WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1st July 2015

Subject: APPOINTMENT OF CHIEF OFFICER

1. Purpose

1.1 To consider the Appointment of the Board's Chief Officer.

2. Recommendations

2.1 That the Partnership Board formally appoints Keith Redpath as their Chief Officer.

3. Background

3.1 Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 states: "(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. Main Issues

4.1 Section 9 of the 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 be seconded by the employing party to The IJB and will be the principal advisor to and officer of the IJB.

4.2 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 West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

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4.3 The Chief Officer is responsible for the operational management and performance of Integrated Services, and such other hosted Partnership services as are delegated to the Integration Joint Board.

4.4 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 Chief Officer on the operational delivery of Acute Services provided to the West Dunbartonshire population.

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4.5 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, Keith Redpath 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 NHS Board and by West Dunbartonshire Council in December 2013 and the CHCP Committee in February 2014. It was agreed, at that time by the constituent authorities that the current CHCP Director, Keith Repath 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.

4.6 It is proposed that Keith Redpath is formally appointed as Chief Officer of the Integration Joint Board. The NHS Board and West Dunbartonshire Council, as the constituent authorities have approved Keith Redpath's appointment as Chief Officer Designate and it is proposed the Chief Officer Designate is formally appointed as Chief Officer to the IJB.

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5. People Implications

5.1 The people aspects are dealt with under sections 9, 10 and 11 of the integration scheme.

6. Financial Implications

6.1 The Chief Officer's financial responsibilities are detailed in section 11 of the Integration Scheme.

7. Professional Implications

7.1 The appointment of a Chief Officer is required by section 10 of the 2014 Act.

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 If the Integrated Joint Board do not appoint to the Chief Officers role it will be non compliant with section 10 of the 2014 Act.

10. Impact Assessments

10.1 This paper is covered by the Equality Impact Assessment which was undertaken for the Integration Scheme.

11. Consultation

The appointment is being recommended as per section 9 in the Integration Scheme and the Integration Scheme were subject to public consultation.

12. Strategic Assessment

12.1 Not Applicable.

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Date: 23rd June 2015

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Appendices: **None**

Background Papers:

West Dunbartonshire Council: Establishing a Shadow Health and Social Care Partnership for West Dunbartonshire (December 2013)

Greater Glasgow & Clyde NHS Board: Establishing Shadow Health and Social Care Partnerships - East Renfrewshire, Inverclyde and West Dunbartonshire (December 2013)

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

West Dunbartonshire CHCP Committee: Confirmation of a Shadow Health and Social Care Partnership for West Dunbartonshire (February 2014)

NHS Greater Glasgow & Clyde Health Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (January 2015)

West Dunbartonshire Council: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015)

West Dunbartonshire Shadow Integration Joint Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015) Head of Strategy, Planning & Health Improvement

Integration Scheme (Body Corporate) Between West Dunbartonshire Council and Greater Glasgow Health Board.

Wards Affected: **ALL**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1st July 2015

Subject: APPOINTMENT OF CHIEF FINANCE OFFICER

1. Purpose

1.1 To consider the appointment of the Board's Chief Finance Officer.

2. Recommendation

2.1 That the Partnership Board formally appoints Jeanne Middleton as its Chief Finance Officer.

3. Background

3.1 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 Partnership Board.

4. Main Issues

4.1 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.

4.2 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.

4.3 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 an deliver the Integration Joint Board's strategic objectives sustainably and in the public interest.

4.4 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.

4.5 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.

4.6 The Chief Officer will deliver the Health and Wellbeing Outcomes prescribed by the Scottish Ministers within the total delegated resources. Where there is a forecast overspends against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the IJB and the appropriate finance officers of the Parties must agree a recovery plan to balance the overspending budget, which is subject to the approval of the Integration Joint Board.

4.7 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.

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The Council and NHS Board have been through a joint recruitment process to appoint Jeanne Middleton as Head of Finance /Chief Financial Officer to the Health and Social Care Partnership and it is recommended the IJB appoint Jeanne Middleton as Chief Finance Officer of the Integration Joint Board.

5. People Implications

5.1 The people implications are dealt with under Section 11 of the integration scheme.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 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 Partnership Board.

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 Not applicable.

10. Impact Assessments

10.1 This paper is covered by the Equality Impact Assessment which was undertaken for the Integration Scheme.

11. Consultation

Not applicable.

12. Strategic Assessment

12.1 Not Applicable.

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Date: Wednesday 24th June 2015

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Appendices: **None**

Background Papers:

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

Integration Scheme (Body Corporate) Between West Dunbartonshire Council and Greater Glasgow Health Board .

Wards Affected: **ALL**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1st July 2015

Subject: Membership of the Partnership Board

1. Purpose

1.1 To confirm the constitutional membership of the Partnership Board.

2. Recommendation

2.1 The Partnership Board is recommended to appoint the non-voting members of the Partnership Board, including confirming the designated professional advisors as detailed below.

3. Background

3.1 The constitution of the Health & Social Care Partnership Board is established through the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2 As confirmed within the approved Integration Scheme for West Dunbartonshire (see item 5) it has been agreed that:

- The Council will formally identify three representatives to be voting members on the Partnership Board, to serve for a period of three years.
- The Health Board will formally identify three representatives to be voting members on the Partnership Board, to serve for a period of three years. The Health Board retains the discretion to replace its nominated members on the Integration Joint Board.
- The term of office of the chair and vice chair will be three years. The first chair of the Partnership Board will be nominated by the Council; and the first vice-chair will be nominated by the Health Board. As required by the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, the parties will alternate nominating the chair and vice-chair.

3.3 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 states that when an integration joint board is established it must include the following non-voting members:

- The chief officer of the integration joint board.
- The proper officer of the integration joint board appointed under section 95 of the Local Government (Scotland) Act 1973(1).
- The following professional advisors:
- The chief social work officer of the local authority.
- 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(2).

- 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.
- A registered medical practitioner employed by the Health Board and not providing primary medical services.

- At least one member in respect of each of the groups:

- Staff of the constituent authorities engaged in the provision of services provided under integration functions.
- Third sector bodies carrying out activities related to health or social care in the area of the local authority.
- Service users residing in the area of the local authority.
- Persons providing unpaid care in the area of the local authority

3.4 Integration joint boards are also to incorporate representation from each of their area's agreed localities as detailed within their first year Strategic Plans (see Meeting Agenda item 6).

3.5 Given the delegations of the Integration Scheme (as detailed in the Meeting's Agenda item 5), an additional two professional advisors are being recommended to the voting members for appointed to the Partnership Board:

- A registered Allied Health Professional nurse who is employed by the Health Board.
- The chief housing officer of the local authority.

3.6 As confirmed within the Integration Scheme, the individuals to be appointed as non-voting members with respect to each of the above categories are to be formally determined by the Partnership Board's voting members.

4. Main Issues

4.1 The voting members from the elected members of the Council are:

- Gail Casey (to be Chair).
- Martin Rooney.
- Jonathan McColl.

4.2 The voting members from the non-executive directors of the Health Board are:

- Ros Micklem (to be Vice-Chair).
- Heather Cameron.
- Allan Macleod.

4.3 The following individuals are recommended to the Partnership Board to appoint to as non-voting members:

- Keith Redpath – as the Chief Officer of the Partnership Board (see Meeting Agenda item 3).
- Jeanne Middleton – as Chief Financial Officer of the Partnership Board (see Meeting Agenda item 3).
- Professional Advisors to the Partnership Board:
- Jackie Irvine – as the Chief Social Work Officer of the Council.
- Kevin Fellows – as Clinical Director for the Health & Social Care Partnership.
- Wilma Hepburn – as the Lead Nurse for the Health & Social Care Partnership.
- Helen Turley – as the Chief Housing Officer of the Council.
- Alison Wilding (GP) – as Chair of the HSCP's Locality Core Group for the Clydebank area (see Meeting Agenda item 6).
- Selina Ross - as Chief Officer of West Dunbartonshire CVS (Third Sector Interface).
- Ross McCulloch (RCN) – as NHS Staff Side Co-Chair of HSCP's Joint Staff Forum.
- Barbara Barnes – as Co-Chair of the West Dunbartonshire HSCP Public Engagement Forum and as Chair of the HSCP's Locality Engagement Network for the Alexandria & Dumbarton area (see Meeting Agenda item 6).
- Anne McDougall– as Co-Chair of the West Dunbartonshire HSCP Public Engagement Forum and as Chair of the HSCP's Locality Engagement Network for the Clydebank area (see Meeting Agenda item 6).
- Lindsay Lockhart – as Chair of Carers of West Dunbartonshire.

4.4 With respect to a registered medical practitioner employed by the Health Board and not providing primary medical services to join the Partnership Board as a professional advisor in a non-voting capacity, the Chief Officer is working with the Health Board's Medical Director and the Chief Officer of the Acute Division to identify a senior consultant to fulfil this role. Once that individual has been agreed, the Chief Officer will bring forward a report to a future meeting of the Partnership Board recommending their appointment.

4.5 With respect to the Chair of the HSCP's Locality Core Group for the Alexandria & Dumbarton area (see Meeting Agenda item 6) a process is soon to commence to identify this individual – once that is completed, the Chief Officer will bring forward a report to a future meeting of the Partnership Board recommending their appointment.

4.6 With respect to the Lead Allied Health Professional to join the Partnership Board as a professional advisor in a non-voting capacity, the Chief Officer is working with the Health Board's Lead Allied Health Professional and Director of Nursing to identify a senior member of staff. Once that individual has been agreed, the Chief Officer will bring forward a report to a future meeting of the Partnership Board recommending their appointment.

4.7 Council Trade Unions have been invited to nominate a local authority staff side Co-Chair of the HSCP's Joint Staff Forum and a response is awaited. Once that individual has been identified and confirmed as a Co-Chair of the Joint Staff Forum, the Chief Officer will bring forward a report to a future meeting of the Partnership Board recommending their appointment.

5. People Implications

5.1 The non-voting members recommended includes staff side representation from the NHS and provision for additional council trade union representation.

6. Financial Implications

6.1 The non-voting members recommended includes the Chief Financial Officer of the Health & Social Care Partnership.

7. Professional Implications

7.1 The non-voting members recommended include professional advisors.

8. Locality Implications

8.1 The non-voting members recommended includes the chairs of the two locality core groups identified for West Dunbartonshire (see Meeting Agenda item 6).

9. Risk Analysis

9.1 The Council and the Health Board are obliged to ensure that the constitution of the Partnership Board is as prescribed in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

9.2 The voting members of the Partnership Board are obliged to appoint non-voting members as per the approved Integration Scheme for West Dunbartonshire.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 Not applicable.

12. Strategic Assessment

12.1 Not applicable.

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Date: 24th June 2015

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Appendices:	**None**
Background Papers:	The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014
Wards Affected:	All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1 July 2015

Subject: Standing Orders and Code of Conduct

1. Purpose

1.1 To present the Partnership Board with Standing Orders to regulate its procedure and business and to provide the Partnership Board with the Model Code of Conduct for Members of Devolved Public Bodies.

2. Recommendation

2.1 The Partnership Board is recommended to approve the Standing Orders and to note the terms of the Model Code of Conduct for Members of Devolved Public Bodies.

3. Background

3.1 In terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, an Integration Joint Board must make Standing Orders for the regulation of its procedure and business and all meetings of the Integration Joint Board and its Committees must be conducted in accordance with those Standing Orders.

3.2 The Code of Conduct which is applicable to Integration Joint Boards is the Model Code of Conduct for Members of Devolved Public Bodies.

3.3 Proposed Standing Orders are appended for consideration and approval and the Model Code of Conduct for Members of Devolved Public Bodies and related Guidance are appended in order that their terms may be noted.

4. Main Issues

4.1 The proposed Standing Orders are based, to some extent, on the Standing Orders that were adopted by the West Dunbartonshire Community Health and Care Partnership. The Standing Orders of the CHCP have, however, had to be amended to take account of the differences between that organisation and the Partnership Board. The proposed Standing Orders have had to reflect the terms of the legislation, in particular the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, and have had to reflect the terms of the approved Integration Scheme for West Dunbartonshire.

4.2 The Standing Orders which are new, or which differ substantially from the Standing Orders of the CHCP, are as follows:-

- Standing Order 2 (Membership);
- Standing Order 3 (Chair and Vice-Chair);
- Standing Order 4.5 (Remote Attendance at Meetings);
- Standing Order 6 (Quorum);
- Standing Order 7 (Conflicts of Interest);
- Standing Order 15 (Voting);
- Standing Order 16 (Proxies).

4.3 The Model Code of Conduct for Members of Devolved Public Bodies and the Guidance relating to that Code of Conduct are deemed to be incorporated into the Standing Orders (Standing Order 7).

4.4 All members of the Partnership Board must observe the Rules of Conduct in the Code. The Code requires members to register their interests, financial and non-financial. Members must review their personal circumstances, at least annually. Members must not at any time advocate or encourage any action contrary to the Code.

4.5 There are provisions for dealing with alleged breaches of the Code and the sanctions which can be applied in the event of a breach are set out in Annex A to the Code.

5. People Implications

5.1 All members of the Partnership Board and all officers involved with the Partnership Board will require to familiarise themselves with the Standing Orders and the Code of Conduct.

6. Financial Implications

6.1 Not applicable.

7. Professional Implications

7.1 Legal advice to members of the Partnership Board can be provided to assist with interpretation of the Standing Orders and Code of Conduct.

8. Locality Implications

8.1 Not applicable.

9. Risk Analysis

9.1 If the Partnership Board does not adopt Standing Orders, it will fail to comply with one of the legislative requirements for such Boards.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 Not applicable.

12. Strategic Assessment

12.1 Not Applicable.

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Date:

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Appendices:

1. Standing Orders for West Dunbartonshire Council Health & Social Care Partnership Board.

2. Model Code of Conduct for Members of Devolved Public Bodies

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3. Guidance on the Model Code of Conduct for Members of Devolved Public Bodies.

Background Papers: Integration Scheme (Body Corporate) between West Dunbartonshire Council and Greater Glasgow Health Board

Wards Affected All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

STANDING ORDERS

JULY 2015

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 and all meetings of the Integration Joint Board or of a Committee or Sub-Committee of the Integration Joint Board must be conducted in accordance with these Standing Orders.

1.2 In these Standing Orders "the Integration Joint Board" shall mean the West Dunbartonshire Health & Social Care Partnership 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 Chair" means the Chair of the Integration Joint Board and, in relation to the proceedings of any Committee or Sub-Committee of the Integration Joint Board, means the Chair of that Committee or Sub-Committee.

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

2. Membership

2.1 Voting membership of the Integration Joint Board shall comprise three councillors nominated by the Council and three persons nominated by the Health Board, at least two of whom must be non-executive directors.

2.2 Non-voting membership of the Integration Joint Board shall comprise:-

(a) the Chief Social Work Officer of the Local Authority;

(b) the Chief Officer of the Integration Joint Board;

(c) the Proper Officer of the Integration Joint Board 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) at least one member from staff of the constituent authorities engaged in the provision of services provided under integration functions;

(h) at least one member from third sector bodies carrying out activities related to health or social care in the area of the local authority;

(i) at least one member from service users residing in the area of the local authority;

(j) at least one member from persons providing unpaid care in the area of the local authority; and

(k) such additional members as the Integration Joint Board sees fit. Any such additional member may not be a councillor or a non-executive director of the Health Board.

The members appointed under paragraphs (d) to (f) must be determined by the Health Board.

2.3 The councillors nominated by the Council as members of the Integration Joint Board shall serve for a period of three years. The Council retains the discretion to replace its nominated members on the Integration Joint Board.

2.4 The persons nominated by the Health Board as members of the Integration Joint Board shall serve for a period of three years. The Health Board retains the discretion to replace its nominated members on the Integration Joint Board.

2.5 A member of the Integration Joint Board mentioned in Standing Order 2.2 (a) to (c) shall remain a member for as long as they hold the office in respect of which they were appointed.

2.6 At the end of a term of office, a member may be reappointed for a further term of office.

2.7 A member of the Integration Joint Board, other than those members mentioned in Standing Order 2.2 (a) to (c), may resign their membership at any time by giving notice in writing to the Integration Joint Board. If a voting member gives notice of their resignation, the Integration Joint Board must inform the constituent authority which nominated that member.

2.8 If a member has not attended three consecutive ordinary meetings of the Integration Joint Board, and their absence was not due to illness or other reasonable cause, the Integration Joint Board may remove the member from office by giving the member one month's notice in writing.

2.9 If a member acts in a way which brings the Integration Joint Board into disrepute or in a way which is inconsistent with the proper performance of the functions of the Integration Joint Board, the Integration Joint Board may remove the member from office with effect from such date as the Integration Joint Board may specify in writing.

2.10 If a member of the Integration Joint Board 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.

2.11 If a 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.

2.12 If a member who is a voting member appointed on the nomination of the Health Board ceases, for any reason, to be a non-executive director or member of the Health Board during a term of office, they are to be removed from office with effect from the day that they cease to be a non-executive director or member of the Health Board.

2.13 Without prejudice to Standing Orders 2.8 to 2.12, a constituent authority may remove a member which it nominated by giving one month's notice in writing to the member and the Integration Joint Board.

3. Chair and Vice-Chair

3.1 A Chair and a Vice-Chair are to be appointed by the constituent authorities for terms of office of three years.

3.2 The constituent authorities shall alternate which of them is to appoint the Chair and Vice-Chair in respect of each successive period of three years.

3.3 The first Chair shall be nominated by the Council and the first Vice-Chair shall be nominated by the Health Board.

3.4 A constituent authority may change the person appointed by that authority as a Chair or Vice-Chair during the three year term of office.

3.5 The local authority may appoint as Chair or Vice-Chair only a councillor nominated by it as a member of the Integration Joint Board.

3.6 The Health Board may appoint as Chair or Vice-Chair only a non-executive director nominated by it as a member of the Integration Joint Board.

3.7 At each meeting of the Integration Joint Board the Chair, if present, shall preside. If the Chair is absent from any meeting, the Vice-Chair, if present, shall preside. If both the Chair and the Vice-Chair are absent, a voting member shall be appointed as Chair by the other voting members present for that meeting.

3.8 Powers, Authority and Duties of the Chair (or Vice-Chair if the Chair is absent)

The Chair 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 of the Integration Joint Board 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.

The decision of the Chair on all matters within his/her jurisdiction shall be final.

Deference shall at all times be paid to the authority of the Chair. When he/she commences to speak, the Chair shall be heard without interruption.

Members shall address the Chair while speaking.

4. Meetings

4.1 The first meeting of the Integration Joint Board shall be convened at a time and place determined by the Chair. Thereafter, the Integration Joint Board shall meet at such place and such frequency as may be agreed by the Integration Joint Board.

4.2 The Chair may convene a special meeting if it appears to him/her that there is an item of urgent business to be considered. Such meetings will be held at a time, date and place determined by the Chair. If the office of Chair is vacant or if the Chair is unable to act for any reason, the Vice-Chair may call such a meeting.

4.3 A request for a meeting of the Integration Joint Board 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 Chair.

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4.4 If such a request is made and the Chair refuses to call a meeting, or does not call a meeting within seven days after the making of the request, the members who signed the requisition may call a meeting. The business which may be transacted at such a meeting shall be limited to the business specified in the requisition.

4.5 Adequate provision shall be made to allow for members to attend a meeting of the Integration Joint Board or a Committee or Sub-Committee of the Integration Joint Board 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.

5. Notice of Meetings

5.1 Before each meeting of the Integration Joint Board, or a Committee or a Sub-Committee of the Integration Joint Board, a notice of the meeting specifying the date, time, place and business to be transacted at it signed by the Chair, or a member authorised by the Chair to sign on the Chair's behalf, shall be sent electronically to every member or sent or delivered to the usual place of residence of every member so as to be available to them at least five clear days before the meeting.

5.2 Members may opt, by way of a written request addressed to the Chief Officer, to have notice of meetings sent or delivered to an alternative address. Such a request will be complied with until it is rescinded in writing.

5.3 A failure to serve notice of a meeting on a member shall not affect the validity of anything done at that meeting.

5.4 In the case of a meeting of the Integration Joint Board called by members, the notice shall be signed by the members who requisitioned the meeting.

5.5 At all Ordinary or Special Meetings of the Integration Joint Board no business other than that on the agenda shall be considered except where by reason of special circumstances, which shall be specified in the Minutes, the Chair is of the opinion that the item should be considered at the meeting as a matter of urgency.

6. Quorum

6.1 No business shall be transacted at a meeting of the Integration Joint Board unless at least one half of the voting members are present.

6.2 If after ten minutes from the scheduled time of commencement of any meeting of the Integration Joint Board, or if during any meeting of the Integration Joint Board, there is no quorum, the meeting shall not take place or shall be terminated, as the case may be.

7. Codes of Conduct and Conflicts of Interest

7.1 Members of the Integration Joint Board shall comply with 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.

7.2 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 Integration Joint Board, or a Committee or Sub-Committee of the Integration Joint Board, before taking part in any discussion on that item.

7.3 Where an interest is disclosed, the other members present at the meeting in question shall decide whether the member declaring the interest is to be prohibited from taking part in discussion of, or voting on, the item of business.

8. Adjournment of Meetings

8.1 If it is necessary or expedient to do so, a meeting of the Integration Joint Board, or of a Committee or a Sub-Committee of the Integration Joint Board, may be adjourned to another date, time or place. A motion to adjourn shall be moved and seconded and put to the meeting without discussion. If such a motion is carried by a simple majority of those present and entitled to vote, the meeting shall be adjourned to the date, time and place specified in the motion.

9. Disclosure of Information

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

- Confidential information within the meaning of Section 50A(2) of the Local Government (Scotland) Act 1973.

- Any document or part of any document marked “not for publication by virtue of [the appropriate paragraph] of Part 1 of Schedule 7A to 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.

- Any information regarding proceedings of the Integration Joint Board from which the public have been excluded unless or until disclosure has been authorised by the Integration Joint Board or the information has been made available to the press or to the public under the terms of the relevant legislation.

9.2 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 would be to the disadvantage of the Integration Joint Board.

10. Recording of Proceedings

10.1 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 Integration Joint Board.

11. Admission of Press and Public

11.1 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 Integration Joint Board shall be open to the public. The Chief Officer shall be responsible for giving public notice of the date, time and place of each meeting of the Integration Joint Board by posting within the main offices of the Integration Joint Board not less than five days before the date of each meeting.

11.2 The Integration Joint Board 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.

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

12. Alteration, Deletion and Recission of Decisions of the Integration Joint Board

12.1 Except insofar as required by reason of legality, no motion to alter, delete or rescind a decision of the Integration Joint Board will be competent within six months from the date of that decision, unless a decision is made prior to consideration of the matter to suspend this Standing Order in terms of Standing Order 13.

13. Suspension, Deletion or Amendment of Standing Orders

13.1 Any one or more of the Standing Orders upon motion may be suspended, amended or deleted at any meeting so far as regards any business at such meeting provided that two thirds of the members of the Integration Joint Board present and voting shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Orders to be suspended.

14. Motions, Amendment and Debate

14.1 It will be competent for any voting member of the Integration Joint Board at a meeting of the Integration Joint Board, or any Committee or Sub-Committee of the Integration Joint Board, to move a motion directly arising out of the business before the meeting or to move an amendment to such a motion.

14.2 No member, with the exception of the mover of the motion or amendment, will speak supporting the motion or amendment until the same has been seconded by a voting member of the Integration Joint Board.

14.3 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 Integration Joint Board, or any Committee or Sub-Committee of the Integration Joint Board, except:-

- On a question of order;

- With the permission of the Chair; or

- In explanation or to clear up a misunderstanding in some material part of his/her speech.

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

14.4 The mover of an amendment and thereafter the mover of the original motion will have the right of reply for a period of not more than five minutes. He/she will introduce no new matter and once a reply is commenced, no other member will speak on the subject of debate. Once these movers have replied, the discussion will be held closed and the Chair will call for the vote to be taken.

14.5 Amendments must be relevant to the motions to which they relate and no member will be at liberty to move or second more than one amendment to any motion, unless the mover of an amendment has failed to have it seconded. The mover and seconder of the motion will not move an amendment or second an amendment, unless the mover of the motion has failed to have it seconded.

14.6 It will be competent for any voting member who has not already spoken in a debate to move the closure of such debate. On such motion being seconded, the vote will be taken, and if a majority of the 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.

14.7 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.

14.8 When a motion and amendment(s) are under debate, no other motion or amendment will be moved except in the following circumstances:-

- To adjourn the debate; or
- To close the debate in terms of Standing Order 14.6.

14.9 A motion or amendment once moved and seconded cannot be altered or withdrawn unless with the consent of the majority of those present.

15. Voting

15.1 Every effort shall be made by members to ensure that as many decisions as possible are made by consensus.

15.2 Only the three members nominated by the Council and the three members nominated by the Health Board shall be entitled to vote.

15.3 Every question at a meeting shall be determined by a majority of votes of the members present and who are entitled to vote on the question. In the case of an equality of votes the Chair shall not have a second or casting vote.

15.4 Where there is an equality of votes, the voting members may agree that the decision will be made by a cut of cards or some other equitable method. If the voting members do not agree such a method of breaking the deadlock then no decision will be taken and the status quo shall prevail. Standing Order 12 shall not preclude reconsideration of any such item within a six month period.

15.5 If the voting members do not agree on a means of resolving a dispute at a meeting of the Integration Joint Board, the formal dispute resolution mechanism specified in the Integration Scheme may be used.

16. Proxies

16.1 If a voting member is unable to attend a meeting of the Integration Joint Board, the constituent authority which nominated the member is to use its best endeavours to arrange for a suitably experienced proxy, who is either a councillor or, as the case may be, a member of the Health Board, to attend the meeting in place of the voting member.

16.2 If a member who is not a voting member is unable to attend a meeting of the Integration Joint Board, that member may arrange for a suitably experienced proxy to attend the meeting.

16.3 A proxy attending a meeting of the Integration Joint Board in place of a voting member may vote on decisions put to that meeting.

16.4 If the Chair or Vice-Chair is unable to attend a meeting of the Integration Joint Board, any proxy attending the meeting in place of the Chair or Vice-Chair may not preside over that meeting.

17. Temporary Vacancies in Voting Membership

17.1 Where there is a temporary vacancy in the voting membership of the Integration Joint Board, the vote which would be exercisable by a member appointed to fill that vacancy may be exercised jointly by the other members nominated by the constituent authority which has the vacancy.

17.2 Where the Chair is to be appointed by a constituent authority but where due to two temporary vacancies the number of members nominated by that constituent authority is one, or a constituent authority has been unable to nominate any members, the Chair must be temporarily appointed by the other constituent authority.

18. Effect of Vacancy in Membership

18.1 A vacancy in the membership of the Integration Joint Board shall not invalidate anything done or any decision made by the Integration Joint Board.

19. Minutes

19.1 The names of the members and others present at a meeting shall be recorded in the minutes of the meeting.

19.2 The minutes of the proceedings of a meeting, including any decision or resolution made at that meeting, shall be drawn up and submitted to the next ensuing meeting for agreement after which they will be signed by the person presiding at that meeting. A minute purporting to be so signed shall be received in evidence without further proof.

20. Committees and Working Groups

20.1 The Integration Joint Board may establish committees and sub-committees of its members for the purpose of carrying out such of its functions as the Integration Joint Board may determine.

20.2 When the Integration Joint Board establishes a committee or sub-committee, it must determine the membership, Chair, remit, powers and quorum of that committee or sub-committee.

20.3 A committee or sub-committee established by the Integration Joint Board must include voting members and must include an equal number of voting members appointed by the Council and the Health Board.

20.4 Any decision of a committee or a sub-committee must be made by a majority of the votes of the voting members of that committee or sub-committee.

20.5 The Integration Joint Board may establish working groups but any working group shall have a limited time span determined by the Integration Joint Board.

20.6 The Integration Joint Board must determine the membership, Chair, remit and any powers and quorum of any working group which it establishes.

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.

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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

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1st July 2015

Subject: Integration Scheme

1. Purpose

1.1 To present the Partnership Board with the Integration Scheme for West Dunbartonshire as approved by the Scottish Government.

2. Recommendation

2.1 The Partnership Board is recommended to note the approved Integration Scheme that underpins the new arrangements within West Dunbartonshire.

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland. The Act requires territorial NHS 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 (was already included within the previous Community Health & Care Partnership [CHCP] in West Dunbartonshire) - should the public bodies involved agree to do so.

3.2 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 and submit that scheme for final approval to Scottish Ministers by 31st March 2015.

3.3 At its May 2014 meeting, the then Shadow Integration Joint Board for West Dunbartonshire directed the then Interim Chief Officer to develop an integration scheme for West Dunbartonshire on behalf of both the Council and the Health Board in accordance with requirements of the legislation; and for subsequent recommendation for approval by the NHS Health Board and the Council.

3.4 The completed integration scheme was then presented and approved by the Health Board at its January 2015 meeting; and West Dunbartonshire Council at its February 2015 meeting.

3.5 As confirmed at the February 2015 meeting of the Shadow Integration Joint Board, the integration scheme was then formally submitted to the Scottish Government for scrutiny and consideration (well in advance of the legislative deadline of the 1st April 2015).

3.6 In May 2015 date the Council and the Health Board received formal confirmation (Appendix 1) that the Scottish Government had approved the attached Integration Scheme (Appendix 2), thereby enabling the

establishment of the new arrangements for West Dunbartonshire (well in advance of the legislative deadline of 1st April 2016).

4. Main Issues

4.1 The model of integration committed to within the Integration Scheme is that of the Body Corporate, establishing a *new West Dunbartonshire Health & Social Care Partnership Board* as the Integration Joint Board for our local area.

4.2 The Integration Scheme details the role and responsibilities of the new Partnership Board, which in essence are:

- Being responsible for the strategic planning of its integrated services (as set out in Annexes 1 and 2 of the scheme).
- Being responsible for the operational oversight of the Health & Social Care Partnership (HSCP), which is the joint delivery vehicle for those integrated services delegated to the HSCP Board (except for NHS acute hospital services).

4.3 The Integration Scheme also details the role and responsibilities of Council and the NHS Health Board in enabling the Partnership Board to discharge its functions.

4.4 Annex 1 of the Integration Scheme details the Health Board services to be delegated to the Partnership Board. Annex 2 of the Integration Scheme details the Council functions to be delegated to the Partnership Board.

4.5 The Act requires that in order for these services and functions to be formally delegated in practice to the Partnership Board, a local Strategic Plan must first be prepared and approved by it (see item 6 of this Meeting's Agenda).

5. People Implications

5.1 As per the legislation, the Integration Scheme details relevant issues for the workforce and in respect of staff governance.

5.2 Staff working under the management of the Health & Social Care Partnership will continue to be employed by either the NHS Health Board or the Council as they are at present, retaining their respective terms and conditions.

6. Financial Implications

6.1 As per the legislation, the Integration Scheme details relevant issues of financial management and governance.

7. Professional Implications

7.1 As per the legislation, the Integration Scheme details relevant issues of professional leadership, advice and adherence to practice standards.

7.2 The Act does not change the current or future regulatory framework within which health and social care professionals practice or the established professional accountabilities that are currently in place within the NHS and local government.

8. Locality Implications

8.1 The Integration Scheme confirms that Partnership Board is responsible for confirming the development of locality arrangements to support its Strategic Plan, which the Act specifies are to be detailed within its first Strategic Plan (see item 6 on the Meeting's Agenda).

9. Risk Analysis

9.1 The approved Integration Scheme supports the evolution of the successful CHCP arrangements that the Council and the NHS Health Board previously developed for West Dunbartonshire. Its approval has enabled the local implementation of the Act in the positive manner committed to by the Council and the Health Board; and that avoids uncertainty for staff or potential disruption for service users and carers.

10. Impact Assessments

10.1 Prior to approval by the Council and the NHS Health Board an Equality Impact Assessment had been completed for the attached integration scheme, with no negative impacts identified.

11. Consultation

11.1 As detailed within the body of its text, the Integration Scheme was informed by a considerable amount of ongoing dialogue and positive interaction with stakeholders, including a formal consultation undertaken at the end of 2015.

12. Strategic Assessment

12.1 The Integration Scheme confirms the requirement of the Partnership Board to approve a Strategic Plan for the area, against which all other items of Partnership Board business will be subsequently assessed (see item 6 of this Meeting's Agenda).

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Date: 24th June 2015

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Appendices:	(1) Scottish Government Letter of Approval of West Dunbartonshire Integration Scheme (2) Integration Scheme (Body Corporate) Between West Dunbartonshire Council and Greater Glasgow Health Board.
Background Papers:	NHS Greater Glasgow & Clyde Health Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (January 2015) West Dunbartonshire Council: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015) West Dunbartonshire Shadow Integration Joint Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015)
Wards Affected:	All

Health and Social Care Integration Directorate
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The Scottish Government
Riaghaltas na h-Alba

Mr Robert Calderwood
Chief Executive, NHS Greater Glasgow and Clyde

Ms Joyce Whyte
Chief Executive, West Dunbartonshire Council

Mr Keith Redpath
Chief Officer, West Dunbartonshire Health and Social Care Partnership

18 June 2015

Dear Colleagues

Approval of Integration Scheme under section 7(2)(a) of the Public Bodies (Joint Working) (Scotland) Act 2014

I write to provide notification of approval of your Integration Scheme by the Cabinet Secretary for Health, Wellbeing and Sport.

The Order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 29 May and will lie in Parliament for 28 days before coming in to force on Saturday 27 June. From 27 June the Integrated Joint Board for the area of West Dunbartonshire Council will be legally established.

I would like to take this opportunity to thank colleagues for collaboratively working together in order to get to this key stage and I look forward to continuing to work with you over the forthcoming months as you progress implementation.

Yours faithfully

FConlan

Frances Conlan
Policy and Strategy Team Leader
Integration and Reshaping Care Division

INTEGRATION SCHEME

(BODY CORPORATE)

BETWEEN

WEST DUNBARTONSHIRE COUNCIL

AND

GREATER GLASGOW HEALTH BOARD

This integration scheme is to be used in conjunction with the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

These regulations can be found at www.legislation.gov.uk

1. Introduction

1.1 This integration scheme describes how the *Public Bodies (Joint Working) (Scotland) Act 2014* is to be implemented for West Dunbartonshire.

1.2 In October 2010, West Dunbartonshire Council and NHS Greater Glasgow & Clyde Health Board (legally known as the Greater Glasgow Health Board) established West Dunbartonshire Community Health & Care Partnership as a joint vehicle for the management and delivery of community health and social care services, under the local auspices of a combined Community Health & Care Partnership Committee whose composition reflects a partnership approach between the Council and the Health Board; and the leadership of a single Director and Senior Management Team. These integrated arrangements have been inclusive of all adult, children and criminal justice services; and their effectiveness positively recognised by the Care Inspectorate and Audit Scotland.

1.3 In December 2013, the Council and the Health Board formally agreed to transition their Community Health and Care Partnership to a Shadow Health and Social Care Partnership; and for its Community Health & Care Partnership Committee to assume the role of Shadow Integration Joint Board; and the Partnership Director to assume the role of Interim Chief Officer from 1st April 2014, in preparation for the full enactment of the Public Bodies (Joint Working) (Scotland) Act 2014 in April 2015. This decision has enabled both the Council and the Health Board to jointly develop, constructively consult with stakeholders and then agree the arrangements for joint working as required by the Act, building on the effective integrated arrangements that have already been successfully developed locally; and reflecting on the considerable learning and insights that accrued in doing so.

1.4 This integration scheme details the 'body corporate' arrangement by which the Health Board and the Council have agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire shall be referred to as the *West Dunbartonshire Health & Social Care Partnership Board*.

1.5 The West Dunbartonshire Health & Social Care Partnership Board's:

- Mission is to improve the health and wellbeing of West Dunbartonshire residents.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.

1.6 The Health & Social Care Partnership Board will set out within its Strategic Plans how it will use its allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act, namely that:

- 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 and efficiently in the provision of health and social care services.

1.7 The Council and Health Board have agreed that children and families health and social care services and criminal justice social work services will be included within the functions and services to be delegated to the Health & Social Care Partnership Board. Consequently the specific National Outcomes for Children and Criminal Justice will also be addressed within its Strategic Plans, i.e.:

- 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.

- We have improved the life chances for children, young people and families at risk.

- Community safety and public protection.

- The reduction of re-offending.

- Social inclusion to support desistance from offending.

1.8 West Dunbartonshire Health & Social Care Partnership 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 partnership arrangement referred to as *West Dunbartonshire Health & Social Care Partnership*.

1.9 The Act requires that the Health Board and Council submit this integration scheme for approval by Scottish Ministers. Once this scheme is approved, the West Dunbartonshire Health & Social Care Partnership Board will be established by Order of the Scottish Ministers as an entity which has distinct legal personality.

2. **The Parties**

WEST DUNBARTONSHIRE COUNCIL, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at Garshake Road, Dumbarton, G823PU ("the Council");

and

GREATER GLASGOW HEALTH BOARD, established under section 2(1) of the National Health Service (Scotland) Act 1978 and having its principal offices at J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH ("the Health Board") (together referred to as "the Parties").

3. **Definitions and Interpretation**

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

3.2 "The Chief Officer" means the Chief Officer of the Integration Joint Board for West Dunbartonshire.

3.3 "The Chief Financial Officer" means the Chief Financial Officer of the Integration Joint Board for West Dunbartonshire.

3.4 "The Council" means West Dunbartonshire Council.

3.5 "The Health Board" means Greater Glasgow Health Board.

3.6 "Hosted Services" means those services of the Parties which, subject to consideration by the Integration Joint Boards through the strategic planning process, the Parties agree will be managed and delivered on a pan Greater Glasgow and Clyde basis by a single Integration Joint Board. Annex 3 specifies the proposed hosting service arrangements for the first year of operation.

3.7 "The Integration Joint Board" means the Integration Joint Board for West Dunbartonshire to be established by Order under section 9 of the Act.

3.8 "The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

3.9 "Integration Joint Board Order" means the Public Bodies (Joint Working) (Scotland) Order 2014.

3.10 "Outcomes" means the Health and Wellbeing Outcomes prescribed in Regulations under section 5(1) of the Act and the National Outcomes for Children and Criminal Justice.

3.11 "The Health & Social Care Partnership" means the Parties' joint service delivery vehicle for functions and services which have been delegated to the Integration Joint Board (except those related to NHS acute hospital services) and through which the Parties will work together in accordance with the Scheme and the Strategic Plan to achieve the Outcomes.

3.12 "Scheme" means this Integration Scheme.

3.13 "Strategic Plan" means the strategic plan for the integrated services specified within this Scheme as prescribed under section 29 of the Act.

4. Integration Model

4.1 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 the Integration Joint Board, 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.

4.2 This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

5. Local Governance Arrangements

5.1 The Parties understand that the Integration Joint Board has the formal status for strategic planning for West Dunbartonshire within both the Council and the Health Board. The Integration Joint Board and the Parties will have to communicate with each other and interact in order to contribute to the overall delivery of the Outcomes for West Dunbartonshire.

