



Good
Governance
Institute

The new Integrated Governance Handbook 2016:

developing governance between
organisations (GBO)

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Final report

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GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Preface

It is now 10 years since we published the seminal **Integrated Governance Handbook**. For many this was a real game changer offering practical advice, clarity of purpose and role, and heralded a less compliance and more thoughtful principle based approach to governance since promoted by the Good Governance Institute. I was pleased to be there at the beginning acting as a governance 'czar' for the NHS supporting the Department of Health, Ministers, regulators and colleagues like Sir Williams Wells and Dr. Roger Moore at the Appointments Commission but also recognising the real strains on NHS trusts and health authorities. John Bullivant and I were given a mandate to pursue this and much support in our endeavours by Bradford and Airedale PCT, Brian Stoten at the NHS Confederation and many, many colleagues, Chairs and Chief Executives. GGI have carried on this torch and I'm please again to be working with them on important debates such as '**the future of the National Health Service**' published at this years annual Festival of Governance.

This volume seeks to record the progress of many of the developments that we promoted in the Integrated Governance Handbook. It also repositions our second main opus on **governance between organisations** which has not yet been widely adopted but must surely have its time now with the pressing need for whole health and social care economy systems that not only deliver but demonstrate accountability for public funds and joined up services.

Professor Michael Deighan
Edinburgh, October 2016

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1. Overview: The 2016 Integrated Governance Handbook: ten years on

The purpose of the original Good Governance Handbookⁱ was to help achieve good governance focused on delivery for patients. It sought to challenge existing and complex committee structures; to better align with the external environment without duplication of effort and to ensure better decision taking properly informed by timely, relevant information. The handbook placed emphasis upon an effective system of support to boards including trained board secretaries, effective audit committees and an assurance framework more properly aligned to the risks which could compromise the clearly defined strategic objectives of the organisation.

The new handbook is not a definitive guide to governance (try Claire Lea's excellent ICSA Handbookⁱⁱ) rather, as with many GGI papers, it is a think piece, seeking to outline challenging ideas for board members and their supports. It is based on our extensive governance reviews of the UK public sector, our regular Chairs dinners and our contacts worldwide in the fields of governance, risk and quality. Hence we set out here some diversions from normal guidance to provide for future discussion.

We are not fans of the traditional Cadbury/Monitor comply or explain approach, preferring the South African Kingⁱⁱⁱ guidance to apply and explain which carries a more thoughtful application of good governance principles. You may still have to comply/explain but from a basis of knowing you have sought to do the right thing and you understand why.

We feel the rigid application of fiduciary duty - to look after the interests and continuation of the institution - is too narrow an understanding of public duty^{iv}. We prefer an appreciation of continuing to provide the best quality outcomes rather than the survival of an outmoded model of service delivery perhaps by an institution with volumes too small to deliver safe care or a lack of capacity to improve beyond mediocrity. We have long advocated a best value model of service redistribution to those who can deliver better outcomes.^v

We have oft been criticised for seeming to align or confuse Management and Governance. We continue to do this unashamedly^{vi} recognising two principles: i) that the board needs management and this is usually the job of the Chair but supported by the board secretary and the SID; ii) what our Dutch colleague Marius Buiting refers to as 'fuzzy logic'^{vii} i.e. the messy interface between management and stewardship. We have explored this dilemma more fully in our debate paper on 'What is a deep dive?'^{viii} We do recognise that there is a boundary between governance and management but there are times when it can be crossed as long as all know when and how to reassert that which applied before.

A key job of the board is to seek assurance that risks to its strategic objectives will be overcome and that the management/clinical workforce has the capacity and flexibility to deliver. To do this requires sophisticated levels of challenge or scrutiny. This we have found is not well developed in the public services and whilst our colleagues at the Centre for Public Scrutiny (CfPS) have developed useful guidance and support for councillors there is still a dearth of good advice and training in the NHS. A key document that needs greater exposure is the Williams Commission Report on Public Service Governance and Delivery^{ix} which has an excellent section emphasising the need for scrutiny to focus on improvement, the crucial principles of separation of executive delivery and review roles and the need for director/governor engagement taking place early enough to influence strategy and plans.

Who is responsible for assurance that all is well? Following Mid Staffs and other disasters, regulators and government agencies have been ambushed into the error that only they can provide public and political assurance, especially when all is going wrong. They cannot. There needs to be a fundamental principle of subsidiarity reestablished that accountability starts with clinical practice, is the responsibility of the board, then the commissioners/funders, and only then with regulators/agencies who cannot assure but only exhort. We are taken with the concept of decision science, which recognises that decision-making is the wider process of engagement with stakeholders, refining assumptions etc. whereas decision taking is the point at which you take the decision. Organisations have responsibilities but these become accountabilities at the point they actually take the decision.

GGI have focused much on risk in our papers and see risk as an opportunity as well as a threat. Our papers on risk^x have been widely applied and provide an approach for determining appetite for risk and tolerance for delegation to management and committees. We see great opportunity for the approach in supporting governance between organisations where an appreciation for the risk appetite of others is critical in partnership working.

The Nolan Principles^{xi} are usually quoted as the mainstay of good governance. We applaud these but would encourage colleagues to adopt the additional two principles used in Scotland viz **respect** and **public service**.^{xii} Holders of public office must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times. They also have a duty to act in the interests of the public body of which they are a board member and to act in accordance with the core tasks of the body (but note our comments on fiduciary duty above).

Quality is and should always be the core principle of delivery. We are encouraged by our colleagues at the Chartered Quality Institute who have recognised the importance of governance underpinning quality on service delivery and strongly believe quality improvement is a guiding principle for the NHS. We need to understand quality and appreciate the concepts and nuances of quality improvement, quality assurance and quality outcomes. Clinical audit practitioners are very strong in recognising that clinical audit is an improvement process and therefore must deliver improvement not just measurement. Sadly the NHS still lacks a widely accepted and coherent quality framework.

Of course our organisations must be well led but leadership must be focused. Far too many boards lose sight of their roles and typically devote time to operational and day-to-day issues rather than fulfilling the broader, more strategic roles of the board. They have a responsibility to respond to Robert Francis's recommendations^{xiii} to foster a common culture across the NHS that puts patients first. The Monitor Well-led Framework^{xiv} includes questions on whether 'appropriate information on organisational and operational performance is being analysed and challenged'. Our reviews suggest boards are too often reviewing the past; graphs of performance that ended last month. Forward-looking leadership would be demanding forward trajectories that would highlight the risks to delivering their objectives/targets with some prospect of more proactive action.

Board members do not arrive fully formed. Executives receive little support for their formal and very different role as a board director and we have seen many captains of industry struggle with the arcane and complex arrangements in the NHS. We are delighted therefore to support Gatenby Sanderson's 'Insight Programme' that sets out to arrange for aspiring NHS non-executive directors to be attached and supported at two NHS trusts, one after the other, for a total of approximately nine months.^{xv}

2. Integration

The main focus of this current work is of course to revisit the integration we raised in the 2006 handbook.^{xvi} Surprisingly, this seems often to have been a difficult concept to grasp. In Wales we were told it was unnecessary as the Welsh Health Service was already integrated in the sense that acute and community was integrated in 2000 and there was a government health and social care department in place. But as the Audit Commission pointed out in 'Transforming health and social care in Wales: Aligning the levers of change.'^{xvii}

'The mergers of Welsh trusts and the integration of acute and community services within them which did take place could probably only have been effective if they had been accompanied by reconfiguration and redesign. In many cases, however, the mergers resulted in duplication of services and complex managerial problems involving different staff terms and conditions that themselves can inhibit successful change.'

Elsewhere, an unfortunate response has been to create additional committees and appointments with Integrated Governance in their titles. However, these rarely covered finance. Post Mid-staffs, Andy Burnham Secretary of State for Health saw the principle starkly:

'the main lesson I take from the problems experienced at mid-Staffs – that in future, we must never separate quality and financial data. They are always two sides of the same coin.'^{xviii}

For us integrated governance is both a **simple** and a **complex** idea.

The **simple** idea is that there is only one governance and that this is the primarily the business of the board. Apart from clinical practice at the point of patient care the board is the key place where all the aspects of governance (clinical, quality, cost, staffing, information etc.), come to play at the same time. Effective governance requires that we do not dissipate the composite whole into fragments that never realign. We have made great play over the years that audit committees for example must (re-) focus on clinical matters. Nowhere else, other than in UK health, would you find the main business of the enterprise subordinated to a discrete committee often with vague terms of reference and a lack of management and audit capacity to ensure and improve safe delivery of the core services of the venture.

The **complex** idea is that integration implies that there are no boundaries. In the Wales example even if we have an integrated acute/community service there will always be a boundary with other core areas such as social services, education, housing, criminal justice and employment. Service users also find confusing that institutional geographical boundaries do not align with their care needs from other providers and independent members/directors are often lost on their accountabilities for resident populations when services are commissioned, provided or hosted by others.

We have found that even within a single acute hospital there are strong divides to departments and specialties, between chronic and acute, diagnostics, mental health and palliative care. The challenge for governance of a truly integrated care in a complex market/collaborative world is to look both inwards and externally using the patient's eyes to challenge whether the services delivered are truly integrated for their particular pathway/package of care.

3. What has happened since 2006?

We have had five Secretaries of State within four administrations (Labour, Coalition and Conservative) and the NHS has operated, in England at least, within a more or less market economy.

Secretary of State	Parties	Dates
Patricia Hewitt	Labour	May 2005 - June 2007
Alan Johnson	Labour	June 2007- June 2009
Andy Burnham	Labour	June 2009 - May 2010
Andrew Lansley	Conservative/Coalition	May 2010 - Sept 2012
Jeremy Hunt	Conservative/Coalition	Sept 2012 - May 2015
Jeremy Hunt	Conservative	May 2015 –

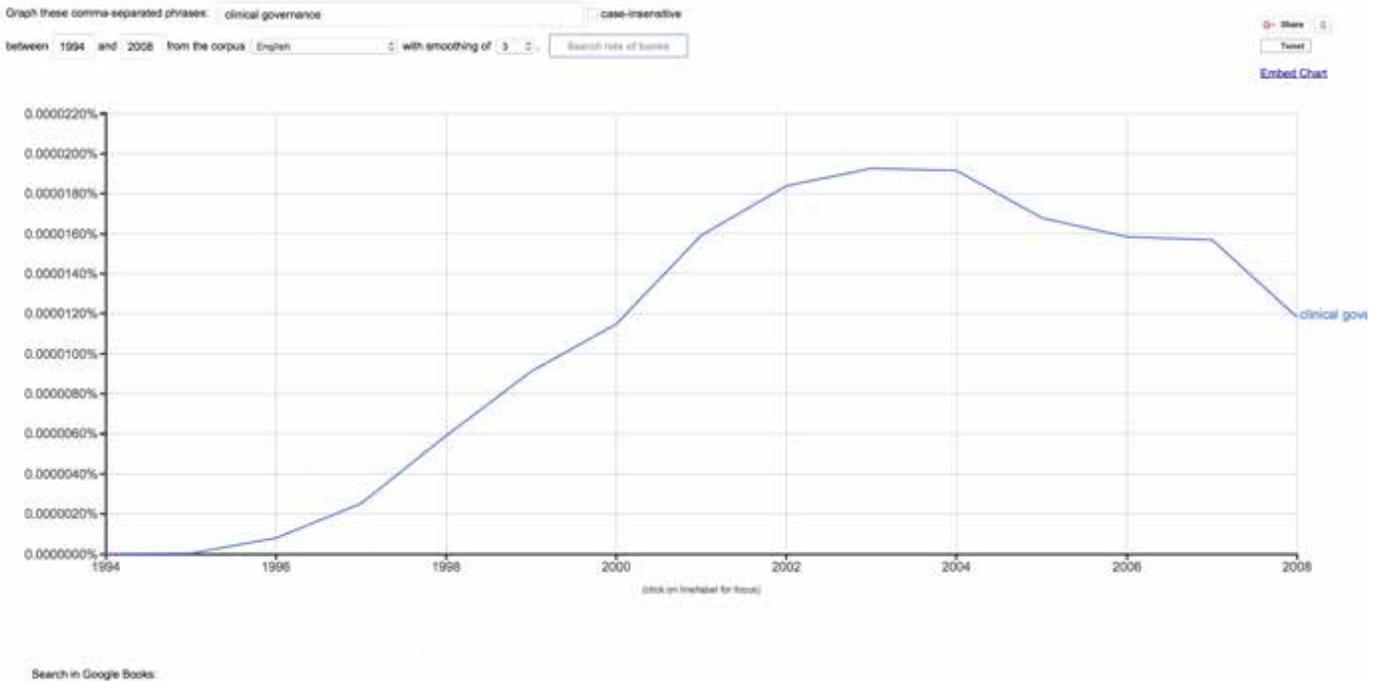
The big reforms in England have been the development and demise of primary care trusts (PCTs) as commissioners, the demise of regional and local health authorities, the emergence from 2004 of Foundation Trusts as the dominant but not universal provider from the 2012 Act, and the promotion of GPs as key commissioners. Elsewhere the situation has been very different with Wales and Scotland rejecting commissioning and foundation trusts (FTs) and developing whole health economy type boards with a gradual move towards health and social care integration which has been in place in Northern Ireland since 1973 but within a commissioner–provider separation model. Significantly Public Health which in England had established a key role as the promoters of the golden thread in commissioning from joint needs assessment through prioritisation to commissioning intentions and actual procurement has found itself now in a variety of institutions: in local government in England, in Health Board providers in Wales and Scotland and in Northern Ireland since 2009 (within the Public Health Agency for Northern Ireland). The move to local government in England is of particular concern as local government has faced the brunt of austerity/Brexit constraints.

There have been the usual overtures towards taking the politics out of health and there has been the usual rise and fall of regulators as scandals both clinical and financial have outstretched their capacity to give comfort that all is well.

