Integrated Care Network

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INTEGRATED WORKING AND GOVERNANCE: A DISCUSSION PAPER

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1. Introduction

In early 2003, the Integrated Care Network (ICN) commissioned the University of Birmingham's Health Services Management Centre (HSMC) to facilitate a one-day workshop on Care Trust Governance. The workshop was commissioned in response to requests from the initial seven care trusts to examine the particular nature of care trust governance in the light of their early experience of the arrangements.

In preparation for this event, HSMC conducted telephone interviews with the chairs or chief executives of each of the then seven current existing care trusts to establish the issues that were emerging with regard to governance. This discussion paper is the product of those interviews, the workshop and further thinking and discussion with those in the field. The authors are particularly grateful to members of the ICN Steering Group who shared their thoughts on an earlier draft. The paper is designed to take consideration of the issues beyond just the care trust model in order to consider the governance of health-social care partnerships more generally. Indeed, it suggests that some of the issues that have arisen around governance in care trusts may lie in the continuing of approaches to corporate governance developed during earlier iterations of partnership in those localities.

This paper adopts the definition of governance given by Hodges *et al* (1996, p.7):

"The procedures associated with the decision-making, performance and control of organisations, with providing structures to give overall direction to the organisation and to satisfy reasonable expectations of accountability to those outside it."

The focus of this paper is thus on corporate governance, and it does not address the issues around service governance (e.g. the relationship between clinical governance and best value) that arise in health and social care partnerships. The next four sections provide some context for the examination of the practical issues around corporate governance that have come to light. Readers who wish to cut straight to that chase may wish to turn immediately to the section headed ‘The respective roles of NHS and local government representatives’.

2. Governance – why does it matter?

In recent years a series of corporate scandals (in both public and private sectors) have served to underline the importance of good governance. As Sullivan and Skelcher (2002), pp.137-138) explain:

"The corporate governance debate in the UK public sector arose from alleged and actual misconduct by members of Parliament, Ministers and those appointed to quango boards during the 1990s. In the latter case, there was considerable public disquiet about lack of transparency and the substantial ministerial patronage involved in the appointment of board members. A series of managerial, performance and financial failures was exposed, including board members not stepping aside from decisions where they had a conflict of interest, lax arrangements for claiming expenses, ineffective or poorly implemented financial management and contracting regulations and inappropriate personnel and remuneration arrangements. The Public Accounts Committee and National Audit Office issued a number of highly critical reports on these issues. Public concern about the probity of governmental bodies was a factor leading to the appointment of the Committee on Standards in Public Life (the then Nolan Committee).

The notion of corporate governance in the public sector returns us to the constituting conditions for public action. These require government that works in the wider public interest, follows proper standards of conduct, is transparent in its decision-making and is accountable to citizens."

In the private sector, too, developments such as the Enron and Transworld scandals have led to a series of official reports on the role of private sector Boards (including, for example, the Cadbury (1992), Turnbull (1999) and Higgs (2003) reports).

Against this background, the NHS Appointments Commission's guide on *Governing the NHS* (2003, pp.3-6) stresses that:

"The NHS Plan sets out a challenging agenda for modernising the NHS and improving and extending the services it provides – a scale of change unprecedented in this country in any area of service provision. This calls for exceptional leadership. Hence in [this guide] managers and Boards are encouraged to think what they themselves do as leaders to create the right context, incentives and operational environment for staff and front line teams to transform patient services.

NHS organisations are part of a more decentralised and fast-changing health and social care system. Their Boards are being called upon to manage a programme of fundamental improvement and modernisation. They are being encouraged to challenge established practice and embrace change.

This guide specifically focuses on governance because it is an essential prerequisite for all modernisation effort. It argues that each Board's prime duty is to ensure good governance. Achieving high standards of patient care depends upon it. The protection of patients, staff and the wider public depend upon it. Accountability for the proper use of unprecedented amounts of public money depends on it. And, critically, good governance arrangements ensure that front line teams have appropriate protection and space within agreed rules to learn from failures as well as successes…

The message that runs through this entire guide is that, whatever type of Board, the interests of patients are best served by a strong system of governance."

Good governance, in short, is argued to be synonymous with good organisations, good services and good outcomes for users and carers.

The responses to these scandals and subsequent guidance have not been entirely consistent between the NHS and local government. Nonetheless, the importance of effective governance – and the consequences of governance arrangements that are perceived internally or externally as flawed – is never far from the collective minds of the organisations concerned. It may be that it is this context – as much as any new challenges in themselves – that are making partnership board members – and in particular care trust board members - more sensitive to issues around their responsibilities and accountabilities.

2.1 Research on corporate boards

The research on corporate boards – the formal meetings at which corporate decisions are presumed to be made – is, at best, lukewarm about their impact. In the NHS, the performance of the boards created following the implementation of the '*Working for Patients*' (Department of Health, 1989) reforms in the 1990s became the subject of two observation-based research studies (Peck, 1995, Ferlie *et al*, 1996). Peck (1995) observed from his detailed study of one board that it appeared that this board was merely approving strategic directions established by the managers. Ferlie *et al* (1996) note from their research on eleven boards that it is '*problematic to assess the overall effectiveness of the role of the non-executives in the formulation of strategy or in monitoring and ensuring probity'* (p159). At around the same time as these studies were being conducted, Rao (1992) was interviewing 250 councillors across the UK with the aim of understanding the influences upon them. He concludes that, '*the majority of councillors showed a greater preference for dealing with individual problems…only a minority gave first priority to participating in policy making…there is a clear tension between the pressures of representation and decision-making'* (p29-30). What these studies underline is that there has always been a gap between the role prescribed by government for elected members and non-executive directors – e.g. setting and monitoring strategy – and the experience of the boards themselves.

