Corporate Governance across Health and Social Care – Post Integration

Introduction

This paper set out key principles to be applied in the governance of integration. It does not and cannot provide concrete solutions for each aspect of governance but does provide the parameters within which those solutions can be found. The basic principles were discussed and agreed with officers from IJBs and Health Boards in 2017, updated to take account of the passage of time and recent clarification received from the SGHSCD. The intention is to provide underpinning guidance for all of the main strands of governance element, each of which should be discussed individually with the IJBs and Local Authorities to inform the detailed arrangements in each body.

One of the most important questions in governance is 'How do you KNOW?'. Bearing in mind that within the Health Board systems there can be multiple statutory bodies, all of which are mutually reliant for assurance, asking this question from each of their perspectives and within each category, is a powerful tool for analysing the effectiveness of any proposed systems and the systems currently in place.

Legislation requires review of Integration Schemes at least every five years which would require the review process to start as soon as possible. These principles should be a key component of that review process so that the Integration Schemes can more fully reflect the agreed governance arrangements now in place in each IJB area.

General Principles to be applied

1. Must comply with statute and regulations, informed by SGHSCD interpretation
2. Must follow the approved Integration Schemes or revise the Integration Scheme in line with guidance
3. The following principles will be applied:
    a. The guiding principle will be of measured, pragmatic collaboration in the interests of the population;
    b. Principles and detail will be communicated with clarity and consistency;
    c. No omission, no unnecessary duplication;
    d. The standard of accountability and assurance must be maintained, and should be as consistent as possible throughout the system, predicated on the level of risk and providing each party with the necessary assurance to fulfil their governance

responsibilities in line with the accountabilities set out by the SGHSCD (see Accountabilities below);

e. Independent oversight at the appropriate level is a fundamental component of all governance and assurance systems;

f. Any delegation of governance must take into account the resources available to maintain levels of assurance. Due consideration shall be given to the level of support services required to deliver any solution within the context of the provisions set out for these services within the Integration Schemes.

g. Authority and responsibility and therefore control and assurance should reside in the same body as far as possible;

h. Ultimately, where the Chief Officer has operational management responsibilities, the accountable officers for delivery are still the Chief Executives of the NHS Board and Council. Operational activities directed by the Chief Officer of the IJB are enacted through their role as a senior member of the management team in both the Local Authority and Health Board and accountable to the respective chief executives;

i. All solutions can only be based on current understanding and current circumstances and will require regular review in order to reflect both experience of and changes in their operation and distribution of risks and the evolution of joint working;

j. Whilst each IJB has to develop a system appropriate for its own requirements and circumstances, wherever practicable, common solutions across the Health Board area should be sought;

k. IJB members are bound by the Standards Commission Advice for IJB Members which requires them to act in the interests of the IJB and may require them to act against the aims and priorities of the Council or Health Board they represent. Therefore the presence of council or Health Board members on the IJB does not and cannot replace the need for appropriate formal consultation with the parent bodies.

l. Once agreed, these principles should be embedded within the formal governance framework of each party to the agreement and recorded within their Code of Corporate Governance or equivalent.

Langland's Principles

The Langland's principles, which are considered best practice for all public bodies in Scotland are as follows. The most relevant principles to decisions on Health and Social Care Integration governance are highlighted in yellow, although all are applicable to both the IJB and the partner organisations:

1. Good governance means focusing on the organisation's purpose and on outcomes for citizens and service users

1.1 Being clear about the organisation's purpose and its intended outcomes for citizens and service users
1.2 Making sure that users receive a high quality service
1.3 Making sure that taxpayers receive value for money

2. Good governance means performing effectively in clearly defined functions and roles

2.1 Being clear about the functions of the governing body
2.2 Being clear about the responsibilities of non-executives and the executive, and making sure that those responsibilities are carried out
2.3 Being clear about relationships between governors and the public

3. Good governance means promoting values for the whole organisation and demonstrating the values of good governance through behaviour

3.1 Putting organisational values into practice
3.2 Individual governors behaving in ways that uphold and exemplify effective Governance

4. Good governance means taking informed, transparent decisions and managing risk

4.1 Being rigorous and transparent about how decisions are taken
4.2 Having and using good quality information, advice and support
4.3 Making sure that an effective risk management system is in operation

5. Good governance means developing the capacity and capability of the governing body to be effective

5.1 Making sure that appointed and elected governors have the skills, knowledge and experience they need to perform well
5.2 Developing the capability of people with governance responsibilities and evaluating their performance, as individuals and as a group
5.3 Striking a balance, in the membership of the governing body, between continuity and renewal

