For meeting on
11 AUGUST 2016

Agenda *2016*

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

NHS Greater Glasgow and Clyde

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East Dunbartonshire Council
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East Dunbartonshire Health & Social Care Partnership
BOARD MEETING 11th August 2016 at 9.30 am
Tom Johnston Chamber, 12 Strathkelvin Place, Kirkintilloch, G66 4TJ

AGENDA

Sederunt and apologies

Any other business - Chair decides if urgent

Signature of minute of meeting Health & Social Care Partnership Board :26th May 2016

Item no	Contact Officer	Standing items	Paper Reference number
1	Martin Cunningham	Minute of East Dunbartonshire Health & Social Care Partnership Board Meeting – 26th May 2016	2016/17_01 **1- 8**
2	Karen Murray	Chief Officers Report	2016/17_02 **9 - 48**
3	Jean Campbell	i) 15/16 Final Annual Accounts for the HSCP Board ii) Forecast Outturn HSCP Budgets 16/17 (Adult Services) at Month 3	2016/17_03(i) 2016/17_03(ii) **49 - 84**
4	Andy Martin	Delayed Discharges Performance Update	2016/17_04 **85 - 88**
5	Fiona McCulloch	Performance Report Quarter 4 (2015-16)	2016/17_05 **89 - 98**
		Governance - Extended Scope of Functions to Include NHS Children and Families Service, Children's Social Work Services and Criminal Justice Social Work Services	
6	Karen Murray	ED HSCP Integration Scheme: Delegation , Direction and Strategic Planning of Additional Functions and Services	2016/17_06 **99 - 154**
7	Sandra Cairney	Ratification of Current Strategic Plans for extended functions	2016/17_07 **155 - 156**
8	Jean Campbell	Children's Health, Children's Social Work & Criminal Justice Services Opening budget 2016/17.	2016/17_08 **157 - 162**
9	Sandra Cairney	Revisions to Health & Social Care Partnership Administrative Scheme • Scheme of Delegation to Officers • Code of Conduct for Members of East Dunbartonshire HSCP Board	2016/17_09 **163 - 202**
10	Karen Murray	Chief Social Work Officer: Governance and Accountability Protocol - revision and consultation **P.T.O.**	2016/17_10 **203 - 224**

		Items for Discussion	
11	Sandra Cairney	Annual Performance Report (2015-16)	2016/17_11 **225 - 252**
12	Sandra Cairney	Strategic Plan – one year progress and update 2016/17	2016/17_12 **253 - 310**
13	Karen Murray	Strategic Acute Service Planning	2016/17_13 **311 - 318**
14	Sandra Cairney	HSCP Complaints Procedure	2016/17_14 **319 - 332**
15	Karen Murray	HSCP Management Structure Progress Report	2016/17_15 **33 - 344**
16	Jean Campbell	Audit Committee – Revised Terms of Reference	2016/17_16 **345 - 351**
17	Jean Campbell	East Dunbartonshire HSCP Financial Reserves Policy	2016/17_17 **352 - 358**
18	Jean Campbell	Update Report on Implementation of the Living Wage	2016/17_18 **359 - 370**
19	Andy Martin	Alcohol and Drug Partnership Update Report	2016/17_19 **371 - 374**
20	Andy Martin	Update on Intermediate Care Update	2016/17_20 **375 - 386**
21	Andy Martin	Mental welfare Commission Report on Emergency Detention Certificates	2016/17_21 **387 - 422**
22	Karen Murray	Communications Objective Creating a Brand	2016_17_22 **433 - 430**
		Documents for Information	
23	Karen Murray	PAG minutes – 16th December 2015 and 16th March 2016	2016/17_23 431 - 442
24	Jean Campbell	Draft minutes of the HSCP Audit Committee – 20th June 2016	2016/17_24 **443 - 446**
25	Linda Tindall	HSCP Board Development update	2016/17_25 **447 - 448**
26	Sandra Cairney	HSCP Records Management Plan	2016/17_26 **449 - 450**
		Date of next meeting – 6th October 2016 Topic presentation – 'Understanding the additional scope in services, NHS C&F, CSW & CJSW'	
		Date of half day seminar – 18th August 2016, 9.30 – 12.30, Seminar Room 3, ACH Stobhill 'Improving the understanding of assessing continuous improvement, performance management systems and performance data	

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 26 May 2016.**

Voting Members Present:		EDC Councillors **GEEKIE, MCNAIR & O'DONNELL**
		NHSGGC Non-Executive Directors **R. FINNIE, & TRISH McAULEY**
Non Voting Members present:		
	K. **Murray**	Chief Officer - East Dunbartonshire HSCP
	J. **Duffy**	Trade Union / Employees Representative – EDC
	A. **McCready**	Trade Union / Employees Representative - NHS
	G. **Morrison**	HSCP Clinical Lead Representative
	G. **Thomson**	Voluntary Sector Representative
	W. Hepburn	Professional Nurse Adviser

Rhondda Geekie (Chair) presiding

Also Present:	F. **Borland**	HSCP Communications Officer
	S. **Cairney**	HSCP Head of Strategy, Planning & Health Improvement
	J. **Campbell**	HSCP Chief Finance and Resources Officer
	M. **Cunningham**	Corporate Governance Manager - EDC
	K. G**ardner**	Depute Chief Social Work Officer - EDC
	A. **Martin**	HSCP Head of Adult & Primary Care Services
	M. **McGrady**	**Consultant in Dental Public Health,** Oral Health Directorate
	F. **McLinden**	General Manager Oral Health Directorate– NHSGG&C
	J. **Slavin**	Finance Officer – EDC
	L. **Tindall**	Organisational Development Lead NHSGGC

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of I. Fraser, I. Black, P. Mazzoncini A. Bowman, M. Brickley, & C. Shepherd

CHAIRS REMARKS

The Chair, having not been at the meeting held on 31st March 2016, commented on the minute reflecting the positive commitment that both the HSCP and the Council had made in signing up to the Smoke Free Charter. The Chair further highlighted that she expected that the East Dunbartonshire Canal Festival will have smoke free zones to further reinforce the commitment to reducing smoking. The Chair thanked the Vice Chair for having chaired the May Board meeting, in her absence. The Chair welcomed Jean Campbell to her first meeting of the HSCP Board, since her appointment as Chief Finance and Resources Officer to the HSCP.

SEMINAR ON HEALTH IMPROVEMENT KEY DELIVERABLES AND SPECIFIC CONTRIBUTIONS TO PLACE COMMUNITIES

The Board heard from Sandra Cairney and David Radford outlining the progress made to health improvement across East Dunbartonshire, the challenges , the elements of good practice across the Community Planning Partnership and the contributions to the "Place" methodology across East Dunbartonshire.

The Board remarked on the following:-

- Health and financial challenges posed by obesity across the country and specifically in East Dunbartonshire.
- The range of activities, community assets and capacity building – including the future role of the Board in these activities.
- The concentrated work undertaken in our most deprived areas – the success of the Place methodology, the Baby Café and the application of these focussed efforts across the area. The Board noted that evaluation and monitoring of the various projects would ensure best practice was applied elsewhere across the area.

Thereafter the Board thanked the officers for their informative presentation.

1. MINUTE OF MEETING – 31 MARCH 2016

There was submitted and noted a minute of the meeting of the HSCP Board held on 31 March 2016. In response to questions the Chief Officer confirmed that approval from the Standards Commission was awaited while the Smoke Free Charter would be signed and publicised including at this year's Canal Festival.

2. CHIEF OFFICER'S REPORT

The Chief Officer submitted a Report HSCP/024/16/KM, copies of which had previously been circulated, which summarised the national and local developments in relation to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014, since the March meeting of the Partnership Board.

In particular the Chief Officer highlighted the following:-

Local Implementation Update

NHS GGC Chief Executive wrote to East Dunbartonshire Council Chief Executive on 29th April 2016 to acknowledge and welcome the Council's decision to delegate Children's Social Work and Criminal Justice Social Work functions to the HSCP Board.

Appointment of Chief Finance and Resources Officer - Jean Campbell

Appointment of HSCP Communication Officer - Fiona Borland

A fixed term Project Officer has been appointed to the HSCP to revise the Scheme of Integration to include the additional functions delegated to the HSCP Board by the NHS Board and the Council.

The March report for older people's bed days lost to delayed discharge showed a continuation in the improving trend seen from December 2015 and the total bed days lost for 2015/16 was 3635, just within the 50% target reduction set for the Partnership from the 2009/10 outturn

The Chair and the Chief Officer of the HSCP Board and the Chief Executives of the Council and the Health Board met with representatives of the Scottish Government Directorate for Health and Social Care Integration on 21st April 2016.

Development of the next level of the management structure for the HSCP was progressing. The process is being undertaken in partnership between the two employing organisations and their trades union and staff partnership representatives.

HSCP Board members should have received a communication from the NHS Board, issued on 6th May to advise of the engagement processes being undertaken on the proposal to move the GP Out of Hours Service, which currently serves people living in the Bearsden and Milngavie areas of East Dunbartonshire.

The Chief Officer for the HSCP has intimated to the Chief Executive of the NHS Board, the Chief Executive of the Council and the Chair of the HSCP Board, her intention to retire from the service on 30th September 2016. The Chief Executive of the NHS Board has requested the Director of HR for the NHS Board agrees the process and timetable for recruitment to the post to be taken forward, jointly with the Council. The Director of Human Resources for the NHS Board has made contact with East Dunbartonshire Council to commence the recruitment process.

National Implementation Progress Update

The Scottish Parliamentary elections were held on Thursday 5th May, and in the run up to the elections there has been very little national guidance issued.

On 9th May 2016, a guidance document, informed and agreed by Scottish Government, COSLA, CCPS and Scottish Care, was issued to support the delivery of the Living Wage Commitment to Care at Home and Housing Support.

On 17th May the HSCP Chief Officer received a letter from Health Improvement Scotland (HIS) indicating that Ruth Glassborrow, Director of Safety and Improvement for HIS has been assigned to be the key point of contact with East Dunbartonshire HSCP to facilitate the linkage between local priorities for improvement support and the national and tailored support programmes on offer from HIS.

On 13th May the Director of Public Health and Intelligence for National Services Scotland (NSS) wrote to the HSCP Chair to confirm that NSS has secured funding to continue the support the HSCP has received in 2015/16 from the Information and Statistics Division (ISD) Local Intelligence and Support team for 2016/17.

Following consideration, the Board agreed to:

a) Note the progress on local implementation activities; and
b) Request a future report on the local implementation of the Living Wage Commitment to Care at Home and Housing Support.

3. FINANCE REPORT

Report HSCP/025/16/JC by the Chief Finance and Resources Officer, copies of which had previously been circulated, updated the Board on the HSCP's likely out-turn for 2015/16 and the final position and outlook for 2016/17. The Board noted the HSCP would generate a surplus in 2015/16 which could be carried forward as a reserve into 2016/17 for investment into the strategic priorities outlined in the Strategic Plan.

Following consideration, the Board welcomed the Chief Finance Officer and agreed to note the final out-turn for 2015/16.

4. WINTER PLAN

Report HSCP/026/16/KM by the Chief Officer, copies of which had previously been circulated, presented the Board with a final report on the East Dunbartonshire Health and Social Care Partnership Winter Plan 2015/16.

The Report reviewed the delivery of the Plan and provided the actions undertaken to ensure services were prepared for all possible adverse events during the winter period. Members noted there were no disruptions reported by HSCP services during the winter period.

Following consideration, the Board noted the contents of the Report.

5. DELAYED DISCHARGES

The Chief Officer presented Report HSCP/027/16/KM, copies of which had previously been circulated, advising the Board on the progress being made in relation to the Delayed Discharges Action Plan.

Members noted the Scottish Government provided an allocation of £510,000 to East Dunbartonshire HSCP to support improvement in reducing Delayed Discharges. A report was presented to the HSCP in December 2015 outlining the proposed allocation of the funding and the Action Plan to support progress.

Thereafter the Board noted:

a) the contents of the Report; and

b) the achievements of the 50% target reduction of bed days lost to delayed discharge in 2015/16.

6. INTERMEDIATE CARE MODEL

The Chief Officer submitted Report HSCP/028/16/KM, copies of which had previously been circulated, seeking the Board's consideration and approval on a range of proposed

service developments designed to further reduce delays of patients from East Dunbartonshire in hospital.

The report proposed a number of service developments, including the commissioning of an intermediate facility in a local care home, an associated model of GP provision, community clinical and home care support, and a process of proactive care management to ensure that patients from East Dunbartonshire were discharged within the Scottish Government's target of 72 hours from being declared fit for discharge.

Following consideration, and having noted the discussions regarding blockages caused by the complexity and assessment of cases, the Board agreed to:

a) Note the content of the report;
b) The recommendations made by the Multi-disciplinary Delayed Discharges Planning Group of the HSCP to move to implementation of Option 1 and Option 4;
c) The financial and commissioning proposals associated with implementation of Option 1 and Option 4;
d) Requested a report to the Board after 6 months of the pilot's implementation to monitor progress and impact of the pilot on delayed discharges.

7. COMMISSIONING OF COMMUNITY CARE PACKAGES

The Head of Adult and Primary Care Services presented Report HSCP/029/16/AM, copies of which had previously been circulated, informing the Board of the steps undertaken to identify an appropriate service to support the safe discharge home of a patient with complex needs, and to seek approval to commission the identified service by a negotiated route and at the terms proposed.

Following consideration, the Board requested regular progress updates and thereafter noted:

a) The progress on securing an appropriate care package for the patient with complex needs to be discharged home;
b) That the HSCP Strategic Development Group approved the proposal to commission the service for one year; and
c) Further work would being undertaken by the commissioning team with support from Council Procurement and Legal departments the development of a framework for commissioning of complex care packages.

8. ORAL HEALTH DIRECTORATE – PERFORMANCE REPORT

Report HSCP/030/16/KM by the Chief Officer, copies of which had previously been circulated, advising the Board of the performance of the Oral Health Directorate (OHD) in respect of national waiting times (access) targets and guarantees, the progress of capital works across OHD premises, the progress on delivery of the current Oral Health Improvement and prevention strategies across GG & C and report on oral health activity/performance specific to the residents of East Dunbartonshire HSCP.

Following consideration, the Board agreed that work across the various Health teams should continue and data should be provided for participating schools to assist the progress towards the 2022 targets. Thereafter the Board noted:

a) The information provided and acknowledged the maintenance of the acute access waits across all specialties;
b) The progress on the capital projects;
c) The health improvement programmes and performance; and
d) The oral health activity and performance data specific to residents within East Dunbartonshire HSCP.

9. ALCOHOL & DRUG PARTNERSHIP (ADP) ALLOCATION FUNDING 2016/17

Report HSCP/031/16/KM by the Chief Officer, copies of which had previously been circulated, advising the Board of recent reductions in the budgetary allocation made to East Dunbartonshire Alcohol & Drug Partnership and to outline to the Board the proposed revisions to funding across the ADP's activities.

Following consideration, the Board noted the reduction in funding by the Scottish Government resulting in the recommendations from the Alcohol and Drug Partnership (ADP) to deliver a reduction in expenditure of £124,757 per annum to ensure delivery of services within the reduced ADP funding allocation for 2016/17.

10. HSCP INFORMATION GOVERNANCE PLAN

Report HSCP/032/16/KM by the Chief Officer, copies of which had previously been circulated, updated the Board on the progress to date with regard to a number of strategic information governance plans required to be in place by the 31st March 2017.

Following consideration, the Board noted the contents of the Report and progress to date.

11. HSCP RISK MANAGEMENT REGISTER

Report HSCP/033/16/KM by the Chief Officer, copies of which had previously been circulated, provided the Board with a copy of the Health & Social Care Partnership Risk Management Register, which covered risk policy, procedure, process, systems, risk management roles and responsibilities.

Following consideration, the Board:

a) Approved the updated HSCP Risk Management Register
b) Instructs officers to progress the HSCP Risk Strategy for future approval by the Board.

12. REVISION TO SCHEME OF INTEGRATION & TRANSITION PLAN

Report HSCP/034/16/KM by the Chief Officer, copies of which had previously been circulated, sought the Board's approval for a detailed Transition Plan that sets out the preparatory processes and approvals for the delegation of certain additional functions pertaining to NHS local children's services and Council Social Work Children and Criminal Justice services.

Following consideration, the Board:

a) Approved the Transition Plan at Appendix 1;
b) Noted the outline timescales for the proposed delegation of the additional health and social care functions; and
c) Requested that the Chief Officer provides regular updates on the progress of actions contained within the Transition Plan.

13. STRATEGIC PLANNING GROUP AND LOCALITY GROUP UPDATES

Report HSCP/035/16/KM by the Chief Officer, copies of which had previously been circulated, informing the Board of the actions undertaken and agreed by the Strategic Planning Group (SPG) and Locality Planning groups.

Following consideration, the Board noted the contents of the Report.

14. PUBLIC USER AND CARER GROUP UPDATE

Report HSCP/036/16/KM by the Chief Officer, copies of which had previously been circulated, informed the Health & Social Care Partnership Board of the activity undertaken by the Public, Service Users and Carers Network (PSU&CN) for the period between December 2015 and March 2016.

Following consideration, the Board:

a) Noted the activities undertaken by the Public, Service User and Carer Network;
b) Approved the PSU&CN Terms of Reference; and
c) Agreed the improvement actions outlined in the Equality Impact Assessment.

15. DEVELOPMENT PROGRAMME FOR THE HSCP BOARD 2016/17

Report HSCP/037/16/KM by the Chief Officer, copies of which had previously been circulated, invited Board members to consider and agree the attached proposals for further HSCP Board development.

Following consideration, the Board:

a) Considered the programme of development activities contained in Appendix 1; and

b) Agreed the dates, times and topics for the development programme as detailed in Appendix. 1.

16. DATE OF NEXT MEETING

Members of the Partnership noted the next meeting of the Health & Social Care Partnership Board was Thursday 11 August 2016 at 9.30am in the Council Committee Room, Southbank Marina.

Agenda Item Number: 2

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11th August 2016**
Report Number	**2016/17-02**
Subject Title	**Chief Officer Update Report**
Report by	**Karen Murray, Chief Officer East Dunbartonshire Health and Social Care Partnership**
Contact Officer	**Karen Murray, Chief Officer East Dunbartonshire Health and Social Care Partnership. 0141 201 4212. Karen.Murray@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 This is the highlight report to the Health and Social Care Partnership Board on national and local developments in respect of the Public Bodies (Joint Working) (Scotland) Act 2014, since the May 2016 meeting of the Partnership Board. This month the report advises HSCP Board members that Ministerial approval has been granted for the revised Scheme of Integration to include the additional Children's Services and Criminal Justice Social Work Services functions delegated to the HSCP.

2.0 SUMMARY

2.1 The local implementation progress update highlights key activities that have been undertaken within the HSCP since the May meeting of the HSCP Board. Many of these activities relate to the approval of the Revised Scheme of Integration and progress with the transition plan for the delegation of the additional in scope functions. The NHS Board approved its Financial Plan at the June meeting of the NHS Board and the Board has now confirmed the 2016/17 opening budget for NHS services delegated to the HSCP and a final recurring savings target of £1.37M. The report contains a brief update on the joint process for the appointment of a new Chief Officer. Audit Scotland has been appointed as external auditors to the HSCP for 5 years from 2016 to 2021. Peter Lindsay will lead the local external audit team and he has already been in attendance at the second HSCP Audit Committee meeting held on 20th June 2016.

Scottish Government advice has been issued to Integration Joint Boards (IJBs) that all IJBs are required to adopt a template Code of Conduct for Board members that has been agreed with the Commissioner for Ethical Standards and the Standards Commission. In compliance with this advice a revised Code of Conduct for the Health and Social Care Partnership is included in the reports for approval by the HSCP Board and submission to Scottish Government for approval.

2.2 The national progress update identifies national guidance and correspondence, relevant to the activities and responsibilities of the HSCP Board issued since the May board meeting, for information. This report aims to provide members with information to allow them to access reports and publications of relevance to the HSCP Board. A third Integration Joint Board Development Day for Chairs and Vice Chairs was held on Monday 27th July and a note of the themes that emerged from discussions on the day has been circulated to participants.

Scottish Government has been in contact with all HSCP Chief Officers with a request from the Ministerial Steering Group to obtain an initial assessment of IJB's 2016/17 financial and risk position and information on the implementation of the Living Wage commitments. This has been completed and submitted to Scottish Government and COSLA.

Chief Officers have also received a request for information from the Health and Sport Committee of the Scottish Parliament in the form of a survey which is to be completed and returned to Scottish Government by 17th August 2016. The survey is designed to provide information that will allow the Committee to understand the issues for IJBs in three key areas, budget setting; delayed discharges and social and community care workforce.

COSLA are taking forward a proposal to develop an elected member briefing note on integration. This proposal has arisen from feedback that elected members are seeking to understand better the role of local authorities as integration parent bodies and the support that could be made available to elected members who do not sit on IJBs to help them fulfill that role. The proposed briefing note will be appropriately focused on the legitimate interests of local authorities as integration parent bodies, specifically their interest in the council's ongoing statutory duties in relation to social work and to Best Value.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

a) Welcomes the Ministerial Approval for the Revised Scheme of Integration, granted on 5th July 2016;
b) Notes the letter from NHS GGC to the Chief Officer confirming the Health Board approval of the 2016/17 financial plan and the opening NHS budgets for 2016/17 allocated to East Dunbartonshire HSCP;
c) Notes the updates on local integration progress;
d) Notes the updates on national guidance issued and the requests for information from Scottish Government.

4.0 MAIN REPORT

Local Implementation Update

4.1 The consultation on the Revised Scheme of Integration closed on 21st June 2016. The revised scheme was approved by the Council on 21st June 2016 and by the Health Board on 28th June 2016. The scheme was submitted to Scottish Government and approved by the Cabinet Secretary on 5th July 2016. The Chief Officer was formally notified of the approval of the scheme on 11th July 2016 with confirmation that the scheme came into effect on 5th July 2016.

4.2 On 28th June NHS GGC Board approved the Financial Plan for 2016/17 and on 5th July the Chief Executive of the Health Board wrote to HSCP Chief Officers to confirm the opening budgets for NHS services for 2016/17. A copy of the letter is attached at **Appendix 1.**

4.3 On 14th July the Chief Officer received correspondence from Audit Scotland's Director of Audit Services following confirmation of the appointment of Audit Scotland as the external auditors to the HSCP Board for a five year term. The document attached at **Appendix 2** provides an introduction to Audit Scotland and the management team carrying out the audit. Peter Lindsay, Senior Audit Manager was in attendance at the second meeting of the HSCP Audit Committee on 20th June.

4.4 Advice has been received from Scottish Government that it is a statutory requirement for East Dunbartonshire HSCP Board to adopt a Model Code of Conduct for its members which is specific to East Dunbartonshire HSCP. Members will be asked to approve the revised Model Code of Conduct at Report 2016/17-09 and to consider whether they require to update their declarations of interest as a consequence of the changes to the scheme of integration and the additional range of new functions now delegated to the HSCP Board.

4.5 The Director of Education and Children's Services for the Council stepped down on 31st July 2016. Operational management responsibility for the Council's Children's Social Work Services and Criminal Justice Social Work Services from 1st August 2016 is held by the Head of Children's Social Work Services, who has reported to the Chief Officer of the HSCP since the 1st August 2016 in respect of the management of these services. The statutory functions of the Chief Social Work Officer remain the responsibility of the Council.

4.6 Chief Officers for all NHS GGC IJBs have been invited to attend the private session of the NHS Board Annual Review for 2015/16 on 4th August 2016. The Chief Officer will give a verbal update on the Annual Review Meeting to the HSCP Board.

4.7 The Chief Officer will provide a verbal update to members on progress with recruitment to the HSCP Chief Officer post.

National Implementation Update

4.8 Twenty eight Chairs and Vice Chairs of IJBs from across Scotland attended the third IJB Development Day on Monday 27th June 2016. Speakers included the Cabinet Secretary for Health, Wellbeing and Sport, the Director General, Health and Social Care, Scottish Government, the Chair of Health Improvement Scotland and Councillor Peter Taylor, COSLA Health and Wellbeing Spokesperson. The major themes discussed during the day were; Finance and Budgets; Communications and Community Empowerment; Workforce; Governance; Evidence and Data and Behaviours.

4.9 The Ministerial Strategic Group for Health and Community Care contacted Chief Officers on 4th July 2016 to request completion of a template to gather information on the financial and risk position for HSCPs and to gather information on implementation of the Living Wage. A copy of the correspondence and the completed template for East Dunbartonshire HSCP are attached at **Appendix 3**.

4.10 Chief Officers of IJBs also received a request from the Scottish Government Health and Sport Committee, on 8th July, in the form of a survey, to be completed and returned to Scottish Government by Wednesday 17th August. A copy of the request and the survey are attached at **Appendix 4**, for information. Officers will draft responses to the survey and share the responses with the HSCP Chair prior to submission.

4.11 COSLA are taking forward a proposal to develop an elected member briefing note on integration. This proposal has arisen from feedback that elected members are seeking to understand better the role of local authorities as integration parent bodies and the support that could be made available to elected members who do not sit on IJBs to

help them fulfill that role. The proposed briefing note will be appropriately focused on the legitimate interests of local authorities as integration parent bodies, specifically their interest in the council's ongoing statutory duties in relation to social work and to Best Value.

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Date: 5th July 2016
Our Ref: RC/BOB

Enquiries to: Robert Calderwood
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Dear Karen

2016/17 Financial Allocation to East Dunbartonshire Health & Social Care Partnership

The Board approved the 2016/17 Financial Plan for NHS Greater Glasgow and Clyde on 28 June 2016.

The attached paper outlines the main assumptions as they apply to HSCPs and Appendix I gives specific details for your partnership including some recently agreed adjustments to Facilities budgets. Some further adjustments are required for telecoms, property maintenance and rates budgets. The prescribing out-turn figures for 2015/16 which form the basis for setting the current year budget have only recently become available and therefore the net uplift to your current prescribing budget will be applied during July.

The adjustments in the attached schedule will be processed in the Health Board ledger in time for the closure of the June reporting period and should be reflected in the out-turn you report to your HSCP Board for the first quarter of 2016/17.

Yours sincerely

Robert Calderwood
Chief Executive

NHS
Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Summary

The Board's Financial Plan was approved by the Board on 28 June 2016.

This paper provides details of uplifts for pays, non-pays and prescribing growth in 2016/17. This will form the basis for updating budgets for 2016/17.

Salaries Inflation

(1) Agenda for Change

A provision has been made for an increase of 1.0%. In addition, a provision has been made for a flat rate increase of £400 for staff earning less than £22,000.

(2) Medical & Dental

A provision has been made for a general increase of 1.0%.

(3) Other Staff Groups

A provision has been made for a general increase of 1.0%.

(4) Employers' National Insurance

A provision has been made for the abolition of the contracted out rebate of 3.4% in employers' national insurance contributions in respect of staff who are members of the superannuation scheme.

