INVERCLYDE HSCP Health and Social Care Partnership

Agenda 2015

Inverclyde Integration Joint Board

For meeting on:

10	August	2015

Municipal Buildings, Greenock PA15 1LY

Ref: SL/AI

Date: 30 July 2015

A meeting of the Inverclyde Integration Joint Board will be held on Monday 10 August 2015 at 3pm within the Municipal Buildings, Greenock.

Gerard Malone
Head of Legal and Property Services

BUSINESS

1.	**Apologies, Substitutions and Declarations of Interest**	**Page**
2.	**Minute of Inverclyde Shadow Integration Joint Board of 28 May 2015**	**p**
3.	**Membership of the Inverclyde Integration Joint Board** Report by Head of Legal & Property Services	**p**
4.	**Integration Joint Board – Integration Scheme – Standing Orders and Code of Conduct** Report by Head of Legal & Property Services	**p**
5.	**Appointment of Chief Officer** Report by Chief Executive, NHS Greater Glasgow & Clyde and Chief Executive, Inverclyde Council	**p**
6.	**Appointment of Chief Finance Officer** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**
7.	**Financial Regulations** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**
8.	**Audit and Risk Management Strategy - Update** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**
9.	**Inverclyde Health & Social Care Partnership – Due Diligence Process** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**
10.	**Establishment Plan 2015/2016** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**

11.	**Update on Delayed Discharge Performance** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**
12.	**Update on Prescribing and Medicines Management 2015** Report by Chief Officer Designate, Inverclyde Health & Social Care Partnership	**p**

Enquiries to - **Sharon Lang** - Tel 01475 712112

Inverclyde Shadow Integration Joint Board

Thursday 28 May 2015 at 3pm

Present: Councillors V Jones, S McCabe, J McIlwee and L Rebecchi, Dr D Lyons, Mr A Macleod, Mr R Finnie, Dr H MacDonald, Mr B Moore, Ms L Bairden, Mr R Taggart, Ms D McCrone, Ms M Telfer, Mr I Bruce and Ms S McLeod.

Chair: Councillor McIlwee presided.

In attendance: Ms D Gillespie, Head of Mental Health, Addictions & Homelessness, Ms B Culshaw, Head of Health & Community Care, Ms H Watson, Head of Planning, Health Improvement & Commissioning, Ms A Howard, Service Manager, Criminal Justice Services, Ms V Pollock (for Head of Legal & Property Services), Ms S Lang, Legal & Property Services and Ms K Haldane, Executive Officer, Your Voice Inverclyde Community Care Forum.

Prior to the commencement of business, the Chair advised the Board that the Inverclyde Integration Scheme had now been formally approved by the Scottish Government and that the process was under way to have the Inverclyde Integration Joint Board formally established by Order of the Scottish Parliament. The next meeting would therefore be the inaugural meeting of the Inverclyde Integration Joint Board.

396 Apologies, Substitutions and Declarations of Interest 396

Apologies for absence were intimated on behalf of Mr K Winter, Dr C Jones, Mr A Black and Ms C Roarty.

No declarations of interest were intimated.

397 Health & Social Care Integration – Remit and Membership of Inverclyde Shadow Integration Joint Board 397

There was submitted a report by the Head of Legal & Property Services (1) seeking approval of the proposed remit of the Shadow Integration Joint Board (Shadow IJB), (2) setting out the proposed membership arrangements and (3) advising of the appointment of the Chair and Vice-Chair of the Shadow IJB.

Decided:

(1) that approval be given to the remit for the Shadow IJB as set out in Appendix 1 to the report;

(2) that the proposed membership arrangements for the Shadow IJB set out in Appendix 2 be noted; and

(3) that the appointment of Councillor Joe McIlwee as Chair and Mr Ken Winter as Vice-Chair of the Shadow IJB be noted.

398 **Health & Social Care Integration – Standing Orders for Meetings of the Shadow Integration Joint Board** 398

There was submitted a report by the Head of Legal & Property Services seeking approval for procedural Standing Orders to govern the conduct of meetings of the Shadow Integration Joint Board (Shadow IJB).

Decided: that approval be given to the proposed Standing Orders detailed in Appendix 1 of the report as the Standing Orders to govern the conduct of meetings of the Shadow IJB.

399 **Financial Governance Arrangements – Progress Report** 399

There was submitted a report by the Chief Officer Designate, Inverclyde Health & Social Care Partnership advising the Shadow IJB of progress in developing a financial governance and reporting framework for the IJB once operational.

Decided: that the Shadow IJB note the contents of the report and agree to receive progress and implementation updates at future Board meetings.

400 **Health & Social Care Partnership Integration Update** 400

There was submitted a report by the Chief Officer Designate, Inverclyde Health & Social Care Partnership (1) on the preparation and submission of the Inverclyde HSCP Integration Scheme to the Scottish Government for approval, (2) setting out the intentions and preparations for local implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 and (3) presenting a draft outline of the proposed Strategic Plan for approval.

The Head of Planning, Health Improvement & Commissioning advised the Board that since the writing of the report, and as indicated by the Chair at the commencement of the meeting, the Inverclyde Integration Scheme had now been formally approved by the Scottish Government.

Decided:

(1) that the approval of the Inverclyde Integration Scheme by the Scottish Government be noted; and

(2) that approval be given to the draft outline for the Inverclyde Strategic Plan.

401 **Health and Social Care Integration – First Meeting of Inverclyde Integration Joint Board** 401

There was submitted a report by the Chief Officer Designate, Inverclyde Health & Social Care Partnership providing Members of the Shadow IJB with details of the business which it is likely will require to be transacted at the first meeting of the Inverclyde IJB once it has been formally established.

The Chief Officer Designate advised the Board that in addition to the list of suggested agenda items set out in the appendix, it was proposed to submit reports on prescribing and the updated position in relation to delayed discharges.

Decided: that the contents of the report be noted.

402 **Proposed Dates of Future Meetings** 402

There was submitted a report by the Head of Legal & Property Services requesting the Shadow IJB to consider a timetable of future dates based on five meetings per year.
Decided: that it be agreed that the Inverclyde Integration Joint Board meet at 3pm on the following dates:

Monday 10 August 2015
Tuesday 10 November 2015
Tuesday 26 January 2016
Tuesday 15 March 2016
Tuesday 10 May 2016

403 **Update on Delayed Discharge Performance** 403

There was submitted a report by the Chief Officer Designate, Inverclyde Health & Social Care Partnership providing an update on progress towards achieving the target for delayed discharge from 1 April 2015.
Decided: that the progress towards achieving the delayed discharge target and the ongoing work to maintain performance be noted.

AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Head of Legal & Property Services**	**Report No:**	**VP/LP/107/15**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Membership of the Inverclyde Integration Joint Board**		

1.0 PURPOSE

1.1 The purpose of this report is to consider the membership of the Inverclyde Integration Joint Board ("IJB").

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards.

2.2 This report sets out the proposed membership arrangements for the Inverclyde IJB.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:-

(1) notes its prescribed members, being the:

- voting members at Section A of Appendix 1 of this report; and
- minimum non-voting members at Section B of Appendix 1 of this report; and

(2) agrees the stakeholder members at Sections C and D of Appendix 1 of this report.

Gerard Malone
Head of Legal & Property Services

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards. As a minimum this must comprise:

- voting members appointed by Greater Glasgow and Clyde NHS Board ("the NHS Board") and Inverclyde Council;
- non-voting members who are holders of key posts within either the NHS Board or Inverclyde Council; and
- representatives of groups who have an interest in the IJB.

4.2 There is flexibility for the IJB to appoint additional non-voting members as it sees fit.

4.3 The Order states that Councils must nominate Councillors as voting members. The NHS Board should nominate non-executive directors as voting members. If, within the NHS Board, this cannot be achieved there is scope for the appointment of "appropriate persons" as agreed by the Scottish Ministers. This would mean the appointment of executive directors by the NHS Board, but subject to there being a minimum of two non-executive directors on the IJB.

4.4 The arrangements for the Chair and Vice-Chair, who are drawn from the nominations of the parties, are set out in clause 2.3 of the Integration Scheme.

4.5 There is also provision within the Order for the appointment of proxies. Proxies for voting members of the IJB are to be arranged by the authority which nominated them as voting members. If a non-voting member is unable to attend a meeting of the IJB that member may arrange for a suitably experienced proxy to attend the meeting.

4.6 The membership of the Shadow IJB reflected most of the prescribed membership for the IJB.

5.0 VOTING MEMBERSHIP

5.1 The Integration Scheme sets out that Inverclyde Council and Greater Glasgow and Clyde NHS Board shall each appoint four voting members. Inverclyde Council approved its voting members on 19 February 2015 and the NHS Board approved its voting members on 21 April 2015

5.2 To ensure continuity of membership on the development of expertise in the functions of the IJB, named proxy members have been identified by the Council. The IJB is asked to note these appointments. The NHS is in the process of identifying its proxy voting members

5.3 The names of the voting members are set out in Appendix 1 Section A.

6.0 NON-VOTING MEMBERSHIP – PROFESSIONAL ADVISERS

6.1 The professional advisers are non-voting members. These are identified as:

- the Chief Social Work Officer;
- the Chief Officer of the IJB;
- the Section 95 Officer of the IJB (Chief Financial Officer);
- a General Medical Practitioner;
- a Registered Nurse either employed by the NHS Board or a General Medical Practitioner; and
- a Medical Practitioner who is not a GP.

The latter three post-holders are on the nomination of the NHS Board.

6.2 Dependent on their role, not all of these post-holders may have proxies but where necessary they will arrange to be represented in their absence.

6.3 The IJB is asked to note the professional adviser members detailed at Appendix 1 Section B.

7.0 NON-VOTING MEMBERSHIP – STAKEHOLDER MEMBERS

7.1 The IJB is required to appoint stakeholder members who are non-voting members. These comprise at least one representative of the following groups, all of whom must be operating within the area of the IJB:-

- staff working within an integrated function;
- third sector bodies carrying out health or social care activities;
- service users; and
- unpaid carers.

7.2 As stated at paragraph 4.5, the Order provides that such stakeholder members may arrange for a suitably experienced proxy to attend individual meetings.

7.3 The IJB is asked to agree the stakeholder members as detailed in Appendix 1 Section C.

8.0 NON-VOTING – ADDITIONAL MEMBERS

8.1 The IJB may appoint additional non-voting members, provided they are not a Councillor or non-executive director of the NHS Board. Based on the members identified for the Shadow IJB, the proposal for the IJB is detailed at Appendix 1 Section D.

8.2 As stated at paragraph 4.5, the Order provides that such stakeholder members may arrange for a suitably experienced proxy to attend individual meetings.

8.3 The IJB is invited to agree the non-voting additional members as detailed in Appendix 1 Section D.

9.0 IMPLICATIONS

9.1 Finance

There is no direct financial implication in respect of the proposal.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
n/a	n/a	n/a	n/a	n/a	n/a

Annually Recurring Costs/(Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
n/a	n/a	n/a	n/a	n/a	n/a

9.2 Legal

The membership of the IJB is set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

9.3 Human Resources

None.

9.4 Equalities

None.

9.5 Repopulation

There are no direct implications in respect of repopulation.

10.0 CONSULTATIONS

10.1 The interim Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

10.2 The report has also been subject to consultation with representatives from Greater Glasgow and Clyde NHS Board.

11.0 BACKGROUND PAPERS

Public Bodies (Joint Working) (Scotland) Act 2014
The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Draft Standing Orders for the Inverclyde Integration Joint Board

Inverclyde Integration Joint Board Membership

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Joe McIlwee (Chair) Councillor Stephen McCabe Councillor Ciano Rebecchi Councillor Vaughan Jones	Councillor Gerry Dorrian Councillor Jim Clocherty Councillor Kenny Shepherd Councillor Ronnie Ahlfeld
Greater Glasgow and Clyde NHS Board	Mr Ken Winter (Vice Chair) Dr Donald Lyons Mr Allan MacLeod Mr Ross Finnie	To be advised
SECTION B. NON-VOTING PROFESSIONAL ADVISORY MEMBERS		
Chief Officer of the IJB	Brian Moore (To be confirmed – See separate agenda item)	
Chief Social Worker of Inverclyde Council	Brian Moore	
Chief Finance Officer	Lesley Bairden (To be confirmed – See separate agenda item)	
Registered Medical Practitioner who is a registered GP	Inverclyde Health & Social Care Partnership Clinical Director Dr Hector MacDonald	
Registered Nurse	Professional Nurse Advisor Ms Cathy Roarty	
Registered Medical Practitioner who is not a registered GP	Chief Medical Officer Dr Chris Jones	
SECTION C. NON-VOTING STAKEHOLDER REPRESENTATIVE MEMBERS		
A staff representative (Council)	Mr Robin Taggart (UNISON Branch Secretary)	
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Mr Ian Bruce Manager CVS and Chief Executive Inverclyde Third Sector Interface	

A service user	Ms Margaret Telfer Chair Inverclyde Health and Social Care Partnership Advisory Group	
A carer representative	Mr Alistair Black	
SECTION D. ADDITIONAL NON-VOTING MEMBERS		
Representative of Inverclyde Housing Association Forum	Ms Sandra McLeod, Director of Housing & Customer Services, River Clyde Homes	

AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Head of Legal & Property Services**	**Report No:**	**VP/LP/108/15**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Integration Joint Board Integration Scheme, Standing Orders and Code of Conduct**		

1.0 PURPOSE

1.1 The purpose of this report is to consider the governance arrangements of the Inverclyde Integration Joint Board (IJB).

2.0 SUMMARY

2.1 This report sets out the approved Integration Scheme, together with a request to approve the procedural Standing Orders which will govern the conduct of meetings of the IJB. The report also highlights the requirement for members to subscribe to and comply with the Code of Conduct for Members of Devolved Public Bodies.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board:-

(1) notes the contents of the Integration Scheme detailed in Appendix 1 of this report;

(2) approves the Standing Orders detailed in Appendix 3 of this report as the Standing Orders to govern the conduct of meetings of the Inverclyde Integration Joint Board; and

(3) notes the terms of the model Code of Conduct for Members of Devolved Public Bodies as detailed in Appendix 4 of this report.

Gerard Malone
Head of Legal & Property Services

4.0 INTEGRATION SCHEME

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland. The Act requires health boards and local authorities to integrate strategic planning and service provision arrangements for adult health and social care services. The Act also provides the local discretion to allow for the inclusion of further functions – such as criminal justice and children's health and social care (which services were already included within the previous Community Health and Care Partnership (CHCP) in Inverclyde) – should the public bodies involved agree to do so.

4.2 The Act requires that the Council and the Health Board jointly prepare, jointly consult upon and then approve an Integration Scheme for their local integration authority. An Integration Scheme is a document which sets out how the IJB will work once established and covers many topics including type of integration model, the scope of the services to be included within the IJB and financial arrangements.

4.3 The Inverclyde Integration Scheme is a legally binding document and is attached as Appendix 1 of this report.

4.4 The Integration Scheme covers matters such as:-

- the aims and outcomes of the IJB;
- the Integration Model i.e. IJB;
- the functions to be delegated to it;
- the governance arrangements that it will operate under;
- clinical and care governance arrangements;
- workforce matters including the role and responsibilities of the Chief Officer;
- financial governance and operation;
- risk, claims and complaints;
- information sharing;
- participation and engagement;
- dispute resolution.

4.5 The Inverclyde Integration Scheme was approved by the Scottish Ministers and the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment Order 2015 laid before the Scottish Parliament on 29 May 2015, coming into force on 27 June 2015. A copy of the Order is at Appendix 2 of this report.

4.6 It should be noted that the Act requires that in order for the services and functions set out in Annex 1 and Annex 2 of the Integration Scheme to be formally delegated in practice to the IJB, a local strategic plan must first be prepared and approved by it. (See separate item on this meeting's agenda).

5.0 STANDING ORDERS

5.1 The Standing Orders attached at Appendix 3 are based on the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014 ("the Order"). The Order lists certain mandatory provisions which require to be included within Standing Orders. Most of these are identical to the provisions of the Standing Orders of the Shadow IJB. The key additions are as follows:-

- the detailed provisions on membership of the IJB as contained in Standing Orders 2 and 3;
- the introduction of a dispute resolution mechanism to be used in the case where there is an equality of votes, Standing Order 17.4; and
- the provision to allow members to contribute to a meeting of the IJB through remote access – Standing Order 10.6.

5.2 Other aspects of the content of the proposed Standing Orders have been carried forward from the Standing Orders adopted by the Shadow IJB. For example, the existing provisions for

public access to meetings and exempt items have been retained. Essentially these provide for public access to all reports except those which are certified as exempt under Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973.

5.3 In addition, as the Chair does not have a casting vote, those provisions adopted by the Shadow IJB to address situations where consensus cannot immediately be reached between voting members have also been retained.

5.4 It is good practice to regularly review key governance documents. It is recommended that such a review takes place after the IJB's first year of operation.

6.0 CODE OF CONDUCT

6.1 The IJB is a devolved pubic body in terms of the Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the 2000 Act"). The 2000 Act provides for Codes of Conduct for members of relevant public bodies and imposes on those bodies a duty to help their members comply with the relevant code. Accordingly, the Standing Orders for the IJB (Standing Order 19) describe that members of the IJB shall subscribe to and comply with the Standards in Public Life – Code of Conduct for Members of Devolved Public Bodies.

6.2 Members of the Board of NHS Greater Glasgow and Clyde have already subscribed to the Code of Conduct for Members of Devolved Public Bodies. All members of the IJB are required to subscribe to the code and a copy of the code and the related guidance note are attached as Appendices 4 and 5.

6.3 The code requires members to observe the rules of conduct to ensure equity and transparency and to register their interests, financial and non-financial. With this in mind, all members must review regularly, at least annually, their personal circumstances with these requirements in mind. They must not at any time advocate or encourage any action contrary to the code.

6.4 Members should note that the 2000 Act sets out the provisions for dealing with alleged breaches of the code and the sanctions that can be applied in the event of a breach. These are set out in Annex A to the code which is appended to this report.

6.5 The IJB will require to create a register of members' interests. A form and guidance will be provided to members to enable them to register relevant interests.

7.0 PROPOSALS

7.1 It is proposed that the IJB notes the terms of the approved Integration Scheme, approves the Standing Orders and notes the requirement of all members of the IJB to subscribe to and comply with the Model Code of Conduct for Members of Devolved Public Bodies.

8.0 IMPLICATIONS

8.1 Finance

There are no direct financial implications in respect of the proposals.

8.2 Legal

The Integration Scheme is a legally binding agreement between the Council and the Health Board. The Order attached at Appendix 2 establishes the IJB as a separate legal entity and once the strategic plan is approved, the service and functions referred to in the Integration Scheme will be fully delegated to the IJB. The IJB then has the full autonomy and capacity to act on its own behalf and so can make decisions about its functions and responsibilities as it sees fit.

The IJB is required to adopt Standing Orders for meetings under the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. The Standing Orders at Appendix 3 are drafted to comply with this obligation.

The Model Code of Conduct for Members of Devolved Public Bodies offers clarity as to the standards of conduct that are expected of them in the important role which they exercise. Whilst serving on the IJB, its members carry out their functions on behalf of the IJB itself and not as delegates of their respective Health Board or Council.

8.3 Human Resources

None.

8.4 Equalities

None.

8.5 Repopulation

There are no direct implications in respect of repopulation.

9.0 CONSULTATIONS

9.1 The interim Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

9.2 The report has also been subject to consultation with representatives from Greater Glasgow and Clyde NHS Board.

10.0 BACKGROUND PAPERS

Public Bodies (Joint Working) (Scotland) Act 2014

The Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014

Inverclyde Health and Social Care Partnership

Integration Scheme

Between

INVERCLYDE COUNCIL
And
GREATER GLASGOW AND CLYDE HEALTH BOARD

1. Introduction

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act") requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. They can also choose to integrate planning and delivery of other services – additional adult health and social care services beyond the minimum prescribed by the Scottish Ministers; children's health and social care services and criminal justice social work services. The Act requires the parties to prepare jointly an integration scheme setting out how this joint working is to be achieved. To achieve this, the Health Board and Local Authority can either delegate between each other, or can both delegate to a third body called the Integration Joint Board. Delegation between the Health Board and Local Authority is commonly referred to as a "lead agency" arrangement. Delegation to an Integration Joint Board is commonly referred to as a "body corporate" arrangement.

1.2 This document sets out the Integration Scheme ("the Scheme") for Inverclyde, where Inverclyde Council and NHS Greater Glasgow and Clyde have agreed to a body corporate arrangement which will be known as the Inverclyde Health and Social Care Partnership. The Scheme sets out the detail as to how the Health Board and Local Authority will integrate services. When the Scheme has been agreed locally, the Act requires the Health Board and Local Authority to submit jointly the Scheme for approval by Scottish Ministers. The Scheme follows the chosen model and includes the matters prescribed in Regulations. The body corporate arrangement is the one which most closely reflects Inverclyde's existing Community Health and Care Partnership arrangements, so following this option will support as smooth a transition as possible from our existing Community and Health Care Partnership (CHCP) arrangements to the new Inverclyde Health and Social Care Partnership (HSCP).

1.3 Once the Scheme has been approved by the Scottish Ministers, the Inverclyde Integration Joint Board (which has distinct legal personality) will be established by Order of the Scottish Ministers.

1.4 As a separate legal entity the Integration Joint Board has full autonomy and capacity to act on its own behalf and can, accordingly, make decisions about the exercise of its functions and responsibilities as it sees fit. However, the legislation that underpins the Integration Joint Board requires that its voting members are appointed by the Health Board and the Local Authority, and is made up of elected Councillors, NHS non-executive directors, and other Members of the Health Board where there are insufficient NHS non-executive directors. Whilst serving on the Integration Joint Board its members carry out their functions under the Act on behalf of the Integration Joint Board itself, and not as delegates of their respective Health Board or Local Authority.

1.5 The Integration Joint Board is responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of its functions through the locally agreed operational arrangements set out within the Integration Scheme. Many of the requirements of the legislation will be met by building on the existing plans that have been developed through our integrated CHCP arrangements.

This should place the new Inverclyde HSCP in a strong starting position, as the principles and legislative intent are already firmly in place. Further, the Act gives the Health Board and the Council, acting jointly, the ability to require that the Integration Joint Board replaces their strategic plan in certain circumstances. In these ways, the Health Board and the Council together have significant influence over the Integration Joint Board, and they are jointly accountable for its actions.

2. Aims and Outcomes of the Integration Scheme

2.1 The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act, namely:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively in the provision of health and social care services.

2.2 NHS Greater Glasgow and Clyde and Inverclyde Council have agreed that Children's and Family Health and Social Work and Criminal Justice Social Work services should be included within functions and services to be delegated to the Integration Joint Board therefore the specific National Outcomes for Children and Criminal Justice are also included.

2.3 National Outcomes for Children are:

- Our children have the best start in life and are ready to succeed;
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens; and
- We have improved the life chances for children, young people and families at risk.

2.4 National Outcomes and Standards for Social Work Services in the Criminal Justice System are:

- Community safety and public protection;
- The reduction of re-offending; and
- Social inclusion to support desistance from offending.

2.5 The Health and Social Care Partnership will adopt the Inverclyde CHCP vision and values which are consistent with the Act and policy intent. The vision is “Improving Lives”, underpinned the values that:

- We put people first;
- We work better together;
- We strive to do better;
- We are accountable.

Integration Scheme

The Parties

The parties to this Integration Scheme are:-

The Inverclyde Council, established under the Local Government etc. (Scotland) Act 1994 and having its principal offices at Municipal Buildings, Clyde Square, Greenock, PA15 1LY ("the Council").

And

Greater Glasgow Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Greater Glasgow and Clyde"(NHSGG&C)) and having its principal offices at J B Russell House, Gartnavel Royal Hospital Campus, 1055 Great Western Road, Glasgow, G12 0XH ("the Health Board")

(Together referred to as "the Parties" and each being referred to as "the Party")

1. Definitions and Interpretation

1.1 The following are definitions of terms used throughout the Integration Scheme:

"The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"Chair" means the chair of the Integration Joint Board as appointed in accordance with the arrangements made under Article 4 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Chief Finance Officer" means the officer responsible for the administration of the Integration Joint Board's financial affairs appointed under Section 13 of the Act and Section 95 of the Local Government (Scotland) Act 1973;

"Chief Officer" means the Chief Officer of the Integration Joint Board as referred to in Section 10 of the Act and whose role is more fully defined in Part 9 of the Scheme;

"Health and Social Care Partnership" is the name given to the Parties' service delivery organisation for functions which have been delegated to the Integration Joint Board;

"Health Leads" means individuals who have the professional lead for their respective healthcare profession(s) within the Health and Social Care Partnership;

"Host" means the Integration Joint Board that manages services on behalf of the other Integration Joint Boards in the Health Board area;

"Hosted Services" means those services of the Parties more specifically detailed in Annex 3 which, subject to consideration by the Integration Joint Boards through the Strategic Plan process , the Parties agree will be managed and delivered on a pan Health Board basis by a single Integration Joint Board;

"Integrated Services" means the services of the Parties delivered in a Health and Social Care Partnership for which the Chief Officer has operational management responsibility;

"Integration Joint Board" means the Integration Joint Board to be established by Order under Section 9 of the Act;

"The Integration Scheme Regulations" or "the Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"The Scheme" means this Integration Scheme;

"Services" means those Services of the Parties which are delegated to the Integration Joint Board as more specifically detailed in clause 3 hereof;

"Strategic Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults and children and criminal justice social work in accordance with Section 29 of the Act.

1.2 Whereas in implementation of their obligations under section 2(3) of the Act, the Parties are required to jointly prepare an Integration Scheme for the area of the Local Authority setting out the information required under section 1(3) of the Act and the prescribed information listed in the Integration Scheme Regulations therefore in implementation of these duties the Parties agree as follows:

In accordance with section 2(3) of the Act, the Parties have agreed that the integration model set out in sections 1(4) (a) of the Act will be put in place for Inverclyde Council area, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under Section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

2. Local Governance Arrangements

Remit and Constitution of the Integration Joint Board

2.1 The role and remit of the Integration Joint Board is as set out in the Act.

Voting Members

2.2 The arrangements for appointing the voting membership of the Integration Joint Board are that each Party shall appoint four voting representatives.

Chair

2.3 The first Chair of the Integration Joint Board will be nominated by the Council from its voting representatives and the first Vice Chair will be nominated by the Health Board from its voting representatives.

2.4 The Chair and Vice Chair positions will rotate every two years between the Health Board and the Council, with the Chair being from one Party and the Vice Chair from the other.

Meetings

2.5 The Integration Joint Board will make, and may subsequently amend, standing orders for the regulation of its procedure and business and all meetings of the Integration Joint Board shall be conducted in accordance with them.

3. Delegation of Functions

3.1 The functions that are to be delegated by the Health Board to the Integration Joint Board are set out in Part 1 of Annex 1. The Services to which these functions relate, which are currently provided by the Health Board and which are to be integrated, are set out in Part 2 of Annex 1. The functions in Part 1 of Annex 1 are being delegated only to the extent that they relate to the services listed in Part 2 of Annex 1.

3.2 The functions that are to be delegated by Inverclyde Council to the Integration Joint Board are set out in Part 1 of Annex 2. The Services to which all of these functions relate, which are currently provided by the Council and which are to be integrated, are set out in Part 2 of Annex 2.

4. Local Operational Delivery Arrangements

Responsibilities of the Integration Joint Board on behalf of the Parties

4.1 The remit of the Integration Joint Board is as set out in the Act and includes the following:-

- To prepare and implement a Strategic Plan in relation to the provision of the Integrated Services to adults and children, and criminal justice in the Inverclyde area in accordance with sections 29 to 48 of the Act.
- To allocate and manage the delegated budget in accordance with the Strategic Plan.
- The Integration Joint Board is responsible for the operational oversight of Integrated Services, and through the Chief Officer, is responsible for the operational management of the Integrated Services. These arrangements for the delivery of the Integrated Services will be conducted within an operational

framework established by the Health Board and Council for their respective functions, ensuring both Parties can continue to discharge their governance responsibilities, in line with directions from the Integration Joint Board. The framework applies only to operational delivery.

4.2 The Integration Joint Board will put in place systems, procedures and resources to monitor, manage and deliver the Integrated Services.

4.3 The Integration Joint Board is operationally responsible for directing the delivery by the Parties of the functions and services. The Parties will provide reports to the Integration Joint Board on the delivery of the functions. The Integration Joint Board will respond to such reports, via directions to the Health Board and the Council in line with the Strategic Plan.

4.4 In accordance with Section 26 of the Act, the Integration Joint Board will direct the Council and the Health Board to carry out each function delegated to the Integration Joint Board. This will include Adult, Children and Families Health and Social Work Services and Criminal Justice Social Work Services. Payment will be made by the Integration Joint Board to the Parties to enable the delivery of these functions and services in accordance with the Strategic Plan.

Strategic Plan

4.5 The Integration Joint Board will establish a representative Strategic Planning Group to develop the Strategic Plan. This will include assessing the potential impact of the Strategic Plan on the Strategic Plans of other integration authorities within the Health Board area. All Integration Joint Boards within the Health Board area will share plans at consultation.

4.6 The Parties will provide any necessary activity and financial data for services, facilities or resources that relate to the planned use of services provided by other Health Boards or within other local authority areas by people who live within Inverclyde, and commit to an in-year review during the first year between the Parties and the Integration Joint Board to ensure that the necessary support and information are being provided.

4.7 The Health Board and the Council agree that where they intend to change service provision of non-integrated functions that may have an impact on the Strategic Plan, they will advise the Integration Joint Board.

4.8 The Integration Joint Board is responsible for stakeholder engagement in the production of the Strategic Plan and the development of locality arrangements to support the development of the Strategic Plan.

4.9 The consultation process for the Strategic Plan will include other integration authorities likely to be affected by the Strategic Plan, and the Parties as consultees. Through this process the Integration Joint Board will assure itself that the Strategic Plan does not have a negative impact on the plans of the other integration authorities within the Health Board area.

4.10 Arrangements for emergency and acute services planning in the Health Board area will require joint planning with the other integration authorities within the Health Board area and the Health Board which retains operational responsibility for the delivery of these services.

Performance Targets, Improvement Measures and Reporting Arrangements

4.11 Making use of an outcome focused approach and with regard to delivering services in accordance with the national outcomes, the Strategic Plan will provide direction for the performance framework identifying local priorities and associated local outcomes. Performance targets and improvement measures will be linked to the local outcomes to assess the timeframe for change and the scope of change that is anticipated. Initially performance will be gauged on a set of high-level indicators based on the national outcomes, and related to the delegated functions and resources.

4.12 The Council and the Health Board will work together to develop proposals on these targets, measures and arrangements to meet these requirements to put to the Integration Joint Board for agreement based on Council strategic plans and Single Outcome Agreements and local NHS strategic direction and national NHS Local Delivery Plan and related requirements, and based on the Scottish Government prescribed format once this is issued.

4.13 In the first year following the delegation of functions to the Integration Joint Board, a more detailed core set of indicators will be identified from publicly accountable and national indicators and targets that the Parties currently report against. This process will focus on the core suite of indicators for integration, and indicators that relate to services which sit within the Integration Authorities, and can be regarded as proxy measures against delivering the national outcomes, and that allow assessment at local level against the Strategic Plan.

4.14 The Parties have obligations to meet targets for functions which are not delegated to the Integration Joint Board, but which are affected by the performance and funding of integrated functions.

4.15 Therefore, when preparing performance management information the effect on both integrated and non-integrated functions will be considered and details will be provided of any targets, measures and arrangements for the Integration Joint Board to take into account when preparing the Strategic Plan. Such targets, measures and arrangements will be prepared during the first year of the Integration Joint Board's establishment.

Corporate Support

4.16 The Parties are committed to supporting the Integration Joint Board, providing resources for the professional, technical or administrative services required to support the development of the Strategic Plan and delivery of the integration functions.

4.17 The existing Community Health and Care Partnership planning, performance, quality assurance and development support arrangements and resources will be used as a model for the future strategic support arrangements of the Inverclyde Integration Joint Board.

4.18 The arrangements for providing corporate support services will be subject to ongoing review in the first year following the delegation of functions to the Integration Joint Board.

5. Clinical and Care Governance

5.1 The Health Board's Chief Executive is responsible for clinical governance, quality, patient safety and engagement, supported by the Health Board's professional advisers. This responsibility is delegated to the Chief Officer. The Chief Officer, as part of the Health Board's senior management team, will establish appropriate arrangements to discharge and scrutinise those responsibilities. These arrangements will link to the Health Board-wide support and reporting arrangements, including the systems for reporting of serious clinical incidents.

5.2 The Parties are accountable for ensuring appropriate clinical and care governance arrangements for services provided in pursuance of integration functions in terms of the Act. The Parties are also accountable for ensuring appropriate clinical and care governance arrangements for their duties under the Act.

5.3 The Parties are responsible through commissioning and procurement arrangements for the quality and safety of services procured from the Third and Independent Sectors and to ensure that such Services are delivered in accordance with the Strategic Plan. This responsibility is delegated to the Chief Officer as part of both the Health Board's and Council's senior management team.

5.4 The quality of service delivery will be measured through performance targets, improvement measures and reporting arrangements designed to address organisational and individual clinical or care risks, promote continuous improvement and ensure that all professional and clinical standards, legislation and guidance are met. Performance monitoring arrangements will be included in commissioning or procurement from the Third and Independent Sectors.

5.5 The Parties will ensure that staff working in Integrated Services have the appropriate skills and knowledge to provide the appropriate standard of care. Managers will manage teams of Health Board staff, Council staff or a combination of both and will promote best practice, cohesive working and provide guidance and development to the team. This will include effective staff supervision and implementation of staff support policies.

5.6 Where groups of staff require professional leadership, this will be provided by the relevant Health Lead or Chief Social Work Officer as appropriate.

5.7 The members of the Integration Joint Board will actively promote an organisational culture that supports human rights and social justice; values partnership working through example; affirms the contribution of staff through the application of best practice, including learning and development; and is transparent and open to innovation, continuous learning and improvement.

5.8 In relation to Acute Hospital Services, the Integration Joint Board will be responsible for planning of such Services but operational management of such Services will lie with the Health Board and the Director for Acute Services of the Health Board.

5.9 As detailed in section 6 of the Scheme, the Chief Officer will be an officer of, and advisor to, the Integration Joint Board. The Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the Integration Joint Board and be a member of the Corporate Management Teams of the Parties. The Chief Officer will manage the Integrated Services.

5.10 The Parties will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care. A Clinical and Care Governance group will be established, co-chaired by the Clinical Director and Chief Social Work Officer, and will report to and advise the Chief Officer and the Integration Joint Board, both directly and through the co-chairs also being members of the Strategic Planning Group and being non-voting members of the Integration Joint Board. The Clinical and Care Governance group will contain representatives from the Parties and others including:

- The Senior Management Team of the Partnership;
- Clinical Director;
- Lead Nurse;
- Lead Allied Health Professional;
- Chief Social Work Officer;
- Service user and carer representatives; and
- Third Sector and Independent Sector representatives.

5.11 The Parties note that the Clinical and Care Governance Group may wish to invite appropriately qualified individuals from other sectors to join its membership as it determines, or as is required given the matter under consideration. This may include Health Board professional committees, managed care networks and Adult and Child Protection Committees.

5.12 The role of the Clinical and Care Governance Group will be to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection activity.

5.13 The Clinical and Care Governance Group will provide advice to the strategic planning group, and locality groups within the Health and Social Care Partnership area. The strategic planning and locality groups may seek relevant advice directly from the Clinical and Care Governance Group.

5.14 The Integration Joint Board may seek advice on clinical and care governance directly from the Clinical and Care Governance Group. In addition, the Integration Joint Board may directly take into consideration the professional views of the registered health professionals and the Chief Social Work Officer.

5.15 The Chief Social Work Officer reports to the Council on the delivery of safe, effective and innovative social work services and the promotion of values and standards of practice. The Council confirms that its Chief Social Work Officer will provide appropriate professional advice to the Chief Officer and the Integration Joint Board in relation to statutory social work duties and make certain decisions in terms of the Social Work (Scotland) Act 1968. The Chief Social Work Officer will provide an annual report on care governance to the Integration Joint Board, including responding to scrutiny and improvement reports by external bodies such as the Care Inspectorate. In their operational management role the Chief Officer will work with and be supported by the Chief Social Work Officer with respect to quality of Integrated Services within the Partnership in order to then provide assurance to the Integration Joint Board.

Further assurance is provided through:

(a) the responsibility of the Chief Social Work Officer to report directly to the Council, and the responsibility of the Clinical Director and Health Leads to report directly to the Health Board Medical Director and Nurse Director who in turn report to the Health Board on professional matters;

and

(b) the role of the Clinical Governance Committee of the Health Board which is to oversee healthcare governance arrangements and ensure that matters which have implications beyond the Integration Joint Board in relation to health, will be shared across the health care system. The Clinical Governance Committee will also provide professional guidance to the local Clinical and Care Governance group as required.

5.16 The Chief Officer will take into consideration any decisions of the Council or Health Board which arise from (a) or (b) above.

5.17 The Health Board Clinical Governance Committee, the Medical Director and Nurse Director may raise issues directly with the Integration Joint Board in writing and the Integration Joint Board will respond in writing to any issues so raised.

5.18 The relationships between the different components of clinical and care governance and relationships are represented in diagram from at Annex 5.

Professional Leadership

5.19 The Health Board will nominate professional leads to be members of the Integration Joint Board. The Integration Joint Board will appoint professional leads to the Strategic Planning Group, in compliance with Section 32 of the Act.

5.20 NHS professional leads will relate to the Health Board's professional leads through formal network arrangements. The Health Board's professional leads will also be able to offer advice to the Chief Officer and to the Integration Joint Board.

5.21 The Health Board's Medical and Nursing Director roles support the Chief Officer and Integration Joint Board in relation to medical and nurse education and revalidation. The governance responsibilities of the Integration Joint Board and Chief Officer will also be supported by the Health Board's equalities and child protection functions.

6. Chief Officer

6.1 The Chief Officer will be appointed by the Integration Joint Board upon consideration of the recommendation of an appointment panel selected by the Integration Joint Board to support the appointment process, which panel will include the Chief Executives of each Party as advisors. The Chief Officer will be employed by one of the Parties and will have an honorary contract with the non-employing party. The Chief Officer will be jointly line managed by the Chief Executives of the Health Board and the Council. This will ensure accountability to both Parties and support a system-wide approach by the Health Board across all of its component integration authorities, and strategic direction in line with the Council's corporate priorities. The Chief Officer will be the accountable officer to the Integration Joint Board. The Chief Officer will become a non-voting member of the Integration Joint Board upon appointment to his/her role.

6.2 The Chief Officer will provide a single senior point of overall strategic and operational advice to the Integration Joint Board and be a member of the senior management teams of the Parties. As a member of both corporate management teams the Chief Officer will be able to influence policy and strategic direction of both Inverclyde Council and the Health Board from an integration perspective.

6.3 The Chief Officer will have delegated operational responsibility for delivery of Integrated Services, except acute hospital services with oversight from the Integration Joint Board. In this way the Integration Joint Board is able to have responsibility for both strategic planning and operational delivery. The operational delivery arrangements will operate within a framework established by the Health Board and the Council for their respective functions, ensuring both bodies can continue to discharge their governance responsibilities.

6.4 The Chief Officer will provide a strategic leadership role and be the point of joint accountability for the performance of services to the Integration Joint Board. The Chief Officer will be operationally responsible through an integrated management team for the delivery of Integrated Services within the resources available.

6.5 In the event that the Chief Officer is absent or otherwise unable to carry out his or her functions, the Chief Executives of the Health Board and the Council will, at the request of the Integration Joint Board, jointly appoint a suitable interim replacement.

6.6 Inverclyde Integration Joint Board will be responsible for the strategic planning of the Integrated Services as set out in Annexes 1 and 2 of this Scheme. The Council and the Health Board will discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the Chief Officer, who is part of the Corporate Management Team of both the NHS Board and the Council.

6.7 The Council agrees that the relevant Council lead responsible for the local housing strategy will be required to routinely liaise with the Chief Officer in respect of the Integration Joint Board's role in informing strategic planning for local housing as a whole and the delivery of housing support services delegated to the Integration Joint Board.

6.8 The Chief Officer will have accountability to the Integration Joint Board for Workforce Governance. The Integration Joint Board, through its governance arrangements, will establish formal structures to link with the Health Board's Staff Governance Committee and the Council's Staff Representative Forum.

7. Workforce

7.1 Sustained and successful delivery of Integrated Services will be dependent on an engaged workforce whose skill mix adapts over time to respond to the clinical and care needs of the Inverclyde population. The Parties will work together to ensure effective leadership, management, support, learning and development across all staff groups, and will produce a Workforce Plan that will be prepared and put in

place within the first year following the delegation of functions to the Integration Joint Board.

