Festival of Governance Review

2015 - 2018

Good Governance Institute

www.good-governance.org.uk

The Good Governance Institute 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 build 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.

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Good governance, and the success of our work, is all about people working together. It's about humans collaborating and engaging to find a better, fairer way of organisations participating to create a kinder society. It is also about celebrating success, and learning from each other with open minds and in a safe space. The word 'conference' didn't gel with what we were actually doing, but the word "festival' did. It's a word that is discordant and disruptive beside the word 'governance', with the latter's association with the task of 'dull but worthy' organisational protection.

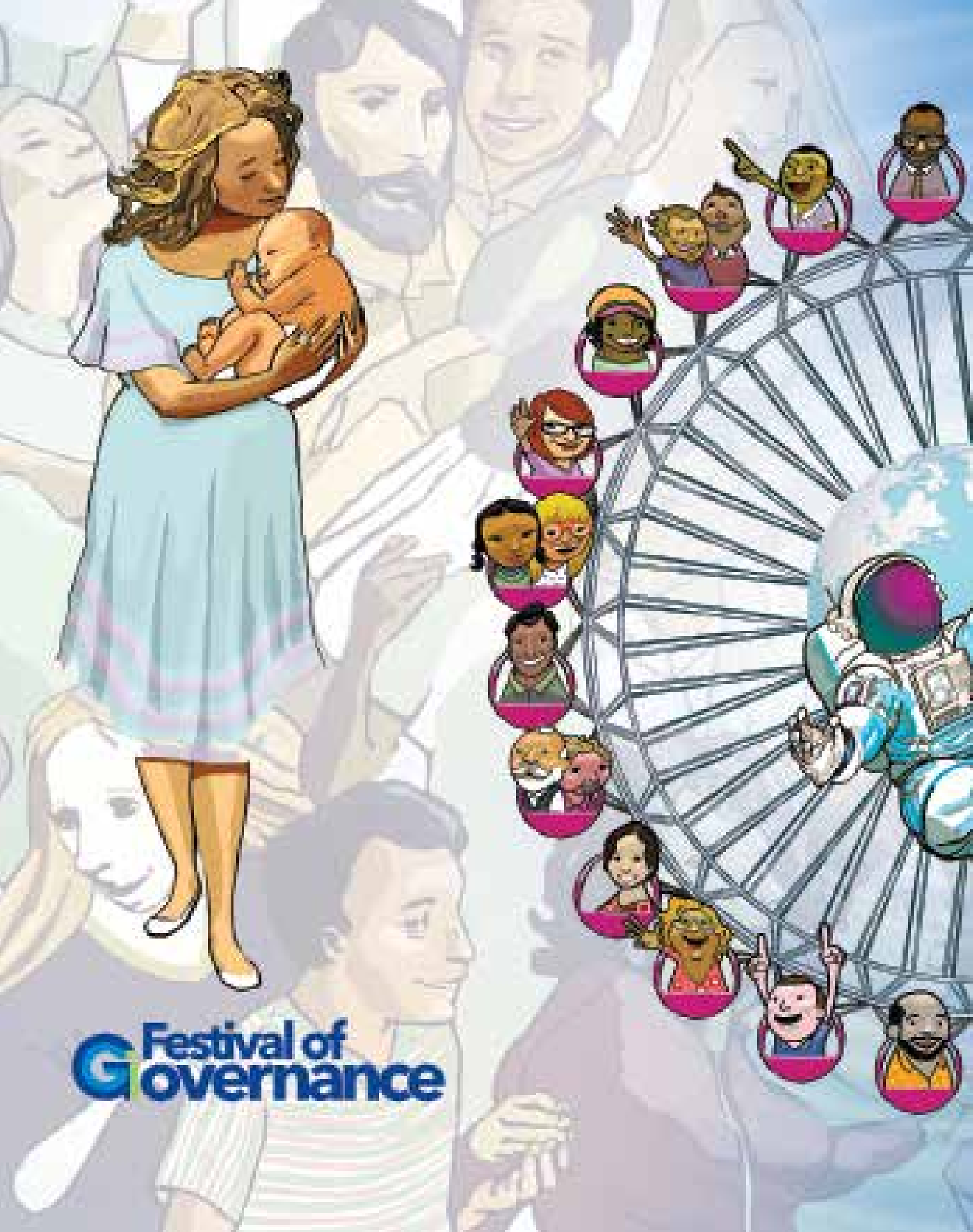
In 2015, the Festival of Governance was announced with vibrant images and big-picture thinking. It was a deliberate move to re-brand governance. For our Festival the party drugs are passion, intelligence and participation. This was the moment for our team, associates, clients, partners and supporters to come together in a way where the whole was greater than the sum of the parts.

GGI is distinctive because we use the best communications skills and methods to directly impact our work. We recruited a young creative team together in fusion with our knowledgeable and experienced directors and associates to create a mix you won't find anywhere else. The Festival is the opportunity to develop these talents and build a narrative year-on-year. So bold, original graphics, sharply crafted social media and edgy short videos bring out the message from the evidence and experienced-based presentations at the Festival. Our younger talent has the opportunity to experiment with new ways of communication and our senior faculty gets the chance to put old wine in new barrels. This is the spirit of the Festival.

Four years on, the Festival of Governance 2018 has grown into two-months of national and international events and publications from GGI as well as our partners and our sponsors.

Welcome to our community!

Andrew Corbett-Nolan
Chief Executive
Good Governance Institute


Festival of
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Governance view

This review of the last four years of our Festival of Governance is dedicated to Caroline Clarke, Group Chief Finance Officer and Deputy Chief Executive, The Royal Free NHS Foundation Trust. She explained to me at Festival 2016 how she told her daughter about what she was doing that day and what the Festival of Governance was all about. It is in that spirit that we have produced the Review to make the subject of good governance as accessible as currently possible.

And of course, to my own mother, who sacrificed her time in order to work on projects including the electrification of Soweto, improving the lives of millions of underprivileged South Africans. Essentially, this Review is dedicated to all the people who work to make the world a better and fairer place for their community.

Jaco Marais, Festival Director, GGI

Festival of Governance

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Festival of Governance
London 2015

Good Governance because...

2015 was the year in which GGI was able to turn outwards to the broader community community in order to explain our governance mission. The Festival emphasised our movement from governance being just a system that is a series of mechanistic processes to one where governance becomes the guardians for all – *'because good governance improves peoples' lives'*.

This very much built on work GGI had undertaken in 2014 for NHS England about creating a compelling narrative for engaging clinicians in good governance.

it improves people's lives

Festival 2015

2015 was a crucial year for good governance in the NHS and wider public sector. As the economy continues to challenge the availability of funding for public services, and as the UK considered the results of the then recent General Election; Boards and Governing Bodies needed to exert strong leadership and make difficult choices.

Because of the Good Governance Institute's unique programme of work, the 2015 Festival was able to bring together content from both our research and development work with the practical day-to-day challenges we are in touch with from the many organisations we work with.

Professor Mervyn King

The King Commission published four key reports that guides thinking on good governance internationally. Festival 2015 was a unique oppprtunity to hear directly from Professor Mervyn King about the development of good governance and why it matters.

Professor Mervyn King, also known as 'Madiba's Judge', was commissioned by Nelson Mandela to lay out a template for good governance to help bolster confidence in South african industry and public services as the country was transitioning from the difficult Apartheid years.

The work developed by Professor Mervyn King and the King Commission has formed the basis of UN Human Rights to clean water, air and arable land.

Workshops

1 - Core skills and tools for board members - GGI's unique insight derived from working with some of the best and most challenged NHS Boards was brought together with our governance research and development programme. This stream included many of the tools that GGI has developed to help those leading governance.

2 - Integrated Reporting - Listening and reporting to stakeholders - stewardship on behalf of stakeholders is at the heart of governance thinking. This stream looked at some of the cutting edge stakeholder engagement approaches being developed by the University of Padua, and at the latest thinking on reporting to stakeholders through the international pilot programme on Integrated Reporting.

3 - Innovation and introducing change - risk appetite, introducing and leading change, taking the right decisions. In a world where bold decisions are needed to maintain public services for the future, this stream included a case study from New York around urgent care services and discusses some of the challenges for the vanguard sites.

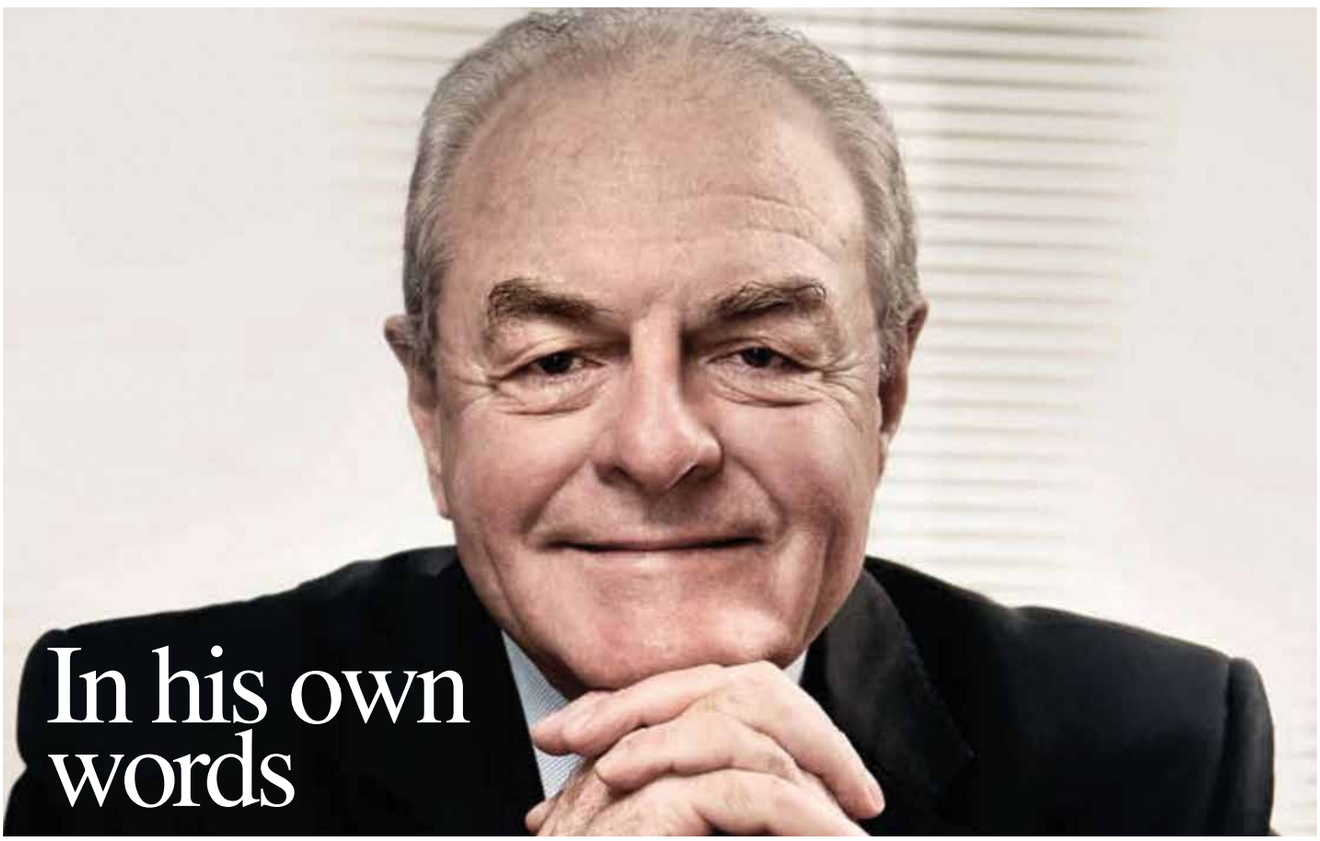
4 - Integration and governance between organisations - taking GGI's 'Goldberg III' report forward, this stream looked at governing solutions which require organisations to work together.

At all sessions participants had the chance to hear from the experts, discuss ideas and solutions with peers and to take away many of the materials that GGI had spent the year developing.

Professor Mervyn King

Professor Mervyn King has for many years provided inspiration and focus for GGI's work. In 2015, Professor King gave the keynote address which very much reinforced the emphasis that governance should provide on the board's duties to all stakeholders and indeed wider society. In a world where 52 of the top 100 economies are not nation states, but are other kinds of organisations, such as companies and corporations, then what happens in the boardroom really matters to the human species.

The duties of directors to report the performance of the enterprise they are accountable for needs to extend beyond profit and assets, and should incorporate the social and environmental impact of any enterprise. This measured and broader accounting for impact has become known as 'integrated reporting'.



In his own words

"The first industrial revolution, which began in the late 18th century, focused on the benefits of water and steam power to mechanise production. Machines started to be used instead of human or animal labour. Although there had been pollution prior to this time, the emissions from mechanised factories were the beginning of the dangerous anthropogenic emissions as we know them today.

By the middle of the 19th century, wealthy families had contributed risk capital to organisations which had unlimited liability. In consequence, in addition to the risk capital, these wealthy families were also liable for all the claims of creditors and employees in the event of bankruptcy. They started to baulk against this. As with today the politicians of the time wanted more jobs to be created and started thinking of creating an artificial person with limited liability.

This was met with opposition, particularly from theologians. It was Lord Thurlow, in 1844, who said how can man have the audacity to create a person. Only the Almighty can create a person. Further, the creation of such a person will be one "who has no body to be kicked, no soul to be damned and no

conscience." The theologians were correct, because the company is an artificial person which has no heart, mind or soul of its own. Directors, once appointed, become the heart, mind and soul of the company. This understanding gives content to the development from the 19th century of the common law fiduciary duties of directors to a company, of good faith and loyalty as well as duties of care, skill and diligence. Those are exactly the duties of the curator of an incapacitated young human being. The common denominator is incapacity.

There were consequences of wealthy families providing equity capital and several of their members becoming directors of the company. One of those consequences was that other stakeholders, particularly employees, saw these shareholders as the owners of the company. Shareholders were also given primacy of place in regard to all the other stakeholders involved in the business of the company; suppliers, creditors, financiers, employees, advisers, etc.

In the late 19th century and early 20th century, the second industrial revolution started with mass production driven by a constant flow of energy, namely electricity. One of those benefitting from mass production was Henry Ford and the Ford Motor Company. There was great demand for his Model T Ford and in 1919 the company made an excessive profit of US$60,000, probably US$6 billion today. The Ford Motor Company announced that the company intended increasing the wages of its employees to work longer hours during the week and weekends so that the company could meet the demand for its Model T Ford. The Dodge Brothers, who were minority shareholders of the Ford Motor Company Limited and later a competitor, contended that the company had a duty to pay the excessive profits as a special dividend to shareholders before increasing the wages of employees because of the primacy of the shareholder. This was disputed by Ford.

The Dodge Brothers instituted an action in 1919 for a declaratory order that the Ford Motor Company was obliged to declare that excessive profit as a special dividend to shareholders before considering increasing the wages of employees. The Court upheld this contention and consequently the concept of the primacy of the shareholder and that directors should steer a company to ensure the maximisation of shareholder wealth, became entrenched.

The concept of shareholder primacy was then reinforced by the Nobel Laureate economist Milton Friedman, who in the 70's wrote: "The sole purpose of the corporation is to make profit without deception or fraud." Tacit in that statement was that the company was not integral to society and that as long as the company was increasing its profits, without deception or fraud, it could do so at any cost

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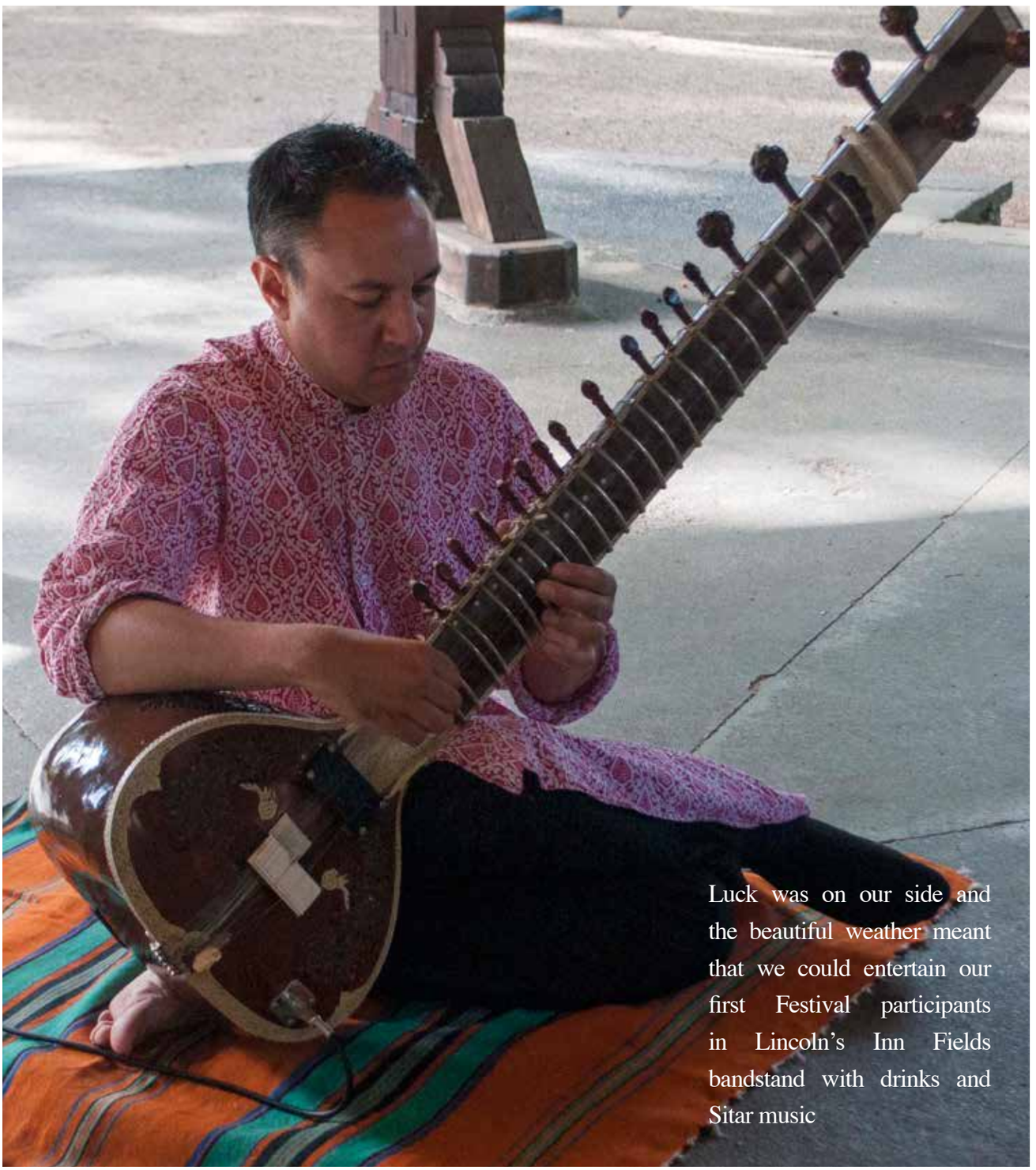
“Good Governance because....”

We invited all attendees to write their reflections on what good governance means to them, and what positive impact good governance brings to the organisations with which they work.



Luck was on our side and the beautiful weather meant that we could entertain our first Festival participants in Lincoln's Inn Fields bandstand with drinks and Sitar music

Continue from p. 19

to society or the environment. The consequence was that the governance of companies, right towards the end of the 20th century, was focused on increasing the monetary bottom line even if it was at a cost to society and the environment. It will be seen that directors were acting lawfully but causing the company to commit wrongs against society and planet earth. The response of society represented by governments was to treat the adverse impacts or actions of how a company made its money with regulation, for example environmental impact laws instead of tackling the source of the adversity viz. how the board decided the company should make its money – its business model – with those decisions driven by the shareholder-centric governance model of the day – maximisation of shareholder wealth.

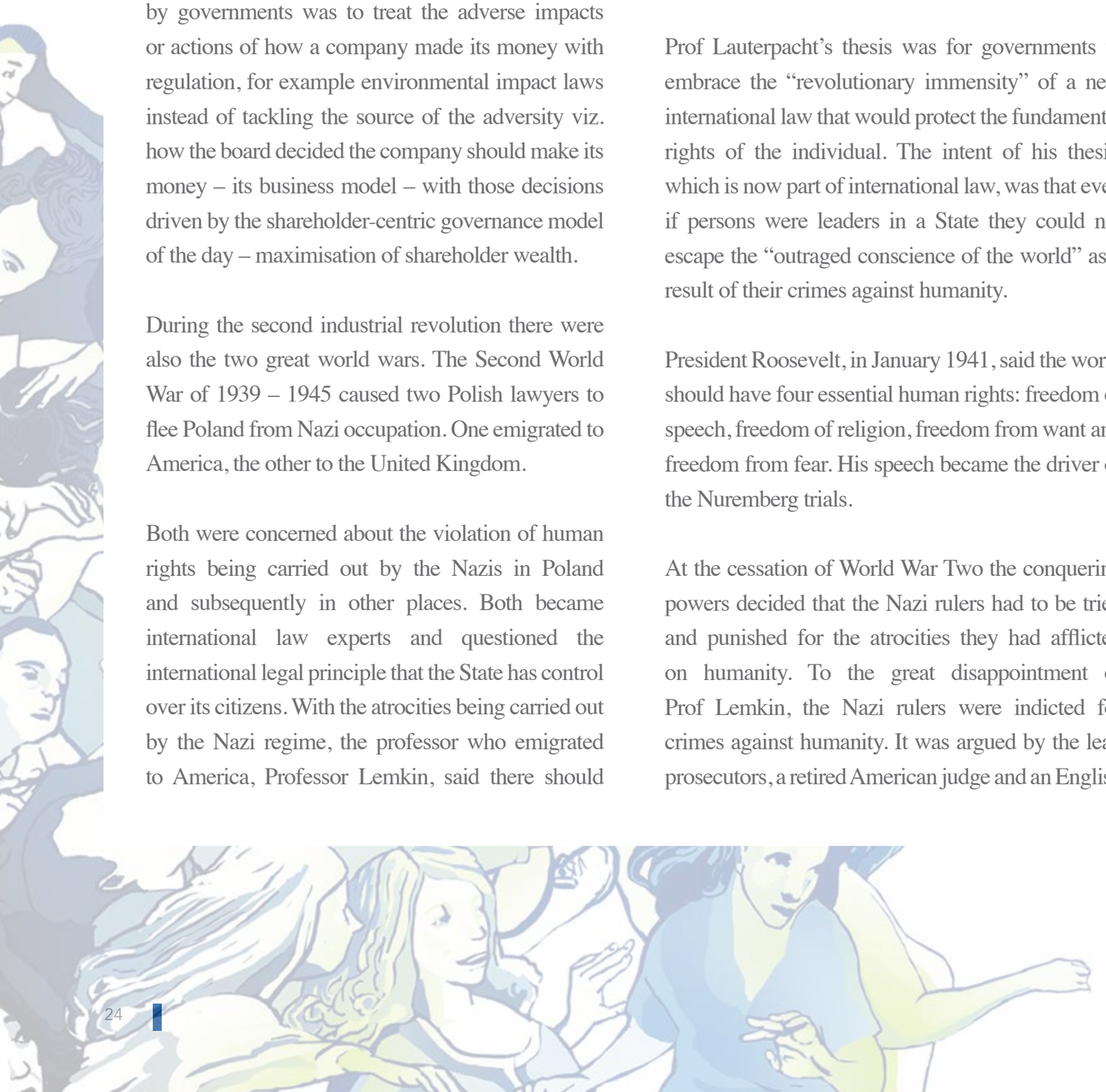
During the second industrial revolution there were also the two great world wars. The Second World War of 1939 – 1945 caused two Polish lawyers to flee Poland from Nazi occupation. One emigrated to America, the other to the United Kingdom.

Both were concerned about the violation of human rights being carried out by the Nazis in Poland and subsequently in other places. Both became international law experts and questioned the international legal principle that the State has control over its citizens. With the atrocities being carried out by the Nazi regime, the professor who emigrated to America, Professor Lemkin, said there should be a crime for such atrocities and he coined the word "genocide" developed from the Greek "gen", "people", and Latin "cide", "to kill". Professor Lauterpacht in the United Kingdom said that international law had to change to give the individual rights which should be universal and override State sovereignty over its citizens. He favoured "crimes against humanity."

Prof Lauterpacht's thesis was for governments to embrace the "revolutionary immensity" of a new international law that would protect the fundamental rights of the individual. The intent of his thesis, which is now part of international law, was that even if persons were leaders in a State they could not escape the "outraged conscience of the world" as a result of their crimes against humanity.

President Roosevelt, in January 1941, said the world should have four essential human rights: freedom of speech, freedom of religion, freedom from want and freedom from fear. His speech became the driver of the Nuremberg trials.

At the cessation of World War Two the conquering powers decided that the Nazi rulers had to be tried and punished for the atrocities they had afflicted on humanity. To the great disappointment of Prof Lemkin, the Nazi rulers were indicted for crimes against humanity. It was argued by the lead prosecutors, a retired American judge and an English



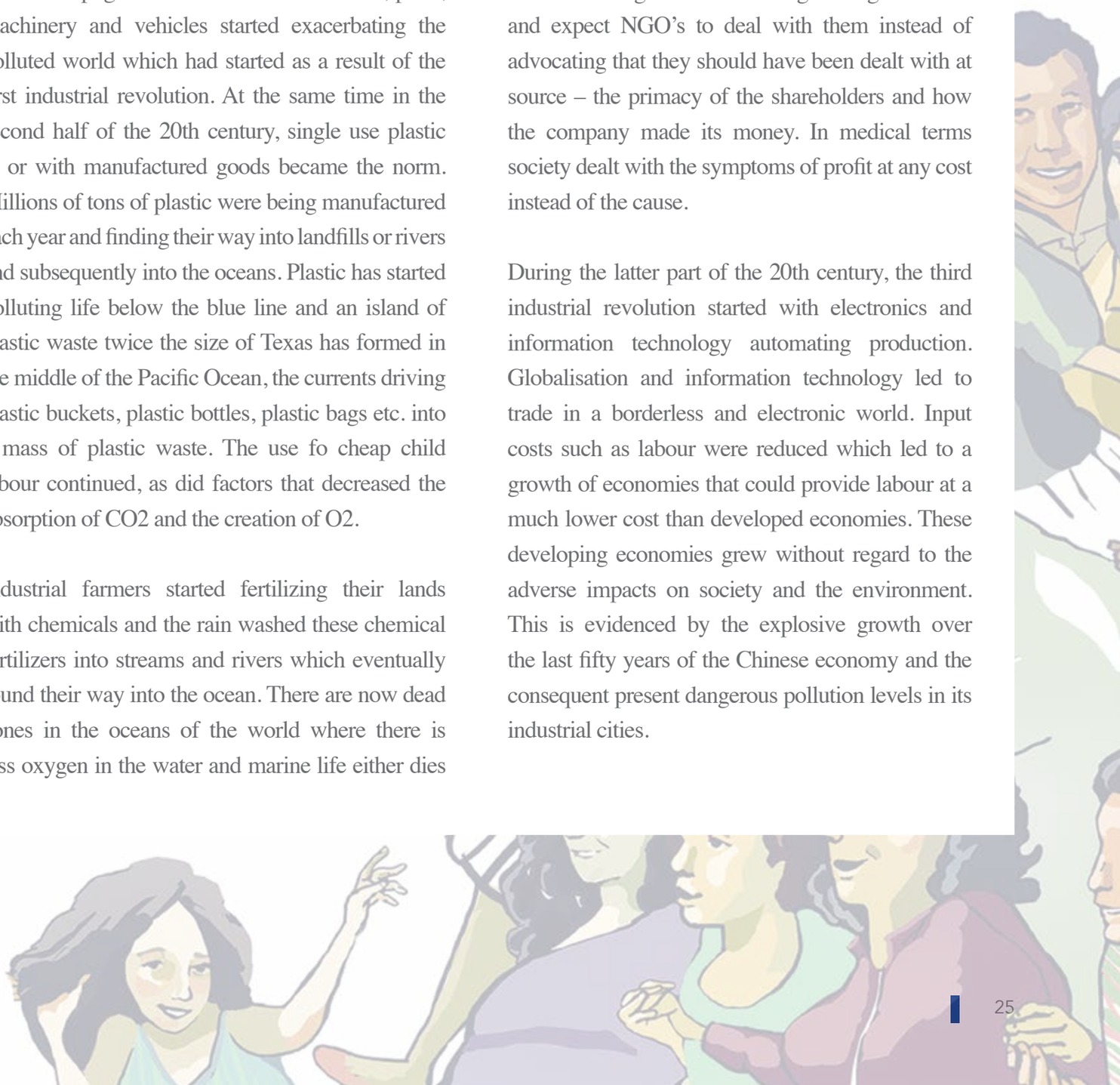
Silk, that no State could overrule the rights of the individual to life, liberty and security of person.

