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Quality Governance - What Happens as the Dust Settles?

Deighan M, Gray P,
Aitken F, Brown J, Connell J, McKellar K, Rooke L and Wells W

Financial and Competing Interests:

Professor Michael Deighan is the director of the Quality Governance Collaborative (QGC) at the Royal College of Physicians of Edinburgh (RCPE); Professor Paul Gray is past Director General of Health and Social Care and Chief Executive NHS Scotland and senior QGC Faculty. Fiona Aitken is External Relations & Quality Governance Assistant at RCPE, Professor John Brown is Chair of NHS Greater Glasgow Clyde and senior QGC Faculty, Professor John Connell is Vice-Chair of QGC at RCPE, Keith McKellar is Chief Executive Officer of the RCPE, Lisa Rooke is head of External Relations & Policy. RCPE, and Sir William Wells is the past Chair of the NHS Appointments Commission.

Quality Governance – What Happens As the Dust Settles?

Three key issues raised in recent months have been governance in emergencies, maintaining excellence in governance and having an integrated approach to governance. This discussion paper focuses on these issues and is targeted at Chairs, Boards, Directors and clinicians. It also establishes criteria for reviewing the impacts of decisions after a six-month gap, in light of a national emergency.

This paper proposes 10 principles of excellence in governance required to ensure that all sectors can be judged on their governance arrangements and can deal with any development that arises with a focus on outcomes for the public good. It looks at governance and mutual aid considerations and invites the questions that might be asked in six months' time, following the implementation of these principles or in response to a specific incident, such as dealing with a serious failing or handling a pandemic. The paper also discusses the notion that governance and mutual aid can straddle both the public and private sectors and that, by following these 10 principles, both sectors can focus on delivering positive public outcomes.

We describe how a practical, focused governance agenda can work for Boards and we reinforce the importance and benefits to the communities, which they serve. Increasingly, organisations involved in health and social care delivery must embrace a multi-agency planning and commissioning agenda, but experience in commissioning jointly in health and social care is limited in some cases. This document, therefore, focuses on the need to develop a more integrated approach to health and healthcare.

10 PRINCIPLES OF EXCELLENCE IN GOVERNANCE

Through the principles set out in this paper, grounded in shared values, diversity, mutual aid and health inequality awareness, this form of governance ensures that all sectors can judge and be judged on their governance arrangements, and ensure they can deal with any development that challenges the public wellbeing.

An essential prerequisite for these principles to work effectively will be a mutually-agreed, command and control governance arrangement, consistent with extant legislation, with the power to take decisions, delegate authority and act as a final point of escalation and forum for dispute resolution.

1. Have joint documentation for effective working partnerships
2. Create agreed joint performance indicators – clinical and non-clinical
3. Assess reputational risk in respect to the wider community
4. Implement assurance and due diligence reviews between organisations
5. Assess organisational capability to discharge governance requirements
6. Have a combined assurance framework in place / whole system framework that recognises subsidiarity

7. Have Board support, including a company secretary, with established governance protocols in place
8. Establish governance protocols, etiquette, shared values and balance of power across partner organisations
9. Have mutual aid, financial flow, and business continuity planning models in place and appropriate monitoring methods
10. Understand and implement our local planning/commissioning model for all organisational sectors, underpinned by a decision-making audit trail.

Having reviewed the evidence and the literature, we believe that these are core principles of governance, which are relevant to the issues we are seeking to tackle. These are not intended as an exhaustive list, and you may wish to adapt it to your particular circumstances; but we do propose it as a useful basis for self-assessment.

Key Question for Board Members

Having implemented the above principles, Board members should be able to review their processes in six months' time to establish:

- Have I have followed the correct criteria to make informed governance decisions?
- Did I review the implications for working across different public and private sectors?
- Was my organisation flexible to manage emergencies, while maintaining accountability?

While these principles represent our recommendation, ownership will remain with the individual corporate Boards, and organisational Chairs will be responsible for the delivery.

DEFINING INTEGRATED GOVERNANCE

Integrated governance (IG) was the first stage in a journey about ensuring better governance within a dedicated healthcare environment[1]. This focused on the building blocks needed to integrate and align financial, clinical and workforce streams. The second more complex stage of this journey is about gaining assurances from communities, partnerships and external providers that their quality governance mechanisms can be publicly held accountable[2].

The Royal College of Physicians of Edinburgh's Quality Governance Collaborative and the World Health Organization have jointly defined excellence in quality governance[3]. Following on from this we can refine this definition to apply to a multi-agency setting as follows:

The means by which all institutions and organisations involved in the design and delivery of healthcare, while ensuring accountability and transparency, translate health policy into established practice and management to improve the quality, efficiency, and adaptability of healthcare.

