A NEW VIEW

Good governance in a clinically led organisation

I consider myself to have been fortunate to have worked with the same clinical commissioning group (NHS Northumberland CCG) for over three years.

During this time the majority of the key individuals remained the same and its member practices and geographical alignment were unaltered. As I move on to pastures new I've reflected on the 40 months in Northumberland and have some observations about good governance within clinically led organisations such as CCGs.

It might help to firstly give a bit of background on Northumberland CCG. The CCG has always been clinically led. It has a GP as accountable officer and the executive board has 70% of its members from primary medical care (60% currently GPs in 2014). The Governing Body is not a decision making body; it is there to give assurance to the CCG (the GP practice members) on the work of the executive. It is in the executive board that decisions are made (guided and informed by the views of the members).

So, to my reflections on good governance in CCGs:

1) The word governance without the word clinical in front is like the kiss of death.

   There, I've said it. Remember where CCGs have come from. Built on the rhetoric of "Liberating the NHS" and the negative messaging about NHS bureaucrats, and subsequent manager bashing in the media. GPs started GP consortia and then CCGs in the understandable belief that they could run organisations without any bureaucracy, and governance was seen to sum up the term.

   Let's face it, for the majority of the NHS workforce, including the non-clinical workforce, the mention of risk registers, policies, assurance etc. is like mentioning the plague.

   However, as time passed, CCGs began to develop and the authorisation criteria emerged, it became clear that governance was going to be important. My belief is that this has caused resentment in many clinicians involved in CCGs. They wanted to be free, light organisations. However, the fact that they are statutory bodies, funded by the tax payer, under significant public and media scrutiny has meant that good governance is essential and that has meant that the supporting protocols, policies and structures have had to be developed. Fighting the battle to ensure that the systems etc. put in place are proportionate, necessary and important have been vital.

In Northumberland, I identified this as a real issue a couple of years' ago and started an 'accepting governance' journey with our primary care directors.

The first step on this journey was to make clear the consequences of governance failures. Fortunately, there are plenty of examples in the media of the consequences both personal (jail terms) and organisational (fines and negative publicity) of IG, financial probity, risk assessment failures. I've found that, whilst it's not a silver bullet, the ability to tie the consequences of not doing something in the right way back to either patient impact from fines and the subsequent inability to improve services or to personal impact helped to develop at least an acceptance of the moderate systems I put in place.

2) Members' organisations are a bit like local authorities with experts as councillors

The fact that CCG's are members' organisations has real challenges from a governance perspective:

- How do you ensure that decision making truly reflects members' views?
- How do you balance a need for confidentiality with the need to engage with members and the potential conflicts of interests that are inherent?
- How do the employment rights of employees and the constitutional rights of members work together if things don't go according to plan?

Whereas in a local authority, the councillors are often lay people without the expert knowledge, in a CCG the members are experts in their field of work and quite rightly have strong views. The members on the executive board (or in other CCG's members' councils etc.) represent the views of their colleagues and dependent on the individual will feel more or less happy to support a decision that may be unpopular with colleagues as providers (voters).

Unfortunately I haven't worked my way through this challenge yet. I suspect it will become more commonly experienced as decisions get tougher, finances get tighter and as CCG's possibly merge and get bigger.

3) Conflicts of interest are inherent – all we can do is deal with them sensibly

CCGs are a mess of potential conflicts of interest. Apart from the fact that the members are providers, they often do sessional work for/are married to/are in business with etc. other providers.

In early 2014/15 I presented an annual review of the times when there had been a conflict of interest in any one of the CCG's key meetings to the executive board. Seeing it all in one paper was daunting to say the least. However, I also included how we'd handled the conflict and often it had to be a case of accepting it, getting the vitally important insights that the primary care based directors had and finding a way to ensure that the final decision was as un-conflicted as possible.

If anything we became far more open because of the conflict of interest situation; inviting all potential providers to give their views and hopefully reaching a better outcome as a result.

4) The words risk registers and assurance frameworks are almost as strong a sleeping draught as the word ‘governance’.

No one wants to do risk registers – it’s as simple as that, but with clinicians there is a way in. I believe that good risk registers simply document what we all do every day as managers and leaders i.e.:

- We’re doing something, what could go wrong?
- What can we do to stop that happening?
- What have we done?
- Is it working and if it’s not working well enough what else can we do?

I also believe that completing a risk register helps to think through the above. Clinicians, fortunately, have been taught a useful maxim in their clinical training relating to documenting patient care - “If it’s not written down it didn’t happen”. This has been invaluable in emphasising why the ‘bureaucracy’ of risk registers is actually necessary.

I don’t for a second say that Northumberland has the exempla corporate risk register but we spent a good chunk of time as an executive thinking about the organisational risk appetite and how a commissioner of services should assess certain risks. As a result I think there is one other thing about risk assessment for managers to think about; CCGs are not providers of care and therefore the types of risks and the way they are assessed should differ.

One of the objectives of the work of the Good Governance Institute has been to:

> *Develop a consistent language to describe governance that is engaging for clinicians and the public*

I have to support this objective but would take it further and say that it has to be engaging for the 99% of managers and staff who don't eat, sleep and breathe governance too.

I'd also say that it's not just about the language, it's about the approach. In my experience, if we can keep the systems and processes light and manageable when appropriate, people find it easier to accept when you state that they're about to cross a line or that a particular process has to be more strongly controlled.

I've always told CCG colleagues that my aim is to keep our actions and decisions legal and safe and to help move things forward. If I can't robustly defend a process on those grounds then it's over the top and needs to be changed.