Good Governance Institute

ALLOCATE

The surprising benefits to performance that mechanising assurance can bring

White paper

May 2018

The Good Governance Institute

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 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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Allocate is a recognised global leader in workforce and assurance software. The purpose of Allocate's HealthAssure is to reduce risk, improve quality and to provide full board assurance. Using national frameworks and guidance as part of an integrated solution, we work with healthcare organisations to provide a system to monitor assurance from ward to board. We provide full 'software as a service' and ensure that the system is built to fit the specific organisation type. We ensure full training and ongoing support by the Allocate Customer Success team, with a named analyst provided for each customer.

The surprising benefits to performance that mechanising assurance can bring

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

Other recent GGI reports and board development tools have considered integrated governance, governance between organisations, scrutiny and assurance, system transformation and new models of care, enablers in the delivery of system transformation, the future of the NHS, and of course good governance.

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

Healthcare is a risky business. In the National Health Service (NHS), the onus is constantly on organisations to assess clinical interventions and operational effectiveness in order to ensure that strategic and operational objectives are being achieved. In the complex environment the NHS operates in everyday, we need to find a way to have confidence that our services are running safely and performance is optimised.

In my opinion, the only realistic way of achieving this efficiently is by having an advanced system of assurance in place, which generates accurate information and data that enables confidence in the organisation's performance. For healthcare leaders, it is a huge undertaking to design such complex systems themselves, and this is where the regulators and national bodies come in, designing frameworks for assurance that help to ensure that standards of care are met around the country.

The bottom line is that, without assurance, you cannot safely manage your organisation.

Nevertheless, there are challenges, as the NHS responds to massive change at the national strategic level, with the requirement to improve service delivery and user experience while reducing costs. At the same time, workforce challenges are significant, and NHS organisations must motivate people to enter, and stay in, the health service, both at an individual level and across heath economies as structures move towards more collaborative working. It is also important that changes in structure and process are embedded at the frontline.

In this national climate, it will be challenging to implement and retain effective quality and safety assurance, and leaders will need to ask how they can establish assurance processes that are at the appropriate level and have the sustainability and flexibility to flex and adjust to the environment. As STPs progress, further structural challenges will present themselves as boards, each with their own statutory requirements for governance and assurance, work together, leading to multiple overlapping systems. There may be a lot to learn from areas that have a longer history of integration and devolution, as change management and behaviours will be just as important as structures and processes. With it looking unlikely that there will be primary legislation to reinforce the changes in the national agenda any time soon, local health economies must be proactive in moving forwards.

Therefore, it is timely to explore how we can most effectively meet this challenge, and evaluate the value that mechanised assurance processes can add. As we move forward, there are three main changes I would like to see:

- A greater awareness by boards of the thinking around the challenges to assurance that the current dynamics in the sector could bring
- In tandem with this awareness, boards working together in visible and substantive debate
- More awareness of the value that ward-based assurance can create

I hope that this paper will go some way in encouraging debate in this area and provide a useful resource for boards as they navigate their way through current and future challenges.

Hugh Ashley, General Manager UK & Ireland, Allocate

‘The definition of genius is taking the complex and making it simple’

- Albert Einstein

2. Executive summary

The Good Governance Institute (GGI) was asked by Allocate to investigate the benefits that mechanising assurance, and the use of integrated assurance software, can bring to NHS organisations. It is clear that negotiating the current challenges that the NHS is facing, and moving towards integration and system working, will require a more robust approach to assurance. Also important will be making the use of the abundant amount of data that the NHS collects on a daily basis more robust and more efficient.

Mechanising assurance is potentially a significant help in giving boards greater confidence in organisational operation, allowing them to adequately fulfil their strategic role as they navigate the current national change in direction. For staff, a more efficient assurance process could free up their time and allow for more time to be spent on the wards focusing on performance and quality improvement.

However, as with all governance processes, this would need to be underpinned by a positive culture and consistent behaviours in terms of how assurance is viewed, and the information it generates used. Assurance can often be viewed as an end in itself and not a means to various ends, including potentially enhancing operational performance. Through engagement with NHS colleagues and the development of case studies, we have explored how mechanising assurance may facilitate performance improvement and what NHS trusts will need to consider moving forward. Quality assurance is, after all, the bedrock of all quality management systems.

In this report we have made a number of recommendations:

Boards should:

- Challenge whether their existing systems of assurance are comprehensive, value for money and meet internal operational and scrutiny requirements as well as external compliance
- Question whether the system is sufficiently mechanised to be future proof, both internally and in support of current and future partner and funder requirements
- Have a view of the quality, completeness and value of information presented to it
- Challenge whether their existing systems of assurance allow for the most effective use and analysis of data that supports decision making for quality improvement

Mechanising assurance may be helpful in facilitating the ward to board link in assurance, ensuring that staff are fully engaged in the use of the system. Staff understanding of how assurance may help to improve quality is critical. An assurance system that standardises the process between divisions and facilitates staff involvement should support the concept of subsidiarity, which pushes down control and responsibility as 'near to the coalface as possible',[1] helping to create appropriate accountabilities at different levels. Establishing this principle will be essential when we move onto inter-organisational assurance.

Issues for debate:

Within the context of the new Sustainability and Transformation Partnerships (STPs), it is important to note that there will still be cultural, professional and extended geographical boundaries to manage. Boards will need to ask themselves:

- Have we, the board, identified in our Assurance Framework (the BAF) the potential risk to our strategic objectives if our partners/providers fail in their service delivery?
- If so, have we the controls and assurance in place so that we can mitigate the risks and act promptly if required?[2]

Boards could test their assurance systems with partners by agreeing a joint objective and risk, or following a simple pathway across boundaries identifying known failure points.

National questions:

- How can the number of regulators and complexity of the regulatory and data collection process be simplified, to reduce the burden on providers?
- How can the definition of assurance and its value be simplified for providers and their stakeholders, particularly as the sector moves towards system working?
- How can we get leadership right at a national, central level, while still allowing local autonomy and innovation?

In 2018, the Handbook to the NHS Constitution will be renewed, and GGI would encourage this process to consider how to make assurance more simple, as well as more conducive to improving quality and performance. As we have developed this paper, a number of recommendations have emerged which we would encourage the process of renewing the Handbook to consider. In section 2.10 of this paper, we include a full list of recommendations, for providers, regulators, GGI and Allocate.

3. Introduction and context

The NHS in England is facing a new and increasingly demanding operating environment. Governance today is growing in complexity, in an environment of very tight budgets coupled with increasing demand, rigid targets and a demanding regulatory environment, and complicated place based autonomies.

With the publication of NHS England's NHS Five Year Forward View in October 2014[3] and the ongoing development and implementation of the 44 STPs, the NHS is moving towards a very different picture of system integration and a 'prevention rather than cure' approach, with the development of new models of care and expansion of primary care underpinning this.

This policy movement will create a whole set of governance challenges which will need addressing to ensure the success of system transformation. These include the need for organisations to develop shared risk arrangements, ensure appropriate organisational representation (and at the right levels), to consider funding and regulatory requirements as well as the need to work openly, transparently and collectively. Within this requirement for collaborative working, many local health leaders have spoken of the challenges associated with being asked to work collectively on their local STP while still being held to account as individual organisations, and within the environment of competitive behaviours established by the Health and Social Care Act 2012.[4]

In the wider system, the situation is no less complicated, with the role of clinical commissioning groups (CCGs) being compromised and uncertain, while social care and care homes are facing a well-documented crisis in terms of workforce, budgets, and demand.[5] Despite this, there seems to be no appetite for the legislation of health and social care integration, such as that seen in Scotland with the Public Bodies (Joint Working) (Scotland) Act 2014 which sets out the legislative framework for Integration Joint Boards (IJBs).

With this in mind, it seems likely that systems will need some kind of shared assurance system or framework. As the performance of individual organisations grows more closely related to the performance of the system as a whole, organisations will need to have an awareness of what is going on elsewhere in the system and any risks or performance and quality issues that may affect them.

Organisations currently use a myriad of different assurance systems, so how easily can this be facilitated? Can a mechanised and automated approach to assurance allow for more effective and efficient assurance between as well as within organisations?

It is clear that, for both individual organisations and wider systems, there is no room for deterioration in performance or the quality of care. NHS organisations must ensure that they have systems that work, and the right behaviours in place to support these systems. The executive and board in NHS organisations have enough to do, with the board being primarily a strategic body, without being distracted by the detail of day to day operations. In this paper, we explore how far mechanising assurance can help organisations to improve their performance. Does the assurance system in place matter in itself, or is it more about how effectively it is used?

4. Methodology and acknowledgements

GGI is always concerned to support healthcare boards to have insight into the key issues that they need to be informed about. We have previously developed various series of reports and assurance tools for boards on issues of strategic interest such as telehealthcare, long-term conditions and new care models.

To inform this paper, we conducted an in-depth literature review to underpin our research. In addition, we engaged with NHS colleagues through an online survey, a round table event, online engagement, and a series of interviews, to ensure an awareness of particular areas of concern and potential routes forward. The paper also includes several case studies, demonstrating a few examples of much good work going on around the country.

GGI would like to thank all those who helped with the development of this white paper. In particular, we are grateful to The Christie NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and the Royal Wolverhampton NHS Trust, who gave us insight into the governance and assurance in their organisations in order to develop the case studies which are included within this white paper.

GGI would also like to thank Allocate, who came to us with the idea for this report, and who have supported us throughout the process of producing the paper.

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5. Governance: what is it all about?

Stripped back to its primary function, good governance in healthcare is all about ensuring that the organisation is performing well for its patients and stakeholders, and delivering its strategic objectives. An effective board is integral to this, with research showing that leadership is the most important influence on organisational culture:[6] high-quality leadership and governance is a fundamental factor in delivering the mission of the NHS to close the health and wellbeing gap, the care and quality gap and the funding and efficiency gap.[7]

In many cases, governance is often seen as being simply the processes and structures involved in achieving the desired performance outcomes and demonstrating compliance for the regulators. While this is important, it does raise the question of how the people at all levels of the organisation fit into this. In recent years, inspired by the work and ideas of Professor Mervyn King, best known as Chair of the South African King Committee on Corporate Governance, GGI has developed the mechanics and dynamics model of governance, in which the leaders and staff that make up the NHS play a central role.