Two further areas for consideration are the UK and Scottish Government documents[4] on devolved accountability[5], and indeed the Health and Social Care Act [2012]provision for governance between organisations[6] which request greater transparency in decision making, and for organisations to behave with due probity.

Despite the early developmental work on governance between organisations (GBO)[7] we do not believe that broad governance integration has been formally considered as an achievable strategy. We outline below our motives and assertions of the feasibility of practical governance tools to make this happen.

Importance of Strategic Linkages

Governance is currently disjointed in certain sectors. An example of this is provided by health and social care organisations, which integrate planned and locally-led community and service-user engagements. They have common partnerships, but often with mismatched priorities, and minimal interchange of information on joint risk assessments or on governing through specific agreed rules, which meet health, community and organisational needs. We are striving to attain a bigger and more aligned picture within this paper, as the linkages across health, social care, education, housing, criminal justice and the private/independent sectors need to be evaluated to ensure *effective, coherent and joined up clinical and care governance arrangements*[8].

Legislation is in place to develop governance arrangements to enable a common approach to partnerships[4]. One specific area where joint planning is essential is security, as without the establishment of standard behaviours, any risks, such as pandemics, could have catastrophic consequences.

Making it Happen: The Role of the Board/ Company Secretary

One of the key recommendations in the *Integrated Governance Handbook*[1] is the appointment of a dedicated qualified company secretary both to guide the Board and act as the professional advisor to the Chair and CEO. We realise that the creation and management of efficiencies, including financial, clinical and other skills and resources, requires a specific individual with a unique set of skills. In making this suggestion, we considered best practice from FTSE companies, who follow this precept.

Governance is complex: without an individual who can negotiate across a number of settings, establishing new protocols for governance (and indeed ways of working), no change in practice will occur. Three approaches could be considered:

- Each organisation could have its own dedicated company secretary performing the statutory role.
- The creation of a multi-agency company secretary role with responsibility for wider community organisations.
- The final option is the use of an individual company secretary per organisation but with a nominated lead to support the local company secretary network, as was established to support the cadre of NHS company secretaries by The Institute of Company Secretaries and Administrators (ICSA)[9]

The methodology to make any form of governance work is well known and is designed to manage the risks that could compromise outcomes. The task of accomplishing this is entirely different for each organisation and it would be foolhardy not to invest in tested mechanisms, safeguarding the organisations' authority and reputation.

Assurance Frameworks: Combined Assurance Frameworks/ Whole System Frameworks

One of the most important challenges for any Board/organisation is their Assurance Framework and how they use it. Our recommended 10 principles are intended to guide assurance activity; we also observe that any organisation with large numbers of key strategic objectives, underpinned by associated risks, in their assurance frameworks might find their assurance arrangements unworkable. If the organisation can equate its performance to a robust assurance framework then it is more likely to be working well. The gold standard we would like to achieve where integration of health and social care is developing is one of combined assurance frameworks operating under the principle of subsidiarity.

Another core factor will be to review the role of the internal/external/quality improvement audit**.** In the IG document, a critical success factor is to closely scrutinise how internal/external auditors are used within NHS organisations. The new approach proposed above will clearly broaden the role of auditors, since many of them manage multi-functional roles across public sector bodies. We envisage a need to consider their skill base including clinical expertise associated with such a change in practice.

Within the NHS context, we would also recommend a review of the Audit Committee Handbook, and indeed consider a revised role for Audit Committees. We recommend this be reviewed to include other public sector body audit documentation.

Driving the Agenda Forward– The Implications of Governance among Organisations: Security and Mutual Aid Strategies at a Time of Increased Public Risk

There are four key areas in terms of governance and security to consider in a multi-agency approach:

1. Overall multi-sector organisational security aspects. e.g. pandemic planning
2. Mutual aid and business continuity management
3. National resilience planning
4. Planned and delivered multi-agency patient pathways

These points can often be considered independent of the governance process and not fully understood by Boards. The evidence also indicates that broader, more tangible approaches, with a clinical focus, are needed to address these elements throughout the entire public and private sector.

All NHS organisations have a duty to put in place continuity arrangements, under the Civil Contingencies Act [2004] and the Health and Social Care Act [2012]. The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) sets out these requirements for all organisations. This translates to the maintenance of services to set standards during any disruption, and recovery of these standards as soon as possible.

In practical terms, this level of planning needs improvement as some Board Directors struggle to understand how to implement business continuity planning as a means to avert catastrophic system failure. Outlined below is a short case study synopsis, which has reaching personal and financial implications:

Case Study Synopsis - Governing Through the 'Fog-of-War'
Full Case in Study Appendix: 1

A national Hospice (a registered charity) receives approximately 43% of its funding from its Health and Social Care Partnership (HSCP) to provide palliative care services within its community. The remaining balance of funding is generated from other charitable fundraising activities. The Hospice has limited financial reserves, which are held as investments (low to medium risk stocks and limited cash). Although the Hospice had experienced no financial loss over the last two years, previous losses have diminished its reserves to the minimum required six-months of operating expenditure.

