Good Governance Institute

The GGI lean governance method

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Our session

- Context and introduction
- The cost of governance and assurance – work by Strasys
- Lean governance on the frontline – case study
- The GGI lean governance approach
- Some detail – great meetings and plain English ToRs
- Questions and clarifications

Good governance

GGI's dimensions of board governance

- Mission/vision
- Strategy
- Leadership
- Assurance
- Transparency
- Stewardship

King IV Report - https://www.good-governance.org.uk/publications/papers/king-iv-for-health-and-social-care

King's meaningful outcomes

- Ethical culture
- Value creation
- Control
- Legitimacy

NHS/education/other context

- The regulators as governance customers (and the board as quacking ducks)

What GGI are seeing more & more of

Context

- the heat turning up on **money, workforce** and **quality**

  and the relative risks likely to increase
- organisations rated ‘Good’ by CQC being found wanting
- governance systems not giving warning, particularly with ‘HILPs’
- NHS ‘structurally’ understaffed by at least 10%

Three advances in NHS governance this year

Classification: Official

Publication reference: PR2076

NHS England

Code of governance for NHS provider trusts

27 October 2022

Classification: Official

Publication reference: PR2075

NHS England

Guidance on good governance and collaboration

20 October 2022

Our new quality statements

This bulletin was sent at 18-07-2022 03:44 PM BST

CareQuality Commission

The independent regulator of health and social care in England

A regular update for health and social care professionals on how CQC is implementing its new strategy and transforming how it regulates

Our new quality statements

A key part of our future regulatory model is a new single assessment framework. This will form the basis for our assessments of quality in providers, local authorities and integrated care systems.

In this new framework we'll continue to use our existing five key questions (safe, effective, caring, responsive and well-led).

Under each key question there will be a set of topic areas and quality statements. The statements replace our existing Key Lines of Enquiry (KLOEs) and describe what good care looks like and will link to the regulations.

Today we've published the quality statements in full on our website.

Read the quality statements

We believe that assurance misunderstood/unloved

- Assurance, and what assurance is actually needed,
  very poorly understood
- The opportunity cost of assurance, especially meetings, invisible
- Assurance skills e.g.: writing papers poor
- Regulators encouraging ‘grudge compliance’
- Non-executives being drawn to checking,
  whilst executives aren’t (e.g.: too much looking at the small
  things and not enough at the big issues)
- Poor linkage between/use of different governance discipline

https://www.good-governance.org.uk/publications/insights/assurance-and-the-dog-that-didnt-bark

Assurance: ‘tells’ GGI is seeing

- Board committees doing management’s work
  or repeating management’s work:
  - progress chasing
  - receiving data and attempting to interpret it in the moment
  - huge papers
  - repetitive discussions
  - management groups reporting into board committees
  - multiple reporting tiers
  - mindset that ‘assurance is the board’s business’

- Inability to answer the ’big assurance questions’
- Looking backwards, not forwards too
- Focus on process not impact
- Poor linkage between BAF and the work of the
  management assurance groups

AND all this done with very significant time spent on assurance.

Well-led

‘Tells’ of requires improvement/good

- Long, detailed agendas and papers – nothing could possibly be missed
- Management groups reporting into board committees
- Lots of managers attending board committees routinely
- Non-executives ‘owning’ managerial areas
- Risk ‘owned’ by one committee rather than all committees
- Focus on the reds

‘Tells’ of outstanding

- Clear distinction between management and the board
- Strong, formal trust management group
- Outward-looking and informed non-executives
- Good balance between formal board meetings, briefings, seminars and board development
- Executives value board meetings
- Focus on the greens

Palettes of language

Requires improvement/good

- Reassurance
- Checking
- Progress chasing
- Activity
- Run rate
- Performance
- Budgets and spend
- Holding the executives to account
- Discussion about detailed issues
- Looking backwards

Outstanding

- Assurance
- Triangulation
- Impact checking
- Productivity
- Effectiveness and efficiency
- Value creation
- Holding ourselves to account
- Discussion on big issues
- Looking forwards as well as backwards

Walker Review of Corporate Governance of UK Banking Industry

- Right symbiosis between regulator scrutiny and good corporate governance
- Unitary board structure fit for purpose and indeed needs strengthening
- Principal deficiencies in BOFI boards related much more to patterns of behaviour than to organisation
- Board level oversight of risk needed significantly increasing
- Inequitable balance of risk between institutional fundowners and the taxpayer
- Inadequate oversight of remuneration