5.2 The Parties understand that the Integration Joint Board has a legal personality distinct from the Council and Health Board; and the consequent autonomy to manage itself. There is no role for either Party to independently sanction or veto decisions of the Integration Joint Board.

5.3 In exercising its functions, the Integration Joint Board must take into account the Parties' requirement to meet their respective statutory obligations. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities; and therefore also retain their formal decision-making roles for those functions not delegated.

5.4 The remit and constitution of the Integration Joint Board is established through the legislation, with the Parties having agreed that:

5.4.1 The Council will formally identify three representatives to be voting members on the Integration Joint Board, to serve for a period of three years. The Council retains the discretion to replace its nominated members on the Integration Joint Board.

5.4.2 The Health Board will formally identify three representatives to be voting members on the Integration Joint Board, to serve for a period of three years. The Health Board retains the discretion to replace its nominated members on the Integration Joint Board.

5.4.3 The term of office of the chair and vice chair will be three years. As required by the Integration Joint Board Order, the parties will alternate nominating the chair and vice-chair.

5.4.4 The first chair of the Integration Joint Board will be nominated by the Council; and the first vice-chair will be nominated by the Health Board.

5.4.5 The Parties acknowledge that the Integration Joint Board will include additional non voting members as specified by the Integration Joint Board Order, the individuals to be formally determined by the Integration Joint Board's voting members.

5.4.6 The Integration Joint Board will make, and may subsequently amend, standing orders for the regulation of its procedure and business.

6. Delegation of Functions

6.1 The functions that are to be delegated by Health Board to the Integration Joint Board are set out in Part 1 of Annex 1, and only to the extent that they relate to the services described in Part 2 of Annex 1.

6.2 The functions that are to be delegated by West Dunbartonshire Council to the Integration Joint Board are set out Part 1 of Annex 2, and only to the extent that they relate to the services described in Part 2 of Annex 2.

6.3 The Parties will recommend to the Greater Glasgow and Clyde Integration Joint Boards that each of the Hosted Services listed in Annex 3 be managed and delivered on a pan Greater Glasgow and Clyde basis through a designated Lead Health & Social Care Partnership during the first year of their operation and subject to review for subsequent years.

7. Local Operational Delivery Arrangements

7.1 The Parties understand that the Integration Joint Board will be responsible for the strategic planning of its integrated services as set out in Annexes 1 and 2 of this Scheme.

7.2 The Parties agree that the Strategic Plan will provide direction for the Integration Joint Board's performance framework, identifying local priorities and associated local outcomes and taking into account national guidance on the core indicators for integration.

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

7.4 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 West Dunbartonshire; 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.

7.5 Arrangements for NHS acute hospitals and Health Board Acute Division services most commonly associated with the emergency care pathway will require joint planning with the other Integration Authorities within the Health Board area; and with the Health Board which retains operational responsibility for the delivery of these services.

7.6 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.

7.7 The Parties understand that the Integration Joint Board will be responsible for assuring itself that systems, procedures and resources are in place to monitor, manage and deliver the functions and services delegated to it. This assurance will be based on regular performance reporting, including the annual performance report; and through the strategic planning process.

7.8 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. Payment will be made by the Integration Joint Board to the Parties to enable the delivery of these functions in accordance with the Strategic Plan.

7.9 The Integration Joint Board is responsible for the operational oversight of the Health & Social Care Partnership, which is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS acute hospital services); and through the Chief Officer who will be responsible for the operational management of said Health & Social Care Partnership. These arrangements for integrated service delivery will be conducted within an operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both parties can continue to discharge their governance responsibilities.

7.10 The Parties agree that the management of NHS acute hospital services will be retained within the Health Board. The Parties agree that the Health Board Chief Executive will ensure provision of updates on a regular basis to the Chief Officer and the Integration Joint Board on the operational delivery of NHS acute hospital services delegated to the Integration Joint Board.

7.11 The Parties are committed to supporting the Integration Joint Board, providing the professional, technical or administrative support required for the development of the Strategic Plan, and the oversight and delivery of the integration functions (including information, financial and public health support and analysis). The support arrangements and resources put in place for the predecessor community health and care partnership will be used as a model for the future strategic support; and will be regularly reviewed by the Health Board, the Council and the Integration Joint Board.

7.12 The Parties will identify a core set of indicators that relate to integrated services from publicly accountable and national indicators and targets by 31st March 2016. The Parties will share all performance information, targets and indicators with the Integration Joint Board; provide information on the data gathering and reporting requirements for performance targets and improvement measures; and clarify where the responsibility for each measure lies, whether in full or in part. Where there is an ongoing requirement in respect of organisational accountability for a performance target for the Health Board or Council this will be taken into account by the Integration Joint Board when preparing the Strategic Plan. The performance targets and improvement measures will be linked to the national and local Outcomes to assess the timeframe and the scope of change. Improvement measures will be a combination of existing and new measures that will allow assessment at local level. The core set of indicators will be reviewed regularly to ensure the improvement measures contained continue to be relevant and reflective of the national and local Outcomes to which they are aligned. The Parties will also prepare a list of any targets, measures and arrangements which relate to functions of the Parties, which are not delegated to the Integration Joint Board, but which are affected by the performance and funding of integration functions and which are to be taken account of by the Integration Joint Board when preparing the Strategic Plan. This work will be completed by 31st March 2016, and thereafter subject to on-going review.

8. Clinical and Care Governance

8.1 The Parties understand that clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed. Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

Clinical and care governance for integrated health and social care services requires co-ordination across a range of services, (including procured services) so as to place people and communities at the centre of all activity relating to the governance of clinical and care services.

8.2 The Parties are committed to actively promoting 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. The Parties will put in place structures and processes to support clinical and care governance for integrated services that can provide assurance to the Integration Joint Board.

8.3 The quality of integrated service delivery will be measured through performance targets, improvement measures and reporting arrangements designed to address organisational and individual 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 procurement from the Third and Independent Sectors.

8.4 The Parties understand that the Act does not change the current or future regulatory framework within which health and social care professionals practice or the established professional accountabilities that are currently in place within the NHS and local government; and that all health and social care professionals remain accountable for their individual clinical and care decisions.

8.5 The Parties will nominate relevant professional leads for consideration and appointment by the Integration Joint Board in compliance with the regulations, as advisors to the Integration Joint Board, the Chief Officer and local strategic planning and locality planning arrangements. The Chief Officer and the Integration Joint Board will also be supported by the equalities and public protection capabilities of both Parties.

8.6 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.

8.7 The Health Board Chief Executive, as the accountable officer, is responsible for clinical governance, quality, patient safety and engagement, supported by the Health Board's professional advisers. The Health Board's Medical Director is responsible for the systems which support the delivery of clinical governance and medicines governance, including Health Board-wide medicines governance framework; infection control; the patient safety programme; and the Clinical Governance Forum. The Clinical Governance Forum is responsible for demonstrating compliance with statutory requirements in relation to clinical governance; authorising an accurate and honest annual clinical governance statement; and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland. Professional leads nominated by the Health Board will relate to and be supported by the Health Board's Medical Director and Director of Nursing through formal

network arrangements and the Area Clinical Forum. In their operational management role the Chief Officer will work with and be supported by these professional leads with respect to quality of integrated services within the Partnership in order to then provide assurance to the Integration Joint Board.

8.8 The Chief Officer has delegated responsibilities, through the Parties' Chief Executives, for the professional standards of staff working in integrated services. The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership. The Parties will ensure that staff working in integrated services have the appropriate skills and knowledge to provide the appropriate standard of care. Partnership managers will manage teams of Health Board employed staff, Council employed staff or a combination of both; and will promote best practice, cohesive working and provide guidance and development to their team. This will include effective staff supervision and implementation of staff support policies. Where groups of staff require professional leadership, this will be provided by the relevant Health Board professional lead or the Council's Chief Social Work Officer as appropriate.

8.9 The Chief Officer will ensure that clear strategic objectives for clinical and care governance are agreed, delivered and reported through an annual clinical and care governance action plan. This will include actions to: ensure the quality of service delivery (including that delivered through services procured from the third and independent sector); address organisational and individual care risks; promote continuous improvement; and ensure that all professional and clinical standards, legislation and guidance are met.

8.10 The Parties will establish a local Clinical and Care Governance Group for integrated services within the Partnership. This, when not chaired by the Chief Officer, will report to the Chief Officer; and through the Chief Officer to the Integration Joint Board. Its membership will include the Partnership's Senior Management Team; Clinical Director; Lead Nurse; Allied Health Professions Lead; and Council's Chief Social Work Officer. Through its representative membership, the Clinical and Care Governance Group will interface with the Health Board Clinical Governance Forum; Health Board professional committees; the Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection Committees as appropriate.

8.11 The Integration Joint Board may seek advice on clinical and care governance directly from the Clinical and Care Governance Group and also the Health Board Clinical Governance Forum; Health Board professional committees; Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection. In addition, the Integration Joint Board may directly take into consideration the professional views of the lead health professionals and the Council's Chief Social Work Officer.

8.12 The Clinical and Care Governance Group will provide advice to strategic planning and locality planning groups within the area of the Integration Joint Board. Strategic planning and locality planning groups may seek advice on clinical and care governance directly from the Clinical and Care Governance Group; and may directly take into consideration the professional views of the lead health professionals and the Council's Chief Social Work Officer.

8.13 Details of the primary support structure for clinical and care governance relating to the Integration Joint Board and the Parties are set out in Annex 4.

8.14 Further assurance will be provide through:

- The responsibility of the Chief Social Work Officer to report directly to the Council.

- The responsibility of the health professional leads to relate to the Medical Director and Director of Nursing, who in return report to the Health Board on professional matters.
- The Health Board Clinical Governance Forum which will also provide professional guidance as required.

8.15 The Chief Officer will take into consideration any decisions of the Council or Health Board which arise from 8.14 above.

8.16 The Health Board's Medical Director, Director of Nursing, Clinical Governance Forum and the Council's Chief Social Worker 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.

8.17 The Parties agree that they will work together and with the Integration Joint Board to deliver an organisation in which those individual staff delivering care will:

- Practice in accordance with their professional standards, codes of conduct and organisational values.
- Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
- Ensure the best possible care and treatment experience for service users and families.
- Provide accurate information on quality of care and highlight areas of concern and risk as required.
- Work in partnership with management, service users and carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
- Speak up when they see practice that endangers the safety of patients or service users in line with local policies for public interest disclosure and regulatory requirements.
- Engage with colleagues, patients, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

9. Chief Officer

9.1 The Chief Officer will be accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Plan.

9.2 The Chief Officer's formal contract of employment will be with one of the Parties, and be then seconded to the Integration Joint Board by that Party. The Chief Officer will hold an honorary contract with the other Party. The Chief Officer will be jointly line managed by the Council's Chief Executive and the Health Board's Chief Executive. Where there is to be prolonged period where the Chief Officer is absent or otherwise unable to carry out their responsibilities, the Council's Chief Executive and Health Board's Chief Executive will jointly propose – at the request of the Integration Joint Board - an appropriate interim arrangement for approval by the Integration Joint Board's Chair and Vice-Chair.

9.3 The totality of the Chief Officer's objectives will be set annually and performance appraised by the Council's Chief Executive, the Health Board's Chief Executive in consultation with Integration Joint Board's Chair and Vice-Chair.

9.4 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 Parties agree that Chief Officer will be responsible for the operational management of the integrated services within the Partnership, with the management of NHS acute hospital services retained within the Health Board. The Parties agree that the Health Board Chief Executive will ensure provision of updates on a regular basis to the Chief Officer and the Integration Joint Board on the operational delivery of NHS acute hospital services delegated to the Integration Joint Board.

9.5 The Chief Officer will routinely liaise with their counterparts of the other Integration Authorities within the Health Board area in accordance with sub-section 30(3) of the Act.

9.6 The Parties agree that the Council's Chief Social Work Officer and the Health Board's Medical Director, Director of Nursing, and professional leads will routinely liaise with the Chief Officer with respect to the arrangements and support for clinical and care governance.

10. Workforce

10.1 The Parties understand that staff governance is a system of corporate accountability for the fair and effective management of all staff, i.e. that staff should be:

- Well informed.
- Appropriately trained.
- Involved in decisions which affect them.
- Treated fairly and consistently.
- Provided with an improved and safe working environment.

10.2 The Parties, through the Chief Officer, will develop a joint Workforce Development and Support Plan and Organisational Development strategy in relation to staff delivering integrated services (except for NHS acute hospitals services), taking account of existing workforce development policies and procedures of both Parties, and rationalising these in partnership with other integration authorities within the same the Health Board area. These will be prepared within the first year of operation of the Integration Joint Board and put in place by 31st March 2016. The Parties will include the Integration Joint Board in their review.

10.3 The Parties agree that the Chief Officer will convene a local joint Staff Partnership Forum, with formal linkages to their respective corporate trade union partnership forums. The Chief Officer will ensure that staff governance matters will be reported as appropriate and required to the Parties through their appropriate governance and management structures.

11. **Finance**

11.1 The Parties will provide the Integration Joint Board with assurance that its delegated resources are appropriately robust to allow it to carry out its delegated services and functions, both prior to the approval of its Strategic Plans and at the start of each financial year. 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.

11.2 The Integration Joint Board will appoint a Chief Financial Officer, who will be the Accountable Officer for financial management and administration of the Integration Joint Board. The Chief Financial Officer will be line managed by the Chief Officer, and professionally supervised and formally supported by the Council's Section 95 Officer and the Health Board's Director of Finance.

11.3 The Parties confirm the following arrangements in relation to the determination of the amounts to be paid, or Set Aside, and their variation, to the Integration Joint Board by the Parties:

(a) Amounts to be paid by the Parties to the Integration Joint Board in respect of all of the functions delegated by them to the Integration Joint Board (other than those to which sub-paragraph [b] applies):

(i) Payment in the first year to the Integration Joint Board for delegated functions.

Delegated baseline budgets for 2015/16 will be subject to due diligence and comparison to actual expenditure in previous years together with any planned changes to ensure they are realistic, with an opportunity in the second year of operation to correct any base line errors.

(ii) Payment in subsequent years to the Integration Joint Board for delegated functions.

In subsequent years, the Chief Officer and the Chief Finance Officer should develop the funding requirements for the Integrated Budget based on the Strategic Plan and present it to the Parties for consideration as part of the annual budget setting process. The draft budget should be evidence based with full transparency on its assumptions. The following principles apply:

- Individual Party responsibility, including pay awards, contractual uplift, prescribing, resource transfer, and ring fenced funds.
- In the case of demographic shifts and volume each Party will have a shared responsibility for funding. In these circumstances an agreed percentage contribution, based on net budget of each Party, by individual client group excluding ring fenced funds (e.g. Family Health Services and General Medical Services) will apply.
- The prescribing budget will be delegated to the Integration Joint Board. It is proposed that prescribing will be managed by the Health Board across the area of the six Greater Glasgow and Clyde Integration Joint Boards, with an agreed Incentive Scheme which requires to be approved by all Parties across the six Integration Joint Boards.
- Efficiency targets will be set by each Party.

Following determination of the payment, the amounts to be made by each Party, the Integration Joint Board will refine the Strategic Plan to take account of the totality of resources available.

(b) Amounts to be made available by the Health Board to the Integration Joint Board in respect of NHS acute hospital services:

(i) Carried out in a hospital in the area of the Health Board or provided to the partnership population by another territorial NHS Health Board through cross boundary flow arrangements.

Set Aside baseline budgets for 2015/16 will be subject to due diligence and comparison to actual expenditure in previous years together with any planned changes to ensure they are realistic, with an opportunity in the second year of operation to correct any base line errors.

The initial Set Aside base budget for each Integration Joint Board will be based on their historic use of NHS acute hospital services. The actual unit cost which would apply as part of any change to activity or service redesign is dependent on the scale of change planned and requires agreement in advance by all Parties. Any redesign of service requires to be agreed across the three Integration Joint Boards and be reflected in the Strategic Plans.

In subsequent years, the Health Board, Chief Officer and the Chief Finance Officer should develop the funding requirements for the Set Aside budget based on the Strategic Plan and present it to the Parties for consideration as part of the annual budget setting process. The draft budget should be evidence based with full transparency on its assumptions. Any adjustment to the Set Aside budget requires to be agreed by all Parties with each Parties contribution being adjusted proportionate to the rolling three year usage by each Party.

(ii) Provided for the areas of two or more Councils.

Where the Integration Joint Board agrees that it will host services on behalf of other Integration Joint Boards the principles outlined in (a) above would apply.

11.4 The Chief Officer will deliver the Outcomes within the total delegated resources (paid and Set Aside) 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. If the recovery plan is not successful the Parties will consider making interim funds available based on the agreed percentage contribution for joint responsibilities, as outlined above, with repayment in future years on the basis of a revised recovery plan agreed by the Parties and Integration Joint Board. If the revised plan cannot be agreed by the Parties or is not approved by the Integration Joint Board, the dispute resolution mechanism in herein, will be followed.

11.5 Where an underspend in an element of the operational budget 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 Parties in the same proportion as individual Parties contribute to joint pressures.

11.6 In year variances in any agreed Lead Partnership hosted services follow the principles noted above. In the event of an overspend the Recovery Plan requires agreement of all Integration Joint Boards. Failure to reach agreement will require interim additional contributions in proportion to service usage pending final agreement of the Recovery Plan.

11.7 In year pressures in respect of Set Aside budgets will be managed in year by the Health Board, with any recurring over or underspend being considered as part of the annual budget setting process.

11.8 Either Party may increase their in year payment to the Integration Joint Board. Neither Party may reduce the payment in-year to the Integration Joint Board nor hosted services managed on a lead partnership basis to meet exceptional unplanned costs within the Parties without the express consent of the Integration Joint Board and the other Party and where relevant the other Greater Glasgow and Clyde Integration Joint Boards.

11.9 The Chief Finance Officer is responsible for ensuring that appropriate financial services are available to the Integration Joint Board and the Chief Officer.

11.10 Recording of all financial information in respect of 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.

11.11 Initially, consolidation of information for the Integration Joint Board will take place outwith the core financial ledgers.

11.12 The Chief Officer and Chief Finance Officer of the Integration Joint Board will be responsible for the preparation of the annual accounts, financial statement prepared under section 39 of the Act, the 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 Health Board accounts timetable. The Chief Finance Officer will provide reports to the Chief Officer on the financial resources used for operational delivery.

11.13 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 in relation to activity for Set Aside budgets.

11.14 Monthly financial reports will be provided to the Chief Officer in respect of paid services. Quarterly information will be provided on activity associated with the Set Aside budgets.

11.15 Financial reports will include a subjective and objective analysis of budgets and actual / projected outturn. Detailed financial transactions will continue to be recorded in the financial ledgers of each Party.

11.16 The schedule of cash payments to be made in settlement of the payment due to the Integration Joint Board is as follows. The net difference between payments made to the Integration Joint Board and resources delegated by the Integration Joint Board, Resource Transfer and virement between Parties and Integration Joint Board will be transferred between agencies quarterly in arrears, with a final adjustment on closure of the Annual Accounts. The timetable will be prepared in advance of the start of the financial year.

11.17 In the event that the Integration Joint Board becomes formally established 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 establishment of the Integration Joint Board to 31st March 2016.

11.18 The Parties agree that Strategic Plans will take account of all resources available to the Partnership, including capital assets owned by the Health Board on behalf of Scottish Ministers, and the Council.

11.19 Capital and assets and the associated running costs will continue to sit with the Parties. The Parties agree that the Chief Officer and the Chief Financial Officer will be formally and appropriately engaged within Health Board and Council corporate processes regarding minor works and minor equipment, making the best use of existing resources and developing capital programmes.

11.20 The Parties agree that where the Integration Joint Board identifies the need for new capital investment within the Strategic Plan, a business case will be developed by the Chief Officer for both Parties to transparently consider through their corporate processes. The Parties agree that process by which a business case has been considered, the decision reached and the basis for that decision will be formally reported back to the Integration Joint Board.

12. Participation and Engagement

12.1 Given the predecessor community health and social care partnership that the Parties had established as a key element of and pro-active participant within local Community Planning Partnership arrangements, this Scheme has benefitted from a considerable amount of ongoing and positive engagement with a range of stakeholders over the period since the legislation was first announced; and benefited from the participation of local stakeholders who have experienced the realities of effective integration in practice.

12.2 Throughout the development of this Scheme, the Parties jointly consulted all of the stakeholder groups prescribed in Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014. The extensive consultation undertaken adopted a multi-modal approach, incorporating electronic material promoted and accessible via the Council and the Health Board intranet and internet websites; circulation of both paper and electronic copies of material to mailing lists; briefings to elected members; discussions at staff team meetings and with trade unions; participation at external forums (including Third and Independent sectors) and invited groups (including users and carers groups); and specially organised meetings. Engagement also consultation with the other Councils within the Greater Glasgow and Clyde Health Board area. Comments from across all these consultation processes was captured, collated and then considered within the final preparation of this Scheme. The response to the consultation from across stakeholder groups was substantively positive and encouraging.

12.3 The Parties jointly undertook an Equalities Impact Assessment as part of the process of finalising this Scheme: no negative impacts were identified, and positive opportunities were adopted.

12.4 The predecessor community health and care partnership arrangements previously established by the Parties for the delivery of health and social care services for adults and children across West Dunbartonshire included integrated participation and engagement arrangements that are supported by and contribute to local Community Planning Partnership arrangements; and routine collaboration with stakeholders as part of the local Community Planning Partnership to develop services that meet the needs of local people and support local Single Outcome Agreement priorities. The Parties are committed to continuing that constructive participation and engagement.

12.5 The Parties undertake to work together to support the Integration Joint Board in the production of its participation and engagement strategy. The Parties agree to provide communication and public engagement support to the Integration Joint Board to facilitate engagement with key stakeholders, including patients and service users, carers and Third Sector representatives and Councils within the Greater Glasgow and Clyde Health Board area.

12.6 The Parties will also provide support through existing corporate support arrangements and public consultation arrangements. The participation and engagement strategy will be produced by 31 March 2016. In the meantime, each of the Parties agrees to use its existing systems for participation and engagement, and to ensure that these accord at all times with the principles and practices endorsed by the Scottish Health Council and those set out in the National Standards for Community Engagement.

13. Information Sharing and Data Handling

13.1 The Council, the Health Board and the other local authorities within the Health Board area have established and work together through the Joint Information & Health Systems Group to develop, review and maintain an Information Sharing Protocol. The Protocol 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 Protocol 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, while recognising the circumstances in which staff must share personal data to protect others without the consent of the individual. The Protocol complies with the laws regulating this, most notably the Data Protection Act 1998. The Parties acknowledge that the Protocol has been reviewed and revised to take into consideration the terms of the Act.

13.2 Within a month of the first meeting of the Integration Joint Board, the Parties will request the Data Sharing Partnership extends an invitation to the Integration Joint Board to become a member and will invite the Integration Joint Board to be a party to the Protocol. Any reasonable amendments to the Protocol proposed by the Integration Joint Board will be considered through the Data Sharing Partnership.

13.3 The Parties shall work together to ensure that the Protocol is reviewed on a two yearly basis and that as part of this process the views of the Integration Joint Board will be canvassed and considered.

13.4 The Chief Officer will ensure appropriate arrangements are in place in respect of information governance and the requirements of the Information Commissioner's Office on behalf of and with the necessary technical and corporate support from both Parties. Staff within the Partnership will continue to be obliged to operate in accordance with the local Data Sharing Protocol and the data confidentiality policies of their employing organisations.

14 Complaints

14.1 With respect to the functions delegated to the Integration Joint Board, both of the Parties will retain separate complaints policies reflecting distinct statutory requirements: the Patient Rights (Scotland) Act 2011 making provisions for complaints about NHS services; and the Social Work (Scotland) Act 1968 making provisions for the complaints about social work services. The Parties will work together with the Chief Officer to ensure the arrangements for complaints are clear and integrated from the perspective of the service user. In the event that complaints are received by the Integration Joint Board or the Chief Officer, the Parties will work together to achieve where possible a joint response, identifying the lead party in the process and confirming this to the individual raising the complaint.

14.2 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. The final stage will be the consideration of complaints by the Scottish Public Sector Ombudsman. In relation to social work complaints these are, subject to review,

presently considered by a local Social Work Complaints Review Sub-Committee prior to the Ombudsman.

14.3 The means through which a complaints 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.

14.4 The Parties agree that staff delivering integrated services will apply the relevant Party's complaints policy depending on the nature of the complaint made. Where a complaint made could be dealt with by both Parties' policies, the appropriate member of senior management team will determine whether both need to be applied separately or a single joint response is appropriate. Where a joint response to such a complaint is not possible or appropriate, the material issues should be separated and progressed through the respective Party's procedures.

14.5 Details of the complaints procedures will be provided on-line, in printed literature and on posters. Clear and agreed timescales for responding to complaints will be provided. 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. The person making a complaint will always be informed which Party's policies are being applied.

14.6 The Parties will ensure that complaints performance will be reported on in accordance with national and corporate reporting arrangements. The Parties will produce a joint report on a six monthly basis for consideration by the Integration Joint Board.

15. Claims Handling, Liability and Indemnity

15.1 The Parties understand that the Integration Joint Board, while having legal personality in its own right, has neither replaced nor assumed the rights or responsibilities of either the Health Board or the Council as the employers of the staff delivering integrated services; or for the operation of buildings or services under the operational remit of those staff.

15.2 The Parties will continue to indemnify, insure and accept responsibility for the staff that they each employ; their particular capital assets that integrated services are delivered from or with; and the respective services themselves that each Party has delegated to the Integration Joint Board.

15.3 Liabilities arising from decisions taken by the Integration Joint Board will be equally shared between the Parties.

16. Risk Management

16.1 The Parties along with the other local authorities in the Health Board area have developed a model risk management policy and strategy to support integrated service delivery (except for NHS acute hospital services). This will be available to the Integration Joint Board at its first meeting; and the Integration Joint Board will be consulted in any reviews of the Policy and Strategy.

16.2 The Chief Officer will be responsible for ensuring that suitable and effective arrangements are in place to manage the risks relating to the integrated services within the scope of the Integration Joint Board. The Parties will provide the Chief Officer and the Integration Joint Board with relevant specialist advice and support (including internal audit, clinical and non-clinical risk managers, and health and safety advisers).

16.3 The Chief Officer will work with the Parties to jointly prepare an annual strategic risk register that will identify, assess and prioritise risks related to the preparation and delivery of the Strategic Plan; and identify and describe processes for mitigating those risks. This process will also take due cognisance of the overall corporate risk registers of both Parties. The first strategic risk register will be prepared within the first year of operation of the Integration Joint Board.

16.4 Strategic risk registers will be presented to the Integration Joint Board for approval on an annual basis. The Parties agree that the Health Board's Director of Finance and the Council's Section 95 Officer will ensure that the Integration Joint Board is provided with the necessary technical and corporate support to develop, maintain and scrutinise strategic risk registers.

16.5 The Chief Officer is responsible for drawing to the attention of the Integration Joint Board and the Parties any substantive developments in-year that lead to a substantial change to the strategic risk register in-year. The Chief Officer will formally review the risk register on a six monthly basis.

16.6 The Chief Officer will ensure that the approved strategic risk register is provided to both of the Parties to enable them to take account of its content as part of their overall risk management arrangements. Both Parties agree to share their corporate risk registers with the Integration Joint Board on an annual basis.

17. Dispute Resolution Mechanism

17.1 The Parties aim to continue to adopt a collaborative approach to the integration of health and social care.

17.2 The Parties will use their best endeavours to quickly resolve any areas of disagreement. Where any disputes do arise that require escalation to the Chief Executives of the respective organisations, those officers will attempt to resolve matters in an amicable fashion and in the spirit of mutual cooperation.

17.3 In the unlikely event that the Parties do not reach agreement, then:

- The Chief Executives of the Health Board and the Council will meet to resolve the issue.
- If unresolved, the Health Board and the Council will each prepare a written note of their position on the issue and exchange it with the others.
- The Leader of the Council, Chair of the Health Board and the Chief Executives of the Health Board and the Council will then meet to resolve the issue.
- In the event that the issue remains unresolved, representatives of the Health Board and the Council will proceed to mediation with a view to resolving the issue. The process for appointing the mediator will be agreed between the Chair of the Health Board and Leader of the Council.

17.4 Where the issue remains unresolved after following the processes outlined in section 17.3 above, the Chief Executives of the Health Board and the Council will jointly and formally notify Scottish Ministers in writing of the issues and be bound by their determination.

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 to the Act

Column A	*Column B*
	(Health Boards); and functions conferred by— The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 The Health Boards (Membership and Procedure) (Scotland) 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

Column A	*Column B*
	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 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:
  - General medicine.
  - Geriatric medicine.
  - Rehabilitation medicine.
  - Respiratory medicine.
  - Psychiatry of learning disability.
- 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 services.
- School Nursing.
- Speech and Language Therapy.
- Specialist Health Improvement.
- Community Children's Services.
- Child and Adolescent Mental Health Services
- 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 Local Authority to the Integration Joint Board

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
Schedule 1 – Functions Which Must Be Delegated	
National Assistance Act 1948 Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958 Section 3 (Provision of sheltered employment by local authorities)	
The 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 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.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
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.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
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 have been delegated.
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.
The 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.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 39 (Matters which may be managed.)	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
The Housing (Scotland) Act 2001	
Section 92 (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002	
Section 4 (Accommodation more expensive than usually provided)	
Section 5 (Local authority arrangements for residential accommodation outwith Scotland.)	
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.

Column A *Enactment conferring function*	*Column B* *Limitation*
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.)	
The Housing (Scotland) Act 2006	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The 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 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
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.)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 7 (Choice of options: adult carers.)	
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.)	

Schedule 2 – Additional Functions To Be Delegated On A Discretionary Basis

National Assistance Act 1948

Section 45
(Recovery in cases of misrepresentation or non-disclosure)

Matrimonial Proceedings (Children) Act 1958

Section 11
(Reports as to arrangements for future care and upbringing of children)

Social Work (Scotland) Act 1968

Section 5
(Powers of Secretary of State).

Section 6B
(Local authority inquiries into matters affecting children)

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)

Section 78A
(Recovery of contributions).

Section 80
(Enforcement of duty to make contributions.)

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 81 (Provisions as to decrees for aliment)	
Section 83 (Variation of trusts)	
Section 86 (Adjustments between authority providing accommodation etc., and authority of area of residence)	
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)	
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)	
Section 9 (Power to impose requirements as to the keeping of	

Column A *Enactment conferring function*	*Column B* *Limitation*
foster children)	
Section 10 (Power to prohibit the keeping of foster children)	
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	

Column A *Enactment conferring function*	*Column B* *Limitation*
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 40 (Supervisory bodies)	
Community Care and Health (Scotland) Act 2002 Section 6 (Deferred payment of accommodation costs)	
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)	

Column A *Enactment conferring function*	*Column B* *Limitation*
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 plan)	
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 allowances schemes)	
Section 80 (Permanence orders)	
Section 90 (Precedence of court orders and supervision requirements over order)	
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 7 (Visits)	
Section 8 (Interviews)	

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 9 (Medical examinations)	
Section 10 (Examination of records etc)	
Section 16 (Right to move adult at risk)	
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: regulations)	
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*	

Column A *Enactment conferring function*	*Column B* *Limitation*
section 183)	
Social Care (Self- Directed Support)(Scotland) Act 2013 Section 8 (Choice of options: children and family members) Section 10 (Provision of information: children under 16)	

Part 2: Services delegated by the Council 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.
- The legislative minimum delegation of housing support, including aids and adaptations.
- Day services.
- Local area co-ordination.
- Self-Directed Support.
- Occupational therapy services.
- Re-ablement services, equipment and telecare.
- Residential and non-residential care charging.
- Respite provision for adults and young people.
- Social work services for children and young people:
    - Child Care Assessment and Care Management.
    - Looked After and Accommodated Children.
    - Child Protection.
    - Adoption and Fostering.
    - Child Care.
    - Special Needs/Additional Support.
    - Early intervention.
    - Throughcare Services.
- Social work criminal justice services, including Youth Justice Services.

Annex 3: Hosted Service Arrangement

The Parties will recommend to the Greater Glasgow and Clyde Integration Joint Boards that the Services listed in below are managed by one Integration Joint Board as Lead Partnership on behalf of the other Integration Joint Boards.

Where an Integration Joint Board is also the Lead Partnership in relation to a hosted service listed below, the Parties will recommend that:

a) It is responsible for the operational oversight of such service(s).

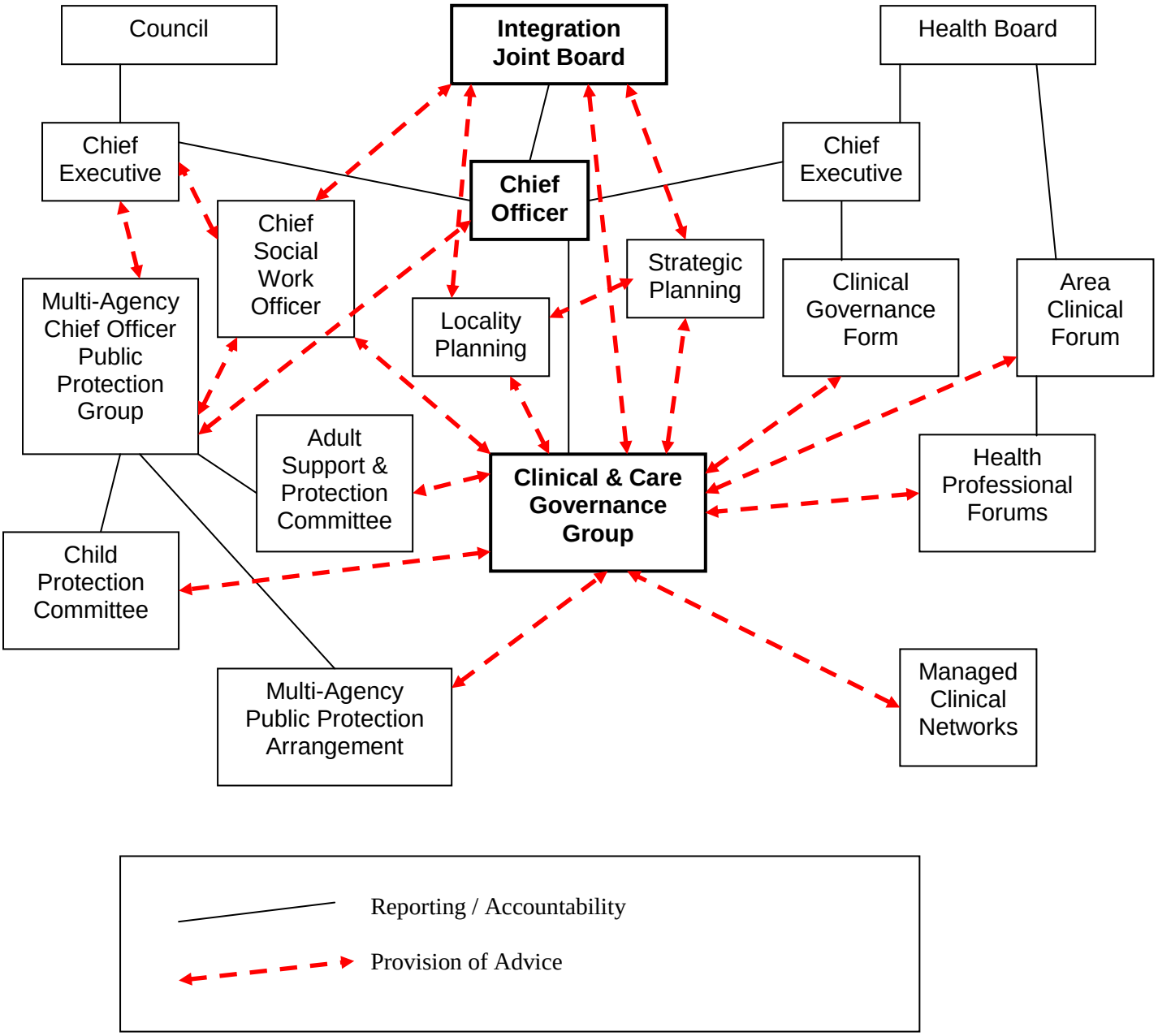
b) Through its Chief Officer will be responsible for the operational management on behalf of all the Integration Joint Boards.

c) 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

Out of hours services require to be delegated. Integrated Joint Boards will be asked to agree that the Renfrewshire Integration Joint Board will act as host for strategic planning of these services with delivery on behalf of all Integrated Joint Boards by the Acute Division of the Health Board.

Annex 4: Clinical & Care Governance – Primary Supports and Relationships



WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1st July 2015

Subject: Strategic Plan 2015/16

1. Purpose

1.1 To present the Partnership Board with the first Strategic Plan for the West Dunbartonshire Health & Social Care Partnership.

2. Recommendation

2.1 The Partnership Board is recommended to approve Strategic Plan, and thereby enabling the full delegation of responsibilities and resources to the Partnership Board.

3. Background

3.1 Public Bodies (Joint Working) (Scotland) Act 2014 that in order for responsibilities and resources to be formally delegated in practice to an integration joint board, a local Strategic Plan must first be prepared and approved by it.

3.2 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.

3.3 At its February 2015 meeting, the Shadow Integration Joint Board for West Dunbartonshire approved the formal commencement of the preparation of a Strategic Plan for consideration and approval at the first meeting of the new Health & Social Care Partnership Board.

3.4 The completed Strategic Plan for 2015/16 is appended for consideration and approval.

4. Main Issues

4.1 As the Shadow IJB is aware, West Dunbartonshire is one of the few areas of Scotland that has already had in place:

- An integrated strategic planning process, which has produced integrated Strategic Plans across the duration of the previous Community Health & Care Partnership.
- Locality arrangements, one for the Clydebank area and one for the Dumbarton and Alexandria area.
- Constructive and routine collaboration with stakeholders as part of the local Community Planning Partnership to develop services that meet the needs of local people and support local Single Outcome Agreement priorities.

4.2 As endorsed at the February 2015 meeting of the Shadow Integration Joint Board's this Strategic Plan:

- Is predominantly and logically based on the previously approved actions and targets for 2015/16, including incorporating the local Integrated Care Fund Plan and local Integrated Children's Services Plan.
- Details refreshed locality arrangements that build upon the arrangements that the previous Community Health & Care Partnership had developed within Clydebank and Dumbarton and Alexandria.

4.3 It is important to note that the Key Performance indicators included relate to a combination of routine service activity and developmental initiatives; and delivery that is predominantly under the direct management of the HSCP as well as outcomes that are heavily influenced by the practice and contributions of other stakeholders (e.g. other council departments; other NHSGGC divisions; or NHS external contractors). It is also important to note that there is not a necessarily direct correlation between specific actions for delivery set out within the Strategic Plan and each of the indicators included, as the actions here deliberately represent high-level commitments.

4.4 In accordance with good practice and building on the learning of the previous Community Health & Care Partnership, the Strategic Plan's Key Performance Indicators also includes those indicators within the local Single Outcomes Agreement that the HSCP has lead responsibility for.