The challenge to the hospice Board would be re-examining the governance arrangements, systematically considering pandemic operating pressures, and looking at the governance response beyond the immediate crisis.

The case study looks at the complexities of governance in a national emergency, the short-term considerations, the immediacy of decision making and the long-term fall out if the decisions are inappropriately made.

It is important to note that this is not a unique study but one that has global implications.

Further Outcomes

The approach outlined above can be summarised by the integration of contingency planning and mutual aid into the governance profile criteria. Furthermore, we also identify a suite of further guidance that will be developed to ensure efficient implementation.

The documents listed below will be the QGC RCPE's next steps and offerings for the support of governance and mutual aid considerations within health care:

- Consolidation documentation for effective working partnerships
- Governance performance indicators
- Due diligence review structure and process
- Board assurance guidance from Executive and Non-Executive Directors
- Governance Maturity Matrices based on the 10 principles
- Presentations and national feedback seminars

CONCLUSION – GOVERNANCE IN SIX MONTH'S TIME

This paper has set out how the implementation of the 10 principles of excellence in governance in a multi-agency context can develop a more integrated approach to health and social care, equipping organisations and their partners to respond effectively to developments and incidents as they arise. Looking at issues of governance and mutual aid, this paper determines the need to create strategic linkages across health and social care and beyond into other associated sectors, and discusses the importance of a company secretary to guide the Board, Chair and subsequently the CEO.

The role of an effective assurance framework and the role of auditors – internally and externally – are also determined as vital in developing a robust governance framework. Finally, the case study highlights the need for a multi-agency approach with business continuity planning in order to be successful.

In conclusion, we explain how this agenda needs to be reviewed annually to ensure that governance is not only integrated in health and social care but also with the other sectors that it engages with. In order to best deliver benefits to our communities and our patients, healthcare should govern in a multi-agency context adhering to the principles of mutual aid, subsidiarity, with a focus on patient dignity and diversity.

APPENDIX: 1 - CASE STUDY – Governing through the 'fog-of-war'

1.0 BACKGROUND

A Hospice (a registered charity) receives approximately 43% of its funding from their local Health and Social Care Partnership (HSCP) to provide palliative care services within its community. The remaining balance of funding is generated from other charitable fundraising activities. The Hospice has limited financial reserves, which are held as investments (low to medium risk stocks and limited cash). Although the Hospice had experienced no financial loss over the last 2 years, previous losses have diminished its reserves to the minimum required 6-months of operating expenditure.

1.1 GOVERNANCE ARRANGEMENTS

The Hospice is governed by a non-executive Board of Trustees, which operates a 3 sub-committee structure (finance, clinical and capital projects). The CEO leads a senior management team covering specific functional areas: medical, integrated clinical services, finance, and fundraising/income generation. Board sub-committees are chaired by a non-executive board member and are comprised of two board members plus members of the SMT and others as necessary, including co-opted members. The CEO attends the Board, as do the other members of the SMT. The Board meets quarterly, as do the Committees, although the frequency of meetings, in times of difficulty, has increased to as often as monthly.

1.2 PANDEMIC OPERATING PRESSURES

The Coronavirus (COVID-19) pandemic presented a number of immediate challenges for the Hospice that translated into additional and immediate financial pressures. For example, essential front line medical and nursing staff required to self-isolate or be removed from duties, resulting in the need to bring in expensive locum cover.

Planned fundraising events had to be postponed or were cancelled and all of its charity shops (which depend on volunteer assistants to operate) had to be closed. This immediately impacted on income, with over 50% of the annual total typically being generated from these activities.

The Hospice was approached by the HSCP to expand its service by provide additional support for non-COVID-19Covid vulnerable groups. However, the local NHS were unable to provide the necessary additional staffing resources and the Hospice had to decline.

2.0 RESPONSE – IMMEDIATE

The Hospice established a business continuity group and undertook an immediate series of steps to manage risk and focused on prioritising critical palliative care services alone. This required additional specific expenditure, but was judged essential to "keep the doors open" (with the alternative being to close the In Patient Unit and transfer all patients to the local NHS hospital).

Board sub-committees moved to remote (video based) meetings. The CEO and Chair maintained their existing lines of communication, as and when necessary. The Chair increased the frequency of communication, through regular email updates to the Board and the CEO similarly provided regular email updates.

