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Joint appointments and shared decision-making arrangements: considerations for councils of governors

This briefing aims to support councils of governors with:

- Information about joint appointments and shared decision-making arrangements, which we are seeing increasing numbers of in the NHS.
- Considerations for councils in relation to fulfilling their statutory role.

There is no one size fits all when it comes to ways of working between councils and boards, nor in terms of trust partnership arrangements. Governors should always discuss any knowledge gaps, issues or concerns with their trust contact, chair and/or governance lead in the first instance. This briefing should not supersede any advice given to governors by their trust.

This briefing is 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).

Summary: considerations for councils of governors

- Foundation trusts (FTs) will wish to engage their council of governors about, and secure their understanding of and support for, introducing significant new partnership arrangements. Governors are not required to approve partnership arrangements that fall short of significant transactions (as defined in your constitution).
- Before any joint non-executive appointment process between an FT and a non-FT takes place, roles and responsibilities should be clarified between the trust and NHS England (NHSE) to ensure the council is appropriately involved. The trusts should plan ahead in case either body seeks early termination of an appointment or does not wish to reappoint.
- All partners in a shared decision-making arrangement involving one or more FTs should be clear how the council will be supported to continue to undertake its statutory role of holding the board to account for its performance via the non-executive directors (NEDs) , under the new arrangements.

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**[1]: there is no legal definition and groups can take various 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.

The provider landscape

Provider collaboration has accelerated since the enactment of the Health and Social Care Act 2022 and trust leaders believe that by working together, NHS organisations can provide better care to patients and be more efficient. Trust leaders also tell us that collaboration between trusts is essential to making real change and delivering on the ambitions of system working in relation to improving population health, reducing inequalities in access and outcomes, and preventing ill health. 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.

[1] 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.

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 chief executive, 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[2].

Other collaborative options are available, and involvement in one or more is 'expected[3]' 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 board) raise their own risks, including where the buck stops when jointly-taken decisions affect trusts. There are also potential challenges for NEDs in terms of seeking and receiving adequate assurance, and ensuring that each trust is fulfilling their statutory obligations.

Considerations for governors

Joint appointments

The council is responsible for making NED and chair appointments and so must be involved in any joint non-executive appointments being made between two or more trusts. In relation to all joint NED appointments, the council's statutory duties and powers remain the same as in NED appointments to your own FT – but you may need to use those powers in partnership with NHSE and/or another council depending on which types of trust you are appointing jointly with.

[2] 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.

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

How this would happen in practice is a matter to discuss with your FT and for them to discuss with the other appointing trust(s).

If an NHS trust is involved, NHSE is responsible for the NED appointment and so ways of working and decision-making between the council and NHSE will need to be facilitated by your FT, and discussed and agreed.

Where two or more FTs are involved, the trusts and councils will need to agree the process for making the appointments to ensure the councils are able to exercise their respective powers.

Considerations for boards seeking to make joint appointments are set out in our good governance guide chapter, and governors involved in joint appointments may also find it useful to read the section on joint appointments.

Shared decision-making models

Foundation trusts should give appropriate and early consideration to the needs and expectations of the council of governors where there is a proposal 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 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 also 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.

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