NHS Providers governance survey 2023

Background

This annual survey seeks to explore members' views in relation to boards, board assurance committees and how trusts are developing in relation to the system(s) which they are part of. The results of this survey will be used to inform our influencing work, and feed into our board development programmes.

This report contains all the main findings of the 2023 survey, and where applicable, compares the results to previous years. There is also a shorter summary briefing available which highlights notable issues and provides a more discursive overview of what this year's survey tells us.

The NHS Providers governance survey was completed by company secretaries, chairs, and others responsible for corporate governance in trusts and foundation trusts in September and October 2023.

If you would like further detail or to discuss any of these findings, please contact Izzy Allen, senior policy advisor (governance) at izzy.allen@nhsproviders.org.

Contents

Key findings

1. 86% of respondents agree (48%) or strongly agree (38%) that the **board has time to focus on key risks and issues**. 6% disagree.
2. 78% of respondents agree (55% agree and 23% agree strongly) that **executive directors provide constructive challenge to the board**. 6% disagree, 2% strongly disagree.
3. Almost all (99%) respondents agree (47%) or strongly agree (52%) that **the way the committees report to the board can provide it with assurance**.
4. 20% of organisations surveyed are part of two or more **integrated care systems** (ICSs), 30% are part of two or more **provider collaboratives** (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).
5. The majority of trusts (58%) now have at least one **associate non-executive director (NED)** in post.
6. The average **number of board assurance committees** (in addition to statutory audit and nominations/remuneration committees) is four, with three being the most common number (mode), one the lowest and eight the highest.
7. Around two in five (41%) respondents agree (34% agree, 7% strongly agree) that **trust NEDs are confident about their roles and responsibilities in the system(s)**, up from 24% last year (19% agree, 5% strongly agree).
8. Over one third (35%) of respondents agree (33% agree, 2% strongly agree) that the trust **board is confident that there are clear roles for trusts, integrated care boards (ICBs), integrated care partnerships (ICPs), place-based partnerships and collaboratives**. 16% of respondents disagree (13% disagree, 3% strongly disagree).
9. 12% of respondents agree that **risk is managed effectively across the system(s)** they are part of (1% strongly agree, 11% agree), down from 20% in 2022 (6% strongly agree, 14% agree).
10. Two in five (40%) respondents agree (32%) or strongly agree (8%) that the trust board is **confident that conflicts of interest are managed effectively across the system(s)**, while 17% disagree.

Sample and analysis

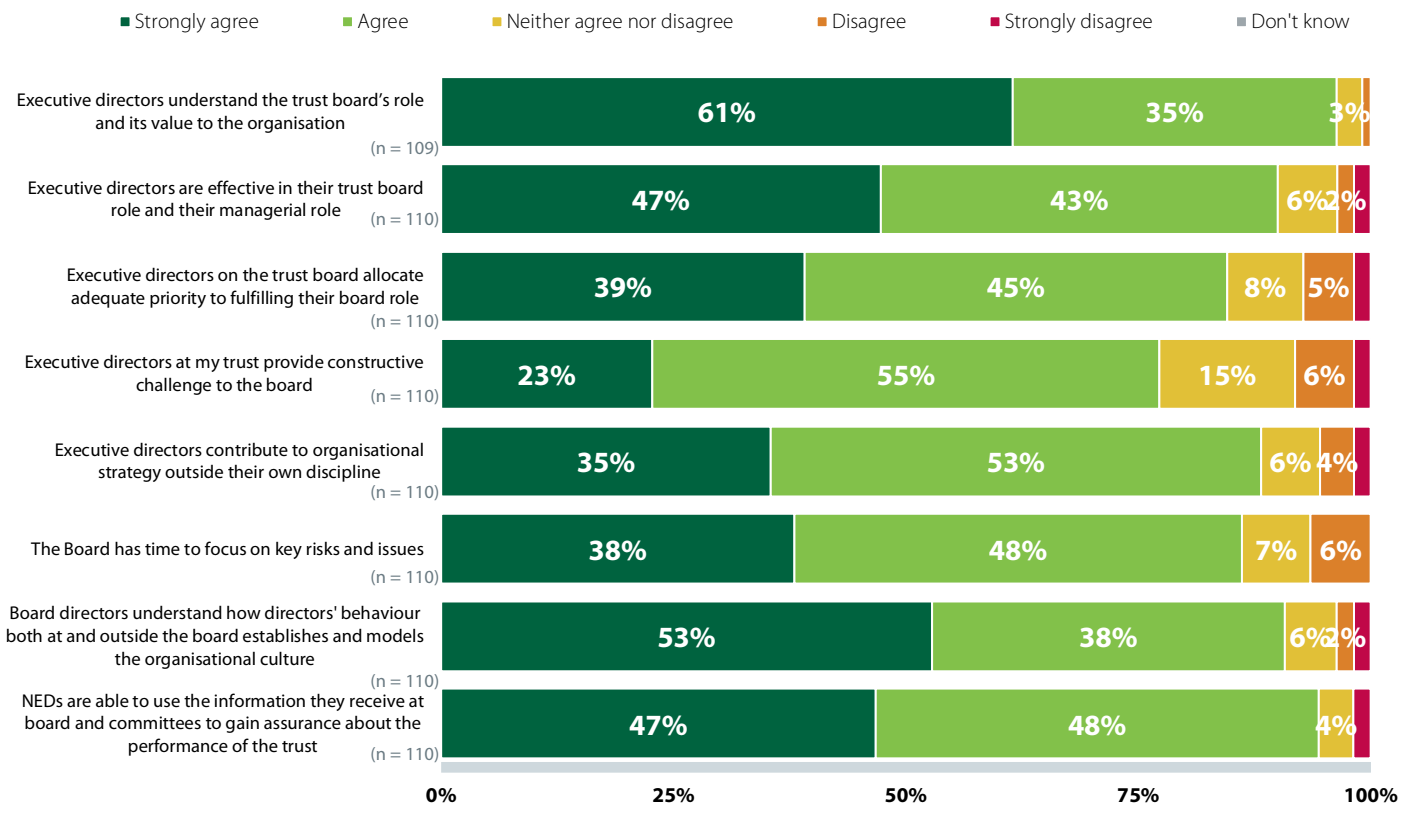
We received 110 responses to the survey from 94 unique trusts. This accounts for 45% of the sector (209 trusts in England).

- We use 'governance lead' here to distinguish company secretary/director of governance respondents from chairs. Throughout this report we highlight any notable differences between chairs' and governance leads' perspectives.
- All trust types and regions are represented in the survey.[A] This report highlights any notable response variations between trust types or regions.
- 72% of responses are from foundation trusts (FTs) and as in recent years there are no significant differences between FT and NHS trust responses.
- Respondents were also asked to indicate how many ICSs, provider collaboratives and place-based partnerships their organisation is part of.[B]

The board

FIGURE 1

To what extent do you agree with the following statements:



As in last year's survey, all statements in this section received high proportions of agreement, indicating a good degree of confidence among chairs and governance leads in relation to these indicators about the operation of boards.

There is always a danger that strong approval ratings gloss over important differences when reviewing quantitative outcomes, and so we should not ignore the proportion of neutral (neither agree nor disagree) or the minority of respondents selecting disagree/strongly disagree.

Most notable in terms of neutrality and disagreement are:

- Those neutral/disagreeing that executive directors (EDs) provide constructive challenge at the board. Like last year, this statement has the largest proportion of neutral responses in this section(15%) as well as those who disagree (6% disagree, 2% strongly disagree), although it is a slightly improved picture overall year on year with 78% agreeing or strongly agreeing versus 73% in 2022.
- EDs' prioritisation of their board role (though also a slight improvement in agreement from 82% agreeing/strongly in 2022 to 84% this year).
- EDs' contribution to strategy (87% in 2022 to 88% this year).
- Whether the board has time to focus on key risks and issues (this question is new for this year).

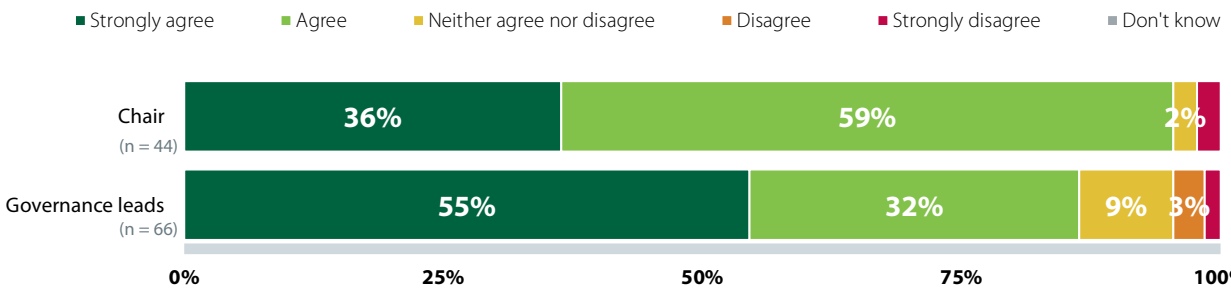
There were no 'strongly disagree' responses at all in 2022 but some, albeit small proportions, this year.

Notable findings about the board

1
Executive directors are effective in their board role as well as their managerial role

FIGURE 2

By job role:



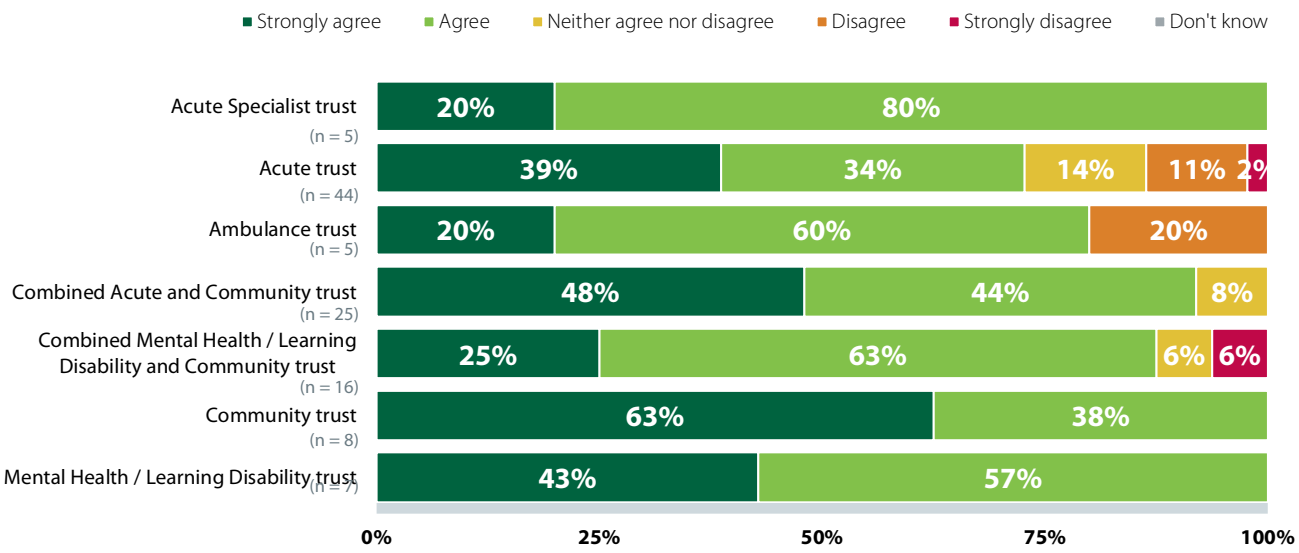
Chairs are more likely to agree (59%) or strongly agree (36%) that EDs are effective in their trust board role as well as their managerial role, compared to governance leads (32% agree, 55% strongly agree). One in 20 governance leads disagree with this statement (3% disagree, 2% strongly disagree) with nearly one in ten neither agreeing nor disagreeing.