Sir David Walker: https://www.good-governance.org.uk/publications/insights/asking-the-right-questions-why-constructive-challenge-is-key-to-board-effectiveness

Walker: patterns of behaviour (constructive challenge)

- ‘The sequence in board discussion on major issues should be:
  - presentation by the executive
  - a disciplined process of challenge
  - decision on policy or strategy
  - full empowerment of the executive to implement.
- The essential ‘challenge’ step in the sequence appears to have been missed in many board situations and needs to be unequivocally clearly recognised and embedded for the future
- The most critical need is for an environment in which effective challenge of the executive is expected and achieved’

A virtuous cycle of respect, trust & candour

Jeffrey Sonnefeld, Harvard

What is the data telling us?

What is the true resource dedicated to governance, assurance and checking?

Dr. Nadeem Moghul

STRASYS

How do you think your organisation is spending its £1?

www.strasys.uk

nadeem.moghal@strasys.uk

Boiling the ocean

Having the Assurance at Trust in the North-West

Aaron Cummins

Chief Executive
University Hospitals of Morecambe Bay NHS FT

Impact statement

As a result of introducing lean governance you will have:

1. Improved **executive oversight and board assurance**, whilst at the same time **reduced opportunity costs and time returned to senior clinicians and managers**.
2. **Fewer but more impactful assurance meetings.** Those attending meetings will understand their contribution to meetings and as such meetings will be more productive.
3. **Actions** that are followed up more quickly and completely, and parallel systems such as your **risk registers or clinical audit will work better.**
4. Governance and assurance that are better understood and valued by staff.
5. Staff that are able to explain why assurance is important, and how it works in your Trust.
6. Increased competence to manage out issues at team and division level, and the executive leadership will be more confident that important matters are properly escalated building a **mature 'no surprises' culture**.

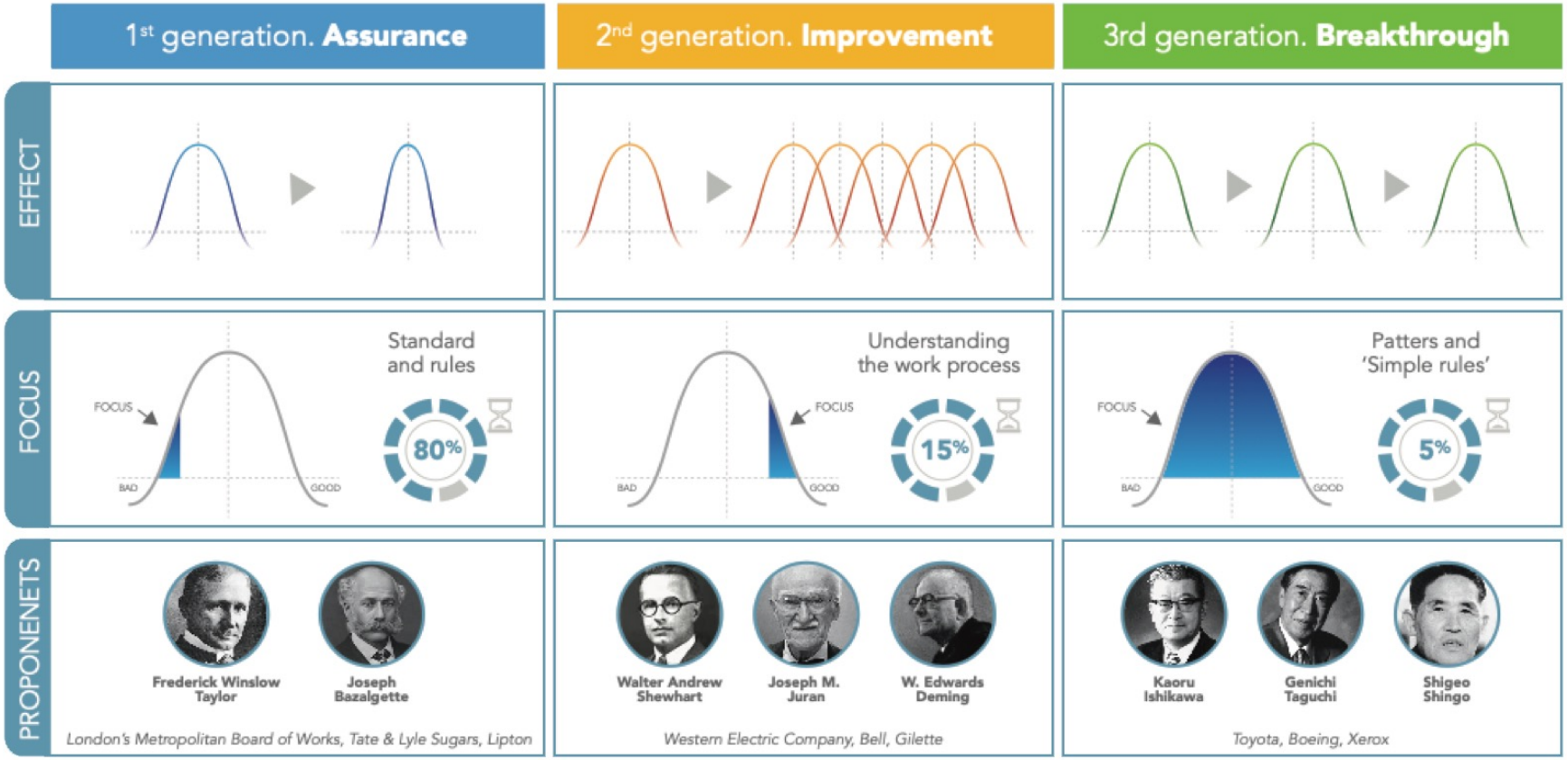
All this will build a compelling narrative to CQC and at the same time support the development of a positive culture of mutual respect and shared responsibility.

