Greater than the sum of its parts?

Sharing board leadership between NHS trusts

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About the author

Paul Roberts spent 36 years in the NHS including 28 as a chief executive. He was formerly chief executive of both University Hospitals Plymouth NHS Trust and, having led the merger, Gloucestershire Health and Care NHS Foundation Trust. He retired in 2023 but is still passionate about the NHS, with particular interests in integration, strategic partnership, governance and the relationship between culture and organisational effectiveness. Following retirement, he was interim chief executive for Royal Devon University Healthcare NHS Foundation Trust.

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Key points

- The last decade has witnessed the biggest shift in the architecture of the NHS provider sector since the creation of NHS trusts. This has included a shift towards much larger trusts and a dramatic rise in the number of trusts sharing board-level leadership. This arrangement is now in place in a third of English NHS trusts.

- This significant change in organisational form has developed organically and been subject to little scrutiny, evaluation and research. Now, ten years on from Sir David Dalton's pioneering review of organisational forms, this report unpacks what works and what doesn't when it comes to shared leadership models.

- Drawing on the insights of those who know the subject best – NHS leaders who have established and led provider group models at system or regional level – it puts forward a set of recommendations for those considering similar arrangements.

- Shared leadership models offer a beneficial and pragmatic option for NHS trusts and local systems when they are delivered for the right, clearly defined and locally determined reasons and when implemented flexibly and sensitively.

- While these changes are disruptive, shared provider leadership arrangements offer an alternative approach to a merger in which a pathway towards integration and closer working arrangements can be managed and determined at a controlled pace as benefits are delivered.

- Several trust group models are already showing the benefits of working together, including more aligned clinical strategies, shared learning, joint investment in critical infrastructure and clearer routes towards clinical and economic sustainability.

- Despite the varied nature of shared provider leadership models, the NHS, national regulators and independent policy organisations would benefit from recognising, supporting and evaluating them, given the importance of these models in the evolving NHS provider landscape. National regulators, including the Care Quality Commission, should consider adapting the arrangements for inspecting and reporting on groups of separate trusts under one board, or shared senior directors, to reflect this new type of governance arrangement more consistently across England.

- The critical role that trust chairs play in the development of shared provider group models, particularly in their formative period, should be formally acknowledged, with NHS organisations encouraged to resource the role and its support arrangements.

- NHS England could benefit from developing standard governance models which are compliant with a revised NHS Code of Governance to reduce the cost and complexity of developing local arrangements. This would strengthen and simplify governance and ensure common approaches between participating trusts as quickly as possible.

Background

Context

The last few years have seen a significant change in the architecture of the NHS provider sector. As well as the increasing size of NHS trusts, there has been a shift towards trusts sharing board leadership and working as formally constituted 'groups.'

More than a third of English NHS trusts are now part of a shared board leadership partnership, but this significant change in organisational form has largely taken place under the radar.

This matters. The 208 English NHS trusts consume over £80 billion of the NHS revenue budget and employ nearly 1.3 million people, providing and supporting over 300 million patient healthcare contacts. Given their scale in the UK economy, the significance they have for patients in providing specialist healthcare and the value placed on them by local communities, NHS trusts are important organisations. Whether they are organised in a way that delivers the best results for the people they serve is therefore an important, if not widely understood, issue.

It remains to be seen whether the new Labour government will have a view. Lord Darzi's investigation of the NHS has little directly to say on NHS provider form, while advocating strongly for improved leadership, culture and productivity in the sector.

Despite the absence of a clear current national policy direction supporting shared leadership arrangements, many regions, systems and organisations in England regard them as beneficial in addressing the significant challenges faced by the NHS provider sector. The reasons for this are explored in detail in this report.

While strategic alliances and mergers between NHS trusts are almost as old as trusts themselves, over the last ten years there has been added impetus towards acute hospitals grouping together either in non-statutory partnerships or through merger. To illustrate this, between 2011 and 2022 the average trust revenue budget more than doubled.

Outside the acute sector, community and mental health trusts have frequently merged with each other and larger specialist mental health trusts have also been established. The compulsory competition requirements however, abolished in 2022, make the distribution of community and mental health trusts a more complicated picture.

In December 2014 Sir David Dalton, an experienced NHS chief executive, who led the coming together of acute NHS trusts in Greater Manchester, wrote a report on new organisational options for providers of NHS care, including the development of 'hospital chains' and other organisational models. While the main focus was on the levelling up of performance, at the time it was also explicitly about potential routes for trusts unable to attain foundation trust status and those struggling with sustainability issues. In 2015 NHS England introduced the vanguard programme for hospital chains focused mainly on addressing the viability of small NHS trusts/hospitals. However, in 2016, the NHS foundation trust gateway was closed.

Several 'groups' were established across England between 2014 and 2022, at which point the government published the integrating care white paper signalling a change, although not necessarily a U-turn, in policy direction.

At this stage most attention was focused on the further development of integrated care systems (ICSs), the establishment of integrated care boards (ICBs) and of integrated care partnerships (ICPs). There was some focus on the continuing need for NHS provider organisations to work together and therefore, prior to the white paper, in August 2021, NHS England published Working Together at Scale: Guidance on Provider Collaboratives.