> 'Leadership starts with each person charged with governance duties, but in addition, the governing body as a collective must set the ethical example and tone'[8]

The mechanics of governance, therefore, are the structures and processes of governance, or, 'what you can see on paper': audit, risk management, policies, committee structures and terms of reference. The dynamics, on the other hand, are the people that put this into practice, their behaviours, etiquette and leadership styles, and the organisational culture and strategy. While many organisations have good structures in place, which is of course vital, it is rarer to find organisations that have positive and effective dynamics in place. The organisations that are most successful are those that marry the two. The bottom line is that although organisations do need good mechanics in place, it will be difficult to progress without the right behaviours and etiquette.

Good governance begins with setting a clarity of purpose, roles and behaviours. Boards of NHS organisations need to ask themselves one fundamental question: 'What is the point of this organisation?', establishing the purpose of the organisation and then the vision to support the achievement of the purpose. In order to achieve the organisation's purpose, those in governance roles need to have clarity about their contribution to this and demonstrate behaviours that will support the achievement of the organisation's purpose.[9] The role of the board should be primarily strategic, acting as the guiding mind of the organisation and making decisions to help the organisation achieve its strategic objectives.

While the board's role is not to be involved in the day to day running of the organisation, it does need to be 'assured' of the performance of the organisation and the principal risks facing it, to ensure that these risks are handled and do not hinder the achievement of the organisation's purpose and strategic objectives. The assurance process needs to be sound if boards are able to properly fulfil their responsibilities.[10] This relies on having an effective system in place, as well as buy-in at both staff level and board level in order to have a lasting impact.

Governance is concerned with:[11]

VISION

BEING CERTAIN WHY THE ORGANISATION EXISTS IN THE FIRST PLACE, ITS PURPOSE, AND WHAT DIFFERENCE IT INTENDS TO MAKE

STRATEGY

THE PLANNED MEANS BY WHICH THE ORGANISATION DELIVERS THE VISION

LEADERSHIP

HOW THE ORGANISATION IS ABLE TO DELIVER THE VISION OVER TIME

ASSURANCE

THAT THE ORGANISATION DOES WHAT IT SAYS IT WILL DO AND BEHAVES IN THE MANNER IT HAS AGREED

PROBITY

THAT THE ORGANISATION MEETS STANDARDS OF OPENNESS AND TRANSPARENCY, ACTS WITH INTEGRITY AND IN GOOD FAITH IN THE PUBLIC SECTOR, TAKING NOTE OF THE NOLAN PRINCIPLES OF PUBLIC LIFE

STEWARDSHIP

THAT THE ORGANISATION IS RESPONSIBLE WITH RESOURCES, ESPECIALLY WITH OTHER PEOPLE'S RESOURCES (SUCH AS CREDIT)

6. Where does assurance fit in?

6.1 A positive declaration that a thing is true

'Boards need to be confident that the systems, policies and people they have put in place are operating in a way that is effective, is focused on key risks and is driving the delivery of objectives.'[12]

To ensure that a board is confident that its organisation is delivering its strategic objectives as well as high-quality care for patients on a day to day basis, NHS organisations need to have in place an assurance system that the board can be confident in. Without some kind of robust assurance system, the board will not be able to understand the myriad elements of what is going on in the organisation at any one time. The assurance system should continually inform the board of performance data, principal risks facing the organisation and significant aspects of regulatory compliance. However, the term 'assurance' can often be misunderstood, and the concept difficult to define. This confusion may well be augmented by the fact that, at present, there are no national guidelines for assurance in the NHS.

What is assurance and why is it so important?

Assurance could be described as 'a positive declaration that a thing is true'. Assurance is therefore the information and evidence provided or presented to a board, which is intended to stimulate confidence that everything in the organisation is as it should be, even though they may not have witnessed this for themselves.[13] For example, the Airedale Inquiry into nursing failures at Airedale NHS Trust, found:

'The most striking failure was in the disconnection between what was happening on the wards at night, and what the Board knew. The Board had no idea.'[14]

The deaths of the patients at the heart of this scandal occurred on the wards during the night: the Board never would have seen what was going on. However, it should have had assurance that someone knew what was going on and acted on this.[15] This represents a striking failure in the assurance processes in this hospital.

Therefore, assurance is the process by which organisations demonstrate that they are operating effectively and achieving performance. This includes:

- Delivering targets and objectives
- Preventing and managing risk
- Following best practice
- Meeting needs of patients
- Complying with statutory, regulatory and other requirements

Essentially, assurance is the generation and delivery of accurate and up to date information about the 'efficiency and effectiveness of an organisation's policies and operations, and the status of its compliance with statutory obligations. Assurance is the process of establishing the integrity and validity of disclosures, including statements and reports.' Effective assurance relies upon the quality of evidence, which should assure the board that performance and the quality of care are consistent with national and organisational standards, that risks are properly controlled and that the strategic objectives are being achieved. In order to validate this evidence, assurance should come from more than one source.[16]

6.2 Sources of assurance

Sources of assurance include:

Data and information:
• Reports and briefings • Comparative data and statistics • Comparison and benchmarking over time, both internally and externally • Provision of evidence that data is reliable and accurate
People:
• Talking to staff and patients • Asking questions in order to validate the data and information provided in reports and briefings
Observation:
• Taking a staff member's and/or patient's eye-view • Structured visits, walkabouts, case studies, in order to learn what is actually happening throughout the organisation • Comparison of the data and the outcomes of observations – do they correlate? • Deep dives

With the wide range of data that is now required to be collected by NHS trusts, there is a benefit in triangulating this information and evidence to ensure that a single, consistent version of the truth is presented both internally and externally.

6.3 The value of assurance

Although assurance has long been considered an integral aspect of governance, in recent years boards have had more of an onus placed upon them to ensure that they are confident of the performance, both in terms of financial sustainability and clinical quality, of the organisations which they lead. Chief executives in NHS trusts are required to sign, on behalf of their boards, an annual governance statement. This covers, for example, the governance framework of the organisation, risk assessment, the risk and control framework, and the review of the effectiveness of risk management and internal control.[17] To provide this, boards therefore need to be able to demonstrate that they have been properly informed through assurances about the true picture of their risks, and, based on the evidence presented to them, have made appropriate conclusions.[18]

When effective assurance systems are not in place, the board may not be able to fulfil its internal scrutiny, with what the board believes is happening being very different to what is actually happening in the wards. Various studies, for example on hospital acquired infections and compliance with employment checks, have demonstrated that boards may report compliance with standards, when in fact they are not being delivered in practice,[19] suggesting that the systems in place are not providing adequate assurance.

> 'This is not just a case of mendacity of boards, but almost a worst state of affairs – boards are genuinely unaware that standards they claim are being met are not being delivered in practice universally consistently.'[20]

An example might be the regulatory requirement to ensure that all employed staff meet training and review requirements whereas the board might reasonably want assurance that these requirements are also met by agency and visiting staff who are not employed by the trust.

High profile failings of care have demonstrated this disconnect, as for example in the events at Mid Staffordshire NHS Foundation Trust. The Francis Report into the failings concluded that the board had had a 'vestigial' clinical governance system, and therefore were 'blind' to the concerns that were then raised by the Healthcare Commission's investigation in 2009.[21] Assurance needs to provide a clear line of communication between the ward and the board. While the concept of assurance being ward to board being well known in the NHS, it has been suggested to us that in fact assurance should be ward to board and beyond. NHS board members have an ethical and moral duty in their role, to look after something that is not theirs, and aim to leave it in a better place than they found it. With this in mind, the public are looking to the board of NHS organisations to assure them about the condition and performance of local NHS services. Assurance systems should be able to facilitate this link.

The 'Board Assurance Framework' (BAF) is a principle mechanism by which a board tracks focus on the progress of the organisation's strategic objectives and keeps an eye on and mitigates against any risks that may hinder the achievement of these objectives. In addition to the BAF, boards of healthcare organisations also need to be confident that there are effective systems in the place for the following, which are collectively known as assurance systems:

- To endorse, monitor and develop appropriate policies and guidance for the management of the organisation and the minimisation of risk
- To report and monitor progress against both the strategy and the business plan
- To identify and assess risks and hazards, and act accordingly
- To ensure that the required compliances are maintained[22]

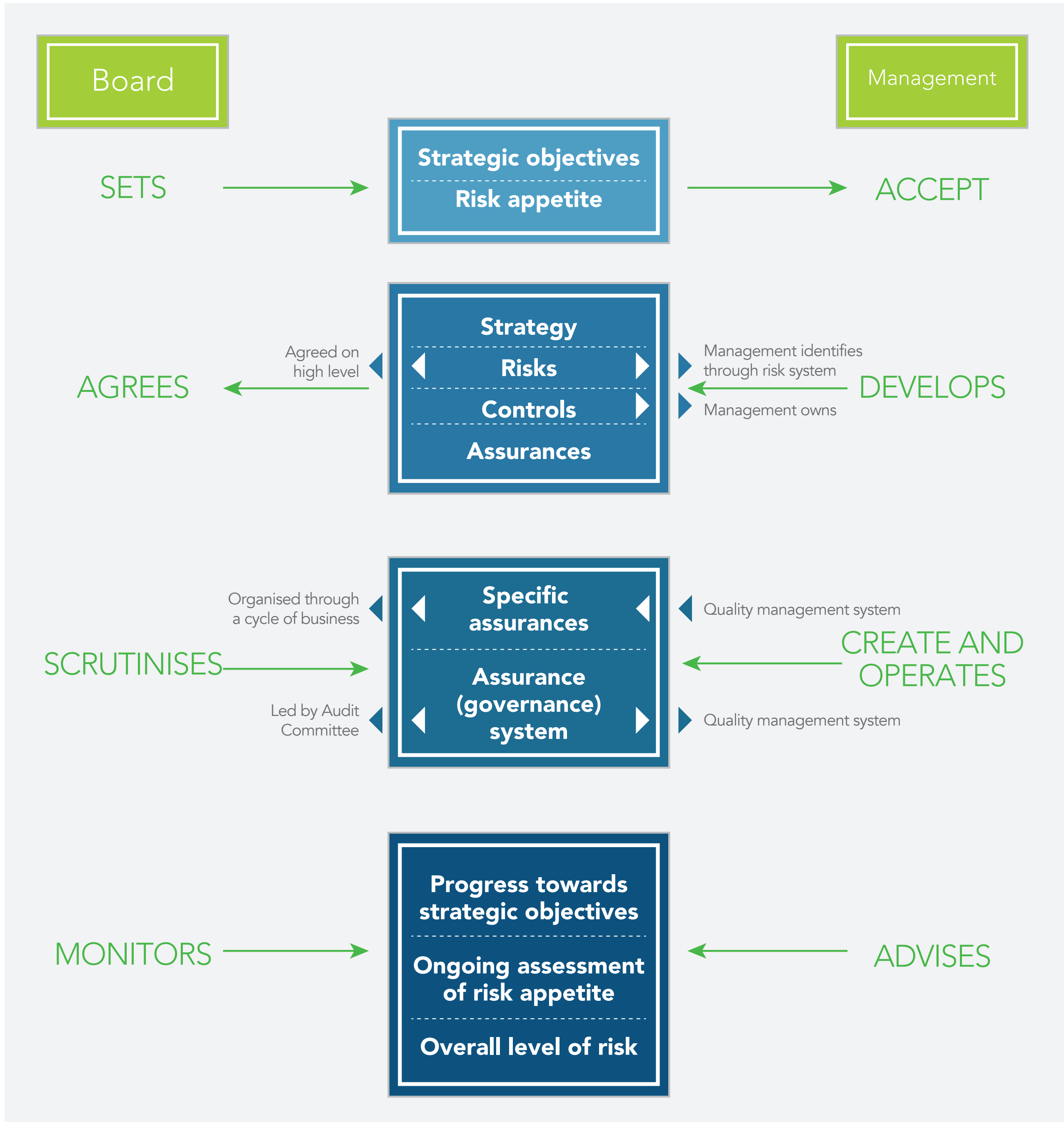
Assurance should not offer just a retrospective view of what is going on in the organisation, but a progressive and forward looking view of performance, able to support with both the analysis of trends and the projecting of trajectories. It makes sense that an organisation that is better able to identify where a deterioration in performance or quality and safety of care may occur will then be better positioned to deploy the resource and extra support necessary to mitigate any negative impact upon patients, compliance, and the delivery or consequent modification of strategic objectives. Many board papers in the NHS currently do not project forward trend lines, perhaps due to the difficulty felt by many in the NHS in converting data into useful information. Meanwhile, an effective assurance system should weave together evidence around, for example, quality, finance, workforce and partnerships, rather than dealing with them in siloes.