4.5 Building on the learning from the previous Community Health & Care Partnership, a consolidated performance report in relation to the commitments within the Strategic Plan will be routinely provided to the Partnership Board.

4.6 As per the recommendations of Audit Scotland and evidenced by the consistently positive response to the performance reporting by the former Community Health & Care Partnership Committee, this streamlined and best practice system will continue to mitigate against unnecessary duplication of and piecemeal reporting and ensure that the Partnership Board is able to transparently draw conclusions based on a coherent and comprehensive presentation of data and information.

5. People Implications

5.1 The Workforce Section of the Strategic Plan 2014/15 summarises the key issues and priorities.

5.2 The Strategic Plan confirms that a Workforce and Organisational Development Strategy in relation to staff delivering integrated services (except for NHS acute hospitals services) will be completed during 2015/16 and presented to the Partnership Board for endorsement at a future meeting before 31st March 2016.

6. Financial Implications

6.1 The Finance Section of the Strategic Plan 2015/16 summarises the financial context and the resources being delegated to the Partnership Board.

6.2 Based on prevalence data and analysis of service usage, it is likely that the current level of demand for services is going to increase over the coming years. This is also going to be accompanied by further changes in the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately West Dunbartonshire has had the benefit of a strong local track record for improvement, across health and social care services, which have been integrated since 2010; and as such provide a solid foundation for the further developments necessary for the new HSCP through 2015/16 and beyond.

7. Professional Implications

7.1 This Strategic Plan has benefitted from the comments and contributions of the professional advisors that had been identified for recommendation to the Partnership Board at the time of its preparation. More broadly, the perspectives and commitments of a broader range of professionals are reflected as per the process summarised in Section 11 of this report.

8. Locality Implications

8.1 In developing this Strategic Plan, comments and contributions were invited from the existing locality groups within West Dunbartonshire – these have informed the final document.

8.2 The Strategic Plan 2015/16 details refreshed locality arrangements that build upon the arrangements that the previous Community Health & Care Partnership had developed within Clydebank; and Dumbarton and Alexandria.

8.3 A locality core group will be established for each of the two localities, with a locality network group structure where the representatives on the core group involve the wider networks, teams or services in locality programmes and specifically through an annual planning meeting. Additional links with wider community planning partnership services and mechanisms will also be available to support locality work as and when required.

8.4 The locality arrangements detailed within the Strategic Plan have been subject to a dedicated engagement process, been positively received and further refined in response to constructive feedback.

9. Risk Analysis

9.1 The full delegation of responsibilities and resources to the Partnership Board can only legally occur once it has approved a Strategic Plan.

9.2 The deliverance of this Strategic Plan represents a commitment on the part of all involved to establishing the new HSCP in an orderly fashion that emphasises continuity – and minimises potential disruption or uncertainty –

for staff and service users; and that prioritizes continuous quality improvement of services for the benefit of the local communities of West Dunbartonshire.

10. Impact Assessments

10.1 An Equalities Impact Assessment and a Strategic Environmental Assessment Pre-Screening have been completed for the attached Strategic Plan, with no negative impacts identified.

10.2 The Strategic Plan includes a specific section concerning Equalities and the approach proposed to address pertinent requirements of legislation.

11. Consultation

11.1 The Act requires that the stakeholder constituencies invited to contribute to the development of the Strategic Plan 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.

11.2 The preparation of the Strategic Plan has reflected the on-going, participative and community planning approach that the previous Community Health & Care Partnership ensured informed the development of its previous Strategic Plans. This has included the considerable engagement that already shaped both the approved local Integrated Care Fund Plan; and the approved local Integrated Children's Services Plan. The membership of the delivery and improvement groups in place to take forward both of those key local plans incorporates all of the statutory stakeholder consultees above; and so have formed the basis for a virtual strategic planning group with whom the HSCP will engage on an on-going basis in relation to this Strategic Plan.

12. Strategic Assessment

12.1 The Strategic 2015/16 forms the basis against which the all other items of Partnership Board business will be subsequently assessed.

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West Dunbartonshire Health & Social Care Partnership.

Date: 24th June 2015

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Appendices: West Dunbartonshire Health & Social Care Partnership Strategic Plan 2015/16

Background Papers: West Dunbartonshire Shadow Integration Joint Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015)

West Dunbartonshire Shadow Integration Joint Board: West Dunbartonshire Integrated Care Fund Plan 2015/16 (November 2014)

West Dunbartonshire Community Health & Care Partnership Committee: Community Planning West Dunbartonshire - Integrated Children's Services Plan 2014 – 17 (November 2014)

Wards Affected: All

West Dunbartonshire
Health & Social Care Partnership

STRATEGIC PLAN

2015-16

CONTENTS

ACKNOWLEDGEMENTS

The Chief Officer and the Senior Management Team would like to thank everyone who contributed to the development of this Strategic Plan; and all those staff and colleagues who continue to work so hard to deliver high quality services to the communities of West Dunbartonshire.

Please send any feedback on this Strategic Plan to:

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INTRODUCTION

The Scottish Government's Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. In December 2013, the Council and the Health Board formally agreed to transition their Community Health and Care Partnership to a Shadow Health and Social Care Partnership; and for its Community Health & Care Partnership Committee to assume the role of Shadow Integration Joint Board. This decision enabled both the Council and the Health Board to jointly develop, constructively consult with stakeholders and then agree the arrangements for joint working as required by the Act, building on the effective integrated arrangements that had already been successfully developed locally; and reflecting on the considerable learning and insights that accrued in doing so.

The approved integration scheme for West Dunbartonshire details the 'body corporate' arrangement by which the Health Board and the Council have agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire is known as the *West Dunbartonshire Health & Social Care Partnership Board*.

The West Dunbartonshire Health & Social Care Partnership Board's:

- **Mission is to improve the health and wellbeing of West Dunbartonshire residents.**
- **Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.**
- **Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.**

Appendix 1 lists the health and social care services delegated by the Health Board and Council to the Health & Social Care Partnership Board. The purpose of this Year One Strategic Plan is to set out how the Health & Social Care Partnership Board will begin to use its allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Act, namely that:

- 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 and efficiently in the provision of health and social care services.

Given that children and families health and social care services and criminal justice social work services have also been delegated to the Health & Social Care Partnership Board the specific National Outcomes for Children and Criminal Justice will also be addressed here, i.e.:

- Our children have the best possible start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.
- Community safety and public protection.
- The reduction of re-offending through implementation of the Whole Systems Approach to youth offending.
- Social inclusion and interventions to support desistance from offending.

The Health & Social Care Partnership Board is responsible for the operational oversight of *West Dunbartonshire Health & Social Care Partnership* (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS acute hospital services); and through the Chief Officer, who is responsible for the operational management of the Health & Social Care Partnership. These arrangements for integrated service delivery will be

conducted within an operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both organisations can continue to discharge their governance responsibilities. The management of NHS acute hospital services is retained within the Health Board. In addition to local services provided for and with the residents of West Dunbartonshire, WD HSCP has formal responsibilities for a number of wider geographic functions:

- NHSGGC Eye Care Service.
- NHSGGC Musculoskeletal Physiotherapy Service.
- Management of Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership.

In keeping with the spirit of the participative approach of the previous Community Health and Care Partnership, this Strategic Plan has been informed by an understanding of perspectives of the strategic planning stakeholders specified by the Act (including staff side representation and the two localities identified within West Dunbartonshire) and from on-going engagement through the year with our citizens and service users, reflecting the cyclical commissioning process for the review of services. The specific local actions set out reflect on-going self-evaluation processes within the HSCP service areas; engagement within local Community Planning Partnership fora; and dialogue with both service user groups and the wider communities in West Dunbartonshire. It is underpinned by an appreciation of local health and social care needs (e.g. the area's health and wellbeing profile); and other relevant sources of evidence.

The delivery of this Strategic Plan represents a commitment on the part of all involved to establishing the new WD HSCP in an orderly fashion that emphasises continuity – and minimises potential disruption or uncertainty – for service users and staff; and that prioritises continuous quality improvement of services for the benefit of the local communities of West Dunbartonshire.

Keith Redpath
Chief Officer

STRATEGIC NEEDS ASSESSMENT

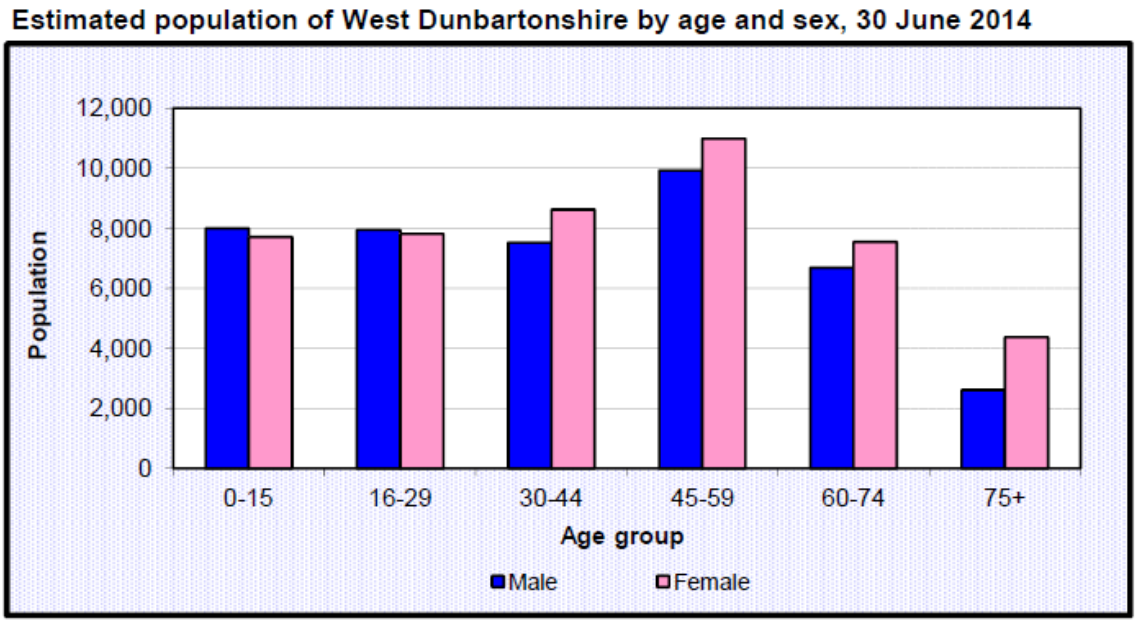
West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. According to the National Records for Scotland, the 2014 population for West Dunbartonshire is 89,730; a decrease of 0.1 per cent from 89,810 in 2013. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland.

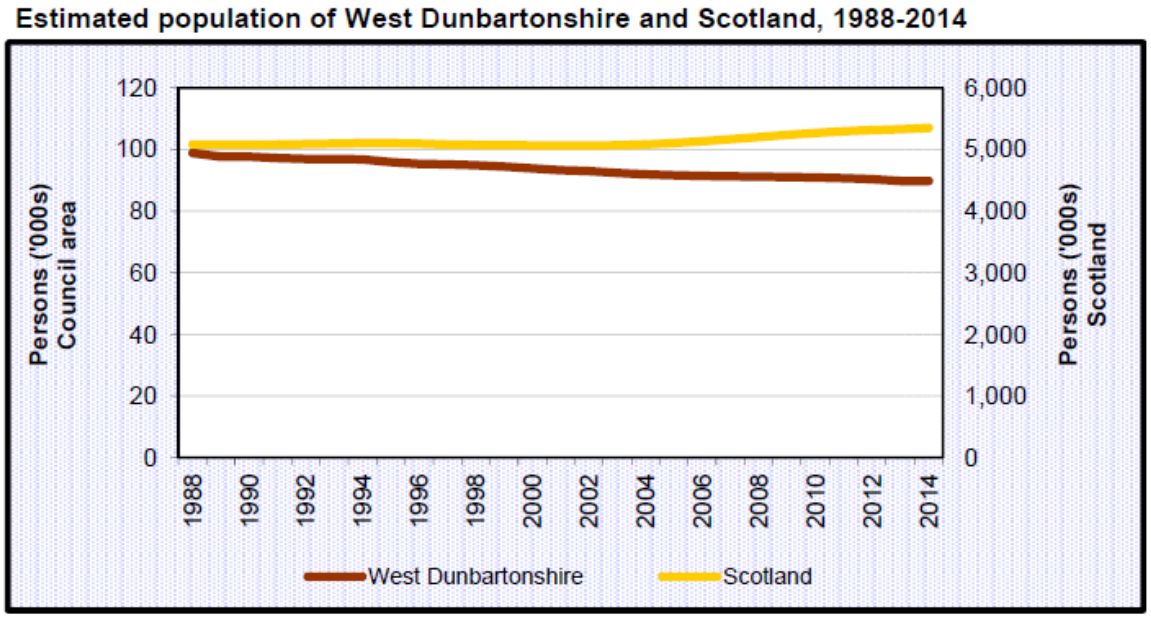
Age group	Male pop. West Dunbartonshire	Female pop. West Dunbartonshire	Total pop. of West Dunbartonshire	% of total pop. of West Dunbartonshire
0-15	8,001	7,702	15,703	17.5%
16-29	7,943	7,814	15,757	17.6%
30-44	7,527	8,623	16,150	18.0%
45-59	9,931	10,984	20,915	23.3%
60-74	6,679	7,540	14,219	15.8%
75+	2,615	4,371	6,986	7.8%
All ages	42,696	47,034	89,730	100.0%

Age group	Male pop. Scotland	Female pop. Scotland	Total pop. of Scotland	% of total pop. of Scotland
0-15	465,869	445,413	911,282	17.0%
16-29	488,533	487,504	976,037	18.3%
30-44	497,779	521,523	1,019,302	19.1%
45-59	563,177	593,612	1,156,789	21.6%
60-74	407,894	443,061	850,955	15.9%
75+	173,132	260,103	433,235	8.1%
All ages	2,596,384	2,751,216	5,347,600	100.0%

In West Dunbartonshire, 17.6 per cent of the population are aged 16 to 29 years. This is smaller than Scotland where 18.3 per cent are aged 16 to 29 years. Persons aged 60 and over make up 23.6 per cent of West Dunbartonshire. This is smaller than Scotland where 24.0 per cent are aged 60 and over.

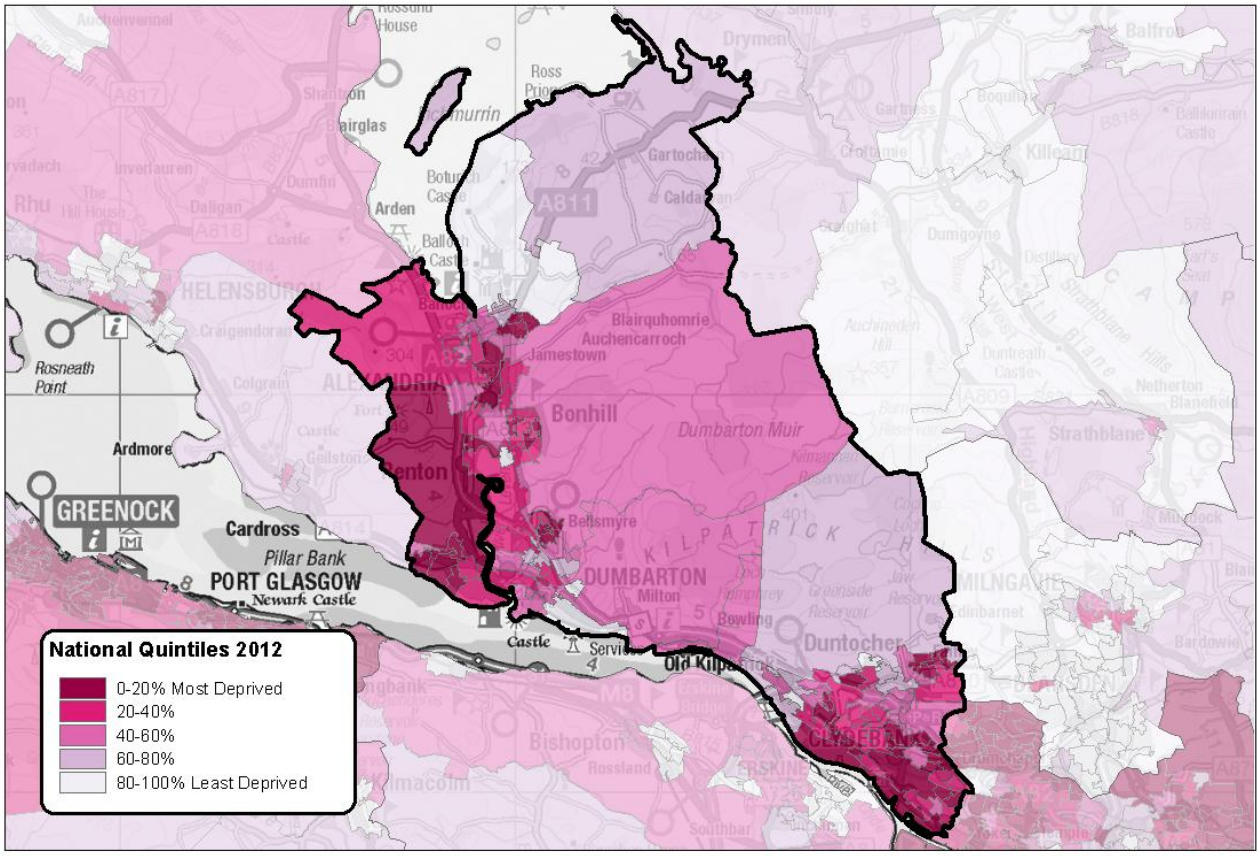
National and local evidence indicates that the population of West Dunbartonshire is ageing due to a combination of factors: that the number of births within the area is dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling.



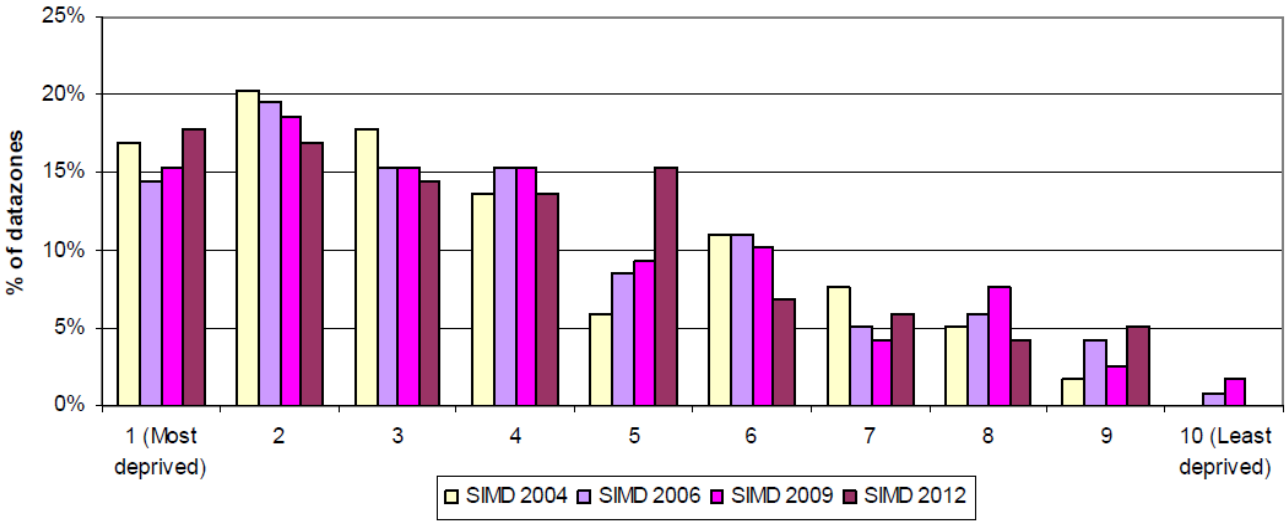


Since 1988, West Dunbartonshire's total population has fallen overall. Scotland's population has risen over this period.

The map below shows the levels of deprivation in West Dunbartonshire based on the most recent Scottish Index of Multiple Deprivation (SIMD 2012) published on 18 December 2012.



The decile graph below shows what percentage of West Dunbartonshire's datazones are found in each of the SIMD deciles.



Most of West Dunbartonshire's datazones are found in the more deprived deciles in SIMD 2012. This is similar to the pattern observed for SIMD 2009.

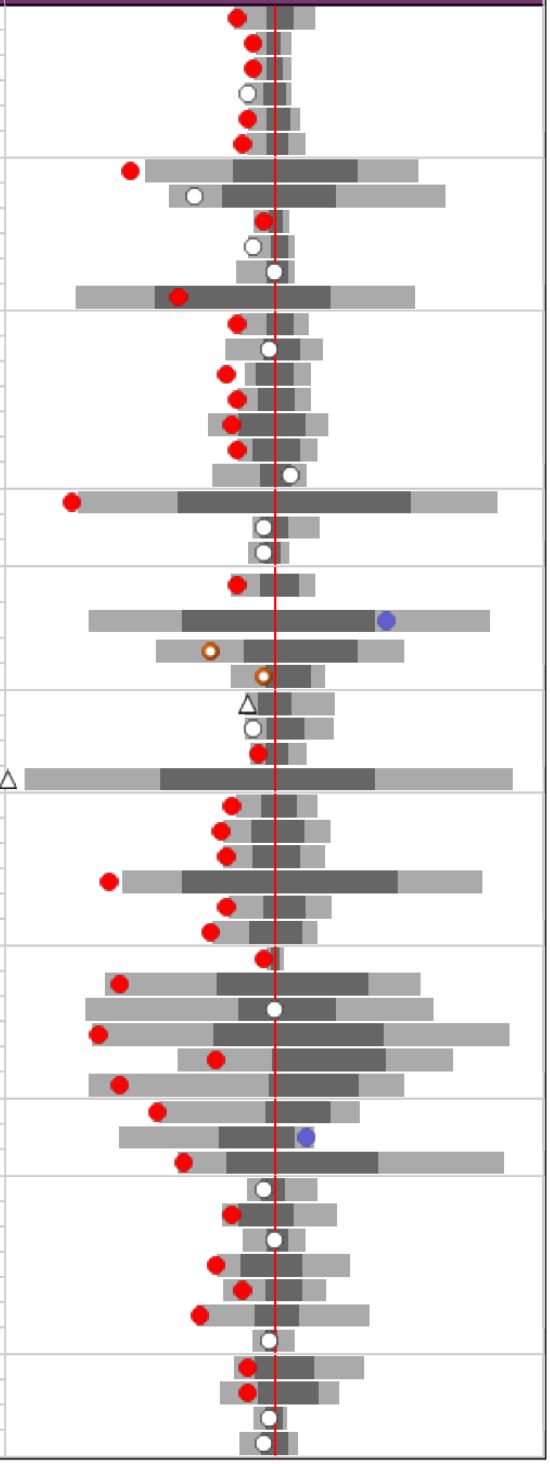
The most recent Health & Wellbeing Profile for West Dunbartonshire is summarised below.

ScotPHO
Period: 2013

Health & Wellbeing Profiles (West Dunbartonshire)

Printed Date: 11-JUN-2015 15:09

Domain		Indicator	Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Male life expectancy [18]	2011	n/a	74.1	yrs	76.6
	2	Female life expectancy [18]	2011	n/a	78.7	yrs	80.8
	3	Deaths all ages [12]	2012	1,060	1,387.4	sr4	1,187.5
	4	All-cause mortality among the 15-44 year olds. [12]	2012	45	141.0	sr4	105.3
	5	Early deaths from CHD (<75) [12]	2012	62	81.9	sr4	60.7
	6	Early deaths from cancer (<75) [12]	2012	162	212.7	sr4	173.4
Behaviours	7	Estimated smoking attributable deaths [3,13,16]	2012	184	413.2	sr4	325.9
	8	Smoking prevalence (adults 16+) [3,14]	2013	142	27.0	%	23.0
	9	Alcohol-related hospital stays [15]	2013	832	975.9	sr4	704.8
	10	Deaths from alcohol conditions [17]	2011	29	32.8	sr4	23.8
	11	Drug-related hospital stays [12,15]	2012	99	113.9	sr4	116.6
	12	Active travel to work [3,14]	2013	23	11.0	%	16.0
Ill Health & Injury	13	Patients registered with cancer [12]	2012	575	714.7	sr4	634.1
	14	Patients hospitalised with chronic obstructive pulmonary disease (COPD) [12,15]	2012	572	705.8	sr4	659.9
	15	Patients hospitalised with coronary heart disease [12]	2012	445	553.8	sr4	440.3
	16	Patients hospitalised with asthma [12]	2012	108	116.8	sr4	91.2
	17	Patients with emergency hospitalisations [12]	2012	7,438	8,653.4	sr4	7,500.2
	18	Patients (65+) with multiple emergency hospitalisations [12]	2012	904	6,142.6	sr4	5,159.5
	19	Road traffic accident casualties [12]	2012	47	53.3	sr4	63.2
Mental Health	20	Population prescribed drugs for anxiety/depression/psychosis [3]	2013	17,783	19.8	%	17.0
	21	Patients with a psychiatric hospitalisation [12]	2012	278	322.0	sr4	291.6
	22	Deaths from suicide [17]	2011	15	16.4	sr4	14.5
Social Care & Housing	23	Adults claiming incapacity benefit/severe disability allowance/ employment and support allowance	2013	6,085	6.8	%	5.1
	24	People aged 65 and over with high levels of care needs who are cared for at home [3]	2013	399	40.7	%	34.7
	25	Children looked after by local authority [3]	2013	347	18.3	cr2	14.4
	26	Single adult dwellings	2013	17,439	38.9	%	37.7
Education	27	Average tariff score of all pupils on the S4 roll [13]	2012	n/a	182.0	mean	193.0
	28	Primary school attendance	2010	6,227	94.4	%	94.8
	29	Secondary school attendance	2010	5,075	90.1	%	91.1
	30	Working age adults with low or no educational qualifications [3]	2013	10,500	18.6	%	12.6
Economy	31	Population income deprived	2013	17,310	19.3	%	13.2
	32	Working age population employment deprived	2013	10,165	17.4	%	12.2
	33	Working age population claiming Out of Work benefits	2013	10,985	18.8	%	13.0
	34	Young people not in employment, education or training (NEET). [3]	2013	460	10.6	%	7.8
	35	Children Living in Poverty	2012	4,645	22.8	%	15.3
	36	People claiming pension credits (aged 60+)	2013	2,490	11.9	%	7.7
Crime	37	Crime rate	2013	5,208	58.0	cr2	40.5
	38	Prisoner population [3,13]	2012	199	273.5	sr4	171.2
	39	Referrals to Children's Reporter for violence-related offences [3]	2013	16	2.1	cr2	2.1
	40	Domestic Abuse [3]	2012	1,518	168.0	cr9	113.1
	41	Violent crimes recorded [3]	2013	139	15.5	cr9	12.7
	42	Drug crimes recorded [3]	2013	1,090	121.4	cr9	66.9
Environment	43	Population within 500 metres of a derelict site	2013	54,800	60.7	%	29.7
	44	People living in 15% most 'access deprived' areas	2013	5,034	5.6	%	15.0
	45	Adults rating neighbourhood as 'a very good place to live' [3,14]	2013	n/a	45.0	%	55.0
Women's & Children's Health	46	Teenage pregnancies [12]	2011	136	49.2	cr2	44.6
	47	Mothers smoking during pregnancy [12]	2012	244	24.9	%	20.0
	48	Low birth weight [12]	2012	19	2.0	%	2.0
	49	Babies exclusively breastfed at 6-8 weeks [12]	2012	144	15.0	%	26.5
	50	Child dental health in primary 1	2013	597	61.1	%	66.7
	51	Child dental health in primary 7	2013	269	32.9	%	47.7
	52	Child obesity in primary 1	2013	108	11.3	%	10.1
Immunisations and Screening	53	Breast screening uptake [12]	2011	2,799	69.3	%	72.5
	54	Bowel screening uptake [12]	2011	7,543	51.8	%	55.1
	55	Immunisation uptake at 24 months - 5 in 1 [12]	2013	1,030	97.9	%	98.2
	56	Immunisation uptake at 24 months - MMR [12]	2013	995	94.6	%	95.3



Notes:

3. Data available down to council (local authority) area only.
12. Three-year average number, and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis; please see the technical report for more information.
16. Two-year average number, and 2-year average annual measure
17. Five-year average number, and 5-year average annual measure
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies

Spine Chart Key:

% =percent
cr2 =crude rate per 1,000 population
cr9 =crude rate per 10,000 population
mean=average
sr4 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.
yrs =years

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

The following tables show at a selection of high level indicators for the previous Community Health & Care Partnership to provide an overview of demand and performance.

Indicator	2013/14	2014/15	
	Value	Value	Target
Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	33.15	33.15	33.15
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review	76.1%	76.1%	75%
Balance of Care for looked after children: % of children being looked after in the Community	89%	89.8%	89%
Number of children with mental health issues (looked after away from home) provided with support	50	64	23
Number of children with or affected by disability participating in sports and leisure activities	175	143	172
Percentage of child protection investigations to case conference within 21 days	80.2%	94.5%	95%
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%	100%
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	98%	98%	98%
Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	92.6%	92.2%	90%
PCMHT average waiting times from referral to first assessment appointment (Days)	28	16	14
Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013	2	0	0
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	5	1	0

Indicator	2013/14	2014/15	
	Value	Value	Target
Average waiting times in weeks for musculoskeletal physiotherapy services	9	16	9
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95%	95%	91.5%
Number of patients in anticipatory care programmes	1,024	1,645	1,200
Percentage of identified patients dying in hospital for cancer deaths	27%	29%	35%
Percentage of identified patients dying in hospital for non-cancer deaths	49.6%	38%	40%
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	41%	39.2%	40%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%	100%	100%
Crude rate of people aged 75+ in receipt of Telecare per 100,000	22,666	23,994	22,410
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	51%	55%	55%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98.2%	98%	96%
Number of patients on dementia register	613	638	672
Total number of homecare hours provided as a rate per 1,000 aged 65+	642.3	590.5	695
Percentage of homecare clients aged 65+ receiving personal care	82.7%	93%	82%
Percentage of people aged 65 and over who receive 20 or more interventions per week	51.3%	31%	45%
Percentage of people aged 65 or over with intensive needs receiving care at home	40.71%	40.2%	51%
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	87%	86%
Number of carers of people aged 65+ known to CHCP	1,348	1,446	1,680

The following tables show at a high level, a comparative snapshot of the different (former) CH(C)P areas demand for and impact on Acute Services, in particular delayed discharges , emergency attendances and admissions (noting that the time periods are different than for the previous table).

Crude rate of new A&E attendances per 100,000 against the agreed local targets

	Apr 14 - Mar 15	2014-15 Target	Variance %
East Dunbartonshire CHP	1589	2888	-45.0%
East Renfrewshire CHCP	1896	2888	-34.3%
Glasgow City CHP	2784	2888	-3.6%
Inverclyde CHCP	3066	2888	+6.2%
Renfrewshire CHP	2787	2888	-3.5%
West Dunbartonshire CHCP	1815	2908	-37.6%

Relative number of Emergency Admissions aged 65+ per 1,000 (Apr 14 - Mar 15)

	Rate of unplanned admissions per 1,000
East Dunbartonshire CHP	248
East Renfrewshire CHCP	225
Glasgow City CHP	315
Inverclyde CHCP	313
Renfrewshire CHP	305
West Dunbartonshire CHCP	282

Relative percentage of GP referrals to A&E

	Apr 14 – Mar 15
East Dunbartonshire CHP	10.0%
East Renfrewshire CHCP	13.8%
Glasgow City CHP	10.0%
Inverclyde CHCP	6.8%
Renfrewshire CHP	6.8%
West Dunbartonshire CHCP	9.7%

Comparative rate of acute bed days lost to delayed discharges (inc AWI)

	Apr 14 to Mar 15 Actual	Target	Variance %
East Dunbartonshire CHP	4,916	3,680	+33.6%
East Renfrewshire CHCP	2,896	2,415	+19.9%
Glasgow City CHP	38,152	26,555	+43.7%
Inverclyde CHCP	3,462	3,362	+3.0%
Renfrewshire CHP	5,325	8,104	-34.3%
West Dunbartonshire CHCP	5,802	3,819	+51.9%

Total number of individual patients - complex and non-complex - delayed across the year 2014

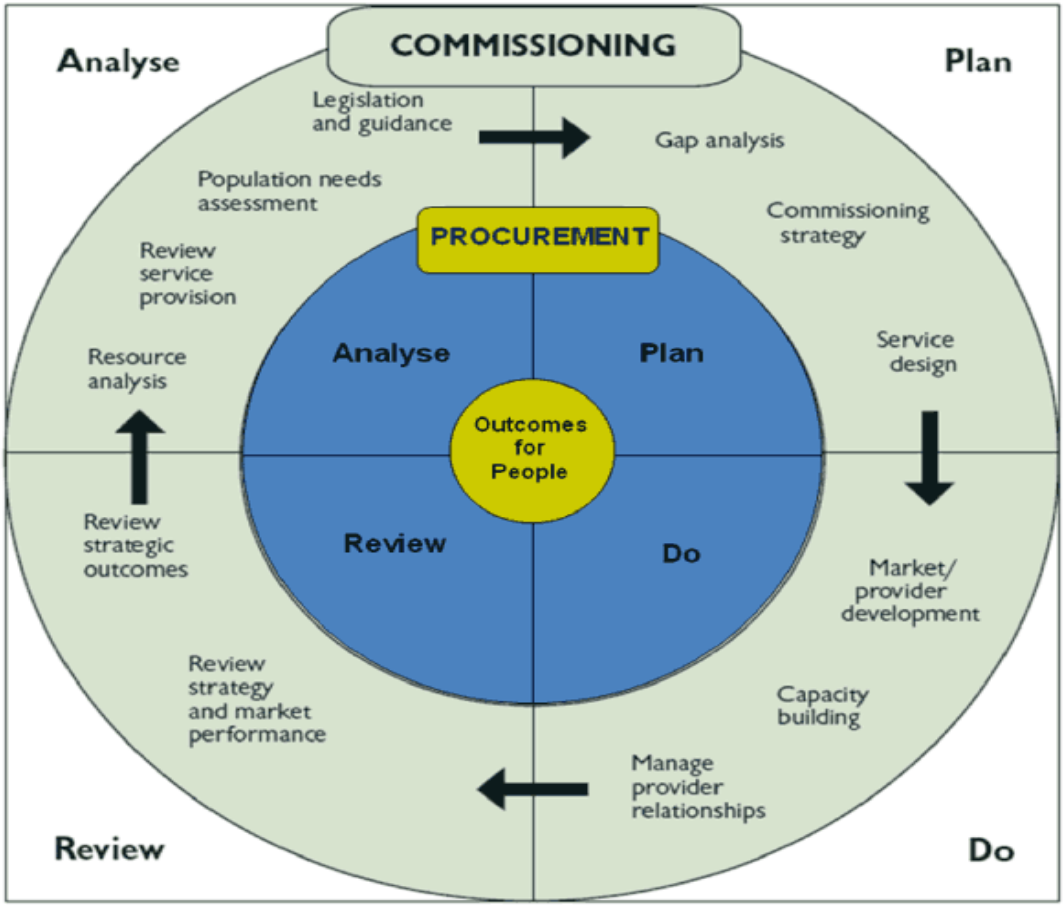
	Complex	Non Complex
East Dunbartonshire CHP	10	209
East Renfrewshire CHCP	1	167
Glasgow City CHP	70	1643
Inverclyde CHCP	2	195
Renfrewshire CHP	43	179
West Dunbartonshire CHCP	10	213

Relative rate of unplanned admission (Feb 14 - Jan 15)

	Total Population	No. of unplanned admissions	Rate of unplanned admissions per 100,000 population
East Dunbartonshire CHP	105,860	5379	5,081
East Renfrewshire CHCP	91,500	3827	4,182
Glasgow City CHP	596,550	26181	4,388
Inverclyde CHCP	80,310	4799	5,975
Renfrewshire CHP	173,900	9550	5,491
West Dunbartonshire CHCP	89,810	4328	4,819

STRATEGIC COMMISIONING CONTEXT

This Strategic Plan has been developed with regards to the strategic commissioning process advocated by Audit Scotland, and benefitting from on-going engagement with a full range of local stakeholders (including locality groups, the 3rd and independent sectors and communities).



West Dunbartonshire Council

West Dunbartonshire Council's mission is to lead and deliver high quality services which are responsive to the needs of local citizens, and realise the aspirations of our communities.
The Council's Strategic Plan 2012-17 identifies the following strategic priorities:

- Improve economic growth and employability.
- Improve life chances for children and young people.
- Improve care for and promote independence with older people.
- Improve local housing and environmentally sustainable infrastructure.
- Improve the wellbeing of communities and protect the welfare of vulnerable people.

The Council's Strategic Plan also stresses a commitment to assure success through:

- Strong financial governance and sustainable budget management.
- Fit-for-purpose estate and facilities.
- Innovative use of Information Technology.
- Committed and dynamic workforce.
- Constructive partnership working and joined-up service delivery.
- Positive dialogue with local citizens and communities.

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde's (NHSGGC) purpose is to deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.

The NHSGGC Corporate Plan for 2013-16 sets out five strategic priorities:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness.
- Tackling inequalities.

The Scottish Government's 2015-16 Local Delivery Plan (LDP) for the NHS has six priorities:

- Health inequalities and prevention.
- Antenatal and early years.
- Person-centred care.
- Safe care.
- Primary care.
- Integration.

The NHSGGC Health Board has agreed a Strategic Direction that establishes how it will progress its five corporate priorities alongside the LDPs six improvement priorities over 2015/16; and that provides a framework for the overall planning system including the initial strategic plans which are being developed by the six HSCPs within the GGC area (of which this Strategic Plan is one).