7.2 Workforce Governance is a system of corporate accountability for the fair and effective management of staff. Workforce Governance in the Integration Joint Board will therefore ensure that staff are;

- Well Informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently with dignity and respect in an environment where diversity is valued
- Provided with a continually improving and safe working environment promoting the health and wellbeing of staff, patients/clients and the wider community

7.3 The Chief Officer, on behalf of the Parties, will develop a Workforce Plan during the first year describing the current shape and size of the workforce, how this will develop as services become more integrated, and what actions will need to be taken to achieve the necessary changes in workforce and skills mix. This will be linked to an Organisational Development Plan that builds on the cultural integration that has already taken place within the CHCP, bringing health and social care values closer together through integrated teams and management arrangements, and underpinned by our vision and values as noted at 2.5..

7.4 The Parties will engage with staff, staff representatives, stakeholders and partner organisations; and make use of relevant information and guidance from education and regulatory bodies for various staff groups; in planning this work, building a collaborative approach through co-operation and coproduction. Both the Workforce Plan and the Organisational Development Plan will be developed and put in place during the first year following the delegation of functions to the Integration Joint Board, and will be reviewed by the Parties on an annual basis.

7.5 Members of the management team may be employed by either the Health Board or the Council, and senior managers may be given honorary contracts from the party

who is not their direct employer. These will allow delegated responsibility for both discipline and grievance with the Health Board and the Council employee groups.

7.6 A Joint Staff Forum will act as a formal consultative body for the workforce. The Forum is founded on the principle that staff and staff organisations will be involved at an early stage in decisions affecting them, including in relation to service change and development. . These Partnership arrangements will meet the required national standards and link to both the Health Board and Council's staff consultative arrangements.

8. Finance

Introduction to this clause

8.1 This clause sets out the arrangements in relation to the determination of the amounts to be paid, or set aside, and their variation, to the Integration Joint Board from the Council and the Health Board.

8.2 The Chief Finance Officer (CFO) will be the Accountable Officer for financial management, governance and administration of the Integration Joint Board. This includes accountability to the Integration Joint Board for the planning, development and delivery of the Integration Joint Board's financial strategy and responsibility for the provision of strategic financial advice and support to the Integration Joint Board and Chief Officer.

Budgets

8.3 Delegated baseline budgets for 2015/16 will be subject to due diligence and based on a review of recent past performance, existing and future financial forecasts for the Health Board and the Council for the functions which are to be delegated.

8.4 The Chief Finance Officer will develop a draft proposal for the Integrated Budget based on the Strategic Plan and present it to the Council and the Health Board for consideration as part of their respective annual budget setting process. The draft proposal will incorporate assumptions on the following:

- Activity changes

- Cost inflation
- Efficiencies
- Performance against outcomes
- Legal requirements
- Transfer to or from the amounts set aside by the Health Board
- Adjustments to address equity of resource allocation

This will allow the Council and the Health Board to determine the final approved budget for the Integration Joint Board.

8.5 Either Party may increase its in year payment to the Integration Joint Board.

8.6 The process for determining amounts to be made available (within the 'set aside' budget) by the Health Board to the Integration Joint Board in respect of all of the functions delegated by the Health Board which are carried out in a hospital in the area of the Health Board and provided for the areas of two or more Local Authorities will be determined by the hospital capacity that is expected to be used by the population of the Integration Joint Board and will be based on:

- Actual Occupied Bed Days and admissions in recent years;
- Planned changes in activity and case mix due to the effect of interventions in the Strategic Plan;
- Projected activity and case mix changes due to changes in population need (i.e. demography & morbidity).

8.7 The projected hospital capacity targets will be calculated as a cost value using a costing methodology to be agreed between the Council, the Health Board and the Integration Joint Board. If the Strategic Plan sets out a change in hospital capacity, the resource consequences will be determined through a detailed business case which is incorporated within the Integration Joint Board's budget. This may include:

- The planned changes in activity and case mix due to interventions in the Strategic Plan and the projected activity and case mix changes due to changes in population need;
- Analysis of the impact on the affected hospital budgets, taking into account cost behaviour (i.e. fixed, semi fixed and variable costs) and

timing differences (i.e. the lag between reduction in capacity and the release of resources).

Budget Management

8.8 The Integration Joint Board will direct the resources it receives from the Parties in line with the Strategic Plan, and in doing so will seek to ensure that the planned activity can reasonably be met from the available resources viewed as a whole, and achieve a year-end break-even position.

Overspends

8.9 The Chief Officer will deliver the outcomes within the total delegated resources and where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the Integration Joint Board and the appropriate finance officers of the Parties must agree a recovery plan to balance the overspending budget, which recovery plan shall be subject to the approval of the Integration Joint Board. In the event that the recovery plan does not succeed, the first resort should be to the Integration Joint Board reserves, where available, in line with the Integration Joint Board's Reserves policy. The Parties may consider as a last resort making additional funds available, on a basis to be agreed taking into account the nature and circumstances of the overspend, with repayment in future years on the basis of the revised recovery plan agreed by the Parties and the Integration Joint Board. If the revised plan cannot be agreed by the Parties, or is not approved by the Integration Joint Board, mediation will require to take place in line with the dispute resolution arrangements set out in this Scheme.

Underspends

8.10 Where an underspend in an element of the operational budget, with the exception of ring fenced budgets, arises from specific management action, this will be retained by the Integration Joint Board to either fund additional capacity in-year in line with its Strategic Plan or be carried forward to fund capacity in subsequent years of the Strategic Plan subject to the terms of the Integration Joint Board's Reserves Strategy. Any windfall underspend will be returned to the Parties in the same proportion as individual Parties contribute to joint pressures in that area of spend., as the default position unless otherwise agreed between the Parties.

Unplanned Costs

8.11 Neither Party may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within either the Council or the Health Board without the express consent of the Integration Joint Board and the other Party.

Accounting Arrangements and Annual Accounts

8.12 Any transaction specific to the Integration Joint Board e.g. expenses, will be processed via the Council ledger, with specific funding being allocated by the Integration Joint Board to the Council for this.

8.13 The transactions relating to operational delivery will continue to be reflected in the financial ledgers of the Council and Health Board with the information from both sources being consolidated for the purposes of reporting financial performance to the Integration Joint Board.

8.14 The Chief Officer and Chief Finance Officer will be responsible for the preparation of the annual accounts and financial statement in line with proper accounting practice, and financial elements of the Strategic Plan and such other reports that the Integration Joint Board might require. The year-end balances and in-year transactions between the Integration Joint Board and the Parties will be agreed in line with the NHS Board accounts timetable. The Chief Finance Officer will provide reports to the Chief Officer on the financial resources used for operational delivery and strategic planning.

8.15 Periodic financial monitoring reports will be issued by the Chief Finance Officer to the Chief Officer in line with timescales agreed by the Parties. Financial Reports will include subjective and objective analysis of budgets and actual/projected outturn, and such other financial monitoring reports as the Integration Joint Board might require.

8.16 In advance of each financial year a timetable of reporting will be submitted to the Integration Joint Board for approval, with a minimum of four financial reports being submitted to the Integration Joint Board. This will include reporting on the Acute activity and estimated cost against Set Aside budgets.

Payments between the Council and the Health Board

8.17 The schedule of payments to be made in settlement of the payment due to the Integration Joint Board will be Resource Transfer, virement between Parties and the net difference between payments made to the Integration Joint Board and resources delegated by the Integration Joint Board will be transferred between agencies initially in line with existing arrangements, with a final adjustment on closure of the Annual Accounts. Future arrangements may be changed by local agreement.

8.18 In the event that functions are delegated part-way through the 2015-16 financial year, the payment to the Integration Joint Board for delegated functions will be that portion of the budget covering the period from the delegation of functions to the Integration Joint Board to 31 March 2016.

Capital Assets and Capital Planning

8.19 Capital and assets and the associated running costs will continue to sit with the Parties. The Integration Joint Board will require to develop a business case for any planned investment or change in use of assets for consideration by the Parties.

9. Participation and Engagement

9.1 Consultation on this draft Integration Scheme has taken place as part of the Integration transitional arrangements during the year 2014/15, and in accordance with the requirements of the Act (consultation timetable referenced at Annex 4).

9.2 The stakeholders consulted in the development of this Scheme were:

- All stakeholder groups as prescribed in Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 (see Annex 4)
- The other five local authorities within the Health Board catchment area.

9.3 All responses received during consultation have been reviewed and taken into consideration in the production of this Scheme.

9.4 The Parties commit to agreeing shared principles for engagement and participation that the Integration Joint Board will use. This engagement strategy will be in line

with the principles and practice endorsed by the Scottish Health Council and those set out in the National Standards for Community Engagement, and will be developed and produced by the Strategic Planning Group that will include representation from the existing forums as detailed at 9.5. The participation and engagement strategy will be produced by the end of the first year of the delegation of functions to the Integration Joint Board.

9.5 Existing forums, including the CHCP People Involvement Network and Advisory Group and Third Sector Interface along with other community networks and stakeholder groups with an interest in health and social care provided by NHS Greater Glasgow & Clyde and Inverclyde Council will be part of the process of engagement.

10. Information-Sharing and Data Handling

10.1 The Council and the Health Board have worked along with all local authorities in the Health Board area through the Joint Information and Health Systems Group to develop, review and maintain an Information Sharing Protocol. The Information Sharing Protocol will be reviewed by the Integration Joint Board two years following the delegation of functions to the Integration Joint Board and at least every two years thereafter. The review will consider any future changes in information governance or data protection legislation, and the Integration Joint Board will consider, as part of the review process, any amendments required to improve the Information Sharing Protocol.

10.2 The Parties positively encourage their staff to share information appropriately about their service users when it benefits their care and when it is necessary to protect vulnerable adults or children. The document describes how the Parties will exchange information with each other - particularly information relating to identifiable living people, known legally as “personal data”. The purpose of the document is to explain why the partner organisations want to exchange information with each other and to put in place a framework which will allow this information to be exchanged in ways which respect the rights of the people the information is about and with their explicit consent to share, while recognising the circumstances in which staff must share personal data to protect others, without the consent of the individual. This

protocol complies with the laws regulating this, particularly the Data Protection Act 1998.

10.3 This Protocol will be reviewed every two years and, as a consequence of submission to Information Commissioners Office (ICO) for endorsement, will be subject to audit at the discretion of the Information Commissioner. All Parties agree to such auditing and undertake to provide all necessary cooperation with the ICO in the event of an audit being held or considered.

11. Complaints

The Parties agree the following arrangements in respect of complaints.

11.1 The Parties will work together with the Chief Officer to agree a single streamlined process for complaints relating to integrated arrangements that complies with all applicable legal requirements. This will be based on the existing Inverclyde Community Health Care Partnership complaints procedures.

11.2 The Parties agree that as far as possible complaints will be dealt with by front line staff. Thereafter the existing complaints procedures of the Parties provide a formal process for resolving complaints. Complaints can be made by patients, service users and customers or their nominated representatives using a range of methods including an online form, face to face contact, in writing and by telephone. A decision regarding the complaint will be provided as soon as possible and will be no more than 20 working days, unless there is good reason for requiring more time and this reason is communicated to the complainant. If the complainant remains dissatisfied, an internal review might be offered if appropriate. If the complainant still remains dissatisfied, the final stage will be the consideration of complaints by the Scottish Public Services Ombudsman (SPSO). In relation to social work complaints these are, subject to review, presently considered by a Social Work Complaints Review Committee prior to the Ombudsman.

11.3 The Parties agree to work together and to support each other to ensure that all

complaints that require input from both Parties are handled in a timely manner. Details of the complaints procedures will be provided on line, in complaints literature and on posters. Clear and agreed timescales for responding to complaints will be provided.

11.4 If a service user is unable, or unwilling to make a complaint directly, complaints will be accepted from a representative who can be a friend, relative or an advocate, so long as the representative can demonstrate that the service user has authorised that person to act on behalf of the service user.

11.5 The Parties will produce a joint complaints report on an annual basis for consideration by the Integration Joint Board. This report will include details of the number and nature of complaints, and the proportion of complaints responded to within the agreed timescales.

11.6 The means through which a complaint should formally be made regarding Integrated Services and the appropriate member of staff within the Health & Social Care Partnership to whom a complaint should be made will be detailed on the Parties' websites and made available in paper copies within premises.

12. Claims Handling, Liability & Indemnity

12.1 The Council and the Health Board agree that they will manage and settle claims in accordance with common law of Scotland and statute.

12.2 The Parties will establish indemnity cover for integrated arrangements.

13. Risk Management

13.1 The Parties along with all local authorities in the Health Board area have developed a model risk management policy and strategy to support integrated service delivery. This will be available to the Integration Joint Board at its first meeting for noting and approval. The first integrated risk register will be presented to the Integration Joint Board within six months following the delegation of functions to the Integration Joint Board.

13.2 The Parties will support the Chief Officer and the Integration Joint Board with relevant specialist advice, (such as internal audit, clinical and non-clinical risk managers and health and safety advisers).

13.3 The Chief Officer will have overall accountability for risk management ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the Integration Joint Board. The Chief Officer working with the Chief Executives of the Parties will review existing strategic and operational risk registers on a six-monthly basis, identify the appropriate risks to move to the shared risk register and agree mitigations.

14. Dispute Resolution Mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the undernoted process:

a) The Chief Executives of the Parties will meet to resolve the issue;

b) If unresolved, the Parties will each prepare a written note of their position on the issue and exchange it with the others for their consideration within 10 working days of the date of the decision to proceed to written submissions.

c) In the event that the issue remains unresolved following consideration of written submissions, the Chief Executives of the Parties, the Chair of the Health Board and the Leader of the Council will meet to appoint an independent mediator and the matter will proceed to mediation with a view to resolving the issue.

14.2 Where the issue remains unresolved after following the processes outlined in (a)-(c) above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached: the Chief Executives of the Parties, and the Chief Officer will jointly make a written application to Scottish Ministers stating the issues in dispute and requesting that the Scottish Ministers give directions.

Annex 1

Part 1

Functions Delegated by the Health Board to the Integration Joint Board.

Column A	*Column B*
The National Health Service (Scotland) Act 1978 All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978.	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17I (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 48 (residential and practice accommodation); section 55 (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A (remission and repayment of charges and payment of travelling expenses); section 75B (reimbursement of the cost of services provided in another EEA state); section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013); section 79 (purchase of land and moveable property); section 82 use and administration of certain endowments and other property held by Health Boards); section 83 (power of Health Boards and local health councils to hold property on trust); section 84A (power to raise money, etc., by appeals, collections etc.); section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); section 98 (charges in respect of non-residents); and paragraphs 4, 5, 11A and 13 of Schedule 1 (Health Boards). and functions conferred by— The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; The Health Boards (Membership and Procedure) (Scotland)

Column A	*Column B*
	Regulations 2001, The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004) The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; The National Health Service (Discipline Committees) (Scotland) Regulations 2006; The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; and The National Health Service (General Dental Services) (Scotland) Regulations 2010. The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011
Disabled Persons (Services, Consultation and Representation) Act 1986 Section 7 (persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002 All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003 All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by: section 22 (approved medical practitioners); section 34 (inquiries under section 33: cooperation) section 38 (duties on hospital managers: examination, notification etc.); section 46 (hospital managers' duties: notification); section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards); section 230 (appointment of patient's responsible medical

Column A	*Column B*
	officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall); section 281 (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations 2005; The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and The Mental Health (England and Wales Crossborder transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004 Section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010 All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010.	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise
Patient Rights (Scotland) Act 2011 All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011.	Except functions conferred by The Patient Rights (complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36.

Functions prescribed for the purposes of section 1(8) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
The National Health Service (Scotland) Act 1978	

Column A	*Column B*
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17I (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38 (care of mothers and young children); section 38A (breastfeeding); section 39 (medical and dental inspection, supervision and treatment of pupils and young persons); section 48 (residential and practice accommodation); section 55 (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A (remission and repayment of charges and payment of travelling expenses); section 75B (reimbursement of the cost of services provided in another EEA state); section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013); section 79 (purchase of land and moveable property); section 82 use and administration of certain endowments and other property held by Health Boards); section 83 (power of Health Boards and local health councils to hold property on trust); section 84A (power to raise money, etc., by appeals, collections etc.); section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); section 98 (charges in respect of non-residents); and paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards); and functions conferred by— The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 The Health Boards (Membership and Procedure) (Scotland)

Column A	*Column B*
	Regulations 2001/302; The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004; The National Health Service (Discipline Committees) (Scotland) Regulations 2006; The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; The National Health Service (General Dental Services) (Scotland) Regulations 2010; and The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011.
Disabled Persons (Services, Consultation and Representation) Act 1986 Section 7 (persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002 All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003 All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (approved medical practitioners); section 34 (inquiries under section 33: cooperation) section 38 (duties on hospital managers: examination, notification etc.); section 46 (hospital managers' duties: notification); section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards); section 230 (appointment of patient's responsible medical officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall); section 281 (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations

Column A	*Column B*
	2005; The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and The Mental Health (England and Wales Crossborder transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004 Section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010 All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(public functions: duties to provide information on certain expenditure etc.); and section 32 (public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011 All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36.

Part 2

Services delegated by the Health Board to the Integration Joint Board

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine:-
  - Geriatric medicine;
  - Rehabilitation medicine (age 65+);
  - Respiratory medicine (age 65+); and
  - Psychiatry of learning disability (all ages).

- Palliative care services provided in a hospital.
- Services provided in a hospital in relation to an addiction or dependence on any substance.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.
- Health Visiting
- School Nursing
- Speech and Language Therapy
- Specialist Health Improvement
- Community Children's Services
- CAMHS
- District Nursing services
- The public dental service.
- Primary care services provided under a general medical services contract,
- General dental services
- Ophthalmic services
- Pharmaceutical services
- Services providing primary medical services to patients during the out-of-hours period.
- Services provided outwith a hospital in relation to geriatric medicine.
- Palliative care services provided outwith a hospital.
- Community learning disability services.
- Rehabilitative Services provided in the community
- Mental health services provided outwith a hospital.
- Continence services provided outwith a hospital.
- Kidney dialysis services provided outwith a hospital.
- Services provided by health professionals that aim to promote public health.

Annex 2

Part 1

Functions Delegated by the Council to the Integration Joint Board

Column A Enactment conferring function	Column B Limitation
National Assistance Act 1948	
Section 45 (Recovery in cases of misrepresentation or non-disclosure)	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
Disabled Persons (Employment) Act 1958	
Section 3 (Provision of sheltered employment by local authorities)	
Matrimonial Proceedings (Children) Act 1958	
Section 11 (Reports as to arrangements for future care and upbringing of children)	
Social Work (Scotland) Act 1968	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 6B (Local authority inquiries into matters affecting children)	
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.

Column A Enactment conferring function	Column B Limitation
Section 12AZA (Assessments under section 12A - assistance) Section 12AA (Assessment of ability to provide care.) Section 12AB (Duty of local authority to provide information to carer.) Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	So far as it is exercisable in relation to another integration function.
Section 13ZA (Provision of services to incapable adults.) Section 13A (Residential accommodation with nursing.) Section 13B (Provision of care or aftercare.) Section 14 (Home help and laundry facilities.) Section 27 (supervision and care of persons put on probation or released from prison etc.) Section 27 ZA (advice, guidance and assistance to persons arrested or on whom sentence deferred)	So far as it is exercisable in relation to another integration function.
Section 28 (Burial or cremation of the dead.) Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.) Section 78A (Recovery of contributions). Section 80 (Enforcement of duty to make contributions.) Section 81 (Provisions as to decrees for aliment) Section 83 (Variation of trusts) Section 86 (Recovery of expenditure incurred in the provisions of accommodation, services, facilities or payments for persons ordinarily resident in the area of another local	So far as it is exercisable in relation to another integration function.

Column A Enactment conferring function	Column B Limitation
authority from the other local authority)	
Children Act 1975	
Section 34 (Access and maintenance)	
Section 39 (Reports by local authorities and probation officers.)	
Section 40 (Notice of application to be given to local authority)	
Section 50 (Payments towards maintenance of children)	
The Local Government and Planning (Scotland) Act 1982	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Health and Social Services and Social Security Adjudications Act 1983	
Section 21 (Recovery of sums due to local authority where persons in residential accommodation have disposed of assets)	
Section 22 (Arrears of contributions charged on interest in land in England and Wales)	
Section 23 (Arrears of contributions secured over interest in land in Scotland)	
Foster Children (Scotland) Act 1984	
Section 3 (Local authorities to ensure well-being of and to visit foster children)	
Section 5 (Notification by persons maintaining or proposing to maintain foster children)	
Section 6 (Notification by persons ceasing to maintain foster children)	
Section 8 (Power to inspect premises)	

Column A Enactment conferring function	Column B Limitation
Section 9 (Power to impose requirements as to the keeping of foster children)	
Section 10 (Power to prohibit the keeping of foster children)	
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which are integration functions
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
Housing (Scotland) Act 2001	
Section 1 (Homelessness strategies)	
Section 2 (Advice on homelessness etc.)	
Section 5 (Duty of registered social landlord to provide accommodation)	
Section 6 (Duty of registered social landlord: further provision)	
Section 8 (Common housing registers)	
Section 92 (Assistance for Housing Purposes)	Only in so far as it relates to an aid or adaptation.

Housing (Scotland) Act 2006

Section 71(1)(b) (Assistance for housing purposes)	Only in so far as it relates to an aid or adaptation as defined at Section 1(2) of the Public Bodies (Joint Working) (Prescribed Local Authority Functions) (Scotland) Regulations 2014.

Children (Scotland) Act 1995

Section 17
(Duty of local authority to child looked after by them)

Sections 19
(Local authority plans for services for children).

Section 20
(Publication of information about services for children)

Section 21
(Co-operation between authorities)

Section 22
(Promotion of welfare of children in need)

Section 23
(Children affected by disability)

Section 24
(Assessment of ability of carers to provide care for disabled children)

Section 24A
(Duty of local authority to provide information to carer of disabled child)

Section 25
(Provision of accommodation for children etc.)

Section 26
(Manner of provision of accommodation to children looked after by local authority)

Section 27
(Day care for pre-school and other children)

Section 29
(After-care)

Section 30
(Financial assistance towards expenses of education or training)

Section 31
(Review of case of child looked after by local authority)

Section 32
(Removal of child from residential establishment)

Section 36 (Welfare of certain children in hospitals and nursing homes etc.)	
Section 38 (Short-term refuges for children at risk of harm)	
Section 76 (Exclusion orders)	
Criminal Procedure (Scotland) Act 1995	
Section 51 (Remand and committal of children and young persons).	
Section 203 (Reports)	
Section 234B (Drug treatment and testing order).	
Section 245A (Restriction of liberty orders).	
Adults with Incapacity (Scotland) Act 2000	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 40 (Supervisory bodies)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions.

Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions.

Community Care and Health (Scotland) Act 2002

Section 4 (The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002)	
Section 5 (Local authority arrangements for residential accommodation out with Scotland.)	
Section 6 (Deferred payment of accommodation costs)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	

The Mental Health (Care and Treatment) (Scotland) Act 2003

Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	

Management of Offenders etc. (Scotland) Act 2005

Section 10 (Arrangements for assessing and managing risks posed by certain offenders)	

Section 11
(Review of arrangements)

Adoption and Children (Scotland) Act 2007

Section 1
(Duty of local authority to provide adoption service)

Section 4
(Local authority plans)

Section 5
(Guidance)

Section 6
(Assistance in carrying out functions under sections 1 and 4)

Section 9
(Assessment of needs for adoption support services)

Section 10
(Provision of services)

Section 11
(Urgent provision)

Section 12
(Power to provide payment to person entitled to adoption support service)

Section 19
(Notice under section 18: local authority's duties)

Section 26
(Looked after children: adoption not proceeding)

Section 45
(Adoption support plans)

Section 47
(Family member's right to require review of plan)

Section 48
(Other cases where authority under duty to review plan)

Section 49
(Reassessment of needs for adoption support services)

Section 51
(Guidance)

Section 71
(Adoption allowance schemes)

Section 80
(Permanence Orders)

Section 90
(Precedence of certain other orders)

Section 99
(Duty of local authority to apply for variation or revocation)

Section 101
(Local authority to give notice of certain matters)

Section 105
(Notification of proposed application for order)

Adult Support and Protection (Scotland) Act 2007

Section 4
(Council's duty to make inquiries.)

Section 5
(Co-operation.)

Section 6
(Duty to consider importance of providing advocacy and other.)

Section 7
(Visits)

Section 8
(Interviews)

Section 9
(Medical examinations)

Section 10
(Examination of records etc)

Section 11
(Assessment Orders.)

Section 14
(Removal orders.)

Section 16
(Right to move adult at risk)

Section 18
(Protection of moved person's property.)

Section 22
(Right to apply for a banning order.)

Section 40
(Urgent cases.)

Section 42
(Adult Protection Committees.)

Section 43
(Membership.)

Children's Hearings (Scotland) Act 2011

Section 35
(Child assessment orders)

Section 37
(Child protection orders)

Section 42
(Parental responsibilities and rights directions)

Section 44
(Obligations of local authority)

Section 48
(Application for variation or termination)

Section 49
(Notice of application for variation or termination)

Section 60
(Local authority's duty to provide information to Principal Reporter)

Section 131
(Duty of implementation authority to require review)

Section 144
(Implementation of compulsory supervision order: general duties of implementation authority)

Section 145
(Duty where order requires child to reside in certain place)

Section 153
(Secure accommodation)

Section 166
(Review of requirement imposed on local authority)

Section 167
(Appeals to Sheriff Principal: Section 166)

Section 180
(Sharing of information: panel members)

Section 183
(Mutual Assistance)

Section 184
(Enforcement of obligations on health board under Section 183)

Social Care (Self- Directed Support)(Scotland) Act 2013

Section 3
(Support for adult carers.)

Only in relation to assessments carried out under integration functions.

Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 8 Choice of options: children and family members)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

Annex 2

Part 2

Services currently provided by the Local Authority which are to be integrated

Scottish Ministers have set out in guidance that the services set out below must be integrated.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision for adults and young people
- Occupational therapy services
- Re-ablement services, equipment and telecare

In addition Inverclyde Council will delegate:

- Criminal Justice Services
    - Criminal Justice Social Work
    - Prison Based Social Work
    - Unpaid Work
    - MAPPA

- Children & Families Social Work Services
    - Child Protection
    - Fieldwork Social Work Services for Children and Families
    - Residential Child Care including Children's Homes
    - Looked After & Accommodated Children

- Adoption & Fostering
- Kinship Care
- Services for Children with Additional Needs
- Throughcare
- Youth Support / Youth Justice
- Young Carers

- Services for People affected by Homelessness

- Advice Services

- Strategic & Support Services
  - Health Improvement & Inequalities
  - Quality & Development (including training and practise development, contract monitoring and strategic planning)
  - Business Support

Annex 3 – Hosting Arrangements

The Parties will recommend to the Greater Glasgow and Clyde Integration Joint Boards that the Services listed in this annex are managed by one Integration Joint Board on behalf of the other Integration Joint Boards. Where an Integration Joint Board is also the Lead Partnership in relation to a Service in this annex the Parties will recommend that:

(a) It is responsible for the operational oversight of such Service(s);

(b) Through its Chief Officer will be responsible for the operational management on behalf of all the Integration Joint Boards; and

Such Lead Partnership will be responsible for the strategic planning and operational budget of the Hosted Services.

Service Area	**Host Integration Joint Board**
• Continence services outwith hospital	Glasgow
• Enhanced healthcare to Nursing Homes	Glasgow
• Musculoskeletal Physiotherapy	West Dunbartonshire
• Oral Health – public dental service and primary dental care contractual support	East Dunbartonshire
• Podiatry services	Renfrewshire
• Primary care contractual support (medical and optical)	Renfrewshire
• Sexual Health Services (Sandyford)	Glasgow
• Specialist drug and alcohol services and system-wide planning & co-ordination	Glasgow
• Specialist learning disability services and learning disability system-wide planning & co-ordination	East Renfrewshire
• Specialist mental health services and mental health system-wide planning & co-ordination	Glasgow
• custody and prison healthcare	Glasgow

Annex 4

Summary of Consultation

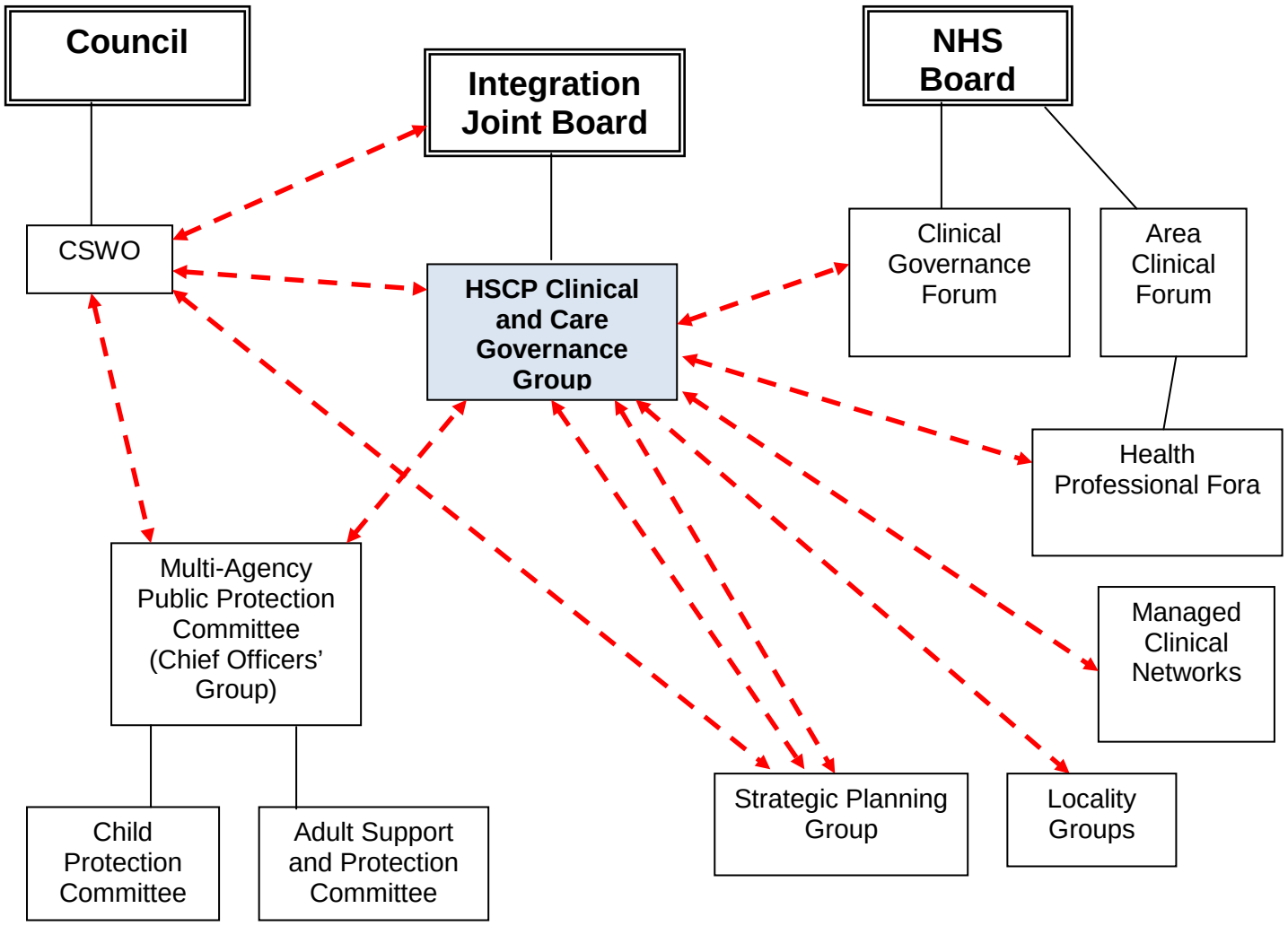
Type Of Consultee	Name of Group/Individual	Means of Consultation
Health Professionals	Inverclyde Staff Partnership Forum	Presentation at meeting and email to all staff
Social Care Professionals		
Primary Care	General Practitioners & Practice Managers	
Users of health care &/or social care	Inverclyde CHCP Advisory Group & People Involvement Network	Presentation at group meetings and distributed to network members
Carers of users of health care &/or social care	As Above and Inverclyde Carers Centre Board Inverclyde Carers Council	
Commercial Providers of health care &/or social care	Scottish Care CVS Inverclyde All Commissioned Service Providers	X 2 Provider Forum Sessions and distributed to all organisations
Non Commercial Providers of health care &/or social care	CVS Inverclyde Inverclyde Third Sector Interface All Grant Funded Third Sector Organisations	
Staff of Inverclyde CHCP who are not health or social care professionals		Via email to all staff
Senior Managers of Inverclyde Council	Corporate Management Team, Inverclyde Council	Presentations and briefing papers
Elected Members of Inverclyde Council	Inverclyde Health & Social Care Committee	Presentations and briefing papers
	Inverclyde CHCP Sub Committee	
Non-Executive Directors of Health Board	Greater Glasgow Health Board	Presentations and briefing papers
	Inverclyde CHCP Sub Committee	
Organisations operating in Inverclyde	Inverclyde Alliance Community Planning Partnership Board	Presentations and briefing papers
Other local authorities within the NHS GGC catchment	East Renfrewshire Council; West Dunbartonshire Council; Renfrewshire Council; East Dunbartonshire Council; Glasgow City Council.	Sharing draft Integration Scheme at various stages of development via email and officer meetings.

Notes

- Consultation has taken account of the parties' statutory obligations in relation to participation and engagement
- Consultation has been synchronised with existing consultation processes and forums to enable engagement with specific groups such as service users, carers, providers, the workforce and partners
- Consultation has taken place via a range of media to support open access for all groups

Annex 5

Clinical and Care Governance – Key Supports and Relationships



SCOTTISH STATUTORY INSTRUMENTS

2015 No. 222

PUBLIC HEALTH

SOCIAL CARE

The Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment Order 2015

Made - - - -	*27th May 2015*
Laid before the Scottish Parliament	*29th May 2015*
Coming into force - -	*27th June 2015*

The Scottish Ministers make the following Order in exercise of the powers conferred by section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(**a**) and all other powers enabling them to do so.

Citation and commencement

1. This Order may be cited as the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment Order 2015 and comes into force on 27th June 2015.

Amendment of the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015

2.—(1) The Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015(**b**) is amended as follows.

(2) In the Schedule, at the end and in the appropriate columns, insert—

"**Integration joint boards established on 27th June 2015**

Argyll and Bute Integration Joint Board	The area of Argyll and Bute Council
East Dunbartonshire Integration Joint Board	The area of East Dunbartonshire Council
East Lothian Integration Joint Board	The area of East Lothian Council
East Renfrewshire Integration Joint Board	The area of East Renfrewshire Council
Edinburgh City Integration Joint Board	The area of Edinburgh City Council
Inverclyde Integration Joint Board	The area of Inverclyde Council

(**a**) 2014 asp 9.
(**b**) S.S.I. 2015/88.

Midlothian Integration Joint Board	The area of Midlothian Council
North Lanarkshire Integration Joint Board	The area of North Lanarkshire Council
Renfrewshire Integration Joint Board	The area of Renfrewshire Council
Shetland Islands Integration Joint Board	The area of Shetland Islands Council
West Dunbartonshire Integration Joint Board	The area of West Dunbartonshire Council".

SHONA ROBISON
A member of the Scottish Government

St Andrew's House,
Edinburgh
27th May 2015

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015 ("the establishment Order") in order to establish integration joint boards for the purposes of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act").

The Schedule to the establishment Order contains a list of integration joint boards established for specified local authority areas. Article 2 amends this list to insert details of integration joint boards to be established on 27th June 2015.

By virtue of the 2014 Act, once an integration joint board is established, it is to carry out such statutory health and social care functions as the local authority and health board for that area delegate to it. Full provision for the delegation of functions and the local operation of each integration joint board is set out in an integration scheme prepared under section 1 or 2 of the 2014 Act, which has been approved by the Scottish Ministers in advance of the integration joint board being established.

Printed in the UK by The Stationery Office Limited under the authority and superintendence of Carol Tullo, the Queen's Printer for Scotland.

£4.25

S201505282 06/2015 19585

http://www.legislation.gov.uk/id/ssi/2015/222

ISBN 978-0-11-102804-9

9 780111 028049

INVERCLYDE HEALTH & SOCIAL CARE PARTNERSHIP

INVERCLYDE INTEGRATION JOINT BOARD

STANDING ORDERS FOR MEETINGS

1 General

1.1 These Standing Orders are made under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. These Standing Orders shall regulate the procedure and business of the Integration Joint Board (IJB) and all meetings of the IJB or of a Committee or Sub-Committee of the IJB must be conducted in accordance with these Standing Orders.

1.2 In these Standing Orders "the Integration Joint Board" or "the IJB" shall means the Inverclyde Integration Joint Board established in terms of the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015, as amended by the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment Order 2015.

1.3 In these Standing Orders, "the Chairperson" means the Chairperson of the IJB, and in relation to the proceedings of any Committee or Sub-Committee of the IJB, means the Chairperson of that Committee or Sub-Committee.

1.4 Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with these Standing Orders.

2 Membership

2.1 The IJB shall have two categories of members:

i. Voting Members from Inverclyde Council ("the Council") and Greater Glasgow and Clyde NHS Board ("the Health Board") as set out in Standing Order 2.2; and
ii. Non-Voting Members as set out in Standing Order 2.3

For the avoidance of doubt, any reference to "Member" or "Members" throughout these Standing Orders, unless otherwise stated includes both Voting Members and Non-Voting Members.

2.2 Voting membership of the IJB shall comprise four persons appointed by the Council and four persons nominated by the Health Board. If the Health Board is unable to fill its places with Non-Executive Directors it can nominate other appropriate people, who must be members of the Health Board to fill their spaces, but at least two must be Non-Executive Directors.

2.3 Non-voting membership of the IJB shall comprise:

a) the Chief Social Work Officer of the Council;
b) the Chief Officer of the IJB;
c) the Proper Officer of the IJB appointed under section 95 of the Local Government (Scotland) Act 1973;
d) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

e) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract;
f) a registered medical practitioner employed by the Health Board and not providing primary medical services.
g) One member in respect of staff of the constituent authorities engaged in the provision of services provided under integration functions;
h) One member in respect of third sector bodies carrying out activities related to health or social care in the area of the local authority;
i) One member in respect of service users residing in the area of the local authority;
j) One member in respect of persons providing unpaid care in the area of the local authority; and
k) Such additional members as the Integration Board sees fit. Such additional members may not be a councillor or a non-executive director of the Health Board.

2.4 The Members appointed under Standing Order 2.3 (d) to (f) must be determined by the Health Board.

2.5 The acts, meetings or proceedings of the IJB shall not be invalidated by any defect in the appointment of any Member.

3 Term of Office of Members

3.1 A Member of the IJB in terms of Standing Order 2.3 (a) to (c) will remain a Member for as long as they hold the office in respect of which they are appointed. Otherwise, the term of office of Members of the IJB shall be for two years or until the day of the next ordinary Elections for Local Government Councillors in Scotland, whichever is shorter.

3.2 Where a Member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Member they replace.

3.3 At the expiry of a Member's term of office, the Member may be reappointed for a further term of office provided that he/she remains eligible and is not otherwise disqualified from appointment.

3.4 A Voting Member ceases to be a Member of the IJB if they cease to be either a Councillor or a non-executive Director of the Health Board or an Appropriate Person in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

4 Proxies

4.1 Named Proxy Members for Voting Members of the IJB may be appointed by the constituent authority which nominated the Voting Member. The appointment of such Proxies will be subject to the same rules and procedures for Members. Proxies shall receive papers for meetings of the IJB but shall be entitled to attend or vote at a meeting only in the absence of the principal Voting Member they represent.

4.2 If the Chairperson or Vice-Chairperson is unable to attend a meeting of the IJB, any Proxy Member attending the meeting may not preside over that meeting.

4.3 If a Non-Voting Member is unable to attend a meeting of the IJB that Non-Voting Member may arrange for a suitably experienced Proxy to attend the meeting.

5 Temporary Vacancies in Voting Membership.

5.1 Where there is a temporary Voting Member vacancy, the vote which would be exercisable by a Voting Member appointed to that vacancy may be exercised jointly by the other Voting Members nominated by the relevant constituent authority.

5.2 In the event that due to two or more temporary vacancies, a constituent authority is consequently able to nominate only one or no Voting Members and where that constituent authority also appointed the Chairperson, the Chairperson of the IJB must be temporarily appointed by the other constituent authority.

5.3 Where a temporary vacancy, or the circumstances in which Standing Order 5.2 applies, persist for longer than six months the Chairperson of the IJB must notify the Scottish Ministers in writing of the reasons why the vacancy remains unfilled.

6 Effect of Vacancy in Membership

6.1 A vacancy in the membership of the IJB will not invalidate anything done or any decision made by the IJB.

7 Resignation of Members

7.1 A Member may resign their membership of the IJB at any time during their term of office by giving notice in writing to the IJB. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified.

7.2 If a Voting Member gives notice under Standing Order 7.1 the IJB must inform the constituent authority which nominated that Voting Member.

7.3 Standing Order 7.1 does not apply to a Member appointed under Standing Order 2.3 (a) to (c).

8 Removal of Members

8.1 If a Member has not attended three consecutive ordinary meetings of the IJB, and their absence was not due to illness or other reasonable cause as determined by the IJB, the IJB may remove the Member from office by providing the Member with one month's notice in writing.