It might be tempting to assume that formal meetings in the private sector are more effective at fulfilling their prescribed functions than those in the public sector. The research does not support this view. The investigation of the roles of private sector boards is typically based on questionnaires and interviews which elicit the board members' personal views of the role of the board on which they serve. For example, Mace (1971) interviewed 175 American directors involved with manufacturing, mining and retail companies. He concludes that, `*three important functions are performed by boards of directors: the board provides advice and counsel; the board serves as some sort of discipline; and the board acts in crisis situations'* (p13). He found that boards do not undertake the '*classical functions'* often ascribed to them in policy documents, that is: '*establishing basic objectives, core strategies, and broad policies; asking discerning questions'* (p13).

Like most such studies, Mace's work has a key methodological weakness in being entirely reliant on the insight and objectivity of the participants on the board. Demb and Neubauer (1992) recognise this point in their more recent study. In answer to their question "Are you involved in strategy", they reflect that, '*perhaps it is not surprising that the vast majority answered "yes"'* (p75).

There is, however, a limited and illuminating literature based on the observations of private sector boards. In one study, Winkler (1974, 1975) observed board meetings in nineteen companies and noted that, '*most board meetings we observed were formalistic affairs, with meagre debate, few probing questions, little serious discussion even. They were certainly not the forum in which the critical decisions of capitalism were made...effectively, the board was a legitimising institution for decisions taken earlier and elsewhere*' (1975, p140). In another, Brannen *et al* (1976) observed divisional board meetings, which included worker directors, at the British Steel Corporation. They reported that, '*the agenda would be strictly adhered to, and given that the agenda almost always remained the same, the meetings followed a predictable pattern. The full-time directors would not question each other, and would rarely contribute unless asked to by the chairman...without doubt, the dominant characteristic of board meetings was the emphasis upon the controlled and rational presentation of arguments and the avoidance of conflict*' (p175).

Many commentators have discussed the reasons for the apparently marginal impact of boards on the decision-making of organisations. Pettigrew (1992) summarises many of these when he suggests that, in addition to superior expertise, information, and advice available to management, there are norms of board conduct which restrict the outsiders' abilities to act as strident independent voices.

2.2 So, what are boards for?

One view is that the work of boards is *instrumental* and *palpable*, that they are there to achieve decisional coherence above all. That is, they are there to make decisions, to engage in deliberation, to conciliate about content in conflicts. This is the view reflected in much of the prescriptive guidance on the role of boards. They are to be measured, on this account, by how far they decide efficiently and effectively on that on which they are officially supposed to decide (Simon, 1997 [1945]). This is the view about boards commonly held by the public, and, apparently, many policy-makers.

The other view is that boards are for doing something organisationally important but which is unspoken, does not appear on the agenda, but which gets done, successfully or otherwise, in the course of members being in the same place and speaking or remaining silent according to certain conventions. Boards are places where participants tell narratives about who they collectively are, sustain culture, organise shared emotions, sustain loyalty, conciliate over social relations in conflicts. This second view is that the work of boards is *social, symbolic* and *implicit*: they are held to sustain organisational cohesion above all (Schwartzman, 1989; Huff, 1988; Weick, 1995).

Is there any evidence that within Boards responsible for the governance of health and social care partnership boards this symbolic role is more important than the instrumental role? The most detailed study of health and social care partnership in action over the last five years explored in detail the role of the Joint Commissioning Board (JCB) in Somerset through a combination of participant questionnaires and observation (see Peck et al, 2002). Overall, the JCB spent much of its time receiving and/or approving papers prepared by a group of managers who were viewed as controlling the agenda and content of discussion. At the same time, the JCB set parameters on the content of these papers and could, on occasions, decline to approve papers which did not fit within them. Clearly, however, the JCB was not fulfilling the instrumental role of setting policy and priorities in the way prescribed in government policy, and, indeed, in its own constitution. Although most of the JCB members recognised its instrumental limitations, the majority did not therefore conclude that it was not worthwhile. In particular, the JCB seemed to participants to make at least three important symbolic contributions to the local system. Firstly, it was a symbol of inter-agency partnership between health and social services which set the context for partnership elsewhere in the local system. Secondly, it was a vehicle for sustaining the commitment to mental health of senior players within the NHS and the Local Authority. Thirdly, it was a way of bringing added public accountability to the commissioning and providing of health care.

2.3 A (very) short history of governance between health and social care

It is sometimes easy when facing the pressures of the present to lose sight of the fact that the relationship between health and social care has a past. In a previous generation, policy-makers in the 1970s attempted to foster a close working relationship between the NHS and local government over the implementation of community care through so-called joint planning arrangements. The relationship between the appointed members of the NHS and the elected members of local government took place within Joint Consultative Committees. Wistow and Hardy (1991) conclude that, despite extensive efforts, there was widespread agreement amongst participants that this machinery was not successful. More recently, in the early 1990s, local authority nominees were removed from the boards of NHS bodies as the then government sought to bring in more private sector expertise. Over the course of the last five years there have been tensions between the NHS Confederation and the Local Government Association over, for instance, the proposal to create care trusts (see Glasby and Peck, 2003).