While this guidance sets out a clear expectation that NHS trusts become part of at least one provider collaborative, it covered a wide range of collaborative forms with shared leadership models as just one example. The guidance was therefore largely descriptive rather than prescriptive.

Despite the reports and later guidance, since 2014 and also since 2022, there has not been a concerted national drive for the development of hospital chains or groups. Indeed, one of Dalton's conclusions was that there were many potential options based on local circumstances, as 'one size does not fit all'.

Nevertheless, often for very local reasons, or because of the drive of individual leaders (regional directors, and trust chairs and chief executives), a wide range of shared leadership arrangements have been, and continue to be, developed and delivered.

About this report

This report distils and shares the expertise and experience of those who have led the establishment of NHS provider group models; those who have supported their establishment at system or regional level; as well as those who are sceptical about their value. The aim is to support colleagues who are engaged in, or considering, similar approaches.

While there is a dearth of academic literature on shared leadership in healthcare (or in the NHS specifically), plenty has been written about mergers both in the business sector and the healthcare sector. Nonetheless, this does not cover the more informal, non-statutory partnerships that constitute shared leadership.

This report provides access to insight, learned over the last few years, about what works and what doesn't when it comes to shared leadership models. It has been informed by those that know the subject best: some of the most successful NHS leaders in England.

Participants in this project often have different views about the subject and the report describes these perspectives, because they are useful to colleagues contemplating similar arrangements. These issues are always matters of judgement, experience and local context.

What is a shared NHS provider leadership model?

The term 'shared NHS provider leadership model' is ambiguous. For some it relates to groups while for others it denotes hospital chains or federations. Some regard the model as strategic partnerships without a specific label or an evolved version of narrower local provider collaboratives. One participant in our research remarked that without defining terms it will be difficult to arrive at clarity about the national policy direction.

This project has used a simple definition of shared NHS provider leadership: **partnerships between NHS provider organisations where board director roles – executive or non-executive – are shared by more than one NHS trust. This is usually, at least, a chair and/or a chief executive**.

In exploring ten exemplars as part of this project, and with an informal knowledge of a wider range of other partnerships, three dimensions mark out these partnerships:

1. **Depth of the relationship**

At the shallower end of the spectrum, in one partnership, two trusts were sharing a chair on a temporary basis due to the experience of the chair and a requirement to stabilise the governance arrangements in one of the trusts. In another, the temporary sharing of a chief executive was to fill a vacancy while one of the trusts recruited a substantive chief executive.

At the deeper end of the spectrum, in several cases, two or more trusts had shared a range of executive and non-executive director posts as well as corporate functions and clinical services, as part of a long-term close partnership. These have also generally established some sort of committees in common arrangement, or similar formal joint governance arrangement.

Some trusts have shared joint governance arrangements somewhere between these two ends of the spectrum.

2. **Trajectory of the relationship**

One group of similar trusts in an overlapping geographical area shares only a chair and is exploring the advantages and disadvantages of further partnership options without having a plan to share more roles or establish joint governance.

A number of trusts have a plan to merge either all the trusts in the partnership (between two and four), or some of the trusts. In two cases these plans were public and widely understood, and in four cases these plans are a tacit acknowledgement of the likely destination, but not formally announced. Tacit acknowledgement of a likely future merger was quite common because political sensitivity led participants to be cautious about going public about their potential plans.

The term 'group' was used by participants in two different ways: both to refer to several separate statutory organisations working closely together under common strategic leadership, as well as to a group of hospitals that is now part of one organisation as the product of a merger. The term therefore lacks clarity.

3. **Strategic purpose**

Shared leadership partnerships are set up for a range of different reasons, including talent management, horizontal and vertical integration, and to simplify governance and accountability arrangements. This is explored in detail in the next chapter.

All NHS shared leadership partnerships occupy different places along the three dimensions, making this a heterogeneous phenomenon. Yet despite the distinctiveness of each example, there are a range of common features, risks and opportunities that warrant exploration given the rapid growth in these arrangements. We explore these in the next chapter, as we turn to the **purpose, governance** and **leadership** of shared NHS provider leadership models.

Recommendation: Despite the heterogenous nature of shared NHS provider leadership models, the NHS, and regulators nationally and independent policy organisations should recognise them, support them and evaluate them as a discrete phenomenon given the importance of these models in the evolving NHS provider landscape.

Purpose

What are shared NHS provider leadership models for?

Many trusts are sharing board-level leadership for a reason, or often for several reasons. It is no accident that over a third of trusts have some form of shared leadership model in place.

However, some trust chairs and chief executives reported a tendency for systems or regulators to regard joint chairs and\or chief executives, and the close board partnerships which result, as an instant solution to a range of strategic and performance issues.

One chief executive participant talked of system leaders acting as though they had 'outsourced their performance challenges' by advocating for shared leadership and a potential merger rather than tackling the root cause of the problems they faced. On the other hand, one ICB leader described a common tendency for trust leaders and executives to act defensively and to resist such preferred changes for narrow organisational reasons. Reasons which were often contested.

The new Secretary of State for Health and Social Care has made it clear that the NHS needs to reform. Despite the enthusiasm for such models by most participants, there is a risk of pursuing the politician's logic: "Something must be done, this is something, therefore we must do it.'