3.0 THE CHALLENGES OF GOVERNING AS THE "FOG-OF-WAR" DESCENDS

As the crisis developed and pressures increased, the CEO requested authority to drawdown reserves, to meet the increasing cost pressures, without the usual Board approval process, on an as required and unlimited basis. This request was a direct response to the rapidly developing situation and the immediate pressure that this was placing on the finances; the need to solve immediate problems in the "here-and-now" was how it was described. This request was accompanied by further requests to suspend other standard governance arrangements. These requests can be challenging to refuse given the apparent "life-and-death" urgency of needing to make immediate "decisions in-the-field".

The "fog-of-war" had started to descend and the pressures of the "here-and-now" were centre stage and demanding the full attention of the executive. When the fog has cleared and the adrenalin of the crisis passed, the decisions taken in the heat of events need to be explained and justified. This is where the correct governance systems become essential in providing a framework or baseline. This has been the basis of the British Army's move from command and control to in the field empowerment as those in the "fog of war" need to make decisions.

3.1 GOVERNANCE RESPONSE

These requests were not agreed by the Chair who, in consultation with the chair of the finance committee, moved with the Board to make a financial facility available to be drawn on (akin to an overdraft) against revised financial projections and with a reporting mechanism linking back to the Finance Sub-Committee.

The CEO and SMT provided regular (focused) updates to the Finance and Clinical Governance Sub-Committees. These were all formally noted and a "paper-trail "of decisions, including a note of the specific circumstances, recorded. The Board secretary played a pivotal role in coordinating these communications and in maintaining this record.

The Chair emphasised to the Board the importance of their remaining objectives. The Board, with the CEO and SMT, through the Finance Committee regularly monitored the solvency of the organisation.

The business continuity group took the lead in developing emergency appeals for donations and pursuing grant applications; these were in large part successful. These

are critical in terms of mitigating income loss and served as an important indicator for the Board.

4.0 SAFETY IN COMMUNICATION

A regular line of dialogue was maintained with the HSCP. It is essential to keep funders aware of the challenges and the mitigation steps (and compromises) that have been taken; this is likely to be important in the future.

5.0 THE VALUE & THE CHALLENGE OF ESTABLISHING MUTUAL SUPPORT NETWORKS

Key lines of dialogue were established with other hospices in the area with the aim of establishing a mutual network. Whilst lines of communications already existed between the CEOs and an on-call cover rota was already in place, recent tensions over resource allocation and hostile approaches around mergers had caused tensions and divisions to develop. This was further compromised with the perceived roles that local NHS service providers played in supporting some of the hostile approaches and was widely seen to be reflective of financial and service opportunism. This served to diminish trust between been organisations. As a result, whilst the pooling of resources may have seemed an appropriate step, these historic tensions resulted in a reluctance to co-operate - although this was presented as a concern around exposing medical and nursing staff to increased risk of infection, and concerns around HSCP boundary complications.

6.0 GOVERNANCE RESPONSIBILITIES BEYOND THE IMMEDIATE CRISIS

"*Nothing lasts forever…"* and this will also be the case with this crisis.

Given the limited nature of reserves, the challenge of spending a substantial proportion of these reserves to guide the hospice through the crisis, only to result in financial collapse post-crisis, is drawn sharply into focus. This must be in the forefront of the collective conscience and decision making of the Board.

In addition to the business continuity group, a business recovery group was established (involving the CEO, SMT and two Board members) with a view of planning the post-crisis recovery process. It is clear that post-COVID-19 , the Hospice will no-longer have 6-months reserves and this will need to be considered in the context of the organisation's governance practices. The responsibility of the Board as directors and trustees of a charity is also relevant and decisions around the financial viability of the organisation and the "reasonableness" of expectations around funding and recovery will all need to be considered.

10 Principles of Excellence in Governance

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Glossary of Terms

Mutual Aid is a voluntary cooperative exchange of resources, services and participation. Organisations, groups, and individuals take responsibility to care for one another and build integrated social relations for the mutual benefit and development of society, organisation and culture.

Subsidiarity (Governance) is the principle that decisions should always be taken at the lowest possible level or closest to where they will have their effect, for example in a local area rather than for a whole country[10]

(In politics) subsidiarity is the principle that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level[11.]

Command and control (Governance):
A style of management in which only one person or a small group take all the important decisions and tell people what to do[12] - With specific responsibly devolved/ given to a core individuals or groups

Assurance framework:
Assurance is defined as "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization." An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.[13]

Reputational risk:
Reputational risk is a threat or danger to the reputation of a business/entity/ group or individual.

Devolved accountability (Governance):
Devolving responsibility to within the organisation and holding the devolved parties responsible for the agreed outcomes.

Commissioning (Model) is the continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.[14]

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