8.2 If a Member acts in a way which brings the IJB into disrepute or in a way which is inconsistent with the proper performance of the functions of the IJB, the IJB may remove the Member from office with effect from such date as the IJB may specify in writing.

8.3 If a Member is disqualified under Article 8 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 during a term of office they are to be removed from office immediately.

8.4 If a Voting Member who is a Councillor appointed on the nomination of the local authority ceases, for any reason, to be a Councillor during a term of office they are to be removed from office with effect from the day that they cease to be a Councillor.

8.5 Subject to paragraphs 8.1 to 8.4, a constituent authority may remove a Member which it nominated by providing one month's notice in writing to the Member and the IJB.

8.6 Where the Health Board or the Council remove an IJB Member, they should nominate a new Member at the earliest opportunity. The ability of the Health Board and Council to remove Members includes all Members nominated by them including the Chairperson and the Vice-Chairperson. The Health Board and the Council are not required to provide reasons for removing a Member nominated by them and can do so at any time but must provide the Member with one month's notice of the decision.

8.7 The Health Board and the Council may not remove IJB Members that are drawn from each other's organisations, so the Health Board may not remove a Councillor who has been chosen to serve as a Member by the Council and the Council may not remove a non-executive director who has been chosen to serve as a Member by the Health Board.

9 Chairperson and Vice-Chairperson

9.1 The Chairperson and Vice-Chairperson will be drawn from the Health Board and the Council Voting Members of the IJB. If a Voting Member appointed by the Council is to serve as Chairperson then the Vice-Chairperson will be a Voting Member nominated by the Health Board and vice versa. The first Chair of the IJB will be appointed on the nomination of the Council.

9.2 The Council may appoint as Chairperson or Vice-Chairperson only a Councillor nominated by it as a Voting Member of the IJB.

9.3 The Health Board may appoint as Chairperson or Vice-Chairperson only a non-executive director nominated by it as a Voting Member of the IJB.

9.4 The appointment to Chairperson and Vice-Chairperson is time limited to a period not exceeding two years, with the roles carried out on a rotational basis between the Council and the Health Board. The term of office of the first Chairperson will be for the period to the next local government elections in 2017, thereafter the term of office of the Chairperson will be for a period of two years. The Council or Health Board may change their appointee as Chairperson or Vice-Chairperson during an appointing period.

9.5 At each meeting of the IJB, the Chairperson, if present, shall preside.

9.6 If the Chairperson is absent from any meeting of the IJB the Vice-Chairperson, if present, shall preside.

9.7 If both the Chairperson and Vice-Chairperson are absent from any meeting of the IJB, a Voting Member chosen at the meeting by the other Voting Members attending the meeting is to preside. In the event of a Proxy Member attending a meeting in place of a Voting Member, Standing Order 4.2 will apply.

9.8 Powers, Authority and Duties of Chairperson and Vice-Chairperson

The Chairperson shall amongst other things:-

a) Preserve order and ensure that every member has a fair hearing;

b) Decide on matters of relevancy, competency and order, and whether to have a recess during the meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the meeting;

c) Determine the order in which speakers can be heard;

d) Ensure that due and sufficient opportunity is given to Members who wish to speak to express their views on any subject under discussion;

e) If requested by any Member ask the mover of a motion, or an amendment, to state its terms;

f) Maintain order and at his/her discretion, order the exclusion of any member of the public who is deemed to have caused disorder or misbehaved.

9.9 The decision of the Chairperson on all matters within his/her jurisdiction shall be final. However, on all matters on which a vote may be taken, Standing Order 17.4 applies. This means that where there is an equality of voting, the Chairperson does not have a second or casting vote.

9.10 Deference shall at all times be paid to the authority of the Chairperson. When he/she speaks, the Chairperson shall be heard without interruption and members shall address the Chairperson while speaking.

10 Meetings

10.1 The first meeting of the IJB is to be convened at a time and place determined by the Chairperson. Thereafter, the IJB shall meet at such place and such frequency as may be agreed by the IJB.

10.2 The Chairperson may convene Special Meetings if it appears to him/her that there are items of urgent business to be considered. Such meetings will be held at a time, date and venue as determined by the Chairperson. If the office of Chairperson is vacant or if the Chairperson is unable to act for any reason, the Vice-Chairperson may at any time call such a meeting.

10.3 A request for a special meeting of the IJB to be called may be made in the form of a requisition specifying the business proposed to be transacted at the meeting and signed by at least two thirds of the Voting Members, presented to the Chairperson.

10.4 If a request is made under Standing Order 10.3 and the Chairperson refuses to call a meeting, or does not call a meeting within 7 days after the making of the request, the Voting Members who signed the requisition may call a meeting.

10.5 The business which may be transacted at a meeting called under Standing Order 10.4 is limited to the business specified in the requisition.

10.6 Adequate provision will be made to allow for Members to attend a meeting of the IJB either by being present together with other Members in a specified place, or in any other way which enables Members to participate despite not being present with other Members in a specified place.

11 Notice of Meeting

11.1 Before each meeting of the IJB, a notice of the meeting specifying the time, place and business to be transacted at it and approved by the Chairperson, shall be sent electronically to every Member or sent to the usual place of residence of every Member so as to be available to them at least five clear days before the meeting.

11.2 Members may opt in writing addressed to the Chief Officer to have notice of meetings delivered to an alternative address. Such notice will remain valid until rescinded in writing.

11.3 A failure to serve notice of a meeting on a Member in accordance with Standing Orders 11.1 and 11.2 shall not affect the validity of anything done at that meeting.

11.4 In the case of a meeting of the IJB called by Members the notice is to be signed by the Members who requisitioned the meeting in accordance with Standing Order 10.3.

11.5 At all meetings of the IJB, no business other than that on the agenda shall be discussed or adopted except where by reason of special circumstances, which shall be specified in the minutes, the Chairperson is of the opinion that the item should be considered at the meeting as a matter of urgency.

12 Quorum

12.1 No business shall be transacted at a meeting of the IJB unless there are present, and entitled to vote both Council and Health Board Voting Members and at least one half of the Voting Members are present.

12.2 If within ten minutes after the time appointed for the commencement of a meeting of the IJB a quorum is not present, the meeting will stand adjourned to such date and time as may be fixed and the minute of the meeting will disclose the reason for the adjournment.

13 Committees

13.1 The IJB may establish committees and sub-committees of its Members for the purpose of carrying out such of its functions as the IJB may determine. When the IJB establishes such a committee or sub-committee, it must determine the membership, Chairperson, remit, powers and quorum of that committee or sub-committee.

13.2 A committee established under Standing Order 13.1 must include Voting Members, and must include an equal number of the Voting Members appointed by the Health Board and the Council.

13.3 Any decision of a committee or sub-committee established under Standing Order 13.1 must be agreed by a majority of the votes of the Voting Members who are members of the committee or sub-committee.

13.4 The IJB may establish working groups but any working group shall have a limited time span determined by the IJB.

13.5 The IJB must determine the membership, Chairperson, remit, powers and quorum of any working group it establishes.

14 Alteration, Deletion and Rescission of Decisions of the Integration Board

14.1 Except insofar as required by reason of illegality, no motion to alter, delete or rescind a decision of the IJB will be competent within six months from the decision, unless a decision is made prior to consideration of the matter to suspend this Standing Order in terms of Standing Order 15.

15 Suspension, Deletion or Amendment of Standing Orders

15.1 Any one or more of the Standing Orders in the case of an emergency as determined by the Chairperson upon motion may be suspended, amended or deleted at any meeting so far as regards any business at such a meeting provided that two thirds of the Voting Members of the IJB present and entitled to vote shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Order(s) to be suspended.

16 Motions, Amendment and Debate

16.1 It will be competent for any Member of the IJB at a meeting of the IJB to move a motion directly arising out of the business before the meeting.

16.2 The mover of a motion or an amendment will not speak for more than ten minutes, except with the consent of the IJB. Each succeeding speaker will not speak for more than five minutes. When the mover of a motion or amendment has spoken for the allotted time he/she will be obliged to finalise speaking, otherwise the Chairperson will direct the Member to cease speaking and to resume his or her seat.

16.3 Subject to the right of the mover of a motion, and the mover of an amendment, to reply, no Member will speak more than once on the same question at any meeting of the IJB except:-

- On a question of Order
- With the permission of the Chairperson
- In explanation, or to clear up a misunderstanding in some material part of his/her speech.

16.4 In all of the above cases no new matter will be introduced.

16.5 The mover of an amendment and thereafter the mover of the original motion will have a right of reply for a period of not more than 5 minutes. He/she will introduce no new matter and once a reply is commenced, no other Member will speak on the subject of debate except as provided for in Standing Order 16.3. Once these movers have replied, the discussion will be held closed and the Chairperson will call for the vote to be taken.

16.6 Amendments must be relevant to the motions to which they relate and no Member will be permitted to move more than one amendment to any motion, unless the mover of the proposed amendment receives no votes in support of the proposed amendment.

16.7 It will be competent for any Member who has not already spoken in a debate to move the closure of such debate. A vote will be taken, and if a majority of the Voting Members present vote for the motion, the debate will be closed. However, closure is subject to the right of the mover of the motion and of the amendment(s) to reply. Thereafter, a vote will be taken immediately on the subject of the debate.

16.8 Any Member may indicate his/her desire to ask a question or offer information immediately after a speech by another Member and it will be the option of the Member to whom the question would be directed or information offered to decline or accept the question or offer of information.

16.9 When a motion is under debate, no other motion or amendment will be moved except in the following circumstances:
- to adjourn the debate in terms of Standing Order 18; or
- to close the debate in terms of Standing Order 16.7.

16.10 A motion or amendment once moved cannot be altered or withdrawn unless with the consent of the majority of those Voting Members present at the meeting.

17 Voting

17.1 Every effort shall be made by Voting Members of the IJB to ensure that as many decisions as possible are made by consensus.

17.2 Only the four Members nominated by the Health Board, and the four Members appointed by the Council shall be entitled to vote.

17.3 Each question put to a meeting of an IJB is to be decided by a majority of the votes of the Voting Members attending and who are entitled to vote on the question. In the case of an equality of votes the Chairperson shall not have a second or casting vote.

17.4 Where there is an equality of votes, if the Members still wish to pursue the issue voted on the Chairperson may either adjourn consideration of the matter to the next meeting of the IJB or to a special meeting of the IJB to consider the matter further or refer the matter to dispute resolution as provided for in the Integration Scheme. Otherwise, the matter shall fall.

18 Adjournment of Meetings

18.1 If it is necessary or expedient to do so a meeting of the IJB may be adjourned to another date, time or place.

18.2 A meeting of the IJB may be adjourned by a motion. Such a motion shall be put to the meeting without discussion. If such a motion is carried by a simple majority of those Voting Members present and entitled to vote, the meeting shall be adjourned to another day, time and place specified in the motion.

19 Codes of Conduct and Conflicts of Interest

19.1 All Members of the IJB shall subscribe to and comply with the terms of the Model Code of Conduct for Members of Devolved Public Bodies and the Guidance relating to that Code of Conduct, both of which are deemed to be incorporated into these Standing Orders. All Members who are not already bound by its terms shall be obliged, before taking up membership, to agree in writing to be bound by the terms of the Model Code of Conduct for Members of Devolved Public Bodies.

19.2 The Chief Officer shall keep a Register in which all Members shall record their interests and hospitality offered by virtue of their membership of the IJB.

19.3 A Member must disclose any direct or indirect pecuniary or other interest in relation to an item of business to be transacted at a meeting of the IJB, before taking part in any discussion on that item.

19.4 Where an interest is disclosed under Standing Order 19.3 the other Members present at the meeting in question must decide whether the Member declaring the interest is to be prohibited from taking part in discussion of, or voting on, the item of business.

20 Disclosure of Information

20.1 No Member or officer shall disclose to any person any information which falls into the following categories:-

a) Confidential information within the meaning of Section 50(a)(2) of the Local Government (Scotland) Act 1973.
b) The full or any part of any document marked “not for publication by virtue of the appropriate paragraph of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973 unless and until the document has been made available to the public or press under section 50B of the said 1973 Act.
c) Any information regarding proceedings of the IJB from which the public have been excluded unless or until disclosure has been authorised by the Council or the Health

Board or the information has been made available to the press or to the public under the terms of the relevant legislation.

20.2 Without prejudice to the foregoing no Member shall use or disclose to any person any confidential and/or exempt information coming to his/her knowledge by virtue of his/her office as a Member where such disclosure would be to the advantage of the Member or of anyone known to him/her or which would be to the disadvantage of the IJB, the Council or the Health Board.

21 Recording of Proceedings

21.1 No sound, film, video tape, digital or photographic recording of the proceedings of any meeting shall be made without the prior written approval of the IJB.

22 Minutes

22.1 The names of the Members and others present at a meeting of the IJB shall be recorded in the minutes of the meeting.

22.2 Minutes of the proceedings of each meeting of the IJB, including any decision made at that meeting, shall be drawn up and submitted to the next ensuing meeting of the IJB for agreement after which they must be signed by the person presiding at that meeting. A minute purporting to be so signed shall be received in evidence without further proof.

23 Admission of Press and Public

23.1 Subject to the extent of the accommodation available and except in relation to items certified as exempt and items likely to involve the disclosure of confidential information, meetings of the IJB shall be open to the public. The Chief Officer shall be responsible for giving public notice of the time and place of each meeting of the IJB by posting on the websites of constituent bodies not less than five clear days before the date of each meeting.

23.2 The IJB may by resolution at any meeting exclude the press and public therefrom during consideration of an item of business where it is likely in view of the nature of the business to be transacted or of the nature of proceedings that if members of the press and public were present there would be a disclosure to them of exempt information as defined in Schedule 7A to the Local Government (Scotland) Act 1973 or it is likely that confidential information would be disclosed in breach of an obligation of confidence.

23.3 Every meeting of the IJB shall be open to the public but these provisions shall be without prejudice to the IJB's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The IJB may exclude or eject from a meeting a member or members of the Public and Press whose presence or conduct is impeding the work or proceedings of the IJB.

APPENDIX 4

Model Code of Conduct for Members of Devolved Public Bodies

February 2014

The Scottish Government
Riaghaltas na h-Alba

MODEL CODE OF CONDUCT FOR MEMBERS OF DEVOLVED PUBLIC BODIES

CONTENTS Page

SECTION 1: INTRODUCTION TO THE MODEL CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. This Model Code for members was first introduced in 2002 and has now been revised following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of a public body, it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Model Code of Conduct.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present. In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your board (if appropriate) will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how the public body's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Model Code of Conduct

1.7 You must observe the rules of conduct contained in this Model Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Model Code of Conduct.

1.8 The Model Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE MODEL CODE OF CONDUCT

2.1 The general principles upon which this Model Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity
You must make decisions solely on merit and in a way that is consistent with the functions of the public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

Respect
You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body.

2.2 You should apply the principles of this Model Code to your dealings with fellow members of the public body, its employees and other stakeholders. Similarly you should also observe the principles of this Model Code in dealings with the public when performing duties as a member of a public body.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of a public body.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the body with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of the public body in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the public body regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term "gift" includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;

(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or

(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain, or for political purposes or used in such a way as to bring the public body into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the public body.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by your public body, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Model Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the body's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex B** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

---

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the public body of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and

(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Model Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Model Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the public body. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Model Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the objective test ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your

public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Model Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared, if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Model Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of a public body. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of a public body as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Model Code).

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non Financial Interests) of Section 4 of the Model Code; or

(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Model Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Model Code does not attempt the task of defining "relative" or "friend" or "associate". Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Model Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of a public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Model Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Model Code or any other relevant rule of the public body or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that

preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Model Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;

ii) all meetings of one or more committees or sub-committees of the public body;

(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking.

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Undertaking" means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

ISBN: 978-1-78412-180-8 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS21717 (02/14)

Published by the Scottish Government, February 2014

w w w . s c o t l a n d . g o v . u k

STANDARDS COMMISSION FOR SCOTLAND

GUIDANCE ON THE MODEL CODE OF CONDUCT for MEMBERS of DEVOLVED PUBLIC BODIES

INTEGRITY IN PUBLIC LIFE

Standards matter: A review of best practice in promoting good behaviour in public life. Extracts from the 2013 report by the Committee on Standards in Public Life

"Codes do not have an impact simply by existing. Principles and rules are necessary but not sufficient to created high standards. Organisations also need the right culture, effective monitoring and strong leadership."

"Many of the requirements for high standards require action at organisational level. But high standards also require individuals to take personal responsibility – by observing high standards themselves, by demonstrating high standards to others through their own behaviour and by challenging inadequate standards when they see them. Mindlessly following rules and processes is not enough if people do not also engage their judgement about what is important. An individual who has internalised sound ethical principles and the reasons they are important is better able to make appropriate decisions than someone simply following a set of rules"

"Practice what you preach – hypocrisy is very damaging to trust.

Introduction

The public rightly expects exemplary standards of behaviour from those serving on the boards of public bodies when undertaking their duties. It is your personal responsibility to comply with the requirements of the Model Code of Conduct as adopted by your public body and your actions should be part and parcel of winning the public's respect and trust in the work you do.

There is a statutory framework governing behaviour in public life, comprising:

- Codes of Conduct which members of devolved public bodies must comply with when carrying out their duties;
- A set of arrangements for dealing with complaints that a member of a public body has acted inappropriately and has contravened the Code of Conduct.

Each public body has a Code of Conduct, based on the Model Code, and each will also have its own internal policies which apply the Code in the context of the body's work.

It is essential to note that as a member of a public body
it is your personal responsibility
to make sure you are familiar with the Code of Conduct and internal policies for your public body and that your actions accord with these.

In other words, simply ticking boxes is not enough; you have to understand the reasons behind good ethical behaviour and apply these thoughtfully on a case by case basis.

This note offers a brief guide on what the Code means for you as a Member of a public body but it is not a substitute for the Code itself, which contains more detail. As a Board Member you must read and abide by the Code.

Section 2: Key principles of the Model Code of Conduct

Exemplary standards of behaviour mean behaving and, importantly, being seen to behave in accordance with nine key principles of public life which you as a Board Member are expected to uphold in carrying your duties. More detail about each principle is provided in the Code. In brief they are:

- Duty
- Selflessness
- Integrity
- Objectivity
- Accountability and Stewardship
- Openness
- Honesty
- Leadership
- Respect

The Code of Conduct is there to help you interpret and to apply these principles. However it is your responsibility to do the thinking and make sure you are meeting the provisions of the Code. In working through this process you may need to exercise your judgement. Sometimes making that judgement is difficult but there are two crucial points: you must exercise it objectively; and

you should bear in mind that perception by informed members of the general public, who know the facts, is an important factor.

This is not the same thing as members of the public not *liking* a decision made or opinion expressed legitimately in the course of your work; it is more about whether you have acted properly.

The Code of Conduct applies to your actions as a member of a public body. However, bear in mind that opinions you express in a personal capacity will attach to you in all your walks of life. It is very difficult to persuade people that you can take a different view, or even have an open mind, in your capacity as a Member of a Devolved Public Body from a view you may have expressed in your personal capacity. This is particularly pertinent in respect of using social media where the separation of public and private comments can be very unclear to someone reading them.

If you need advice, the following sources may help:

- The Code of Conduct;
- Your public body's Standards Officer;
- Your public body's own internal policies (e.g. on use of facilities; gifts; etc.);
- The "On Board" manual published by the Scottish Government.
- Information published on the websites of the Standards Commission for Scotland and the Commissioner for Ethical Standards

You should always think ahead. If you have any concerns about a possible problem, speak to your Standards Officer, Chief Executive or Chair so that action can be taken before a situation becomes a serious problem or a complaint is made against you.

The following information provides a brief guide to the sections in the Code of Conduct – for more details about each section it is important to read the Code of Conduct:

Section 3: General Conduct

You must treat everyone you come into contact with in the course of your work for your public body with courtesy and respect, even if you disagree with their views. A board functions most effectively when diverse views are debated openly and respectfully, and the decisions reached collectively are likewise respected. It also functions most effectively when everyone understands and respects the different and complementary roles of the executive (staff) and non-executive (board members).

Gifts and hospitality

The general rule is that you should not, in your role as a Board Member, accept gifts or hospitality. If you do, there is always the risk it could be interpreted as you being given or invited to something which you wouldn't normally attend, and therefore you may potentially be influenced to show favour towards whoever offers you these gifts and hospitality. Even if this is not the case, there is a risk that your actions could be interpreted that way.

Clearly judgements have to be proportionate. The Code sets out some guidelines to help you decide what action you should take. Your public body should also have an internal policy on the acceptance of gifts/hospitality which will set the Code's guidelines in the context of your particular organisation's work.

Confidentiality

Although Freedom of Information legislation provides widespread public access to information, it is legitimate in some circumstances for a public body to require information and documents to be treated in a confidential manner. Sometimes it is a matter of timing – information that may eventually be released but for the moment it must be kept confidential. You must respect the requirement for confidentiality, even if you do not agree with this requirement.

A related point is that it is not acceptable to disclose information (even if not explicitly confidential) to which you have privileged access as a result of your position if this disclosure leads to personal or financial gain, or is used for political purposes, or would result in damage to the reputation of your public body.

Using Public Body Facilities

The equipment and assets (IT, telephones, photocopiers, meeting rooms, offices etc.) of a public body are paid for by taxpayers – you should only use them in accordance with the organisation's policies. Generally this means only using them in connection with legitimate business of the organisation.

Social Media

When using social media the distinction between work and private life can get blurred, and hastily made comments can get misconstrued. You should be mindful of your role and take care not to compromise your position as a member of a public body by publicly undermining (or appearing to undermine) the actions of the organisation, staff or colleagues. This applies whether you are using your own or the organisation's equipment to access and post comments on social media.

Appointment to Partner Organisations

If you become a director or board member of a company as a nominee of a public body, you need to be conscious of potential conflicts of interest between your two positions. The main point to bear in mind is that if you are nominated in order to represent your public body's interests, then you are still bound by the Code but you may also be required to abide by the rules of the board you have been appointed to. More is said about this in the section on declaration of interests.

Sections 4 & 5: Interests

To ensure complete transparency of decision making by public bodies, and to avoid accusations that members are being inappropriately influenced, the Code requires that you make open to public view all your relevant interests. "Relevant Interests" are all the circumstances that might be considered to affect your judgement during the course of your work for a public body. There are two elements to this – registration of interests and declaration of interests:

Section 4: Registration of Interests

Your public body has a statutory duty to keep a register of the interests of its Members, and this information must be available for public view. It is your responsibility to keep your entries in the register up to date. **You must read the relevant section of the Code for more information.**

Details about two of the categories, namely Category 1 – Remuneration; and Category 2 – Related Undertakings; are considered so important this information must be registered whether or not it is relevant to your role in the public body.

Information about the registration of other interests in relation to the remaining categories is detailed within the Code of Conduct.
Category 3 – Contracts;
Category 4 – Houses, Land and Buildings;
Category 5 – Interests in Shares and Securities;
Category 6 – Gifts and Hospitality;
Category 7 – Non Financial Interests;

Under these categories, you may need to make the judgement on whether the interest could be considered relevant to the work of the public body and whether someone looking in from the outside might consider that your vote or support for a decision could be biased as a result of your interest. If you are in any doubt you should register the interest.

There is no requirement to *register* the interests of those connected to you; however, there **may be** a requirement to *declare* such an interest.

When deciding whether to register gifts or hospitality, remember that they could be offered from any source and not only when you are taking part in official business. The important point to think about is whether these could, or the perception is that these may, influence you in your role as a board member of your public body.

Section 5: Declaration of Interests

This is an area of the Code which comes under particular public scrutiny. It is important that the public and other interested parties have confidence that decisions are being made in accord with the public interest and not for any other reason. So in addition to your entries in the Register of Interests, you may need to declare an interest at a Board or Committee meeting of

your public body prior to a particular item being discussed. Any interest you declare may or may not already be on the Register

You need to consider the objective test:
whether an ordinary member of the public with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your decision making.

- If you consider the objective test is met, you should declare your interest and leave the meeting for the duration of the item under discussion/decision.
- If you consider the objective test is not met you do not need to make a declaration and you can take part in the discussion/decision.
- Occasionally, in the interests of transparency you may wish to explain to the meeting that you have considered the matter in question and reached the conclusion that there is no conflict of interest and the objective test is not met, so you will take part in the item under discussion/decision.

The Code goes into more detail about interests which require declaration – **this is an important area, and it is your responsibility to ensure you are aware of the requirements detailed in section 5 of the Code.**

Remember that the Code only requires registration of ***your*** interests but you must consider whether at a Board meeting for a particular item scheduled to be discussed you should declare any financial or non-financial interests of people or organisations you are connected with. The same principle of the objective test applies.

Membership of More than One Public Body:

Sometimes members may sit on the boards of more than one public body. It is also possible that a member of staff of one public body may be a member of another. This can bring considerable benefits of experience and expertise to each board. Being a member of more than one public body is unlikely, by itself, to result in a conflict of interest, but there can be instances where this will occur. Examples which may cause an issue include:

- When you are a member of more than one body, the duty of collective responsibility applies to each of them. If you find yourself being required to take a decision on something which you have already taken a view on as part of another board or its organisation has stated a clear position on a matter, you will probably need to declare an interest and withdraw.
- In issues involving approval of funding from one body to another, there can be no dubiety; you must declare an interest and withdraw if you are a member of the body potentially receiving the funding.
- Similarly in respect of any quasi-judicial decisions – you cannot be involved in the decision making if you are a member of another body which plays a part in, or is the subject of, that decision.
- In any situation where there is a potential conflict between your differing roles, a sense of proportion is needed, but ultimately you will need to make a judgement based on the objective test.

Directly Elected Members:

Direct elections: if you sit on a public body as a result of a direct election (separate from Council elections) you do not automatically have a conflict of interest (and need to declare) just by virtue of being directly elected; but you still need to apply the objective test on a case by case basis.

Dispensations

The Code does allow for dispensations and these may be granted by the Standards Commission. In the vast majority of cases, however, applying clear reasoning to the objective test should be the guide.

Section 6: Lobbying and Access to Members of Public Bodies

Public bodies aim to be open and accessible to the views and opinions of others, and to make their decisions based on the widest possible evidence and arguments. As a Member you will probably be approached by those wishing to make their views known. This is perfectly legitimate but care is needed, and in these situations you should **be guided by the Code**, in particular:

- Do not do or say, anything that could be construed as your being improperly influenced to take a particular stance on an issue;
- You must not give or be perceived to give preferential access to any one side of an argument
- You must not accept any paid work in which you give advice on how to influence the public body and its members.

Roles, Responsibilities and Sources of Information:

The Chair of the Board

The Chair has additional responsibilities over and above those of Board Members. The Chair should ensure that all Board Members have a proper knowledge and understanding of their corporate roles and responsibilities which should include strategic leadership and the conduct of the Board business. You should seek the advice of your Chair if you are unsure about how to handle an issue.

Scottish Government Sponsor Team

Sponsor teams are responsible, on behalf of Ministers, for the bodies they sponsor. They are the day to day link between the body and the Minister and should ensure, amongst other things, that the public body has in place a Code of Conduct for Board Members approved by Scottish Ministers.

Duties of Public Bodies covered by this framework:

- Promote the observance by its Board Members of high standards of conduct and assist Members in observing the Code of Conduct for Members. This could include offering training for new Members, or refresher courses from time to time;

- Must have a designated Standards Officer to assist board Members observe the requirements detailed in the Code of Conduct and to ensure that the organisation keeps the Register of Members' Interests available, up to date and open to public view

The Commissioner for Ethical Standards in Public Life in Scotland (Commissioner for Ethical Standards)

- Is independent of Government, Scottish Parliament and the Standards Commission for Scotland when investigating alleged contraventions of the Code;
- Receives complaints about the conduct of Members. Complaints can be made by anyone, including members of the public, or staff and Members of the public body you work with.
- If the Commissioner for Ethical Standards considers that there has been a breach of the Code a report about the investigation and the outcome from that process will be issued to the Standards Commission.

The Standards Commission Scotland (Standards Commission)

- Is independent of Government, Scottish Parliament and the Commissioner for Ethical Standards when considering alleged contraventions of the Code of Conduct;
- When a report is passed to it by the Commissioner for Ethical Standards, the Standards Commission determines what action will be taken following consideration of the case.
- Should the Standards Commission hold a Hearing and a breach of Code is determined it will thereafter apply one of the sanctions available to it as detailed in the Ethical Standards Act;
- Provides guidance to public bodies on;
  - the promotion and observance of high standards of conduct by members of devolved public bodies and assist them with that task.
  - the registers of interests for members of devolved public bodies.

Last Word

This guide is designed to help you abide by the Code of Conduct and meet the expectations that bear on those who serve in public life. If in doubt, and before you act, you should seek advice from your Chair, Chief Executive or Standards Officer.

Useful Addresses

Standards Commission for Scotland	www.standardscommissionscotland.org.uk
Commissioner for Ethical Standards	www.ethicalstandards.org.uk
Scottish Government – On Board Guide	www.scotland.gov.uk/Publications/2006/07/11153800/0
Scottish Government – Model Code of Conduct	Http://www.scotland.gov.uk/Resource/0000/00442087.pdf
Scottish Government – Ethical Standards	http://scotland.gov.uk/governance/ethical-standards
Audit Scotland	http://www.audit-scotland.gov.uk
Ethical Standards in Public Life etc. (Scotland) Act 2000	http://www.legislation.gov.uk/asp/2000/7/contents

STANDARDS COMMISSION
SCOTLAND
Room T2.21,
The Scottish Parliament
Edinburgh
EH99 1SP
Tel: 0131 348 6666
E-mail: enquiries@standardcommission.org.uk
www.standardscommissionscotland.org.uk

INTEGRITY IN PUBLIC LIFE

AGENDA ITEM NO: 5

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th August 2015**
Report By:	**Robert Calderwood Chief Executive John Mundell Chief Executive**	**Report No:**	**IJB/07/2015/HW**
Contact Officer:	**Helen Watson Head of Service: Planning Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**APPOINTMENT OF CHIEF OFFICER**		

1.0 PURPOSE

1.1 The purpose of this report is to consider the Appointment of the Integration Joint Board's Chief Officer.

2.0 SUMMARY

2.1 Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 states the requirement for the Integration Joint Board to formally appoint a Chief Officer.

2.2 Section 6.1 of the Inverclyde Integration Scheme sets out the arrangements in relation to the Chief Officer agreed by the Council and the NHS Board. The Chief Officer appointed by the Integration Joint Board (IJB) will be employed by either the Council or the NHS Board and will have an honorary contract with the other party. The Chief Officer will be the principal advisor to and officer of the IJB. The proposed Chief Officer meets these criteria.

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board formally appoints Brian Moore as its Chief Officer.

Brian Moore
Chief Officer Designate
Inverclyde HSCP

4.0 BACKGROUND

4.1 Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 states the requirement that: "(1) an integration joint board is to appoint a member of staff, a chief officer." And "(6) before appointing a person as chief officer an integration joint board is to consult each constituent authority".

4.2 Section 6.1 of the Inverclyde Integration Scheme sets out the arrangements in relation to the Chief Officer agreed by the Council and the NHS Board. The Chief Officer appointed by the Integration Joint Board (IJB) will be employed by either the Council or the NHS Board and will have an honorary contract with the other party. The Chief Officer will be the principal advisor to and officer of the IJB.

4.3 The Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the Integration Joint Board and be a member of the corporate management teams of Inverclyde Council and NHS Greater Glasgow and Clyde.

4.4 The Chief Officer is responsible for the operational management and performance of Integrated Services that are delegated to the Integration Joint Board.

4.5 In relation to delegated acute services the Chief Officer of Acute Services will be responsible for the operational management and performance of acute services and will provide updates on a regular basis to the Integration Joint Board Chief Officer on the operational delivery of Acute Services provided to the Inverclyde population.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: There are no financial issues within this report.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

REPOPULATION

5.5 There are no repopulation issues within this report.

6.0 CONSULTATION

6.1 In terms of section 10(6) of the 2014 Act, the Integration Joint Board is required to consult with each constituent authority. In preparation for the Integration of Health and Social Care, Brian Moore has been acting as Chief Officer designate during the period of shadow integration for the Health and Social Care Partnership (HSCP). This was agreed as part of the shadow arrangements for the HSCP and papers were approved by the NHS Board and by Inverclyde Council, and then the CHCP Sub-Committee on 9th January 2014. It was agreed, at that time by the constituent authorities that the current CHCP Director, Brian Moore would take on the additional role as the Chief Officer (CO) designate of the shadow Health and Social Care Partnership (HSCP) and at the point legislation enabled the full establishment of the Health and Social Care Partnership and subject to confirmation by the IJB the Chief Officer Designate would become the substantive Chief Officer for the HSCP.

7.0 BACKGROUND PAPERS

7.1 Public Bodies (Joint Working) (Scotland) Act 2014

AGENDA ITEM NO: 6

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/08/2015/HW**
Contact Officer:	**Helen Watson Head of Service: Planning Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**APPOINTMENT OF CHIEF FINANCE OFFICER**		

1.0 PURPOSE

1.1 The purpose of this report is to consider the Appointment of the Integration Joint Board's Chief Finance Officer.

2.0 SUMMARY

2.1 Section 13 of the Public Bodies (Joint Working) (Scotland) Act 2014 states the equipment for the Integration Joint Board to formally appoint a Chief Finance Officer.

2.2 The Integration Joint Board is required to appoint a Chief Finance Officer as a proper officer who has responsibility for the administration of its financial affairs in terms of s.95 of the 1973 Act. That proper officer will be the Chief Finance Officer.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board formally appoints Lesley Bairden as its Chief Finance Officer.

3.2 To note that this is a short term appointment.

Brian Moore
Chief Officer Designate
Inverclyde HSCP

4.0 BACKGROUND

4.1 Section 13 of the Public Bodies (Joint Working) (Scotland) Act 2014 amends the Local Government (Scotland) Act 1973, by extending the application of Part 7 of the 1973 Act (with the exception of sections 101A and 105A) to Integration Joint Boards. Accordingly, the Integration Joint Board requires to appoint a proper officer who has responsibility for the administration of its financial affairs in terms of s.95 of the 1973 Act. That proper officer will be the Chief Finance Officer of the Integration Joint Board.

4.2 The Chief Finance Officer is accountable to the Integration Joint Board (IJB) for the planning, development and delivery of the IJB's financial strategy; is responsible for the provision of strategic financial advice and support to the Integration Joint Board and Chief Officer, and for the financial administration and financial governance of the Integration Joint Board.

4.3 The Chief Finance Officer is the Accountable Officer for financial management and administration of the Integration Joint Board. The Chief Finance Officer's responsibility includes assuring probity and sound corporate governance and has responsibility for achieving Best Value.

4.4 The Chief Finance Officer is a key member of the Senior Management Team, helping it to plan, develop and implement business strategy and to resource and deliver the Integration Joint Board's strategic objectives sustainably and in the public interest.

4.5 The Chief Finance Officer is responsible for developing the financial strategy of the IJB and must be actively involved in, and able to bring influence to bear on all material business decisions to ensure immediate and longer term financial implications, opportunities and risks are fully considered, and alignment with the Integration Joint Board's financial strategy. The Chief Finance Officer must lead the promotion and delivery by the Integration Joint Board of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively. The Chief Finance Officer is responsible for creating, in conjunction with the Council Section 95 Officer and Health Board Director of Finance, a collaborative arrangement.

4.6 During the first year of the Integration Joint Board, the Chief Officer and the Chief Finance Officer will develop the funding requirements for the Integrated Budget in 2016/17 based on the Strategic Plan. Following the determination of the amounts to be paid by the Council and NHS Board, the Integration Joint Board will refine the Strategic Plan to take account of the resources available.

4.7 The appointment will be made on a short term basis as the nominee is due to take up a position in another partnership area. Pending the appointment of a replacement Chief Finance Officer, support will be made available from Greater Glasgow and Clyde Corporate Finance Team regarding Chief Finance Officer functions and health related budgets.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: There are no financial issues within this report.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend	Virement From	Other Comments

			this Report £000		

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

REPOPULATION

5.5 There are no repopulation issues within this report.

6.0 CONSULTATION

6.1 Not applicable.

7.0 BACKGROUND PAPERS

7.1 Public Bodies (Joint Working) (Scotland) Act 2014

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 7

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/06/2015/LB**
Contact Officer:	**Lesley Bairden**	**Contact No:**	**01475 712257**
Subject:	**FINANCIAL REGULATIONS**		

1.0 PURPOSE

1.1 The purpose of this report is to provide the Integration Joint Board (IJB) with draft Financial Regulations, for information, with the final Financial Regulations, supported by a detailed Finance Manual, to be approved by the IJB Audit Committee, upon conclusion of outstanding issues.

2.0 SUMMARY

2.1 This report provides the background to and current issues relating to the draft Financial Regulations relating to the Integration Joint Board for Inverclyde's Health and Social Care Partnership. The Financial Regulations provide the financial governance framework in which the IJB will operate.

2.2 The Financial Regulations, supported by a detailed Finance Manual are informed by both the:

- Professional guidance developed by the Integrated Resources Advisory Group (IRAG), a national group established to develop guidance to support the implementation of the Public Bodies Joint Working (Scotland) Act 2014.
- Work to date from officer working groups comprising NHS and Local Authority finance professionals developing IRAG guidance into a set of procedures that will support the IJB in decision making in strategic and operational finance matters

2.3 The Draft Financial Regulations remain subject to revision to reflect ongoing local and national work in a number of areas including:

- Treatment of VAT
- Treatment of overheads and support services
- Reserves strategy
- Year end accounts – treatment and content

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Note the contents of this report and agree the content of the Draft Financial Regulations

2. Agree to remit to the IJB Audit Committee the approval of the final Financial Regulations and Finance Manual, upon conclusion of the outstanding issues.

Brian Moore
Chief Officer Designate

Lesley Bairden
Chief Financial Officer Designate

4.0 BACKGROUND

4.1 For the last 18 months the IJB Chief Financial Officer Designate along with other finance officers from NHS Greater Glasgow and Clyde and the six Councils coterminous with the Board have been working closely to ensure appropriate financial arrangements are in place to support the IJB and HSCP as part of the Technical Finance Working Group.

4.2 The outputs from the Technical Finance Working Group (TFWG) are an agreed set of specimen documents and policies which each IJB can then customise and draw upon as required. This approach allows consistency between partnerships and continuity for NHSGGC.

4.3 Inverclyde Council Financial Regulations will be revised, as will the Standing Financial Instructions for NHSGGC to recognise the impact of the IJB.

5.0 FINANCIAL GOVERNANCE

5.1 As described above, the TFWG have produced and recommended a number of guidance papers, providing a high level set of principles for each partnership to follow as best practice, but also to adopt and revise to meet local requirements. To date the following papers have been agreed:

a. Governance Statement and Statement of Internal Control
b. Financial Regulations and Standing Financial Instructions
c. Risk Management, Insurance and Business Continuity
d. Managing Integrated Budgets Guiding Principles
e. Budget Setting
f. Scheme of Virement
g. Capital Planning Process
h. Managing Financial Performance

5.2 Work remains ongoing to develop papers on:

1. Financial Governance Checklist
2. Internal and External Audit Arrangements
3. Treatment of VAT (national issue)
4. Reserves Strategy
5. Annual Accounts (national issue)

The outstanding work should be completed before the end of the current financial year 2015/16.

5.3 The policies agreed to date have been customised for Inverclyde IJB with a draft set of Financial Regulations and a supporting Finance Manual for consideration and approval by the IJB Audit Committee, in due course. There are no specific issues to highlight and there is no conflict with the Inverclyde Council Financial Regulations or the NHSGGC Standing Financial Instructions.

Subsequent updates will be brought for approval, to the IJB Audit Committee, as each of the remaining outstanding issues is resolved. In addition to the issues above work remains ongoing on the treatment of overheads and running costs relating specifically to the IJB.

6.0 OPERATIONAL CONSIDERATIONS

6.1 As previously discussed, a commencement date of 1 April 2016 for financial responsibilities of the IJB will allow a clean and transparent transfer of resources, including set aside budgets for large hospital services, for the IJB and its partners. This will align with the Strategic Plan covering the period 2016-19.

6.2 In the interim, aligned financial reporting will be brought to the IJB for information, effective from the next meeting of the IJB on 10 November, with inclusion of large hospital set aside and hosted service budgets from April 2016. An example report is included with the Due Diligence paper elsewhere on the agenda.

6.3 Financial reporting will broadly follow the integrated reporting previously presented to the CHCP however it will be further developed to include reporting for large hospital services and for hosted services, with a methodology currently being developed NHSGGC wide during 2015/16.

6.4 Strategic reporting will be developed to include a longer term financial strategy, annual financial performance statements and other requirements as determined in the final professional guidance.

7.0 OTHER ISSUES

7.1 Employment status of the Chief Officer and Chief Financial Officer remains subject to confirmation, along with associated VAT treatment. An update will be provided upon confirmation.

7.2 As Inverclyde already has an integrated management structure there are no cost implications or savings opportunities resulting from this legislative change. However the costs of servicing the IJB will be required to be identified and funded. An update will be provided upon confirmation.