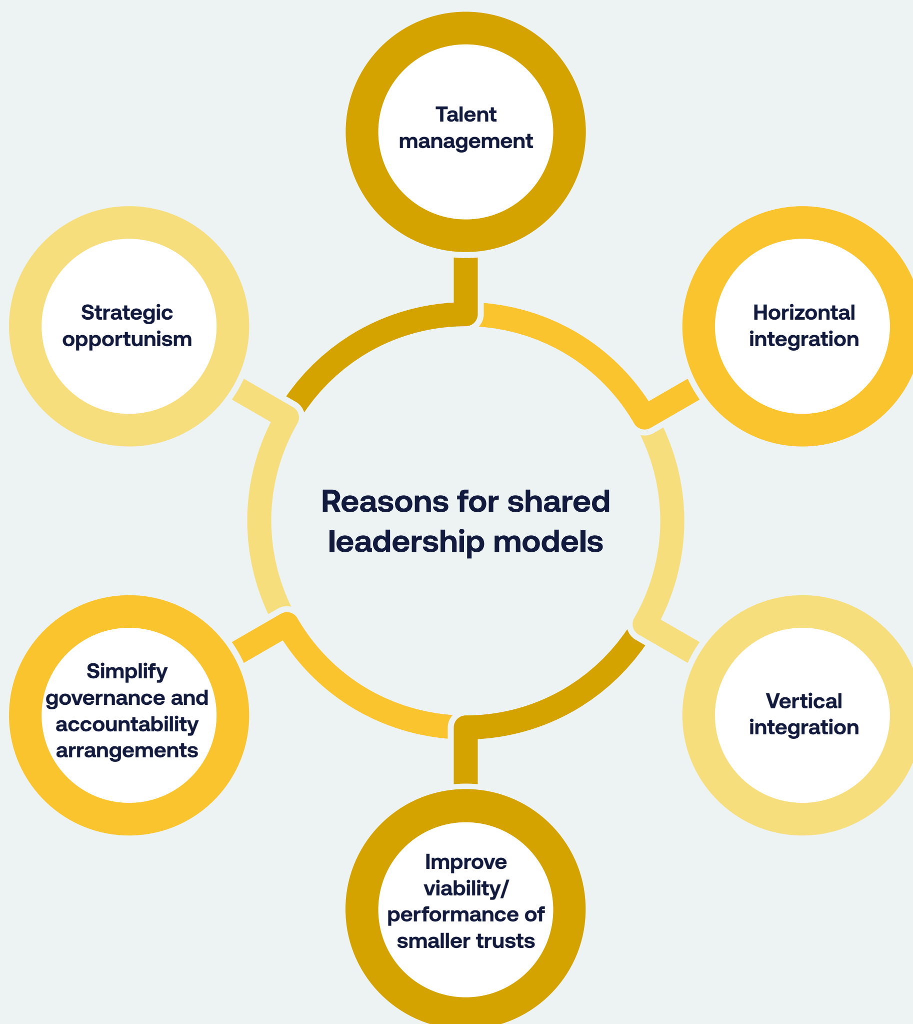
All participants felt that it was important to be clear about the purpose or purposes of the partnership to support such radical and potentially disruptive change:

- **Clear to themselves:** has the board thoroughly explored the alternative options, the risks and opportunities of the model sufficiently?

- **Clear to system partners:** how does the sharing of board leadership help to address specific problems?
- **Clear to colleagues:** why might such a relationship with a neighbouring trust where there has often been historical distrust help to improve the experience of patients and staff?
- **Clear to communities:** how can the public be reassured about the advantages rather than threats to local services of such a relationship?

While reasons given by participants for establishing these partnerships were unique to each local circumstance, it is possible to identify some generic purposes. These are not mutually exclusive and in most of the exemplars, more than one was stated.

Figure 1: Reasons for establishing shared leadership models



- **Talent management** - making best use of talented, experienced people (chair/ chief executive).

  One of the principal drivers for the establishment of hospital chains presented in Sir David Dalton's report in 2014 was the lack of availability of people to run some of the largest and most complex organisations, but he championed the case for fully using those who were capable of such roles. This seems to accord with the views of the majority, although not all participants in this project. It is true that in many cases the development of a partnership has been heavily predicated on the leadership of a high-profile individual, chair or chief executive. (See section on leadership, below.)

- **'Horizontal' integration** – trusts with a similar or overlapping portfolios working under combined leadership to implement a **shared clinical strategy, share learning** and/or **gain the advantages of scale.** (Typically acute/acute, mental health/mental health, and/or community/community).

  Acute trusts coming together through merger has been a common occurrence since the 1990s. It was the development of the thinking around hospital chains by Dalton and others which articulated the case for alternative arrangements short of formal merger. Horizontal integration has been less common in mental health and rare in community trusts, although there are several good examples. This is partly because the 2012 NHS legislation set up a requirement for competition in community-based services leading to a complex landscape of competing organisations.

  More recently the development of common electronic patient record (EPR) systems has been a catalyst for shared governance. Most of these arrangements require clinicians to work together to develop shared, detailed clinical pathways. Lack of common EPRs is therefore sometimes a barrier to the success of these arrangements.