This national history has impacted differently upon relationships between health and social care at a local level. Peck (1998) describes a very different local context in one Northern city to that which he encountered in Somerset (Peck et al, 2002). It may be that the influence of local history is playing a significant role in the ways in which concerns about governance are being expressed – or not – in 2003. Furthermore, it may be that the progression of partnership at a local level – broadly from joint commissioning in JCBs to integrated purchase and provision in care trusts – has led to problems in governance arrangements that are only now becoming apparent.

2.4 Partnership working and governance

The recent development of a broad range of health and social care partnerships raises challenges about governance and the extent to which services can demonstrate that they are transparent, accountable and working according to proper standards of conduct in the public interest. As Sullivan and Skelcher (2002, p.159) explain:

> *"Partnerships present a challenge to the principles of public sector corporate governance. They are located at arm's length from the processes of representative democracy yet have a key role to play in delivering improved public services…They can have extensive public involvement mechanisms but also be governed by boards whose operations demonstrate a considerable democratic deficit. Their legal forms can vary considerably, as can their statutory base and financial relationships. Overall, the governance of partnerships is an area of considerable complexity and potential confusion."*

The governance of partnerships is especially complicated, as such arrangements can involve a large number of partner organisations and can take a number of legal forms (from statutory bodies to charitable trusts and from joint committees to companies).

Against this background, the remainder of this paper discusses a number of the key themes which have arisen from research, teaching and consultancy, and which some health and social care communities report are exercising their local partnership arrangements. Wherever possible, practical examples are included to demonstrate some of the ways in which agencies in different areas of the country are seeking to resolve these issues.

Key themes include:

- The respective roles of NHS and local government representatives.
- Openness and accountability.
- The role of users and carers.

These themes constitute the substantive sections of this paper.

3. The respective roles of NHS and local government representatives

3.1 Elected members

One of the potential strengths of the boards of partnership organisations is the diversity of perspectives that members from disparate backgrounds bring to discussions. It is in this context that the following concerns need to be seen.

Within the NHS, there are sometimes concerns about the role of elected members on the boards of care trusts. Often, councillors sit on other local partnership boards – such as joint commissioning boards - as representatives of their local authority. These councillors often combine membership of such boards with senior positions within the Local Authority (e.g. cabinet member for social services). This is entirely appropriate and produces boards that are seen to represent the importance of partnership within the health and social care system.

However, it may be that the success of these arrangements has meant that they have been carried over into the nomination of local authority nominees on care trusts. On the care trust board, that representative function is not a part of the formal role of the elected member. The role is rather one of contributing on a personal basis to the effective governance of the care trust. This suggests that it will be difficult for cabinet members of the local authority, for instance, to fulfil this role as it would be difficult for them not to contribute to discussions from the perspective of the corporate interests of the local authority. In these circumstances, it may be that the concerns of NHS colleagues are reasonable.

Of course, there are other differences between NHS and local authority appointees to care trusts. They do not go through the same appointments process, for example. However, it is suggested that these differences need to be accepted as part of the inevitable diversity that partnership brings. Some of these differences are as follows:

- The potential difficulty for council nominees in 'wearing two hats at once' i.e. apparently representing their local authority – which as has been noted above is not part of the formal role - and yet being a non-executive director with a much broader corporate responsibility for the care trust.
- Cultural differences between local councillors and 'traditional' NHS non-executive directors in all partnership boards i.e. the contrast between the ways in which NHS boards and local authority committees do business.
- A lack of clarity in some areas over how councillors should feed back to the local authority or feed ideas/information from the council into their care trust – in other partnership boards this is as much a problem for NHS members in reporting back to their trust as it is for local authority boards.
- The potential for political tensions between councillors from different political parties during any partnership board meeting, including care trust boards.
- The asymmetry of briefing between local authority councillors by officers – which is often quite formal and routine – and non-executive directors by executive directors – which is often quite ad-hoc.

These differences, and others, need to be explicitly acknowledged by boards. They need to be resolved by the board corporately rather than located in local authority nominees. The advent of children's directorates and trusts may bring similar challenges for NHS executives and non-executive directors charged with contributing to the corporate governance of bodies within the formal structures of local authorities.

One further thought, based on discussions with one local authority in the West Midlands. This authority is clear that it is not for cabinet members, or other councillors involved in health and social care overview and scrutiny committees, to be nominated to the boards of care trusts. Indeed, they view membership of such boards – and councils nominate to a large number of such external bodies – as one component of the development of the future cadre of member leaders within the authority.

3.2 A 'democratic deficit'?

Of course, elected members often feel comfortable with 'wearing two hats at once', serving both as councillors and as NHS board members. After all, they have combined individual advocacy on behalf of electors with policy making for decades. For them, and as noted above, this dual role is one they are used to performing on a number of local bodies, and frequently they are representing the local authority on such bodies. Their presence brings positive value due to members' knowledge of community needs, breadth of expertise and links to partner organisations.