8.0 IMPLICATIONS

8.1 **Finance**

There are no direct financial implications within this report. It should be noted that there will be costs associated with facilitating the IJB and ensuring appropriate governance. As the position is clarified all one off and recurring cost implications will be reported.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

Legal

8.2 There are no specific legal implications arising from this report.

Human Resources

8.3 There are no specific human resources implications arising from this report.

Equalities

8.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

Repopulation

8.5 There are no repopulation issues within this report.

9.0 CONSULTATION

9.1 The Council's Chief Financial Officer and Director of Finance NHSGGC have been consulted.

10.0 BACKGROUND PAPERS

10.1 There are no background papers for this report.

Inverclyde Health and Social Care Partnership

Integration Joint Board Financial Regulations

Version	**Inverclyde Integration Joint Board Financial Regulations 2015 Draft 1**		
Owner	**Lesley Bairden Chief Financial Officer Designate**		
Approved by	**Integration Joint Board**	**Inverclyde Council**	**Greater Glasgow & Clyde HB**
Date Approved	**00/00/0000**	**00/00/0000**	**00/00/0000**
Date for Review	**00/00/0000**		
Replaces Previous Version			

Financial Regulations - Index

Section C: Future Considerations

The Integration Joint Board positively promotes the principles of sound corporate governance within all areas of the Board's affairs. These Financial Regulations are an essential component of the corporate governance of the Integration Joint Board.

Section A: Introduction and General Issues

1. What the Regulations Cover

1.1 Both the Health Board and the Council operate under Financial Regulations/Standing Financial Instructions in the operational delivery of services. As this service delivery will continue to be carried out within the Health Board and the Council, these Financial Regulations relate specifically to the affairs of the Integration Joint Board itself and therefore are more limited and focussed in scope. All operational and transactional finance matters for delivery of Inverclyde Health and Social Care Partnership will comply with Inverclyde Council Financial Regulations and NHS Greater Glasgow & Clyde Standing Financial Instructions.

1.2 Inverclyde Health and Social Care Partnership is governed by the Inverclyde **Integration Joint Board** established by Scottish Ministers as a consequence of the Integration Scheme approved by Inverclyde Council and Greater Glasgow and Clyde Health Board in terms of the Public Bodies (Joint Working) (Scotland) Act 2014. Inverclyde Council and Greater Glasgow and Clyde Health Board have delegated functions and resources to the Integration Joint Board. The IJB will direct the Council and the Health Board on how resources will be spent in line with the approved Strategic plan, and allocate resources back to the Council and Health Board in accordance with this direction. The Integration Joint Board retains responsibility for oversight and management of expenditure within the allocated budgets.

1.3 Under Scottish Government Regulations, for all Integration Joint Boards in Scotland the Chief Officer, supported by the Chief Financial Officer must ensure that there are adequate systems and controls in place for the proper management of its financial affairs.

1.4 These Financial Regulations of the Inverclyde Health and Social Care Partnership detail the responsibilities of the Integration Joint Board for its own financial affairs.

1.5 The Regulations also set out the respective responsibilities of the Chief Officer and the Chief Financial Officer of the Integration Joint Board.

1.6 The Chief Officer and the Chief Financial Officer will follow these Regulations at all times in relation to the conduct of the IJB's own financial affairs.

1.7 All actions that affect the Integration Joint Board's finances should only be carried out by properly authorised employees. The Chief Officer will establish a clear and effective framework of authorisation for the Integration Joint Board.

1.8 The Chief Officer and the Chief Financial Officer will ensure that the Integration Joint Board only commits to expenditure that it is legally able to commit to and is within scope of the approved Integration Scheme and Strategic Plan. Where this is not clear, the Chief Finance Officer will consult the Accountable Officer of Greater Glasgow and Clyde

Health Board and/or the Section 95 Officer of Inverclyde Council.

1.9 If it is believed that anyone has broken, or may break, these Regulations, this must be reported immediately to the Chief Financial Officer, who may then discuss the matter with the Chief Officer to determine what action to be taken.

1.10 The Chief Officer and other authorised persons will ensure that all expenditure within the Integration budget meets proper accounting standards.

1.11 The Chief Financial Officer will interpret the regulations and put them into practice in a way which takes account of the obligations in the Integration Joint Board's standing orders relating to contracts, if and when applicable.

1.12 The Integration Joint Board will consider and approve any alterations to these Financial Regulations on an ad hoc basis as required for specific issues. The Financial Regulations will be periodically reviewed every 3 years..

1.13 These Financial Regulations are supported by detailed policies within the accompanying Finance Manual.

2. Corporate Governance

2.1 Corporate governance is about the structures and processes for decision-making, accountability, controls and behaviour throughout the Integration Joint Board. The basic principles of corporate governance are as follows.

Openness Anyone with an interest in the affairs of the IJB should have confidence in the decision-making and management processes and the individuals involved in them. This confidence is gained through openness in its affairs and by providing full, accurate and clear information which leads to effective and timely action and scrutiny.

Integrity There should be honesty, selflessness, objectivity and high standards of conduct in how the Integration Joint Board's funds and affairs are managed. Integrity depends on the effectiveness of the control framework and on the personal standards and professionalism of members and officers involved in the running of its affairs.

Accountability There needs to be a clear understanding by everyone involved in the Integration Joint Board's affairs of their roles and responsibilities. There should also be a process which provides appropriate independent examination of the decisions and actions of those involved in the council's affairs, including how the Integration Joint Board's funds and performance are managed.

2.2 These financial regulations are an essential part of the corporate governance of the Integration Joint Board.

2.3 Members of the IJB are required to follow any formally agreed national codes of conduct.

3. Responsibilities under these Financial Regulations

3.1 The Integration Joint Board will continuously work to secure best value for money, and economy, efficiency and effectiveness in how the organisation directs its resources.

3.2 The Chief Financial Officer (in consultation with the Chief Officer) will advise the Integration Joint Board on the financial implications of the Integration Joint Board's activities. The Chief Financial Officer will ensure that budget holders receive impartial advice, guidance and support and appropriate information to enable them to effect control over expenditure and income.

Strategic Plan and Integrated Budget

3.3 The Integration Joint Board will approve a Strategic Plan which sets out arrangements for planning and directing the functions delegated to it by Inverclyde Council and Greater Glasgow and Clyde Health Board. The Strategic Plan will cover a three-year period and will determine the budgets allocated to each operational partner for operational service delivery in line with the Plan, recognising that these may need to be indicative. The Integration Joint Board will publish its Strategic Plan as soon as practicable after finalisation of the plan.

3.4 The Chief Officer and the Chief Financial Officer will develop a case for the integrated budget based on the Strategic Plan and present it to Inverclyde Council and Greater Glasgow and Clyde Health Board for consideration and agreement as part of the annual budget setting process. Regulations 11 and 12 provide further guidance.

Budget Management

3.5 Budget holders within the Council and the Health Board will be accountable for all budgets within their control as directed by the IJB in line with its Strategic Plan. The Integration Joint Board will ensure appropriate arrangements are in in place to support good financial management and planning. The IJB must follow the agreed policies, as set out in the supporting Finance Manual (FM), in relation to:

- Management of Integrated Budgets – Guiding Principles (FM Section 1)
- Budget Setting (FM Section 2)
- Scheme of Virement (FM Section 3)
- Capital Planning (FM Section 4)
- Managing Financial Performance (FM Section 5)
- Reserves policy and strategy (FM Section 6 – to be developed)

3.6 Inverclyde Council's Section 95 Officer and Greater Glasgow and Clyde Health Board Director of Finance will provide the Chief Financial Officer with management accounts and forecasts to allow the Integration Joint Board to monitor the overall financial performance of the Integration Joint Board's functions in relation to the approved Revenue Budgets.

3.7 The Chief Financial Officer will provide to each meeting of the Integration Joint Board budget monitoring reports along with explanations for any significant variations from budget and the action planned to deal with them.

4. The Framework for Financial Administration

4.1 The Financial Regulations set out the responsibilities of Board Members, the Chief Officer and the Chief Financial Officer within the context of the Integration Joint Board's financial management framework.

4.2 The Chief Financial Officer will monitor how the Financial Regulations operate within the Integration Joint Board, and will provide the IJB with a written framework which governs its financial affairs.

5. Reviewing the Financial Regulations

5.1 The Integration Joint Board will consider and approve any alterations to these Financial Regulations. The *Integration Joint Board* may also withdraw these financial regulations. If so, this will come into force from the first working day after the end of the Integration Joint Board meeting at which the change or withdrawal was approved.

6. Legal Advice

6.1 Inverclyde Council and Greater Glasgow and Clyde Health Board will provide legal advice regarding these Financial Regulations as required in relation to the functions delegated to the Integration Joint Board.

7. More Information

7.1 For more information or clarification on these Regulations, please contact the Chief Financial Officer for Inverclyde's Health & Social Care Partnership.

Section B: Specific Areas

8. Financial Reporting

Introduction

This Financial Regulation gives advice on the Integration Joint Board's requirements for accounting procedures and records, production and publication of Annual Accounts, maintenance of a joint property register and the presentation of External Audit reports to the Board.

Preparing Procedures, Records and Accounts

8.1 The Chief Financial Officer will prepare the Annual Accounts in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom (The CODE), reporting the Integration Joint Board's financial performance for the year to 31 March to the Integration Joint Board. The approved Accounts must also be forwarded to the Controller of Audit no later than the 30th June of the same year, or such date as decided by the Controller of Audit.

8.2 The accounts of the Integration Joint Board will be hosted by Inverclyde Council.

8.3 The Chief Financial Officer must provide any information necessary for the closure of the Accounts and within prescribed timescales. Details of the information required and procedures to be followed will be issued annually by the Chief Financial Officer. The format of the Accounts and the relevant notes to the Accounts of the Health Board and the Council will be in line with national CIPFA and / or LASSAAC guidance.

Presenting External Audit Reports

8.4 The Chief Financial Officer will ensure the presentation of all External Audit reports including reports on the audited Annual Accounts to the Integration Joint Board and make such reports available to the Health Board and Local Authority.

8.5 In consultation with Inverclyde Council, which hosts the annual accounts, the Chief Financial Officer will make appropriate arrangements for the public inspection of the Integration Joint Board's Accounts.

9. Capital Planning

Introduction

This Financial Regulation details the Integration Joint Board's requirements in relation to its three year Capital Plan.

9.1 The Chief Officer annually, in consultation with Inverclyde Council and Greater Glasgow and Clyde Health Board, will prepare a Capital Plan to make best use of existing resources and identify the asset requirements to support the Strategic Plan.

9.2 The Capital Plan will be submitted to the Integration Joint Board for approval.

9.3 Business Cases will be prepared by the Chief Officer and Chief Finance Officer and submitted to Inverclyde Council's Capital Planning Group or Greater Glasgow and Clyde Health Board's Capital Planning Group for approval.

9.4 The Chief Officer will be a member of both partners' Capital Planning Groups.

9.5 Where new capital investment is required to deliver the Strategic Plan both partners should consider the Business Plan.

10. Control of Capital Expenditure

Introduction

This Financial Regulation details the Integration Joint Board's requirements for monitoring Capital Expenditure in relation to the approved Capital Plan.

10.1 The Integration Joint Board does not receive a capital funding allocation. Capital projects are funded by either Inverclyde Council or Greater Glasgow and Clyde Health Board and expenditure will be controlled in accordance with their financial regulations.

10.2 The Integration Joint Board will receive financial monitoring reports from both partners which include information on capital expenditure against approved schemes relevant to the services delegated to the Integration Joint Board.

10.3 In matters relating to capital planning and expenditure, the Capital Planning Guidance developed for the partnerships in GG&C should be followed.

11. Strategic Plan and Financial Plan

Introduction

This Financial Regulation details the Integration Joint Board's requirements for the preparation of a Strategic Plan covering the next three financial years.

11.1 The format of the Strategic Plan will be determined by the Chief Officer taking into account legislative requirements in terms of consultation and approval processes and national guidance in terms of content.

11.2 The Chief Officer will each year update the Strategic Plan which will incorporate a financial plan for the resources within the scope of the Integration Joint Board. The Strategic Plan will set out the level of capacity required in each year for three years in all sectors in the care pathway and the allocation of resources within the scope of the plan across the sectors. The Chief Officer will develop a case for an Integration Budget based on the Strategic Plan for approval by the IJB.

11.3 The Guidance on Budget Setting developed for the partnerships in the Board area should be followed.

12. Control of Revenue Expenditure

Introduction

This Financial Regulation sets out the principles of the Integration Joint Board's requirements for budget monitoring, variance reporting and virement to control revenue expenditure. Detailed policies support these principles as identified at 3.5 above.

13. Internal Audit

Introduction

Greater Glasgow and Clyde Health Board and Inverclyde Council shall decide upon the internal audit service to review internal control systems operated within the Integration Joint Board and decide upon which Chief Internal Auditor and internal audit team from either the Health Board or the Local Authority shall be the incumbent. Internal audit shall independently and objectively examine, evaluate and report on the adequacy of internal control, governance and risk management arrangements within the IJB. The guidance developed on Internal Audit for the partnerships across the Board area should be followed.

14. Board Members' Expenses

Introduction

This Financial Regulation details the Integration Joint Board's requirements for the payment of Board Members' expenses and provides guidance on claims procedures.

14.1 Payment of voting Board Members' allowances will be the responsibility of the Members' individual Council or Health Board, and will be made in accordance with their own Schemes.

14.2 Members are entitled to payment of travel and subsistence expenses relating to approved duties. Members are required to submit claims on the Integration Joint Board's agreed expenses claim form and as far as practicable to provide receipts in support of any expenses claimed.

14.3 Non-voting members of the Integration Joint Board will be entitled to payment of travel expenses. Non-voting members are required to submit claims on the Integration Joint Board's agreed expenses claim form and as far as practicable to provide receipts in support of any expenses claimed. The costs relating to expenses incurred by the non-voting members of the Integration Joint Board will be shared equally by the Health Board and the Council.

14.4 The Chief Financial Officer will ensure that a record of all expenses paid under the Scheme, detailing name, amount and nature of payment.

Section C: Future Considerations

The following areas are a generic list of headings that will need to be fully developed if the Integration Joint Board takes on operational responsibilities in the future:

15. Petty Cash

Introduction

This Financial Regulation details the Integration Joint Board's requirements for the operation of petty cash expenditure. The Integration Joint Board's Petty Cash requirements will be provided for by the host partner. The Integration Joint Board will not hold petty cash.

16. Inventories

Introduction

This Financial Regulation gives details of Integration Joint Board's requirements for inventories. All items of equipment, plant, machinery, vehicles, computer equipment, software and other similar items will be held by the parent bodies.

17. Income

Introduction

This Financial Regulation details the Integration Joint Board's requirements for Income. The only receipts to be processed through the books of accounts of the Integration Joint Board will be the allocations from the parent organisations and the directions to the parent bodies. This will not be in cash but transactions through the ledger. All other income, charges, and grants will be processed through the parent organisations. All arrangements for the collection, custody, control and banking of cash will be made by the parent organisations.

18. Payroll, Travel and Subsistence

Introduction

This Financial Regulation provides details of the Integration Joint Board's requirements for payroll, travel and subsistence. The Chief Officer and the Chief Financial Officer of the Integration Joint Board will employees of either the Health Board or the Council and the employing organisation is responsible for payment of salaries and expenses, it is essential that the Integration Joint Board has

systems in place to ensure timeous and accurate information is passed to that organisation's Payroll Section.

19. Orders for Work, Goods and Services

Introduction

The method of purchasing has a major impact on the Value for Money obtained. All procurement will be made via the normal procurement route of the parent organisations and in accordance with these organisations' Standing Financial Instructions/Financial Regulations and Codes relating to Contracts. This applies also to orders for computer hardware, software and telecommunications.

20. Payment of Accounts, Contributions & Subscriptions

Introduction

This Financial Regulation details the Integration Joint Board's requirements for payments of accounts, etc. All payments will be made via the accounts payable processes of the parent organisations and in accordance with those organisations' Standing Financial Instructions or Financial Regulations as appropriate.

21. Contracts for Building, Engineering and Associated Works

Introduction

This Financial Regulation details the Integration Joint Board's requirements in relation to payments for Contracts for Building, Engineering and Associated Works. Non-current assets are owned by the parent organisations which will arrange for any required maintenance works to be undertaken. All contracts placed for maintenance works will be procured in accordance with the parent organisations' Standing Financial Instructions or Financial Regulations as appropriate. All payments for this work will be made via the accounts payable processes of the parent organisations and in accordance with the parent organisations' Standing Financial Instructions or Financial Regulations as appropriate.

22. Property and Security

Introduction

This Financial Code details the Integration Joint Board's requirements for Property and Security. All non-current assets and associated liabilities remain with Inverclyde Council and Greater Glasgow and Clyde Health Board.

23. Internal Control and Authorisation

Introduction

This Financial Code provides advice on authorisation and internal control. The Integration Joint Board requires that the Chief Officer and the Chief Financial Officer be accountable. This means they will understand and accept responsibility for their actions. Employees engaged in financial administration must therefore:

- **be capable of performing work allocated to them;**
- **devote sufficient time to carry out their duties properly;**
- **undertake their tasks efficiently;**
- **be demonstrably above reproach.**

24. Retention of Financial Documents

Introduction

This Financial Code provides guidance on the retention and disposal of financial documents. A Retention of Documents service will be provided by one of the parent body.

25. VAT

Introduction

This Financial Regulation provides advice on VAT.

The Guidance on VAT developed nationally for partnerships should be followed.

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/10/2015/LB**
Contact Officer:	**Lesley Bairden**	**Contact No:**	**01475 712257**
Subject:	**AUDIT AND RISK MANAGEMENT STRATEGY - UPDATE**		

1.0 PURPOSE

1.1 The purpose of this report is to provide the Integration Joint Board (IJB) with a position statement on the Internal and External Audit function for the IJB, along with an associated Risk Management Strategy.

2.0 SUMMARY

2.1 This provides the background to and current issues relating to the Internal and External Audit function and associated Risk Strategy, required to support the Integrated Joint Board for Inverclyde's Health and Social Care Partnership.

2.2 The scope of internal audit covers:

- The IJB Strategic Plan and planning process
- The Financial Plan, underpinning the Strategic Plan
- Relevant issues raised from either partner internal auditors

2.3 The scope of External Audit will, in the main, be the review and sign off of the IJB Annual Accounts.

2.4 Work remains ongoing to identify who will provide the Internal Audit function, with Grant Thornton providing the External Audit function to the IJB.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Note the contents of this report
2. Agree to receive detailed proposals on the function, membership and frequency of the Audit Committee at the next meeting of the IJB
3. Agree to receive updates as outstanding issues are clarified, with updates to be reported to each meeting of the IJB

Brian Moore
Chief Officer Designate

Lesley Bairden
Chief Financial Officer Designate

4.0 BACKGROUND

4.1 For the last 18 months the IJB Chief Financial Officer Designate along with other finance officers from NHS Greater Glasgow and Clyde and the six Councils coterminous with the Board have been working closely to ensure appropriate financial arrangements are in place to support the IJB and HSCP as part of the Technical Finance Working Group.

4.2 The outputs from the Technical Finance Working Group (TFWG) are an agreed set of specimen documents and policies which each IJB can then customise and draw upon as required. This approach allows consistency between partnerships and continuity for NHSGGC.

4.3 One aspect of this work is a specimen risk policy, which was developed by risk professionals from NHSGGC and coterminous Councils, as a sub group of one work stream.

5.0 AUDIT ARRANGEMENTS

5.1 As described above and in more detail in the Draft Financial Regulations report, elsewhere on the agenda, the TFWG have produced and recommended a number of guidance papers. In specific relation to audit, work remains ongoing to develop papers on:

1. Financial Governance Checklist
2. Internal & External Audit Arrangements
3. Annual Accounts (national issue)

5.2 It is recognised that as the legal status of the IJB is akin to a Local Authority, Council Internal Audit Services are better placed to service the IJBs; however this is for local determination. This may cause particular issue within Inverclyde as the available resource of the Internal Audit Service will mean limited capacity to take on additional work, as well as issues around separation of duties and independence. Work remains ongoing to develop a solution, reflecting a risk based approach as adopted within Inverclyde.

5.3 The IJB will need to consider the remit, membership and frequency of its Internal Audit committee cycle; a pragmatic approach would be to meet in advance of each IJB main meeting, which may be reviewed as the business of the Board develops. A terms of reference will be developed for approval.

5.4 An initial indication of the work expected to be involved is:

- Planning arrangements – strategic plan
- Reporting arrangements – progress reports on audit plan delivery
- Arrangements or any additional work such as risk management support, advice and support, co-ordination of the annual governance statement along with any required investigations

The responsibility for internal audit of all operational matters will remain with the partner organisations.

5.5 A national short life working group is currently reviewing a number of technical aspects relating to the content and presentation of the IJB annual accounts. This is being led by CIPFA and will seek the views of Audit Scotland.

5.6 Grant Thornton has been appointed to provide the external audit function for IJBs, as yet the associated cost and / or any opportunities for a shared approach with other IJBs, in the longer term, is to be determined.

5.7 The outcome of the above will be reflected in revised versions of the Financial Regulations for the IJB as each issue is resolved and approved by the IJB Audit Committee.

6.0 RISK STRATEGY

6.1 The Integration Scheme refers to a risk management policy to be made available to the IJB, with a specimen Risk Management Policy and Strategy included at Appendix 1 for information. As stated above this has been developed as part of the TFWG outputs and provides a starting point for each IJB and will require revision to reflect Inverclyde's IJB.

6.2 The IJB is required to maintain a risk register, reflecting its strategic activities and taking, taking cognisance of significant issues from each partner's own risk registers, which are updated annually.

6.3 The internal audit functions, set out at 2.2 above does not include any support for risk management. As with internal audit this may cause particular issue within Inverclyde Council as the available resource of the Internal Audit Service will mean limited capacity to take on additional work. Discussion is ongoing to determine a solution.

7.0 OTHER ISSUES

7.1 There remains ongoing discussion as to the requirement for indemnity insurance for the IJB and whether this is required over and above the existing insurance of each partner organisation.

7.2 Scottish Government advice is that IJBs should join CNORIS (Clinical Negligence and Other Risks Indemnity Scheme) for the operation of the Board itself. The cost per IJB will be a flat rate of £3,000 and for those IJBs coterminous with NHSGGC this cost has been absorbed by the Board. This will provide indemnity for the Board Members and the low cost of the premium reflects the perceived risk. Appendix 2 summarises the levels of cover provided.

8.0 IMPLICATIONS

8.1 **Finance**

The financial implications within this report cannot yet be quantified. The treatment of costs relating to Internal Audit Services, if provided by the Council, is ongoing as part of a wider discussion relating to support costs. This will also include treatment of costs associated with facilitating the IJB. There will be costs associated with employing external auditors and the sum is not yet known. As the position is clarified all one off and recurring cost implications will be reported.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
TBC					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect	Annual Net Impact £000	Virement From	Other Comments

		from			
TBC					Internal Audit External Audit Risk Management Support and Facilitation of IJB

Legal

8.2 There are no specific legal implications arising from this report.

Human Resources

8.3 There are no specific human resources implications arising from this report.

Equalities

8.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

Repopulation

8.5 There are no repopulation issues within this report.

9.0 CONSULTATION

9.1 The Council's Chief Financial Officer, Director of Finance NHSGGC and the Council's Chief Internal Auditor have been consulted.

10.0 BACKGROUND PAPERS

10.1 There are no background papers for this report.

[Relevant Local Authority Logo Here]

NHS Greater Glasgow and Clyde

[Area] Integration Joint Board

Risk Management Policy and Strategy

Version No.	1.0		
Date Effective:	00/00/0000	Review Date:	00/00/0000

CONTENTS

Policy – the risk management approach

1.1 The **[Area]** Integration Joint Board is committed to a culture where its workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

1.2 In doing so the Joint Board aims to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within the Joint Board and others who interact with the services delivered under the direction of the Joint Board.

1.3 The Integration Joint Board believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems.

Key benefits of effective risk management:

- appropriate, defensible, timeous and best value decisions are made;
- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- a positive reputation established for the Joint Board.

1.4 The Joint Board purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the Joint Board can take an effective approach to managing risk in a way that both address significant challenges and enable positive outcomes.

1.5 In normal circumstances the Joint Board's appetite/ tolerance for risk is as follows:

[IJB to insert here the normal level of risk that will be acceptable, unacceptable and tolerable – for example, low or green risk shown in the matrix here could be 'acceptable.']

This can be seen clearly in the following matrix:

[IJB to insert the matrix it will use]: *Example:*

Likeli-hood	Consequent Impact				
	1	2	3	4	5
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5

1.6 The Joint Board promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients and the Joint Board.

1.7 The Joint Board will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to the wider governance arrangements of the Joint Board.

1.8 The Joint Board, through the following risk management strategy, has established aRisk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

Strategy - Implementing the policy

1. Introduction

1.1 The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the Integration Joint Board;
- establish communication and sharing of risk information through all areas of the Integration Joint Board;
- initiate measures to reduce the Integration Joint Board's exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

1.2 This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

1.3 **Strategic risks** represent the potential for the Integration Joint Board (IJB) to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

1.4 **Operational risks** represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the Joint Board's activities. Parent bodies will retain responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the IJB.

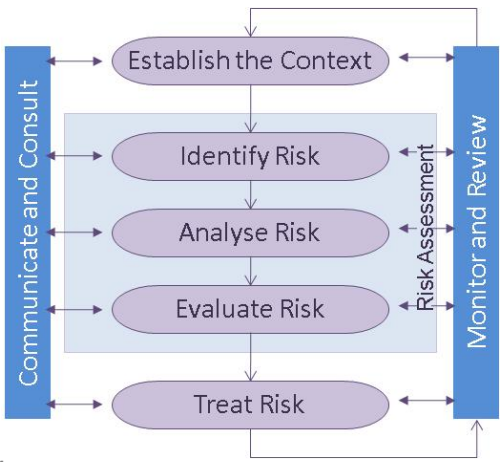
1.5 All risks will be analysed consistently with an evaluation of risk as being ***[IJB to agree evaluations]*** *Examples, low/ mod/ high/ very high/ red/ amber/ yellow/ green?]*. ***[IJB to agree what level of risk will be referred to as 'significant' and therefore be subject to closer scrutiny by the Board]***. *Examples, 'high and above' or risks scoring >nn*.

1.6 This document represents the risk management framework to be implemented across the Joint Board and will contribute to the Joint Board's wider governance arrangements.

2. Risk management process

2.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects[1] It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

2.2 The IJB embeds risk management practice by consistent application of the risk management process shown in the diagram on the right, across all areas of service delivery and business activities.



[1] Australia/ New Zealand Risk Management Standard, AS/NZS 4360: 2004

3. Application of good risk management across the IJB activities

3.1 Standard procedures (3.1.1 – 3.1.10) will be implemented across all areas of activity that are under the direction of the IJB in order to achieve consistent and effective implementation of good risk management.

3.1.1 Full implementation of the risk management process. This means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

3.1.2 Identification of risk using standard methodologies, and involving subject experts who have knowledge and experience of the activity or process under consideration.

3.1.3 Categorisation of risk under the headings below:

- Strategic Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes.
- Operational Risks: such as risks that may arise from or impact on Clinical Care and Treatment, Social Care and Treatment, Customer Service, Employee Health, Safety & Well-being, Business Continuity/ Supply Chain, Information Security and Asset Management.

3.1.4 Appropriate ownership of risk. Specific risks will be owned by/ assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

3.1.5 Consistent application of the agreed risk matrix to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place. The risk matrix to be used is attached in Appendix 1.

3.1.6 Consistent response to risk that is proportionate to the level of risk. This means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with cost effective measures to bring it to a level where it is acceptable or tolerable for the Joint Board in keeping with its appetite/ tolerance for risk. In the case of opportunities, the Joint Board may 'take' an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the Joint Board is confident in its ability to achieve the benefits and manage/ contain the associated risk.

3.1.7 Implementation and maintenance of risk registers as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

3.1.8 Reporting of strategic risks and key operational risks to the IJB on a [**IJB to agree fequency**] basis.

3.1.9 Operation of a procedure for movement of risks between strategic and operational risk registers that will be facilitated by **[the Senior Management Team – IJB to agree]**

3.1.10 Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

Realising the risk management vision

4. Risk management vision and measures of success

[IJB to insert local risk management vision statement here]

***Example**: Appropriate and effective risk management practice will be embraced throughout the Integration Joint Board as an enabler of success, whether delivering better outcomes for the people of [Area], protecting the health, safety and well-being of everyone who engages with the IJB or for maximising opportunity, delivering innovation and best value, and increasing performance.*

4.1 In working towards this risk management vision the Joint Board aims to demonstrate a level of maturity where risk management is embedded and integrated in the decision making and operations of the IJB.

4.2 The measures of success for this vision will be:

[IJB to insert local measures of success here]

Examples:

- *good financial outcomes for the Joint Board*
- *successful delivery of the strategic plan, objectives and targets*
- *successful outcomes from external scrutiny*
- *fewer unexpected/ unanticipated problems*
- *fewer incidents/ accidents/ complaints*
- *fewer claims/ less litigation*

Risk leadership and accountability

5. Governance, roles and responsibilities

5.1 Integration Joint board

Members of the Integration Joint Board are responsible for:

- oversight of the IJB's risk management arrangements;
- receipt and review of reports on strategic risks and any key operational risks that require to be brought to the IJB's attention; and,
- ensuring they are aware of any risks linked to recommendations from the Chief Officer concerning new priorities/ policies and the like *(A 'risk implications' section on relevant board papers could facilitate this)*.

5.2 Chief Officer

The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The Chief Officer will keep the Chief Executives of the IJB's partner bodies informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB.

5.3 Chief Financial Officer

The Chief Financial Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.

5.4 Senior Management Team **[or other name to be agreed by the IJB]**

Members of the Senior Management Team are responsible (either collectively, or by nominating a specific member of the team) for:

- supporting the Chief Officer and Chief Financial Officer in fulfilling their risk management responsibilities;
- arranging professional risk management support, guidance and training from partner bodies;
- receipt and review of regular risk reports on strategic, shared and key operational risks and escalating any matters of concern to the IJB; and,
- ensuring that the standard procedures set out in section three of this strategy are actively promoted across their teams and within their areas of responsibility.

5.5 Individual Risk Owners

It is the responsibility of each risk owner to ensure that:

- risks assigned to them are analysed in keeping with the agreed risk matrix;
- data on which risk evaluations are based are robust and reliable so far as possible;
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise;
- risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk;
- controls that are in place to manage the risk are proportionate to the context and level of risk.

5.6 All persons working under the direction of the IJB

Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsbility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas. This approach requires everyone to:

- understand the risks that relate to their roles and activities;
- understand how their actions relate to their own, their patient's, their services user's/ client's and public safety;
- understand their accountability for particular risks and how they can manage them;
- understand the importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements; and,
- understand that good risk management is a key part of the IJB's culture.

5.7 Partner Bodies

It is the responsibility of relevant specialists from the partner bodies, (such as internal audit, external audit, clinical and non clinical risk managers and health and safety advisers) to attend meetings as necessary to consider the implications of risks and provide relevant advice. It is the responsibility of the partner bodies to ensure they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the IJB.

5.8 Senior Information Risk Owner

Responsibility for this specific role will remain with the individual partner bodies.

Resourcing risk management

6. Resourcing the risk management framework

6.1 Much of the work on developing and leading the ongoing implementation of the risk management framework for the Joint Board will be resourced through the Senior Management Team's arrangements (referred to in 5.4).

6.2 Wherever possible the IJB will ensure that any related risk management training and education costs will be kept to a minimum, with the majority of risk-related courses/ training being delivered through resources already available to the IJB (the partner body risk managers/ risk management specialists).

7. Resourcing those responsible for managing specific risks

7.1 Where risks impact on a specific partner body and new risk control measures require to be developed and funded, it is expected that the costs will be borne by that partner organisation.

7.2 Financial decisions in respect of the IJB's risk management arrangements will rest with the Chief Financial Officer.

Training, learning and development

8. Risk management training and development opportunities

8.1 To implement effectively this policy and strategy, it is essential for people to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

8.2 Training is important and is essential in embedding a positive risk management culture across all activities under the direction of the IJB and in developing risk management maturity. The Senior Management Team will regularly review risk management training and development needs and source the relevant training and development opportunities required (referred to in 5.4).

Monitoring activity and performance

9. Monitoring risk management activity

9.1 The Joint Board operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

9.2 Monitoring will include review of the IJB's risk profile at Senior Management Team level.

9.3 **[IJB to agree here, how and how often 9.2 should be undertaken]** **Example: Quarterly or six monthly; all strategic and shared risks and key operational risks**.

9.4 It is expected that partner bodies will use IJB risk reports to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.

10. Monitoring risk management performance

10.1 Measuring, managing and monitoring risk management performance is key to the effective delivery of key objectives.

10.2 Key risk indicators (KRIs) will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, budget monitoring PIs (Performance Indicators) can provide assurance that key financial risks are under control.

10.3 The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

10.4 Reviewing the Joint Board's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act review cycle that will shape future risk management priorities and activities of the Joint Board, inform subsequent revisions of this policy and strategy and drive continuous improvement in risk management across the Joint Board.

Communicating risk management

11. Communicating, consulting on and reviewing the risk management framework

11.1 Effective communication of risk management information across the Joint Board is essential to developing a consistent and effective approach to risk management.

11.2 Copies of this policy and strategy will be widely circulated via the Senior Management Team and will form the basis of any risk management training arranged by the IJB.

11.3 The Policy and Strategy (version 1.0) was approved by the Integration Joint Board at its meeting of **[00/00/0000]**.

11.4 This policy and strategy will be reviewed regularly to ensure that it reflects current standards and best practice in risk management and fully reflects the Integration Joint Board's business environment.

Appendix 1 Risk Matrix

[IJB to insert its chosen risk matrix here]

Note, the common matrix currently used across the majority of partners within the NHS GGC wide area is a 5x5 matrix.

Clinical Negligence and Other Risks Indemnity Scheme

NHS National Services Scotland

CNORIS

Confirmation of Cover 2015/16

The following organisations are covered by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) for all Health Services in Scotland and for Health and Social care services covered by Integration schemes.

NHS Ayrshire & Arran

East Ayrshire Integrated Joint Board

North Ayrshire Integrated Joint Board

South Ayrshire Integrated Joint Board

NHS Borders

NHS Dumfries & Galloway

NHS Education

NHS Fife

NHS Forth Valley

NHS Grampian

NHS Greater Glasgow & Clyde

NHS Health Scotland

NHS Highland

NHS Lanarkshire

NHS Lothian

Mental Welfare Commission for Scotland

National Services Scotland

National Waiting Times Centre

NHS Orkney

NHS Quality Improvement Scotland

Scottish Ambulance Service

NHS Shetland

The State Hospital

NHS Tayside

NHS Western Isles

NHS 24

Mrs Deirdre Evans
CNORIS Scheme Director
NHS National Services Scotland
May 2015

Version: 2.0 (May 2015)
Author: NHS National Services Scotland

Purpose of this Guidance Note

There will be occasions when CNORIS scheme members are required to confirm the extent of cover available to them under the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). This guidance note sets out the cover for the listed Members, and can be provided to external organisations as Members see fit. This guidance is effective from 1 April 2015 until 31 March 2016 inclusive.

Introduction

In my capacity as CNORIS Scheme Director, I can confirm that with effect from 1 April 2015, the bodies listed herein are admitted Members of CNORIS, which has been created by authority of the Scottish Ministers.

CNORIS is subject to scheme rules and governed by the National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2015.

Cover

General:
CNORIS provides indemnity to Member organisations in relation to Employer's Liability, Public / Product Liability and Professional Indemnity type risks (inter alia). The level of cover provided is at least £5m Public Liability, £10m Employers Liability, and £1m Professional Indemnity. The Scheme will provide "Indemnity to Principal" where required. CNORIS also provides cover in relation to Clinical Negligence.

Work Experience and Student Placements:
CNORIS provides indemnity to Member organisations in relation to their legal liability associated with work experience recruits of whatever age acting on behalf of the Member organisations. CNORIS will similarly provide indemnity to member organisations in relation to their legal liability associated with students working with the Member organisation on placement from an educational establishment.

Volunteers:
CNORIS provides indemnity in relation to legal liability of Member organisations associated with volunteers of whatever age acting directly on behalf of the Member organisation. For the avoidance of doubt, no cover is provided in relation to voluntary organisations.

Further Information

For further information please contact

Irene A Hallett
CNORIS Scheme Manager
NHS Central Legal Office
NHS National Services Scotland
Anderson House
Breadalbane Street
Bonnington Road
Edinburgh EH6 5JR
Tel: 0131 275 7549
Mob: 07814 632164
Email: irenehallett@nhs.net

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health & Social Care Partnership**	**Report No: IJB/11/2015/LB**
Contact Officer:	**Lesley Bairden**	**Contact No: 01475 712257**
Subject:	**INVERCLYDE HEALTH & SOCIAL CARE PARTNERSHIP DUE DILIGENCE PROCESS**	

1.0 PURPOSE

1.1 The purpose of this report is to provide the Integration Joint Board (IJB) with the partnership starting budget for 2015/16 (excluding set aside budgets for large hospital and hosted services) and the associated due diligence process undertaken to arrive at this budget.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal Assent in April 2014. This established the framework for the integration of Health & Social Care in Scotland.

2.2 The IJB is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of the Integration Scheme. NHS Greater Glasgow and Clyde (NHSGGC) and Inverclyde Council have delegated functions to the IJB which has the responsibility for strategic planning, resourcing and ensuring delivery of all integrated services.

2.3 The IJB is required to allocate the resources it receives from NHSGGC and Inverclyde Council in line with the Strategic Plan. As previously agreed, the formal delegation of resources will commence in April 2016 allowing for a clean and transparent transfer of resources, including those budgets set aside for large hospital service and for services hosted on behalf of the IJB.

2.4 In the interim (i.e. for the remainder of the current financial year) aligned reporting will be brought to the IJB, effective from the next meeting in November.

2.5 Due diligence work, as recommended in the guidance provided around the formation of IJBs, has been undertaken to consider the sufficiency of the revenue budget for Inverclyde Health and Social Care Partnership for 2015/16.

2.6 Inverclyde operated as an integrated CHCP from October 2010 and from that date fully aligned financial reporting was a standing item on each sub-committee agenda. The full history of reports is available via the Council website.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Note the due diligence work undertaken
2. Note the 2015/16 original revenue budget
3. Agree to receive aligned revenue reporting for the remainder of financial year 2015/16, with full budget delegation operating from 1st April 2016/19 supported by a 2016/19 Financial Strategy.

Brian Moore
Chief Officer Designate

Lesley Bairden
Chief Finance Officer Designate

4.0 BACKGROUND

4.1 As set out in section 2 above, this report will demonstrate the due diligence process for arriving at the 2015/16 revenue budget for Inverclyde Health & Social Care Partnership, providing assurance to the partnership on sufficiency of the budget.

4.2 Part of the resources for which the IJB will have a responsibility for planning are held within NHSGGC for acute hospital services, as defined in the Integration Scheme. This is known as the set aside budget. During 2015/16, NHSGGC will work with partnerships to develop an agreed methodology to calculate the set aside budget.

4.3 A methodology will also be agreed for reporting on those services that are hosted on behalf of the partnership.

5.0 DUE DILIGENCE

5.1 The due diligence process relates to the partnership's revenue budget for NHS Primary Care and Social Work services. As stated above Inverclyde CHCP has regularly reported an aligned financial position since 2010. The table below shows the year end position for both the NHS and the Council for financial years 2012/13 to 2014/15:

	Budget £'000	Outturn £'000	Over/(Under) £'000
2012/13			
Social Work	47,758	47,647	(111)
NHS	71,498	71,529	31
Total	**119,256**	**119,176**	**(80)**
2013/14			
Social Work	47,993	47,932	(61)
NHS	71,113	71,094	(19)
Total	**119,106**	**119,026**	**(80)**
2014/15			
Social Work	49,037	48,755	(282)
NHS	73,883	73,877	(6)
Total	**122,920**	**122,632**	**(288)**

5.2 In addition to detailed reporting to each CHCP Sub-Committee from October 2010 to March 2015, an annual report was presented to the Council's Health & Social Care Committee and the Inverclyde position was reported to the Board periodically as part of the total partnership position. A financial position was also reported, with appropriate challenge, as part of the biannual Organisational Performance Review process. The last aligned report to the CHCP Sub-Committee for the period to December 2014 is included at Appendix 1 for illustration.

5.3 The total annual net revenue budget for 2015/16 is £119,391,000 comprising £70,624,000 NHSGGC and £48,787,000 Social Work. It should be noted that the Social Work budget is net of £2.2 million external funding for Criminal Justice and Prison Services. In addition to the original budget for Social Work Services, further allocations will be made for the cost of pay award and contractual inflation, not allocated until agreed.