Making Meetings Matter: https://www.good-governance.org.uk/what-we-do/services/simplifying-governance

The GGI lean governance approach

1. Find out, order and cost what is in place
2. Using lean and rules, redesign the assurance structure
    a. Governance mechanics ‘good to go’
3. Implement the change using two tried and tested implementation approaches
4. Review and Check

Quality management overview



SIPOC applied to assurance groups

Suppliers	Inputs	Process	Outputs	Customers
• Individual Staff • Information Systems • Internal Audit	• Reports • Minutes • SME insight	• Agenda & Work Programme • Scrutiny • Insight • Constructive Challenge • Checking • Deep dives	• Reports • Specific assurances	• Accountable Officer • Board • Regulator • System assurance

Hours/days spent in meetings – analysis of 85 meetings

Business area	Total no. of Meetings	Total Meeting Time in Hours per Year (not prep or report development, actions etc.)	No. of Days
Chief Operating Officer	1	600	25.0
Corporate	16	3,496	140.7
Executive Chief Nurse Office (includes quality and estates and facilities)	20	6,821	233.8
Executive Chief People Officer	7	2,580	107.5
Executive Director Finance and Performance	5	2,115	88.1
Executive Medical Director	16	4,744	184.2
Programme Management Office	1	0	0.0
Strategy and Improvement	1	306	12.8
Cancer Diagnostics and Clinical Support Division	14	2,421	94.1
Division of Medicine	1	828	34.5
Division of Surgery	2	732	30.5
Women's & Children Division	1	528	22.0
Grand Total	**85 Meetings**	**25,171 Hours**	**1,048.8 Days**

This is analysis is for 85 of the 214 regular monthly meetings.

Number of meetings by individuals

Example trust: Meetings which directors are expected to attend (per the ToR) but don't attend in practice. For example:

Status	Number of meetings expected to attend as per ToRs reviewed	Meetings List in Meeting Survey
Executive Chief Nursing Officer	27	21
Executive Medical Director	24	14

Attendance at meetings is variable:

Attendance at Meetings (based on 85 meetings analysed)	No. of Meetings	%
< 50% Attendance	10	12%
51% to 70% Attendance	15	18%
71% to 80% Attendance	11	13%
>80% Attendance	28	33%
Meetings not Minuted and no ToR	20	24%

Example: streamlined & impactful governance

Total No. of meetings identified through GGI's audit (completed March 2021)		**Total No. of meetings in the trust's updated governance** (as at September 2021)	
Area of the governance structure	Total no. of meetings	Area of the governance structure	Total no. of meetings
Trust board & assurance committees	8	14	7
Corporate structure	182	Corporate structure	67
Care group structure	85	Care group structure	64
Total	**275**	**Total**	**138**

Example: GGI's impact at a previous client

At a previous trust that we worked with, we managed to reduce the total number of management groups by 157 (from 275 groups to 138).