In addition, local government often likes to emphasise the 'democratic deficit' which it perceives exists within the NHS, and within a range of different partnership arrangements (that is, partnerships and NHS bodies being controlled by appointed board members without a democratic mandate who are argued to be less accountable to the public than local councillors). As an example of this, Sullivan and Skelcher (2002, p.151) summarise recent research into the 'democratic deficit' in regeneration partnerships, suggesting that these ways of working are much less transparent and accountable than in local authorities (see Box 1) which have a much more explicit democratic mandate and a subject to a series of statutory responsibilities concerning openness and communication with the public.

Box 1: The 'Democratic Deficit'

What proportion of partnerships…	Study 1 - Robinson *et al* (2000) %	Study 2 - Hall *et al* (1998) %
Publish a delivery plan	75	n/a
Publish newsletters	60	65
Publish paper for meetings*	54	47
Have a code of conduct*	46	41
Hold publicly-accessible Board meetings*	46	29
Publish an annual report*	43	41
Hold annual general meetings open to the public*	29	n/a
Have a register of members' interests*	21	12
Memorandum of association*	n/a	41
Publication of accounts*	n/a	35
Standing orders*	n/a	35

* indicates a statutory requirement on the local authority

Elected member nominees on partnership boards may well encourage partnership boards to be as open as possible, in the ways suggested in the table. However, it is important that local authorities and their nominees recognise the legitimacy of NHS institutions, albeit that this legitimacy is derived from a different source than their own. In addition, in the near future, the NHS may have access to new forms of community accountability – through so-called foundation organisations – which may require local authority members to review their traditional perceptions of this perceived deficit.

3.3 Ways forward

In response to the contrasting concerns of the NHS and of local government, there may be a number of potential ways forward which have been identified above:

- Reviewing the membership of current or proposed care trust boards to ensure that potential conflicts of interest for local authority nominees are reduced.
- Developing new training opportunities for councillors to learn about the NHS and for non-executive and executive directors to learn about local government. This should focus not only on understanding the way in which different organisations operate, but also on understanding the different perspectives, skills and experiences which different people bring to the partnership boards. It should also include the importance of understanding community needs and of understanding local accountability. Such training could also be locally agreed condition of members accepting a nomination to a partnership Board.
- Ensuring job descriptions, person specifications, codes of conduct and member appraisal for all board members (see Box 2). If members of partnership boards are not able to fulfil their duties properly, then appropriate personal development and training opportunities should be made available. Ultimately, the individual could be asked to stand down and be replaced.

Box 2: Member Appraisal: Devon and Cornwall Police Authority

Devon and Cornwall Police Authority is introducing a scheme of member appraisal. The Authority is responsible for ensuring efficient and effective policing for the two counties and the Isles of Scilly, one of the largest policing areas in the country. It is made up of 19 members from constituent local authorities, magistrates and appointed individuals. The appointed members are fully independent and go through a selection process by the Authority, but the Magistracy select their own representatives, as do the constituent county and unitary councils. To date, Devon and Cornwall has been fortunate in the calibre of its members, but current arrangements do not guarantee this. The agenda for police authorities is growing and it is essential that all members perform to the best of their ability. Furthermore, the police element of the council tax is growing and it important that local people can be confident that members are pulling their weight and are addressing the critical issues.

Members have now decided that the performance culture for officers should be matched by performance appraisal for members. Job descriptions have been established, objectives are being defined and a formal appraisal process will be in place before the end of this year. The aims are:

- To help identify the contribution that each member can make, utilising their different skills and strengths.
- To provide a means to take the Authority forward by building on positive achievements and identifying any factors inhibiting members' contributions.
- To assist in the personal development requirements and aspirations of members.

Members believe that, if applied sensitively, appraisal can encourage each member, enhance transparency and accountability and ensure consistency of standards. The emphasis is on encouragement and self improvement. It is too early in the scheme to be definitive about possible sanctions should this fail to work but, ultimately, independent members could fail to be reselected and constituent authorities could be approached to select a different member. All constituent authorities will be made aware of the scheme and new members selected by them will be fully aware of the appraisal process before they agree to serve.

For further information, contact Graham Davey, Chief Executive, Devon and Cornwall Police Authority (*graham.davey@devonandcornwall.pnn.police.uk*).

In the longer run, however, there will be continued debate about the most appropriate site of health and social care partnerships. Should powers and services be delegated to the NHS (as in the case of Care trusts) or is there a case for bringing health services into the remit of local government (perhaps using the Children's Trust model)? Will services move on a general national trend across the health and social care interface in the way that services for people with learning difficulties, which arguably have more to do with education, leisure and employment than with traditional health care, are moving towards local government away from the NHS? Alternatively will they move on a case by case basis as determined by the history and needs of a given locality?

An interesting case study in this context are the proposals in Kent, where a government innovations forum is reported to be considering a measure which would enable local authority social services departments to commission both health and social care (see Box 3).

Box 3: Local Government-led Health Care?

"The country's best councils would take control of hospital care for older people, under radical plans discussed this week. The proposal would see social services departments take control of the entire budget for health and social care for older people, allowing them to develop preventive approaches to care and reduce hospital admissions. The idea is the brainchild of Kent Council, one of 22 rated excellent in the comprehensive performance assessment, which came together with central government to form the innovations forum this week. The group, which will work on ideas to improve public services, and is co-chaired by local government minister Nick Raynsford, was set up as part of a government promise to offer greater freedom to the highest performing councils."