For paragraphs (1) to (4), this gives a composite uplift of 2.98% with the following recurring uplift:

Salaries Inflation	£9,583,168

(5) Incremental Pay Progression – AfC

The experience of monitoring Agenda for Change (AfC) related pay trends has helped the Board develop a detailed understanding of the effect of incremental pay progression. This has enabled us to carry out a detailed forecast of pay growth for 2016/17, using current staff turnover ratios by staff category. The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(6) Incremental Pay Progression – Consultants

The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(7) Auto-enrolment to Superannuation

A provision has been made for the estimated cost of additional staff remaining within the Superannuation scheme following automatic re-enrolment on 1 April 2016. This will be applied to budgets as the actual costs are confirmed.

(8) Discretionary Points

A provision has been made for the on-going impact of funding additional discretionary points. This gives the following recurring uplift:

Discretionary Points	£100,000

Supplies Inflation

(1) PPP and similar costs

Provision has been made for the following recurring uplift:

PPP Inflation	£209,813

(2) General non pay uplifts – a provision of 1.0% has been made for other supplies, excluding drugs which will be separately funded. This gives the following recurring uplift:

Supplies Inflation	£603,142

Capital Charges

It is not possible to establish allocations for capital charges costs at this stage until the effects of the revaluation are assessed and capital charge forecasts are finalised. When this is complete the funding allocations for 2016/17 will be confirmed. It has been agreed that capital charges budgets will be removed from partnerships during 2016/17 and managed on a whole system basis.

Prescribing Growth – Primary Care

The prescribing cost growth projection for 2016/17 is based on information from the Board's Prescribing Advisers. It includes provision for likely growth in volume / prices, based on current trends, related to drug treatments prescribed within Primary Care.

The recurring uplift for 2016/17 is:

Partnerships	
Increase in Volume	£12,200,000
New Drugs	£8,500,000
Targeted Cost Savings	(£5,000,000)
Prescribing Growth	£15,700,000

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Allocations to individual partnerships are currently being finalised and will be applied to budgets prior to closure of the June reporting period. The Board will continue to operate the risk sharing arrangement for prescribing costs during 2016/17.

Resource Transfer

A provision of 1.7% has been made for uplifts to resource transfers. This gives the following recurring uplift:

Resource Transfer	£2,207,688

Cost Savings

Local Cost Savings plans for 2016/17 have not yet been fully developed and quantified. An interim recurring amount of £10.4m has been identified for 2016/17 reflecting the collective cost savings programme to achieve £69.0m.

Chief Officers were advised by the Chief Executive on 14 March 2016 that further recurring local savings will be required during 2016/17 to meet the overall partnerships savings requirement of £20.0m. The allocation of the overall savings requirement is shown in appendix I.

Cost Savings	(£20,000,000)

It is recognised that Partnerships may not be able to release the full £20.0m in 2016/17. Non recurring relief is limited but availability of non-recurring relief to offset the full year effect will be subject to further discussion during the year, so no funding will be released at this stage.

The Board will endeavour to cover 2015/16 unachieved savings of £7.8m from non recurring sources, however further savings schemes may need to be identified as part of the contribution to the £10m of unidentified savings in the Board's financial plan should the national programme of work fail to identify sufficient savings to cover this gap.

Service Commitments

Provision has been made to fund service commitments arising from specific funding allocations. This gives the following recurring uplifts:

Integrated Care Fund	£59,354,000

Funding for other service commitments will be dealt with separately.

NHS
Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Appendix I

Details of the specific uplifts and other adjustments are detailed in the table below.

Partnership Budgets	East Dun £k
Rollover Budgets	*66,221.6*
Uplifts Applied	
Pay incl low pay allowance	211.4
National Insurance rebate withdrawn	314.8
Auto Enrolment (NR - Amounts to M2 only)	29.8
RT Uplift incl addictions RT	205.0
Non Pay Uplift	23.1
PPP	
Net Prescribing adjustment tbc	
Social Care funding	4,309.0
Facilities Budget withdrawn	-151.0
Depreciation Budget Withdrawn	-119.0
Savings	
Savings Targets Applied (Month 2)	-910.0
Outstanding Savings Targets to be applied (Month 3)	-457.8
2016.17 Opening Budget	**69,676.9**
Anticipated Funding & Minor adjustments	7,475.6
2016.17 budget as at 30.06.16	**77,152.5**

McMartin, Geraldine

From: AuditAppointments <AuditAppointments@audit-scotland.gov.uk>
Sent: 14 July 2016 13:23
To: Murray, Karen; Campbell, Jean
Subject: Audit Scotland Appointed Auditor Information 2016/21
Attachments: East Dunbartonshire Integration Joint Board.pdf

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Done, Print please

For the attention of:

Karen Murray
Jean Campbell

As your newly appointed external auditors for 2016/21 we would like to share with you some background information about our organisation, the principles that guide our work, as well as the management team responsible for carrying out the audit. The document attached provides an Introduction to Audit Scotland. We will be in touch with you later in the summer to arrange key meetings. We look forward to working with you and your colleagues during the next five years. Please contact Peter Lindsay – plindsay@audit-scotland.gov.uk should you require further information at this stage.

Best Regards

Fiona Kordiak
Director of Audit Services

Local government audits

Introduction to Audit Scotland

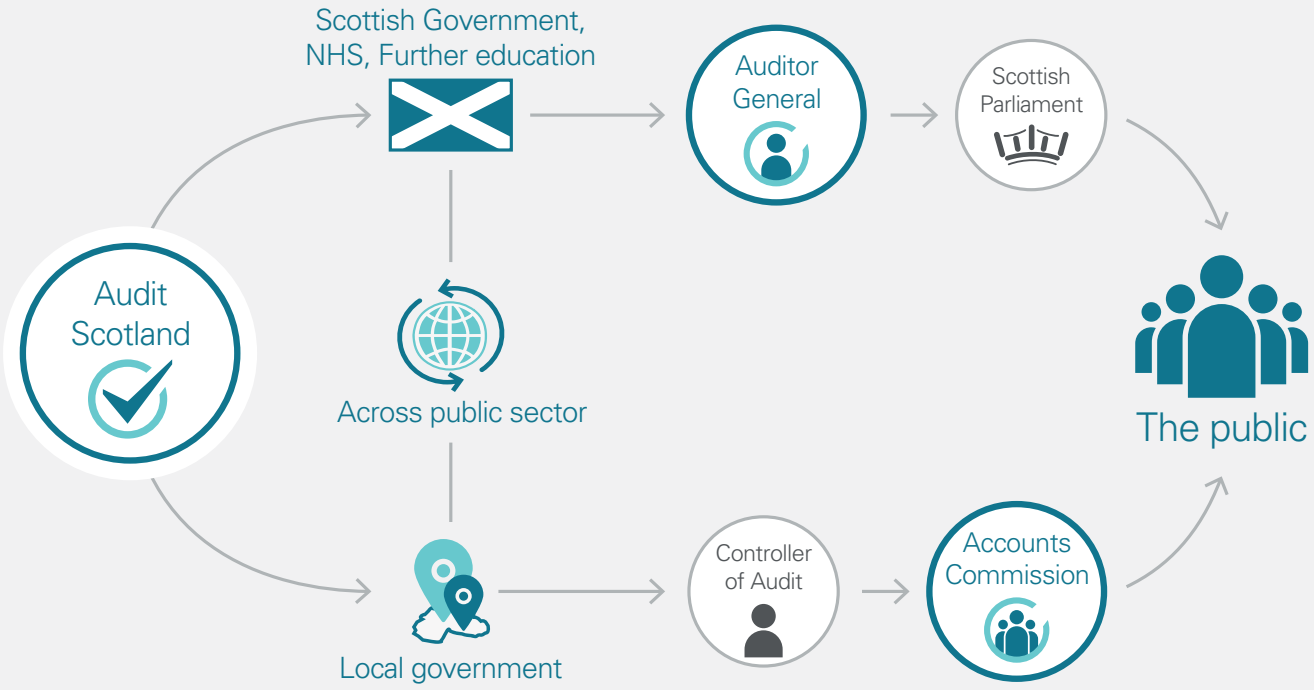
East Dunbartonshire Integration Joint Board

AUDIT SCOTLAND

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The **Auditor General** is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The **Accounts Commission** is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- **Audit Scotland** is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

Who's who

Accounts Commission

The Accounts Commission is the public spending watchdog for local government. They hold all councils in Scotland to account and help them improve. They operate impartially and independently of councils and of the Scottish Government, with a duty to help ensure public money is spent properly, efficiently and effectively. They meet and report in public. Members are appointed by Scottish Ministers.

The Commission's work includes audits and reports on local councils, reports on Best Value and Community Planning and performance audit reports, which examine value for money issues across public bodies. *Find out more about their role and legal responsibilities*.

Controller of Audit

Fraser McKinlay is the current Controller of Audit. He has statutory responsibility for reporting to the Accounts Commission on matters of public interest in local authorities . This involves oversight of the annual financial audit, reports about specific issues on councils and best value reports of individual councils.

The Controller is appointed by the Accounts Commission following consultation with, and subject to the approval of, Scottish Ministers.

Fraser is also Audit Scotland's Director of Performance Audit and Best Value. In this role he oversees all national performance audits and best value work on behalf of both the Accounts Commission and the Auditor General for Scotland.

Meet your senior audit team

For every audit there is a comprehensive exercise to ensure the appointed audit team has extensive knowledge, skills and experience to maximise the value of external audit. In addition we consider: staff rotation and continuity, ethical standards and conflicts of interest; statutory obligations; diversity; staff development, travel and carbon footprint. Before their work begins, we will introduce the wider audit team, and provide detailed information about our audit approach, meetings and timescales for reporting.

Fiona Mitchell-Knight, Assistant Director, is your appointed auditor. The local audit team will be led by Peter Lindsay, who will be responsible for the day to day management of the audit and who will be your primary contact.

Fiona Kordiak CPFA

Director, Audit Services

fkordiak@audit-scotland.gov.uk

Fiona leads the Audit Services Group and is a member of Audit Scotland's management team. She is responsible for ensuring that we comply with the highest ethical standards and international standards of auditing. Fiona has worked in public sector audit for nearly 30 years. She is a member of the CIPFA Scotland branch executive committee and is a past chair of the Local Authority (Scotland) Accounts Advisory Committee.

Fiona Mitchell Knight FCA BA (Hons)

Assistant Director

fmitchell-knight@audit-scotland.gov.uk

Fiona was appointed as an Assistant Director of Audit in 2007. Fiona trained as a chartered accountant in the private sector in England. She has over 20 years experience of public sector audit with Audit Scotland, covering local government, health and the further education sector. Fiona has led the audits on a range of clients including Glasgow City Council, Aberdeenshire Council, North Ayrshire Council, Ayrshire and Arran Health Board and NHS National Services Scotland.

Peter Lindsay CPFA

Senior Audit Manager

plindsay@audit-scotland.gov.uk

Peter has over twenty years experience of public sector internal and external audit with both Audit Scotland and PricewaterhouseCoopers,covering local government, education and NHS. Peter's previous experience has also involved secondments to Scottish Enterprise and the Social Work Inspection Agency.

About our work

We give independent assurance to the people of Scotland that public money is spent properly, efficiently and effectively.

77	Central government bodies and Scottish Parliament (including police, fire, Scottish Water)
23	NHS bodies
32	Councils
74	Joint boards and committees (including 30 health integration boards)
21	Further education colleges

227 Public bodies audited

Principles of public audit

The principles of public audit are shared across the UK and are based on:

Statutory

- Opinions on the financial statements and regularity
- National performance audits and Best Value audits

Best practice

- Opinions on management commentaries, remuneration reports and governance statements

Adds value

- Public reporting of audit findings
- Wider scope reporting

In our Code of audit practice, public audit principles include a combination of specific legal requirements, professional requirements, and requirements that ensure public audit adds value for audited bodies, the public and their elected representatives.

Why we're auditing East Dunbartonshire Integration Joint Board

Staff from Audit Scotland, along with firms of auditors we appoint, check whether public organisations:

- manage their money to the highest standards
- get the best possible value for public money.

How we report what we find

We produce a range of local and national reports about the performance and financial management of Scotland's public bodies. All our reports will be published and accessible to the public.

- **Annual audits**
  We publish annual audit reports for all the public bodies we're responsible for auditing. We also publish our audit plans and any significant reports to management.

- **Public reports**
  We publish a wide range of reports on matters of public interest. These include overview reports on how different sectors perform during each financial year. These reports are considered by the Scottish Parliament and/or the Accounts Commission.

- **Section 102 reports**
  Section 102 reports* empower the Controller of Audit to submit reports to the Accounts Commission on various matters, including any matters arising from the accounts or audit of a local authority and performance against the dates relating to best value.

  **Section 102(1) of the Local Government (Scotland) Act 1973*

Our Code of Audit Practice

We published our updated, stronger *Code of Audit Practice* in May 2016, following extensive consultation. This code outlines the responsibilities of our auditors.

With the public audit landscape in Scotland changing, including additional devolved tax raising powers, and public bodies expected to work together more extensively to improve services and increase efficiency, an updated code needs to maximise the value of public audit.

In order to achieve world class public audit and give reassurance that we are all receiving value for money from public spending, the new code aims to assist improvement by audited bodies in the delivery of services. It does this by requiring auditors to use their work to provide explicit conclusions on four key aspects: financial sustainability, financial management, governance and transparency, and value for money.

We achieve the four principles of audit above,as an organisation, by working together: the Auditor General, the Accounts Commission and Audit Scotland. Read our publication Public audit in Scotland

Our quality framework is based on our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice. To ensure that we achieve the required standards Audit Scotland conducts peer reviews, as well as internal quality reviews and external reviews by the Institute of Chartered Accountants of Scotland (ICAS).

Auditing Best Value

In 2016 we are introducing a new approach to auditing Best Value in Local Government. The Accounts Commission wrote to council leaders in November 2015 about this and again recently with an overview of the approach. The new arrangements increase our focus on continuous improvement as well as the outcomes for communities and the quality of service experienced by the public. The approach also includes greater integration of our audit processes for each council (local annual audit and Best Value) so that we are able to deliver more regular assurance and a richer, more rounded picture of how effectively all 32 councils are performing.

The new approach will apply to audit planning and the annual audit reports for each council. We will spread our audit work over the five years of the audit appointment, and this wider scope of work will be evident in your Annual Audit Report. At least once during the five year appointment, a Best Value Assurance Report (BVAR) will be submitted to the Accounts Commission and published for your council. Further details on the new approach will be issued to councils during the autumn.

Local government audits

Introduction to Audit Scotland

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

McMartin, Geraldine

Subject: FW: Delegation and allocation of resource - Return by 18th July
Attachments: IJB template.xlsx; Progress towards the Living Wage - Analysis to be published on SPICe.docx; Understanding cost of Living Wage - template to IJBs (002) (2).docx

From: Eilidh.Smith@gov.scot [mailto:Eilidh.Smith@gov.scot]
Sent: 04 July 2016 16:24
To: eddie.fraser@east-ayrshire.gcsx.gov.uk; icolvin@north-ayrshire.gov.uk; tim.eltringham@south-ayrshire.gov.uk; Susan.Manion@scotborders.gcsx.gov.uk; julie.white4@nhs.net; Sandy.Riddell@fife.gcsx.gov.uk; sstrachan@clacks.gov.uk; patricia.cassidy@falkirk.gov.uk; adam.coldwells@nhs.net; jproctor@aberdeencity.gov.uk; Pamela.Gowans@moray.gcsx.gov.uk; deborah.jones16@nhs.net; jan.baird@nhs.net; christina.west@nhs.net; Murray, Karen; Murray, Julie (ERC); david.williams@glasgow.gcsx.gov.uk; Moore, Brian (INV); Leese, David; Redpath, Keith; hewittj@northlan.gcsx.gov.uk; harry.stevenson@southlanarkshire.gov.uk; David.A.Small@nhslothian.scot.nhs.uk; Rob.McCulloch-Graham@edinburgh.gov.uk; Eibhlin.McHugh@midlothian.gov.uk; jim.forrest@westlothian.gov.uk; caroline.sinclair@orkney.gov.uk; vicky.irons@nhs.net; laura.bannerman@dundeecity.gov.uk; david.lynch@nhs.net; robertpackham@nhs.net; carol.smith82@nhs.net; simon.bokor-ingram@nhs.net; ron.culley@cne-siar.gov.uk
Cc: paula@cosla.gov.uk; vicki@cosla.gov.uk; Geoff.Huggins@gov.scot; Alison.Taylor@gov.scot; Paul.Leak@gov.scot; Gavin.Reid@gov.scot; Alan.Wood@aberdeenshire.gcsx.gov.uk; sandy.berry@nhs.net; caroline.whyte@argyll-bute.gcsx.gov.uk; katy.lewis@nhs.net; dave.berry@dundeecity.gov.uk; craig.mcarthur@east-ayrshire.gov.uk; Campbell, Jean; David.King@nhslothian.scot.nhs.uk; Bairden, Lesley (ERC); Moira.Pringle@nhslothian.scot.nhs.uk; d.bozkurt@nhs.net; ewan.murray@nhs.net; jancarter@nhs.net; Sharon.Wearing@glasgow.gcsx.gov.uk; LesleyAird@north-ayrshire.gcsx.gov.uk; David.King@nhslothian.scot.nhs.uk; Margaret.Wilson@moray.gcsx.gov.uk; LesleyAird@north-ayrshire.gcsx.gov.uk; Pat.Robinson@orkney.gcsx.gov.uk; janemsmith@nhs.net; Lavers, Sarah (REN); Paul.McMenamin@scotborders.gov.uk; karlwilliamson@nhs.net; Sharon.Lindsay@aapct.scot.nhs.uk; ewan.murray@nhs.net; Middleton, Jeanne; patrick.welsh@westlothian.gov.uk
Subject: Delegation and allocation of resource - Return by 18th July

All,

Building on the discussion at the last Chief Officers' network meeting, the Ministerial Strategic Group for Health and Community Care has agreed that Scottish Government and COSLA officials should contact Chief Officers to obtain an initial assessment of IJBs' 2016/17 financial and risk position. Alongside this, we are also looking to gather information on implementation of the Living Wage commitment and to provide an opportunity for Chief Officers to inform the future considerations of the policy. The Chief Officers who were in attendance at the network meeting expressed support for this type of exercise. This is a one-off exercise as this information will be available through IJB Annual Financial Statements next year.

The MSG has also agreed that we should develop a template for the Annual Financial Statement and we will work closely on this with COSLA, SG Health Finance, SG Local Government Finance, Chief Officers and Chief Financial Officers, through their networks later this year.

Please could you complete the attached templates by 18th July and return them to both myself and Vicky Bibby at COSLA. I appreciate the tight timescales at a time of year when a lot of people will be taking leave but we would appreciate your support in this exercise.

Please feel free to contact me if you have any questions or queries

Thanks

Eilidh

Eilidh Smith | Policy Manager | Integration and Reshaping Care | Scottish Government
St Andrew's House | Regent Road | Edinburgh | EH1 3DG | 0131 244 3793 | 07813 367080

Living Wage
IJB Finance Template

	2016/17			Notes
	Payment £m	Set Aside £m	Total £m	
Income LA Health Board *				
Total Income				
Expenditure Hospital Community Healthcare FHS & Prescribing Social Care				
Total Expenditure				
Savings Target				
% Savings identified				
Hospital Bed Days				

**** If income from the HB is indicative,please include the figure and note the date you expect it to be finalised.***

Please lodge in SPICe Collection

PROGRESS TOWARDS THE LIVING WAGE

Background

The Cabinet Secretary for Health, Wellbeing and Sport said she would provide estimates of the cost of achieving payment of the Living Wage for care workers. This paper fulfils that commitment.

Taking forward the Fair Work agenda in social care, including progress towards the Living Wage, is a priority for, and a responsibility shared between Scottish Government, local authorities and care providers and all partners are expected to make a contribution. Local government has already made the commitment to pay the Living Wage to its own directly employed staff and some care providers are also already paying the Living Wage. These national estimates show how the costs of increasing wages in the sector would increase over time as the enhanced Minimum Wage and Living Wage rates rise each year. This demonstrates the long-term commitment necessary to deliver the Living Wage.

The Scottish Government fully supports the Living Wage Campaign and will continue to encourage employers to join the over 450 other Scots-based Living Wage accredited employers. We value the care workforce. It is important to attract and retain the right people in social care and we recognise the impact that wages and other terms and conditions can have on the quality of care. We have published statutory guidance which requires local authorities to consider fair work practices as part of the procurement process.

We provided £12.5m in 2015/16, as part of a tripartite agreement with local authorities and care providers worth £25m to improve the quality of care by jointly investing to encourage fair work practices for care workers, including progress to the Living Wage.

Care workers employed by local authorities already receive the Living Wage. This analysis therefore presents the costs of achieving the Living Wage in independent and voluntary sector care providers. It covers care workers providing social care to adults in both care home and home care/housing support settings.

Further explanatory notes are provided in the Annex to this paper.

Relationship to national policy

As part of 2016/17 budget we have allocated £250m for social care and have directed that a proportion of this should support the additional costs to meet Living Wage from 1 October 2016. This timeline is to allow for review and, where necessary, refresh of contracts to enable implementation.

This national analysis provides context for the delivery of this commitment. It is recognised, however, that there are many different assumptions that can be made in undertaking an analysis of this kind. The local cost of delivery to service commissioners will depend on current wage rates within local markets and the balance between in house and externally commissioned services. We are aware that

many local partnerships are working with pr oviders to develop their own, more fine grained cost estimates as they move to implement the commitment on Living Wage.

The Scottish Government encourages all employers to pay the Living Wage. In agreeing t he budget settlement we have fo cussed on support for care workers directly supporting vulnerable adults. This recognises the need to tackle problems of recruitment and retention to improve t he quality of care in the context of demographic pressures. We encourage loc al partners and providers to expand on this initiative to include other groups of workers, including ancillary staff, where this is regarded as affordable and sustainable and meets local priorities.

This national analysis gives an indication of the likely scale of costs, but there will be elements that increase as well as decrease costs in practice. Our analysis excludes on-costs such as em ployers' national insur ance contributions and the impact of any differential rates of pay that employers may wish to retain between staff to recognise qualifications, etc. These factors will te nd to unde r-estimate the full cost of implementation. On the other hand, it is based on UK wage data which s hows a lower starting point than the position in Sc otland. In addition, no assumptions have been made about the potent ial for savings due to antic ipated improved recruitment and retention as wages increase.

On this basis, and given that implementation is from Oc tober, our estimate of the cost of inc reasing wages fr om current levels to Living Wage in 2016/17 is around £37m.

Estimated Costs

One can make different assumptions about the underlying wage levels, wage progression and number of workers over the period to 2020/21. This analysis uses the ONS Annual Survey of Hours and Earnings (ASHE) as the starting point to estimate the impact of introducing the enhanced minimum and living wages.

In this analysis, we assume an underlying increase in wages of 1% per year. This is a relatively low wage growth assumption but in line with recent developments in the public sector. The Office for Budget Responsibility forecasts hourly earnings across the UK economy to increase by 20% over the period from 2015/16 to 2020/21 (or around 4% per year). Applying this forecast to the 2015/16 wage bill of the workers considered in this analysis would amount to a recurring annual increase above the 2015/16 level of £235m by 2020/21.

The number of workers in the private and voluntary sector is held constant at 83,040 over the period. The cost estimated is gross pay to employees based on 52 weeks of work. As such, it includes holidays at the same pay rate. The estimate excludes employers' national insurance contributions.

In addition to 1% wage growth the analysis considers the costs of uplifting the wages of low-paid care workers to enhanced minimum and living wage levels.

The wage distribution underlying the analysis is shown in the Annex.

Table 1 - 1% wage uplift to all care workers plus introduction of enhanced minimum/living wage[1].

COST OF 1% WAGE UPLIFT (£m) – Private and Voluntary						
	2015/16	2016/17	2017/18	2018/19	2019/2020	2020/21
Annual uplift		***12***	***12***	***12***	***12***	***13***
Recurrent increase above 2015/16 level		***12***	***24***	***36***	***49***	***61***
Workers associated		83,040	83,040	83,040	83,040	83,040
ADDITIONAL INVESTMENT REQUIRED TO MEET ENHANCED MINIMUM WAGE (£m) – Private and Voluntary						
	2015/16	2016/17	2017/18	2018/19	2019/2020	2020/21
Enhanced Minimum Wage		£7.20	£7.69	£8.20	£8.76	£9.35
Annual uplift		**9**	**16**	**21**	**29**	**37**
Recurrent increase above 2015/16 level		**9**	**24**	**46**	**75**	**112**
Workers associated		20,760	24,912	33,216	41,520	49,824
FURTHER INVESTMENT REQUIRED TO MEET LIVING WAGE (£m) – Private and Voluntary						
	2015/16	2016/17	2017/18	2018/19	2019/2020	2020/21
Living Wage	£7.85	£8.25	£8.65	£ 9.20	£9.75	£10.35
Annual uplift	***38***	***9***	***6***	***13***	***9***	***11***
Recurrent increase above 2015/16 level	***38***	***47***	***53***	***67***	***76***	***86***
Workers associated	33,216	33,216	41,520	49,824	49,824	58,128
TOTAL						
Annual uplift	***38***	***30***	***34***	***47***	***50***	***60***
Recurrent increase above 2015/16 level	***38***	***68***	***102***	***149***	***199***	***259***

Discrepancies in tables between totals and sums of components are **due to rounding**

In addition to the workers included in this analysis, adult social care is also provided by personal assistants that are directly employed through funding provided by the Independent Living Fund (ILF) and through Self-directed Support (SDS).

Using data from ILF on pay rates and hours provided as well as survey data on the use of SDS funding, we estimate that the full year cost of uplifting these personal assistants from the enhanced minimum wage to the living wage amounts to £5.7m

[1] The living wage analysis in this table is similar to that undertaken by SPICE for the year 2015/16 and includes a lower number of workers, based on data by the Scottish Social Services Council. The 2015/16 figure presented here amounts to £38.3m. The equivalent SPICE figure in their 2015 analysis came to £45.9m.

(again including holid ays but excluding other on-cost s) and would benefit 3,000 workers.

The number of care workers in adult soci al care including personal as sistants benefiting from this uplift in 2016/17 is therefore estimated at more than 36,000.

Annex

Explanatory Notes

(1) The UK Government (UKG) has introduced a new mandatory minimum wage for over 25s from April 2016 which it refers to as the National Living Wage (NLW). In this document it is referred to as the enhanced minimum wage. This new enhanced minimum wage will start at a rate of £7.20 per hour set by UKG from April 2016 and the Office of Budgetary Responsibility has stated that they believe it will increase to £9.35 in 2020. The statutory enhanced minimum wage is applied to a baseline wage growth of 1% at all wage levels in this analysis and for 2016/17 we have applied the £7.20 rate to all age groups. While data on the age profile of the workforce is available, there is no information on wages by age. The enhanced minimum wage is therefore applied to all age groups. Incorporating assumptions on age-dependent wage levels into the analysis would change the cost split between enhanced minimum wage and living wage but the total cost of all components (1% wage increase, enhanced minimum wage, living wage) would not be affected. To project the increase in enhanced minimum wage rates over the term we have used OBR projections.