The annual budget is identified by service area:

2015/16 Revenue Budget	Health £'000	Council £'000	Total £'000
Strategy / Planning & Health Improvement	711	2,065	2,776
Older Persons / District Nursing & Community	3,577	21,346	21,346
Learning Disabilities	560	6,413	6,973
Mental Health - Communities	2,314	1,106	3,420
Mental Health - Inpatient Services	9,363		9,363
Children & Families	2,836	10,344	13,180
Physical & Sensory		2,156	2,156
Addiction / Substance Misuse	1,959	1,039	2,998
Assessment & Care Management		1,584	5,161
Support / Management / Admin	1,762	1,982	3,744
Homelessness		732	732
Family Health Services	19,844		19,844
Prescribing	16,203		16,203
Resource Transfer	9,203		9,203
Integrated Care Fund	2,292		2,292
HSCP NET EXPENDITURE	**70,624**	**48,767**	**119,391**

6.0 2015/16 REVENUE BUDGET

6.1 The main issues relating to the 2015/16 revenue budget are set out below:

6.2 Social Work

a. Whist the starting budget for 2015/16 for Social Work is less than the 2014/15 outturn it should be recognised that the budget reflects agreed savings of £1.2 million from the 2013/15 budget as well as £0.7 million from the 2015/17 budget. Actions are in place to deliver these savings.

b. In addition to these savings, the 2015/16 budget includes pressure funding of £0.36 million within Learning Disabilities and £0.75 million within Older People's Services to reflect the continued increase in demographic pressures and complexity of cases. A further £0.25 million has also been agreed for 2016/17.

c. Funding is not yet allocated for inflationary pressures or pay award, with each element released from central funds as agreed.

d. The main areas of volatility within the Social Work budget reflect those previously reported to the CHCP Sub Committee and Health and Social Care Committee, namely;
   - Increased numbers and complexity of cases within Older People's Services, manifesting within Nursing & Residential Care and Homecare.
   - Within Homecare the continued roll out of a new framework agreement for provision of services is ongoing.
   - Children's purchased Residential Care is demand led, based on statutory order, so is difficult to predict. A small variation in number will have significant cost implication.
   - Homelessness Services remain with a downward trend in occupancy, resulting in a cost pressure from void properties. Work is ongoing in this area to review the levels of service provision.

6.3 Detailed financial reporting during 2015/16 (and thereafter) will address all issues above as a matter of course. The reporting will also detail the use of reserves, including the Integrated Care Fund and Delayed Discharge funding specific to Social Work.

6.4 Health

a. The opening NHS budget for Inverclyde reflects, in the main, the recurring budget, whereas the prior year budgets and outturns include resources relating to a number of non-recurring initiatives, project funding and resource allocation adjustments (RAM). This is standard practice within the Board and similar budget revisions will be made throughout 2015/16.

b. The Health budget includes £0.37 million saving for 2015/16 and plans are in place to deliver this. This saving is Inverclyde's local target, part of the collective Partnership's overall target of £15 million, which includes a number of service wide proposals and use of one off resources.

c. Funding allocations for inflation and pay award will be added to the budget as individual areas are agreed.

d. The main areas of volatility within the Heath budget are also as previously reported to the CHCP Sub-Committee and to the Board via the Quality & Performance Committee;
   - Children & Families impact of previous service wide redesigns resulted in cost pressures existing until end point staffing is reached. This position continues to improve and the recent centralisation of medical staff will further reduce this local pressure.
   - Equipment cost pressures continue to increase linked to demographics and demand for community based equipment.
   - Mental Health Inpatients staff cost pressure until endpoint reprovision of Ravenscraig Services, including the costs related to staff protection.
   - Prescribing remains a complex area of cost with numerous factors that will result in cost implications. Through significant work from the Inverclyde Prescribing Team the outturn for 2014/15 was £67,000 overspent – a significant and sustained improvement within Inverclyde. The Partnership wide risk sharing agreement on prescribing remains in place, recognising the volatility of the nature of the service.

6.5 As above with Social Work detailed financial reporting during 2015/16 (and thereafter) will address all issues above as a matter of course.

7.0 FUTURE CONSIDERATIONS

7.1 The Council has set a budget for 2016/17 of £47.94 million, inclusive of £1.01 million savings and £0.25 million growth; however this does not reflect inflation or pay increases for the period 2015/16 or 2016/17. Work is currently ongoing to plan for the 2017/18 budget, with a Council overall savings target of £6.4 million.

7.2 Within NHSGGC financial planning it is recognised that the savings challenges will be in excess of the targets from recent years, in part due to changes in the NHS Superannuation Scheme and National Insurance changes in 2016/17 and work has been ongoing within the Board to mitigate the funding gap. At a Partnership wide level the planning assumption for 2016/17 is a further £15 million to be achieved from local and system wide proposals and work remains ongoing to identify savings proposals.

7.3 Both Inverclyde Council and NHSGGC will be at risk from the impacts of continued austerity measures, loss of Scottish Government funding, impacts of population decline and demographic pressures within Older People's Services and by the wider Welfare Reform agenda, to name a few factors.

7.4 The factors outlined above, the identification and inclusion of set aside budgets for hospital services along with existing financial planning will be reflected in a financial strategy 2016/17 and beyond to be developed for Inverclyde Health & Social Care Partnership.

8.0 ASSURANCE STATEMENT

8.1 It is the opinion of the Chief Financial Officer Designate that the initial budget allocation, based on 2015/16 and subsequent assumptions, to the Partnership is sufficient to deliver the outcomes as determined in the financial plan, subject to successful delivery of agreed savings programmes and effective risk mitigation of any pressure areas.

8.2 Given the demand led nature of Health and Social Care Services, the Partnership may need to deviate from the original budget and plans in order to flex and adapt to specific service pressures in any area. Through robust budgetary control and full and transparent financial reporting this will be appropriately managed and controlled. All significant variances and remedial actions will be brought to the attention of the Joint Board at the earliest opportunity and will be implicit in the standing agenda item for financial reporting.

9.0 IMPLICATIONS

9.1 **Finance**

All financial implications are addressed in the report above.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

Legal

9.2 There are no specific legal implications arising from this report.

Human Resources

9.3 There are no specific human resources implications arising from this report.

Equalities

9.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

Repopulation

9.5 There are no repopulation issues within this report.

10.0 CONSULTATION

10.1 The Council's Chief Financial Officer and Director of Finance NHSGGC have been consulted.

11.0 BACKGROUND PAPERS

11.1 There are no background papers listed for this report, however detailed financial reporting for Inverclyde CHCP is available via the Inverclyde Council website www.inverclyde.gov.uk/meetings

Inverclyde council

APPENDIX 1

AGENDA ITEM NO:

NHS Greater Glasgow and Clyde

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date: 26 February 2015**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/20/2015/LB**
Contact Officer:	**Lesley Bairden**	**Contact No: 01475 712257**
Subject:	**Community Health & Care Partnership – Financial Report 2014/15 as at Period 9 to 31 December 2014.**	

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde CHCP Sub-Committee of the Revenue and Capital Budget current year position as at Period 9 to 31 December 2014.

2.0 SUMMARY

REVENUE PROJECTION 2014/15

2.1 The total Health and Community Care Partnership revenue budget for 2014/15 is £120,397,000 with a projected underspend of £181,000 being 0.15% of the revised budget. This is a reduction in projected spend of £181,000 since the break even position last reported to the Sub-Committee as at period 7.

2.2 The Social Work revised budget is £49,071,000 and is projected to underspend by £181,000 (0.37%), a reduction of £181,000 since last reported, mainly due to the projected costs of adult care packages.

2.3 This position is net of Residential Childcare, Fostering and Adoption as any under / over spend is managed through the approved earmarked reserve. At period 9, it is projected that there will be a transfer of £194,000 to the reserve at 31 March 2015; however this will be subject to the CHCP containing any further Older Peoples or other cost pressures within budget.

2.4 It should be noted that the 2014/15 budget includes agreed savings for the year of £1,732,000 with a projected over recovery of £74,000 from early implementation.

2.5 The Health revenue budget is £71,326,000 and is projected to budget as previously reported at period 7.

2.6 The Health budget for 2014/15 includes £179,000 local savings, currently projected to be achieved in full.

2.7 Prescribing is projected to budget, and given the volatility of prescribing forecasts, a cost neutral position is being reported within GG&C, reflecting the established risk sharing protocols. Inverclyde is £16,000 (0.2%) underspent on the year to date.

CAPITAL 2014/15

2.8 The total Health and Community Care Partnership approved capital budget for 2014/15 is £333,000 and is projected to underspend by £30,000.

2.9 The Social Work capital budget is £195,000, with projected slippage of £25,000 (being 13%) reflecting £32,000 Kylemore retentions, offset by £7,000 overspend on the expansion of the Hillend Respite Unit from 3 to 4 beds. The underspend of £25,000 will be returned to the Council's Capital Programme.

2.10 The CHCP Sub-Committee agreed to the replacement of Neil Street and Crosshill Children's Homes at its meeting on 24 April 2014. The replacement programme is funded through a contribution from the Residential Childcare, Adoption & Fostering earmarked reserve and prudential borrowing. The project planning phase is April 2014 to May 2015, with build work to commence 2015/16.

2.11 The Health capital budget is £138,000 and will now fund Fire Alarm works to 2 Health Centres as the costs of these projects has increased from the original estimated costs. The planned Cathcart Centre roofing works will now be met from revenue budgets along with other revenue funded works. The Health capital budget has slippage of £5,000 and the Fire Alarm work for the third Health Centre will be reviewed as part of the 2015/16 programme of works.

EARMARKED RESERVES 2014/15

2.12 The Social Work Earmarked Reserves for 2014/15 total £3,005,000 with £2,218,000 projected to be spent in the current financial year. To date £1,390,000 spend has been incurred which is 63% of the projected 2014/15 spend. The spend to date per profiling was expected to be £1,509,000 therefore project slippage equates to £119,000 (8%), relating to numerous projects within the Change Fund and Independent Living reserves.

It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely:

- Children's Residential Care, Adoption & Fostering.
- Deferred Income.

2.13 As advised to the last Sub-Committee £264,000 funding for improving Delayed Discharge performance was agreed and this in included within Deferred Income, not reported to Sub-Committee as this reserve simply deals with timing issues relating to spend. The Service will provide periodic performance reports on Delayed Discharge.

3.0 RECOMMENDATIONS

3.1 The Sub-Committee note the current year revenue budget projected underspend of £181,000 for 2014/15 as at 31 December 2014.

3.2 The Sub-Committee note the current projected capital position:

- Social Work capital projected slippage of £25,000 in the current year and over the life of the projects.
- Health capital projected slippage of £5,000.

3.3 The Sub-Committee note the current Earmarked Reserves position.

3.4 The Sub-Committee note the position on Prescribing.

3.5 The Sub-Committee approve the Social Work budget virements as detailed at Appendix 7.

Brian Moore
Corporate Director
Inverclyde Community Health &
Care Partnership

4.0 BACKGROUND

4.1 The purpose of the report is to advise the Sub-Committee of the current position of the 2014/15 CHCP revenue and capital budget and to highlight the main issues contributing to the 2014/15 budget projected underspend of £181,000 (0.15%) and the current capital programme position of £30,000 slippage.

4.2 The current year consolidated revenue summary position is detailed in Appendix 1, with the individual elements of the Partnership detailed in Appendices 2 and 3, Social Work and Health respectively. Appendix 4 shows the year to date position for both elements of the Partnership. Appendix 5 provides the capital position. Appendix 6 provides detail of earmarked reserves. Appendix 7 details budget virements. Appendix 8 provides detail of the employee cost variance by service.

5.0 2014/15 CURRENT REVENUE POSITION: £181,000 PROJECTED UNDERSPEND

5.1 SOCIAL WORK £181,000 PROJECTED UNDERSPEND

The projected underspend of £181,000 (0.37%) for the current financial year remains predominantly due to client commitment cost within Older Person's Services offset, in part, by turnover, both within Internal Homecare and other Services and by a one off contribution from NHS for demographic pressures as previously reported. This is a reduction in projected costs of £181,000. The material projected variances and reasons for the movement since last reported are identified, per service, below:

a. **Strategy: Projected £50,000 (2.40%) underspend**

The underspend relates predominantly to continued turnover of £42,000, a further £5,000 since period 7.

b. **Older Persons: Projected £355,000 (1.67%) overspend**

The projected overspend reflects continued increasing costs in Homecare which is projected to overspend by £272,000. There is a projected overspend of £72,000 within Residential and Nursing purchased places, per the current number of clients receiving care, less the one off contribution from NHS for pressures. This is a reduction in costs of £5,000.

This reflects the continued increasing trend from 2013/14 and is representative of the national position. A budget pressure bid was included as part of the current budget cycle.

c. **Learning Disabilities: Projected £28,000 (0.44%) overspend**

The projected overspend relates to turnover a number of running cost budgets, including transport, offset in part by turnover savings. The reduction in costs of £76,000 reflects the current number of clients in receipt of care packages, with previously committed costs for a complex needs case not required in the current financial year.

It should be noted that the current year budget includes £350,000 pressure funding, with a further budget increase of £200,000 in 2015/16 reflecting the pressures expected within this service. A further budget pressure bid was included as part of the current budget cycle, reflecting projected service demand.

d. **Mental Health: Projected £155,000 (12.09%) underspend**

The projected underspend remains primarily due to turnover of £97,000, of which £32,000 relates to early achievement of a saving. The reduction in projected costs of £32,000 is due to further turnover of £9,000 and a reduction in client costs of £24,000.

e. **Children & Families: Projected £237,000 (2.33%) underspend**

The main reason for the underspend remains turnover of £105,000 and a projected underspend of £21,000 relating to the Children's Panel, along with Respite underspend of £33,000. This is a further underspend of £64,000 since last reported of which £33,000 reflects current respite commitments, with the remainder relating to revised projections over a number of budget lines.

There is a projected underspend within residential childcare, adoption and fostering of £194,000, however given the volatile nature of the service and the high cost implications this is impossible to predict and, in line with the agreed strategy, the under or over spend at year end will be transferred to or from the earmarked reserve set up to smooth budgetary pressures. This will be subject to the containment of any further unfunded cost pressures with Older People Services.

It should be noted that a one off contribution from this reserve has been agreed as part of the funding structure on the Reprovision of Children's Homes. This funding structure also includes permanent virement from the Residential Schools budget to fund the annual cost of loans charges in financial years 2015/16 and 2016/17.

f. **Physical & Sensory: Projected £32,000 (1.42%) underspend**

The underspend reflects turnover of £43,000 offset in part by client package costs. The reduction of £64,000 mainly relates to a decrease in client numbers.

g. **Addictions / Substance Misuse: Projected £45,000 (3.98%) underspend**

The projected underspend remains due to £35,000 turnover and the increase in projected costs of £41,000 mainly relates to client package costs.

h. **Support & Management: Projected £65,000 (2.83%) underspend**

The underspend mainly relates to turnover, a further £16,000 since period 7.

i. **Assessment & Care Management: Projected £119,000 (7.30%) underspend**

The projected underspend remains due to turnover from vacancies. This is a further projected underspend of £35,000.

j. **Homelessness: Projected £139,000 (18.18%) overspend**

The projected overspend reflects the reduction in costs and income from scatter flats and the Inverclyde Centre. Previous income projections had allowed for an increase in usage / occupancy however this downward trend appears to be crystallising and subsequent increase to void rental income is the main reason for the increased projected costs of £99,000.

This projected overspend has been further compounded by the non-achievement of £40,000 saving in the current financial year which was predicated on additional income from the additional two units at the Inverclyde Centre. A detailed review of all Homelessness budgets will be undertaken and thereafter reported to the relevant Sub-Committee via the Council's Corporate Management Team.

5.2 HEALTH £NIL PROJECTED VARIANCE

The Health budget is £71,326,000 with the current projected spend to budget. This is after the previously reported NHS contribution to Older People cost pressures in the Council, recognising the cross system approach within the CHCP for joint commissioning. The significant projected variances, along with reasons for the movement from period 7, per service, are identified below.

a. **Children & Families: Projected £77,000 (2.53%) overspend**

There remain historic supply pressures within Children & Adolescent Mental Health Services (CAMHS) of £35,000 along with salary overspends within CAMHS due to Resource Allocation Model (RAM) adjustments and this pressure will exist until the staff cohort changes over time to reflect the RAM. This has been further compounded in 2014/15 by a budget reduction of £27,000 for system wide savings. It should be noted that this pressure will reduce by £75,000 in 2015/16 due to changes in consultant and work is ongoing to find solutions for supernumerary employees.

At this stage non-recurring funding has not been applied as the CHCP are containing these cost pressures within the overall position and work remains ongoing to establish a recurring funding solution, with a number of options identified on a system wide basis for 2015/16.

This is a reduction in projected overspend of £15,000, from vacant posts.

b. **Health & Community Care: Projected £15,000 (0.40%) underspend**

The projected underspend remains due to vacant posts mainly within nursing, and in particular treatment rooms. This is an increase in costs of £55,000 mainly from bank and nursing costs, including transfer of Podiatry bank costs previously projected within Management & Administration.

c. **Management & Administration: £45,000 (1.99%) underspend**

The projected underspend reflects continued pressures within portering, in line with prior year spend, offset by additional funding and realignment of budget savings. The reduction in projected costs of £21,000 is mainly due to transfer of Podiatry bank costs to Health & Community Care.

d. **Learning Disabilities: Projected £56,000 (9.77%) underspend**

The projected underspend remains due to turnover, primarily in nursing costs. This includes a non-recurring underspend of £11,000 relating to a refund of prior year agency costs, a further underspend of £3,000.

e. **Addictions: Projected £81,000 (4.20%) underspend**

The projected underspend remains due to turnover and the reduction in costs of £68,000 is due to revision of any likely recruitment by the end of the financial year.

f. **Mental Health Communities: Projected £15,000 (0.67%) overspend**

This remains a result of turnover within nursing staff costs, including maternity leave, offset by a projected overspend within pharmacy costs, which is in line with the previous year. This is a projected cost increase of £58,000 due to increased rent for Crown House and further prescribing costs.

g. **Prescribing: Nil Variance**

Prescribing is projected to budget, and given the volatility of prescribing forecasts, a cost neutral position is being reported within GG&C, reflecting the established risk sharing protocols. Inverclyde is £16,000 (0.2%) underspent on the year to date.

6.0 CHANGE FUND

6.1 The original allocation over service areas for 2014/15 was:

Service Area Budget 2014/15	£'000	
Acute – Health	202	13%
CHCP – Health	123	8%
CHCP – Council	830	55%
Community Capacity - Health	11	1%
Community Capacity - Council	356	23%
Grand Total	**1,522**	100%
Funded By:		
Change Fund Allocation	1,228	
Slippage brought forward from 2013/14	294	
Total Funding	**1,522**	

6.2 The Change Fund Executive Group meet on a regular basis and review all projects in detail. The latest current year position is:

Service Area Budget 2014/15	Current Budget £'000	Projected Outturn £000	Projected Variance £000
Acute – Health	219	207	(12)
CHCP – Health	113	84	(29)
CHCP – Council	823	863	40
Community Capacity - Health	11	11	0
Community Capacity - Council	356	364	8
Grand Total	**1,522**	**1,529**	**7**
Projected Over Commitment / (Slippage) at 31 December 2014			**7**

The costs will continue to be managed within the available resources and to ensure nil slippage or overspend in the final year of the Change Fund.

7.0 2014/15 CURRENT CAPITAL POSITION – £30,000 UNDERSPEND

7.1 The Social Work capital budget is £4,831,000 over the life of the projects with £195,000 for 2014/15, comprising:

- £115,000 for Kylemore Children's Home retentions, with the final underspend of £32,000 being returned to the Council's Capital Programme.
- £80,000 to expand the Hillend respite unit, with the overspend of £7,000 being met from the Council's Capital Programme.

The slippage of £25,000 is 13% of the current year budget.

7.2 The CHCP Sub-Committee agreed to the replacement of Neil Street and Crosshill Children's Homes at its meeting on 24 April 2014. The replacement programme is funded through a contribution from the Residential Childcare, Adoption & Fostering earmarked reserve and prudential borrowing. The project planning phase is April 2014 to May 2015, with build work to commence 2015/16.

7.3 The Health capital budget of £138,000 is now projecting slippage of £5,000 as the funding of the Fire Alarm works has now been revised to meet the costs of 2 of the planned 3 Health Centre works. The funding for the upgrade of the 3rd Health Centre Fire Alarm system will be reviewed as part of the 2015/16 programme of works.

7.4 In addition to the Health capital funding a further £113,000 works will be funded from revenue maintenance:

- £50,000 asbestos encapsulation within Greenock and Port Glasgow Health Centres reception upgrade.
- £23,000 Gourock Health Centre Reception.
- £40,000 Cathcart Centre roofing works.

7.5 Appendix 5 details capital budgets and progress by individual project.

8.0 EARMARKED RESERVES

8.1 The Social Work Earmarked Reserves for 2014/15 total £3,005,000 with £2,218,000 projected to be spent in the current financial year. To date £1,390,000 spend has been incurred which is 63% of the projected 2014/15 spend. The spend to date per profiling was expected to be £1,509,000 therefore project slippage equates to £119,000 (8%), relating to numerous projects within the Change Fund and Independent Living reserves.

It should be noted that the reserves reported exclude those earmarked reserves that relate to budget smoothing, namely:

- Children's Residential Care, Adoption & Fostering.
- Deferred Income.

8.2 As advised to the last Sub-Committee £264,000 funding for improving Delayed Discharge performance was agreed and this in included within Deferred Income, not reported to Sub-Committee as this reserve simply deals with timing issues relating to spend. The Service will provide periodic performance reports on Delayed Discharge.

9.0 VIREMENT

9.1 Appendix 7 details the virements that the CHCP Sub-Committee is requested to approve. As at period 9 there are no requested virements.

10.0 IMPLICATIONS

10.1 **Finance**

All financial implications are discussed in detail within the report above.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

10.2 **Legal**
There are no specific legal implications arising from this report.

10.3 **Human Resources**
There are no specific human resources implications arising from this report

10.4 **Equalities**
There are no equality issues within this report.

10.5 **Repopulation**
There are no repopulation issues within this report.

11.0 CONSULTATION

11.1 This report has been prepared by the Corporate Director, Inverclyde Community Health & Care Partnership and relevant officers within Partnership Finance and the Council's Chief Financial Officer have been consulted.

12.0 BACKGROUND PAPERS

12.1 There are no background papers for this report.

APPENDIX 1

INVERCLYDE CHCP

REVENUE BUDGET PROJECTED POSITION

PERIOD 9: 1 April 2014 - 31 December 2014

SUBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
Employee Costs	46,703	48,074	46,983	(1,091)	(2.27%)
Property Costs	2,971	3,367	3,240	(127)	(3.77%)
Supplies & Services	59,463	59,457	60,269	812	1.37%
Prescribing	15,912	16,203	16,203	0	0.00%
Resource Transfer (Health)	9,041	9,041	9,158	117	1.29%
Income	(14,940)	(15,657)	(15,549)	108	(0.69%)
Contribution to Reserves	0	(88)	(88)	0	0.00%
	119,150	**120,397**	**120,216**	**(181)**	**(0.15%)**

OBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
Strategy / Planning & Health Improvement	2,822	3,032	2,973	(59)	(1.95%)
Older Persons	20,971	21,253	21,608	355	1.67%
Learning Disabilities	6,804	6,886	6,858	(28)	(0.41%)
Mental Health - Communities	3,793	3,527	3,387	(140)	(3.97%)
Mental Health - Inpatient Services	9,228	9,190	9,187	(3)	(0.03%)
Children & Families	12,948	13,224	13,064	(160)	(1.21%)
Physical & Sensory	2,272	2,253	2,221	(32)	(1.42%)
Addiction / Substance Misuse	3,111	3,058	2,932	(126)	(4.12%)
Assessment & Care Management / Health & Community	5,268	5,361	5,227	(134)	(2.50%)
Support / Management / Admin	4,170	4,564	4,454	(110)	(2.41%)
Criminal Justice / Prison Service **	0	0	0	0	0.00%
Homelessness	743	739	878	139	18.81%
Family Health Services	21,039	21,004	21,004	0	0.00%
Prescribing	15,912	16,203	16,203	0	0.00%
Resource Transfer	9,041	9,041	9,158	117	1.29%
Change Fund	1,028	1,150	1,150	0	0.00%
Contribution to Reserves	0	(88)	(88)	0	0.00%
CHCP NET EXPENDITURE	**119,150**	**120,397**	**120,216**	**(181)**	**(0.15%)**

** Fully funded from external income hence nil bottom line position.

PARTNERSHIP ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
NHS	70,088	71,326	71,326	0	0.00%
Council	49,062	49,071	48,890	(181)	(0.37%)
CHCP NET EXPENDITURE	**119,150**	**120,397**	**120,216**	**(181)**	**(0.15%)**

( ) denotes an underspend per Council reporting conventions

** £2.3 million externally funded

APPENDIX 2

SOCIAL WORK

REVENUE BUDGET PROJECTED POSITION

PERIOD 9: 1 April 2014 - 31 December 2014

	2013/14 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
		SOCIAL WORK					
8	25,250	Employee Costs	25,976	26,069	25,152	(917)	(3.52%)
	1,431	Property costs	1,453	1,438	1,306	(132)	(9.18%)
	919	Supplies and Services	808	815	967	152	18.65%
	482	Transport and Plant	366	381	481	100	26.25%
	1,021	Administration Costs	879	896	987	91	10.16%
8	32,751	Payments to Other Bodies	33,457	33,535	33,952	417	1.24%
	(13,922)	Income	(13,877)	(13,975)	(13,867)	108	(0.77%)
9		Contribution to Earmarked Reserves		(88)	(88)	0	0.00%
	47,932	**SOCIAL WORK NET EXPENDITURE**	**49,062**	**49,071**	**48,890**	**(181)**	**(0.37%)**

	2013/14 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over / (Under) Spend £000	Percentage Variance
		SOCIAL WORK					
	2,005	Strategy	2,112	2,080	2,030	(50)	(2.40%)
	21,541	Older Persons	20,971	21,253	21,608	355	1.67%
	6,159	Learning Disabilities	6,251	6,313	6,341	28	0.44%
	1,308	Mental Health	1,382	1,282	1,127	(155)	(12.09%)
3	9,070	Children & Families	10,228	10,181	9,944	(237)	(2.33%)
	2,465	Physical & Sensory	2,272	2,253	2,221	(32)	(1.42%)
	1,033	Addiction / Substance Misuse	1,193	1,130	1,085	(45)	(3.98%)
	2,128	Support / Management	2,220	2,298	2,233	(65)	(2.83%)
	1,576	Assessment & Care Management	1,690	1,630	1,511	(119)	(7.30%)
1	0	Criminal Justice / Scottish Prison Service	0	0	0	0	0.00%
2	0	Change Fund	0	0	0	0	0.00%
	647	Homelessness	743	739	878	139	18.81%
		Contribution to Earmarked Reserves		(88)	(88)	0	0.00%
	47,932	**SOCIAL WORK NET EXPENDITURE**	**49,062**	**49,071**	**48,890**	**(181)**	**(0.37%)**

( ) denotes an underspend per Council reporting conventions

1 £1.9m Criminal Justice and £0.3m Greenock Prison fully funded from external income hence nil bottom line position.
2 Change Fund Expenditure of £1.2 million fully funded from income.
3 Children & Families outturn includes £194k to be transferred to the earmarked reserve at year end 2014/15
4 £9 million Resource Transfer / Delayed Discharge expenditure and income included above.

5

Original Budget 2014/15	49,062
Pay & Inflation etc.	119
Budget transfer to Delayed Discharge Earmarked Reserve	(88)
Budget transfer to Client Finance Team	(22)
Revised Budget 2014/15	49,071

6 There are currently 30 clients receiving Self Directed Support care packages.
7 The underlying £274k projected overspend at period 7 has been offset by non recurring funding contributions.
8 Within Older Peoples Services £361k of vacancies have been offset by purchased Homecare costs.
9 Council contribution to Delayed Discharge earmarked reserve

APPENDIX 3

HEALTH

REVENUE BUDGET PROJECTED POSITION

PERIOD 9: 1 April 2014 - 31 December 2014

	2013/14 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
		HEALTH					
	21,319	Employee Costs	20,727	22,005	21,831	(174)	(0.79%)
	1,083	Property	1,518	1,929	1,934	5	0.26%
	4,320	Supplies & Services	2,914	2,826	2,878	52	1.84%
	20,717	Family Health Services (net)	21,039	21,004	21,004	0	0.00%
	16,038	Prescribing (net)	15,912	16,203	16,203	0	0.00%
3	8,863	Resource Transfer	9,041	9,041	9,158	117	1.29%
	(1,246)	Income	(1,063)	(1,682)	(1,682)	0	0.00%
	71,094	**HEALTH NET EXPENDITURE**	**70,088**	**71,326**	**71,326**	**0**	**0.00%**

	2013/14 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2014/15 £000	Revised Budget 2014/15 £000	Projected Out-turn 2014/15 £000	Projected Over/(Under) Spend £000	Percentage Variance
		HEALTH					
	3,144	Children & Families	2,720	3,043	3,120	77	2.53%
	3,755	Health & Community Care	3,578	3,731	3,716	(15)	(0.40%)
	2,040	Management & Admin	1,950	2,266	2,221	(45)	(1.99%)
	540	Learning Disabilities	553	573	517	(56)	(9.77%)
	1,900	Addictions	1,918	1,928	1,847	(81)	(4.20%)
	2,283	Mental Health - Communities	2,411	2,245	2,260	15	0.67%
	9,516	Mental Health - Inpatient Services	9,228	9,190	9,187	(3)	(0.03%)
	1,070	Planning & Health Improvement	710	952	943	(9)	(0.95%)
1	1,228	Change Fund	1,028	1,150	1,150	0	0.00%
	20,717	Family Health Services	21,039	21,004	21,004	0	0.00%
	16,038	Prescribing	15,912	16,203	16,203	0	0.00%
	8,863	Resource Transfer	9,041	9,041	9,158	117	1.29%
	71,094	**HEALTH NET EXPENDITURE**	**70,088**	**71,326**	**71,326**	**0**	**0.00%**

( ) denotes an underspend per Council reporting conventions

1	Change Fund Allocation to CHCP 2014/15	1,228
	Add: Transitional Funding	135
	Less: Transfer to Acute Projects:	
	Stroke Outreach Team	(52)
	AHP Weekend Working	(83)
	Rapid Assessment Team	(41)
	Palliative Care CNS 0.5wte	(37)
		1,150

2	Original Budget 2014/15	70,088
	Pay & Inflation	415
	Keepwell / Childsmile	117
	GMS Cross Charge / FHS Adjustments	(35)
	Prescribing	291
	Transitional Funding - Integration	135
	Other including Hotel Services Allocation and Skills Mix Funding	315
	Revised Budget 2014/15	71,326

3 Contribution to Older Peoples pressures

APPENDIX 4

REVENUE BUDGET YEAR TO DATE

PERIOD 9: 1 April 2014 - 31 December 2014

	SOCIAL WORK SUBJECTIVE ANALYSIS	Budget to Date £000	Actual to Date £000	Variance to Date £000	Percentage Variance
	SOCIAL WORK				
	Employee Costs	18,657	17,900	(757)	(4.06%)
1	Property costs	1,020	806	(214)	(20.98%)
	Supplies and Services	575	668	93	16.17%
	Transport and Plant	276	341	65	23.55%
	Administration Costs	644	475	(169)	(26.24%)
1	Payments to Other Bodies	24,062	23,161	(901)	(3.74%)
	Income	(10,177)	(10,005)	172	(1.69%)
	SOCIAL WORK NET EXPENDITURE	**35,057**	**33,346**	**(1,711)**	**(4.88%)**

HEALTH SUBJECTIVE ANALYSIS	Budget to Date £000	Actual to Date £000	Variance to Date £000	Percentage Variance
HEALTH				
Employee Costs	16,131	16,088	(43)	(0.27%)
Property Costs	1,149	1,078	(71)	(6.18%)
Supplies	1,983	2,063	80	4.03%
Family Health Services (net)	15,541	15,541	0	0.00%
Prescribing (net)	12,382	12,382	0	0.00%
Resource Transfer	6,780	6,780	0	0.00%
Income	(1,426)	(1,426)	0	0.00%
HEALTH NET EXPENDITURE	**52,540**	**52,506**	**(34)**	**(0.06%)**

( ) denotes an underspend per Council reporting conventions

1 Timing differences between profiled budget and actual spend.

APPENDIX 5

INVERCLYDE CHCP - CAPITAL BUDGET 2014/15

Period 9: 1 April 2014 to 31 December 2014

Project Name	Est Total Cost	Actual to 31/3/14	Approved Budget 2014/15	Revised Est 2014/15	Actual to 31/12/14	Est 2015/16	Est 2016/17	Future Years	Start Date	Original Completion Date	Current Completion Date	Status
	£000	£000	£000	£000	£000	£000	£000	£000				
SOCIAL WORK												
Kylemore Children's Home	1,212	1,129	115	83	41	0	0	0	01/10/11	30/06/12	19/03/13	The budget for 2014/15 relates to retentions, with final costs expected at £83k so the £32k underspend will be returned to the Council's capital programme.
SWIFT Financials	27	27	0	0	0	0	0	0	03/09/12		31/08/14	Budget allocated for development of SWIFT financial module. No further spend expected
Hillend Respite Unit (note 1)	87	0	80	87	67	0	0	0	28/05/14		14/11/14	Increase of one bed within respite unit. Building work is completed and the £7k overspend is met from the capital programme.
Neil Street Children's Home Replacement	1,858	0	0	0	0	1,775	83	0	01/04/14	31/03/16		Planning phase April 2014 to May 2015.
Crosshill Children's Home Replacement	1,622	0	0	0	0		1,622	0	01/04/14	31/03/17		Planning phase April 2014 to May 2015.
Social Work Total	**4,806**	**1,156**	**195**	**170**	**108**	**1,775**	**1,705**	**0**				
HEALTH												
CHCP Formula Allocation 2014-15 (see 2 below)												
Port Glasgow Health Centre - Fire Alarm	50		50	51	0	0	0	0	tbc	by 31/03/15	31/03/15	Fire Advisor recommendation, revised to current estimate of works
Greenock Health Centre - Fire Alarm	30		30	82	0	0	0	0				Fire Advisor recommendation, revised to current estimate of works
Gourock Health Centres - Fire Alarm and Reception Upgrade	18		18	0	0	0	0	0				Fire Advisor recommendation and works to improve privacy
Cathcart Centre Roofing Works	40		40	0	0	0	0	0	tbc	by 31/03/15	31/03/15	Repair leaks to mezzanine level
Health Total	138	0	138	133	0	0	0	0				
Grand Total CHCP	**4,944**	**1,156**	**333**	**303**	**108**	**1,775**	**1,705**	**0**				

Note:

1. The expansion of the service is funded from a contribution from revenue reserves, as agreed by Policy & Resources Committee 24/09/13. The final total is subject to confirmation.

2. Funding of £138k for local formula capital allocation / capital backlog maintenance.

Additional planned works are being met from revenue maintenance:	£000
Cathcart Centre Roofing Works	40
Gourock Health Centre reception upgrade	23
Port Glasgow and Greenock Health Centres - Asbestos Encapsulation	50
	113

Gourock Fire Alarm upgrade will be reviewed for inclusion in the 2015/16 capital programme

EARMARKED RESERVES POSITION STATEMENT — APPENDIX 6
CHCP SUB COMMITTEE

Project	Lead Officer/ Responsible Manager	Total Funding 2014/15 £000	Phased Budget To Period 9 2014/15 £000	Actual To Period 9 2014/15 £000	Projected Spend 2014/15 £000	Amount to be Earmarked for 2015/16 & Beyond £000	Lead Officer Update
Self Directed Support / SWIFT Finance Module	Derrick Pearce / Andrina Hunter	407	166	153	263	144	SDS project and SWIFT financial module. Spending plans are regularly reviewed.
Growth Fund - Loan Default Write Off	Helen Watson	28	2	1	3	25	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any delinquent debt. This requires to be kept until all loans are repaid and no debts exist.
Change Fund - Older People	Brian Moore	1,422	850	820	1,422	0	Brought forward reflects Council elements of NHS Change Fund. Detailed costs by project are reviewed on a regular basis by the Change Fund Executive Group and position is reported to the CHCP sub committee as an integral part of the financial report. The New Funding of £1.128m has reduced by £100k as the agreed contribution to Caladh House has been transferred to the specific reserve.
Support all Aspects of Independent Living	Brian Moore	403	180	284	298	105	There are plans in place to spend £298k of the £403k, including a contribution to the 2014/15 Sheltered Wardens' saving of £70k, thus leaving a balance to be spent in 2015/16 of £105k, made up of the Dementia Strategy of £67k, the Ravenscraig Re-provisioning of £27k plus an uncommitted balance of £11k. The agreed £48k for Caladh House Renovations has been transferred to the specific Caladh House reserve.
Information Governance Policy Officer	Helen Watson	57	41	29	41	16	The spend relates to the Council's Information Governance Officer.
Joint Equipment Store	Beth Culshaw	50	31	2	50	0	This reserve is to fund a range of equipment to meet the emerging demand linked to increasing frailty of older people and increased incidence of dementia. It will be spent in full in 2014/15, mainly on the replacement of old hoists that are no longer fit for purpose.
Support for Young Carers	Sharon McAlees	65	46	11	21	44	This reserve is for an 18 month period to enable the implementation of a family pathway approach to young carers, which will aim to develop a sustainable service to young carers and their families. The recruitment process took longer than anticipated, hence slippage against profiled spend.

EARMARKED RESERVES POSITION STATEMENT — APPENDIX 6
CHCP SUB COMMITTEE

Project	Lead Officer/ Responsible Manager	Total Funding 2014/15 £000	Phased Budget To Period 9 2014/15 £000	Actual To Period 9 2014/15 £000	Projected Spend 2014/15 £000	Amount to be Earmarked for 2015/16 & Beyond £000	Lead Officer Update
Caladh House Renovations	Beth Culshaw	475	129	13	22	453	This reserve has been created to contribute to the costs of the Caladh House renovation works. The reserve was established at the end of 2013/14 from a £145k revenue budget early savings, £112k from CHCP inflation, £118k from existing CHCP Earmarked Reserves and £100k from the Change Fund. The tender will be issued shortly but no construction costs will be incurred in 2014/15. £13k has been spent on the feasibility study and there will be a further £9k in property fees recharged before the end of March 15.
Making Advice Work	Helen Watson	38	29	38	38	0	This reserve is to fund an18 month project to pilot the effectiveness of a telephone triage financial advice service for Inverclyde wide clients with the funding coming from Scottish Legal Aid Board. This project is complete.
Stress Management Services	Helen Watson	10	6	10	10	0	Funding has been received from the Health Board for a contract with Inverclyde Physiotherapy to provide stress management services. This project is complete.
Welfare Reform - CHCP	Andrina Hunter	50	29	29	50	0	This reserve is to fund expenditure on Welfare Reform within the CHCP.
Total		**3,005**	**1,509**	**1,390**	**2,218**	**787**	

APPENDIX 7

CHCP - HEALTH & SOCIAL CARE

VIREMENT REQUESTS

Budget Heading	Increase Budget £'000	(Decrease) Budget £'000
No virements requiring approval		
	0	**0**

Notes

APPENDIX 8

EMPLOYEE COST VARIANCES

PERIOD 9: 1 April 2014 - 31 December 2014

	ANALYSIS OF EMPLOYEE COST VARIANCES	Early Achievement of Savings £000	Turnover from Vacancies £000	Total Over / (Under) Spend £000
	SOCIAL WORK			
1	Strategy	0	(42)	(42)
2	Older Persons	0	(361)	(361)
3	Learning Disabilities	(12)	(17)	(29)
4	Mental Health	(32)	(65)	(97)
5	Children & Families	0	(105)	(105)
6	Physical & Sensory	0	(43)	(43)
7	Addiction / Substance Misuse	0	(35)	(35)
8	Support / Management	0	(74)	(74)
9	Assessment & Care Management	0	(134)	(134)
10	Criminal Justice / Scottish Prison Service	0	13	13
11	Homelessness	0	(10)	(10)
	SOCIAL WORK EMPLOYEE UNDERSPEND	**(44)**	**(873)**	**(917)**
	HEALTH			
12	Children & Families		38	38
13	Health & Community Care		(61)	(61)
14	Management & Admin		(40)	(40)
15	Learning Disabilities		(61)	(61)
16	Addictions		(76)	(76)
17	Mental Health - Communities		(21)	(21)
18	Mental Health - Inpatient Services		70	70
19	Planning & Health Improvement		(23)	(23)
	HEALTH EMPLOYEE UNDERSPEND		**(174)**	**(174)**
	TOTAL EMPLOYEE UNDERSPEND	**(44)**	**(1,047)**	**(1,091)**

1 1 vacancy which will not be filled before 31/03/15
2 26 vacancies along with maternity leave savings - NB offset by external costs, due to recruitment issues
3 Early achievement of saving on 1 post. 3 vacancies being filled, 1 vacancy wll not be filled by 31/03/15
4 Early achievement of saving on 1 post. 1 vacancy in the process of being filled
5 1 vacancy being filled and 4 which will not be filled before 31/03/15
6 3 vacancies being filled and 2 which will not be filled before 31/03/15
7 2 vacancies which are in the process of being filled
8 3 vacancies being filled and 4 which will not be filled before 31/03/15
9 5 vacancies being filled and 2 which will not be filled before 31/03/15
10 Overspend met from grant funding
11 1 vacancy being filled
12 Ongoing impacts of RAM and supernumerary employee
13 Nursing turnover and agency refunds
14 Portering pressure, offset by budget transfers from savings realignment
15 Nursing turnover and agency refunds
16 Turnover within Community Addictions Team
17 Nursing turnover and maternity leave
18 Bank cover
19 Turnover

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10th August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/11/2015/HW**
Contact Officer:	**Helen Watson Head of Service: Planning Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**ESTABLISHMENT PLAN 2015/16**		

1.0 PURPOSE

1.1 The purpose of this report is to present the draft Establishment Plan 2015/16 for approval by the Integration Joint Board (IJB).

