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What is a deep dive?

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Final Report

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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Introduction

As the Airedale Griggs Booth enquiry, into nursing failures at Airedale NHS Trust, found:

“The most striking failure was in the disconnection between what was happening on the wards at night, and what the Board knew. The Board had no idea.” **It never could but it should have had assurance that someone did and if not should have acted...**

What we will try to do in this paper is explain:

- What is the purpose of a deep dive?
- What triggers a deep dive?
- Who should be involved in a deep dive?
- What would justify a non executive director (NED) engagement?
- What does assurance would look like?
- How to exit with confidence that the issue is now resolved but that should it reappear it will be identified to the board promptly?

What is it?

So what is a deep dive? The regulators use the term routinely but have not sought to define exactly what a deep dive is. Following the Francis report into the tragedy at Mid-Staffs, the, then, Prime Minister asked Professor Sir Bruce Keogh, the NHS Medical Director, to conduct a series of 'deep-dive' reviews into other hospitals with worrying mortality rates. Keogh developed a methodology but preferred to call these **reviews** and the CQC claim to have moved on from using the deep dive term.

We believe that there is a place for boards as the 'first line regulator' to undertake their own deep dives **when there is a lack of capacity or independent assurance that management and clinical actions have been sufficient, timely or widespread**. This must be linked to the risk appetite of the board and its setting of tolerance of failure and escalation.

Other types of review

There are many forms of investigation and enquiry. We have root and branch reviews, 15 step walkabouts, audits, ask the CEO, judicial review, root cause analysis (RCA), but a deep dive is something special. It should happen early, develop an understanding of the problem and it should put things right. It responds to a trigger; often a triangulation of data or events and it reflects a lack of assurance that all is not well.

From a common sense point of view, it would be reasonable to expect a deep dive to be:

- an investigation of something gone awry, not understood or where independent assurance is lacking
- something more than usual performance management, audit, assurance
- a limited exercise producing understanding, conclusions and actions

The deep dive should be able to demonstrate that we know what is wrong, we have a solution and we have instigated a regime of assurance that is consistent with our current risk appetite and tolerance levels for the issue.

What are the triggers?

The deep dive can be triggered by a number of issues or a worrying trend.

The key trigger is likely to be a failure in patient safety or continuity of care but the problem could be a waste of resources, capacity, fraud or incompetence.

Most complaints and incidents should result in a prompt response and improvement. The board should expect all staff to be conscious of their duties of care and candour and to fix things that go wrong and escalate concerns that need solution beyond them. Staff should know how to by-pass intimidating or bullying tactics to remain quiet and audit should routinely review the mechanisms of complaints, untoward incidence reporting, and whistle blowing. A board member should be able to identify a model of subsidiary where problems are dealt with as close to the action as possible, escalated within agreed criteria or tolerances. Boards should be explicit about their risk appetite and the delegation within agreed tolerances of activity, trends and adverse events.

But there are times when the board director should become directly involved. Some would claim this is always a management role whereas our Dutch colleague Marius Buiting talks of the 'fuzzy logic' that must exist between management and board stewardship. The key to this is assurance. If this is missing then the Board member has a duty to act. If management cannot provide or seem to be explaining away the problem a deep dive is necessary.

Examples of triggers (e.g in the Keogh reviews: **mortality rates** which have been consistently high for two years or more)

Other triggers might be:

- unexplained demand or variance in performance
- failure to provide care across organisation boundaries
- non-compliance of standards or checklists
- unsatisfactory response to board director or governors enquiries
- red flagged risks persistently un-mitigated
- cultural failures e.g. in relation to safeguarding, whistleblowing or disciplinaries
- early warning systems unheeded
- failure to invest in strategic aims such as shift to community led services
- sluggish response to review recommendations
- failure to follow up internal audit, clinical audit or complaints
- persistent communication or handover problems within the organisation
- commissioner disquiet
- supply chain problems with suppliers
- reputational risk
- failure to adopt or adapt proven innovations throughout the organisation
- lack of evidence that learning has followed previous investigations

What is the independent director role?

The independent director should:

- spot the trigger which suggests that controls and assurance are weak
- seek authority to commission the deep dive which will require a clear specification to:
 - o define key lines of enquiry and any benchmarking comparisons needed
 - o seek to define and give the necessary assurance
 - o report that assurance achieved
 - o define the acceptable tolerance before escalation - this may be zero tolerance
 - o confirm management have the competence and capacity to make the improvement

Advantages of NED involvement

The NED has special role and authority in a professional service such as the NHS. They are not management and they have life experiences and authority that are different to NHS clinicians and managers. They carry gravitas, authority, power and influence that can trump, say, a doctor's mistrust of middle managers. They have an ambassadorial role too which allows them to be effective at the boundaries of care, for instance between acute and ambulance or health and social care or housing when delayed transfers have become an issue.