- **'Vertical'** integration – trusts that manage different parts of the **clinical pathway** coming together to combine leadership for secondary (and sometimes primary) care **leadership for a defined area or 'place/s'**. (Acute/community and sometimes mental health, and/or primary care).

A significant number of acute trusts have taken on the management of community services in recent years and some of these trusts are working together in groups, combining some of the benefits of both vertical and horizontal integration.

Some, but a smaller number of acute and community trusts, have taken on the contract for primary care services. This has tended to take place where primary care has been in workforce and/or financial crisis. There are strong advocates for this model particularly in areas of deprivation and poor health outcomes.

There seem to be fewer examples of shared leadership between acute and community/mental health trusts, but this report explores one of them.

- A larger and/or better performing trust **improving the viability and/or performance of a smaller, less resilient trust**.

  The Dalton review proposed enabling 'the best care found in successful NHS trusts to be extended to those hospitals who experience difficulty in meeting standards for patients' via the establishment of chains, or other shared leadership models. As one option he envisaged certain organisations being 'pre-approved', to avoid the long drawn-out NHS transaction process to take over or partner with another less successful organisation, a process sometimes known as 'credentialing'.

  In recent years, as well as successes there have been some high-profile problems within a few of the large trusts that were created by better performing trusts taking over the management of less well-performing trusts. This has led to scepticism by some, but not all, participants involved in this report. There was a reluctance to acknowledge this publicly as a reason for a partnership or merger. 'A partnership of equals' was the term often used, partly because of the negative impact any alternative narrative might have on colleagues in the struggling organisation.

  A partnership potentially, but not always, leading to merger was more commonly described as being to bolster the financial and clinical sustainability of one or more of the trusts. The clinical sustainability of

smaller acute hospitals/trusts has been a topic of debate for many years, accelerated by sub-specialisation and specialist workforce shortages. Financial viability is often linked to size, critical mass and the relative cost of capital (particularly in private finance initiative – PFI – hospitals) and support services, but the financial benefits of joint leadership are subject to considerable debate.

Some participants pointed to such benefits in their own organisations while others gave examples of problems elsewhere. It would need a thorough evaluation to reach an evidenced conclusion other than that these arrangements can work, but do not always do so. This report covers some of the conditions that should make success more likely.

- **Simplifying the governance and accountability arrangements within a system.**

  A chair of two trusts said: “There were too many organisations with divergent strategies for the system to make cohesive decisions”. This sentiment was common from both trust and ICB leaders. This seems to be of particular relevance when there were contested decisions about the configuration of clinical services to be made.

  Arguably, one chair, chief executive and/or board leading more than one organisation can make difficult decisions, often on services which have been contested for many years. This contrasts with the situation when the board of an entirely independent trust perceives itself to be losing out to the neighbour and will not support the decision regarded as the best for the system as a whole.

- **Strategic opportunism**

  While this cannot truly be described as strategic purpose, it was interesting how many joint leadership arrangements were agreed following the retirement or exit of a chair or chief executive. Clearly it is much more palatable to join posts together when there is a vacancy, but equally to delay the assumed advantages of such a partnership because of individual postholders raises interesting questions.

There was strong consensus that clarity of purpose is essential for decision-makers and that in some cases external pressure led to a lack of an agreed set of strategic aims. Most participants advocated the upfront articulation of these strategic aims with local staff and communities, although for some a pragmatic caution in describing the end point was necessary.

Recommendation: When deciding to develop a shared leadership partnership, trusts and systems should be clear about their reasons for doing so, given the impact and opportunity cost of delivering.

Scepticism

It should be emphasised that most of the participants in this project are strong advocates of either group models (without merger) or shared leadership arrangements (leading to one or more merger). They feel that in their contexts these arrangements would be beneficial and, in many cases, they felt that these benefits were generalisable to other local circumstances.

However, there were sceptics, including some of those actually embarking on shared leadership arrangements, particularly if they felt they had been strongly encouraged into these arrangements. One participant described feeling 'coerced' in their local context.

- Some participants felt strongly that the push for groups, shared leadership and mergers was frequently the wrong strategy.
- In some cases, this perspective was based only on their local context, but in others this was a more general view.
- They felt that group models or mergers had become 'a fashionable solution in search of a problem.'
- The main reasons given were as follows:
  — Small trusts, particularly specialist and community trusts, often perform well financially, clinically and culturally, so why destabilise the best-performing organisations?

- Much of the literature from both within and outside the NHS suggests that the evidence for improved performance from mergers and takeovers is weak. While there is very little literature on shared leadership, some of the evidence on mergers might also apply to shared leadership models.
- Many of the benefits of groups/mergers, where they exist, are medium to long term when the problems they are seeking to solve are urgent or immediate. Expectations were therefore often unrealistic.
- In many cases the problems that forming a shared leadership arrangement seeks to address might be solved through a less disruptive intervention, perhaps a different form of provider collaborative.
- Several well-known examples were quoted by participants of high-performing trusts merging or taking over poorly performing trusts that have led to a deterioration in performance of the new trust as a whole.
- The reduced number of small- and medium-sized trusts limits the opportunity for the NHS to develop and nurture the future leaders of larger more complex organisation. (See leadership section).
- Some group models were seen as being dependent upon a ‘heroic’ leadership model, built around the experience, influence and reputation of a particular individual. This made it too dependent on an individual and could lead to future failure. (See leadership section).