In the NHS of the 21st century what is the most effective and efficient way for organisations and their boards to ensure this model of assurance is being delivered? However assurance evolves, the process should be simple and able to facilitate a genuine culture of quality improvement. In the words of one NHS Chief Operating Officer:

It would be helpful 'for everything to be a little bit more simple… we just keep feeding the beast and I don't see it stopping, I just see it getting worse'

Assurance alignment in an NHS Trust:
The Board Assurance Framework (BAF)

VERSION 1.0 - OCTOBER 2017

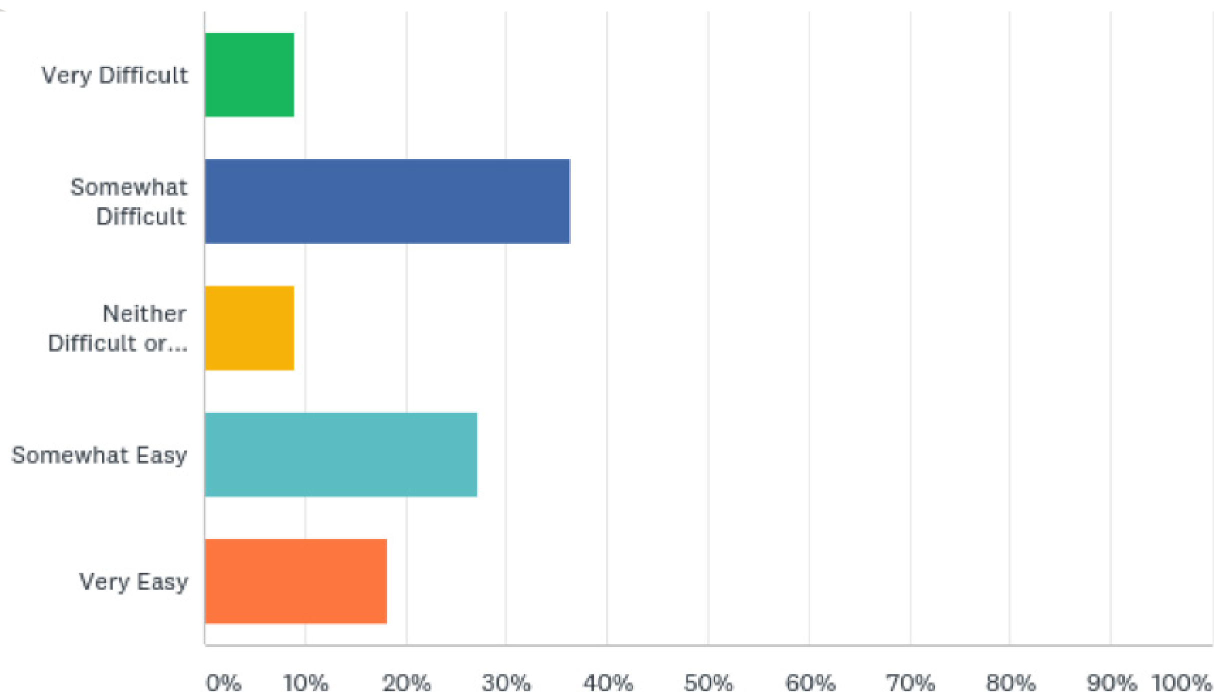


7. Assurance for performance and quality improvement

7.1 Assurance in the NHS: box ticking or quality improvement?

It appears that, whatever system is used, assurance is often a tricky concept to pinpoint with the UK NHS, and the impact it can bring undervalued. In a survey of those involved in the assurance process in NHS organisations, 45% of respondents said that it is either somewhat difficult, or very difficult, to describe the value of assurance within the NHS:

Q: How difficult do you find it to describe the value of assurance within the NHS?

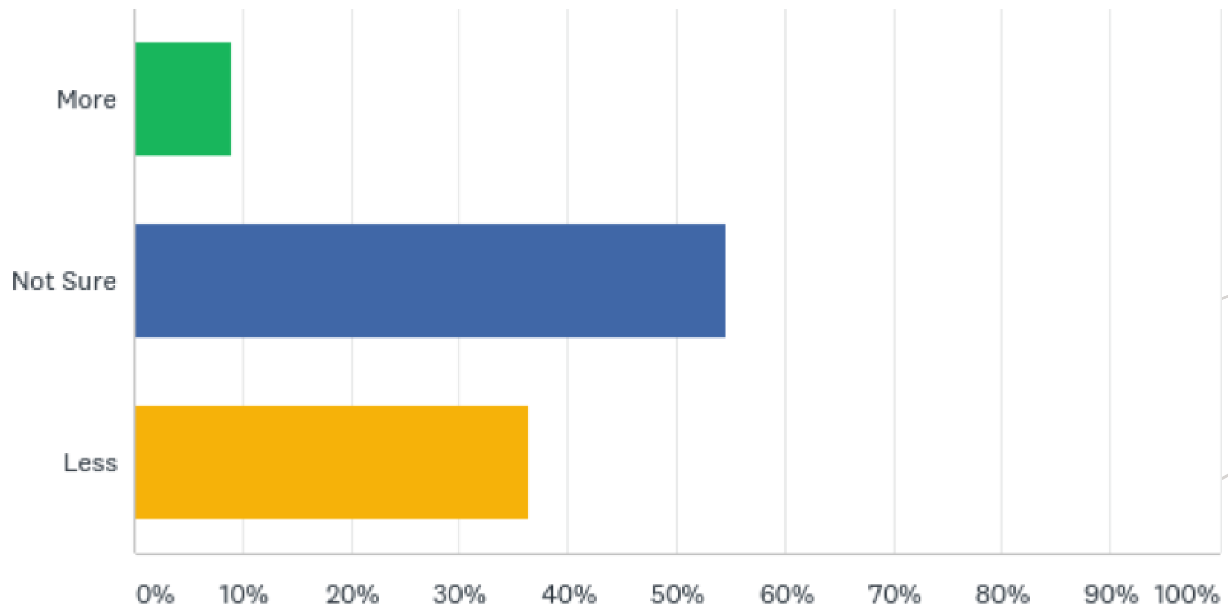


One respondent commented that '[it is] dependent on people's understanding of assurance, and also how much they want to invest into it', while another commented that assurance is often seen as simply compliance and monitoring via the CQC and other external agencies, reflecting a wider view that assurance is often just about 'keeping the regulators happy'. Assurance should not be for the regulators, but for the board on behalf of the public it serves.

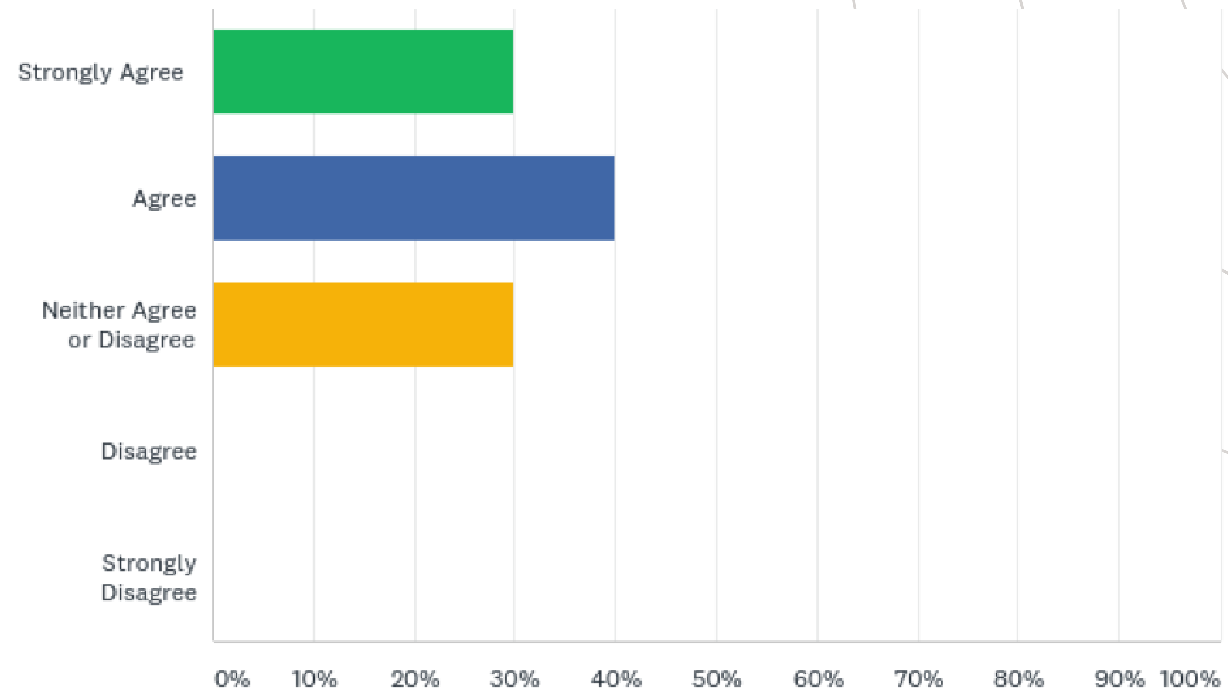
While it is true that assurance needs to be able to ensure that a hospital is performing in line with national standards and regulatory requirements, to avoid failings such as those at Mid-Staffordshire NHS Foundation Trust being repeated, we would argue that assurance has a role beyond this. An assurance system should also play a role in enabling continuous improvement in quality and safety, and supporting a hospital in going further than simply meeting the regulators' standards. In this case, too much of a focus on assurance as compliance could be dangerous. It could be argued that a focus mainly on passing inspections from the regulator is expensive, distracting and both disincentivises and demoralises staff, while acting as a barrier to instilling a genuine positive culture of quality improvement.