6. Good governance means engaging stakeholders and making accountability real

6.1 Understanding formal and informal accountability relationships
6.2 Taking an active and planned approach to dialogue with and accountability to the public
6.3 Taking an active and planned approach to responsibility to staff
6.4 Engaging effectively with institutional stakeholders

SGHSCD Statement of Accountabilities and responsibilities

As per an official SGHSCD email of 16 October 2019 the general responsibilities arising from the integration legislation are as follows:

1. The NHS and Councils are responsible for delegating the right functions and money to the IJB, providing the membership of the IJB, and supporting the IJB and Chief Officer;

2. The IJB is responsible for producing a strategic commissioning plan and financial plan for the functions and money delegated to it, and then issuing directions and making the associated payments to the NHS Board and Council for the delivery of services; and then publishing the retrospective Annual Performance Report and Financial Statement setting out what was achieved in the year past;

3. The NHS Board and Council are responsible for delivering the services and reporting back to the IJB on that delivery;

4. The whole partnership – NHS Board, Council and IJB – are responsible for understanding the impact of their shared responsibilities to the population and adjusting their plans etc. in response.

When considering how statutory responsibility for services is affected by integration, it may help to bear in mind that ultimate responsibility remains with the delegating body (HB/LA); and primary responsibility lies with the body which has been delegated the functions (i.e. the IJB or HB/LA under lead agency arrangements); and this is unaffected whether or not the body which has been delegated the functions provides the services (lead agency) or issues directions for delivery (IJB).

So more specifically, the governance arrangements are as follows:

a) The duties imposed on Health Boards to provide health care (by, for example, the National Health Service (Scotland) Act 1978) and on Local Authorities to provide social care (by, for example, the Social Work (Scotland) Act 1968) are not discharged by the delegation required by the 2014 Act, and therefore those bodies remain ultimately responsible for the provision of health and social care services respectively. To discharge this responsibility the HB and LA will obtain assurance that the delegated functions and sums are used for the purpose for which they were delegated. They will do this through the provisions of the integration scheme and content of the strategic plan (ultimately through the powers under S38) and (although it is a report to the local community and not to the HB & LA) also through the annual performance reports.

b) Having published the Strategic Plan, the IJB commissions services by issuing directions and making payments to the HB and LA and will obtain assurance that the functions and sums have been delivered and used in accordance with the directions.

c) The HB and LA must also give the IJB chief officer post-holder the operational responsibility for provision of services, in which capacity she/he is responsible to the HB & LA CE respectively.

d) In the normal course of carrying out their respective functions (both directed and retained) the HB and LA will have established proper systems of internal control and governance.

e) To avoid duplication, the HB and LA MAY but are not required, ask the IJB to carry out these governance functions on their behalf in respect of the delegated/directed services. In this case, strictly speaking it is not the IJB carrying out this role, but the membership of the IJB acting as a governance committee of the HB & LA.

f) In relation to hosted services: HB and LA functions are delegated to IJBs and they then direct the HB & LA to provide services. In doing this they may specify that the services should be provided in a hosted way by the HB or LA, which entails that the CO of one of the IJBs, in the capacity as operational director of the HB/LA, manages the provision of services to patients from all the IJBs.

Local Operational Delivery Arrangements

There are important distinctions to be drawn between:

i) The role of the Chief Officer (CO) as an officer of both the Local Authority and the Health Board and their role as IJB CO. The IJB makes the strategic decision and directs the parties to undertake its operational activities in line with its strategy and directions. The IJB CO then manages these activities in their capacity as an officer of the relevant partner body.

ii) The IJB and the HSCP: The IJB is a legal entity subject to public sector (in this case Local Authority) governance and accountability regulations, and an HSCP can be merely formalised joint working arrangements, without legal status. In practice, the HSCP term is often used to apply to all staff working within it, even though they are technically still NHS or Council employees. Between the IJB and the Health and Social Care partnership; it would be perfectly feasible to have an IJB as a legal entity without a HSCP and vice-versa.

Across NHSScotland the regulations have been interpreted differently even where the Integration Schemes have been similar. Broadly speaking there have been two key models:

Commissioning: the interpretation is that responsibility for delivery, including for hosted services, remains with the partner bodies

Operational/Fully delegated: the understanding is that the governance of the delivery of delegated functions will be undertaken by the IJB.