Recommendation: It is advisable to take a sceptical perspective, as described in this report, which can provide a useful lens to examine a proposal to form a shared leadership partnership, ensuring all options and alternatives are covered and risks are mitigated.

Different experiences of shared leadership

Most of the interviews were deliberately focused on the chair/chief executive’s experiences of their local context and their version of shared leadership. This is because while there are always generalisable insights, there is also a unique complexity of every situation.

One participant felt that a common operating model of vertically integrated acute and community services for trusts in his group was a key factor in the success of the enterprise. However, they did recognise that such vertical integration was not politically or practically achievable everywhere.

Another participant felt that the specific context of a number of influential leaders (chief executives and chairs) leaving roles and creating vacancies was significant in the ability to achieve a political consensus about reconfiguring organisations (see strategic opportunism). It also influenced which organisation would take the lead in the process, which was not the best performing of the trusts.

A contingent local issue that came up in three of the exemplars was the benefit of fitting in with the organisational arrangements of local authorities. The configuration of local authorities is variable and has a particularly important impact for mental health and community trusts. Some participants felt that this was not always understood at national or even regional level.

According to some participants, the Dalton review was rightly ambiguous about whether a particular organisational form was the right one. A tentative conclusion would be that there is a clear need for system leaders and regulators to test the reasons for these arrangements, and to apply an optimism bias when examining the stated benefits.

Systems and regulators have a valid and key role in ensuring that any arrangements benefit the population and can be supported from a regulatory perspective.

Recommendation: Provider trusts would benefit from a national framework that helps organisations and systems formally to consider the merits of shared partnership arrangements.

Clarity on national policy

Since the Dalton report in 2014 and the resulting vanguard programme in 2015, it is unclear whether there is a national view on the development of group models and on whether groups of statutory organisations are preferred to large-scale mergers. NHS England has supported both approaches in particular local contexts, but participants often described conflicting perspectives from NHS England colleagues at regional and national level. As has already been said in this report, national guidance on NHS provider collaboratives is largely descriptive rather than prescriptive.

The recent Darzi report does not provide any real clues as to the likely view of government. However, all participants felt that a national approach, a regional approach derived from new government policy, or a national review, could be problematic as local context is significant in plotting a successful course. Some participants felt that the absence of national direction was helpful as it allowed local leaders to develop their own solution, with one participant saying ‘if you are afraid of the answer, don’t ask the question’.

A strong case was made by several participants for much greater clarity. Their arguments were broadly as follows:

- At a time of severe performance and viability challenge for the NHS, if groups have been shown to provide benefits, the NHS nationally should adopt them as a route to better performance and sustainability.
- If there is not a clear mandate to develop shared leadership/group models (and mergers) then local leaders and boards, acting for defensive or personal reasons, might resist such initiatives preventing the realisation of the benefits for patients and staff.
- Several participants were frustrated by a lack of consistency between regional NHS England leaders and the national team. In at least one case a shared leadership arrangement was stopped when a new senior NHS England appointment was made. It is argued that a clear policy framework for shared leadership should at least allow for more consistency.
- One of the barriers to the efficient development and operation of group models is the inadequate governance and regulatory models. An inevitable outcome of a clearer policy on shared leadership would be the national development of governance and regulatory arrangements more fitted for this revised purpose.

Recommendation: NHS England would benefit from developing a clear national policy when encouraging further shared NHS provider leadership models, emphasising that these plans are derived from, and justified by, the local context rather than being imposed upon local systems as a national prescription.

Governance

The last few years have shown NHS leaders and politicians the importance of good governance. Inquiries into organisational, service and individual failures have been frequent and the consequences for patients, staff and organisations of getting it wrong can be catastrophic. Joining boards together in group models has governance implications and chairs, chief executives, boards and system leaders cannot afford to get this wrong.

However, many participants described the high level of energy and effort required to develop joint governance arrangements for group models. They felt that early in the development of the partnership, when effort could be focused on engagement, culture and strategy, the development of strong governance was a potential diversion of capacity. This was the opposite of arguing that effective governance is unimportant, rather that, because it is important, there should be clearer ways and better support to achieve it.

The NHS Confederation and NHS Providers are currently carrying out work on governance issues relating to NHS provider collaboratives, including shared leadership models.

The Darzi review is particularly critical of regulation and the burden it places on NHS trusts as well as the significant cost to the taxpayer.

The role of chairs

There was a wealth of experience from the chairs who participated in the research, but one theme that emerged was the seeming lack of understanding of the role of non-executive chairs at national and government level.