(Community Care, 2003)

4. Openness and accountability

4.1 Standards, accountability and freedom of information

According to the Committee on Standards in Public Life (www.public-standards.gov.uk), holders of public office should be as open as possible about the decisions they make and account for them to the public. The NHS Appointments Commission (2003, p.14) also emphasises that "*the need for public accountability puts a special obligation on NHS Boards to conduct themselves and their business in an open and transparent way that commands public confidence*." Also significant is the Freedom of Information Act 2000, which creates a general right of access to recorded information held by public authorities.

This raises a number of key issues for the governance of health and social care partnerships:

- What has the partnership been set up to achieve?
- How does it make decisions?
- How does it communicate decisions to others?
- How is its performance assessed?
- How does it relate to wider stakeholders outside the immediate partnership?

Similar issues were also raised at our care trust governance workshop in May 2003, although they apply equally to all forms of partnership. Delegates debated:

- The relationship of integrated organisations like care trusts with the wider local authority.
- The difficulty of assessing and reporting performance when central monitoring processes require separate health care and social care data.
- The value of the care trust policy as a means of cementing previously informal relationships and facilitating discussions and agreement about organisational mission, decision-making and accountability. While some of

these issues may not necessarily have answers yet, the advent of these forms of partnership arrangements are at least starting to provoke debate about these issues and put them higher on the agenda.

4.2 Ways forward

In response to some of these issues, different health and social care communities are adopting a range of different approaches:

- Many partnership boards emphasise the importance of a detailed and explicit partnership agreement, both to help partners be clear about their respective roles and responsibilities, and to ensure that the partnership can be open and accountable to wider stakeholders and the public (see Boxes 4 and 5).
- Partnerships need to consider how to conduct their business in a way that is transparent and open to public scrutiny (see Box 6).
- Some partnerships have commissioned formal evaluations of their work so that they can demonstrate the impact they are having and be clear about the benefits that they bring (see Box 7).
- With regard to measuring and reporting performance, some health and social care partnerships are beginning to develop local performance frameworks which integrate the various health and social care targets of partner agencies (see Box 8).

Box 4: Partnership Agreements

In Northumberland, the initial process of drafting a formal partnership agreement was undertaken as a necessary adjunct to the development of a shared vision and a shared understanding of the priorities for health and social care, rather than as an end in itself. The agreement sets out clearly the undertakings given by each party and the intended basis of their relationship. It is the intention of the parties to operate the agreement in a spirit of mutual trust as partners. The partnership agreement is reviewed on an annual basis and any amendments agreed by both sides, together with an annual strategic agreement between the Care trust and the County Council on the funding provided by the Council to the Care trust for the delivery of adult social care and the results that the Care trust commits itself to achieving in return.

For further downloadable examples of health and social care partnership agreements, visit *www.integratedcarenetwork.gov.uk/themes/governance_res.php?type=10*.

Box 5: Accountability Arrangements

In Sandwell, a multi-agency partnership between the Local Authority and the three PCTs has been commissioning all mental health services using pooled budgets since 1 April 2003. Similar arrangements have been in place for Learning Disability services since October 2002. Membership of the Mental Health Partnership Board comprises three elected members and one non-executive from each of Rowley Regis and Tipton, Oldbury and Smethwick and Wednesbury and West Bromwich PCTs, supported by the jointly appointed Strategic Partnership Manager for Mental Health Services. In addition there are a number of co-opted members drawn from Social Services, the PCTs and Sandwell Mental Health NHS and Social Care trust, including service users and carers, who have been selected to ensure a balance of skills and experience.

Accountability is ensured by:

- Approval of service strategies that meet the needs of local service users and carers and which fit with both the agreed values and principles of partner agencies and within the best value framework.
- Overseeing and agreeing all interagency planning.
- Performance managing the delivery of adult mental health services across Sandwell.
- Ensuring service user and carer views are properly represented.
- Producing an annual report on the actions of the Board to each PCT and the Council.

Box 6: Openness and Transparency

Fairfax County, Virginia, is governed by an elected Board of Supervisors consisting of nine members elected by district, plus a Chairman elected at large. The law requires that districts be of approximately equal population and that each Supervisor (other than the Chairman) be a resident and qualified voter of his or her district, and be elected only by voters living in that district. All voters in the County may vote for the Chairman. The Board elects the Vice Chairman annually from among its members at its first meeting in January. Board members are elected for four-year terms. There is no legal limit to the number of terms a member can serve.

The Board establishes County government policy, passes resolutions and ordinances, approves the budget, sets tax rates, approves land use plans and makes appointments. These actions are taken in open meetings which citizens are encouraged to attend. All decisions are made in public, but the Board may go into Closed Meeting to discuss issues exempt from the Virginia Freedom of Information Act (FOIA), such as legal or personnel-related issues.