While international law was starting to oblige governments to act or to refrain from acting in certain ways, companies continued to lawfully carry on business as usual, namely maximising profit even if it was at a cost to society and the environment. The anthropogenic emissions from factories, plant, machinery and vehicles started exacerbating the polluted world which had started as a result of the first industrial revolution. At the same time in the second half of the 20th century, single use plastic in or with manufactured goods became the norm. Millions of tons of plastic were being manufactured each year and finding their way into landfills or rivers and subsequently into the oceans. Plastic has started polluting life below the blue line and an island of plastic waste twice the size of Texas has formed in the middle of the Pacific Ocean, the currents driving plastic buckets, plastic bottles, plastic bags etc. into a mass of plastic waste. The use fo cheap child labour continued, as did factors that decreased the absorption of CO2 and the creation of O2.

Industrial farmers started fertilizing their lands with chemicals and the rain washed these chemical fertilizers into streams and rivers which eventually found their way into the ocean. There are now dead zones in the oceans of the world where there is less oxygen in the water and marine life either dies or flees the area. These habitats which had been teeming with life have become biological deserts. The sea life which escape these dead zones are then caught in modern nets spread between two trawlers. As is well known our seas have been overfished.

Society's reaction during the 20th century of these adverse impacts from companies' business models was to ask its governments to regulate against them and expect NGO's to deal with them instead of advocating that they should have been dealt with at source – the primacy of the shareholders and how the company made its money. In medical terms society dealt with the symptoms of profit at any cost instead of the cause.

During the latter part of the 20th century, the third industrial revolution started with electronics and information technology automating production. Globalisation and information technology led to trade in a borderless and electronic world. Input costs such as labour were reduced which led to a growth of economies that could provide labour at a much lower cost than developed economies. These developing economies grew without regard to the adverse impacts on society and the environment. This is evidenced by the explosive growth over the last fifty years of the Chinese economy and the consequent present dangerous pollution levels in its industrial cities.



Likewise in India. With the increase of industry and motor vehicle ownership the pollution of major Indian cities has become acute. On 8th to the 11th November 2017 the Delhi local government closed all the schools in the city because the levels of pollution were dangerous to health. And a cricket test match between India and Sri Lanka was stopped.

The development of information technology enabled research to be done much more quickly and this research showed that towards the end of the 20th century, major companies listed on some of the great stock exchanges in the world had only 30% of their market capitalisation represented by additives in a balance sheet according to financial reporting standards. The focus right through the 19th and 20th centuries on financial capital had changed. It changed because of a realisation that natural assets were finite and that ecological overshoot had been reached, namely companies and individuals were using natural assets faster than nature was regenerating them: unsustainable development. Further, landfills had started toxifying underground water systems and planet Earth was running out of suitable space for landfills.

The other 70% of market capitalisation was made up of what became known as intangible assets. Asset owners and asset managers had realised that a company which had a long term strategy of value creation in a sustainable manner would probably survive and thrive in the changed world of the 21st century whereas a company that focused only on improving the bottom line at any cost would eventually fail. Further, society was starting to turn its face against companies that were having a negative impact on society or the environment. Wireless and mobile communication started galvanizing civil society against poor corporate citizenry.

At the beginning of the 21st century I was asked to chair the United National Committee on Governance and Oversight and to redo the governance framework of the various agencies in the UN, which included UNEP and UNCTAD. At about the same time, on the northeast coast of America, thought leaders in Boston were trying to work out how the boards of companies could report on the 70% of value on which there was no accountability in an annual report which consisted only of the balance sheet, profit and loss statement and related notes according to financial reporting standards.

In Boston they started in earnest drawing guidelines for sustainability reporting which led to the founding of the Global Reporting Initiative (GRI) which moved its headquarters to Amsterdam. That is when I was asked to become the chairman of the GRI.

Companies now started reporting in two silos – the annual financial statement and a sustainability report according to the then GRI Guidelines now GRI Standards.

At the beginning of 2010 the International Federation of Accountants (IFAC) and the UN Community on

Trade and Development called a meeting at the UN headquarters in Geneva. The invitees included, inter alia, the World Chairmen of the Big Four, the World Bank, the Institute of Internal Auditors, major asset owners, asset managers and regulators. The meeting was held under Chatham House Rules.

At that meeting, the IFAC stated that it was clear that annual financial statements, as we had been doing them since the great depression of the 1930s were critical but on their own not sufficient to discharge a board's duty of being accountable. I was able to say, as chairman of the GRI, that a sustainability report, without the numbers, was meaningless. But I went on to argue that to continue reporting in two silos was divorced from reality.

No company has ever operated on a basis that financial capital was in one building, human capital in another, natural capital in yet another, intellectual capital somewhere else, as with social and manufactured capital. There has always been a symphony of these sources of value creation because of their interconnection and interdependency together with the relationships between the company and its stakeholders, such as its employees, suppliers, lenders of money, service providers, shareholders, etc. These sources of value creation and relationships have always been integrated.

His Royal Highness, Prince Charles, had in 2006 started the Accounting for Sustainability Trust (A4S) because he argued that the annual reports of companies in which the Royal Family invested had not reported on how their business models had impacted on society and the environment.

Sir Michael Peat, who was then the treasurer to the Royal Household met with me towards the end of 2009. This led to the historic meeting at St James' Palace, called by his Royal Highness Prince Charles, in which the great institutions in the world, the great regulators, the Big 4 auditing firms, great asset owners, asset managers were invited and the discussion was, how did a board of directors discharge their duty of accountability to the incapacitated company that was so dependent on it if it didn't report on how the company was operating, namely on an integrated basis? The outcome was the formation of the International Integrated Reporting Council (IIRC) of which I became the chairman and I am still the chairman.

In the International <IR> Framework it was pointed out that in a value creation situation, there are inputs, and the major inputs can be listed under six capitals, viz. financial, manufactured, human, intellectual, natural and social, which would include the relationship between the company and its stakeholders. A company should build these six capitals into its business strategy in the resource constrained world of the 21st century, and not merely focus on financial capital. The sustainability issues critical to the business of the company, such as the conservation of water to the brewer of beer should be part of the company's long term sustainable value creation strategy. Now the board was dealing with the outcomes of a company's business model rather than leaving them to regulators and NGOs.

The biggest user of natural assets and the biggest polluter are both private and public companies. Companies had been acting lawfully because of a shareholder-centric governance model but committing wrongs against society and the environment. Lawful wrongs is an oxymoron but directors were lawfully directing companies to maximise profit instead of focusing on the long term health of the company as pointed out by Prof Lynn Paine of Harvard University.

The outcomes-based approach of integrated reporting is to look at the value creation chain from inputs into the company's business model, its output, being its product or service and the effects that that product or service has when it goes out into society on the three critical dimensions of sustainable development, the economy, society and the environment. This outcomes-based approach is now recognised in the Sustainable Development Goals of the UN of April 2015 in which the UN states that in order to achieve sustainable development by 2030, account has to be taken of the indivisible and integrated dimensions of the economy, society and the environment. The goal is to achieve this by 2030 otherwise planet Earth may not be sustainable for those who come after us by the end of this century.

We have now entered the fourth industrial revolution based on digitisation, artificial intelligence, the internet of things, nano-technology, bio-technology and 3D printing but with diminishing natural assets and continuing population growth, 7.4 billion people at present, 9.3 billion by 2045 according to the extrapolation done by the UN. It is clear that it is no longer an option to carry on business as usual. Society, with radical transparency at its fingertips through social media, no longer accepts these lawful wrongs against humanity committed by a company. It wants the collective mind of boards to act in the best interests of these incapacitated artificial persons which society created and of which society is the licensor, so that they have positive impacts on the economy, society and the environment.

A major study has been done by the Boston Consulting Group on the "Total societal impact, a new lens for strategy." It is reported: "For decades, most companies have oriented their strategies toward maximizing total shareholder return (TSR).

Now, however, corporate leaders are rethinking the role of business in society. Investors are increasingly focusing on companies' social and environmental practices as evidence mounts that performance in those areas affects returns over the long term. Standards are being developed for which environmental, social, and governance (commonly referred to as ESG) topics are financially material by industry, and data on company performance in these areas is becoming more available and reliable, increasing transparency and drawing more scrutiny from investors and others.

The great companies that will survive and thrive into the 21st century are those which have their boards applying their collective minds to the fact that the corporate tools of yesterday can no longer be used today, that the mindset of the board has to change to one on an integrated basis, hoping to achieve positive outcomes on the three dimensions of the economy, society and the environment.

Companies have to have a business strategy which results in long term value creation in a sustainable manner. Every company should address at the end of each financial year what were the positive and negative impacts of how the company made its money on the economy, society and the environment.

Good corporate citizenry demands that a board should develop strategy as to how the company will enhance the positive impacts on the three critical dimensions and eradicate or ameliorate the negative impacts on them. In this way, the company will be creating holistic value for society. By focusing on the financial only a company may well be destroying value. Good corporate citizenry is consistent with human rights. Poor corporate citizenry is inconsistent with human rights.

In July 2000, the United Nations launched the 10 principles of its Global Compact. It was based on the unprecedented rise in partnerships between business, civil society, governments and the United Nations leading to the Sustainable Development

Goals of April 2015. The UN stated that business has to be a part of a solution to the global challenges of people, planet and profit.

The Global Compact contains 10 principles for a company to exhibit good corporate citizenship. The 10 principles are derived from the universal Declaration of Human Rights, the international labour organisations Declaration on Fundamental Principles and Rights, the RIO Declaration on Environment and Development and the UN Convention against Corruption.

Principle One is that business should support and respect the protection of internationally proclaimed human rights and make sure that they are not complicit in human rights abuses. Further business should promote a greater environmental responsibility and encourage the development and diffusion of environmentally friendly technologies.

Human rights are defined in the United Nations as rights inherent to all human beings or rights to which a person is inherently entitled simply because he or she is a human being, regardless of nation, location, language, religion or ethnic origin. It is based on the foundation that all human beings are born free and equal in dignity and rights. Everyone has the right for an environment adequate for his health and well-being.

The consequences of companies not being good corporate citizens are too horrible to contemplate. There will be no sustainable development and the outraged conscience of society against poor corporate citizenship will continue.

We are in the fourth industrial revolution. We are in the age of immediacy. Tomorrow is another day but it is a day of radical transparency where no company can keep a secret in its corporate closet anymore. Boards have to think on an integrated basis about the long term health of the company. That is when a company will be seen to be a good corporate citizen in a world which is not what it used to be. Boards can no longer continue to operate, quite lawfully, on trying to maximise profit but having a negative impact on society and the environment. That is poor corporate citizenry and committing wrongs against humanity.

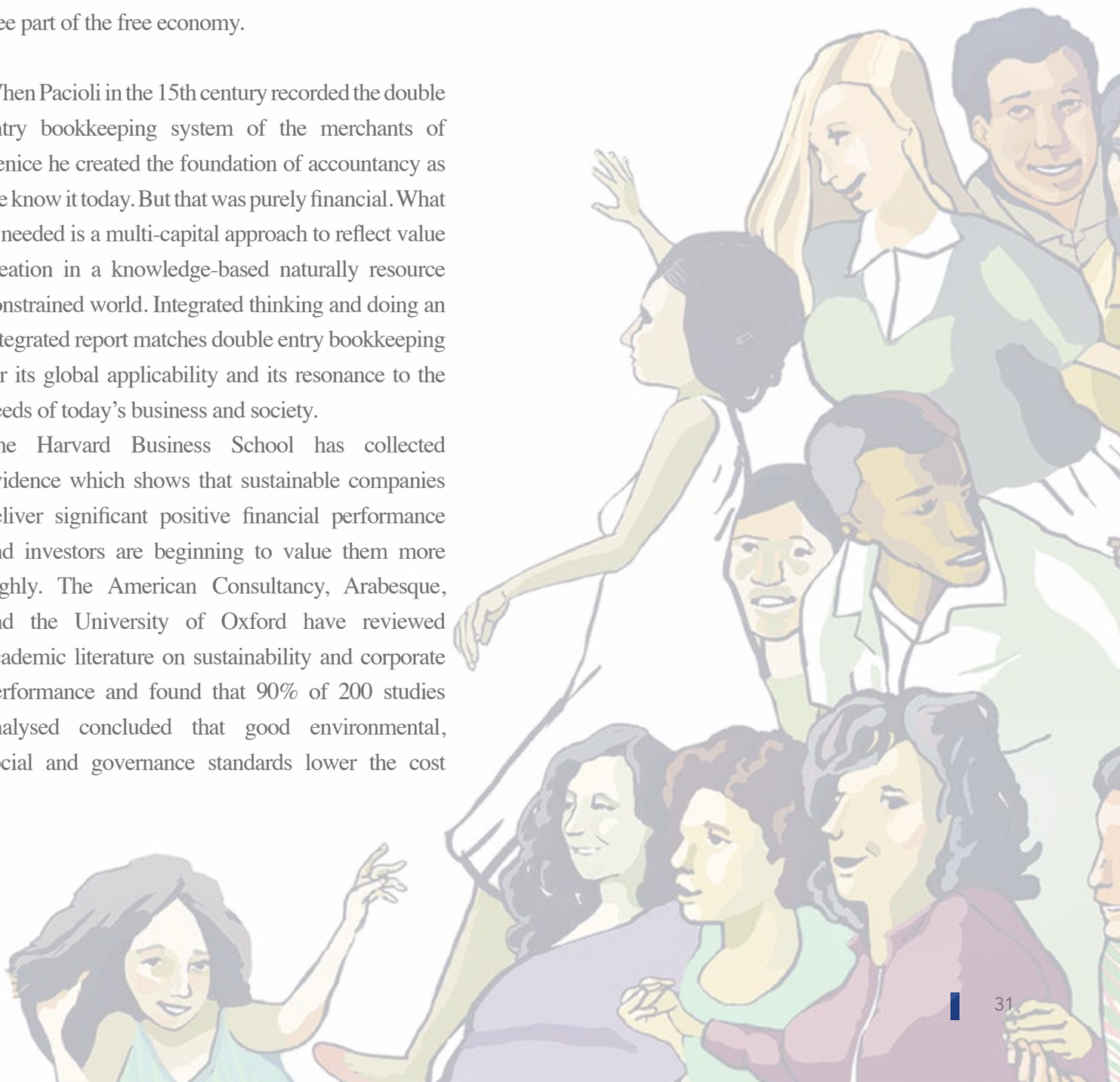
And after all, there is not only a corporate necessity to do this. There is moral duty to ensure that development is sustainable. We have to achieve sustainable development that meets the needs of the present, without compromising the ability of future generations, your children, your grandchildren, to meet their needs. This is a primary ethical and economic imperative. While we have crimes against humanity, we also cannot afford lawful wrongs against humanity. There has to be a change from shareholder centric governance models to company centric models – the long term health of the company.

Nelson Mandela in his “Long Walk to Freedom” said, “Action without vision is only passing time, vision without action is merely day dreaming, but vision with action can change the world.”

There is a revolutionary immensity in the vision of integrated thinking resulting in a business model which embraces sustainability issues pertinent to the business of the company, with positive impacts on the three dimensions of sustainable development. It has the outcome of dealing with lawful wrongs at source, in the boardroom, and meeting the outraged conscience of the world to corporate profit subsidised by society and the environment. That has been the free part of the free economy.

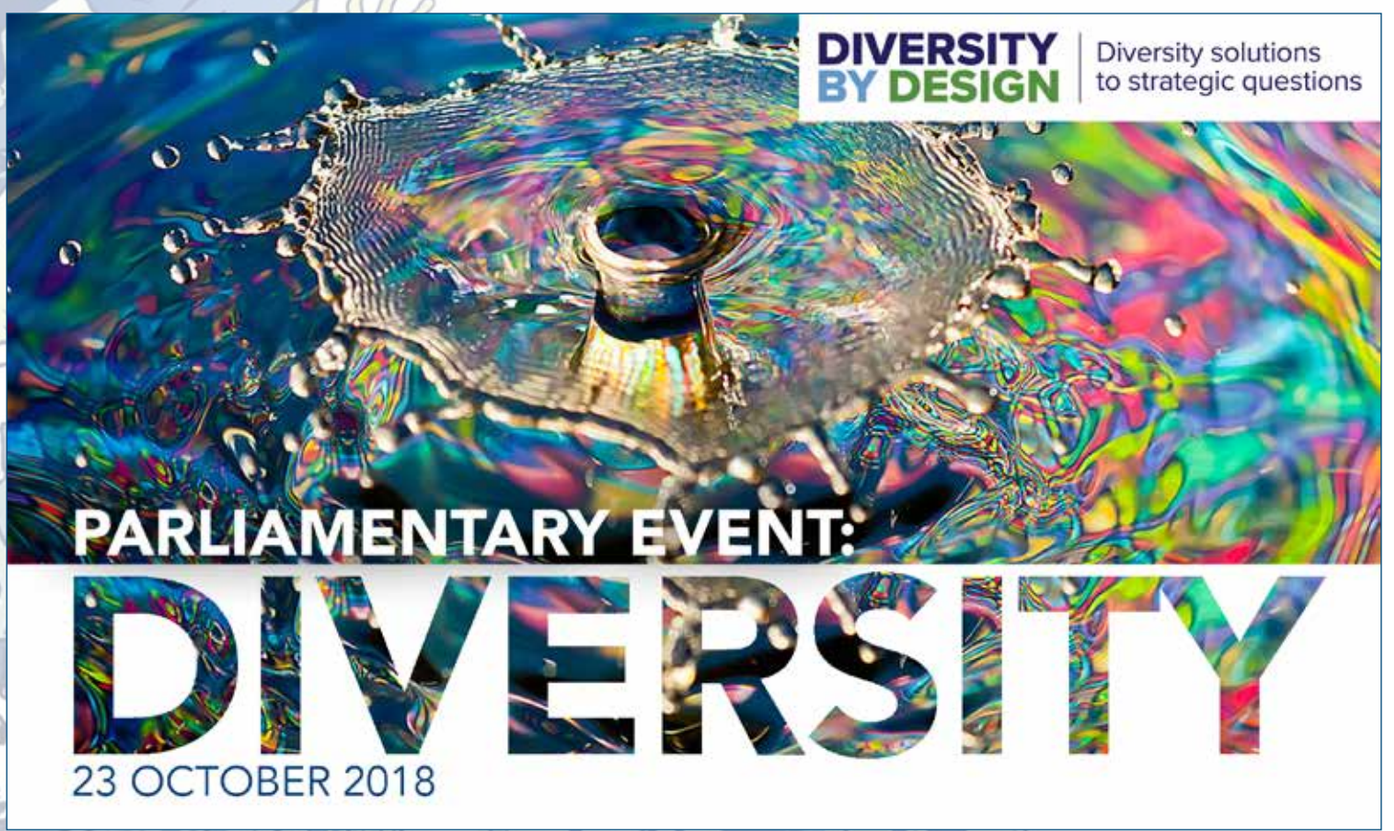
When Pacioli in the 15th century recorded the double entry bookkeeping system of the merchants of Venice he created the foundation of accountancy as we know it today. But that was purely financial. What is needed is a multi-capital approach to reflect value creation in a knowledge-based naturally resource constrained world. Integrated thinking and doing an integrated report matches double entry bookkeeping for its global applicability and its resonance to the needs of today's business and society.

The Harvard Business School has collected evidence which shows that sustainable companies deliver significant positive financial performance and investors are beginning to value them more highly. The American Consultancy, Arabesque, and the University of Oxford have reviewed academic literature on sustainability and corporate performance and found that 90% of 200 studies analysed concluded that good environmental, social and governance standards lower the cost of capital; 88% show that good environmental and social governance practices result in better operational performance; and 80% show that stock price performance is positively correlated with good sustainability practices. In short it has become good, hard-nosed business to ensure that a company's business model does not have adverse impacts against humanity.



As there is universal recognition of crimes against humanity, which connotes conduct with wilful intent, there should be universal recognition of wrongs against humanity by steering a company for the maximisation of profit at any cost instead of focusing on its long term health which is in the better long term interests of all its stakeholders. Such focus is a moral necessity for those who come after us. After all, we are transient caretakers of this planet and have a duty to leave it in a state that will not further prejudice the needs of those who come after us.

Replace the negative outrages of society against corporate wrongs with positive corporate outcomes on all three of the dimensions of the economy, society and the environment, then we will have a good corporate citizenry and humanity having its right to clean water, clean air and arable land – in short – the right to life.



To book your place at one or all of the events please visit:
WWW.FESTIVALOFGOVERNANCE.ORG

What is Good Governance?

The current arrangements for assurance are deeply flawed. Is a principles-based solution the answer?

England's current governance system for the NHS has a number of critical flaws. It has no clarity of purpose and outcome and often providers are confused whether they are sovereign bodies or branch units. The system is not properly risk based. Its critics have said that it neither values staff, nor does it hold them to account. There's no coherent quality framework or agreed process of continuous improvement. Providers are not rewarded for productivity or diverting patients to better service options, rather they are erratically rewarded or penalised for accepting increased activity. Boards are focused on access compliance rather than strategic population health outcomes, and board agendas, priorities and assurance systems are a mess.

Dr John Bullivant
Chair - the Advisory Board
Good Governance Institute

In England, we have a discredited arrangement of commissioners and providers, still supposedly working to gain the benefits of competition, but this now sits within a new collaborative model. The system now includes elected local authorities, private and third sector providers, academic partners, an increasingly vocal and litigious population, and a demotivated workforce. There's no appetite for legislation nor structural reform and England is falling behind in integrating health and social care. Our partners in local government might respect health government targets, but they will not yet be held to account for them. They are suspicious of partnerships within an NHS model, which bail out NHS budgetary failures, yet leave the local authority partner to cut services in order to meet their statuary duty and balance their books.

The system is creaking, but retrievable. GGI believe that King IV, the corporate governance code for South Africa, offers some insight to the answers and is consistent with the revised UK Corporate Governance Code from the Financial Reporting Council. King IV has a greater focus on the application of governance principles rather than compliance with 'governance rules'. Here, we set out some of the issues, while the details of King IV and the FRC Code are discussed in another of our GGI publications.

> "Organisations only exist in order to deliver on their purpose and, similarly, governance only exists in order to help them do that."
>
> Professor Deon Rossouw, CEO of The Ethics Institute.

Principles

Governance cannot be simply about hitting targets or compliance with rules. The NHS has misunderstood the competitive business model and is now in danger of compromising a new collaborative approach by an unhealthy focus on centrally-led targets rather than local clinical and economic priorities. Governance must be based on high-minded principles, such as fairness. King IV offers a coherent set of principles for delivering good governance and performance outcomes.

Subsidiarity

In essence, King is defining subsidiarity as a principle of social organisation that holds that 'social and political issues should be dealt with at the most immediate (or local) level that is consistent with their resolution'. As the Good Governance Handbook stated in 2015, 'Establishing this principle will be essential when we move onto inter-organisational assurance'.

Trust

Back in 2009, the Audit Commission published a seminal paper, 'Taking it on Trust", which clearly set out the proper arrangements between boards and their managements. It made it clear that, while it should trust the judgments of their managers, boards have the responsibility to challenge whether what they are told is true and actionable. No such concordat exists between Boards (providers or commissioners) and the government agencies who scrutinise and performance manage the trusts they supervise, both routinely and through special measures.

Because it has been established as an NHS Foundation Trust, the Trust is required to comply with the conditions set out in the NHS Provider Licence. The Licence is the main tool used by NHS Improvement to regulate providers of NHS services. This is very one-sided. We would see NHS Improvement as what King describes as a 'holding company' and the individual trusts as 'subsidiary companies'. King makes it clear that the adoption and implementation of the policies, structures and procedures of the 'holding company' is a matter for consideration and approval by the board of the subsidiary company as a separate legal entity.

The board of the holding company should ensure that the group governance framework recognises each subsidiary within the group as a separate and independent juristic person, to whom its directors owe fiduciary duties.

In addition, the board should ensure that the group governance framework addresses governance matters as is appropriate for the group as a whole.

This suggests the need for a more mature and engaging process between NHS bodies and the 'centre'. This will be essential as new structures emerge for place-based service delivery where there's no formal agreement for the non-NHS partners to be directed by the agencies of the Department of Health. Central government must seek to establish a new relationship with NHS providers and their partners. When provided with honest declarations of missed targets, it's not good enough to simply demand only the right answer that targets are achieved.