Looking at responses by trust type, members from community trusts (n = 8) are the most likely to strongly agree with this statement (88%), as was found last year. Ambulance trust respondents (n = 5) are the most likely to disagree with this statement (20%). Members from community (88%) and acute specialist trusts (80%) responded the most favourably, with the largest proportion of respondents strongly agreeing – this was also the case in last year's survey. The only trust type with members who disagree with this statement is acute (2%).

2
Executive directors on the board allocate adequate priority to fulfilling their board role

FIGURE 3

By trust type:



Responses from chairs and governance leads are similar, but when considering trust type there is interesting variation. Members from acute specialist, community, and mental health/learning disability (MHLD) trusts responded the most favourably, with all (100%) respondents agreeing or strongly agreeing with this statement. Respondents from ambulance trusts are the most likely to disagree (while 20%, this is only one respondent).

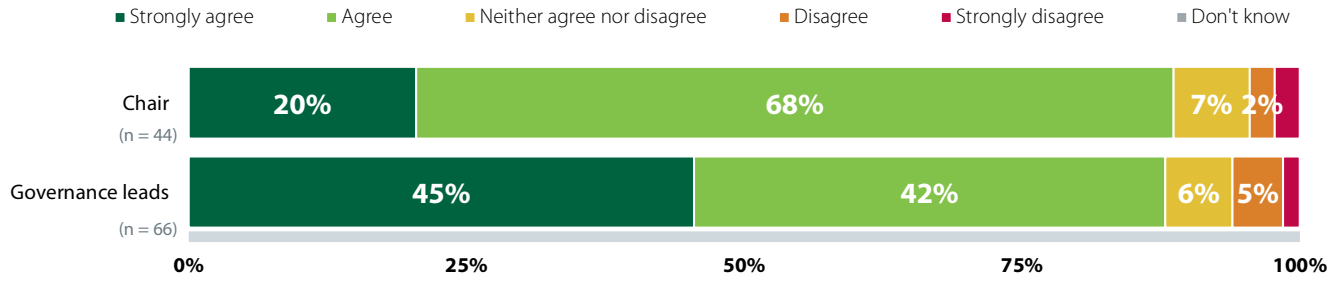
3
Executive directors at my trust provide constructive challenge to the board

Governance leads are more likely to disagree with this statement (9% disagree, 2% strongly disagree) compared to chairs (2% disagree, 2% strongly disagree).

All respondents (100%) from acute specialist (80% agree, 20% strongly agree) and community trusts (50% agree, 50% strongly agree) agree with this statement. Members from acute trusts are the most likely to disagree (14% disagree, 2% strongly disagree), followed by combined MHLD and community trust members (6% disagree, 6% strongly disagree). Responses from other trust types are similar.

4
Executive directors contribute to organisational strategy outside their own discipline

FIGURE 4



Governance leads are more likely to strongly agree (45%), compared to chairs (20%). All (100%) acute specialist (80% agree, 20% strongly agree) and community (25% agree, 75% strongly agree) trust members agree with this statement. Combined MHLD and community trust members are the most likely to disagree (6% disagree, 6% strongly disagree), followed by acute trust (5% disagree, 2% strongly disagree) and combined acute and community trust members (4% disagree).

5
The trust board has time to focus on key risks and issues

All (100%) respondents from acute specialist (40% agree, 60% strongly agree) and community trusts (38% agree, 63% strongly agree) agree with this statement. Members from ambulance trusts are the most likely to disagree (20%), followed by MHLD trusts (14%).

6

Board directors understand how directors' behaviour both at and outside the board establishes and models the organisational culture

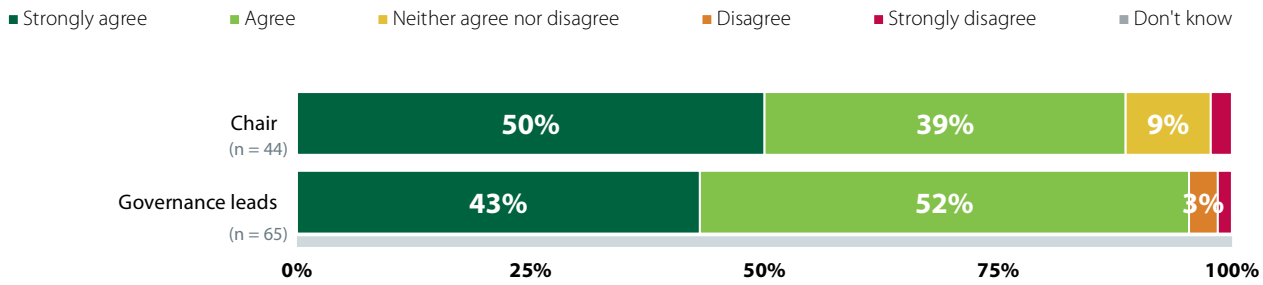
There is little variation by trust type, with most trust types having all (100%) respondents agreeing except combined MHLD and community trusts (6% strongly disagree), combined acute and community trusts (4% disagree), and acute trusts (2% disagree, 2% strongly disagree).

7

NEDs are able to use the information they receive at board and committees to gain assurance about the performance of the trust

FIGURE 5

By job role:



There is slight variation between job roles for this statement; governance leads are more likely to agree (52% agree, 43% strongly agree) than chairs (39% agree, 50% strongly agree), but they are also more likely to disagree (3% disagree, 2% strongly disagree).

Responses between trust types are similar. However, combined MHLD and community trusts (6% strongly disagree) and acute trusts (2% strongly disagree) are the only trust types with respondents who disagree.

Comments on board governance

Respondents were asked to comment on any of their responses in this section. 15 comments were received, with both chairs and governance leads highlighting the volume and complexity of information coming to boards and the competing operational pressures on executives affecting the board's performance.

Indicative comments:

"A lack of challenge (constructive or otherwise) and a 'tick box' culture to the provision of information. Lots of detail and no context. A failure to identify risk areas or gaps."

CHAIR, ACUTE TRUST, NORTH EAST AND YORKSHIRE

"The frequency of meetings and pace of change make it a challenge for executive directors to get out of the operational detail and raise their heads to a strategic level. Assurance reporting is in place but is too detailed and difficult for NEDs to see the key issues which also leads them in to interesting but unnecessary detail."

GOVERNANCE LEAD, AMBULANCE TRUST[1]

"Failure to produce timely board reports of satisfactory quality suggests board meetings are not prioritised. The vast majority of challenge at board meetings comes from non-executive directors."

GOVERNANCE LEAD, ACUTE TRUST, MIDLANDS

8

Please tell us how your board members triangulate what they hear at the board about patient safety

A new question for this year, most respondents mentioned ward or site visits, highlighting the value of regular conversations with staff and patients, and using complaints and patient experience feedback or staff survey results. The role of quality committees in scrutinising data and reporting back to the board is mentioned by a high proportion, and many utilise reports from freedom to speak up guardians, internal and external audits, and Care Quality Commission (CQC) findings. Only one respondent commented that there is little patient safety visibility at their board.

Indicative comments:

"Clinical site visits and patient stories are very powerful mechanisms for triangulating patient safety."

CHAIR, ACUTE TRUST, SOUTH WEST

[1] We do not identify ambulance trusts by region as this would identify the respondent.

"The board receives regular reports in respect of patient safety and other 'quality' related items. Additional oversight is provided by a dedicated Quality Committee… The board carries out regular walkabouts of hospital areas and speaks with patients and staff. A regular patient or staff story is also presented by a service user or member of staff at open session board meetings."

GOVERNANCE LEAD, ACUTE TRUST, SOUTH EAST

"Through triangulating information/assurance received at committees to the information/reports provided to board, more specifically through the Integrated Performance Report. Chairs of committees provide assurance reports to the board which highlights the areas of assurance, moderate assurance and those areas that need escalating to the board."

GOVERNANCE LEAD, AMBULANCE TRUST

9
What are your trust's priorities for board development and support for your board?

Areas most commonly mentioned are:

- strategic development and priorities
- working as a unitary board, either due to having new members, to manage the transition and change, or to improve team cohesion in general
- culture change
- risk
- collaborative working.

Regularly but less frequently mentioned are equality, diversity and inclusion (EDI), focusing on being 'well led', patient safety, and digital.

Indicative comments:

"To date they have been about bord roles, behaviours and good governance and to some extent equalities. Moving forward I think they will be about being part of a system and driving improvements. Assuming the New Hospital Programme ever happens, we will have an enormous amount of time and energy taken up by that."

CHAIR, ACUTE TRUST, EAST OF ENGLAND

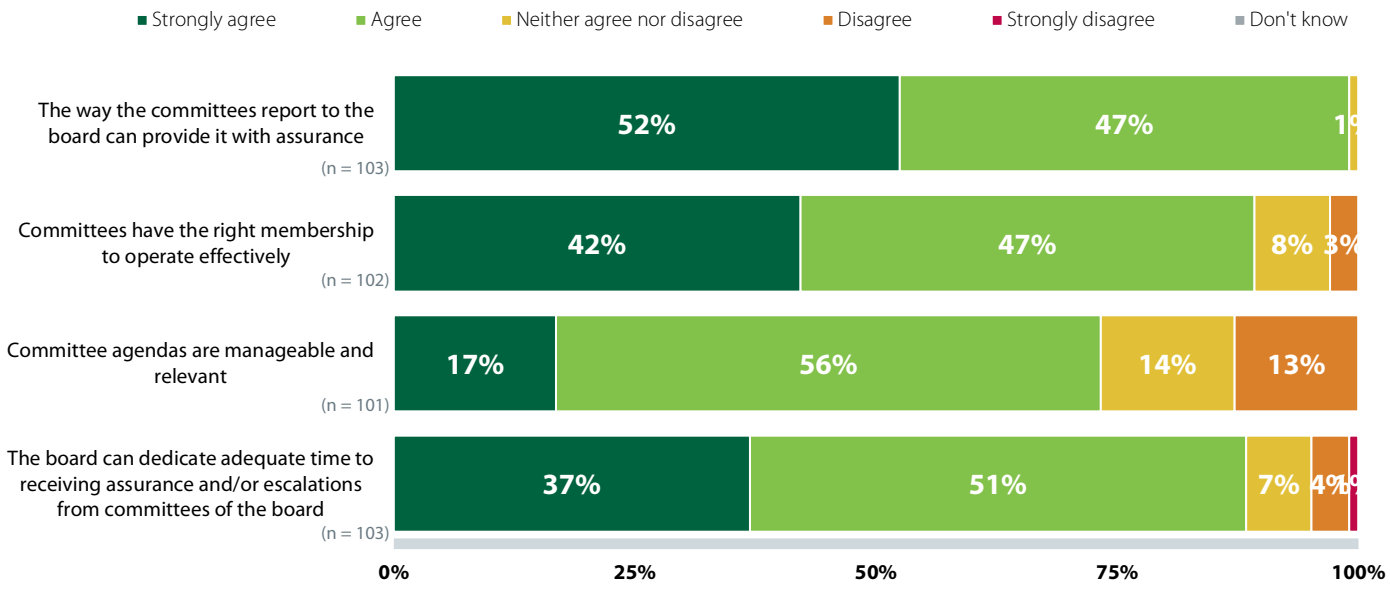
"Shifting from firefighting and survival to strategy and culture transformation."

