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Integration in a diverse health and social care system: How effective are Integration Joint Boards?

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1. Executive summary

Integration Joint Boards (IJB) were established by The Public Bodies (Joint Working) (Scotland) Act 2014, as part of a framework to integrate health and social care in Scotland. Local authorities and NHS boards jointly delegate, to IIBs, the responsibility of planning and resourcing service provision for delegated adult health and social care services. They also delegate a budget to IJBs, which decide how financial resources should be spent[1]. According to Audit Scotland, IJBs are "…responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults, in the local population."[2]

The focus of health and social care stakeholders has shifted to IJBs, given their important role in ensuring that services are well integrated and that people are receiving appropriate care in the correct location. Recognising this shift, and the need to facilitate open discussion on the effectiveness of IJBs to date, the Royal College of Physicians of Edinburgh ("the College") hosted a symposium on Friday 7 September 2018. The symposium was chaired by **Professor Michael Deighan FRCP Edin** and it consisted of a debate, a workshop session, and an expert panel of speakers[3].

Contributions from the audience were also welcomed, a selection of which are included in this paper. **Four core outcomes of the symposium were established**. These are as follows:

1. **A publication**, summarising the discussion during the symposium and bringing together the 5 core themes **(finance; staff; clinical and social governance; voice of the user and performance)** that the audience felt would most help IJBs to fulfil their duties.
2. A follow up meeting based on stakeholder feedback, exploring **IJB communication and culture**, **sustainability of membership and legal responsibilities.**
3. The College would establish **governance surgeries** on IJBs, free and accessible to health and social care stakeholders including voting and non-voting members of IJBs.
4. Develop **maturity matrix model** of good governance practice for IJBs.

[1] SPICe, August 2016, pp. 6.
[2] Audit Scotland, March 2018, pp. 1.
[3] See appendix 1 for a list of speakers.

2. Core themes

During the IJB symposium, a round table workshop session discussed "What are the 5 core areas of governance which would help you to discharge your duties?". The audience discussed this in groups, and fed their responses back to the symposium. The responses rotate around 5 the main themes noted below, which were also referred to at different points throughout the symposium by the speakers and audience. These broad themes are as follows:

Theme 1: Finance – it was recognised that there is currently a lack of clarity regarding prioritisation of funding and overspend. The group described confusion, on occasion, as to whether an IJB has failed to control expenditure, or whether insufficient resources have been delegated to the IJB by the local authority and NHS board. Greater clarity in this regard is called for.

Theme 2: Staff – varied views were expressed about the understanding of the roles and responsibilities of IJB members including whether organisational understanding of health and social care integration was uniform across all staff groups. For example, there appears to be some confusion between the roles and responsibilities of voting and non-voting board members, as well as between the roles and responsibilities of local authority board members and NHS board members. It was also recognised that staff "on the ground" require more support to deliver integration, as they are vital to this process.

Theme 3: Clinical and social governance – it was established that clinical and social governance is vital to ensuring quality, safe care. The complexity of this agenda was recognised. There was also discussion about how clinical and social governance mechanisms remain distinct and separate. It is vital for high quality safe care to have appropriate integrated assurance frameworks.

Theme 4: Voice of the user – the discussion indicated that patient and user involvement will be crucial to IJB development, as they are the people using the service, and receiving care.

Theme 5: Performance – it was established that IJB governance must be made simpler. There was concern that IJBs can lose sight of strategic goals. The role of targets was also raised, vis-à-vis how accurate they are for measuring the direction of IJBs. It was commented that pace of change is perhaps not as urgent as the understanding of integration process. A final concern was sustainability of IJB members – turnover caused by party political reshuffles and elections can upset the composition of boards, potentially affecting progress, and creating the feeling of being "back to square one". The group strongly supported IJB governance being made simpler and for leadership to focus on strategic goals.

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3. Symposium commentary

The commentary from the symposium can be **grouped into 3 core areas – governance, localism, and performance**. Financial, staff, and clinical governance are grouped under the "governance" heading.

Governance

Professor John Connell (Academic Lead, Royal College of Physicians of Edinburgh) stated that a clear understanding is needed on who is accountable for service delivery. There is a risk that the complex relationships among integration authorities, local authorities and NHS Boards might distort the clear understanding of who is accountable and this could be put to the test when there is service failure. Clear guidelines are needed in terms of defined functions and roles with clarity over areas including the function of the governing body, responsibilities of executives and non-executives, and the relationship with the public. The question was also raised about what impact the drive towards regionalisation – north, west and east - would have on IJBs. More clarity from government is required around this point.