Fiduciary Duty

The concept of fiduciary duty raises another issue for NHS Boards. As we set out in a discussion paper in 2016, an NHS board cannot operate solely to protect the interests of the institution over the needs and rights of the population it services. Treasury guidance for *those with responsibility for deciding how public money should be spent* includes the five-case rule for investment. However, these have a structural bias towards financially-centred decisions and need a sixth case, where decision-makers consider the overall benefit and sustainability for the public of the proposed change. We suggest:

Case 6. The sustainability case: The proposal must support the sustainability of an existing or new service to patients. *(For more information, read: 'NHS organisations should prioritise the interests of service users over those of the organisation: fiduciary duty or not?' GGI, April 2016).*

Assurance, risk and delegation

The Board Assurance Framework (BAF) is broken. It's no longer fit for purpose, yet is a formal requirement of good board practice and subject to external review. Recent papers by both the Walton Centre and 360 Assurance have investigated current practice and conclude that there's wide variation in application, definitions and understanding by users, although content still largely reflects the 2003 guidance. In

> "Governance got a bad name because people persist in seeing it in terms of compliance, structures and policies. Of course, these things are important only as tools to help deliver outcomes."
>
> Professor Deon Rossouw, CEO of The Ethics Institute.

particular, it's clear that most BAFs suffer from the absence of clear, measurable, time-limited strategic objectives. They do not link to forward trajectories of performance against which risk can be identified and mitigated. Boards must be brave enough to define their objectives and their system of delegation of risk to management and committees within agreed tolerances. Audit committees and their auditors can check that escalation processes are working. The board can then focus on what risks are compromising forward delivery and what rebalance of strategic objectives are necessary.

Stakeholders

King IV (like its predecessors) advocates a stakeholder-inclusive approach, in which the governing body takes account of the legitimate and reasonable needs, interests and expectations of all material stakeholders as well as the best interests of the organisation in the execution of its duties.

Looking at the NHS, we could construe the shareholders as the citizens represented by government (de facto owners), whereas the real stakeholders are the local population, users, staff and partners currently represented by commissioners, governing bodies of CCGs and Foundation Trusts as well as local authority councillors as well as the professional organisations and unions.

System-based considerations

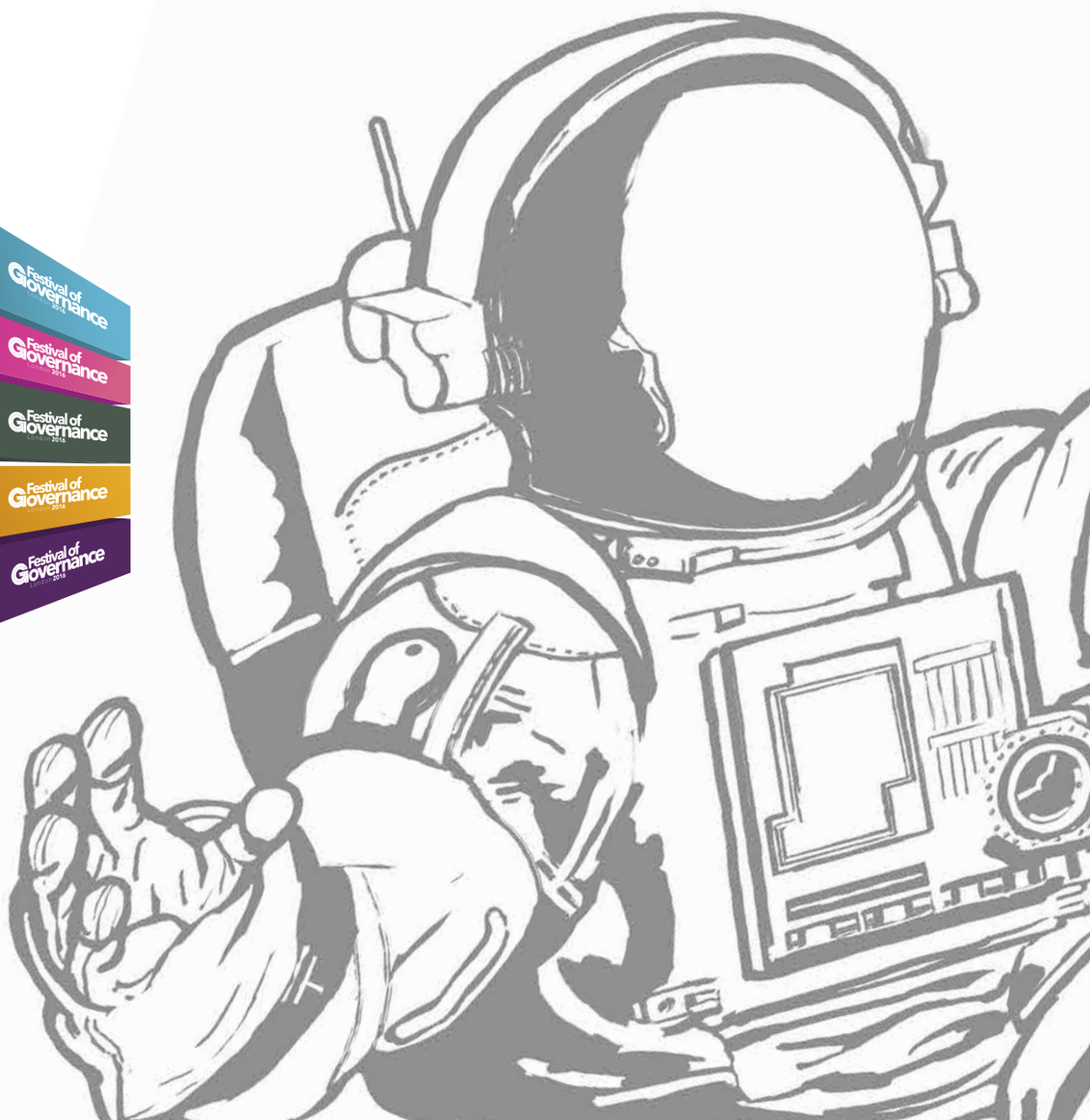
We cannot fix these issues with a compliance-based regime. King IV has application to existing entities. With its clarity of purpose and outcomes, the principles-based approach provides legitimacy for multi-agency, place-based collaborations to set direction with effective and ethical oversight, scrutiny and accountability.

Many will reject the approach because it's not required. We hope that even stretched organisations will see that the King model provides a fresh start for collaboration between organisations, a mature relationship with policy makers and regulators, and an inclusive genuine approach to stakeholder inclusion and public reporting. *For a more detailed exposition of King IV, see our recent publication: King IV for health and social care, GGI, 2018*

Festival of Governance
London 2016

Good Governance because...

workshops



“It is very important for a person’s self-esteem to have a bigger life’s purpose than one’s own survival. GGI exists to support leaders who create a fairer, better world. And, it’s my own life’s purpose to connect people around such causes.

We designed festival 2016 with an open agenda. At the beginning of the day, we did not know what new ideas would emerge from the workshops or what would be discussed on the Q&A panel. But we were confident that our participants were bound by a common purpose to create a future that is better than the one that is inevitable, given our current circumstances.”

Jaco Marais,
Creative Director, GGI

the future is in our hands

Caroline Clarke

Caroline has been Royal Free London NHS Foundation Trust's chief finance officer since 2011. She was formerly director of strategy at NHS North Central London. Prior to that she was an associate partner in KPMG's health strategy team. She has spent most of her career in NHS finance, having been director of finance at Homerton University Hospital NHS Foundation Trust and City and Hackney Primary Care Trust. She is currently a member of the advisory board to the Learning Clinic and sits on the Chartered Institute of Public Finance and Accountancy health panel.

Lord Bob Kerslake

Lord Bob Kerslake was the Head of the Home Civil Service, after the retirement of the former holder, the Cabinet Secretary, Sir Gus O'Donnell on 31 December 2011 until September 2014. He continued to be Permanent Secretary at the Department for Communities and Local Government. He was the Chair of King's College Hospital NHS Foundation Trust 2015 - 2017. He was introduced as a Crossbench life peer in the House of Lords on 17 March 2015, and is the President of the Local Goverment Association.

Professor Jaideep Prabhu

Jaideep Prabhu is a member of the editorial boards of the Journal of Marketing, the International Journal of Research in Marketing and the Journal of Management Studies. He is an associate editor of Customer Needs and Solutions and BMJ Innovations, is on the editorial advisory board of The Schmalenbach Business Review, and is a member of the senior advisory board of the European Journal of Marketing. He has consulted with or taught executives from ABN Amro, Bertelsmann AG, British Telecom, the UK's Department of Trade and Industry (DTI), and many more organisations around the globe.

Angela Rippon OBE

Angela Rippon is an English television journalist, newsreader, writer and presenter. She presented radio and television news programmes in South West England before moving to BBC One's Nine O'Clock News, becoming a regular presenter in 1975. She was the first female journalist permanently to present the BBC national television news. Since 2009, she has co-presented the BBC consumer show Rip Off Britain and since 2013, she has co-hosted Holiday Hit Squad on the BBC.

Sir William Wells

A memorable moment came when Sir William Wells accepted the 2016 Good Governance award from Baroness Virginia Bottomley.

Sir William has Chaired many NHS organisations over several decades, and was founding Chair of the NHS Appointments Commission that helped raise the bar for NHS boards by overseeing NHS board appointments and developing the national cadre of NHS non-executive directors. Sir William's contribution to the NHS governance system we have today, with the pivotal focus on accountable local NHS boards, underpinned the entire NHS reforms of the Blair and Brown governments that delivered a stepped-change in the quality and performance of the health system in England.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Future of the NHS

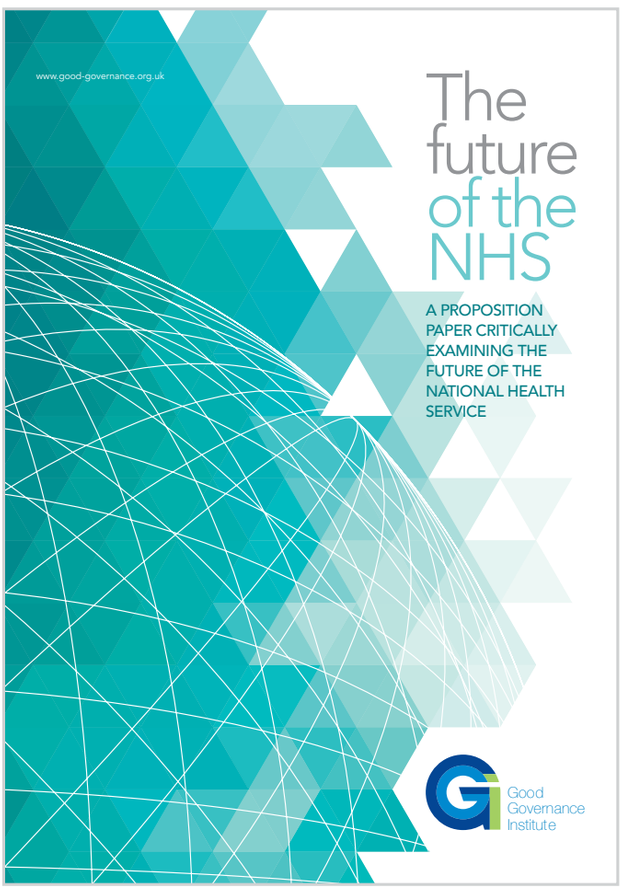
a radical look at what needs to change

Mark Butler, Director of Development, GGI

The future of the NHS is an eternal topic of speculation and, mostly, concern. Over the years GGI has sought to stimulate independent thinking and doing on the subject, in a way that is both conceptually strong and practically relevant. Looking back, it is surprising what still has resonance and what does not, as the world moves on. Here we take a quick look back, but also look forward to what the future may hold.

Sir William Wells, former Chair of the Appointments Commission as well as much else, is in a unique position to provide exactly the right mix of critical rigour and delight in new ideas which keeps everyone on their toes. He is also someone who, for good reason, is taken seriously, and can help bring together the kind of stimulus group which GGI regularly uses in its work to remain sharp and relevant.

In 2016 GGI published "The Future of the NHS" whose recommendations sprang from a gathering, supported by Sir William, which also included two former Secretaries of State for Health and leaders from across the UK health systems and other partners. The intention was to cut through the thickets of the perpetual "health crisis" to consider what would make the NHS realistically sustainable. The 11 recommendations promote succinct actions on financial sustainability, political, integration, social and structural change. Much remains powerful. Arguments and actions about reaching long-term financial settlement, and about a new sharpness around costing and performance methodologies, look certain to be at the heart of the new 10-year deal due to emerge shortly at national level. More specific recommendations, which are equally powerful, have so far found less resonance. The need for an individual savings programme and the plea for cross-party consensus runs the risk of being looked back on in years to come as the "if only"s, which were sadly missed at the time. More



needs to be done to make sure this does not happen. Both the underlying themes of opening up the NHS as a great partner (with whoever it needs to partner with), and of shifting the balance of power with patients and citizens, are still perceptive and challenging. Indeed, they now have a longer reach, given the changing environment since 2016, and could form the basis for a future based on a set of radically-altered relationships.

The idea of "place" as a unifying concept of value for the future of health and care (indeed for the whole sweep of public services and public value) finally seems to have found its time. At its heart is a shared commitment by organisations and local people to understand and then meet the needs of neighbourhoods and communities by pooling resources and assets. It comes with a fundamental belief in active accountability to those communities. In truth the framing of public value around local territorial outcomes is hardly new. Most of the effective public health interventions this century have succeeded using such a model. But it has proven difficult for institutions which provide services to overcome concerns about their own autonomy, and to mediate conflicting perceptions of accountability and governance, in order to make the concept work. The cultural dissonances between publicly-funded organisations have made any practical progress problematic. The idea of opening up the NHS, especially to commercial partners, which "the Future of the NHS" proposes, was looking like a step-too-far even two years ago.

The landscape has changed in several ways over the last couple of years, perhaps more quickly than many of us thought it would. The generation of greater agency at local level has been stimulated as a pressing requirement in the absence of a credible national narrative enabling necessary change. The modelling of what good looks like in terms of multi-agency working, ambition and innovation has generated examples of cross-border decision-making and effective joint funding, not least in the likes of the city deals.

The fundamental shift of narrative to localised integration of health, care and public health as a way of life has led to more application to overcoming external obstacles. The regulatory models, so often accused of being too judgmental, unsupportive and patronising, have themselves undergone scrutiny

and challenge. Populism, at the good end of the spectrum, has led to numerous examples of action to develop or preserve community assets. Even though the operating environment for public-facing organisations is extremely tough, localism is clearly alive and less reconciled to a narrative of inevitable stasis or decline. Locally, the national role is seen as about enabling the local. It remains to be seen whether this view will be shared at national level.
This change of emphasis brings with it new challenges around public connectivity and "ownership" and related issues of governance, accountability and legitimacy which remain unclear. Three issues may help show what the future might look like.

Firstly, "How population health will deliver a sustainable NHS", the joint report GGI published with IBM WatsonHealth in February 2018, captures one of the fast-moving strands of thinking and doing which will characterise the future, and connect the national with the local. This powerful paper sets out in practical terms what policy-makers, the leadership of the emerging STPs and ICSs and individual Boards can do to pursue population health as the agent for a sustainable NHS and a collective intent for a place or system. The paper, drawing on relevant experience in the USA to the UK, argues for a profound shift towards effective partnership working, the high value of developmental support and facilitation in each system, and the rigour around governance culture and structures, on which sustainability will be built.

Secondly, quietly and undemonstratively, more mature models of system leadership and learning have started to emerge in specific places. The brutal, expensive and unnecessary methods of "turnaround", and the negative attitude to incumbent leadership which it perpetuates, are still sadly evident in part of the national NHS psyche – a continuation of the out-of-date Monitor view of the world. This needs to stop. Bringing together NHS national functions, hopefully with a more refined and modern culture, should see this off once and for all. More encouraging are the different types of capacity-building, both across and between systems. These can be seen in schemes of buddying and mentoring between organisations and individuals, brokered in a way that provides sympathetic and decisive support. These more subtle and energising models of system leadership and governance are in their infancy, and still not moving at the pace they need to. However, GGI is currently working with systems where the culture of doing the right thing, and taking the time to do it well, is an established driving force. Even two years ago this would have been unthinkable. This is a delicate early bloom, which needs protection from the frost of short-termism and blunt-force performance measurement. Supported properly, learning like this from what works will provide the engine room for place-based success.

Thirdly, workforce is finally being taken seriously as a strategic risk. There is some way to go. GGI's work with NHS Professionals on the future of the

health and care workforce resonates with the view that place-based, system-conscious solutions are the only route to sustainability. "People in Place", the forthcoming report, argues that the future of the workforce currently looks far from secure, but can be made to be. Doing more of the same around health and care workforce will not deliver what is now needed. The underlying workforce challenges are complex and go beyond the current focus on gaps in a static, professionally-divided workforce. The real mitigation of the underlying and material risks will need to be much more dynamic, pursued at scale and grounded in local service changes, which have secured public and staff buy-in to make them happen and then work successfully. The paper argues that the future depends critically on the building blocks of an open definition of what is meant by the workforce and the employer, will depend on local communities and relationships, and will be made possible by high-impact collective leadership, supported and enabled by national policy, where needed. Workforce solutions are likely to be most successful if they are different area-by-area not part of any monolithic plan or limited to one dominant service. Realistically, it concludes the workforce, like core resources, will continue be unevenly distributed but will also be the touchstone for the future.

It is interesting how international these shifts have become – another theme in the "The Future of the NHS" and its sister document on Scotland published by GGI in 2017. GGI has long been respectful and attentive to the concepts, insights and intelligence generated by Sir Mervyn King, in a series of reports from South Africa, which have always framed governance as a growing, responsive and dynamic foundation for social and economic progress. The publication of the King IV report in 2017 provides a parallel shift in thinking which is relevant to the new health and care models, whatever form they may take. The underlying principles are strong and universal, providing an underpinning for overcoming the perceived and real differences in governance culture and organisational form which has thwarted pace and agility at local level. It also sets out a model for neighbourhood and community engagement and accountability based on integrated reporting to those communities. This active accountability is not about difference or organisation autonomy but about collective intent translated into something tangible and visible to citizens, with their involvement. It makes the different between effective and efficient governance. It also applies to all organisations with a stake in the future of the NHS, health and care.

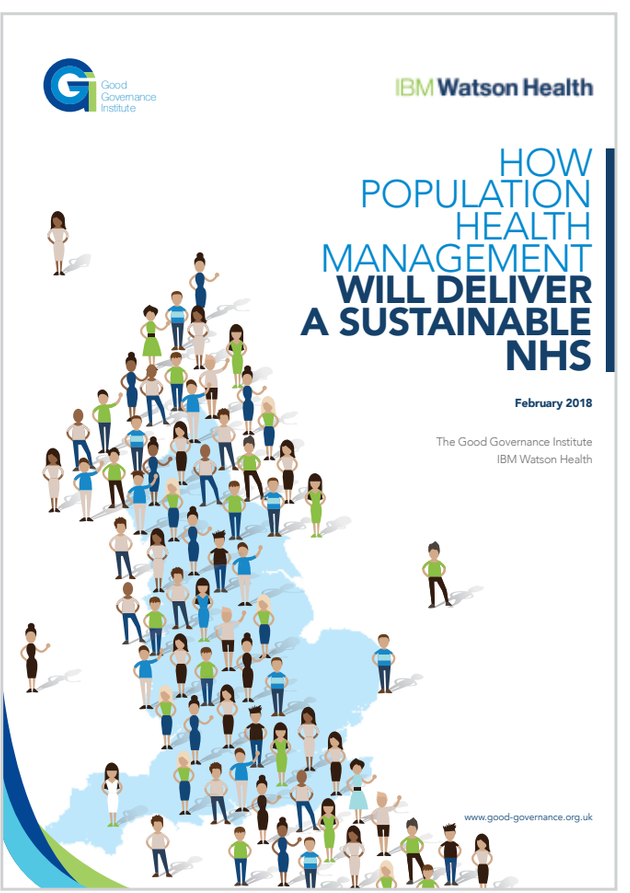
The Future of the NHS as a report title will always get attention. GGI shall do more in future itself. But the challenge for the NHS here is about substantive action. What is needed is a shift from simply promoting the sanctified NHS (the UK's defining institution) as a means of securing increased resourcing. The need is to convert popular support from the NHS as a national totem to collective, local, place-based action across the public domain,

involving the citizens themselves, public sector agencies, and charitable and commercial partners. The future of the NHS is not about the NHS. It is about recasting health and care as a collective enterprise between citizens, neighbourhoods, communities, agencies, leaders and politicians. It is about the migration to a new place-based, narrative which recognises energetic systems are required to generate local solutions to endemic problems which are seen and felt locally.

There are numerous problems to be overcome to achieve such a place-based future – not least the stranglehold of the Treasury and the current lack of agility in resources; the decline in local finances and tangible assets; the perverse incentives, methodologies and disproportionate emphasis on regulatory regimes over investment in organisational development and trust; the professional silos protecting self-interest over collective gain; the narrowness of current engagement with the public around public services; and the unthinking fuelling of a rose-tinted, mythical NHS in its 70th year. This is exactly the wrong time to celebrate the NHS as a kind of stand-alone embodiment of all that is good in the world.

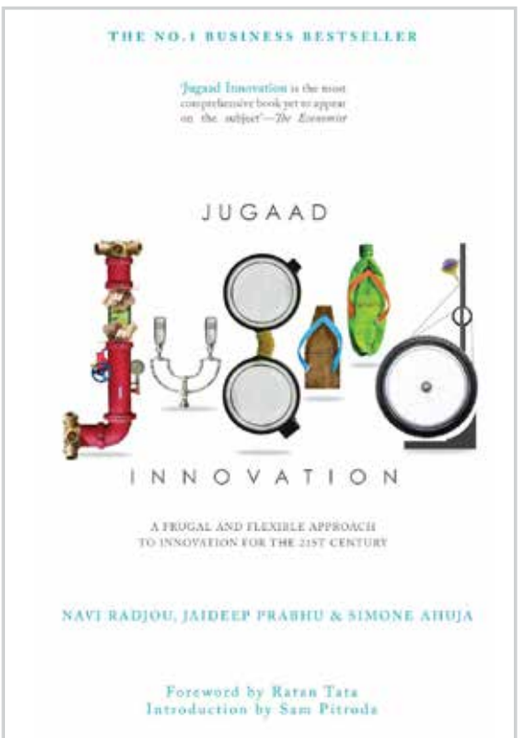
The role of the NHS now is to be humble rather than self-righteous and bombastic; open to alternative approaches, rather than closed to commercial innovation; skilled and able to help convert the public buy-in to active support for change - something which everyone can help to create. Ultimately, the NHS will have to commit to doing the right thing continuously, potentially in the face of strong opposition, and to advocate for the same with others – something GGI will continue to promote in everything it does.

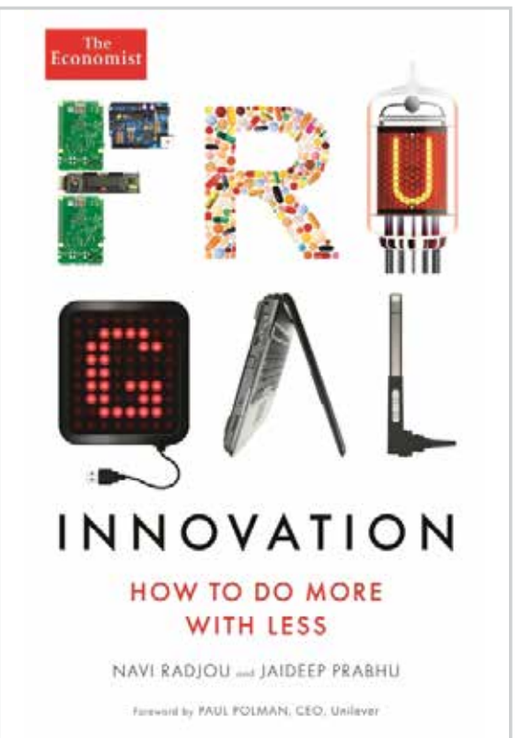
The one thing that gives hope is that thoughtful and decisive engagement with these issues, in the vein promoted by Sir William over the years, makes it possible to feel realistically optimistic that something sensible, visionary and fit for purpose will emerge.



Perfect Ward sponsor table in the 2016 Governance Village

Roy Lilley, Health Policy broadcaster interviewing festival participants for Good Governance TV at Festival 2016





Jaco Marais, Creative Director, GGI

GGI creates opportunities for learning and development of leaders through thought-provoking, challenging and distinctive study tours.

In 2015 GGI embedded me in India. The time difference meant that working remotely from India gave me the mornings to myself, and the afternoons working online. While I was there, I worked to build links with organisations that were exemplifying the rapid modernisation of India's culture and Economy.

I came across the term Jugaad.

Jugaad is a colloquial Hindu/ Urdu concept that loosely translates to frugal innovation and it means to find innovative ways around the problems of lacking resources.

After researching Jugaad, I found Prof. Jaideep Prabhu, co-author of *Jugaad and Frugal innovatio*n. The books revealed to me that the NHS could benefit from a established grassroots culture that is all about doing more, better for less.

Chaos, cars, and cows as GGI and a delegation of twelve NHS executives and consultants brave the madness of Bangalore. For many it's their first insight into India – an opportunity to frame cultural context to the experience ahead and imagine the challenges of providing socialised, sustainable healthcare models in a country where the words "system" and "governance" are far-off concepts; often replaced with a vague but nationally recognised "culture" of sorts.

Our first stop: the Temple of the Bull. We strip off our shoes and stand in awe of the massive, shining black bull who was carved from a single stone; he's adorned with burnt orange, saffron, and red flowers. The Hindu swamis flank him in similarly coloured robes. The building itself is a marvel: intricately carved statues shape the building's pyramid roof. It's comforting to experience the silence and peace of the temple amidst the disorder of Bangalore; a place of refuge from what one delegate can only explain as an "assault of the senses".

This opinion no doubt originated from the experience of our second destination: an authentic local market. We arrive at the market, manage to pull aside into what seems to have been designated as the "parking" area, and find our cars immediately log-jammed with little chance of escape, pressed between a banana vendor, tuk-tuk driver, and a completely unphased cow. GGI's Concept Director, Jaco Marais, no novice to Bangalore, finds himself in the precarious position of leading the group across ten lanes of unforgiving traffic. He leads the way: boldly stepping in front of whatever vehicle presents itself with his hand outstretched and blocking their path, as if to say "you'll wait". Wide eyed but assured by his confidence, we follow into the madness of the market.

Bananas, coconuts, corianders; silver-spectacled serving platters, ginger root, and minted-madness, the market completely shocks. We're framed by shops full of saris and silks in every possible variety and colour: bejeweled, patterned, or matte, but all marvelous – an overwhelming and constantly moving environment occasionally interrupted by sitting cow, lazily chewing on a bit of hay.

Eventually, we retire to the hotel over a glass of wine before collapsing into our beds; exhausted by Bangalore's electric energy.

Emily Taylor, Study Tour Organiser, GGI

Taking the bull by its horns is something I had developed out of necessity. Of course it was Emily Taylor who was the real hero of this study tour managing a programme packed full of events that ran to schedule in a city known for over-population and traffic delays.

RAJIV GANDHI INSTITUTE OF CHEST DISEASES BANGALORE

indegene Healthcare

BRITISH COUNCIL

Jaco Marais visits Judge Business School to speak to Prof. Jaideep Prabhu, author of Jugaad and Frugal Innovation, about how students there are shaping the future.

Professor Jaideep Prabhu

Judge Business School, University of Cambridge

“The original Jugaads were actually vehicles that farmers cobbled together from spare parts. They would take the wooden chassis of a cart and use water pumps as engines to create vehicles – part tractor, part truck – to transport goods and people. Sometimes they’d use a scooter or a motorbike as the engine.