CHAIR, COMBINED ACUTE AND COMMUNITY TRUST, NORTH EAST AND YORKSHIRE

Committees of the board

FIGURE 6

To what extent do you agree with the following statements:



Overall, a positive picture in terms of committee health. Ensuring committee agendas are manageable and relevant is, like last year, the statement most frequently disagreed with, likely reflecting the comments noted above regarding the volume of issues and complexity of information the committees are seeking to scrutinise.

Notable findings about committees

10

Committees have the right membership to operate effectively

There is variation in responses between job roles: governance leads are less likely to agree (41% agree, 43% strongly agree) compared to chairs (55% agree, 41% strongly agree), and more likely to be neutral (10%) or disagree (5%).

The only trust types with members who disagree are acute specialist (20% disagree), MHLD (14% disagree), and acute (2% disagree). The regions with respondents who disagree are the Midlands (12% disagree) and the North West (7% disagree).

11
Committee agendas are manageable and relevant

Responses between job roles are similar for this statement, although governance leads are more likely to disagree (16%) than chairs (9%), and less likely to agree (governance leads: 49% agree, 21% strongly agree; chairs: 66% agree, 11% strongly agree).

Members from ambulance trusts responded the most favourably, with all (100%) agreeing that committee agendas are manageable and relevant. Respondents from MHLD trusts are the most likely to disagree (29%). There are no members from acute specialist trusts who disagree with this statement; responses between all other trust types are similar.

Responses also varied by region; members from the South East (71% agree, 21% strongly agree) and the East of England (64% agree, 9% strongly agree) responded the most favourably, with no respondents from these regions disagreeing with this statement. Members from the South West are the most likely to disagree (30%).

12
The board can dedicate adequate time to receiving assurance and/or escalations from committees of the board

Chairs responded slightly more favourably, being more likely to agree (55% agree, 36% strongly agree) compared to governance leads (49% agree, 37% strongly agree), and less likely to disagree (chairs: 2% strongly disagree; governance leads: 7% disagree).

Responses varied slightly by trust type. MHLD trust members are the most likely to disagree (29%). Responses between regions also varied slightly. The following regions have respondents who disagree: the North East and Yorkshire (5% disagree, 5% strongly disagree), North West (7% disagree), Midlands (6% disagree), and London (6% disagree).

Comments on committee governance

The comments built a clear sense that in a significant minority of trusts committee agendas are reported to be trying to cover too many items and/or too much detail. Many who chose to comment said that work is needed to make committees more efficient, and concerns are expressed about ensuring the right areas are being prioritised.

Indicative comments:

"Committee agendas are very busy and time has to be managed very carefully. The board agenda is equally busy and we are reviewing how the board agenda is structured (between statutory reports and other business) to give more prominence to assurance and escalations from board committees."

GOVERNANCE LEAD, COMMUNITY TRUST, SOUTH EAST

"Agendas are still too large. There is too much risk in just using the strategic objectives/assurance framework and risk agenda as a driver for committee agendas. there is a pressure to have oversight over everything just in case something is missed."

GOVERNANCE LEAD, COMBINED MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST, MIDLANDS

"Information overload a risk. Too much crammed within agendas at both board and committee levels. Risk of too much detail."

CHAIR, COMBINED ACUTE AND COMMUNITY TRUST, NORTH EAST AND YORKSHIRE

13

Number of assurance committees

Excluding statutory audit and nominations/remuneration committees, the average number of assurance committees across responding trusts is four, with three being the most common number (mode), one the lowest and eight the highest.

14

Changes made or planned to committee structures relating to system working and/or collaboration

Many respondents noted that system and collaboration considerations are now embedded in all relevant committees and are not managed through a separate committee. This is a shift from 2022's finding, when a good number of respondents reported creating or planning to establish separate committees to consider these matters. Respondents also said that their terms of reference have either been or are soon to be updated to include system collaboration. Some members mentioned implementing boards and committees in common, and joint committees in provider collaboratives.

Indicative comments:

"System working is embedded within current structures and continues to be reviewed. Reports from the ICB/P are presented direct to the board, with the chief executive a member of both bodies."

GOVERNANCE LEAD, COMBINED ACUTE AND COMMUNITY TRUST, EAST OF ENGLAND

"We are working to ensure the system position is included on all appropriate papers and have a section on system working at the start and end of each agenda of the sub committees."

GOVERNANCE LEAD, COMBINED MHLD AND COMMUNITY TRUST, MIDLANDS

"System working is considered in all committees, and a specific ICS report is taken to Strategy, Involvement and Planning committee."

CHAIR, COMMUNITY TRUST, EAST OF ENGLAND

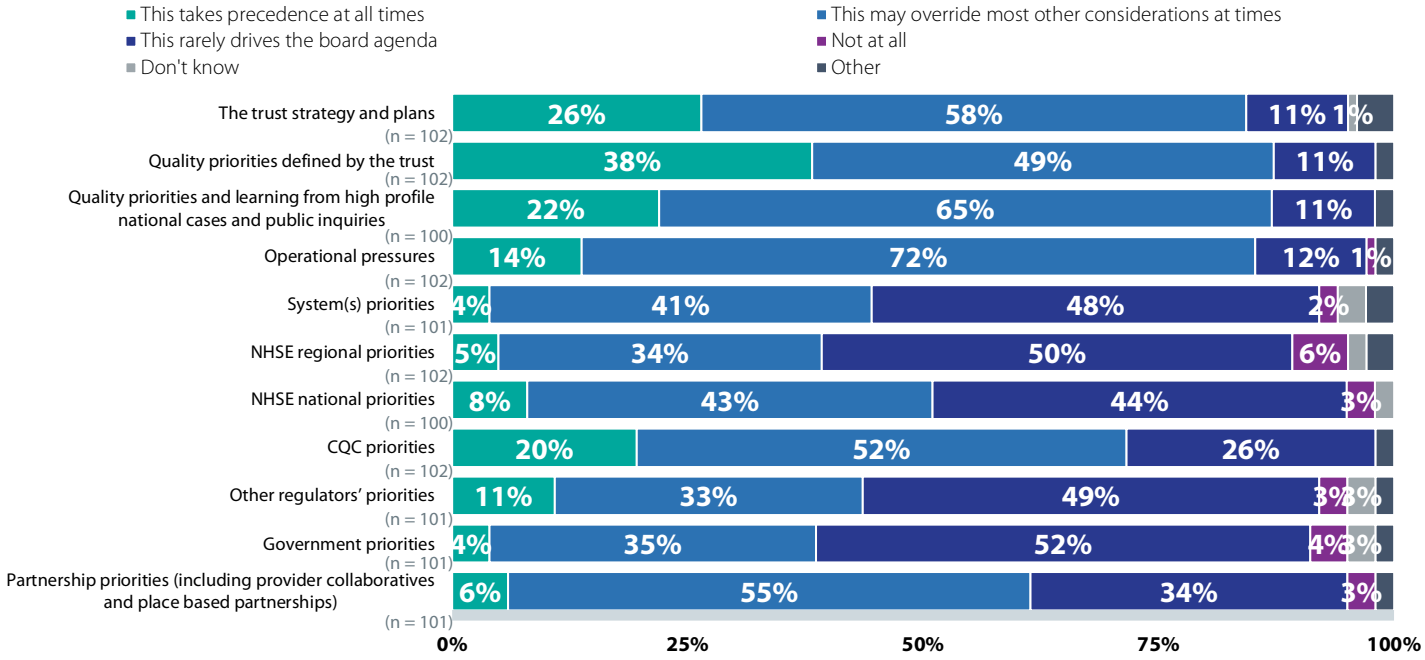
Trust board priorities

We sought to understand the balance between the chair/governance lead feeling able to control the board agenda, and that agenda potentially being dictated by system, regulatory or other priorities that would not otherwise be the board's own.

As many respondents note in their comments, when it comes to setting the board's priorities it is very hard to capture this complex decision-making process through a quantitative question in a survey. That said, we are perhaps able to make some general observations about board priorities from the results.

FIGURE 7

To what extent are the board's priorities determined by the following:



There appears a good degree of confidence that the trust's strategy and plans, quality and operational priorities tend to take precedence for the board. Board attention is also focused on learning from national cases or inquiries when relevant. CQC priorities are the next most likely to take precedence followed by partnership priorities.

External priorities distinct from the board's strategy take precedence on occasion in a significant number of trusts. In terms of influence over the board's attention, respondents report that national NHS England (NHSE) priorities are most likely to take precedence ahead of system priorities, then other regulator's priorities (not NHSE/CQC), followed by NHSE regional priorities and government priorities.

Notable findings about board priorities

In a number of cases, chairs and governance leads had different perspectives about board priorities:

- Chairs are more likely to say that the **trust strategy and plans** take priority at times (66%) compared to governance leads (52%). Governance leads are more likely to say that this rarely drives the board agenda (17%), compared to chairs (2%).
- Chairs are more likely to say that care **quality priorities** defined by the trust may override considerations at times (61%) compared to governance leads (40%), while governance leads are more likely to say that this rarely drives the board agenda (17%, chairs: 2%) and that this takes precedence at all times (41%, chairs: 34%).
- No chairs said that **system priorities** take precedence at all times (compared to 7% of governance leads), and chairs are more likely to say that this rarely drives the board agenda (59%) than governance leads (39%).
- Governance leads (9%) are more likely to say that **NHSE regional priorities** (as distinct from trust strategy) takes precedence at all times; no chairs said this. Chairs are more likely to say that this does not drive the board agenda at all (11%) compared to governance leads (2%).
- Findings are similar in relation to **NHSE national priorities**. Chairs are less likely to say that this takes precedence at all times (2%) compared to governance leads (13%), and more likely to say that this rarely drives the board agenda (52%, governance leads: 38%) and that it does not drive the board agenda at all (7%, governance leads: 0%).
- Governance leads are more likely to say that **other regulators' priorities** take precedence at all times (18%) compared to chairs (2%).
- Governance leads (7%) are also more likely to say that **government priorities** take precedence at all times: no chairs said that this is the case. Chairs are more likely to say that government priorities do not drive the board agenda at all (7%) compared to governance leads (2%).
- Chairs are more likely to say that **partnership priorities** may override most other considerations at times (66%) than governance leads (47%), while governance leads are more likely to say that they rarely drive the board agenda (40%) than chairs (25%).