'Assurance is not primarily about defence but rather about having an adequate and effective control environment and strengthening the integrity of reports for better decision-making.'[23]

Q: Do you feel more or less 'regulator' focus makes assurance simpler?



Q: Do you agree that there is more focus on preparing to be inspected than creating a culture of quality through assurance?



'Any regulation should be effective and light touch… NHS culture should be learning, supportive, and [focused on] accountability'

'The NHS needs more support locally as to how to transform and board members must be trained how to hold executive directors to account for quality and safety'

Moving forward, there may be a strong case to reduce the burden on boards of meeting particular performance targets, and the current culture of removing leaders who are not perceived to be performing adequately, and instead support organisations to improve performance and quality in a more meaningful manner. The assurance of quality should be a fundamental part of quality management, providing the 'first generation' of the quality management process.

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Quality Management Overview

	1st generation. **Assurance**	2nd generation. **Improvement**	3rd generation. **Breakthrough**
EFFECT			
FOCUS	Standard and rules 80%	Understanding the work process 15%	Patters and 'Simple rules' 5%
PROPONENETS	Frederick Winslow Taylor, Joseph Bazalgette *London's Metropolitan Board of Works, Tate & Lyle Sugars, Lipton*	Walter Andrew Shewhart, Joseph M. Juran, W. Edwards Deming *Western Electric Company, Bell, Gilette*	Kaoru Ishikawa, Genichi Taguchi, Shigeo Shingo *Toyota, Boeing, Xerox*

Version: November 2017

Denmark: a case study

In 2015, the health service in Denmark made the decision to phase out its hospital accreditation scheme, which had been in place since 2005, and to replace it with a new approach which has a much stronger focus on quality improvement methodology and person centred care.

Bent Hansen, the President of Danish Regions, spoke of the decision:

'Quality work must be simplified and focused. The time has come to strengthen it by putting the patient at the centre, rather than focusing on compliance with a variety of standards. Accreditation has been justified and useful, but we move on. We need a few national targets to be met locally with strong commitment from the staff and with room for local solutions.'

While this makes clear that national standards and oversight are not being discarded, they are being rolled back somewhat, following staff feedback which showed that despite the improvements the accreditation system has brought, 'it has also resulted in excessive bureaucracy and has failed to instil genuine commitment to quality improvement among front line staff.' A few key national standards will be combined with more freedom and support for frontline staff to implement improvements that will benefit patients, for example enabling the access to and systematic use of real-time data, to assist with making evidence-based improvement decisions.[24]

The current operating environment of the NHS in the UK means that it really needs it staff to be bold, innovative, and willing to take risks,[25] if the service is to be sustainable for future generations. Decision makers and leaders need to ensure that assurance systems can facilitate this, rather than hindering through reinforcing an overly regulation heavy approach. The boards and workforce of NHS organisations also need to ensure that they have tools which assist them in quality improvement. An automated assurance approach that enables a more effective use of real-time data, such as that being introduced in Denmark, could play an active role in improving performance and quality. As healthcare slowly catches up with the digital age, mechanising the assurance processes used in the NHS could be a key to empowering staff.

7.2 Questions and issues in assurance

In our interviews, a number of themes, questions, and issues, were consistently revisited. These are outlined below.

Questions:

- Should assurance systems be integrated within organisations? Is there value in having one assurance system?
- Should assurance systems be integrated between organisations? How will assurance look in STPs?
- How can we ensure that assurance is forward looking and that we have assurance that risks to future performance are covered?
- How can we ensure that we are using data as effectively as possible?

As we progress with integration, there are a number of issues to confront. For example, already there is a lack of central guidance and some confusion by government agencies and regulators on whose role assurance really is. These issues need to be understood and resolved before we move on to a new, trickier issue: the need for assurance when decisions and services are organised on a multi-agency basis, especially with the currently loose structure of STPs and Integrated Care Systems (ICSs).[26]

Issues:

- Ensuring that the assurance process is reliable in order to release management and board capacity to deal with other issues
- Subsidiarity: ensuring that decisions are made at the appropriate level
- Ensuring staff buy-in and engagement in the assurance process
- Boundary issues within STPs (and beyond)
- Population issues: providers are accountable for the residents in their patch even when they are treated elsewhere
- Gaining assurance on the quality of locum and visiting doctors
- Gaining assurance on the use and governance of research data
- Gaining assurance on the quality and safety of clinical trials

Mechanising assurance: a definition

A mechanised assurance process could be described as one that is in real time, automated and online, providing a framework for managing, monitoring and reporting on regulatory and compliance regimes, quality standards, business objectives, plans and risks. It would also incorporate external information, including national frameworks and standards, policy updates and national alerts.

A mechanised assurance system could help to ensure the organisation has a ward to board link, ensuring a visible trail of data in one place and a 'single version of the truth', while providing a clearer line of communication and accountability through all levels of the organisation. A board that has an accurate and evidence-based insight into what is going on at all levels of the organisation is likely to be a board that is able to comprehend gaps in performance, where they exist, and ensure that steps are taken to mitigate the risk surrounding this. Demonstrating evidence externally could also become simpler through mechanising assurance.

7.3 How can we address these challenges?

In order for a board to succeed, it needs to have systems in place that are fit for purpose. Healthcare is a particularly complex sector, with boards being responsible for a range of compliances, and so individual systems are often in place that require investment of time and energy, but this is often compartmentalised.

As the NHS becomes more digitised, there is a case to make assurance more streamlined and efficient through mechanisation and automation. The use of a mechanised assurance system could assist with the development of 'right touch governance' by helping to clarify the roles of management, the governance team, the board and the regulators. Benefits of this approach could potentially include:

Each stakeholder has the relevant view allowing them to focus on what is important to them

The organisation thinks in terms of its objectives, obligations and commitments based on its governance framework, while compliance with regulatory standards is a by-product

Evidence and assurance for the compliance frameworks is a by-product of the management process

There is a significant reduction in duplication

It is easier to spot gaps in accountability i.e. which criteria are not covered

It is easier to spot gaps in assurance and compliance

Outputs that have no corresponding relevance to compliance can be identified

Managers are able to understand where their own responsibilities affect standards

Board assurance can be enhanced by making it directly relevant to the organisational structure, governance framework and corporate objectives[27]

Ward data is presented in a format that aids triangulation and allows the board to spot early warning signs rather than discrete messages that do not trigger concerns in themselves[28]

The assurance system will become valued as an integral element of the organisation's quality management system

Mechanised assurance can provide greater efficiency and correlation between different divisions and departments. With more traditional systems, there can often be inconsistency between divisions, with little or no centrally prescribed framework. It has been pointed out that 'this means that frequently there is no standard reporting template, common currency or language, or approach, which makes the task of implementing a coherent set of metrics, appropriately stratified at each level which cogently builds up through the organisation through to the board, extremely challenging.'[29] An assurance system that standardises the process between divisions and facilitates staff involvement should support the concept of subsidiarity, which pushes down control and responsibility as 'near to the coalface as possible',[30] helping to create appropriate accountabilities at different levels. Establishing this principle will be essential when we move onto inter-organisational assurance.

In the case study below, we consider how mechanised assurance at the Royal Wolverhampton NHS Trust has been implemented in order to standardise the approach to assurance throughout the organisation and improve the quality and efficiency of data going to board and committee level.

7.4 Case study: Royal Wolverhampton NHS Trust

The Royal Wolverhampton NHS Trust is one of the largest providers of acute and community services in the West Midlands, with over 800 beds on its New Cross site, as well as providing services from West Park Hospital and Cannock Chase Hospital. The Trust employs more than 8000 staff.

During a review of assurance processes during March 2013, it was identified that 'the reporting and flow of information relating to quality performance was disjointed and not clearly mapped to the governance / assurance structure… quality information presented to the committees needed to be reviewed and revised to ensure the right level of detail and information is being received by the right committee.' At the same time, the Trust was considering how to implement a sustainable system for monitoring of NHS Litigation Authority (NHSLA) standards and CQC outcomes, providing data that could be easily reviewed, analysed and acted upon. The decision was therefore made to roll out a mechanised assurance system more broadly across the organisation, with the following objectives:

- To ensure ward to board information is robust
- To enable reports/data to be aligned with the Trust committee structure
- To map and agree internally produced indicators
- To develop a mechanism for 'early warning' including tolerance levels
- To have a central system which receives all the agreed quality and safety indicator feeds
- To relieve some of the time burden from the from the clinical teams in terms of collating / reporting of the data

Now that the mechanised system has been in place for several years and has become part of the 'status quo', the Trust have found that the system has helped make achievements in the organisation. These includes an improvement in data quality as, because reports are now scheduled and circulated automatically and there is a clear accountability framework which is supported by the system, wards are much more proactive in terms of the quality of the data being reported and captured. There has also been an improvement in the 'measures' being reviewed:

'The system has essentially supported the improvement and development of metrics and bought real clarity to what is being measured and why. This means that the data can be used in a more intelligent way really helping those receiving the data to be able to question the differences and variations and establish a reason for these'.