(2) Living Wage (LW) levels are set by the Living Wage Foundation. New rates are announced on the first Monday of November each year. The Foundation advises that employers should implement the rise as soon as possible and within 6 months with all employees receiving the new rate by 1st May the following year. LW in 2015 was £7.85; the new rate of £8.25 was announced in November 2015. These are not legal requirements. Payment of the Living Wage is advocated and encouraged by Scottish Government. Our analysis shows estimates of how LW may increase to 2020 and assumes a LW rate of £10.35 per hour in 2020-21. Our assumptions for what the rate will be each year are shown in the Living Wage line of the table.

(3) The "annual uplift" line for enhanced Minimum Wage/Living Wage gives estimates of the annual cost of increasing wages in the care sector from the previous year's level to the higher level for that year. For the enhanced Minimum Wage the uplift is a legal requirement.

(4) The "Recurrent increase above 2015/16 level" row sets out the overall additional cost of achieving pay levels for each year compared with current costs reflecting the cumulative impact of each annual uplift on recurring costs.

(5) The "workers associated" line is the number of people benefiting from these increases in pay. It is provided on a head-count basis.

(6) Headcount figures for care home and care at home workers are taken from the Report on 2014 Workforce Data by the Scottish Social Service Council (http://data.sssc.uk.com/images/WDR/WDR2014.pdf). This source also provides the data on headcount by type of employer as well as weekly hours worked.

(7) The analysis uses the ONS Annual Survey of Hours and Earnings (ASHE). It takes wages for "Care workers and home carers" (code 6145) at the UK level as the basis for the analysis. This is a less well paid subcategory of "Caring personal

services" (code 614). For Scotland only data for "Caring per sonal services" are available (these show higher pay levels than the UK average) but not for "Care workers and home carers". We decided to us e the UK data as it provides the most relevant c ategory of work ers. Using Sc ottish wage data on "Caring personal services" would increase current pay esti mates and decrease the cost of introducing higher wages.

(8) The est imate for personal as sistants starts from the assumpti on that all personal assistants are lifted from the enhanced mini mum wage of £7.20 to the living wage of £8.25. Data by ILF provides hourly ra tes and hours deliv ered that allow t he extra costs to be estimated. The number of work ers is estimated on the assumption tha t each personal assist ant works 30 hours a w eek, which is in line with the hours worked by carers who provide care at hom e, and works 46.2 out of 52.2. weeks in a year.

Underpinning wage assumptions

Enhanced Minimum Wage ("National Living Wage")

Percentile	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
10	£6.64	£7.20	£7.69	£8.20	£8.76	£9.35
20	£6.98	£7.20	£7.69	£8.20	£8.76	£9.35
25	£7.11	£7.20	£7.69	£8.20	£8.76	£9.35
30	£7.30	£7.37	£7.69	£8.20	£8.76	£9.35
40	£7.72	£7.80	£7.88	£8.20	£8.76	£9.35
50	£8.18	£8.26	£8.34	£8.43	£8.76	£9.35
60	£8.73	£8.82	£8.91	£8.99	£9.08	£9.35
70	£9.45	£9.54	£9.64	£9.74	£9.83	£9.93
75	£9.88	£9.98	£10.08	£10.18	£10.28	£10.38
80	£10.38	£10.48	£10.59	£10.69	£10.80	£10.91
90	£12.21	£12.33	£12.46	£12.58	£12.71	£12.83

Living Wage

Percentile	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
10	£7.85	£8.25	£8.65	£9.20	£9.75	£10.35
20	£7.85	£8.25	£8.65	£9.20	£9.75	£10.35
25	£7.85	£8.25	£8.65	£9.20	£9.75	£10.35
30	£7.85	£8.25	£8.65	£9.20	£9.75	£10.35
40	£7.85	£8.25	£8.65	£9.20	£9.75	£10.35
50	£8.18	£8.26	£8.65	£9.20	£9.75	£10.35
60	£8.73	£8.82	£8.91	£9.20	£9.75	£10.35
70	£9.45	£9.54	£9.64	£9.74	£9.83	£10.35
75	£9.88	£9.98	£10.08	£10.18	£10.28	£10.38
80	£10.38	£10.48	£10.59	£10.69	£10.80	£10.91
90	£12.21	£12.33	£12.46	£12.58	£12.71	£12.83

A) Commitment to pay Living Wage to care workers supporting adults in care homes and care at home / housing support settings - 2016/17.	
Are you confident that there is sufficient financial provision for this policy in your area and that you will be able to implement it from October 1st 2016? If not, what is the cost pressure likely to be and why?	
How much of a contribution have you, or do you expect to be able to secure from providers?	
Are you able to say how many staff this will effect in your area?	
Have there been any difficulties locally that could impede implementation of the commitment?	
Have there been any implications from this commitment beyond adult social care? And how have you addressed them in your area?	
What approach will you take for SDS direct payments with regards to the Living Wage?	

B) Costing any future commitments on the Living Wage	
We have attached the SG estimate for the likely costs of The Living Wage commitment across Scotland in the email. What, if any, changes would you make to the costing estimates which were used for 2016/17 with regards to any future commitment? What should be the scope of any future Living Wage policy?	

McMartin, Geraldine

From: Health and Sport <HealthandSport@parliament.scot>
Sent: 08 July 2016 12:17
Subject: Health and Sport Committee Integration Authorities Survey 2016
Attachments: IJB survey.docx

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Done, Print please

Dear Chief Officer

Integration authorities will be a key area of interest for the Health and Sport Committee over the course of the five year parliamentary session. The Committee has recently agreed its work programme for autumn 2016, further information can be found here: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/100023.aspx .

The Committee is keen to explore three key areas in relation to integration authorities:

- Budget setting
- Delayed discharges
- Social and community care workforce

The questions attached are designed to allow the Committee to understand each of these aspects. Integration authorities are encouraged to supplement answers to increase committee understanding. The Committee will follow up answers which are unclear.

It would be much appreciated if your integration authority could respond to the questions detailed in this survey by **Wednesday 17 August 2016**. Please can responses be emailed to HealthandSport@parliament.scot.

If you require any further information regarding this survey please contact:

Rebecca

Rebecca Macfie
Senior Assistant Clerk
Health and Sport Committee

Direct Dial 0131 348 5247
Email:rebecca.macfie@parliament.scot

Room T3.60
The Scottish Parliament
Edinburgh
EH99 1SP

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Health and Sport Committee Integration Authorities Survey 2016

Integration authorities will be a key area of interest for the Health and Sport Committee over the course of the five year parliamentary session. The Committee has recently agreed its work programme for autumn 2016. The Committee is keen to explore three key areas in relation to integration authorities:

- Budget setting
- Delay ed discharges
- Social and community care workforce

The following questions are designed to allow the Committee to understand each of these aspects. Integration authorities are encouraged to supplement answers to increase committee understanding. The Committee will follow up answers which are unclear.

It would be much appreciated if your integration authority could respond to the questions detailed in this survey by **Wednesday 17 August 2016**. Please can responses be emailed to **HealthandSport@parliament.scot.**

If you require any further information regarding this survey please contact:

Rebecca Macfie, Senior Assistant Clerk, Health and Sport Committee, Tel: 0131 348 5247 rebecca.macfie@parliament.scot

Budget Scrutiny: Integration Authorities

The Committee has chosen to consider the integration of health and social care as part of its consideration of the Scottish Government's budget. The following questions are designed to explore the budget setting process for 2016-17 and how budget allocation reflects the priorities set out in the performance framework.

1. Which integration authority are you responding on behalf of?

2. Please provide details of your 2016-17 budget:

	£m
Health board	
Local authority	
Set aside budget	
Total	

3. Please provide a broad breakdown of how your integration authority budget has been allocated across services, compared with the equivalent budgets for 2015-16.

£m 2015-16		**2016-17**
Hospital		
Community healthcare		
Family health services & prescribing		
Social care		
Total		

4. The 2016-17 budget allocated £250m for social care. Please provide details of the amount allocated to your integration authority and how this money has been utilised.

Budget setting process

5. Please describe any particular challenges you faced in agreeing your budget for 2016-17

6. In respect of any challenges detailed above, can you describe the measures you have put in place to address these challenges in subsequent years?

7. When was your budget for 2016-17 finalised?

8. When would you anticipate finalising your budget for 2017-18?

Integration outcomes

9. Please provide up to three examples of how you would intend to shift resources as a result of integration over the period of your Strategic Plan:

10. What efficiency savings do you plan to deliver in 2016-17?

11. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

Performance framework

12. (a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes

(b) If possible, also show how your budget links to these outcomes

National Outcome	Indicators	2016-17 budget
People are able to look after and improve their own hea lth and wellbeing and live in good health for longer.		
People, including those with dis abilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, indepe ndently and at home or in a homely setting in their community.		
People who use health and social car e services have pos itive 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 healt h inequalities.		

National Outcome	Indicators	2016-17 budget
People who provide unpaid c are are supported to look af ter their own health and wellbeing, inc luding to reduce any negative impact of their caring role on their own health and wellbeing.		
People who use health and social car e 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 infor mation, support, care and treatment they provide.		
Resources are used effectively and efficiently in the provision of health and social care services.		

Delayed Discharges

In relation to delayed discharge the Committee is interested in three areas. The extent to which the IJB is able to direct spending, how much money is available to tackle delayed discharge and how well it is being spent to eradicate the problem.

1. As an Integrated Authority what responsibility do you have for tackling the issue of delayed discharges?
2. What responsibility do you have for allocating expenditure including additional sums allocated by the Scottish Government to tackle delayed discharges?
3. How much was spent in 2015-16 on tackling delayed discharges? If necessary this answer can be based on your shadow budget for 2015-16.
4. What is the total funding (in 2016-17) you are directing to address the issue of delayed discharges? Please provide a breakdown of how much money has been received from each of the following for this purpose:

   a. NHS board
   b. Local authority
   c. Other (please specify)
5. How was the additional funding allocated by the Scottish Government to tackle delayed discharges spent in 2015-16? How will the additional funding be spent in the current and next financial years?
6. What impacts has the additional money had on reducing delayed discharges in your area?
7. What do you identify as the main causes of delayed discharges in your area?
8. What do you identify as the main barriers to tackling delayed discharges in your area?
9. How will these barriers to delayed discharges be tackled by you?
10. Does your area use interim care facilities for patients deemed ready for discharge?
11. If you answered yes to question 10, of those discharged from acute services to an interim care facility what is their average length of stay in an interim care facility?

12. Some categories of delayed discharges are not captured by the integration indicator for delayed discharges as they are classed as 'complex' reflecting the fact that there are legal processes which are either causing the delay (e.g. application for guardianship orders) or where there are no suitable facilities available in the NHS board area. Please provide the total cost for code 9 delayed discharges for 2015-16? What is your estimate of cost in this area in the current and next financial years?

Social and Community Care Workforce

In relation to the social and communi ty care workforce the Committee is interested in the rec ruitment of suit able staff including com missioning from private providers and the quality of care provided.

1. As an Integrated Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?

2. Are there adequate levels of these social and community care staff in your area to ensure the Scottish Government's vision of a shift from hospital based care to community based care for older people is achieved? If not, please indicate in what areas a shortage exists.

3. Other than social and community care workforce levels, are there other barriers to moving to a more community based care?

4. What are the main barriers to recruitment and retention of social and community care staff working with older people in your area?

5. What mechanisms (in the commissioning process) are in place to ensure that plans for the living wage and career development for social care staff, are being progressed to ensure parity for those employed across local authority, independent and voluntary sectors?

6. What proportion of the care for older people is provided by externally contracted social and community care staff?

7. How are contracts monitored **by you** to ensure quality of care and compliance with other terms including remuneration?

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 3(i)

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Committee Meeting	**11th August 2016**
Report Number	**2016/17_03(i)**
Subject Title	**15/16 Final Annual Accounts for the HSCP Board**
Report by	**Jean Campbell, Chief Finance & Resources Officer**
Contact Officer	**Jean Campbell, Chief Finance & Resources Officer, 0141 201 4210**

1. PURPOSE

1.1. The purpose of this report is to present to the committee the Unaudited Accounts for the East Dunbartonshire Health and Social Care Partnership for the period from the 3rd September 2015 – 31st March 2016. These are contained as Appendix 1 to this report.

2. SUMMARY

2.1. The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

2.2. The regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate.

2.3. The Annual Accounts have been adjusted following initial audit feedback and updated advice and present a favourable year end position for the partnership, with an overall surplus of £1.388m which will be carried forward as reserves into 2016/17 to meet the priorities set out in the strategic plan and to provide some resilience for on-going pressure and slippage in savings plans.

3. RECOMMENDATIONS

3.1. It is recommended that the Board:-

a) Note the unaudited accounts for 2015/16.
b) Note the financial position for the HSCP and agree to maintain the carry forward balance as a reserve to meet priorities set out in the Strategic Plan and provide resilience for future financial challenges.

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal Assent in April 2014. This established the framework for the integration of Health & Social Care in Scotland.

4.2 The IJB is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of the Integration Scheme. NHS Greater Glasgow and Clyde (NHSGGC) and East Dunbartonshire Council have delegated functions to the IJB which has the responsibility for strategic planning, resourcing and ensuring delivery of all integrated services.

4.3 The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

4.4 LASAAC [The Local Authority (Scotland) Accounts Advisory Committee] has produced additional guidance on accounting for the integration of health and social care.

4.5 The annual accounts for the IJB will be prepared in accordance with appropriate legislation and guidance.

4.6 The regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. The IJB or committee whose remit includes audit and governance must meet to consider the unaudited annual accounts as submitted to the external auditor no later than the 31st August immediately following the financial year to which the annual accounts relate.

4.7 The regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the IJB, the Chief Officer and the Chief Financial Officer, namely:

Management Commentary / Foreword	Chair of the IJB Chief Officer
Statement of Responsibilities	Chair of the IJB Chief Financial Officer
Annual Governance Statement	Chair of the IJB Chief Officer
Remuneration Report	Chair of the IJB Chief Officer
Balance Sheet	Chief Financial Officer

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Partnership are as undernoted.

5.2 Financial – The Annual Accounts present a favourable position for the partnership and allow for the carry forward of a surplus of £1.388m as a reserve.

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

East Dunbartonshire Health & Social Care Partnership

Annual Accounts2015/16

(Unaudited)

CONTENTS

INTEGRATION JOINT BOARD ANNUAL ACCOUNTS

MANAGEMENT COMMENTARY

1 Purpose and objectives

The Integration Joint Board was established as a body corporate, by order of Scottish Ministers on the 27th July 2015 and empowered on the 3rd September 2015, for the area of East Dunbartonshire, covering a population of around 105,000. The main population centres are Bearsden, Milngavie, Bishopbriggs, Kirkintilloch and Lenzie along with the rural villages including Milton of Campsie, Lennoxtown, Twechar, Torrance and Balmore.

Its purpose is to deliver certain Health and Social Care services as prescribed within the Integration Scheme on behalf of East Dunbartonshire Council and NHS Greater Glasgow& Clyde (NHSGG&C) Health Board. These include all adult and community care health and social care services, and some prescribed acute services.

The IJB Strategic Plan 2015 – 2018 outlines the vision, strategic objectives and services to be delivered within the partnership:

- To improve the quality and consistency of services for service users, carers, service users and their families,
- To provide person centred, seamless, integrated, quality health and social care services in order to care for people in their own homes, or a homely setting, where it is safe to do so,
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

Our Vision is “Working with people to build strong communities, promote wellbeing and provide access to care and support.

> *“**We will have a healthcare system where we have integrated health and social care, afocus on prevention, anticipation and supported self-management. When hospitaltreatment is required, and cannot be provided in a community setting, day casetreatment will be the norm. Whatever the setting, care will be provided to the higheststandards of quality and safety, with the person at the centre of all decisions. Therewill be a focus on ensuring that people get back into their home or communityenvironment as soon as appropriate, with minimal risk of readmission”.***
>
> **A Route Map to the 2020 Vision for Health and Social Care**

The Strategic Plan has been designed to meet the outcomes and performance measures for integration within the Scottish Government’s National Performance Framework, focussed on achieving the nine national health and wellbeing outcomes.

Table 1 National Health & Well Being Outcomes

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5	Health and social care services contribute to reducing health inequalities.
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7	People who use health and social care services are safe from harm.
Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

2 Financial review

The partnership's performance is presented in these Annual Accounts. The activities of the Health and Social Care Partnership are funded through an arrangement whereby the Council and Health Board agree their respective contributions and it is for the partnership thereafter to deliver on the priorities set out in the strategic plan. The scope of budgets agreed for inclusion within the HSCP for 2015/16 from each of the partnership bodies were:-

IJB Budgets 2015/16 (from the 3rd September 2015 to the 31st March 2016))

IJB Health Budget	£48,067,000
IJB Social Work Budget	£26,059,000
TOTAL	£74,126,000

This includes an element of funding provided by the Scottish Government to deliver on the key outcomes in the form of delayed discharge and integration funding of £2.21m.

Further work has progressed to identify the indicative set aside budget for the Acute Services to be included within the integrated budget. These notional budgets are based on direct costs per bed day for each relevant speciality within the IJB based on average activity for the 3 years 2011/12 – 2013/14 provided by NHSGGC Information Services department and cost for 2013/14 taken from the NHS Scotland Cost Book. Accident & Emergency outpatient attendances will be included at 3 year average activity and direct cost per attendance for 2013/14.

The costing methodology for future years will be the subject of a review within the NHS Board to develop a more accurate costing framework for unscheduled care services which

may in time be used to identify resource shifts to either release funds to HSCPs where activity falls or identify changes to the payment to Acute Services where activity increases. An allocation has been determined by the Greater Glasgow & Clyde Health Board for East Dunbartonshire of £9.570m.

During 2015/16, a due diligence exercise was carried out to consider the sufficiency of the budget provided for the partnership by the Health Board and the Council. This identified significant financial pressure in relation to adult social care packages which have been the subject of regular reports to the IJB. This culminated in an agreement from the Council that in the first year, there would be an under writing of reported pressures from Council reserves.

The table on page 17 shows a net underspend of £1.388m on the partnership funding available for 2015/16.

In terms of the final position for Adult Social Work services, there was an increase in expenditure in relation to care home placements over and above projections as a result of the impact of winter pressures, year-end accruals and conclusion of the financial assessment. A combination of mitigations such as redundancy cost re-direction to Council centralised provision, increase in bad debt provision, application of surpluses from carry forwards from previous financial years and an adjustment to the financial allocation from the Council to reflect the under-writing arrangement, to cover reported cost pressures, provides an overall surplus on budget of £1.398m.

In terms of the final position for NHS budgets, there was a surplus generated across community NHS budgets of £400k in relation to Adult Community Care Services. In addition there was planned slippage of £400k against the HSCP's delayed discharge funding allocation. This was transferred to the Council to carry forward as reserves into 2016/17 leaving a small under spend of £7k at 2015/16.

The overall position for the HSCP is that of surplus of £1.388m which will be allocated to reserves and carried forward to 2016/17. An element of the carry forward is required to meet on-going commitments; however there will be a surplus to meet the priorities set out in the Strategic Plan, and to provide some resilience for on-going pressure and slippage in savings plans.

The partnership continues to face significant financial pressures from demographic growth particularly amongst the elderly population generating demand and increased costs across a range of adult care services.

Both partnership organisations continue to face significant financial challenge. The health board has savings of £70m to secure during 2016/17 with a number of initiatives underway to deliver on this challenge. Of the £70m savings target, £20m relates to Health & Social Care Partnerships of which £1.37m relates to East Dunbartonshire.

The Council is also facing significant challenges with £10.9m to close the funding gap during 2016/17 predominantly delivered through the Council's transformation and budget reduction programme with the aim of protecting the provision of frontline service delivery.

There is some recurring and additional funding available to partnerships from the Scottish Government in 2016/17 in the form of Integration Funding (ED - £1.7m) and Delayed Discharge Funding (ED - £510k) and additional funding from a share of £250m (ED £4.31m) aimed at delivering the living wage across the care home and care at home sectors, support

additional spend on expanding social care to support the objectives of integration and raising charging thresholds for all non-residential services.

The period of public sector austerity and reduction in the overall level of UK public sector expenditure is anticipated to extend over the medium term horizon. Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2018/19. The partnership will prepare a financial plan aligned to its strategic priorities to plan ahead to meet the challenges of demographic growth and policy pressures, taking appropriate action to maintain budgets within expected levels of funding and to maximise opportunities for delivery of the Strategic Plan.

Financial governance arrangements have been developed to support the IJB in the discharge of it's business including financial scoping, budget preparation, standing orders, financial regulations and the establishment of an Audit Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

3 Operational review

The period since the partnership has gone 'live' and the preparation running up to this date have been focussed on establishing robust governance and management arrangements to effectively deliver on the outcomes agreed for the partnership. The appointment of the Chief Officer, Interim Chief Finance Officer, Head of Adult and Community Care Services and Head of Strategic Planning as well as the establishment of an Integrated Joint Board (IJB) and the Audit Committee are fundamental to effectively deliver on the agenda.

The preparation of the Strategic Plan captures the outcomes to be achieved by the Partnership and sets the agenda and way forward on how this will be delivered. This also identified a suite of performance indicators which will measure and provide a level of scrutiny on how well the partnership is delivering it's objectives.

In 2015/16, 61% of our performance indicator targets have been achieved (based on Quarter 4 data).

In terms of Outcome one which aims to ensure people are able to look after and improve their own health and well-being and live in good health for longer, there are a number of areas of positive performance for the partnership that demonstrates effective delivery in this area. The number of successful smoking quits at 12 weeks in the 40% most deprived areas of East Dunbartonshire and the number of alcohol brief interventions per year have exceeded targets pointing to a healthier population taking control of their own health outcomes. There is also good performance in relation to the percentage uptake of bowel, cervical and breast screening programmes. There are some areas for improvement in terms of patient access to GP teams and the rates of unplanned care where specific actions are in place to improve performance and target resource to ensure effective delivery.

In terms of Outcome two which seeks to ensure people are able to live independently and at home or in a homely setting in their community, there are a range of good performance indications. Of particular significance is the achievement of the 50% target reduction for the partnership of the number of acute bed days lost to delayed discharges (including Adults with Incapacity). This is a key area which ensures people who are assessed as fit for discharge, from hospital, return home or to a homely setting as soon as possible. There has been substantial investment in this area through delayed discharge funding, Change Fund

monies and integration funding to deliver on this particular objective and the partnership is showing signs of continued improvement in this area. There is also good performance on the timescales for completion of a community care assessment to the point of service delivery, the percentage of people with intensive needs being supported at home, the increase in homecare support at weekend, during evening and overnight all exceeding targets during 2015/16. The number of admissions to care home is also ahead of target demonstrating that more people are being supported in their own homes.

The performance management framework will be further developed to ensure we have a robust process for scrutinizing performance across the full range of objectives which are to be delivered through the HSCP including benchmarking to compare with other partnerships and provide a culture of improvement and sharing good practice.

Chief Officer	**Chairperson**	**Chief Finance & Resources Officer**
Date	**Date**	**Date**

STATEMENT OF RESPONSIBILITIES FOR THE STATEMENTS OF ACCOUNT

The Integration Joint Board is required:

• To make arrangements for the proper administration of its financial affairs andto secure that it has an officer responsible for the administration of thoseaffairs. In this Integration Joint Board, that officer is the Chief Finance & Resources Officer.
• To manage its affairs to achieve best value in the use of its resources andsafeguard its assets; and
• To approve the statement of accounts

Chairperson

Date

Responsibilities of the financial officer

As financial officer I am responsible for the preparation of the Integration JointBoard's statement of accounts which, in terms of the CIPFA/LASAAC Code ofPractice on Local Authority Accounting in the United Kingdom ("the Code ofPractice"), is required to give a true and fair view of the financial position of theIntegration Joint Board at the financial year end and its income and expenditure forthe year then ended.

In preparing the financial statements I am responsible for:

• Selecting suitable accounting policies and applying them consistently;
• Making judgements and estimates that are reasonable and prudent;
• Complying with the Code of Practice.

I am also required to:

• Keep proper accounting records which are up to date; and
• Take reasonable steps to ensure the propriety and regularity of the financesof the Integration Joint Board;

Statement of Accounts

The Statement of Accounts presents a true and fair view of the financial position ofthe East Dunbartonshire Integration Joint Board as at 31 March 2016, and its income andexpenditure for the year then ended.

Chief Finance & Resources Officer

Date

REMUNERATION REPORT

1 Integration Joint Board

The members of the Integration Joint Board are appointed by nomination from the partner organisations in equal numbers to sit on the Board. This will be a minimum of three nominees each as voting members. The Council have nominated three Councillors and the Health Board have nominated three non–executive Directors for a period not exceeding three years.

The Chair person and the Vice Chairperson will be drawn from the Health Board and the Council voting members of the IJB – the first Chairperson has been appointed from the Council for the period to the local government elections in May 2017. Thereafter the term of office will rotate to a nomination of the Health Board for a period of two years.

2 Senior officers

The IJB does not directly employ any staff, all partnership officers are employed through either the Health Board or the Council and remuneration for senior staff is reported through those bodies.

The Chief Officer is appointed by the Integration Joint Board on consultation with the Health Board and Local Authority. The Chief Officer is employed by NHS GGC and seconded to the Integration Joint Board.

An interim Chief Finance Officer was seconded part time from the Health Board to the IJB for the period to the 31st March 2016 following which a full time post was appointed in the form of the Chief Finance & Resources Officer. The costs associated with this post for 2015/16 were already built into health budgets, no transfer was made into the integrated budget for this support and the costs were borne entirely by the Health Board, therefore at no cost to the IJB.

3 Remuneration policy

Board Members

The remuneration of Senior Councillors is regulated by the Local Governance (Scotland) Act 2004 (Remuneration) Regulation 2007. A Senior Councillor is a Councillor who holds a significant position of responsibility in the Council's political management structure, such as the Chair or Vice Chair of a committee, sub-committee or board (such as the Integrated Joint Board).

The remuneration of Non-Executive Directors is regulated by the Remuneration Sub-committee which is a sub-committee of the Staff Governance Committee within the NHS Board. Its main role is to ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health and Social Care Directorates.

The Integrated Joint Board does not pay allowances or remuneration to voting board members. They are remunerated by their respective organisations and any additional expenses are disclosed within the financial accounts (where material).

The position for which remuneration is paid to Board members by the respective partner organisations is;

Name	Office held as at 31 March 2016	Partner Organisation
R Geekie	Chairperson (IJB) and Leader of the Council	East Dunbartonshire Council
I Fraser	Vice Chairperson (IJB) and Non- Executive Director	NHS Greater Glasgow
M. O'Donnell	Board Member (IJB) and Councillor	East Dunbartonshire Council
A McNair	Board Member (IJB) and Councillor	East Dunbartonshire Council
R Finnie	Board Member (IJB) and Non-Executive Director	NHS Greater Glasgow
T. McAulay	Board Member (IJB) and Non-Executive Director	NHS Greater Glasgow

Chief Officer

The appointment of an IJB Chief Officer (CO) is required by section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 which includes the statement "An integration joint board is to appoint, as a member of staff, a Chief Officer". The Chief Officer is regarded as an employee of the IJB although their contract of employment is with the NHS Greater Glasgow & Clyde Health Board. The post is funded by the IJB and the remuneration of the Chief Officer is set by Greater Glasgow& Clyde Health Board in line with Senior Officer grading structures and, as with non-executive Directors, is regulated by the Remuneration Sub-committee.