The disadvantage is that they may enjoy playing with the train set and not wish to give up a quasi-management role. They must, therefore, seek approval to commission the deep dive limiting themselves to helping to draw up terms of reference for the deep dive which defines explicitly the outcome required.

It is for others then to:

- a. gather and analyse both hard data and soft intelligence held by many different parts of the system.
- b. conduct planned and unannounced site visits noting NHS Improvement visiting guidelines.
- c. listen to staff and patients as well as to those who represented the interests of the local population, including local commissioners and elected representatives.

The process should involve convening a meeting of all involved departmental or statutory parties - a Risk Summit - to agree with each part of the system a coordinated plan of action and support to accelerate improvement.

The commissioning NED should report back to the board that the assurances are now in place, both in the area which caused concerns and that a management plan is in place to spread the lessons widely. The Audit Committee could require Internal Audit to check this has happened.

(This approach is drawn from several sources but includes elements of the review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE, 16 July 2013)

In summary, the deep dive is looking for three things:

1. **Analysis;** factual accuracy, relevance, reliability and understanding
2. **Capacity and competence** to improve
3. **Assurance** that the problem is resolved

The deep dive should be able to demonstrate that we know what is wrong, that we have a solution and that we have instigated a regime of assurance that is consistent with our current risk appetite and tolerance levels for this issue. The report should evidence that learning has or will take place.

What is assurance?

The Leadership Academy (Healthy Board 2013) describes a key role for the board as ensuring accountability by seeking assurance that systems of control are robust and reliable.

GGI would go further and say that the board must own the assurance that controls are working. If they are not assured they must say so and recognise if they can live with the ambiguity or must seek positive, possibly independent assurance that services and systems are safe.

NHS organisations also have a responsibility to provide assurance to their many stakeholders (including patients, governors, public, commissioners, partners and regulators), 'to account for their use of public resources, and to give reassurance that services are comprehensively and consistently safe, joined up and are value for money'.

Likewise commissioners are accountable for the quality of what they buy and must have an active programme to ensure that their providers are competent to deliver safe services and will report when things go wrong. Again the commissioners, (in England the CCGs), must set their own risk appetite clarifying to providers the tolerance of performance they find acceptable.

What does independent assurance look like?

Independent assurance involves people who are not directly associated with the initiative or delivery area. This brings a fresh perspective and constructive challenge for teams tasked with delivering in complex, high risk and strategically important environments.

Examples of independent assurance include:

- internal and external audit
- national inspectorates, CQC, HIW etc.
- deanery reports/Royal Colleges reports
- external reviews undertaken by independents such as GGI
- NAO/WAO
- UKAS Accreditation schemes

These are **not** independent assurance:

- management reports
- local clinical audit
- local project / programme teams
- general legal advice

When do I back off because of legal or external investigation constraints?

In the event of a police investigation into any of the activities in the organisation there should be clear ground rules that enable both the police and the organisation to carry out investigations in parallel so that the board can discharge its duties to provide safe services (see Airedale enquiry).

NED's engagement with patients, family and carers (if any) should be coordinated so they know what the family have been told about on-going investigations.

What support does a NED need?

A NED must have authority but that must be coordinated, probably through the Board Secretary who will advise on seeking Chair or Board authorisation. NEDs will need technical support in setting up the terms of reference for the commission and agreeing scope and timescales. Any paperwork generated must be copied and retained by the Board Secretary. NEDs should not keep files at home and accessed computer files should be professionally deleted after the deep dive is completed.

The NED may need training, support and advice on liability. They should have successfully applied for a DBS check (formerly CRB check) if they are receiving reports on individuals. They will need skills of enquiry and sensitivity. They should avoid giving direction to staff. If they uncover illegal activity such as fraud or evidence of harm to patients they must disclose this and see action is taken. They can seek advice from the Board Secretary, Chairman or SID but if they believe they are being ignored they may need access to external advice. They can whistleblow as any member of staff or they may seek advice from a mentor. GGI file about a dozen cases a year and recommend the NED notify their Board Secretary and have appointed a GGI officer as a paid or un-paid mentor to whom they may pass confidential information. GGI staff will treat these discussions as confidential but are bound by the same requirement to disclose illegality or harm.

NHS Improvement visiting guidelines:

If Chairs or NEDs are required to visit wards or other areas with access to patients as part of their role they should follow NHS Improvement's visiting guidelines and ensure:

- it is clear why they are visiting and what the expected outcome is
- the visit is planned beforehand, identifying where they are going and who they will need to speak to and notifying senior staff well in advance
- visits to areas that give access to patients are made with someone else
- they identify themselves to ward staff and who should be clear about the purpose of the visit
- when speaking to patients ensure they are clear about who the visitors are and why they are there

How to exit with confidence that the issue is now resolved but that should it reappear it will be identified to the board promptly?