This resulted in the following efficiencies for the trust:

Annually

1,384
Hours of Executive Time Has Been Released

417
Fewer Meetings to be Attended per Year by Execs

336
Hours of Non-Exec Time Released

168
Fewer Meetings for Non-Exec Directors to Attend

Detailed example

Key change	Impact	No. of Meetings/Staff Time Saved Annually	Executive Time Saved	NED Time Saved
Quality & Finance and Performance Comm – No. of Meetings Reduced	• Quality and Finance and Performance Committee reduced to bi-monthly meetings • Streamlined agenda focussing on key assurance for strategic and risk areas	12 fewer meetings	120 hours 60 fewer meetings attended	120 hours 60 fewer meetings attended
Audit Committee – No. of NEDs Reduced	• Audit Committee representation of NEDs reduced from 6 to 3	N/A	N/A	24 hours 12 fewer meetings attended
Strategy & Transformation Committee Moved from Assurance Structure to Programme Group	• Group focus is on operationalising the strategy and transformation work • Reports to TMG for exec input rather than execs attending each meeting • Finance and Performance acts as principal assurance committee	1 fewer meeting in assurance structure	120 hours 60 fewer meetings attended	48 hours 24 fewer meetings attended
EDG – Change of Agenda to Focus on Look Back at the Week and Look Ahead to Next Week – Keep Themes – Informal	• Reduce meeting time from 2.5 hours to 1 hour max	1.5 hours per week	525 hours	N/A

Standard documentation

- Agenda
  - Agenda Planning Session Template
- Meeting etiquette
- Minutes
- Action plan
- Escalation
- 3A’s
- Purpose slide
- Plain English ToRs
- Annual cycle of business
- Annual review

‘3 A’s’ template (alert, assure & advise)

[Insert name] Governance Meeting. Key Issues Report. (This report should be a maximum of 2 sides of A4 paper)		
Report Date:		**Report of:** [Insert name] Care Group Governance Meeting
Date of last meeting:		Membership Numbers: [State the number of members in attendance] **Quoracy met** = [For example: 100% attendance including the Chair and DeputyChair]
1	**Agenda**	The [committee/group name] continues to meet [add in meeting frequency]. The [committee/group name] considered an agenda which is attached [attach agendawhen sending]
2a	**Alert**	The [committee/group name] wish to alert members of the [add in name of groupthat your meeting reports to under the governance structure] that: • [Provide details of the key 3 or 4 matters you wish the committee or groupthat you report to under the governance structure to be alerted to and which have been discussed in your meeting].
2b	**Assurance**	The [committee/group name] wish to assure members of the [add in name ofgroup that your meeting reports to under the governance structure] that: • [Provide details of the key 3 or 4 matters you wish the committee or groupthat you report to under the governance structure to be assured of and which have been discussed in your meeting.]
2c	**Advise**	The [committee/group name] wish to advise members of the [add in name ofgroup that your meeting reports to under the governance structure] that: • [Provide details of the key 3 or 4 matters you wish the committee or groupthat you report to under the governance structure to be advised of and which have been discussed in your meeting.]

2d	**Review of Risks**	[Provide a brief update on any risk that needs to be escalated, for example if arisk is showing mitigating actions that are outside the agreed timescale or thatmeet a certain risk score that require their escalation in line with the Trust’s RiskManagement Policy].		
2e	**Sharing oflearning**	[Provide a details of key points of learning that should be shared across the CareGroup. This may be taken from the sections above, or additional information)		
3	***Actions to be considered by the [add in name of group that your meetingreports to under the governance structure]***	[Provide any additional actions not referenced above that you would like thecommittee/group that you report, to consider or undertake on your behalf.]		
4	***Report compiled by***	[Name of Chair and officer who compiled the report]	Minutes availablefrom:	[Name of officer from where the minutes of the meeting may be obtained]

Phase II: implementation through the ‘three cycles’ programme

This is a significant O/D process that will unlock waste and improve assurance grip driven by classic PDSA and the influence model.