The SGHSCD have stated that the Act is not directive about operational arrangements and therefore this issue is for local determination. However, they have also stated that where a Health Board or local Authority asks the IJB to carry out governance functions on its behalf in respect of the delegated/directed services, it is not the IJB carrying out this role, but the membership of the IJB acting as a governance committee of the HB and Council and therefore there may need to be further work/clarification within those IJBs operating the ‘Fully Delegated’ model in order to ensure full consistency with SGHSCD guidance

In any event Integration Schemes require review at least every five years and therefore the review process in all IJB areas will need to start as soon as possible.

Code of Corporate Governance.

The following principles will apply:

i) The Scheme of Delegation of the Health Board and Local Authority as described within the Standing Orders should reflect the areas where strategic decisions have been delegated to IJBs

ii) Schemes of Delegation must provide IJB Chief Officers with the authority required to undertake their functions and also specify the delegation and reservation of powers;

iii) Each party must understand their own assurance process and requirements and collectively, the parties should ensure that the overall system provides cohesive and coherent assurance with no omissions and no unnecessary duplication. This implies but does not necessarily require the use of assurance mapping across the system.

iv) The remits of Board, Local Authority and IJB Standing Committees should reflect the roles of Assurance Committees in other bodies and the provision of cross-assurances including the timing and content of Committee and especially Audit Committee annual reports. ; Where control weaknesses in one body impact on the Governance Statement of another body, suitable assurance on remedial action will be provided and reported to their Audit Committee.

v) Any delegation of operational responsibility and governance thereof must take into account the resources available to maintain appropriate levels of assurance and governance; with a full understanding of whether IJBs have governance infrastructures which would provide a level of the level of governance oversight acceptable to the partner bodies;

vi) Existing processes to ensure that laws and guidance are enacted should be extended to include the IJBs whose own governance processes should ensure compliance.

vii) Internal Audit arrangements need to be coherent and cohesive with coordinated audit planning with agreement on the sharing of audit outputs and assurance on follow-up and an agreed approach to audit planning which takes account of the principles within this document.

viii) Best Value assurances will build on the existing arrangements in the partner bodies, operating on the principle that the IJB operational activities are enacted through the partner bodies and therefore subject to their Best Value arrangements. In the first instance, this means that the partner bodies should provide assurance on Best Value (BV) to the IJB, accepting that NHS BV requirements are analogous but not identical to their Council equivalents. Equally, IJBs must provide assurance to the partner bodies on best value in respect of commissioning and delivery of the strategic plan.

Strategy

Regulations, also reflected within the Integrations Schemes, require the Health Board and Local Authority to take account of the Strategic Plans of the IJBs. It is also the case that the Act requires IJBs to take account of the views of their partner bodies, in formulating their strategy and also allow the partner bodies to request a revision to the Strategic Plan if both are in agreement.

These regulations establish the primacy of IJBs in decisions around delegated functions and provide for the views of the partner bodies to be taken into consideration. However, holistic planning for health and care systems with complex interdependencies facing significant financial, workforce and demographic pressures require a collegiate approach and must recognise the significant resource restrictions facing all bodies.

The additional complexity involved creates a risk that consultation processes can become unwieldy and unnecessarily complex. Streamlined processes are therefore required for approval of the setting of strategic direction including changes to major service provision, which reflect the importance of public engagement and consultation with stakeholders but also the need to shift the balance of care and do not unduly delay the urgent action required to create sustainable services. The following principles will apply:

i) In all strategy and service redesign developments there must be absolute clarity around which body will make the final decision and the extent to which that body must take account of stakeholder views.

ii) In recognition of the need for holistic solutions across the Health board area, IJBs will consult the partner bodies, as key stakeholders, on major strategic change for delegated functions, including those for hosted services, whilst retaining the final decision-making authority, with the host IJB making the final decision for hosted services;

iii) The consulted parties, including the Health Board, Local Authority and other IJBs where appropriate, will identify which Committee (or their Board) will provide their formal response, minimising the number of consultation meetings required whilst ensuring that the implications are fully explored, particularly in relation to clinical and care governance, which must be taken into account in all strategic decisions.

iv) Strategic Planning processes should be co-ordinated as far as possible, so that, from an early stage, interdependencies are explored and all stakeholders' objectives are taken into account. Whilst IJBs do not have responsibility for property, it is vital that the partner bodies' Property Strategies are congruent with the IJB strategies.