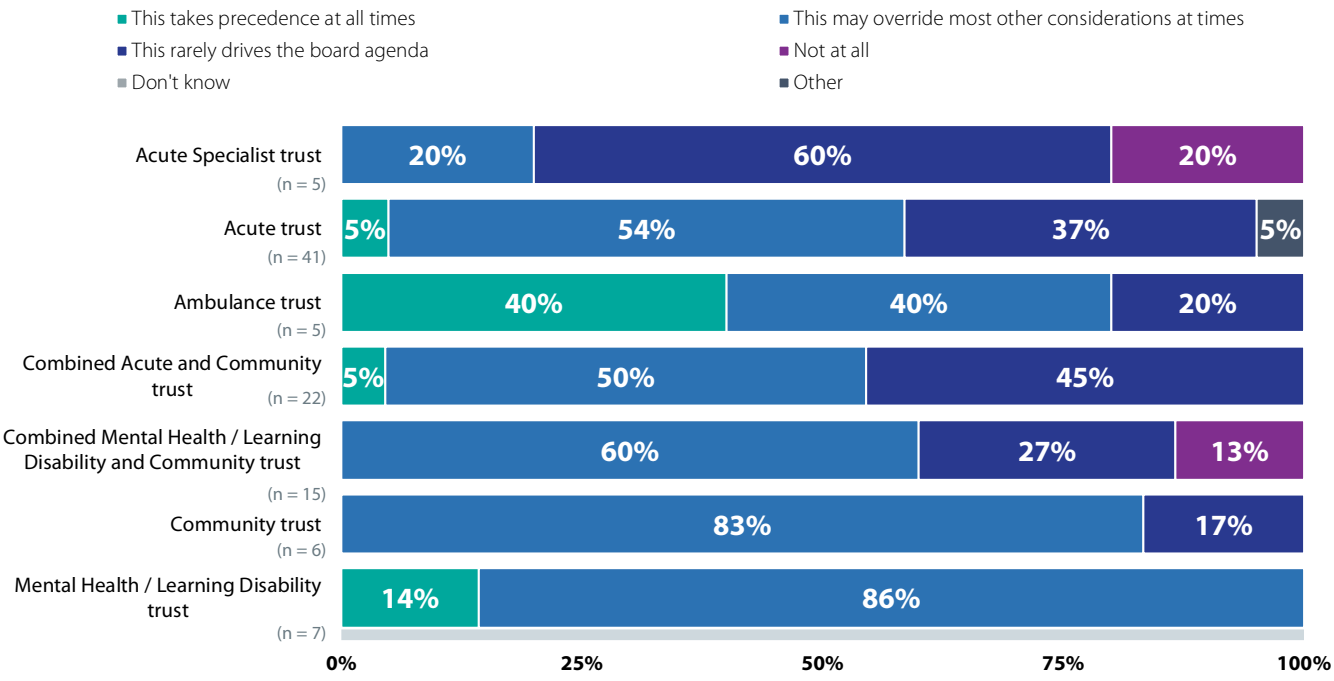
There are no notable regional differences however some observations are worthwhile about variations between types of trust:

- Between 10-20% of respondents from acute, ambulance, combined acute and community, and combined MHLD trusts said that **trust strategy and plans** rarely drive the board agenda.
- **Quality priorities** rarely drove board agendas for between 12-13% of acute, combined acute and community trusts and combined MHLD and community trusts.

- **Operational pressures** are most likely to take precedence at ambulance trusts (20% all the time and 80% at times).
- Combined MHLD and community trusts (7%) and acute trusts (3%) have the only respondents who say that **system(s) priorities** do not drive the board agenda at all.
- The only trust types to say **NHSE regional** and **national priorities** take precedence at all times are ambulance (40%, 40%), combined acute and community (9%, 9%), and acute (5%, 2%). Those trust types that said this does not drive the board agenda at all are combined MHLD and community (20%, 7%), combined acute and community (4%, 5%), and acute (5%, 3%) trusts.
- There is significant variation by trust type as to the extent partnership priorities take precedence:

FIGURE 8

Partnership priorities (including provider collaboratives and place-based partnerships), by trust type:



In the comments, trust leaders stressed the importance of patient safety and quality, and said that these areas typically drive the board agenda. Respondents also highlighted the fact that priorities are constantly changing due to operating in a dynamic environment and having competing pressures coming from various sources: some felt that the question is poorly structured to enable satisfactory responses and analysis. Some respondents also said that NHSE and ICS priorities are aligned with and reflected in their trust's plans.

Indicative comments:

"Trust strategy and plans provide the roadmap however we operate in a dynamic environment and have to constantly test the fitness of our strategies and plans. The new system world requires you to think beyond your organisations and recognise the interdependencies on performance and sustainability."

CHAIR, ACUTE TRUST, NORTH WEST

"Operational pressures ride rough shod over strategic discussions, given the challenges in the Trust. We always ensure that quality has the final voice in any discussion, as well as a frequent voice throughout. But it is a balancing game, hence why no specific item takes precedence."

CHAIR, ACUTE TRUST, MIDLANDS

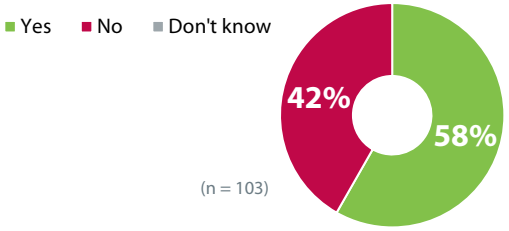
"The focus of the board agenda is still around quality, financial and operational matters which impact the trust. System working update is a standard item on the agenda but does not drive the agenda."

GOVERNANCE LEAD COMBINED ACUTE AND COMMUNITY TRUST, SOUTH WEST

Associate non-executive directors (NEDs)

FIGURE 9

Do you have associate NEDs?:

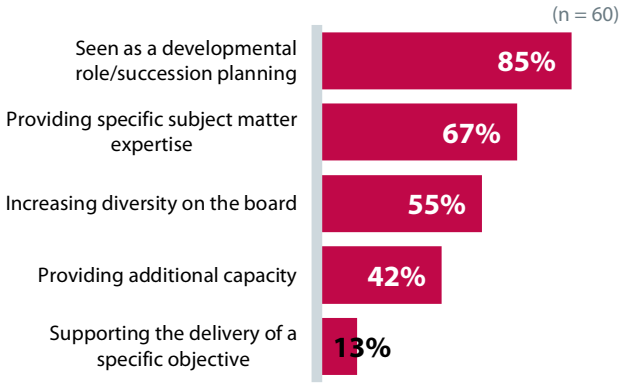


Almost three in five (58%) respondents said that their trust has associate NEDs. The trust type with the largest proportion of respondents who said they have associate NEDs is ambulance trusts (80%), followed by combined acute and community (70%) and acute (60%). Acute specialist and combined MHLD and community trust members are both the least likely to say they have associate NEDs (40%).

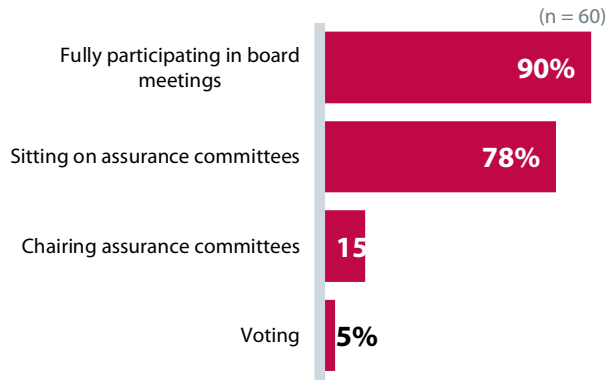
We asked for more information about why associate NEDs have been employed and how they participate in the activities of the board. Respondents were able to select all applicable options:

FIGURE 10

Why associate NEDs are employed:



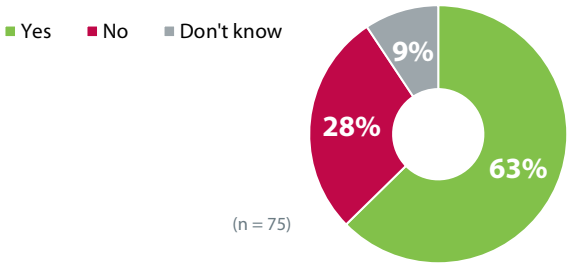
How associate NEDs participate:



Support for maximising the effectiveness of councils of governors

FIGURE 11

Would you benefit from additional support from NHS Providers to maximise the effectiveness of your council of governors within the context of current legislation?

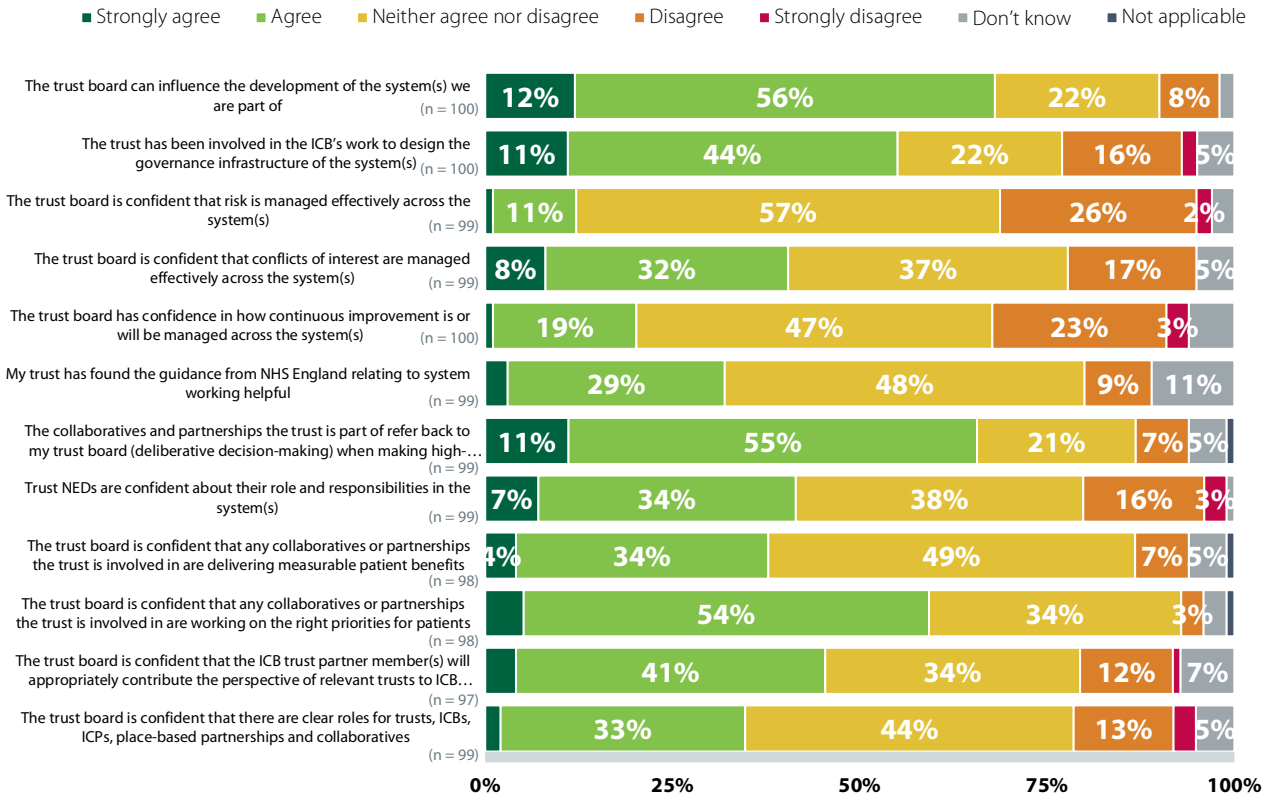


Over three in five respondents from FTs (63%) said that they would benefit from additional support from NHS Providers to maximise the effectiveness of their council of governors. Just under three in ten (28%) said that they would not and 9% do not know.