Delivering this is heavy-lifting but the gains will be substantial:

- PDSA over three monthly cycles to embed new system
- Measurements of resource use and meetings quality to ensure the virtuous win-win of better results for less resource usage
- Training and support to break the tyranny of habit and build skills for productive meetings
- Communications programme to ensure that staff value assurance meetings, know how the new system works and can confidently explain this when asked

How it works: the influence model + PDSA

Three cycles: PDSA

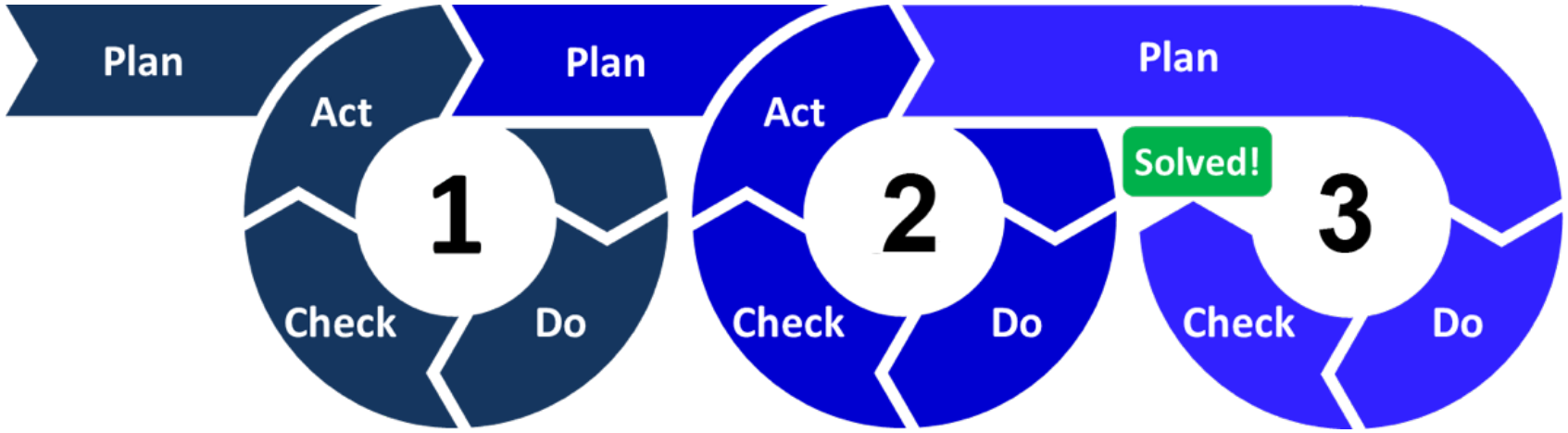


Diagram of the Plan-Do-Study-Act Cycle

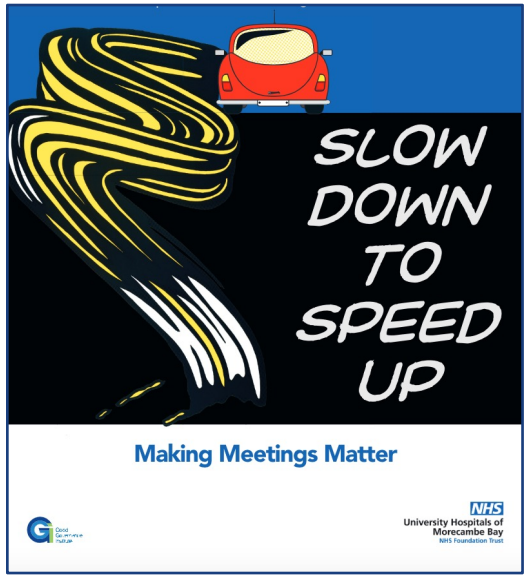
‘Three Cycle’ approach methodology overview

Deming’s ‘Plan, Do, Study, Act’ improvement cycle is well-established in the NHS – and it works. GGI have developed what we call the ‘Three Cycle’ approach to using PDSA to initiate and embed high-standard quality governance in NHS organisations.