v) Any arrangements must take into account and make best use of the limited resources available for Strategic Planning. There may be an opportunity for IJBs to share specialist skills which would also enhance co-ordination and efficiency.

vi) The MSG review highlighted the need for faster progress with Large Hospital Set-aside (LHS). As part of this process, the implications for Health Strategy need to be explored further and clarity achieved on the lead role for strategic decisions on LHS which recognises the interdependences between non-delegated acute and LHS functions.

vii) As noted above, IJB members are bound by the Standards Commission Advice for IJB Members which requires them to act in the interests of the IJB and may require them to act against the aims and priorities of the Council or Health Board they represent. Therefore the presence of council or Health Board members on the IJB does not and cannot replace the need for appropriate formal consultation with the parent bodies.

Risk Management

All Integration Schemes required *The Partners and the Integration Joint Board to develop a Risk Management Strategy (RMS)*. However, it is still the case that many Health Board's, Local Authorities and IJBs do not have an RMS which that does not record how their risk management systems interact with those of their partner bodies or how shared risks will be managed.

In many cases, the IJB RMS does not reflect the local understanding of the governance of operations and therefore of operational risks and many contain inconsistencies and passages which are simply inappropriate.

The following principles will apply:

i) The Risk Management Strategies of the IJB and the parties will be amended so that they consistently and clearly set out :

   a. Responsibility for managing operational risks consistent with the agreed model of operational delivery

   b. A process and timetable for identifying risks where one body is responsible for the service, but the risks are of a nature or materiality that it could have a significant impact on the other body.

   c. The definition of 'shared' risks will need to be explored carefully as the management of individual operational risks cannot be shared effectively, but there are many risks which impact on both parties and this requires an effective escalation process between bodies and a formal process to ensure the exchange of relevant risk information.

   d. Clear assurance arrangements both internally and to other bodies; if a full Board Assurance Framework or Assurance Mapping approach is not practicable, then any arrangements must ensure that assurances are received over controls mitigating key risks whether internally or from partner bodies noting the principle that there must be no omissions and no unnecessary duplication.

   e. Resourcing of Risk Management should be agreed to ensure that appropriate support is available, in line with the Integration Scheme and the recommendations of the MSG report.

   f. Whatever solution is arrived at, there will need to be consideration of how operational risk registers will be hosted under partnership working and how all appropriate HSCP staff will have appropriate access to the operational risk register, no matter who they are employed by.

   g. Audit Committees should be clearly sighted on the extent to which they rely on the risk management systems of other bodies and should receive appropriate year-end assurances on their operation.

Performance Management

The requirements on performance reporting to the IJB are set out in regulations, in guidance, in the Integration Scheme and in further guidance issued by the Scottish Government in January 2017. However, linkages between the IJB and the partner bodies are less clear and given that Partner bodies retain ultimate responsibility for the functions they will require assurance on performance for delegated functions. Equally, IJBs need to be aware of the impact of their performance on the achievement of targets for non-integrated functions.

Whilst regulations and SGHSCD guidance already provide for IJBs to provide assurance in the retrospective Annual Performance Report and Financial Statement, it is not sufficient for internal control purposes only to receive assurance at year-end.

The MSG report and Audit Scotland review of HSCI have both commented on the need to improve the use of directions. This has also featured in a number of IJB Internal Audit reports.

The following principles will apply:

i) IJBs will continue to monitor mandatory targets for which their partner bodies are responsible and include their achievement within their Strategic Plans;

ii) For delegated functions, the IJB will take the lead in Performance Management and therefore have primary responsibility for deciding on appropriate remedial action where required, and monitoring its implementation and effectiveness and providing appropriate reports and assurance to the nominated Committee of the partner body.

iii) IJBs should produce detailed directions in order to fulfil their Strategic Plan and should receive assurance that these directions are being implemented.

iv) For Large Hospital Set-Aside (LHS) functions, the Health Board will take the lead and provide assurance and reports to the IJBs;

v) Both the Health Board and Local Authorities will agree clear reporting arrangements with the IJB which provide the partner bodies with appropriate and ongoing assurance on the achievement of objectives for which they are still accountable or where they continue to bear significant risk, respecting the principles set out in ii) above.

vi) Wherever possible, performance reports will overtly state the link to key risks and provide overt assurance on whether the performance reports are consistent with their description and risk scoring within the IJBs Strategic Risk Register and those of the partner bodies. In general, where there is a risk there should be a measure of performance and vice-versa,

Clinical and Care Governance

The Health Board and Council are still ultimately responsible for the quality of their services whether for delegated functions or not and therefore require to receive appropriate assurances around clinical and care governance.

