed it will not be issuing any in 2023/24. CQC is currently undertaking a small number of ICS pilot

[1] NHS Providers annual governance survey 2023

assessments, which, it has said, will be used to inform subsequent formal assessments of ICSs. Many stakeholders believe that CQC needs to do more work to develop its approach to ICS assessments, and especially to reconsider the added value of system ratings. This is relevant because the issues of assessing system performance in practice, and also providing a single rating for the quality of care provided across a complex landscape of differently constituted NHS providers, local authorities, and private companies, is understandably challenging.

Secretary of State intervention powers

While much of the Act set out to enable devolved decision-making, schedule six established new powers for the secretary of state for health and social care that were previously devolved to local authorities.

Briefly, the powers enable the secretary of state to:

1. Require NHS commissioning bodies to notify them about any 'substantial' service reconfiguration.
2. 'Call-in', or make final decisions about, such reconfigurations.
3. Require commissioning bodies to consider undertaking a service reconfiguration.

Powers one and two commenced on 31 January 2024, with the third not yet commenced. Our On the day briefing sets out the key issues providers should be aware of in relation to the powers, and NHSE are also updating their *Planning, assuring and delivering service change for patients* guidance to reflect the changes.

Culture and relationships

Transparency and mutual respect are the usual key principles when navigating this moving landscape. Boards can take steps to become more aware of their own and (existing or prospective) partners' organisational and board cultures by directly acknowledging and exploring them as the basis for sustainable relationships when working in systems.

Board members who believe their organisations are successful at working with others commonly attribute their success to paying early and then ongoing attention to establishing and sustaining shared values and behaviours. One way of doing this is to explicitly develop a culture of openness and transparency to foster trust, and to agree expected standards of conduct by partners and how any issues will be jointly and fairly managed. Bumps in the road, and turnover of colleagues and partners may disrupt partnerships based on long-standing relationships. Therefore going into joint

working with the foundation of a firm commitment to shared values and principles will stand all players in good stead.

This short section of *Provider collaboration: a practical guide to lawful, well-governed collaboratives* is relevant.

In this resource, for more on quality and safety and this aspect of organisational culture see our section on culture and problem-sensing.

Aligning strategy and plans

NHS providers are required to contribute to the delivery of the objectives of any ICB they are a partner of, including any workforce and financial plans the trust agrees with the ICB. These objectives are set out in the joint forward plans, first published in 2023, and updated annually. It is vital to be linking with your ICB(s), with agreed, ongoing ways of feeding into this plan, to ensure your trust will be involved in future planning. This will help with alignment where appropriate and will help the board understand the system objectives and plans that they are signing up to and which should be reflected in your own trust's plans.

Our annual governance survey found in 2023 that 68% of respondents agreed they could influence the development of their system(s) – up from 62% in 2022. However this leaves more than one in four respondents not feeling able to agree that they have such influence (though only 8% disagreed in 2023, down from 12% in 2022: the rest were neutral). There is real variation between different providers' experience in systems.

Your board will want to agree how it receives assurance around delivery of your commitments, probably using existing reporting mechanisms. You will also want to understand how you will be informed about system-wide progress towards relevant objectives, and how different contributing bodies can best work together towards shared objectives.

Decision-making, board oversight and control

We set out the evidence about why the unitary board model provides the best prospect of good governance in our section Why boards? In the context of system working, board oversight and control remains as important as ever, and as decision-making may be increasingly devolved through partnership working, retaining oversight that is proportionate to risk is important.

As key statutory partners in systems, boards should assure themselves that their organisation is suitably appraised of, able to influence, and lead if appropriate, activity across and between other organisations where necessary to achieve ICS or trust objectives. Whatever activity your organisation undertakes or aspires to lead, the governance (control) infrastructure should be proportionate and firmly linked to your organisation's own to provide a clear line of sight for your board. Your board remains responsible and liable for the activities it undertakes in partnership.