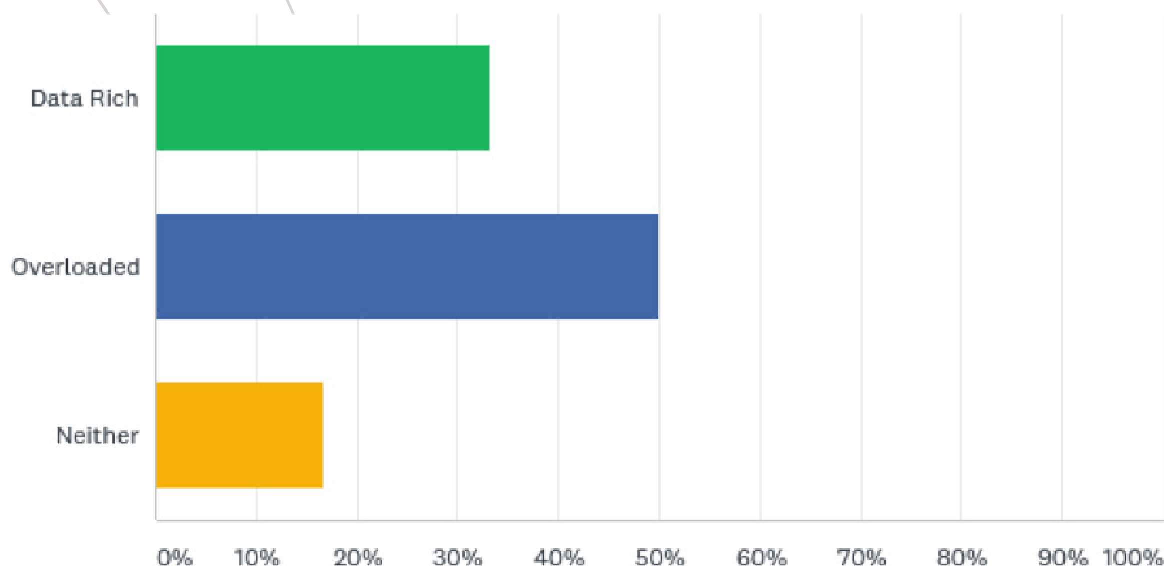
The mechanised system therefore reviews and captures performance metrics, which relieves the clinical areas of the task, and also means that they can receive the reports on a monthly basis automatically and are ready to 'act' on the data and outcomes. This also frees up a large portion of administrative time the nurses are expected to undertake. The Trust receives feedback at staff level that the system works much better for them than more traditional systems, while at Board level, the clinical directors and non-executive directors all support the use of the system.

7.5 Using data intelligently

As digital health becomes a more prominent feature in the agendas of healthcare organisations, the amount of data is increasing enormously and putting extra pressure on assurance systems. It was estimated in 2014 that the volume of global health care data in 2013 was 153 exabytes. To put this into perspective, an exabyte is one billion gigabytes, and all the words ever spoken by humans equals five exabytes. The report projected an annual growth rate of 48%.[31] Clearly, this is something that NHS organisations and their boards will need to be increasingly alive to. However, the NHS has often been criticised for not using its large amount of data intelligently. For example, Professor Derek Bell, President of the Royal College of Physicians, Edinburgh, says:

'The NHS is data rich but information poor. This applies across the system, particularly in relation to the presentation of information to NHS boards. There is a need for 'live data' presented in the correct way to facilitate informed and prioritised decisions focused on both clinical quality and financial challenges. This is also to inform the day to day operational management and strategic planning.'32

Q: ***In the NHS there is an abundance of data – do you feel that we are 'data rich' or overloaded with data and KPIs?***



The collection and use of data is vital for assurance, providing a live picture of the organisation's performance and where there may be issues. However, in addition to the challenge of using this abundance of data intelligently, the majority of interviewees we spoke to criticised the amount of data and information required by the national bodies and questioned how useful and relevant this data actually is. One interviewee told us:

'We need to ensure we're collecting the right information, it should be about first class patient care and minimising harm'.

Another said that while they perceive there is a better confidence in the NHS in the quality of data, there is greater anxiety about how that data is presented and then used in decision making. They pointed out that if out of date, inaccurate or misleading data is presented to the board, this can adversely affect decision making, which could then have a negative impact on quality and performance.

Research by the King's Fund has shown that non-executive directors 'need to work hard to assure themselves on quality.' While observing various organisations, researchers noticed the following:

'Where non-executives received good-quality data, they were more likely to be instrumental in making the links between different aspects of the business and clinical quality, and in specifying the type of data they needed in order to assure the quality of clinical care.'[33]

As NHS organisations continue to grapple with the challenge of data quality over the coming years, they may need to consider how mechanising systems and processes can make their use of data more efficient and intelligent, and assurance may be a good place to start. As one interviewee put it:

'the more you have one version of the truth that everyone has confidence in, people are freed up to tackle performance problems rather than re-working the data'.

Another interviewee stated that improving performance is not always about doing things differently, but sometimes about having a better understanding about what is currently going on. With this in mind, ensuring that data is in real time and accurate is an important detail to have in place.

To ensure that data is being used intelligently in this way, it will be beneficial to implement mechanised assurance systems in order to improve the use of data, and ensure that it is higher quality, up to date and accurate. This can help improve board awareness of the organisation's performance and lead to better, evidence-based decision making. An NHS organisation that has been doing this well to support improvements is the University Hospitals of Morecambe Bay NHS Foundation Trust.

7.6 Case study: University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust operates across South Cumbria and North Lancashire, serving a population of around 365,000. The Trust operates from three main sites: Furness General Hospital in Barrow-in-Furness, Royal Lancaster Infirmary in Lancaster and Westmoreland General Hospital Kendal, with a total of 933 beds.

In recent years the Trust has been on a significant improvement journey, having been placed in special measures in 2014. In its most recent Care Quality Commission (CQC) inspection in 2016, the Trust was rated as 'good', with the Chief Inspector of Hospitals Professor Sir Mike Richards describing the Trust's progress as a 'truly remarkable turnaround'.[34] It was in the period of the Trust's improvement journey that the decision was taken to begin to mechanise assurance. It had been identified within the Trust that improved data collection, business intelligence and analysis was required. Historically a Trust-wide approach to data had been in place, rather than a site-based approach. The Trust is based across five main sites with relatively large geographical distances between them which led to variations and cultural differences between the sites, and it was accepted that had there been a more sophisticated way of analysing data this may have helped to avoid some of the failings that had taken place. Indeed, the CQC report published in June 2014 found that *'patient safety information was not accurately maintained on the wards and departments; this resulted in unreliable local performance data and metrics. Consequently assurances taken from this information may not have been robust.'*[35]

In the years since this CQC report, the Trust has been working to make its data and assurance systems more sophisticated, automating as much as possible in order to identify and manage 'hotspots' more effectively. This has included implementing mechanised assurance, with the aim of being able to analyse trends and track trajectories to identify deviation from expected outcomes and take corrective action before patient outcomes deteriorate. Implementation has been supported by staff engagement and ensuring that new processes are clinically led.

The change in process is delivering achievements for the organisation, facilitating its focus on having 'one source of truth', and the delivery of the CQC's action to ensure data was accurate. We were told that now the Trust is able to efficiently analyse data it therefore has a better sense of 'dark spots' and can see the risk profile 'nearly instantaneously.' It is also easier to get a rich picture of, for example, complaints, and if trends are arising, to get information more quickly and deploy resource or take corrective measures.

These achievements are perhaps enabled in part by the ownership of the change in processes throughout the organisation. Reports and dashboards are monitored at divisional meetings, at corporate level, and at sub-board and board meetings.

'It works at all levels and has relevance to everybody… it can't be one [level] more than the other'.

8. The importance of culture and behaviours

8.1 The dynamics behind effective assurance

Despite the value that mechanising assurance can bring with regard to making the assurance process more efficient and up to date, and strengthening accountabilities; a mechanised process alone is unlikely to lead to significant improvements in performance and quality. While mechanisation could bring benefits, there is still the risk that mechanising assurance could be overly focused on being simply a performance recording tool, used to reinforce a culture of box-ticking and defending the organisation from regulators and other commentators.

In a successful NHS organisation, any process of governance must be underpinned by appropriate behaviours and a culture of quality improvement at all levels of the organisation. As one interviewee said, 'any process can be of all value or no value at all, because of behaviours.' Assurance is no different, and the board must ensure that it is proactive in instilling a culture of high quality, sustainable care, as well as having mechanisms in place for continuous improvement.[36] A mechanised assurance system could arguably facilitate this provided it is used in a manner that is conducive to this. In the words of one interviewee:

'Mechanisation can be very valuable in supporting people to implement the assurance system but only if they fully understand the system, how it works, and how it adds value… it needs to support the way an organisation operates, rather than imposing a way of operation, and needs to be underpinned by the people using it.'

Another interviewee had similar views:

'The behaviours needed for effective assurance are multi-faceted…the people using the system, its accessibility and how simple it is to use, levels of engagement and confidence in its outputs… is it additional to the day job or helpful to the day job?'

This suggests that while mechanising assurance may be helpful in facilitating the ward to board link in assurance, ensuring that staff are fully engaged in the use of the system and how it may help to improve quality is critical.

In the case study below, we explore how The Christie NHS Foundation Trust has been fusing together an existing culture of quality improvement and staff pride with a mechanised assurance system, in order to bring about further improvements.

8.2 Case study: The Christie NHS Foundation Trust

The Christie NHS Foundation Trust is a 188 bed comprehensive cancer centre in Manchester, serving a population of 3.2 million people across Greater Manchester and Cheshire, with 26% of patients being referred from across the UK. With a strong focus on research as well as cancer care, The Christie has one of the largest clinical trial portfolios and is part of Manchester Cancer Research Centre, working in partnership with the University of Manchester and Cancer Research UK, as well as being one of seven partners in the Manchester Academic Health Science Centre.[37] The Christie is widely considered as one of the leading cancer centres in Europe, and in its most recent CQC inspection in 2016, was awarded the rating of 'outstanding'.

The Christie made the decision to implement a mechanised assurance system in order to have one repository, a 'go-to place', of data and evidence, as well as evidence frameworks and key lines of enquiry. The main focus was on using the system to undertake self-assessment, both of corporate and clinical services, in order to prepare for the upcoming inspection. The tool helped staff to focus on what they needed to know and what they would be able to demonstrate as evidence, and helped to get the message out quickly about what the 'key lines of enquiry' expectations entailed.

The process has a significant impact on the clinical audit and improvement programme, in which the system became well-embedded and improved compliance dramatically, in a short space of time. Prior to the introduction of the system, it was described that 'people didn't know what they didn't know', but the use of a more streamlined system allowed for an easier identification of priorities and risks, and helped focus on pockets not doing as much audit in order to spread resource more effectively. This not only took some anxiety out of the inspection process, but the improvement in quality has continued in the time since the inspection. Awareness of clinical audit and improvement has increased through the use of the tool, with increased oversight and engagement at all levels, and audits are now seen as an important resource. The system has become embedded in the clinical audit and improvement programme, with it being described that it 'brought out a sense of competition' in staff to demonstrate their good work. The clinical audit report is taken to Board, which facilitates good discussions and has enabled the board to see the full extent of the clinical audit and improvement programme, facilitating the 'ward to board' link.