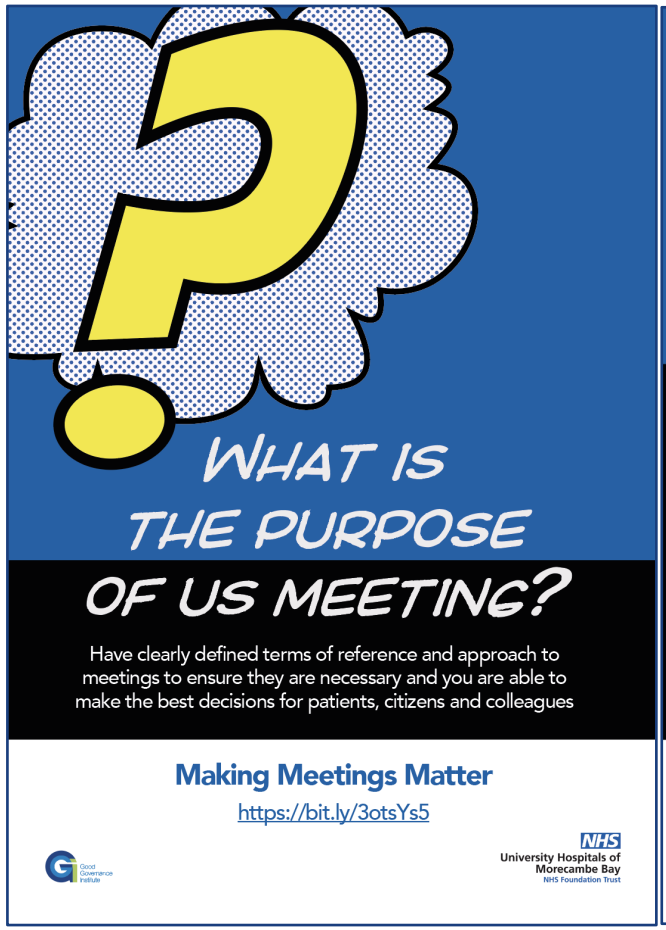
Usual training

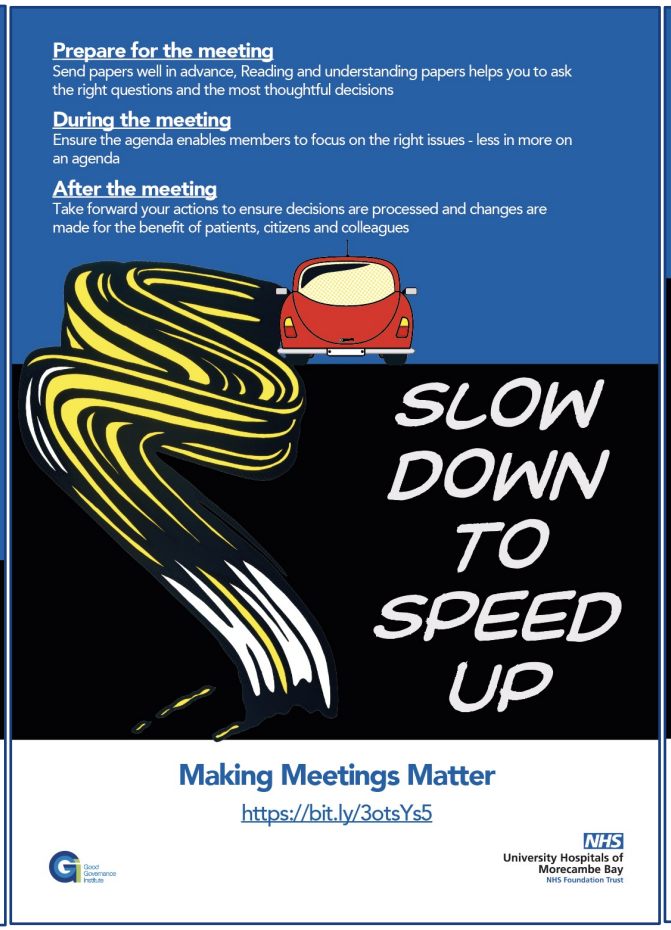
- Chairing meetings
- Observing meetings
- Report writing
- Minute taking & action planning