Right at the heart of Cambrige; “fab-labs”, “make-a-space” or “tech shops”, as they’re called are bringing together like-minded tinkerers and makers. Company employees and people in the university ecosystem go there to get access to digital manufacturing tools, laser cutters, 3D printers, circuit board printers, cheap, adaptable computers and so on. They also get access to like-minded people to bounce ideas off, which are empowering people to do remarkable things.

This frugal innovation revolution is linked to entrepreneurship and other trends in society where students want to make a difference. They don’t want to work in large companies or the government any more – they want to do it themselves and now they’re empowered to do that.”

“

Fingerprint medical records

A group of PhD students from different departments here in Cambridge had an idea of how to solve a universal public health problem in rural communities: how do doctors get access to a patient’s medical records? For instance, doctors travel from the city to the countryside to do big vaccination programmes. They might find a mother with her child and they will have no way of identifying them or accessing their medical records, because they have no paper records there. The records may be in the district hospital, but how to link them with the mother? So, they thought, what if we could use her fingerprint as identification? Convert the visual information into text, which the doctor can then SMS to the district hospital. They could pull up the patient’s records and send them to the doctor.

They went on to develop the idea, entered a local competition, and won about £5,000. With this money, they tried to jerry-rig a solution, and they bootstrapped by working in the “make-space”. Here, they met people from ALM (a big company in Cambridge) and in about two to three years, they’d developed several alterations of a small device – a fingerprint reader that converts the information. When the time came to graduate with their PhD’s, they were ready to set up a company. They set up a social business and they got several million pounds funding from DIFID, the Gates Foundation, and ALM. What’s remarkable is that four of our own students achieved all this without any technical knowledge – and I could give you plenty more examples like this.

Raspberry Pi

Another outstanding example is a hand-held computer called the Raspberry Pi. It initially cost $30, but now a $5 version has been developed. Students in the faculty of computing here noticed that fewer people were applying to study computer science at universities like Cambridge. And often those who did apply had never opened up a computer to tinker around inside, mainly because it’s so difficult to do so. Because they’d never tinkered, they’d never done any coding.

To solve this problem, the students wanted to develop a computer basic enough that you could tinker with it. It needed to combine displays, keyboards, memory devices and it needed to code. It needed to be cheap enough that even if it was broken, it wouldn’t be a big deal. Initially, they thought they would sell about a thousand

units just to generate some interest. They've now sold 17 million in the space of about five years.

Finding different applications in all kinds of contexts is driving this "maker" movement, where people are using cheap devices to make other frugal devices. Here in Cambridge, someone sends Raspberry Pi's with web cams and sensors up in a hot-air balloon for his own do-it-yourself weather reporting.

One of my former students has taken the Raspberry Pi and loaded it with the Kahn academy. He makes it available to kids who don't have access to the Internet but have access to TV, which can act as a display. It can also help with education because it enables peer-to-peer learning, using what is already there. Sometimes the teachers won't show up at the village school, but the students show because they want to learn and they get a midday meal.

Now, can you imagine developing the capability of devices like this?

The NHS at the centre of the local economy

I believe that the NHS is better able to serve its mission with constrained resources by partnering.

The NHS collaborates with charities, with volunteer groups, and religious groups to help deliver social care; care in the home. Working with communities is a very effective way of doing more with less. It's often people living within communities that understand and care about others in their community. You can tap into their knowlege for an additional or less expensive resource than you'd have within the NHS.

This idea is a smart way of stimulating innovation around challenges, around needs. It allows an organisation like the NHS to understand what the community needs are and develop appropriate solutions. But they don't have to put in all the effort and energy – others can do it for them. *The NHS can cherry pick from innovations and then they can scale them; they can leverage economies of scale*.

They can do this in a systematic way, where in a place like Cambridge, they can engage with the local eco-system. For example, start-ups can address any NHS problems and the organisation can then use its procurement might to stimulate this kind of activity. This enables the NHS to get the appropriate solution on good, financially-viable terms. Governments are doing something similar now; stimulating local entrepreneurial talent by offering challenges. In Exeter, for instance, the"Smart Cities" programme issued a challenge to start-ups, saying: "we would like you to develop a solution to improve our energy efficiency."

Master of Studies in Social Innovation

Our centre for social innovation (literally, two doors away) has set up a very interesting master's programme called a Master of Studies in Social Innovation. The university has allowed us to create this new degree specifically for working people around the world that would like to study but can't afford to take a year off work.

We take a one-year, full-time curriculum and spread it out over two years. Students come here to study for a couple of weeks every six months and, the rest of the time, the learning happens online and in peer groups, using things like Skype and e-mail. This programme is an entirely new space in business schools both academically and intellectually. There's a great interest in the programme, particularly from people in developing countries who work in areas such as healthcare, education, and financial services like micro-finance.

MBA students with a social conscience

This trend is a very interesting one, which I noticed after having been in various business schools for over twenty years. An MBA is a very expensive degree so students are generally looking for a return on their investment, using it to work in finance, consulting and in large multinationals. But, I've noticed a growing minority who want to get the business skills an MBA offers and use them to make a difference. They form the networks they need by meeting people in a place like Cambridge, and then they use their skills and network to set up their own business.

So, there's this interesting mix of motives: partly they want to make a name for themselves; partly they want to make some money and put food on the table. But equally they want to make a difference. They want to change the world and make it a better place.

There's also a shift in how MBA students now place more emphasis on society. It's not as if they've suddenly become very socialist in their thinking, but there's more emphasis on social business and hybrid forms of social enterprise. So, there's a shift to smaller organisations and start-ups. And there's a shift towards not only wanting to have a profit impact but also a social impact.

There's this rise in interest in social enterprise and social innovation. This is happening both in the west and in developing countries where people see social problems around them all the time. Equally, they realise that solving a social problem and meeting an unmet need will not only help people improve themselves but also generate wealth, which can be shared and disseminated.

Community Care Models

BRAC, an international development organisation based in Bangladesh, is the largest non-governmental development organisation in the world. The organisation employs over 100,000 people, roughly 70 percent women, and it reaches more than 126 million people with its services. Established by Sir Fazle Hasan Abed in 1972 after the independence of Bangladesh, BRAC is present in all 64 districts of Bangladesh as well as 13 other countries in Asia, Africa, and the Americas.

For example, BRAC would identify women from the community, and train them to make electrolyte solutions for sick children. These women would then go door-to-door, teaching other mothers how to make it. BRAC would then check and cross check. They spent some time figuring out this system and then used financial aid to dramatically scale this solution across the entire country. In about ten years, they solved the serious problem of child mortality caused by dysentery and diarrhoea.

I believe that there are many organisations from developing countries that could inspire the NHS, directly and indirectly, by showing them how to do more with less.

The Dutch organisation Buurtzorg or 'neighbourhood

care' adapted a grassroots community model successfully, cutting costs while not compromising on quality. Using this disruptive model, Buurtzorg essentially displaced some people from the system. They discovered that their administrators, their back-office people, were sucking up resources, but not necessarily creating value. The value was created on the frontline through the nurses who were in the community and who were in direct contact with patients. Here, nurses were forming relationships, getting to know patients, and serving their needs. Buurtzorg re-purposed its resources, moving them away from the back-office to the frontline. I think we need this approach in social services.

You need to place people where they're most needed and most valued. And everything else that can be done cheaper, faster, and more accurately should be outsourced, even to technology.

Amazon, but for government

The UK government and the cabinet office had an initiative called contracts finder, a digital platform that's essentially like Amazon, but for government.

Citizens have become very demanding because they've got used to using platforms like Amazon, where they can get everything online with the press of a button and have it delivered to their home. They're not prepared to spend a long time getting a driving license, or making an appointment. These days they don't even want to fill out paperwork. So, now there's pressure on governments. This can be seen as an opportunity to operate like Amazon, trying to become faster, better, cheaper. They can do this through frugal innovation internally, or even better, they can partner with others who are able to do it.

Vibrant communities

I think vibrant communities are ones in which there's an engagement between all these different parts of society who need to work together. Today, a breakdown has occurred between state and communities, between companies and their consumers, between for-profit and non-profit organisations, between large and small companies. All these parties really need to work together to create a vibrant economy and society. Unfortunately, suspicions, mistrust and fear have broken down our social contracts.

A new social contract

I think it is our mind-sets that we need to change. We need to try new things, we need to work with other people, and we need to be a bit sceptical before scaling things up. We also need to draw on multiple intellectual disciplines; we can't just rely on hard science. It's important to consider behavioural science, because even if you have a great technical solution, you still need people adopt it. In an ideal harmonious society, we need to re-vitalise our social contracts by working and collaborating together.

”

Matthew Hopkins, in his previous role as Chief Executive of Barking, Havering and Redbridge University Hospitals NHS Trust ,talked to Jaco Marais on how they engage with staff to drive innovation for better patient experience.

Matthew Hopkins

Chief Executive at Barking, Havering and Redbridge University Hospitals NHS Trust 2014 - 2018

Left: Matthew closes Festival 2016 with an inspirational talk on how to set out and achieve big changes.

Festival 2016 was very much about inspiring leaders to develop a vision and to take ownership of the future of their organisation. I asked Matthew Hopkins, who was our closing speaker at Festival 2016 Good Governance with the theme "because the future is in our hands", how he made change happen?

How did you begin to make change happen?

BHRUT was a very different organisation four years ago.

The improvements in quality and performance that we have achieved over the last four years was about the board having a very clear vision that I think the staff and our stakeholders can buy into. At the beginning of this journey, we talked very much about aspiring to be an outstanding organisation both from the patients' perspective and the staff perspective. We wanted to achieve an organisation where patients wanted to be treated and where the staff thought is a great place to work. And where they would like to be treated if they, or members of their family, were ill.

We set about a step-wise journey of improvement. First, we went through a process of engagement with staff to determine a set of values and behaviours that were expected of them in the work that they do.

Together, we came up with five words that resonate with staff members:

P Passion
I give the best of myself, I work with compassion and kindness and I make a difference everyday

R Responsibility
I do what I said I would do, I step up, I speak up and I recognise other people's contribution

I Innovation
I solve problems, I keep it simple and I look for opportunities to improve our care

D Drive
I deliver with pace, I lead by example and I welcome challenge

E Empowerement
I support my colleagues, I listen to understand, I delegate and trust people

How has the organisation instilled the PRIDE values at BHRUT?

We talk very much in the organisation of having taken pride in our work. So, it was a values-based approach with staff.

Under each of those five headings we listed three behaviours that we ask our staff to live on a day-to-day basis. These behaviours talk to things such as speaking up when they have concerns

through to taking a responsibility and to find solutions to issues.

Four years later, those values and behaviours are now so well embedded that staff talk to them as a way of articulating those who live by the PRIDE values and those that don't. And how are individuals that struggle to behave in the right way held to account?

The third strand was, therefore, to get a sense of accountability into the organisation, both in terms of behaviour but also compliance with policy and improvement.

Values, behaviours and a sense of accountability were the three key strands of the building blocks to change.

Drive?
How does BHRUT get motivated?

Staff remembered a CQC inspection where the inspector said that this organisation has the potential to be outstanding. That gave the sense of confidence and ambition that was previously lacking, given the difficult quality and financial background over the previous decade.

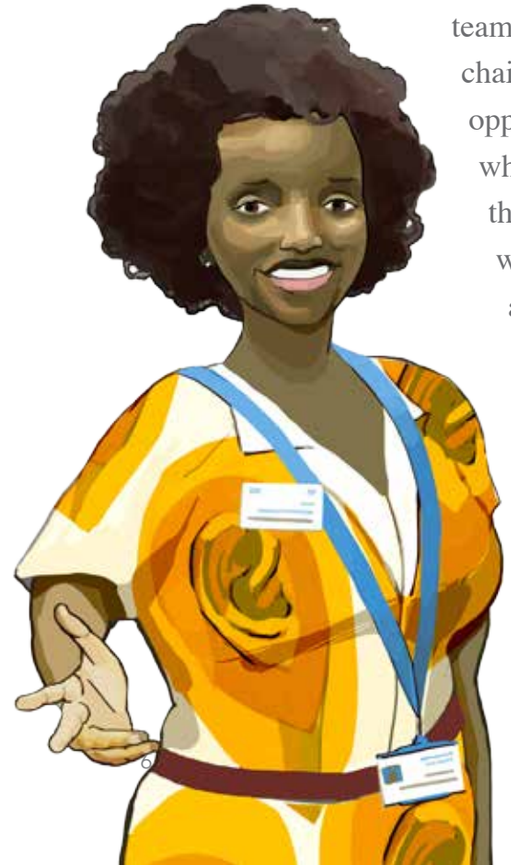
A very important key element to us and has been to establish a single-improvements approach, which enabled us to be fortunate enough to be selected to partner with the Virginia Mason Institute in Seattle, America.

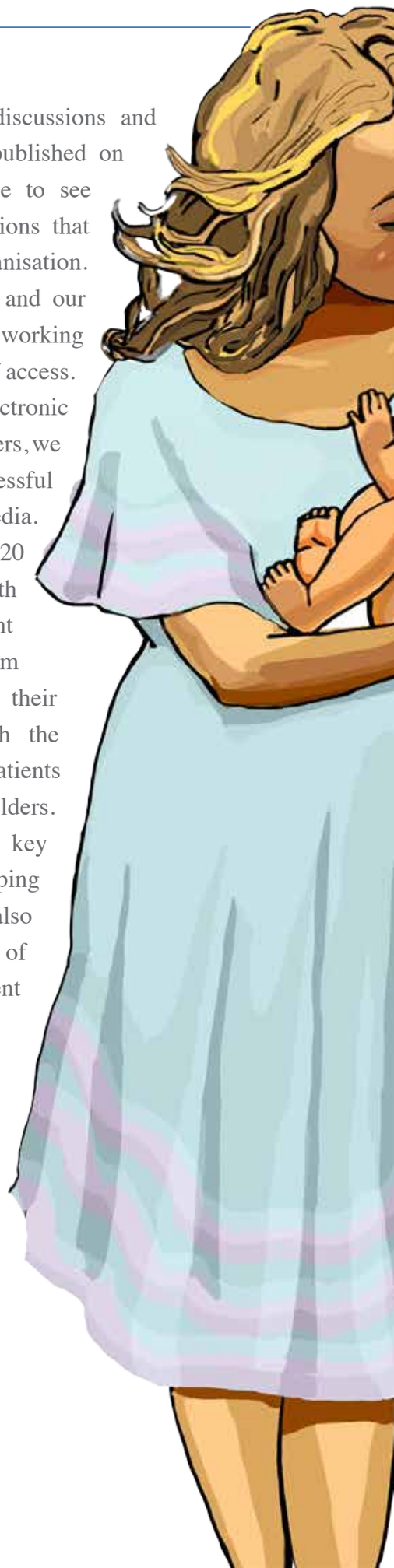
As part of that partnership, we were able to emulate some of their work in the Virginia Mason Institute - the hospital of the decade - and drive our own organisation forward to become one of the safest in the UK.

The importance of a single improvement methodology is that we train our staff in the same way and we celebrate the work that they do. We are currently in the process of training our leaders to be able to lead improvement work. They will be able to make improvements on a day-to-day basis, without having to look up the hierarchy for permission. We are essentially building an ethos to encourage our staff to come to work, not just to do their jobs, but to improve their departments as well. This is a culture change that we hope will last well into the future.

How do you communicate over such a large trust serving such a diverse community?

We use a range of channels. The most successful has been the face-to-face opportunities. We have a regular business rhythm of these opportunities, where staff are able to meet with me and other members of the executive team, as well as the Trust chair. This gives them the opportunity to talk about what the life is like on the front-line, working with our organisation, and meeting patient demands. The communications team then take the themes of these discussions and make sure those are published on our Intranet for people to see the kinds of conversations that are going on in the organisation. Our refreshed Intranet and our website are both now working well as a single point of access. In addition to weekly electronic magazines and newsletters, we have been pretty successful in developing social media. We have now between 20 or 30 departments with their own Twitter account and they use the platform to communicate with their team as well as with the wider organisation, patients and other stakeholders. Twitter has been a key component in us developing a sense of family, but also developing a sense of open and transparent communication.





When did you begin to realise the seeds of change are sprouting?

I think it is fair to say that BHRUT had a long history of unsatisfactory patient waiting times. When we looked at this problem back in 2014, there was a sense that staff had known about these problems but felt unable to raise concerns. Winding the clock forward to the junior doctor strike in 2016, those same staff members were very vocal about the potential impact on patient safety and patient wait times. I could see that the culture had turned to one that puts patient safety and patient experience first. For me to see the same members of staff taking part in an organisational culture that encourages staff to raise concerns and helping to mitigate the impacts of the junior doctors strike was for me a quiet hooray moment!

Do you have an example of patient feedback leading change?

I was recently involved in opening a facility to improve end-of-life care on one of our cancer wards. The dignity of a patient wanting to say goodbye to their loved-ones was not being respected in a ward of four beds separated by curtains. By making improvements in how this team manage their stores, they were able to free up a room for the specific purpose of wheeling in a bed and providing loved-ones with some private time. This team went further by encouraging some patients and staff in fundraising. Not only did they provide a facility, they also provided the facility with a laptop with Skype capability to allow family members across the world to share the patient's final moments. I am encouraged that this particular team will continue to innovate and work around the current resource constrains we are facing.

What are you doing to engage the patient and the wider community in East London?

We have the Patient Partnership Council where patients are closely involved in improving the care of other patients based on their own experiences. The Patient Partnership Council also makes decisions on what our leaders should be doing and what our organisational strategy should be. We will soon have a member of the Patient Partnership Council as a member of our board.

We are well on the way to integrating the patient voice into our decision-making. When we improve our work using the PRIDE-way, our improvement methodology, we will always include a patient in those weekly meetings to ensure that the views of the patient are being considered when improvements are made.

This is a journey and one of our Board members is very keen for us to continue to further integrate our hospitals into our local communities, so that they reflect the needs of our hard-to-reach communities. There is a real drive to innovate and improve work in this area. We are partnering with Northumbria Healthcare NHS Foundation Trust, which is an outstanding organisation, to ensure real patient involvement and how to make engaging with communities part of our governance processes.

What are the priorities of the East London STP?

We are primarily focused on improving primary care. We also have reduced the projected deficit. We intend to do this with better, integrated working, managing demand, and improving access to primary care rather than hospital care.

What does the ideal future look like for NHS?

Nationwide, we need to improve access to health and social care alternatives to showing up at the hospital. In an ideal future, the patient would be able to access the specific service for their specific need at the time they need to access it. The impact on hospitals would be to only need to treat the people for whom the hospital is needed. But this would only work if the alternatives are just as accessible as the hospital, where the lights are on 24 hours a day and seven days a week. This would be real sea change in behaviour and we don't live in an ideal world. Of course, we have to realise that we are dealing with a diverse customer-base and there will be some people who will continue to turn up at the hospital, even though that is not the best place for them to receive appropriate services for their situation. We have to ensure that we have slick processes to make sure they are discharged to the appropriate service for them as quickly as possible.

Future technologies exist that makes access to GP services available via Skype or FaceTime, and mobile technologies are being used to manage chronic illnesses in the comfort of the patient's home. I would hope for those to become more widespread.

Why is the NHS so behind other industries in terms of patients managing their own records electronically?

My own GP practice enables me to order a prescription, reschedule an appointment and, to some extent, have access to my own patient records. The technology exists. In the NHS there is such variability. The NHS does not operate as a single entity but is instead made up of hundreds of franchises. This variability and the investment

picture is why the NHS, as a whole, is lacking behind other industries in terms of managing data. I myself am using my phone more and more and so it is for this generation and the next to demand better access to these services.

What is next for BHRUT?

We recently had three of our nurses assaulted on one of our wards. This is an increasing problem across the NHS, with 10% more instances of violence and aggression than last year. I think unless we do something different, we will fail in our duty to provide members of staff with a safe working environment. One of the next things we are going to start with is a conversation with our staff on how to reduce the incidences of public violence towards them. We intend to initiate a series of conversations with staff members to improve this problem, based on their own experiences. In this 70th year of the NHS, it is for us to ask how we can improve the relationship with some of our community to be more respectful towards our staff.

How is the board able to achieve the future objectives of the organisation?

We have a leaders agreement, which determines a set of behaviours for anybody with line management responsibility. It sets out what board members are supposed to do to support managers and what managers are responsible for, in terms of delivering improvement and engaging their staff in change.

Our board has been on a journey of improvement and we are highly motivated to see that journey continue well into the future.”

Solidarity Summer camp 2016

Gdansk, Poland

Jaco Marais, Creative Director, GGI

The doctrine for a small, white, Christian boy growing up under the National Party in Apartheid South Africa was that communists like the African National Congress (ANC) were dangerous and evil and capitalism was fair and godly.

It was a sort of battle of minds perfectly illustrated by the movie Rocky IV. Rocky IV is a 1985 American sports drama film written, directed by, and starring Sylvester Stallone. The film co-stars Dolph Lundgren, Burt Young, Talia Shire, Carl Weathers, Tony Burton, Brigitte Nielsen and Michael Pataki. Rocky IV was the highest grossing sports movie for 24 years. It was one of the few films released by South African censors the same year it was released.

In the film, the Soviet Union and its top boxer make an entrance into professional boxing with their best athlete Ivan Drago, who initially wants to take on World champion Rocky Balboa. Rocky's best friend Apollo Creed decides to fight him instead but is fatally beaten in the ring. Enraged, Rocky decides to fight Drago in the Soviet Union to avenge the death of his friend and defend the honor of his country.

At the end of the film Rocky gives a victory speech, acknowledging that the local crowd's disdain of him had turned to respect during the fight. He compares it to the animosity between the U.S. and the Soviets, and says that seeing him and Drago fight was "better than 20 million", alluding to a possible war between the U.S. and the Soviets. Rocky finally declares, "If I can change, and you can change, then everybody can change!" The Soviet General Secretary stands up and reluctantly applauds Rocky, and his aides follow suit. Rocky ends his speech by wishing his son watching the match on TV a Merry Christmas, and raises his arms into the air in victory as the crowd applauds.

I also remember work parties, where we would volunteer to hide mini-bibles in matchboxes to be airdropped over Eastern Bloc countries.

Of course this was all a big distraction from South Africa's own impending 'fall of walls' as 'revolutionaries' and 'terrorists' were united under the slogan of: " One man one vote".

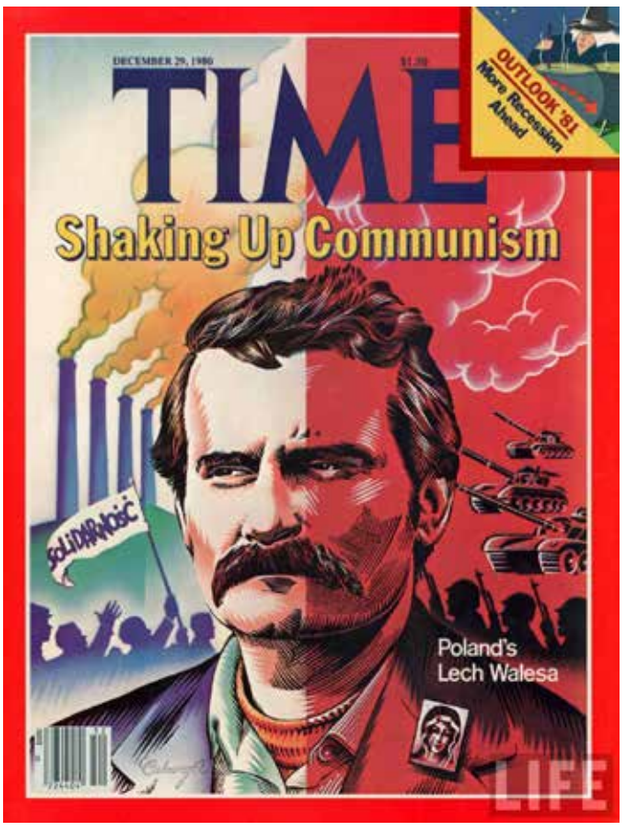
You can imagine how confusing it was for the government censors when Lech Wałęsa lead the Solidarity movement of factory workers to a revolution over communism that spread through Eastern Europe and lead to the fall of the Berlin Wall in 1989.

Thirty years wiser, I had experience of: reconciliation, immigration, poverty, success, coming out as gay, transcendental meditation and world travel. And, I was sitting in the Dockyards of Gdansk in the Solidarity museum, opposite Lech Wałęsa!

I asked the first democratically elected president of Poland: What are your wishes were for the future of the Solidarity Movement and the Solidarity Museum?

His answer was refreshing: " I wish for the flags of the past to be laid down and for people to collectivise around new issues that need changing in new ways appropriate for the time."

I will never forget Solidarity Summer Camp for as long as I live.



Reflecting back on it, 'Solidarity' movements have been and still are a part of my every day life. We have changed South Africa, gay rights; our minds and we are busy changing international gay rights and immigration policies. I was now more than ever committed to my life-purpose of connecting people around these and other causes.

The patient safety summit

An instrument for affecting culture change, engaging staff in error and harm.

Entering the Trust buildings in early 2015 it became quickly evident that the staff were not supported to learn from error and harm to patients. The infrastructure was largely missing. The processes were weak. The clinical governance staff were mostly interim, fire fighting, with uncertain capacity, capability and confidence. The data was stark: nationally the Trust was the second lowest at incident reporting per 1000 bed days; a backlog of over 180 serious incidents, many dating over six months old; evidence of same error recurrence. The Trust, having previously gone through a difficult financial challenge, had made disinvestment decisions that exposed staff and patients to a culture where learning was a low priority, a place where almost no learning was enabled. With the support of the Good Governance Institute, a great deal of organisational governance was rebuilt, especially clinical governance. The primary objective was to build the foundations of learning, taking advantage of the human want to learn and improve, through embedded systems and instruments. One such key instrument was the Patient Safety Summit.

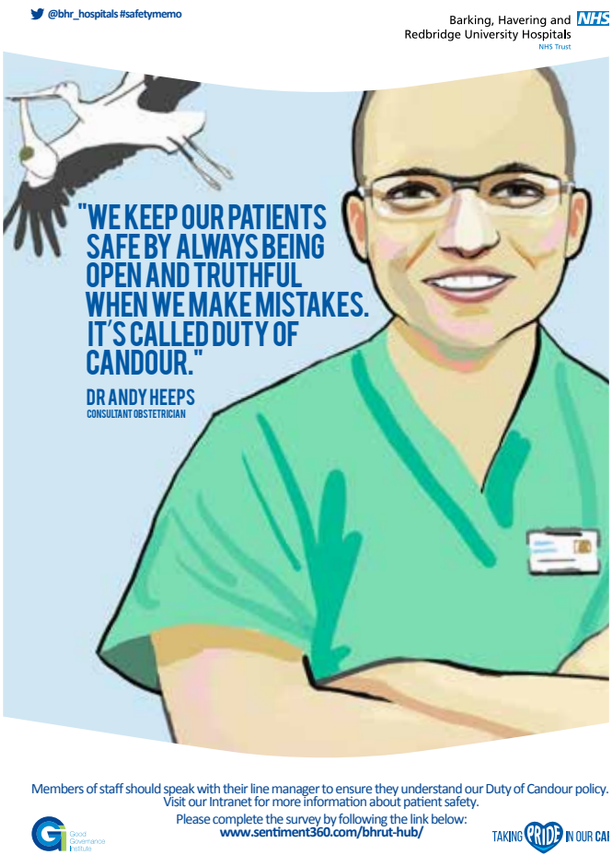
Dr. Nadeem Moghal is the Clinical Director of Professional Learning at the Royal College of Pathologists and a Senior Clinical fellow at the Nuffield Trust. He was previously the Medical Director at Barking, Havering and Redbridge University Hospitals NHS Trust

"TO KEEP PATIENTS SAFE WE ENCOURAGE STAFF MEMBERS TO SPEAK UP WHEN THEY NEED TO RAISE CONCERNS."