Members of the public are allowed to speak at the Board to express their views on issues of concern. Board meetings are shown live on cable television and the Board's agenda is published ten days in advance in a free newspaper mailed out to citizens.
Elsewhere in the US, Board members often run online consultations and chairs often appear in chat rooms on web sites made available through local cable services.
For further information, visit *www.fairfaxcounty.gov.*

Box 7: Commissioning Formal Research

In Somerset, the former Health Authority and the County Council commissioned an independent evaluation of the Somerset Joint Commissioning Board and the Somerset Partnership NHS and Social Care Trust – the first combined mental health provider in the UK. Quoted as a good practice example in 'The NHS Plan', Somerset nevertheless commissioned a two-and-a-half year study of:

- The aspirations and beliefs of partner agencies and how these changed over time.
- The impact of the changes on staff.
- The impact of the changes on service users and carers.

The results of the study were widely disseminated and Somerset is to be congratulated on taking such decisive step – not only taking a lead in terms of integrated working, but also in terms of its willingness to open local developments up to outside scrutiny through independent research.

For further information, see Peck *et al* (2002a)'s *Modernising Partnerships*.

Box 8: Integrated Performance Frameworks

As Bradford mental health services were developing their application to be a Care trust, they were very aware that the new organisation would straddle two different accountability frameworks - one for the NHS and one for social care. In addition, they would also have to respond to the two different inspection regimes supporting these performance assessment frameworks - the Commission for Health Improvement (CHI) and the Social Services Inspectorate (SSI).

Over the first year of the Care trust's existence, there has been a concerted effort to try to identify key elements of both frameworks and a mapping exercise to ensure that the Trust and Directors' objectives incorporate key requirements for both the local authority and the NHS. In addition, the European Foundation for Quality Management (EFQM) model has been used as a means of bringing together the two inspection regimes and an assessment tool has been developed to map the standards that the Care trust needs to meet onto the EFQM.

For further information on EFQM, visit *www.efqm.org.*

5. The role of users and carers

5.1 User and carer involvement

In 2000, *The NHS Plan* emphasised the government's commitment to creating a patient-centred NHS which puts the needs of users central to service design and delivery. As the Department of Health (2000, p.88) acknowledged:

"Patients are the most important people in the health service. It doesn't always appear that way. Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment and more influence over the way the NHS works."

This has since become a statutory requirement under section 11 of the Health and Social Care Act 2001, which places a duty on NHS Trusts, PCTs and Strategic Health Authorities to involve and consult patients and the public in service planning and operation, and in the development of proposals for change.

A similar commitment also exists within social care, which also has a long heritage of attempting to involve service users and their carers in decisions about services (see Barnes, 1997) for an overview.

It is now recognised good practice to seek the active involvement of users and carers at a range of different levels within health and social care - in making decisions about their own care, in planning services more generally, in carrying out training and research and in helping to set the strategic direction of organisations. Many partnerships have service user and carer representatives on their governing body, and each PCT and NHS Trust will be required to appoint a member of newly formed Patient and Public Involvement Forums to serve as a non-executive board member from 2003 (NHS Appointments Commission, 2003).

5.2 User and carer board members

However, this formalisation of what has become increasingly common practice raises a series of issues which need careful thought and planning:

- Is there a danger that service user and carer representation on boards will become tokenistic rather than a genuine attempt to involve users and carers in decision-making?
- Could user and carer representatives become isolated from fellow Board members? That this is a real danger is illustrated in Box 9, where a service user sitting on a partnership Board recounts her experience of isolation and frustration at her role.
- How can service users and carers be supported to be effective Board members and what sort of training, induction and support mechanisms will they require?
- How are service users and carers appointed to Boards and what does this process feel like for them (see Boxes 9 and 10)?
- There is also the tension as to whether the user/carer is representing all users/carers or 'just' themselves or a group which they may have been nominated to represent (e.g. an older people's club or a Patient's Forum).
- Is there a fundamental tension between treating user and carer Board members on the same basis as other members on the one hand and providing additional support on the other? Often, this tension can be most severe in situations where most Board members are private and independent individuals, but where users and carers are official representatives and delegates of wider user and carer groups. Hardly surprisingly, this can lead to tensions as the users and carers are present on a different basis to everyone else with a different role and mandate.
- On the other hand, will other members accept that the personal experiences of service users on the board – the stories of others – are legitimate for corporate governance boards (as opposed to service governance fora)?

Box 9: Service User Involvement: A Personal Perspective

"It soon became apparent that there was a real conflict between my responsibilities as a board member and as someone receiving the service. As a non-executive director the role involves areas such as governance and finance. The National Service Framework for Mental Health, amongst other directives, was driving a non-negotiable change in terms of service delivery. Many of the priorities of service users and carers seemed quite opposed to the requirements this role expected me to fulfil…. The question of in whose best interests we were working came up so much. Was the organisation for which I was partly responsible or the views of service users and carers to take precedence?

Often I felt very alone in my position and struggled with whom I could discuss certain issues. I felt torn between the confidential aspects of decision-making within the Trust and the needs of users and carers. For the first year I knew no one in the same position as myself. I was part of many user groups… and a member of a proactive group called the 'User and Carer Evaluation Group' which met regularly to put views forward to the executives. At the time this was probably the group with the most knowledge and experience about the system. However I felt uncomfortable about what I could or could not openly discuss with them. There seemed to be a 'public face', which the trust board maintained, and whichever decision I took seemed like a disloyalty to one or the other. I was fortunate to have a good support system from other service users and carers, and two of the executive directors. But I still felt very caught in the middle and whilst I listened readily to advice, the final decision had to be taken very much alone. Being in a very unusual and isolated position I was in grave danger of distancing myself from either fellow service users or from board colleagues in the quest for solidarity."