Community Planning West Dunbartonshire

The aim of the Community Planning West Dunbartonshire is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business here. Single Outcome Agreements (SOA) are the means by which the Community Planning Partnership agrees its strategic priorities for the local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

The 2014-17 SOA for West Dunbartonshire focuses on the following interconnected priorities:

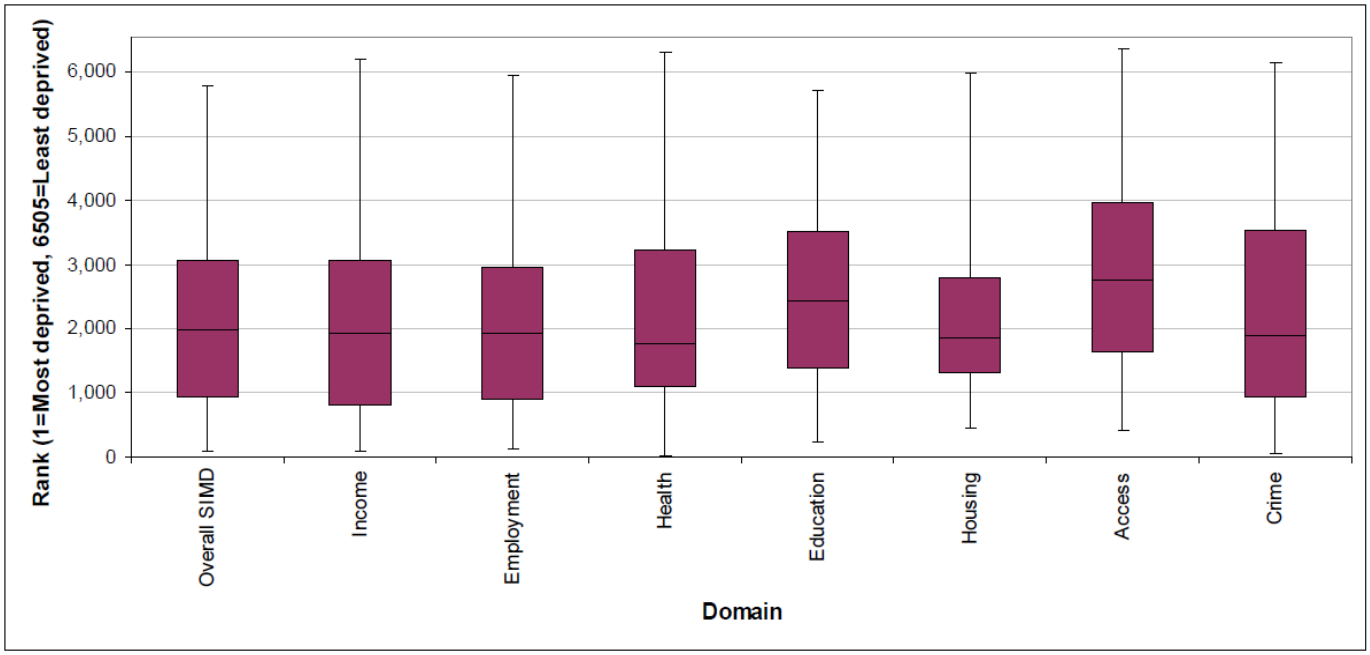
- Employability & Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

As a key partner within Community Planning West Dunbartonshire, the HSCP is committed to:

- Ensuring that community planning takes a streamlined approach to delivering outcomes.
- Demonstrating an appreciation that our priorities and outcomes are inter-connected.
- An emphasis on early intervention and prevention across all of our priorities.
- A commitment to pro-active and rigorous self-evaluation and scrutiny of activities across community planning partners as a driver for continuous improvement.

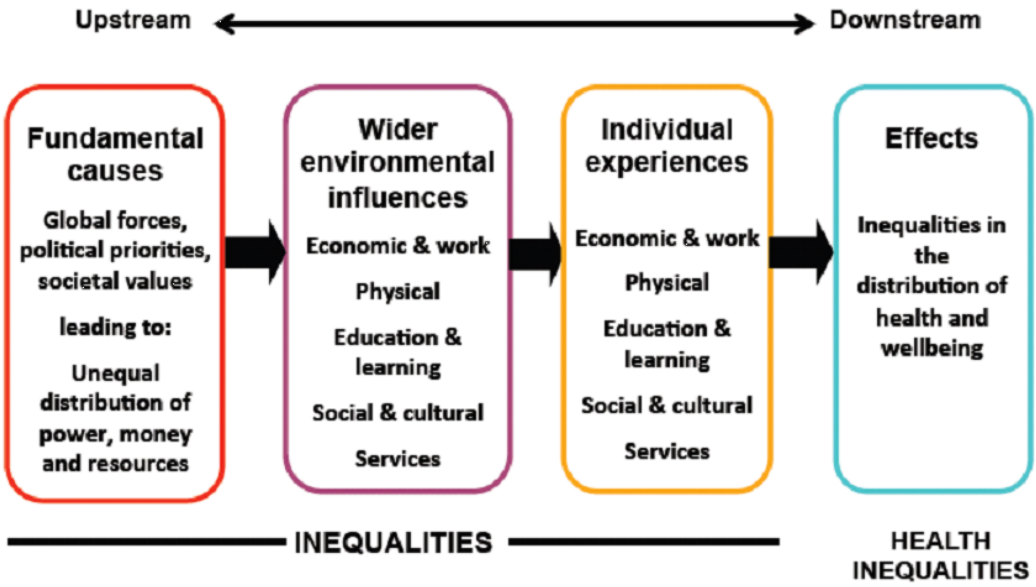
Inequalities

Within West Dunbartonshire – as is true across Scotland - there are significant differences in health, access, experience and outcomes of health care between different groups depending on their age, gender, race, disability, sexual orientation, income and social class. The box plot below summarises West Dunbartonshire's ranks in the overall SIMD 2012 and individual SIMD domains. Boxes show the middle 50% of values and the middle (median) value; whiskers show the minimum and maximum ranks.



The primary determinants of health are well recognised as being economic, social and environmental. One common definition of health inequalities is that they are those systematic and avoidable differences in health between population groups which result from the unequal distribution of resources within populations; and the associated accumulation and interaction of multiple risk factors. Health inequalities are an example of a wicked issue: i.e. one that by definition involves complex, messy and often intractable challenges; where the causes are complicated, ambiguous and often interconnected (as illustrated overleaf); and where there are no clear solutions. The highly regarded Marmot Review (Fair Society, Healthy Lives; 2010) argued that while traditional government policies have focused resources only on some segments of society, in order to improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient.

Figure 1: Health inequalities: theory of causation (summary version)



Within West Dunbartonshire we are formally committed to a determinants-based approach to health inequalities, with our local-term goal being to have tackled population-level health inequalities as a result of our having collectively addressed its root causes through the local Community Planning Partnership – by stimulating sustainable economic growth and employment; promoting educational attainment and aspiration; and supporting community cohesion and self-confidence. The HSCP will continue to provide clear leadership in championing this progressive and evidence-based approach to addressing health inequalities in a streamlined and integrated manner.

An effective and coherent suite of early years interventions is a key element of any serious attempt to tackle (health) inequalities – whilst avoiding placing unrealistic expectations on any given programme to address health inequalities in of itself (particularly in the short-to-medium term). Our Integrated Children's Services Plan expresses our collective commitment to the principles of early intervention and prevention as part of Getting It Right For Every Child (GIRFEC), i.e. that our children and young people are safe, healthy, active, nurtured, achieving, respected, responsible and included. Similarly, neighbourhood-level asset-based initiatives that promote community cohesion are (hopefully) part of a solution – but only if they are energised within a strategic, long-term and determinants-based effort across partners. A good example of this is the successful and award winning West Dunbartonshire Link Up initiative where older people, carers and local services are working jointly to help older people maintain their independence. This service was fostered by the CHCP and local CVS both in response to feedback from older people and their carers; and is an initiative the new HSCP will seek to continue to develop through 2015/16.

SERVICE COMMITMENTS 2015/16

Given that this is the first year of the HSCP and its inaugural Strategic Plan, the commitments set out here predominantly reflect a continuation of the work that was being progressed by the shadow HSCP, both in relation to the key targets identified and actions already approved for 20125/16 by the predecessor Shadow Integration Joint Board.

Adults & Older People

The emphasis of the HSCP current activity for adults and older people revolves around and relates to a range of overlapping and interconnected workstreams first delivered within the Older People's Change Fund Plan and now part of the approved local Integrated Care Fund Plan.

During 2015/16 the HSCP will work with partners to implement the local Integrated Care Fund Plan, delivering upon its key elements as follows:

<u>Anticipatory Care - Long Term Conditions and Frailty</u>

- Improve access to Health Improvement services and to lifestyle support services.
- Develop community based clinical support for patients with long term conditions.
- Develop a House of Care approach across community services linked to Acute Sector specialisms.
- Identify a cohort of clients/patients at high risk of admission or failure of care package and develop alternatives to admission.
- Plan rapid response and alternative choices on behalf of at risk clients.
- Improve coordination and ensure that information is updated and shared.
- Place anticipatory care plans and social care information on e-KIS which will be available to our integrated nursing and social care teams and to the Scottish Ambulance Service and Out of Hours services.
- Introduce Anticipatory Care Planning Nursing team, linked to Out of Hours services.

<u>Developing Services with the Independent Sector</u>

- Improved liaison with independent sector providers.
- Improved care for patients in all care settings.
- Development of capacity in line with changing demand.

- Introduce additional respite and rehabilitation options.

Developing Community Capacity

- Further develop the LinkUp service to streamline referrals from and between the 3rd and Independent sectors and provide access to non statutory provision.
- Develop a Social Prescribing model.
- Increase the number of volunteers including those representing health specific organisations.
- Maintain a dedicated helpline number manned by volunteers.
- Further develop a shared assessment process between key 3rd sector delivery partners.
- Support a shared staff development and training programme.
- Support carers through Carers of West Dunbartonshire and do this in partnership with West Dunbartonshire CVS.
- Identify and support more carers.
- Increase referrals for support by a further 25%.

Respite

- Will extend bureau model for older peoples respite services this to provide equivalent supports for younger adults with a requirement for respite.
- Reduce "failure" rate and costs.
- Increase the number of respite weeks provided by 20% and to maintain that level.
- Increase the level of self directed support for respite by 10%.
- Improve access to out of hours and short break respite.
- Improve access and support for carers.
- Provide respite at home.

Primary Care Dementia Service

- Link to supported discharge team to ensure successful transition.
- Support additional carers in collaboration with Carers of West Dunbartonshire.
- Avoid Admission to EMI and Acute Hospital beds particularly from care homes.
- Improve the health of carers.

Care at Home Provision and Reablement

- Support additional numbers of clients to live as independently as possible.

- Deliver reablement services for home care clients.
- Support more carers in West Dunbartonshire in collaboration with Carers of West Dunbartonshire.
- Increase support for younger adults with complex health conditions to manage their own care at home.
- Contribute to our Anticipatory Care Planning approach.
- Increase appropriate use of Telecare and Step Up, Step Down provision.
- Provide a focus for volunteer input.

Out of Hours Care

- Provide alternatives to admission.
- Provide Rapid Response Out of Hours.
- Develop Neighbourhood Services.
- Integrate Social Work and Health Out of Hours provision.

End of Life Care

- Each patient with Palliative Care needs is held on Palliative Care Register.
- Reduce the proportion of people within West Dunbartonshire known to be at the end of life, dying in hospital.
- Use Supportive and Palliative Action Register (SPAR) to provide a tool to aid the identification of cancer and non-cancer patients entering a palliative phase.
- Enhance training for care home and home care staff.
- Achieve a 20% decrease in the number of palliative care patients dying in hospital.
- Carers will be supported throughout the whole process and referred to appropriate sources of help.

Facilitating Discharge

- Reduce the number of bed days consumed by patients ready for discharge to target.
- Reduction in bed days because of readmission/admission.
- Carers will be involved and supported.

Improving Co-Production

- Increase in the number of patients able to manage their own conditions.

- Support to carers to continue to care.
- Increased peer support and 3rd Sector engagement.
- Better patient information.

The HSCP will also:

- Progress the delivery of its two new replacement Older People's Residential Care Home and Day Care facilities – one in Dumbarton and the other in Clydebank/.
- Expand our capacity to support Access to Funds requests made on behalf of those using our services.
- Develop a Market Facilitation Plan in partnership with care providers currently working in West Dunbartonshire and those who may in the future be providers within the area (Appendix 2 for more details).

Primary Care

Access to primary medical services is a key consideration in improving the delivery of services and ensuring patients are at the heart of how these are designed and provided. Patients should have increased confidence that the care delivered by all parts of primary care is safe, effective and person centred. This requires a culture of ongoing review of decisions taken, and interventions made, as well as encouraging comment and input from patients and the wider public. Agreed care pathways assist both staff and patients understand and achieve the best approaches for care which is safe, person centred and clinically and cost effective. It is recognised that the combination of targeted action within primary care, and both informing and empowering the individual with a condition, will improve their sense of wellbeing and avoid repeated admission to hospital.

The HSCP will work with local primary care contractors and staff to:

- Develop Anticipatory Care as a model of prevention and work with GPs to develop self-care models, and preventative interventions.
- Continue to develop care for patients with long term conditions inc. additional nursing support to patients, GP practices and care homes.
- Further develop use of care planning and management to reduce hospital inpatient care.

- Increase range of urgent access options to advice and appointments for GPs.
- Work with GP practices to monitor their provision of third available appointment, planned appointments and 24 hour access.
- Continue to implement Scottish Patient Safety Programme in the community.
- Bring forward plans for a new Clydebank Health & Care Centre to replace current provision.

Acute Division – Unscheduled/Emergency Care

In February 2012 NHS Greater Glasgow and Clyde established the Clinical Services Fit for the Future Programme to review services in order to prepare a single clinical strategy for NHS GGC for 2015 onwards. This Clinical Services Strategy was approved by the Health Board in January 2015 and is intended to provide a shared vision for the Health Board and the new Integration Joint Boards across the NHSGGC area.

The overarching aim of the clinical strategy is to provide a balanced system of care where people get care in the right place from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

Within the context then of the Clinical Services Strategy, the key priority areas for the HSCP in relation to Acute Services during 2015/16 are:

- Reduction in bed days lost to delayed discharge - with the reconfiguration of acute sites in 2015 into a reduced bed base, the impact of delayed discharges on the delivery of acute care becomes even more critical.
- Reduction in the number of A&E presentations - where alternatives to A&E presentation exist, these services need to be maximised and plans developed to increase the scope and number of these services available in the community.
- Reduction in the number of emergency admissions - where alternatives to emergency admission exist for patients whose acuity does not require acute admission, these services need to be maximised and plans developed to increase the scope and number of these services.
- Relationship Building between Primary and Acute Care Services - working to describe clearer pathways and better communication between primary and secondary care.

NHSGGC Musculoskeletal (MSK) Physiotherapy

The MSK Physiotherapy service incorporates 37 sites across NHSGGC. Referrals have risen 27.9% in the past 2 years with the service receiving 88,302 referrals in 2014/15. The current waiting time target to-date is 9 weeks for a routine appointment. Looking forward, the Allied Health Professions (AHP) National Delivery Plan sets a target of 4 weeks by March 2016.

Key changes planned to respond to the 2016 4 week target include implementing:

- Referral Management Centre.
- Netcall - appointment reminder system.
- National GP MSK resource.
- Risk stratification.

NHSGGC Eye Care

The previous CHCP led the development of primary care eye care services across NHSGGC over the last four years, and the HSCP will continue to do this going forward by:

- Continue to develop and maintain a local optometry network.
- Contribute to the development of networks across NHSGGC and facilitate profession-wide leadership.
- Support the development of a quality and governance framework for community optometry.
- Develop the primary – secondary care interface, including referral and after care for serious eye conditions.
- Develop community optometry as the front line service for primary eye care in partnership with general practice.

The HSCP will also host the Diabetic Retinal Screening Service for the Health Board, ensuring that:

- It continues to provide annual reviews for all diabetic patients across the NHSGGC area (approx. 81,000).
- It meets its national quality assurance and performance targets.

Mental Health

The HSCP is committed to the full spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families.

During 2015/16 the HSCP will work with partners to:

- Relocate older peoples continuing care mental health beds to West Dunbartonshire.
- Support a national campaign to raise awareness of Power of Attorney.
- Deliver and implement a local West Dumbarton Dementia Strategy, including working with partners to develop Dementia Friendly West Dunbartonshire.
- Expand access to therapeutic psychological therapies across West Dunbartonshire.
- Roll out Greater Glasgow and Clyde Mental Health Trauma Services across all West Dunbartonshire.
- Roll out the West of Scotland Perinatal Service to Mental Health Services within Dumbarton and Alexandria.

Learning Disability

People with learning disabilities should be supported to live independently in the community wherever possible. The national Keys to Life Strategy (2013) supports our ability to improving quality of life for people with learning disabilities and informs our local actions.

Key local actions for the HSCP in taking this forward include:

- Work with third sector to relocate local clients with a learning disability diagnosis who are currently living in specialist care facilities out of area back within West Dunbartonshire.
- Work to with people with learning disability and sensory impairment to increase their uptake of the national screening programme.
- Implement improvement actions to reduce discrimination.
- Engender closer operational links across HSCP services to support effective transitions.
- Support continued partnership with Housing Services to maintain effective connectivity with the Local Housing Plan and wider housing services and housing providers.

Alcohol and Drugs

The HSCP convenes, holds the budget for and chairs the Alcohol and Drug Partnership (ADP), which is responsible for developing and leading local strategies to deliver improved outcomes.

During 2015/16 the HSCP will undertake its role in:

- Internal redesign of alcohol and drug services to ensure fit with Recovery Orientated Systems of Care (ROSC) (this will include issues linked to workforce development).
- Quantification of availability and access to New Psychoactive Substances (NPS); within that identification of uptake of services and possible changes to service delivery as a result of this work, and using intelligence to develop appropriate information and training for young people and their families regarding the dangers of new psychoactive substances.
- Work with children and families - Children Affected by Parental Substance Misuse (CAPSM).
- Review and redesign local data systems to enable access to specific information.

Carers

The implementation of Carers Strategy 2012 – 2022 will be led by the HSCP with its partners; with carers, the third and private sector, to ensure actions are realistic, achievable and inextricably linked to the needs of carers – both young carers and adults - in West Dunbartonshire.

Key local actions for the HSCP in taking this forward include:

- Continuing to implement the Carers Information Strategy.
- Articulate and promote the value and benefits of a carer's assessment.
- Undertake targeted work to support sustainable caring, whilst promoting and improving the health and well-being of carers.
- Development of Respite Bureau.
- Work closely with primary health care to support carers with the appropriate information, ensure that they are engaged in the care planning and that the outcomes for the patient and carer are enhanced.

Housing

The Local Housing Strategy sets out the housing issues in West Dunbartonshire for the period 2011 to 2016. The strategy shows how the Council and its partners mean to address these issues. It deals with both private and rented housing. The Strategy goes with a Strategic Housing Investment Plan which details the funding priorities for affordable housing in West Dunbartonshire. It is the Council's main document on: housing, homelessness, housing support services and fuel poverty.

The local Housing Strategy seeks to ensure clear strategic leadership about housing priorities for older people. It aims to ensure appropriate information and advice to make informed choices and that older people are assisted to remain in and make best use of existing housing stock. It seeks to invest in new housing which meets the needs of older people and to provide low level preventative support. We also have a significant cohort of younger adults with complex health conditions who also require a strategic approach to their housing needs and we will extend our activities to this group.

The Council's Housing Section will work with the HSCP to:

- Establish a housing support service enabling long term clients to be supported within West Dunbartonshire.
- Continue to develop plans for new and refurbished Housing.
- Develop Services at Points of Transition.
- Provide preventative interventions and supports.
- Ensure rapid access to assessment, and provision of aids and adaptations.
- Seek to develop supported housing solutions for younger adults with complex needs.

This will contribute to:

- Reduced waits for OT assessment and aids and adaptations
- The development of new models of care at home such as extra care housing
- In conjunction with 3rd Sector and Local Housing Associations develop housing with care options for all care groups.

Children and Young People

The Integrated Children's Services Plan (ICSP) is the vehicle by which the HSCP and other community planning partners will address the new statutory requirements as described within the Children and Young Person Act (Scotland) 2014 and delivering Getting It Right For Every Child (GIRFEC). As the HSCP has well established integrated strategic and service delivery arrangements across children and young people's services the ICSP plan reinforces our commitment to these arrangements and reiterates the agreed priorities across and with partners to ensure that children, young people and families receive the best opportunities through delivery of service as community planning in practice.

The Children and Young Person Act brings about a specific duty on local areas to have an ICSP in place, with new guidance is awaited from Scottish Government - after which the HSCP will lead a review across community planning partners to update our local ICSP accordingly.

During 2015/16 the HSCP will undertake its role and provide leadership to:

- Deliver the UNHCR Rights of the Child.
- Implement its commitments within the Integrated Children's Services Plan.
- Implement the National Early Years Framework and deliver the workstreams of the Early Years Collaborative.
- Lead the delivery of our Child Protection Committee Improvement Action Plan.
- Continue to identify and intervene in the lives of vulnerable children as identified in our joint work with Police Scotland through the Concern Management Hub.
- Deliver Corporate Parenting.
- Deliver a local Parenting Strategy.
- Deliver the Family Nurse Partnership Programme.
- Develop our multi-agency approach to supporting children with regards to their mental health and emotional well being.
- Deliver the Whole Systems Approach to Youth Offending.
- Redesign our Children's Home provision.
- Review and redesign our community based supports and introduce a consistent process for accessing the right service at the right time

Health Improvement

Health improvement is a key function of public health and is pursued through wide-ranging health promotion effort, aimed at promoting good health and preventing ill-health through maximising the population health benefits of treatment of ill-health. This includes helping individuals, in so far as they are able, to take responsibility for their own health and wellbeing and that of others.

Key workstreams that the HSCP will lead include:

- Implement local stop-smoking service action plan targeting intensive support for people from 40% most deprived datazones.
- Pilot intensive support for people with COPD to stop smoking
- Develop and pilot an intervention to support people to change their smoking behaviour to protect children from secondhand smoke
- Continue to test approaches to reduce smoking rates in pregnancy
- Work with West Dunbartonshire Leisure to ensure delivery of nutrition and physical activity programmes across the life-course.
- Work with educational settings to implement "Setting the Table".
- Begin implementation of new teenage pregnancy and young parent strategy
- Ensure implementation of the refreshed sexual health and blood borne virus framework
- In partnership with WDC Educational Services, review and update RSHPE (Relationships, Sexual Health and Parenthood Education) policy and LAC (Looked After Children) sexual health and relationships policy.
- Build capacity to ensure delivery of Alcohol Brief Interventions within priority and wider settings
- Deliver training on alcohol and drugs to a range of staff with identified need. Continue to lead Choose Life suicide prevention programme.
- Support delivery of youth mental health Project 99.
- Continue to implement HSCP Cancer Information Action Plan to ensure delivery of Scottish Government "Detect Cancer Early" campaign.
- Maintain Healthy Working Lives Gold Award for Health and Social Care Partnership and West Dunbartonshire Council.

Public Protection

Public Protection provides a range of measures which can be used together to take steps to decide whether someone is an adult at risk of harm, balancing the need to intervene with an adult's right to live as independently as possible; or where a child needs protection from harm. It also encompasses the effective and robust management of High Risk Offenders (including those subject to Multi-Agency Public Protection Arrangements – MAPPA – and Serious Violent Offenders). It is everyone's business to help protect adults and children who may be at risk - and as such public protection is an integral part of all delivery of adults and children's services within the HSCP.

The Child Protection Committee ensures that agencies, services and organisations work together to protect children and provide support to parents, carers, children and young people. The key priorities of the Child Protection Committee are:

- Child Protection Performance and Demand Analysis.
- Improvement and Workforce Development.
- Communication and Inclusion.
- Planning for Outcomes.
- Practice Guidance and Development.
- Improve the safety of children in West Dunbartonshire.

The work of the Adult Support and Protection Committee is driven by both national governance and accountability and meeting the needs of the local population. The priority work streams identified by the Scottish Government include:

- Financial harm.
- Adult Protection in nursing and care homes.
- Adult Protection in A&E departments.
- Service user and carer involvement.
- Data collection.

Criminal Justice

West Dunbartonshire Council delivers criminal justice services in formal partnership with Argyll and Bute and East Dunbartonshire councils. Criminal Justice services undertake a range of statutory duties concerned with the assessment and supervision of offenders subject to community sentences or subject to supervision following a custodial sentence. This is the fourth Area Plan for the North Strathclyde Community Justice Authority (NSCJA) and is for the three year period April 2014 – March 2017. Locally, the HSCP will work with partners to achieve:

- A continued reduction in the one year reconviction rate in the North Strathclyde Community Justice Authority area
- The effective provision of person centred, evidence led support services and interventions for women offenders as recommended by the Commission on Women Offenders in both community and in-custody settings
- Effective and enhanced support services and interventions for high risk offenders including sex offenders and perpetrators of domestic abuse, whilst ensuring the 'victim's voice' is heard in the North Strathclyde Community Justice Authority area
- An increased focus on alternatives to custody and community sentences where appropriate, including diversion; community payback order (CPO); Drug Treatment and Testing Orders (DTTO); the use of electronic monitoring, where suitable; and alternatives to remand.
- Continue to support a prison culture where the maximisation of opportunities for prisoners to work towards positive destinations is the norm, addressing the cross cutting issues that contribute to offending and re offending.
- A smooth and efficient transition into the new Structure for Community Justice.

KEY PERFORMANCE INDICATORS

As part of the development work in support of the Public Bodies (Joint Working) (Scotland) Act, a range of indicators for health and social care partnerships have been developed in consultation with a wide range of stakeholders across all sectors, and by the Ministerial Steering Group.

These indicators will develop and improve over time - and some of them still require data development. The indicators have been, or will be, developed from national data sources so that the measurement approach is consistent across all areas. They can be grouped into two types of complementary measures:

(1) Outcome indicators based on survey feedback[1], to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.

[1] While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

(2) Indicators derived from organisational/system data primarily collected for other reasons[2]:

- Premature mortality rate.
- Rate of emergency admissions for adults.
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

Importantly, the above suite of indicators remain to be tested in practice, and Scottish Government has acknowledged that will need to be tested out with new partnerships to understand their usefulness both for reporting progress and identifying areas for improvement to help with strategic planning.

Given the developmental status of the above, the following suite of key performance indicators have been prepared for the HSCP for 2015-16, relating to a combination of routine service activity and transformational initiatives within the context of the national Outcomes and commissioning context set out earlier; and which address many of the nationally sponsored indicators above (overleaf).

Work will be on-going through 2015/16 between the HSCP, the Council and the Health Board to further develop a robust and timeous suite of performance indicators for future years.

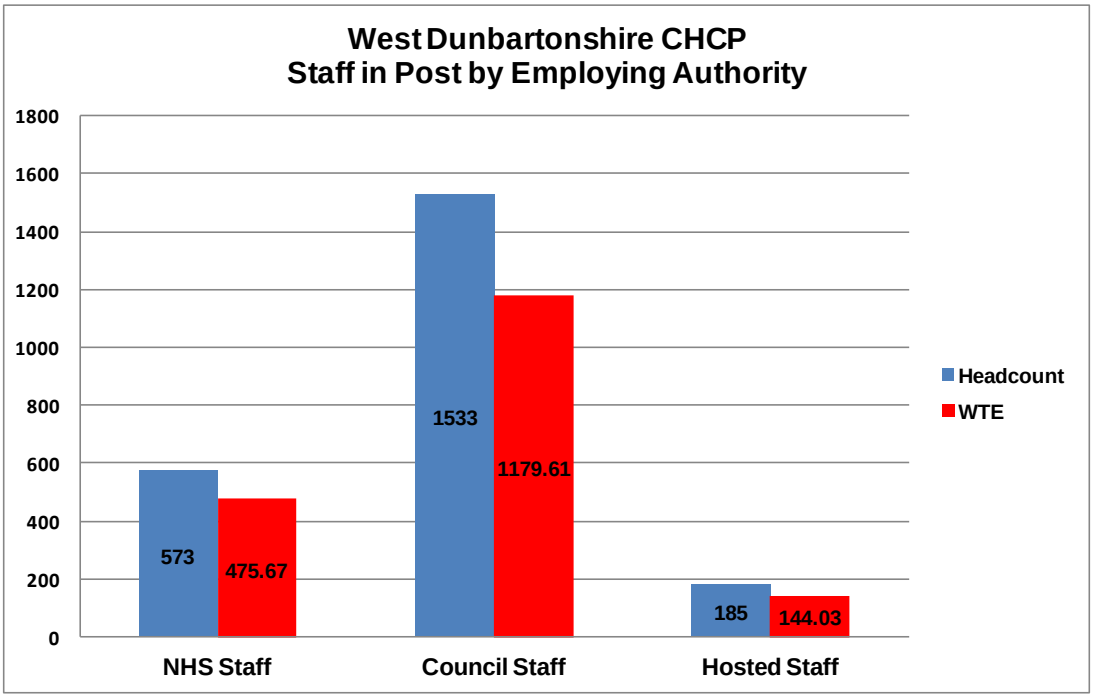
[2] These indicators will be available annually or more often.

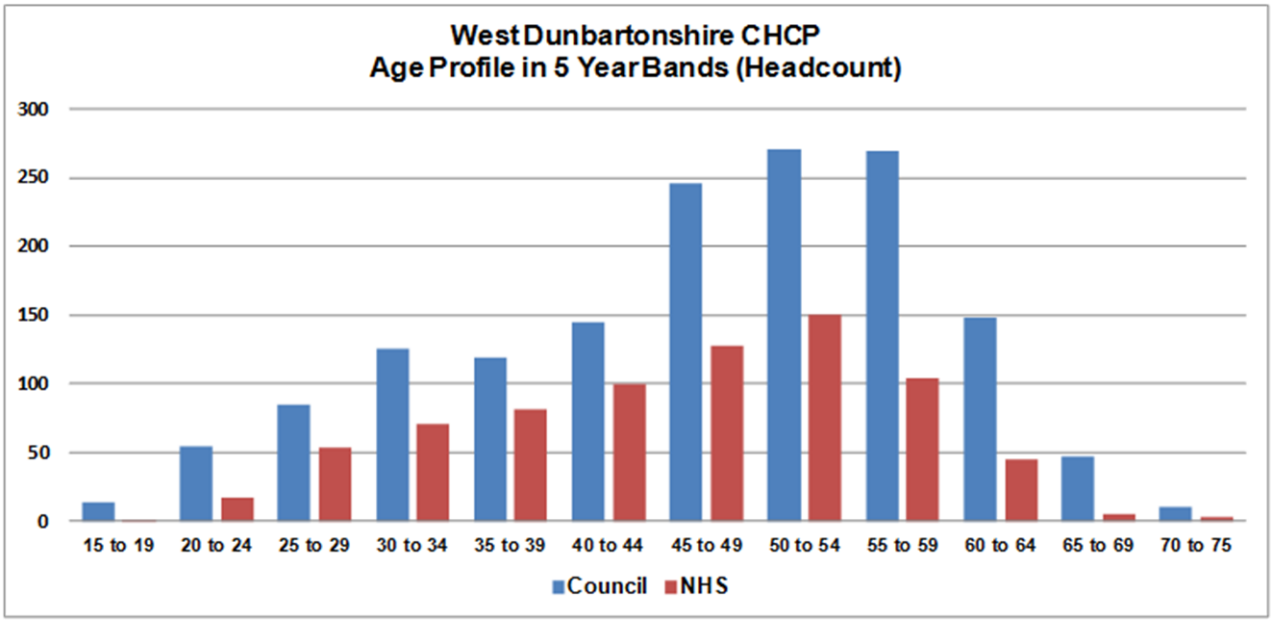
Performance Indicator	Target 2015-16
Rate of stillbirths per 1,000 births	4.3
Rate of infant mortality per 1,000 live births	3.1
Percentage of pregnant women in each SIMD quintile booked for antenatal care by the 12th week gestation	80%
Percentage of all children aged 0-18 years with an identified "named person" as defined within the Children's and Young People's Act	100% (2016 target)
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review - Early Years Collaborative Stretch Aim	80%
Percentage of children who have reached all of the expected developmental milestones at the time the child starts primary school - Early Years Collaborative Stretch Aim	80%
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97%
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	95%
Number of children with or affected by disability participating in sports and leisure activities	172
Number of children completing tailored healthy weight programme	65
Child and Adolescent Mental Health Services (CAMHS) 18 weeks referral to treatment	100%
Number of children with mental health issues (looked after away from home) provided with support	23
Balance of Care for looked after children: Percentage of children being looked after in the Community	89%
Percentage of Council-operated children's residential care homes which are graded 5 or above	100% (2017 target)
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	69%
Number of successful smoking quits, at 12 weeks post quit, in the 40% most deprived areas	95
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	90%
Number of alcohol brief interventions using setting appropriate screening tool (at least 80% in priority settings and up to 20% in wider settings.)	688
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	91.50%
Number of Drug-Related deaths	14
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	0
Number of acute bed days lost to delayed discharges	3,819
Number of acute bed days lost to delayed discharges for Adults with Incapacity	466
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	40%

Performance Indicator	Target 2015-16
Number of unplanned admissions for people 65+ as a rate per 1000	240
Percentage of patients achieved 48 hour access to appropriate GP practice team	95%
Percentage of patients advanced booking to an appropriate member of GP Practice Teams	90%
Number of adults 65+ who access tailored physical activity programme in a range of community settings	150
Percentage of homecare clients aged 65+ receiving personal care	83%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	97%
Percentage of people aged 65 or over with intensive needs receiving care at home	40%
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	65%
Percentage of Care Plans reviewed within agreed timescale	74%
Total number of homecare hours provided as a rate per 1,000 population aged 65+	600
Percentage of Council Home Care services which are graded 5 or above	100% (2017 target)
Percentage of Council-operated older people's residential care homes which are graded 5 or above	100% (2017 target)
Total number of respite weeks provided to all client groups	6,540
Total number of clients aged 65 years+ with a respite package	50
Percentage of people newly diagnosed with dementia who receive a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.	100% (by end 2015/16)
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	88%
Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related grounds	6
Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	33.15
Percentage of child protection investigations to case conference within 21 days	95%
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling	98%
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence	80%
Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence	90%
Sickness absence rate amongst WD HSCP NHS employees	4%
Number of days lost to sickness per WD HSCP Council employee	8

WORKFORCE

As at 31st March 2015 just short of 1800 whole time equivalent staff were employed within the then CHCP by its two employing authorities.





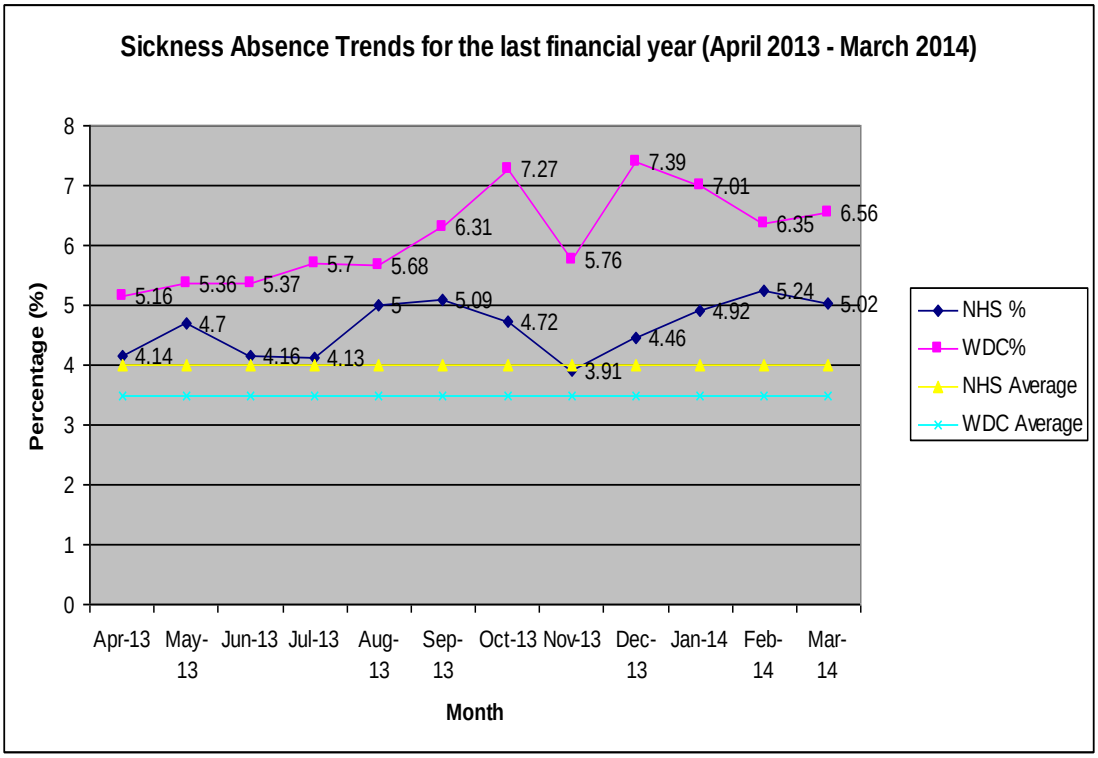
Staff governance is a system of corporate accountability for the fair and effective management of all staff, i.e. that staff should be well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment. The Chief Officer will convene a refreshed local joint Staff Partnership Forum, with formal linkages to their respective corporate trade union partnership forums.

In 2014 the then CHCPs Senior Management Team identified a number of key priorities for the workforce to be addressed across the short and medium term (i.e. the next 1-5 years). These were:

- To assess the implication of workforce structures which arise from the new HSCP structure.
- The development of a robust out of hours/unscheduled care services.
- Talent Management and Succession Planning within the workforce to mitigate the impact of future skills loss associated with an ageing workforce profile.
- The use of agile technologies to assist the workforce, improve productivity and free up additional capacity from existing resources.
- Building on existing capacity within the volunteer and third sector workforce while ensuring the maintenance of quality and standards of service.
- Creating career pathways to encourage retention among key staff groups (e.g. Occupational Therapy, Community Specialist Nurses).
- Increasing levels of Mental Health Officer Qualification among social care staff;
- Assessing workforce training needs in dementia care and engaging educational partners regarding appropriate mechanisms for provision.
- Improve staff wellbeing and staff absence management.

The HSCP will develop a joint Workforce Development and Support Plan and Organisational Development strategy in relation to staff delivering integrated services (except for NHS acute hospitals services), taking account of existing workforce development policies and procedures of both NHSGGC and the Council. These will be prepared within and put in place by 31st March 2016.

The chart below shows the whole CHCP sickness absence trends for the last financial year April 2013 to March 2014, across both NHS-employed and Council-employed staff.



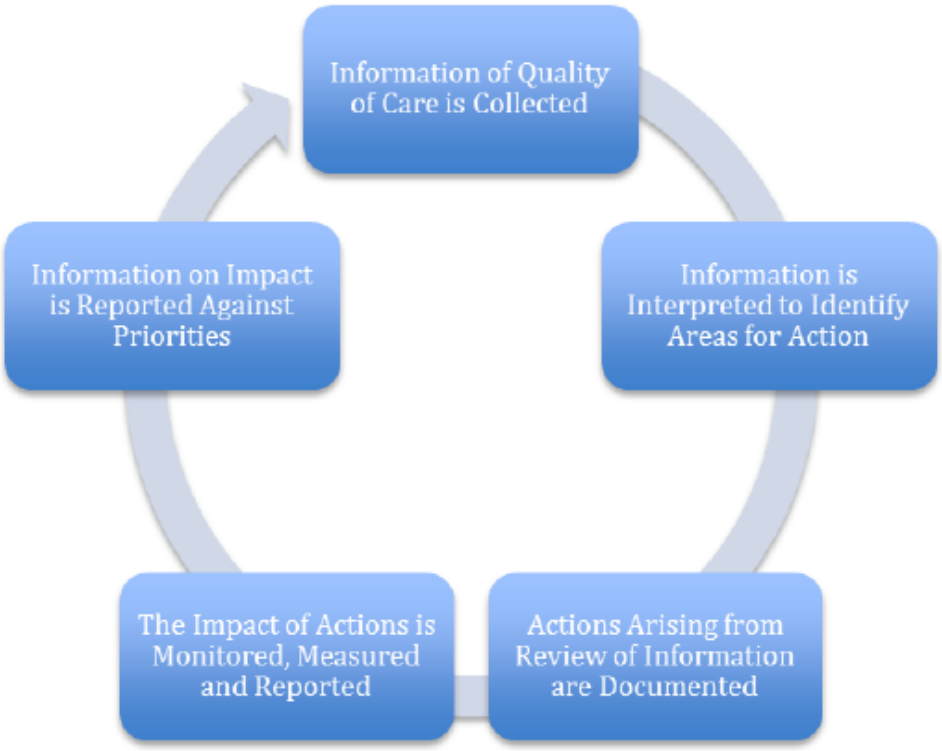
The main causes of sickness absence amongst NHS-employed staff were anxiety/stress related reasons; other musculoskeletal problems; and back problems. The main causes of sickness absence amongst Council-employed staff were acute medical conditions; other musculoskeletal problems; and anxiety/stress related reasons.