The NED is acting on behalf of the board and must meet the objective of securing assurance handing the issue back to routine management, compliance and review. The board should have set its revised risk tolerance by instigating the deep dive, modifying this with a temporary period of monitoring when the fix is in and then, say, within 6-12 months relax the tolerance levels when the issue can be safely handed back to normal practice with the proviso that should the tolerance levels be breached the board (or sub-committee) will re-engage. Management must give assurances of the **capacity and competence** to improve, if necessary highlighting how this affects other programmes and priorities.

Should we have a programme of deep dives or just initiate when required?

The board should determine this in light of robustness of existing systems and the purpose of the programme. A programme of deep dives can be intended as a learning exercise so that when a trigger initiates the need, all directors are conversant with the approach and their role. They should have practiced what level of assurance is satisfactory and have learnt how to lead (or delegate) and report the deep dive.

For example, North West Surrey CCG procure a six-monthly "deep dive" to provide an in-depth review of a broad range of quality indicators. They supplement the monthly clinical quality review meetings held with each of the CCG's main providers. The CCG has clinical leads for each of these provider contracts, with full engagement in clinical quality meetings.

Kent and Medway undertake Serious Incident (SI) "Deep Dives", following agreement by the board that all NEDs, in rotation, should conduct an in-depth review of a sample of Level 4 and 5 SIs. The NED report provides evidence that learning has taken place.

Other types of deep dives: visioning solutions

A deep dive analysis has been recorded as 'a strategy of immersing a team rapidly into a situation, to provide solutions or create ideas. Deep dive analysis will normally focus in areas such as process, organization, leadership and culture. It is commonly used when brainstorming products, process development stages and process improvement.'

The Sustainable Development Unit (SDU) use deep dives as a visioning exercise:

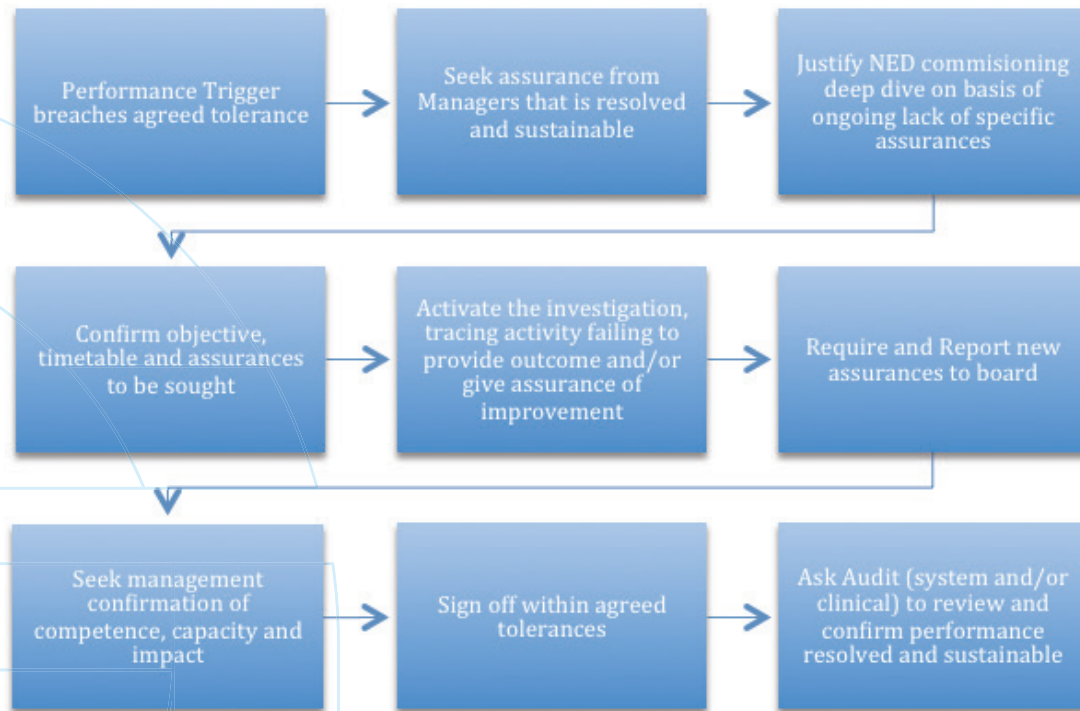
"As a group select one area that you believe must be included in the next strategy. For this area outline the area chosen, what are the opportunities for progress in this area by 2020 and the practical actions that could be included in the strategy to make these things happen."