(Brodie, 2003)

Box 10: The Experience of Service Users on Governing Boards

User Participation in the Governance and Operations of Social Care Regulatory Bodies

This is a project which was originated by the National Institute for Social Work to be jointly managed with Shaping Our Lives, the national user controlled organisation and network. The Project has subsequently been based at the Social Care Institute for Excellence (SCIE). It is supported by the Joseph Rowntree Foundation.

Its aim has been to explore user representation in the governance of formal national and local social care organisations like the General Social Care Council and Training Organisation for Personal Social Services (Topss). It aims to promote and support the implementation of strategies for effective participation by service users in the governance, standard-setting and regulatory functions of the new bodies set up to regulate and improve service, conduct, practice, training and occupational standards in social care. It also aims to develop and advocate cost-effective models for implementing best practice in preparing and supporting user-members of governing bodies, committees and panels, enabling them to communicate with and represent the views of the wider user constituencies, and ensuring access to the information and back-up services they need to make an effective contribution.

A report will be published later in 2003 followed by a national seminar jointly organised by SCIE and Shaping Our Lives, with support from the Joseph Rowntree Foundation to explore service users' views more generally about ideas, philosophies and good practice for user involvement in social care and related bodies.

Overall, the advantages and disadvantages of user and carer involvement on governing Boards have been summarised by Brodie (2003):

Advantages:

- Provides a better, user-centred service by ensuring a focus on how users are affected by decisions.
- Promotes an awareness of what service users can offer by showing capabilities and challenging stereotypical ideas of users.
- Can raise issues that otherwise would not be thought of or deemed unimportant.
- Gives a voice to service users and carers.

- Gives a positive message to other service users of what is achievable – gives hope.
- Can challenge the dominant medical perspective.
- Helps to alleviate negative language and discrimination against service users.
- Can uncover areas of bad practice when service users are powerless.
- Brings about a more holistic understanding of service user and carers' needs.

Disadvantages:

- The dilemma of balancing corporate responsibility against service users' wishes – feeling caught in the middle.
- Issues raised that hit raw nerves and emotions that lead to difficulties coping.
- Worries of 'being sucked into the system' and losing the service user viewpoint.
- Losing the energy to challenge.
- Burnout – too much demand from the organisation and not wanting to say 'no' when a user viewpoint is needed.
- Difficulty finding users to be involved.
- Still needing care and receiving care within the organisation can lead to an uncomfortable arrangement.
- Being expected to be an agent of government directives and resource cuts which conflict with the interests of users.

5.3 Ways forward

In seeking to build on these advantages and minimise the disadvantages, Brodie (2003) provides the following advice for agencies who are considering appointing service users or carers onto partnership Boards:

- Users and carers need to feel they are equal and be equal.
- They should not have to feel the pressure of justifying their position any more than other Board members.
- They should be clear as to what their role is.

- The organisation must ensure they have people to whom users can turn for support and who can offer guidance.
- Emotional support is also essential as service users and carers will often have been affected by experiences that come up in board discussions.
- The organisation should ensure they are linked into a wide network of other users and carers for support and advice.
- Users should be able to have necessary training and guidance in their role from peers and professionals.
- Just as with other members, user views should be listened to and heard, even if they do not conform to traditional roles and ways of speaking.
- Users should be made to feel part of a team of other non-executives (or other members) and not feel that they are different or feel discriminated against by the nature of the position they speak from.
- The organisation must not overwork this person or put unreasonable demands on them.
- The organisation needs a structure that enables wider user/carer views to be influential to the board.

In addition, Brodie (2003) also recommends Arnstein’s (1969) ‘Ladder of citizen participation’ as a means of assessing efforts at involving service users (see Box 11). Using this model, health and social care organisations have a responsibility to ask themselves at which level they are involving service users and carers and to take action to ensure more meaningful forms of involvement in the future.

Box 11: Different Levels of User Involvement

Levels:

1. Manipulation
2. Therapy
3. Informing
4. Consultation
5. Placation
6. Partnership
7. Delegated power
8. Citizen control

Levels 1-3 have a one-way flow of information aimed at achieving public support through public relations.
Levels 4-5 have a two-way flow of information.
Levels 6-7 lead to real participation and a sharing of power.
Level 8 leads to users controlling funds and making decisions.

(Arnstein, 1969, quoted in McIver, 1993, pp.52-53)

Also significant would be a commitment by partnership boards to consider their composition in order to ensure either that:

1. All board members are private individuals and not delegates from a particular group of people; or

2. Boards contain a number of different members who represent wider groups.

In principle, this should prevent a situation whereby users and carers are the only people present who have a representative mandate and feel distanced from other Board members.