In many of these situations, highly able people had been asked to chair several trusts and found themselves the only joint appointment. This had various impacts:

- Non-executive chairs do not have the executive levers to make things happen and, in some circumstances, they were operating with reluctant or even hostile trust chief executives/boards. Quickly resolving shared executive leadership in these circumstances was raised by several participants as being essential.
- The sheer governance burden, even in an individual trust, is significant. If this is repeated over multiple trusts the expectations can be overwhelming. Developing common approaches and deputising vice-chair roles is essential, but can take time to achieve given the differing governing regimes in all trusts.
- Sometimes this took place with conflicting advice from board secretaries and lawyers from the different participating trusts.
- Board chairs felt that their role can be misunderstood by colleagues from NHS England, external stakeholders and regulators. They are often expected to carry the capacity and knowledge of executives. In some cases, there is a risk that to manage this they must become more executive in their approach. This was, unsurprisingly, sometimes a concern for the chief executives involved as well.
- Several chairs thought support was provided ‘on the cheap.’ Two contrasted this with the greater support they have received in other sectors. They felt that a more widely recognised requirement for properly resourced private offices in large multiple organisational institutions was an urgent priority.
- Some chairs felt that a more readily available suite of shared governance models recommended by NHS England would have been helpful, saving time and cost. They felt it would recognise and reflect the importance of good governance.

Recommendation: The critical role that trust chairs play in the development of NHS provider group models, particularly in their formative period, should be properly acknowledged, and NHS organisations encouraged fully to resource the role and its support arrangements.

Complexity

Over the 30 years in which trusts have existed they have become much larger and more complex. Quite rightly chairs, chief executives and boards are expected to be able to demonstrate that they have good management and leadership systems to offer assurance to patients, staff and regulators that they are safe and effective. This challenge is made even greater by the growing trend for much larger trusts born out of the merger of smaller trusts, with shared leadership arrangements and the development of groups of statutory organisations led by single boards.

Participants made a range of pertinent points:

- The conditions likely to lead to effective unitary board governance are tried, tested and well-understood. Where NHS organisations or groups of NHS organisations use arrangements that conform less to well-established unitary board governance, there may be greater governance or regulatory risk.
- With shared leadership there are potentially greater risks surrounding the capacity of those leaders, their ability to oversee and control organisations effectively, and to adopt visible leadership styles.
- Group models, where more than one trust is effectively governed by a single decision-making forum (such as boards in common), raise their own risks, including knowing 'where the buck stops' when jointly taken decisions affect multiple trusts.
- There are also potential challenges for non-executive directors in terms of seeking and receiving adequate assurances given the scale and complexity of the organisations. Most governance regimes and board development programmes have been designed for single unitary boards.

Many of these issues have been effectively tackled in several well-established trust groups. However, most of the chairs and some of the chief executives who participated in this research said that they had to seek their own solutions, often involving an expensive instruction for lawyers and management consultants.

While some of this might be unavoidable, given that all local arrangements are different, and boards will want to assure themselves about the legality of their particular arrangements, the development of model governance guidance for groups would be a helpful starting point for such ventures.

Equally, while the chairs in this project were not afraid of picking up the phone to each other, the development of a more structured network for the chairs involved in these developments would be highly valued by participants.

Recommendations: It would be useful for NHS England to develop standard governance models which are compliant with a revised the NHS Code of Governance to reduce the cost and complexity of developing local arrangements.

A network for the chairs of NHS provider groups should be established to complement the existing network for chief executives. The NHS Confederation's Acute Network believes that this issue is solved best by local relationships, communication, trust and ways of working. To that end, we are exploring building peer learning sets of local partnerships who may come together, learn from one another, share approaches and improve in their area.

Regulation

A number of chairs and chief executives pointed out that the regulatory environment exercised by the Care Quality Commission (but also NHS England) was almost entirely geared towards individual trusts and/or hospitals rather than much larger, more complex organisations or groups of organisations. They felt that the regulators need to reflect on these expectations and adapt their regimes accordingly.

Darzi is critical of the regulatory regime for trusts generally and points out that while in 2007 there were fewer than five 'regulatory' staff per trust, there are now 35. While not specific to trust groups this does illustrate the level of

regulatory challenge that providers are facing, and the complexity of groups can act as a multiplier.

Unsurprisingly, clarity is needed on how the CQC and NHS England satisfy themselves on the effectiveness of the assurance gained by boards of individual organisations and the relationship with the joint boards that many groups have. The role and expectations of group chairs and chief executives, group medical and nursing directors, trust-level accountable officers and devolved local directors needs to be recognised and understood in adaptable regulatory approaches to performance management and inspection.

The concept, advocated by Sir David Dalton in 2014 and Lord Stevens, former chief executive of NHS England, in 2015, of 'credentialling' seems to have lost currency. Indeed, the King's Fund published a sceptical review of the concept as far back as 2014. Some of the evidence of historically strong trusts getting into difficulties makes it a harder concept to promote. Nevertheless, some participants running large groups of organisations argued for a more nuanced approach to risk-based inspection and reporting, taking into account the relative current and historical performance of different parts of the group.

Some participants felt that it was important for the CQC to recruit inspectors who are familiar with large trusts and groups to ensure that inspections are relevant to the complexities involved.

Recommendation: Regulators, particularly the CQC, should consider adapting arrangements for inspecting and reporting on groups of separate trusts under one board, or shared senior directors, to reflect this new type of governance arrangement more consistently across England.

Leadership

Given the complexity of modern NHS organisations, the challenges they face and the complexities of governance discussed above, the importance of both organisations and groups of organisations being well-led remains supremely important.