JENI DEBORAH MWEBAZE

GOVERNANCE MANAGER
SPECIALIST MEDICINE DIVISION

Barking, Havering and Redbridge University Hospitals NHS Trust



What constitutes the Patient Safety Summit (PSS)?

It is a meeting of staff open to all the disciplines in the Trust, doctors, nurses, managers, students, allied medical staff, administrators, and a patient partner. Including a patient partner early in the implementation of the patient safety summit was seen by some as high risk. The patient partner proved transformative to the debates. The patient partner is not a single issue advocate, but genuinely focused on supporting learning, often asking a key question, bringing the room back on what really matters.

A recent serious or notable incident reported in the last ten days is identified by the corporate quality and safety team. The incident is described into a standard one page form, shared across the organisation by email as part of the weekly invitation to staff to attend the PSS.

The chair of the PSS starts each PSS by actively framing the meeting to build a moment of psychological safety – reminding staff at the start of the following principles:

- This is about the care of a patient and what did not go well
- We are here to learn from why
- There is no such thing as a silly question

- Every question and comment adds to the opportunity to learn
- This is not about who, but what happened and why
- This is about what needs to be done immediately to keep staff and patients safe
- The information collected is used to help the round table
- No minutes are taken

The clinical team responsible for the patient presents the story for no more than 10-15 minutes. The remaining hour is all about the Q&A.

Chairing and psychological safety

To establish the PSS it was imperative that the MD and Chief Nurse chaired the PSS every week – signalling it's importance and value. The challenge becomes sustaining the senior leadership chairing responsibility – but if patient safety is a primary responsibility of the medical director and chief nurse, then it should be a diary priority too. In addition to setting the scene, building the environment of psychological safety, drawing in staff from all the disciplines present is key to encouraging perspectives often missed. Psychological safety is key to the engagement by staff in sometimes very difficult set of issues. Staff have to feel safe to tell the story, to raise questions. The Chair has to be vigilant of tone, the agenda, bringing back the debate, the conversation, on the why, not the who. Questions from a manager in pathology to a vascular surgeo, a student nurse asking the paediatric team about what was seemingly assumed, revealing new learning – this opportunity doesn't exist anywhere else in the organisation.

Weekly rhythm

The PSS is held every week, and on both hospital sites, using the same case each week, to ensure wider engagement and common messages of learning shared across the Trust. It is held on the same day, at the same time, every time. This does not suit all of the staff all of the time, but once fixed, it became an established rhythm in the Trust, and continues to this day, three years later with stable attendance numbers.

Continued professional development, sharing the learning

Every PSS attracts a certificate of attendance as evidence of continued professional development for appraisals. Following the PSS the equivalent of an alert is sent by email, formulated as a case report, with key messages as way of encouraging awareness of risks, as well as learning that could be applied to other services. The hope is that staff engage with the incident and learning, discuss it at their huddles, testing relevance in their clinical

areas. There is currently no systematic mechanism that tests understanding, reflection, or application of learning from the post PSS alert.

Impact

The PSS is one instrument for culture change. It has an contributed to learning from error and harm. Along with other actions, amd initiatives, the Trust is now consistently in the top quartile for incident reporting, with a steady and sustained decline in the rate of serious incidents; measures indicating an organisation engaged with wanting to learn, and improving the quality of care through that learning.

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Improving the PSS

1. *Increasing medical staff attendance:* Experience shows that winning the hearts and minds will reach a limit in terms of engagement and attendance especially where there are many other competing priorities. It is reasonable to expect a doctor to attend four patient safety summits a year. This will require a policy standard and it's adherence evidenced by PSS CPD attendance certificates in appraisals.

2. *Measuring engagement with the post PSS story and learning*: in addition to sending out the post PSS alert, the incident could be added to the Trust learning or CPD platform with questions and reflection to enable measurable engagement.

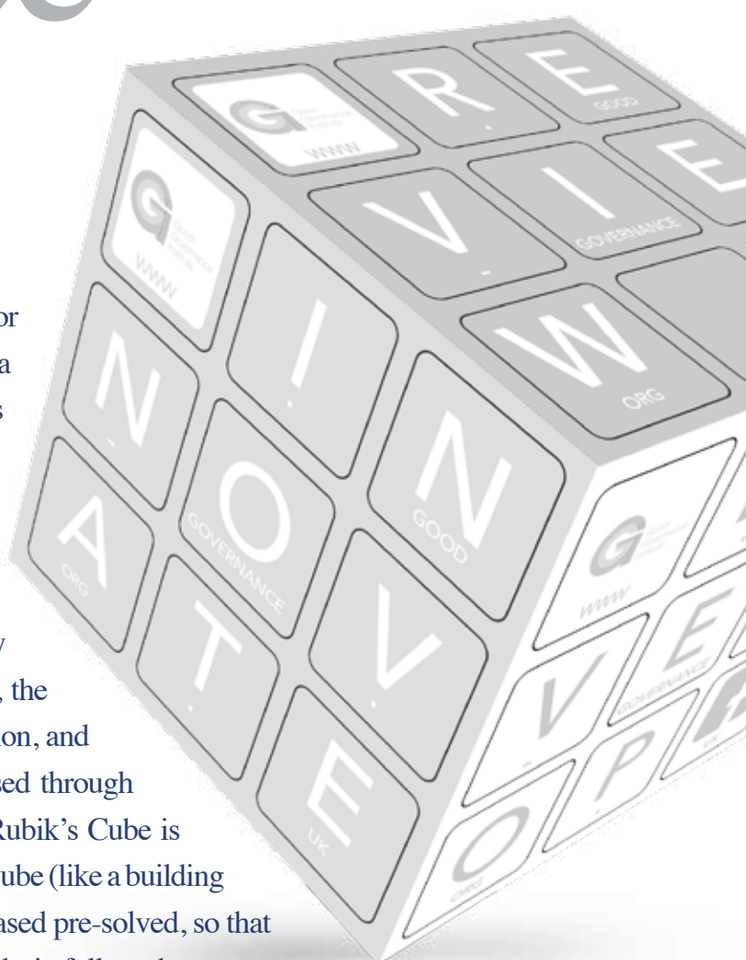
3. *Spreading the model into services:* It should be possible for each service to conduct a PSS for serious or notable incidents, decided locally, at a rhythm that works for the whole team. The same principles will need to apply around building psychological safety, chairing to maintain that environment and encouraging an inclusive approach.

The illustrations accompanying this feature article are from the award-winning series of Patient Safety Memos, developed by the Trust and GGI. These memos were theme-based briefings which captured the duties of all staff around Patient Safety. They are true likenesses of nurses, doctors, administrative staff, pharmacists, porters, technicians, cleaners, managers and medics all improving patient experience in their departments. The campaign was featured at the ISQUA conference in Tokyo, 2017.

https://www.bhrhospitals.nhs.uk/safety-memos

Festival of Governance 2017

Good Governance because...



The Rubik's Cube was invented by Ernő Rubik, a Hungarian Sculptor and Professor of Architecture in 1974. Initially it was designed as a learning aid to help students at the Budapest College of Applied Arts understand 3D modelling. However, the puzzle went on to become a mainstream success in the 1980s and, to date, has sold 380 million units worldwide.

The concept behind the Rubik's Cube was as complex as the toy itself. When considering advanced architecture and interior design, the artist must consider the implications of working in the third dimension, and how the structural integrity of a construct must not be compromised through the incorporation of moving parts. The interlocking nature of the Rubik's Cube is intentionally designed to limit mobility. This is so the structure of the cube (like a building or a sculpture) cannot be compromised. However, the cube is purchased pre-solved, so that the purchaser knows that the puzzle can be solved. All they need do is follow the correct combination of twists and turns to return the cube to its correct state.

leadership is a changing landscape

Managing complexity

Collaborating with the other side of the cube

Philip Cockayne, Consultant, GGI

If you consider the Rubik's Cube as a metaphor, one can apply it almost seamlessly to a business or organisation. A business has a combination of fixed assets (like the interlocking principle of the Rubik's Cube) which limit what can and can't be done in order to solve any potential problems. However, most organisations leave plenty of clues which help management solve some of the challenges. (For the Cube, this could be sequences of colours, corner pieces aligned, etc. which all help the solver plan their best strategy.)

The Good Governance Institute (GGI) thinks of the Rubik's Cube as not only the perfect metaphor for an organisation, but also an equally valuable metaphor for deciding how best to solve the problems faced. Organisations usually approach GGI because there's a problem they want us to solve which, for capacity, capability or competency reasons, the organisation cannot solve themselves. Like the Rubik's Cube, they have all the right pieces to restore order but rather than relying on the Board or the Executive to solve these problems, the organisation requests GGI's support.

This is essentially why, when it came to update the website last year, Jaco Marais, our creative director used the six sides of the cube to demonstrate the services GGI offers our clients. The client hands us a cube (i.e.

their organisation) and requests our help in solving the puzzle. This package of support comes in variety of different themes, which we simplified from 108 distinct service offerings to six themes. These translate well onto the six faces of a Rubik's Cube. The first three are easiest to explain. In order to solve a problem, we have to **Review** where the organisation is currently at, and what their main challenges are. This includes diagnosing the problem and proposing a solution. This leads us on to **Develop** that solution and support implementation. Finally, sometimes the client is happy with the state of their company (the cube is in its complete state) but they need help creating tools and processes (like a matrix) to **Sustain** this state.

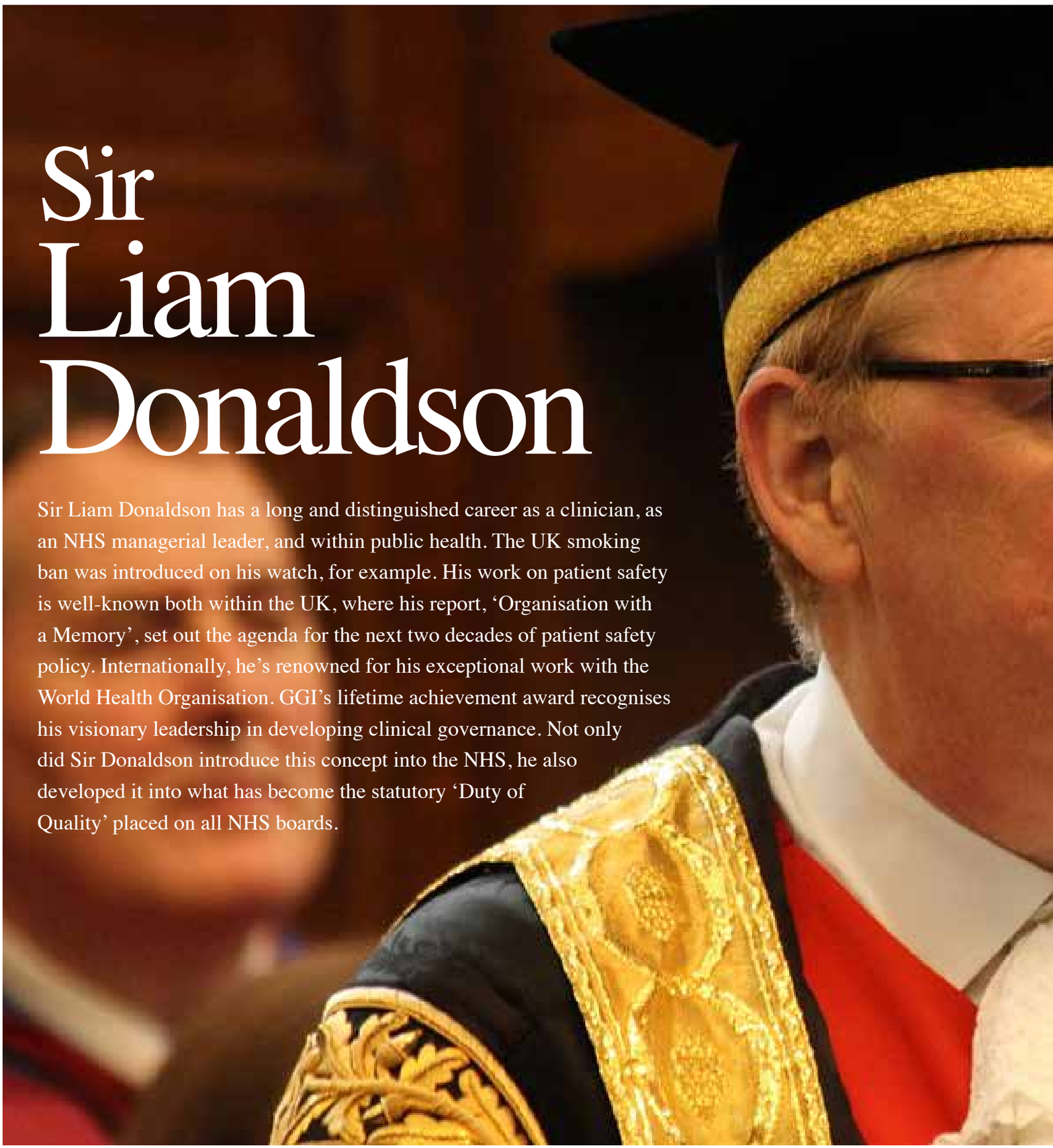
This *'Review, Develop, Sustain'* model provides a useful tool in explaining the core services GGI provides. When it comes to governance, you need to have the following:

- mechanical components – structures, processes, policies, frameworks
- dynamics – leadership, culture, engagement, which dictate how governance works within an organisation.

Sometimes, an organisation can have the perfect combination of governance mechanics but still face challenges implementing them. This is often due to an imbalance, usually relating to the 'dynamics' of how governance functions. Therefore, GGI also provides 'dynamic' services, to support the more mechanical *'Review, Develop, Sustain'* interventions. These include:

- **Engage** – sometimes clients need communications and engagement support in ensuring staff understand the importance of good governance
- **Innovate** – other times, GGI acts as the facilitator, rather than a problem solver, to help the client solve problems on their own
- **Inspire** – presenting case studies and thought-leadership content to enable organisations to solve problems independent of GGI.

This story of the Mechanics (Review, Develop, Sustain) and the Dynamics (Innovate, Engage, Inspire) is a powerful story in helping GGI explain governance. The Rubik's Cube provides a great metaphor through which to articulate the support that we provide.



Sir Liam Donaldson

Sir Liam Donaldson has a long and distinguished career as a clinician, as an NHS managerial leader, and within public health. The UK smoking ban was introduced on his watch, for example. His work on patient safety is well-known both within the UK, where his report, 'Organisation with a Memory', set out the agenda for the next two decades of patient safety policy. Internationally, he's renowned for his exceptional work with the World Health Organisation. GGI's lifetime achievement award recognises his visionary leadership in developing clinical governance. Not only did Sir Donaldson introduce this concept into the NHS, he also developed it into what has become the statutory 'Duty of Quality' placed on all NHS boards.

Good Governance TV

Clinical governance has changed the way in which the NHS is governed, and the role of NHS boards across the UK. Clinical governance has become a well-recognised term internationally too, and is one further way in which our NHS has contributed to health system reform globally. Most importantly of all, NHS patients have for two decades benefitted from the emphasis that the board's duty of clinical governance ensures that quality considerations sit alongside finance and performance in NHS board working.

Jaco Marais, Creative Director, GGI

“How did you get into clinical governance and how did it evolve in the UK?

In 1997, Tony Blair was elected as Prime Minister during a landslide election. At this time, I was Regional Director of NHS in the Northeast of England. Along with all the other Regional Directors, I was also part of the National Health Services Executive Board, which was chaired by the Chief Executive of the NHS, Sir Duncan Nichol. So, I was involved in what was happening on the financial side of healthcare and I was interested the concept of corporate governance. It occurred to me that what mattered – what was at the heart of the NHS – was clinical care.

Back then, the NHS had no comprehensive way to promote the quality of care patients received. It was believed that good quality was just an inherent part of the way that doctors and nurses delivered their services. You didn’t need to be explicit about it… You didn’t need check it… You didn’t need to measure it. The NHS didn’t have any governance at all and needed a solution to control how quality could be assured and improved.

This was made clear by several incidents demonstrating the NHS’s lack of quality service and patient safety. For example, the Bristol Children’s heart surgery affair saw serious failures in the standards of care. There were also some other incidents around the country where poor care was left unchallenged. Where something should have been done to protect patients from further harm, the NHS had a tendency not to intervene and do anything.

Tony Blair’s administration wanted to produce a white paper for the NHS and the board was asked to prepare some content for the report. The process of writing these white papers is often very frenetic. At various points, ministers would say, “We don’t have enough good ideas, can somebody not come up with something better than this?” Fortunately, I had this concept of clinical governance up my sleeve and I was able to inject it into a crucial white paper right at the start of a new government.

The concept had traction and took hold as an innovative new way of driving quality in the NHS. That’s really is how clinical governance was born.

What were the key principles at the beginning?

One core element of it was to broaden the way that health professionals looked at their practice.

Historically, the paradigm of clinical practice was to look after the patient in front of you to the best of your ability and do the best that you can for

them. But this didn't always happen, and staff weren't trained to think about their service and how it was performing. For example, if you were running a diabetic service, you would look after each diabetic patient in isolation. Out of the 100 patients you treated in a year, you wouldn't see the statistics that showed how many went blind, how many had heart attacks or strokes, or how many got leg ulcers, etc. You wouldn't know your results compared to other services in the country – and how these compared to the best in the world.

We needed was to widen the paradigm. To expand the current clinical practice to say that you're not just responsible for the patient in front of you, but also for understanding your service. To quality assure it and, over time, improve the quality. To put in place a developmental, not a controlling measure. To develop a way to empower doctors and other health professionals to enthusiastically and passionately drive forward better quality care.

Can you explain why, today, it's called a framework instead of a system?

As with any bureaucracy, this idea came in very quickly and rather late in the preparation of this key white paper. The reaction of the civil servants was a sort of consternation, because these things are normally introduced very slowly and they felt that they needed to put the civil service stamp on it. I called it a system because I felt that it was very important that it was all pervasive, comprehensive, and applied everywhere. The definition was very good, so all they did was to change the word 'system' to 'framework'.

A framework and a system are two different things. A framework is something that people can take or leave, whereas a system reshapes everything and everybody is involved. I think I wouldn't design it any differently. The government implemented a legal duty of quality, which cemented clinical governance into a statutory framework.

The regulatory side of it to make sure that everything was working.

A system is pervasive and supports frontline staff to improve their service from the ground up. Where systems were in place, we created enthusiasm and passion and I think the frontline staff needed to be supported in this way. In 2010, the National Patient Safety Agency (NPSA) was abolished. The NHS should be regretting that now – it was an opportunity lost and they did things like abolishing the national patient safety agency. When I travelled around the world people in other countries would say: "we envy you to have a beacon standing for safety and care, wish we had one", and then the embarrassment of having to say the government abolished it to save money and to save (in their mind bureaucracy). I think it was very short sighted.

A different set of ministers, a different set of leadership at the NHS. One of the characteristics I found out about, the most senior level and management of the NHS, (with a few exceptions) is that when they are in post they are not interested in public health & preventing disease. And they are not really interested in quality and safety. Because their job is very much about maintaining financial balance and making sure the waiting lists are kept short. When they come out of post into post retirement jobs, they go around lecturing about public health and quality.
Not mutually exclusive at all. I've said many times to health care audiences, a business plan of a hospital and the quality plan should be one and the same.

What can you tell me about heading towards the future and Artificial Intelligence?

First of all, I'm very optimistic about the younger generation of health care professionals, doctors and nurses. They seem to be very passionate about quality and safety in a different way to perhaps the older generation. Secondly, if you look at technology, it splits into two broad strands. The technology side deals with information and data, while the machinery and equipment side is used for diagnosis and treatment. On the technology side, the NHS is light years behind other industries and needs to catch up. Given the availability of data, we're not letting it inform us in the same way it would if A.I. was at its peak.

For example, there are some schemes in place that monitor vitals and characteristics tens of thousands of acutely ill patients. These databases are in place across many of our hospitals, providing millions and millions of data points collectively. Using algorithms, companies like Apple or Google, would be able to say, within a short space of time, which patients run the risk of becoming sick or dying. They would be able to flag this information up on a nurse's

I-pad, ensuring that they get the care that they need.

It's a truism in technology that, over time, equipment not only gets smaller but also can be operated by a lay person instead of needing a technical person. It's inevitable that we'll get to a point where patients will receive their own diagnostic information through handheld equipment which, 30 years ago, would have been so big and heavy that it would take up a room in a hospital. There are two disruptive forces that I predict will impact positively. Firstly, young people who are used to having information at their fingertips on their mobile phones, won't tolerate the dinosaur approach the NHS has towards information and they will demand change. Secondly, patients will be empowered with more information. Initially, patients won't understand the information, but it would be a short jump to having A.I. software that will help lay persons to understand it.

Patients are likely to go into their health service and say, "I'm pretty sure my thyroid gland is producing too much thyroid hormone, and I need a drug to block it." They will know which drugs could potentially treat them and what their side effects are. Doctors can then confirm their diagnosis and treatment policy.

Dogma and the cult of personality

"that which one thinks is true"

Andrew Corbett-Nolan, Chief Executive, GGI

The word dogma comes from the Greek, meaning literally "that which one thinks is true". More generally it is applied to some strong belief that the ones adhering to it are not willing to rationally discuss. Today we are aware of the concept of 'fake news', a device used by some leaders to manipulate followers. It is easy to quickly see the connection between dogma and the cult of personality.

Populism is a mode of political communication or orientation that is centred around contrasts between the 'common man' or 'the people' and a real or imagined group of 'privileged elites', traditionally scapegoating or making a folk devil of the latter. Such a view sees populism as demagogy, merely appearing to empathise with the public through rhetoric or unrealistic proposals and promises in order to increase appeal. As Sir Joseph Porter says in Gilbert and Sullivan's HMS Pinafore "if you want to get a vote, scratch a bigot's itch".

Thomas Friedman writes that "the quality of political leadership declines with every 100 million new users of Facebook and Twitter".

My case study is the awfully sad story of Baby Gard. Charlie Gard lived just 11 short months. He had a

neurogenerative disease which left him with terrible brain damage, unable to move, and suffering from severe epilepsy. This brought him into the care of Great Ormond Street Hospital. After Charlie had suffered seizures before last Christmas, the entire clinical team formed the view that Charlie had suffered irreversible neurological damage and that, as a result, any chance of benefit from treatment had departed.

British and European law recognises that a child is a person, not property, with their own rights, including the right not to be exposed to extreme and unnecessary suffering. Parents cannot treat the children as they wish – the child's welfare must be protected.

In cases where relatives and doctors come into conflict, courts appoint a guardian who weighs up the representations of both sides, and reports to and guides a judge. For example, doctors can seek injunctions in cases in which Jehovah's Witnesses refuse to allow their child to receive life-saving blood transfusions. Parents have duties toward, not just rights over, their children.

Lengthening Charlie Gard's life would have caused prolonged and intense suffering. The demand for extended life, no matter the quality of life, is insufficient and in some cases amounts to a call for torture. What must be determined is which option is in the best interests of the patient, not which will allow them to live for the longest. In the case of Baby Gard, the judgement was not about cost saving, but about minimising harm and allowing the patient to die with dignity. The risks of complications and likelihood of pain attached to the alternative options were too high to sanction. Great Ormond Street worked tirelessly in their treatment of Charlie. He had an extremely rare disease that is very difficult to identify. The hospital went outside of the NHS to get rapid genome sequencing for him, and he was seen by a world expert in mitochondrial disease within two weeks of being transferred to the hospital.

The most devastating passage in the statement put out by the hospital reads:

"At the first hearing in Charlie's case in March, our position was that every day that passed was a day that was not in his best interests. That remains our view of his welfare. Even now, Charlie shows physical responses to stressors that some of those treating him interpret as pain and when two international experts assessed him last week, they believed that they elicited a pain response.

"In the hospital's view there has been no real change in Charlie's responsiveness since January. Our fear that his continued existence has been painful to him has been compounded by the Judge's finding, in April, that since his brain became affected by RRM2B [his genetic disease], Charlie's has been an existence devoid of all benefit and pleasure. If Charlie has had a relationship with the world around him since his best interests were determined, it has been one of suffering."

Charlie's parents, however, refused to believe his brain was damaged. There lay the root of the problem. But here's the really wicked thing about all this. The parents were reinforced in their refusal to accept this tragic situation, and the whole court process pointlessly prolonged, because of the pressure largely emanating from activists and media on the American political right (along with right-to-life campaigners) screaming that a baby was about to be killed by a socialised health care "death panel" enforced by the British government. This campaign led the parents to believe that such pressure could change the court's mind. And so the parents were reinforced in their refusal to face the sad reality.

The commentary emanating from America, however, was staggeringly ill-informed. The website American Thinker, for example, ran one hysterical piece after another. Thus, the case represented: *"a perfect crystallization of the full heart and soul of socialized or 'single payer' health care"*, a *"tyrannically impersonal medical system"* in which *"the individual human being is property of the State"*.

American Thinker wrote:

"Little Charlie Gard appears to be under a death sentence courtesy of Great Ormond Street Hospital and the British Courts" in *"a totalitarian state where the courts decide whether my child can live or die, where they can withhold medical treatment as and when they decide, where they can prevent treatment in another nation, where the rights of the individuals involved can be thrown on the floor and trashed like so much refuse"*

"...it is almost inhuman indifference to the plight of the parents by the Great Ormond Street Hospital, who insist that the parents should have no hope of improvement in their son and acquiesce in his death"

The hospital staff and the judges were labelled murderers, and were subjected to death threats, vilification, and heated and widespread abuse, both online and in person. Campaigners protested outside the hospital, many of them camping there.

Nigel Farage said that "the UK medical establishment closed ranks on Charlie Gard's parents and the State took away their rights". Of course, this is absurd. It is a flagrant mischaracterisation to describe consensus amongst medical professionals as "closing rank", and judges (not the State) balanced the rights of the parents against the rights of the child.

People seek to channel the emotions such a case inevitably draws out towards causes far removed from the specific patients and relatives that the case involves. The suffering and emotion of those professionally charged with the care of the baby – hospital staff, doctors, medical experts, judges – are kept firmly out of the public eye. Though many would concur that this is proper and appropriate, it limits their power to capture public support, and renders them vulnerable to being portrayed as cold, emotionless – even ruthless.