We were told that a key element to the success of The Christie's implementation of the mechanised assurance system was the existing positive, supportive culture of the organisation. This was something noted in the CQC report, which described that 'all the staff we spoke with were proud, highly motivated and spoke positively about the care they delivered… a friendly and open culture.'[38] Therefore, the implementation of the system was viewed positively, and owned locally, as staff were keen to demonstrate their evidence and show their success.

'… it becomes everybody's business.'

9. The future of assurance in system working

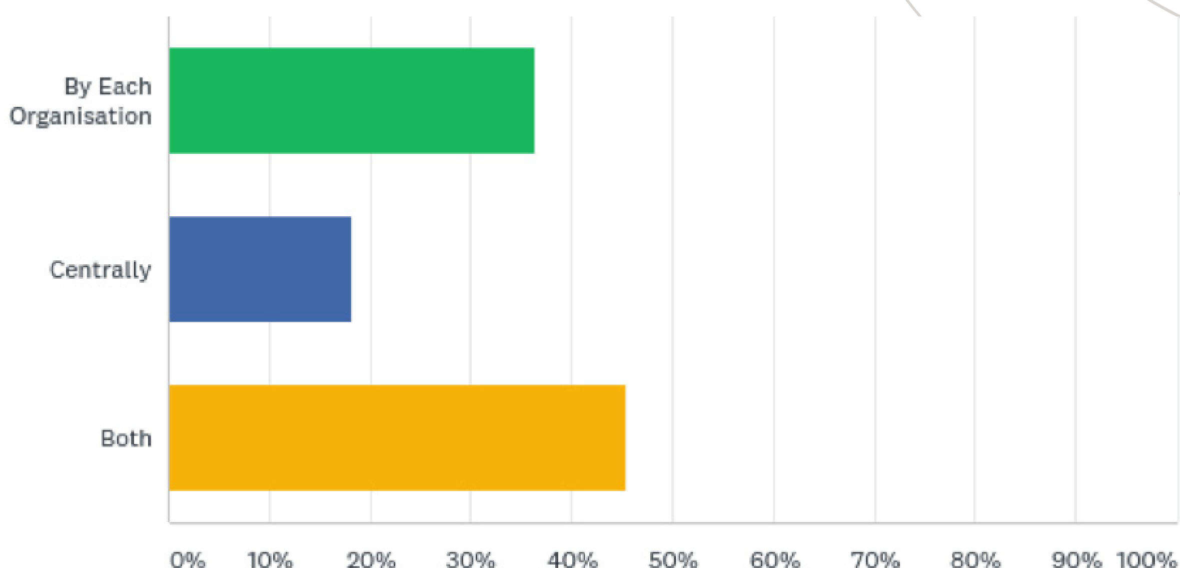
As STPs progress in development, with some integrating further into Integrated Care Systems,[39] the question of implementing assurance across systems will need to be thoroughly considered in order to ensure collaboration is underpinned by strong and effective governance. Interviewees from the NHS had mixed feelings about how far the complex nature of STPs will act as a barrier in introducing system wide assurance. One, for example, told us, *'I believe assurance will be more complex, as STPs do not have a formal or legislated structure and clearly defined data governance.'* Another said, however, that *'[it should not be too complex], if everyone works towards the same goal for patients and staff with objectivity, not letting their [own] services influence the best outcome.'* Whilst existing organisational self-interest is a barrier that will need to be overcome, this will require careful change management and a willingness to collaborate with and trust other partner organisations, as part of the wider STP development. Furthermore, the recently defined footprints will still have cultural, professional and extended geographical boundaries to manage.

The lack of guidance and the peculiarities of the historical development of the NHS means that there has been a tendency towards silos of activity rather than integration. Integration requires joined up thinking as well as practice and there has always been a tendency to separate quality of services and resources (money, staff, and assets). Several reviews have commented on the difficulties in bringing together service quality at organisational boundaries. Meanwhile, public services cannot allow others to compromise their obligations and performance. The moral imperative is to secure better joined up service delivery to achieve improved outcomes. This should be a joint effort between organisations (especially considering the lack of formal reorganisation). It is worth noting that the old business excellence model (EFQM) described partners as a resource and not as a relationship. Partner organisations must be explicit in their expectations of those they work with and follow up when agreed performance is slow or outcomes lacking, but this still needs sensitivity and respect.[40]

Our interviewees had various suggestions on how to facilitate the collaboration across systems to aid assurance. One thought it may be helpful to begin shared assurance by starting with something that has significance for all partners, and shared accountabilities, for example the movement of patients from the hospital, to the community, to their own home, or winter issues. This would help getting a process of shared assurance in motion. Another said that it is helpful, before doing anything, to set out shared objectives and principles and formalise these in some way' – *'I don't see how you operate without knowing that'.*

Structurally, a key theme to explore will be how to bring together the different assurance systems that different organisations use effectively, and how to triangulate them to ensure added value. In a survey of NHS directors, respondents were asked whether they believe assurance should be delivered by each organisation or centrally controlled within the system:

Q: In STPs, do you believe assurance should be delivered by each organisation or centrally controlled?



This variability of responses suggests that there is a need for more central guidance on creating effective assurance in STPs. It seems that most likely there will be a requirement for both; In the words of one respondent, 'whilst wanting to achieve at STP level, individual organisations still need to undertake their own assurance'. Particularly in the STP stage of integration, where organisations retain a fairly significant degree of autonomy, individual assurance will remain necessary. In addition, as one interviewee pointed out, there is a potential that NHS directors become distracted by the STP process and take their eye off the ball of everyday service delivery, and ensuring the right systems and processes are in place internally could help mitigate this risk. However, in a world of shared risk arrangements, organisations will also need to be aware of, and be assured on, what is going on elsewhere in the system. Furthermore, a shared assurance system may provide an opportunity to focus less on regulatory demands and more on patient outcomes, improved health of the local economy and quality improvement at all levels of the system. It has previously been noted that STPs could provide an opportunity to review the benefits of different systems and work to deliver place-based quality assurance, central to which is wider footprint benchmarking and sharing of learning.[41]

Multi agency working brings new expectations of NHS organisations (and their partners), and a significant aspect of integration will be the introduction of population health management. Population health management aims to optimise the health of populations over individual life span and and across generations.[42] It is the nexus that brings together an understanding, through big data, of population need (public health), with patient engagement and healthcare delivery to embrace the triple aim of better care and patient experience, improved outcomes, and lower cost (and in the NHS context, the reduction of health inequalities.[43] Boards of individual organisations and wider systems face a key opportunity, through population health management, to address current issues and move towards greater collaboration between sectors.[44] This will create complex governance and decision making challenges and assurance systems will need to be robust, supported by behaviours and relationships, as organisations will share accountabilities for their populations. The use of data will be a crucial component of population health management, and it may be that an automated assurance process is the most efficient and reliable way of ensuring that this data is being used in a valuable and ethical manner.

Some areas of the country that are further ahead with the integration and devolution agenda are already making progress with this, for example, Greater Manchester Health and Care Partnership. This system has created a new model, which acknowledges the 'need to construct a new assurance framework to recognise the devolved powers to the Partnership team and which takes account of the broader place-based beyond the NHS.'[45] The vision for assurance is that Greater Manchester is 'assured, regulated, and performance managed as a PLACE.' This means that:

- Greater Manchester is responsible for its own performance
- Principle accountability sits locally, not nationally
- Collective responsibility is accepted for the performance of the system as whole
- Greater Manchester infrastructure should develop and provide appropriate tools and support[46]

The principles behind the process are as follows:

- Subsidiarity
- Open, honest, transparent and comparable
- A problem or issue anywhere in our system is everyone's problem
- Peer challenge, review and support
- Manage the Greater Manchester and locality reputation
- Identify and manage risk
- Objective and measurable
- Approach to be able to be modified to situation, from support and constructive criticism through to intervention
- Ensure political, clinical and managerial leadership across the programmes
- Facilitate good practice learning and network development[47]

This work will be underpinned by governance arrangements and a Memorandum of Understanding, changing the way partners are working together, for example 'supporting greater insights into system delivery by sharing intelligence and developing reports which better illustrate root causes of poor performance.' Ownership of the assurance framework lies with the Partnership's Performance and Delivery Board.[48]

That said, shared assurance will rely on an improvement on the quality of data and how information and technology are being used, not only in acute hospitals but also, as one interviewee pointed out, in out of hospital settings where progress may be lagging behind that of the bigger, and often more advanced, acute organisations. To manage this, it was suggested that there needs to be agreement about what we need to measure (from a clinical rather than managerial perspective), and a push to provide real time data to populate an assurance framework that is relevant to all providers. This interviewee emphasised that 'even where the data exists, sharing it is a problem', particularly in their footprint, a rural area with large geographical distances to negotiate.

GGI suggests that moving forwards, mechanising assurance between and within organisations could be helpful in navigating these challenges by allowing the sharing of data more quickly and easily. By automating this process as much as possible, this could help deliver efficiencies in the use of data, whilst also creating simpler communication channels between different organisations, thus streamlining the whole process of system assurance. Meanwhile, at a national level, further guidance will be needed on data governance, particularly at a system level, and public and patient engagement will be necessary to gain confidence in the sharing of patient data.

GGI's Maturity Matrix for system working can be found in Appendix I, exploring a wider range of governance issues pertinent to STPs in England, Integration Joint Boards (IJBs) in Scotland, and Public Service Boards (PSBs) in Wales.

10. Conclusions

10.1 How mechanised assurance can deliver quality and performance improvement

Negotiating the current challenges that the NHS is facing, as well as providing assurance in system working, will require a more robust approach to healthcare assurance. An assurance system that all levels of the organisation have confidence will leave the board more time to focus on strategic issues, while giving managers and clinicians less time 'feeding the beast' and more freedom to focus on ensuring high quality care is being delivered. Areas of poor performance can be highlighted more easily and the problem fixed quicker. Moving forward, the NHS will need to ensure it uses the abundant amount of data it collects on a daily basis more robustly and efficiently. This will further support staff to improve performance instead of needing to rework the data. Mechanising the process would also facilitate ward to board assurance, engaging staff in performance and giving the board a greater comfort in what is going on, allowing them to better fulfil their role as a strategic rather than operational body.