The remuneration report presents the pension entitlement attributable to the post of Chief Officer but the IJB has no formal ongoing pension liability. Instead the IJB will fund employer pension contributions as they become payable during the Chief Officers' period of service. There will therefore be no pension liability reflected on the IJB balance sheet for this post.

4 Remuneration

The IJB accounts will reflect the remuneration of the Chief Officer for the period from the 3rd September 2015 to the 31st March 2016 when the partnership became 'live':

Name and Post Title	Salary, Fees and Allowances	Taxable Expenses	Total Remuneration 2015/16
	£	£	£
K Murray Chief Officer	70-75k	0	70-75K

5 Pension benefits

The Chief Officer is a member of the NHS Superannuation Scheme (Scotland) under the pre 2008 entitlements. This is a final salary pension which means that pension benefits are based on final year's pay and the number of years an individual has been a member of the scheme. The scheme's normal retirement age for employees is 65. The lump sum payable on retirement can alter from year to year due to added years and commutation.
Costs of the pension scheme contributions for the year to 31 March 2016 are shown in the table below:

	To 31 March 2016
K Murray	£
In Year pension benefits	17,000
Accrued Pension Benefits • Pension • Lump Sum	 45,000 - 50,000 145,000 – 150,000
Movement in accrued pension benefits • Pension • Lump Sum	 2,500 – 5,000 7,500 – 10,000

Chief Officer **Chairperson**

Date **Date**

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

The Integration Joint Board is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, safeguarding public funds and assets and making arrangements to secure best value in their use.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes the system of internal control. This is designed to manage risk to a reasonable level, but cannot eliminate the risk to failure to achieve policies, aims and objectives and can therefore only provide reasonable but not absolute assurance of effectiveness.

Governance framework

The system of internal control is based on a framework designed to identify and prioritise the risks to the achievement of the Partnerships key outcomes, aims and objectives and comprises the structures, processes, cultures and values through which the partnership is directed and controlled.

The system of internal control is an ongoing process designed to identify and prioritise those risks that may impact the ability of the Partnership to deliver its aims and objectives. In doing so it evaluates the likelihood and impact of those risks and seeks to manage them efficiently, effectively and economically.

Governance arrangements have been in place throughout the year and up to the date of approval of the statement of accounts.

Key features of the governance framework during 2015/16 are:

- The Integrated Joint Board (IJB) is a formal full partner of the East Dunbartonshire Community Planning Partnership Board (CPPB) and will provide regular relevant update to the CPPB on the work of the Health & Social Care Partnership

- The Integrated Joint Board comprises six voting members – three non-executive Directors of the Healthboard and three local Councillors from the Local Authority. The Board are charged with responsibility for the planning of Integrated Services through directing the Council and the Healthboard to deliver on the strategic priorities set out in the Strategic Plan. In order to effectively discharge their responsibilities, board members are supported with a development programme aimed at providing opportunities to explore individual member and Board collective responsibilities and values that facilitate decision making, develop understanding of service provision within the HSCP and engage with staff delivering these services and specific sessions on the conduct of the business of the IJB.

- IJBs are ‘devolved public bodies’ for the purposes of the Ethical Standards in Public Life (Scotland) Act 2000 which requires them to produce a code of conduct for members. The members of the IJB have adopted and signed up to the Code of Conduct for Members of Devolved Public Bodies and have committed to comply with the rules and regularly review their personal circumstances on an annual basis.

- The IJB has produced and adopted a Scheme of Administration that defines the powers, relationships and organisational aspects for the IJB. This includes the Integration Scheme, Standing Orders for meetings, Terms of reference and membership of IJB committees, the Scheme of Delegation to Officers and the Financial Regulations.

- The Strategic Plan for 2015-2018 was approved at the inaugural meeting of the HSCP Board on the 3rd September 2015. It sets out the identified strategic priorities for the HSCP under each of the nine national outcomes and describes for each priority what success will look like and the outcome measures to be used to monitor delivery.

- Financial regulations have been developed for the Health & Social Care Partnership in accordance with the Integrated Resources Advisory Committee (IRAG) guidance and in consultation with the Director of Finance of East Dunbartonshire Council and the Assistant Director of Finance of NHS Greater Glasgow and Clyde. They set out the respective responsibilities of the Chief Officer and the Chief Finance Officer in the financial management of the monies delegated to the partnership.

- Establishment of an Audit Committee. The Audit Committee will advise the Partnership Board and its Chief Financial Officer on:
    - The strategic processes for risk, control and governance and the governance statement.
    - The financial governance and accounts of the Partnership Board, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors.
    - The planned activity and results of both internal and external audit as they relate to the activities of the Partnership Board.
    - The adequacy of management response to issues identified by audit activity, including external audit's management letter/report.
    - The effectiveness of the internal control environment.
    - Assurances relating to the corporate governance requirements for the Partnership Board.
    - Appointment of the internal audit service or for purchase of non-audit services from contractors who provide audit services.

- Performance Reporting – regular performance reports are presented to the IJB to monitor progress on an agreed suite of measures and targets against the priorities set out in the strategic plan. This includes the provision of exception reports for targets not being achieved identifying corrective action and steps to be taken to address performance not on target.

- Clinical and Care Governance arrangements have been developed and led locally by the Associate Clinical Director for the HSCP and involving the Chief Social Work Officer for East Dunbartonshire Council.

- A Risk Management Register has been developed which covers the partnership's risk policy, procedure, process, systems, risk management roles and responsibilities.

- Internal / External Review of Governance Arrangements – there has been specific work undertaken by each partners audit functions on the integrity of financial governance, financial assurance and risk assessment arrangements as they relate to the integration of adult health and social care services.

- Information Governance – the Public Records (Scotland) Act 2011 (Section1 (1)) requires the HSCP Board to prepare a Records Management Plan setting out the proper arrangements for the authority's public records. In addition, under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a Freedom of Information Publication Scheme.

With regard to the entries taken from the Health Board and Council Accounts, the IJB is not aware of any weaknesses within their internal control systems and has placed reliance on the individual Statements of Internal Financial Control where appropriate.

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Review of Effectiveness

East Dunbartonshire IJB has responsibility for reviewing the effectiveness of the governance arrangements including the system of internal control. This review is informed by the work of the Chief Officer and the Senior Management Team who have responsibility for the development and maintenance of the governance environment, the Annual Governance Report, the work of internal audit functions for the respective partner organisations and also by comments made by external auditors and other review agencies and inspectorates.

The partnership has put in place appropriate management and reporting arrangements to enable it to be satisfied that its approach to corporate governance is both appropriate and effective in practice.

On the basis of internal audit work, there were a range of audit work relevant to the operation of internal controls of relevance to the IJB. These were generally found to operate as intended with reasonable assurance provided on the integrity of control. A number of recommendations have been made for areas for further improvement and action plans developed to address the risks identified.

There has been specific work undertaken by each partners audit functions on the integrity of financial governance, financial assurance and risk assessment arrangements as they relate to the Council's contribution toward the integration of adult health and social care services and the robustness of the process for setting NHS budgets to be allocated to IJB's. The Council's internal auditors were able to provide reasonable assurance over the areas reviewed and the auditors acting for NHS Greater Glasgow and Clyde found no significant issues or findings from their review. There were a number of areas identified with actions to be progressed and these are being taking forward within the partnership.

There have been regular Integrated Joint Board meetings since the partnership came into being which have received a wide range of reports to enable effective scrutiny of the partnerships' performance including regular Chief Officer Updates, Financial reports, quarterly performance reports and service development reports which contribute to the delivery of the Strategic Plan. There been a number of development sessions for members as well as induction visits to some of the operational hubs of service delivery. These have been very positive and have resulted in a programme of development activities being agreed for 2016/17.

The Accounts Commission published a report on Health and Social Care Integration in December 2015 providing a national overview of the emerging arrangements for setting up, managing and scrutinizing Integration Authorities as they become established. East Dunbartonshire undertook a process of Self Evaluation against the recommendations and

developed an action plan to progress areas for improvement to ensure effective implementation.

Governance Improvement Plans

There are a number of areas of improvement identified which will be progressed during 2016/17 which will seek to enhance governance arrangements within the partnership:

- External Reports – there are a number of areas of scrutiny as partnerships develop and the HSCP will take cognisance of these and develop action plans which seek to improve governance arrangements in line with best practice. Reports published by the Accounts Commission in respect of 'Health & Social Care Integration' and 'Changing Models of Health and Social Care' are key documents in this regard.

- Internal Audit Reports – There have been a number of areas the subject of scrutiny through organisation internal audit processes including delayed discharge, homecare review, Clients budgetary accounts and Social Care contract monitoring which are of interest to the HSCP. These highlighted areas requiring further improvement and formal action plans have been developed to mitigate the risks identified – these will continue to be monitored for compliance during 2016/17.

- There is a review of planning structures to effectively support decision making and progress of developments which deliver on the priorities set out in the Strategic Plan.

- Information Governance – The Public Records (Scotland Act) 2011 (Section 1(1)) requires the HSCP Board to prepare a Records Management Plan setting out the partnership's proper arrangements for it's public records. Under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a freedom of information publication scheme to be approved by the Scottish Commissioner. Both these document s are in early stage of development and will be presented to the IJB in early 2017 for implementation by the 1st April 2017.

- Risk Management – the development of a HSCP risk register will be further enhanced by the development of a HSCP Risk Management Strategy.

- Public protection arrangements will be strengthened with the appointment on the new Chief Social Work Officer to progress this agenda.

Assurance

The system of governance (including the system of internal control) operating during 2015/16, provides reasonable assurance that transactions are authorised and properly recorded; that material errors or irregularities are either prevented or detected within a timely period; and that significant risks impacting on the achievement of our strategic priorities and outcomes have been mitigated.

Systems are in place to continually review and improve the governance and internal control environment and action plans are in place to address identified areas for improvement.

Certification
It is our opinion that reasonable assurancecanbe placed upon the adequacy and effectiveness of the East Dunbartonshire Integration Joint Board's systems of governance.

Chief Officer **Chairperson**

Date **Date**

STATEMENT OF INCOME AND EXPENDITURE

	Notes	2015-16 Gross Expenditure	Gross Income	Net
		£000	£000	£000
Local Authority Services				
• Social Work		24,064	(25,462)	(1,398)
• Housing		18	(18)	0
• Neighbourhood		387	(387)	0
• Fleet		192	(192)	0
Sub Total	2	24,661	(26,059)	(1,398)
Health Care Services				
• Community Healthcare		32,577	(32,584)	(7)
• Hosted Services		5,913	(5,913)	0
• Acute Services		9,570	(9,570)	0
Sub Total	2	48,060	(48,067)	(7)
Corporate Services	3	17	0	17
(Surplus)/deficit on provision of services		72,738	(74,126)	(1,388)
Net income and expenditure		72,738	(74,126)	(1,388)

BALANCE SHEET

	Notes	31 March 2016
		£000
Current Assets		
Short term debtors	4	1,405
Current Liabilities		
Short term creditors	5	(17)
Net assets		**1,388**
Usable reserves	6	1,388
Unusable reserves		
Total Reserves		**1,388**

The Statement of Accounts present a true and fair view of the financial position of the Integration Joint Board as at 31 March 2016 and its income and expenditure for the year then ended.

The unaudited financial statements were authorised for issue on 20th June 2016 and the audited financial statements were authorised for issue September 2016.

Chief Finance & Resources Officer

Date

NOTES TO THE FINANCIAL STATEMENTS

1 Accounting policies

1.1 General principles

The East Dunbartonshire Integration Joint Board is formed under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a partnership arrangement between East Dunbartonshire Council and Greater Glasgow and Clyde Health Board.

Integration Joint Boards (IJB's) are specified as section 106 bodies under the Local Government (Scotland) Act 1973 and as such are required to prepare their financial statements in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

The Financial Statements summarise the Integration Joint Boards transactions for the 2015-2016 financial year and its position at the year end of 31 March 2016.

1.2 Accruals of income and expenditure

Activity is accounted for in the year that it takes place, not simply when the payments are made or received. In particular:

- All known specific and material sums payable to the IJB have been brought into account.
- Where revenue and expenditure have been recognised but cash has not been received or paid, a debtor or creditor for the relevant amount is recorded in the Balance Sheet.

1.3 Going Concern

The Accounts are prepared on the going concern basis, which provides that the entity will continue in operational existence for the foreseeable future.

1.4 Accounting Convention

The financial statements are prepared under the historical cost convention as modified for the valuation of certain assets.

1.5 Funding

The Integration Joint Board receives contributions from its funding partners namely East Dunbartonshire Council and Greater Glasgow & Clyde Health Board to fund its services. Expenditure is incurred in the form of charges for services provided to the IJB by these partners.

1.6 VAT status

The VAT treatment of expenditure in the IJB Accounts depends on which of the partner agencies is providing the service as these agencies are treated differently for VAT purposes.

Where the Council is the provider, income and expenditure excludes any amounts related to VAT, as all VAT collected is payable to H.M. Revenue & Customs and all VAT paid is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is irrecoverable from H.M. Revenue and Customs.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid as input tax and will seek to recover its full cost as Income from the Commissioning IJB.

1.7 Support Services

Support services were not delegated to the Integration Joint Board through the Integration Scheme and are instead provided by the Health Board and Council free of charge as a 'service in kind'. The support services provided is mainly comprised of: provision of the Interim Chief Financial Officer, financial management, human resources, legal, committee services, ICT, payroll, internal audit and the provision of the Chief Internal Auditor.

The cost attaching to the preparation of the Strategic Plan is also considered to be a support service provided as a 'service in kind'. The preparation of this document occurred prior to the partnership going 'live' and is not considered as material for inclusion within these Accounts.

1.8 Provisions, contingent liabilities and assets

Provisions

Provisions are made where an event has taken place that gives the IJB a legal or constructive obligation that probably requires settlement by a transfer of economic benefits or service potential and a reliable estimate can be made of the amount of the obligation.

Provisions are charged as an expense to the appropriate service line in the Income and Expenditure Statement in the year that the IJB becomes aware of the obligation and measured at the best estimate at the Balance Sheet date of the expenditure required to settle the obligation, taking into account relevant risks and uncertainties.

When payments are eventually made, they are charged to the provision held in the Balance Sheet. Estimated settlements are reviewed at the end of each financial year. Where it becomes less than probable that a transfer of economic benefits will be required (or a lower settlement than anticipated is made), the provision is reversed and credited back to the relevant service.

1.9 Contingent assets and liabilities

A contingent asset or liability arises where an event has taken place that gives the IJB a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the IJB. Contingent liabilities or assets also arise in circumstances where a provision

would otherwise be made but, either it is not probable that an outflow of resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but disclosed in a note to the Accounts where they are deemed material.

1.10 Events after the reporting period

Events after the Balance Sheet date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts is authorised for issue. Two types of events can be identified:

- Adjusting events: Those that provide evidence of conditions that existed at the end of the reporting period. The Annual Accounts are adjusted to reflect such events.
- Non-adjusting events: Those that are indicative of conditions that arose after the reporting period and the Statements are not adjusted to reflect such events. Where a category of events would have a material effect, disclosure is made in the notes of the nature of the events and their estimated financial effect.

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts.

1.11 Reserves

The reserves are created by appropriating amounts out of revenue balances. When expenditure to be financed from a reserve is incurred, it is charged to the appropriate service in that year so as to be included within the Income and Expenditure Statement. Movements in reserves are reported in the Movement in Reserves Statement.

1.12 Corresponding Amounts

The Integration Joint Board was established on 3rd September 2015 and hence the period to 31st March 2016 is its first year of operation. Consequently there are no corresponding amounts for previous years to be shown.

1.13 Exceptional Items

When items of income and expenditure are material, their nature and amount is disclosed separately, either on the face of the Income and Expenditure Statement or in the notes to the accounts, depending on how significant the items are to the understanding of the IJB's financial performance.

1.14 External Audit Costs

The appointed Auditors to ED HSCP were Audit Scotland. Fees payable to Audit Scotland in respect of external audit service undertaken in accordance with the Code of Audit Practice in financial year 2015/16 were £17k. Given the IJB cannot physically pay for invoices, this will be paid through the Council or the Health Board and charged as a cost in the IJB Accounts.

1.15 Claims Handling, Liability and Indemnity

The HSCP 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. The Health Board and Council 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 has delegated to the HSCP Board. Liabilities arising from decisions taken by the HSCP Board will be equallyshared between the Council and Health Board.

With specific respect to the HSCP Board's strategic planning responsibilities and decisions that it may make, during 2015/16 arrangements were made for members of the HSCP Board to join the Clinical Negligence & Other Risks Indemnity (CNORIS) scheme. The risks associated with Integration Joint Boards membership of CNORIS is considered low and therefore an annual contribution of £3,000, payable each financial year; has been set, with the Health Board having agreed to meet this cost for all of the IJBs within its area. The contribution level has been assessed at this level due to the limited risks anticipated in relation to the statutory status of IJBs; and CNORIS cover being provided mainly in relation to indemnity for IJB members and officials.

1.16 Standards issued not yet effective

IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors requires disclosure of information on the expected impact of new accounting standards that have been issued but are not yet effective. These have been reviewed and are not deemed to be significant for the financial statements.

2 Related party transactions

The East Dunbartonshire Integration Joint Board was established on the 3rd September 2015. In the year the following financial transactions were made with the Greater Glasgow & Clyde Health Board and East Dunbartonshire Council relating to integrated health and social care functions:

Income – payments for integrated functions

	2015-16
	£000
NHS Greater Glasgow & Clyde	48,067
East Dunbartonshire Council	26,059
Total	**74,126**

Expenditure - payments for delivery of integrated functions

	2015-16
	£000
NHS Greater Glasgow & Clyde	48,060
East Dunbartonshire Council	24,661
Total	**72,721**

The NHS Board figure contains £9.570m set aside for certain hospital services as prescribed within the Scheme of Integration. This reflects a notional allocation based on direct costs per bed day for each relevant speciality within the IJB and average activity for the 3 years 2011/12 – 2013/14 provided by NHSGGC Information Services department. The costs for 2013/14 are taken from the NHS Scotland Cost Book.

The costing methodology for future years will be the subject of a review within the NHS Board to develop a more accurate costing framework for unscheduled care services which may in time be used to identify resource shifts to either release funds to HSCPs where activity falls or identify changes to the payment to Acute Services where activity increases. An allocation has been determined by the Greater Glasgow & Clyde health board for East Dunbartonshire of £9.570m.

3 Corporate expenditure

	2015-16
	£000
Staff Costs	
Audit Fees	17
Total	**17**

4 Short Term Debtors

	31 March 2016
	£000
Central government bodies	7
Other local authorities	1,398
Total	**1,405**

The short term debtor relates to the reported surplus on the respective health and social care expenditure and is money held by the parent bodies as reserves available for the HSCP.

5 Short Term Creditors

	31 March 2016
	£000
Central government bodies	17
Other local authorities	0
Total	**17**

This relates to the external audit fee as disclosed in note 1.14 to these accounts.

6 Movement in reserves

Usable reserves – general fund	31 March 2016
	£000
Balance at 31 March brought forward	0
Surplus / (deficit) on provision of services	1,388
Other comprehensive expenditure and income	0
Total comprehensive expenditure and income	1,388
Balance at 31 March carried forward	1,388

7 Post balance sheet events

The Unaudited Accounts were issued on the 30th May 2016 and the Audited Annual Accounts were authorised for issue by the 30th September 2016. Events taking place after this date, are not reflected in the financial; statements or notes. Where events taking place before this date provided information about conditions existing at the 31st March 2016, the figures in the financial statement and notes have been adjusted in all material respects to reflect the impact of this information.

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 3(ii)

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11 August 2016**
Report Number	**2016/17_ (3ii)**
Subject Title	**Forecast Outturn HSCP Budgets 16/17 (Adult Services at Month 3)**
Report by	**Jean Campbell, Chief Finance & Resources Officer East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, Resource and Finance Officer, EDHSCP 0141 201 4210 - Jean.Campbell@ggc.scot.nhs.uk**

1. PURPOSE

1.1. The purpose of this report is to update the Board on the projected financial outturn for the Health & Social Care Partnership for 2016/17.

2. SUMMARY

2.1 The financial performance in relation to the forecast outturn for the Health & Social Care Partnership is based on the period 3 reporting cycle for the period to 30th June 2016 (dates vary between NHS and Council reporting cycles which do not align). This is early in the financial year and the position can vary significantly based on unknown demand pressures which may occur throughout the year and the volatile nature of Social Work budgets.

2.2 The current position indicates a breakeven position for NHS budgets overall and a current breakeven position for SW budgets, albeit there continues to be pressure on care home placements which is currently being offset by surplus in other adult social care budgets.

2.3 There are monies available to meet any ongoing demographic pressures and there is partnership reserves of £1.388m carried forward from 2015/16 to provide some resilience in 2016/17. There are also monies provided to deliver the Living Wage which will incur a part year cost in 2016/17 only. However, reserves are non-recurring monies and will therefore require measures in place to manage any budget pressures on an ongoing basis.

2.4 There are a number of risks to the financial out turn for the partnership in respect of the financial position of the NHS GG&C Board which set it's budget for 2016/17 on the 28th June 2016. The partnership savings requirement is £20m of which collective cost savings schemes of £10.4m have been identified. This leaves a balance of savings to be found from partnerships of £9.6m. The target for East Dunbartonshire is £1.37m of which £1.026m has been identified per previous reports.

2.5 There are similar movements likely to arise within monies allocated by East Dunbartonshire Council. The Council's 2016/17 Revenue Budget was balanced by recognising that savings will accrue from a number of Transformation Work streams that are currently progressing. Improved financial efficiency will arise and the Partnership will be advised once these are determined

2.6 In addition. Children's Social Work and Criminal Justice Services will formally move into the partnership on the 11th August 2016 and this is also an area subject to levels of volatility across budgets and will be included in future monitoring reports.

3 RECOMMENDATIONS

It is recommended that the Board:-

a) Notes the projected outturn position for the HSCP for 2016/17 and that uncertainty exists in both funding and operational costs of demand sensitive areas.

4.0 BACKGROUND

4.1 East Dunbartonshire Health & Social Care Partnership (HSCP) was established on the 3rd September 2015 and 2016/17 represents the first year that budgets will be fully aligned for Adult Services. The incorporation of Children's Social Work and Criminal Justice Services on the 11th August 2016 will further increase the budgets, responsibilities and reporting requirements for the partnership and work is underway to scope and agree the extent of this provision.

4.2 The table below shows the year to date variance and estimated out –turn forecast for the HSCP.

Partnership Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	Out-turn Forecast £000
NHS Community Budgets*	25,166	5,019	4,984	35	0
Oral Health	10,377	2,554	2,534	20	0
FHS & Prescribing	43,030	10,758	10,758	0	0
Adult Social Care*	40,500	7,441	7,045	396	0
SUB-TOTAL	**119,073**	**25,771**	**25,320**	**451**	**0**
Acute Set Aside	16,560	4,140	4,140	0	0
TOTAL	**135,633**	**29,911**	**29,460**	**451**	**0**

*It should be noted that budgets have yet to be adjusted to reflect the savings outlined in the NHS GG&C financial plan of £346k still to be identified and the

partnership's share of Council savings plan in respect of "Total Resourcing" and procurement savings.

HSCP Budget Outturn

4.3 The overall projected out turn for the HSCP is indicating a breakeven position for 2016/17. Any ongoing budget pressures within Older People for Social Work will be managed in year through a combination of management action and potential for use of monies provided to meet demographic pressures. There are also reserves carried forward at the end of 2015/16 and some monies available given the delay in implementing the Living Wage until October 2016. There is also slippage in the allocation made from delayed discharge funding for the intermediate care proposal as the service has not yet commenced.

NHS Budget Outturn

4.4 The table below shows a detailed breakdown of the partnerships NHS budgets for the 3 month period to the 30th June 2016:-

NHS Expenditure £000	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
Addictions – Community	701.5	175.4	204.3	(28.9)
Adult Community Services	4,297.8	1,074.2	1,029.4	44.8
Integrated Care Fund	1,200.0	114.6	114.6	0
Child Services – Community	1,349.4	342.3	321.0	21.3
Learning Disability – Community	306.7	91.0	78.0	13.0
Mental Health – Adult Community	1,249.5	311.5	292.9	18.7
Mental Health – Elderly Services	652.4	161.0	155.4	5.5
Other Services	5,791.2	327.7	367.4	(39.8)
Planning & Health Improvement	733.4	200.3	200.3	0
Resource Transfer to Local Authority	8,884.6	2,221.1	2,221.1	0
Total Integrated Budgets	**25,166.5**	**5,019.1**	**4,984.4**	**34.6**
Family Health Services – Prescribing	18,807	4,848	4,848	0
Family Health Services – GMS	12,793	3,198	3,198	0
Family Health Services – Other	11,437	2,638	2,638	0
Total Ring-fenced NHS Budgets	**43,037**	**10,684**	**10,684**	**0**
Total Directly Managed NHS Budget	**68,203.5**	**15,703.1**	**15,668.4**	**34.6**
Oral Health – Public Dental Service (Hosted)	10,377	2,554	2,534	20

Acute Set Aside	16,560	4,140	4,140	0
Total IJB Health Budget	**95,139.5**	**22,396.1**	**22,341.4**	**54.6**

4.5 The projected out turn for NHS budgets for 2016/17 is that of a breakeven at this point in the financial year. There are a number of budget pressures in relation to Addictions, a consequence of the effect of the savings allocated in respect of the ADP allocation which will be resolved through adjustment to the level of Resource Transfer to the Council, and Other Services, in relation to accommodation charges for KHCC. However, these are offset by surpluses in a number of other areas including Adult Community Services relating to vacancies within District Nursing and Rehab and under spend on management costs within Adult and Mental Health services. The latter will form part of the structure considerations as these are further developed.

4.6 GP Prescribing costs are not available until two months after the month in which prescriptions are dispensed which means that only April expenditure is available, therefore actual is assumed to be on budget at this stage. There would require being 3 months of expenditure in order to effectively project in year trends and work is ongoing to establish a position with regard to these budgets. There remains a risk sharing arrangement in place for 2016/17 across the GG&C board area and this will be managed within the NHSGGC board budgets.

4.7 The Public Dental Service hosted by ED HSCP is projected to achieve a breakeven position. There are a number of savings plans incorporated with the 16/17 budget which are yet to deliver but are expected to be achieved over the course of the current year.

Social Work Budget Outturn

4.8 The table below shows the partnerships Adult Social Care budgets for the 3 month period to the 4th July 2016:-

SW Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
TOTAL SW Budgets	**40,450**	**7,441**	**7,045**	**396**

4.9 The projected out turn for Adult Social Work services shows continued pressure in relation to care home placements, predominantly from a hospital setting in achievement of delayed discharge targets, however these are currently being managed from surpluses across other Adult Social Work budgets. The projected outturn at this point in the financial year is that of a breakeven.

Budget Setting 2016/17

4.10 The NHS GG&C Board has approved the 2016/17 Financial Plan on the 28th June 2016. The plan includes a number of assumptions as they apply to HSCP's including:

- Salaries Inflation – a provision made for an increase of 1%
- Prescribing Growth – a recurring uplift of £15.7m has been agreed based on likely growth in volume / prices based on current trends and current drug treatments prescribed within Primary Care.