A final perspective comes from Peck *et al* (2002) whose evaluation of the integrated mental health Trust in Somerset suggests an important distinction between *tokenism* and *symbolism*. As noted earlier, in this study the Joint Commissioning Board was felt by the researchers and by a number of board members to have a predominantly symbolic function – emphasising the importance of mental health and of inter-agency working. Whereas some board members understood this and were happy with their contribution, others (mainly GP, service user and carer representatives) did not accept the symbolic role of the Board and felt frustrated at what they saw as the failure to ‘make decisions’ and ‘do things’. Arguably, the presence of users and carers was not *tokenistic* (although it may have felt like that to the users and carers involved), but *symbolic* – emphasising the importance of user and carer involvement at all levels of the organisation by making a very clear statement about involvement through the composition of the Board.

In a sense, this observation takes us right back to the research on corporate boards that was summarised at the outset of this discussion document.

6. Conclusion

This paper has attempted to raise issues and suggest ways forward, but it is not intended to be prescriptive, nor is it by any means the final word on the issues discussed. The ICN would welcome comments – and further good practice examples – to be forwarded to Shane Giles or Alix Crawford at the ICN or posted on the ICN website.

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7. Bibliography

Arnstein, S. (1969) A ladder of citizen participation in the USA, *Journal of the American Institute of Planners*, 35, 216-224.

Barnes, M. (1997) *Care, communities and citizens*, London, Longman.

Brannen, P., Batstone, E., Fatchett, D., and White, P. (1976) *The worker directors*, Hutchinson, London.

Brodie, D. (2003) Partnership working: a service user perspective. In J. Glasby and E. Peck (eds) *Care Trusts: partnership working in action*, Abingdon, Radcliffe Medical Press.

Cadbury, A. (1992) *The financial aspects of corporate governance (the Cadbury report)*, London, Burgess Science Press/Professional Publishing.

Community Care (2003) Elite councils consider plans to take control of adult services from NHS, *Community Care*, 22 May, available online (accessed 29/07/03) via www.communitycare.co.uk.

Demb, A. and Neubauer, F. (1992) *The corporate board*, Oxford University Press, Oxford.

Department of Health, (1989) *Working for Patient,.*Cmnd 555, London, HMSO.

Department of Health (2000) *The NHS plan: a plan for investment, a plan for reform*, London, Department of Health.

Department of Health (2002) *Guidance on governance of Care trusts* (updated 5/3/02), available online via www.doh.gov.uk/caretrusts (accessed 17/04/03).

Ferlie, E., Ashburner, L., Fitzgerald, L., and Pettigrew, A (1996) *The new public management in action*, Oxford University Press, Oxford.

Glasby, J. and Peck, E (eds) (2003) *Care Trusts: partnership working in action*. Abingdon, Radcliffe Medical Press.

Hall, S., Nevin, B. and associates (1998) *Competition, partnership and regeneration: lessons from the three rounds of the Single Regeneration Budget Fund*, Birmingham, Centre for Regional and Urban Studies, University of Birmingham.

Higgs, D. (2003) *Review of the role and effectiveness of non-executive directors*. London, DTI.

Hodges, R., Wright, M. and Keasey, K. (1996) Corporate governance in the public services: issues and concepts, *Public Money and Management*, 16(2), 7-13.

Huff, A. (1988) ‘Politics and argument as a means of coping with ambiguity and change’ in Pondy LR, Boland RJ and Thomas H, eds, 1988 *Managing ambiguity and change*, John Wiley, New York, 79-90.

Mace, M. (1971) *Directors: myth and reality*, Harvard University Press, Cambridge, Massachusetts.

McIver, S. (1993) *Obtaining the views of users of primary and community health services,* London, King’s Fund Centre.

NHS Appointments Commission (2003) *Governing the NHS: a guide for NHS boards*, London, NHS Appointments Commission,

Peck, E. (1995) The Performance of an NHS Trust board: actors' accounts, minutes of meetings and observation, *British journal of management*, 6, 2, 135-156.

Peck, E. (1998). Public Consultation in the NHS: integrity, ambiguity, or duplicity*, Health services management research*, Vol. 11, 201-210.

Peck, E., Gulliver, P. and Towell, D. (2002) *Modernising partnerships: an evaluation of Somerset’s innovations in the commissioning and organisation of mental health services – final report*, London, Institute of Applied Health and Social Policy, King’s College.

Pettigrew, A. (1992) On studying managerial élites, *Strategic management journal*, 13, winter, 163-182.

Rao, N. (1992) *Managing change: councillors and the new local government*, Joseph Rowntree Foundation, York.

Robinson, F., Shaw, K. and associates (2000) *Who runs the north-east now? A review and assessment of governance in North East England*, Durham, Department of Sociology and Social Policy, University of Durham.

Schwartzman, H. (1989) *The meeting: gatherings in organisations and communities*, Plenum, New York.

Simon, H (1997) [1945], *Administrative behaviour: a study of decision-making processes in administrative organisations*, 4th edn, Free Press, New York.

Sullivan, H. and Skelcher, C. (2002) *Working across boundaries: collaboration in public services*, Basingstoke, Palgrave.

Turnbull, N. (1999) *Internal control: guidance for directors on the combined code*, London, CIPFA.

Weick, K., (1995) *Sensemaking in organisations*, London, Sage.

Winkler, J. (1974) The two faces of capitalism, *The director*, 26, 10, 91-94.

Winkler, J. (1975) Company directors...or corporate knights, *The director*, 27, 1, 85-87.

Wistow, G. and Hardy, B. (1991) Joint management in community care, *Journal of management in medicine*, 5, 4, 40-48.

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