1.2 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board approves a Strategic Plan that specifies the services and functions that are to be delegated to the IJB, and that that this approval must be in place before the IJB can take formal responsibility for the delegated services and functions. The Integration Joint Board is therefore recommended to approve the Establishment Plan, thereby enabling the full delegation of responsibilities and resources to the IJB from April 2016.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 stipulates that in order for responsibilities and resources to be formally delegated to an Integration Joint Board, a local Strategic Plan must first be prepared and approved by it

2.2 Inverclyde has an established approach to inclusive strategic planning that has developed as part of our integrated CHCP arrangements, which have been in place since 2010. We have a strong foundation of a suite of plans and strategies that have been jointly developed with our stakeholders and that are still extant in terms of local planning cycles.

2.3 On that basis, our first Health & Social Care Partnership Strategic Plan brings together this suite of documents as the underpinning framework to support how we move forward while building on the positives to date.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board approves this Establishment Plan 2015/16 and directs the Strategic Planning Group to develop the Strategic Plan covering the time-frame 2016-19, and that this Strategic Plan should be presented to the first IJB meeting of the financial year 2016/17.

Brian Moore
Chief Officer Designate
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 stipulates that in order for responsibilities and resources to be formally delegated to an Integration Joint Board, a local Strategic Plan must first be prepared and approved by it.

4.2 The legislation also requires that the first Strategic Plan details the locality arrangements that the given integration joint board will establish to support its Strategic Plan.

4.3 Inverclyde community health and social care services have been integrated since 2010, when our CHCP arrangements were formalised, so there is established practice in terms of integrated and inclusive planning practice. This has resulted in a suite of local plans that provide a firm foundation on which to build our HSCP strategic planning arrangements.

4.4 The Establishment Plan 2015/16 has been developed by the Strategic Planning Group in recognition of the robust arrangements that are already in place, and the acknowledgement that these should be built upon.

4.5 The Plan recognises what needs to be done in preparation for our substantive 3 year Strategic Plan, which will describe our plans and ambitions for 2016/19. It also lays out the key planning commitments that were made in our Integration Scheme (such as the commitment for a Workforce Plan and an Organisational Development Plan).

4.6 The legislation requires that the Plan must define at least two localities within each HSCP area. On that basis, the Establishment Plan 2015/16 defines two localities, (Inverclyde East and Inverclyde West), further defining each of these localities into three neighbourhoods to mirror the localities already defined by Inverclyde Alliance. Although both localities will require their own planning arrangements that feed into the Strategic Planning Group, there is no proposal that services should be disaggregated or that there should be separate management arrangements for each locality. There will however be a requirement to disaggregate some performance indicators to locality level.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: the Finance Section of the Establishment Plan 2015/16 summarises the financial context and the resources being delegated to the Integration Joint Board.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
	port does not introduce a new policy, function or strategy or reco a change to an existing policy, function or st Therefore, no Equality Impact Assessment is requi

REPOPULATION

5.5 There are no repopulation issues within this report.

6.0 CONSULTATION

6.1 We have followed the Act's requirement that the stakeholder constituencies invited to contribute to the development of the Establishment Plan 2015/16 include:

- Health professionals.
- Users of health care residing within the area of the local authority.
- Carers of users of health care residing within the area of the local authority.
- Commercial providers of health care that operate within the local authority area.
- Non-commercial providers of health care that operate within the local authority area.
- Social care professionals.
- Users of social care residing within the area of the local authority.
- Carers of users of social care residing within the area of the local authority.
- Commercial providers of social care that operate within the local authority area.
- Non-commercial providers of social care that operate within the local authority area.
- Non-commercial providers of social housing that operate within the local authority area.
- Third sector bodies carrying out activities related to health care or social care that operate within the local authority area.

6.2 The existing plans and strategies that form the basis of the Establishment Plan 2015/16 have all been subject to an inclusive approach to consultation.

7.0 BACKGROUND PAPERS

7.1 Public Bodies (Joint Working) (Scotland) Act 2014.

S T R A T E G I C P L A N

ESTABLISHMENT PLAN
August 2015 – March 2016

IMPROVING LIVES

1. FOREWORD

The Public Bodies (Joint Working) (Scotland) Act 2014 aims to bring community health and social care services together across the whole of Scotland, into Health and Social Care Partnerships (HSCPs) that deliver services and support to the people who need them, in a way that makes sense, prevents duplication of effort, and ultimately provides the best quality of support that we can possibly achieve from the resources at our disposal. Here in Inverclyde we have long supported the principles of integration, and as far back as 2010 we put this into action by establishing our Community Health and Care Partnership (CHCP). That enhanced partnership opened up for us the opportunities of joint working that the rest of Scotland now aspires too. Much of what is required by the legislation is already in place in Inverclyde, so we have firm foundations on which to build, so that we can migrate smoothly from our CHCP arrangements, and into our HSCP.

The 2014 Act and its associated guidance highlight that every HSCP must produce a Strategic Plan, outlining what services will be included and noting key objectives and how partnerships will deliver on the nine national outcomes. These outcomes are included at section 3.6, and are designed to help partnerships demonstrate the difference that joined up services make to the lives of the people who use those services. Since we became a CHCP in 2010, all of our strategic planning has been aimed at *Improving Lives*, and we have worked with communities and stakeholders to bring a focus on making a real difference in everything we do. On that basis, we have already worked with communities to develop a suite of plans and strategies, all of which are designed to improve outcomes.

This Establishment Plan is our first Strategic Plan and covers the time period between August 2015 (the point at which our Integration Joint Board is established and the Inverclyde Health and Social Care Partnership formally comes into being), up to the 31st March 2016. March 2016 marks the end of a number of three-year planning cycles and so defines the point at which many of our existing plans and strategies are due to be refreshed. This plan therefore aims to bring together the key themes that run through all of our existing planning and consolidate them into a statement of our future direction. The Establishment Plan also states the range of resources that will be included within the HSCP to help us in our goal of *Improving Lives*, including services and staff, and the money that will pay for these.

We recognise that lives will be improved though a combination of the supports that the HSCP can deliver, as well as an array of other supports that already exist within the communities of Inverclyde. From unpaid family carers to a range of voluntary organisations, Inverclyde benefits from a strong sense of social justice and community spirit, which will have a crucial role in shaping our future.

We are pleased to present this Establishment Strategic Plan to the Inverclyde Integration Joint Board, and invite all of our stakeholders to join the discussion that will shape how future services are delivered to contribute to making a real difference to the social, economic, physical and mental health of our population.

Brian Moore, Chief Officer – Inverclyde Health and Social care Partnership and **Councilor Joe McIlwee** - Chair of the Inverclyde Integration Joint Board.

2. OUR VISION

2.1 When the integrated Community Health and Care Partnership (CHCP) was created in Inverclyde in October 2010 we agreed that the common, uniting premise across all of our services was the need to make a real and positive difference to the outcomes for people who need health and/or social care services . Recognising the need to focus on a common and unifying purpose, our vision statement was agreed as *Improving Lives*. We believe that this vision still stands today as we transit to our new arrangements as a Health and Social Care Partnership (HSCP).

2.2 Our vision of Improving Lives is underpinned by the values that:

- **We put people first;**
- **We work better together;**
- **We strive to do better;**
- **We are accountable.**

2.3 Our vision and values are consistent with the policy intentions of the integration of health and social care. To realise our vision we will take a strategic approach to how we look at our services, alongside the needs and aspirations of Inverclyde people. We will focus on achieving better outcomes to genuinely improve the lives of everyone in Inverclyde, ensuring that we have the best possible arrangements and choices in place to achieve that, within the limited public purse that funds us.

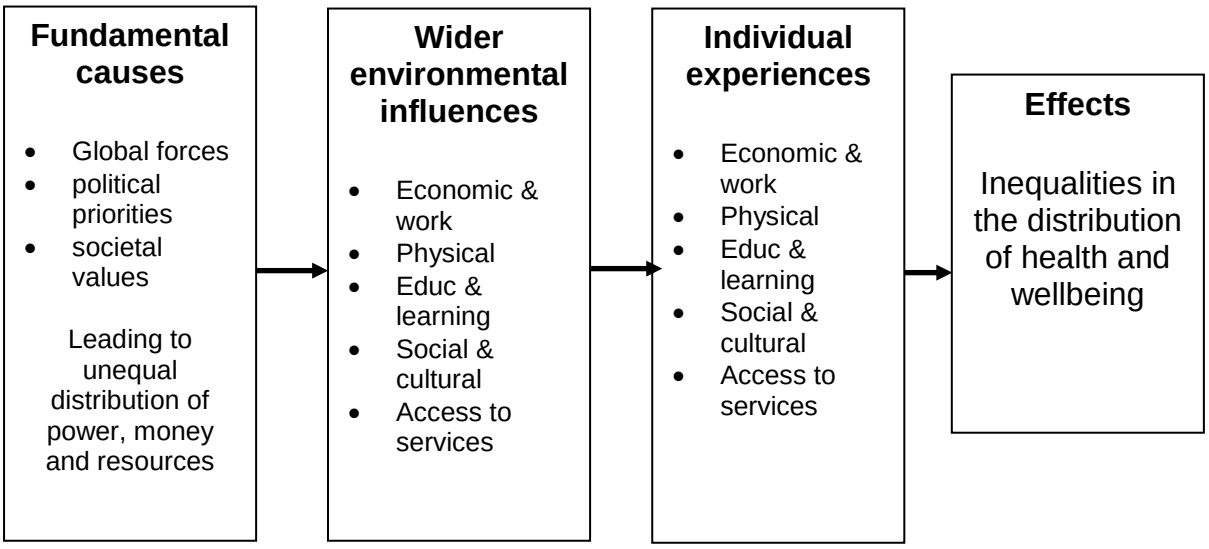
3. OUR PURPOSE

3.1 Our purpose is to work together to deliver and plan health and social care services for the people of Inverclyde. When we say “work together” we mean as a collection of people, groups, organisations and communities made up of:

- individual users of services and our patients as partners in the planning of their own care and support;
- carers and families as partners in the delivery of care and support, who may require support in their own right;
- communities across Inverclyde, the people to whom we are accountable;
- partner organisations in the Community Planning Partnership – Inverclyde Alliance - as partners with whom we work to improve Inverclyde as a place to live and work;
- partners in the third, independent and statutory sectors as partners with whom we take action to commission and organise health and social care service delivery.

3.2 For many years now, Inverclyde has been characterised by some notably unequal health and socio-economic outcomes. An important dimension of our

purpose is therefore to seek to address some of the causes of unequal outcomes, as described below.



Causes of Health Inequalities

3.3 Whenever possible, we are committed to working with our Community Planning Partners to undo, prevent or mitigate the causes of health inequalities. By taking combined action, we hope to break the chain of unequal outcomes described above. Our purpose is underpinned by a drive to reduce the negative effects of inequality experienced by the most vulnerable people of Inverclyde.

3.4 **The Scope of our Purpose:** In Inverclyde we have an 'all-inclusive' health and social care partnership with responsibility for the strategic commissioning of the full range of health and social care services; population health and wellbeing, services for children, adults, older people and people in the criminal justice system. We also work together as a wider partnership to plan for the use of secondary health care hospital services that are needed by the people of Inverclyde.

3.5 We recognise that good quality housing is a vital aspect of improved outcomes, and although the HSCP does not have direct control or responsibility for housing, we are committed to working closely with the Inverclyde Housing Associations Forum (IHAF) to develop a **Housing Contribution Statement** that will describe how we work with key partners to address housing needs with the express view of improving lives in Inverclyde. This might include the strategic intentions to alter existing housing stock or even to build new, specifically designed housing for the future.

3.6 **Articulating our Purpose and Intentions:** The main purpose of our Strategic Plan is to provide strategic direction and keep us focused on the big changes we aim to deliver across the full range of our responsibilities, as agreed

through the suite of Plans and Strategies that underpin our overall direction. We want to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This is a natural progression building on the aspirations and achievements of the Inverclyde Community Health and Care Partnership (CHCP) which existed from 2010 until 2015, when our HSCP arrangements replace the CHCP.

3.7 As stated, our Strategic Plan brings together a number of plans that have already been developed in partnership with our communities and other stakeholders, and that aim to deliver the nine National Health and Wellbeing Outcomes, namely:

1) People are able to look after and improve their own health and wellbeing and live in good health for longer.
2) People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3) People who use health and social care services have positive experiences of those services, and have their dignity respected.
4) Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5) Health and social care services contribute to reducing health inequalities.
6) People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7) People using health and social care services are safe from harm.
8) People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9) Resources are used effectively in the provision of health and social care services.

3.8 We also aspire to achieve the National Outcomes for Children;

- Our children have the best start in life and are ready to succeed;
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens; and
- We have improved the life chances for children, young people and families at risk.

3.9 And to the National Outcomes and Standards for Social Work Services in the Criminal Justice System

- Community safety and public protection;
- The reduction of re-offending; and
- Social inclusion to support desistance from offending.

3.10 We are also required to deliver on the Health and Social Care Integration Principles namely:

- Improve the quality of services;
- Health and social care services are planned and led locally in a way which is engaged with the community (including in particular service users, those who look after service users and those who are involved in the provision of health or social care);
- Best anticipate needs and prevent them arising;
- Make the best use of the available facilities, people and other resources.

The over-arching Community Planning outcomes for Inverclyde seek to deliver the vision of 'Getting it Right for Every Child, Citizen and Community'. The HSCP will work to deliver the wellbeing outcomes agreed for the Inverclyde Alliance, aiming to ensure that all children, citizens and communities in Inverclyde are safe, healthy, achieving, nurtured, active, respected, responsible and included.

3.11 **Changing the Focus of our Purpose:** Traditionally our planning has been based on achieving targets, measured through service outputs (top-down approach). Real change can come about if we move away from these high level targets towards focusing on outcomes and what makes a real difference to the lives of individuals, families and communities through a strategic commissioning approach that is informed by discussions with the people who use our services.

3.12 Strategic needs assessment, taken from the wealth of information we already have, will help us to understand the health and social care needs of the people of Inverclyde, and consider how resources can be organised to meet those needs in the best possible way, with the explicit aim of improving lives. Our Strategic Needs Assessment is appended to this overarching Plan, and should be regarded as a companion document that helps to describe the challenges that we hope to address.

3.13 Outcome focused assessment (bottom-up approach) informs commissioning at the individual level, supporting choice and control, namely the principles of Self Directed Support. Aggregating individual commissioning will in turn inform strategic commissioning options looking across traditional client group boundaries.

3.14 All of this work will be co-ordinated by the Strategic Planning Group, with inputs from representatives across the full range of health and social care stakeholders, with a view to shaping the next substantive Strategic Plan that will take us from 2016 to 2019.

3.15 **Knowing we are achieving our purpose:** The Strategic Planning Group will develop the key actions that need to be included in this plan, including timescales and how we will measure if we are achieving our ambitions. We already know that our initial priorities will focus around the following:

- We will further develop our **Strategic Needs Assessment**, drawing on the information held by the CHCP and the Community Planning Partnership. We need to scope what we currently deliver and consider the drivers for that delivery. Which arrangements have been put in place to deliver targets, and are these still valid? Do they deliver or contribute to the outcomes? Is there a better way? What do our communities really need?

- Change will be delivered through the right commissioning choices, based on outcome-focused assessment. We already have a **Commissioning Strategy**, but does this need to be reviewed?

- The overarching **Commissioning Strategy** provides strategic direction and is underpinned by a number of service or client group Commissioning Plans that have been developed in collaboration with service users, families and communities. We need to consider if there are any gaps in our commissioning plans, but this will be informed by the Strategic Needs Assessment and outcome-focused assessment.

- We need to develop a **Performance Reporting Framework** that lets us know if what we are commissioning is delivering what has been indicated through the Strategic Needs Assessment. Our performance reporting through the former CHCP has started the shift towards outcomes by mapping what we report to the wellbeing outcomes and the National Outcomes for Health & Social Care rather than simply focusing on targets, so we have a good foundation to build on.

- We need to develop a **Workforce Plan**, to make sure that we are shaping the skills and expertise amongst our staff to deliver the future vision.

- We need to develop an **Organisational Development Plan** to ensure that the cultural changes are made to shift everyone's focus towards outcomes rather than the traditional target-driven approach – although accepting that targets are a useful way of measuring success (or otherwise), and inevitably there will still be targets that we will aim to meet, so that we can demonstrate improvement.

- We need to **review our service activity and financial arrangements** to ensure that we are committing limited resources to the right things and are on track to achieve financial balance.

- The **Strategic Plan 2016-19** will be developed by the Strategic Planning Group but will be approved, overseen and scrutinised by the **Integration Joint Board**. This will ensure that there is strong governance around delivering the commitments of the plan, and a mechanism to inform future plans.

4. THE INTEGRATION JOINT BOARD

4.1 Our Integration Joint Board (IJB), made up of voting and non-voting members is responsible for ensuring the planning and delivery of local health and social care services in Inverclyde.

4.2 The Inverclyde IJB has eight voting members. Four of these are Elected Members of Inverclyde Council and four are Non-Executive Directors of NHS Greater Glasgow and Clyde.

4.3 The IJB has a number of non-voting members whose role it is to influence, inform and question the decision makers (the voting members). Our non-voting members are drawn from:

- Service users groups;
- Carers groups;
- Staff Partnership Forum;
- The Third Sector (voluntary and not-for-profit organisations);
- The secondary care (hospital) sector;
- Health and social care professional groups.

4.4 The IJB will be supported by the HSCP Chief Officer and a range of senior level staff, including a Chief Financial Officer, and the Governance arrangements are outlined below.

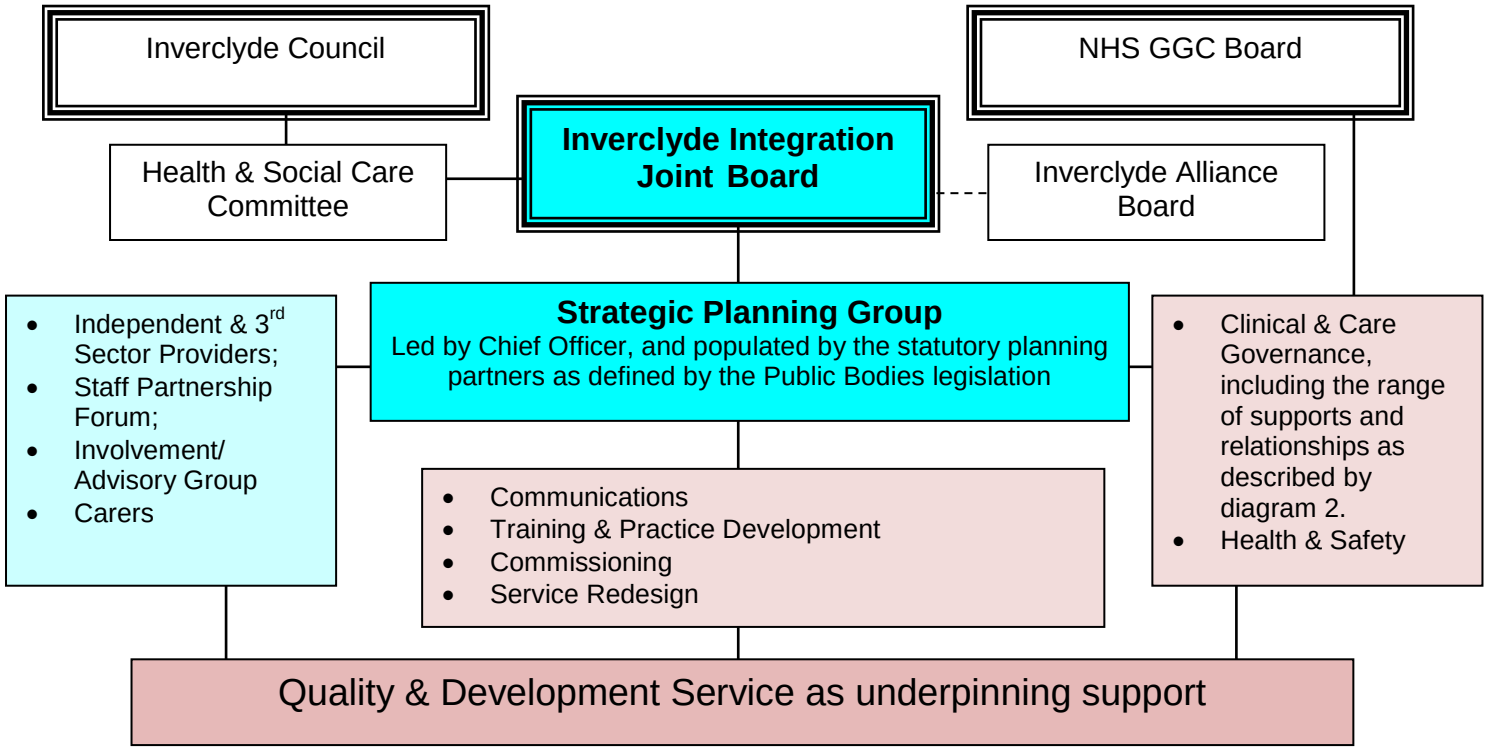


Diagram 1: Reporting and Accountability

4.5 The quality and safety of integrated health and social care services is of paramount importance to the IJB, and as such, there is a strong system of checks and balances in place to support patient and client safety and clinical and care governance. Diagram 2 below highlights the support structures in diagrammatic format.

Clinical and Care Governance – Key Supports and Relationships

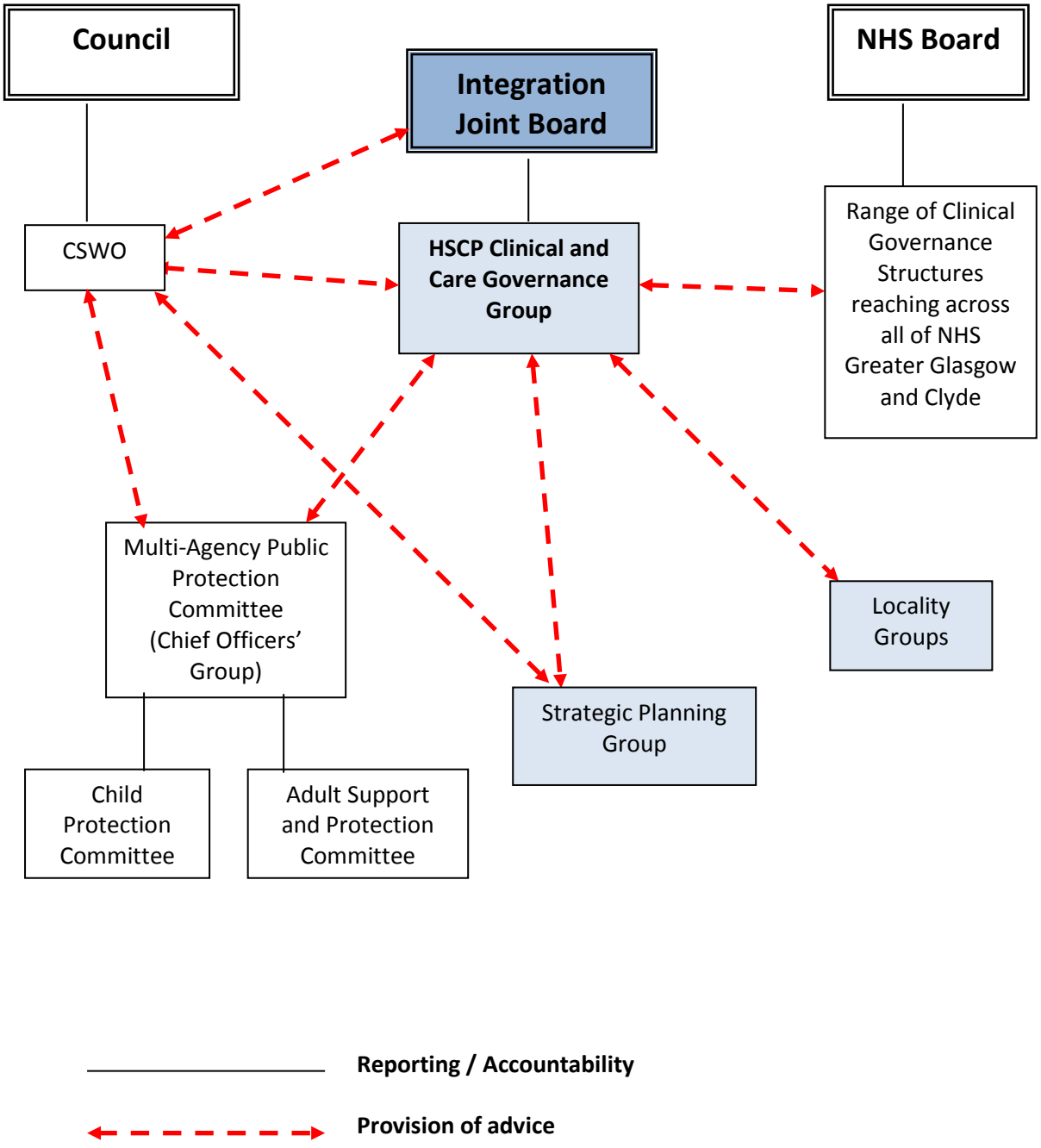


Diagram 2: Clinical and Care Governance Arrangements

5. OUR HEALTH AND SOCIAL CARE SERVICES

5.1 From 1st April 2016, the Integration Joint Board takes formal delegated responsibility from the parent organisations for the services and functions specified in section 5 of this Establishment Strategic Plan. For some services this will mean taking full responsibility for planning, management and delivery, while for others – notably hospital based services – this will mean planning with Acute Services colleagues who will continue to manage and deliver the services as part of the wider hospital structures, but notably, planning will be done in a changed context that takes account of the entire journey through need and service provision, rather than focusing on single episodes of hospital care.

5.2 Services delegated by the **Health Board** to the Integration Joint Board

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine:-
  - Geriatric medicine;
  - Rehabilitation medicine (age 65+);
  - Respiratory medicine (age 65+); and
  - Psychiatry of learning disability (all ages).
- Palliative care services provided in a hospital.
- Services provided in a hospital in relation to an addiction or dependence on any substance.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by allied health professionals in an outpatient department, clinic, or out with a hospital.
- Health Visiting
- School Nursing
- Speech and Language Therapy
- Specialist Health Improvement
- Community Children's Services
- Child and Adolescent Mental Health Services (CAMHS)
- District Nursing services
- The public dental service.
- Primary care services provided under a general medical services contract,
- General dental services
- Ophthalmic services
- Pharmaceutical services
- Services providing primary medical services to patients during the out-of-hours period.
- Services provided out with a hospital in relation to geriatric medicine.
- Palliative care services provided out with a hospital.
- Community learning disability services.
- Rehabilitative Services provided in the community
- Mental health services provided out with a hospital.

- Continence services provided out with a hospital.
- Kidney dialysis services provided out with a hospital.
- Services provided by health professionals that aim to promote public health.

5.3 Services delegated by the **Local Authority** to the Integration Joint Board

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision for adults and young people
- Occupational therapy services
- Reablement services, equipment and telecare

5.4 In addition Inverclyde Council will delegate:

- Criminal Justice Services
  - Criminal Justice Social Work
  - Prison Based Social Work
  - Unpaid Work
  - MAPPA
- Children & Families Social Work Services
  - Child Protection
  - Fieldwork Social Work Services for Children and Families
  - Residential Child Care including Children's Homes
  - Looked After & Accommodated Children
  - Adoption & Fostering and Kinship Care
  - Services for Children with Additional Needs
  - Throughcare
  - Youth Support / Youth Justice
  - Young Carers
- Services for People affected by Homelessness
- Advice Services
- Strategic & Support Services
  - Health Improvement & Inequalities
  - Quality & Development

(including training and practice development, contract monitoring and strategic planning)

- Business Support

6. RESOURCES

6.1 When we think of resources we sometimes think mainly about money. In order to improve the lives of the people of Inverclyde we need to think about drawing on all the available resources in their broadest sense, including resources such as knowledge and experience that people have at their own disposal to make positive changes for themselves. This is what we mean when we talk about having an assets based approach – making the most of what we have. The IJB will use its delegated financial and staff resources creatively to deliver on this aspiration by funding service delivery, staff and buildings but also supporting the development of community supports through co-production principles and individual choice and control (via Self Directed Support, for example); improving access for those who are at risk of poorer outcomes, and the development of preventative approaches.

6.2 **Financial Resources 2015/16**: Inverclyde HSCP has a combined revenue budget from Inverclyde Council and NHS Greater Glasgow and Clyde of around £120 million for the year, made up from £71 million funding from the NHS for Primary Care and £49 million from the Council for Social Work. The services provided from within this budget include:

Service Area	**£million**
Older People	21.3
Children & Families	13.2
Family Health Services	19.8
GP Prescribing	16.2
Resource Transfer NHS to Council	9.2
Mental Health Inpatient Services	9.4
Mental Health Community Services	3.4
Learning Disabilities	7.0
Physical & Sensory	2.2
Addictions & Substance Misuse	3.0
Homelessness	0.7
Health & Community Care and Assessment & Care Management	5.2
Integrated Care Fund	2.3
Strategy, Quality and Health Improvement	2.8
Support, Management and Infrastructure	3.7
Total Net Budget	120.0

6.3 In addition to the above there is a further £2.2 million within the Council spent annually on Criminal Justice and Prison Social Work Services fully funded from external income.

6.4 Within the Council there is also £2.5 million earmarked reserve funds which are non-recurring resources set aside to fund a range of specific projects and initiatives.

6.5 The following charts show the services provided in total, an analysis of the NHS Community Services and an analysis of Council Services:

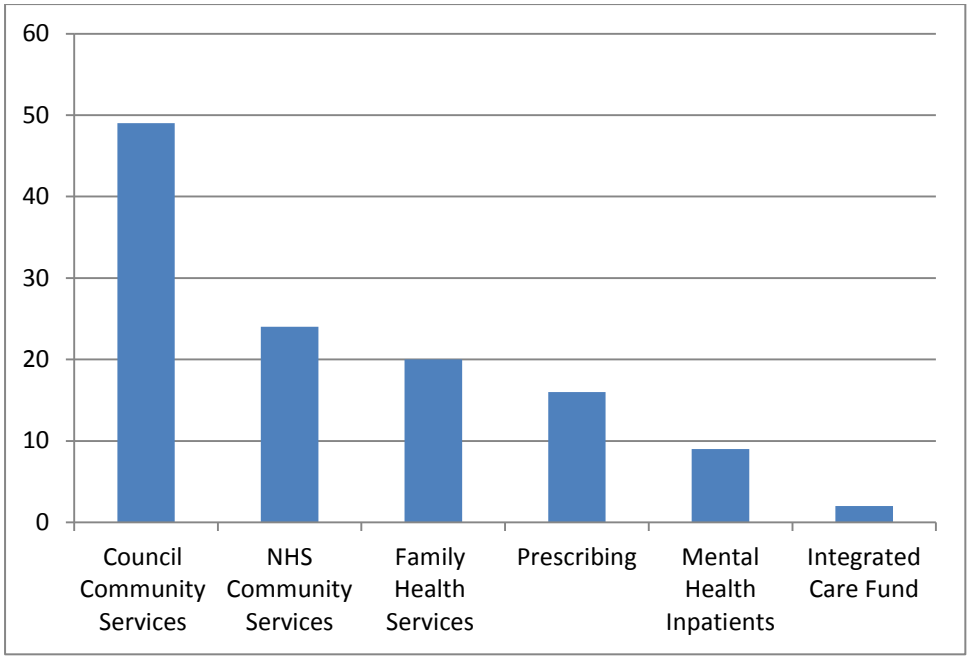


Figure 1: Services Provided

6.6 From the £120 million budget, figure 1 shows that £73 million is spent on community services (61%); £20 million on Family Health Services (17%); £16 million on prescribing (13%); £9 million on Mental Health Inpatient Services (7%), and the other £2 million relates to the Integrated Care Fund (2%).

6.7 Within the total revenue budget of £120 million, £47 million relates to employee costs (39%); purchased care £32 million (27%); Family Health Services £20 million (17%) and prescribing of £16 million (13%).

6.8 When we consider NHS Community services in more detail (second column on figure 1, relating to £24 million spend), the budget is disaggregated as shown in figure 2.

6.9 Figure 3 goes on to illustrate the distribution of the £49 million Council community services spend that features in figure 1.

6.10 Figure 4 aims to illustrate how this joint spend translates to allocations against specific care groups or functions.

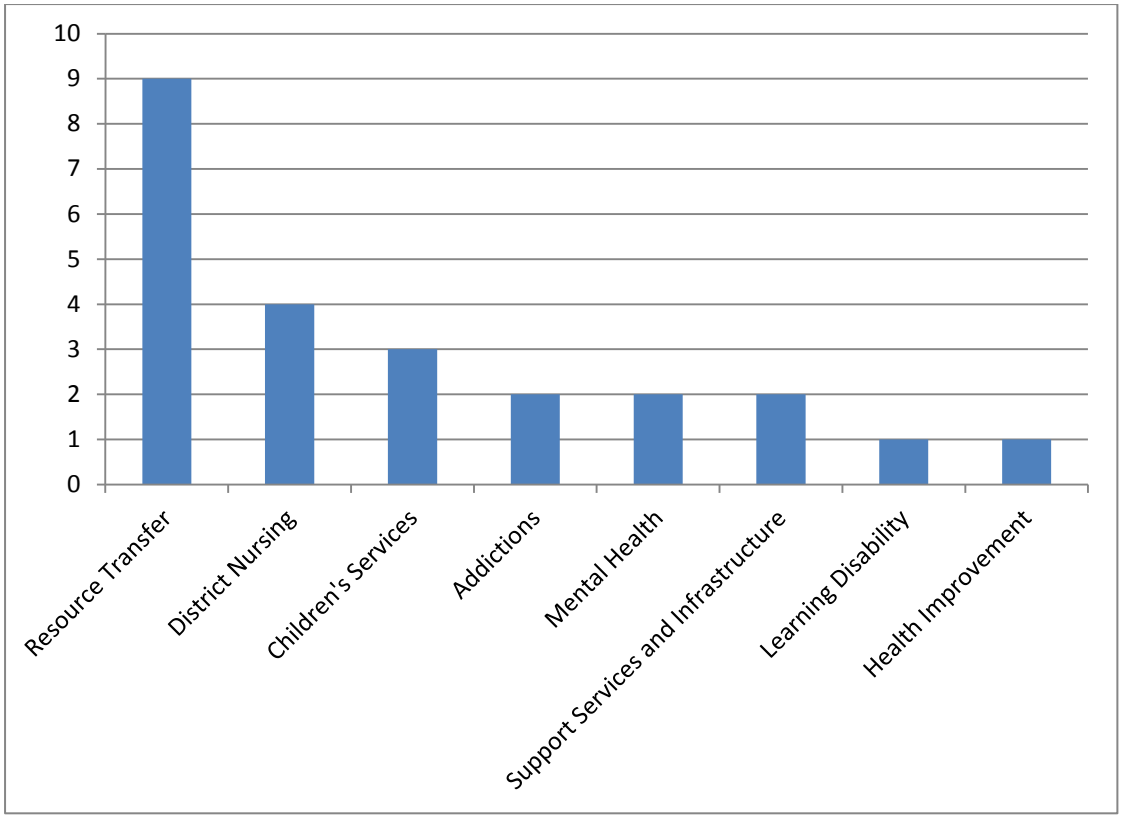


Figure 2: Distribution of NHS £24 million community services spend.

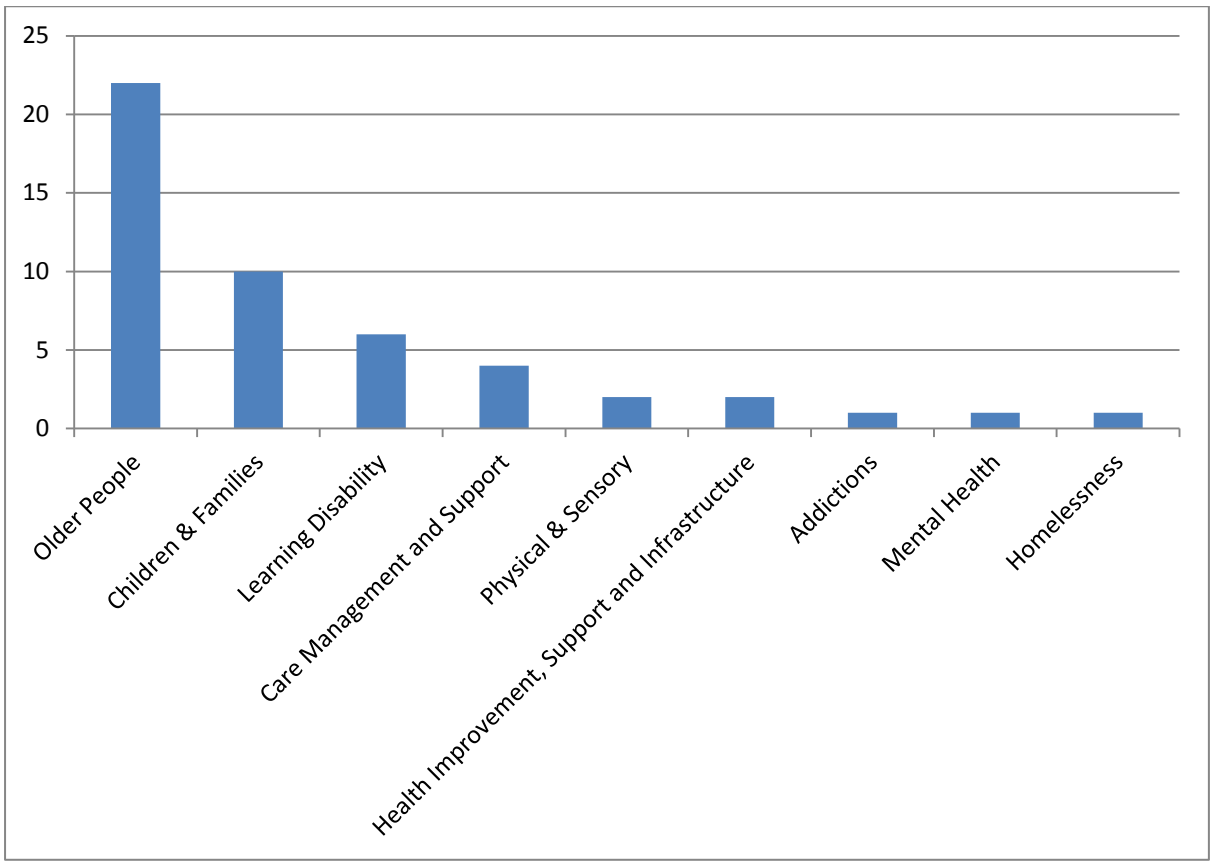


Figure 3: Distribution of Council £49 million community services spend.

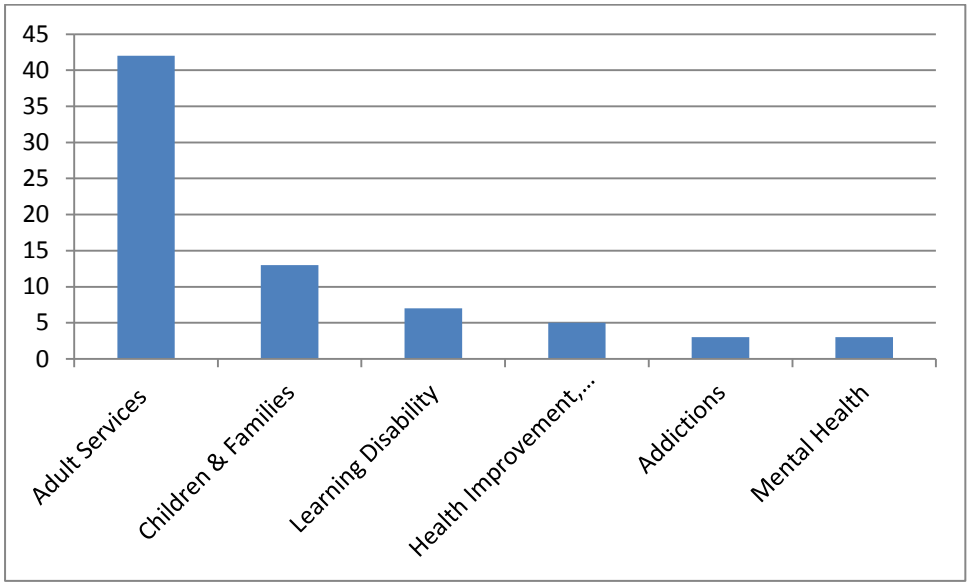


Figure 4: Joint spend against care groups and functions.