- Resource Transfer – a provision of 1.7% has been made for uplifts to resource transfer.
- Cost Savings – The partnership savings requirement is £20m of which savings proposals of £10.4m have been identified. Therefore further work is required to identify proposals to meet the balance required. There may be some non-recurring relief to meet any savings shortfall, however the release of this will be the subject of further discussions throughout the year and is not expected to be quantified and allocated until the month 5 accounting period. Recurring solutions will have to be identified going forward.
- Service Commitments – provision has been made to meet service commitments arising from specific funding allocations is respect of the Integration Care Fund.

Plans Identified to Date	£m	Status
Primary Dental Service Reduction In Dental Bundled Funding Reduction in allocation for Primary Dental Service	 0.228 0.263	Plans identified and detailed PIDs in development.
Sub Total		
NHS Community Services Integrated Care Fund Reduction in Drug / Alcohol allocations	 0.250 0.125	Plans identified and detailed PIDs in development.
Sub Total		
Collective Schemes Identified – Payroll Uplift Funding	0.156	Plans identified
Balance to be Identified	0.346	Review of year end variances
Total Indicative Savings Target	**1.368**	

Financial Risks

4.11 The most significant risks that will require to be managed during 2016/17 are;

- **Prescribing Expenditure** –Prescribing cost volatility represents the most significant risk within the NHS element of the partnership's budget. At this stage of the year it is now possible to make an informed assessment of the in year position against budgets and to estimate the likely out-turn for 2016/17, however based on previous year experience this will require close ongoing monitoring.
- **Achievement of Savings Targets** – Local NHS savings targets of £1.368m have been identified in part and there may be some non-recurring relief to meet any savings shortfall, however the release of this will be the subject of further discussions throughout the year. Recurring solutions will have to be identified going forward. Similarly, there are elements of savings targets for Total Resourcing and procurement which have yet to be allocated out which may present in year pressure.

- **Demographic Pressures** – Increasing numbers of older people is placing significant additional demand on a range of services including Home Care. In addition achieving the required reductions in delayed discharges is creating increased demand for care home places and resulting in increased levels of self directed support payments. These factors increase the risk that overspends will arise and that the partnership Board will not achieve a balanced year end position.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 04

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_04**
Subject Title	Delayed Discharges Performance update
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership

1.0 PURPOSE OF REPORT

1.1 To advise the HSCP Board on the progress being made in relation to the Delayed Discharges Action Plan.

2.0 SUMMARY

2.1 The Scottish Government provided an allocation of £510,000 to East Dunbartonshire HSCP to support improvement in reducing Delayed Discharges. A report was presented to the HSCP in December 2015 outlining the proposed allocation of this funding, and the Action Plan to support progress.

2.2 This report provides a brief narrative outlining the progress made against the priorities set out in the Action Plan.

2.3 Current performance data included in the report provide comparatives with Greater Glasgow and Clyde Partnerships, and are taken from the NHSGG&C Older People's Monitoring Report for June 2016.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

(a) Notes the content of this report

4.0 BACKGROUND

4.1 The NHS Greater & Glasgow & Clyde Corporate Older Peoples monitoring report for May 2016 is attached as **Appendix 1**. For East Dunbartonshire it shows a continuing reduction in bed days lost to delay from January of this year.

4.2 Equally encouraging is the ongoing maintenance at zero of bed days lost to delayed discharges for Adults with Incapacity (AWI). This rose briefly to 10 in the month of December 2016 but has been maintained at zero since..

4.3 There are indications that this positive trend will be set back in the figures for June where a rise in referrals post the fit for discharge date was experienced. Efforts are being redoubled to ensure that early referral to social work is the norm across all hospital sites.

5.0 ACTION PLAN UPDATE

5.1 POA Campaign

East Dunbartonshire is participating in the wider national Power of Attorney awareness campaign. This has already begun to demonstrate impact, both nationally and within East Dunbartonshire A recent television and social media campaign has been undertaken, We have been delighted with the success of this phase – we have reached many more people, not least with our 'myth-busting' adverts which have each had over 25,000 views on social media.

5.2 Patient/s with Complex Needs

As detailed within previous reports to the Board there are two patients currently awaiting discharge from hospital with very complex needs. Between them these delayed discharges account for almost 50% of our current bed days lost figure. Patient KS, a gentleman with Guillaume-Barré has been the subject of a formal procurement process This is now significantly progressed. A specialist provider has been engaged and carers have been recruited who are now being trained by ward staff in the Queen Elizabeth University Hospital with a view to supporting Mr.S to return home in the coming months. Works are currently being arranged to adapt his family home to accommodate his needs. Mr. S's condition has improved somewhat. Although he remains paralyzed from the neck down, he is able to sustain periods of up to 4 hours without being artificially ventilated. Patient HT is a lady with complex Learning Disability and Mental Health conditions currently detained under a treatment order as an in-patient in a specialist Learning Disability acute facility. A potential placement has been identified in a soon-to-open national resource for adults with learning disability who present challenging behaviours. A further Care Programming discussion is scheduled for early August which will start the formal process of her discharge to this facility.

5.3 Weekly Multi-Agency Meeting

This meeting is now established as a regular fixture bringing together all relevant team leads to inform discharge planning and enabling coordinated approaches to bring solutions to problematic discharges. Key to the meeting is the early intelligence brought to discussion by District Nursing, Rehab and Homecare leads who often have detailed knowledge of the community histories of patients passing through the hospital system and are therefore able to assist the identification of those who are unlikely to be able to return home and whose discharge might be delayed.

5.4 Evaluation of ICF-Funded projects

The Integrated Care Fund (ICF) was established by the Scottish Government in 2015 to succeed the previous Older People's Change Fund and to extend extra resourcing to all adult care groups in order to support integration. Initially established for one year only, this fund has now been confirmed as recurring. A number of work streams previously funded by the Change Fund were continued within the allocation of the first tranche of ICF funding for year 2015-16. A comprehensive evaluation of all workstreams funded through the ICF in year 2015-16 has now been concluded. Those relevant to Delayed Discharges planning include *Re-ablement Homecare, Post-Diagnostic Support for Dementia, the Rapid Assessment Link and AWI*. All of these work streams have been evaluated positively and funding to them has been continued.

5.5 Hospital Assessment Team (HAT) – Agile / SMART Working

To enable HAT ream members to work more efficiently and agile, it is proposed to provide them with laptops as per Council SMART working processes, in advance of the refurbishment of KHCC. In addition all HAT ream members have received training and accreditation to use the NHS Portal recently established to access health records as well as Social Work.

Older People's Bed Days Lost to Delayed Discharge Monthy Monitoring Report - June 2016

Bed Days Lost to Delayed Discharge (inc AWIs) - Acute

(patients aged 65 & over on day of admission)

								2015/16												2016/17		
HSCP	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual
East Dunbartonshire	7,359	6,883	6370	5534	2686	4,916	3,636	462	458	287	308	216	146	283	254	379	347	276	220	187	102	238
East Renfrewshire	4,829	4,799	4,093	5171	2445	2,896	1,680	164	84	112	100	155	105	163	170	170	123	156	178	206	327	187
Glasgow City	**53,110**	**56,635**	**64,865**	**43,185**	**39,929**	**38,152**	**21,288**	**2204**	**2106**	**1513**	**1571**	**1668**	**1417**	**1563**	**1484**	**1566**	**2020**	**2028**	**2148**	**2359**	**2166**	**2155**
Inverclyde	6,724	5,497	5578	3744	3010	3,462	1,560	138	97	80	142	167	192	116	99	90	169	143	127	104	95	115
Renfrewshire	16,207	14,319	19792	12,698	5835	5,325	3,633	529	482	436	423	284	262	198	172	153	217	207	270	212	234	285
West Dunbartonshire	7,638	8,644	8611	6050	4925	5,802	3,345	396	284	230	263	242	157	219	187	301	280	301	485	347	380	368
GGC(All above areas)	**95,867**	**96,777**	**109,309**	**76,382**	**58,830**	**60,553**	**35,142**	**3,893**	**3,511**	**2,658**	**2,807**	**2,732**	**2,279**	**2,542**	**2,366**	**2,659**	**3,156**	**3,111**	**3,428**	**3,415**	**3,304**	**3,348**

	Number of Beds Consumed Annually							Monthly Number of Beds Consumed												nthly Number of Beds Consum		
HSCP	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual
East Dunbartonshire	19.2	17.9	16.6	14.4	7.0	12.8	9.4	15	14	9	9	7	5	9	8	12	11	9	7	6	3	8
East Renfrewshire	12.6	12.5	10.7	13.5	6.4	7.5	4.4	5	3	4	3	5	3	5	5	5	4	5	5	7	10	6
Glasgow City	**138.2**	**147.4**	**168.8**	**112.4**	**103.9**	**99.3**	**55.3**	**70**	**65**	**48**	**48**	**51**	**45**	**48**	**47**	**48**	**62**	**66**	**66**	**75**	**66**	**68**
Inverclyde	17.5	14.3	14.5	9.7	7.8	9.0	4.0	4	3	3	4	5	6	4	3	3	5	5	4	3	3	4
Renfrewshire	42.2	37.3	51.5	33.0	15.2	13.9	9.4	17	15	14	13	9	8	6	5	5	7	7	8	7	7	9
West Dunbartonshire	19.9	22.5	22.4	15.7	12.8	15.1	8.7	13	9	7	8	7	5	7	6	9	9	10	15	11	12	12
GGC(All above areas)	**249.5**	**251.9**	**284.5**	**198.8**	**153.1**	**157.6**	**91.2**	**123**	**108**	**84**	**86**	**84**	**72**	**78**	**75**	**81**	**97**	**102**	**105**	**108**	**101**	**106**

AWI identified by code "51X"
Edison extract as at 29th July 2016

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs. Karen E. Murray

Agenda Item Number: 5

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11th August 2016**
Report Number	**2016/17_05**
Subject Title	**Performance Report Quarter 4 (2015-16)**
Report by	**Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager, East Dunbartonshire Health & Social Care Partnership**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to present a summary of the agreed HSCP targets and measures, relating to the delivery of the strategic priorities, for the period January - March 2016 (Quarter 4).

2.0 SUMMARY

2.1 The Health & Social Care Partnership Board agreed to receive and consider quarterly performance reports on the progress of an agreed suite of measures and targets against the priorities set out in the Strategic Plan.

2.2 The Quarter 4 Performance Report sets out:

- Positive Performance (on target) improving (20 measures)
- Positive Performance (on target) declining (3 measures)
- Negative Performance (below target) improving (12 measures)
- Negative Performance (below target) declining (2 measures)

A summary of the performance indicators for Quarter 4 is provided in **Section 1**. The full list of measures and targets is provided in **Section 2.** This includes data from the previous three quarters to demonstrate trends.

2.3 Indicators that are below target and declining are subject to exception reporting. These exception notes provide a brief review of performance and actions to be taken to address deficits. Exception reports are provided in **Section 3**. They include the percentage variance from target and, if available, the actual numbers. The exception reports are ordered from greatest to least percentage variance.

3.0 **RECOMMENDATIONS**

3.1 It is recommended that the Health & Social Care Partnership Board:

- Notes the content the performance report and monitors progress against targets.

SECTION 1 Performance Summary

Key	
Positive Performance (on target) improving / declining	✓
Negative Performance (below target) improving / declining	✗

Positive Performance (on target & improving) is reported in:

Ref		
1.	Number of successful smoking quits at 12 weeks in 40% most deprived areas	✓
2.	Number of alcohol brief interventions per year	✓
4.	Percentage uptake of bowel screening programme	✓
6.	Percentage uptake of cervical screening programme	✓
8.	Percentage uptake of breast screening programme	✓
11.	Rate of unplanned acute bed days 75+ (per 1,000 pop) (Rate at quarter end)	✓
13.	Number of acute bed days lost to delayed discharge	✓
14.	Number of delayed discharges for Adults with Incapacity (Acute Beds) (number at quarter end)	✓
15.	Number of acute bed days lost to delayed discharges for Adults with Incapacity (aged 65+)	✓
18.	Rate of Suicides (per 100,000 pop per year) (2014)	✓
21.	Rate of alcohol related deaths (per 100,000 pop per year) (2014)	✓
23.	Percentage of newly diagnosed people with dementia in receipt of one year's post diagnostic support (as a proportion of those offered)	✓
25.	Number of people 65+ with anticipatory care plans in place in general practice	✓
27.	Percentage of people (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery	✓
28.	Percentage of people 65 or over with intensive needs receiving care at home (percentage at quarter end)	✓
29.	Number of new permanent admissions to care homes for 65+ per month	✓
32.	Percentage of people aged 65+ receiving homecare who receive a service at weekends	✓
33.	Percentage of service users satisfied with their involvement in the design of their care packages	✓
34.	Percentage of service users satisfied with the quality of social care provided	✓
35.	Percentage of people 65+ indicating satisfaction with their social interaction opportunities	✓

Positive Performance (on target but declining) is reported in:

Ref		
3.	Rate of alcohol related admissions (per 1,000 pop – rolling year)	✓
17.	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	✓
31.	Percentage of people aged 65+ receiving homecare who receive a service during evenings or overnight	✓

Negative Performance (below target but maintaining/improving is reported in:

Ref		
5.	Percentage uptake of bowel screening programme (SIMD1)	✗
7.	Percentage uptake of cervical screening programme (SIMD1)	✗
9.	Percentage of patients achieved 48 hour access to GP practice team (2013-14)	✗
10.	Percentage of patients able to access advanced booking of appointments to a member of GP Teams (2013-14)	✗
12.	Number of emergency admissions 75+ (rate per 1,000 pop) (rate at quarter end)	✗
19.	Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment (as at Dec 2015)	✗
20.	Rate of drug related deaths (per 100,000 pop per year) (2014)	✗
21.	Rate of alcohol related deaths (per 100,000 pop per year) (2014)	✗
22.	People with a diagnosis of dementia on the QOF register (as at February 2016)	✗
24.	Number of people 65+ with anticipatory care plans completed within community nursing and older people's mental health services per year	✗
26.	Percentage of Adults with a direct payment in the month who use this to fund personal care (percentage at quarter end)	✗
30.	Percentage of people aged 65+ in permanent care home placement	✗

Negative Performance (below target and declining is reported in:

Ref		
16.	Rate of Long Term Conditions Bed days (rolling year per 100,000 pop)	✗
36.	Percentage of complaints received and responded to within organisational timeframe (currently Health complaints)	✗

SECTION 2 Quarter 4 Quarterly Measures 2015-16

Ref.	Measure	Status	Quarter					Target Timeframe
			Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	
			Value	Value	Value	Value	Target	
1.	Number of successful smoking quits at 12 weeks in 40% most deprived areas		3	6	12	20	18	Rolling Quarterly
2.	Number of alcohol brief interventions per year		198	342	498	625	487	Cumulative quarterly
3.	Rate of alcohol related admissions (per 1,000 pop – rolling year)		4.3	3.8	4.2	4.4	4.8	Rolling Year
4.	Percentage uptake of bowel screening programme (April 13 – Mar 15)		60.6%	63.4%	63.4%	63.4%	60%	2 year rolling period
5.	Percentage uptake of bowel screening programme SIMD1 (April 13 – Mar 15)		43.9%	46.1%	46.1%	46.1%	60%	2 year rolling period
6.	Percentage uptake of cervical screening programme (As at June 2015)		80.5%	80.6%	80.6%	80.6%	80%	Quarterly
7.	Percentage uptake of cervical screening programme SIMD1 (As at March 2015)		74.1%	72.5%	72.5%	72.5%	80%	Quarterly

Ref.	Measure	Status	Quarter					Target Timeframe
			Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	
			Value	Value	Value	Value	Target	
8.	Percentage uptake of breast screening programme (May 2009 – Aug 2013)	✓	76.8%	76.8%	76.8%	76.8%	70%	3 year rolling period
9.	Percentage of patients achieved 48 hour access to GP practice team (2013-14)	✗	94.1%	94.1%	94.1%	94.1%	95%	Annual
10.	Percentage of patients able to access advanced booking of appointments to a member of GP Teams (2013-14)	✗	91%	91%	91%	91%	93.5%	Annual
11.	Rate of unplanned acute bed days 75+ (per 1,000 pop) (Rate at quarter end)	✓	308	302	401	372	392	Quarterly
12.	Number of emergency admissions 75+ rate (per 1,000 pop) (Rate at quarter end)	✗	27	29	35	33	29	Quarterly
13.	Number of acute bed days lost to delayed discharge	✓	1207	670	916	843	951	Quarterly
14.	Number of delayed discharges for Adults with Incapacity (Acute Beds) (Number at quarter end)	✓	3	1	1	0	0	Quarterly
15.	Number of acute bed days lost to delayed discharges for Adults with Incapacity (aged 65+)	✓	427	128	41	0	399	Quarterly
16.	Rate of Long Term Conditions Bed days (rolling year per 100,000 pop)	✗	6,061.6	6,028.3	6559.5	6,733.8	6,562	Rolling Year
17.	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	✓	98.5%	99.5%	99%	98.4%	90%	Quarterly

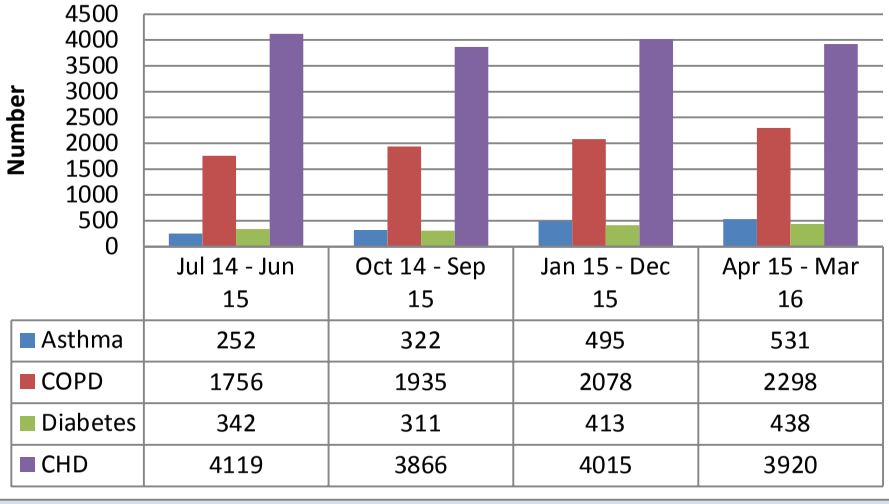
Ref.	Measure	Status	Quarter					Target Timeframe
			Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	
			Value	Value	Value	Value	Target	
18.	Rate of Suicides (per 100,000 pop per year) (2014)	✓	**9.4**	**9.4**	**9.4**	**9.4**	**10**	**Annual**
19.	Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment	✗	**64.4%**	**82.9%**	**66.7%**	**70.5%**	**91.5%**	**Quarterly**
20.	Rate of drug related deaths (per 100,000 pop per year) (2014)	✗	**0.9**	**3.7**	**3.7**	**3.7**	**1.9**	**Annual**
21.	Rate of alcohol related deaths (per 100,000 pop per year) (2014)	✓	**13.4**	**15.6**	**15.6**	**15.6**	**25**	**Annual**
22.	People with a diagnosis of dementia on the QOF register (As at February 2016)	✗	**722**	**727**	**749**	**767**	**950**	**Static Target**
23.	Percentage of newly diagnosed people with dementia in receipt of one year's post diagnostic support (as a proportion of those offered)	✓	**100%**	**100%**	**100%**	**100%**	**100%**	**Quarterly**
24.	Number of people 65+ with anticipatory care plans completed within community nursing and older people's mental health services per year	✗	**40**	**51**	**62**	**63**	**75**	**Cumulative quarterly**
25.	Number of people 65+ with anticipatory care plans in place in general practice	✓	Data not available this quarter	Data not available this quarter	Data not available this quarter	**1,082**	**946**	**Annual**

Ref.	Measure	Status	Quarter					
			Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	Target Timeframe
			Value	Value	Value	Value	Target	
26.	Percentage of Adults with a direct payment in the month who use this to fund personal care (Percentage at quarter end)		76.2%	75.8%	77.4%	78.6%	80%	Monthly
27.	Percentage of people (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery		98.9%	99.5%	100%	100%	100%	Quarterly
28.	Percentage of people 65 or over with intensive needs receiving care at home (Percentage at quarter end)		40.1%	38.5%	38%	38.1%	32%	Quarterly
29.	Number of new permanent admissions to care homes for 65+ per month		20	10	13	11	14	Quarterly
30.	Number of people aged 65+ in permanent care home placement		666	690	679	674	640	Quarterly
31.	Percentage of people aged 65+ receiving homecare who receive a service during evenings or overnight		55%	55%	52.7%	50.9%	50%	Quarterly
32.	Percentage of people aged 65+ receiving homecare who receive a service at weekends		90.1%	90.2%	89.4%	90.2%	84%	Quarterly
33.	Percentage of service users satisfied with their involvement in the design of their care packages		95%	100%	96%	100%	95%	Quarterly

Ref.	Measure	Status	Quarter					
			Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	Target Timeframe
			Value	Value	Value	Value	Target	
34.	Percentage of service users satisfied with the quality of social care provided		**95%**	**98%**	**96%**	**100%**	**99%**	**Quarterly**
35.	Percentage of people 65+ indicating satisfaction with their social interaction opportunities		**86%**	**97.5%**	**92%**	**100%**	**93%**	**Quarterly**
36.	Percentage of complaints received and responded to within organisational timeframe (Currently Health complaints)		**No complaints**	**67%**	**No complaints**	**0%**	**100%**	**Quarterly**

SECTION 3 Exception Reports (descending order of variance from target)

Ref.	Performance below Target	Exception Report	Action(s) to improve	Variance from target
36.	Percentage of complaints received and responded to within organisational timeframe (currently health complaints)	We received one complaint within this quarter which was unfortunately not responded to within the 20 day timeframe. This was due to consent not being sent in time.	Not Applicable	**100% (N=1)**
16.	Rate of Long Term Conditions Bed days (rolling year per 100,000 pop)	The measure provides the rolling year bed day rate per 100,000 population for Asthma, COPD, Diabetes and Coronary Heart Disease. During 2015/16, there has been a rise in bed day rates for all four conditions, particularly Asthma and COPD.	To gain an understanding for the rise in bed days and consider self management approaches to prevent admission	**3% (Rate=171.8)**



	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Asthma	252	322	495	531
COPD	1756	1935	2078	2298
Diabetes	342	311	413	438
CHD	4119	3866	4015	3920

Agenda Item Number: 6

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	**2016/17_06**
Subject Title	East Dunbartonshire Health and Social Care Integration Scheme: Delegation, Direction and Strategic Planning of Additional Functions and Services
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership Karen.Murray@ggc.scot.nhs.uk 0141 201 3553

1. PURPOSE OF REPORT

1.1 The purpose of this report is to notify the HSCP Board of the formal approval of the East Dunbartonshire Health and Social Care Integration Scheme by the Cabinet Secretary for Health and Sport on 5th July 2016 and to seek approval for the commencement of the delegation of the additional functions set out in the Scheme on 11 August 2016, subject to a number of technical processes, as set out in this report.

2. SUMMARY

2.1 The East Dunbartonshire Health and Social Care Integration Scheme ("the Integration Scheme") describes the model of the integrated arrangements, the scope of functions to be delegated to the Integration Authority, the method of determining associated payments and a range of issues including governance, financial management, dispute resolution and workforce.

2.2 On 27 June 2015, the original Integration Scheme for East Dunbartonshire was approved by Order of the Scottish Parliament.

2.3 On the 30th April 2015 East Dunbartonshire Council agreed to a request by NHSGGC Board to extend the functional responsibilities of the East Dunbartonshire Health & Social Care Partnership Board to include local Children's Community Health Service functions.

2.4 On 7 April 2016, NHSGGC agreed to a request by the Council to extend the functional responsibilities of the East Dunbartonshire Health & Social Care Partnership Board to include Social Work Children and Criminal Justice service functions.

2.5 As reported to the HSCP Board at its meeting on 31 March 2016 (Report No. HSCP/014/16/KM), this additional delegation of functions necessitated revision to the Integration Scheme, for approval by the Council, the Health Board and by the Cabinet Secretary. This revision process involved a period

of statutory consultation which was completed during May and June 2016, the results of which were taken into account on the preparation of a final Integration Scheme.

2.6 The Council and Health Board approved the revised Integration Scheme at their meetings on 21 and 28 June 2016 respectively and jointly submitted it for Cabinet Secretary approval, which was granted on 5th July 2016 A copy of this approved revised Integration Scheme is at **Appendix 1**.

2.7 Although a revised Integration Scheme is now formally approved, the activation of functional delegation is a separate process. This process requires that the HSCP Board approve a Strategic Plan for the delegated services and by "directing" the Parties to deliver services pursuant to the delegated functions and in a manner consistent with the Strategic Plan. The HSCP Board will transfer financial allocations to the Council and Health Board to permit the discharge of these directions. The HSCP Board will also place the Chief Officer at the disposal of the Chief Executives of the Council and the Health Board to operationally manage these services and the employees engaged in their delivery.

2.8 It is proposed that the Strategic Plan for the HSCP Board's responsibilities with respect to delegated NHS and Social Work Children's Services should be the East Dunbartonshire Children's Services Plan. The Children's Services Plan is required by the Children and Young People's Act 2014 and is concerned with safeguarding, supporting and promoting wellbeing of children in the area. It should focus on both prevention and meeting presenting needs, it should be integrated from the point of view of the recipient, it should cover both universal and targeted services and it should be multi-disciplinary, involving contributions by a wide range of community planning partners.

2.9 These Children's Services Plan objectives are consistent with the National Health and Wellbeing Outcomes and would provide the HSCP with a framework for the delivery of children's services within a wider model of integration, involving other Community Planning Partners. Due to the extent of functional delegation, the work of the HSCP will form the largest integrated contribution towards the objectives set out within the Children's Services Plan, which would provide a framework that is inclusive with other essential partners, such as Education and Early Years services. This approach ensures that there is a single strategic plan for integrated children's services in the area.

2.10 Subordinate plans, such as Child Protection and Corporate Parenting Plans will provide the HSCP Board with more detailed planning and improvement objectives, in line with the strategic planning requirements of the Public Bodies (Scotland) (Joint Working) Act 2014. A current list of supporting subordinate function-specific plans is detailed in a further report to the HSCP Board (Report 2016/17_06) and the HSCP Board will be asked to adopt the existing plans for the additional delegated functions in order that the HSCP Board can assume responsibility for these functions from 11th August 2016.