National guidance was provided on both professional accountability and clinical governance and this has been reflected in local Integration Schemes. Whilst professional accountability and clinical governance are closely linked, they are separate and the key issue for all bodies is assurance over the overall health and well-being of the population, of the safety and effectiveness of care provided and of the adequacy and effectiveness of the systems and governance structures which provide that assurance.

Professional accountability is generally well-covered within Integration Schemes although the provision of professional advice has not always worked as envisaged. Audits have identified a number of areas where further development is required and the assurance needs of the various parties need both to be better articulated and better met.

The following principles will apply:

i) Consistency of care and clinical governance as far as possible i.e. the level and quality of assurance should be determined consistently (see below) whether in delegated or non-delegated healthcare functions or within social care activities whether delivered in-house or purchased. This will be particularly important as the boundaries between health and social care blur; there is no reason why assurance around the safety and effectiveness of care should change as an individual transitions between one part of the system to another, or if service provision changes. For example the local authority equivalents to SAERs, aggregated incident reports, HAI reports etc. should be reported in parallel and in aggregate with the Health equivalents within IJB reporting.

ii) Proportionality; assurance should be inextricably and overtly linked to the scale of the risk and the extent to which key controls manage that risk

iii) There must be a distinction between professional lines of accountability and governance/assurance.

iv) Independent oversight is a fundamental component of clinical governance assurance; this includes oversight from independent non-executives/councillors/voting members at an appropriate level based on robust, relevant and reliable data

v) Clear linkages to performance data, including operational, financial and quality performance; the ideal is a holistic system which integrates performance, clinical and other data level so that performance is measured once, used often.

vi) Where assurances are not deemed sufficient or they highlight significant unmitigated risks, there must be clarity around which body will take the decision on the appropriate action to be taken and how they will provide

assurance to other parties on the implementation and effectiveness of those actions.

vii) All systems should distinguish between pro-active and reactive, internal and external assurance and develop effective triangulation to ensure that each assurance component contributes to an overall assessment of governance. For example, the key information to be taken from an external review is not about the specific circumstances found but whether they are consistent with assurances received from internal systems. Wherever practicable, the emphasis should be on internal systems which provide advance warning of any issues.

viii) The provisions in the Integration Scheme for seeking professional advice should be reviewed to ensure that they are functioning as intended, both in terms of operational delivery and in the development of IJB Strategic Plans.

ix) Hosted services require particular consideration as assurance will need to be provided to other IJBs as well as the relevant partner body. This aspect of assurance has been notably poor in our experience.

x) Whilst SGHSCD guidance means that there is no requirement for an IJB Clinical and Care Governance Committee, there is considerable merit in having a group whose remit can ensure that these principles are applied consistently across all services within an HSCP regardless of provision and which can assess clinical and care governance at the interface between services.

Staff Governance

IJBs being subject to Local Authority regulations are not subject to the statutory duty of Staff Governance which applies to Health Boards. However, Integration guidance Integration guidance required the Health Board and Local Authority to develop an IJB Workforce and Organisational Development strategy for integrated functions.

The Health Board has a continuing responsibility to ensure that the Staff Governance principles are in place for all staff, including those working within delegated functions and Local Authorities retain a duty of care for the staff they employ.

The following principles will apply:

i) These strategies should be updated regularly to ensure that they are consistent with and support the current IJB Strategic Plan and are coherent with those of the partner bodies

ii) The delivery of the Strategic Plan is dependent on having the right staff in the right areas with the right skills; it is therefore imperative that they receive assurance on the delivery of the IJB Workforce and Organisational Development strategy and /or those of the partner bodies as they relate to IJB functions and risks.

iii) Any decisions made by the IJB around staff employed by the NHS must comply with Staff Governance standards including Staff Governance Monitoring requirements;

iv) Similarly, any decisions made in relation to staff employed by the Local Authority must comply with relevant local policies, in the absence of national guidance.

v) The Health Board Staff Governance Committee must receive appropriate assurances on Staff Governance for staff working within the Health and Social Care partnerships;

vi) In the longer term, to ensure equity of treatment, IJBs may wish to consider how the principles embedded within the Staff Governance standards and any Local Authority equivalent can be applied to all staff to ensure the highest standards of staff governance whilst avoiding unnecessary duplication and the need to run parallel systems.