There have been attempts to bring service users and providers more clearly within the ambit of governance with FT governors, GP members of CCGs, the perpetuation of CHCs in Wales and in England the development of patient representatives and Healthwatch. In Scotland both staff and users have been formally brought within the governance of health and social care, initially within health boards and now in the new integrated health and social care partnerships

Governance itself has had its ups and downs. In 2010 it looked as if governance would withdraw from its emerging significance. Clinical governance too as the Google Ngram 1994-2008 showed a decline in published material from a peak in 2003.

Google Books Ngram Viewer



We as GGI leaders were seriously thinking of new careers, polishing up our chartered 'Quality' credentials, as the future did not look rosy at all. PCTs were given their marching orders; there were no residual authorities to hold the ring and as Lansley famously proclaimed of his reforms:

"We will not fall into the trap of prescribing top down processes or governance requirements to say how this should be achieved"^{xix}

Governance in the new CCGs had a chequered start with GPs naturally assuming the rhetoric actually meant they could be casual about accountabilities. This was not to be. It soon became clear that as statutory, albeit membership, bodies, CCGs would need authorisation, boards, audit committees and even a few lay members. CCGs were still a new organisational form. There was natural antipathy to avoid reestablishing PCT type vehicles and there was a clumsy understanding of conflicts of interest and accountability for public funds. The conclusion of our early work in this area is encapsulated in the 'Developing boards and senior teams: the how to do it guide,'^{xx} which argued for a flexible approach but with clear accountabilities.

At the same time internationally there was much interest in Professor Mervyn King's work on governance, risk appetite and public reporting: more anon. GGI itself undertook a sea change as the Commissioning Institute of Humana rolled back. First Andrew Corbett-Nolan, then David Goldberg, and then David Cockayne joined GGI as the CCGs metamorphosed from GP clubs, to public sector statutory bodies with the full paraphernalia of corporate governance albeit with a multitude of constitutional forms. GGI is now probably the largest bespoke governance house in the UK.

With hindsight it was perhaps not surprising that the ill thought out reforms led to a greater need for governance than expected. GPs are inherently conflicted in their role as the beneficiaries of a policy shift to primary care and whilst they have obviously brought their clinical focus to the necessary reforms of clinical settings the Open University Business School research led by Professor John Storey indicates a rather underwhelming level of impact in the first three years of activity.^{xxi}

CCGs may well by now be coming into their stride as commissioners, but new arrangements seem to favour a collaborative model of strategic sustainable transformation to cope with the enormous issues of capacity and resources; financial, staffing and infrastructure. The NHS is not in a good place in 2016 with morale low, and recruitment challenged as finances deteriorate. Even the reset of finances in 2016 seems to leave an unhealthy number of challenged organisations with commentators saying this can no longer be blamed on rogue administrators. The focus is on closing gaps.

What's good then? At last we seem to be seeing real movement on health and social care integration

with housing, public, mental, prison health and poverty all pressing at the boundaries. All four national health services are engaging in debates on sustainable health care recognising not only the dilemmas of demand over resources but the value of health and social care (together with universities) as significant, even the main employers and buyers of goods and services in the local economy.

We believe this all adds up to a key role for health institutions in the post Brexit economy with economic as well as health and well-being roles. What is no longer possible is to limit decision-making and governance within the institutional boundaries of a hospital or GP practice. This report sets out progress since the 2006 handbook and comments on the building pressure for effective governance between organisations.



4. Early Days of Good Governance

GGI originated in the NHS: based at the NHS Clinical Governance Support Team (NCGST). Michael Deighan and John Bullivant were part of the Board development team and were asked by Richard Douglas at the Department of Health, and Roger Moore and Sir William Wells at the Appointments Commission to develop the concept of **Integrated Governance (IG)** based on the long held view that clinical performance, quality, accountability and governance had become siloed from mainstream board and audit focus.

The origins lie in a paper by Professor Michael Deighan and others : 'The development of integrated governance, NHS Confederation'^{xxiii} in May 2004 which was summarised by John Bullivant to mean we need to:

- move governance out of individual silos into a coherent and complementary set of challenges
- require boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery
- require the development of robust assurance and reporting of delegated clinical and operational decision making in line with well-developed controls
- be supported by board assurance products, which provide board members with a series of prompts with which to challenge their objectives and focus.

All these should be underpinned by intelligent information and public/patient engagement. The Integrated Governance Handbook (IGH) was successfully launched in 2006 (reprinted 2009), alongside an impressive range of new governance tools: board assurance prompts (BAPS), maturity matrices and etiquette bookmarks. These were branded as **good governance** and thanks to a viral and inclusive approach to marketing achieved wide penetration and acceptance in the NHS throughout the UK. Andrew Corbett-Nolan was a significant contributor to these early reports and tools. In 2008 The Department of Health was downsizing centralized support agencies such as the Modernisation Agency and NCGST. John and Michael were caught up in this but encouraged to maintain the work under new sponsorship, initially hosted by Bradford & Airedale PCT (who had hosted the NCGST) and ultimately to go it alone. This soft landing was critical to a fledgling new enterprise and the Institute was born. It continued to champion good governance, firmly based on quality, risk and benchmarking credentials and targeted at the top of the shop - the Chair, the board and the top management and clinical teams. The work continued to be characterised by well-designed publications and tools and a charismatic style of challenge and support to board members and management teams.

5. Key themes in 2006 and the then challenges for the future

It is now ten years since we published the IGH. At the time there was a real concern at the lack of board attention on clinical matters (Bristol hearts inquiry etc.). This was rectified by a robust approach to what was called clinical governance but over time this was sidelined from corporate and audit agendas into subsidiary committees. The IGH sought to identify a number of measures that NHS bodies could adopt to fully incorporate clinical issues into the heart of board agendas, decision taking and management action.

We recognise that over the last ten years the NHS has adopted a number of these IG measures to improve joined up governance. These have included a reduced number of committees, clarifying the annual cycle of business, senior and qualified board secretaries, audit committees that also review clinical systems, usable board assurance frameworks, board etiquette, information dashboards and annual board reviews. The IGH recognised the next big governance agenda would be governance between organisations (GBO) and Professor Michael Deighan, the co-author, anticipated CCGs and clinical department leads in his thoughts on Clinicians in Corporate Governance.

The key themes of the IGH 1 were:

- strategic purpose and challenge
- annual cycle of business
- strengthened audit committees
- measuring governance maturity: the matrix
- board etiquette
- board secretary role
- developing clinical governance and quality

What has actually happened in last ten years?

GGI have sought to pursue these issues. We have had sufficient growth over the last five years to move from opportunistic development of funded materials to investment in key but neglected areas of governance such as strategy, risk and assurance.

Strategic purpose and challenge

We always start our reviews with clarity of purpose. Unless an organisation or committee is clear on its purpose, it is difficult to see how it can have a strategy to deliver and governance fit for that purpose. This is not easy as purpose can change at the whims of politicians who are also likely to set, often rather woolly, strategic goals, guided by much tighter but often unaligned and spurious targets.

The GGI Goldberg papers (I-IV)^{xxiii} tackled this important area of strategy. The series has looked at both the policy and practice of the new NHS. In the most recent report in 2016 David took a pragmatic stance, focusing on what people in the system can themselves achieve now, he offered a perspective and advice to those leading the NHS, local authorities and our politicians:

'CCGs had been given the mandate to innovate and to shift care out of hospitals. However, their hands have been tied by a highly restrictive national contract and tariff structure. Why should financially challenged acute care trusts have any interest in losing services and revenue? What incentives are in place to facilitate a well-planned shift of care into the community, better integrated with primary care?'

Unless and until there is a clear national priority of transformation with tools and flexibility provided to CCGs to enable change and with some clear financial protection of secondary care trusts, David argued, little will change.

In his view, to make real progress in the shift of care from hospitals to primary care, several necessary steps must be taken:

1. In order to deliver on the promise of the NHS as outlined in the visionary 1944 Act national funding is required. The UK cannot deliver the promise and publically assumed entitlement to unlimited choice and care that is growing within the current budget for the NHS. The alternative is rationing.

2. NHS England must set clear expectations for the movement of services out of hospitals into community settings. In the short term, hospitals must be protected financially as services are shifted to primary care. The development and investment in hospital-based outpatient and ambulatory care services occurred over decades. It is unfair to expect the shift of outpatient and ambulatory care services out of hospitals to be able to occur quickly without substantial temporary funding. Otherwise, why should hospital leaders and boards agree to the loss of services? It is counter-intuitive to expect NHS Improvement to advocate the shift of revenue producing services out of financially strapped acute care trusts. Across the country, CCG leaders are struggling to get hospitals to collaborate on the shift of services out of local hospitals. The resistance is palpable and understandable. There is an interesting precedent in the European Union supported farming 'set- asides', where farmers were subsidised for a time to not plant certain crops in order to stabilise market prices and make farming financially viable and sustainable.
3. There is a need for substantial capital investment into local facilities (Health and Social Care Community Hubs) where integrated primary care and outpatient secondary care can co-exist. Small and out-dated GP surgeries must be bought out to facilitate movement of GPs at scale into bespoke hubs. GPs cannot be expected to bear this cost.
4. Technical support is necessary to encourage and support the physical integration of existing GP, community, social care and indeed voluntary sector services locally. The form of this integration will vary from simple co- locating existing GP practices to these new Health and Social Care Community Hubs to full-scale mergers into single provider organisations.
5. CCGs must have greater flexibility to contract differently with acute care trusts away from the fee-for-service tariff system. Sessional funding, capitated funding and other approaches, locally determined are some options.
6. The importance of providing front loaded investment in electronic patient records in acute hospitals (in place in most GP surgeries since the late 1980s) and facilitation of sharing of patient records (already achieved across England for medications and allergies with the National Summary Record (SCR)), not just locally but regionally and nationally cannot be emphasised enough. Success in the full digitilisation of health records and pathways will transform practice, enable clinicians to work more efficiently and more safely, and help to ensure that we still have an NHS in 2048, one hundred years after it began.

Challenge: Ask the questions: good and bad answers

We believe in the importance of the board to ask the right questions. Scrutiny and seeking assurance are the key tools of the independent board member. These are not easy. It was helpful that in 2009 the Audit Commission was forthright in 'Taking it on Trust'^{xxiv} of the role of board members to challenge their staff on the veracity of what they were being told:

'those who are charged with running our hospitals must be more challenging of the information they are given and more skeptical in their approach'

This emphasises the importance of a clear etiquette on how we behave. It very clearly recognises that scrutiny is not a challenge of integrity but a proper role of board members to gain assurance that what they are being told will happen.

We also commend a read of the Williams Commission report on Public Service Governance and Delivery^{xxv} which has an excellent section on scrutiny. This report emphasises the key features of good scrutiny as:

- separation of executive delivery and review roles
- focus on improvement
- independent and constructively critical rather than oppositional
- engaged early enough to influence strategy and plans
- scrutiny, audit, inspection and regulation becoming complementary, clearly aligned and mutually reinforcing

GGI since the early days at NCGST were keen to support board members' ability to challenge and in 2004 and 2006 published the card pack on 'Key challenges to our board level objectives'^{xxvi} and some prompts to reassure us that we were making a balanced response aligning questions to the then current health care standards.

We followed this up in 2008 with a series of 23 BAPs for good governance in health and social care for the Northern Ireland Services.

This approach has been well received and has now been developed as a mainstay of GGI products called BAPs. The format is simple: a short, usually four page document, with a brief introduction explaining the relevance to boards, a timeline or summary process map and then a series of questions and possible answers. We have found by suggesting both good and poor answers to the challenges that board members can better see if they are being fobbed off. Many of the BAPs also include a maturity matrix which allows the board to collectively conduct a review of progress of the organisation in tackling the issue under scrutiny.

The figure below lists a series of these BAPs.

BAP	Focus	Date
Key questions to ask when scrutinising governance between organisations (July 2008)	<p>Key questions for health boards and local authority overview and scrutiny committees (OSC) to ask when scrutinising governance between organisations.</p> <p>This guide is targeted at NHS Boards and those planning healthcare improvement. It is intended to support debate around diabetes service development in a precise and informed manner.</p>	July 2008
Managing long-term conditions	<p>This briefing is targeted at Clinical Commissioning Groups (CCGs), NHS and Health and Wellbeing Board members and others planning healthcare improvement. It is intended to support debate around service quality, operations and planning in a precise and informed manner.</p>	July 2011
Implementing telehealth services	<p>This briefing is targeted at Clinical Commissioning Groups (CCGs), NHS and Health and Wellbeing Board members and others planning healthcare improvement. It is intended to support debate around service quality, operations and planning in a precise and informed manner.</p>	July 2011
Flexible workers in healthcare organisations	<p>This briefing addresses the later definition and is targeted at Clinical Commissioning Groups, NHS and Health and Wellbeing Board members and others planning and enabling healthcare improvement. It is intended to support debate around service quality, operations and planning in a precise and informed manner.</p>	July 2011

<p>Health and Wellbeing Boards</p>	<p>This briefing is targeted at those developing Health and Wellbeing Boards (HWBBs), or who need to understand and work with HWBBs in the future. It is intended to support informed debate as the precise form and role of HWBBs emerge, and to encourage local health and social care economies to lay the foundations for better partnership working.</p>	<p>September 2011</p>
<p>Telecare supported re-ablement</p>	<p>This briefing is targeted at Local Authority councillors with an interest in Adult Social Care, Local Authority Directors of Adult Social Services, NHS Clinical Commissioning Groups (CCGs), Members of Health and Wellbeing Boards (HWBs) and others involved in planning, commissioning and delivering re-ablement services.</p>	<p>October 2011</p>
<p>Safeguarding</p>	<p>This briefing is targeted at organisations that have a responsibility for Safeguarding Adults. It is intended to stimulate debate within NHS Boards, Local Authority Safeguarding Adults Boards and other public service partner boards. Constructive and informed dialogue encourages local health and social care economies to lay the foundations for better partnership working.</p>	<p>December 2011</p>
<p>Quality schemes in healthcare providers for better commissioning</p>	<p>This resource for governing bodies and boards focuses on the ways in which quality review schemes can contribute to a framework of greater quality assurance in healthcare commissioning.</p>	<p>May 2014</p>
<p>Using audit for better commissioner assurance</p>	<p>This resource for governing bodies and boards focuses on the ways in which provider audit activity, both internal and clinical, can contribute to a framework of better quality assurance by healthcare commissioners.</p>	<p>May 2014</p>
<p>Oversight of local diabetes care by Health and Wellbeing Boards</p>	<p>This guide is targeted at members of Health and Wellbeing Boards (HWBs) in England. It is intended to support HWBs in ensuring the highest level of diabetes care and prevention in their area. In particular, it aims to help colleagues who have no clinical training understand key healthcare issues.</p>	<p>October 2014</p>