Trust boards operating in systems

FIGURE 12

To what extent do you agree with the following statements:



In 2022, this survey was undertaken just a few months after ICBs and ICPs became statutory parts of the NHS and ICS footprints were formally established. We asked respondents some new questions this year, but many were asked last year too and it's particularly interesting to reflect on year-on-year variation in responses:

- Over two thirds (68%) of respondents agree (56%) or strongly agree (12%) that the trust board **can influence the development of the system(s)** they are part of. This is up from 62% in last year's survey (47% agree, 15% strongly agree). The proportion of respondents who disagree is smaller than last year (2023: 8% disagree; 2022: 12% disagree), and the proportion of respondents who are neutral is slightly smaller this year (22%) compared to last year (25%).
- Over half (55%) agree (44%) or strongly agree (11%) that the trust has been **involved in the ICB's work to design the governance infrastructure** of the system(s). This is down from last year, when the proportion of those who agree was 61% (46% agree, 15% strongly agree). The proportion of respondents who disagree is similar to last year (2023: 16% disagree, 2% strongly disagree; 2022: 17% disagree, 4% strongly disagree), but the proportion of those neither agreeing nor disagreeing is higher this year (22%) compared to last year (17%).

- The statement that the trust board is **confident that risk is managed effectively** across the system(s) saw the smallest proportion of respondents agree (1% strongly agree, 11% agree). It also had the largest proportion of respondents who disagree (26% disagree, 2% strongly disagree), as well as the largest proportion of neutral responses (57%). The proportion of respondents who are neutral is higher this year (2022: 6% strongly agree, 14% agree, 33% neutral, 34% disagree, 5% strongly disagree, 7% don't know).
- One in five (20%) agree (19%) or strongly agree (1%) that the trust board has **confidence in how continuous improvement is or will be managed across the systems(s**). This is higher than last year (14% agree, 3% strongly agree), but remains one of the statements with the smallest proportion of respondents who agree. This statement had the second largest proportion of respondents who disagree, although fewer respondents disagree with the statement this year (23% disagree, 3% strongly disagree), compared to last year (33% disagree, 4% strongly disagree).
- Around one third of respondents agree (29% agree, 3% strongly agree) that **guidance from NHSE about system working has been helpful**. This is down from last year's survey, when 36% of respondents agreed (32% agree, 4% strongly agree).
- Around two thirds (66%) of respondents agree (55%) or strongly agree (11%) that the **collaboratives and partnerships the trust is part of refer back to their trust board** (deliberative decision-making) when making high risk decisions. This statement had the second largest proportion of respondents who agree, and is up from last year, when 54% of respondents agreed (43% agree, 11% strongly agree). The proportion of respondents who disagree with this statement (7%) is smaller than in last year's survey (18%).
- Around two in five (41%) respondents agree (34% agree, 7% strongly agree) that **trust NEDs are confident about their roles and responsibilities in the system(s)**, up from 24% last year (19% agree, 5% strongly agree). Around one fifth of respondents (19%) disagree with this statement (16% disagree, 3% strongly disagree); this is down from 44% last year (36% disagree, 8% strongly disagree), when this statement had the largest proportion of respondents who disagreed.
- 45% of respondents agree (41% agree, 4% strongly agree) that the trust board is **confident that the ICB trust partner member(s) will appropriately contribute the perspective of relevant trusts to ICB decision-making**. This is up from 40% last year (27% agree, 13% strongly agree). 16% of respondents disagree (13% disagree, 3% strongly disagree), down from 22% last year (20% disagree, 2% strongly disagree).

In relation to new questions asked this year:

- Two in five (40%) respondents agree (32%) or strongly agree (8%) that the trust board is **confident that conflicts of interest are managed effectively across the system(s)**, while 17% disagree.

- Almost two in five (38%) respondents agree (34%) or strongly agree (4%) that the trust board is **confident that any collaboratives or partnership the trust is involved in are delivering measurable patient benefits**; a large proportion (49%) are neutral.
- Around three in five (59%) respondents agree (54%) or strongly agree (5%) that the trust board is **confident that any collaboratives or partnerships the trust is involved in are working on the right priorities for patients**. This statement has the smallest proportion of respondents who disagree (3%).
- Over one third (35%) of respondents agree (33% agree, 2% strongly agree) that the trust **board is confident that there are clear roles for trusts, ICBs, ICPs, place-based partnerships and collaboratives**. 16% of respondents disagree (13% disagree, 3% strongly disagree).

Notable findings about trusts operating in systems

There are some role, regional and trust type variations in responses, set out below. Unless mentioned, no significant variation exists.

15
The trust board can influence the development of the system(s) we are part of

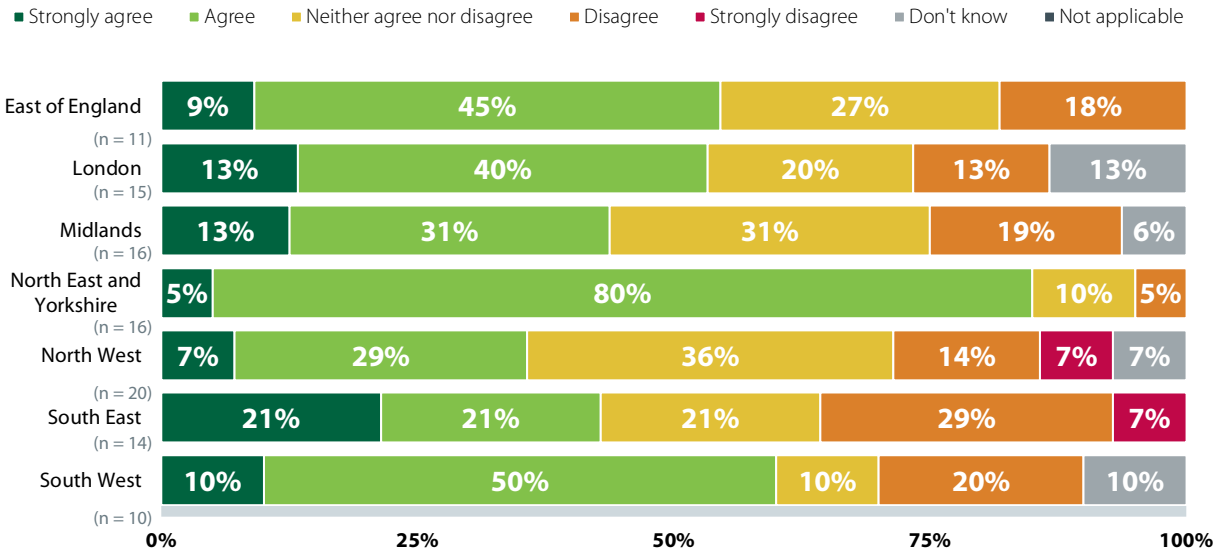
Respondents from acute specialist (20%) and acute (15%) trusts and those from the South East (21%) and South West (20%) are the most likely to disagree. Respondents from the South East are also the least likely to agree (21% agree, 21% strongly agree) compared to members from all other regions.

16
The trust has been involved in the ICB's work to design the governance infrastructure of the system(s)

Chairs are more likely to agree (52% agree, 7% strongly agree) than governance leads (38% agree, 14% strongly agree). However, chairs are also slightly more likely to disagree (18% disagree, 5% strongly disagree) compared to governance leads (14% disagree). Members from ambulance trusts are the least likely to agree with this statement (20%) and the most likely to disagree (40%) compared to all other trust types. Those from combined acute and community trusts (57% agree, 17% strongly agree) are the most likely to agree.

FIGURE 13

By region:



A large proportion of respondents (85%) from the North East and Yorkshire agree (80% agree, 5% strongly agree) with this statement, compared to members from all other regions (the next highest level of agreement is 60%). Members from the South East are the most likely to disagree (29% disagree, 7% strongly disagree). Respondents from London are most likely to say they didn't know (13%).

17
The trust board is confident that risk is managed effectively across the system(s)

Chairs are slightly less likely to agree (9%) and slightly more likely to disagree (34% disagree, 2% strongly disagree) compared to governance leads (13% agree, 1% strongly agree, 20% disagree, 2% strongly disagree). There are no members from ambulance trusts who agree that the trust board is confident that risk is managed effectively across the system(s), and there are no members from community trusts who disagree. Responses from all other trust types are similar.

There is some variation by region; members from the Midlands are the most likely to disagree (50%) with this statement, while those from the North West are the least likely to disagree (7% disagree, 7% strongly disagree).

18

The trust board is confident that conflicts of interest are managed effectively across the system(s)

Chairs are far more likely to disagree (27%) than governance leads (9%). Combined MHLD and community trust members are the most likely to disagree (40%) while no members from acute specialist or community trusts disagree. There is slight variation between regions; members from the Midlands (50%) and South East (50%) are the most likely to agree, and those from the South West are the most likely to disagree (33%).

19

The trust board has confidence in how continuous improvement is or will be managed across the system(s)

Chairs are more likely to disagree with this statement (34% disagree, 5% strongly disagree) than governance leads (15% disagree, 2% strongly disagree). Respondents from combined MHLD and community trusts are the least likely to agree (7%) and the most likely to disagree (40%). No members from community trusts disagree. Members from trusts in the North West (36% agree, 7% strongly agree) and the South West (33% agree) are more likely to agree than those from any other region. Members from the South East are the most likely to disagree (57%).

20

My trust has found the guidance from NHS England relating to system working helpful

Chairs are more likely to disagree with this statement (18%) compared to governance leads (2%). No members from acute specialist, ambulance, or community trusts disagree with this statement. MHLD trust members are the most likely to agree (43% agree, 14% strongly agree).