Financial Governance

All Integration Schemes contained provision for overspends. In general they required the IJB to take action to reduce any overspend but also required the partner bodies to make good any residual shortfall, although the contributions from each varied across regions and was also frequently time dependent.

Almost all integration schemes require the Chief Officer and Chief Finance Officer to present a recovery plan to the Parties and the Integration Joint Board to address in year overspends and any recurring overspends for future financial years and state that the IJBs are responsible for decisions on the budgets delegated to them.

The net effect is that whilst the IJB is responsible for mitigating financial risk, financial responsibility is ultimately borne by the partner bodies. Frequently partner bodies are now exposed to financial risk arising from all expenditure within the IJB, whether or not that expenditure is associated with functions delegated by them and will therefore require to be fully aware of the IJB's financial risk profile.

Whilst Integration Schemes place the responsibility for managing overspends on the IJBs, there is no clarity around the relationship between the IJBs' transformation and cost-savings programmes and those of the partner bodies, which still include IJB functions. In addition, there is a requirement for further detail on the provisions for LHS services.

The MSG report made the following recommendations, with similar issues, also reflected in individual IJB self-assessments:

a) Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration
b) Delegated budgets for IJBs must be agreed timeously
c) Delegated hospital budgets and set aside requirements must be fully implemented.
d) Each IJB must develop a transparent and prudent reserves policy
e) Statutory partners must ensure appropriate support is provided to IJB S95 Officers.
f) IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations

It should be noted that a number of partner bodies have now been impacted by IJB overspends. There has been a particular issue where the overspend lay in areas formally under the control of the other partner body which has meant that financial forecasting has not identified issues as early as possible.

In addition to the MSG recommendations, the following principles will apply:

i) Partner body DoFs and IJB CFOs must design systems to produce comprehensive information that allow each body to understand the financial risk and provide assurance over the financial controls in

operation across the whole system with no omission and no unnecessary duplication.

ii) Savings and transformation/service redesign programmes in partner bodies must include IJB representation and must clearly state responsibility for implementation and the linkages between the monitoring and performance management processes for these programmes and those of the IJB. Given that the financial risks ultimately reside with the partner bodies, the IJB must provide suitable and regular assurances to the relevant Committees of the partner bodies. There will be clear protocols for dispute resolution where the IJB and partner body disagree on key elements of efficiency or service redesign;

iii) The property strategies of partner bodies must take into account the strategic intentions of the IJBs and vice-versa;

iv) As part of the response to the MSG report requiring acceleration in progress, the financial implications of LHS should be explored further to fulfil the requirements of the relevant guidance and provide certainty around the implications of changes to cost and volume.

v) The fraud policies of the partner bodies must reflect HSCI and consider the appropriate mechanism for fraud investigation where, for example, an employee of one body is under investigation for actions undertaken within the other, recognising the principle that all actions are undertaken under the auspices of the financial and other regulations of one or other of the partner bodies.

Information Governance

The agreed Governance Principles for Health and Social Care Integration include the principle that accountability for operational controls is retained by the parent bodies. The staff working in the Health and Social Care Partnerships are employees of the NHS and Local Authorities and in order to fulfil their role will often need to access information held by the organisation that is not their employer in order to provide a safe, efficient and effective Health and Social Care Service. There are threats to the confidentiality, integrity and availability of information processed by the NHS and Local Authorities who have legislative responsibilities to mitigate against these threats (eg Data Protection Act 2018, GDPR, NIS Regulations).

The following principles will apply:

i) Barriers to staff from either body accessing information that may impact on the ability to provide a safe, efficient and effective Health and Social Care Service will be identified and removed whilst complying with legislative requirements for protecting the confidentiality, integrity and availability of information;

ii) The information governance policies, procedures and protocols of the partner bodies shall be amended to reflect integration and partnership working and for each system the data controller and data processor shall be identified with particular consideration given to the role of the IJB and the issues arising from the possibility that staff from outside the body will have access to information and systems;

iii) Partner body EHealth and IT strategies/delivery plans should be congruent with and support the delivery of, of the IJB Strategic Plan and any associated transformation plans.

iv) The partner bodies should work together ensure that their information systems facilitate partnership working and address any issues where staff from other bodies require access to systems.

v) The principles should be monitored through the governance systems of each body with appropriate assurances provided to the IJB and escalation of any Information Governance or eHealth risk which could impact on achievement of their Strategic Plan and result in regulatory penalties and reputational damage.