Deep Dives can also be used as a component of Turning the Curve methodology (see GGI briefing/video).

A deep dive approach

We see much to be commended in the Keogh approach but this needs to be amended to provide a model that can be undertaken by a board director with limited additional resources.

The decision tree provides a model approach.



Clarity of objective

For example: to explain variance in clinical outcomes compared with regional or national norms and seek assurance that a performance improvement trajectory is in place reporting to Board for next 12 months.

Clear terms of reference, scope and timetable for reporting: e.g. will report to Board in 6 weeks

Investigation team: e.g. Board Secretary, information team, clinical advisor, auditors, external advisor/ independent assurance.

References:

"Deep Dive" review of practice in ABM University Health Board <http://www.wales.nhs.uk/sitesplus/863/opedoc/225209> using an established methodology which has been developed over a period of years by DSDC. A Case Study on one of the "deep dives" can be found here <http://www.dementia.stir.ac.uk/case-studies/04-change-deep-dive>

Commissioning for Value - a Deep Dive pack would examine pathways in more detail to identify opportunities for improvements - What to change. See <http://www.rightcare.nhs.uk/index.php/commissioning-for-value/#deepdive>

Kent & Medway Serious Incident (SI) "Deep Dive" undertaken, following agreement by the Trust Board that all Non-Executive Directors, in rotation, should conduct an in-depth review of a sample of Level 4 & 5 SIs. See <http://www.kmpt.nhs.uk/Downloads/whats-happening/27%20September%202012%20Board%20Papers/21a-Deep-Dive-Report-to-Quality-Committee.pdf>

South Tees Deep Dive case study: a comprehensive quality and performance report to help commissioners gain a wide-ranging insight into a local acute provider. see http://www.necsu.nhs.uk/wp-content/uploads/2014/08/A5_South_Tees_CASE_STUDY_INSERT-3.pdf

Fuzzy logic: NVTZ Nederlandse Vereniging van Toezichthouders in Zorginstellingen www.nvtz.nl © 2011 nvtz

Deep Dive Maturity Matrix



DEEP DIVE MATURITY MATRIX

DRAFT VERSION 1.1 - DEC 2015

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.

PROGRESS LEVELS	1	2	3	4	5	6	7
KEY ELEMENTS	1	2	3	4	5	6	7
1. ASSURANCE	No	Board recognise need to 'own' assurance	Board have suite of assurances and recognise value and deficiencies	Board have defined assurances they require subject to VFM test	Board have applied assurances they have identified	Independent assurance systems in place and working	Organisation shares model approach with others
2. TRIGGERS	No	Board recognises need for system of triggers to be escalated to Board	Triggers initiate an assessment of how best to handle concerns	Lack of assurance of progress prompts a NED initiated deep dive	Triggers are acted upon by staff proactively with reports to board on effectiveness	Deep dive programme is proactively based on otherwise ignored areas rather than problems	Organisation shares model approach with others
3. SUPPORTS	No	The board secretary has defined role in support of whole board	Internal audit and clinical audit has defined role in support of collective board	Agreed deep dives can draw on team of support	Deep dive support team can be mobilised promptly and effectively	Deep dive support team can operate across health economy to cover pathways	Health economy has understanding of capacity and commitment to support deep dives
4. TRAINING	No	Staff are inducted and have refresher training in risk, audit, assurance and deep dives	Board members are inducted and have refresher training in risk, audit, assurance and deep dives	Board runs scenario deep dives to improve understanding and skill	Board rehearse successful deep dives and seek to improve and apply learning	Active deep dives are used to train new board members	Board members advise other organisations of their approach
5. RISK APPETITE & TOLERANCE	No	Board has engaged in risk appetite understanding	Board have defined tolerances for devolved management	Board have defined escalation process for devolved management / committees	Management can advise accurately on competence and capacity to undertake improvements	Tolerances are lifted in light of greater assurance	Board members advise other organisations of their approach
6. PROGRAMME & LEARNING	No	Organisation has defined itself as a learning organisation	Staff are inducted and given refresher training in empowerment	Learning and improvements are shared throughout organisation	Learning and improvements are applied to whole organisation	Evidence of improvements modified to suit local circumstances	Organisation is recognised through evidence as a learning organisation
7. ALIGNMENT: INTERNALLY & EXTERNALLY	No	Board is aware of range of investigations, reviews, audit etc.	Board is seeking to use range of investigations, reviews, audit etc. strategically	The range of investigations, reviews, audit etc. are used strategically by board	Organisation has aligned its reviews with partners and commissioners	Organisation has planned its reviews with partners and commissioners	Organisation shares model approach with other health economies

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