Indeed, Lord Darzi's investigation of the NHS emphasises the importance of management and leadership in delivering high-quality, timely care to patients. He criticises the ideologically driven reductions in management and leadership costs of the last ten years. If the consensus is that management and leadership are important, the implications of the trend of joint leadership arrangements is also important.

The literature on healthcare leadership and management is vast and this report therefore confines itself to the points made by participants on challenges and implications for NHS leadership of the growth of NHS shared leadership models. As with other sections of this report, other than on the importance of leadership, there was little consensus on the pros and cons of group models for the development of excellent leadership.

'Heroic leadership'

When Sir David Dalton published his report on options for NHS providers in 2014, he championed the role of leaders of successful organisations who he said should be 'system architects' to devise innovative solutions to spread their success. Some highly experienced and able NHS trust leaders have taken up this challenge and there are truly excellent examples of leaders who have shaped provider partnerships that have been successful for patients and staff.

However, there was a concern expressed by some participants that some of the huge, complex roles that have developed, often created because of the talents and experience of a high-profile chief executive or chair, may be at significant risk with succession planning for the future of these roles.

Examples were quoted of organisations that had been highly successful, had grown and acquired another trust through merger or some other form of partnership, but had struggled significantly when the chair and/or chief executive had retired or moved on.

Some participants even asked whether some of these jobs were doable, not helped by the lack of models for good governance readily available. They argued that with the performance pressures faced by the NHS and the appetite for visible, approachable leadership displayed by many NHS colleagues, such large roles would inevitably struggle. It was pointed out that the smaller NHS trust often had the best staff survey results.

On the other hand, colleagues undertaking these roles expressed a view that well-designed governance together with empowered, high-quality local leadership was often more effective than smaller NHS organisations trying to survive on their own. Two of the trust leaders from very large groups pointed to material improvements in service and financial performance and in their staff surveys since establishing a group. This evidence was compelling if not universal; it suggests a need to enable and encourage the sharing of good practice.

At the very least, regulators, systems and trusts need to carefully weigh up the implications for leadership and succession planning when establishing such partnerships. The debate about the merits or otherwise of ‘heroic leadership’ are best conducted elsewhere.

Recommendation: Trusts and systems should consider the sustainability of leadership, and potential succession plans, for trusts as they form groups and/or merge into very large complex entities.

Developing the executive leaders and managers of the future

If there are more roles leading trust groups at chair, chief executive and board level, it is crucial that a cohort of healthcare leaders is developed to take on these roles successfully. There are good examples of leadership training and development in the NHS with the NHS Confederation's First-Time Chief Executives Programme being a particularly good example. Indeed, two alumni of the programme, currently running a group, participated in this project. But there is a clear need to develop leadership programmes with the aim of supporting ambitious clinicians, managers and non-executives who want to lead groups.

Some participants felt that the relatively new roles of hospital or site chief executives/managing directors are ideal development roles for future trust chief executives. Others feel that the reduced number of opportunities to operate at board level reduced the experience available to managers and leaders developing their executive careers. This issue was the subject of a comment piece in the HSJ in August 2024.

Recommendation: The NHS Leadership Academy and NHS Confederation already provide well-regarded executive programmes and support for senior managers and leaders, including in system leadership. There would be value in providing a specific leader offer, supporting peer communities for leaders wanting to work in this way.

Conclusion and recommendations

Shared leadership models offer a beneficial and pragmatic option for NHS trusts and local systems when they are delivered for clearly defined and locally determined reasons and when implemented flexibly and sensitively.

The way the NHS is structured has never been of much interest either to the public or to most of the 1.5 million staff who work in it. Politicians have sometimes been tempted to take an interest in NHS structures, particularly when a reorganisation, less controversial than fundamental reform, gives the impression of taking decisive action.

But the organisational arrangements of NHS trusts, where most NHS staff work and which deliver nearly half of patient activity, are important. This is because size, complexity and portfolio are key in defining the blueprint for governance arrangements that are vital to the stewardship of clinical services and resources; in shaping the culture of an organisation and the style of its leadership; and in the approach to working together across traditional organisational boundaries.

It is, perhaps, surprising that the significant shift to much larger NHS trusts and the dramatic rise in the number of trusts sharing board-level leadership has been the subject of so little scrutiny, evaluation and research and has been shaped by so little recent conscious central direction. The last ten years has witnessed the biggest shift in the architecture of the NHS provider sector since the creation of NHS trusts in the early 1990s and this trend appears to be a continuing one. The work of Sir David Dalton in 2014 was pioneering and an important influence but was undertaken in an entirely different policy context and operational reality; the NHS of 2024 is different, serving an ageing population who deserve to live, work and die well.

The most experienced of senior NHS leaders bear the scars of numerous reorganisations and therefore scepticism of such unavoidable disruptive change is entirely rational. However, shared provider leadership arrangements, as defined in this report, offer an alternative approach in which a pathway towards integration and closer working arrangements can be managed and determined at a controlled pace as benefits are delivered.

Several trust group models are already showing the benefits of working together, including:

- more aligned clinical strategies
- shared learning
- joint investment in critical infrastructure
- clearer routes towards clinical and economic sustainability.

Some of these groups will go on to merge formally, others will not, but they have local control over the direction and pace of their trajectory.