Annual cycle of business

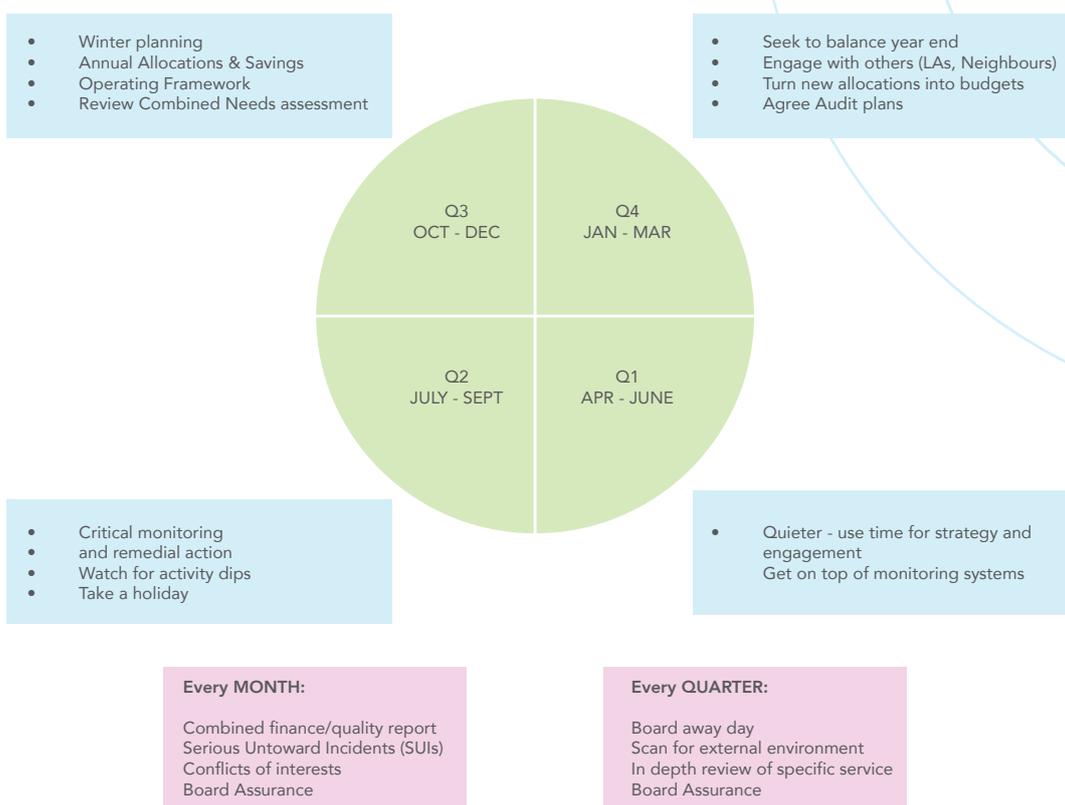
The IGH emphasised the need to plan an annual cycle of business. In 2006 we were engaged with a fairly stable though not be long-lived environment of PCTs fully engaged with commissioning and providers providing. The need therefore was a simple logistic exercise to plot out the year taking note to include Local Government planning and budgeting regimes and ensuring staff and patient survey results were available before final drafting of annual reports. The IGH set out an example cycle of business for an acute hospital. We believe this is a critical document for a board in being able to comprehend the must do's over the coming year. It should highlight when to focus on statutory and public reporting, undertaking staff and patient reviews, statutory returns and the timing of partners organisational budgeting and audit review setting.

In the period 2006-2010 NHS planning had matured into a sophisticated World Class Commissioning (WCC) model often referred to as the golden thread. **As Governing the New NHS: Issues and Tensions in Health Service Management^{xxvii}**, 2012 put it:

“WCC has generally been considered helpful in ‘joining up the dots’ in the range of work done by PCTs. It has encouraged them to identify the ‘golden thread’ that tells the commissioning story from needs assessment, through prioritisation, purchasing intentions, contracting, and procurement, and on to improved health outcomes.”

In 2011/12 as the new models of CCGs were being established we published with Allocate Software some guidance for PCT clusters as they struggled with new but finite responsibilities seeking to both deliver business as usual albeit within a broader footprint whilst planning for their own demise and the creation of CCGs^{xxviii}. The overall pattern is still relevant to health bodies, and board members should have sight of both summary and detailed cycles of business for their organisation and ideally for their colleagues in the wider health economy to allow challenge on appropriate alignment for planning, budgeting, review and reporting. Understanding the cycle helps boards to manage their own affairs and plot strategy awaydays and formal consultations.

OUR BUSINESS CYCLE



Committees of the board and strengthened audit committees

In 2006 it was common to find boards with 20 or more committees. Often the organogram was confusing in presenting board and management meetings all as committees of the board. The IGH challenged this and boards became more streamlined. Auditors made a good living out of committee reviews whereas GGI favoured a more pragmatic 'give all committees a life of six months to conclude business and then retire them'. If they can demonstrate a role or need an extension so be it. More recently we have found that the application of a sound risk appetite approach has the added benefit of better managing committee agendas. An annual review of risk appetite and delegation to both management and committees within agreed tolerances serves to define the committee purpose and remit as well as clarifying appropriate escalation to the board.

Of course there are exceptions; audit and remuneration are standing committees and mental health and charity funds are special cases but for the rest: finance, quality, transformation, strategy etc., they should be treated more as task and finish groups with a clear developmental role then mainstreaming to the board with audit ensuring the systems put in place are working.

Two main themes emerged from the IGH, one positive and one negative. Unfortunately, some organisations interpreted the IG model as needing an IG committee, but these are gradually being absorbed as described above. The positive was the clarity the IGH and subsequent documents produced by GGI and HQIP^{xxix} brought to clinical issues, audit and improvement. The business of most NHS organisations is delivery of clinical services. This must be the business of the board and its audit committee. It is a mistake to palm this critical core function wholly off to a clinical, quality safety or IG committee unless this is a temporary role to task and finish. Our advice is that the board holds clinical services to account, delegates this to management/clinicians within clear tolerances with clear escalation in place. Audit committees should have oversight of clinical audit and strategic improvement programmes assuring themselves that the programme is material, completed and lessons learnt are implemented across the organisations and with partners and suppliers.

Strengthened audit committees

This was another key feature of the IGH. We sought to emphasise the key and special role of audit committees and their relationship with the board, management, audit and auditors and other committees.

In 2015 we produced the Audit Committee Review for NHS Organisations Maturity Matrix^{xxx} which describes six key elements of an Audit Committee review and provides clear steps on how to progress in each of these six areas:

1. Purpose and mandate
2. Independence and initiative
3. Holistic remit
4. Relationship with audit
5. Working methods
6. Skills and experience

Audit Committee review for NHS organisations

Maturity Matrix developed by the Good Governance Institute with input from colleagues working on NHS audit committees, internal auditors and external auditors



Version 1.0 April 2015



Progress Levels	0	1	2	3	4	5
Key elements	No	Basic Level	Early Progress	Firm progress	Maturity	Exemplar
Purpose and mandate	No	Principle accepted. Agreement of commitment and direction	in development	in development	Results being achieved	
Independence and initiative	No	Board sighted on annual programme of work. Annual committee reports to board. Basic use of effectiveness review mechanism in HFMA Handbook	Board asks audit committee to look at particular issues/systems. Committee aware of relevant board responsibilities (eg. CLRN issues). Outline action plan for effectiveness based on self assessment checklist. Key documents for disclosure are signed off	Audit committee programme of work discussed and agreed by board annually. Board identifies issues for audit committee review/annual programme. Key documents for disclosure are signed off with sufficient time for challenge	Board able to rely on committee to provide independent, credible assurance, if considered relevant by board, specific scrutiny and assurance requirements of third parties included in annual programme of audit committee. Key documents for disclosure are challenged to provide value for stakeholders	The committee's work includes relevant broader healthcare economy issues, such as considering the overall deployment of the audit resource. Self assessment leads to key changes in the audit committee's practice, which are then used elsewhere as best practice
Holistic remit	No	Non-executive membership with officers deemed in attendance. At least one meeting annually with auditors without officers	Committee discusses annual programme/meeting agendas and exerts influence over issues discussed. Committee 'commissions' papers from staff and auditors	Committee confident to reject papers, and presentations if necessary. Members report confident they can act independently, and call to the committee who they need to	Board considers audit committee a sound, independent assurance mechanism. There is clear evidence of challenge to poor and/or unreliable sources of assurance	Audit committee has broken new ground in its work, and this has been picked up by other audit committees as best practice
Relationship with audit	No	Holistic remit of mission understood, and defined line of sight to assurance work done outside audit committee (eg quality committee)	Systematic and agreed working relationship between audit committee and other relevant assurance groups. Committee sighted on internal and clinical audit programmes. Risk management system includes audit committee as part of the risk management process	Differentiation over type of work between audit and other assurance committees means audit committee discusses all assurance areas. Audit committee discusses how assurance on key risks is considered by audit and the other board committees. Evidence of challenge when controls are not working or data is unreliable	Board considers audit committee a sound, independent assurance mechanism. There is clear evidence of challenge to poor and/or unreliable sources of assurance	Audit committee contributes to international integrated Reporting Council-style integrated reports
Working methods	No	Dialogue with internal and external auditors around annual committee programme. Clinical audit programme reviewed by committee	Ongoing dialogue and involvement with clinical audit team. Committee leads setting priorities for annual internal audit programme. Annual Governance Statement (AGS) follows standard templates and is signed off by audit committee in a timely fashion	Audit committee agrees annual programme for both internal audit and clinical audit. Annual programme for internal audit and clinical audit aligned to risk profile of the organisation. AGS considered by the audit committee with input from internal audit	Other audit and assurance activities (eg Clinical Pathology Accreditation) drawn into orbit of audit committee. Clear and regular assessment of independence of auditors. AGS is a mature and accurate reflection of the internal control mechanisms	Positive audit lessons taken up as best practice, for example as presentations at national events
Skills and experience	No	Agenda and meeting planning system in place and involves committee Chair. Committee support identified. Meetings papers sent out in timely fashion. Meeting minutes and minutes shared with board	Action follow-up log in place and used. Annual cycle of business in place. Papers only tabled by exception. Chair provides board with verbal reports as well as minutes. Key scrutiny issues systematically addressed eg BAF, risk register, annual accounts, IG toolkit	Written summary of key assurance and other key points provided to board. Systematic forward look at agendas. Annual programme related to material areas eg BAF, significant risk areas, etc	Committee working is reviewed using a formal framework to produce ongoing improvements to process and a clear action plan or set of objectives for the audit committee is produced. This then guides the ongoing work of the audit committee	Audit committee has provided improvement suggestions to national frameworks for audit committee review, such as to the Health Finance Managers Association (HFMA)
Skills and experience	No	Skills and experience for audit committee membership identified by board. Induction process in place. Audit committee has at least one member with recent and relevant financial experience	Members' skills and experience match those identified by board. Development opportunities in place for committee members. Members report confidence in their contribution to meetings	Committee experience includes at least one member with each of the following: 1) relevant professional qualification 2) experience at board level in two significant organisations 3) experience of formal audit/ accreditation/quality processes	Clinician on audit committee. Succession plan in place	Audit committee members contribute to developing audit committees/audit committee practice elsewhere

*Good is only good until you find better - Maturity Matrices are produced under licence from the Benchmarking Institute. Further copies available from info@good-governance.org.uk

A consistent theme of our work over the years is that the audit committees must (re-)focus on clinical matters. Nowhere other than in UK health would you find the main business of the enterprise subordinated to a discrete (quality, governance, clinical) committee with often vague terms of reference and a lack of management and audit capacity to ensure safe delivery of the core services of the venture. We do not believe the audit committee should do the often complex work of these committees but it must have oversight that clinical audit for example is strategic, material and completed leading to improvement. This schema has been well developed in a number of our publications since the original IGH including:

- Integrated Governance: A guide to risk and joining up the NHS reforms' (HFMA, 2011)^{xxxi}
- Building a Framework for Board/Governing Body Assurance By Elaine Dower and John Bullivant , GGI/360 Assurance, February 2014^{xxxii}
- Clinical audit: a guide for NHS boards and partners

Annual review – a maturity matrix

The IGH included a very important measuring instrument – the maturity matrix. The origins of this lies in the waiting times initiatives studies of the VFM Unit in NHS Wales, the work of the all industry Benchmarking Institute and the NHS Wales Benchmarking Reference Centre. They are very simple and easy to use documents based on honest self assessment - 'kid who you like, but don't kid yourself '. The real value seems to be that board members can identify their individual perception of achievement and then debate with others any differences. They can then agree what needs to be done, in a limited timescale, to achieve authorisation, FT status or simple assurance. The approach avoids the narrow pass/fail binary approaches and recognises that improvement and success is a journey of continual improvement. Governance is no different to other fields of endeavour, we need to work at it.

GGI have adopted this approach for nearly all our new topic discussion papers and have constantly revised the original matrix as a ready reckoner for board review. New versions have also been created for higher education, social services, housing, GBO and transformation for health economies.