Collaboration and cooperation are now the expected norm but need not mean complex quasi-organisational structures must be set up. Trusts are free to decide on the approaches that work best for them and their partners, and there is support available from NHSE as well as NHS Providers to help.

Our resource *Provider collaboration: a practical guide to lawful, well-governed collaboratives* articulates the fundamentals of governance in collaboration whatever the purpose and scope of your partnership working, as well as the options for collaborative arrangements, including joint committees or committees in common. NHSE's *Guidance on good governance and collaboration* also explores the various forms of collaboration.

ICB to provider delegation

The 2022 Act introduced new delegation powers. Sections 65Z5 and 65Z6 of the Act allow ICBs and trusts to delegate their functions to each other, jointly exercise functions and form joint committees. Delegates are legally liable for the exercise of the specified functions, but delegators retain overall accountability within NHS accountability structures (e.g. ICBs to NHSE).

The delegation guidance published in September 2022, and updated March 2023 and again in January 2024, recommended that systems should not make use of ICB powers to delegate any of their statutory functions to trusts. NHSE has continued the hold on this formal use of delegation, to ensure that the right processes and legal requirements are in place to safeguard standards, providers, and systems and because there are numerous alternatives to the delegation of statutory functions that would enable providers to, for example, take on commissioning responsibilities or contracting responsibilities on behalf of the ICB.

Notwithstanding this hold, NHSE's guidance *Arrangements for delegation and joint exercise of statutory functions* (FutureNHS login required) explores options for collaboration short of delegation,

as we do in this section of our resource *Provider collaboration: a practical guide to lawful, well-governed collaboratives*.

System risk management

There are two other sections of this resource covering aspects of risk management[2], so here we will only make a few observations about risk in relation to system working.

One of the proposed benefits of closer working between system players is the ability to highlight and work together to resolve or mitigate risk that resides with more than one system partner. In practice, board risk registers probably contain numerous risks that the individual provider cannot reduce or resolve on its own, and when we talk about system risk this is likely what we mean most of the time. The creation of ICBs and their partnerships with NHS providers should offer opportunities to identify and work together to reduce risk (to patients and organisations) that sits across more than one organisation.

In terms of liabilities, should a system risk become an issue, relevant system partners would be jointly and severally liable in law: the adverse outcome of the risk is not 'shared' in the sense that it is reduced. This is explored in more depth in the Managing risk section of our provider collaboration resource.

ICBs are creating risk registers to draw together service risks, provider risks and system risks (for example related to the funding available to the system), and the same principles of effective risk management (as set out in the Risk management section of this resource) will apply to these endeavours and the ongoing management of risk. Effective risk management by the ICB with its partners will need additional negotiation, creating opportunities to determine and share risk appetites across organisations and to negotiate longer-term changes to service or pathway profiles to mitigate risks to patients.

Closer partnership working should support 'dynamic' (or real time operational) risk management between and across organisations. One of the perceived benefits of closer working during Covid was the ability to make swift changes to pathways or services, working with partners, to keep services running as well as possible for patients. Such decisions might be made and implemented on a daily basis. This same process of real-time negotiation and mitigation of risk might continue between

[2] Culture and problem sensing and Risk management

organisations, perhaps facilitated by the ICB. When not faced with the imperative of a pandemic, however, decisions about when, how and for how long to shift the balance of risk between players are not so easily made.

ICBs have asked for support to document decisions to shift risk around their systems, to make sure and also to demonstrate that careful consideration has been given to it. NHSE has published some System risk management principles (requires FutureNHS site log-in) to support ICBs in this space. NHSE has plans to publish similar advice for providers that should support them to join the dots between their own organisational risk practices and those of the ICB and system partners.

While trust boards are keen to look outwards and contribute to reducing risk across their systems, it is an essential part of risk management to take decisions balance the risks to different groups or cohorts of patients, particularly at the interfaces between different services. Having a system-wide understanding of how such decisions can be made swiftly, as safely as possible, and documented appropriately, must be useful. Other questions which NHSE might seek to answer in its forthcoming advice include what approach the regulators will take should one organisation accept greater risk on behalf of another or others (for the greater good) should that risk materialise, and whether ICBs have any power to compel providers to shift risk profiles if their boards would rather not.