The HSCP will implement the following as identified within its Absence Action Plan 2015/16:

- Day one stress Notification to HR team.
- Day one musculoskeletal notification to HR team.
- Managers Stress Workshops.
- Stress Action Plan developed.
- Revised policy update sessions to all Managers.
- In depth absence analysis to be undertaken and routinely presented to the HSCP Senior Management Team.
- Maintain Healthy Working Lives Gold Award.

CLINICAL AND CARE GOVERNANCE

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed. Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.
The Scottish Government's Clinical and Care Governance Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. The Framework identifies a number of process steps to support clinical and care governance as illustrated below.



Many clinical and care governance issues will relate to the organisation and management of services rather than to individual clinical decisions. Clinical and care governance, however, is principally concerned with those activities which directly affect the care, treatment and support people receive.

The Clinical and Care Governance Framework also stresses that effective clinical and care governance should support staff in continuously improving the quality and safety of care; and ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

Clinical and care governance within the HSCP will be achieved by co-ordinating three interlinking strands of work:

- Robust national and local systems and structures that help identify, implement and report on quality improvement.
- Quality improvement work involving staff, service users and the public.
- Establishing a supportive, inclusive learning culture for improvement based on self-evaluation and critical reflection.

The Chief Officer has delegated responsibilities, through the Chief Executives of the Council and the Health Board, for the professional standards of staff working in integrated services. The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership. Partnership managers will manage teams of Health Board employed staff, Council employed staff or a combination of both; and will promote best practice, cohesive working and provide guidance and development to their team. This will include effective staff supervision and implementation of staff support policies. Where groups of staff require professional leadership, this will be provided by the relevant Health Board professional lead or the Council's Chief Social Work Officer as appropriate.

The HSCP will establish a local Clinical and Care Governance Group for integrated services managed within the Partnership. This will be chaired by the Chief Officer, and its membership will include the Partnership's Senior Management Team; Clinical Director; Lead Nurse; Allied Health Professions Lead; and Council's Chief Social Work Officer. Through its representative membership, the Clinical and Care Governance Group will interface with the Health Board Clinical Governance Forum; Health Board professional committees; the Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection Committees as appropriate.

LOCALITY PLANNING

The Public Bodies (Joint Working) (Scotland) Act and explanatory notes places a requirement on Health and Social Care Partnerships to establish effective locality planning arrangements, with the stated expectations that:

- Local clinicians and care professionals will play a greater role in locality planning, which will inform the partnerships' strategic plans.
- Carers, patients, service users and their families will also inform locality planning arrangements.

The Public Bodies (Joint Working) (Scotland) Act 2014 Section 29 specifically requires the partnership to include in its Strategic Plan information on:

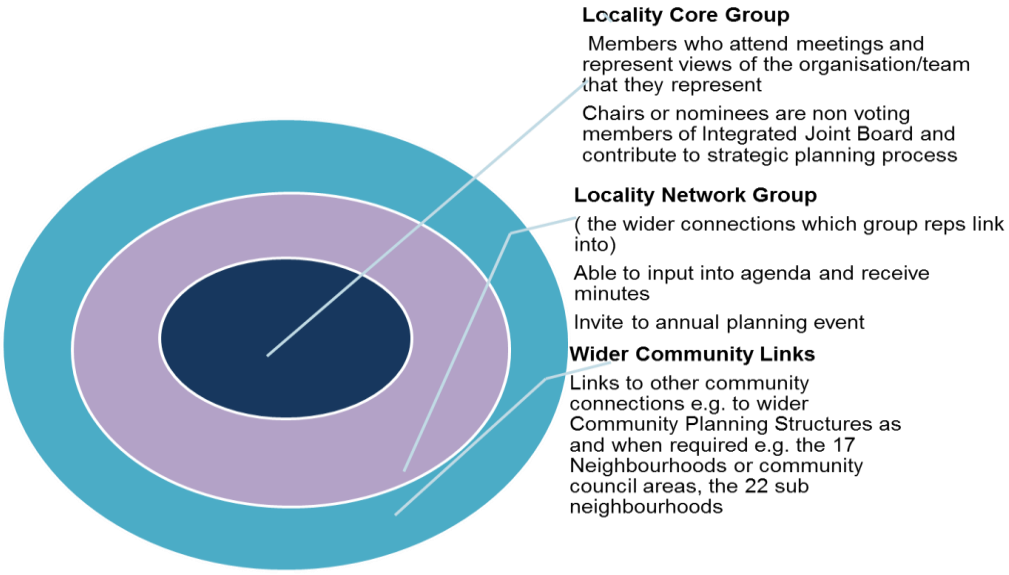
- How it will divide the area of the local authority into two or more localities.
- How it will set out arrangements for the carrying out of the integration functions in relation to each locality.

For West Dunbartonshire two localities have been identified: *Alexandria/Dumbarton* and *Clydebank*. These take account into account:

- The existing good partnership working across each locality which has been developed over a number of years.
- The fact that the populations are of similar size.
- The natural geographical boundaries of the two parts of the local authority.
- Current links into different parts of hospital NHSGGC services.

While the CHCP's locality group arrangements provided a reasonable platform for addressing the requirements of the Act, they required updating to fully comply with the necessary requirements of the Act, notably in relation to the wider range of stakeholders who should be engaged at that level; and to respond to locality-level feedback that meetings should be kept to a minimum but structured to make the best use of everyone's time and commitment.

So, it is proposed to have a *locality core group* for each locality which is involved in the locality plan with a *locality network group* structure where the representatives on the core group involve the wider networks, teams or services in locality programmes and specifically through an annual planning meeting. Additional links with wider community planning partnership services and mechanisms will also be available to support locality work as and when required.

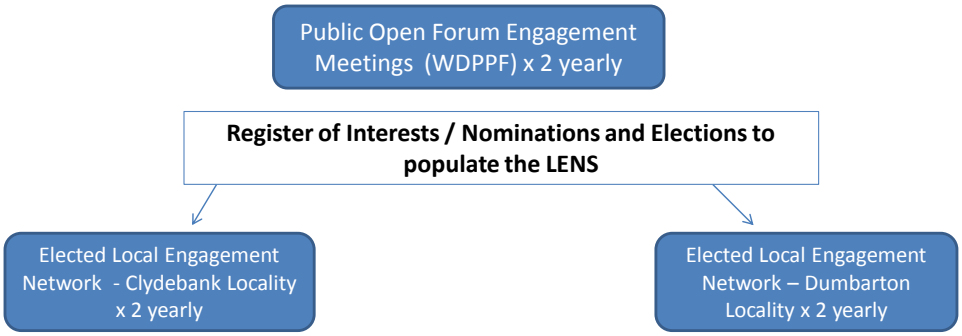


The above proposals have been consulted upon locally, been positively received and further refined in response to constructive feedback. In further developing these arrangements, the HSCP will collaborate with partners to:

- Provide information on current performance and expenditure on a locality basis.
- Work with locality stakeholders to identify two or three issues to prioritise that are of particular concern within their "patch" from a long-list of issues highlighted by profile and performance data; and to develop and then implement a work plan to effect improvements.
- Developing a common structure for the engagement of secondary care and improving the interface between community and secondary care, implementing appropriate elements of the NHSGGC Clinical Services Strategy.
- Supporting locality professional engagement, particularly with the seventeen GP practices and other primary care contractors.
- Having structured engagement with locality community organisations, community members and the public, most notably to develop more supported self-care and provide feedback to providers (including NHS external contractors).

COMMUNITY ENGAGEMENT

Following the completion of our comprehensive Community Engagement Review, we are now looking to update our Public Partnership Forum arrangements in line with its recommendations. The intent is to maintain a West Dunbartonshire-wide forum, strengthened with the introduction of a stronger locality "voice" and a renewed emphasis on increasing the representation and diversity of those involved. The Local Engagement Network is to be a re-development of the previous Public Partnership Forum structure and aims to positively further develop community engagement across Health and Social Care in West Dunbartonshire. The model is the result of extensive consultation with existing and potential stakeholders and allows for evolutionary change over time as the HSCP and its locality planning arrangements also develop (as below).



Elected Chair and Vice Chair per LEN – elected rotating representative role and chair of Open Forum (held 2x yearly)
Agenda categories – General HSCP input, locality based input, community input

Methods of Engagement

Speaking Engagements with Interested Groups | Social media
Briefing notes | Public meetings | Locality projects
Targeted consultations

As required by the new legislation, the HSCP will seek to co-produce a local participation and engagement strategy, which will be delivered by 31 March 2016. In developing these arrangements, the HSCP will work with partners and local communities to apply the principles and practices endorsed by the Scottish Health Council and those set out in the National Standards for Community Engagement. Through the HSCP's processes for community engagement we will ensure that we engage and consult with services users and the wider community routinely, building feedback into all of our interactions. The feedback we receive will be fed into our continuous quality improvement processes to shape further planning and delivery of services.

EQUALITIES FRAMEWORK

The Equality Act 2010 strengthens, harmonises and streamlines 40 years of equalities law in relation to the nine "protected characteristics" of age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. The intent of the Equality Act to protect groups from discrimination, harassment or victimisation readily fits with the over-arching priorities and commitments set out within this Strategic Plan to the delivery of quality person centred supports and services - not least because the requirements of this legislation have been considered in preparing it. Given its legal status, the HSCP Board (alongside the Council and the Health Board) will require to play its part in addressing the general duties outlined in the Equality Act 2010 to:

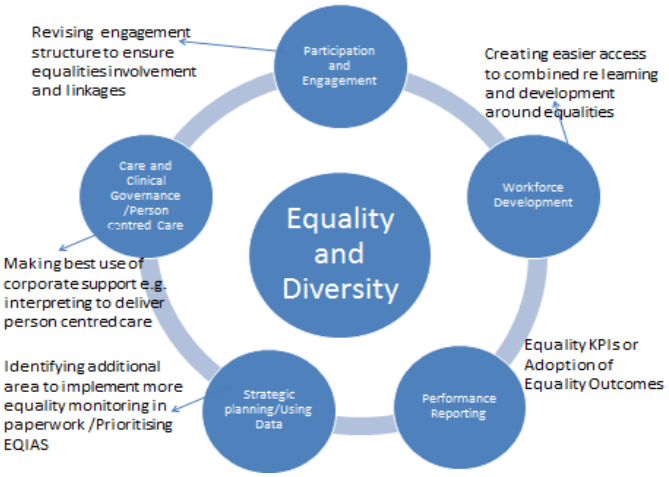
- Eliminate discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Additionally the Scottish Parliament's Equal Opportunities Committee (February 2015[3]) has indicated that Integration Authorities will be added to the listed bodies[4] under the Equality Act 2010 (Specification of Public Authorities) (Scotland) Order 2015 - which will mean that they will be subject to some of the additional public sector specific duties for functions which have been delegated to them. Whilst more guidance on the detail of this is expected from the Equalities and Human Rights Commission, it is likely that the HSCP Board will have additional responsibilities in relation to the specific duties to publish equality outcomes and report progress; and assess and review policies and practices (where policies and practices are locally decided and relate to responsibilities around the delegated functions of the HSCP Board).

With respect to integrated health and social care services in West Dunbartonshire, the former CHCP had already adopted a focus on streamlining processes around equalities responsibilities - such as standardising Equality Impact Assessments processes; actively contributing to both the NHSGGC and Council Equality Outcomes; and mainstreaming reporting as a key community planning partner

[3] http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/87166.aspx
[4] http://www.equalityhumanrights.com/about-us/devolved-authorities/commission-scotland/public-sector-equality-duty-scotland/public-authorities-scotland-who-covered-specific-duties-0

in West Dunbartonshire. This integrated and streamlined approach to considering equality fits well with the intentions of the Equality Act whereby equality should be taken into account in all the day to day organisational functions; and also the Equality & Human Rights Commission Measuring Up report on public bodies performance against the Equality Act 2010(Specific Duties) (Scotland) Regulations 2012 where the importance of considering equality outcomes on a community planning basis was reinforced. Further integrating of equalities responsibilities into on-going planning, delivery and reporting of the HSCP activities is illustrated as below.



As guidance becomes available and the position is clarified, then these matters will be addressed and brought forward to the HSCP Board for consideration. In the meantime, the HSCP will look to continue work with corporate equalities support services within the Health Board and the Council to develop a locally streamlined approach which combines:

- A continued focused approach to the general equalities duties.
- A move to having a stronger organisational response by taking more ownership of the specific equalities duties and equality outcomes in a integrated manner.
- Introduce greater local scrutiny in relation to progress.

Given that the remaining specific duties concern areas (such as procurement and employment) will remain the overall responsibility of the Health Board and the Council, the HSCP will continue to meet its obligations around these areas by implementing the relevant policies and practices as appropriate related to these areas. Similarly where appropriate, the HSCP will continue to contribute to wider corporate equalities programmes of the Council and the Health Board.

FINANCIAL FRAMEWORK

Budget Allocation - West Dunbartonshire Council

Revenue (recurring)

Amounts to be paid by the Council to the Health & Social Care Partnership Board in respect of all of the functions delegated by it to the Health & Social Care Partnership Board is as follows.

	£million	
	2015/16 Full Year	**9 months from July 2015**
Older Persons	15.341	11.506
Adults with physical or sensory disabilities	1.969	1.477
Adults with learning disabilities	11.211	8.408
Adults with mental health needs	2.066	1.550
Service Strategy	1.178	0.884
Children's Panel	0.002	0.002
Children & Families	14.869	11.152
Criminal Justice ***	-	-
Adults with other needs	1.231	0.923
Homecare	9.349	7.012
Housing Adaptations and gardens	0.756	0.567
Other Social Care Services	3.349	2.512
Total	**61.321**	**45.991**

***Criminal Justice cost of 0.371M is funded by Scottish Govt grant giving net cost to HSCP of nil.

Capital

Capital and assets and the associated running costs will continue to sit with the Council.

- Recurrent

	£million	
	2015/16 Full Year	**9 months from July 2015**
Aids and Adaptations – HSCP	0.655	0.491
Aids and Adaptations – Housing Revenue Account (HRA)	0.300	0.225

- Non-recurrent

Replacement of all older people's residential care and day care facilities with two new facilities – one in Dumbarton and the other in Clydebank): £22.652m (full project cost)

Budget Allocation – NHS Greater Glasgow & Clyde

Revenue (recurring)

Amounts to be paid by NHSGGC to the Health & Social Care Partnership Board in respect of all of the functions delegated by it to the Health & Social Care Partnership Board is as follows.

	£million	
	2015/16 Full Year	**9 months from July 2015**
Community		
District Nursing	2.032	1.524
Health Visiting	1.498	1.124
Child Health	1.743	1.307
Specialist Nursing	0.393	0.295
Hospital Inpatient Services	2.073	1.555
Community Mental Health Teams	4.541	3.406
Community Learning Difficulties Team	0.282	0.212
Addiction Services	1.871	1.403
Community AHP	1.139	0.854
Health Promotion	0.914	0.686
Other (includes hosted services – MSK & Eye Care)	11.897	8.923
Family Health Services		
GMS	11.533	8.650
Pharmaceutical Services - GP Prescribing	17.255	12.941
Pharmaceutical Services – Other	3.072	2.304
General Dental Services	4.973	3.730
General Ophthalmic Services	2.166	1.625
Resource Transfer	7.588	5.691
Total	**74.970**	**56.228**

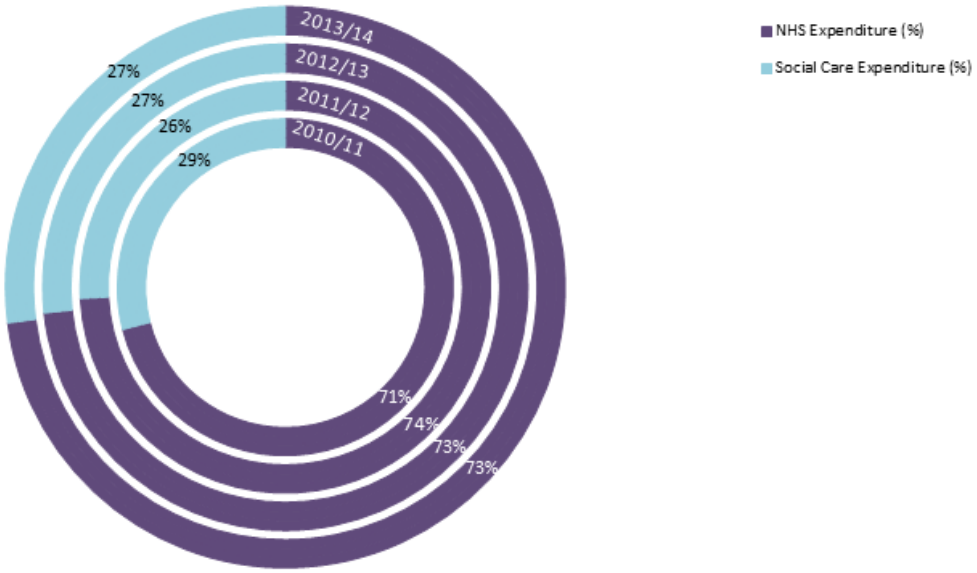
Capital

Capital and assets and the associated running costs will continue to sit with the Health Board. On 23rd June 2015 the Scottish Government announced that a new £19 million Clydebank Health & Care Centre will be funded through its non-profit distributing (NPD) programme.

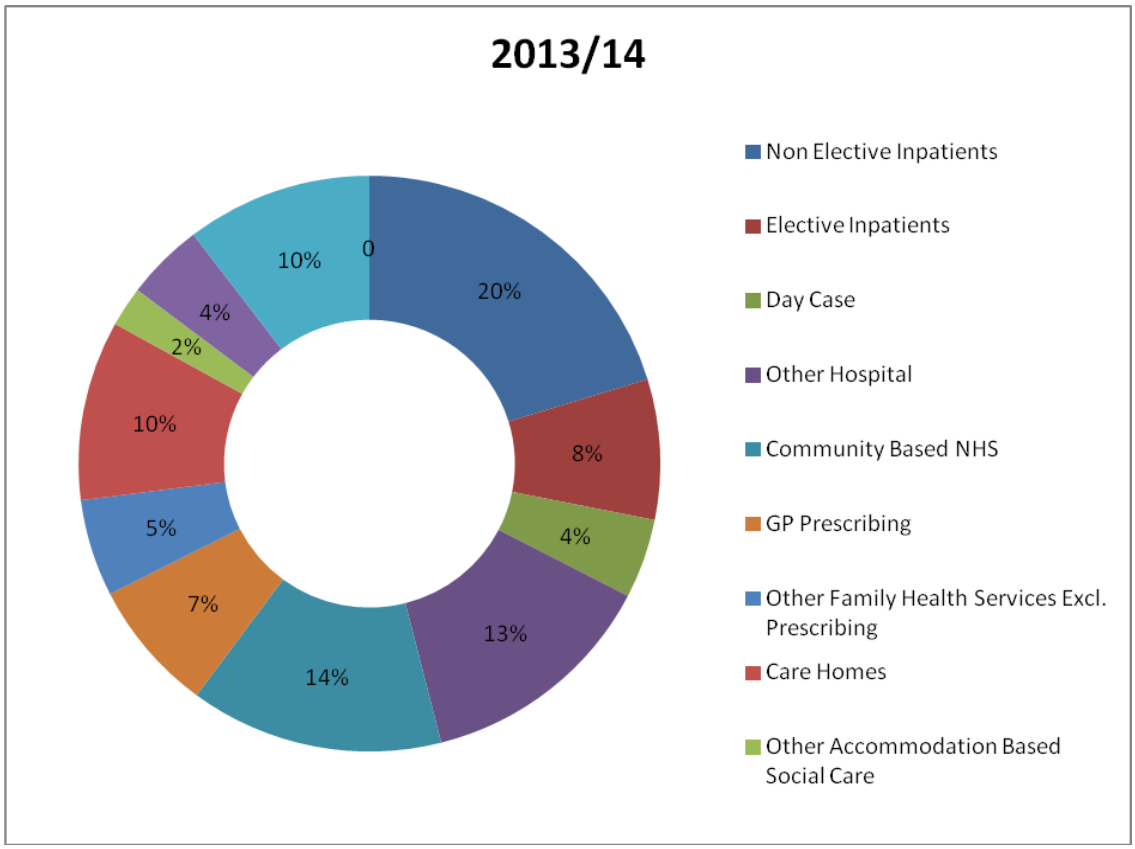
Acute Hospital Budget

During 2015/16 the Health Board Director of Finance will work with HSCPs within the NHSGGC area to develop an agreed methodology to calculate the appropriate budget to represent consumption of unscheduled care services by Integration Joint Boards. Set aside budgets will be then be proposed to each Integration Joint Board with a view to their being available to all those Integration Joint Boards from 1 April 2016.

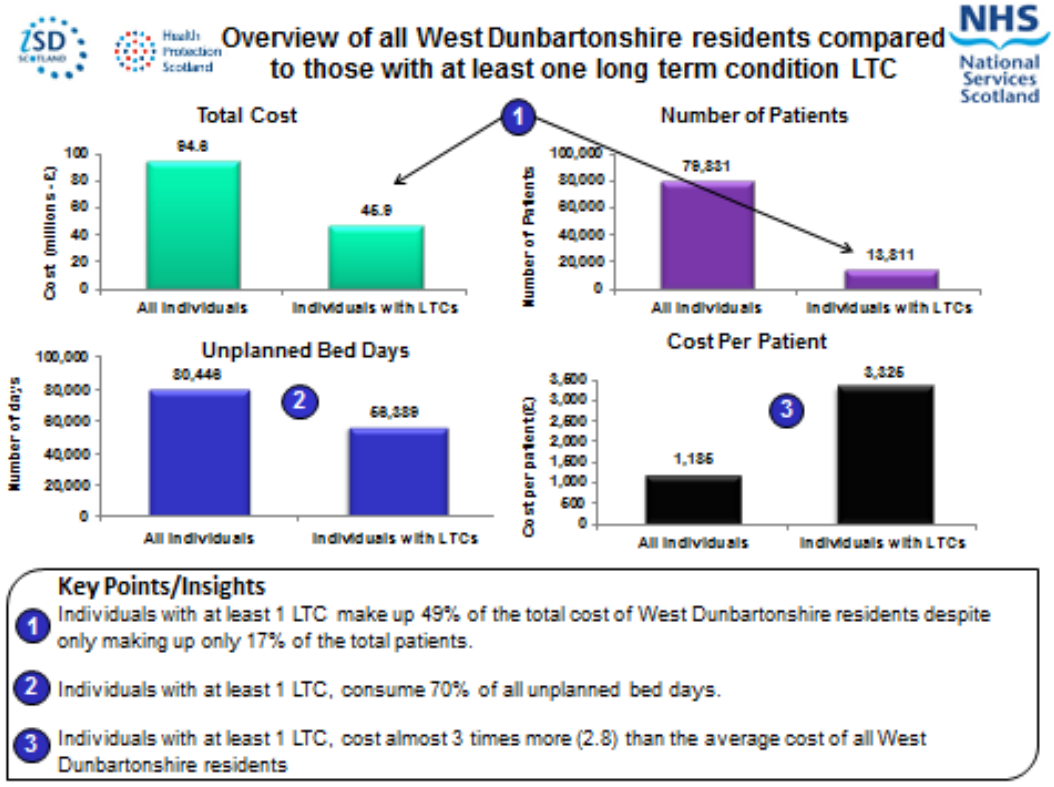
In anticipation of this and to support the broader planning and delivery of services within West Dunbartonshire, working has been undertaken with the national Information Services Division (ISD); with analysis using the Integrated Resource Framework for the financial year ending 31st March 2014 used to highlight the proportion of total NHS and Council social care expenditure.

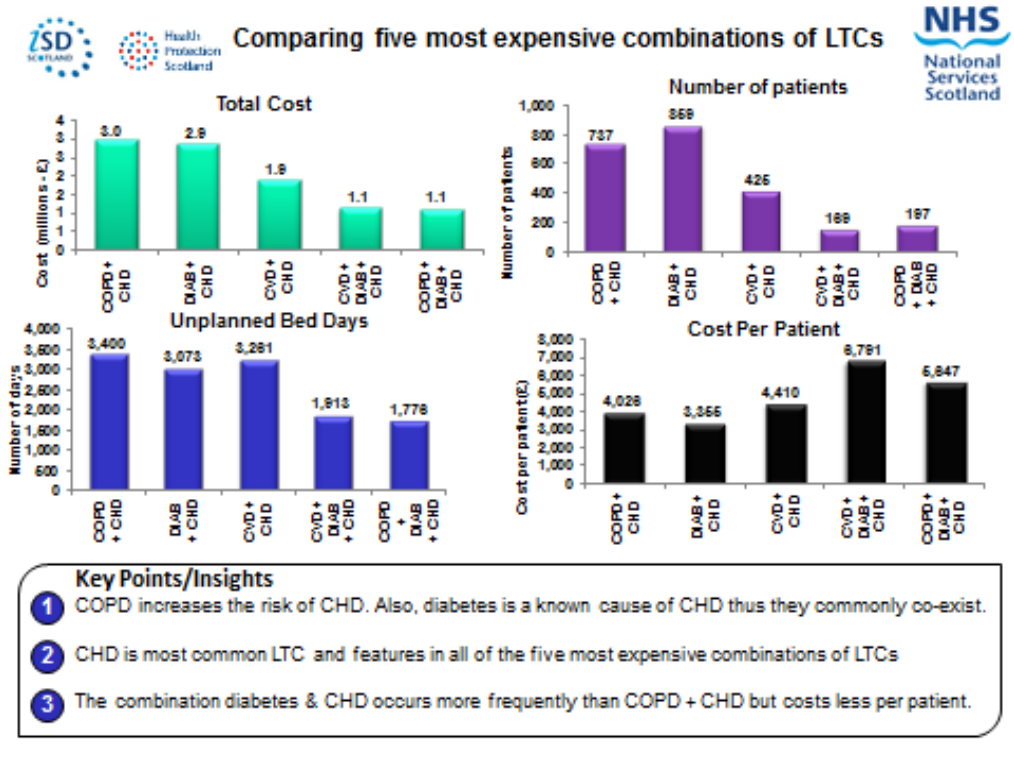


The indicative analysis of that spending for 2013/14 can be seen per sector as:

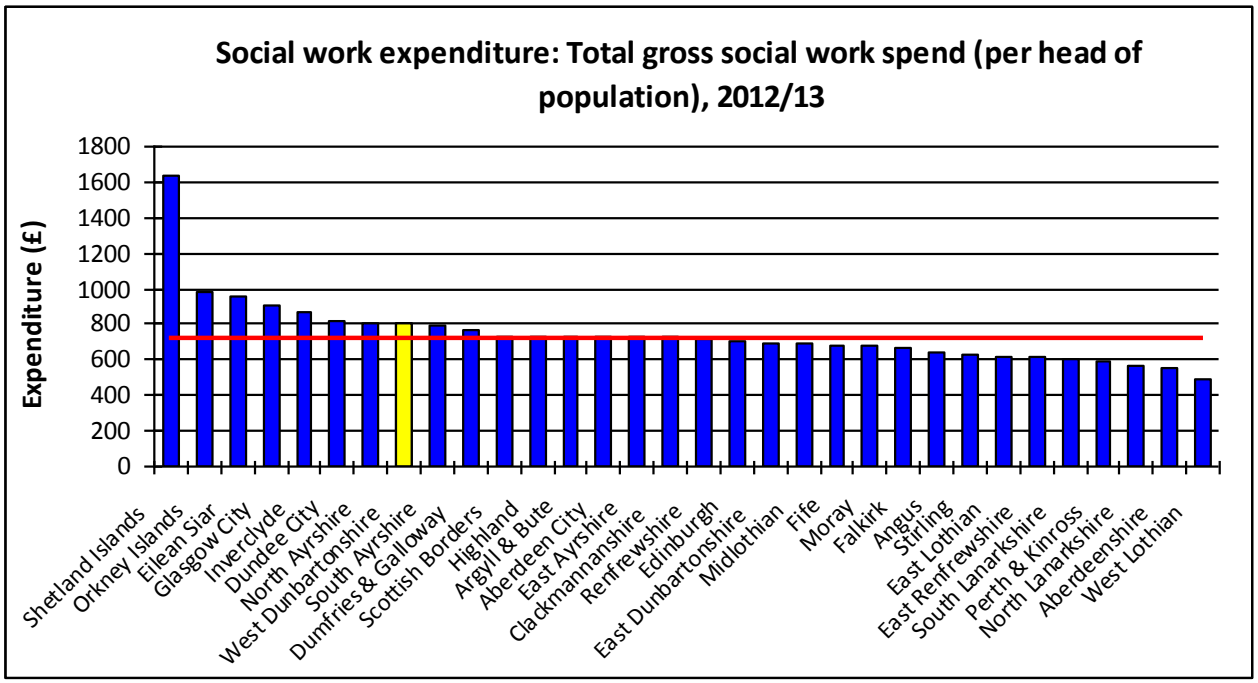


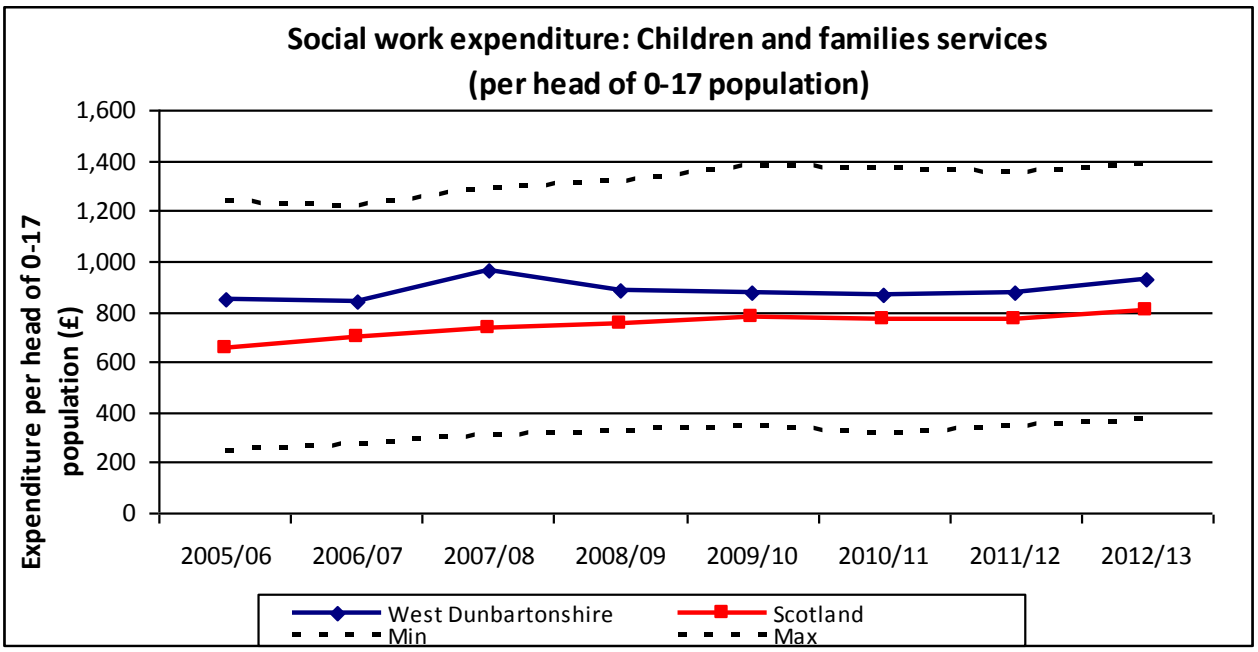
In terms of gauging the financial implication of demands on services, further work has been undertaken with ISD to review and analyse management information relating to Long Term Conditions. The following charts are provided for information and based on SMR01 data for the 12 months ended 31st March 2013 - this work is at an early stage and requires to be treated with caution, particularly costs as these are "NHS" only at this point.

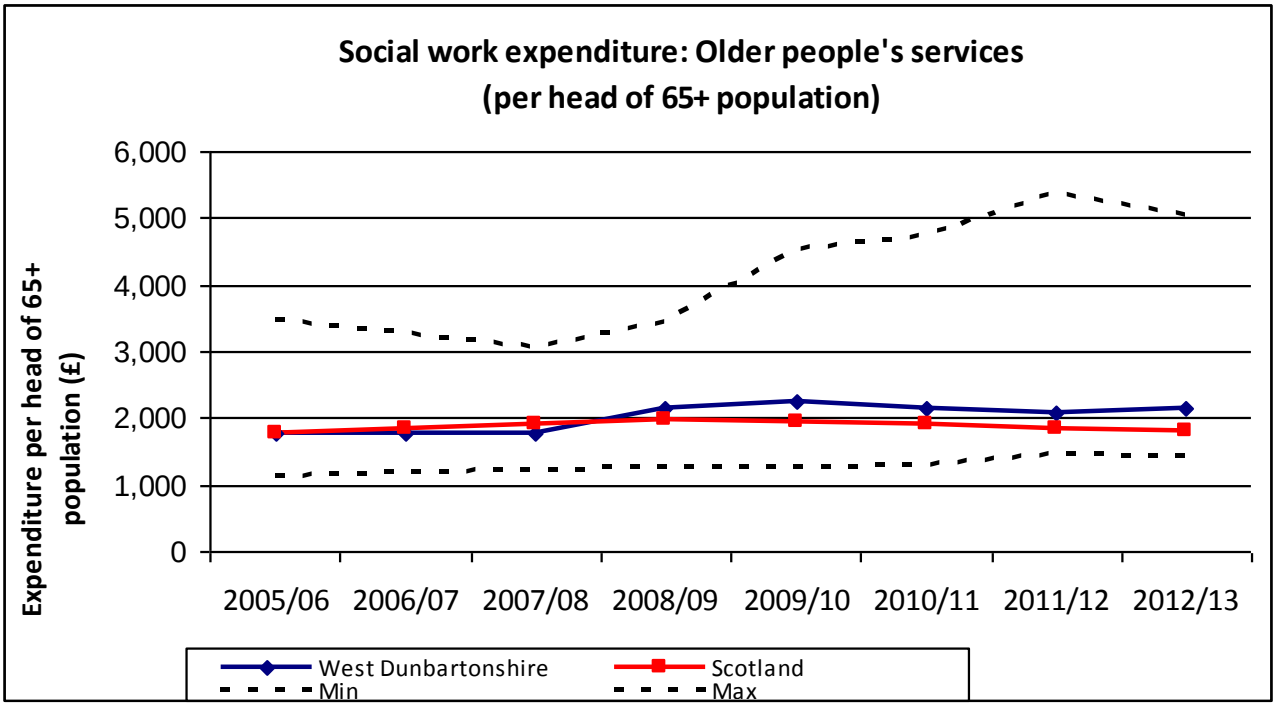




The most recent report on Social Work Spend and Activity 2005/06 - 2012/13 from the Scottish Government presents the following picture in relation to West Dunbartonshire.







Based on prevalence data and analysis of service usage, it is likely that the current level of demand for services is going to increase over the coming years. Local analysis of IORN (Indicators of Relative Need) data has confirmed that we can anticipate a significant increase in the number of people in high needs categories in particular. This is also going to be accompanied by further changes in the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately West Dunbartonshire has the benefit of a strong local track record for improvement across health and social care services; and as such provide a solid foundation for the further developments necessary for the new WD HSCP through 2015 and beyond.

APPENDIX 1: HEALTH & SOCIAL CARE PARTNERSHIP BOARD DELEGATIONS

Services delegated by the Health Board

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine: general medicine; geriatric medicine; rehabilitation medicine; respiratory medicine; psychiatry of learning disability.
- 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 AHPs in an outpatient department, clinic, or outwith a hospital.
- Health Visiting services.
- School Nursing.
- Speech and Language Therapy.
- Specialist Health Improvement.
- Community Children's Services.
- Child and Adolescent Mental Health Services
- 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.

Services delegated by the Council

- 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.
- The legislative minimum delegation of housing support, including aids and adaptations.
- Day services.
- Local area co-ordination.
- Self-Directed Support.
- Occupational therapy services.
- Re-ablement services, equipment and telecare.
- Residential and non-residential care charging.
- Respite provision for adults and young people.
- Social work services for children and young people:
    - Child Care Assessment and Care Management.
    - Looked After and Accommodated Children.
    - Child Protection.
    - Adoption and Fostering.
    - Child Care.
    - Special Needs/Additional Support.
    - Early intervention.
    - Throughcare Services.
- Social work criminal justice services, including Youth Justice Services.

APPENDIX 2: MARKET ANALYSIS AND FACILITATION

The health and social care marketplace in West Dunbartonshire represents a mixed economy approach to service delivery, bringing together differing elements of service delivery agreed shared client outcomes. Within this landscape, the Health and Social Care Partnership (HSCP) provides leadership both in service planning and mapping and in ensuring service quality compliance within an agreed standard of quality assurance of services. This requirement serves to protect people who use health and social care services as well as promoting quality across all statutory services and within the third and independent sectors. As such within our commissioning approach, there is a requirement for analysis of our current position, a description of the agreed direction of travel and the restatement of the underlying philosophy of care across all services within our partnership.

Such a robust market analysis and commissioning approach across the partnership requires an effective dynamic with communities and individuals to understand their needs, their assets and their aspirations; in order to fund and guarantee effective, meaningful and efficient support.

Quality assurance

A cornerstone of this approach to commissioning is our commitment to quality assurance which is already applied to a range of community services. Quality assurance articulates delivery against contract specifications, service users and carers needs as well as appropriate inspection and regulation compliance requirements.

Within the HSCP and wider partners this is expressed as a collection of processes focused on achieving the agreed quality objectives i.e. what the service user has as an assessed need. It is articulated within the HSCP organisational structure through policies, procedures, processes and resources needed to implement quality management. Representing for the HSCP and partners the convergence of inspection processes and customer satisfaction analysis.