The figure below identifies the titles available from GGI with many now recognised by the NICE evidence portico at <https://www.evidence.nhs.uk/search?q=maturity%20matrices>

	Maturity Matrix	Reference
	NHS board maturity matrix	GGI (2015), <i>NHS board maturity matrix</i>
2010	The governance of patient safety maturity matrix	Datix and GGI (2010), <i>The governance of patient safety maturity matrix</i>
2010	Patient safety and cost savings maturity matrix	Datix and GGI (2010), <i>Patient safety and cost savings maturity matrix</i>
2011	The function of safeguarding adults maturity matrix	Datix and GGI (2011), <i>The function of safeguarding adults maturity matrix</i>
2011	Implementing re-ablement and telehealthcare services maturity matrix	GGI (2011), <i>Implementing re-ablement and telehealthcare services maturity matrix</i>
2011	Implementing telehealth services maturity matrix	GGI (2011), <i>Implementing telehealth services maturity matrix</i>
2011	The functions of health and wellbeing board maturity matrix	GGI and NHS London (2011), <i>The functions of health and wellbeing board maturity matrix</i>

2011	Transforming care for people with long-term conditions maturity matrix	GGI and Natural Voices (2011), <i>Transforming care for people with long-term conditions maturity matrix</i>
2011	The governance of diversity and inclusion maturity matrix	GGI and NHS West Midlands (2011), <i>The governance of diversity and inclusion maturity matrix</i>
2012	Clinical audit maturity matrix	GGI and HQIP (2015), <i>Clinical audit maturity matrix</i>
2012	Good governance themes maturity matrix (HQIP)	GGI and HQIP (2015), <i>Good governance themes maturity matrix</i>
2014	Local diabetes services and strategy maturity matrix	Diabetes UK and GGI (2014), <i>Local diabetes services and strategy maturity matrix</i>
2014	Governance and BAF maturity matrix	GGI (2014), <i>Governance and BAF maturity matrix</i>
2014	Commissioning for quality: audit maturity matrix	GGI (2014), <i>Commissioning for quality: audit maturity matrix</i>
2014	Commissioning for quality: quality review schemes and assurance maturity matrix	GGI (2014), <i>Commissioning for quality: quality review schemes and assurance maturity matrix</i>
2015	Governing body maturity matrix	GGI (2015), <i>Governing body matrix</i>
2015	Risk appetite for NHS organisations maturity matrix	GGI (2012), <i>Risk appetite for NHS organisations maturity matrix</i>
2015	NHS director competencies maturity matrix	GGI (2015), <i>NHS director competencies maturity matrix</i>
2015	Audit committee maturity matrix	GGI, <i>Audit committee maturity matrix</i>
2015	Quality and clinical governance maturity matrix	GGI and Barking, Havering and Redbridge University Hospitals NHS Trust (2015), <i>Quality and clinical governance maturity matrix</i>
2015	Assessment and support of NHS Wales 2015/16 integrated 3 year plans maturity matrix	GGI and Welsh Government (2015), <i>Assessment and support of NHS Wales 2015/16 integrated 3 year plans maturity matrix</i>
2015	Good governance outcomes for CCGs maturity matrix	GGI and NHS England (2015), <i>Good governance outcomes for CCGs maturity matrix</i>
2015	Quality and care governance within service areas maturity matrix	Aberdeen City Health and Social Care Partnership and GGI (2015), <i>Quality and care governance within service areas maturity matrix</i>
2016	Good governance for integrated partnerships in Scotland maturity matrix	Aberdeen City Health and Social Care Partnership and GGI (2016), <i>Quality and care governance within service areas maturity matrix</i>

Board etiquette

As soon as we engaged with boards we quickly recognised that boards were very different in style, some overly polite and some quite aggressive in particular exhibiting a stand off between NEDs and directors. Our colleague at NCGST, Jay Bevington was warning against groupthink. Something was missing and so we turned to a model developed by Common Purpose in 2002 to facilitate honest discussion and challenge between established and emerging leaders. This became the Board Etiquette Bookmark^{xxxiii} designed by Cartlidge Levene and published initially by the NCGST and the Northern Ireland Clinical and Social Care Governance Support Team. This was rapidly taken up by boards who adapted and developed to suit their needs. An early refinement which we quite liked was by Shrewsbury & Telford NHS Trust who extended the etiquette into a 'we will do - we won't do' format.

There are two key elements to the etiquette: challenge which echoed the 'Taking it on Trust' document by the Audit Commission in 2009 and anticipated the important document on scrutiny included in the Williams Commissions report. The second was a sense of continuous improvement by giving yourself five minutes at end of the meeting to discuss what we can do better next time.

We are pleased to see that most boards have some form of etiquette for how to behave and many also have a guide for members of the public and press attending what is of course a meeting in public, not a public meeting. In 2015 we published a GBO partnership etiquette.^{xxxiv}

Board secretaries

In 2006 there were few board or company secretaries in post compared with 2016, with near universal coverage for NHS providers and fairly comprehensive in commissioners. In 2006 the post was still rather limited in scope and GGI together with ICSA established the first board secretary training programme.

In 2006 we also published a sample job description and there are now a number of board secretary networks in play to support this key role. There have been a number of issues with the role, specifically with confusion about accountability and relationships. GGI encourage a clear and transparent view of the role, its remit, limits and ideally clarity of accountability to the Chair and the board with line management to the Chief Executive. The board secretary title is still a misnomer and confuses management and clinicians as to its authority. A recent NHS Providers survey found most have the appropriate level of influence but some still bemoan that the 'Board doesn't understand the role or necessarily appreciate it'.^{xxxv}

Recently the role has been developed to a broader concept of Director of Governance sometimes encompassing compliance units, corporate affairs and public relations. There has also been an interesting tendency as clinicians secure management posts and as commissioning has been led by GPs for the board secretary to have a clinical background.

The role of board secretary has clearly established itself now but there are new challenges emerging for which the incumbents need to prepare. NHS organisations commission or provide clinical services and the safety, cost effectiveness and improvement of these must be the key focus of the board. This as we have developed elsewhere is a key challenge for board members who must know enough of the business to steer and challenge. Board secretaries too must have a developed knowledge of the services and context of operation if they are to counsel and advise. Similarly no longer can boards operate solely within the confines of the organisational footprint as service users move in and out of their limited remit. Commissioners, regulators, the media, politicians and the public expect joined up service delivery and will not tolerate a narrow interpretation of accountability. This too puts pressure on the board secretary to develop health economy networks and to advise when suppliers and partners have less effective assurance systems or in the case of local government a noticeably different definitions understanding and appetite for risk.

Developing clinical governance and quality

The 1999 Health Act^{xxxvi}, placed the corporate responsibility 'the duty of quality', articulated as clinical governance, on those responsible for local healthcare systems – organisations, not individuals, although health and safety offences and gross negligence manslaughter do apply to individuals. Clinical governance was to be the responsibility of a corporate body, accountable for the services it organised or provided for patients. In the sixth Shipman report^{xxxvii} Dame Janet Smith indicated that clinical governance 'should consist of an integrated system of different types of activity, all aimed at improving

quality of care’.

The IGH stated:

‘In order to discharge this accountability, a new architecture of corporate systems and processes needed to be formulated and skills embedded at every level. Six years on significant progress has been made, but few organisations have reached the state of maturity where clinical governance, the central business of a healthcare organisation, is the Board’s core accountability issue. Integrated Governance aims to do just this: to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by a Board.’

Later that year NCGST was challenged. The formal response published on the website and repeated in Integrated Governance^{xxxviii} was:

‘When we refer to integrated governance what we are aiming for is ‘governance’ although we may use the term ‘good governance’ or ‘governance that is fit for purpose’. Clinical issues must be at the heart of any organisation that delivers healthcare but they cannot be treated in isolation from finance, staffing, health and safety, performance, non-clinical risks and so on. By bringing together the various strands of governance, NHS Boards can be empowered to direct and control organisations more effectively. Integrated Governance is the means by which we pull together all the competing pressures on Trust Boards and their supports. It is a transitional position to ‘good governance’ but moves beyond the handling of issues in silos. It is clear that all healthcare organisations need to demonstrate that they have strengthened and streamlined the governance arrangements within their organisations and, over time, need to develop a further integration between health, social care and other organisations in their health community.’

Our preference is always to present clinical governance in the context of corporate governance so ensure that the main business of the board- commissioning or delivery of safe, cost effective, joined up services does not get sidelined by the enablers of money, buildings and staffing.

To this end we have developed a model of good governance based on ten key themes which sought to be embedded throughout the organisation. This approach was supported by HQIP and published as the Good Governance Handbook within which we attempted to support the concept of subsidiarity, which implies the pushing down or control and responsibility as near to the coalface as possible. We have described for each of these themes the practical application of each principle at board/governing body, division and department level within a healthcare provider organisation. To help flesh this out further, we have included example assurance questions for each of the themes that might be asked, and an accompanying good and weak answers to these. This follows the model used in other GGI support materials such as the series of Board Assurance Prompts (BAPs).

Good Governance Handbook ten key themes:

1. Clarity of purpose, roles and behaviours
2. Application of principles
3. Leadership and strategic direction
4. Effective relationships – external stakeholders, patients and community
5. Effective relationships - internal incl. members
6. Transparency and public reporting
7. Systems and structures: quality and safety, boundary issues
8. Challenge on delivery of agreed outcomes
9. Risk and compliance
10. Organisational effectiveness: adding value

We have also sought to focus what has been traditionally described as clinical governance in clinical system improvement, emphasising the strategic role of Clinical audit and the need to develop joint models of improvement with social care.^{xxxix}

Business intelligence

The purpose of dashboards highlighted in the IGH was to try and make what was complex comprehensible to boards. The danger is in reporting what is required by others rather than what we need to manage and govern the enterprise. GGI have thought hard about this issue and believe boards need a radical rethink of what they need to see. In the IGH we said:

'In order to fulfil its responsibilities, the Board will want to be given information to help formulate its strategy, benchmark existing services in terms of safety, quality, cost, effectiveness etc, and set measurable objectives and targets. It will need to be assured that the organisation is using appropriate information to performance manage its processes and outcomes and will want to receive relevant reports on the successful implementation of its strategies and policies, and those that comprise responses to regulators, the NHS, partners and the public.'

Unfortunately most boards are overwhelmed by this material. STPs will be excessively overwhelmed if they do not get a grip on priorities from the outset.

A strategic rethink would use a combination of risk appetite, forward trajectories against objectives and integrated reporting. We believe this is so important that we have summarised our ideas on these three below and then developed them further in relation to governance between organisations.

A strategic starting point for a board is clarity of purpose but NHS organisations are complex and we believe can develop focus if they concentrate firstly on what their stakeholders expect of them in the round using integrated reporting. Secondly they should get a grip on prioritising intelligence to the board and this can be best accomplished by using risk appetite, risk tolerance and delegation and then finally they fundamentally re-engineer their assurance systems to look forward using forward performance trajectories accompanied by management of risks which might compromise achievement rather than a backward looking focus on what has already happened.

None of this is easy but when we have rehearsed with Boards it seems to make sense.

Integrated Reporting requires us to understand what our stakeholders, patients, users, partners, commissioners, regulators, politicians, public, press etc. expect from us and for us to be proactive in setting out what we will achieve and sustain as a set of capitals and how we will measure the added value achieved. The annual Integrated Report will record progress of success, failures, learning and plans for the future.

Risk appetite requires the board to be explicit about its collective view of risk in relation to the enterprise, key objectives and the capitals identified in integrated reporting. The board should review its risk appetite annually using the exercise to properly delegate to management, committees and partnership boards within defined risk tolerances. This will dramatically cut down on agenda items and board 'intelligence' since if performance is now and projected within tolerance there is no need to further worry the data.

Finally, board assurance focused on yesterday does little for board decision making. Far better with the clarity and bravery of SMART objective setting the board can require reports on any service area or key capitals that are projected to go off tolerance. The board would expect to see mitigation plans in place and a realignment of trajectories to still achieve the closure of gaps (critical for STPs) by agreed milestones. If it is clear that there is insufficient capacity to achieve the new challenge the Board will need to exercise its role in re-determining their strategic priorities by resetting objectives outcomes and timescales and mitigating stakeholder expectations. This is the business of the board but at present too many are too ill served to be effective.

6. What happened, what didn't?

Issue	Scorecard at 2006	Scorecard at 2016	What next?
Strategic purpose	5/10	7/10	All boards clear on their need for elevating strategy over operational matters but bogged down in finances and staffing issues
Annual cycle of business	4/10	6/10	Seen as management task so boards often unsighted on forward programme and alignment especially with partners in health economy
Committees	2/10	7/10	Numbers of committees greatly reduced but mission creep unless focused by an annual delegation review strengthened audit committees with greater focus on clinical issues
Annual review – a maturity matrix	3/10	7/10	All boards now aware of need for frequent review but developmental needs often neglected; induction still poor
Board etiquette	2/10	5/10	Common for boards to have a code of conduct but should be more routinely reviewed acknowledging behaviours as important as systems and processes
Board secretary	3/10	6/10	Common appointment in providers; less so in CCGs. Role still needs development and recognition
Developing CG and quality	3/10	7/10	Improvement generally but danger of choosing balancing of books or quality/staffing. Needs a complete new approach
Business intelligence and public reporting	2/10	5/10	Still resistance to undertaking recording/reporting not required for compliance: much greater voluntary uptake of doing the right thing and measuring it required
GBO	1/10	5/10	Very weak still; focus on within institution systems and procedures rather than between stakeholders

7. What's next: governance between organisations (GBO)

For us Integrated Governance is both a **simple** and a **complex** idea.

We have discussed the **simple** idea of integration that there is only one Governance and that this is the primarily the business of the board. Apart from clinical practice at the point of patient care the Board is the key place where all the aspects of governance (clinical, quality, cost, staffing, information etc.), all come to play at the same time. Effective governance requires that we do not dissipate the composite whole into fragments that never realign.