2.11 It is proposed that for Social Work Criminal Justice, the current Argyll, Bute and East and West Dunbartonshires' Criminal Justice Social Work Partnership Strategy Map and Operational Action Plan 2014-17 will act as the Strategic Plan for these newly delegated functions. A copy of these is attached at **Appendix 2.**

2.12 In line with the process of "direction", the HSCP Board will transfer financial allocations to the Council and Health Board (the "Parties") to permit the

discharge of these directions. The HSCP Board will also place the Chief Officer at the disposal of the Chief Executives of the Parties to operationally manage these services and the employees engaged in their delivery. It is proposed that for the new delegated functions, the HSCP Board agrees a position for the 2016-17 financial year that the financial allocations that will accompany its direction to the Parties to deliver services will be equivalent in amount and origin to those that will accompany the delegation of functions for 2016-17 by the Parties. In other words, the Parties will receive back the full amounts associated with the delivery of services that is delegated to the HSCP Board by them in the first instance, to permit continuity of service delivery. Amendment to this arrangement in subsequent years would be subject to approval by the HSCP Board, in consultation with the Parties and would be explicitly linked to the priorities and associated investment/disinvestment intentions as set out in the Strategic Plan. Any such amendment would be reflected in a revised "direction" by the HSCP Board to the Parties. Any views expressed by the Parties in respect of any such consultation must be taken into account by the HSCP Board when considering any such amendment.

2.13 The Integration Scheme requires the Council and Health Board to provide corporate, organisational, financial, strategic and operational business support services for all delegated functions and sets out the nature of these support services. To ensure that these support services are adequate to permit the HSCP Board to operate its business processes effectively, but to avoid excessive bureaucracy of additional detailed service level agreements, it is proposed that the Council and Health Board continues to consider the HSCP Board to be a "virtual Directorate" in terms of business support arrangements for the extended areas of functional delegation. This arrangement also provides for equity and "business as usual" parameters to be established at the outset. During 2016-17 and thereafter, these arrangements will be monitored and any issues of concern reported to the HSCP Board for consideration.

2.14 Good Practice Guidance has been prepared by the Scottish Government on how statutory "directions" issued by the HSCP Board to the Council and Health Board should operate, what they should contain and how frequently they should be updated. This good practice guidance is attached at **Appendix 3**, and builds on the specific requirements set out at s26-28 of the Public Bodies (Scotland) (Joint Working) Act 2014. A pan-GGC officer group has been convened to consider this guidance and to devise a common template for use across the GGC area. Further updates will be provided to the HSCP Board as this work progresses.

2.15 The Public Bodies (Joint Working) (Scotland) Act 2014, s10 requires that the HSCP Board appoint a Chief Officer. The job description of the Chief Officer has been amended to reflect the incorporation of the new delegated functions and this change has been applied to the recruitment of a new Chief Officer to replace Karen Murray on her retirement. In the interim, it is proposed that the HSCP Board agrees that the incumbent Chief Officer's duties are extended to incorporate these additional functional areas within the generalities of the current job description.

3. RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

(a) Notes the formal approval of a revised Integration Scheme with

extended functional scope for the HSCP Board, in areas of NHS Community Children's Services, Social Work Children's Services and Social Work Criminal Justice (**Appendix 1**);

(b) Notes the separate process of HSCP Board empowerment of these new functions, and agrees an "integration start day" of 11 August 2016;

(c) Agrees that the overarching Strategic Plan for integrated services pursuant to the delegated functions relating to Health and Social Care Children's Services will be the East Dunbartonshire Children's Services Plan. This plan will be supported by subordinate improvement action plans that will collectively meet the full strategic planning requirements of the Public Bodies (Scotland) (Joint Working) Act 2014;

(d) Ratifies the improvement planning framework that comprises current plans as described at 3.1(c) and detailed in report 2016/17_6, collectively as the HSCP Board's initial Strategic Plan for integrated Health and Social Care Children's Services;

(e) Ratifies the Argyll, Bute and East and West Dunbartonshires' Criminal Justice Social Work Partnership Strategy Map and Operational Action Plan 2014-17 at **Appendix 2**, as the HSCP Board's initial Strategic Plan for these delegated functions;

(f) Directs the Council and Health Board to carry out the new functions delegated to the HSCP Board, in accordance with Section 26 of the Public Bodies (Joint Working) (Scotland) Act 2014, and that these should be delivered in line with the Strategic Plan and pursuant to the functions delegated respectively by them, unless otherwise specified in the Integration Scheme or by subsequent agreement;

(g) Agrees that the financial allocations that accompany its direction to the Parties to deliver services pursuant to the newly delegated functions, will be exactly the same in amount and origin to those that accompany the delegation of functions for 2016/17 by the Parties to the HSCP Board, and that any amendment to these arrangements in subsequent years is carried out in line with the terms of this report;

(h) Agrees to place the Chief Officer at the disposal of the Chief Executives of the Council and the Health Board to operationally manage these services and the employees engaged in their delivery;

(i) Requests that the Chief Officer works with officers of the Corporate Management Teams of both the Council and the Health Board to establish an arrangement for the provision of support services in terms as proposed at paragraph 2.13 of this report;

(j) Notes the Good Practice Guidance on content and practice with respect to IJB statutory direction to constituent bodies at **Appendix 3** and requests that a report is brought to a future HSCP Board meeting on proposals for local implementation;

(k) Agrees that the incumbent Chief Officer's duties are extended to incorporate these additional functional areas, pending appointment of a new Chief Officer with a suitably amended job description.

East Dunbartonshire
Health and Social Care Partnership

Health and Social Care Integration

Integration Scheme between

East Dunbartonshire Council
and
NHS Greater Glasgow and Clyde

(Revised June 2016)

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

1 THE PARTIES:

East Dunbartonshire Council, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at 12 Strathkelvin Place, Kirkintilloch ("the Council"); And

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

(together referred to as "the Parties")

2 DEFINITIONS AND INTERPRETATION

2.1 Definitions and Interpretation:

- "The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;
- "Acute Services" means the services of the Health Board delivered within the acute hospitals for which the Health Board has operational management responsibility, namely accident and emergency; general medicine; geriatric medicine; rehabilitation medicine; respiratory medicine; and palliative care. These are the services in scope for the delegated acute functions and associated Set Aside budget;
- "Chief Officer" means the Chief Officer of the Integration Joint Board
- "East Dunbartonshire Health and Social Care Integration Joint Board" (or "IJB") means the Integration Joint Board to be established by Order under section 9 of the Act;
- "Host" means the Integration Joint Board that manages services on behalf of the other Integration Joint Boards in the NHS Board area;
- "Hosted Services" means those services of the Parties more specifically detailed in **Annex 3** which, subject to consideration by the Integration Joint Boards through the Strategic Plan process, the Parties agree will be managed and delivered on a pan Greater Glasgow and Clyde basis by a single Integration Joint Board.
- "Integrated Services" means services of the Parties for which the Chief Officer has operational management responsibility;
- "Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;

- "The Integration Scheme Regulations" or "Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;
- "Integration Joint Board Order" or "Order" means the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014;
- "Scheme" means this Integration Scheme;
- "Services" means those services provided in exercise of the functions of the Parties which are delegated to the Integration Joint Board as more specifically detailed in clause 6 hereof;
- "Set Aside" means the financial amounts to be made available for planning purposes by the Health Board to the Integration Joint Board in respect of Acute Services.
- "Strategic Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act.

3 PURPOSE AND PRINCIPLES

3.1 This scheme involves East Dunbartonshire Council and NHS Greater Glasgow and Clyde and sets out the agreements for the integration of certain health and social care services. An Integration Joint Board will be established for the purposes of these agreements.

3.2 The IJB will be established by Order for the area of East Dunbartonshire Council, covering a population of around 105,000 people. The main population centres included are Bearsden, Milngavie, Bishopbriggs, Kirkintilloch and Lenzie along with the rural villages including Milton of Campsie, Lennoxtown, Twechar, Torrance and Balmore.

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 IJB, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the IJB comes into force.

5 LOCAL GOVERNANCE ARRANGEMENTS

5.1 Voting Membership

5.1.1 The arrangements for appointing the voting membership of the IJB are that the Parties must nominate the same number of representatives to sit on the IJB. This will be a minimum of three nominees each, or such number as the Parties agree, or the Council can require that the number of nominees is to be a maximum of 10% of their full council membership.

5.1.2 Locally, the Parties will each nominate three voting members.

5.1.3 The Council will nominate councillors to sit on the IJB.

5.1.4 Where the Health Board is unable to fill all its places with non-executive Directors it can then nominate other appropriate people, who must be members of the Health Board to fill their spaces, but at least two must be non-executive members.

5.2 Period of Office

5.2.1 The period of office of voting members will be for a period not exceeding three years.

5.3 Termination of membership

5.3.1 A voting member appointed by the Parties ceases to be a voting member of the IJB if they cease to be either a Councillor or a non-executive Director of the Health Board or an Appropriate Person in terms of the Public Bodies (Joint Working)(Integration Joint Boards)(Scotland) Order 2014,SSI no.285.

5.4 Appointment of Chair and Vice Chair

5.4.1 The Chairperson and Vice Chairperson will be drawn from the Health Board and the Council voting members of the IJB. If a Council member is to serve as Chairperson then the Vice Chairperson will be a member nominated by the Health Board and vice versa. The first Chairperson of the IJB will be a member appointed on the nomination of the Council.

5.4.2 The appointment to Chairperson and Vice Chairperson is time-limited to a period not exceeding three years and carried out on a rotational basis. The term of office of the first Chairperson and Vice Chairperson will be for the period to the local government elections in 2017, thereafter the term of office of the Chairperson and Vice Chairperson will be for a period of two years.

5.4.3 The IJB will include non-voting members including, as a minimum, those prescribed in the Public Bodies(Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

6 DELEGATION OF FUNCTIONS

6.1 The functions that are to be delegated by the Health Board to the IJB are set out in **Part 1 of Annex 1**.These functions are delegated only insofar as they relate to the Services listed in **Part 2 of Annex 1**.

6.2 The functions that are to be delegated by the Council to the IJB are set out in **Part 1 of Annex 2.** These functions are delegated only insofar as they relate to the Services listed in **Part 2 of Annex 2**.

6.3 The Parties will recommend to the Greater Glasgow 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 and Social Care Partnership during the first year of their operation and subject to review for subsequent years.

7 LOCAL OPERATIONAL DELIVERY ARRANGEMENTS

7.1 Responsibilities of the IJB on Behalf of the Parties.

7.1.1 The local operational arrangements agreed by the Parties are:

7.1.2 Local operational delivery arrangements will reflect the integration delivery principles established under section 31 of the Act and will be in pursuance of the National Health and Wellbeing Outcomes.

7.1.3 The IJB is responsible for the planning of Integrated Services and achieves this through the Strategic Plan. In accordance with section 26 of the Act, the IJB will direct the Council and the Health Board to carry out each function delegated to the IJB. Payment will be made by the IJB to the Parties to enable the delivery of these functions in accordance with the Strategic Plan.

7.1.4 The Chief Officer will have day to day operational responsibility to monitor delivery of integrated services, other than acute services, with oversight from the IJB. In this way the IJB is able to have responsibility for oversight for operational delivery. These arrangements will operate within a framework established by the Parties for their respective functions, ensuring the Parties can continue to discharge their governance responsibilities.

7.1.5 The IJB will be responsible for the planning of Acute Services but the Health Board will be responsible for operational management of Acute Services. The Health Board will provide information on a regular basis to the Chief Officer and IJB on the operational delivery of,and the set-aside budget for, these Services.

7.1.6 The IJB will provide assurance 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 which will be provided to the Parties, and through the strategic planning process.

7.1.7 Functions set out at **Annexes 1 (Part 1) and 2 (Part 1)** may by agreement be hosted by the IJB on behalf of another IJB, or one or both of the Parties, or vice versa, where permitted by statute. In this event, Service Level Agreements will set out those arrangements, describing the governance for operational and strategic accountability. The Parties will recommend to the Greater Glasgow and Clyde Integration Joint Boards an arrangement of hosted services in line with **Annex 3**. In any such circumstances, an IJB will retain oversight for the delivery of such in-scope Services that may be hosted by another IJB to its population, engaging on any concerns with the host IJB and Chief Officer.

7.2 Corporate Support Services

7.2.1 The Parties have identified the corporate support services that they provide for the purposes of preparing the Strategic Plan and carrying out integration functions and identified the staff resource involved in providing these services.

7.2.2 There is agreement and a commitment to provide Corporate Support Services to the IJB. The arrangements for providing these services will be reviewed by March 2016 and appropriate models of service will be agreed. This process will involve senior representatives from the Parties and the Chief Officer. The models agreed will be subject to further review as the IJB develops in its first year of operation and to ongoing review as part of the planning processes for the IJB and the Parties.

7.2.3 The Parties agree that the current support will continue to be provided until the new models of Service have been developed.

7.2.4 The Parties will provide the IJB with the corporate support services it requires to fully discharge its duties under the Act.

7.3 Support for the Strategic Plan

7.3.1 The Health Board shall ensure that the overarching Strategic Plan for Acute Services shall incorporate relevant sections of the six Health Board area IJBs' Strategic Plans.

7.3.2 The Health Board will consult with the IJBs within its Health Board area, to ensure that any overarching Strategic Plan for Acute Services and any plansetting out the capacity and resource levels required for the Set Aside budget for such Acute Services is appropriately co-ordinated with the delivery of Services across the Health

Board area. The Parties shall ensure that a group including the Chief Officers of the six Health Board area IJBs will meet regularly to discuss such issues.

7.3.3 The Health Board will share with the IJB necessary activity and financial data for Services, facilities and resources that relate to the planned use of Services by service users within the Health Board area for its service and for those provided by other Health Boards. Regional Services are explicitly excluded.

7.3.4 The Council will share with the IJB necessary activity and financial data for Services, facilities and resources that relate to the planned use of Services by service users within East Dunbartonshire for its Services and for those provided by other councils.

7.3.5 The Parties agree to use all reasonable endeavours to ensure that the other Health Board area IJBs and any other relevant Integration Authority will share the necessary activity and financial data for Services, facilities and resources that relate to the planned use by service users within the area of their Integration Authority.

7.3.6 The Parties shall ensure that their Officers acting jointly will consider the Strategic Plans of the other Health Board area IJBs to ensure that they do not prevent the Parties and the IJB from carrying out their functions appropriately and in accordance with the Integration Planning and Delivery Principles, and to ensure they contribute to achieving the National Health and Wellbeing Outcomes.

7.3.7 The Parties shall advise the IJB where they intend to change service provision of non-integrated services that will have a resultant impact on the Strategic Plan.

7.4 <u>Performance Targets, Improvement Measures and Reporting Arrangements</u>

7.4.1 The Parties will prepare a list of targets and measures that relate to the delegated functions and the extent to which responsibility will lie with the IJB and to be taken account of in its Strategic Plan.

7.4.2 The Parties will prepare a list of targets and measures that relate to non-delegated functions which are to be taken into account of by the IJB when it is preparing a Strategic Plan and the extent to which responsibility will lie with the IJB and to be taken account of in its Strategic Plan.

7.4.3 The Parties will work together to develop proposals on these targets, measures and arrangements referred to at 7.4.1 and 7.4.2, to put to the first meeting of the IJB for agreement based on the Parties' respective strategic plans and agreements.

7.4.4 The Parties will share the targets, measures and other arrangements that will be devolved to the IJB, and will take into account national guidance on the core indicators for integration.

7.4.5 The Parties will provide the IJB with performance and statistical support resources, access to relevant data sources and will share all information required on Services to permit analysis and reporting in line with the prescribed content as set out in Regulations. Where the responsibility for the target is shared, a document will set out the accountability and responsibilities of each organisation.

7.4.6 The Parties will provide support to the IJB, including the effective monitoring of targets and measures.

8 CLINICAL AND CARE GOVERNANCE

8.1 The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements for Services provided in pursuance of integration functions in terms of the Act. The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements for their duties under the Act. The Parties will have regard to the principles of the Scottish Government's draft Clinical and Care Governance Framework including the focus on localities and service user and carer feedback.

8.2 The Parties will be responsible through commissioning and procurement arrangements for the quality and safety of Services procured from the Third and Independent Sectors and to ensure that such Services are delivered in accordance with the Strategic Plan.

8.3 As set out in clause 7.4, the quality of 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 commissioning or procurement from the Third and Independent Sectors.

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

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

8.6 The joint Workforce and Organisational Development Strategy will identify training requirements that will be put in place to support improvements in Services and Outcomes.

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

8.8 In relation to Acute Services, the IJB will be responsible for planning of such Services but operational management of such Services will lie with the Health Board.

8.9 As detailed in clause 9 the Chief Officer will be an Officer of the IJB. The Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the IJB and be a member of the senior management teams of the Parties. The Chief Officer will be responsible for the day-to-day operational management and planning of Integrated Services. The Chief Officer will also be responsible for the planning of Acute Services on behalf of the IJB and will exercise oversight for Acute Services through the receipt of reports from the Health Board.

8.10 The Chief Officer has delegated responsibilities, through the Parties' Chief Executives, for staff working in Integrated Services, as a senior officer of both of the Parties. The Chief Officer, relevant Health Leads and Chief Social Work Officer will work together to ensure appropriate professional standards and leadership. Where groups of staff require professional leadership, this will be provided by the relevant Health Lead or Chief Social Work Officer as appropriate.

8.11 The Parties will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care. A Clinical and Care Governance Group is to be established by the Parties which, when not chaired by the Chief Officer, will report to the Chief Officer and through the Chief Officer to the IJB. It will contain representatives from the Parties and others including:

- the Senior Management Team of the Partnership;
- the Clinical Director;
- the Lead Nurse;
- the Lead from the Allied Health Professions;
- Chief Social Work Officer.

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

8.13 The role of the Clinical and Care Governance Group will be to consider matters relating to professional and clinical matters, patient and service user experience, patient and service user safety, performance standards and improvement, regulation and compliance, and employees set out within an overall Integrated Governance Framework. Where clinical and care governance issues relating to Services that are hosted by arrangements set out at clause 7.1.7, the Clinical and Care Governance Group will obtain relevant information from the host IJB.

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

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

8.16 **Annex 4** provides details of the governance structures relating to the IJB and the Parties. This includes details of how professional groups and Adult and Child Protection Committees are able to directly provide advice to the IJB and Clinical and Care Governance Group.

8.17 Further assurance is provided through:

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

and

(ii) the Health Board arrangements to oversee healthcare governance and ensure that matters which have implications beyond the IJB in relation to health, will be shared across the health care system. The Health Board will also provide professional guidance, as required.

8.18 The Chief Officer will take into consideration any decisions of the Council or Health Board which arise from (i) or (ii) above.

8.19 The Health Board Clinical Governance Forum, the Medical Director and Nurse Director may raise issues directly with the IJB in writing and the IJB will respond in writing to any issues so raised.

8.20 As set out in Clause 14 the Parties have information sharing protocols in place.

9 CHIEF OFFICER

9.1 The Chief Officer of the IJB will be appointed by the IJB as soon as is practicable after the date the Parliamentary Order to establish the IJB comes into force.

9.2 Where the person to be appointed is an existing member of staff of the Council or the Health Board, the person will be seconded to the IJB by that constituent body.

9.3 Where the person is not an existing member of staff of the Council or the Health Board, then the person will be appointed as a member of staff of a constituent body and then seconded to the IJB.

9.4 In the event that paragraph 9.3 applies, the Chief Officer may choose which of the constituent bodies he or she wishes to be appointed to.

9.5 An honorary contract arrangement will be put in place to establish the Chief Officer as an employee of both the Council and the Health Board.

9.6 Before appointing a person as Chief Officer, the IJB will consult the constituent bodies as to the suitability of the appointment and must take into consideration the views expressed by the constituent bodies.

9.7 The Chief Officer role will be as follows, in accordance with (but not limited to) the Act and associated Regulations:

(i) to be accountable for the effective delivery and development of Services provided in the exercise of functions delegated to the IJB and improved outcomes for the population of East Dunbartonshire;

(ii) to develop, deliver and annually review a Strategic Plan and associated policies for delegated functions on behalf of the IJB and for the effective operational implementation of these strategies on behalf of the Council and Health Board, in line with the Strategic Plan;

(iii) to be responsible for a supporting Financial Plan that allocates budgets to meet the objectives as agreed by the IJB, ensuring that financial targets are achieved within the resources available;

(iv) to develop and set standards for the joint delivery of Services, ensuring a robust performance management framework is in place to measure service delivery and ensure continuous improvement;

(v) to ensure that all statutory clinical and non-clinical governance and professional standards are adhered to and that associated systems are in place;

(vi) to be responsible for preparing an annual Performance Report and to report strategic and operational performance to the IJB and on behalf of the constituent bodies, as required;

(vii) to be responsible for ensuring the IJB is highly effective at engaging with its stakeholders and the wider community;

(viii) to be responsible for ensuring an integrated management team is established and effective across the full scope of delegated functions and Services; and

(ix) to be responsible, as a member of both the Council's Corporate Management Team and Health Board's Senior Management Team, for contributing to the overall strategic objectives and priorities as set out in the SOA, the Council's Strategic Planning and Performance Framework and the Health Board's Local Delivery Plan.

9.8 The IJB secures delivery of the delegated functions by giving directions to the Health Board and Council for the delivery of Services. The Chief Officer oversees the process of giving written directions to the Health Board and Council for the delivery of Services.

9.9 The IJB will be responsible for the planning of Acute Services but the Health Board will be responsible for the operational management of Acute Services, as described at clause 7.1.5.

9.10 The Chief Officer will be jointly managed by the Chief Executives of the Health Board and Council.

9.11 The Health Board and the Council will provide a suitable interim Chief Officer where there is a need to provide one. In these circumstances, the IJB will have the opportunity to confirm that it is content for the proposed interim Chief Officer to

undertake the interim Chief Officer's role at the request of the IJB as per the regulations.

10 WORKFORCE

10.1 The development of integrated operational service structures and teams may involve the integration of line management arrangements below the level of the Chief Officer. In this event where an integrated team comprising both Health Board and Council employees is managed by a manager employed by the Council, the Chief Executive of the Health Board will direct his/her staff to follow instructions from the manager employed by the Council. Equally, where an integrated team comprising both Health Board and Council employees is managed by a manager employed by the Health Board, the Chief Executive of the Council will direct his/her staff to follow instructions from the manager employed by the Health Board.

10.2 The Council, Health Board and IJB will work together to establish a system of corporate accountability for the fair and effective management of all staff, to ensure that they are:

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

10.3 This system will be established through formal structures to link with the Health Board's Staff Governance Committee and the Council's Partnership at Work arrangements. In addition any joint staff forum established by the IJB will establish formal structures to link with the Health Board's Area Partnership Forum.

10.4 The Chief Executives of the Council and the Health Board will undertake to work jointly together and in conjunction with the Chief Officer of the IJB and employee stakeholders, to develop and maintain a joint Workforce and Organisational Development Strategy in relation to teams delivering integrated Services. This Strategy will incorporate reference to the engagement of employees, workforce planning and development, organisational development and learning and development of staff. This joint Workforce and Organisational Development Strategy

will be prepared by 1 April 2016 for approval by the IJB, with annual reports thereafter.

11 FINANCE

11.1 This section sets out the arrangements in relation to the determination of the amounts to be paid, or set aside, and their variation, to the IJB from the Parties.

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

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

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

(i) Activity changes

(ii) Cost inflation

(iii) Efficiencies

(iv) Performance against outcomes

(v) Legal requirements

(vi) Transfer to or from the amounts set aside by the Health Board

(vii) Adjustments to address equity of resource allocation

11.5 This will allow the Parties to determine the final approved budget for the IJB.

11.6 Either Party may increase its in-year payment to the IJB.

11.7 The process for determining amounts to be made available (within the 'set aside' budget) by the Health Board to the IJB in respect of all of the functions delegated by the Health Board which are carried out in a hospital in the area of the Health Board and provided for the areas of two or more Local Authorities will be determined by the

hospital capacity that is expected to be used by the population of the IJBas part of an overall planning framework and will be based on:

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

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

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

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

11.10 The Chief Officer will deliver the outcomes within the total delegated resources and where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the IJB 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 IJB. In the event that the recovery plan does not succeed, the first resort should be to the IJB reserves, where available, in line with the IJB's Reserves policy. The Parties may consider as a last resort making additional funds available, on a basis to be agreed taking into account the nature and circumstances of the overspend, with repayment in future years on the basis of the revised recovery plan agreed by the Parties and IJB. If the revised plan cannot be agreed by the Parties, or is not approved by the

IJB, mediation will require to take place in line with the dispute resolution arrangements set out in this Scheme.

11.11 Where an underspend in an element of the operational budget, with the exception of ring fenced budgets, arises from specific management action, this will be retained by the IJB 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 IJB's Reserves policy. Any windfall underspend will be returned to the Parties in the same proportion as individual Parties contributed to investment in that area of spend.

11.12 Neither the Local Authority nor Health Board may reduce the payment in-year to the IJB to meet exceptional unplanned costs within either the Local Authority or Health Board without the express consent of the IJB and the other Party.

11.13 Recording of all financial information in respect of the IJB will be in the financial ledger of the Party which is delivering financial services on behalf of the IJB.

11.14 The transactions relating to operational delivery will continue to be reflected in the financial ledgers of the Parties with the information from both sources being consolidated for the purposes of reporting financial performance to the IJB.

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

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

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

11.18 The schedule of payments to be made in settlement of the payment due to the IJB will be:

- Resource Transfer, virement between Parties and the net difference between payments made to the IJB and resources delegated by the IJB will be transferred between agencies initially in line with existing arrangements, with a final adjustment on closure of the Annual Accounts. Future arrangements may be changed by local agreement.

11.19 In the event that the IJB becomes formally established part-way through the 2015-16 financial year, the payment to the IJB for delegated functions will be that portion of the budget covering the period from the delegation of functions to the IJB to 31 March 2016.

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

12 INTEGRATION SCHEME CONSULTATION

12.1 The list of people consulted on this Integration Scheme complies with the regulations.

(i) The list of people were:

- Health professionals and staff of the Health Board who operate within the boundaries of the East Dunbartonshire area;
- Social care professionals and staff who operate within the boundaries of the East Dunbartonshire area;
- Users of health or social care Services and their carers who reside within the boundaries of the East Dunbartonshire area;
- Commercial and non-commercial providers of social or health care who operate within the boundaries of the East Dunbartonshire area;
- Local authorities or integration authorities who operate within the geographic boundaries of the Health Board;
- Non-commercial providers of social housing who operate within the boundaries of the East Dunbartonshire area; and
- Third sector bodies carrying out activities related to health or social care within the boundaries of the East Dunbartonshire area.
- Members of the general public.

(ii) The methods and participation tools used to engage and consult people and communities were:

- Discussion and approval of the consultative draft by the IJB;
- 42 day consultation period jointly agreed by the Parties;
- Direct correspondence with stakeholder representative groups, bodies and individuals set out at 12.1(i), providing access to the draft Integration Scheme and inviting comment;
- High profile visibility on Council and Health Board websites, providing links to the draft Integration Scheme and background information and inviting public comment;
- Press release issued by the Council, promoting the consultative exercise on behalf of the Parties;
- Active pan-Health Board area consideration of all IJB draft Integration Schemes in its area, to evaluate impact; and
- Account taken of all comments, with amendments made to final Integration Scheme for approval by the Parties.

12.2 During May and June 2016, a further 25 day consultation period was undertaken to support revision to the Integration Scheme, to extend the range of functions delegated to the IJB as set out at Annex 1. This consultative engagement followed the same processes as outlined at 12.1.

13 PARTICIPATION AND ENGAGEMENT

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

13.2 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.