Challenges do still exist to be negotiated, particularly in an environment of increasing collaboration between providers, as several different models will be brought together and will somehow need to be triangulated overcoming problems of definition, completeness and integrity.

Finally, it is particularly important that when implementing any mechanised assurance system, this is underpinned by the right dynamics, for example a culture that is forward looking and revolves around quality improvement. Not only will this likely make any change in established processes more easily managed, it will ensure that maximum value is reaped from the use of a mechanised system to actually make a difference in performance.

10.2 Recommendations for the Secretary of State for Health and Social Care

Every ten years, the Secretary of State of Health and Social Care faces the requirement to renew the NHS Constitution, with the involvement of the public, patients and staff. The Constitution is accompanied by the Handbook to the NHS Constitution, which is renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are designed to ensure that should any government seek to alter the principles or values of the NHS or the contents of the Constitution, there will be the obligation to engage with a full and transparent debate with the public, patients, and staff.[49]

In 2018, the Handbook to the NHS Constitution will be renewed, and GGI would encourage this process to consider how to make assurance more simple, as well as more conducive to improving quality and performance. Below, we have compiled recommendations for providers and regulators which have emerged as we developed this report. We have included some recommendations for GGI and Allocate too.

Providers

NHS organisations delivering healthcare services and providing assurance need to:

- Challenge whether their existing systems of assurance are comprehensive, value for money and meet internal operational and scrutiny requirements as well as external compliance
- Question whether the system is sufficiently mechanised to be future proof, both internally and in support of current and future partner and funder requirements
- Have a view of the quality, completeness and value of information presented to it
- Challenge whether their existing systems of assurance allow for the most effective use and analysis of data that supports decision making for quality improvement
- Create a common understanding and terminology that is shared at all levels of the organisation, around the value of effective assurance systems
- Consider how to ensure that quality assurance is a fundamental part of quality management and quality improvement
- Proactively engage the workforce in quality and performance improvement strategies and ensure this is linked to the assurance process
- Appoint a Chief Clinical Information Officer to provide an interface between clinical areas and technological and data innovation
- Consider how to ensure that assurance is ward to board and beyond, with the public looking to boards for assurance about the performance of their local health services

- Have open and honest conversations on where it is appropriate to have risk
- Be open and collaborative in the sharing of data across organisations to support shared assurance
- Challenge the regulators to reduce the burden of data collection and streamline the amount of data requested

Regulators

Those responsible for inspecting and monitoring NHS organisations, and arm's length bodies helping to set the national policy context, need to:

- Simplify the number of regulators and complexity of the regulatory process
- Streamline the process of inspections and data collection, as well as considering what data is useful to be collected and how this burden can be reduced
- Provide simplification on definitions of assurance and the assurance process, particularly as the NHS and partners in other sectors move towards system working
- Provide clarification on the existing organisational and legislative uncertainty
- Work to get leadership right at a national, central level, while allowing a degree of local autonomy and innovation
- Issue central guidance reasserting the principles of assurance and clarifying accountabilities for collaborative multi-agency working
- Find a way to fairly regulate both individual organsiations and the systems in which they sit
- Ensure regulatory clarity around data sharing and data sets

GGI

As a national resource, GGI should:

- Through GGI's knowledge management programme and ongoing work with boards, continue to play a part in educating the market about the value of assurance and ensuring it is effective
- Support providers and regulators to ensure that assurance systems effectively support and govern the use of AI, and that the right questions are being asked of new technologies
- Help to guide NHS boards through the complex path of balancing current statutory requirements around organisational thinking and assurance with the development of whole-systems assurance solutions
- Develop governance tools to support effective assurance in individual organisations and across systems

Allocate

As an organisation supporting the NHS to create effective assurance process, Allocate should:

- Work with providers and regulators to ensure data is collected, displayed, and used in a way that accurately describes how organisations are performing and supports effective decision making and quality improvement
- Consider how mechanised processes can support effective shared assurance arrangements in STPs
- Support providers to effectively interlink assurance and workforce issues for improved quality and engagement

Appendix I: Maturity Matrix for Sustainability and Transformation Partnerships (STPs-England), Integrated Joint Boards (IJBs-Scotland), and Public Services Boards (PSBs-Wales)

Good Governance Institute

Maturity Matrix for Sustainability and Transformation Partnerships (STPs-England), Integration Joint Boards (IJBs-Scotland) and Public Service Boards (PSBs-Wales)

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

VERSION 2.1

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

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

VERSION 2.1

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

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Appendix II: Case studies: full versions

The Royal Wolverhampton NHS Trust

The Royal Wolverhampton NHS Trust is one of the largest providers of acute and community services in the West Midlands. The Trust has more than 800 beds on its New Cross site, including intensive care beds and neonatal intensive care cots. In addition to the New Cross site, the Trust also provides services from West Park Hospital, which delivers rehabilitation inpatient and day care services, therapy services and outpatient services. The Trust has also taken over Cannock Chase Hospital from Mid Staffordshire NHS Foundation Trust, when the latter trust ceased to provide healthcare services. Cannock Chase Hospital provides general surgery, orthopaedics, breast surgery, urology, dermatology, and medical day case investigations and treatments. The Trust employs more than 8000 staff, making it the second largest employer in Wolverhampton, and is currently hosting the West Midlands Local Clinical Research Network. The Trust has also implemented vertical integration with a number of GP Practices in order to redesign services from initial patient contact through on-going management and end of life care.[50, 51, 52]

The Trust first implemented a mechanised assurance system in 2012, and in the early stages was using the system only for self-assessment, and therefore the use of the system was relatively 'centralised' to the Compliance team. However, in March 2013, the Trust undertook a review of its assurance processes during March 2013. This review identified that 'the reporting and flow of information relating to quality performance was dis-jointed and not clearly mapped to the governance / assurance structure' and that 'quality information presented to committees needed to be reviewed and revised to ensure the right level of detail and information is being received by the right committee.'

It was also identified during this review that, at that time, 'the Board reviewed a more detailed quality dashboard than the sub-committees. The expectation is that the sub-committees would review more detail than the Board or review the same reports in a more detailed manner to reduce the amount of time the Board spends analysing information.' The review recommended that the Trust Board dashboard should be supported by a pyramid of more granular data in similar format dashboards aligned from ward to board which are discussed at sub-committees, as well as at divisional, directorate and ward level. In addition, the flow of quality information should be aligned to good practice within the NHS Operating Framework and National Quality Board guidance.

During this period, the Compliance team were also considering how to implement a sustainable system for monitoring of indicators with regard to the NHS Litigation Authority (NHSLA) standards. It was felt that as an organisation there was a need to ensure both organisational memory and sustainability of the processes and reporting implemented for monitoring practice against policy and to identify how this could be linked to monitoring to the CQC outcomes. This would facilitate the use of data in a smart and effective way, providing data that could easily be reviewed, analysed and acted upon. The Trust also wanted to move away from the first line of assurance and move towards a process that would support the second line of assurance, through cross referencing and reviewing different indicators provided from different data. It was hoped that this would then more easily allow data to be provided in a way that would mean challenge or confirmation of assurance could be identified.

The decision was therefore made to roll out the mechanised system more broadly, in a workstream led by the Compliance Manager and Quality Assurance Lead. This was managed via the Quality Information Project Group (QIPG) that involved stakeholders from across the Trust in order to review the flows of information/data. The broad objectives of the project were:

- To ensure ward to board information is robust
- To enable reports/data to be aligned with the Trust committee structure
- To map and agree internally produced indicators
- To develop a mechanism for 'early warning' including tolerance levels
- To have a central system which receives all the agreed quality and safety indicator feeds.
- To relieve some of the time burden from the clinical teams in terms of collating/reporting of the data.

The project objectives were all supported by a relevant phases and activity plan in order to achieve them.

Part of the success of the implementation of the mechanised system lies with the efforts to ensure buy-in from all levels of the organisation. At staff level, initially there was a lot of scepticism around the system, as there had been limited engagement from clinical end users with previous use of the system and it felt 'clunky'. However, the approach and vision put forward through the Quality Information Project

Group was signed up to by all levels of the organisation, particularly given the recommendations of the review from 2013. The initial metrics focused on were the nurse-led ward performance metrics which had historically been captured and reported through 'bulky' spreadsheets by the wards/sisters and matrons. The mechanised system therefore reviewed and captured these indicators, which relieved the clinical areas of the task, and also meant that they could receive the reports on a monthly basis automatically and were ready to 'act' on the data and outcomes. This also freed up a large portion of administrative time the nurses were expected to undertake. The Trust now receives feedback at staff level that the system works much better for them, while at Board level, the clinical directors and non-executive directors all support the use of the system.

The Trust now uses the mechanised system to provide assurance on nursing key performance indicators (KPIs), alerts from the National Institute for Health and Care Excellence (NICE) and the Central Alerting System (CAS), national guidance, CQC standards, and internal reviews. This is implemented comprehensively and provide reporting from ward to board. It is also beginning to be used in non-clinical areas, for example, with the Estates and Facilities directorate starting to utilise the system for managing compliance, for example on waste audits. We were told that a significant benefit of mechanising assurance is that it brings the ability to align any one of the metrics to any one of the standards or compliance areas that is supports, which allows the Trust to use data in a much smarter way, avoiding challenges relating to duplication or data quality.