Assessing quality is a process by which partners can review the quality of all factors involved in service delivery, placing an emphasis on three aspects:

- Service management - defined and well managed processes, performance information and eligibility thresholds and identification of individuals.

- Competence within service delivery - such as being assured of the knowledge, skills, experience, and qualifications of all staff involved.
- "Soft" elements with organisations such as organisational integrity, confidence in providers, organisational culture, service motivation, team spirit, and quality relationships.

In order to measure effectiveness of service and outcomes for service users; controls include service inspection, where the service is assessed based on the Care Inspectorates Care Standards; where inspectors have a set of agreed standards to support the inspection of quality and care and descriptions of unacceptable service deficiencies. The quality of the service is at risk if any of these three aspects outlined above is deficient in any way.

Recognising that not all services are regulated in this way, the assurance framework within the HSCP relies on robust quality assurance and contract compliance across all services within health, social care, third and independent sector. Current provision by the independent and third sectors is currently clustered around a number of regional/national provider agencies, serviced by a range of smaller more locally based, specialism focussed organisations. However, changing client need and the desire to move to a clearer co-production focus has signalled the need for a review of the market and the opportunities it holds, both for individual organisation and for potential Consortium service arrangements.

Consortium

West Dunbartonshire uses co-production as a keystone in developing effective commissioning systems which use an asset based care *consortia* approach across all partners – public sector, independent sector, third sector and service users – to maximise and contribute to the long term viability of services.

The third sector describes itself as individual organisations within the following categories; charity, voluntary organisation, community group, social enterprise and community business. In addition to the universal support services provided in West Dunbartonshire, the Third Sector provides a range of services and interventions including:

- Residential Services and Supported Accommodation.
- Home Care Support.

- Access to Respite opportunities.
- Care and Repair services.
- Befriending services.
- Carer Support services.
- Peer Support services.
- Sensory impairment services.
- Dementia services.

The third sector play a key role in facilitating the necessary interventions both in building community capacity and supporting co-production through positive service collaboration, development and planning. Both the third and independent sector deliver a wide range of services for older people and those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems as well as supporting.

The independent sector aims to offer choice and value for money, by creating an environment in which care providers can continue to deliver and develop the high quality care that communities require and deserve. The independent sector described as a being a range of small, medium and large providers of health and social care; including single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations; providing residential services, supported accommodation, home care support and access to respite opportunities.

Within the Consortium, there is a need to support a market approach that offers diverse opportunities for the delivery of care to people across West Dunbartonshire who can be active consumers of care and who can direct the service they require. The services may be delivered by existing providers, from partners or indeed from new start-up independent and third sector businesses.

Philosophy of Care

By creating an agreed philosophy of care, partners within the Consortium are agreeing how we measure the quality of service, what is expected of partners and the ongoing impact of the changing policy and legislation landscape. This continuous review of quality will highlight good practice as well as identifying where there are requirements for improvement; supporting a timeous and

focused approach. Overall an approach that refers to the administrative and procedural activities implemented across the partnership so that requirements and goals for all of our services or activity will be fulfilled.

The need to ensure the provision of high quality services across both registered and non-registered service provision is a priority. A tiered approach will be taken to quality monitoring spanning the requisite inspection and reporting duties of Care Inspectorate Registered Providers, through vigorous contract management approaches undertaken through HSCP to self-assessment and proportionate risk-assessment scrutiny for small non-commissioned providers. With the support of partners from the Third Sector Interface and Scottish Care, a suite of consistent quality standards will be created reflecting the agreed Philosophy of Care.

Community capacity building

Building community capacity to support the locality remains a key priority within the West Dunbartonshire partnership. All partners recognise that the significant scale of change needed to shift the balance of care to more community based provision can only be achieved through positive engagement and capacity building activity. Annual sector mapping undertaken by West Dunbartonshire CVS, identifies a considerable provision of low-level, non-commissioned engagement and support activity (145 active organisations) spanning social and physical activity, domestic support and community activity.

These organisations are principally volunteer-led and neighbourhood based and have been identified as requiring ongoing support to maintain sustainability; an activity on which the Third Sector Interface will continue to lead. Building on the groundwork undertaken in developing the LinkUp one-call telephone service for older people and carers, work is progressing to the development of structured neighbourhood asset maps and corresponding development plans to ensure equity of sustainable and appropriate service provisions and clear community pathways across the full local authority area in line with the priorities of older people. The replicability of the LinkUp model facilitates the development of clear pathways which will both connect and harness the services available from organisations and from individual voluntary efforts.

Ongoing dialogue and consultation with older people and representative groups is a key element in all aspects of this activity; maximising the value of their views, experience, abilities and expertise.

Co-production

Co-production is a critical element of the West Dunbartonshire way forward, reflecting its ability to improve well-being through building and supporting social networks; to narrow health inequalities and rebuild traditions of 'mutuality' - all crucial to meeting the aims of Reshaping Care for Older people and helping to bring about an overall reduction in demand for acute health services.

In order to shape the market for the next three years, a full market analysis has been undertaken across the third and independent sectors, highlighting existing and potential providers and signalling the need for service provision to be aligned to the outcomes of the reshaping care agenda and explicitly highlighting co-production as the expected method of working going forward. To facilitate this, third and independent sector partners will continue to work proactively with the provider based in the area to develop capacity via a pipeline approach. This will be taken forward both within and outside of any existing commissioning relationships.

Resource and Leverage

The resources available across the Consortium will become increasingly pertinent; commissioning partners will identify the areas which they see as requiring priority and therefore also more likely to be sustainable for providers to operate within. Where funding pressures may require a re-shaping of service provision and priorities, discussions with the providers can facilitate change to models of delivery which are purposeful in relation to areas which will be vulnerable to reductions in funding or decommissioning of services.

The move to a Consortium approach allows West Dunbartonshire's population to benefit from any funding streams and opportunities which may be developed for both the statutory and third sector over the period. This strengthening of an outcomes focussed approach will increase both service opportunities and sustainability for the population served.

Market Facilitation

The starting point for Market Facilitation will be the development of a Market Position Statement (MPS) for West Dunbartonshire. The MPS will require information in four distinct areas as below.

1. Supply & Demand
   Supply and demand presently and for the future, reviewing current population with 5-10 year projections and the impact of population changes on demand and consequently supply needs. Review of current spend on services coupled with present supply in relation what is being provided, to whom, where and volume of the provision. Review of how the present supply meets anticipated future need and how to support providers adjust to changes in service delivery whether that is a change to how services are delivered or changes to the client profile.
2. Customer Base
   Confirm who the "customers" of the services currently are and who will they be in the future. Going forward we may see more individuals purchasing their own services - so how can we make the market more transparent for them and also support them with the information which will empower them to make the best decisions for their and their families needs.
3. Philosophy of Care
   Consortium partners are agreeing how we measure the quality of service, what is expected of partners and the ongoing impact of the changing policy and legislation landscape.
4. Resources
   The Consortium will lay out what are the totality of resources available to be used, not just what statutory sector can provide but what is available from the community and how are you working in partnership with the available services. In addition, community benefit clauses will also support the best-fit for partners in the delivery of care.

The Consortium partners will ensure and support all partners within the agreed commissioning model to have effective and appropriate systems of:

- Quality control.
- Compliance to regulation and inspection regimes.
- Readiness to deliver.
- Provide alternatives and choices for citizens.

West Dunbartonshire
Health & Social Care Partnership

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board

Subject: 2015/16 Annual Revenue Budget

1. Purpose

1.1 To outline the budget available to the Health & Social Care Partnership (HSCP) Board for 2015/16 from NHSGG&C and West Dunbartonshire Council.

2. Recommendation

2.1 The Partnership Board is recommended to note this report.

3. Introduction

3.1 This report outlines the approved budget available to the HSCP Board for 2015/16 from NHSGG&C and West Dunbartonshire Council. The Council's 2015/16 budget was approved on 4 February 2015, and the Health Board budget was approved on the 23 June 2015.

4. NHS Greater Glasgow & Clyde - Health Revenue Budget

4.1 The final HSCP Board 2015/16 budget reported aligns with the overall NHS Greater Glasgow & Clyde Health Board financial plan. Final adjustments will be actioned in early July in respect of 15/16 uplifts. The HSCP budget amounts to net expenditure of £74.970m and is summarised as Appendix 1.

4.2 The 2015/16 proposed Health budget includes a number of changes from the 2014/15 budget, the most significant of these being as follows:

- The Change Fund, funding for which had been in the Board's baseline, has now been discontinued. That funding, together with additional investment from SG, will now support the new Integrated Care Fund. The funds allocated to West Dunbartonshire HSCP is £1.99m.

- As part of the Barnett consequential funding in 2015/16, SG has provided £30.0m as a contribution to delayed discharges. NHSGGC's share of this funding is £7.1m of which West Dunbartonshire will be allocated £0.597m.

- Pay provision: Current indications are that a provision of 1.0% for pay uplift in 2015/16 is reasonable. On top of the 1.0%, provision has been made for additional the additional costs of a £300 increase for staff earning up to £21,000.

- Superannuation: A provision of £17.0m has been made for the recurring implications of the increase of 1.4% to 14.9% in employers' superannuation contributions.

- Prescribing cost growth projection for 2015/16 is based on initial indications from the Board's Prescribing Advisers. This work is well underway and final amounts will be finalised over the next period.

- Other costs inflation: 1.0% general provision has been set aside for inflation on non-pay costs excluding prescribing costs, energy costs, and capital charges costs. In line with the allocation uplift, 1.8% has been set aside for inflation on Resource Transfer, legal / contractual cost commitments and inflation on amounts payable to other NHS Boards and Voluntary Organisations, related to SLAs agreements

4.3 In addition the HSCP is required to finalise savings adjustments as part of its financial planning process. At this stage draft plans have been finalised as part of Partnerships collective service redesign programme to reduce net expenditure by £15m. This also includes a WD HSCP local savings target of £0.630m.

4.4 Within the local savings programme, the undernoted items mainly comprise of the £0.630m referred to above:

- Integration Fund Realignment – £390k
- Children's Services non recurring - Workforce Turnover - £79k
- Management and Admin efficiencies - £56k
- PHI Accommodation/Admin – Relocate to WDC Offices - £70k
- Addictions change programme - £35k

4.5 The outcome of this work will be included within the final 15/16 revenue budget.

5. West Dunbartonshire Council – Social Care Revenue Budget

5.1 The Council's budget was approved at the full Council meeting of 4 February 2015. The Social Work element of that budget, amounts to a net expenditure of £61.321m and is summarised within Appendix 2.

5.2 The 2015/16 Social Work budget incorporates a number of changes from the 2014/15 budget, the most significant of these being as follows;

- Various items within the Service Reform programme have reduced net expenditure by £0.590m.
- Inflation in respect of pay and has increased net expenditure by £0.546m.

5.3 Within the Service Reform programme, the undernoted items mainly comprise of the £0.590m referred to above:

Additions

- Increased carers and client costs - £0.250m
- Local and external pressures - £1.4m and
- New client costs - £1.5m

Deductions:

- Shifting the balance of care for older people - £0.400m
- Review and restructure of Support costs - £0.270m
- Strategic review and reform of Commissioned Services – £0.490m
- Strategic Review and reform of Children Services - £0.250m

Transfers/Adjustments:

- Contribution to Homeless Service no longer required - £0.350m
- Transfer of Education Day Placement to Education = £0.780m

6. People Implications

6.1 Any workforce implications arising from this budget will be dealt with in conjunction with the NHS and Council HR services as appropriate

7. Financial Implications

7.1 Other than the financial position noted above, there are no financial implications of the operational budgetary control report.

During 2015/16 the Board will work with all Partnerships to develop an agreed methodology to calculate the appropriate budget to represent consumption of unscheduled care services by Integrated Joint Boards. Set aside budgets will be agreed and made available to partnerships from 1 April 2016.

8. Professional Implications

8.1 None

9. Locality Implications

9.1 None

10. Risk Analysis

10.1 The main financial risks to the ongoing financial position relate to currently unforeseen issues arising between now and the financial year-end. Any significant issues will be reported to future Board meetings.

11. Impact Assessments

11.1 None

12. Consultation

12.1 This report was prepared in conjunction with Health and Council Colleagues and was agreed with the (NHS) Director of Finance and Section 95 Officer of West Dunbartonshire Council

13. Strategic Assessment

13.1 None

Jeanne Middleton – Chief Finance Officer

Date: 1 July 2015

Person to Contact: Jeanne Middleton

Appendices: **Appendix 1 – 2015/16 Revenue Budget – NHS Services**
Appendix 2 – 2015/16 Revenue Budget – Council Services

Background Papers: None

Wards Affected:

Appendix 1 – 2015/16 Revenue Budget – NHS Services

	£million	
	2015/16 Full Year	**9 months from July 2015**
Community		
District Nursing	2.032	1.524
Health Visiting	1.498	1.124
Child Health	1.743	1.307
Specialist Nursing	0.393	0.295
Hospital Inpatient Services	2.073	1.555
Community Mental Health Teams	4.541	3.406
Community Learning Difficulties Team	0.282	0.212
Addiction Services	1.871	1.403
Community AHP	1.139	0.854
Health Promotion	0.914	0.686
Other (includes hosted services – MSK & Eye Care)	11.897	8.923
Family Health Services		
GMS	11.533	8.650
Pharmaceutical Services - GP Prescribing	17.255	12.941
Pharmaceutical Services – Other	3.072	2.304
General Dental Services	4.973	3.730
General Opthalmic Services	2.166	1.625
Resource Transfer	7.588	5.691
Total	**74.970**	**56.228**

Appendix 2 – 2015/16 Revenue Budget – Council Services

	£million	
	2015/16 Full Year	**9 months from July 2015**
Older Persons	15.341	11.506
Adults with physical or sensory disabilities	1.969	1.477
Adults with learning disabilities	11.211	8.408
Adults with mental health needs	2.066	1.550
Service Strategy	1.178	0.884
Children's Panel	0.002	0.002
Children & Families	14.869	11.152
Criminal Justice ***	-	-
Adults with other needs	1.231	0.923
Homecare	9.349	7.012
Housing Adaptations and gardens	0.756	0.567
Other Social Care Services	3.349	2.512
Total	**61.321**	**45.991**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board:

West Dunbartonshire Council / NHS Greater Glasgow and Clyde

Subject: FINANCIAL PROCESSES AND PROCEDURES

1. Purpose

1.1 To advise the HSCP Board of the work carried out to date on establishing a set of processes and procedures to determine the governance arrangements for a range of matters in relation to financial management and accountability within the IJB.

1.2 This report describes the work carried out to date on establishing a set of processes and procedures to determine the governance arrangements for a range of matters in relation to financial management and accountability within the Integration Joint Board (IJB).

1.3 Those matters which have been agreed so far are attached to this report, and further information will be brought to the IJB as it becomes available.

2. Recommendation

2.1 The HSCP Board is recommended to approve this report.

3. Background

3.1 In respect of the 6 local authorities within the NHS Greater Glasgow and Clyde area, a Technical Finance Working Group (TFWG) has been established to coordinate the task of producing the various papers which will form the basis of a set of guidance notes to assist the Partnerships in these financial management arrangements.

3.2 The TFWG is chaired by Lynn Brown, Executive Director Financial Services, Glasgow City Council, and is attended by senior officers of each of the 6 local authorities and NHSGG&C. 3 sub-groups were created, and each allocated a number of issues on which they presented papers to the TFWG for approval. Those papers will be combined into a single document, acting as a point of reference for guidance on the range of issues covered.

3.3 The TFWG is aware of a number of issues which are outstanding and subject to national guidance. These issues, and their current status, are noted below.

- Treatment of VAT – the Scottish Government advises that they have finalised agreement with HMRC, and that material will be included in the finalised guidance to be issued to all partnerships in March.
- Status of the IJB – the Scottish Government has provisional assessment from the Treasury that the IJB is a local government body.
- Reserves Strategy – we can now formulate a reserves strategy on the basis of the above provisional assessment that the IJB will be a local government body.
- Formal documentation of accounting treatment, the format of accounts (including structure of notes and content of accounts), and the treatment of support services – Scottish Government advice is that the IJB will need to produce accounts for 2015/16 irrespective of the date of commencement in the Strategic Plan. It is anticipated that these issues will covered in the finalised guidance.

3.4 Those papers which will be submitted to the IJB in due course, include:

- A financial governance system for the proper use of delegated resources
- Statement of Internal Control – Governance Statement & Financial Assurance
- Review of NHS SFIs (financial regulations)
- Internal and External Audit Arrangements
- Business Continuity

3.5 Those papers approved by the TFWG are attached.

4. Main Issues

4.1 Work is ongoing to finalise the financial processes and procedures regulations

5. People Implications

5.1 None

6. Financial Implications

6.1 Sets out processes and procedures in relation to financial management and accountability.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 The NHS Boards SFIs and LA Standing orders are currently in place

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was prepared in conjunction with Health and Council Colleagues and was agreed with the (NHS) Director of Finance and Section 95 Officer of West Dunbartonshire Council.

12. Strategic Assessment

12.1 None

Jeanne Middleton

Date: 1 July 2015

Person to Contact: Jeanne Middleton

Appendices: Attachment 1

Background Papers: None

Wards Affected:

Health and Social Care Integration
Technical Finance Working Group – Workstream 2

Section 1 - Management of Integrated Budgets - Guiding Principles

Section 2 - Budget Setting

Section 3 - Development of Joint Financial Framework
Scheme of Virement – Revised for Integrated Joint Board (IJB)

Section 4 - Capital Planning Process

Section 5 – Managing Financial Performance

Section 1 - Management of Integrated Budgets - Guiding Principles

1. Introduction

1.1 The purpose of this paper is to describe a proposed set of guiding principles for the management of budgets following the integration of health and social care. These are in line with National Finance Guidance produced by Scottish Government Integrated Resources Advisory Group.

2. Background

2.1 The Health and Social Care Partnership (HSCP) will be responsible for managing expenditure within allocated budgets. This responsibility is made more complex by the mix of different Health and Social Work budget categories which will be integrated to form the Integrated Joint Board's (IJB) overall budget.

2.2 Each IJB will be responsible for managing NHS and L.A. service budgets and will be accountable to each agency for the management of budgets allocated by them. Many of these service budgets will derive from general funding allocations and so will be governed by the Standing Financial Instructions/Financial Regulations of each agency on the application of budgets, however, some will also require to be managed in a different way and is detailed further in section 3.

2.3 This paper establishes a set of principles which will guide budget holders in the exercise of their budgetary management responsibility. This will require to be exercised within the context of the already established budget and service planning process currently operated by local authorities and NHSGG&C, and which will take account of the IJB joint strategic plan. IJB must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility (the Chief Finance Officer). The Chief Financial Officer (CFO) is the Accountable Officer for financial management and administration of the IJB. The Chief Officer has all other accountable officer responsibilities. The Chief Financial Officer's responsibility includes assuring probity and sound corporate governance and responsibility for achieving Best Value. Appendix 1 details the responsibilities.

2.4 In establishing these guiding principles, a number of considerations have been key.

These are:

(i) Budget responsibility should as far as possible, follow ability to commit resources/control expenditure CFO will have a key responsibility in ensuring that budget holders are fully aware of their responsibilities as budget holders.

(ii) The need for policies and procedures in respect of control, routine monitoring and reporting of performance in line with local arrangements.

(iii) The need to achieve delegation of responsibility to an appropriate level of financial stability, recognising the statutory responsibilities of local authorities and NHSGG&C to manage their budgets.

(iv) The need to provide for the financial stability for services in the event of sudden changes in demand, to allow them to respond flexibly to such changes.

(v) Where ring-fencing restrictions are in place, there may be limited scope for virement of these resources. This is discussed further in section 3 below.

(vi) The need to have in place clear and proportionate arrangements which support effective service delivery within the budget available.

(vii) The need to manage all aspects of the business of the IJB and the implementation of its strategic plans in a way which achieves best value in the use of its resources and safeguard its assets

(viii) The SFIS/FRegs of each partner organisation and those of IJB will cover virement within and across agency boundaries. This is covered in more detail in a separate paper on virement.

3. Budget Categories

3.1 There are a range of budget categories which are allocated to the IJB. Attached at Appendix 2 is a template which can be used to scope out the budgets for each category.

These are as follows:

Category	Description
1	Directly Managed (DM)
2	Directly Managed, Ring fenced (DMR)
3	Managed on behalf (MOB)
4	Centrally managed with spend/consumption targets (CMT) – Glasgow only
5	Centrally Managed (CM) – Glasgow only
6	Set Aside (Acute) (SA)
7	Other NHS Notional Budgets, outwith Acute (ON)

A more detailed description of each category together with proposed guiding principles for budgetary management, with examples, are provided below:

3.2 Category 1 - Directly Managed (DM)

This category represents those service budgets where NHS and/or LA has allocated full budget managed to the IJB and where there are no specific conditions attached due to the nature of the funding source. Examples of budgets within this category include “district nursing” and “home care”.

3.3 Category 2 - Directly Managed Ring fenced

This category represents those service budgets where NHS and/or LA has allocated budget management responsibility to the IJB, but where there are

specific conditions attached. The nature of the funding source and the conditions attached dictate that the use of funding is ring fenced for specific purposes (e.g. Criminal Justice, or GP Prescribing and ADP)

3.4 Category 3 – Managed on Behalf (MOB)

This category represents those service budgets where NHS and/or LA has allocated management responsibility to the IJB, but where one Joint Board is responsible for managing the service on behalf of one or more other Joint Boards**.** Where this arrangement applies, the responsible IJB will be expected to manage overall service expenditure within available funds.

Examples of budgets which are managed within a HSCP under a hosted arrangement e.g. podiatry and physio

3.5 Category 4 - Centrally Managed, with Spend/Consumption Targets (CMT) – Glasgow only

This category represents those service budgets which remain centrally managed at this stage, but where HSCPs will actively participate in the process of service/expenditure management through the allocation of either spend targets or consumption targets. It is anticipated that over time, a range of service budgets within this category may pass to the direct management responsibility of HSCPs. Examples of budgets with consumption targets are Care Homes and Residential Schools.

3.6 Category 5 - Centrally Managed (CM) – Glasgow only

This category represents those service budgets which will continue to be managed centrally on account of their nature and/or scale where appropriate. Examples of these are grants/payments to voluntary organisation, asylum seekers services, homelessness services.

3.7 Category 6 – Set Aside (Acute) (SA)

The notional budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.

The method for determining the amount set aside for hospital services [To follow- under development by The Integrated Resources Advisory Group (IRAG)

http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/About-the-Bill/Working-Groups/IRAG

3.8 Category 7 - Other NHS Notional Budgets, outwith Acute (ON)

This category is a catch all and includes those service budgets where HSCPs are unable to influence expenditure levels but have a monitoring role (e.g. Family Health Services Non Cash Limited budgets for General Dental Services, GPS, GOS). Such budgets can be regarded as notional allocations.

4. Risk Sharing Arrangements

4.1 A risk sharing arrangement has been established whereby all HSCPs have agreed to adopt the already established joint approach to the management of the Primary Care Prescribing Budget. This will work as follows:

(i) Individual HSCP underspends and overspends will be pooled to arrive at a net overall position relative to overall budget.

(ii) If (i) produces an overall overspend, this will be offset in the first instance against a joint general contingency which has been established by the HSCPs pre integration and held centrally by the Board. If this leaves a residual overspend, each HSCP will establish the scope for containing this within the totality of its service budget, before approaching NHSGG&C Board as a last resort to explore the scope for release of further funding on a recurrent or non recurrent basis as appropriate.

(iii) if (i) or (ii) produces an overall underspend, this will be available for distribution to each HSCP on a pro rata basis, based on the proportion of its primary care prescribing budget to the overall consolidated total of HSCP primary care prescribing budgets.

4.2 A detailed review is ongoing of all FHS budgets including GMS to ensure that the base budget reflects current anticipated patient activity within each IJB.

5. Non Recurring Funding

5.1 HSCPs may receive non recurring funding in any one year from either parent body which will relate to a specific activity. HSCPs must account for such one off funding as required and must not utilise this for purposes other than the basis of the funding, nor should HSCPs plan for any recurrence of such funding. Typical examples will include:

- Contribution towards cost pressures resulting from resource allocation model
- Project funding, including any invest to save initiatives
- One off allocations to assist with specific cost pressure such as impact of winter pressures, specific utility or fuel cost spikes

6. Other Important Points

6.1 HSCP Directors and their teams will engage with NHSGG&C and LA's at appropriate points in the annual service and financial planning process.

6.2 At the start of each financial year, in parallel with establishing HSCP service expenditure budgets, a financial template will be prepared, identifying for each HSCP the different sources of funding which combine to finance the HSCPs annual expenditure budget.

6.3 For each service, an individual template will be prepared. This will provide a detailed set of background information for each service budget, covering the basis of allocation to each HSCP and includes information on funding sources and constraints on use of funds.

Appendix 1

Management of Integrated Budgets – Guiding Principles

The Chief Financial Officer in a public service organisation:

- is a key member of the Leadership Team, helping it to develop and implement strategy and to resource and deliver the authority's strategic objectives sustainably and in the public interest;
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer term implications, opportunities and risks are fully considered, and alignment with the authority's financial strategy; and
- must lead the promotion and delivery by the whole authority of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.

To deliver these responsibilities the Chief Financial Officer:

- must have access to appropriate financial information and analysis.

Core CFO responsibilities:

Developing and implementing organisational strategy

- Contributing to the effective leadership of the authority, maintaining focus on its purpose and vision through rigorous analysis and challenge.
- Contributing to the effective corporate management of the authority, including strategy implementation, cross organisational issues, integrated business and resource planning, risk management and performance management.
- Supporting the effective governance of the authority through development of corporate governance arrangements, risk management and reporting framework; and
- Leading development of a medium term financial strategy and the annual budgeting process for the Integration Joint Board to ensure financial balance and a monitoring process to ensure its delivery.

Responsibility for financial strategy

- Agreeing the financial framework with sponsoring organisations and planning delivery against the defined strategic and operational criteria.
- Maintaining a long term financial strategy to underpin the authority's financial viability within the agreed performance framework.
- Implementing financial management policies to underpin sustainable long-term financial health and reviewing performance against them.
- Co-ordinating the planning and budgeting processes.

Influencing decision making

- Ensuring that opportunities and risks are fully considered, decisions are aligned with the overall financial strategy. and appropriate briefings are provided to the Integration Joint Board.
- Providing professional advice and objective financial analysis enabling decision makers to take timely and informed business decisions. (This will require a strong working relationship with Directors of Finance and related Chief Financial Officers).
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/Integration Joint Board in setting the funding plan/budget.
- Ensuring that advice is provided to the scrutiny function in considering the funding plan/budget.

Financial information for decision makers

- Monitoring and reporting on financial performance that is linked to related performance information and strategic objectives that identifies any necessary corrective decisions.
- Responsibility for the consolidation of appropriate management accounts information received from Health Board and Local Authority.
- Ensuring the reporting envelope reflects partnerships and other arrangements to give an overall picture.

Value for money

- Challenging and supporting decision makers, especially on affordability and Best Value, by ensuring policy and operational proposals with financial implications are signed off by the finance function.
- Reporting to the IJB on the efficiency programmes being delivered within the Operational Units
- Co-ordinating appropriate Benchmarking Exercises.

Safeguarding public money

- Implementing effective systems of internal control that include standing financial instructions.
- Ensuring that the authority has put in place effective arrangements for internal audit of the control environment and systems of internal control as required by professional standards and in line with CIPFA's Code of Practice.
- Ensuring that delegated financial authorities are respected.
- Promoting arrangements to identify and manage key business risks,—risk mitigation and insurance.
- Implementing appropriate measures to prevent and detect fraud and corruption.
-
- Ensuring that any partnership arrangements are underpinned by clear and well documented internal controls.

Assurance and scrutiny

- Reporting performance of both the authority and its partnerships to the board and other parties as required.
- Ensuring that financial and performance information presented to members of the public, the community and the media covering resources, financial strategy, service plans, targets and performance is accurate, clear, relevant, robust and objective.
- Supporting and advising the Audit Committee and relevant scrutiny groups. This now needs to include a review of the Statement of Internal Controls.
- Ensuring that clear, timely, accurate advice is provided to the Chief Officer/ Integration Joint Board and the scrutiny functions on what considerations can legitimately influence decisions on the allocation of resources, and what cannot.
- Ensuring that the financial statements are prepared on a timely basis, meet the requirements of the law, financial reporting standards and professional standards as reflected in the Code of Practice on Local Authority Accounting in the United Kingdom developed by the CIPFA/LASAAC Joint Committee.
- Certifying the annual statement of accounts.
- Ensuring that arrangements are in place so that other accounts and grant claims (including those where the authority is the accountable body for community led projects) meet the requirements of the law and of other partner organisations and meet the relevant terms and conditions of schemes
- Liaising with the external auditor.

Leading and Directing the Finance Function - arrangements will depend on local agreement

- To receive assurance from Directors of Finance that efficient and effective professional services from the finance staff in both Health and Local Authorities is being delivered.
- Identifying and equipping managers and the Leadership Team with the financial competencies and expertise needed to manage the business both currently and in the future.

Management of Integrated Budgets – Guiding Principles'

Budget Categories – Resources Controlled and Managed by the IJB

Budget Category	**Resource**
Budgets Managed and Controlled by the IJB	
Directly Managed	Real cash budget managed and controlled by the IJB
Directly Managed – Ring Fenced	
Centrally Managed	Real cash budget managed and controlled by the IJB – reflects and specific local arrangements
Managed by IJB for Other IJB's Hosted Services xxxxx Managed on Behalf of Services xxxxx	Hosted and Managed on Behalf Of for other IJBs. Real cash budget managed and controlled by the IJB
Sub Total "Real Cash" Budgets within IJB control	**£x**
Budgets Managed for the IJB	
Hosted by XX IJB	Budget managed on behalf of IJB where there will be influence over activity / usage but no budgetary accountability Performance information needs to be available to identify each IJB activity as well as clarity on actions of usage in excess of allocation etc.
Managed on Behalf of by XX IJB	
Recharges	Include any below the line central support recharges and / or any local recharge / SLA arrangements
Capital Allocations	Include any below the line or fixed capital charges as appropriate
Other	To allow for any other local or notional real cash budgets related to IJB
Sub Total "Real Cash" Budgets not within IJB control	**£x**
Total IJB Community & Primary Care Budget	**£x**
Notional Budgets Relating to the IJB	
Acute Services Awaiting direction for what areas to include	Budget allocations to come from IRF – needs a lot development / discussion ! Budgets where there will be some influence / impacts by IJB
Other Services	Any other notional budgets
Sub Total Notional Budgets not within IJB control	**£x**
Total All IJB Resources	**£x**

Section 2 - Budget Setting

1. Introduction

1.1 The legislation requires that the Integration Joint Board (IJB) produce a Strategic Plan which sets out the services for their population over the medium term (3 years). This Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan, which will comprise both the Integrated Budget and the notional budget, i.e. the amount set aside by the Health Board for large hospital services used by the IJB population.

1.2 This paper considers how the Integrated Budget may be determined, taking account of the need to consider existing financial plans of the Local Authority and Health Board, and is drawn largely from the IRAG Professional Guidance.

2. Determination of Budgets

2.1 The IRAG recommends that integration authorities undertake a shadow period in 2014/15, and that allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board, including the planned efficiencies and consideration of recent financial outturn and trends in expenditure. This process must be transparent and the assumptions underlying the budgets must be available to all partners.

2.2 The IRAG also recommends that the financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.

2.3 The initial payments to the IJB should be based on analysis of the shadow period in 2014/15 to provide the Local Authority, Health Board and IJB with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.

2.4 This is an essential part of the financial planning and management of the IJB and all partners must ensure clarity and transparency of information to allow the IJB financial officer, the Health Board accountable officer and the Local Authority Section 95 officer to carry out due diligence and develop confidence in the Integrated Budget.

2.5 The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. While the IRAG guidance advises that partners should aim to give indicative three year

allocations to the IJB, in reality this will not be possible. Both Local Authority and Health Board budgets are determined by funding, which will only be notified on an annual basis. Any indication of future allocations to the IJB should therefore be considered as broad planning assumptions.

2.6 The Chief Officer, and the IJB financial officer where such is appointed separately, should develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process. The business case should be evidenced based with full transparency on its assumptions and take account of:

- **Activity Changes**. The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes;

- **Cost inflation**. Pay and supplies & services cost increases. Pay increases will largely be determined by national agreements. Some supplies & services cost increases will be influenced by contractual arrangements regarding uplifts;

- **Efficiencies**. All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Integration Joint Board, Local Authority and Health Board as part of the annual rolling financial planning process to ensure transparency;

- **Performance on outcomes**. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Local Authority and Health Board;

- **Legal requirements**. Legislation may entail expenditure commitments that should be taken into account in adjusting the payment;

- **Transfers to/from the set aside budget for hospital services** set out in the Strategic Plan;

- **Adjustments to address equity**. The Local Authority and Health Boards may choose to adjust contributions to smooth the variation in weighted capita resource allocations across partnerships; information to support this will be provided by ISD and ASD;

- **Resource Transfer**. Some Social Work expenditure budgets will be funded by resource transfer payments. It is recommended that the Health Board continue paying resource transfer to the Local Authority and exclude it from its payment to the Integration Joint Board. The Local Authority would include in its payment to the Integration Joint Board the social work services funded by the resource transfer. It is assumed that an annual inflationary uplift will continue to be applied to resource transfer by the Health Board.

2.7 The partner Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate

their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.

2.8 The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board.

2.9 The legislation will require that a direction should be in writing and must include information on:

- The integrated function/(s) that are being directed and how they are to be delivered; and
- The amount of and method of determining the payment to carry out the delegated functions.

2.10 It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction.

3. Overheads

3.1 The decision on which overheads to include and whether they are included in the Integrated Budget or as notional budgets is a matter for local decision. While this is predominantly a matter for local authorities, it is recommended that a consistent approach be adopted for Integration Joint Boards in partnership with the same Health Board.

4. Scottish Government guidance on set aside for Large Hospital Services and Hosted Services

4.1 The resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget of each Integration Joint Board. The legislation takes powers for Ministers to set this out in regulations. Each Integration Joint Board will be required to include in its strategic plan the capacity required from the hosted service by its population. It is recommended that the Chief Officer responsible for managing the hosted service take the lead in coordinating the Integration Joint Boards in development of their strategic plans for that service.

4.2 The purpose of the guidance, produced jointly by the Integrated Resources Advisory Group and the Joint Commissioning Steering Group, is to provide advice on;

- Implementing the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) and regulations in respect of the amounts to be set aside for those delegated provided in ‘large hospitals’,

- The treatment of hosted services included in delegated functions.

4.3 The guidance covers;

- A method for establishing the amount to be set aside for the services that are delivered in a 'large hospital', as defined in the 2014 – i.e. showing consumption by partnership residents;
- A method for quantifying and reporting performance for the financial consequences of planned changes in capacity as they relate to 'set aside' budgets for large hospitals, which may be:
    - i) steady state i.e. the strategic plan results in no changes to consumption of services in scope / is designed to avoid increases in consumption.
    - ii) Increased consumption
    - iii) Decreased consumption

4.4 Both ii) and iii) above have implications for transfer to/from the set aside and the integrated budget, on completion of the change programme.

4.5 A link to the Scottish Government guidance is shown below.

http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/working_Groups/IRAG/FinPlLgHospHostServ

4.6 Appendix 2 of the paper on 'Management of Integrated Budgets – Guiding Principles' gives some examples of hosted services budgets (see page 10).

Section 3 - Development of Joint Financial Framework
Scheme of Virement – Revised for Integrated Joint Board (IJB)

1. Introduction

1.1 The purpose of this paper is to set out a scheme for the operation of virement arrangements within the context of managing joint budgets within IJB. This should reflect the financial regulations currently in place within each organisation.

2. Background

2.1 The establishment of an IJB requires local NHS and local authorities' social work managers to take responsibility for the joint planning, resourcing, and delivery of services, lead by the Chief Officer supported by the Chief Finance Officer.

2.2 The retention of existing organisational frameworks in Scotland means that health boards and local authorities will continue to exist as separate legal entities with statutory responsibility for the management of the resources allocated to them under agreed governance arrangements of the IJB.

2.3 To support the establishment of joint working arrangements, there is a need to provide a scheme of virement for the IJB which will overlay the existing arrangements operated by both partner bodies, and work in partnership with them to provide an enabling framework to allow flexible use of resource across agency boundaries where this is required and appropriate in line with the joint strategic plan. The current mechanism used for resource transfer will be followed for this purpose.

2.4 In terms of formal reporting arrangements, existing schemes of virement within local authorities and Health Boards will continue to operate. The level at which virement requires approval of local authority Committee or Health Board will be determined by the various schemes of delegation, which will also identify any differences in the treatment of recurring and non-recurring virement.

2.5 The arrangements described below seek to provide this flexibility, but in doing so seek to guide the use of virement to secure the maintenance of financial stability within the new national context of IJB in partnership with Local Authorities and Health Boards.

2.6 In developing this framework, the over-riding consideration has been to provide an enabling framework which will promote the flexible use of resources in support of the achievement of service aims and objectives while maintaining overall financial stability for the IJB, Local Authority and Health Board.

2.7 Arrangements in respect of virement should be specified in the financial regulations and standing instructions within the partner authorities.

3. **Proposed Scheme of Virement**

Range of services and budgets

3.1 The services which come within the scope of this scheme of virement are the resources covered by the Strategic Plan of the IJB. This will cover the amount in respect of delegated adult social care services, the amount covered by delegated primary and community health care services and for those delegated hospital services and the amount set aside by the Health Board for services provided in large hospitals for the population of the IJB. Whilst the IRAG guidance sets out the minimum budgets that are required to be included IJB will be able to include other services through local agreement i.e. Children's Services

3.2 IJB budget will comprise both new and existing funds. It is recognised that there will generally be limited room for manoeuvre in the short term where costs are fixed in nature (e.g. permanent staffing budgets), however the need to at least provide for the option to use resources flexibly where the opportunity arises is considered important.

3.3 Where budgets have specific conditions attached to their use by the Scottish Government, the operation of virement arrangements will require to ensure that funding continues to be deployed in a way which satisfies these conditions.

3.4 Exercise of virement

It is anticipated that managers will exercise virement in the following circumstances:

3.4.1 Annual budget setting

3.4.1.1 Decisions regarding the deployment of new monies and the redeployment, if applicable, of existing monies including any sustained underspend(s), will typically be made in the context of the annual budget setting process with respect to the Strategic planning process. These may reflect policy decisions agreed at the Integrated Board to change the balance of care from the joint strategic plan or to re-engineer services in a more limited way. A virement scheme will require further development within health board arrangements

3.4.1.2 In either case, the outcome may be that the IJB seek to vire resources across partners, to enable implementation of strategic plans. The payment mechanism will be the current resource transfer arrangements.