14 INFORMATION SHARING AND CONFIDENTIALITY

14.1 With respect to the Services and arrangements set out in this scheme, the Parties agree to continue to be bound by the Greater Glasgow and Clyde Protocol for Sharing Information between East Dunbartonshire Council, East Renfrewshire Council, Glasgow City Council, Inverclyde Council, Renfrewshire Council, West Dunbartonshire Council and NHS Greater Glasgow and Clyde, dated May 2013, which may be updated from time to time in line with statute, policy and best practice. This protocol contains the procedures that will be used to share information with respect to the Services.

14.2 A joint group will be established involving IJB areas on a pan-Health Board basis as required, to review the protocol referred to at 14.1, which will provide opportunity for each IJB to comment on any proposed amendments tothe protocol.

15 COMPLAINTS

15.1 The Parties agree the following arrangements in respect of complaints:

(i) The Chief Officer will have overall responsibility for ensuring that an effective and efficient complaints system operates within the IJB. Complaints will continue to be made either to the Council or the Health Board reflecting distinct statutory requirements: the Patients' Rights (Scotland) Act 2011 makes provision for complaints about health services; and the Social Work (Scotland) Act 1968 makes provision for complaints about social work services;

(ii) In the event that complaints are raised at the service front-line, they will be dealt with by frontline staff. If they are unresolved they will be passed to a relevant senior manager and then the Chief Officer;

(iii) If the complaint is communicated to the complaints team/department of the Parties and relates to integration functions, the Parties will forward this immediately to the offices of the Chief Officer who will acknowledge the complaint within 3 working days of their receipt of the complaint, to the complainant, copied to the forwarding Party. Complaints may also be made in writing direct to the Chief Officer;

(iv) The Chief Officer will follow the relevant complaints procedure of the Party appropriate to the nature of the complaint and the associated functions, which will set out processes and timescales;

(v) Details of the complaints procedures will be provided on line, in promotional service information and on request;

(vi) The Chief Officer will review complaints handling procedures within 12 months of the integration commencement date in order to maximise the potential for integrated processes and with respect to statute, policy or best practice and may be subsequently amended within the terms of this Integration Scheme; and

(vii) Complaints management, including the identification of learning from complaints will be subject to periodic review by the IJB.

16 CLAIMS HANDLING, LIABILITY & INDEMNITY

16.1 The liability of either or both Parties and/or the IJB in respect of any claim that may be made by a third party in respect of any matter connected with the carrying out of integration functions shall be determined in accordance with principles of common law and/or any applicable legislation.

16.2 Where a claim by a third party is received by either of the Parties or the IJB in respect of any matter connected with the carrying out of integration functions (the body receiving such a claim being referred to as the "**Claim Recipient**"), the Claim Recipient, shall, as soon as reasonably practicable, notify any other body or bodies (being either or both Parties and/or the IJB) which the Claim Recipient considers (acting reasonably) could be held to be liable (whether wholly or partly) in relation to the claim were it to be upheld by the court; and the Claim Recipient shall (subject to clause 1.3):

- provide that other body or bodies with all such information in relation to the claim as is available to the Claim Recipient;
- allow that other body or bodies (and/or its or their insurers) to conduct the defence of the claim, subject to that other body or bodies indemnifying the Claim Recipient in relation to any loss or liability (including legal expenses on a solicitor-client basis, and any award of expenses) which the Claim Recipient might thereby incur; and
- avoid taking any step which could prejudice the defence of the claim without the prior written consent of that other body or bodies.

16.3 Where a Claim Recipient considers (acting reasonably) that it itself could be held to be liable along with another Party and/or the IJB in relation to the relevant claim were it to be upheld by the court, the Claim Recipient and the other body or bodies (and/or their respective insurers) shall co-operate with each other in respect of the defence of the claim.

16.4 Any claims arising from activities carried out under the direction of the IJB shall be progressed quickly and in a manner which is equitable to the Parties.

16.5 Each Party will assume responsibility for progressing claims which relate to any building which is owned or occupied by them.

16.6 Each Party will assume responsibility for progressing claims which relate to any act or omission on the part of one of their employees.

16.7 If a third party claim is settled by either Party and it thereafter transpires that liability (in whole or in part) should have rested with the other party, then the Party settling the claim may seek an indemnity from the other Party, subject to normal common law and statutory rules relating to liability

16.8 If a claim has a "cross-boundary" element wereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other to reach agreement as to how the claim should be progresses and determined

16.9 The IJB will develop a procedure with other relevant integration authorities for any claims relating to Hosted Services.

16.10 Claims which relate to an event that pre-dated the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

16.11 Where it is not clear which party should assume responsibility, the Chief Officer (or his/her representative) may liaise with the Chief Executives of the Parties (or their representatives) to determine which party should assume responsibility for progressing the claim.

16.12 The Council insures its liabilities and therefore any requirements of insurers will need to be taken into account when determining responsibility for claims.

16.13 These provisions are subject to any requirements, obligations or conditions of any insurance purchased by either party

17 RISK MANAGEMENT

17.1 The Parties and the IJB will jointly develop a shared Risk Management Strategy that will identify, assess and prioritise significant risks related to the delivery of Services under integrated functions and in particular any which are likely to affect the IJB's delivery of the Strategic Plan. In order to prepare this strategy the Parties and IJBwill jointly:

(i) identify the risk sources, providing a basis for systematically examining changing situations over time and focusing on circumstances that impact upon the ability to meet objectives;

(ii) identify and agree parameters for evaluating, categorising and prioritising risk and thresholds to trigger management activities;

(iii) Demonstrate processes to identify and document risk in a Risk Register;

(iv) Demonstrate the process for monitoring corporate and operational risks including clear lines of accountability and responsibility, reporting lines , governance and frequency;

(v) Develop a process for recording, management and learning from adverse events;

(vi) Develop and agree risk appetite and tolerance linked to corporate objectives; and

(vii) Ensure that risk management services will be part of the corporate support services provided to the IJB by the Parties.

17.2 The Parties will consider and agree which risks should be taken from their own risk registers and placed on the shared risk register.

17.3 The Chief Officer will lead the shared Risk Management Strategy with support from the risk management functions of the Parties. The Parties and the IJB will annually approve the shared Risk Register with in-year and exception reporting. This reporting will allow amendment to risks. Any strategic risk will be communicated to the Parties by the Chief Officer. The Integrated Joint Board will also pay due regard to relevant corporate risks of the Parties.

17.4 The Chief Executives of the Council and the Health Board will undertake to work jointly together and in conjunction with the Chief Officer of the IJB to develop and maintain a shared risk management strategy by 1 April 2016, that sets out –

(i) The key risks with the transition to and establishment of the Health and Social Care governance and accountability arrangements, including the IJB;

(ii) The key risks with the process of integration of delegated functions and Services;

(iii) The key risks associated with the Strategic Planning and operation delivery of the full range of health and social care Services delegated to the IJB;

(iv) Any risks that should be reported on from the integration date;

(v) A standard format and agreed timescale for sharing and consideration by the Parties and the IJB;

(vi) an agreed risk management plan for all identified risks and associated reporting timescales;

(vii) a process for the Parties and the IJB to consider these risks as a matter of course and notification of any relevant changes to one another; and

(viii) the method for jointly agreeing changes to the above requirements between the IJB and the Parties.

17.5 This shared risk management strategy will identify, assess and prioritise risks related to the delivery of Services under integration functions. It will identify and describe processes for mitigating those risks. The strategy will include an agreed reporting standard that will enable other significant risks identified by the Parties and the IJB to be shared across the organisations.

17.6 In the period between the commencement of integration and the approval of a shared risk management strategy, the Parties will operate an interim arrangement based upon the legacy risk registers of the Parties, relevant to integrated functions which will be combined to provide interim continuity of risk management arrangements.

18 DISPUTE RESOLUTION MECHANISM

18.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, they will follow the process as set out below:

(i) The Chief Executives of the Health Board and the Council (or nominated representatives), will meet to resolve the issue;

(ii) If unresolved, the Parties in dispute will each prepare a written note of their position on the issue and exchange it with the other;

(iii) In the event that the issue remains unresolved, representatives of the Parties in dispute will proceed to mediation with a view to resolving the issue. In such circumstances:

- The Parties in dispute will refer the dispute to an independent mediator as agreed by the Parties;
- The Parties in dispute will participate in the mediation process in good faith;
- The cost of the mediation service will be met jointly by the Parties in dispute.

18.2 Where the issue remains unresolved after following the processes outlined in (i)-(iii) above, the Parties in dispute agree to notify Scottish Ministers that agreement cannot be reached and to request a determination on the dispute. In this event, the Health Board and the Council each agree to be bound by the determination of this dispute resolution mechanism.

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.

ANNEX 1 (PART 2)

Services Relevant to Functions 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; and
  - psychiatry of learning disability.
- Palliative care services provided in a hospital.
- Inpatient hospital services provided by general medical practitioners.
- Services provided in a hospital in relation to an addiction or dependence on any substance.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.
- Health Visiting.
- School Nursing.
- Speech and Language Therapy.
- Specialist Health Improvement.
- Community Children's Services.
- 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)	

ANNEX 2 (PART 2)

Services Relevant to Functions to be Delegated by the Local Authority to the Integration Joint Board

Older People Assessment & Care Management Services
Learning Disability Assessment & Care Management Services
Physical Disability Assessment & Care Management Services
Sensory Impairment Assessment & Care Management Services
Rehabilitation and Occupational Therapy Services
Mental Health Assessment & Care Management Services
Alcohol and Drug Services
Adult Intake Services
Homecare Services (in-house and purchased)
Residential and Care Home Services (in-house and purchased)
Day care and day opportunity services
Supported accommodation and supported living
Self-Directed Support Services
Local Area Coordination
Carer and Respite Services
Telecare Services
Planning and Commissioning Services
Housing Support - Aids and Adaptation Services
Greenspace - Care of Gardening Scheme
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 Services

The Parties will recommend to the Greater Glasgow and Clyde Integration Joint Boards that the Services listed in Table 1 below are managed by one Integration Joint Board on behalf of the other Integration Joint Boards.

Where an Integration Joint Board is also the Lead Partnership in relation to a Service in Table 1 the Parties will recommend that:

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

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

and

(iii) Such Lead Partnership carries out the planning and delivery of these hosted services as agreed with each IJB in line with their Strategic Plans, with responsibility for the operational budget for these hosted services.

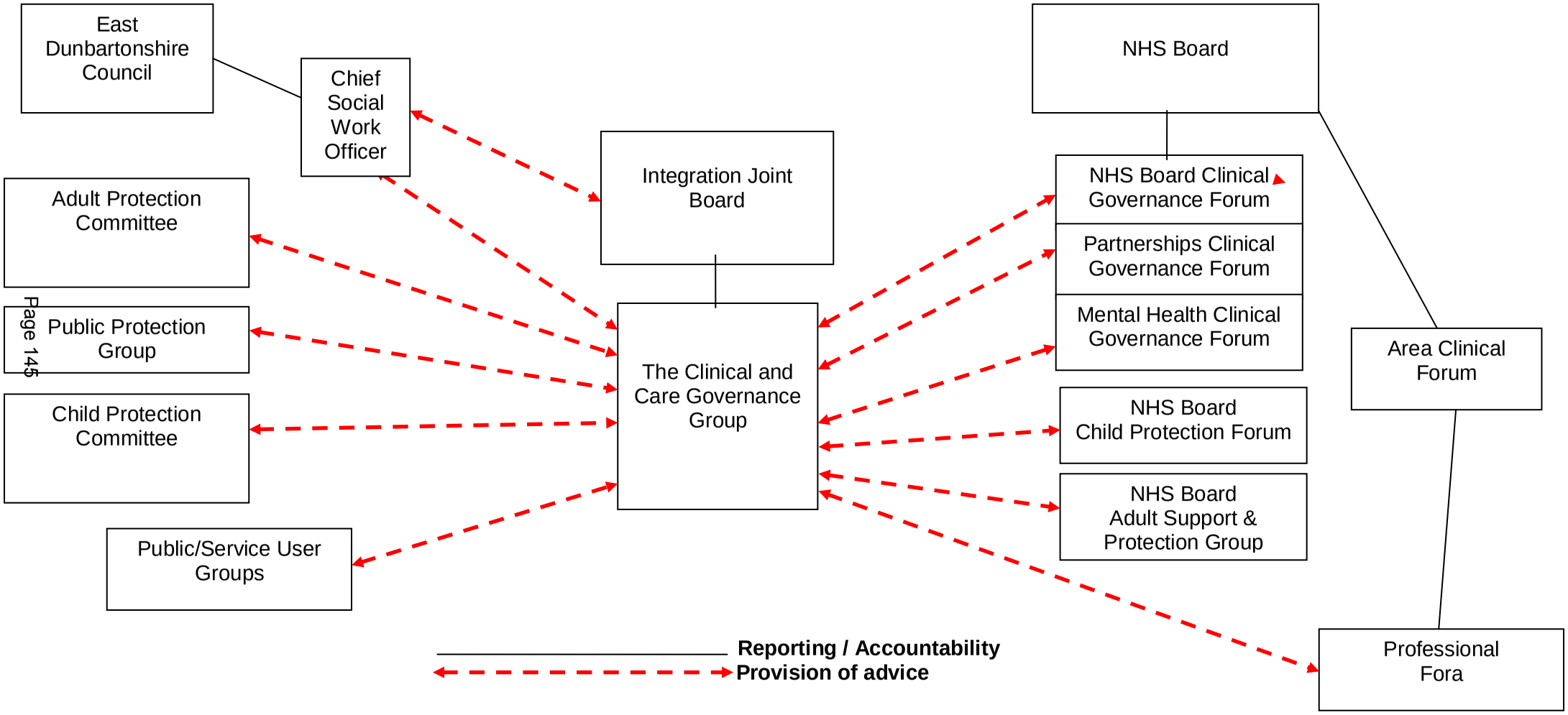
Table 1

Service Area	**Host IJB**
• 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 NHS services require to be delegated. IJBs will be asked to agree that the Renfrewshire IJB will act as host for strategic planning of these services with delivery on behalf of all IJBs by the Acute Division.

ANNEX 4

Clinical and Care Governance Structure



APPENDIX 2

PARTNERSHIP STRATEGY MAP 2014-17

Vision:	**Safer and Stronger**
Mission:	• Our aim is to reduce re-offending and contribute to safer and stronger communities by promoting and delivering effective interventions with offenders. • We will promote social inclusion and the values of respect and anti-discrimination whilst challenging behaviours and attitudes which undermine community safety and work with other partners towards achieving this.

Priorities:	**Justice**	Reducing Re-offending	Strengthening community engagement and resilience	Enhancing efficiency
Outcomes:	**National (Single Outcome Agreement)**	We live our lives safe from crime, disorder and danger	We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others	Our public services are high quality, continually improving, efficient and responsive to local people's needs
	Justice	We experience low levels of crime We experience low levels of fear, alarm and distress We are at low risk of unintentional harm	Our people and communities support and respect each other, exercising both their rights and responsibilities Our public services respect the rights and voice of users	Our public services are fair and accessible Our institutions and processes are effective and efficient We have high levels of public confidence in justice systems and processes
	Community (Partnership)	We work together with partners to reduce re-offending	We engage and consult with our communities and partners to improve and strengthen our services	Our Partnership delivers effective and efficient services

Objectives:	**Customer** **(service delivery, engagement)**	Effective relationships with service users and partners	Assisting service users and staff to maintain constructive contact with families	Assisting service users to have appropriate access to quality services and interventions
		Interventions meet service user outcomes	Assisting service users to engage effectively with their local community	
		Service user opportunities and skills are enhanced		
		National Standards are delivered		
	Internal Process **(Performance, operations, partnerships)**	Work effectively with partners to deliver services	Meaningful two way communication with staff, partners and communities	Consistent approach to service delivery across the Partnership
	Resources **(finance, staff, information, IT, environment)**	A competent and skilled workforce		Working environment and equipment are fit for purpose
		Work effectively as a team		Effective governance of resources
		Fully integrated risk assessment & management		Strong and effective management/leadership
				Planned local implementation of national CJ service redesign

Values:	Innovation	Excellence	Respect	Partnership	Inclusion

Argyll, Bute & Dunbartonshires' Criminal Justice Social Work Partnership

PARTNERSHIP OPERATIONAL ACTION PLAN 2014-17

Objective		Partnership Action
Customer	1.1.1 Effective relationships with service users and partners	a) Ensure the Service is represented at and takes an active role in multi-agency meetings including: Court liaison, SOG, MOG, APIG, CPP, Chief Officer Group or equivalent b) Review service user feedback process c) Incorporate service user feedback into planning process
	1.1.2 Interventions meet service user outcomes	a) Use LSCMI for outcome focussed planning
	1.1.3 Service user opportunities and skills are enhanced	a) Integrate partner agencies into outcome focussed planning b) Increase access to unpaid work other activities via integrated planning at a above c) Regular meetings with partners to develop UPW placements
	1.1.4 National Standards are delivered	a) Audit adherence to national standards b) Feedback to staff on audit reports of national standards performance
	2.1.1 Assisting service users and staff to maintain constructive contact with families	
	2.1.2 Assisting service users to engage effectively with their local community	a) Amend review form to include links for service users to community activities, etc. post supervision
	3.1.1 Assisting service users to have appropriate access to quality services and intervention	See 1.1.2 & 1.3.1

Internal Process	1.2.1 Work effectively with partners to deliver services	a) Identify partners b) Negotiate level of service with partners c) Create and agree SLA/formal arrangements with partners
	2.2.1 Meaningful two way communication with staff, partners and communities	a) Introduce annual consultation with MAPPA partners re multi agency risk assessments & other risk management activities b) Review staff communication systems and structure
	3.2.1 Consistent approach to service delivery across the Partnership	a) Analyse unmet need via CMP review process b) Review availability of local services to highlight access issues
Resources	1.3.1 A competent and skilled workforce	a) Introduce quality assurance outcomes into staff development activities b) Define training budget c) All staff have access to Training Log that records CPD d) Schedule regular refresher training and practitioner development events via Training Plan
	1.3.2 Work effectively as a team	a) Team meetings are held at least once per quarter for all teams
	1.3.3 Fully integrated risk assessment and management	a) Implement LSCMI performance improvement plan b) Visor is incorporated into practice
	3.3.1 Working environment and equipment are fit for purpose	a) Health and safety checks undertaken in each workplace at least once per year b) New UPW attendance sheets implemented to include reporting on faulty equipment
	3.3.2 Effective governance of resources	a) Link management/performance information to deployment of resources b) Meetings of staff, Heads of Service, SMG and PMG to identify efficiencies and gaps (agenda item) c) Create process for determining actual costs of services d) Annual review of resources linked to budget setting e) Create quality assurance process for statistical returns
	3.3.3 Strong and effective management/leadership	a) SMG to engage with staff via attendance at team meetings once per quarter (discuss strategy, performance, efficiency, resources)
	3.3.4 Planned local implementation of national CJ service redesign	a) SMG to develop proposals for implementation b) SMG to agree implementation plan with partner councils and CPP c) Develop communication strategy for staff

2016/17-5. APPENDIX 3.

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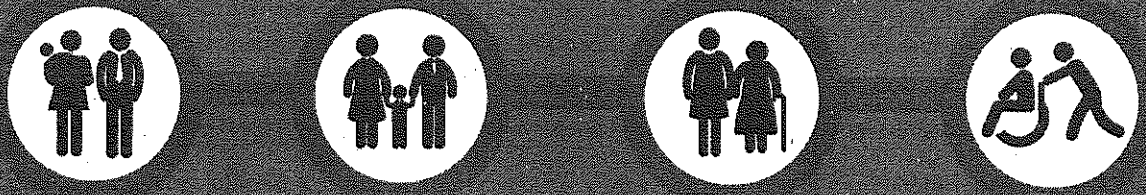
Good Practice Note

Directions from Integration Authorities to Health Boards and Local Authorities



Public Bodies (Joint Working) (Scotland) Act 2014

Health and Social Care Integration

Introduction – the wider context for directions

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) places a duty on Integration Authorities to develop a "strategic plan" (also known as a strategic commissioning plan) for integrated functions and budgets under their control.

1.2 Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using the integrated budgets under their control. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to enable Integration Authorities to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

1.3 Integration Authorities require a mechanism to action their strategic commissioning plans, and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding[1] directions from the Integration Authority to one or both of the Health Board and Local Authority.

1.4 In the case of an Integration Joint Board (IJB), a direction must be given in respect of every function that has been delegated to the IJB[2]. Where the lead agency model is used, the Integration Authority *may* issue directions or may carry out functions itself.

1.5 In either case, a direction must set out how each integrated health and social care function is to be exercised, and the budget associated with that.

2 Form and content of directions

2.1 Directions must be in writing[3] and should set out a clear framework for operational delivery of the functions that have been delegated to the Integration Authority.

2.2 Directions must clearly identify which of the integrated health and social care functions[4] they relate to. The Integration Authority can direct the carrying out of those functions by requiring that a particular named service or services be provided. Where appropriate, the same document can be used to give directions to carry out multiple functions.

2.3 Directions must include detailed information on the financial resources that are available for carrying out the functions that are the subject of the directions, including the allocated budget and how that budget (whether this is payment, or an amount made available) is to be used[5].

---

1 Section 27(4).
2 Section 26(1). This requirement may be removed or varied in relation to a particular Integration Joint Board if an application under section 27(7)(a) is made by the Health Board and Local Authority for the area of the Integration Joint Board.
3 Section 27(5)(b)
4 The functions that have been delegated by the Local Authority and Health Board, as described in the relevant Integration Scheme.
5 Section 27(1)(a),(b) and (c)

2.4 The exercise of each function can be described in terms of delivery of services, achievement of outcomes, and/or by reference to the strategic commissioning plan.

2.5 Directions may stipulate which of the health board or local authority is to carry out a particular function, or may require a function to be carried out jointly. The direction may also specify what the health board and/or local authority is to do in relation to carrying out a particular function.

2.6 The financial resource allocated to each function in a direction is a matter for the Integration Authority to determine. The Act makes particular provision in relation to the allocation of budgets for the sum "set aside" in relation to large hospital functions[6], which gives flexibility for the Integration Authority to direct how much of the sum set aside is to be used for large hospital services and for the balance to be used for other purposes.

3 Process for issuing and revising directions

3.1 A direction will remain in place until it is varied, revoked[7] or superseded by a later direction in respect of the same function.

3.2 The legislation does not set out fixed timescales for directions. This flexibility allows directions to ensure that delivery of integrated health and social care functions is consistent with the strategic commissioning plan, and takes account of any changes in local circumstances. In contrast with the strategic commissioning plan, there is therefore scope for directions to include detailed operational instructions in relation to particular functions (and the associated services).

3.3 Directions issued at the start of the year should be subsequently revised during the year in response to developments.

3.4 For example, should an overspend be forecast on either of the operational budgets – for health or social care services provided by the Health Board and Local Authority – the Chief Officer will need to agree a recovery plan to balance the overspending budget (in line with the provisions in the Integration Scheme and statutory guidance[8] for finance under integration). This may require an increase in the payment to either the Health Board or Local Authority, funded 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.

3.5 A revision to the directions will be required in either case.

[6] Section 28, which allows the integration authority to allocate a "specified amount" of the set-aside budget, but requires top-up payments should additional resource be required.
[7] Section 27(5)(a)
[8] http://www.gov.scot/Resource/0048/00480494.pdf

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Agenda Item Number: 7

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	**2016/17_07**
Subject Title	Ratification of Current Strategic Plans for extended functions
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Sandra Cairney Head of Strategy, Planning & Health Improvement Sandra.Cairney@ggc.scot.nhs.uk 0141 201 3101

1. PURPOSE OF REPORT

1.1 The purpose of this report is to request HSCP Board members agree the ratification of current NHS and Social Work Children's Services and Criminal Justice Social Work Plans in order that the HSCP Board will assume responsibility for existing strategic business plans for new areas of functional delegation from 11th August 2016.

2. SUMMARY

2.1 The HSCP's current Strategic (Commissioning) Plan remains limited in scope to adult health and social care. This Strategic Plan is predicated on the national Health and Wellbeing Outcomes which apply only to adults.

2.2 The developing role of the Community Planning Partnership in terms of Criminal Justice oversight is currently unclear and arrangements to lead the development of a single Integrated Children's Plan require agreement from Community Planning Partners.

2.3 It is proposed that the HSCP Board assumes responsibility for the existing strategic business plans for the new areas of functional delegation, in the first instance and then instructs the Chief Officer to work with key partners towards the development of new transformational integrated plan(s) for the additional in scope functions.

2.4 All of the functions proposed for additional delegation already have strategic business plans, which would provide the basis for this initial assumption of responsibility. This would involve assuming responsibility for the following specific plans.

- Social Work Child Protection Plan
- NHS (local) Child Protection Plan
- NHS (local) Community Children Service Plan (incorporating a suite of

subsidiary service plans)

- Social Work Children's & Criminal Justice Business Improvement Plan (incorporating a suite of subsidiary service plans)
- Partnership Strategy Map 2014-17 (tied into the North Strathclyde Community Justice Authority Area planning arrangements)
- Partnership Operational Action Plan 2014-17

2.5 Copies of these plans have been made available to HSCP Board members prior to the meeting, for their review. A further report to the HSCP Board (Report 2016/17_07) provides assurance that the opening budgets transferred from the NHS and the Council to fund the additional delegated functions transferred to the HSCP Board have been subject to due diligence processes.

3. RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

- approves the proposal to assume responsibility for existing strategic business plans for new areas of functional delegation
- instructs the Chief Officer to work with key partners towards the development of new integrated transformational plan(s) for these additional functions.

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 08

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11 August 2016**
Report Number	**2016/17_08**
Subject Title	**Children's Health, Children's Social Work & Criminal Justice Services Opening Budget 2016/17**
Report by	**Jean Campbell, Chief Finance & Resources Officer East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, ED HSCP Resource and Finance Officer 0141 201 4210 – Jean.Campbell@ggc.scot.nhs.uk**

1. PURPOSE

1.1. The purpose of this report is to present the opening budget for 2016/17 for Children's Social Work & Criminal Justice Services and Children's Health Services.

2. SUMMARY

2.1. The Scheme of Integration which seeks to incorporate Children's Health, Children's Social Work & Criminal Justice Services (CSW &CJ) into the ED HSCP was formally approved by the Scottish government on the 5th July 2016. This will take effect from the 11th August 2016.

2.2. As part of the action plan to effectively support the transition of Children's Health, CSW & CJ Services into the partnership, there were a range of work streams in relation to the financial scoping and governance arrangements for these budgets including a due diligence exercise to understand the budget composition, trends and future demands for this area.

2.3. The report outlines the approved revenue budget available to the HSCP of £11.4m for 2016/17 from East Dunbartonshire Council for the delivery of Children's SW & Criminal Justice services and £1.3m from NHS GG&C for the delivery of Children's Health Services. The Council's budget was approved on the 17th March 2016 and NHS GG&C approved its financial plan on the 28th June 2016.

3. RECOMMENDATIONS

3.1. It is recommended that the Board:-

a) Notes the opening budget position for Children's Health, Children's SW & CJ Services for the HSCP for 2016/17.