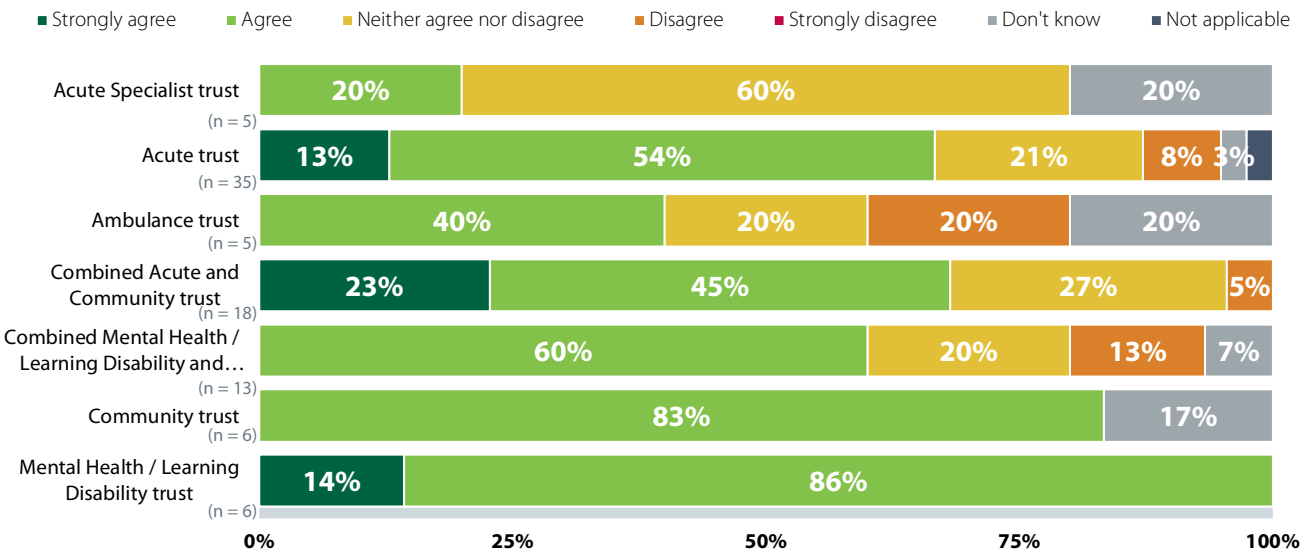
21

The collaboratives and partnerships the trust is part of refer back to my trust board (deliberative decision-making) when making high-risk decisions

Chairs are more likely to agree (64% agree, 14% strongly agree) that the collaboratives and partnerships the trust is part of refer back to their trust board when making high-risk decisions, compared to governance leads (47% agree, 9% strongly agree). Governance leads are more likely to be neutral (25%).

FIGURE 14

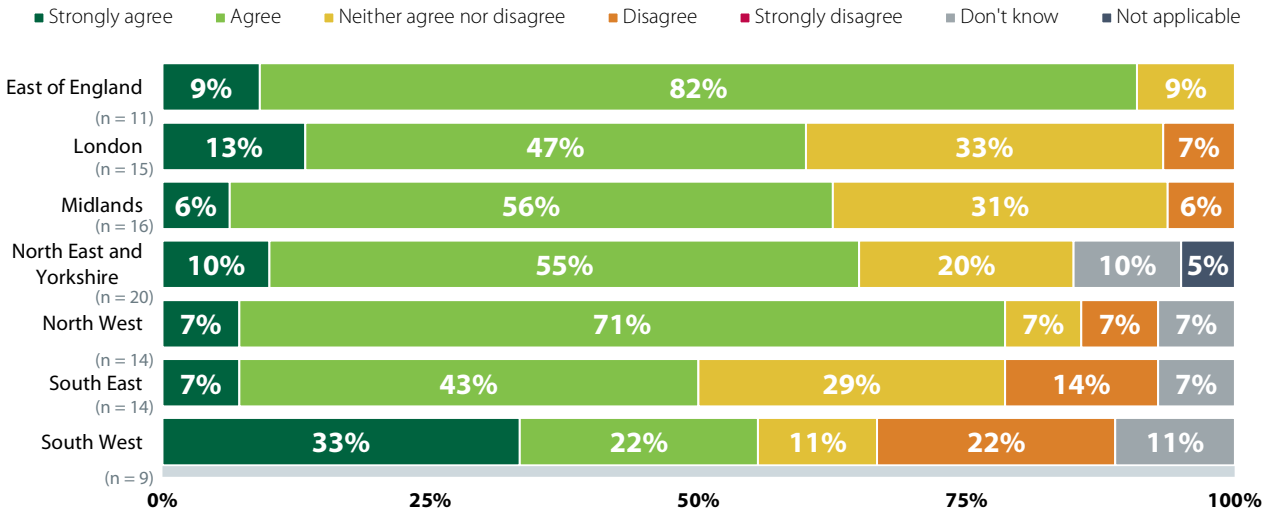
By trust type:



Responses varied significantly by trust type; all members from MHLD trusts agree (86% agree, 14% strongly agree). Acute specialist trust members are the least likely to agree (20%) and the most likely to be neutral (60%). Ambulance trust members are the most likely to disagree (20%).

FIGURE 15

By region:

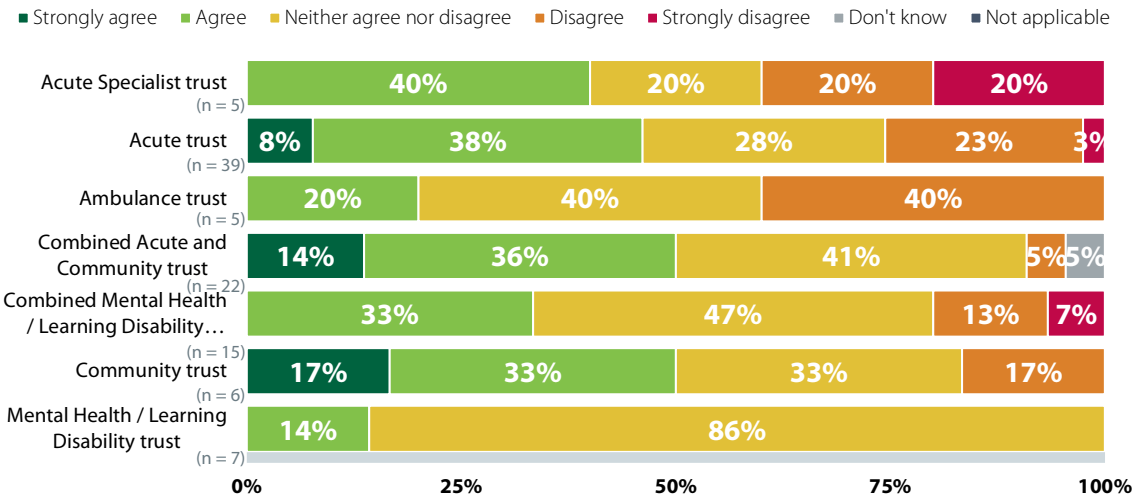


There is also some variation by region, with almost all members from the East of England agreeing (82% agree, 9% strongly agree), more than all other regions. Members from the South West are the most likely to disagree (22%). In several regions there are a significant number of 'don't knows'.

22
Trust NEDs are confident about their role and responsibilities in the system(s)

FIGURE 16

By trust type:

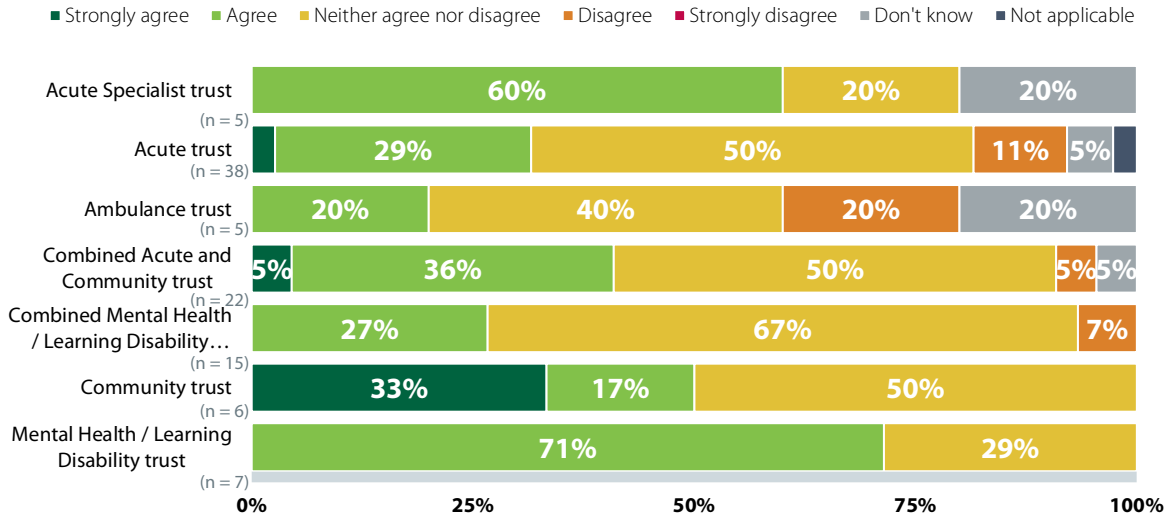


Responses varied by trust type; a large proportion of respondents from MHLD trusts are neutral (86%), and these members are less likely to agree than other trust types (14%). Ambulance trust (40%) and acute specialist trust members (40% disagree, 40% strongly disagree) are more likely to disagree than members from other trust types. Looking at regions, members from the South East are the least likely to agree (7% agree, 7% strongly agree) and no members from the East of England disagree.

23
The trust board is confident that any collaboratives or partnerships the trust is involved in are delivering measurable patient benefits

FIGURE 17

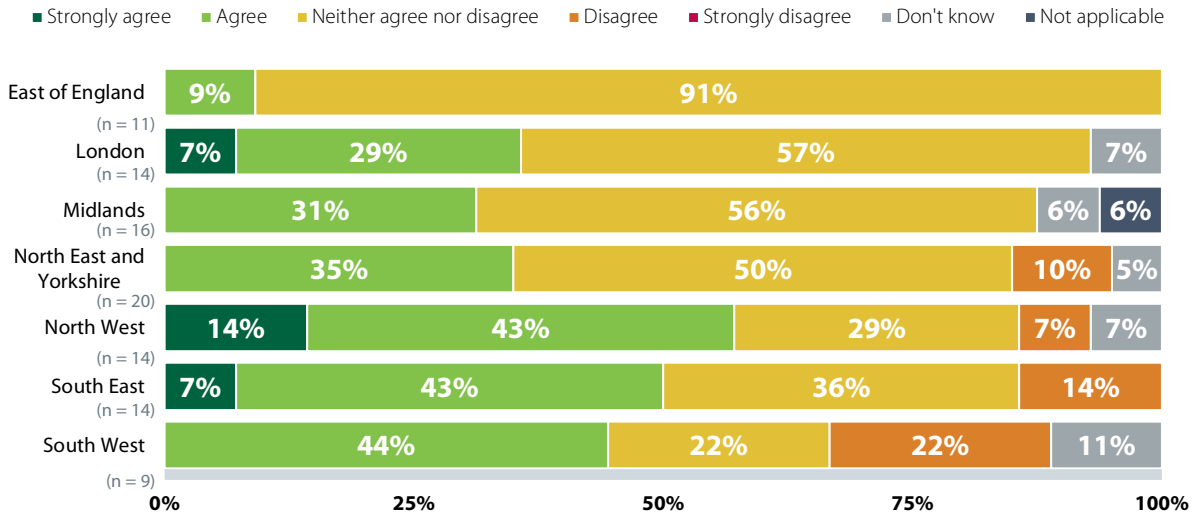
By trust type:



Responses varied by trust type; members from MHLD trusts (71%) and acute specialist trusts (60%) are more likely to agree than other trust type members.