Ill-informed criticism of the hospital (a) undermined patient confidence, (b) depleted staff morale, and (c) may have had lasting damage on the way in which patients and the public regard and deal with medical experts.

I would like to place on record my admiration for the way the Trust board at Great Ormond Street conducted themselves throughout the course of the maelstrom they were experiencing, whilst they were focussed on doing the right thing for their patient. They reacted ethically and with compassion, demonstrating the very best in public sector values. They effectively found themselves being sent out to bat for the whole NHS, and on a global stage.

I imply no criticism, however, when I share with you that their board assurance framework at the time Charlie Gard was first admitted to hospital contained no reference to risks around reputational issues at all, and neither was there any mitigation requiring the Trust board to prospectively agree its own moral or ethical bottom line.

That was just assumed. I make this remark as a wake-up call to the boards of all public organisations, and not to pick on one of the best boards in our NHS. But I think you get my point. At GGI we systematically review the risk systems and risk appetites of boards, but if I search my mind I can think of none where there is prospective preparation for an onslaught by populism. Nor can I think of a board that has worked through scenarios where they become the focus of public outrage.

This is folly, as we know ahead of us lie difficult and complex decisions about changing the pattern of healthcare through STPs, and deciding where resources are best used, which hospitals are developed, and which closed. And of course, we genuinely want to involve the public in these important decisions. There is a fine line, though, between authentic community involvement and finding oneself on the sharp end of the populism pitch-fork.

Extract from the keynote speech at the Festival of Governance 2017

Higher Education

a new market segment for GGI

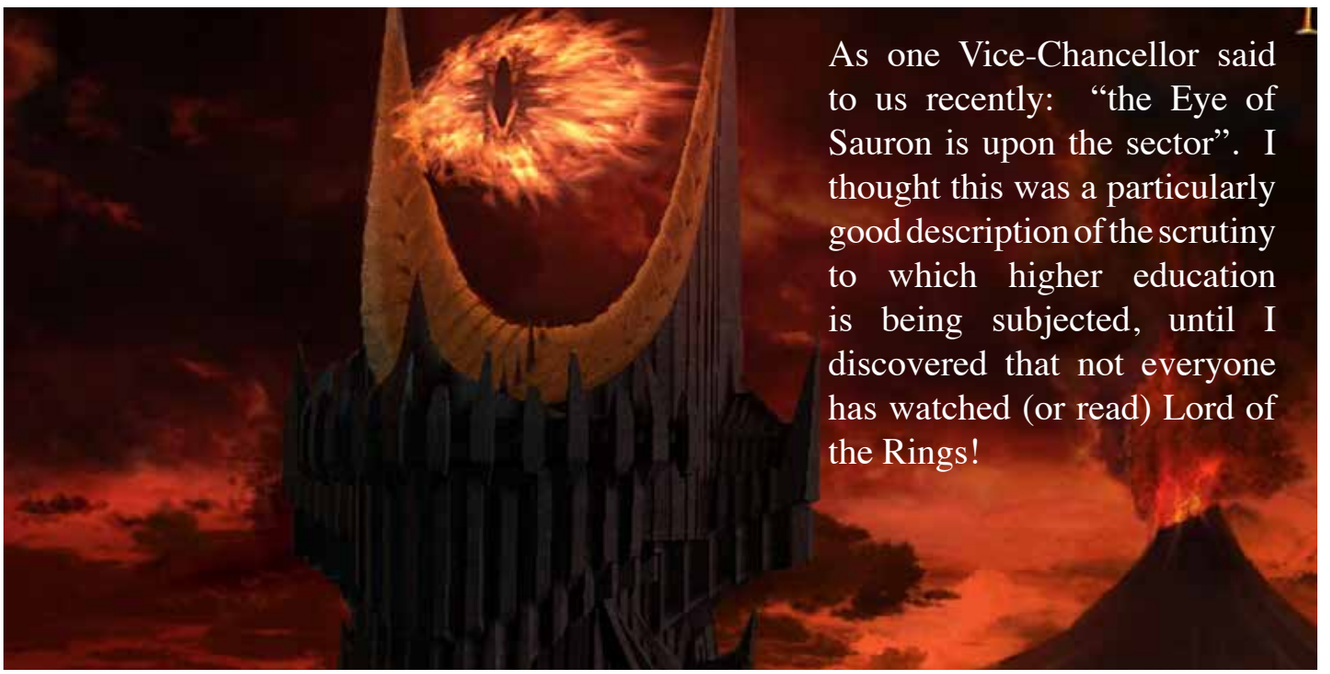
Michael Wood, Company Secretary, GGI

My first exposure to GGI was some 8 years ago when I was still embedded in a university heading up governance. Andrew Corbett-Nolan asked me to sit in on an NHS workshop for newly-appointed Board Secretaries to provide a perspective from a different sector. I immediately formed the view that what GGI was very skilfully (and entertainingly on that occasion) providing was transferable to the world of education, chiefly university governance.

Hence, in 2013 I joined the GGI ship. Our first (and unwittingly high-profile) commission was from Plymouth University, which was having a very unfortunate breakdown in governance played out in the local and national press. We were invited to conduct a full governance review with the strong accent on being progressive and forward-looking, learning from events of the recent past.

We used the well-established GGI tools and methodology to guide us through this first review, but we soon realised after three or four subsequent reviews which came in quick succession that we needed to develop a diagnostic tool specific to higher education, with applicability to further education and even the schools/academies sector.

In true GGI partnership style, we developed our bespoke HE Maturity Matrix in close working with HE colleagues and friends, testing the relevance and robustness of the nine core elements or couplets: purpose and leadership; stewardship and standards; culture and behaviours; skills and capacity; risk and agility; engagement and voice; structures and business flow; finance and resources; impact and reach. The five measurements from Fundamental to Excelling and the descriptors under each element were similarly refined in discussion with sector specialists.



Like any worthwhile diagnostic tool, the core elements are periodically reviewed and updated in the light of policy and sector challenges, but the matrix has proven to be an invaluable assessment guide as we have completed some 25 reviews, corporate and academic governance-related, across all four nations.

Earlier this year and in recognition of the extensive work we have done with HE in recent times, we were particularly pleased to be engaged by the Higher Education Policy Institute (HEPI) to write a thought-piece on the future of HE governance in the UK. This involved us undertaking a major national governance survey, interviewing over 40 key individuals and hosting a number of roundtable sessions.

We are currently finalising our final draft paper which will be launched in late September/early October. We hope a stimulating sector-wide debate will follow.

As an Institute, we are acutely aware of our obligations to share as much of our best practice findings as possible to the benefit of all the sectors we work with. It is remarkable how much 'cross-fertilisation' there is between university boards and health boards in terms of independent/non-executive members. The principles of good governance are universal, but we genuinely believe that different sectors can gain much from being receptive to new ideas and thinking from outside their traditional boundaries as they respond to ever-greater challenges.

As one Vice-Chancellor said to us recently: "the Eye of Sauron is upon the sector". I thought this was a particularly good description of the scrutiny to which higher education is being subjected, until I discovered that not everyone has watched (or read) Lord of the Rings!

The Arts

Art and culture are the defining features of a community, inspiring improvement for all.

Calum Gaffney, Communications and Marketing, GGI

Arts and cultural organisations represent the heritage, history and sense of society like few other sectors are able to. Whether it be an opera house, a national park or a literary festival, the contributions these establishments and events make to society have a positive impact on a daily basis. These monuments to a people, population or society require as meticulous management as that of the biggest hospital or most influential university.

Their contributions do not remain solely at a societal level. We must not lose sight of the influence that these organisations have over the economic stature of any given community and the wealth generation they provide. ***The UK creative industry contributes approximately £90bn net to GDP and it accounts for one in 11 jobs.*** This means that the sector is rising at a more consistent rate than other parts of the economy. With this in mind, it's evident that these creative organisations face the same challenges as other sectors in terms of providing a quality service within an appropriate financial budget.

Therefore, it's hugely important that these creative organisations collaborate together to provide for their community, and that they do so with robust management infrastructures, as well as supportive leadership and continued development of board members and trustees. These features are all vital to their success. If they focus on these areas with clear objectives in place and clarity around how each board member has a role to play in delivering good governance arrangements, then both quality and financial stature will benefit.

For the past two years, GGI's newly established 'Leadership Award' has been presented at the International Opera Awards. By inspiring those involved in the awards, GGI has embraced this special occasion to learn, instill and promote the lessons of good governance. Our message to the world of art

GGI is pleased to support the English National Opera as a Corporate Patron

The parallels that have been identified have demonstrated to us that many lessons can be taken from other sectors. In particular, GGI will focus on how these core challenges can correspond with those of the NHS.

and culture is: "Great art is often created through great partnerships, lessons that must transcend from the medium to the management."

One thing became clear from our discussions with an impressive array of Arts Institutions. Leaders of creative organisations often felt that the catalogue of literature and guidance wasn't substantial enough to represent their daily challenges. This led GGI to host a series of developmental debates that brought together executives, non-executives, trustees, artists and journalists. We gave them a space to voice concerns and present ideas on the hot topics of governance in the cultural sector. The success of these events has been evident in the continuation of these developmental sessions, alongside the publishing of a governance guidance paper: *'A proposition paper critically examining governance development and the arts'*. Disseminated across the UK, this paper is a key resource for any art organisation looking to utilise governance as a way to drive organisational ambition, dynamism, and creativity.

As this programme of work has been developed, the role of the individual executive in arts organisations has become the focus of improvement and learning.

This year's Festival of Governance includes a learning session: ***'Artistic Director / Medical Director'***. GGI is well known for its distinctive educational events and this will be no exception. ***We aim to generate discussion around how collaboration between organisations does not – and, more importantly – should not stop at sector boundaries.*** There's much to learn from both. As we step into a world full of increasing tensions and restrictions, creating an open dialogue between what is often regarded as 'unrelated' areas of industry provides the platform for innovative solutions to emerge. GGI wish to be at the forefront of this discussion and we welcome you to join us.

GGI sponsors the Leadership Award at the International Opera Awards

POPULISM SUMMER CAMP 2017

TIMISOARA, ROMANIA

Laura Botea, Programme Director, GGI

The European Summer Camp brings together a group of like-minded individuals in different location every year. Since 1999, when the first Summer Camp took place, it has brought together individuals interested in 'thinking outside the box' to identify new solutions and generate new thinking about the issues affecting not just individual organisations but society as a whole.

In October 2017 GGI, together with our partners NVTZ and the European Health Futures Forum (EHFF), took Summer Camp to Timisoara, Romania (the birthplace of the Romanian anti-communist revolution of 1989 and active civil society hub) to examine alternatives to our understandings of what 'leadership' and 'followership' means for the 21st century.

We looked through the lens of how ‘leaders’ and ‘followers’ have shaped the community around us, as reflected in:

- History and the rise of populism
- Art, architecture and the creation of public space
- The birth and changing nature of cultural and political movements

Designed to offer an opportunity for participants to engage in group discussions and activities, as well as to offer opportunities for individual self-reflection, we were guided through Timisoara’s local history, the current political landscape and understanding the individuals and organisations that are currently shaping it. From the Romanian anti-communist revolution, through to Timisoara’s current ambitions as the European Capital of Culture in 2021, Timisoara is a city that has been transformed.

As a second time Summer Camp participant, and a Timisoara native, I was struck by the changes in my own perceptions and previously established ideas of the city and the community itself.

Together with young colleagues, interested in shaping communities in the future, Summer Camp offered a unique opportunity to commence establishing this network of individuals that can shape the nature of the organisations and communities that we are part of. Leading into this year’s Summer Camp in Marseille, examining ways of collaborative working as they are reflected in the creation of public spaces, political and social movements enabled us to look to the future in exploring current emerging frameworks for place-based and innovative solutions to challenges faced by our communities and beyond. This theme will be explored more during this year’s Festival of Governance.

First Innings

GGI takes you places other consultancies don't

Darren Grayson, Director of Delivery, GGI

What is a NHS lifer doing, leading a governance review of the England and Wales Cricket Board (ECB? After nearly thirty years in the NHS, I joined the Good Governance Institute and found myself asking that exact question.

Some people may tell you that they were motivated to join the NHS by a higher calling. Others may say that they joined in order to be part of the greatest British institution and contribute to its mission. Or they wanted to treat and care for patients and people, free at the point of care, irrespective of their ability to pay.

To be completely honest, I joined the NHS after university in the late 1980's, for no better reason than I needed something to do. After nearly thirty years, I'd had the privilege of working at just about all levels in the NHS, including a Regional Health Authority, District Health Authority, Strategic Health Authority, Primary Care Trust, Acute Trust and Community Trusts. Over a period of fourteen years, I'd held about a dozen different positions, including four chief executive posts. This made me, in a way, the very definition of a 'NHS lifer'.

Except I wasn't. Closing in on 50, I'd reached the point in my life, where I knew that I wanted and needed to do something different… Enter GGI. I started out in familiar territory with the NHS, getting involved with CCG governance reviews, Trust Board development, and things that were very much in my comfort zone. I was soon presented with opportunities to work with the private sector, including Aviva Health and Care UK in the third sector, as well as having a modest involvement in our higher education practise.

Then, in spring 2017, the ECB needed 'expert' support for an external governance review. I found myself sitting in ECB HQ, at Lords, talking with

the ECB executives and wondering just how my experience as a presumed NHS lifer, had led me to this point.

It helped, of course, that I am a devoted cricket fan and an avid follower of the England team. But I have to concede that it was not without some trepidation that I set out on my travels across the County grounds of England to meet with County Chairmen and listen to their views. These were usually expressed with passion and in colourful terms, detailing how the national governance of the game could and should be modernised and improved. What I found was a group of highly talented and successful men (all men), both in the counties and at the ECB, who'd given the better part of their lives to the game of cricket. Most were volunteers and all had strong opinions about what changes were needed and why.

When it came to pulling all the evidence together – distilling the essence of what I had heard and read – it struck me that there were enormous parallels with my work in the NHS. Way back in my early career in the early 1990's, I set up and directed a review of cardiac services across a district health authority. This involved gathering evidence and views from people, analysing data, reviewing best practice in other areas and marshalling a diverse team of professionals. It was our job to come up with a set of evidence-based and actionable recommendations that were accepted and implemented by the health authorities of the time. I'd led similar pieces of work on mental health services as a commissioner and on acute services as a provider CEO. Of course, the subject was cricket, not health care, but the skills; experience and knowledge that I had developed in the NHS were directly relevant and applicable to our work with the ECB.

This story ends well, as our recommendations for modernising governance were accepted and implemented by the ECB with only a few minor tweaks. ***We presented a challenging and rewarding piece of work that GGI, and possibly only GGI, could have completed in the correct way.*** The ECB were so pleased with our work, that they have invited us to work with them again on their continuing governance arrangements. And, I got to do something different with what I have learnt in the NHS!

Poli-*sea* change

Jonathan Hazan, Chair, Patient Safety Learning

With the departure of Jeremy Hunt from the Department of Health and Social Care, the patient safety landscape is undergoing another change. During his tenure, Hunt made patient safety his personal mission, with patient safety policy largely led by him and his department. With the arrival of Matt Hancock in the role of Secretary of State for Health and Social Care, it remains to be seen whether there will be such an emphasis on patient safety coming from DHSC. This gives an opportunity for others to play a part in shaping patient safety policy.

Going back a few years, the National Patient Safety Agency (NPSA) was a focal point for patient safety policy in England. Established in 2001 following the publication of An organisation with a memory, much of the NPSA's activity was to do with the National Reporting and Learning System (NRLS), a central database that all NHS providers submitted patient safety incidents to. One of the advantages of a such a central system is that data submitted to the NRLS could be used to spot types of incidents that may occur rarely in a single organisation but become evident when data is aggregated across a large number of organisations. In this way, the NPSA was able to determine issues for the patient safety alerts that it would publish. One such example was on the safe use of nasogastric feeding tubes. There was, however, no way of enforcing compliance with these alerts and research done by the patient safety charity Action against Medical Accidents (AvMA) has shown that NHS trusts did not always comply with the alerts.

The abolition of the NPSA in 2012 left a gap patient safety activity. The NPSA's patient safety functions, including the NRLS, were transferred to the newly created NHS Commissioning Board Special Health Authority (now known as NHS England). NHS England's first chief executive was Sir David

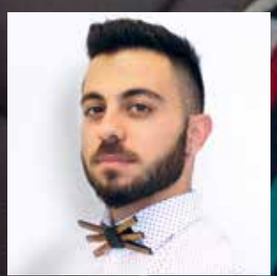
Nicholson, who was viewed with distrust by many patient safety campaigners because of his involvement in events surrounding the Mid Staffs scandal. His replacement, Sir Simon Stevens, has made his focus on other areas and in 2016, the patient safety functions of NHS England were transferred to NHS Improvement.

In a cabinet reshuffle in September 2012, Jeremy Hunt was appointed Health Secretary, succeeding Andrew Lansley. Lansley's controversial reforms of the NHS were enacted in the Health and Social Care Act of 2012, although his most important contribution to patient safety was the establishment of the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2010. Chaired by Sir Robert Francis QC, the inquiry has had a profound effect on patient safety policy to this day. That the events at Mid Staffs came to light at all is the result of campaigning by Julie Bailey and the Cure the NHS group that she formed. The report of the inquiry was published in February 2013 and Jeremy Hunt made a statement in parliament announcing further work on implementing its recommendations. This including the commissioning of Don Berwick, internationally renowned healthcare improvement expert, to write a report recommending that the NHS become a learning organisation.

The Mid Staffs scandal marked the rise of the patient safety campaigner and the use of social media to bring patient safety issues to wider prominence and in turn influence policy. The relatives of those who have been harmed now have a much greater voice thanks to platforms such as Twitter. Jeremy Hunt also says he was profoundly affected by hearing stories from people such as Deb Hazeldine, James Titcombe and Scott Morrish, who all speak passionately and powerfully about their experiences of losing loved ones and the need for change. As a result, Jeremy Hunt made patient safety the defining issue of his tenure as health secretary and although he was a polarising politician, no other health secretary before him has taken so much action on patient safety.

North meets South at the Barnet CCG Community Day

GGI was commissioned by Barnet Clinical Commisioning Group (CCG) to help them organise one of their biggest communications campaigns. Our aim was to make the local community aware of the new facilities and services included in Barnet CCG's scope. This aim turned into a new and unique challenge for our team. Our brief was to entertain, feed, water and educate the public. It was an opportunity to not only entertain the public through this venture, but also to educate them about the new facilities that Barnet CCG was offering and the organisations they wished to further involve.



Pantelis Soteriou, Engagement Officer, GGI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A significant amount of time and effort was spent on the background organisation and preparation. Each and every member of the GGI team made a contribution towards the community day.

We called and visited nearly every organisation in Barnet from care homes to sandwich shops, but our combined efforts could only rewarded on the day of the event.

Thankfully, Saturday, the 25th of September was a glorious day in Finchley. My partner and I travelled all the way from South East London, accompanied by a crew of helpers we had assembled from his cleaning business. We were the set up crew. Our little team arrived at Finchley Memorial Hospital, each of us holding a double shot of coffee, ready to transform the hospital grounds in just two hours! Following our long, busy ride to Barnet, we got out of the car, ready to join the rest of the GGI team to set up for a fun day in the grounds of Finchley Memorial Hospital.

The marquees were being erected and half the team was already on site, decorating the space. Age UK, Healthwatch Barnet, Jewish Care, Eclipse Barnet – Richmond Fellowship, CAMHS, MSK/CLCH, End of Life Care Project Team, Dementia Club UK, Diabetes UK, Carers Trust, Home Instead, the Barnet Tai Ji Circle, face painters, children's entertainers, inflatable organs and Vegan Food Trucks all set up shop before the clock struck nine creating a carnival of activities where just two hours before was the empty grounds of a neighbourhood hospital. The gates were opened and the site filled up quickly. Face painters blurred the lines between the definitions of adults and children, yoga instructors gave classes on mindfulness and health, dance teachers made everybody join in, and colourful balloons hovered over every corner of the site. On one side of the site, inflatable body organ models gave spectators a tour of what might, or hopefully, will be prevented from occuring on the inside of a breast or bowel. Some found this kind of gross but I found the tour through the inflatable bowel very educational and it was my personal highlight of the day.

Barnet Clinical Commissioning Group Chair, Debbie Frost delivered a great speech providing focus for the event, but it was by no means over until she announced the much-anticipated, winner of the Great Barnet Bake Off.

In my time with GGI, I have organised various events, but none have been quite so fulfilling. Not only were we able to positively influence the governing body of an organisation, but also the local community that they support. This achievement was very gratifying. Involving professionals and locals outside of the organisation allowed us to add personal flair to a community day that left Barnet, and a sizable portion of South London, with many happy memories and Instagram posts.

Festival of Governance 2018

Good Governance because...

70 YEARS OF THE NHS 1948 - 2018

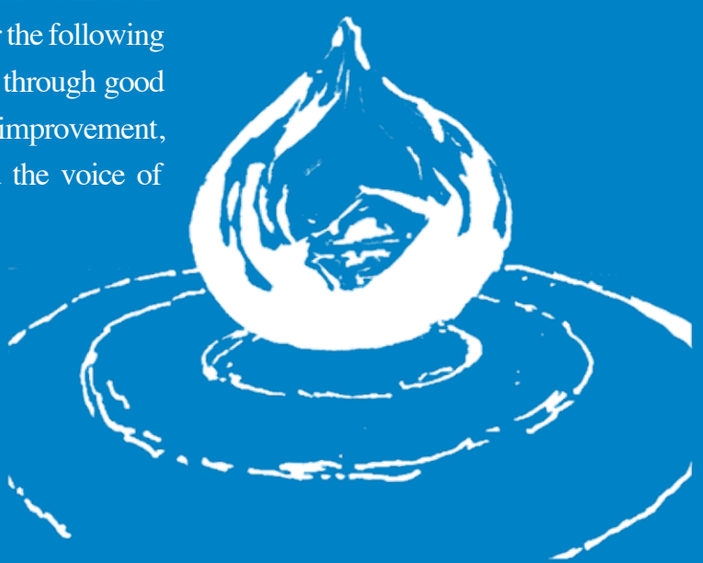
Governance can never be defined as an activity that stands on its own. Good governance by its definition, is a communal activity. The Festival of Governance is unique in that we have brought together leaders and decision-makers from across multiple sectors bound by a common passion for good governance. Our Festival brings together a community of likeminded people with a common purpose.

This year's Festival of Governance will explore the impact this community has on the local communities of people they serve, and we will explore what leaders of organisations are capable of when we work together to create a better, fairer world.

communities are defined by collaboration

Our Festival programme this year runs from 27 September 2018, when we kick off with our Annual Lecture headlined by the Rt Hon Jacqui Smith. Over the following weeks, we will look at how communities are created and sustained through good governance, hosting various events exploring issues of engagement, improvement, diversity, immigration, sustainability, technology, partnerships and the voice of communities.

Your involvement is, as always, key to making the Festival of Governance a success.



27TH SEPTEMBER 2018

GGI Annual Lecture

Our annual Festival of Governance is an opportunity to bring our clients, partners and contributors together, to celebrate examples of good governance and to share ideas and experiences with a wide range of colleagues, where old friends meet and new ones are made.

In this year, when we celebrate 70 years of our NHS, GGI's Good Governance award is dedicated to managers who have been the stewards of the country's cradle-to-grave health service. Dame Julie Moore, the outgoing chief executive of University Hospitals Birmingham NHS Foundation Trust will receive the 2018 GGI Lifetime achievement Award on behalf of NHS leaders who have navigated and transformed our unique and valued NHS since 1948.

Festival of Governance 2018 aims to explore the impact this community has on the local communities of people they serve, and we will explore what leaders of organisations are capable of when we work together to create a better, fairer world.

12 Great George Street
London, SW1P 3AD
United Kingdom

Programme for the 2018 GGI Annual Lecture

17.30 Registration and welcome reception

18.00 Welcome from the Chair, *Imelda Redmond CBE, National Director of Healthwatch England*

18.05 Launch of the Festival Review and introduction to the Festival of Governance 2018 by *Jaco Marais, Festival of Governance Director, GGI*

18.15 First keynote address by the *Rt. Hon. Jacqui Smith, former Home Secretary and Chair of University Hospitals Birmingham NHS Foundation Trust*

18.35 Presentation of NHS 70th Anniversary Special Good Governance Award by *Baroness Dido Harding, Chair, NHS Improvement:* Leadership in delivering good governance: *Dame Julie Moore*

18.50 Second keynote address by *Andrew Corbett-Nolan, Chief Executive, GGI*

19.10 Q&A with keynote speakers

19.30 Festival reception

Over the following weeks, we will look at how communities are created and sustained through good governance, hosting various events exploring issues of engagement, improvement, diversity, immigration, sustainability, technology, partnerships and the voice of communities.

Rt. Hon. Jacqui Smith

Former Home Secretary and Chair of University Hospitals Birmingham NHS Foundation Trust

Jacqui Smith is currently Chair of University Hospitals Birmingham NHS Foundation Trust. She is Vice Chair of the Birmingham and Solihull sustainability and transformation plan board. She also works in Jordan and Egypt on political development projects. She has presented several radio documentaries, including a recent series on prison reform for BBC Radio 4, and appears on BBC and Sky News as a political commentator. Jacqui was MP for Redditch between 1997 and 2010 and served as a government minister for 10 years from 1999 to 2009, during which time she was a health minister and the UK's first female Home Secretary.

Andrew Corbett-Nolan

Chief Executive
Good Governance Institute

Andrew has worked in healthcare since joining the NHS in 1987. He specialises in board development work, and some of the more complex governance reviews that GGI undertakes.He has led many of the important programmes of work undertaken by GGI, including the development of the new governance arrangements for Clinical Research Networks, the review of the Welsh Healthcare Specialist Services Commissioning, and the development of governance review tools for NHS England. He served as European Secretary for the Joint Commission International and International Consultant for COHSASA in Cape Town. He is Director of the Governance Office for the European Society for Quality in Healthcare and a Member of the European Healthcare Futures Forum.

Jaco Marais

Festival of Governance Director
Good Governance Institute

Jaco has been a director with GGI since its formation in 2009 and has been involved in developing the organisation as it is today. Jaco is working to develop Good Governance TV, GGI's YouTube channel, he directs the Festival of Governance, GGI's annual conference and he works on GGI's International Study Tours. He also directed the GGI website steering group from design phase to launch in 2017. Most recently Jaco designed a staff engagement campaign centered on patient safety that saw the reporting of serious incidents significantly increase while the severity of those fell off appreciably. He has successfully designed and directed engagement programmes for organisations engaging with clients, staff, public and community groups both nationally and internationally.

Imelda Redmond (CBE)

National Director of Healthwatch Englandt

Imelda has 20 years' experience working in senior roles in the not-for-profit sector. Most recently she was CEO of the charity 4Children where she led the organisation through a period of significant change. Before that she was Director of Policy and Public Affairs at Marie Curie Cancer Care, and Chief Executive of Carers UK where she received a CBE for her services to disadvantaged people in 2009. Imelda is passionate about championing patients' needs and ensuring that their views are listened to.