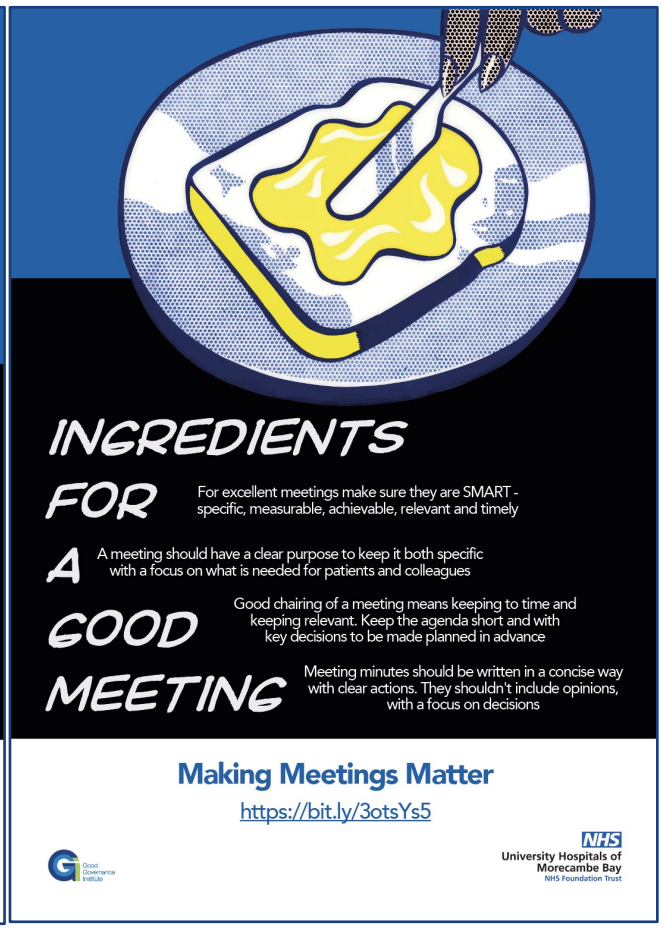
Example imagery



Next steps & your involvement







Review & chart progress

- Opportunity cost?
- Can everyone explain the system?
- Better meetings?
- Better governance?

Introduction to matrices: measuring outcomes

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Maturity matrix to support effective governance meetings at clinical directorate/care group level

PROGRESS LEVELS / KEY ELEMENTS	0 NO ACTION	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Progress becomes mainstreamed	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistend achievements
STRUCTURE	No	Structure developed and agreed. Shared with all staff in care groups/specialty. Roles and responsibilities agreed	Structure across whole care groups discussed at care groups and specialty level, with terms of reference agreed for each standard meeting	Structure shared across all care groups, and structure of other care groups and specialties reviewed and discussed to identify any useful learning points	Annual review of meeting's work confirms positive added value. Structure refined. Task and finish groups set up for one-off projects of work	Structure, with amendments and improvements, has been working for 24 months. Evaluation of structure as remaining fit for purpose two years running	Structure externally recognised as adding value. Other organisations have reviewed the structure as a possible model for their own structure
ENGAGEMENT	No	Attendees for meetings defined and informed. Quorum defined	First three meetings held and quorum maintained. Meeting etiquette discussed and agreed.	No surprise non-attendees from core members at last three meetings. Apologies with reason for no show always given. Substitutes usually attend for planned no shows	At least 75% of core membership have attended last three meetings. Examples of staff initiated issues being picked up at meetings. Membership reviewed and if needs be developed	Attendance at meetings reviewed for past year and 75% attendance maintained. Refinement to membership based on cycle of business. Engagement by care groups and specialty staff is recognised by external parties as a mark of good practice e.g. CCGs and CQC	The working methods of the care groups/specialty has been used by other organisations to help develop their own approach. The engagement by staff in the governance process has been promoted in a peer review forum as national best practice
RECORDING AND ACTION PLANS	No	Standard format for meeting recording discussed and agreed. This includes adoption of trust templates	Meeting notes and action plans for last three meetings drafted and distributed within five working days	Meeting notes and action plans for last three meetings reviewed at following meeting, with actions initiated against majority of action points. Commitment to minimise carried over items	Action plans are reviewed and examples of tangible improvements have been identified. Meeting records are routinely reported to the next tier up. Meeting recording is characterised as timely and lean by those attending meetings	Action plans are systematically being met, with evidence of tangible improvements to practice, compliance or meeting targets. The recording of meetings provides reliable evidence of activity for third parties e.g. internal audit, the CQC, assurance to CCGs	Meeting and action plan recording is recognised as being best practice by external parties e.g. commendations from auditors, mentions in CQC reports. Examples of how activity is recorded are used to influence other organisations
CONTENT AND CYCLE OF BUSINESS	No	Standard agenda agreed, to include consideration of trust template, and first meeting held. Dates organised and advertised for coming three	Outline annual cycle of business discussed and developed, and shared with next tier up	Annual cycle of business finalised and published with care groups and specialty. Group is "commissioned" by group it reports to.	Annual cycle of business reviewed and updated each meeting. Contributions to cycle of business from work of other specialties and/or care	The BAF relies on the work of meetings to migrate assurance to board level. The content of meetings matches the external compliances the organisation	Other organisations are using the work of the care groups/specialty to provide example templates for their own governance meetings.