Now we need to look at the **complex** idea of integration that implies that there are no boundaries. The current government is seeking to embrace reforms in England at the boundary without further legislation. This is going to be clumsy and is not the approach fully adopted in Scotland and partially in Wales. In addition there is real pressure to amalgamate or merge commissioners, services and providers without recourse to rationalisation of institutions. This will require stronger leadership, influence and risk sharing than mere partnership working. It is perhaps salutatory that the old Business excellence model regarded partners as resources rather than relationships. The new world will require working together towards common rather than partisan goals.

Back in 2007 we developed what we thought at the time were three key themes of GBO, supported by an enhanced view of assurance at the boundary. These were:

1. Continuity of care
2. Partnerships and networks
3. Mutual aid and business continuity

These themes were developed by a commission from HFMA to write a second IGH on GBO but curiously this was rejected by the editorial board as too clinical and therefore not of sufficient interest to Directors of Finance (DoFs).

An article based on the book was published by Health Finance in 2011 and a maturity matrix produced but the fuller document although promoted by Amazon and others was never published until GGI tidied the manuscript and made it available on our website in 2015.^{xi}

This delay was unfortunate. It was probably exacerbated by the preoccupation in England with the focus on a market economy which pitched providers against commissioners and local providers against each other. We suspect the market also created within the NHS workforce an antipathy to new market entrants whether from the private or voluntary sector. The government was promoting new entrants from the US and Europe but had not convinced the public that this was good thing.

Interestingly there was a perfectly plausible approach to widening the range of providers. Back in 2000 the NHS Plan (paragraph 6.19) established a new 'best value' regime which required each NHS organisation to review at least one major service, including clinical services, each year.^{xii}

Faced with a strong reaction to what was considered an over-bureaucratic and over-audited initiative, this was soon watered down. The journal Public Finance^{xiii} was soon able to report that Best Value in the NHS had been banished to back room services:

'The NHS will be spared the rigid Best Value regime imposed on local government and will focus on back-room support rather than clinical services.'

'The NHS Executive has accepted some of the principles of Best Value, such as improving collaboration and consultation. But it believes that the rigid structure of the procedure in town halls, with auditors watching councils' every step and signing off Best Value plans, is unnecessary in the health service, which is more trusted by the government. The Executive believes existing performance management systems, including clinical and corporate governance, controls assurance, the National Institute for Clinical Excellence and the new Commission for Health Improvement, together with annual visits to all NHS bodies by regional offices of the Executive, already provide the backbone of a Best Value system.'

So whilst Scotland extended the initiative to the whole Scottish budget, best value in the NHS in England become simply a repackaged version of the old 1980s market-testing legislation, which required health bodies to market-test blue-collar services in catering, cleaning and laundry.

The principle of best value, lost in the bureaucracy of oversight is in practice quite simple and could have resonance today especially for collaborative health economics: There are four simple challenges to retention of a mediocre service:

1. Do we need this service? – maybe ask consumers
2. Do we need to provide it: why?
3. If we continue to provide it, does it compare with the best, if not do we have the appetite and capacity to improve? If not can we justify heroically hanging on to delivering such a mediocre service?
4. If we are the sole provider, what can we do help create alternative and better providers?

None of this was a claim to privatisation rather a plea to focus on patient outcomes and to overcome acceptance of mediocrity or heroic attempts to deliver beyond capacity.

New roles and responsibilities, holding partners to account

The Act which preceded that plan had also ought to develop partnership working. Section 7.2 of the Health Act 1999 enabled local councils and the NHS to work more closely together. The Act swept away the legal obstacles to joint working by allowing the use of:

- pooled budgets: this involves local health and social services putting money into a single dedicated budget to fund a wide range of care services
- lead commissioning: either the local authority or the health authority/primary care group takes the lead in commissioning services on behalf of both bodies
- integrated providers: local authorities and health authorities merge their services to deliver a one-stop package of care.

In the foreword to 'Integrated Governance: delivering reform on two and a half days a month', Professor Bryan Stoten, Chair, Warwickshire PCT and Chair, NHS Confederation set out his views:

'We have long talked about 'partnership' working but making that real needs a far more rigorous governance framework than we have generally had available to us. At a time of new values of commissioning within the NHS, increasingly complex models of primary care and a new more powerful alignment between health and social care there is going to be more opportunity to influence the new agendas. This we can only achieve if we understand our responsibilities...'

Partnership working then is not new but effective governance across boundaries is still in its infancy. Our concept of GBO had anticipated our current need to look at whole systems governance. STPs will need a new approach to leadership spanning institutional boundaries and boards of individual organisations (and their auditors and regulators) will need to get used to risk sharing, delegation to partners, and public accountability outside their usual sector specific comfort zone.

In their Q&A guidance the Department of Health make it clear that the footprints will not replace other local NHS governance structures.^{xliii} The local, statutory architecture for health and care remains, as do the existing accountabilities for Chief Executives of provider organisations and Accountable Officers of CCGs. The STPs are about ensuring that organisations are able to work together at scale and across communities to plan for the needs of their population. Organisations are still accountable for their individual organisational plans, which will form part of the first year of their footprint's STP.

The Department of Health do recognise tensions and NHS England and NHS Improvement have agreed a joint Dispute Resolution Process^{xliiv} which includes as a last resort a formal arbitration process:

'organisations should do all they can to avoid disputes and, when they occur, to resolve them swiftly and independently. Resorting to arbitration is a sign that the parties have failed in their duty to work together effectively.'

The new STP footprints are not statutory bodies, but collective discussion forums which aim to bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities however each footprint will need to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence

of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. They will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan.^{xlv}

To accompany our early GBO guidance we set out some principles for use by board members which we term 'An etiquette for partnerships'. These principles included the advice to agree and appoint an arbitrator to handle and determine partnership disputes, better to do this early on and never use than find it difficult to agree an honest broker in the middle of a dispute.

The partnership etiquette principles in full are:

1. Be clear if it's a contract, SLA, Grant, Partnership, Network, Community of Practice (COP). Does our governance reflect this?
2. Agree common objectives, values, outcomes and measures
3. Define our emerging plans with partners and agree necessary changes in relationship and expectations
4. Log, share and track agreed decisions and ensure all parties affirm and provide assurance of delivery of performance and outcomes
5. Agree to share information which provides early warning of variance and completion of agreed actions / commitments
6. Agree and appoint an arbitrator to handle and determine partnership disputes
7. Identify and share common risks (and escalation plans) including risks of partner/supplier failure to deliver
8. Share with partners knowledge of reputational risks in timely manner
9. Clarify and update first contact point for control of each decision/agreement and escalation contacts for concerns over assurance
10. Give adequate notice of intent to withdraw specific commitments

Grip and Scrutiny in an ambiguous world of accountability

'Grip' is one of those elusive terms used in governance. The Carter Review of unwarranted variations uses the term 13 times, CQC like it and it is often used in their reports:

'It is our expectation that providers should use our inspection reports to get to grips with their problems and ensure they sort them out.'

'We will continue to monitor the trust closely, and will be returning in the near future to check that the trust has got an improved grip on these immediate issues.'

And the new guidance on mergers and acquisitions in the NHS: Lessons learnt and recommendations^{xlvi}, extols boards to 'Get a grip on the target business as quickly as possible and maintain the momentum of integration.'

Maintaining grip across organisational boundaries without mergers is even more formidable. Holding partners to account requires a sophisticated approach to challenge and an understanding of the partners approach to accountability. Local government uses the term scrutiny and it is becoming more prevalent in health. Scrutiny itself is evolving both in legislation and in practice. In 2014 DH offered guidance to health and local government on the changing context in light of the 2012 Act and the advent of new players such as Healthwatch.^{xlvii}

This affirmed the primary aim of health scrutiny is to act as a lever to **improve** the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved. At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service and in testing this information by drawing on different sources of intelligence. In the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service

providers – for example, by seeking the views of local Healthwatch.

It is interesting that as commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation. The guidance says that:

- local authorities may be bodies which are scrutinised, as well as bodies which carry out health scrutiny.
- the duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be “relevant health service providers”.

However the Department of Health report recognised that being both scrutineer and scrutinee is not a new situation for councils but warned ‘It will still be important, particularly in making arrangements for scrutiny of the council’s own health role, to bear in mind possible conflicts of interest and to take steps to deal with them’.

Local authorities may appoint a discretionary joint health scrutiny committee (Regulation 30) to carry out all or specified health scrutiny functions, for example health scrutiny in relation to health issues that cross local authority boundaries. Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority’s health scrutiny function about substantial reconfiguration proposals.

There are therefore arrangements in place to deal with some of the complex issues arising from whole system health and social care management but there are also cautions.

The Williams Commission in Wales whilst identifying scrutiny as an important lever to secure improvement believed it was one which needed development. Too few recognised the fundamental importance of scrutiny in driving improvement. And too many viewed scrutiny as no more than a burdensome process which had to be tolerated but could be ignored. Scrutiny that is resisted or undervalued within organisations is unlikely to be successful when extended to other public sector organisations. The Commission found that under-resourcing scrutiny mechanisms had contributed to major governance failures. For example, the joint inspection by Wales Audit Office (WAO) and Health Inspectorate Wales (HIW) into Betsi Cadwaladr found that the health board collectively lacked the capability and capacity to provide the appropriate levels of scrutiny in relation to service.

The Commission identified five key features of good scrutiny:

- separation of executive delivery and review roles
- focus on improvement
- independent and constructively critical rather than oppositional
- engaged early enough to influence strategy and plans
- scrutiny, audit, inspection and regulation must become complementary, clearly aligned and mutually reinforcing

All of these issues come more sharply into focus as we consider arrangements across wide health and social care economies. The Centre for Public Scrutiny (CfPS) for example have argued that ‘Integration’ is arguably the greatest policy priority facing those who plan and deliver health and social care services.^{xlviii} Councils are central to making integration a reality, working with clinical commissioning groups (CCGs) and providers of health and social care services to establish a shared framework for delivering seamless health and social care. However, the experience in Scotland makes it clear that external scrutiny cannot be the starting point for integration arguing that it is those public bodies that are most self-aware of their strengths and weaknesses and act upon that knowledge, that tend to be better performers. The Crerar report (2007)^{xlix} in Scotland made it clear that external scrutiny can be a catalyst for improvement in the way that services are delivered especially when it influences behaviours and the culture of service providers. However, the primary responsibility for improving services lies with the organisations that provide them. The Crerar report recommended that the degree of future external scrutiny should be dependent upon the range and quality of performance management and associated self-assessment in place within public services.

CfPS have identified some common themes to overcome: potential barriers to effective scrutiny when working across boundaries:

Overcoming potential barriers to effective scrutiny of integration

Some common themes emerged from the inquiry days about overcoming potential barriers to effective scrutiny:

Potential barrier	Possible solution
Lack of clarity about different roles and responsibilities causes tension between health and wellbeing boards, commissioners, providers and scrutiny	➡ Agree a common statement of roles and responsibilities to help avoid duplication and help to plan scrutiny effectively
Scrutiny is not included at an early stage or does not get the information it needs leading to reactive and less influential scrutiny, rather than helping to improve integration plans	➡ Agree a common approach that sets out clear arrangements for scrutiny to be built in to the whole cycle of planning, commissioning, delivery and evaluation
Party politics leads to conflicts within scrutiny and between scrutiny, council executives and partner bodies	➡ Agree a non-partisan approach that separates councillors' scrutiny role and their representative role
Information about the way health and social care services are planned, operated and funded can be complex and proposals for changes are not always well received	➡ Agree to support scrutiny so that councillors can navigate the health and social care system, appreciate its complexities and respond effectively to proposals for change
Lack of clarity about the policy development and 'holding to account' roles of scrutiny causes tensions about the timing of involving scrutiny	➡ Agree that scrutiny is a balance between collaboration and challenge about priorities and outcomes
Frequent changes in scrutiny arrangements, chairs or members leads to scrutiny becoming inconsistent	➡ Agree a consistent approach to organising scrutiny to help long term effectiveness of the function

PIECING IT TOGETHER

9

GGI support the view that scrutiny is an important lever to secure improvement but one which needs development. For NHS Boards seeking to operate effectively in complex partnership arrangements, they must now not only understand their own roles and accountabilities within, but also recognise and have a grip on their responsibilities and obligations beyond their organisation boundaries.

Public reporting

GGI have been strong supporters of Integrated Reporting (IR) as an effective way of engaging and reporting to stakeholders.

Working with partners, Grant Thornton, we explored this during 2015/16 with a series of national workshops to public sector bodies to better understand and grasp the potential of this initiative promoted by Judge Mervyn King.

IR has at its heart the concept of agreeing with stakeholders what they value and what capitals they wish to see improved. The system requires organisations to agree value creation with stakeholders in these capitals and then set about improving and reporting on progress and learning. At the moment the system has the advantage of not being a statutory requirement so avoids the failure regime of targets or the stultification of pro forma annual reports.

IR is designed to be a dynamic system which helps commissioners, providers and partners to meet

and engage with service users, staff and families at the outset of planning public reporting rather than the usual scramble as publication date looms. Grant Thornton found in their review of annual reports¹ a largely failed regime of simple compliance which adds little insight or value. By contrast private and public bodies like Crown Estates, National Trust and, to date a very few, NHS organisations, have found the concept of integrated reporting has a positive and informing experience.

There are barriers. In the workshops DoFs in particular whilst applauding the approach as the right way to go pointed out that national target reporting and annual reports will always take priority. They simply did not have the time or inclination to take on a new burden of reporting however useful it might be.

Our riposte to that is to create an IR focus for all reportings. Do it once and use it as the hub for disgorging data into the externally dictated reporting mechanisms. To make this work we need a significant shift towards integrated thinking – joined up-ness - as well as public reporting.

What are our capitals?