As this report sets out, clarity of purpose is essential, as is ensuring that these initiatives are rooted in local needs rather than driven by the more remote 'one size fits all' prescription that has tended to characterise NHS reorganisation. These changes are disruptive, not only to the board members directly affected, but to wider staff members and potentially to the confidence in the NHS of local communities. But where they offer clear benefits, NHS provider shared leadership represents a credible and necessary option.

Since shared provider leadership models are here to stay and likely to increase, it is important that the regulators and NHS England do what they can to provide practical support and provide a more supportive environment. It would also be useful for key healthcare policy organisations to help the NHS to rigorously evaluate the benefits, or otherwise, of these models. To that end we make a series of recommendations, aimed at national bodies and local leaders:

- Despite the varied nature of shared provider leadership models, the NHS, national regulators and independent policy organisations would benefit from recognising, supporting and evaluating them, given the importance of these models in the evolving NHS provider landscape. National regulators, including the CQC, should consider adapting arrangements for inspecting

and reporting on groups of separate trusts under one board, or shared senior directors, to reflect this new type of governance arrangement more consistently across England.

- When deciding to develop a shared leadership partnership, it should be understood and owned by the system and board and be the subject of engagement with the workforce and other stakeholders. It is essential for trusts and systems to be clear about their purpose and reasons for developing the partnership, given the impact and opportunity cost of delivering such models:
  - Be clear to themselves: has the board thoroughly explored the alternative options, the risks and opportunities of the model sufficiently?
  - Be clear to system partners: how does the sharing of board leadership help to address specific problems?
  - Be clear to colleagues: why might such a relationship with a neighbouring trust where there has often been historical distrust, help to improve the experience of patients and staff?
  - Be clear to communities: how can the public be reassured about the advantages rather than threats to local services of such a relationship?
  - The transition to a shared leadership model requires considerable energy, commitment and drive. While it will often be the right option, all alternative options should be explored alongside this.

- A national framework which helps organisations and systems to formally consider the merits of shared partnership arrangements would be a useful and welcome supportive addition. Where the momentum for the partnership is initiated by NHS England or the local ICB rather than the trusts involved, it is critical to agree clear and realistic expectations and have clarity on organisational and individual roles clearly laid out in a proposal, as well as including a balanced view of the risks to a group model and be clear on how these would be mitigated.

- The critical role that trust chairs play in the development of shared provider group models, particularly in their formative period, should be formally acknowledged, with NHS organisations encouraged to resource the role and its support arrangements.

- NHS England could benefit from developing standard governance models which are compliant with a revised NHS Code of Governance to reduce the cost and complexity of developing local arrangements. This would strengthen and simplify governance and ensure common approaches between the participating trusts as quickly as possible. Performance and engagement may seem like more important priorities, but good governance is the foundation of innovative organisations forms and requires more focus to achieve.

- Trust leaders should ensure there are formal support arrangements for their own roles as early as possible. The establishment of a network for the chairs of NHS provider groups to complement the existing network for chief executives would serve a useful purpose for shared learning and the building of key relationships.

- There will be many colleagues directly affected by these arrangements. It is vital that NHS England and boards treat both executives and non-executives with fairness and openness in what can be very stressful situations. Trusts and systems should also consider the sustainability of leadership and potential succession plans for trusts as they form groups and/or merge into very large complex entities.

- The NHS Leadership Academy and NHS Confederation already provide well-regarded executive programmes and support for senior managers and leaders including system leadership. There would be value in providing a specific leader offer, supporting peer communities for leaders wanting to work in this way.

The NHS has many talented leaders who are determined to derive benefits from exploring new ways of NHS organisations working better together. This can only be to the long-term gain of the NHS, the people who work in it and, most importantly, the people it serves.

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We would like to thank the trust chief executives, chairs and integrated care board leaders who so graciously gave their time to reflect on their experiences of shared leadership models. We are grateful for their time and expertise, and the richness of their contributions to this report.

Appendix: methodology

This report is based on the knowledge, information and experience gained from detailed interviews with 14 chairs and chief executives of NHS trusts and ICBs. The interviews covered ten trusts/groups within eight systems and across six NHS England regions.

These senior colleagues were interviewed under Chatham House Rules, so that the points they made are contained in the report but are not attributed. There are many political sensitivities and individuals affected when establishing these partnerships between NHS organisations and assurances of confidentiality meant that insights could be offered freely and safely. This is also why there are no exemplars written up in the report, but there are strong points made based on local experiences.

Prior to each interview board papers, media reports and other relevant documents were examined as background reading. While the details of the interviews varied according to the local context of the NHS organisation and system, they followed a broadly similar structure:

- The purpose and nature of the partnership/s.
- The history of the partnership/s.
- The benefits and disbenefits that had been delivered so far.
- What positive or negative lessons had been learned.
- What advice participants have for colleagues.

Despite undertaking literature searches with appropriate specialist libraries, there was no specific or relevant academic literature on the phenomenon of shared leadership models in healthcare providers as defined above. However, the relevant policy documents from NHS England and the Department of Health and Social Care were read. The Health Service Journal has been a useful source on local developments in the creation and abolition of such partnerships.

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