Integrating health and social care has been an aspiration for over 10 years. Professor Connell said that the intentions of the 2014 Bill were admirable, but asked whether we have "got it right" in terms of the structures to deliver successful integration. Professor Connell believes that we should be seeking value for money but that the notion we would see significant financial saving was unlikely. He also cited the example of one Scottish region, were IJBs had different interpretations of the Act, leading to some confusion around roles and responsibilities. Furthermore, according to Professor Connell, it is unclear who makes decisions about site closures of, for example, hospitals. It is the lack of clarity around roles and responsibilities that is at the heart of the problem, according to Professor Connell. It was noted by the group that under the legislation, IJBs are statutory agencies in their own right and they are accountable to the public and the Scottish Parliament, and which can be directed by Scottish Ministers.

Other problems cited by Professor Connell were that IJBs are making decisions about service planning without having control over NHS staff, that turnover as a result of council elections can interrupt decision making, and concerns around complex regional planning and the need for this to be streamlined.

Anne O'Brien (NHS Professionals) raised the point that when clinical governance guidelines were introduced in Northern Ireland for health and social care integration, for example, the social care sector questioned what the guidelines meant for them. Some staff believed that health and social care integration simply equated to being paid by the same body and did not comprehend the relevance of the process to them. To resolve these issues, the Clinical and Social Care Governance Support Team worked with the institute for excellence to produce a practical workbook for social workers: *Board Assurance Challenges for Good Clinical and Social Care Governance* (2007). This was revised in 2013 and different organisations in England have drawn inspiration from this document. This is an example of good practice in conferring the roles and responsibilities of different components of the health and social care sector.

Cllr Tim Brett (Fife Council, Tay Bridgehead Ward) asked about the support that social care staff received on clinical governance in Northern Ireland. Anne O'Brien said that they saw clinical governance initially as being about heath and not social care. The boards themselves were responsible for both health and social care.

Eddie Fraser (East Ayrshire IJB) also highlighted staff governance as an issue. He stated that in East Ayrshire, staff standards are produced collectively and there has been intermediate care success. He advised that the health and social care partnership go out, talk about what they want to achieve in the communities, and they recruit. This point relates to staff buy in. If there is a clear direction about how health and social care integration will be delivered at community level, this can help recruit staff and reinforce an understanding of roles and responsibilities. Recruitment is done in teams for council and health staff.

Turning to experiences of governance in Manchester, **Dr Richard Preece (Manchester Health and Social Care Partnership)** highlighted Clinical Commissioning Groups (CCG) which have single strategic commissioning functions. Chief Officers are joint appointed and they oversee a pooled budget. Spending is decided on an assistance based approach. Dr Preece stated that the appropriate stakeholders "sit in the same" room and make decisions together. This joint approach helps to develop consensus and removes the possibility of a "blame culture", because nobody is excluded from decision making.

Eddie Fraser added that while governance is important, we must keep our eye on the prize. Integration authorities are set up to tackle "real challenges" such as alcohol and drug abuse, and their role is to go out and improve health and social care outcomes.

"Localism"

Geoff Huggins (Scottish Government), stated that resources should be "used for people". One of the key questions is what will work best for people in a given area. He noted that the Scottish health and social care system is very diverse – allowing for different use of hospitals, for example. There is a need to support and achieve outcomes, and clinical governance is important for ensuring safe and good quality health and social care.

Geoff Huggins also said that understanding the complexities of local systems needs people close to the system. Initiatives bringing care closer to services and the individual are required and money is there to support the outcomes.

According to Dr Richard Preece, the relationship with the voluntary sector is very important when we get to neighbourhood level. He said that the structure in Manchester looks simple in reality but in practice it can be more complex. It is important to understand the needs of the local population, and most health and social care workers understand their local population well. Dr Preece referred to the principle of subsidiarity – the concept that a central authority should perform only those tasks which cannot be performed at a more local level - and asked how much control should integration authorities exercise. In Manchester, staff are allowed to get on with the job at hand because they know their populations best in theory, but with different levels of progress.

Dispersed leadership is important, but underpinning this is the question how do we retain accountability in the system? Someone must be accountable for individual care, Dr Preece stated. Within a top down structure, Manchester Health and Social Care Partnership want an overview of the system. The people who are leading across the system are working in the system – how do we capture their views? How can we get the balance between political, clinical and managerial aspects of governance?

Performance

One of the focuses on integration authorities is whether they are performing well, and this is certainly the case with IJBs. According to Geoff Huggins, some good progress has been made on delayed discharge for example, but in other areas too. Some improvements are local, some have been across a local authority area, and some have been across an NHS health area. He indicated that there are 3 progress clusters – IJBs which have met expectations, those which are performing adequately, and those which are not doing as well.