6.11 Having considered the headline spending patterns, figure 5 provides a breakdown of care services that the HSCP purchases from external providers. Figure 6 goes on to consider these by client group.

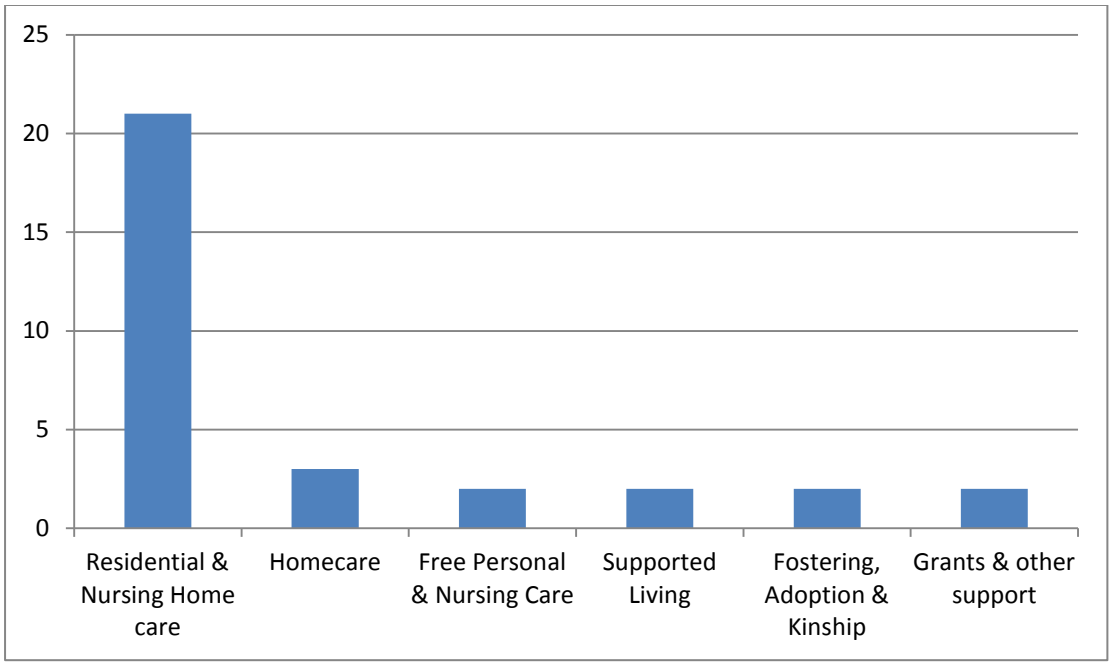


Figure 5: Purchased care services.

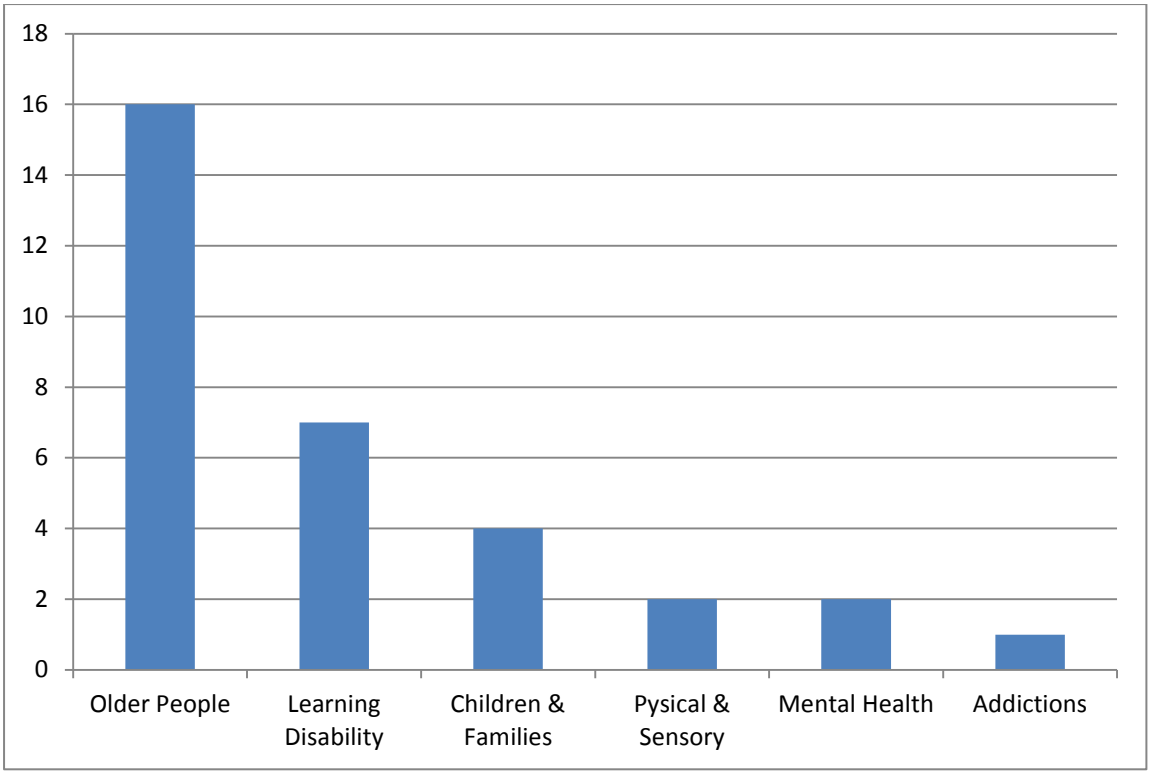


Figure 6: Purchased care services by client group.

6.12 **Capital**: In addition to the revenue budget as detailed above, the HSCP also has capital expenditure of around £1.9 million planned for 2015/16:

- £1.8 million for replacement of Neil Street Children's Home, funded through Council Prudential borrowing;
- £0.1 million on repairs funded by NHS.

6.13 The responsibility for assets will remain with the Council and the NHS Board. On 23 June 2015 the Scottish Government announced funding for a new £19 million Greenock Health Centre, and although the planning for this will be overseen by the NHS Board, it will be designed and built to enhance the principles of the Health & Social Care Partnership, and support its aspirations to undo, prevent or mitigate the causes of health inequalities.

6.14 **Acute Hospital Budget:** During 2015/16 the partnerships co-terminus with NHSGGC will work with the Health Board to develop an agreed methodology to calculate the appropriate budget to represent consumption of unscheduled care services by Integration Joint Boards. Set-aside budgets can then be proposed to each IJB to allow for planning effective from 1 April 2016.

7. UNDERSTANDING INVERCLYDE

7.1 We will further develop our Strategic Needs Analysis to understand as fully as we can what all of the information we collect tells us about the people of Inverclyde, the communities in which they live, their needs and assets and how they access and receive services.

7.2 The Strategic Needs Assessment appended to this Plan provides a useful reference point at this early stage in the HSCP's existence.

8. LOCALITIES

8.1 We embrace the notion of 'one Inverclyde' and we strive to improve the lives of all Inverclyde people. We recognise that there are stark differences between the communities and neighbourhoods that make up Inverclyde, and that people have strong affiliations to particular towns or areas, which helps account for the strong sense of community that fortunately still exists in our area.

8.2 We intend to continue to plan and deliver services on a 'one Inverclyde' basis, but recognise that local differences can sometimes mean that areas – or localities – will have different priorities dependent on needs perceived by the members of those communities and evidenced through the Strategic Needs Assessment.

8.3 We also believe that localities will help to ensure local leadership of the development of health and social care services and supports. In Inverclyde we will have two health and social care localities, which will have sub-localities or neighbourhoods. Our aim is to have smaller planning divisions, but with big enough areas to make planning sense, and to influence the overall planning approach as required. The boundaries of our neighbourhoods are aligned to the approach being taken by the CPP in the creation of localities, as required in the Community Empowerment (Scotland) Act. The two localities will be Inverclyde East and Inverclyde West.

8.4 Inverclyde East will comprise the neighbourhoods and communities of:

Kilmacolm and Quarriers Village
Population 6,396

Port Glasgow
Population 15,100

- Devol
- Slaemuir
- Oronsay
- Woodhall
- Kelburn
- Park Farm
- Parkhill
- Clune Park
- Lilybank
- Port Glasgow Town Centre
- Chapleton

Greenock East and Central
Population 15,008

- Gibshill
- Strone
- Weir Street
- Cartsdyke
- Bridgend

- Greenock Town Centre
- Well Park
- Drumfrochar
- Broomhill
- Prospecthill

8.5 Inverclyde West will comprise the communities and neighbourhoods of:

Greenock South and South West
Population 14,031

- Bow Farm
- Grieve Road
- Neil Street
- Whinhill
- Overton
- Pennyfern
- Peat Road
- Hole Farm
- Cowdenknowes
- Barrs Cottage
- Fancy Farm
- Branchton
- Braeside
- Larkfield

Greenock West and Gourock
Population 23,887

- Greenock West End
- Cardwell Bay
- Midton
- Gourock Town Centre
- Ashton
- Levan
- Trumpethill

Inverkip and Wemyss Bay
Population 5,888

8.6 The Joint Strategic Needs Assessment that accompanies this Establishment Plan highlights some of the key characteristics and issues experienced within these localities and neighbourhoods. It is intended that a full scoping exercise of the current groups and networks that exist in these two Localities and related neighbourhoods is undertaken. This will help us to determine how best to set up opportunities for discussion around health and social care at a local level, to avoid duplication and develop sustainable engagement structures given that we are a small area with limited resources. We intend to build on existing asset-based community development approaches rather than develop new ones, working in established ways that communities have grown accustomed to.

9. STRATEGIC PRIORITIES

9.1 It is recognised that there is a busy planning landscape in Inverclyde already around health and social care, with a wide range of joint plans already in existence to articulate our aims and aspirations as a partnership. These plans and strategies have been subject to consultation to ensure that the voices of all relevant parties are included, and some have been specifically co-produced with local people. We do not seek to undo this good work in the creation of our Strategic Plan, rather we aim to strengthen the intentions that have already been articulated taking action to refresh and re-focus where necessary. A list of current plans and strategies is included at appendix 1.

9.2 Our strategic priorities are based on our vision and values as well as the national outcomes, and will provide a framework to improve services and describe how we will achieve our vision. Where we can we will link back to existing strategies and plans that have already been agreed through robust engagement processes.

9.3 The table below shows where some of our main local plans, strategies and work streams relate to the national outcomes:

	National Outcome	Plans, Strategies and Work streams
1.	People are able to look after and improve their own health and wellbeing and live in good health for longer	➢ *Shifting the Balance of Care* ➢ *Prevention and Health Improvement* ➢ *Anticipatory Care Planning* ➢ *Recovery* ➢ *Inverclyde CHCP "Making Well-Being Matter in Inverclyde" Mental Health Improvement Delivery Plan 2014-2016* ➢ *Inverclyde Active Living Strategy* ➢ *Inverclyde Alcohol and Drugs Strategy* ➢ *Inverclyde Dementia Strategy* ➢ *Self-Management/ Self Care*
2.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	➢ *Reablement* ➢ *Intermediate Care* ➢ *Consideration of RSLs to review their Allocations Policy in tandem with Housing Options Services and Allocations Services* ➢ *Joint Strategic Commissioning Plan for Older People* ➢ *The Keys to Life* ➢ *Joint Strategic Commissioning Plan for Adults with a Learning Disability* ➢ *Inverclyde Autism Strategy Action Plan 2014-2024* ➢ *Inverclyde Local Housing Strategy* ➢ *Inverclyde Integrated Care Plan*
3.	People who use health and social care services have positive experiences of those services, and have their dignity respected	➢ *People Involvement Framework* ➢ *People Involvement Advisory Network* ➢ *NHS Quality Strategy* ➢ *Clinical and Care Governance* ➢ *Releasing Time to Care* ➢ *Inverclyde Palliative Care Action Plan* ➢ *Community Empowerment and Capacity Building*
4.	Health and social care services are centred on helping to maintain or improve the quality of life of people	➢ *Self-Directed Support* ➢ *Co-production in Strategic Planning* ➢ *Consider provision of independent housing advice*

	National Outcome	Plans, Strategies and Work streams
	who use those services	*and advocacy services*
5.	Health and social care services contribute to reducing health inequalities	➢ *Inequalities SOA Outcome Delivery Plan* ➢ *Financial Inclusion Strategy, including Fuel Poverty Strategy* ➢ *Employability Strategy* ➢ *Homelessness Strategy* ➢ *Equalities Impact Assessments* ➢ *Health Impact Assessments*
6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	➢ *Inverclyde Carers Strategy* ➢ *Inverclyde Young Carers Strategy* ➢ *Inverclyde Short Breaks Strategy* ➢ *RSL Allocations Policies*
7.	People using health and social care services are safe from harm	➢ *Scottish Patient Safety Programme* ➢ *Clinical and care governance* ➢ *Quality assurance* ➢ *Child Protection* ➢ *Adult Protection* ➢ *MAPPA* ➢ *Consider provision of Specialist Supported Accommodation, including preventative support services* ➢ *Partnership approach to tackling antisocial behaviour*
8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	➢ *Staff Governance Standards* ➢ *HSCP Training and Development Plan* ➢ *Codes of Conduct* ➢ *Staff Engagement* ➢ *Practice Governance*
9.	Resources are used effectively in the provision of health and social care services	➢ *Financial Panning* ➢ *Efficiencies* ➢ *Service Reviews* ➢ *Local Housing Strategy and Strategic Housing Investment Plan* ➢ *Modernisation and Transformation agenda* ➢ *Strategic and Collaborative Commissioning*

9.4 In addition we have a number of agreed strategic commissioning themes which we intend to align our services and support against in order to encourage cross system thinking and action. We hope that this will mean that things are not thought of only in terms of the client group or age range to which they predominantly relate, but rather, across the experience of using our services and the things that are most important to those who need support to improve their lives and their outcomes.

9.5 The strategic commissioning themes are:

- Employability and Meaningful Activity
- Recovery and Support to live independently
- Early intervention, prevention and Reablement
- Support for families
- Inclusion and Empowerment

10. GETTING INVOLVED

10.1 Inverclyde CHCP has an established record of engaging with communities, through mature and well-connected networks. We want to build on that as an HSCP and shift the emphasis by:

- Maximising the principles of co-production, inclusion and empowerment
- getting communities engaged at an even earlier stage;
- finding ways to include the views of groups who have traditionally been less likely to participate;
- building on the assets that are already inherent in our communities.

10.2 Our first full Strategic Plan will be co-produced by all the partners of the Strategic Planning Group, including representatives of local people, users of services and carers throughout the remainder of 2015/16 in order that our new, more detailed plan is ready for sign-off in April 2016.

10.3 A programme of engagement around the plan across our range of stakeholders will be commenced once this plan is endorsed for consultation by the Inverclyde Integration Joint Board. In compiling this Establishment Plan we have made use of the information we already have from engagement with carers and users of local services, local people, staff and partner organisations, as well as the wealth of evidence gathered to inform the plans we are already signed up to.

Appendix 1 – Existing Plans and Strategies that support the Establishment Plan.

Service	Ref	Title	Approved
Children & Families & Criminal Justice	1.	NSCJA Area Plan 2014-2017	NSCJA Board – 14th March 2014
	2.	Family Nurse Partnership Programme in Inverclyde (2014)	CHCP Sub-Committee 23rd October 2014
	3.	Residential Children's Units (2014) Part of wider CHCP accommodation strategy	CHCP Sub-Committee 24th April 2014
	4.	Family Placement Strategy – Review of Allowances and Fees for Foster Carers (2014) Integrated Family Placement Strategy (2009)	CHCP Sub-Committee – 27th February 2014
	5.	Healthy Child Programme (Re-design) (2013)	CHCP Sub-Committee – 28th August 2013
	6.	Inverclyde Parenting Strategy (2012)	CHCP Sub-Committee 12th January 2012
Community Care & Health	1.	Joint Strategic Commissioning Plan for Older People 2013-2023	CHCP Sub-Committee 9th January 2014
	2.	A Shared Approach to Shaping Demand and Design for Hospital Services (2015)	CHCP Sub-Committee 8th January 2015
	3.	Inverclyde CHCP's Implementation of the Scottish Government's National Strategy "Keys to Life" for Services for People with a Learning Disability (2014)	CHCP Sub-Committee 23rd October 2014
	4.	Update on Prescribing (2014) CHCP Prescribing Action Plan?	CHCP Sub-Committee – 27th February 2014
	5.	Inverclyde Autism Strategy Action Plan 2014-2024 Committee report indicates this is a draft?	CHCP Sub-Committee 27th February 2014
	6.	Older People's Strategy 2012-2013	CHCP Sub-Committee 1st March 2012
	7.	Reshaping Care for Older People – Inverclyde Local Change Plan	CHCP Sub-Committee – 13th February 2012
	8.	Review of Homecare Services (2011)	CHCP Sub-Committee 25th August 2011
	9.	Inverclyde Palliative Care Planning & Implementation Action Plan (2014)	This is an implementation plan setting out how we intend to deliver on the wider NHSGGC commitments. This has not been submitted to any committee.

Planning, Health Improvement & Commissioning	1.	Inverclyde CHCP Learning & Development Plan 2014-2015	This is a management plan and as such is not submitted to committee. It is relevant in this context as it supports the development of our staff to deliver on strategic priorities.
	2.	Inverclyde CHCP Staff Partnership Forum Communication and Engagement Plan (2010)	CHCP Staff Partnership Forum, September 2010
	3.	CHCP Commissioning Strategy 2013-2023	CHCP Sub-Committee 18th October 2012
	4.	CHCP Carers Strategy 2012-2015	CHCP Sub-Committee 28th August 2014
	5.	Inverclyde Carers Strategy 2012-2015 Review of Inverclyde Carers Strategy 2012-1015	CHCP Sub-Committee 20th October 2011 CHCP Sub-Committee 10th January 2013 CHCP Sub-Committee 28th August 2014
	6.	People Involvement in Inverclyde CHCP: A Framework	CHCP Sub-Committee 28th April 2011
	7.	Inverclyde CHCP Short Breaks Strategy 2012-2015	CHCP Sub-Committee 28th February 2013
	8.	Chief Social Work Officer – Annual Report (2014)	CHCP Sub-Committee – 23rd October 2014
	9.	Workforce Monitoring Report (2014)	CHCP Sub-Committee – 23rd October 2014
	10.	NHSGGC Director of Public Health Report 2013	CHCP Sub-Committee 24th April 2014
	11.	Inverclyde CHCP Benchmarking (2014)	CHCP Sub-Committee 24th April 2014
	12.	Self Directed Support Implementation Update (2014)	CHCP Sub-Committee – 27th February 2014
	13.	Inverclyde CHCP "Making Well-Being Matter in Inverclyde" Mental Health Improvement Delivery Plan 2014-2016	CHCP Sub-Committee 27th February 2014
	14.	NHSGGC Clinical Service Fit for the Future (Jan 2013)	CHCP Sub-Committee 10th January 2013
	15.	NHSGGC Clinical Service Fit for the Future – Update (2013)	CHCP Sub-Committee – 23rd October 2013
	16.	Inverclyde Childsmile Programme	CHCP Sub-Committee 25th April 2013
	17.	Inverclyde – Health in Mind (2013) Event	CHCP Sub-Committee – 28th February 2013
	18.	Suicide Prevention and Mental Health Improvement (2013)	CHCP Sub-Committee 28th February 2013

	19.	Community Health Care Partnership – NHS Estate (2013)	CHCP Sub-Committee – 10th January 2013
	20.	Welfare Reforms Update (2015)	Policy & Resources Committee 3rd February 2015
	21.	Welfare Reform Update (2014)	Policy & Resources Committee 18th November 2014
	22.	Progress in Mainstreaming Equality (2014)	Policy & Resources Committee 20th May 2014
	23.	Active Living Strategy (2014)	Policy & Resources Committee 20th May 2014
	24.	Financial Inclusion Strategy 2012-2017 (draft)	Single Outcome Programme Board 2nd March 2012
Mental Health, Addictions & Homelessness	1.	Inverclyde Alcohol & Drug Partnership Strategy 2010-2013	ADP Committee July 2010
	2.	Inverclyde Local Housing Strategy 2011-2016	Education & Communities Committee 25th February 2011
	3.	Inverclyde Dementia Strategy 2013-2016 (Draft)	CHCP Sub-Committee 28th February 2013
	4.	Inverclyde CHCP – NHS Continuing Care Facilities and Community Services for Specialist Nursing, Older People's Dementia and Adult Mental Health Intensive Supported Living (Oct 2014)	CHCP Sub-Committee 23rd October 2014
	5.	Inverclyde CHCP – NHS Continuing Care Facilities and Community Services for Specialist Nursing, Older People's Dementia and Adult Mental Health Intensive Supported Living (Feb 2014)	CHCP Sub-Committee 27th February 2014
	6.	Inverclyde CHCP – NHS Continuing Care Facilities and Community Services for Specialist Nursing, Older People's Dementia and Adult Mental Health Intensive Supported Living (Oct 2013)	CHCP Sub-Committee – 24th October 2013
	7.	Inverclyde CHCP – NHS Continuing Care Facilities and Community Services for Specialist Nursing, Older People's Dementia and Adult Mental Health Intensive Supported Living (April 2013)	CHCP Sub-Committee 25th April 2013
	8.	Inverclyde Council Commissioned Services for Specialist Nursing Care Older People's Dementia and Adult Mental Health Intensive Supported Living Services (2013)	CHCP Sub-Committee 25th April 2013
	9.	Inverclyde Council Commissioned Services for Specialist Nursing Care Older People's Dementia and Adult	CHCP Sub-Committee 28th February 2013

		Mental Health Intensive Supported Living Services (2013)	
	10.	The Mental Health Strategy for Scotland 2012-2015 (including local implementation)	CHCP Sub-Committee 10th January 2013
	11.	Homelessness Services (re-design) (2012)	CHCP Sub-Committee 28th August 2012

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/09/2015/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Update on Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on performance towards achieving the target for Delayed Discharge.

2.0 SUMMARY

2.1 The Delayed Discharge target reduced from 4 weeks to 2 weeks on 1 April 2015, reflecting the ongoing strategic commitment to Shifting the Balance of Care.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the target and the ongoing work to maintain performance.

Brian Moore
Chief Officer Designate
Inverclyde HSCP

4.0 BACKGROUND

4.1 From April 2015 the target for Delayed Discharge, which had been in place since 2013, decreased from 4 weeks to 2 weeks. NHS Greater Glasgow and Clyde has also reported on the number of bed days lost due to delayed discharges. This provides a more complete picture of the impact of hospital delays.

4.2 There is a proposal for a new target to discharge a higher proportion of patients within 72 hours of being ready for discharge. We have therefore started to measure the proportion of patients discharged within 72 hours of being ready and the associated bed days lost. This data will be reported on in future reports although at this time it is recorded for May and June (Appendix A Chart 1.)

5.0 PERFORMANCE

5.1 We continue to maintain positive performance in relation to the 14 day Delayed Discharge target.

We have consistently achieved zero delays of more than 4 weeks since February 2015 and zero delays over 2 weeks since April 2015 (Appendix A Chart 1). In July the census data will show that we again had zero service users staying longer than 14 days with 2 service users who were medically fit and waiting on support packages to be arranged.

We have also had a corresponding reduction in the number of acute bed days lost for all adults and particularly for those over 65 years of age (Appendix A Chart 2).

The performance indicates positive outcomes for service users who are returning home, or moving on to appropriate care settings earlier and spending less time inappropriately in hospital.

5.2 There are a decreasing number of service users experiencing a delay in discharge from hospital (Table 1).

Table 1

2015	Jan	Feb	Mar	Apr	May	Jun
No. of Individual delays	23	18	16	19	14	16

This performance is set against a background of increasing referrals for social care and community supports following discharge (Appendix A Chart 3). During June 2015, 152 individuals were referred for social care support of which 34 people required a single shared assessment indicating complex support needs. A total of 16 individuals were identified as being delayed following the decision they were medically fit for discharge.

5.3 Work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of early commencement of assessments regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring a home care package and residential care placement.

5.4 To demonstrate outcomes for service users we have included examples of three recent discharges:-

a) A patient had poor skin integrity which required turning at regular intervals throughout the day and night. The decision to facilitate a return home was based on the service user's wishes and using the Home First ethos. Early identification of needs and collaboration between the Discharge Team, Ward and the Inreach District Nurse identified a safe discharge plan.

   Use of the Through the Night Homecare service, along with District Nurses Night Service, allowed for assessment of overnight care and health needs ensuring appropriate care arrangements were established. This support plan prevented an admission to long term care and was in place before the service user was a delayed discharge.

b) An older service user was admitted to hospital in a very weak condition partly due to physical frailty and dementia. Within a few days of admission the service user was medically fit for discharge. This decision though appropriate was unexpected for the family, who were concerned how to support the discharge within 14 days.

   Intensive support was given to the family by the Discharge Team to manage the impact of the change in their parent's health upon the family. It enabled them to fully participate in the assessment process and to plan for discharge. The discharge subsequently went ahead 9 days after the medically fit date with the full agreement and involvement of the family. The Discharge Team had identified the service user at admission and so were well placed to meet with the family and support them through an emotional time as they took a decision on the long term care requirements of their parent.

   The improved early identification was instrumental in early assessment and timely discharge for this individual. The impact on the family was recognised and addressed early, as this can often be one of the main factors in a delayed discharge.

c) An older service user was admitted to hospital following a stroke. Due to poor balance and an unsteady gait there was an evident risk of falls particularly during the night when attempting to get out of bed to use the toilet.

   Discharge Team staff were able to secure a change in accommodation within a very sheltered housing complex where the service user moved to on discharge.

   The support plan included the Through The Night service for 2 weeks to support a continence management programme devised by the District Nurses. This complemented the Homecare Reablement service which worked with the service user to regain confidence around transfers and mobilising, improving gait and balance reducing the risk of further falls.

This illustrates the effectiveness of discharge planning which in this case meant facilitating an assessment in the person's home rather than in the hospital ward. This allowed for a discharge home and the service user was counted as a delayed discharge.

6.0 PROPOSALS

6.1 Partnership working across the HSCP and Inverclyde Royal Hospital has focussed on improving our discharge processes and is informed by the Joint Improvement Team *'Home First'* document.

6.2 We continue to utilise and update our Home First Strategic Action Plan (Appendix B), monitored at a monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital. The attached action plan shows progress in each of the 10 areas.

6.3 There is a continued focus to develop integrated and joint improvements to continually improve the hospital journey and discharge processes.

6.4 Key elements of the work plan include:-

- We are looking at providing staff in A&E with access to the SWIFT database. This will allow for an understanding of current community supports and contacts and will inform decisions around admission
- We are exploring the nursing/medical interventions in the community which could avoid admission
- Following the redesign of the Discharge Team we are now scoping the current Nursing staff (Community and Acute) that has a specific focus on discharge.

6.5 We will continue to develop our performance monitoring with an emphasis on the hospital discharge pathway and in particular the outcomes for service users, their families and carers.

7.0 IMPLICATIONS

Finance

7.1 There are no specific financial implications from this report. All activity will be contained within existing budgets.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal

7.2 None.

Human Resources

7.3 There are no Human Resource implications at this time.

Equalities

7.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO -

Repopulation

7.5 None.

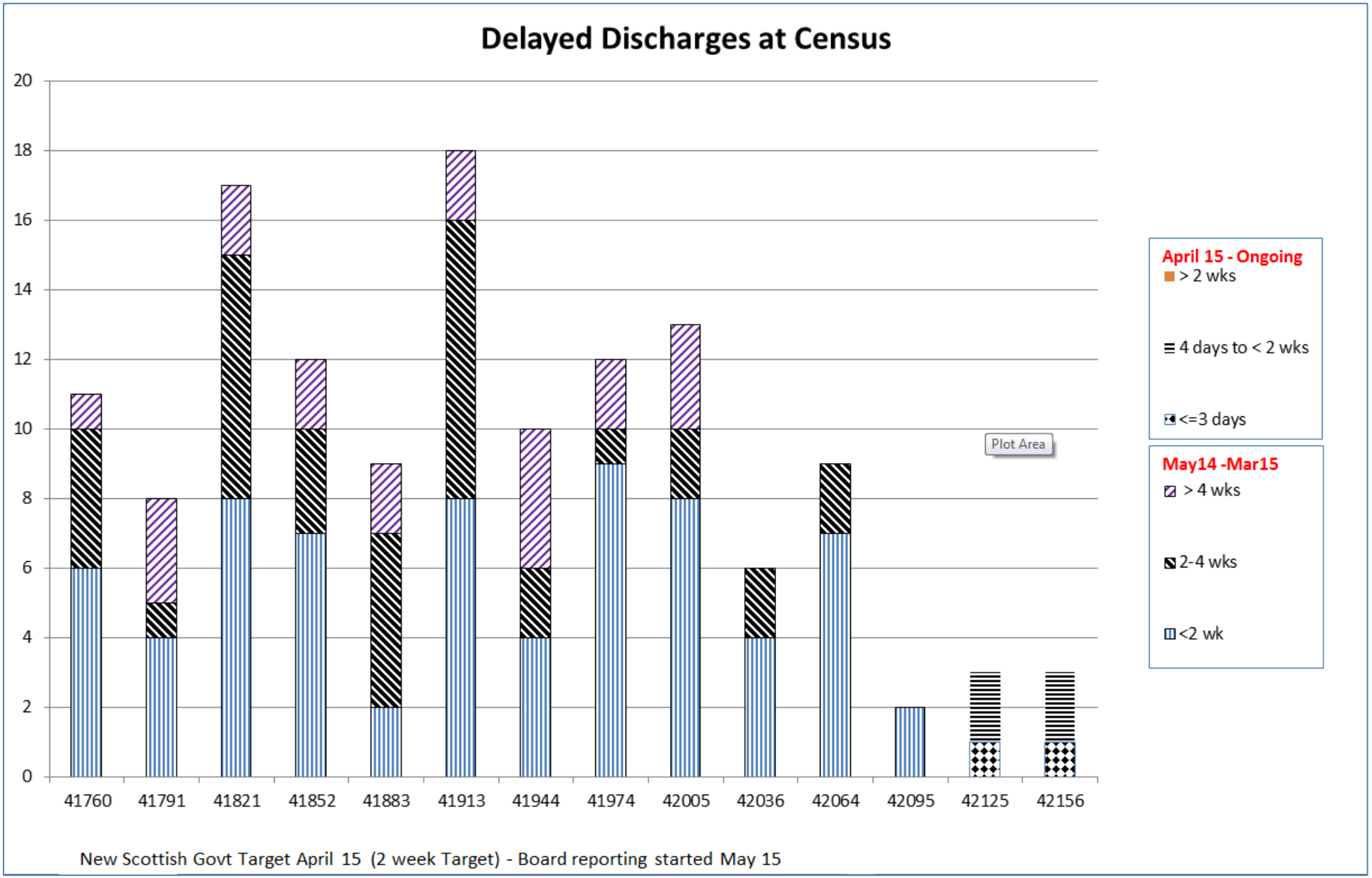
8.0 CONSULTATIONS

8.1 The Inverclyde Delayed Discharge Plan is jointly developed alongside our partners in NHS Greater Glasgow and Clyde.

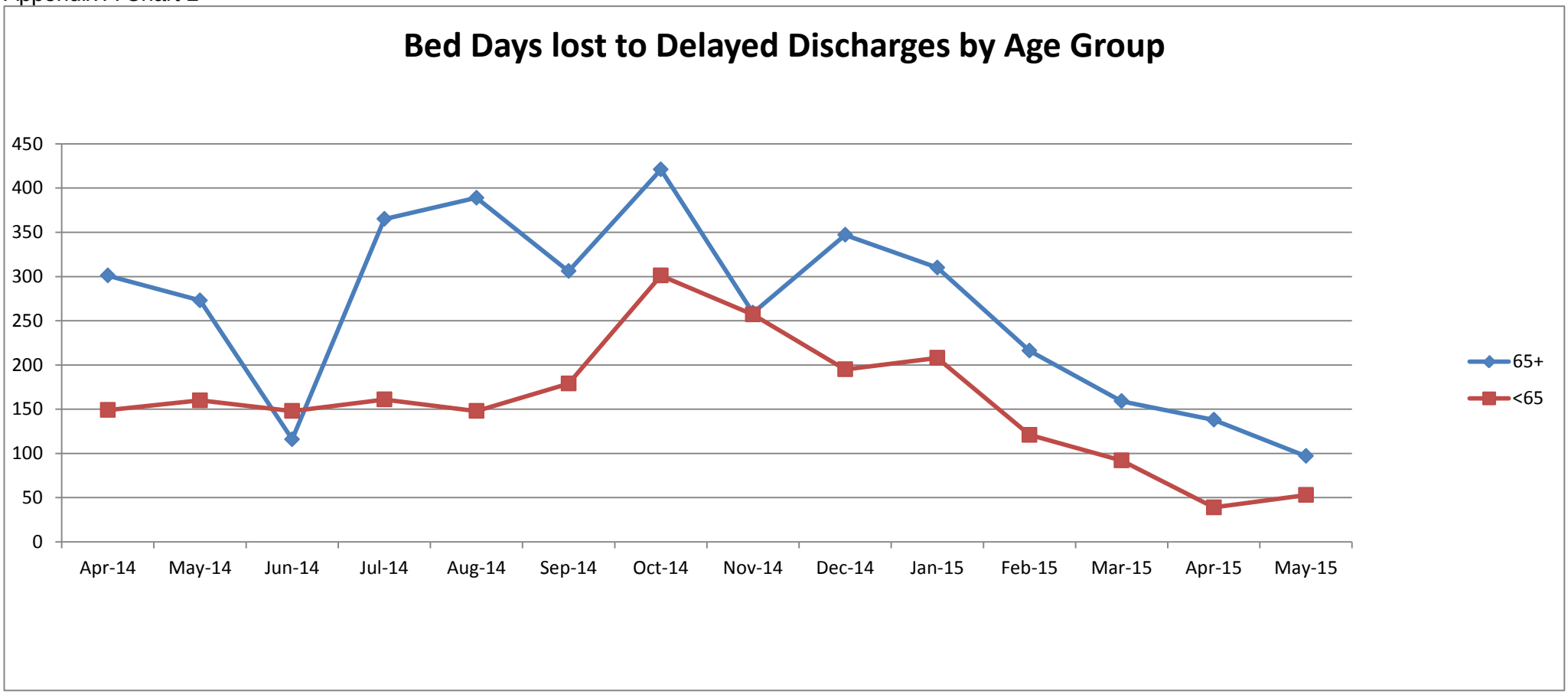
9.0 LIST OF BACKGROUND PAPERS

9.1 None.

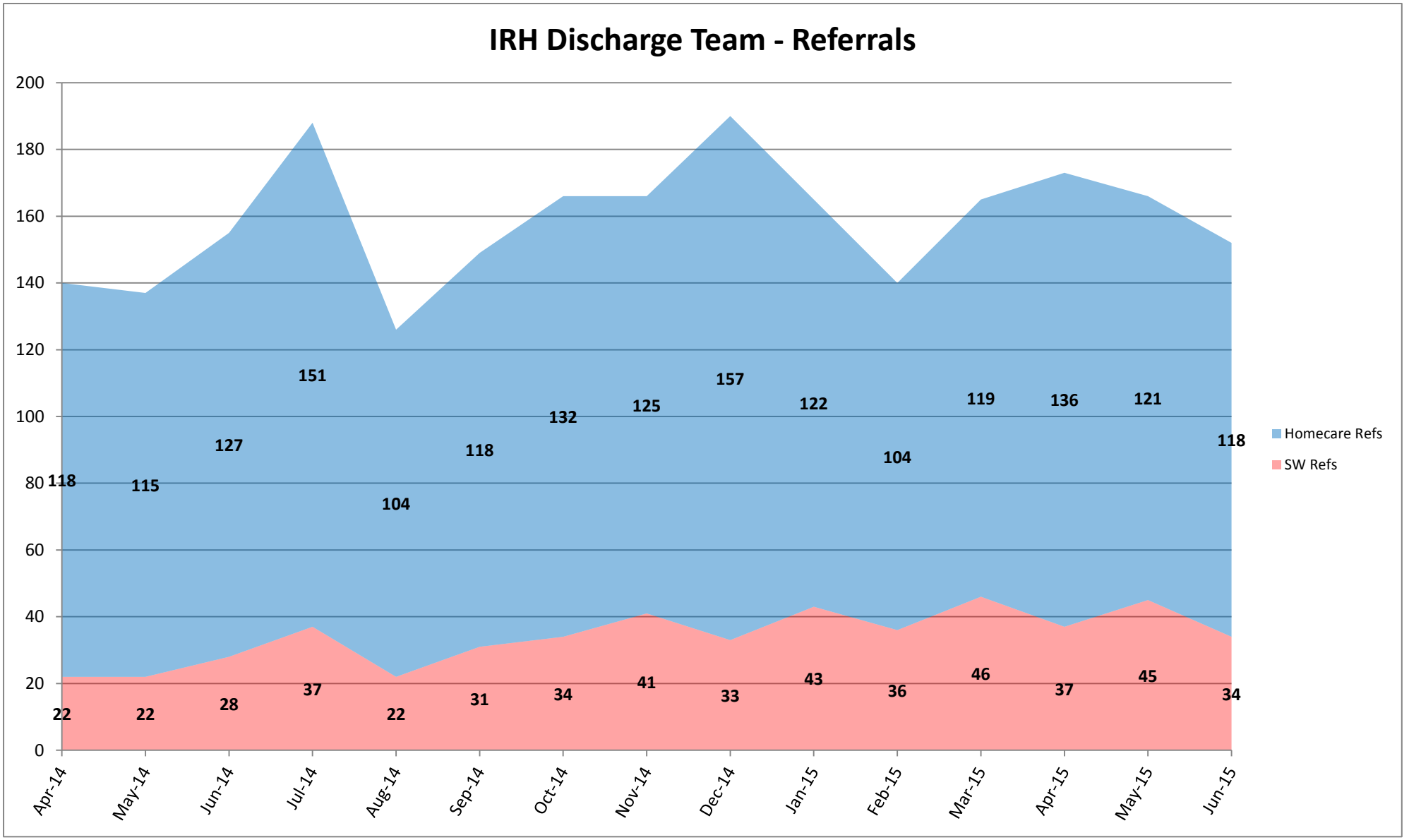
Appendix A Chart1



Appendix A Chart 2



Appendix A Chart 3



Appendix B

Home First- Ten Actions to Transform Discharge
Action Plan July 2015

Action	Task	Responsible	Update	Action	Issues	Timescale
Use Data to Know How You Are Doing	Performance Management	Service Manager Assessment & Care Management	Monitor effectiveness of new processes in SW discharge team New spreadsheet in place to monitor all discharges Capture more comprehensive information Delayed Discharge numbers reduced Lessons learned from Discharges	Monitor use of spreadsheet Identify SU journey key points and develop Performance Management Report Case Review	Capture work of In reach DN Admin support	**Review July 15**
	Embed a change culture	All managers	Admissions from community Older People's Service Development Reference Group (OPSDRG) will be conduit for development monitoring and sharing.	Review Anticipatory Care Plans Utilise case studies and share practice at OPSDRG		**Sept 15 Review**

Action	Task	Responsible	Update	Action	Issues	Timescale
Scale up Coordinated and Anticipatory Care.	Embed anticipatory care approaches in practice	Project Manager- Reshaping Care	Awareness raising and training planned for Summer- links to other pathways, falls, A&E, etc.	Deliver revised objectives and ACP work plan Outcome of eKIS review will inform approaches in acute		**July 15**
	Review where access to read only SWIFT would add value.	Project Manager- Reshaping Care	A&E identified as key area New discharge nurse trained	Consider as part of ongoing intermediate care/falls/A&E response pathway General Manager ECMS will attend next meeting	Discuss key acute lead at next meeting	**July 15**
	Review use of EKIS and ACP's within A&E and wards	Project Manager- Reshaping Care	This is part of the ACP group action plan	GP AP Lead will lead review of medical use	Inputting and sharing information via eKIS continues to be challenging	**July 15**
	Improve knowledge and education in care homes	Independent Sector Lead	Links to intermediate care strategy and specialist nurse review/ role development	CHLN supporting SPAR & ACP's Virtual team of staff established and meeting regularly to establish support and sharing practice.	Monitor admissions via CH liaison nurses.	**Review September 2015**
	Improve knowledge in primary care of community services which can support	Project Manager- Reshaping Care Project Manager- Primary care	CPD group to be arranged by GP ACP Lead	Promote discharge to assess and home first strategy. Promote stroke portal.		**Review September 2015**

	someone to stay at home.					