FIGURE 18

By region:



There is also variation by region. Members from the East of England are less likely to agree (9%) and had a considerable proportion of respondents who are neutral (91%).

24

The trust board is confident that any collaboratives or partnerships the trust is involved in are working on the right priorities for patients

There is little variation in responses by role, region or trust type.

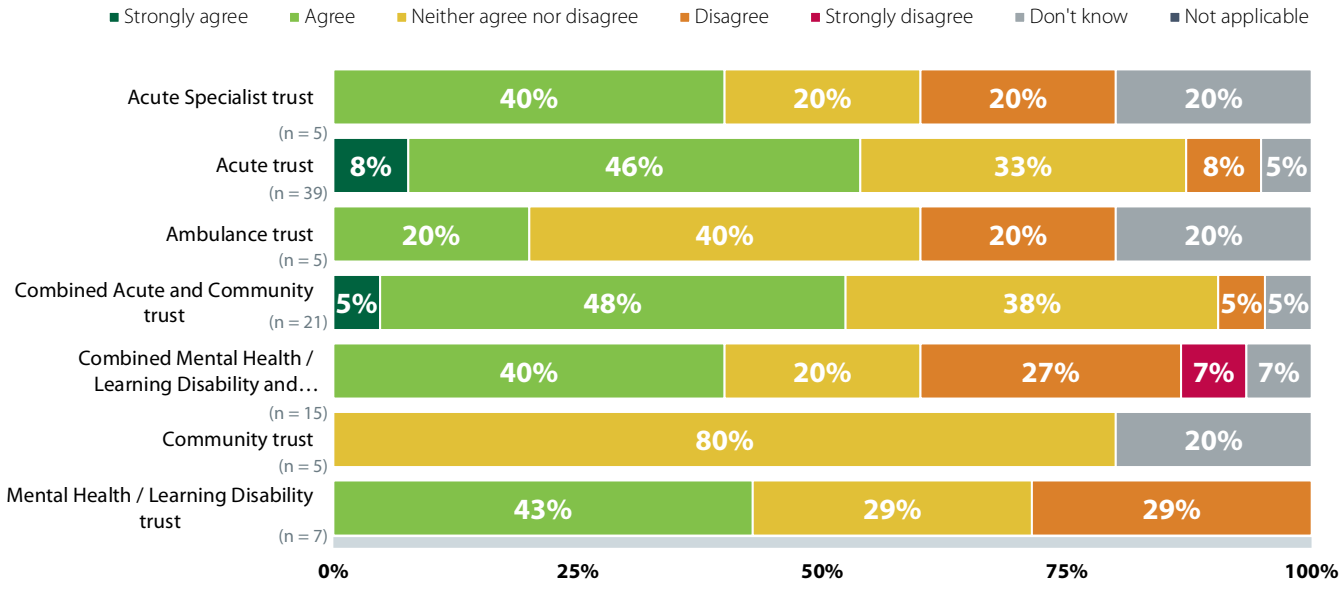
25

The trust board is confident that the ICB trust partner member(s) will appropriately contribute the perspective of relevant trusts to ICB decision-making

Chairs are more likely to agree (47% agree, 5% strongly agree) than governance leads (37% agree, 4% agree), but also more likely to disagree (16% disagree, 2% strongly disagree, governance leads: 9% disagree).

FIGURE 19

By by trust type:



No members from community trusts agree with this statement. Members from combined MHLD and community trusts (27% disagree, 7% strongly disagree) are the most likely to disagree. Responses are similar across the regions save that no members from the East of England disagree with the statement.

26

The trust board is confident that there are clear roles for trusts, ICBs, ICPs, place-based partnerships and collaboratives

Chairs are considerably more likely to disagree (23% disagree, 7% strongly disagree) compared to governance leads (6% disagree). No community trust members agree with this statement, but responses from all other trust types are similar. Respondents from the East of England are less likely to agree (9%) compared to members from all other regions.

Comments on trust boards operating in systems

In the comments, there is a sense of uncertainty as some respondents felt that some areas lacked clarity, or that it is too soon to be able to comment on the statements. This may explain the high proportion of both neutral responses and 'don't knows' in this section.

Several members said that their board is not yet confident enough to influence systems and that system working is as yet immature. Other respondents highlight confusion over the role of trust NEDs, and some said that the ICB is still in its infancy, and therefore struggles to add value. There are also concerns raised

over approaches to risk, with members saying it is hard to see trust risks clearly reflected in ICB risk registers, and that trusts would like to see a coordinated risk register across the system.

Indicative comments:

"I think it's hard to see how clearly the Trust risks are reflected in the ICB risk register. Also, it's difficult to get a clear picture of how ICB colleagues are united in their views of individual trusts. In summary, at times it feels like different arms of the ICB don't speak to each other."

CHAIR, COMBINED ACUTE AND COMMUNITY TRUST, NORTH WEST

"Early days and we ALL still have a lot of maturity to develop in terms of system working. Good thing is we are now all in the same room and talking about the same things."

CHAIR, ACUTE TRUST, NORTH WEST

"There is still a lack of clarity regarding the role of trust NEDs and therefore knowledge of priorities and outcomes is poor."

CHAIR, AMBULANCE TRUST

"Not sure there is a real clarity on risks across the system and where responsibility sits and I think the systems at an ICB level are still in the forming stages."

CHAIR, ACUTE TRUST, NORTH EAST AND YORKSHIRE

System governance processes and structures

Respondents give many examples of processes and structures that they feel are particularly ineffective, noting too many meetings, duplication of work, and that governance arrangements are still developing. Some members also say that the link between system and trust governance is unclear, and they are not persuaded that the governance direction within the ICS is fit for purpose.

Governance processes which are thought effective included provider collaborative boards and joint committees allowing providers to work closely together on issues, and having regular meetings of key professional groups.

Indicative comments:

"There is duplication with system, place and individual organisation committees, i.e. three layers of quality committee and we contribute to more than one place and therefore there are four quality committees. Having independent chairs of places that are not linked to the NEDs on the ICB board at system makes no sense."

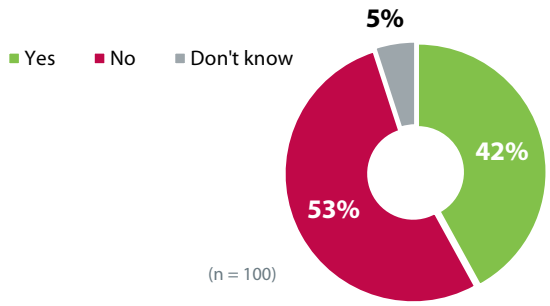
GOVERNANCE LEAD, ACUTE TRUST, NORTH EAST AND YORKSHIRE

"Provider collaborative is still in development but moving forward. Directors, particularly executives, are now being asked to attend a lot of meetings which could be streamlined for increased effectiveness."

GOVERNANCE LEAD, COMBINED ACUTE AND COMMUNITY TRUST, SOUTH EAST

27
Do you have board members in your trust undertaking a joint/shared post within your system(s)?

FIGURE 20



Around two in five (42%) respondents said that they do have board member(s) undertaking joint or shared posts within the system(s) (up from 37% last year), and 5% did not know.

Members from MHLD trusts (57%) and combined acute and community trusts (50%) are more likely than other trust types to say that they do, while members from community trusts (17%) are less likely than all other trust types.

No members from the East of England said that they have board members undertaking joint/shared posts. Respondents from London are the most likely to say that they do (71%).

28
The notable challenges or benefits of having board members undertaking joint/shared posts within systems

Members reported several benefits, the most common being shared intelligence and more joined up ways of working. Respondents also mentioned having greater influence, strengthening partnership working, gaining insight into system working, and achieving economies of scale. Members are less likely to provide challenges, but issues that are mentioned include time pressures and conflicts of interest.

Indicative comments:

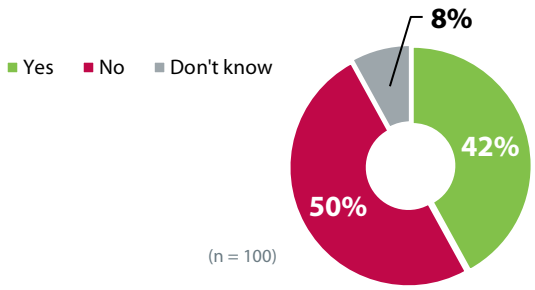
"It brings benefits of shared learning and collaboration opportunities we would not normally have without the distractions of mergers."
CHAIR, ACUTE TRUST, NORTH EAST AND YORKSHIRE

"Joint chair between two trusts which is providing a stronger / louder voice within the system. Chair is supported by a NED in common."
GOVERNANCE LEAD, ACUTE TRUST, LONDON

29

Do you have a board member who is also a trust partner member on an ICB?

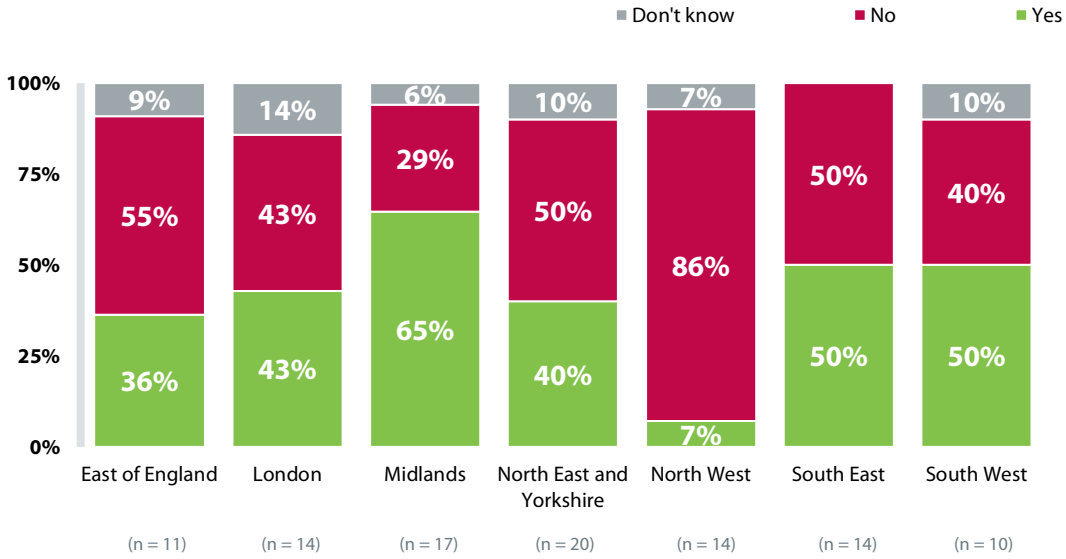
FIGURE 22



This is a new question this year. Members from MHLD trusts (71%) and combined MHLD and community trusts (67%) are more likely to say yes than other trust types. No respondents from acute specialist or ambulance trusts said yes.