Geoff Huggins posed the rhetorical question, "should we have done integration differently?". He went onto explain that the negotiated settlement was between three different bodies – the Scottish Government, local authorities and NHS – and that this was a complex balance. Knowing what we know now, some things may have been done differently, according to Geoff Huggins.

Regarding the legislation, Geoff Huggins explained that we are seeing diversity across Scotland, with different responsibilities and different teams. This indicates a degree of subsidiarity, which was legislated for by the negotiating partners. He indicated that we may see a greater use of subsidiarity in the future when Audit Scotland report back in November 2018 following their current audit of IJBs. This report has now been published[4]. The first Audit Scotland report on integration indicated that health and social care partnerships should step back and understand the implications and implementation of governance. Ultimately, there is a lot of work yet to be done, and much of this comes down to local relationships and ability to work effectively.

According to Geoff Huggins, the Scottish Government are reviewing the process. **Paul Gray (CEO, NHSScotland)** and COSLA have been working on what changes could be made and the Scottish Government is working on the financial aspect. The final recommendations will come to the Scottish Government for consideration. Geoff Huggins added that this is a challenging agenda, in a complex and high pressure environment, and that challenges and service to the public can be best managed by working collectively and collaboratively together. It was raised by the delegation that there should be a mutual assurance framework to straddle health and social care.

On performance, Anne O'Brien stated that in Northern Ireland, themes from quality standards were adapted into challenges for boards, and then a matrix was used to measure performance. Where are we now, Anne O'Brien asked? She said that success can be built on by having a common language to make health and social care integration real. She reflected that being able to see that different iterations in the system have stood test of time (the framework is still being used), is very encouraging, and that this was a testament to social work professionals in Northern Ireland. The sharing of case studies on quality and process improvement were also cited by Anne

[4] Audit Scotland, November 2018.

O'Brien as an useful way to promote good practice and manage knowledge, in response to a question from Brian **Whittle MSP (South Scotland region)** on good practice.

Dr Richard Preece indicated that good progress has been made in Manchester but that the process of health and social care integration in the area is still only two years old. Interestingly, IJBs are of similar age.

Professor Derek Bell (President, Royal College of Physicians of Edinburgh) added that there are opportunities going forward. IJBs are early in a journey which has many miles left to travel. There are chances to tweak the system but hardwiring and then changing the system can be disruptive. We must be data informed to make sure that we know our population and their needs. There are opportunities to share learning, best practice, and work together to develop a shared learning and problem solving approach.

The next section of this paper (pp.7) will outline further considerations.

4. Further considerations

This paper now outlines some further considerations, which are in part influenced by the group discussion, and which provide topics for further discussion and debate among Scotland's health and social care stakeholders, including integration authorities.

1. Corporate leadership and accountability

We must ensure that the purpose of IJBs is focused and reviewed often, and services must meet regional objectives and match the requirements of the local population. Appropriate integrated assurance frameworks are vital in that regard. Financial and business planning must follow strategic goals and maintain viability. Key stakeholders should be consulted to develop enduring and effective partnerships. Change must be managed effectively and robust risk management and continuity plans must be in place.

2. Safe, quality and effective care

Recognised guidelines must be followed by IJBs, and serious adverse incidents and healthcare acquired infections must be reduced and controlled. As indicated in the 5 themes on page 2 of this paper, appropriate integrated assurance frameworks are vital to quality, safe, effective care.

3. Accessible, flexible and responsible services

Staff vacancies must be well managed by IJBs, and staff must be recruited and retained in roles appropriate to their skills. Reduction of waiting times and costs must be a focus for IJBs. Patients and service users should have the flexibility to choose a range of care but care environments must be appropriate. Patients and users will be vital in informing the future development of IJB-managed services.

4. Improving and protecting health and social well-being

IJBs must play their part in improving and protecting health and social care locally. Integrated assurance frameworks are vital to achieving this.

5. Effective and informative communication

IJBs must ensure that individuals are fully involved in their progress along care pathways. It is helpful for IJBs to have access to a full and wide range of views, and IJBs must provide information on what they provide and to what standard. Information systems should be developed to ensure that health and social care professionals understand the relevance of the information that they are asked to collect. Understanding roles and responsibilities is crucial.

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Appendix 1

Speakers included:

- **Professor Derek Bell FRCP Edin**, President, Royal College of Physicians of Edinburgh
- **Geoff Huggins**, Director, Health and Social Care Integration, Scottish Government
- **Anne O'Brien**, Director of Clinical Governance and Operations, NHS Professionals
- **Professor John Connell FRCP Edin**, Academic Lead for the Royal College of Physicians of Edinburgh
- **Eddie Fraser**, Chief Officer, East Ayrshire Integration Joint Board
- **Dr Richard Preece**, Executive Lead for Quality, Greater Manchester Health and Social Care Partnership

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