Dame Julie Moore

Setting new standards for good governance

Between 2006 and 2018, Dame Julie Moore was Chief Executive of University Hospitals Birmingham (UHB), one of the most consistently excellent organisations in the country.

She has recently stepped back from this position in order to take on new roles as an Associate Non-Executive Director at Worcestershire Acute Hospitals Trust; a professor of healthcare systems at the University of Warwick; and as part of the organising committee for the Birmingham 2022 Commonwealth Games.

During her time leading UHB in 2010, Dame Julie oversaw the completion of the Queen Elizabeth Hospital, consolidating UHB's services into the largest single-site hospital in the country. More recently, she has led the Trust through the merger, by acquisition, with Heart of England NHS Foundation Trust. The new combined Trust, which retains UHB's title, employs more than 20,000 members of staff, treats more than 2.2 million patients annually, and has an annual turnover of around £1.6 billion, making it one of the largest Trusts in the country. Incredibly, since Julie's appointment, the Trust has roughly trebled in size.

Chris Smith, Consultant, GGI

As one of the largest employers in Birmingham, UHB plays a central role in reducing disadvantage and increasing prosperity in the community. Between 2005 and 2006, the Trust established the Learning Hub, a training centre which helps unemployed people within the local community get back into work by providing pre-employment training, advice and guidance. The Learning Hub has now supported more than 2,500 people into employment. The Trust has also collaborated with Birmingham City Council in a European Social Funds and Youth Employment Initiative called Youth Promise Plus. It is part of the Birmingham Health Partners, a strategic alliance between the NHS and University of Birmingham which, by accelerating access to new and innovative medicines and technology, aims to improve health and wellbeing in the region. Between 2013 and 2014, the Trust began to report on its environmental impact, which it regards as an integral part of its ability to deliver best in care.

The Trust is also a regional centre for cancer, has the second largest renal dialysis programme in the UK, and has the largest solid organ transplantation programme in Europe. It is a regional Neuroscience and Major Trauma Centre and hosts the UK's only National Institute for Health Research Surgical Reconstruction and Microbiology Research Centre. Since 2001, it has also hosted the Royal Centre for Defence Medicine, becoming the primary receiving hospital for all military patients.

GGI has a long history of working with UHB, and we have recently undertaken a review of governance over the last ten years of Dame Julie's tenure with the aim of identifying best practice, which might be applied to the wider NHS. Some of our key findings include:

Vision and values

For many organisations, vision and values statements can be little more than tick-box exercises with little inherent meaning for staff and stakeholders. At UHB, however, one of the key reasons for the continuing success is the strength and clarity of vision at all levels of the organisation.

Over the last ten years, UHB has had one mission, one set of values, and one set of objectives, each of which was initially informed by an engagement exercise with staff, stakeholders, and the general public. This consistency has created a confidence in the direction of travel for the organisation as well as the systems and process which underpin them instead of this?

The vision, "Delivering best in care", is reinforced at every opportunity. For example, by linking decision-making at meetings to the mission of the organisation, the application of values-based appraisals, and within all Trust documentation. Staff are familiar with the vision and values, understand how their work contributes to the realisation of organisational goals, and role-model appropriate behaviours, which are in tune with the vision – a point noted by the CQC in their most recent inspection.

Developing leadership

Recent research undertaken by the King's Fund reveals that leadership vacancies across NHS Trusts are widespread, with 37% reporting at least one vacant post for a board-level executive. The average tenure of an NHS Chief Executive is now just 18 months.

The impact of executive churn on NHS organisations can be marked, impacting on performance, culture, staff morale, and wider organisational relationships.

With this in mind, the level of Board stability at UHB is significant. The average length of tenure for an Executive Director at the Trust is eight years, with many having worked their way up through the organisation.

Part of the reason for this is Dame Julie's visible and inclusive leadership style. The Trust clearly employs a distributed leadership approach which, in contrast to heroic or command-and-control leadership models, emphasises the importance of leadership at all levels of the organisation to build capacity for improvement and change.

This, we were told, means *"there is an emphasis on leadership and making sure people are always aspiring to the next level here."* Dame Julie Moore. It should be noted that recent appointments to Chief Executive and Chief Nurse at UHB, have both been internal.

Engaging quality

Committed to the vision "Delivering best in care" and supported by a leadership model that continually inspire improvement in UHB employees, staff at all levels are able to take ownership of the quality agenda. This is role-modelled by the Board where a whole-Board Quality Committee has been introduced to reinforce the belief that quality does not belong to certain individuals or a sub-sect of the Board, but is everyone's responsibility.

Similarly, Dame Julie chairs an Executive Root-Cause Analysis meeting at which selected omissions in care are reviewed and Trust-wide learning generated and implemented. Leadership visibility is an important component of these meetings, which are attended by a wide range of staff. The Trust was also one of the first organisations to introduce unannounced Board ward governance visits, a practice which has now become commonplace in the NHS. Importantly, these visits, which include all Non-Executive Directors, take place immediately prior to a Trust Board meeting, allowing for meaningful and real-time feedback to be presented. Again, this process is helping to reinforce quality as a key concern of the Board.

Digital maturity

The Trust is now widely recognised as a pioneer with regards to the development and use of digital technology, and this underpins the high-quality of care delivered at the organisation. Its award-winning, in-house Prescribing Information and Communication System (PICS) was introduced in 1999 and has been repeatedly refined. The system has increased compliance with prescribing from 50% to 95% and created a 17% reduction in the mortality rate in Birmingham in comparison to standardised mortality ratios throughout England. UHB has made its PICS system available to the NHS on a licence-free basis. The system is currently utilised in other Birmingham Trusts, improving the quality of information and supporting integration and closer working across hospitals.

Recently, the Trust has also successfully completed the development of a new patient administration system. In 2016, it was one of 16 Trusts granted Global Digital Exemplar status in recognition of the world-class digital services it provides. Staff at the Trust have consistently been involved in the development and trialling of IT systems, improving their usability and uptake. We were told that, "there is a real understanding of why we have the digital systems, what they bring and how they increase accountability by demonstrating the consequences of poor performance."

27TH SEPTEMBER 2018

GGI ANNUAL LECTURE FESTIVAL OF GOVERNANCE 2018

LONDON

27TH SEPTEMBER 2018

ENABLING RADICAL CHANGE IN POPULATION HEALTH MANAGEMENT

LONDON

IBM Watson Health BOOK NOW

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MARSEILLE

16TH OCTOBER 2018

CCGS, NEW MODEL CONSTITUTION & ICS: WHAT THE CCG LAY MEMBERS NEED TO KNOW?

MANCHESTER

17TH OCTOBER 2018

BOARD ASSURANCE FRAMEWORK REVIEW EVENT

LIVERPOOL

23RD OCTOBER 2018

PARLIAMENTARY EVENT - DIVERSITY: THE NEW PRESCRIPTION FOR THE NHS

LONDON

9TH NOVEMBER 2018

ARTISTIC DIRECTOR VS MEDICAL DIRECTOR

ENGLISH NATIONAL OPERA, LONDON

NOVEMBER TBC 2018

PATIENT SAFETY LEARNING

LEEDS

SERIES OF WORKSHOPS 2018

NHS IMPROVEMENT: WELL-LED FOR THE FUTURE

Festival of Governance 2018

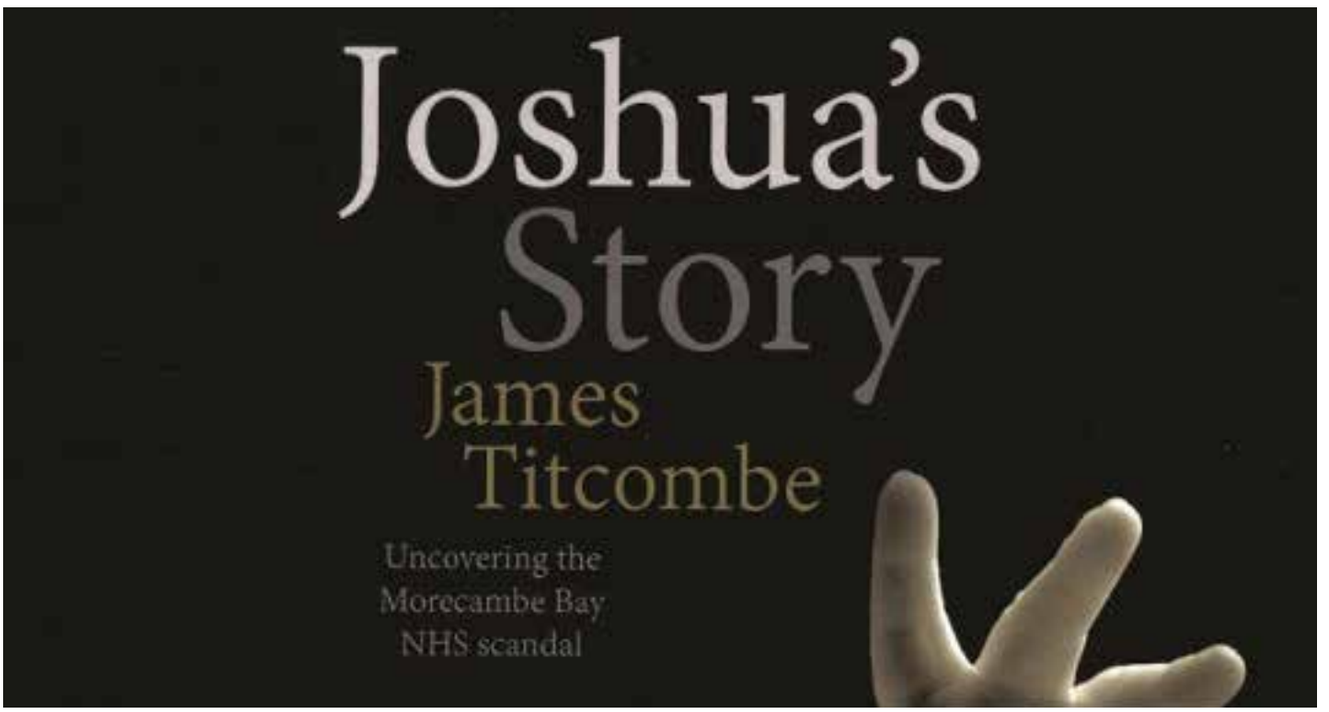
EVENTS

This year, the Festival will be staged across a series of events and debates over a two-month period, both in the UK and Europe.

To book your place at one or all of the events, please visit:

WWW.FESTIVALOFGOVERNANCE.ORG

Ulysses Kilim,
Marketing Manager, GGI



Jonathan Hazan, Chair, Patient Safety Learning

One of the most influential figures in patient safety has been James Titcombe, the death of whose newborn baby son Joshua in 2008 led him on a quest to discover the truth of what happened at Furness General Hospital. James uncovered a scandal that went to the highest levels of the healthcare system and led to sweeping changes to the system of regulation and inspection. The repercussions of the Morecambe Bay scandal and the subsequent inquiry led by Bill Kirkup are being felt even to this day, with changes still occurring at the healthcare and professional regulators.

James Titcombe was asked by the new leadership at the Care Quality Commission to become the regulator's patient safety advisor and continued to play an important role in patient safety policy. Along with a number of others, James contributed to the creation of the Healthcare Safety Investigation Branch (HSIB), a new independent body modelled on the lines of the Air Accident Investigation Branch. One of the most significant developments in recent years, HSIB should be able to fill the "regulatory gap" in responsibility for conducting investigations into patient safety issues. HSIB has published two investigation reports to date, both of which are high quality and differ in approach from those which have been published by other bodies. The first report, Implantation of wrong prostheses during joint replacement surgery, is notable for the involvement of the patient in the investigation and report.

James Titcombe continues to have an influence on national patient safety policy. In 2015, he published a book, Joshua's Story, which was launched at an event with Jeremy Hunt giving the keynote speech. James subsequently left the CQC to join me in creating a new independent organisation to promote areas of patient safety that have traditionally been underrepresented. Launched in 2017, Patient Safety Learning is working with patients, healthcare professionals and patient safety experts to develop new ways of sharing patient safety learning, promote culture change and support healthcare organisations around the world in creating the conditions needed to provide the safest care possible. We are an expanding team and have recently been joined by Helen Hughes, our new chief executive, who brings with her a huge wealth of knowledge, experience and passion. We are shortly to launch a green paper in patient safety and will be engaging in a consultation on the future priorities for patient safety.

With all the changes in patient safety over the past few years, we believe that Patient Safety Learning can become an important focal point for patient safety activity and has a real opportunity to influence patient safety policy in the UK and further afield.

To book your place at one or all of the events please visit:
WWW.FESTIVALOFGOVERNANCE.ORG

Community *Say-so!*

Legitimacy and the public

Andy Payne, Engagement Director, GGI

The call from government to move from competition to collaboration is loud. However, the road map is emerging slowly and with little direction from the centre. Great demands are being put on health and social care providers by an aging population, an increase in preventable illness, and high levels of chronic illness. This, alongside continuing financial pressures, means a period of unprecedented challenge and change.

These exceptional circumstances are putting pressure on organisations to rethink the way they govern, and causing them to review the balance between sovereign decision-making and seeking a wider sense of collaboration and legitimacy. In partnership with the public and local organisations, corporations are building a place-based community network of services and social capital, which are able to deal effectively with our current challenges.

In my previous role as Head of Network Development for Healthwatch England, I saw the role of the local Healthwatch, as enabling the public to play an active part in the re-imagining of health and social care. The role also included helping to establish a shared vision and approach to improving the wellbeing of everyone, which builds on individual, family and community strengths in collaboration with services. *The reaction to change, particularly to the closing of hospitals, from sections of the public is often very emotional, making this a difficult task.*

Hospitals can be seen as iconic in the lives of people, helping to establish a sense of community and local pride. They are the physical embodiment of our aspiration for an equal, safe and a caring society. The legitimacy and involvement required to achieve these aspirations in the 21st Century

demands organisations look outside of their current governance to establish a new mandate with partners and the public.

To steer and lead a local health and care economy forward, the mechanics and dynamics of good governance is effective engagement with the public. Boards, individually and collectively, need to embrace their communities to build new visions together. Using effective communication is vital in order to build a consensus by devoting time beyond the traditional routes, such as governors. Creating a relationship with the wider public that is open, transparent and evidence-based is necessary. As is making use of all communication channels to convey messages and investing in engagement methods such as deliberative events, citizens' juries, focus groups and outreach.

As Engagement Director at the Good Governance Institute, I understand that it's imperative for us to:

- **work with our clients and partners to strengthen communication and engagement with the public**
- **ensure boards, committees in common, integrated care organisations/systems have an authentic and open relationship with the communities they serve**
- **present, discuss and constructively challenge the evidence and data collected from the involvement of the public**
- **help steer the system so that it's delivering for all**
- **provide assurance that it has a vision and plan for improving wellbeing and reducing health inequalities**

These tasks will not be an easy challenge. However, they must not be ignored and left in the 'too difficult pile'. We need good leaders to help us build legitimacy and create a health and social care approach for this and the 22nd Century.

Imelda Redmond (CBE)
National Director of Healthwatch England
Chair, Annual Lecture 2018
27th September 2018, London

New models of care

learning the lessons from Dudley CCG, Procuring a Multi-specialty Community Provider (MCP)

Paul Maubach, Accountable Officer, NHS Dudley CCG

Dudley is a large metropolitan borough in the West Midlands. It is predominantly urban and has a diverse population of roughly 315,000 people. As with many parts of the NHS, we in Dudley recognise that services have historically been fragmented with greater emphasis placed on acute care than care in the community, that not enough attention has been placed on prevention and self-care, and that the system as it currently stands is not financially viable.

However, there is also a strong and rich history of collaboration and partnership working in the region which was vital to the awarding of Multi-specialty Community Provider (MCP) Vanguard status to Dudley CCG in 2015.

Since that point, at Dudley CCG we have worked tirelessly, alongside partner organisations, Dudley Metropolitan Borough Council, Dudley Group Foundation Trust, Dudley and Walsall Mental Health Partnership Trust, Black Country Partnership Trust and Birmingham Community Foundation Trust, to set the parameters of, test, and procure an MCP. The Good Governance Institute have been our governance partners throughout this process.

It is envisaged that the MCP will receive a single, whole population budget for all those patients registered with those practices forming part of the MCP, and also non-registered patient's resident in Dudley. The contract will run for 15 years and will be commissioned to deliver a set of specific health outcomes.

This has been a significant and challenging undertaking for all involved, but one that we feel, given the aforementioned challenges, provides the best opportunity to improve quality of care and the sustainability of services for the people of Dudley. There is also, we believe, significant learning for the NHS and those proposing to undertake similar procurement exercises in the near future. This has been captured in various documents and blogs including our recent report: Developing an MCP - learning from the experience of Dudley CCG.

The dissemination of materials is ongoing. However, we detail some of the key emergent learning for the wider system here:

1. The formal procurement of the MCP is both a technically complex and resource intensive task. Staff at Dudley CCG have effectively had to procure the MCP concurrently with the fulfilment of their existing days jobs, and have therefore needed to be both committed to the vision for the MCP we have developed and resilient in the face of the challenges and set-backs we have experienced throughout the procurement exercise. The CCG also received financial and technical support from regulators and externals agencies which has been crucial, the resourcing of which should be appreciated and reflected in future procurement exercises

2. The environment that the NHS currently operates in, one of significant regulatory and media scrutiny, does not always allow Boards to be fully transparent in their working, nor for lessons to be appropriately shared and learnt from. That being said, the organisations involved in the procurement of Dudley MCP have reflected on the relationship between the NHS and the public and concluded that, if the direction of travel is for increasing personalisation of care and self-agency, then there is a need to engage the public in an open and transparent manner, encouraging them to take greater ownership of their health and wellbeing. Early and ongoing engagement with partner organisations and the public has helped ensure that there was a shared understanding of the challenges facing the health and care sector in Dudley and collective agreement on the way forward. This is apparent in the range of engagement activities undertaken by the CCG including public consultations, social media, and through the local press which helped frame local values and priorities

3. Although pursuing an MCP was, in many ways, a logical choice to help ensure that general practice in the area is sustainable into the future, it also represents a significant transformation to the way in which primary care is delivered. We felt strongly that the MCP model, by giving access to multi-disciplinary teams and improving coordination of care between services, would improve GP work life balance, offer increased career flexibility, and make the GP profession a more attractive proposition in Dudley. Involving GPs appropriately and transparently in the development and procurement process and working to ensure there is sufficient buy-in to a shared vision has been vital. The CCG have also provided training and development support to local GPs to ensure they have been able to effectively contribute to the procurement exercise

4. Manage conflict of interest transparently and appropriately. In procuring the MCP, we recognised that decisions would be taken by General Practice as to what services will and will not be included, and to whom the MCP contract will be awarded to. In a similar fashion to co-commissioning in a CCG context, the inherent conflict of interest within this procurement exercise have had to be rigorously and transparently managed.

5. In my experience, staff working at the coalface will more often align themselves to teams rather than their parent organisations. This is often beneficial, supporting partnership working and the use of multi-disciplinary teams as individuals are less entrenched in their organisational silos and more able to work towards a common purpose - patient care. However, it seems clear to me that NHS organisations have struggled to recreate this ethos of partnership and collaboration in more senior and Board positions. This is perhaps a result of deep-rooted systems and behaviours developed around the commissioning and competition at the heart of the 2012 Health and Social Care Act. A major challenge for STPs and the Boards of local NHS Boards will be how to break this down in pursuit of system working and integration

6. The MCP has the potential to create significant workforce and employment opportunities. In Dudley, the NHS is the largest employer in the borough and this is creating opportunities for us to re-define roles and working practice in the future. The CCG are already beginning to engage with schools and the voluntary sector to see how the workforce can both be grown and cost-efficiencies realised

We are not at the end of our journey yet but feel confident that the steps we have taken already to procure the MCP will ensure that the people of Dudley receive the best quality of care closer to home.

Reducing inequalities in Scotland

Good Governance in Scotland

Hilary Merrett, Senior Associate, GGI

GGI has been privileged to be involved in pioneering work in Scotland, delivering integrated health and social care services to communities as part of a national drive to reduce inequalities.

In 2014 the Public Bodies (Joint Working) (Scotland) Act required new partnership bodies to be established to organise for the integration of a range of services. The Act set up 31 Integration Authorities – Health and Social Care Partnerships (HSCPs) across Scotland, to be governed by Integration Joint Boards. These Health and Social Care Partnerships between local council and NHS bodies are now to be responsible for achieving fundamental changes to how acute and community health care services, as well as social care services, are planned, funded and delivered.

In Aberdeen City, GGI began work in June 2015 with the shadow Integration Joint Board and its parent bodies on a governance development programme. This was designed to prepare the IJB for formally assuming statutory authority in April 2016, and to support it in the early stages of its operations.

GGI's work with Aberdeen City HSCP involved three phases: *Diagnostic, Delivery, Assessment*

The **Diagnostic** phase involved working with members of the IJB from the Aberdeen City Council, NHS Grampian and other stakeholders to identify new governance structures, processes and systems, supported by optimum board dynamics, behaviours and etiquette. The IJB was an entirely new type of body, bringing together two very different cultures, to deliver an ambitious strategy for integration.

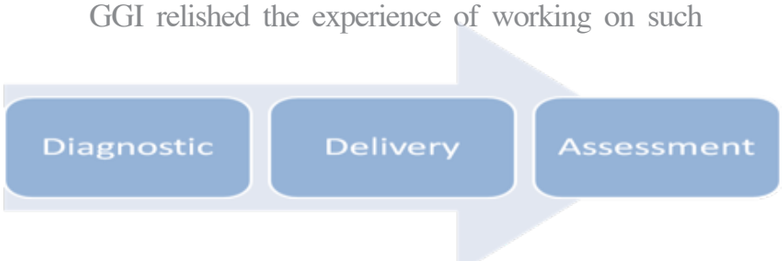
Key outputs from this phase of the programme included:

- *The negotiation and development of the IJB Risk Appetite statement*
- *The agreement of a methodology for assessing board effectiveness and establishment of a baseline using GGI's Board effectiveness maturity matrix*
- *The design of structures and systems for providing a fit for purpose governance structure*
- *The production of the ACHSCP Board Assurance and Escalation Framework*

In the **Delivery** phase of the programme, GGI worked with the Integration Joint Board in implementing its governance structure and, in particular, supporting the design and delivery of structures and systems for clinical and care governance across delegated services. Service delivery was designed don a locality basis where strong local leadership would be essential in ensuring that integration worked well at all levels of the system.

The **Assessment** phase between November 2016 and February 2017 involved assessing the progress made in terms of IJB and Committee effectiveness and the overall progress towards maturity within the key dimensions of clinical and care governance. The assessment reviewed how well the Assurance and Escalation Framework had been implemented, including the understanding and application of the IJB's Risk Appetite. It describes GGI's assessment of progress towards implementation of each of the key elements of the framework.

GGI relished the experience of working on such



Their challenge is to deliver the national Health and Wellbeing Outcomes (ref):

- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer
- **Outcome 2:** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- **Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
- **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- **Outcome 5.** Health and social care services contribute to reducing health inequalities
- **Outcome 6.** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- **Outcome 7.** People using health and social care services are safe from harm
- **Outcome 8.** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services

a ground-breaking initiative, with such profound potential for improving service delivery for the community. One of the most impressive aspects of working on this project was witnessing the high level of enthusiasm and commitment of those involved, amongst both Board members and the wider ACHSCP team. GGI were also struck by the notable positive shift in dynamics and team working within the IJB: this augurs well for partnership working across Scotland where partners can learn from each other in support of joint goals for service improvement and transformation.

Fire Authority governance

A pivot for place-based public services

Donal Sutton, Strategy Director, GGI

With a long-standing tradition of public trust in the fire service and strong community presence, Fire Authorities have a clear contribution to make to collaborative working as a core element of the public sector. Currently fire and rescue services across England are operating in a period of considerable change and strain within public services. The sustainability of funding, recent high-profile governance failures, and a new national inspection regime are all part of the immediate context. Although challenging, this environment also presents valuable opportunities to further embed effective collaboration and partnership working with communities.

Increasingly, public sector organisations are building 'place-based' approaches to transformation which focus on the distinctive nature of the people and places they serve. There are a number of important issues to acknowledge for Fire Authorities in this regard.

Just over a year on from the tragic fire at Grenfell Tower which claimed 72 lives, the public inquiry into the disaster is placing high-profile scrutiny on the circumstances leading up to and surrounding the fire. The inquiry is hearing a range of evidence, including that relating to building planning and fire safety regulation, and the roles of emergency services and local government. There is understandably a strong public appetite to better understand how the various elements of government and public services can improve and work better together to prevent such a tragedy from ever occurring.

Specific challenges to the governance of Fire Authorities have been recently highlighted at Avon Fire and Rescue Authority and Cambridgeshire and Peterborough Fire Authority. These experiences emphasise the need to demonstrate effective governance in order to deliver high quality services

and maintain public confidence.

These elements will be tested as part of the new national inspection regime overseen by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMIC). Working with an expanded remit, HMIC will oversee the first inspection programme and framework for all 45 fire and rescue services in England. The 2018/19 inspection programme is assessing:

- how effective each service is at preventing, protecting against and responding to fire and other risks
- whether the service provides value for money
- how well the service looks after its people and ensures fairness and diversity

It is intended for these inspection reports to help the public see how well their fire and rescue service is performing. While images of 'blue light' services rushing to tackle emergencies are salient, the reality for the fire service is that much more time is spent on prevention than on emergency response.

In 2018 GGI have worked with East Sussex Fire Authority to undertake a governance review, and through this programme we have seen the excellent stakeholder engagement and preventative work undertaken with the community. The prevention agenda places fire services in direct and regular contact with communities who trust and respect them. Moreover, Fire Authority Members are ideally placed to utilise their platforms as locally elected representatives to engage and influence the community voice.

There are more formal mechanisms too, such as the Integrated Risk Management Plans that each fire and rescue authority must produce to identify and assess all foreseeable fire and rescue related risks that could affect its community, and the Policing and Crime Act 2017 which places a duty of collaboration on the police, fire and rescue, and emergency ambulance services.

These elements provide a rich environment for community collaboration in the design and delivery of public services, as well as supporting specific priorities of the public health agenda. Whether helping people live independently and safely in their homes, reducing anti-social behaviour, or contributing to public health messages and neighbourhood renewal, Fire Authorities can and should act as an effective conduit for community collaboration.

Collaboration *or bust!*

a look at how big businesses are working together to tackle sustainability and social issues

Sarah McCarthy, Corporate Copywriter, GGI Review

From resource scarcity to climate change, today's companies operate in an environment of increasing sustainability concerns. Good governance requires constant evaluation to ensure that companies are operating optimally to cause minimal impact on the environment. Recently, rival corporations have broken down the traditional barriers of competition, forming unprecedented partnerships to tackle some of these pressing concerns. In this age of collaboration, great things are being achieved, but we also discover that there are some challenges to teaming up.