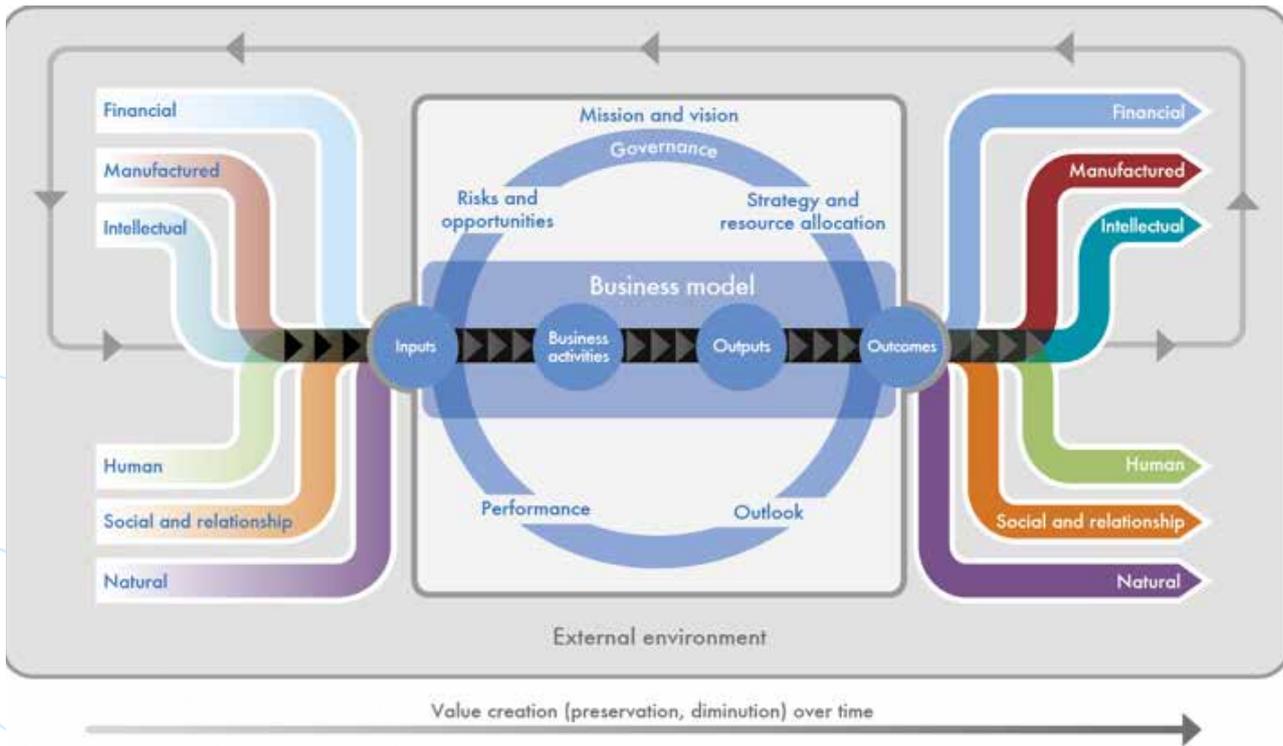
Of course these are the existing traditional areas of money, staff numbers and buildings but we also value the skill base of our staff, the patient experience, our efficiency, our national research and our contribution to local public health, employment and well being, our impact on the environment and leadership in local and national debates.

How do we define and report this kind of joined up-ness?

We have been working with a number of organisations encouraging story telling as a component of ambitious ‘turning the curve’ style aspirations. This might be describing an agreed future as what will it feel like in 2020 for a patient being admitted or discharged from hospital. What is it like to be the charge nurse on night shift in a children’s ward? What is the experience of a NED or governor seeking assurance that services have improved systematically across the patch? These stories are both aspirational and measurable but avoid the trap of setting objectives low enough to be comfortably achieved or so wishy-washy as to be meaningless. The public will contribute to and understand what is being offered and will recognise their role and celebration in achieving the desired outcomes. Falling short on some storylines is not a failure but a learning point immune from regulatory sanction.

At our Leaders Forum in 2016 we invited a number of chairs and CEOs to discuss why we were struggling to get traction behind IR in the NHS in spite of the national promotion. The conclusion was that the approach had merit, the language was awful but it could well have most value with health and wellbeing boards or the new whole system partnerships arrangements.

The framework illustrated is much like an input-output model with all the capitals input transformed through a series of processes to a better state. Much like the business excellence model it provides a framework for thinking and understanding our complex world rather than a solution to problems. It incorporates a feedback loop recognising that the transformed outputs then become inputs to the next iteration of the model, hopefully with greater insight to their interconnectivity.



*'Integrated Reporting reflects and supports 'integrated thinking', defined as the ability of those within the organisation, especially management, to understand the interconnections between the full range of functions, operations, resources and relationships which have a material effect on the organisation's ability to create value over time.'*⁴ⁱ

Risk appetite, delegation and escalation

In 2012 struggling with the GP leaders of the new CCGs we were despairing at their insouciance to governance, rather crudely regarding such matters as simply 'administration'. GP practices as small businesses are reminiscent of the peculiar authority of family businesses which pose many governance challenges. As one KPMG Partner noted: 'Many people (and many family businesses even) are under the impression that governance in family business is a contradiction in terms. Establishing corporate governance structures in a family-run business would be like having the health department inspect your mother's kitchen – a ridiculous notion...'⁴ⁱⁱ

The Practical Guide to Corporate Governance⁴ⁱⁱⁱ confirms a number of governance challenges for family owned businesses, but also identified that they had many positive characteristics known as 'the family business edge' which consistently demonstrated:

- long-term view in decision-making
- ability and willingness to adopt unconventional strategies, enabling family businesses to respond rapidly to changing market circumstances and giving them the flexibility to take advantage of opportunities and address emerging risks
- desire to build a business for future generations, translating to a focus on sustainability and reducing the risk that controlling shareholders will run down company assets and destroy value
- commitment of family management to their company, providing continuity in the way the business is run

Typically, family businesses in the first generation—and sometimes in the second generation—are managed by the founders and other family members. These businesses often face the challenge of attracting good specialists to assume management positions. They face even more difficulties in retaining such qualified professionals. The relationship between family/ managers and non-family professionals needs to be carefully crafted to maintain a well-functioning management team and to lead the company to success.

Faced with these characteristics together with their vehement commitment not to recreate the outgoing PCTs, we needed a strong driver to engage GPs in the fundamentals of governance. We felt it was

obvious that the new CCG organisations would need strong attention to good governance but the ministerial rhetoric created a very different view from the GPs.

Our solution to this was twofold. It was not to bombard GPs with the usual paraphernalia of NHS accountability and compliance but to appeal on the one hand to their attitude to risk and on the other to confront very naïve views about conflicts of interest.

Back in 2006 HM Treasury issued guidance for private and public organisations stating that it is essential that the board's attitude to risk is communicated to the whole organisation and applied in decision making regarding the prioritisation of policies, work streams, programmes, projects, operational service delivery and the funding that goes with them. Arguably if the organisation has not made a formal statement on its risk appetite, it will have a control problem. Without such a statement managers are running their business with insufficient guidance on the levels of risk that they are permitted to take, or not seizing important opportunities due to a perception that taking on additional risk is discouraged. Interestingly apart from a few universities we found few public bodies that had adopted this advice. The GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts^{liv} was an instant success and is still the top Google hit for 'risk appetite NHS':

'It is essential that the Board's attitude to risk is communicated to the whole organisation and applied in decision making regarding the prioritisation of policies, work streams, programmes, projects, operational service delivery, and the funding that goes with them. Failure to define a risk appetite will confuse those who carry out the intentions of the board and may result in too aggressive or timid a handling of the issue.'

The guide initially developed with Maggie Aiken from the Southwark Business Support Unit (BSU), Paul Moore, then CRO at University Hospital of South Manchester NHS Foundation Trust and colleagues elsewhere. The work also built on ideas developed by Professor Mervyn King and the IRCC.

The document identified:

- a high-level outline of risk and risk appetite
- example questions that CCG boards should be asking of themselves
- ideas for better board working for CCGs, to prompt discussion
- a maturity matrix, by which boards can develop their own generic risk appetite and which can also be applied to specific risk
- the means by which existing risk management systems including risk registers and board assurance frameworks can be refreshed and made relevant to board agendas and decision taking.
- examples of risk appetite applied to strategic objectives

(see Annexe 1 following reference to risk appetite matrix)

Our approach is now widely adopted in the NHS including providers . Rather than repeat our advice here is the report to the Wrightington, Wigan & Leigh NHS Foundation Trust Board on 30 May 2012 prepared by Helen Hand, Board Secretary and presented by the CEO, Andrew Foster.

RISK APPETITE 2012/13

Introduction/Executive Summary

This report has been produced to ask the Trust Board to give consideration to its “appetite for risk” as an organisation. In reviewing the Trust’s annual governance statement, feedback from Deloitte included the need for the Board to determine its appetite for risk moving forward. It was recommended that this should be described within future annual reports and annual governance statements.

Deloitte were unable to offer any immediate examples of best practice in this area from other Foundation Trusts they have worked with. Research of best practice recommendations has been undertaken and the information below is provided to support the Board in making this decision.

Risk Appetite

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation’s risk appetite.

A report produced by KPMG suggests that a well defined risk appetite should have the following characteristics:

- Reflective of strategy, including organisational objectives, business plans and stakeholder expectations
- Reflective of all key aspects of the business
- Acknowledges a willingness and capacity to take on risk
- Is documented as a formal risk appetite statement
- Considers the skills, resources and technology required to manage and monitor risk exposures in the context of risk appetite
- Is inclusive of a tolerance for loss or negative events that can be reasonably quantified
- Is periodically reviewed and reconsidered with reference to evolving industry and market conditions
- Has been approved by the Board.

The Good Governance Institute (GGI) has produced a briefing paper on risk appetite for NHS organisations with a matrix to support better risk sensitivity in decision taking.

The Financial Reporting Council (FRC) recognised that the Board has particular responsibility for identifying risks linked to the strategy, or resulting from external developments such as political and regulatory change. However, some operational risks are just as capable of damaging the long-term viability or reputation of the Trust as strategic risks, and in its oversight and monitoring capacity the Board need to focus on those risks capable of causing most damage to the Trust if they materialise, regardless of how they are classified. It helps to identify different types of risk appetite (money, quality, regulation and reputation) but always to assess these in the round.

The GGI advise that risk appetite involves taking considered risks where the long-term benefits outweigh any short-term losses. It may be appropriate to incur a loss if this paves the way to eventual success. The Public Accounts Committee (PAC) has supported well- managed risk taking, recognising that innovation and opportunities to improve public services requires risk taking, providing that we have the ability, skills, knowledge and training to manage those risks well. A practical example given by the GGI for monitoring the Trust’s risk profile are the CQC Quality Risk Profiles (QRPs) as they are an important tool in that they bring together a wide range of information on the risk of potential non- compliance with the CQC essential standards of quality and safety. The QRPs are now regularly monitored at Divisional level and by the Quality Executive.

The Trust has set its strategic objectives for 2012/13 and these are reflected within the Board Assurance

Framework (BAF). The monthly monitoring of the BAF by designated committees and the Board is the key process for managing and assessing the strategic and operational risks during the year.

Recommendation

The Board is asked to:

- Note the content of this report.
- Consider and agree the risk appetite of the Trust having regard to the GGI Matrix attached. A provisional self assessment for further discussion is suggested as:

Key Elements	Risk Levels	Appetite
Financial/VFM	2 (Cautious)	Moderate
Compliance/regulatory	2 (Cautious)	Moderate
Innovation/Quality/Outcomes	4 (Seek)	Significant
Reputation	3 (Open)	High

The guide with a matrix developed from the Treasury guidance was reissued and then developed in Scotland with the help of Jonathan Passmore, Vice-Chair of Aberdeen City Health and Social Care Partnership IJB as a guide for the new integrated health boards (Oct 2015). This is possibly where it has greatest value in understanding not only our risk appetite but also that of our partners and stakeholders. Aberdeen City Health and Social Care Partnership (ACHSCP) was established through the Public Bodies (Joint Working) (Scotland) Act 2014.^{lv} The newly established entity is tasked with integrating health and social care services in Aberdeen city, working with the partner bodies of Aberdeen City Council and NHS Grampian to deliver fundamental changes to how acute and community health care services, as well as social care services, are planned, funded and delivered.

The Scottish guide has as an introduction:

Integrated Joint Boards (IJBs) provide services directly e.g. Community Health Services; they host services for others e.g. Out of hours primary care, and they develop strategic plans for other services such as acute medicine, seeking assurances that these services are on track to deliver agreed performance.

This complexity requires clarity of roles and responsibilities, a shared vision expressed in definable objectives, and identification of the risks and opportunities that influence outcomes.

Crown Estates have identified as one of the few public sector leaders in develop the IR approach in the UK. They define risk as ‘anything that can threaten the achievement of our objectives and our ability to manage our reputation. It is important to recognise that as a business we are not averse to taking risk and seeking out opportunities; they are an inherent part of delivering our strategy and creating long-term sustainable value. It is important that we are aware of the risks facing the business to enable informed decisions to be made about how best to manage and take appropriate risks in a controlled and measured manner. To assist this we set out the parameters for an acceptable level of risk taking. This is known as our ‘risk appetite’.