FIGURE 23

By region:



Respondents from the Midlands (65%) are more likely than those from all other regions to report having a board member who is also a trust partner member on an ICB; those from the North West are the least likely to say this (7%). Responses from all other regions are similar.

When asked about any notable challenges or benefits having a trust partner member on the ICB brought to the trust, respondents highlight improved communication with the ICB, having more influence on the ICB, and having insight into discussions. Some members also mentioned having greater representation for their sector. There are very few members who note challenges but the most common challenge identified

is capacity to participate. The potential for duplication and managing conflicts of interest are also mentioned. One member commented that the role is not designed to bring benefits to their trust, but to represent all acute trusts.

Indicative comments:

"The chief executive is also a board member of the ICB as the provider representative on the board. This of course has a conflict of interest and divided loyalties element to it."

GOVERNANCE LEAD, ACUTE TRUST, SOUTH EAST

"The trust's chief executive's role as the provider representative offers an opportunity to ensure that the Trust's views are communicated as well as to obtain additional intelligence regarding the rest of the system."

GOVERNANCE LEAD, ACUTE TRUST, SOUTH EAST

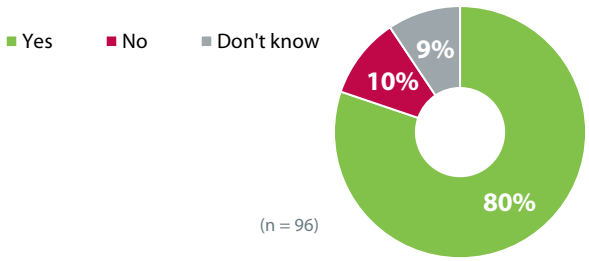
"At least have "ears in the room" a bit more."

CHAIR, COMBINED MHLD AND COMMUNITY TRUST, MIDLANDS

30

Do you have a board member who is also part of formal provider collaborative or place-based partnership leadership?

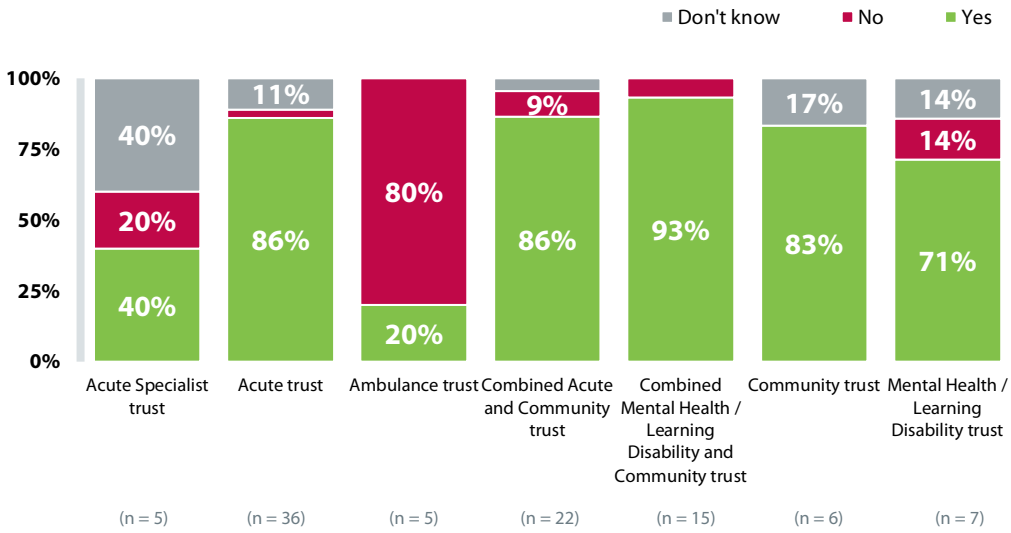
FIGURE 24



Most respondents (80%) said that they do have a board member who is also part of formal provider collaborative or place-based partnership leadership.

FIGURE 25

By trust type:



Respondents from ambulance trusts are the least likely (20%) to say that they have a board member who is also part of formal provider collaborative or place-based partnership leadership, followed by members from acute specialist trusts (40%).

All members from the South East reported having a board member who is also part of formal provider collaborative or place-based partnership leadership. Members from the South West are the least likely to have one (22%).

Respondents report many benefits of having a board member who is also part of formal provider collaborative or place-based partnership leadership. The most common is having greater influence. Other benefits mentioned by members include gaining a wider perspective and insight, better collaboration, ensuring there is a focus on the population, having a voice, and enabling triangulation. Of the few challenges mentioned, time and conflicts of interest are the most common. One respondent said relations with local government were challenging.

Indicative comments:

"Allowing board to understand system dynamics and allowing committee chairs to understand how we weave system collaboration into respective committee work. Brings wider understanding of inter-dependency and importantly removes issues of lack of trust and increases relationships."

CHAIR, ACUTE TRUST, NORTH WEST

"Challenge is in attending a significant number of meetings across the system, ICB, ICP and Place."

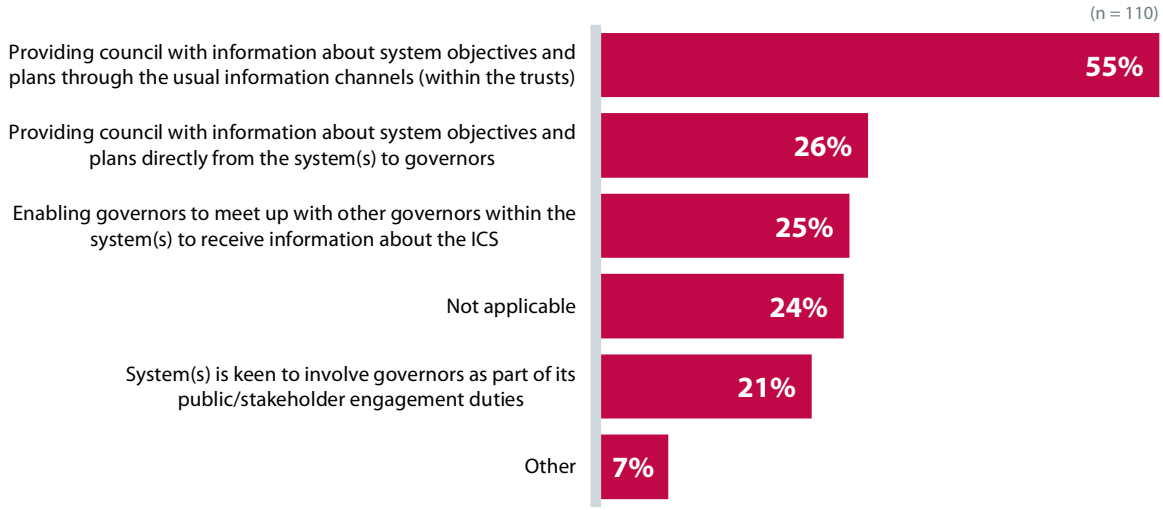
GOVERNANCE LEAD, COMBINED ACUTE AND COMMUNITY TRUST, NORTH EAST AND YORKSHIRE

31

Involving governors in systems

FIGURE 26

Ways in which NHS Foundation Trusts are involving governors in their system(s):



Respondents are able to select all ways that applied. The most common way that FT respondents are involving their governors in their system(s) is by providing the council with information about system objectives and plans through the usual information channels (within trusts); over half (55%) of respondents say they are doing this. This is down from 75% last year.

Around one quarter of foundation trust members are providing council with information about system objectives and plans directly from the system(s) to governors (26%) (down from 33% last year) and enabling governors to meet up with other governors within the system(s) to receive information about the ICS (25%), also down from last year (41%).

Around one fifth (21%) say that the system(s) is keen to involve governors as part of its public/stakeholder engagement duties, a similar proportion to last year (20%).

Other comments about involving governors in systems:

"Don't currently have enough information about what's happening at system level (relating to governance or governors) to meaningfully involve and inform governors at this stage."

GOVERNANCE LEAD, COMBINED ACUTE AND COMMUNITY TRUST, NORTH EAST AND YORKSHIRE

"System strategy updates directly from our director of strategy."

Governance lead, combined acute and community trust, South East

"There are only two FTs in our system, we being one, and we have proactively held a joint event between both pools of governors. It went well."

CHAIR, COMBINED MHLD AND COMMUNITY TRUST, MIDLANDS

32

Final comments about how system working is impacting boards and organisational governance.

In the final comments, several respondents said that system working is taking up too much time due to both the increased number of meetings and the significant complexity of understanding roles and responsibilities. Members also raised concerns over the additional layer of bureaucracy and challenge.

Indicative comments:

"Huge numbers of meetings with a lot of duplication, really need to streamline and make more efficient use of people's time."

GOVERNANCE LEAD, ACUTE TRUST, LONDON

"Need more comms and information flow. Need more time/capacity which does not exist."

CHAIR, ACUTE TRUST, SOUTH WEST

"We currently participate in many successful provider collaboratives which have been highly successful. We are now being diverted down a road of integrated governance which does not have clearly set out aspirations for patient benefit and runs the risk of reducing focus on quality and performance within the trust."

CHAIR, MENTAL HEALTH / LEARNING DISABILITY TRUST, LONDON

Appendix

A Sample

Trust types

Trust type	Responses	% of responses	% of sector
Acute Specialist trust	5	5%	33%
Acute trust	44	40%	52%
Ambulance trust	5	5%	40%
Combined Acute and Community trust	25	23%	47%
Combined Mental Health/Learning Disability and Community trust	16	15%	43%
Community trust	8	7%	50%
Mental Health/Learning Disability trust	7	6%	25%
Grand Total	110	100%	45%

Regions

Region	Responses	% of responses
East of England	11	10%
London	18	16%
Midlands	19	17%
North East and Yorkshire	21	19%
North West	15	14%
South East	15	14%
South West	11	10%
Grand Total	110	100%

Job roles

Role	Responses	% of responses
Chair	43	39%
Company secretary	48	44%
Director of governance	11	10%
Other (including Director of corporate affairs, Deputy director of corporate affairs)	7	6%
Total	109	100%

B How many of the following is your organisation a part of:

Integrated care systems

Integrated care systems	Responses	% of responses
1	79	80%
2	14	14%
3	2	2%
4	3	3%
5	1	1%
Total	99	100%

Provider collaboratives

Provider collaboratives	Responses	% of responses
0	2	2%
1	60	67%
2	17	19%
3	1	1%
4	5	6%
5 or more	4	4%
Total	89	100%

Place-based partnerships

Place-based partnerships	Responses	% of responses
1	40	47%
2	17	20%
3	10	12%
4	7	8%
5 or more	11	13%
Total	85	100%