As the environment in which organisations operate is constantly evolving, the three pillars of corporate governance – transparency, accountability and security – need to be updated accordingly. When new issues come to light, new environmental challenges and social concerns need to be tackled. It's these issues that, in part, have given rise to the age of collaboration and the relatively recent concept of collaborative governance.

Collaborative governance is the process by which multiple actors, individuals, private corporations and government institutions, come together and evolve, implement and oversee rules, providing long-term solutions to these challenges. And it seems to be having a positive impact. When the community private and public sectors communicate effectively and work together, they can achieve far more than

any one sector could achieve on its own.

Today, talk of partnerships, networks and alliances fill the media. The language of competition has become intertwined with the language of dialogue, participation, and co-operation. In the public sector, when the ANC government came to power in South Africa, collaboration, participation and consensus underpinned the heart of the renaissance. And in Brazil, presidential candidate Luiz Lula da Silva's campaign and administration bought together a network of almost 1,000 corporate members to spearhead the country's corporate responsibility movement.

"Collaboration is this era's source of hope."

Simon Zadek, Senior Fellow, CSR Initiative

Collaboration is happening on a global scale. The United Kingdom's Ethical Trading Initiative (ETI) and the United States' Fair Labor Association (FLA) joined forces to establish code compliance and good practice in labour standards along global supply chains. But in this age of collaboration, it's not only ethical associations that are partnering up. Business competitors, too, have realised that more can be achieved by working together to tackle big sustainability issues.

After environmental campaign group Greenpeace targeted global drinks giants for using refrigerators that emit fluorinated gases, such as HFCs, Coca-Cola joined forces with Unilever and MacDonald's to develop a sustainable refrigeration company. Refrigerants Naturally! prevents global warming and ozone-layer depletion by promoting the sale of climate-friendly natural refrigeration – and pushing for a regulatory framework that encourages the use of these alternative solutions globally.

"The idea of doing this together rather than separately is mostly to provide an example of what is possible," says Antoine Azar, chair of Refrigerants Naturally!.

In the Côte d'Ivoire and Ghana, an unprecedented sustainability strategy called CocoaAction has united twelve of the largest chocolate and cocoa companies in the world, including Nestlé and Mars. The initiative has attracted the attention of Harvard Business School, which has showcased CocoaAction as a prime example of corporate collective action for social good. The initiative helps local farmers meet growing demand and aims to make cocoa farming sustainable. It also provides a powerful framework to align industry support for farmer productivity and community development.

"Deepening collaboration with key partners has been a top priority during my first two months," says CocoaAction's president Richard Scobey. *"We have also been brainstorming with important stakeholders about how we can better leverage the strengths of each of our organisations to accelerate sustainability and poverty reduction in cocoa farming."*

In the competitive construction industry, Skanska

broke new ground by collaborating with its rivals to establish the Supply Chain Sustainability School, which educates its suppliers about sustainability. Consuming vast amounts of energy and natural resources, the built environment is responsible for 40% of the UK's carbon footprint. This, together with the fact that the major construction companies share a handful of suppliers, means that improving their environmental performance has a dramatic impact on the sustainability of the sector as a whole.

Despite the obvious environmental, sustainability and social benefits, competitors need to tread carefully when it comes to collaboration. In 2011, Unilever and Procter & Gamble were fined £280m by the European Commission for breaking antitrust legislation when they sought to move the market towards lower-impact laundry detergents. This case raised the important question of how to balance pre-competitive behaviour with collusion.

The consumer goods giants co-operated in the settlement and the fines were reduced by about half. However, £140m is still a significant price to pay considering the initiative was intended to shift consumers away from big-box powder detergents, thereby reducing energy, packaging and shipping, storage and selling space, and helping to reduce waste disposal. So what was their crime? According to the European Union's vice-president for competition policy, Joaquim Almunia, the companies began to co-ordinate their efforts in 2002.

"They sought to ensure that no one could use this initiative to gain a competitive advantage over the others, so they agreed to protect their respective market shares," explained Almunia. *"They also agreed not to decrease prices when decreasing the size of packages, and afterwards, they agreed to a price increase."*

Collaboration for the greater good is nowhere more evident in the world of technology. Tim Burners Lee, who invented the World Wide Web nearly three decades ago, has teamed up with a small group of developers to work on Solid, a platform that aims to change the existing power dynamics of the web. Today, technology giants such as Google, Amazon and Facebook have gained control over personal data, something Burners Lee feared but never intended when the web was born.

With Solid, he and his team are crusading to give users their privacy back by giving them greater control over who can accesses the content that they produce. Berners Lee tells

Vanity Fair that the current centralisation of the web has, "*ended up producing – with no deliberate action of the people who designed the platform – a large scale emergent phenomenon which is anti-human*."

Not only has the Internet revolutionised the way we our lives, it's one of the most democratising and collaborative forces in the world today. Software such as LibreOffice and GNU Image Manipulation are examples of "open source" software that makes its source code available to users who are able to copy it, learn from it, upgrade it, or share it. In contrast to proprietary software, open source defies the old thinking of control through ownership, promoting collaboration and providing financial and innovation benefits to business.

Another innovative approach to collaboration, made possible by the web, is crowdfunding. From a giant Lionel Richie head to helping victims of life-threatening accidents, crowdfunding has helped fund a wide variety of causes. Even President Donald Trumps' ex-layer Michael Cohen has raised over $150,000 to cover his legal expenses, including $5 from a "Vladimir Putin". UK sites such as GoFundMe, JustGiving, and Seedrs all demonstrate the collaborative power of individual people – rather than corporations or government – to solve social problems.

Today, an increasing number of start-ups are realising the power of collaboration. Collaborating with more established companies enables newcomers to understand how their industry operates and how they can thrive within it. There's a growing trend for start-ups to not only be motivated by the bottom line, but have a positive impact on society, too. And the two don't have to be mutually exclusive. Combining a great idea with buy-in from corporations who share the vision and already possess power in the market is the easiest way to open the gateway to success.

Tictrac is a personalised health and wellness platform that empowers people to live healthier lives. Instead of going directly to the consumer, the Virgin team that developed the app formed relationships with insurance companies and government bodies that had existing, well-established customer networks. With endorsement from healthcare providers, consumers had greater trust in the product, sharing insightful data that, in turn, promotes their health and wellbeing.

When academics and industry experts come together to collaborate, they can form a formidable team by offering each other complementary skills: the former can offer their intellectual capacity and research and development resources, while the latter has the finances and expertise to drive projects forward.

The Sustainable Business and Innovation team at Nike brought together designers, scientists, coders and students to produce a digital tool that drives innovation, reforms design thinking, and promotes sustainability in the fashion industry. Nike collaborated with the London College of Fashion to collect insight and feedback during the development of their Making app, which helps product creators make more informed decisions about the environmental impacts of the materials that they use.

EUROPEAN SUMMER CAMP 2019: MIGRATION

MARSEILLE, FRANCE

Ulysses Kilim, Marketing Manager, GGI

We're all familiar with the diversity dimensions that we are born with: gender, age, race, etc. We're less familiar with the dimensions we acquire in our lifetime: culture, life experiences, domains worked in, education, background, etc. These interesting dimensions are responsible for setting up your thinking patterns, beliefs and problem-solving approaches.

Diversity is an intellect multiplier but only when diverse groups can collaborate together. We'll seek to find that common language that we need to help diverse communities come together and collaborate. We'll seek to create an inclusive environment that fosters diverse perspectives without judgement. And we'll aim to achieve this, once again, in Marseille, a city considered by some to be corrupt, dangerous, and brutal to its poor. On the contrary, we'd like you to come and some see it as the future face of France. The annual, European Summer camp, established in 1999, has welcomed leaders from across the world to places of real historical significance, which stimulate learning from the past, but also embody the future. This year, the Summer Camp community is entering a new phase and 2019 will be particularly insightful. By focusing on young leaders and the world we want to live in, we'll build upon our network of established leaders. Young does not mean a restriction in age; it's about spirit, energy, and a commitment to creating the future.

The phenomenon of migration and its knock-on effect on diversity within our communities is the main topic for Summer Camp 2019.

Following a similar approach to previous years, we'll be holding workshops, attended by speakers from various countries working in multiple sectors,

including health, academia, youth, human rights and politics. These workshops will include materials that we feel are important in order to develop our skillsets and knowledge, as well as inspirational in order to achieve the level of leadership that we require today within our communities. The primary purpose is to stimulate meaningful conversations about the common issues we've identified and try to bring about new perspectives.

We are inviting open-thinking professionals committed to sharing, contributing, and learning with a sense of community to join the 2019 European summer camp. We' will be exploring themes surrounding migration from several dimensions and perspectives and introduce new insights with no clearly laid out deliverables of skills, competencies or knowledge. It will be entirely up to individuals to shape their own perspectives and holistic development.

Having worked in varied industries and lived very different lives, every one of us has unique experiences. This year, the Summer Camp will be all about recognising each other's strengths and learning from each other's experiences. We'll also have the opportunity to experience the culture of our beautiful hosting city, Marseille, and her people, while being sympathetic to her weaknesses. After Camp, we'll return to our communities equipped with a fresh set of ideas.

The Summer Camp is a voluntary, self-funding, organic gathering. Over the last 20 years, with every new member joining, our community has grown to incorporate a much wider diversity of age, nationals, backgrounds, and disciplines of participating members. We look forward to welcoming you among us soon!

DIVERSITY BY DESIGN

The new prescription for the NHS

23rd October 2018

Simon Fanshawe

Oh no, not another report on diversity! That was the first response of most of the people I interviewed for this report. But when I explained what we were trying to achieve, they became more interested. Because the report's aim is to reframe the debate about diversity in the NHS, for Boards and execs of Trusts, in terms of the dividends it can deliver for patient health, staff success and innovation in the design and delivery of services.

Diversity works so often, so brilliantly in the NHS in wards and clinics. There are doctors and nurses and porters and auxiliaries and administrators using their languages, cultures, sexual orientation, ethnicity, gender to deliver even better patient centred care. Gay men in sexual health clinics treating other gay men, having franker conversations so more testing and better health outcomes. Black and Asian female nurses helping women who have little or no English through the labours of childbirth or the trauma of A&E. There are many examples. But also it is striking that, while the NHS as a service is free at the point of need and doesn't discriminate against those who walk through the door to receive care, it seems, from the evidence, to discriminate against some who walk through the door to give care.

The diversity deficits are really shocking. The WRES Team (Workforce Race Equality Standard) have done a sterling job in supporting its co-founder, Roger Kline's, contention that holding Trusts to account through sound NHS wide data is the starting point for change.

And there is relatively little progress year on year. In 1964 Woody Allen made a joke. He said "I have a tape recorder and when I talk into it, it just goes 'I know, I know'". Boards react like that to the reported diversity figures. Much wringing of hands about how bad it was and still more when the figures are again reported with no significant difference. So the report set out to outline a framework for Boards and Execs to make change, to improve the prospects in the NHS for staff from groups who the data tell us are faced with a concrete ceiling.

The first is to find real traction in the Trust. Diversity must be linked specifically to the achievement of the Trust's strategic aims. No more general 'blah, blah' general statements. And to follow that with a commitment to change the way they recruit and promote staff to take the bias that obviously exists, out of these processes. And the report lays out the research and practice that can show how to achieve that change. And to discuss and agree on what measurements will actually drive change.

It is an ambitious report. It requires Boards and execs to commit to change. It shows ways in which that can deliver a better health service. And there is a sense of urgency about this in the face of reduced resources and increased demands. The report asks questions as well as suggesting solutions and we hope that Trusts will join with us in debating this new way forward for developing talent better in the NHS in the future.

Some stand out statistics from latest reports:

- *It is still the case that white staff (across all grades) who have been shortlisted are 1.6 times more likely than BME staff to be appointed to a job even once shortlisted.*
- *the proportion of BME staff in Bands 8a-9 and Very Senior Managers is still only 10.4% compared with 16.3% in the workforce as a whole.*
- *it remains twice as likely that BME staff, compared to white staff, do not believe there are equal opportunities for career development and progression*

Buddying

East Lancashire Hospitals NHS Trust improving through partnerships

Kevin McGee, Chief Executive, East Lancashire Hospitals NHS Trust

It was a great achievement for East Lancashire Hospitals NHS Trust (ELHT) to be rated 'good' in our most recent CQC inspection, demonstrating the hard work and dedication of all our staff since being placed in special measures as a result of Sir Bruce Keogh's review four years ago. However, as I have consistently said, the journey is not over and I am confident that all staff at ELHT are fully committed to continuing our improvement journey to achieve an 'outstanding' rating from the CQC. It is my firm belief than an organisation should never stand still, it must always be striving for the next improvement.

The opportunity to work with, and support other organisations is a core part of our approach to quality improvement - providing opportunities for us to celebrate our successes, hone our methodologies, and develop our staff – a view shared by The Foundation Trust Network whose 'Review of Buddying Arrangements, with a Focus on Trusts in Special Measures and their Buddying Organisations' highlighted the benefits of mutual learning and support. And indeed, there have been a number of examples of effective 'buddying' in the NHS including our own experience with Salford Royal NHS Foundation Trust, and University Hospital Birmingham NHS Foundation Trust's partnership with George Eliot Hospital NHS Trust.

Therefore, when NHS Improvement asked me, in 2017, whether ELHT would consider a 'buddying' arrangement with North Lincolnshire and Goole NHS Foundation Trust (NLAG) it was something my Board and I felt we could not say no to.

Now, almost a year into our buddying programme, we are able to reflect on some of the key challenges

and learning from our experience. Although a lot of this smacks of common sense, it is too often overlooked or unapplied within the NHS.

Culture and behaviours

On first glance, ELHT is well placed to support NLAG – we were both Keogh Trust's, and we both operate across three sites, serving a similar size population, with a similar size income. However, this assessment devalues the importance of cultural alignment and personal relationships. We know that stressed organisations are often experiencing significant churn and can adopt a defensive, or 'bunker' mentality, hindering collaboration and it is therefore important for the leadership of each organisation to develop relationships with their counterparts and build a shared understanding and ownership of the challenges. This is something we were particularly mindful of when developing our support offer

Capacity and resource

It is easy to underestimate the time and resource commitment required to make a success of a buddying arrangement, and those organisations that fail to appreciate this risk not only losing the benefits from the collaboration but also significant reputational damage. This issue of capacity assessment and mapping should be an open, transparent and continuous process that is explored at the on-boarding and planning stages and in joint governance arrangements.

To book your place at one or all of the events please visit:
WWW.FESTIVALOFGOVERNANCE.ORG

Evaluation and learning

Perhaps the greatest value, from our experience, has been derived from the shared learning and development opportunities that the buddying arrangement has provided for our, and NLAG's, staff. We have been particularly mindful of the opportunity for staff to:

- Reflect on divergent ways of working and learn from good practice
- Socialise and network beyond our individual organisations
- Take on leadership roles and responsibilities and gain valuable and significant experience of delivering large quality improvement programmes
- Generate and promote learning for the wider health and social care system

Communication and visibility

Organisations receiving buddying support are often doing so at the behest of a regulator and, as such, the morale of the staff at the organisation may be low, with suspicions about the value in "yet another programme imposed on us". It is important therefore that staff understand the buddying relationship as beneficial rather than burdensome, and not as something that is "being done to them." Ensuring clear and transparent communication and engagement with staff can help address cynicism and maintain workforce morale throughout the duration of the arrangement, provided it is based on authentic engagement and connects to the way staff feel and see their organisation.

Regulation

As buddying arrangements are typically an improvement exercise to support a challenged NHS organisation, it should come as no surprise that regulators can have a significant impact in the effectiveness of any partnership. In our experience, there are three areas in which regulators can add value to buddying programmes:

- Selecting the most appropriate buddying organisations, in tandem with those involved
- Working with buddying organisations to set relevant and realistic performance indicators and be guided by the buddying organisations as to what will work best. In monitoring performance, regulators should be mindful that rapid development cannot always be achieved
- Providing support, and where necessary, resources to ensure the success of the arrangement

The direction of travel for health and social care is clearly one of increased partnership and collaboration. In such an environment Boards will need to be cognisant of the potential benefits and challenges to be derived from bringing together a range of organisations with often strikingly different cultures and backgrounds. In this context, buddying arrangements should be pursued by a wide range of organisations pursuing improvement, not just equivalent organisations and not just those that have been directed to. The learning from our experience, and that of a range of other organisations involved in buddying arrangements, is captured in a report we have recently published, in collaboration with the Good Governance Institute.

Nina Atwal, Consultant, GGI

In the realm of healthcare, the word on everyone's lips is: Integration. While this means different things for different organisations, and within the boundaries of geographies, the defining feature of this buzzword is collaborative working between health and social care organisations.

Integration, short for *Integrated Care Systems (ICS)*, has been defined by NHS England (NHSE) and NHS Improvement (NHSI) as "those in which commissioners and NHS providers - working closely with GP networks, local authorities and other partners - agree to take shared responsibility for how they operate their collective resources for the benefit of local populations."

The planning guidance document released by NHSE and NHSI, "Refreshing NHS Plans 2018/19", offers a concrete framework within which health and social care organisations are expected to operate. However, organisations are still very much left to their own devices as to how to go about integrating in their respective geographies, what the options are, and which option is best for them. Many leaders reference the fact that there is no evidence of real integration in the UK and, therefore, little or no evidence on what the benefits are. At the moment it seems like trial and error for many. This uncertainty is exacerbated by different ways of working, rooted in the early days of the NHS.

The NHS of the early 2000's was a world where competition was promoted through various Health

Integration and *Collaboration* are the new buzzwords for the NHS

Acts and the NHS Foundation Trust movement. As a result, organisations had a tendency celebrate individual successes, as opposed to collective successes, within the health and care system. This way of working is still prevalent in organisations today and it has the potential to be a major impediment to successful integration. For example, the funding mechanism for NHS providers is still framed through mechanisms developed for the NHS internal market. The move towards integration necessitates a major shift in rationale from one of competition to one of collaboration. Shared outcomes provide the measure of success and ensuring that this principle trickles down from board level to front line staff of all organisations in the system.

Bridging the gap between 'siloed' and segmented ways of working, requires a return to the defining principle and purpose of a National Health Service which is ultimately: to serve the population. The recognition of the changing needs of the population, coupled with the acknowledgment of the strain to deliver services in the current NHS model, has brought about the move to the ICS.

In order for the Integrated Care Systems to be a viable solution to the challenges of healthcare provision, there needs to be the collective accountability for population health outcomes.

Thinking about health provision in terms of public health and solutions that match is the way forward. In order for this to be sustainable, this new way of framing the purpose of health provision and integration needs to extend to all stakeholders, with the purpose of bringing the community together around this shared goal of improving population health.

In order for these partnerships to have legitimacy and longevity, they need to be supported by governance frameworks and structures built from the ground up. These can be proliferated through forums, which bring leaders together and the sharing of learning resources and tools, which is exactly what the Good Governance Institute and the Festival of Governance is for.

Thank You

to everyone that contributed to the Festival Review, and especially to those colleagues that have been involved since the inception of the Festival in 2015.

GGI would like to thank each participant for their contributions. Participants are credited in the role they had at the time they contributed to each respective Festival.

Festival of Governance 2015

Professor Mervyn King, Chairman, International Integrated Reporting Council
Dr John Bullivant, Chairman, GGI
Andrew Corbett-Nolan, Chief Executive, GGI
Nicola King, Associate, GGI
Stephen Hay, Associate, GGI
David Cockayne, Managing Director, GGI
Christopher Smith, Team Leader, Knowledge Management, GGI
Simon Fanshawe OBE, Co-founder, astar-fanshawe
Di Sarkar, Director of Nursing, Basildon and Thurrock University Hospitals NHS Foundation Trust
Aaron Porter, Assistant Director, Governance, Leadership Foundation for HE
Jayne Brown OBE, Director, GGI
Peter Molyneux, Senior Associate, GGI
Claire Jones, Associate, GGI
Professor Maureen Williams, Vice-Chair, NHS Liverpool CCG – Speaker for "Listening and reporting to stakeholders" stream
Dottoressa Piera Poletti, Director, Centro Ricerca e Formazione di Padova
Michael Wood, Director, GGI
Gareth Kelly, Senior Manager, Grant Thornton LLP
Stephanie Elsy, Senior Associate, GGI
Donal Sutton, Service Development Executive, GGI
Professor Sue Proctor, Senior Associate, GGI
Samantha Jones, Director of New Care Models Programme, NHS England
Dr Marius Buiting, Directeur van de Nederlandsche Vereniging voor Toezichthouders in de Zorg, Utrecht
Dr Richard Park, CEO, CityMD, New York City
Professor Ramu Kannan, Chief Information Officer, CityMD, New York City
Candy Morris CBE, Senior Associate, GGI
Ann Sutton, Senior Associate, GGI
Darren Thorne, Director of Operations, GGI
David Goldberg, Director, GGI
Richard Samuel, Accountable Officer, NHS Fareham and Gosport CCG and NHS South East Hampshire CCG
Time Loveridge, Director of Business Development & Strategy, East Midlands Ambulance Service NHS Trust
Caroline Donovan, Chief Executive, North Staffordshire Combined Healthcare NHS Trust

Festival of Governance 2016

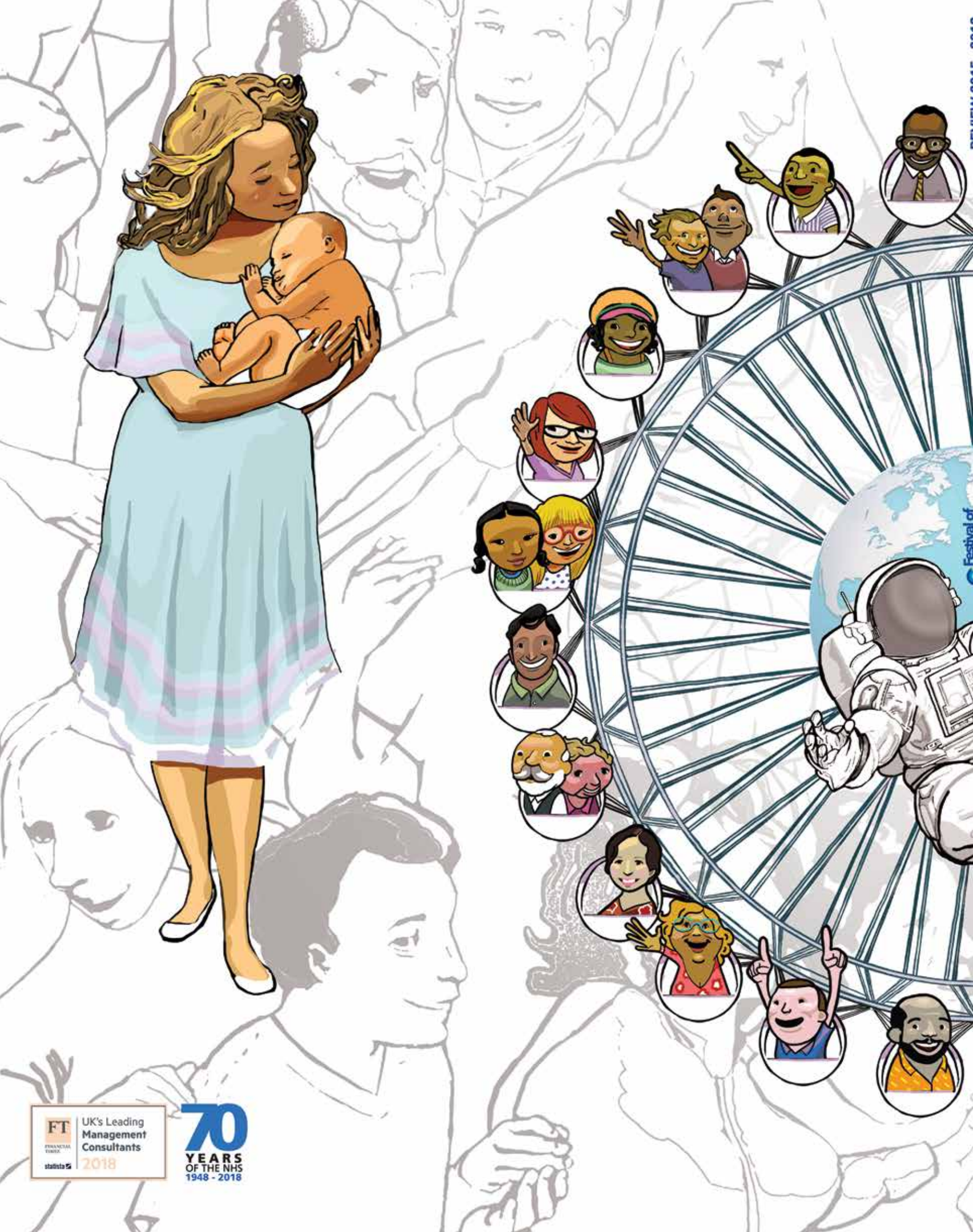
Lord Kerslake, Chairman, King's College Hospital NHS Foundation Trust and Former Head of Civil Service
Caroline Clarke, Chief Finance Officer and Deputy Chief Executive, The Royal Free Hospital NHS Foundation Trust
Simon Fanshawe
Sir David Nicholson, Former Chief Executive of the NHS
Angela Rippon OBE, Television Presenter
Andrew Corbett-Nolan, Chief Executive Officer, GGI
Leslie Brissett MSc DSC, Co-Director dynamic at board level, Tavistock Institute of Human Relations
Dr Caroline Jessel, Lead for Clinical Transformation, Medical Director, NHS England
Matthew Hopkins, Chief Executive, Barking, Havering & Redbridge University Hospitals NHS Trust
Joe Rafferty, Chief Executive, Mersey Care NHS Trust
David Cockayne, Managing Director, GGI
Jayne Brown, Senior Associate, GGI
Mr Gareth Kelly, Senior Manager, Grant Thornton UK LLP
Mark Butler, Senior Associate, GGI
Nicola King, Senior Associate, GGI
Andrew Corbett-Nolan, Chief Executive, GGI
Nicola King, Associate, GGI

Festival of Governance 2017

Professor Martin Green OBE, Chief Executive, Care England
Andrew Corbett-Nolan, Chief Executive Officer, GGI
Dr John Bullivant, Chairman, GGI
Anne O'Brien, Director, NHS Professionals
Dr Jonathan Lubin, Chair North Locality and Governing Body Member, NHS Barnet CCG
Angela Helleur, Improvement Director, NHS Improvement
David Cockayne, Managing Director, GGI
Prof. Eileen Fairhurst, Chairman, East Lancashire Hospitals NHS Trust
Hilary Merrett, Senior Associate, GGI
Liz Gilmore, Director, Jerwood Gallery

Festival of Governance 2018

Rt. Hon. Jacqui Smith, former Home Secretary and Chair of University Hospitals Birmingham NHS Foundation Trust
Andrew Corbett-Nolan, Chief Executive Officer, GGI
Imelda Redmond (CBE), National Director of Healthwatch England
Jaco Marais, Festival of Governance Director, GGI
Dame Julie Moore
Baroness Dido Harding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