Crown Estates recognise that ownership of risk management is the responsibility of the Board. The board recently undertook an external evaluation which made observations to strengthen further CA’s approach. These were predominantly focused on clarifying responsibility for reporting and ownership of risk, and further progressing the discussion on risk appetite.^{lvi}

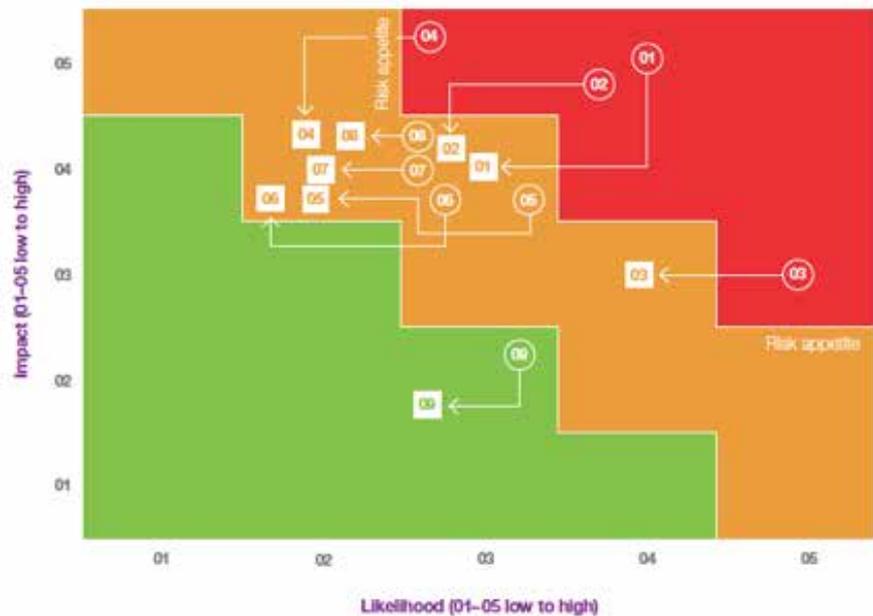
Risks and opportunities heat map

Our top risks and opportunities

- 01 Investment performance
- 02 People risks
- 03 Ability to manage a major incident (incl. cyber security breach)
- 04 London's attractiveness/competitiveness
- 05 Health and safety
- 06 Development performance
- 07 Information systems
- 08 Government policy
- 09 Adverse effect of climate change

- Gross risk (before mitigating controls)
- Net risk (after mitigating controls)

By regularly reviewing our key risks and opportunities, the Board ensures that our risk exposure remains appropriate and in line with the boundaries of our risk appetite.



King III (the King Code and Report on Governance for South Africa, 2009), offered advice to organisations large and small, public and private that are adopting a risk appetite approach: The board should be responsible for the governance of risk and set levels of risk tolerance and risk appetite annually.

The board might appoint a committee responsible for risk. This committee should:

- Consider the risk management policy and plan
- Monitor the risk management process
- Convene at least twice per year
- Be evaluated once a year by the board
- Have a minimum of 3 members
- Have as its members executive and non-executive directors, members or senior management, and independent risk management experts to be invited in necessary
- With regards to risk, the board should:
 - Delegate to management the responsibility to design, implement and monitor the risk management plan
 - Ensure that risk assessments are performed on a continual basis
 - Ensure that frameworks and methodologies are implemented to increase the probability of anticipating unpredictable risks
 - Ensure that management considers and implements appropriate risk responses
 - Ensure continual risk monitoring by management
 - Receive assurance regarding the effectiveness of the risk management process
 - Ensure that there are processes in place enabling complete, timely, relevant, accurate and accessible risk disclosure to stakeholders

The draft **King IV** Report on Corporate Governance for South Africa was released on 15 March 2016 and further emphasises the importance of risk management to assist the company in considering the interdependences of risk. The board should consider what constitutes excessive risk taking and set the level of risk appetite and tolerance. The board and associated committee/s should have the appropriate level of oversight and approval. King IV recommends that there should be overlap in membership between the audit and risk committee and that the risk committee should constitute at least three directors, the majority being non-executives.

- ultimate risk and opportunity management rests with the board. The board should oversee the adequacy and effectiveness of risk and opportunity management and this should focus on the organisation's resilience to withstand vulnerabilities including recovery plans.
- the level of disclosure regarding the effectiveness of the risk and opportunity management

process has increased. King IV is calling for organisations to disclose the processes for managing risk and opportunity, key focus areas, mechanisms for monitoring the effectiveness of risk and opportunity management and how uncertainties have affected performance and future strategies.

The next session considers how whole health economies might approach governance and risk. As David Nicholson set out in 2009 in his forward to the operating framework for the NHS in England 2010/11^{lvii}:

'In order to achieve the transformation required, we need to focus on how we share risk across the system and re-balance the risk between providers and commissioners...it is vital that NHS organisations do not respond by just trying to transfer risk to another organisation. We will not succeed if we have islands of success in a sea of failure. We have to recognise that we have a zero sum game. If risk is transferred elsewhere in the system, it doesn't take the risk away. The people who pay are patients. They don't recognise organisational boundaries. What they recognise are services that are joined-up across the system.'

Whole health economy review: advent of accountable care organisations and sustainability and transformation plans

Perhaps the greatest incentive to engage with GBO is the advent of **Sustainability and Transformation Plans**. These continue the trend towards integration established with the Better Care Fund.

The Spending Review of 2015 set out plans that health and social care services are integrated across the country. In every region, this must be planned by 2017 and implemented by 2020. NHS England intends that from 2017/18 onwards, STPs will be the single process for being accepted onto programmes with transformational funding, through the reward based Sustainability and Transformation Fund (STF). This step is presented as intended to reduce bureaucracy and help with the local join-up of multiple national initiatives. The STF will be earned by satisfactory answers to the questions set, cutting budgets and staying within expenditure for 2016/17 as well as keeping books balanced for the following four years.

In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined the approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England has produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately to deliver the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. All NHS organisations have been asked to produce two separate but interconnected plans:

- a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021; and
- a plan by organisation for 2016/17. This will need to reflect the emerging Sustainability and Transformation Plan.

44 geographical areas, known as 'footprints' have been decided. NHS England stated these should be 'locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, along with how they best fit with other footprints,'^{lviii} such as local digital roadmaps and learning disability units of planning. Each of these footprints has an Executive Chair, who will oversee the development of their local plan.

This all marks a sea change in direction from the market economy, the emphasis on organisational separation and autonomy.

The Black Country STP has established four key principles^{lix}:

1. Subsidiarity – build on local planning arrangements and partnerships
2. Mutuality – act together to maximise access to development funding
3. Added value – don't duplicate or compromise existing work/partnerships
4. No boundaries – don't allow the creation of the STP to create new boundaries that might compromise the delivery of care

GGI have recently undertaken comprehensive collaborative governance development programmes, which present valuable system learning opportunities for STP initiatives. These include:

Morecambe Bay (Bay Health Partners – Better Care Together) – supporting the collaborative of 11 organisations across NHS, local authority and GP federations in their Vanguard programme to create a system that will take responsibility for the whole health and social care needs of the local 365,000 residents within a single budget.

Aberdeen City Health and Social Care Partnership (ACHSCP) – establishing the governance systems to deliver the statutory integration of health and social care across the Aberdeen metropolitan area, working with the Integrated Joint Board in both shadow form, and since assuming formal powers.

The focus of ACHSCP has been to develop a governance framework which delivers robust assurance mechanisms, while facilitating the innovation necessary to drive change across care delivery in Aberdeen. Working in shadow form in the run up to taking on statutory authority in April 2016, the partnership was afforded the opportunity to develop team working and strengthen board dynamics. These efforts have been a crucial focus, given the diverse background of board members. The shadow phase assisted the board in developing a coordinated approach through engaging with principles of Integrated Governance. Outputs of this phase include an agreed etiquette for board and committee meetings to support effective partnership dynamics.

Much of the governance development focus has been framed around the IJB’s approach to risk. Defined as ‘The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time’^{lx}, the IJB aims to use risk appetite as a central governance platform to link decision making from board to locality team level. Combined with the IJB’s integrated Board Assurance and Escalation Framework, the focus on risk appetite has served as an effective and pragmatic bridge between the transformational ambitions of ACHSCP and the practical operations and governance needs underlying these.

The IJB has also committed to adopting an Integrated Reporting approach to the production of its annual Performance Report. The central concept at the heart of IR is to agree with stakeholders what they value and what ‘capitals’ they wish to see improved. The IJB’s locality model values creation with stakeholders, and as such ACHSCP wish to embed governance which supports the delivery of improvement and reporting on progress and learning in an authentic and meaningful way.

In addition GGI have helped NHS Wales to develop the **NHS Wales Planning Framework** in support of the Development of Local Health Boards’ and Trusts’ 2014/15 – 2016/17 Integrated Plans. This included a Maturity Matrix and a peer review process encouraging sharing of both plan approach but also tackling boundary and all wales commissioning issues. At the Finance Academy Workshop in 2016 it was made clear that failure to balance the books over the three year plan period had four levels of escalation which reflect increasing levels of concern:

1. Routine arrangements - this reflects normal business
2. Enhanced monitoring
3. Targeted intervention
4. Special measures^{lxi}

So far in addition to Betsi Cadwaladr which is already in special measures, three additional health boards in Wales are to be placed under ‘targeted intervention’ the increased level of scrutiny and control by the Welsh Government due to doubts about their ability to tackle challenges
Progress in England will be measured through a new CCG Assessment Framework, which will apply from 2016/17, replacing the CCG assurance framework. It will reach beyond CCGs, asking how local health and care systems and communities can measure their own progress.

Regulation

The regulation of STPs and transformational work remains a challenge, and it is unclear how funding bodies and regulatory institutions will come together to work across whole-systems of care.

There are many challenges that will face such health economies as they develop new models of care and consider how the risks surrounding them might be mitigated.

These are common themes that have been faced by organisations around the country in developing and delivering their new models of care.

Agreeing the model/vehicle for delivery

As the King's Fund^{lxii} point out, "Institutional separation between primary care, hospital care and social care is a significant obstacle" to integrated care within the UK.

The different health and care organisations within an STP, although working towards the same goal, will likely have different cultures and histories. This coupled with a backdrop of health and social care organisations historically working in silos means that a cultural step-change will be required to ensure that joint governance arrangements are agreed and respected.

There must be a shared agreement around deliverables and accountability. Each organisation has a responsibility to hold others to account.

Technology will need to be grown and developed to support the better sharing of information, and the greater understanding of population health and pressures across the economy.

The governance framework for STPs, might include MoUs, the development of Terms of Reference, sharing and agreeing a common annual cycle of business as good starting points.

Leaders will need to agree on the model that is most appropriate for delivering the objectives of the Health, Care and Wellbeing Transformation Programme.

GGI have developed a System Transformation Maturity Matrix as an example of how system leaders could develop the elements underpinning the delivery of new models of care. (see Annexe 2 following reference to System Transformation Maturity Matrix)

Funding

The different health and care organisations within a STP are funded differently and have differing restrictions on their expenditure. Steps will need to be taken to ensure that this is understood, appreciated and adequately addressed through any emerging governance mechanisms.

The STP group is a partnership and each organisation must feel comfortable with their role and the risks associated with this, within this model.

An 'Integration Scheme' should be developed which contains an agreed framework for funding. An Integration Scheme is a formally developed document which states, for example, the scope of services, rules of engagement, and governance arrangements across a new model of care. An example of this is the Aberdeen City Health and Social Care Partnership in which the local health services and the local authority follow their existing budget setting processes in paying money to an Integration Joint Board (IJB) to which they delegate their services.

Management of joint risk

The tools to support the management of joint risk will need to be rapidly developed and agreed. We would expect these to include a joint BAF, risk registers and formal project management. There should be a focus on risk appetite and risk tolerance, which should be reviewed at least once a year, and in periods of increased uncertainty. Leaders should consider establishing a framework for risk pooling.

Internal and external communication

Difficult decisions around the delivery of health and care in the region will, doubtless, need to be taken and by putting communication and public reporting with stakeholders at the heart of the transformation programme, these are more likely to engender public support.

As Chris Ham set out in April 2016:

*'Not for the first time, the fault lines between commissioners and providers have been exposed in an NHS that is struggling to deal with the competitive legacy of Andrew Lansley's **2012 Act**. All the more important, therefore, that national bodies are consistent in their commitment to STPs as the main hope for the NHS and its partners to overcome the unprecedented pressures they face. As well, the commitment of leaders of national bodies must be reflected in the actions*

of their staff at all levels if the noise around contract negotiations is not to drown out the signal around STPs.”

If this is to happen, then the yawning chasm in planning at a national level should be filled by the development of a 45th STP, covering the whole of England and setting out how national bodies plan to sustain and transform care. Based on the **NHS five year forward view**, the national STP should spell out how organisational performance, particularly among providers in difficulty, will be tackled without derailing nascent efforts to collaborate and establish system leadership. A good start would be to require system-wide recovery plans in which organisations are held to account collectively, in place of organisational recovery plans. Separating the noise of contract negotiations from the signal of STPs’.^{lxiii}



8. New Challenges for the future

In this report we have tried to set out the context of integrated governance and progress since the original handbook was published in 2006. We have also revived the embryonic promotion of governance between organisations and tried to argue that it is now timely to establish a new form of integrated governance which transcends organisational boundaries.

We believe that any form of governance must be principle based, that it should recognise how systems and behaviours are intrinsically linked if we are to deliver good governance and that there are a number of practical approaches that can and should be adopted as early as possible. GGI also believes that it is necessary to be brave in both setting out and applying new ways of working but that guidance should evolve into practical application. Our advice is therefore informed but not yet authoritative and we hope that you will engage with us in developing governance by doing.