However, to ensure the system adds value, we were told that is necessary that those using the system have a real understanding of the data and what will add assurance value, as well as an understanding of the quality of the data being collected, as well as what the data is telling us, both in isolation and when looking at the wider picture. Furthermore, there were challenges to negotiate in the implementation of the assurance system. These included:

- A need to standardise the approach to identification and agreement a metric or indicator, as well as data quality. Therefore, the Trust developed a one page 12 question form for each indicator that has to be completed and approved for the organisational 'data manual' which provides an organisational memory as to what/when/why an indicator is in place. The process for management of the indicator also includes a process for 'retiring' a metric and why, the historic data remains available within the 'archive' ready to be re-established if the need arises.
- Data provision and reporting: The Trust identified a number of departments that needed to take steps to improve information flow and so the workstream leads met with each of those departments or specialist leads to review what they were currently reporting, and to who, and then mapped the flow of the data they were currently investing in and helped them to identify the gaps in reporting level. They considered how that information could be utilised with other data to provide more of an overview in terms of assurance as well as creating a 'picture' of quality, if managed differently
- Accountability: The Trust identified that there had to be a clear accountability framework published alongside ward performance indicators to provide clarity to all levels of the organisation as to what their responsibility is when receiving reports and acting on the results
- Change Management: Unsurprisingly, there was some resistance in changing the status quo. This required a much more facilitative approach in engagement using a trial process to demonstrate the benefits before rolling out for their area and demonstrating the benefits of collecting the data once and using numerous times (COUNT) methodology. In addition, the Trust found that when challenging the measures being reported against the 12 standardised questions this really made those colleagues think and review what was being reported and why, leading to greater engagement and clearer indicators.
- Reporting: As the data can be used at many different ways and across different levels, the Trust worked with stakeholders across the trust to establish the type of reports that would be useful and add value, as well as supporting quality and improvement
- Ownership of data: The Trust sometimes faced an attitude that the system was the responsibility of the governance team, however have tackled this by making sure that there is clarity around who is the 'data provider', therefore if there are any challenges to the data from the clinical areas they are clear on who they need to speak to and clarify with. This is also supported by making those areas 'data providers' that can upload to the system directly for the purposes of reporting ensuring they retain 'ownership' of that data

Now that the mechanised system has been in place for several years and has become part of the 'status quo', the Trust have found that the system has helped make achievements in the organisation. These includes an improvement in data quality as, because reports are now scheduled and circulated automatically and there is a clear accountability framework which is supported by the system, wards are much more proactive in terms of the quality of the data being reported and captured. There has also been an improvement in the 'measures' being reviewed:

'The system has essentially supported the improvement and development of metrics and bought real clarity to what is being measured and why. This means that the data can be used in a more intelligent way really helping those receiving the data to be able to question the differences and variations and establish a reason for these'.

Finally, the mechanised system brings in useful trend reporting at various levels across the Trust again to identify any variance and differences against alongside levels of staffing and patient experience. This means that the data can be used as one layer of intelligence rather than stand alone and helps to bring focus to areas that require improvement and in some cases helps to identify the potential reason for the variances.

Ultimately, the Trust believes that mechanising assurance has enabled them to ensure that assurance is progressive, not just retrospective:

'What this system does is flag to all levels with accountability for either one or many metrics where there is a potential cause for concern or conversely identified those areas that are doing something really well, enabling cross ward discussions.'

The system provides organisational memory in terms of performance, as well as helping the organisation to challenge where the variations can be identified and identifying where improvements can be made.

With thanks to Sue Hickman, Compliance Manager and Deputy Head of Assurance at the Royal Wolverhampton NHS Trust.

University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust serves a population of around 365,000 across South Cumbria and North Lancashire. The Trust operates from three main hospital sites: Furness General Hospital in Barrow, Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal. In addition, it provides outpatient services at Queen Victoria Hospital in Morecambe, Ulverston Community Health Centre, and in a range of community facilities. The Trust has a total of 933 beds spread across the following core services:

- 382 Medical beds
- 347 Surgical beds
- 102 Children's beds
- 87 Maternity beds
- 15 Critical Care beds

The trust employs more than 5,000 staff and has a total income of £324 million.[53, 54] In recent years the Trust has been on a significant improvement journey, having been placed in special measures in 2014. In its most recent Care Quality Commission (CQC) inspection in 2016, the Trust was rated as 'good', with the Chief Inspector of Hospitals Professor Sir Mike Richards describing the Trust's progress as a 'truly remarkable turnaround'.[55]

It was in the period of the Trust's improvement journey that the decision was taken to begin to mechanise assurance. It had been identified within the Trust that improved data collection, business intelligence and analysis was required. Historically a Trust-wide approach had been undertaken, rather than a site-based approach basis. The Trust is based across five main sites with relatively large geographical distances between them, this did lead to variations and cultural differences between the sites, and it was accepted that had there been a more sophisticated way of analysing data this may have helped to avoid some of the failings that had taken place. Indeed, the CQC report published in June 2014 found that *'patient safety information was not accurately maintained on the wards and departments; this resulted in unreliable local performance data and metrics. Consequently assurances taken from this information may not have been robust.'*[56]

Over the past three to four years, therefore, the Trust has been working to make its data and assurance systems more sophisticated, in order to identify and manage 'hotspots' more effectively, and as part of this are now looking to automate these systems as much as possible. The Trust has therefore implemented a range of mechanised systems which work in conjunction together, including the mechanisation of assurance. This fits into a piece of work undertaken on developing a data warehouse: a place where all of the organisation's data can be held, qualified and assured, and extracted. In parallel, the business intelligence team are working on a Sherlock system, which, when it is has been fully developed, will be used to interrogate the data warehouse. Whereas the organisation has in the past relied on extracting data manually, the mechanisation of this will allow for much quicker and more sophisticated access to reports. The Trust is most interested in being able to analyse trends and track trajectories to identify deviation from expected outcomes and take corrective action before patient outcomes deteriorate.

The approach the Trust is working towards is that mechanised systems will be implemented comprehensively across the Trust and that each division should be sighted on their operational performance and managing any risks arising from this, for example related to workforce, patient experience, patient safety, and finance. With a range of commissioner requirements to report on in addition to regulatory requirements, the mechanised system allows for reporting of this range of requirements. At executive level, the system allows for aggregation and oversight of any problem areas. At board level, the data is also aggregated and reported.

In order to implement the system successfully, the Trust has made sure to put effort into staff engagement to show staff that the Executive is working with them, and to ensure that the system works for staff, not the other way round, freeing up manpower and allowing staff to use their time more efficiently. We were told that an important factor in ensuring the mechanisation was implemented successfully was making sure the Trust was getting the right people on board to work with the systems, as in the past there had been lots of different people asking for and using different information, but no co-ordination. The new processes are clinically led and are therefore integrating this and providing more streamlined data and assurance.

Changing the processes involved in data and assurance did have its challenges, including making sure that the system has been designed to fit the majority of staff's requirements, for example that the data is being understood by everyone and that there is therefore 'one version of the truth'. In addition, as there is a lot of work going on throughout the organisation to improve the use of information technology, such as electronic patient records, there are competing priorities and it can be difficult to devote the amount of development time needed for the significant work to deliver efficiencies.

However, the workstreams of mechanising and automating assurance are clearly bringing achievements for the organisation, facilitating its focus on having 'one source of truth', and the delivery of the CQC's action to ensure data was accurate. We were told that now the Trust is able to efficiently analyse data it therefore has a better sense of 'dark spots' and can see the risk profile 'nearly instantaneously.' It is also easier to get a rich picture of, for example, complaints, and if trends are arising, to get information more quickly and deploy resource or take corrective measures.

These achievements are perhaps enabled in part by the ownership of the change in processes throughout the organisation. Reports and dashboards are monitored at divisional meetings, at corporate level, and at sub-board and board meetings.

'it works at all levels and has relevance to everybody… it can't be one [level] more than the other'

As the Trust is still extracting some data manually, we were told that the work is still in progress. However, as the Trust continues to progress, it is making the investment to get as much of the process automated as possible, to create even further efficiencies and improvements.

With thanks to Mary Aubrey, Director of Governance and Paul Jones, Board Secretary, at University Hospitals of Morecambe Bay NHS Foundation Trust.

The Christie NHS Foundation Trust

The Christie NHS Foundation Trust is a 188 bed comprehensive cancer centre in Manchester, serving a population of 3.2million people across Greater Manchester and Cheshire, with 26% of patients being referred from across the UK. With a strong focus on research as well as cancer care, The Christie has one of the largest clinical trial portfolios and is part of Manchester Cancer Research Centre, working in partnership with the University of Manchester and Cancer Research UK, as well as being one of seven partners in the Manchester Academic Health Science Centre.[57] The Christie is widely considered as one of the leading cancer centres in Europe, and in its most recent CQC inspection in 2016, was awarded the rating of 'outstanding'.

It was in the run up to this CQC inspection that The Christie made the decision to implement a mechanised assurance system, in order to have one repository, a 'go-to place', of data and evidence, as well as evidence frameworks and key lines of enquiry, although the trust did continue to use existing assurance systems alongside, for example the accountable committee structure. Therefore, the main focus was on using the system to undertake self-assessment, both of corporate and clinical services, in order to prepare for the upcoming inspection. The tool helped staff to focus on what they needed to know and what they would be able to demonstrate as evidence, and helped to get the message out quickly about what the 'key lines of enquiry' expectations entailed.

One of the most significant ways that The Christie's use of a mechanised assurance system has had impact on was the clinical audit and improvement programme, in which the system became well-embedded and improved compliance dramatically, in a short space of time. Prior to the introduction of the system, it was described that 'people didn't know what they didn't know', but the use of a more streamlined system allowed for an easier identification of priorities and risks, and helped focus on pockets not doing as much audit in order to spread resource more effectively. This not only took some anxiety out of the inspection process, but the improvement in quality has continued in the time since the inspection. Awareness of clinical audit and improvement has increased through the use of the tool, with increased oversight and engagement at all levels, and audits are now seen as an important resource. The system has become embedded in the clinical audit and improvement programme, with it being described that it 'brought out a sense of competition' in staff to demonstrate their good work. The clinical audit report is taken to Board, which facilitates good discussions and has enabled the board to see the full extent of the clinical audit and improvement programme, facilitating the 'ward to board' link.

We were told that a key element to the success of The Christie's implementation of the mechanised assurance system was the existing positive, supportive culture of the organisation. This was something noted in the CQC report, which described that 'all the staff we spoke with were proud, highly motivated and spoke positively about the care they delivered… a friendly and open culture.'[58] Therefore, the implementation of the system was viewed positively, and owned locally, as staff were keen to demonstrate their evidence and show their success. This supportive culture is further evidenced by the fact if one area of the organisation is falling behind in any way, other areas help them, and the mechanised assurance system is able to facilitate this. Everything is all in one place, making it less unwieldy than other assurance systems and easier to link evidence, allowing for a leaner assurance process.

'… it becomes everybody's business'

That said, as a smaller, specialist, organisation, The Christie is always changing and improving, often adding new services, which can lead to some challenges in mechanising assurance as the set up of the system, designed for a larger general acute hospital, does not always mirror the organisation's structure. This has led the team at The Christie to try and 'find the best fit', which sometimes feels counterintuitive. To negotiate this, as described above, the system is used alongside other systems so that the difference systems are balanced and one particular system is not relied on too much.

Overall, however, the system has had a long term impact, most particularly for the clinicians, who have a key role to play in delivering performance. Perhaps significant in the the success of implementing and embedding the system is the ethos around which the system is used – not as a performance management tool, but as a tool to facilitate success and improvement.

With thanks to Jackie Bird, Chief Nurse & Director of Quality, and Julie Gray, Assistant Director of Nursing and Quality, at The Christie NHS Foundation Trust.

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