3.4.2 In year budget adjustments

3.4.2.1 The Chief Officer with the agreement with the joint Chief Finance Officer of the IJB will be able to transfer resources between partners of the operational Integrated Budget. This will require in-year balancing adjustments to the allocations from the IJB to the Local Authority and the Health Board i.e. a reduction in the allocation to the body with the underspend and a corresponding increase in the allocation to the body with the overspend.

3.4.2.2 Decisions regarding the redeployment of existing monies will typically be made in year in the light of emerging underspends, or less frequently, slippage in the use of new monies. In addition, decisions may be required regarding the deployment of new monies where new allocations of funds are made available in year.

3.4.2.3 In either case, budget adjustments may be required, which could be of a recurring or non-recurring nature and may result in the IJB seeking to vire resources across partners to reflect strategic plans.

3.5 Set Aside (Acute)

3.5.1 It is recommended that partners avoid the creation of a bureaucratic process for reporting and adjusting for monthly activity and cost variances. However, the operational budgets will be predicated on agreed capacity plans and failure to meet this commitment could cause material overspends.

3.5.2.1 It is recommended that partners should establish a process for the Chief Officer and the hospital sector to jointly monitor in year actual demand against plan and provide for virement, if required, based on practical thresholds.

3.5.3 The method for determining the amount set aside for hospital services [To follow - under development by The Integrated Resources Advisory Group (IRAG)

http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/About-the- Bill/Working-Groups/IRAG

3.6 Guiding principles

3.6.1 The guiding principles which have shaped the development of this scheme are set out below:

3.6.2 Budget responsibility should as far as possible, follow ability to commit resources/control expenditure.

3.6.3 The need to achieve real delegation of responsibility to appropriate level, but also to recognise the statutory responsibilities of local authorities and NHS GG&C to manage the overall envelope(s) of resources available to them.

3.6.4 The need to provide for sufficient short term financial stability for services experiencing sudden changes in demand, to allow these to respond flexibly to changes in demand.

3.6.5 The need to limit ring-fencing restrictions where possible to allow scope for genuine virement of resources where appropriate.

3.6.6 The need to devise arrangements which have in place clear and proportionate arrangements which support effective service delivery.

3.7 **Procedural arrangements (see Appendix 1)**

It is envisaged that virement will be exercised in accordance with the following procedures:

3.7.1 Virement opportunities will emerge from the process of: -

(a) Setting the budget for the Joint Strategic Plan and
(b) Reviewing financial plans in the context of service reform or revisions to the joint Strategic Plan.

Any virement proposals will require the support and commitment of the Integrated Joint Board Chief Financial Officer and Health and Local Authority finance officers as a necessary precondition of submission. It is important that all parties are agreed to what is being proposed. Commitment of all parties, evidenced by authorised signatures, will be necessary before virement proposals are submitted for processing.

3.7.2 Virement requests will emerge from the routine financial management processes.

3.7.3 Where virement of funds is proposed from service budgets where the decision to vire may conceivably have an impact on service provision by another HSCP, area wide partnership or city wide managed service, virement proposals will require the support and commitment of the head of that service along with the relevant Chief Finance Officers as a necessary precondition of submission. It is important that all parties are agreed to what is being proposed. Commitment of all parties, evidenced by authorised signatures, will be necessary before virement proposals are submitted for processing.

3.7.4 Subject to any ring-fencing constraints that will exist locally, there should be as much scope for viring resource as possible, allowing the Integrated Joint Boards maximum freedom to discuss and reach agreement on an appropriate allocation of the total resources which are at their disposal. In reaching a decision in this regard, the Chief Financial Officer must be consulted and agree with any proposals.

3.7.5 Virement proposals should be submitted in writing or electronically using a prescribed form.

3.7.6 Where a request is being made to vire funds from one allocation budget to another budget within the Integrated Joint Board say for balancing the budgets between the Local Authority and the Health Board, a completed form providing details of the request, including supporting explanation should be submitted by the Chief Officer in consultation with the Chief Financial Officer of the Integrated Joint Board to the HOF (SWS) for SWS budgets or relevant financial officer or to the HOF (NHS Partnerships) for Health Boards budgets. The HOF (SWS) or relevant financial officer or the HOF (NHS Partnerships) will be responsible for countersigning this before submission to Financial Services (local authorities) or Financial Services (NHS) for processing.

3.7.7 Virement proposals exceeding the locally agreed limits will require to be submitted by the Chief Officer and Chief Financial Officer to the Integrated Joint Board for approval.

3.7.8 All budget movements during the year will require to be reported as required to Committee for authorisation within 4 weekly financial monitoring reports or relevant financial period.

3.8 Overspends/underspends

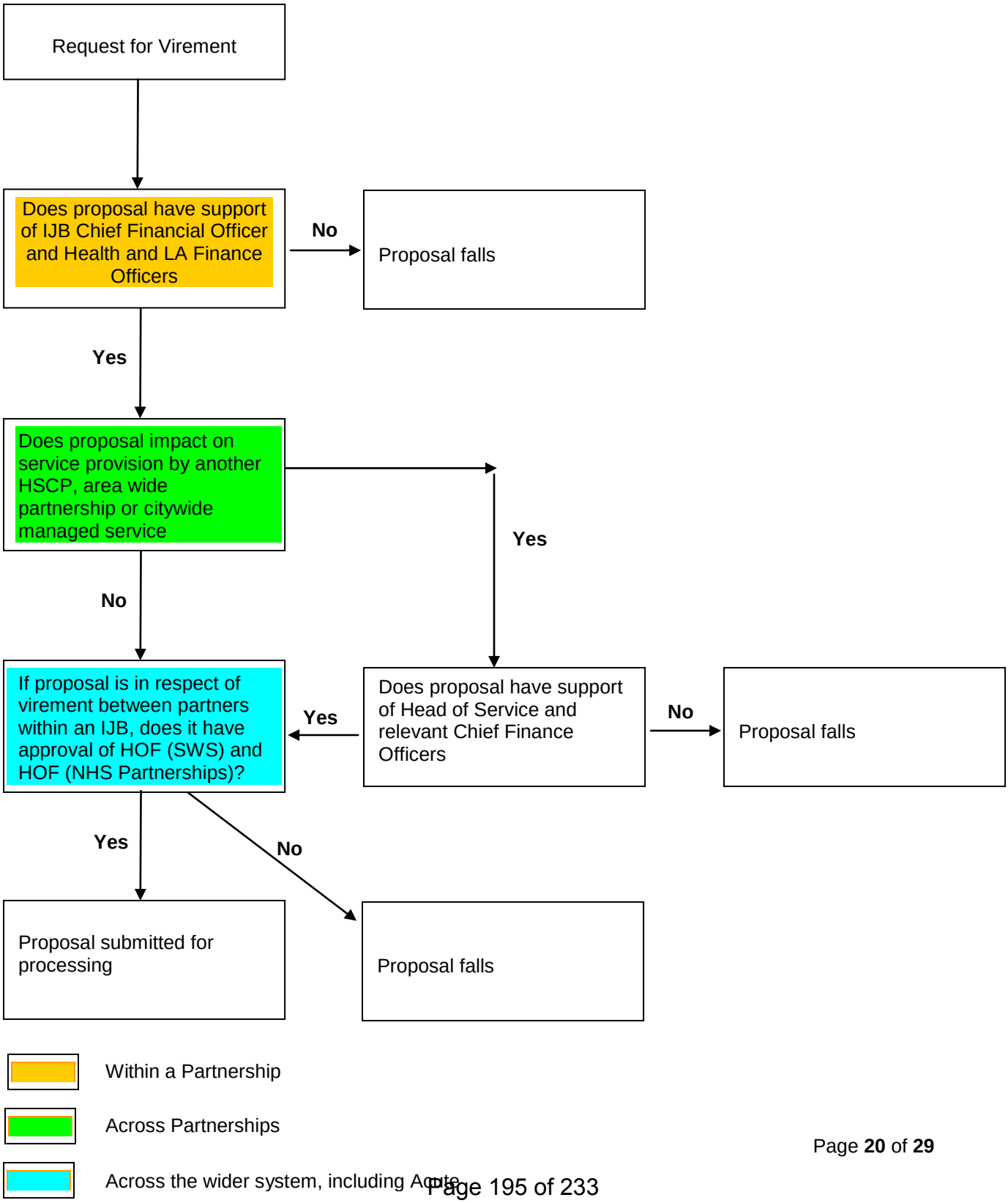
3.8.1 Where resources have been vired from one partner to another, and an overspend arises in relation to resources so transferred, it will be the responsibility of the Integrated Joint Board's Chief Officer and Chief Financial Officer to manage this within the context of the Integrated Joint Board's overall services budget and advise each partner, as appropriate, regarding how this overspend will be managed or contained.

3.8.2 Where resources have been vired from one partner to another and an underspend arises in relation to resources so transferred, it will be the responsibility of the Integrated Joint Board's Chief Officer and Chief Financial Officer to manage this within the context of the Integrated Joint Board's overall services budget and advise each partner, as appropriate, regarding how this underspend will be managed. This will have to take account of the reserves policy in place for the Integrated Joint Board.

3.8.3 In framing virement proposals, managers will require to take cognisance of existing contractual arrangements and any other conditions attached to funding.

Scheme of Virement

Procedural arrangements in respect of Virement within or across Partnerships (NB – does not include potential need for LA or HB approval as stated in the respective Schemes of Delegation).



Section 4 - Capital Planning Process

1. Introduction

1.1 The Strategic Plan considers all of the resources available to deliver the objectives approved within the Integration Scheme, including non-current assets owned by the Health Board on behalf of Scottish Ministers, and local authority. The purpose of this paper is to describe the arrangements for making effective use of non-current assets for the delivery of health and social care integration.

2. Background

2.1 The Integrated Resources Advisory Group (IRAG) professional guidance for shadow integration arrangements indicates that as the Integration Joint Board (IJB) will not directly own any property or assets, nor receive any capital allocations, grants or have the power to borrow or invest in capital expenditure, the Chief Officer of the IJB is recommended to consult with the local authority and Health Board partners to make best use of existing resources and develop capital programmes.

2.2 This paper acknowledges that in the short term at least, current arrangements within each partner organisation will continue to apply, but that in the longer term the Chief Officer will wish to consider alternative arrangements in the discharge of the IJB business.

2.3 The IRAG states that in developing the Strategic Plan, the Chief Officer of the IJB is advised to consider the CIPFA guidance on place based asset management. www.cipfaproperty.net/fileupload/upload/one%20public%20estate_v2112201111519.pdf

2.3 The respective processes for the approval of the capital programmes of the Health Board and local authorities are attached at Appendices 1 and 2.

2.4 Where the Chief Officer identifies the need for new investment within the Strategic Plan, a business case should be developed for the proposal for both partners to consider. Options may include one or both of the partners approving the project from its capital budget or where appropriate using the hub initiative as the procurement route to deliver the capital investment. This is a matter for local agreement.

3. Proposal for management of the Capital Plan

3.1 It is proposed that each HSCP will initially prepare a capital plan in tandem with the rolling annual capital planning process operated within each partner organisation. This will be the outcome of a strategic review of HSCP service priorities, and should take the form of an itemised list of proposed capital spending, set out in priority order. A brief summary should be provided for each scheme and this should include the following items: title of scheme, brief overview, timing, intended benefits, funding plan including, net funding requirement, revenue funding consequences.

3.2 Each HSCP will be expected to update and formally approve its capital plan on an annual basis.

3.3 In tandem with an annual update of its capital plan, each HSCP shall review its premises needs, including existing owned and leased clinical and office premises. The output of this review should be a premises plan which identifies **(a)** requests for new/upgraded accommodation **(b)** planned disposal/vacation of premises no longer required, over the forthcoming period. Major requirements for new/upgraded accommodation would almost certainly feature within the HSCPs capital plan with minor schemes being set out in a supplementary listing. (In Glasgow, this function is managed by Access, the Council's Property and ICT provider. Other authorities may have similar arrangements).

3.4 There will be an annual process by the lead Chief Finance Officer and involving all HSCP Chief Officers or designated representatives to reach agreement on an allocation of formula capital funding to each individual HSCP in respect of minor works and minor equipment. This is in accordance with current arrangements which are in place within the NHS Scheme of Delegation.

3.5 It is proposed that the HSCPs Capital Plan be developed within a Joint Capital Planning Group (JCPG). Together with the supplementary listing of planned minor premises schemes, the HSCPs Capital Plan would be submitted for approval by the HSCP Management Team, and thereafter to the IJB.

4. Joint Capital Planning Group

4.1 It is proposed that a local JCPG will be established within each HSCP. This group will be responsible for taking an overall strategic overview of HSCP capital plans with a view to assessing potential sources of finance and also assessing opportunities for joint proposals across more than one HSCP, and providing advice on how best to take forward capital proposals within the Health Board and/or LA capital planning processes. Responsibility for prioritising capital projects will continue to be exercised by the Health Board and LA partners within already established capital planning/capital bidding processes. In this light it will be important for group membership to include officers possessing a good working knowledge of existing and potential sources of finance.

4.2 Following review by JCPG, HSCP capital plans will be taken forward within the Health Board and LA capital planning process as appropriate.

4.3 A joint operational capital sub group will also be established within each HSCP at a local level, comprising of officers with appropriate skills and experience.

4.4 The joint operational capital sub group will take responsibility for;

- maintenance of a register identifying all LA and NHS Community based properties, utilising information provided by partners. This will be used as a reference point when considering draft HSCP capital plans.
- maintenance of a register of jointly occupied premises, recording details of joint funding agreements related to such jointly occupied premises and ensuring that this is kept up to date. This work will be co-ordinated by LA and

NHS Capital planners, who will be accountable to the Chief Officer HSCP (tbc) in this regard on a day to day basis.

5. Rolling Capital Planning Process

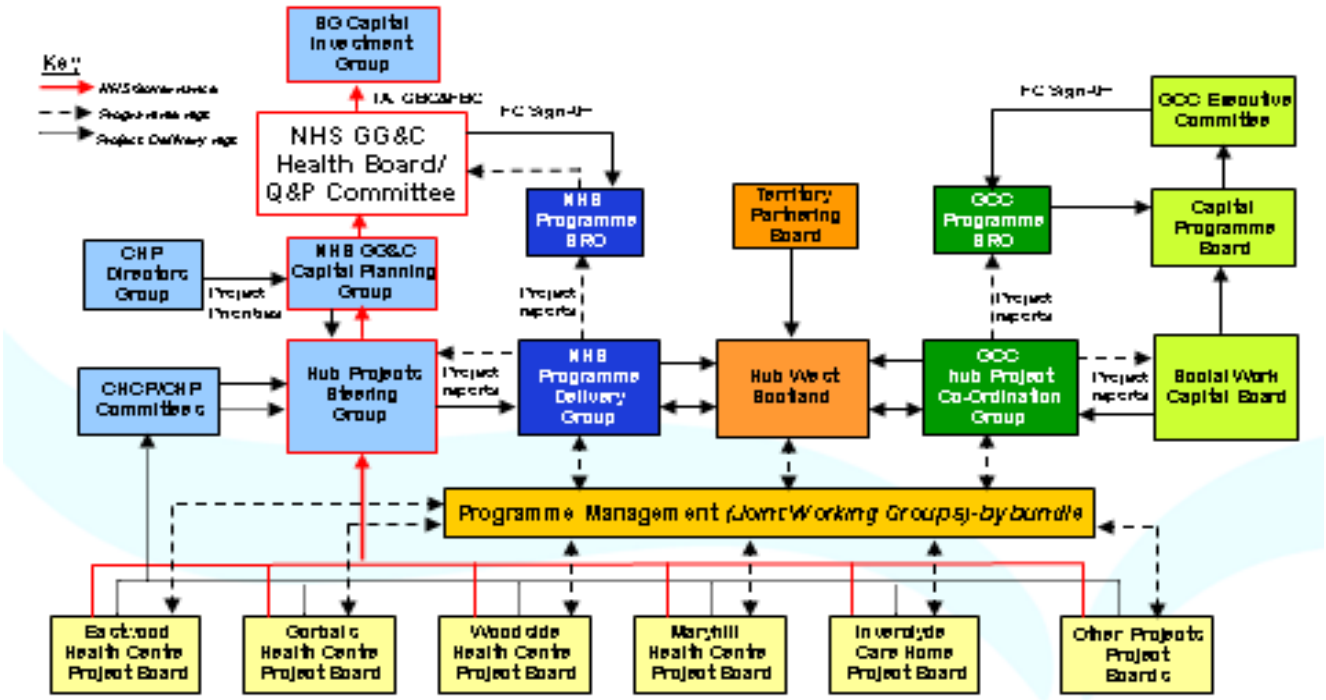
5.1 Both Health Board and LA operate a rolling capital programme. The governance arrangement for Health is shown at Appendix 1. The governance arrangements within the appropriate LA will be attached at Appendix 2 to provide an HSCP specific paper. The governance arrangements within Glasgow are attached as an example.

6. Business Case Preparation and Guidance

Existing documented procedures for developing business cases to source capital funding should be utilised. Where a project is funded via Health Board, the Health Board documentation and process will be followed. Where a project is funded via LA, the LA documentation and process will be followed. Where joint bids are being made, the approval of both partners through their respective processes will be required. Approval levels with the Health Board and LA will be determined by the appropriate Schemes of Delegation.

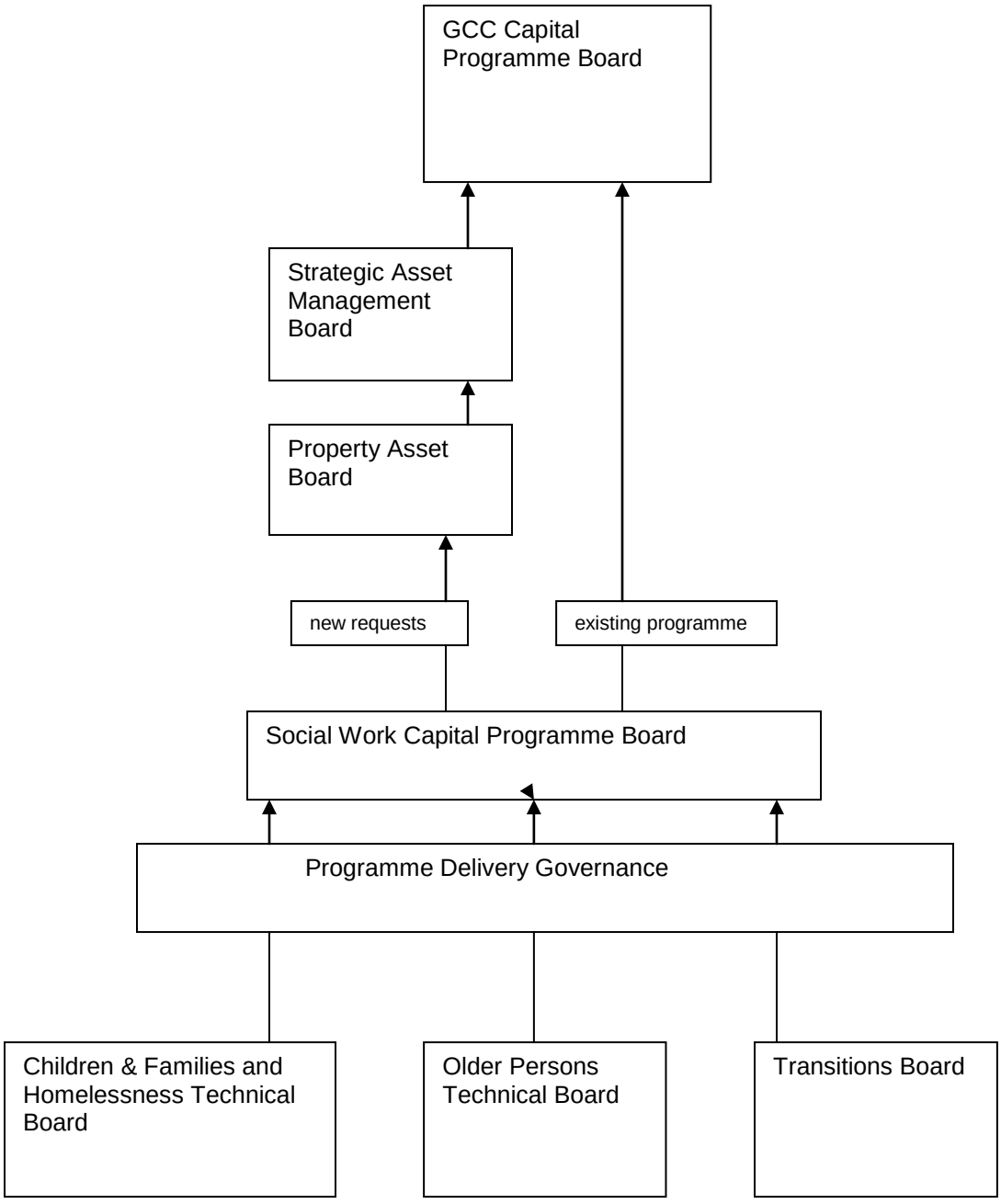
Appendix 1

Governance Arrangements –



Local Authority Capital Planning – Governance Arrangements

Glasgow City Council – Social Work Services



Section 5 - Managing Financial Performance

1. Introduction

1.1 The purpose of this paper is to outline provisions for managing in-year financial performance of the Integrated Budget, as directed in the Integrated Resources Advisory Group (IRAG) professional guidance for shadow integration arrangements. This will require that the Chief Officer receives financial performance information for both their operational role in the Health Board and Local Authority and strategic role in the Integration Joint board (IJB).

2. Budget monitoring

2.1 The Health Board and Local Authority Directors of Finance and the IJB financial officer will establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the IJB as a whole. It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person to carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.

2.2 Whilst the Health Board and Local Authority will each continue with their own schedule of in-year financial reporting and forecasting requirements, reporting to the IJB will be in line with the schedule of IJB meetings. Full reporting requirements to be confirmed in line with new IJB governance arrangements.

2.3 The Health Board and Local Authority will agree a consistent basis for the preparation of management accounts reported to the IJB. This should initially reflect the current reporting arrangements for each organisation.

3. Budget Management

3.1 The IJB will direct the resources it receives from the Health Board and the Local Authority in line with its Strategic Plan, and in so doing seek to ensure that the planned activity can reasonably be met from the available resources viewed as a whole and achieve a year end breakeven position. This is essential for the financial stability of the IJB itself and for the Health Board and Local Authority.

3.2 The Chief Officer will be responsible for the management of in-year pressures and should take remedial action to mitigate any net variances and deliver the planned outturn. Expenditure outwith the total resources available should not be incurred.

3.3 The Chief Officer will be able to transfer resources between the two arms of the operational Integrated Budget subject to appropriate approvals. This will require in-year balancing adjustments to the allocations from the IJB to the Local Authority and Health Board. Further guidance is available in the Scheme of Virement document.

3.4 Managing overspends

3.4.1 If an overspend is forecast on either arm of the operational Integrated Budget, the Chief Officer and the Chief Finance Officer should agree a recovery plan to balance the overspending budget. Where appropriate, approval should be sought in line with the scheme of delegation. This plan should include clear options and target savings with named persons responsible for delivering them, which are closely monitored and controlled.

3.4.2 In addition, the IJB may increase the payment to the overspending partner, by either

- Utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or

- Utilising the balance on the general fund, if available, of the IJB in line with the reserves policy.

3.4.3 If the recovery plan is unsuccessful and there are insufficient general fund reserves to fund a year end overspend, then the partners have the option to:

- Make additional one-off payments to the IJB;

- Provide additional resources to the IJB which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to address this; or

- Reprioritise in-year expenditure, subject to other governance arrangements).

3.4.4 The IJB will not ordinarily be required to contribute to the management of in-year overspends on non-integrated budgets in the Local Authority or Health Board. In the event of a projected in-year overspend elsewhere across the Local Authority or Health Board non-integrated budgets, they should contain the overspend within their respective non-integrated resources.

3.4.5 The exception to this general principle relates to exceptional circumstances as defined by local arrangements.

3.4.6 The IJB will not be required to contribute to overspends in other IJBs within the Board area other than in those specific budget areas where risk sharing applies as set out in the Management of Integrated Budgets Guiding Principles document. Otherwise, the responsibility for this lies with the overspending IJB who should apply the process noted above within their own authority for in-year overspends. However, financial risk should be managed through the financial management process noted above and the use of reserves, where available.

3.5 Managing underspends

3.5.1 Any net underspends on either arm of the operational integrated budget, with the exception of ring fenced budgets should be returned to the IJB by the Local Authority or Health Board and carried forward through the local authority general fund, where the accounts of the IJB will be held.

3.5.2 The exception to this general principle relates to exceptional circumstances as defined by local arrangements.

3.5.3 In some years the IJB may plan for an underspend in order to build up reserve balances, although in practice the scope for this will be constrained given the context of financial challenge at least over the short to medium term.

4. Reserves

For further information on reserves refer to Reserves Strategy document.

5. Financial Returns

5.1 The Health Board and the Local Authority are currently required to complete the following financial/statistical returns for the Scottish G overnment:

- Health - routine financial performance monitoring returns are submitted to the SGHSCD and any other statutory organisation as required. Including Scottish Financial Returns (SFRs) for Annual Accounts and Cost Book SFRs.

- Local Authority – Local Financial Returns (LFRs), Provisional Outturn and Budget Estimate (POBE) and Free Personal and Nursing Care data (FPNC).

5.2 Proposals will be developed by the Scottish Government to revise these returns to reflect the integration arrangements. Information on the revised arrangements for the LFR3 will be issued by Scottish Government. Guidance on the SFR will continue to be provided in the Unified Board Accounts Manual.

6. Statutory Performance Indicators

6.1 All Local Authorities are required to report annually on a set of operational and financial performance indicators known as Statutory Performance Indicators (SPIs) as specified by Audit Scotland. Of those specified for Social Work, none relate specifically to finance.

6.2 From 2013/14, all Local Authorities are also required to participate in the Local Government Benchmarking Framework (LGBF) which will be used by Audit Scotland to compare their performance against a suite of indicators. Of the 8 listed for Social Work Services, 4 relate specifically to financial measures. Details can be found at:
http://www.improvementservice.org.uk/benchmarking/index.html

6.3 The Health Board is required to report on a range of performance measures including HEAT targets and standards; targets identified at Health Board level; and other local performance indicators specified by the CHP in its wider Development Plan.

The specific HEAT target for financial performance sets out that NHS Boards are required to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement. NHS Boards have an obligation to operate within their allocated funds and ensure value for money.

6.4 As a tool for performance management, there will be a requirement to continue reporting on all these indicators.

7. Role of budget holders

7.1 The Chief Financial Officer will ensure that budget holders receive impartial advice, guidance and support and are provided with accurate, timeous and appropriate information to enable them to effect control over expenditure and income.

7.2 Budget holders are ultimately responsible for the budgets assigned to them and will be held accountable for all such budgets within their control.

7.3 The IJB will ensure arrangements are put in place to hold budget holders to account, particularly where financial problems or potential overspends have been identified. This should consist of formal meetings held on a regular basis chaired by the Chief Officer and/or Chief Financial Officer, where the Budget Holder will be expected to report on areas of concern and propose corrective actions.

7.4 Budget holders have a responsibility to formally report any major financial problems identified within the service to the Chief Financial Officer who can instruct appropriate action and report to the IJB if required.

7.5 Budget holders should alert and consult the Chief Financial Officer where no budget is available but where expenditure is essential to the discharge of the functions of the IJB.

7.6 Budget holders should at all times comply with the LA's code of Practice on Financial Management and Control and NHS Health Boards SFIs Budgetary Control and Reporting and Scheme of Delegation.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 1 July 2015

Subject: West Dunbartonshire Health & Social Care Partnership (HSCP) Due Diligence Process and 2015/16 Budget.

1. Purpose

1.1 To advise the Board of the due diligence undertaken in respect the proposed 2015/16 revenue budget which has been done in light of the 2012/13, 2013/14 and 2014/15 financial information.

2. Recommendations

2.1 The Board is recommended to:

1) note the due diligence work undertaken as the basis for 2015/16; and
2) approve the 2015/16 budget.

3. Background

3.1 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. It establishes the framework for the integration of health and social care in Scotland.

3.2 The Integration Joint Board (IJB) is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of an Integration Scheme. NHS Greater Glasgow & Clyde Board and West Dunbartonshire Council have delegated functions to the Integration Joint Board which has responsibility for planning, resourcing and operational delivery of all integrated services.

3.3 The IJB is required to allocate the resources it receives from the Health Board and Local Authority in line with the Strategic Plan. The Board is able to use its power to hold reserves so that in some years it may plan for an underspend to build up reserve balances and in others to break even or to use a contribution from reserves in line with the reserves policy. A Reserves Policy will be subject of a future report to this Board.

3.4 Due diligence work, as recommended in the guidance provided around the formation of IJBs, has been undertaken to consider the sufficiency of the budget provided for the Partnerships as outlined in Appendices 1 to 3.

4. Current Position

4.1 The due diligence work undertaken has been informed by an overview of both the Health Boards and Councils financial performance covering the following periods:

- 2012/13 final expenditure;
- 2013/14 final expenditure;
- 2014/15 final expenditure; and
- 2015/16 budget.

4.2 Part of the resources for which the IJB will be responsible is currently held within the Health Board for acute hospital services, this will be known as the Set Aside budget.

It has been agreed that the Set Aside budget for Acute hospital services to be included within the integrated budget are those which have been identified as offering the best opportunity for improvement through integration - as the specialties' activity profiles have a high proportion of unplanned bed days.

Integration authorities will be responsible for strategic planning of these services as such unplanned activity may be potentially avoidable given improvements in primary care and community services. It is recognised that not all unplanned admissions are potentially avoidable but inclusion of these services within the scope of the Integrated Strategic Plan should ensure that the focus of integrated health and social care arrangements is on preventative and anticipatory care.

The following services below are those services in scope and as a result will be included in the Set Aside budgets for the Health & Social Care Partnership:

- accident and emergency services provided in a hospital;
- inpatient hospital services relating to the following specialties:
    - general medicine;
    - geriatric Medicine;
    - rehabilitation medicine;
    - respiratory medicine;
    - psychiatry of learning disability;
- palliative care services provided in a hospital;
- inpatient hospital services provided by general medical practitioners (N/A in NHSGGC);
- services provided in a hospital in relation to an addiction or dependence on any substance; and
- mental health services provided in a hospital except secure forensic mental health services.

During 2015/16 the Health Board will work with all Partnerships to develop an agreed methodology to calculate the appropriate budget to represent

consumption of unscheduled care services by Integrated Joint Boards. Set aside budgets will be agreed and made available to partnerships from 1 April 2016.

4.3 The table below summarises the 2012/13, 2013/14 and 2014/15 actual outturn at each consecutive year end for both Health and Social Care Service financial performance.

	2012/13			2013/14			2014/15		
	Annual Budget £'000	Annual Actual £'000	Variance £'000	Annual Budget £'000	Annual Actual £'000	Variance £'000	Annual Budget £'000	Annual Actual £'000	Variance £'000
West Dunbartonshire Council - Social Work	58,874	58,529	345	60,017	60,144	-127	59,962	61,444	-1,482
Greater Glasgow & Clyde - Health	73,203	73,197	6	73,974	73,916	58	74,727	74,716	11
	£132,077	**£131,726**	**£351**	**£133,991**	**£134,060**	**-£69**	**£134,689**	**£136,160**	**-£1,471**

4.4. The actual outturn for each consecutive year shown above is included below for comparison to the proposed 2015/16 budget. The total proposed budget is £136.3m.

	Social Work	Health	TOTAL
2012/13 Actual spend	£58,529	£73,197	£131,726
2013/14 Actual spend	£60,144	£73,916	£134,060
2014/15 Acutal spend	£61,444	£74,716	£136,160
2015/16 Budget	£61,321	£74,970	£136,291

4.5. The overall summary position shown above is further detailed in Appendices 1 to 3 of this report which includes a breakdown of individual costs at care group level.

5. Due Diligence – Main Finding

5.1 Investment

For 2015/16 the Council has identified planned inflationary and budget pressure uplifts of £3.169m to address the 2014/15 overspends linked to increased demand for services as well as projected demand pressures for 2015/16.

5.2 The 2015/16 IJB budget incorporates a number of changes from the 2014/15 budget, the most significant of these adjustments are reported within the WDHSCP 2015/16 Budget Report (sections 4 and 5).

5.3 Planned Efficiencies

The Health Board has completed the HSCP 2015/16 budget in line with the overall NHS Greater Glasgow & Clyde Health Board financial plan. Final adjustments have been actioned in period 2 in respect of 15/16 uplifts.

In addition the HSCP is required to finalise savings adjustments as part of its financial planning process. It should therefore be noted that plans based on productivity and efficiency proposals, against relevant base budgets, have been submitted to the Health Board and approved. Significant effort has been applied to ensure budget reductions have been obtained wherever possible through service redesign and efficiency programmes. At this stage final plans are in place within Partnerships collective service redesign programme to reduce net expenditure by £15m.

Contained within this amount the net savings target for WDHSCP is £0.630m and deductions have been applied to 2015/16 opening budgets.

5.4 The Council Social Care budget is completed in line with the overall West Dunbartonshire Council financial plan and all growth and efficiency items agreed by Council on 4 February 2015 have been allocated and removed from the budget. In doing so, the Council has agreed Social Work Services planned efficiencies of £2.58m for 2015/16. Action plans have been drawn up to deliver the planned savings many of which will be delivered through the strategic service and reform change programme.

5.5 Progress on the delivery of planned efficiencies for both Health and Council will be monitored through the Senior Management Team with regular updates to the Health and Social Care Joint Board throughout 2015/16.

5.6 Financial Risks

The main financial risks identified are:

5.6.1 Planned Efficiencies

The Health savings plans based on productivity and efficiency proposals, against relevant base budgets, have been submitted to the Health Board and approved. Significant effort has been applied to ensure budget reductions have been obtained wherever possible through service redesign and efficiency programmes. At this stage final plans are in place within Partnerships collective service redesign programme to reduce net expenditure by £15m. Contained within this amount the net savings target for WDHSCP is £0.630m and deductions have been applied to 2015/16 opening budgets.

For 2015/16 the Council has assumed Social Work Services planned efficiencies of £2.58m for 2015/16. Action plans have been drawn up to deliver the planned savings many of which will be delivered through the strategic service and reform change programme. With these efficiencies and the agreed growth as noted above the Socual Work budget has increased by just under £0.6m.

Progress on the delivery of planned efficiencies for both Health and Council will be monitored through the Senior Management Team with regular updates to the Health and Social Care Joint Board throughout 2015/16.

5.6.2 Financial Planning for 2015/16 and Beyond - NHS

The NHS GG&C Board's financial plans for 2015/16 and 2016/17 currently suggest a savings challenge in excess of that in recent years, brought about in part by the requirement to fund changes to the NHS Superannuation Scheme in 2015/16 and to employer's National Insurance contributions in 2016/17. Work has been ongoing across the Board to mitigate the gap.

At a Partnerships level, the current planning assumption is for savings of around £15m for each of the next two financial years. Planning work has focused on the structured approach taken over the previous four financial years: whole-system services review and redesign, integrated with system-wide and local financial and resources planning.

It is recognised that plans for 2015/16 will be a mix of both recurring and non-recurring savings, while Chief Officers will continue to work collectively and locally to develop more detailed plans for full recurring release by the end of March 2017.

5.6.3 The Council, in setting its budget for 2015/16, also made decisions which aim to generate efficiencies for financial years from 2016/17 onwards. There remained target savings to be identified for 2016/17 and 2017/18 of £4.5m and £6.8m cumulative.

The main funding risks going forward for the Council relate to potential loss of Scottish Government funding which could be impacted by the ongoing UK austerity measures and may also be impacted by expected further population loss within the area.

Other significant pressures relate to inflation on staff pay and other lines; potential impact of welfare reform; potential impact of ongoing anticipated demographic change where the population is expected to continue to age and require care for longer.

5.7 Specific Health Services Pressures

- **Adult Community Services**

Equipu (community equipment service) was overspent by £64,000 in 2014/15. This area of overspend is common across all CHCP/CHP areas and has been affected by the additional activity associated with Change Fund initiatives. Action plans are in place to address this area of overspend.

5.8 Specific **Council Service Pressures**

- **Older People Residential Accommodation**

Staff absence cost pressures of £0.400m in 2014/15.

- **Physical Disability Care costs**
  Continuing rise in number of high cost care packages where care at home packages are geared towards re-abling clients as much as possible and are regularly reviewed to adapt to changing capabilities of clients. The position is under review.

- **Community Placements** – Continuing shortage of fostering parents resulting in requirement to use high cost external fostering agencies. The position is under review.

5.9 Ongoing Monitoring and Review

Projected outturn against annual budget will be subject to ongoing monitoring and review and will be reported to the Integration Joint Board at regular intervals over the course of the financial year. This is a key component of financial governance as it ensures that the impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and other planned and unplanned activity changes are monitored and reviewed on an ongoing basis. The requirement for ongoing monitoring of and reporting of progress against approved efficiency savings is a further key component of sound financial management.

5.10 The requirement for ongoing monitoring of and reporting of progress against approved efficiency savings is a further key component of financial governance. Financial management reports to the West Dunbartonshire Community Health & Care Partnership 2014/15 highlighted the key financial issues which are challenging in terms of delivery in 2014/15 and this approach will continue in 2015/16 and going forward.

5.11 It is anticipated that Health & Social Care partnerships will be VAT neutral ie the VAT costs and recovery for the partners will be in line with current levels. This will need to be monitored throughout the year as part of the financial management reporting process and national risk mitigation plans.

5.12 Assurance Statement

It is the opinion of the Chief Financial Officer that the initial budget allocated to the Partnership is sufficient to deliver on the outcomes highlighted within the Strategic Plan, subject to effective risk mitigation and the successful delivery of efficiency initiatives as detailed in the report.

Given the needs led nature of Health and Social Care services, it is possible that there will be deviations from original plans over the course of the financial year. Robust budgetary control, monitoring and reporting procedures are in place and any budget variances arising during the financial year and remedial proposals will be brought to the attention of the Health & Social Care Partnership Joint Board at the earliest opportunity.

6. Financial Implications

6.1 The due diligence work has highlighted areas of financial risk for the Partnership Budgets for 2015/16 and 2016/17. Ongoing monitoring of these areas will take place throughout the financial year.

7. People Implications

7.1 Any workforce implications arising from this budget will be dealt with in conjunction with the NHS and Council HR services as appropriate

8. Professional Implications

8.1 None

9. Locality Implications

9.1 None

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was prepared in conjunction with Health and Council Colleagues and was agreed with the (NHS) Director of Finance and Section 95 Officer of West Dunbartonshire Council.