For the next ten years of this great governance odyssey we believe there are some key features to be tackled. Some we know well, and indeed have been promoting or waiting for the right timing, and some need some careful thought and development

1. STPs and other groupings need to be guided by a set of principles that all can sign up to.
2. Collaborative models need to understand the extent to which they are unraveling the 2012 Act, the duty of CCGs to commission on behalf of patients and the thorny issue of patient choice. A lighter touch joint commissioning based on principles of intelligent funding and focused on outcomes might be the answer.
3. Transformation will need investment and disinvestment. Combined authorities should set out their principles of disinvestment in advance and follow these less they fall foul of judicial review. Best value reviews might be the best way to demonstrate the need to create new forms of provision.
4. The combined authorities will need to take decisions, some of these will be unpalatable to be internal partners and stakeholders. It would be prudent to establish a formal arbitrator in advance; it is much more difficult to agree on a name after the battle lines have been drawn.
5. Combined decision making needs a new kind of leadership which can rise above self interest but still command support from disadvantaged players including the organisation the leaders represent.
6. We need to establish a fundamental principle of subsidiarity recognising that accountability starts with clinical practice, is the responsibility of the board, then the commissioners/funders, and only then with regulators/agencies who cannot assure but only exhort. This is doubly important when decisions are being taken by partner groups. Accountability still rests with the individual statutory bodies. They cannot outsource these accountabilities to quasi bodies. To give such bodies room to analyse and debate their relative accountabilities, they must be unencumbered by issues rightly dealt with at operational level within respective partner institutions.
7. Scrutiny must be recognised as an important lever to secure both accountability and improvement but one that needs development. NHS boards and others seeking to operate effectively in complex partnership arrangements must not only understand their own roles and accountabilities within but also recognise their responsibilities and obligations beyond their organisational boundaries.
8. Transformation plans will need effective stakeholder engagement on a much higher level of competence than has been the norm. This needs to be ethically rather than PR driven with genuine and early involvement of stakeholders if it is to be credible. On the plus side, patient / user/ staff / partner engagement and support will trump negative political/press perspectives.
9. Public reporting needs to break out of the prescribed annual report debacle and move to a model more akin to Professor Mervyn King's Integrated Reporting albeit within a more friendly language.
10. Some standard shibboleths need sorting and moving mainstream with a common understanding. These include induction, clarity of roles, annual reporting, cycles of business, board assurance,

scrutiny, risk appetite, delegation, escalation, etiquette.

11. There needs to be national planning framework with proper accountability to cover progress on investment, training and recruitment, inspection and review, national audits. If the Department of Health or NHS England cannot ,or will not, do this the NHS and its representative bodies should themselves establish a collective model.
12. There should be effort placed on developing a coherent and credible national quality framework and improvement methodology.
13. Clarity should be given to auditors on expectations on them to develop offerings that can cover clinical as well as system / financial audit and cross boundary as well as organisationally focused audits

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10. Key references

- i. Good Governance Handbook, HQIP and GGI, 2014
- ii. The ICSA Health Service Governance Handbook, ICSA, 2015
- iii. King Code on Corporate Governance (1-4), Institute of Directors South Africa, 1994;2002;2009;2016
- iv. NHS organisations should prioritise the interests of service users over those of the organisation: fiduciary duty or not?, GGI, 2016
- v. Benchmarking for Best Value in the NHS, Bullivant, 1998
- vi. Governing the New NHS: Issues and Tensions in Health Service Management, Routledge, 2010
- vii. NVTZ Nederlandse Vereniging van Toezichthouders in Zorginstellingen, NVTZ, 2011
- viii. What is a deep dive?, GGI, 2015
- ix. The Report of the Commission on Public Service Governance and Delivery, Welsh Government, 2014
- x. Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, GGI, 2012
- xi. The 7 principles of public life, Committee on Standards in Public Life, 1995
- xii. Ethical standards in public life, Scottish Government, 2014
- xiii. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, The Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC, 2013
- xiv. Well-led Framework, Monitor, 2015
- xv. The Insight Programme: Improving the quality and diversity of NHS boards, GGI, 2016
- xvi. Integrated Governance Handbook, Department of Health, 2006
- xvii. Transforming health and social care in Wales, Audit Commission, 2004
- xviii. Andy Burnham, Clinical Governance, 2009
- xix. Liberating the NHS: Commissioning for Patients. A Consultation on Proposals, Department of Health, 2010
- xx. 'Developing boards and senior teams: the how to do it guide', Leading for Health, 2010
- xxi. Methods of Mobilizing Clinical Engagement and Clinical Leadership in and around Clinical Commissioning Groups: First Year Findings - February 2014 to February 2015, OUBS, 2016
- xxii. The development of integrated governance, NHS Confederation, 2004
- xxiii. Goldberg Report (1-4), GGI, 2012; 2014;2015;2016
- xxiv. Taking it on trust, Audit Commission, 2009
- xxv. Remove
- xxvi. Key challenges to our board level objectives, GGI, 2004;2006
- xxvii. Governing the New NHS: Issues and Tensions, Health Service Management, 2012
- xxviii. The Annual Cycle of Business: PCT Clusters – Local Arms of the National Commissioning Board, 2011
- xxix. Clinical audit: a guide for NHS boards and partners, HQIP and GGI, 2014
- xxx. Audit Committee review for NHS organisations maturity matrix, GGI, 2015
- xxxi. Integrated Governance: A guide to risk and joining up the NHS reforms, HFMA, 2011
- xxxii. Building a Framework for Board/Governing Body Assurance, GGI and 360 Assurance, 2014
- xxxiii. Etiquette of the Board, GGI, 2016
- xxxiv. GBO partnership etiquette, GGI, 2015
- xxxv. Member briefing: Company secretary role and remuneration, NHS Providers, 2015
- xxxvi. Health Act, 1999
- xxxvii. The Shipman Inquiry – Sixth Report, Dame Janet Smith, 2005
- xxxviii. Integrated Governance: delivering reform on two and a half days a month, HFMA, 2007
- xxxix. Clinical audit: a guide for NHS boards and partners, HQIP and GGI, 2014; Quality Improvement/Clinical Governance Maturity Matrix, GGI, June 2016; City health and social care partnership, a maturity matrix to support the development and improvement of quality and care governance within service areas, GGI, 2015
- xl. Integrated Governance II: Governance Between Organisations, Whole system governance across the boundaries of care, GGI, 2011
- xli. The NHS Plan: A plan for investment A plan for reform, HMSO, 2000
- xlii. Best Value in NHS banished to back room, Public Finance, 1999
- xliii. Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, NHS England, 2016
- xliv. Dispute Resolution Process for the 2016/17 Contracting Process, NHS England, 2016
- xlv. Developing Sustainability and Transformation Plans to 2020/21 letter, NHS England, 2016
- xlvi. NHS: Lessons learnt and recommendations – Summary, NHS Improvement, 2016
- xlvii. Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny, Department of Health, 2014
- xlviii. Piecing it together: Effective scrutiny of health and social care integration, CfPS, 2015
- xlix. Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in

- Scotland (The Crerar report), Scottish Government, 2007
- I. Uncharted Waters, Grant Thornton, 2014
 - li. Understanding transformation: building the business case for integrated reporting, Integrated Reporting, 2012
 - lii. Governance, 2012
 - liii. Practical Guide to Corporate Governance, International Finance Corporation/OECD, 2009
 - liv. GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, GGI, 2012
 - lv. Public Bodies (Joint Working) (Scotland) Act 2014, Scottish Government, 2014
 - lvi. Integrated Report, Crown Estates 2016
 - lvii. Operating framework for the NHS in England 2010/11, Department of Health, 2009
 - lviii. Sustainability and transformation plans, NHS England, 2016
 - lix. Planning Workshop 2016 Presentation, West Midlands NHS, 2015
 - lx. Orange Book: Management of risk – principles and concepts, HM Treasury, October 2004
 - lxi. International Integrated Reporting Council, <http://integratedreporting.org/>
 - lxii. Accountable care organisations in the United States and England Testing, evaluating and learning what works, Kings Fund, 2014
 - lxiii. Separating the noise of contract negotiations from the signal of STPs, Chris Ham, 2016

Annexe I - Risk Appetite for NHS Organisations Matrix



Risk Appetite for NHS Organisations A matrix to support better risk sensitivity in decision taking

Risk levels Key elements	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) Preference for safe ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VfM	Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risk to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/regulatory	Avoid anything which could be challenged, even unsuccessfully. Play safe.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo. Innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussions for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussions for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	SIGNIFICANT

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Annexe II - System Transformation Maturity Matrix



System Transformation Maturity Matrix

VERSION 2.1 JUNE 2016

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=====

PROGRESS LEVELS KEY ELEMENTS	Maturity Levels						
	0 No	1 BASIC LEVEL Principle /Accepted	2 AGREEMENT OF COMMITMENT AND DIRECTION Plans in place	3 PRACTICE MAINTSTREAMED Early progress	4 RESULTS BEING ACHIEVED	5 MATURITY Comprehensive assurance in place	6 EXEMPLAR
1. PURPOSE AND CLARITY OF REMIT	No Purpose, values, vision, and remit clarified, debated and agreed across partner organisations with a strong focus on delivering improved outcomes	The Joint Board / Committee (group) is clear on their roles and responsibilities. Joint strategic objectives have been discussed and agreed	Members are able to take decisions with authority on risk sharing on behalf of their parent body. Conflicts have a resolution mechanism	The organisations are tangibly working towards the delivery of their collective strategic objectives. A joint BAF has been created	Performance against defined strategic objectives are recorded and improving. The strategy is regularly reviewed	The organisations are able to evidence how they are recognised as leading the local health and social care system	The organisations influence national and international standards and are recognised for publishing and sharing examples of best practice. Success has allowed the organisations to redefine / extend remit
2. LEADERSHIP AND STRATEGY	No The group have identified shared risks to achieving their joint objectives / purpose. Each organisation will record such risks in their systems	Risk appetite has been discussed and resolved in relation to joint objectives	Continuity plans are regularly tested. The group uses scenario testing or similar exercises to develop joint understanding of risk and opportunities	The organisations are able to track improvement against the (measurable) strategic objectives. There are no surprises in outcomes data	A high degree of risk sensitivity is demonstrable across the organisations. The organisations are comfortable being held to account	The organisations are responsive to risks, and are able to rapidly address challenges. The group is assured that the collective BAF is balanced and reflects priority issues	A joint audit has confirmed assurance. The sharing of risk has created extra value in the system
3. RISK SHARING	No The partner organisations (group) have agreed a joint commitment and accountability to compliance with national guidelines	Potential internal and external system failures are identified in a shared way, and these are jointly mitigated. There is ongoing effective communication around potential pressure points	The organisations are able to track improvement against the (measurable) strategic objectives. There are no surprises in outcomes data	Issues are systematically identified and are addressed if necessary by jointly commissioned deep dives	National standards and local targets are consistently achieved across the health economy	The parent boards are confident they have intelligent analysis and assurance across the health economy. Lessons learned and best practice are shared within the group & externally	The organisations have been audited and are recognised nationally as a collective learning organisation. Initiatives and improvements introduced by staff are shared within and beyond the group. The organisations can demonstrate they are employers of choice
4. ASSURANCE OF DELIVERY ACROSS BOUNDARIES	No A collective engagement strategy is in place for staff and wider partners. Staff and partner input is sought and valued as a means of driving improvement	Staff are engaged in developing the approach to system transformation in targeted areas.	Mechanisms are in place to ensure that staff feedback is routinely collected. The group receives reports on internal engagement including feedback.	Staff are recognised as effective ambassadors for their organisations. Appropriate group forums exist for staff to learn from any improvement initiatives, and for staff to receive structured feedback	Third party feedback confirms the effectiveness of the approach to staff engagement. Audit provides evidence of sustainable positive change in regards to staff engagement	The organisations have been audited and are recognised nationally as a collective learning organisation. Initiatives and improvements introduced by staff are shared within and beyond the group. The organisations can demonstrate they are employers of choice	
5. INTERNAL STAKEHOLDERS	No						

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DRAFT VERSION 2.1 JUNE 2016

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. O=====

PROGRESS LEVELS KEY ELEMENTS	0	1	2	3	4	5	6
	No	Principle Accepted	Plans in place	Early progress	RESULTS BEING ACHIEVED	Comprehensive assurance in place	EXEMPLAR
6. EXTERNAL STAKEHOLDERS	No	A collective engagement strategy is in place for patients, the public and wider stakeholders. Patients, public and wider stakeholder input is sought and valued as a means of driving improvement across the group	Patient and stakeholders are engaged in developing the approach to system transformation in targeted areas. Stories define how the vision impacts users and staff	Mechanisms are in place to ensure that patient feedback is routinely collected. Patients and carers are engaged and feel confident providing their feedback to the organisations via a variety of means	Effective partnership engagement working is in place and can be evidenced through improved outcomes	A review of external stakeholders demonstrates that the joint work undertaken by the organisations is trusted by both service users and the local community	The group actively contribute to the improvement of health and social care in their health economy. The group engages and learns from other providers and have experienced tangible operational and strategic benefits.
7. TRANSPARENCY AND CANDOUR	No	The group have agreed to share assurance systems; to commission joint audits and deep dives as necessary and to share and publish results	A conflicts of interest register is reviewed and updated by the group and individual boards	The board has defined the need for probity in all dealings with partners and contractors	Each board is confident that appropriate group actions to mitigate conflicts can be actioned and followed through	Reputational risks are routinely considered by all organisations. The group is seen publically as open and transparent	The group have adopted standards such as integrated reporting to share their commitment, success, failures and learning
8. SYSTEMS AND STRUCTURES	No	The group has identified the need to define governance structures and systems fit for purpose	The group has established or aligned governance structures and systems fit for purpose	Decisions and operational plans are now clearly aligned to the various partner organisations and the joint strategic objectives	Systems are aligned and allow for the easy sharing of information, risk and assurance	Audit demonstrates the consistent achievement of delivery across the group to national standards and local joint objectives	The group has shown it is able to share and use data to drive system-wide improvement. Results and Assurance are routinely shared externally
9. PARTNERSHIP ETIQUETTE AND COMPLIANCE WITH COLLECTIVE DECISION MAKING	No	The group has agreed to a joint etiquette on decision taking	The group has defined a joint etiquette for decision taking based on parent organisations defining their individual risk appetite and tolerance for delegation	Group decisions are usually accepted by parent organisations. Conflict resolution mechanism working	Member organisations have demonstrated an ability to hold to collective decision-making processes	Member organisations have audit evidence that collective decision making processes have not compromised their corporate responsibilities	Collective decision making arrangements have been recognised as model system by external regulators
10. SYSTEM WIDE QUALITY IMPROVEMENT	No	The group has identified the strategic outcomes it wishes to achieve together	Improvement plans are in place recognising health economy priorities such as service resilience, vfm, sustainability, handover etc	Joint strategic objectives have clear performance trajectories and recognition of risks that could compromise achievement	The group have confidence in the quality of results, and are able to present one version of the truth externally	Audit and peer review demonstrates the consistent achievement of delivery	The group is able to promote its success regionally, nationally and internationally

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