Systems will stand themselves in good stead by acknowledging these issues and beginning their own deliberations on them.

Considerations about executive directors (including trust ICB partner members)

Executive capacity is the issue trusts consistently tell us is causing the greatest challenge for them in relation to system working. Our governance survey clearly shows trusts are keen to work with partners where it can benefit their organisations and patients. Nonetheless, the additional system meetings, relationship-building and accommodating partners requires inevitably impacts on already-pressured executive and leadership 'bandwidth'.

Ensuring executive efforts are focused where they can have most impact is more crucial than ever. Boards can support executives representing the trust in systems by being clear about their organisation's own strategy, aims and objectives, and ensuring the executives are clear about their own delegated authority in system decision-making (and what is reserved to the board). Our resource *Provider collaboration: a practical guide to lawful, well-governed collaboratives* contains support and

advice for those undertaking roles in partnerships and collaboratives, including understanding delegated authority, managing conflicts of interest, and managing risk.

Under the 2022 Act, ICBs are required to have at least three partner members on their board, drawn from the leadership of partner organisations within the ICS. One must be from a trust or foundation trust, one from a primary care provider, and another from a local authority. The trust partner member posts are usually held by chief executives. Trusts with directors who are also on the ICB tell us that this gives them welcome influence, the opportunity to be part of system discussions, and 'a seat at the table'[3].

Partner members are full members of the ICB unitary board and while supposed to bring knowledge and a perspective of their sector, should not act as delegates of that sector. As a member of the unitary ICB board, then, trust partner members should be concerned with the interests of the whole system. There are inherent tensions in fulfilling this role, which existing national guidance does not resolve.

We conducted interviews with ten trust ICB partner members in summer 2023. They told us a lack of clarity about the trust partner member role led to misconceptions about their remit among other providers and ICB members in the system. Trust partner members would be well advised to establish a shared understanding of their role on the ICB with not only the ICB chair/CEO and other ICB board members, but also with other provider trusts in their system.

Trust partner members also expressed concerns about managing conflicts of interest. As noted, the Act did not remove any existing directors' duties (to their own organisations) but added the duty to cooperate, to have regard to the 'wider effect' of their decisions on health and wellbeing, quality of services and efficiency and sustainability (the 'triple aim'). The Act also created the trust partner member role on NHS commissioning bodies (ICBs). While conflicts of interest have always been part and parcel of good governance, this set up the potential for different forms of conflicts of interest which, while not insurmountable, will need to be identified and managed appropriately.

NHS Providers commissioned law firm McDermott, Will & Emery to provide advice to company secretaries and any director working in system settings. The advice sets out the various duties on directors and advises that early discussion with the board at home and the ICB about managing any

[3] NHS Providers annual governance survey 2023

arising conflicts is advisable, and in this way most issues can be managed through the usual process of declaration, recording and possibly at times, removal from decision-making that might introduce a conflict.

Considerations about non-executive directors

NEDs' responsibilities to their trust and as part of the unitary board are unchanged in law and remain around seeking assurance and providing challenge and support.

We are seeing an improving position in relation to NEDs' levels of confidence about their role and responsibilities in systems but there is still a majority that do not express confidence: our annual governance survey 2023 found that 41% of respondents agree (34% agree, 7% strongly agree) that trust NEDs are confident about their roles and responsibilities, up from 24% last year (19% agree, 5% strongly agree).

NEDs may need to be encouraged to consider their assurance needs about the system, for example: about strategic alignment between the provider and ICB strategy and plans, how the trust is involved in decision-making at system level that affects the trust, including about finances, and how risk is managed or understood in an integrated way across providers. NEDs have expressed concern about how challenging it is to triangulate information about ICB or partnership activities in some scenarios. It is worth exploring this with NEDs.