Introduction to matrices: measuring outcomes

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Maturity matrix to support the development and improvement of quality and clinical governance in divisions

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

APRIL 2018

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Initial achievements evident	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistent achievements
IMPLEMENTING BEST PRACTICE E.G. NICE GUIDELINES	No	Knowledge about best practice sits with individuals. Having a structured way to share best practice uniformly is accepted but not developed. The review of new best practice guidelines is often delayed. Clinical guidelines are not routinely updated to reflect best practice until after the clinical guideline has expired	Process in place to ensure new national guidelines come to the attention of divisions and specialties, and that a gap analysis is performed. Process for measuring and monitoring best practice is identified, but not yet implemented systematically. Where best practice is not implemented, this is referenced on the risk register but with limited plans to address gaps	New national best practice is being systematically picked up for adoption by the division/specialty. Evidence of the local situation is collated and evaluated. Multiple examples of best practice being picked up and locally implemented within the last 24 months. Gaps in compliance are routinely captured on the risk register with action plans to close gaps agreed, and implementation monitored	Application of best practice guidelines is systematically monitored and results discussed. Results are shared between specialty and division, and variances with action plans reported upwards. There exists evidence of positive clinical outcomes and experience for patients as a result of the consistent application of national guidelines	Systematic application of best practice locally is routinely reported and learning points shared within and across divisions. The delivery of excellence in care and experience can be consistently demonstrated through ongoing monitoring. There exists evidence that services provided by division/specialty are systematically improving year-on-year	Contribution to the development of national and international standards by being recognised for publishing examples of excellent practice or other peer review recognition. Examples of other organisations learning from this service
CQC REGULATION	No	Division and specialty leadership promote the importance of clinical, quality and regulatory standards more broadly with staff. Staff are aware of CQC quality domains and ratings	Division/specialty has mapped its compliance against all relevant standards and is aware of any gaps. This process has involved staff, and there are dynamic performance measurements in place e.g. clinical audits. Quality dashboards have been developed at both divisional and specialty level, and these are aligned to the CQC quality domains	Compliance mapping is systematic and kept up to date. Action plans have been developed and implementation progress is being managed. Results and issues are shared within the division/specialty. There are action plans in place to improve performance against any gaps in CQC compliance. Trust-wide rolling programme of peer review inspection is in place	Compliance reviews include an external to the division/specialty component. Evidence of inter-division/specialty sharing of improvement points exists. External recognition being achieved, for example CQC 'Good' rating for service concerned	Inter-division working on standards compliance is achieving consistent results for the trust in broad-theme areas e.g. patient safety and patient experience. Year-on-year consistency or improvements can be demonstrated. Results comparisons with other trusts is used as a spur for adopting better compliance against standards	A CQC rating of "Outstanding" in the majority of specialties. Other organisations learn from the work. The trust benchmarks in the upper decile for standards compliance nationally
RISK MANAGEMENT	No	Staff are aware of the trust's risk management policy and understand key elements of this e.g. risk assessment, risk escalation, etc. This is included within the induction process. New risks are being entered into the risk register and the division/specialty have started to review these	There exists evidence that risks are being reviewed and calibrated, and action plans agreed. There are examples of appropriate escalation of risks. Risk registers are systematically reviewed at divisional and specialty level, and risk informs quality improvement activity. There are examples of risks being escalated to the corporate risk register. The risk management system is externally tested and recognised, through internal audit	Risk identification is proactive and a key part of annual business planning and quality assurance cycles. SMART action plans are in place for all risks. Division and specialty leadership are fluent in the trust's risk management approach, and understand the trust's risk appetite approach. There are examples of different divisions and specialties collaborating to mitigate risks	No risks overdue for review on the division or speciality risk register. Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant actions taken, and of risk score reductions. Divisional and specialty leadership are confident that the risk system is picking up issues they consider important and relevant to better patient care. Staff are aware of the top risks within the division/specialty, and what is	Internal audit provides positive assurance that risk management is robust and adding value. Staff are involved in peer learning exercises within the trust and externally. There is evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time	Trust benchmarks within the top decile for achievement of risk management training. Improvements derived from risk management are shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning efforts

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