Jeanne Middleton – Chief Finance Officer

Date: 1 July 2015

Person to Contact:	Jeanne Middleton
Appendices:	Appendix 1 :2014/15 CHCP Committee Report (NHS) 2 :2013/14 CHCP Committee Report (NHS) 3 :2012/13 CHCP Committee Reports (NHS) 4 :Revenue Budgetary Control Summary 2014/15 5 :Revenue Budgetary Control Variance 2014/15 6 :Revenue Budgetary Control 2013/14 7 : CHCP 2013/14 year end var 8 : Revenue Budgetary Control 2012/13
Background Papers:	NHS and Social Care Financial Reports presented at each CHCP committee on financial performance of WD CHCP.
Wards Affected:	All

Appendix 1 – 2014/15

WEST DUNBARTONSHIRE COUNCIL

Report by the Chief Officer Designate of the Health and Social Care Partnership

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Subject: **Financial and Capital Works Report for the year ended 31 March 2015 (NHS Only)**

1. Purpose

The purpose of the report is to provide an update of the current year financial position and of the financial planning by the NHS Board and by the CHCP.

2. Recommendations

The Committee is asked to note the content of the Financial and Capital Works Report for the year ended 31 March 2015.

3. Background:

The report provides an update of the financial planning by the NHS Board and by the CHCP, and of the overall revenue position of the CHCP and its Capital Programme for 2014/15 (NHS only).

4. Main Issues:

Financial Planning for 2015/16 and beyond

4.1 The Board's financial plans for 15/16 and 16/17 currently suggest a savings challenge in excess of that in recent years, brought about in part by the requirement to fund changes to the NHS Superannuation Scheme in 15/16 and to employer's National Insurance contributions in 16/17. Work has been ongoing across the Board to mitigate the gap.

4.2 At a Partnerships level, the current planning assumption is for savings of around £15m for each of the next two financial years. Planning work has focused on the structured approach taken over the previous four financial years: whole-system services review and redesign, integrated with system-wide and local financial and resources planning.

4.3 It is recognised that plans for 15/16 will be a mix of both recurring and non-recurring savings, while Chief Officers will continue to work collectively and locally to develop more detailed plans for full recurring release by the end of March 2017.

Revenue Position 2014/15

4.4 West Dunbartonshire CH(C)P's (NHS-only) revenue position reported for the year ended 31 March 2015 was £11,000 underspent.

4.5 An overspend within the provision of community equipment through the Equipu service is slightly lower than in previous years. Although additional funding has been provided for the specialist care package for which the CHCP took responsibility in 2010/11, this remains a pressure area. Work is ongoing to try to reduce this cost pressure. Offsetting these areas of overspend are underspending across a number of areas but mainly Planning & Health Improvement and Addictions and Hosted Services (Retinal Eye Service and the Integrated Eye Service).

4.6 The overall summary position is reported in the table below, with further comments on the significant variances highlighted in section 4.7 of this report. An additional detailed breakdown of individual costs at care group level is reported in Annexe 1 of this report.

	Annual Budget £000	Year to Date Budget £000	Year to Date Actual £000	Variance £000
Pays	25,628	25,628	25,418	210
Non Pays	54,478	54,478	54,677	(199)
	80,106	80,106	80,095	11
Less Income	(5,379)	(5,379)	(5,379)	0
Net Expenditure	**74,727**	**74,727**	**74,716**	**11**

Significant Variances

4.7 Comments on significant issues are noted below:

- **Mental Health (Adult)** reported an underspend of £11,000, resulting from vacancies within the Community Mental Health Teams. This was offset in part by planned non-recurring expenditure within non pay areas (purchase of equipment and property maintenance).

- **Addictions** reported an underspend of £43,000, as a result of Psychology and Nursing vacancies. The Residential Rehabilitation budget, within Other Community Addictions (non-pays), is also underspent.

- **Learning Disabilities** reported an underspend of £21,000 as a result of a vacancy within Dietetics.

- **Adult Community Services** reported an overspend of £140,000. Equipu (community equipment service) is overspent by £64,000. This area of overspend is common across other CHPs and has been affected by the additional activity associated with Change Fund initiatives. As noted above, the spend on the specialist care package is causing a pressure despite additional funding and is overspent by

£87,000 year to date (slightly lower than reported at the January 2015 meeting).

- **Planning and Health Improvement** reported an underspend of £36,000 as a result of the secondment of a service manager to Glasgow City CHP and a vacant admin post.

- **Prescribing:** the reported GP Prescribing result is based on the actual result for the 10 month period to 31 January, extrapolated to 31 March. The total result across all Partnership's for the first ten months is 0.7% under budget. West Dunbartonshire CHCP is reporting a £14,000 underspend. Under the risk sharing arrangement, this local underspend position has been adjusted to report a cost neutral position within the CHCP:

- **Hosted Services** reported an underspend of £33,000 as a result of lower spend against Medical Fees and payments within the Glasgow Integrated Eye Service and Retinal Screening Service.

Capital Programme 2013/14

4.8 Formula Capital

The CHP's final capital programme for the year is outlined in the table below. This includes an additional allocation of £50,000 from the CHCP's endowment fund for the Outpatients Department in Dumbarton Health Centre:

Project	**Spend (£000)**
Dumbarton Health Centre Refurbishment Works	119
Fruin Ward Kitchen	25
Dumbarton Health Centre CCTV upgrade	6
Dumbarton Joint Hospital – alarm/automatic doors	17
Total	**167**

5. People Implications

5.1 There are no people implications, arising from this report.

6. Financial Implications

6.1 Other than the financial position noted above, there are no financial implications of the budgetary control report.

7. Risk Analysis

7.1 The main financial risks to the ongoing financial position relate to currently unforeseen issues arising between now and the financial year-end. Any significant issues will be reported to future Committee meetings.

8. Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9. Consultation

9.1 This report is for information only and relates only to the NHS element of the CHCP, with no requirement for consultation.

10. Strategic Assessment

10.1 This report provides an update on the CHCP's revenue and capital position (NHS only) and does not seek to affect the Council's main strategic priorities.

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Keith Redpath
Director.

Person to Contact: Jonathan Bryden**,** Head of Finance - Clyde CHPs (0141 618 7660)

Appendix: Financial Statement 1 April 2014 to 31 March 2015

Background Paper: None

Wards Affected: All

Appendix 1
West Dunbartonshire Community Health Partnership
Financial Year 1 April 2013 to 31 March 2014

	Annual Budget £000	Year to Date Budget £000	Year to date Actual £000	Year to date Variance £000	% Variance
Expenditure					
Mental Health (Adult)	4,583	4,583	4,571	12	0.26%
Mental Health (Elderly)	3,151	3,151	3,151	0	0.00%
Addictions	1,929	1,929	1,886	43	2.23%
Learning Disabilities	575	575	554	21	3.65%
Adult Community Services	10,729	10,729	10,869	(140)	(1.30%)
Children & Families	4,693	4,693	4,693	0	0.00%
Planning & Health Improvement	1,062	1,062	1,026	36	3.39%
Family Health Services (FHS)	23,088	23,088	23,088	0	0.00%
Prescribing	17,241	17,241	17,241	0	0.00%
Other Services	3,064	3,064	3,058	6	0.20%
Resource Transfer	7,633	7,633	7,633	0	0.00%
Hosted Services	819	819	786	33	4.03%
Change Fund	1,539	1,539	1,539	0	0.00%
	80,106	80,106	80,095	11	0.01%
Income	(5,379)	(5,379)	(5,379)	0	0.00%
Net Expenditure	**74,727**	**74,727**	**74,716**	11	**0.01%**

Members should note that NHS GG&C financial convention of reporting underspends as positive variances (+) and overspends as negative variances (-) has been adopted for all financial tables within the report.

WEST DUNBARTONSHIRE COUNCIL

Report by the Director of Community Health and Care Partnership

Community Health and Care Partnership Committee: 21 May 2014

Subject: **Financial and Capital Works Report for the year ended 31 March 2014 (NHS Only)**

1. Purpose

The purpose of the report is to provide an update of the current year financial position and of the financial planning by the NHS Board and by the CHCP.

2. Recommendations

The Committee is asked to note the content of the Financial and Capital Works Report for the year ended 31 March 2014.

3. Background:

The report provides an update of the financial planning by the NHS Board and by the CHCP, and of the overall revenue position of the CHCP and its Capital Programme for 2013/14 (NHS only).

4. Main Issues:

Financial Planning for 2014/15

4.1 The draft overall Board savings target for 14/15 remains around £33m, with £6m being the Partnerships target. Partnership Directors and staff have developed an overall programme which should deliver this level of savings, largely through system-wide redesign programmes.

Revenue Position 2013/14

4.2 West Dunbartonshire CH(C)P (NHS-only) revenue position reported for the year ended 31 March 2014 was £58,000 underspent. This is broadly in line with a full-year forecast position of an underspend of £50,000.

4.3 Funding has been provided for the additional costs in 2013/14 of the specialist care package for which the CHCP took responsibility in 2010/11. A high level of activity within the provision of community equipment through the Equipu service has resulted in continued overspending in this area. However, this continues to be offset by underspending within Physio, Planning & Health Improvement expenditure and within Accommodation & Admin.

4.4 Significant additional funding has been provided to the CHCP for the running costs of the new Vale Centre, and also for MSK Physio, in the CHCP's role in managing the Board-wide service, to allow the waiting times to be brought into line with the new HEAT target.

4.5 The overall summary position is reported in the table below, with further comments on the significant variances highlighted in section 4.6 of this report. An additional detailed breakdown of individual costs at care group level is reported in Annexe 1 of this report.

	Annual Budget £000	Year to Date Budget £000	Year to Date Actual £000	Variance £000
Pays	25,479	25,479	25,191	288
Non Pays	53,479	53,479	53,709	(230)
	78,958	78,958	78,900	58
Less Income	(4,984)	(4,984)	(4,984)	0
Net Expenditure	**73,974**	**73,974**	**73,916**	**58**

Significant Variances

4.6 Comments on significant issues are noted below:

- **Mental Health – Adult Community Services** was £8,000 overspent year to date. The Crisis Service was overspent as a result of the impact of the previous year's savings. There is also a recurring pressure within the Management pays budget. These are offset by pays underspend within the Primary Care Mental Health Team resulting from staff turnover and vacancies.

- **Mental Health – Elderly Services** reported an underspend of £1,000 year to date. Vacancies and non pays underspends within Elderly Mental Health Inpatient services are offsetting pressures within Elderly Community pays and travel.

- **Learning Disabilities** reported an underspend of £24,000, as a result of vacancies within Admin and Dietetics.

- **Adult Community Services** reported an overspend of £143,000. Equipu (community equipment service) is overspent by £211,000. This area of overspend is common across other CHPs and has been affected by the additional activity associated with Change Fund initiatives. This is being offset by an MSK Physio underspend of £136,000 arising from vacancies, maternity leave and posts going through recruitment.

- **Planning and Health Improvement** reported an underspend of £58,000 as a result of vacancies, maternity leave and long term sickness absence. These vacancies have now been filled and cover is in place for maternity leave.

- **Other Services** (incorporating Accommodation & Admin, and Executive) reported an underspend of £34,000 mainly arising from vacancies.

- **Hosted Services** (Retinal Screening and the Glasgow Integrated Eye Service) reported an underspend for the year of £73,000. The latter service has largely been phased out and budget distributed to CHPs. The remaining budget to pick up Family Health Services costs was underspent in the year. Within Retinal Screening an accrual for expected equipment servicing costs was not required.

- **Prescribing:** a cost neutral position has been included in the March Financial Report at CHCP level. Next year a 'gross' position, together with the level of offset, will be reported.

Capital Programme 2013/14

4.7 Formula Capital

The CHP's final capital programme for the year is outlined in the table below:

Project	**Spend (£000)**
Dumbarton Joint Hospital addictions	46
Feasibility Study to review DHC accommodation/replacement windows	36
Clydebank HC – encapsulation and new windows	56
Total	**138**

5. People Implications

5.1 There are no people implications, arising from this report.

6. Financial Implications

6.1 Other than the financial position noted above, there are no financial implications of the budgetary control report.

7. Risk Analysis

7.1 The main financial risks to the ongoing financial position relate to currently unforeseen issues arising between now and the financial year-end. Any significant issues will be reported to future Committee meetings.

8. Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9. Consultation

9.1 This report is for information only and relates only to the NHS element of the CHCP, with no requirement for consultation.

10. Strategic Assessment

10.1 This report provides an update on the CHCP's revenue and capital position (NHS only) and does not seek to affect the Council's main strategic priorities.

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Keith Redpath
Director.

Person to Contact: Jonathan Bryden**,** Head of Finance - Clyde CHPs (0141 618 7660)

Appendix: Financial Statement 1 April 2013 to 31 March 2014

Background Paper: None

Wards Affected: All

Appendix 1
West Dunbartonshire Community Health Partnership
Financial Year 1 April 2013 to 31 March 2014

	Annual Budget £000	Year to Date Budget £000	Year to date Actual £000	Year to date Variance £000	% Variance
Expenditure					
Mental Health (Adult)	4,683	4,683	4,691	(8)	(0.17%)
Mental Health (Elderly)	3,128	3,128	3,128	0	0.00%
Addictions	1,883	1,883	1,879	4	0.21%
Learning Disabilities	557	557	533	24	4.31%
Adult Community Services	10,530	10,530	10,673	(143)	(1.36%)
Children & Families	4,461	4,461	4,445	16	0.36%
Planning & Health Improvement	1,187	1,187	1,129	58	4.89%
Family Health Services (FHS)	23,271	23,271	23,271	0	0.00%
Prescribing	16,612	16,612	16,612	0	0.00%
Other Services	2,676	2,676	2,642	34	1.27%
Resource Transfer	7,519	7,519	7,519	0	0.00%
Hosted Services	847	847	774	73	8.62%
Change Fund	1,604	1,604	1,604	0	0.00%
	78,958	78,958	78,900	58	0.07%
Income	(4,984)	(4,984)	(4,984)	0	0.00%
Net Expenditure	**73,974**	**73,974**	**73,916**	58	**0.08%**

Members should note that NHS GG&C financial convention of reporting underspends as positive variances (+) and overspends as negative variances (-) has been adopted for all financial tables within the report.

Appendix 3 FY 2012/13

WEST DUNBARTONSHIRE COUNCIL

Report by the Director of Community Health and Care Partnership

Committee: 15 May 2013

Subject: Financial and Capital Works Report for the period ended 31 March 2013 (NHS Only)

1. Purpose

- The Committee is asked to note the content of the Financial and Capital Works Report for the period ended 31 March 2013.

2. Recommendations

- This report is submitted for Committee's consideration and comment.

3. Background:

The report provides an update of the overall revenue position of the CHCP and of the CHCP's Capital Programme for 2013/14 (NHS only).

4. Main Issues:

4.1 Board Financial Planning for 2013/14

Although the Board's Financial Plan – and therefore the overall savings target - for 13/14 has yet to be finalised, it is expected to be in the region of £30m-£35m. It was reported to the CHCP Committee at its November 2012 meeting that the assessment of Partnership savings potential from system-wide redesign work would have resulted in a shortfall which would require to be allocated to CHPs for savings at local level. It is now anticipated that the system-wide savings will be sufficient and no local target will be set. Furthermore, it has been accepted that the savings already made in the Musculoskeletal ('MSK' Physio) service, which West Dunbartonshire CHCP hosts for the Board, are already sufficient and so no further savings will be required in the current 4-year period.

4.2 Revenue Position 2012/13

West Dunbartonshire CH(C)P's (NHS-only) revenue position reported for the period ended 31 March 2013 was £5,000 underspent.

Overspending on the specialist care package for which the CHCP took responsibility in 2010/11 and on community equipment and continence expenditure are being offset by underspending within Physio, Planning & Health Improvement expenditure and within Adult Mental Health Community Services

The full-year summary position is reported in the table below, with further comments on the significant variances highlighted in section 4.3 of this report. An additional detailed breakdown of individual costs at care group level is reported in Annexe 1 of this report.

	Annual Budget £000	Year to Date Budget £000	Year to Date Actual £000	Variance £000
Pays	24,764	24,764	24,452	312
Non Pays	53,228	53,228	53,534	(306)
	77,992	77,992	77,986	6
Less Income	(4,789)	(4,789)	(4,789)	0
Net Expenditure	**73,203**	**73,203**	**73,197**	**6**

4.3 Significant Variances

Comments on significant issues are noted below:

- **Mental Health – Adult Community Services** recorded an underspend of £11,000. This occurs as a result of vacancies within the Primary Care Mental Health Team, and also within Rehab Services.

- **Mental Health – Elderly Services** reported an overspend of £143,000. This is mainly the result of providing for the potential backpay costs resulting from Agenda for Pay nursing regradings which are currently being discussed.

- **Health & Community Care** reported an overspend of £43,000. The main areas of pressure were Equipu and the Specialist Care Package. There were offset by an underspend within Physiotherapy.

- **Planning and Health Improvement** reported an underspend of £101,000. This is a result of reduced hours within the management team, vacancies and maternity leave within the Health Improvement team and long-term sickness within the Planning department.

- **Accommodation & Other** reported an overspend of £45,000. This resulted from pressures within Heat, Light & Power, and water rates, as well as admin staff previously funded by income from GPs.

- **Hosted Services** reported an underspend of £49,000. This occurred within the Integrated Eye service, where provision had been made for the purchase of an autograder. Ultimately, this was funded from capital slippage and so the provision wasn't required.

4.4 Capital Programme 2012/13

- Formula Capital

  The Partnerships Formula Capital Allocation report provides capital funding for the CHCP of £216,000. This includes an acceleration of the 13/14 formula capital allocation. In addition, a further allocation of £40,000 has been provided for additional Healthcare Environment Inspectorate ('HEI') type expenditure, giving a total allocation of £256,000

  The local Capital Planning Group has identified the following priorities and the Board's Capital Planning team are now taking these forward.

Project	**Allocation (£000)**
Replacement windows, Addictions Building, Dumbarton Jt Hospital	25
Demolition of Lodge House	20
Refurbishment of clinic rooms in DHC	20
To refurbish seminar room as used for clinic space in DHC	10
Refurbish one podiatry room DHC	10
Refurbish one DSR room in DHC	5
Refurbish of 4 clinical rooms at CHC	40
Replacement of windows at CHC	20
Replacement of flooring waiting areas in CHC	10
Refurbish one public toilet in each of CHC and DHC	7
Physio depts in DHC and CHC	5
Corridor doors in the long corridor in the Glenarn ward	10
Partition in the filing area for health visitors 2 rooms in CHC	34
Dumbarton Joint Hospital HEI works	40
Total	**256**

5 People Implications

5.1 There are no people implications, other than a number of current vacant posts.

6 Financial Implications

6.1 Other than the financial position noted above, there are no financial implications of the budgetary control report.

7 Risk Analysis

7.1 The main financial risks to the ongoing financial position relate to currently unforeseen issues arising between now and the financial year-end. Any significant issues will be reported to future Committee meetings.

8 Equalities Impact Assessment (EIA)

8.1 No significant issues were identified in a screening for potential equality impact of this report.

9 Consultation

9.1 This report is for information only and relates only to the NHS element of the CHCP, with no requirement for consultation.

10 Strategic Assessment

10.1 This report provides an update on the CHCP's revenue and capital position (NHS only) and does not seek to affect the Council's main strategic priorities.

Keith Redpath
Director.

Person to Contact: Jonathan Bryden**,** Head of Finance - Clyde CHPs (0141 618 7660)

Appendix: Financial Statement 1 April to 31 March 2013

Background Paper: None

Wards Affected: All

Annex 1
West Dunbartonshire Community Health Partnership
Financial Year 1 April 2012 to 31 March 2013

	Annual Budget £000	Year to Date Budget £000	Year to date Actual £000	Year to date Variance £000	% Variance
Expenditure					
Mental Health (Adult Community)	4,455	4,455	4,444	11	0.25%
Mental Health (Elderly)	3,211	3,211	3,354	(143)	(4.45%)
Addictions	1,989	1,989	1,989	0	0.00%
Learning Disabilities	580	580	584	(4)	(0.69%)
Health & Community Care	10,088	10,088	10,045	43	0.43%
Children & Families	4,472	4,472	4,478	(6)	(0.13%)
Planning & Health Improvement	1,269	1,269	1,168	101	7.96%
Family Health Services (FHS)	23,982	23,982	23,982	0	0.00%
Prescribing	16,195	16,195	16,195	0	0.00%
Executive & Admin, Accommodation costs & Other	2,171	2,171	2,216	(45)	(2.07%)
Resource Transfer	7,371	7,371	7,371	0	0.00%
Hosted Services	850	850	801	49	5.76%
Change Fund	1,358	1,358	1,358	0	0.00%
	77,991	77,991	77,985	6	0.01%
Income	(4,694)	(4,694)	(4,694)	0	0.00%
Net Expenditure	**73,297**	**73,297**	**73,291**	6	**0.01%**

Members should note that NHS GG&C financial convention of reporting underspends as positive variances (+) and overspends as negative variances (-) has been adopted for all financial tables within the report.

WEST DUNBARTONSHIRE COUNCIL
REVENUE BUDGETARY CONTROL 2014/2015
CHCP SUMMARY

Appendix 4

MONTH END DATE **31 March 2015**

PERIOD **Year End**

Actual Outturn 2013/14	Departmental Summary	Total Budget 2014/15	Total Spend 2014/15	Actual Variance 2014/15	
£000	**Departmental Summary**	£000	£000	£000	%
1,181	Strategy, Planning & HI	1,214	1,002	(212)	-17%
3,412	Residential Accommodation for YP	3,359	3,564	205	6%
2,733	Community Placements	2,424	2,876	452	19%
1,893	Residential Schools	1,692	1,880	188	11%
3,882	Childcare Operations	3,970	3,945	(25)	-1%
3,786	Other Services - Young People	4,078	3,951	(127)	-3%
11,738	Residential Accommodation for Elderly	11,981	12,605	624	5%
1,455	Sheltered Housing	1,353	1,390	37	3%
1,056	Day Centres Older People	1,062	1,107	45	4%
77	Meals on Wheels	82	90	8	10%
290	Community Alarms	286	278	(8)	-3%
2,938	Community Health Operations	3,075	3,046	(29)	-1%
9,199	Residential Learning Disability	9,526	9,476	(50)	-1%
2,131	Physical Disability	1,690	2,065	375	22%
1,417	Day Centres Learning Disability	1,588	1,478	(110)	-7%
277	CHCP HQ	250	245	(5)	-2%
1,721	Mental Health	1,885	1,603	(282)	-15%
9,468	Homecare	8,841	9,878	1,037	12%
365	Other Specific Services	366	16	(350)	-96%
1,125	Addiction Services	1,240	1,049	(191)	-15%
0	Older Peoples Change Fund	0	(100)	(100)	0%
60,144	**Total Net Expenditure**	**59,962**	**61,444**	**1,482**	**2%**

£000	Subjective Summary	£000	£000	£000	%
36,243	Employee	35,763	36,934	1,171	3%
1,151	Property	965	977	12	1%
1,677	Transport and Plant	1,259	1,431	172	14%
1,214	Supplies, Services and Admin	1,138	1,226	88	8%
33,462	Payments to Other Bodies	33,819	33,982	163	0%
1,015	Other	1,053	1,345	292	28%
74,762	**Gross Expenditure**	**73,997**	**75,895**	**1,898**	**3%**
(14,618)	**Income**	**(14,035)**	**(14,451)**	**(416)**	**3%**
60,144	**Net Expenditure**	**59,962**	**61,444**	**1,482**	**2%**
0		0	0	0	0

services

Adverse	0	#DIV/0!
Favourable	0	#DIV/0!
Nil Variance	0	#DIV/0!
	0	#DIV/0!

WEST DUNBARTONSHIRE COUNCIL Appendix 5
REVENUE BUDGETARY CONTROL 2014/2015
ANALYSIS FOR VARIANCES OVER £50,000

MONTH END DATE **31 March 2015**

PERIOD **Year End**

Budget Details		Variance Analysis				
		Total Budget	Total Spend	Actual Variance		RAG Status
		£000	£000	£000	%	
Strategy, Planning & Health Improvement (Souman Sengupta)		1,214	1,002	(212)	-17%	→
Service Description	This service area is cost of Quality Assurance, Performance and Information, Strategy and Policy and Health Improvement teams.					
Main Issues / Reason for Variance	Underspend in staffing costs due to vacancies and delay in SVQ					
Mitigating Action	No mitigating action is required as variance is favourable					
Anticipated Outcome	An underspend will be achieved by holding back vacancies which will assist					
Residential Accommodation for Young People (Jackie Irvine)		3,359	3,564	205	6%	→
Service Description	This service area covers the cost of residential accommodation for young					
Main Issues / Reason for Variance	This overspend is primarily on the use of overtime and sessional staff to					
Mitigating Action	Managers were been advised to reduce cover costs wherever possible					
Anticipated Outcome	This projected variance is based on the assumption that the sickness cover					
Community Placements (Jackie Irvine)		2,424	2,876	452	19%	→
Service Description	This service area is the cost of fostering / adoption / kinship carers					
Main Issues / Reason for Variance	Continuing high numbers of children in fostering combined with reduction in					
Mitigating Action	Current fostering recruitment campaign underway to increase available					
Anticipated Outcome	Despite recent campaign, there will still be a need to continue to use					
Residential Schools (Jackie Irvine)		1,692	1,880	188	11%	→
Service Description	This service area covers the cost of children in day and residential schools.					
Main Issues / Reason for Variance	Additionals client placed in residential schools					
Mitigating Action	Residential school placements are demand led and outwith managers					
Anticipated Outcome	The over spend is likely to continue for the remainder of the year unless					
Childcare Operations (Jackie Irvine)		3,970	3,945	(25)	-1%	
Service Description						
Main Issues / Reason for Variance						
Mitigating Action						
Anticipated Outcome						
Other Services - Young People (Jackie Irvine)		4,078	3,951	(127)	-3%	→
Service Description	This service area is services for young people including throughcare.					
Main Issues / Reason for Variance	Underspend in payments to other bodies for new services commissioned					
Mitigating Action	No mitigating action required as variance is favourable.					
Anticipated Outcome	Underspend will be achieved.					
Residential Accommodation for Elderly (Chris McNeill)		11,981	12,605	624	5%	→
Service Description	This service area is the provision of both WDC and external care homes for					
Main Issues / Reason for Variance	Higher staffing costs due to additional 1-1 client needs and increased level					
Mitigating Action	Ongoing work in respect of absence management to reduce need for cover.					
Anticipated Outcome	It is anticipated that in light of the overspend to date, the year position will					
Sheltered Housing (Chris McNeill)		1,353	1,390	37	3%	→
Service Description	Provision of Sheltered Housing Service					
Main Issues / Reason for Variance	Increased payment for external provision partially offset by underspend in					
Mitigating Action						
Anticipated Outcome						
Day Centres Older People (Chris McNeill)		1,062	1,107	45	4%	→

Service Description					
Main Issues / Reason for Variance					
Mitigating Action					
Anticipated Outcome					
Meals on Wheels (Chris McNeill)	82	90	8	10%	→
Service Description					
Main Issues / Reason for Variance					
Mitigating Action					
Anticipated Outcome					
Community Alarms (Chris McNeill)	286	278	(8)	-3%	→
Service Description					
Main Issues / Reason for Variance					
Mitigating Action					
Anticipated Outcome					
Community Health Operations (Chris McNeill)	3,075	3,046	(29)	-1%	→
Service Description					
Main Issues / Reason for Variance					
Mitigating Action					
Anticipated Outcome					
Residential Learning Disability (John Russell)	9,526	9,476	(50)	-1%	→
Service Description	This service area is the provision of residential based services for clients				
Main Issues / Reason for Variance	Client demand change - increased direct payment clients , partially offset by				
Mitigating Action					
Anticipated Outcome					
Physical Disability (Chris McNeill)	1,690	2,065	375	22%	→
Service Description	This service area is the provision of services to clients with a Physical				
Main Issues / Reason for Variance	Overspend on Direct Payments due to two new clients (£90K). Also				
Mitigating Action	The transfer of out of authority clients has now been actioned. Monitoring				
Anticipated Outcome	It is anticipated that in light of the overspend to date, the year end position				
Day Centres Learning Disability (John Russell)	1,588	1,478	(110)	-7%	→
Service Description	This service area is day care for clients with a disability.				
Main Issues / Reason for Variance	Underspend in employee costs due to recruitment of new staff for enhanced				
Mitigating Action	No mitigating action required as variance is favourable.				
Anticipated Outcome	Underspend will be achieved to reduce the overall overspend within CHCP.				
CHCP HQ (Director)	250	245	(5)	-2%	→
Service Description					
Main Issues / Reason for Variance					
Mitigating Action					
Anticipated Outcome					
Mental Health (John Russell)	1,885	1,603	(282)	-15%	→
Service Description	This service area is expenditure in relation to mental health clients.				
Main Issues / Reason for Variance	Underspend in Housing support due to reduction in hours required. Also				
Mitigating Action	No mitigating action required since variance is favourable.				
Anticipated Outcome	Underspend will be achieved to reduce the overall overspend within CHCP.				
Homecare (Chris McNeill)	8,841	9,878	1,037	12%	→
Service Description	This service area is the provision of both internal and externally provided				
Main Issues / Reason for Variance	Increased number of homecare hours are now being delivered based on				
Mitigating Action	Managers are reviewing best options to achieve maximum staff utilisation				
Anticipated Outcome	If absence rates improve and supply staff are utilised it is hoped that this				
Other Specific Services	366	16	(350)	-96%	→
Service Description	This service area is the contribution to homeless service in respect of				
Main Issues / Reason for Variance	Payment to Homeless Account no longer required due to rent levels being				
Mitigating Action	No mitigating action required as variance is favourable.				
Anticipated Outcome	Underspend will be achieved to reduce the overall overspend within CHCP.				
Addiction Services (John Russell)	1,240	1,049	(191)	-15%	→
Service Description	This service area is the provision of services to clients with Addiction				
Main Issues / Reason for Variance	Reduced client need has resulted in an underspending in temporary rehab				
Mitigating Action	No mitigating action required since variance is favourable.				
Anticipated Outcome	Underspend expected by the end of the year.				
Older Peoples Change Fund (Chris McNeill)	0	(100)	(100)	0%	→
Service Description	This services funds the change in which older people receive care between				
Main Issues / Reason for Variance	Additional income received from Health Board to assist with Integration				

WEST DUNBARTONSHIRE COUNCIL APPENDIX 6

REVENUE BUDGETARY CONTROL 2013/2014 - TO 31 MARCH 2014

DEPARTMENT: CHCP

2012/13 Oı	Service	est 1314	Probable Outturn	Actual	Variance - PO against Actual	
£			£	£	£	Favourable/ Adverse
1404116	STRATEGY, PLANNING & HEALTH IMPROVEMENT	1347347	1,196,131	1,173,971	- 22,160	Favourable
5391372	RESIDENTIAL ACCOMMODATION FOR YOUNG PEOPLE	5454974	5,596,493	5,719,466	122,973	Adverse
2374050	RESIDENTIAL SCHOOLS	2026630	2,163,639	2,157,208	- 6,431	Favourable
3394870	CHILDCARE OPERATIONS	3314044	3,625,581	3,580,765	- 44,816	Favourable
3519150	OTHER SERVICES - YOUNG PEOPLE	3737803	3,722,569	3,622,606	- 99,963	Favourable
11465760	RESIDENTIAL ACCOMMODATION FOR ELDERLY	11207491	11,759,620	11,730,176	- 29,444	Favourable
1332995	SHELTERED HOUSING	1339808	1,347,394	1,454,510	107,116	Adverse
1087969	DAY CENTRES OLDER PEOPLE	1073468	1,057,785	1,065,285	7,500	Adverse
120802	MEALS ON WHEELS	89218	89,058	84,542	- 4,516	Favourable
296620	COMMUNITY ALARMS	277321	288,681	290,149	1,468	Adverse
2968235	COMMUNITY HEALTH OPERATIONS	2953877	2,869,682	2,909,018	39,336	Adverse
8567897	RESIDENTIAL - LEARNING DISABILITY	9470567	9,440,861	9,198,707	- 242,154	Favourable
1140702	PHYSICAL DISABILITY	1061952	1,233,617	1,298,618	65,001	Adverse
1545588	DAY CENTRES - LEARNING DISABILITY	1536281	1,564,294	1,550,713	- 13,581	Favourable
911983	OTHER SERVICES - DISABILITY	930125	879,096	904,119	25,023	Adverse
207071	CHCP HQ	193288	233,906	276,206	42,300	Adverse
1809860	MENTAL HEALTH	1820170	1,806,828	1,720,906	- 85,922	Favourable
9093788	HOMECARE	9000344	9,100,971	9,468,115	367,144	Adverse
364877	OTHER SPECIFIC SERVICES	366846	366,240	365,205	- 1,035	Favourable
1127467	ADDICTION SERVICES	1343684	1,262,163	1,124,700	- 137,463	Favourable
110755	OTHER DISABILITY SERVICES		-		-	
0	CPP - CHILDRENS SERVICES	412348	412,347	448,854	36,507	Adverse
293760	OLDER PEOPLES CHANGE FUND		-		-	
58529687	TOTAL NET EXPENDITURE	58,957,586	60,016,956	60,143,839	126,883	Adverse

COMMUNITY HEALTH AND CARE PARTNERSHIP 201314 year end var

SERVICE : Residential Accommodation for Young People **£122,973Adv**
This adverse variance is mainly due to legal costs relating to Adoptions and an increase in fostering costs.

SERVICE: Childcare operations **£44,816 Fav**
This favourable variance is mainly due to additional income for recharge of additional Occupational Therapist to capital.

SERVICE : Other Services –Young People **£99,963 Fav**
This favourable variance is due to vacant posts and a reduction in the uptake of respite, due to ill health of clients.

SERVICE: Residential Accommodation for the Elderly **£29,444 Fav**
This favourable variance is mainly dueto increased income from fees and charges. This has offset overspends in the costs for external care homesdue to higher than anticipated demand, together with staffing overspend due to agency cover costs being more than anticipated.

SERVICE :Sheltered Housing **£107,116 Adv**
This adverse variance is due to overtime.

SERVICE : Community Health Operations **£39,336 Adv**
This adverse variance is mainly due to back pay for an appeal that was successful. There was an increase in water rates charged at Bridge street as previously the meter was faulty.

SERVICE : Residential Learning Disabilities **£242,154 Fav**
This favourable variance is mainly due a reduction in the cost of flexible respite and change to clients packages.

SERVICE :Physical Disability **£65,001 Adv**
This adverse variance is due one new client in residential care and an increase in supported accommodation packages.

SERVICE : Other Services Disability **£25,023 Adv**
This adverse variance is due to the increased cost for housing support packages.

SERVICE : CHCP HQ **£42,300 Adv**
This adverse variance is mainly due to an overspend on various supplies and services lines.

SERVICE : Mental Health **£85,922 Fav**
This favourable variance is mainly due to a reduction in residential care due to delayed discharge from hospital of some clients. There is also an underspend in supporting people as delay in West Cliff project commencing.

SERVICE: Homecare **£367,144 Adv**
This adverse variance is made up of several issues. Cover costs are higher than anticipated and this has led to overspends in both staffing and payments to other bodies (agency staff). There is also lower than expected income from charges.

SERVICE: Addictions **£137,463 Fav**
This favourable variance is mainly due to spend on temporary placements being less than anticipated and a decrease in supporting people packages.

Service :CPP Children Services **£36,507 Adv**
This adverse variance partly due to an increase in employee costs through appeals for regrading being successful and a reduction in funding from CPP.

WEST DUNBARTONSHIRE COUNCIL

Appendix 8

REVENUE BUDGETARY CONTROL 2012/2013 - year end position

DEPARTMENT: CHCP

SERVICE SUMMARY

2011/12 Outturn	Service	Budget 2012/13	rev actual	YTD Variance	Variance	Comments
£		£	£	£	Favourable/ Adverse	
1299764	G01 - STRATEGY, PLANNING & HEALTH IMPROVEME	1,552,671	1,404,916	- 147,755	Favourable	Vacant posts not filled as anticipated.
5095643	G02 - RESIDENTIAL ACCOMMODATION FOR YOUNG	5,175,313	5,390,168	214,855	Adverse	Increase in costs of fostering .Increase in the use of independent agencies.Legal costs for Adoptions
2071881	G03 - RESIDENTIAL SCHOOLS	2,002,577	2,374,050	371,473	Adverse	Increase in the number of admissions
3114568	G04 - CHILDCARE OPERATIONS	3,549,851	3,394,870	- 154,981	Favourable	Vacant posts not filled as anticipated.
3715577	G05 - OTHER SERVICES - YOUNG PEOPLE	3,674,968	3,519,150	- 155,818	Favourable	Vacant posts not filled as anticipated.
11391716	G06 - RESIDENTIAL ACCOMMODATION FOR ELDERL\	11,550,706	11,465,760	- 84,946	Favourable	Delay in filling vacant posts,Increase in CET and free personal care costs
1321448	G07 - SHELTERED HOUSING	1,365,432	1,332,995	- 32,437	Favourable	Vacant posts not filled as anticipated.
1061959	G08 - DAY CENTRES OLDER PEOPLE	1,111,448	1,087,969	- 23,479	Favourable	Budget for Drivers Recharge overstated
112515	G09 - MEALS ON WHEELS	112,510	120,802	8,292	Adverse	
253872	G10 - COMMUNITY ALARMS	267,307	296,620	29,313	Adverse	Increase in overtime costs and costs paid to for call handling increased
3015908	G11 - COMMUNITY HEALTH OPERATIONS	3,038,504	2,968,235	- 70,269	Favourable	Vacant posts not filled as anticipated.
8218672	G12 - RESIDENTIAL - LEARNING DISABILITY	8,561,021	8,567,897	6,876	Adverse	
1118318	G13 - PHYSICAL DISABILITY	1,026,321	1,140,702	114,381	Adverse	Increase in payments to other bodies due to increase in the number of client packages
1532269	G14 - DAY CENTRES - LEARNING DISABILITY	1,585,277	1,545,588	- 39,689	Favourable	One of day centre Auchentoshan closed saving made on property costs .rates and credit for electricity
867360	G15 - OTHER SERVICES DISABILITY	872,785	911,983	39,198	Adverse	Vacant posts not filled as anticipated.
433009	G16 - CHCP HQ	227,977	207,071	- 20,906	Favourable	Vacant posts not filled as anticipated.
1736540	G17 - MENTAL HEALTH	2,076,899	1,809,860	- 267,039	Favourable	Delay in client uptaking service
8958321	G19 - HOMECARE	9,123,340	9,093,788	- 29,552	Favourable	Increase in income for housing support charges
375166	G20 - OTHER SPECIFIC SERVICES	366,846	364,877	- 1,969	Favourable	
1335105	G21 - ADDICTION SERVICES	1,154,328	1,127,467	- 26,861	Favourable	Temporay placements less than expected
458742	G22 - OTHER DISABILITY SERVICES	117,747	110,755	- 6,992	Favourable	
2	G23 - FAIRER SCOTLAND - CHILDRENS SERVICES	-	-	-		
0	G24 - OLDER PEOPLES CHANGE FUND	360,000	293,760	- 66,240	Favourable	
-1	G26 - FAIRER SCOTLAND - ADDICTIONS	-	- 1	- 1	Favourable	
57488354	TOTAL NET EXPENDITURE	58,873,828	58,529,282	- 344,546	Favourable	