Provider NEDs are increasingly representing their organisations in system meetings, such as chairing or joining committees of the ICB. NEDs may also be involved in providing a degree of independent scrutiny on fora that steer provider collaborative or other partnership working arrangements. Participating in system meetings is likely to bring both challenges and benefits for NEDs, their boards and their organisations. NEDs' time is valuable, often limited and under increasing pressure.

Expanding system demands on their time may risk them not having enough time to properly focus on their role within your organisation. There are significant potential risks to organisations (and systems) if NEDs are too stretched to provide effective oversight, challenge and support. On the other hand, the ICB constitution does not enshrine as much NED challenge in its decision-making as would be optimal for good governance, and so NEDs' independent involvement in system structures might be welcomed as an aid to robust decision-making. NEDs with an understanding of system working and the potential of partnerships for improving patient care will surely bring insights back to their boards

and be more able to join the dots for their board colleagues, as well as having a more rounded perspective themselves.

It's worth noting, that while it is legal for NHS trusts to delegate to NEDs, FTs cannot do so – any FTs sending their chair to represent them and make decisions in system fora, while unlikely to see any legal challenge as a result, are acting unlawfully.

Councils of governors

Councils of governors hold the board of their FT to account for its performance, via the board's NEDs. Provider board performance will now be measured in part by the organisation's contribution to achieving the objectives of the ICS it is part of, and so councils have a legitimate interest in the board's role in their system or systems.

However, the statutory role and responsibilities of governors remain solely in relation to their own provider board and so councils have no powers in relation to other parts of the system – such as the leaders of the ICB or of other provider organisations. It is worth discussing and reinforcing this with your council so everyone is clear. Governors have expressed concerns about how to fulfil their responsibilities to represent the interests of their constituencies given the requirement for FTs to look beyond their own boundaries. It remains the case that governors can represent the interests of members and the public in their interactions with the FT without being actively involved in all parts of the ICS.

NHSE has issued an addendum to Your statutory duties guide for governors , *System working and collaboration: the role of foundation trust councils of governors*. The addendum supplements the existing guidance and explains how the legal duties of councils support system working and collaboration. It helpfully sets out the context of the Act, makes it clear that the FT is free to appoint a governor from an ICB (but is not required to do so), and outlines how governors should undertake their statutory duties in the new context. It includes illustrative scenarios to aid understanding.

Governors will of course require information about how and to what end the board is engaging with its system partners. The majority of FTs told us (in our governance survey 2023) that they provide their governors with information about system working through the usual council information channels. However in some ICSs, FTs have brought their governors together to share information about system working, while some ICBs have involved governors as a ready-made constituency of knowledgeable volunteers to consult with about developing patient and public engagement

strategies. In any interaction with the ICB or other system partners, governors are effectively members of the public, and have no powers as individuals (all powers apply to them as a council and in relation to their own FT).

It is also worth noting that trusts' new duty to have regard to effect of decisions across the ICS may mean that sometimes the board takes decisions in the best interests of patients across the system, rather for the direct benefit of governors' constituents. Having a conversation about this to explain it to the council before the issue arises will likely stand you in good stead. This may be particularly pertinent in cases where the council may be asked to approve a significant transaction, so reinforcing governors' understanding of the new duties on boards to think outside their own trust borders is recommended. The addendum also helpfully articulates that the council's role in approving transactions is to assure itself that due diligence has been exercised by the board in reaching its decision. It is not about re-scrutinising the decision itself.

Governors may wish for the FT's support to undertake public engagement and membership recruitment across a wider geography, to reflect the trust's expanding sphere of interest in the context of system working. However there is no need to introduce new or different engagement mechanisms. It was always the case that governors should keep their ears to the ground, and might wish to, for example, attend local patient participation groups or other public meetings to understand the local context. However in our view governors are fundamentally able to represent the interests of their constituencies by virtue of being drawn from those constituencies, be that a staff or patient group representative, or from the public in a particular geographical location.