Action	Task	Responsible	Update	Action	Issues	Timescale
Develop Intermediate Care	Develop Intermediate Care Strategy and deliver step up beds.	Project Manager-Reshaping Care	Draft complete	Establish process and timescales for tender. Comments from partners.		**August 15**

Action	Task	Responsible	Update	Action	Issues	Timescale
Screen and Assess for Frailty	Review role of Fast Track Assessment service.	To be discussed at next meeting	Gerontology nurse is now seeing increased numbers of patients in community working as part of RES	Identify use, capacity and effectiveness of fast track clinic. Develop strategic approach to development of service alongside gerontology role.	Role Geriatrician	**August**
	Consider relevance of early Comprehensive Geriatric Assessment at IRH	General Manager – RAD	Research evidence suggests, more appropriate admissions, reduced LOS etc.	Strategic Group considering a model which relies more on the MDT		**September 2015**

Action	Task	Responsible	Update	Action	Issues	Timescale
Integrate Discharge Planning		Lead Nurse-RAD DN In reach?	Explore tissue viability guidance.	(Re) Assessment from community base	This issue has implications	**July - Dec**

			Prescribed active nursing care.		for care delivery in community and relationships with families.	
	Review number and role of Staff linked directly to discharge in Inverclyde	Lead Nurse RAD DN Team Leader	Looking at restructure of service and use of Nurses/AHP focus on discharge. OT in reach post and ECAN nurse at recruitment.	There will be a SLWG with 2 work streams Starting with nurses and moving on to AHPs EC&CG will attend the first meeting. Aims: -Clarity of roles -Awareness of services -Gaps & overlaps -Processes Ensure active Nursing Support transition from Acute to Community is included	Discharge Nurses x2 DN In reach x1 Gerontology Nurse x1 ECAN x2 (Pending) OT In reach X1 RAS x2 (Physio OT) SW Discharge Team SW x2.5 SWA x2 TL x.5	**July - Dec**
	Monitor new SW assistant role in discharge team	ASM Assessment & Care Management	SW assistant is now managing noncomplex cases and highlighting complex/ potential delayed discharges in	Continue to review		**July**

			advance			

Action	Task	Responsible	Update	Action	Issues	Timescale
Build Capacity for Care & Support at Home	OPMHT	Service Manager Mental Health	Adopted same process as discharge early identification of service users. Dedicated SW to ward 4	Progressing well.		**Sept Review**
	Finalise local hospital discharge booklet	Project Manager-Reshaping Care	Final meeting taken place with Your Voice.	Final editing and to pass to communications group and Strategic group for sign off. Agree how this will be disseminated will raise in huddle for information when ready for use		**August**
	Consider extended/revised hours and access to community rehabilitation, enablement etc.	RES Team leader Lead OT ASM Assessment & Care Management	Links to intermediate care strategy, falls pathway etc. Extended hours for Discharge Team	Review referral data Identify current demand and capacity Identify options for changing / extending hours to best effect.		**August 2015**
	Lack of access to transport out of	Discuss at next meeting		Consider models of provision elsewhere	This has potential	**Timescale to be agreed at**

	hours				to compromise use of extended hours services and future OOH developments for supporting discharge/ admission avoidance	**next meeting**

Action	Task	Responsible	Update	Action	Issues	Timescale
Assertive Management of Risk	Awareness Campaign Embed Home First ethos	Project Manager- Reshaping Care	Lead Nurse Meeting for ECMS to be completed	Discharge Nurses to be involved	Discuss acute lead at next meeting	**July**
	Risk awareness training	Project Manager- Reshaping Care	Utilise the above meetings to raise awareness prior to formal training	Identify Training Facilitator Plan Training Lessons learned from recent discharges- case studies.	Discuss acute lead at next meeting	**July**

Action	Task	Responsible	Update	Action	Issues	Timescale

Support People Moving on to Long Term Care	Supporting individuals wishes & supporting families and carers and decision making	ASM Assessment & Care Management	Utilise the home first meetings to raise awareness prior to formal training. Use of ward meetings and DPM. Carers In reach worker.	Investigate advocacy at an early stage. Identification of SU and Families wishes at referral stage. Arrange meeting to review carers input	 Referral stage too early?	**July** **June** **July**
	Ensure Choice Guidance is understood and followed.	Discharge Manager	Discharge manager updated strategic meeting on 01/04/15	Continue to raise / discuss on an individual case by case basis.		**Completed**

Action	Task	Responsible	Update	Action	Issues	Timescale
Understand Adults with Incapacity Issues	Ensure process for assessing capacity and 13za is timely and within legislation	Service Manager Assessment & Care Management	Process more transparent on Larkfield wards due to use of 5 point action plan	Continue to monitor and review	Retain for monitoring	**August**

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**10 August 2015**
Report By:	**Brian Moore Chief Officer Designate Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/05/2015/MM**
Contact Officer:	**Margaret Maskrey Lead Clinical Pharmacist**	**Contact No:**	**01475 506142**
Subject:	**Update on Prescribing and Medicines Management 2015**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board on prescribing and medicines management within Inverclyde Health and Social Care Partnership (HSCP).

2.0 SUMMARY

2.1 Prescribing and medicines management that is safe, clinically effective, cost efficient and acceptable to the patient is essential for health and social care organisations. Prescribing decision-making occurs within a complex environment of guidelines and formularies, clinical autonomy, established practice, new therapies, cost pressures and patient expectation. From a financial management perspective, prescribing is a variable, complex and unpredictable activity. Medicines management encompasses wider aspects of use of medicines including community pharmacy activities and medicines use in care homes and social care settings.

2.2 Within this context, the challenge is delivery of safe, clinically effective and cost efficient prescribing and medicines management despite the volatility and complexities. This is facilitated by development and implementation of initiatives in health and social care across the HSCP, to support cost efficiency on our prescribing budget, while continuing to prioritise safe use of medicines and patient-centred care.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note and endorse this paper on the current situation within our HSCP with respect to: -

- Current issues in prescribing and medicines management
- Prescribing and medicines management support
- Prescribing expenditure position

Brian Moore
Chief Officer Designate
Inverclyde HSCP

4.0 BACKGROUND

4.1 Safe, clinically effective, cost efficient and patient-centred prescribing and medicines management are essential for health and social care organisations. Prescribing decision-making occurs within a complex environment of national and local guidelines and formularies, clinical autonomy, local established practice, new therapies, cost pressures and patient expectation, and from a financial management perspective is a variable, complex, and unpredictable activity. Medicines management encompasses wider aspects of use of medicines including community pharmacy activities and medicines use in care homes and social care settings.

4.2 The challenge is delivery of safe, clinically effective prescribing and management of medicines, with patient-centred care and cost minimisation on expenditure, despite the volatility and complexities, by implementation and monitoring of supportive prescribing plans and development of new initiatives.

4.3 The HSCP Prescribing Team works with health care and social care professionals across Inverclyde to promote and improve safe, high quality, evidence based, cost effective prescribing and medicines management, and to support management and monitoring of the local prescribing budget. Most prescribing in Inverclyde occurs within the 16 GP practices, although other healthcare professionals are increasingly taking on non medical prescribing roles. The management of medicines, however, goes beyond medical practices and includes community pharmacy, public health, care home activity, as well as social care worker practices and patient/carer education. The contribution of the public and their knowledge of medicines are important to medicine concordance for achieving effective benefits from their medication, reduction in potential for adverse drug reactions that can possibly lead to hospitalisation, and minimisation of medicines waste.

4.4 Prescribing plans are developed by analysis of prescribing data, with comparisons to current best practice, and identification of specific drug pressures, and then implemented through discussion and agreement with support for prescribers. This is in the context of Inverclyde HSCP historically having the highest cost and highest volume of medicines prescribed and dispensed per weighted patient of all NHS Greater Glasgow and Clyde (NHSGGC) HSCPs/sectors. Support and advice are also provided to other health and social care professionals, and patient medication review undertaken in community settings and within care homes to improve safety and effectiveness of medicines management and reduction of waste.

5.0 PROPOSALS

5.1 **Current issues in Prescribing and Medicines Management**

- Medicines Safety. Changing clinical guidelines and national drug alerts result in increasing GP workload for medication review with potential therapeutic changes. Communication issues at the primary/secondary care interface and between health and social care can affect accurate medicines reconciliation. Integration of health and social care has resulted in increased input to safe use of medicines in care homes, social care and community settings.

- Clinically effective medicines. Effectiveness can be improved by implementing clinical guidelines and a range of prescribing indicators, with medication review for high risk patients e.g. older people, specific long term conditions, or specific combinations of medicines. Patient/carer education and patient-centred use of medicines supports improved clinical outcomes.

- Cost effectiveness. Cost minimisation on prescribing budget is supported by

improving formulary compliance, reducing use of unlicensed medicines, identifying and working on specific therapeutic areas of cost and volume pressure, improving repeat prescribing processes and reducing waste in health and social care. Current principal cost pressures are the continuing short supply of commonly prescribed drugs leading to price increases; non drug prescribing increases e.g. gluten free products, Oral Nutritional Supplements, incontinence and stoma appliances; uptake of new medicines; and prescribing volume and cost growth.

- Patient-centred care. Patient-centred use of medicines and patient and carer education can improve concordance, reduce adverse drug reactions, improve clinical outcomes and reduce waste.

5.2 **Prescribing and Medicines Management Support**

- The HSCP Medicines Management Group meets 2 monthly and now includes representatives from health and social care. Quarterly Prescribing Reports including comparative data for HSCPs/sectors, NHSGGC and practices within Inverclyde are regularly provided to GP practices and HSCP managers to monitor prescribing patterns and budget. NHSGGC prescribing bulletins on topical issues are widely distributed.

- A programme of annual prescribing feedback visits to GP practices is undertaken by the Lead Clinical Pharmacist. Prescribing Team resource is allocated to all 16 practices across the HSCP, with a higher level of resource to those practices with larger patient list sizes, and practices with increased need for prescribing support. At a GP practice level, the Prescribing Team supports achievement of prescribing indicators and audits; runs medication review clinics for targeted groups of patients; undertakes domiciliary visits; utilises pharmacist independent prescribing skills; and answers medicine enquiries to assist in complex decision-making.

- A programme of annual prescribing feedback visits to GP practices is undertaken by the Lead Clinical Pharmacist. Prescribing Team resource is allocated to all 16 practices across the HSCP, with a higher level of resource to those practices with larger patient list sizes, and practices with increased need for prescribing support. At a GP practice level, the Prescribing Team supports achievement of prescribing indicators and audits; runs medication review clinics for targeted groups of patients; undertakes domiciliary visits; utilises pharmacist independent prescribing skills; and answers medicine enquiries to assist in complex decision-making.

- Other healthcare professionals with prescribing rights are supported to develop skills for safe, clinically effective and cost effective prescribing via the local Non Medical Prescribers' Forum; the development of community pharmacist clinical and prescribing skills is promoted in line with national guidance; and support and advice is provided to other health and social care professionals across the HSCP.

- Medicines Safety. Support is provided by answering enquiries on national drug alerts, clinical guidelines, drug interactions, and on the use of unlicensed medicines. All 16 GP practices are delivering additional GP face to face medication review for patients on significant numbers of medicines or high risk drug combinations under the Polypharmacy Local Enhanced Service (LES) with the aim of reducing adverse drug reactions. The potential number of additional reviews under the 2015/16 LES is 1236. This LES also promotes additional focus on accurate medicines reconciliation on hospital discharge. 15 GP practices are also undertaking improvements to their repeat prescribing systems via the Repeat Prescribing LES. With integration of health and social care, increased input to the safe use of medicines in care homes, social care and community settings, has led to the development of an HSCP Adult Medication Support Policy.

- Clinically effective medicines. Implementing national and NHSGGC evidence based clinical guidelines and formularies, and use of a range of prescribing indicators support improvements to clinical effectiveness of medicines and clinical outcomes. One example of a prescribing indicator focuses on the use of antibiotics. Antibiotics can be very useful and clinically effective, however the consequences of antibiotic overuse include the increasing emergence of resistant strains of bacteria such as MRSA, extended-spectrum beta-lactamase *E. coli* and the increase in incidence of *C. difficile* infection. International comparisons have shown that resistance rates are strongly related to antibiotic use in primary care. Prescribing indicators promote an audit of antibiotic prescribing, and encourage prescribers to undertake a facilitated education session and adhere to NHSGGC guideline recommendations for the safe and effective management of infections***.*** Work in this area has shown some reduction in prescribing ***(Appendix 1)***. Various prescribing indicator baseline figures and quarterly updates are provided to practices and HSCP.

- Cost effectiveness. All 16 GP practices are using ScriptSwitch® IT Prescribing Decision Support to increase the use of NHSGGC preferred list Drug Formulary preparations and 15 practices are undertaking the Repeat Prescribing LES to improve processes and reduce waste. Compliance with NHSGGC Wound Dressings Formulary is promoted via feedback to community nurses. Overall Formulary compliance is continuing to increase ***(Appendix 2)***. Prescribing cost and volume growth are significant pressures. Inverclyde HSCP prescribing volume has historically been higher than NHSGGC average (***Appendix 3***). However, in recent years, the volume growth has been lower than NHSGGC average ***(Appendix 4)***. Horizon scanning identifies specific drug pressures, including monitoring uptake of new medicines e.g. new oral anticoagulants; the continued problem of supply issues for frequently prescribed generic drugs leading to increased prices and short supply, with resultant changes to drug therapy; as well as identifying prescribing growth in particular therapeutic areas e.g. respiratory, diabetes and pain management, leading to liaison with NHSGGC specialists to develop best practice prescribing management initiatives.

- Patient-centred care. Prescribing, dispensing and administering medicines and formulations that are acceptable to patients support patient-centred care. This is important to improve concordance, safe and effective use of medicines, reduce adverse drug reactions, improve clinical outcomes and reduce waste. The Prescribing Team inputs to patient-centred use of medicines and patient/carer education by undertaking patient medication review clinics and domiciliary visits and by developing and delivering training for care home staff and home care workers.

5.3 **Prescribing Expenditure Position**

- Inverclyde prescribing drug budget allocation for 2014/2015 is £16,194,320. Prescribing expenditure for 2014/2015 is £16,262,187. This is £67,868, 0.42% overspent on budget allocation. The NHSGGC position is £743,148, 0.34% within prescribing budget allocation.

- The prescribing budget setting process takes the following factors into account at individual GP practice level – previous year's expenditure, Drug Tariff changes, drug patent loss, short supply, horizon scanning adjustments for new drugs, cost efficiencies from achievement of prescribing indicators, medication reviews and improvements to medicines management via NHSGGC Prescribing LES's and a movement towards the National Resource Allocation Calculation (NRAC) formula.

- The prescribing budget setting process takes the following factors into account at individual GP practice level – previous year's expenditure, Drug Tariff changes, drug patent loss, short supply, horizon scanning adjustments for new drugs, cost

efficiencies from achievement of prescribing indicators, medication reviews and improvements to medicines management via NHSGGC Prescribing LES's and a movement towards the National Resource Allocation Calculation (NRAC) formula.

- At March 2015, the annualised NHSGGC cost per weighted patient is £167, lowest of the Scottish Health Boards. The Scottish average is £186 and the Inverclyde average is £175, second highest of the HSCPs/sectors in NHSGGC. It should be noted that patients of Glasgow Nursing Home Medical Practice are not included in individual HSCPs/sectors figures for 2014/2015, although they are included in the overall NHSGGC average figure of £167 ***(Appendix 5)***. Some variation is seen in cost per weighted patient between individual GP practices within Inverclyde HSCP. ***(Appendix 6)***.

6.0 IMPLICATIONS

FINANCE

6.1 Financial implications:

One of Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A	Prescribing	2014/15	2014/15 Inverclyde prescribing expenditure is £16,262,187 (GIC), therefore £67,868, 0.42% overspent on budget allocation	N/A	2014/15 NHSGGC prescribing expenditure is £743,148, 0.34% within prescribing budget allocation

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

LEGAL

6.2 There are no legal issues within this report.

Prescribing is undertaken within a complex environment of legal framework, national and Health Board guidance, and professional standards.

HUMAN RESOURCES

6.3 There are no human resources issues within this report.

EQUALITIES

6.4 There are no equality issues within this report.

Medicines are prescribed according to patient need.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
✓	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

REPOPULATION

6.5 There are no repopulation issues within this report.

7.0 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the Lead Clinical Pharmacist.

8.0 LIST OF BACKGROUND PAPERS

8.1 None.

9.0 LIST OF APPENDICES

9.1 Appendix 1:
NHSGGC HSCPs/Sectors Total Antibiotic Use : Items Antibiotics per 1,000 list size per day

9.2 Appendix 2:
NHSGGC HSCPs/Sectors Formulary Preferred List Prescribing Percentage

9.3 Appendix 3:
NHSGGC HSCPs/Sectors Annualised items per 1000 weighted list size

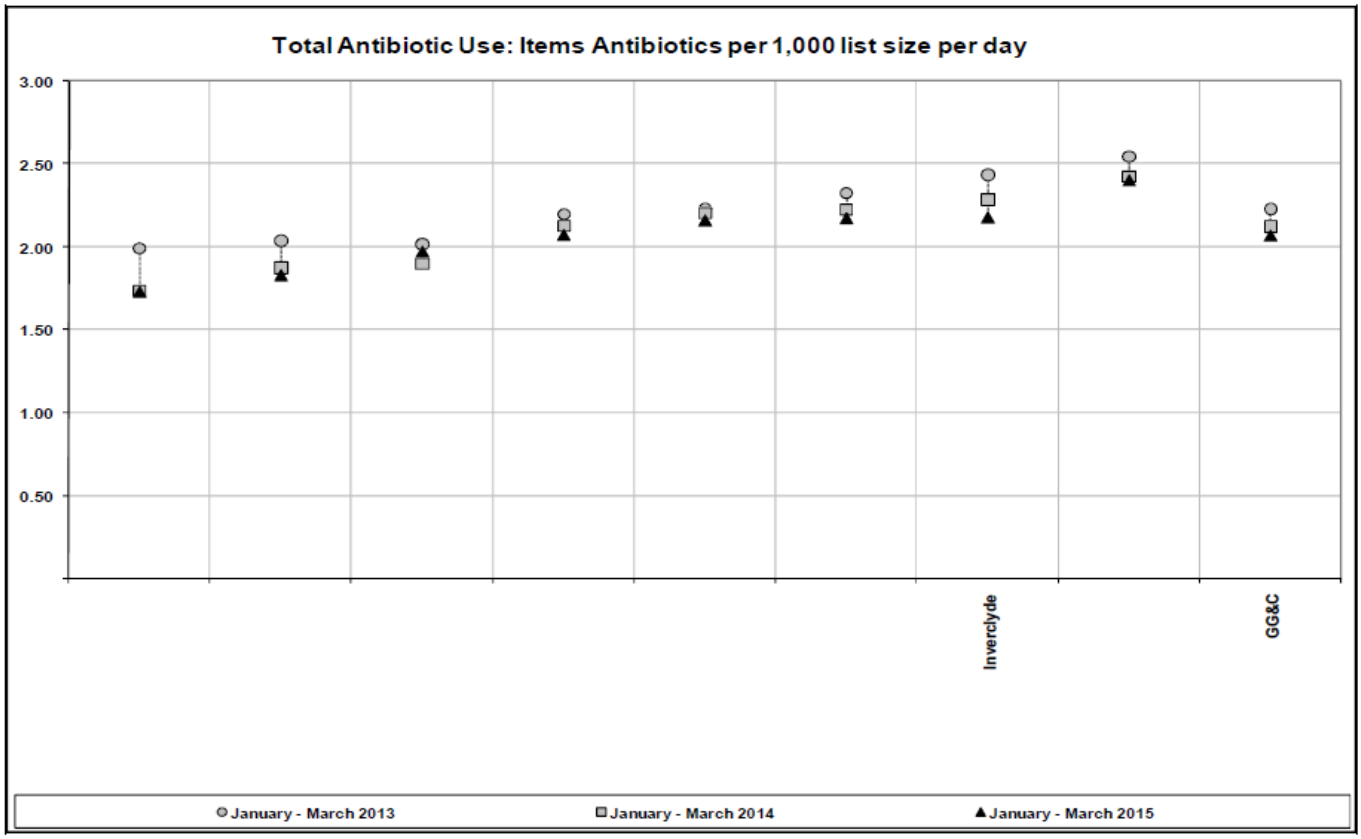
9.4 Appendix 4:
NHSGGC HSCPs/Sectors Items dispensed Growth (%)

9.5 Appendix 5:
NHSGGC HSCPs/Sectors Annualised cost per weighted list size

9.6 Appendix 6:
GP Practices in Inverclyde HSCP Cost per weighted patient per quarter (Jan - Mar 2015)

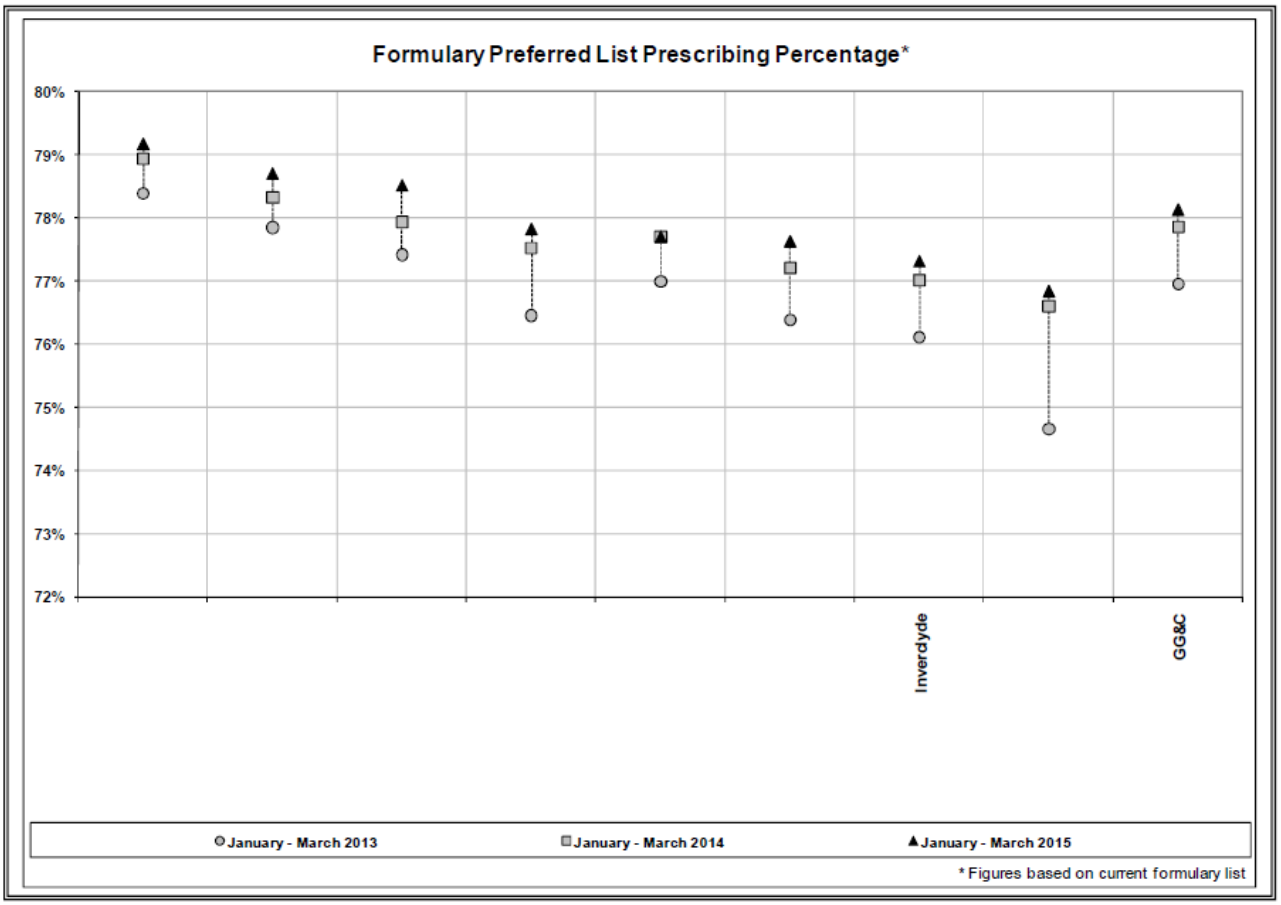
Appendix 1

NHS GG&C HSCP/Sectors

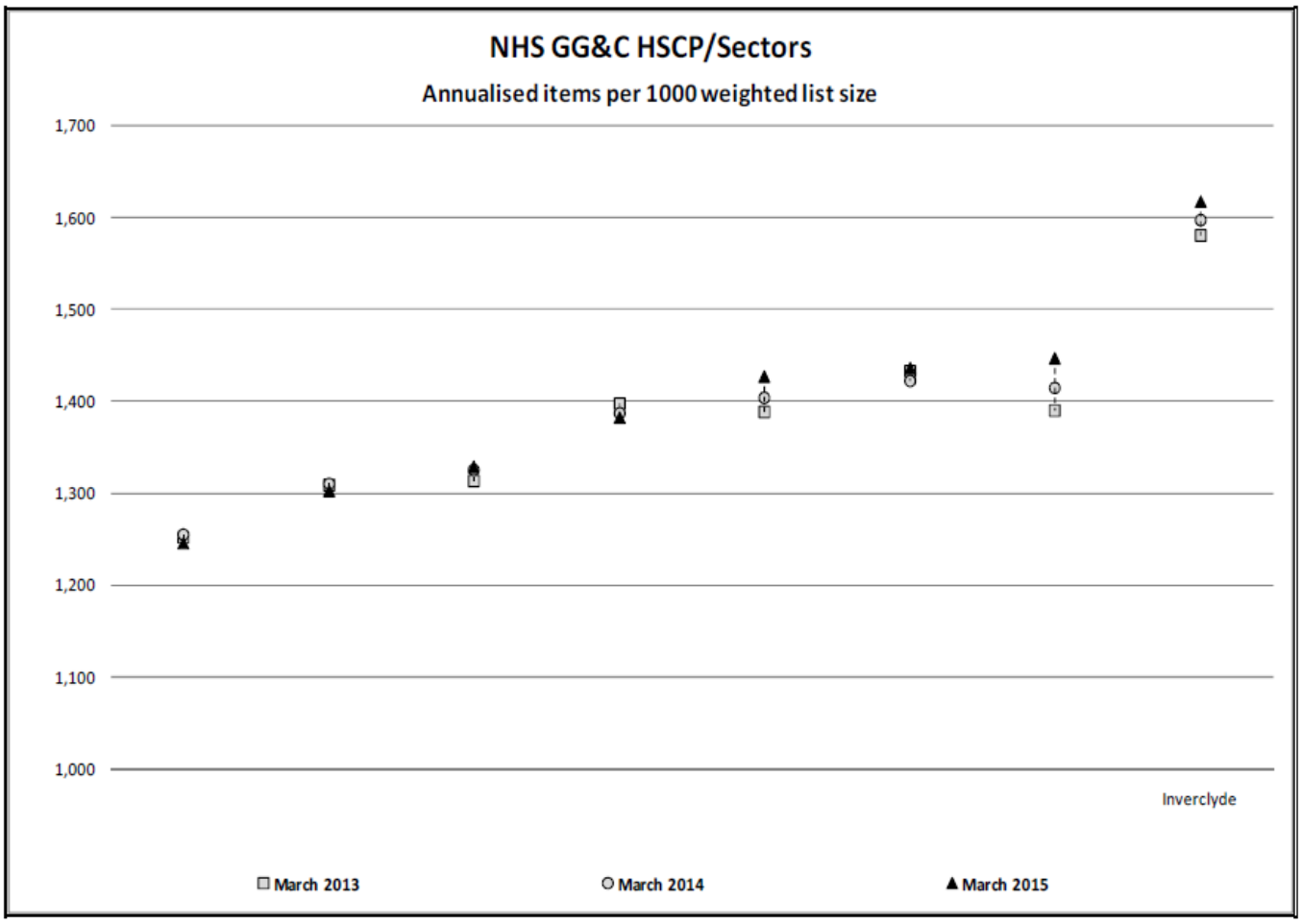


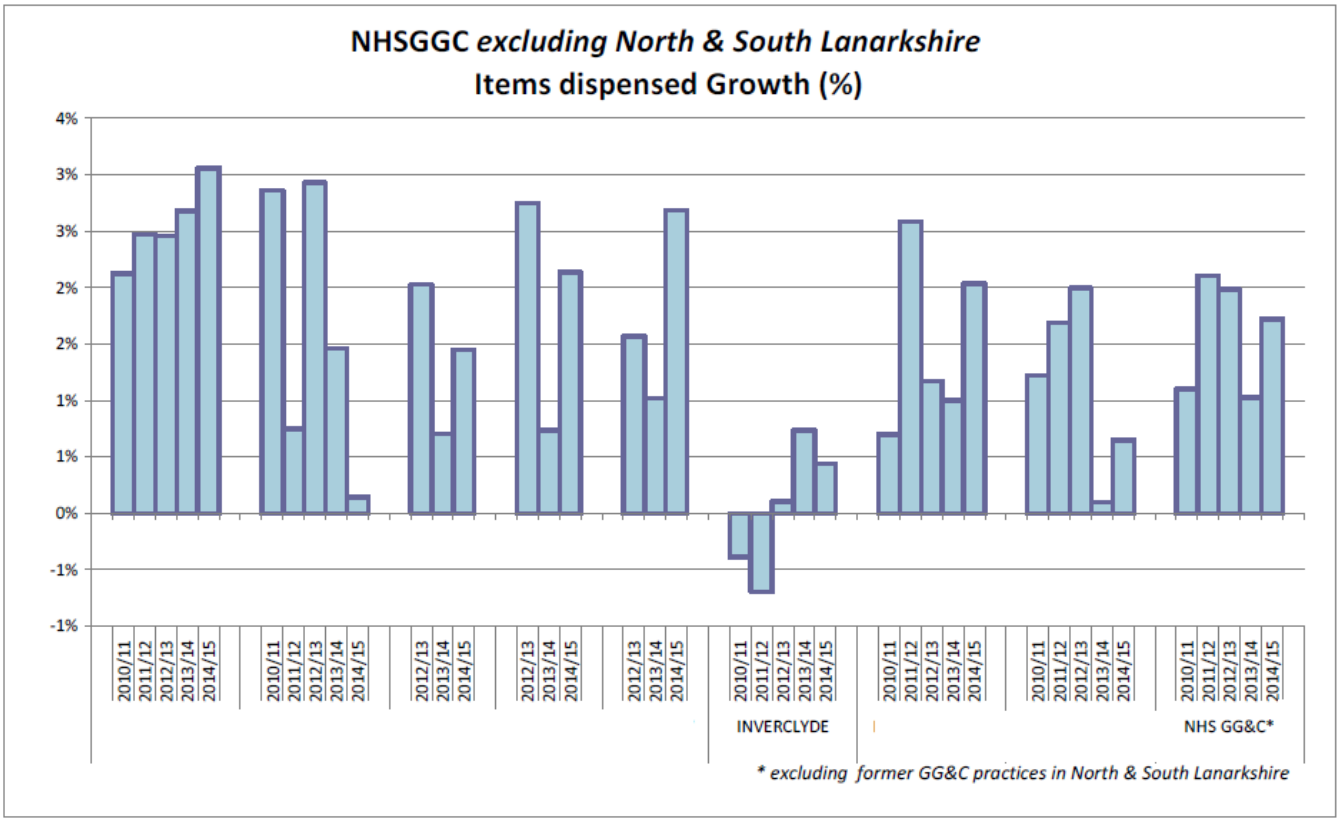
NHS GG&C HSCP/Sectors

Appendix 2



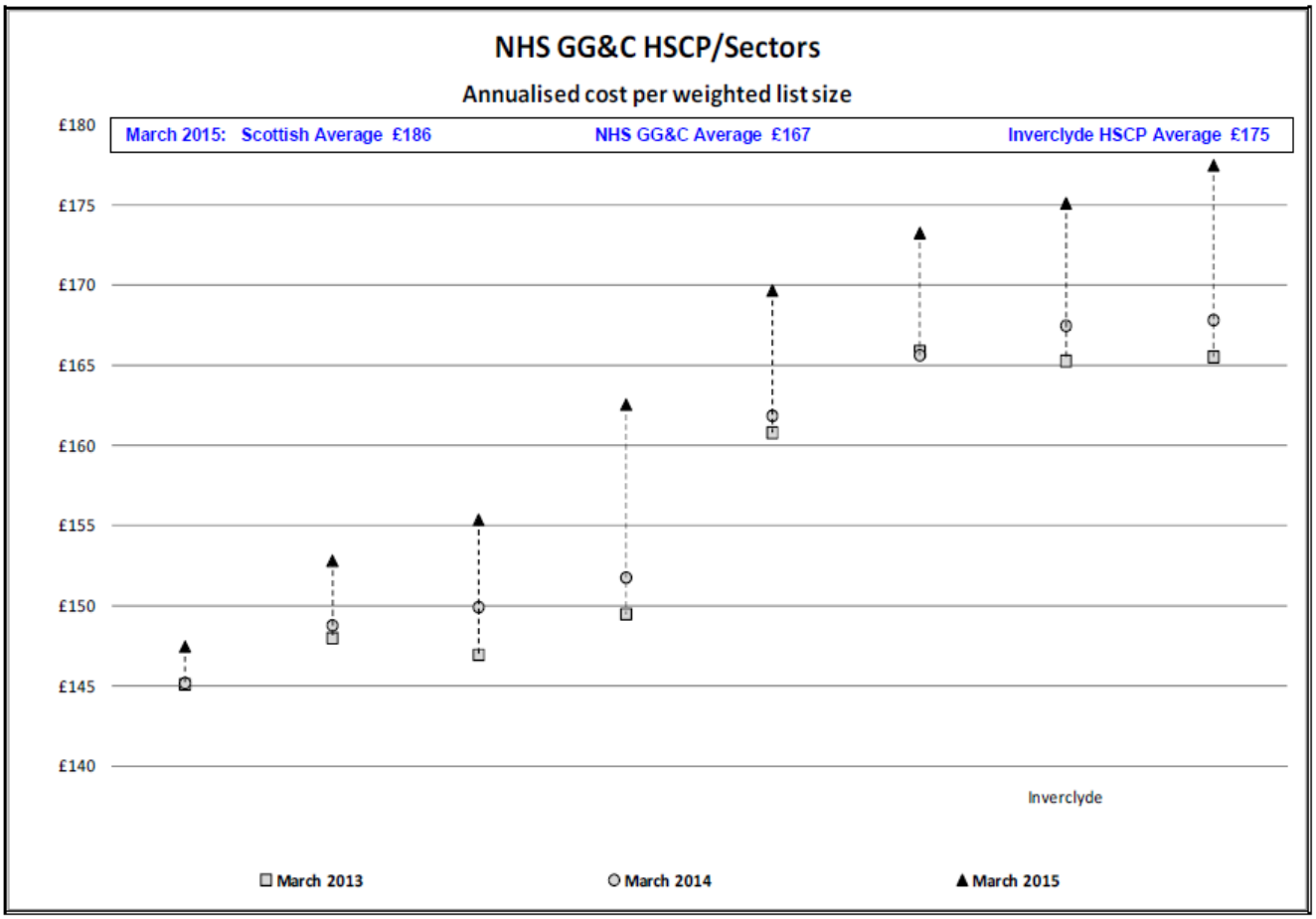
Appendix 3


NHS GG&C HSCP/Sectors
Annualised items per 1000 weighted list size
1,700
1,600
1,500
1,400
1,300
1,200
1,100
1,000
Inverclyde
March 2013
March 2014
March 2015



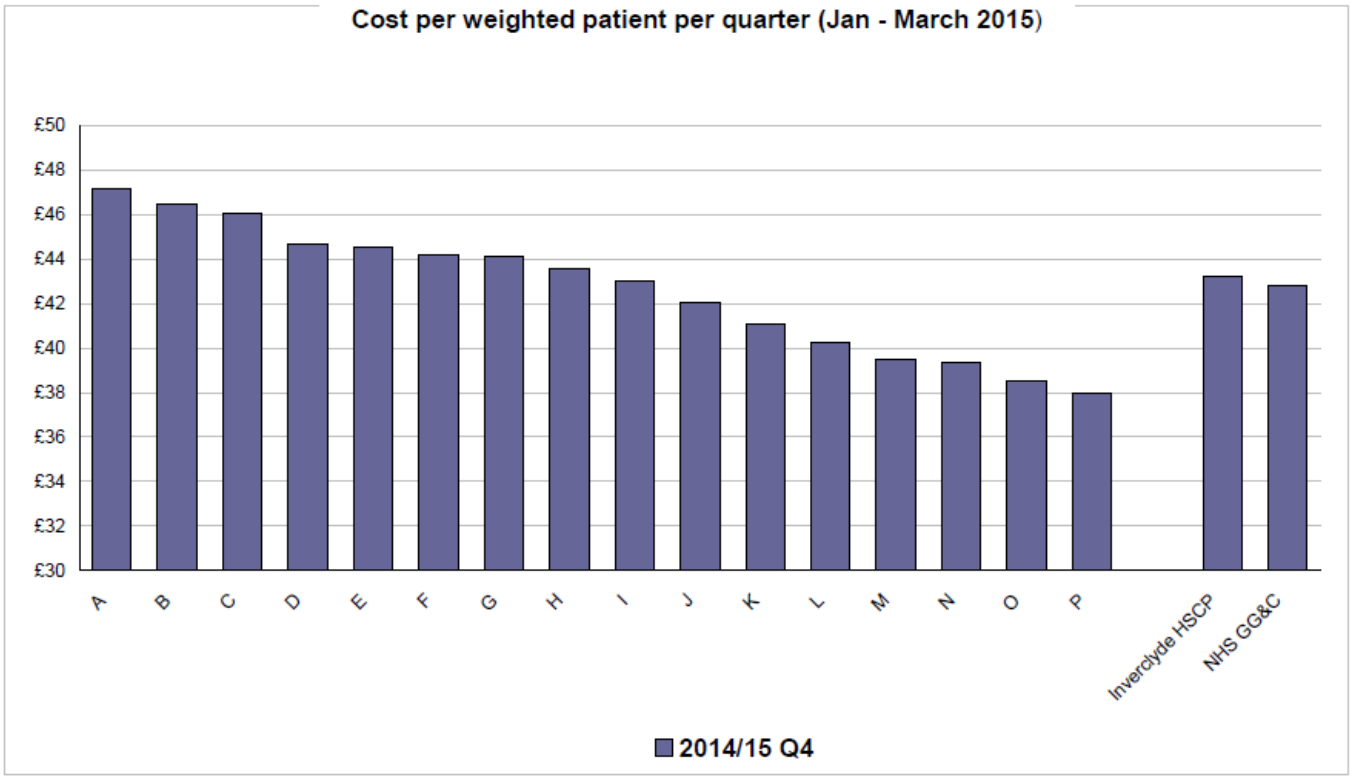
NHS GG&C HSCP/Sectors

Appendix 5


NHS GG&C HSCP/Sectors
Annualised cost per weighted list size
March 2015: Scottish Average £186
NHS GG&C Average £167
Inverclyde HSCP Average £175
£180
£175
£170
£165
£160
£155
£150
£145
£140
Inverclyde
March 2013
March 2014
March 2015

Inverclyde HSCP **Appendix 6**

GP Practices in Inverclyde HSCP



Practice	2014/15 Q4
A	£47.18
B	£46.43
C	£46.03
D	£44.68
E	£44.50
F	£44.21
G	£44.14
H	£43.55
I	£43.02
J	£42.05
K	£41.09
L	£40.27
M	£39.51
N	£39.31
O	£38.50
P	£37.93
Inverclyde HSCP	£43.19
NHS GG&C	£42.82

INVERCLYDE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

AGENDA AND ALL PAPERS TO:

Council

Councillor J McIlwee	1
Councillor S McCabe	1
Councillor L Rebecchi	1
Councillor V Jones	1

Proxies (for information only)

Councillor G Dorrian	1
Councillor J Clocherty	1
Councillor K Shepherd	1
Councillor R Ahlfeld	1

NHS

Mr Ken Winter	1
Dr Donald Lyons	1
Mr Allan Macleod	1
Mr Ross Finnie	1

Professional

Dr Hector MacDonald, Clinical Director HSCP	1
Ms Cathy Roarty, Professional Nurse Adviser	1
Dr Chris Jones, Chief Medical Officer, Clyde	1
Mr Brian Moore, Chief Officer Designate, Inverclyde HSCP	1
Ms Lesley Bairden, Chief Finance Officer	

Staff Side

Mr Robin Taggart, UNISON Branch Secretary	1
Ms Diana McCrone	1

Service User

Ms Margaret Telfer, Chair, Inverclyde HSCP Advisory Group	1

Third Sector

Mr Ian Bruce, Manager CVS and Chief Executive Inverclyde Third Sector Interface	1

IHAF

Ms Sandra McLeod, Director of Housing & Customer Services, River Clyde Homes	1

Carers

Mr Alistair Black, 114 Forsyth Street, Greenock PA16 8RW	1

Officers

Chief Executive	1
Corporate Communications & Public Affairs	1
Head of Children & Families and Criminal Justice	1
Head of Community Care & Health	1
Head of Planning, Health Improvement & Commissioning	1
Head of Mental Health, Addictions & Homelessness	1
Corporate Director Education, Communities & Organisational Development	1
Chief Financial Officer	1
Corporate Director Environment, Regeneration & Resources	1
Head of Legal & Property Services	1
V Pollock, Legal & Property Services	1
S Lang, Legal & Property Services	1

INVERCLYDE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

Chief Internal Auditor		1
File Copy		1
	TOTAL	**36**

AGENDA AND ALL NON-CONFIDENTIAL PAPERS TO:

Karen Haldane, "Your Voice", 12 Clyde Square, Greenock		1
	TOTAL	**37**