4.0 BACKGROUND

4.1 East Dunbartonshire Health & Social care Partnership (HSCP) was established on the 3rd September 2015 for all Adult Social Work and Health Services. Significant work was carried out at that time to establish effective governance arrangements including the Integration Scheme, Standing Order for meetings, Terms of Reference and membership of IJB committees, the Scheme of Delegation to Officer and the Financial Regulations and these will apply equally to the budgets transferring in relation to Children's Health, Children's Social Work & Criminal Justice Services.

4.2 There was further agreement by both partnership bodies to include Children's Health Services and a process of consultation was progressed in January 2016. The Council agreed the further transfer of Children's Social Work & Criminal Justice Services on the 26th May 2016 and work has progressed to develop and implement a Transition Plan to effectively transfer these services into the Health & Social Care Partnership. This included a range of work streams in relation to the financial scoping and governance arrangements for these budgets including a due diligence exercise to understand the budget composition, trends and future demands for this area

4.3 The Scheme of Integration which seeks to incorporate Children's Health, Children's Social Work & Criminal Justice Services (CSW &CJ) into the ED HSCP was formally approved by the Scottish government on the 5th July 2016. This will take effect from the 11th August 2016.

4.4 Work has progressed to scope the resources to transfer to the Health & Social Care Partnership for 2016/17. The Council's budget was approved at the full Council meeting on the 17th March 2016 and the Financial Plan for NHS GG&C approved on the 28th June 2016. The totality of budgets for 2016/17 to support the delivery of Children's Health, Children's Social Work & Criminal Justice Services (CSW &CJ) are shown in the table below:

Area of Service Expenditure	Gross Budget 2016/17 £	Income 2016/17 £	Net Expenditure 2016/17 £
Children's Health Budget	1,349,353	0	1,349,353
Children's SW Budget	11,464,080	0	11,464,080
Criminal Justice	926,791	(998,388)	(71,597)
TOTAL	13,740,224	(998,388)	12,741,836

4.5 **Children's Social Work & Criminal Justice Services.**
The element of the budget relating to Children's Social Work & Criminal Justice Services amounts to a net expenditure of £11.4m. This can be broken down as follows:-

Area of Service Expenditure	Gross Budget 2016/17 £	Income 2016/17 £	Net Expenditure 2016/17 £
Chief Social Work Officer	130,954	-	130,954
Fieldwork	3,229,408	-	3,229,408
Resources	7.929,319	-	7,929,319
Criminal Justice (ring-fenced)	926,791	(998,388)*	(71,597)
Miscellaneous (Care Commission, admin, voluntary organisations etc)	174,399	-	174,399
TOTAL	**12,390,871**	**(998,388)**	**11,392,483**

* This includes income for expenditure relating to fleet, central support and management overheads which sit elsewhere within Council budgets.

4.6 The CSW & CJ budget for 2016/17 is judged to be reasonable and deliverable, however there are intrinsic risks and concerns in volatile and demand led areas.

4.7 The 2016/17 budget incorporates a number of changes from the 2015/16, the most significant pressures and risks being as follows;

- Demand Volatility in relation to residential school placements and accommodation, fostering and adoption payments in response to legislative requirements to address assessed need. An additional £800k has been included in the 2016/17 budget to meet current known pressures.
- Increase in payments for kinship care, link and residency carers to achieve parity with fostering payments.
- Inflation – limited provision is available to address price movements with 2.5% assumptions for residential placements, fostering & adoption payments and 1% included for direct payments. Any increase in provider rates beyond these assumptions will require to be managed within available budget.
- Employee Costs – budget provision is allowed for pay awards, living wage, equal pay, pensions, NI costs, grading outcomes, displaced etc but uncertainties and finite provisions represent risk. Turnover savings for in year movements in staffing and recruitment delays of 4% have been incorporated within the budget.
- The budgets pertaining to Criminal Justice have accountabilities and relationships into the wider Criminal Justice partnership and are subject to consideration within the monies available to this partnership also. Any pressures across the partnership budget are subject to an agreement to make a contribution to meet any deficit.
- There are wider financial difficulties facing the Council, the resources available to the IJB are within scope for areas with potential for achieving financial efficiency. The Council uses a "hierarchy" for determining savings to ensure options maximise efficiency, focus resources on vulnerable groups and maximise income streams before making service reductions. The Council has an existing policy established at Special

Council on 16 December 2014 in report CE/24/14/GC to implement measures to contain cost and achieve savings. Additionally, a range of transformational changes and budget reduction activities and projects are anticipated to act as a means of addressing wider financial pressure facing the Council and HSCP. There remains a number of savings in respect of Total Resourcing to be allocated across the Council for employee terms & conditions, essential car user and procurement totalling £3.6m and procurement savings of £2m. The element of these savings relating to Children's Social Work & Criminal Justice Services may present a further risk once these have been applied.

- The costs associated with residential school placements are met through an equal contribution from Social Work and education where there continues to be an educational input within the placement. This has applied to all placements over the last number of years in an effort to alleviate pressures on Children's SW budget, however going forward where there is no educational aspect to the placement, the full costs will be met from Children's SW budgets.
- The implementation of the living wage is limited, at this time, to Adult Social Work Services, however the impact on commissioned Children's services will need to be assessed and may have a future financial implication if these services to support children are not able to adequately recruit staff.

4.8 In addition to the recurring budget detailed above, there are funds which have been carried forward from 2015/16 specifically to meet commitments in respect the development of a family assessment and contact service and also the provision of two flats to accommodate young people within a supported living context. This totals an additional £238k.

4.9 Following the approval of the Children's Social Work & Criminal Justice Services budget 2016/17, there have been a number of recurring adjustments to the budget;

- Budget transfer from education for residential school placements where there is no educational input and costs relates entirely to social care (£180k)
- Budget transfer to Shared Services for printing provision now met from the Council managed print service (£4k).

These adjustments have been incorporated into the agreed budget to be transferred.

4.10 An assessment was undertaken as to the extent to which non-recurring funding and expenditure has been evaluated and included in budget allocations where applicable. The historic carry forward of budgets within Children & Families have been removed where these no longer have a commitment in 2016/17 in relation to the Early Years Change Fund. Further carry forwards in relation to developments relating to a family assessment and contact service and also the provision of two flats to accommodate young people within a supported living context have been retained. It would seem reasonable to include funding where there is an on-going commitment.

4.11 On the 12th February the Council presented its report on the Strategic Planning and Performance Framework from 2015/16 to 2017/18. The report gives specific consideration to financial risks, uncertainties facing the Council, the level of reserves, as well as governance and scrutiny arrangements. The annual budget process includes consideration of a wide range of pressures including demand and assessed need, contract price inflation, direct payments inflation, increased residential school placements, fostering and adoption placements. This provides assurance that any future pressures are considered and, whilst these are based on the most up to date information and therefore subject to change, there is a robust process for monitoring budgets and reviewing any changes.

4.12 There are a number of savings and efficiency targets built into the agreed 2016/17 budget. This includes a 4% turnover savings target and a number of 'Total Resourcing' savings relating to terms and conditions for employees and procurement savings still to be applied. These are attached to specific cost efficiencies and once the work is concluded to identify, fully cost and embed these initiatives they will be allocated accordingly. The impact of these initiatives requires to be continually reviewed.

4.13 **Children's Health Services.**
The element of the budget relating to Children's Health Services amounts to a net expenditure of £1.3m. This can be broken down as follows:-

Area of Service Expenditure	Gross Budget 2016/17 £	Income 2016/17 £	Net Expenditure 2016/17 £
Health Visiting	1,119,952	0	1,119,952
School Nursing	170,814	0	170,814
Admin & Accommodation	57,987	0	57,987
Child Services Other	600	0	600
TOTAL	**1,349,353**	**0**	**1,349,353**

4.14 The Children's Health budget for 2016/17 is judged to be reasonable and deliverable.

4.15 The 2016/17 budget incorporates a number of changes from the 2015/16, the most significant pressures and risks being as follows;

- Pay Provision – a provision of 1% for pay uplift in 2016/17 has been applied to all pay budgets and this is considered to be reasonable. In addition, a provision has been made for a flat rate increase of £400 for staff earning less than £22,000. There is also provision for the abolition of the contracted out rebate of 3.4% in employer's national insurance contributions for staff who are members of the superannuation scheme and the estimated costs of additional staff remaining within the Superannuation Scheme following automatic enrolment on the 1st April 2016. An analysis of the pay trends for Agenda for Change (AFC) relating to incremental pay progressions has indicated this will not be a cost pressure in 2016/17, therefore no additional provision has been made in this regard.
- Other Cost Inflation – 1% general provision has been set aside for inflation on non pay costs excluding prescribing costs which will be funded separately.
- Cost Savings - The partnership savings requirement is £20m of which savings proposals of £10.4m have been identified. Therefore further work is required to identify proposals to meet the balance required. There may be some non-recurring relief to meet any savings shortfall, however the release of this will be the subject of further discussions throughout the year. Recurring solutions will have to be identified going forward. An element of the savings proposals for the ED HSCP have been allocated to Children's Health Services relating to board wide universal services for Children of £18k.

- Additional monies have been made available from the Scottish Government under the requirements of GIRFEC for additional health visitors and additional monies have been included of £76k which may set to rise for 2017/18 depending on caseload levels across ED.

4.16 Children's Health, Children's Social Work & Criminal Justice Services
In terms of due diligence and seeking to provide financial assurance to the HSCP that resources are adequate for it to carry out its function, a review based on budgets , non-recurring funding / expenditure, medium term financial forecasts, savings and efficiency targets was undertaken.

4.17 The basis for the anticipated budget allocations to the HSCP looked at the previous three years and the process of determining budget has been applied consistently throughout this period and in line with Council and NHS budget setting guidelines. The budgeted allocations appear to be reasonable, subject to suitable rigour with expected budget lines and expenditure included.

4.18 The risk of increasing service demands and the associated budget pressures necessitate that these allocations be kept under review in order to ensure that budgets are sufficient for the HSCP to be able to discharge its responsibilities.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 9

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	**2016/17_09**
Subject Title	Revision to Health and Social Care Partnership Administrative Scheme.
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Sandra Cairney Head of Strategy, Planning & Health Improvement Sandra.Cairney@ggc.scot.nhs.uk 0141201 3101

1. PURPOSE OF REPORT

1.1 The purpose of this report is to advise the HSCP Board of the potential impact of the revised Integration Scheme on the HSCP's Administrative Scheme, and to agree matters that require attention and updating. To advise the HSCP Board that Scottish Government, supported by the Standards Commission, require each IJB to produce their own Code of Conduct and submit this to the Scottish Government for approval.

2. SUMMARY

2.1 A number of documents that define the HSCP Board's powers, relationships and organisational aspects that were developed during the transitional shadow period, and immediately thereafter, were drawn into a single frame of reference, called an Administrative Scheme. This was approved by the full HSCP Board on 3 September 2015. The documents that comprise the Administrative Scheme include:

- Integration Scheme
- Standing Orders for Meetings
- Terms of reference and membership of IJB Committees
- IJB Members Code of Conduct
- Scheme of Delegation to Officers
- Financial Regulations

2.2 These documents have been scrutinised to consider which if any may require some attention or amendment to reflect the wider range of functions that are to be delegated to the HSCP Board by the Council and Health Board.

2.3 Three elements of the Administrative Scheme have been identified as relevant for attention or updating at this time:

- The HSCP Board adopted a Model Code of Conduct at the Board meeting on the 3rd September 2015. The Scottish Government has advised that it is now a statutory requirement, under the Ethical Standards in Public Life etc. (Scotland) Act 2000, that the HSCP Board adopts a Code of Conduct which is specific to East Dunbartonshire Health & Social Care Partnership. This Code for Integration Joint Boards has been specifically developed by the Scottish Government using the Model Code and the statutory requirements of the 2000 Act. Following approval by the HSCP Board, the revised Code of Conduct will be submitted to the Scottish Government for approval **Appendix 1**. An IJB cannot make an amendment to the template Code developed by Scottish Government, the Commissioner for Ethical Standards and the Standards Commission, IJBs are required to implement the Code in full. Once the HSCP Board Code of Conduct has been approved by the Scottish Government the HSCP Board must publish their Code and a Register of Members' Interests.
- IJB Code of Conduct – HSCP Board members are asked to consider whether they need to update their registration of interests as a consequence of the HSCP Board now assuming delegated responsibility for a range of new functions as set out in the revised Integration Scheme. Members are required to update their declaration of interests annually, so all HSCP Board members should submit a completed declaration of interests form to Louise Martin, Head of Administration for the HSCP by the 30th September 2016. Members can find the declaration of interests form at **Appendix 1(Annex C)**. The Chief Officer will be happy to help any member who requires assistance with completion of the form.
- Scheme of Delegation to Officers - This document was approved with a list of statutory functions listed within its contents. This list required updating to reflect the wider range of functions now delegated to the HSCP Board. Rather than continue to replicate this range of statutory functions, at 4.2 the document now simply refers to the functions and services as set out in the Integration Scheme. Additionally Annex 1 has been removed, with a reference instead to the Chief Social Work Officer Governance and Accountability Protocol, which has also been updated and is the subject of a separate report to the HSCP Board on 11 August 2016. These changes will more effectively "future-proof" the Scheme of Delegation to Officers. A copy of the updated Scheme of Delegation to Officers is at **Appendix 2**, for approval.

3. RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

a) approves the revised East Dunbartonshire Code of Conduct and requests the Chief Officer to submit the Code to Scottish Government for approval

b) reviews individual member registration of interests as a consequence of the HSCP Board now assuming delegated responsibility for a range of new functions as set out in the revised Integration Scheme, and to update their annual declaration. Members are asked to raise any such matters directly and individually with the Chief Officer

c) asks the Chief Officer, after approval is received from Scottish Government, to publish the Code of Conduct for the HSCP Board and the Register of Members' Interests

d) approves the changes proposed for the Scheme of Delegation to Officers

East Dunbartonshire

Health and Social Care Partnership

CODE OF CONDUCT

for MEMBERS of

EAST DUNBARTONSHIRE

INTEGRATION JOINT BOARD

August 2016

sustainable thriving achieving
East Dunbartonshire Council
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NHS
Greater Glasgow and Clyde

CONTENTS

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

The East Dunbartonshire Integration Joint Board, known as the 'East Dunbartonshire Health & Social Care Partnership Board', will be referred to as the 'HSCP Board' throughout the remainder of this document.

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 2000 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 2000 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. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 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.

The Public Bodies (Joint Working) (Scotland) Act 2014 (Consequential Amendments & Savings) Order 2015 has determined that Integration Joint Boards are "devolved public bodies" for the purposes of the 2000 Act.

1.4 This Code for Integration Joint Boards has been specifically developed using the Model Code and the statutory requirements of the 2000 Act. As a member of the East Dunbartonshire Health & Social Care Partnership Board "the HSCP Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the HSCP Board.

This Code applies when you are acting as a member of the East Dunbartonshire HSCP Board and you may also be subject to another Code of Conduct.

Appointments to the Boards of Public Bodies

1.5 Whilst your appointment as a member of an Integration Joint Board sits outside the Ministerial appointment process, you should have an awareness of the system surrounding public appointments in Scotland. Further information can be found in the public appointment section of the Scottish Government website at http://www.appointed-for-scotland.org/.

Details of IJB membership requirements are set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and further helpful information is contained in the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance, which also includes information on Equality Duties and Diversity.

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 IJB on which you serve and of wider diversity and equality issues.

1.6 You should also familiarise yourself with how the East Dunbartonshire HSCP Board policy operates in relation to succession planning, which should ensure that the HSCP Board has a strategy to make sure it has members in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this 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 Code of Conduct.

1.8 The 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 in the first instance seek advice from the Chair of the HSCP Board. 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" and the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance. These publications will provide you with information to help you in your role as a member of an Integration Joint Board, and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the 2000 Act sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate, the sanctions that will 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 CODE OF CONDUCT

2.1 The general principles upon which this 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 East HSCP Board and in accordance with the core functions and duties of the HSCP Board.

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 East Dunbartonshire HSCP Board 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 East Dunbartonshire HSCP Board 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 East Dunbartonshire HSCP Board and its members in conducting public business.

Respect

You must respect fellow members of the East HSCP Board and employees of related organisations supporting the operation of the HSCP Board 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 the East Dunbartonshire HSCP Board.

2.2 You should apply the principles of this Code to your dealings with fellow members of the East Dunbartonshire HSCP Board, employees of related

organisations supporting the operation of the HSCP Board and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the East Dunbartonshire Integration Joint Board.

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 the HSCP Board.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of related organisations supporting the operation of the HSCP Board in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings. You should familiarise yourself with the Standing Orders for theEast Dunbartonshire HSCP Board, which govern the Board's proceedings and business. The "Roles, Responsibilities and Membership of the HSCP Board" guidance, will also provide you with further helpful information.

Relationship with IJB Members and Employees of Related Organisations

3.3 You will treat your fellow HSCP Board members and employees of related organisations supporting the operation of the HSCP Board with courtesy and respect. It is expected that fellow HSCP Board members and employees of related organisations supporting the operation of the HSCP Board 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 and the Health Board or local authority of the HSCP Board should be able to provide this information to any HSCP Board member on request.

Public bodies should promote a safe, healthy and fair working environment for all. As a member of the East Dunbartonshire HSCP Board you should be familiar with any policies of the Health Board and local authority of the HSCP Board as a minimum 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 applying to the HSCP Board 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 HSCP Board. 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 HSCP Board.

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 that the East Dunbartonshire HSCP Board may be involved in determining, or who is seeking to do business with your HSCP Board, 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 the East Dunbartonshire HSCP Board then, as a general rule, you should ensure that your HSCP Board pays for the cost of the visit.

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

3.10 As a member of a devolved public body, you should familiarise yourself 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 East Dunbartonshire HSCP Board 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 East Dunbartonshire HSCP Board into disrepute.

Use of Health Board or Local Authority Facilities by Members of the IJB

3.13 Members of the East Dunbartonshire HSCP Board 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 Health Board or local authority 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 East Dunbartonshire HSCP Board.

Appointment to Partner Organisations

3.14 In the unlikely circumstances that you may be appointed, or nominated by the East Dunbartonshire HSCP Board, as a member of another body or organisation, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their IJB 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 IJB. It is your responsibility to take advice on your responsibilities to the HSCP Board 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 HSCP Board's Register (Annex C). 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.

This requirement also applies where, by virtue of your employment in a particular post, you are required to be a member of the HSCP Board.

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

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.

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 IJB 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 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 IJB 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. This requirement also applies where, by virtue of your membership of a particular group, you have been appointed to the HSCP Board.

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 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 HSCP Board. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions. For further detail on the declaration requirements of the East Dunbartonshire HSCP Board, you can refer to the IJB's Standing Orders.

5.2 IJBs inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the East Dunbartonshire HSCP Board 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 the East Dunbartonshire HSCP Board You will wish to familiarise yourself with your HSCP Board's standing orders and the "Roles, Responsibilities and Membership of the Integration Joint Board" guidance.

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 in the first instance.

5.5 As a member of the East Dunbartonshire In HSCP Board you might also 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 IJB and another body. Keep particularly in mind the advice in paragraph 3.15 of this 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 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 an IJB. 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 an IJB 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 Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the HSCP Board, or you have been appointed to the HSCP Board by virtue of your position under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014; you do not, for that reason alone, have to declare that interest.

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.

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 of the integration joint board, before taking part in any discussion on that item.

Where an interest is disclosed under the above terms the onus is on the member declaring the interest to decide whether, in the circumstances, it is appropriate for that member to take part in the discussion of, or voting on the item of business.

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.

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 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 do not have to declare an interest solely because you are a Councillor or Member of another Devolved Public Body or you have been appointed to the HSCP Board by virtue of your position under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

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 HSCP Board, or a committee of the integration joint board, before taking part in any discussion on that item.

Where an interest is disclosed under the above terms the onus is on the member declaring the interest to decide whether, in the circumstances, it is appropriate for that member to take part in the discussion of, or voting on the item of business.

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.

The Financial Interests of Other Persons

5.10 The 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 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 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 the HSCP Board 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 an IJB is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss this at the earliest opportunity 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 HSCP Board 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 East Dunbartonshire HSCP Board 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 East Dunbartonshire HSCP Board 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 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. You should also familiarise yourself with the “Roles, Responsibilities and Membership” guidance for members of an Integration Joint Board.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the East Dunbartonshire HSCP Board 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 East Dunbartonshire HSCP Board.

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 East Dunbartonshire Integ HSCP Board.

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 Code.

6.7 You should not accept any paid work relating to health and social care:-

(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 Board and its members.

This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the HSCP Board, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

Members of Integration Joint Boards are appointed because of the skills, knowledge and experience they possess. The onus will be on the individual member to consider their position under paragraph 6.7.

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 chair of the East Dunbartonshire HSCP Board in the first instance.

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE.

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

a)	Censure	The Commission may reprimand the member but otherwise take no action against them;
b)	Suspension	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.
		Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;
c)	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:
		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.
		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.

ANNEX B

DEFINITIONS AND EXPLANATORY NOTE

Chair	**I**ncludes Board Convener or any person discharging similar functions under alternative decision making structures.
Code	Code of conduct for members of devolved public bodies.
Cohabitee	**I**ncludes 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 474(1) of the Companies Act 2006. A "group", within section 474 (1) of the Companies Act 2006, means a parent undertaking and its subsidiary undertakings.
Parent Undertaking	**I**s 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.

East Dunbartonshire
Health and Social Care Partnership

1. EAST DUNBARTONSHIRE HSCP BOARD

Received	
Date Entered	

Ethical Standards in Public Life Etc (Scotland) Act 2000
Code of Conduct for Members of the East Dunbartonshire HSCP

REGISTER OF INTERESTS – AUGUST 2016 – JULY 2017

Note: If no interest in any category please state "None" or "Nil". Where there is insufficient space to record all registerable interests please request continuation sheet from …… on 0141-……

Name:	

SECTION 4 OF CODE – CATEGORY ONE: REMUNERATION

❖ Remuneration from Employment

	Name of Employer & Nature of Post held	Nature of Business	Additional comments
Details of Employment held			

❖ Remuneration from self-employment

	Name of Business	Nature of Business	Additional comments e.g. Frequency
Details of self-employment			

held			

❖ **Remuneration as holder of paid office**

	Nature of Office held	Organisation	Additional comments e.g. Frequency
Details of offices held			

❖ **Remuneration as a Director of an Undertaking**

	Registered Name of Undertaking	Nature of Business	Additional comments
Details of directorships held			

❖ **Remuneration as a Partner in a Firm**

	Name of Partnership	Nature of Business	Additional comments
Details of Partnerships held			

❖ **Remuneration from a trade, profession or other work**

	Nature of work	For whom undertaken & frequency	Additional comments
Details of remuneration from trade, profession or other work			

SECTION 4 OF CODE – CATEGORY TWO: RELATED UNDERTAKINGS

	Name of subsidiary, parent or other organisation and nature of business	Relationship to organisation where remunerated directorship under Category One	Additional comments
Details of non-remunerated directorships			

SECTION 4 OF CODE – CATEGORY THREE: CONTRACTS

	Description of Contract (excluding consideration)	Duration of Contract	Additional comments
Details of contracts entered into			

SECTION 4 OF CODE – CATEGORY FOUR: HOUSES, LAND AND BUILDINGS

	Description of interest	Description of approximate Location	Additional comments
Details of interests in houses, land and buildings			

SECTION 4 OF CODE – CATEGORY SIX: SHARES AND SECURITIES

	Registered Name of Company or Body	Description of nature of holding (value need not be disclosed)	Additional comments
Details of interests in shares and securities which may be significant to, or relevant to, or bear upon the work of the Partnership			

SECTION 4 OF CODE – CATEGORY SIX: GIFTS AND HOSPITALITY

	Description of gift or hospitality	Additional comments
Details of gifts and hospitality received		

SECTION 4 OF CODE – CATEGORY SEVEN: NON-FINANCIAL INTERESTS

	Description of interest	Additional comments
Details of non-financial interests which may be significant to, or relevant to, or bear upon the work of the Integration Joint Board		

Date of Preparation:

Number of Continuation sheets:

Signed: _____

Revisions to registration

Revision	No 1	No 2	No 3	No 4	No 5
Sections Covered					
Date received					
Entered in Register					

East Dunbartonshire
Health and Social Care Partnership

East Dunbartonshire Health and Social Care Integration Joint Board Scheme Setting Out Powers Delegated To Officers

Scheme Of Delegation to Officers

August 2016

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

Contents

1 INTRODUCTION

1.1 This Scheme of Delegation (the Scheme) was approved by East Dunbartonshire Health and Social Care Integration Joint Board on 3 September 2015 in respect of the Public Bodies (Joint Working) (Scotland) Act 2014. The Scheme contains details of those functions both statutory and non-statutory which the Health and Social Care Integration Joint Board (hereinafter referred to as 'the IJB') has chosen to delegate to its officers.

1.2 This Scheme of Delegation should to be read and used alongside the Integration Scheme, relevant Standing Orders relating to Meetings or Contracts, Financial Regulations, Directions and other relevant instruments which together make up the wider Scheme of Administration and framework of governance within the IJB. The IJB's Governance is based upon the principles of:

- Openness;
- Accountability;
- Responsiveness;
- Democracy.

1.3 This Scheme of Delegation contributes to these fundamental principles by defining a route for certain decisions enabling the IJB to be:

- Speedy and responsive in taking decisions;
- Efficient – by freeing the formal decision making structures of the IJB to focus on other key decisions which have to be taken under full public scrutiny;
- Accountable – by holding appropriate employees fully accountable for the decisions they take.

2 CORE PRINCIPLES

2.1 The IJB has determined that all powers which are not specifically reserved to the IJB, its committees, or sub-committees are delegated to officers. The matters reserved by the IJB or committees are mainly the strategic policy or regulatory issues requiring to be decided by the IJB, while the day to day operational matters of running the IJB's services are delegated to officers.

2.2 Every attempt has been made to list the specific powers which are available to officers. However if a specific power is not mentioned in this Scheme of Delegation, it does not necessarily mean that officers cannot exercise that power. Unless it has been specifically reserved to the IJB, the power will still be delegated to officers. The powers reserved to the IJB are detailed in this Scheme of Delegation.

2.3 Delegations to Officers

2.3.1 The undernoted powers are delegated to Officers of the IJB:-

(i) The Chief Officer will have delegated responsibility for all matters in respect of the operation, development and implementation of policy unless specifically reserved to the IJB, its committees or sub-committees in accordance with the principles listed in 2.4 and 2.5 below, together with such Statutory Duties as may have been specifically and personally assigned to him/her;

(ii) The Chief Officer will be responsible for the appointment of all posts within services pursuant to functions delegated to the IJB, in line with the Integration Scheme;

(iii) Such delegations are at all times to be exercised in accordance with the relevant law, the Integration Scheme, any relevant Standing Orders relating to Meetings or Contracts, Financial Regulations, Directions and other relevant instruments which together make up the wider Scheme of Administration and framework of governance within the IJB and other relevant policies and procedures;

(iv) Where clarification is required, the Chief Officer will determine which matters are operational or otherwise;

(v) The Chief Officer is a full, direct employee of either the Council or the Health Board and is bound by the employment policies and procedures of which organisation directly employs them. The Chief Officer will be seconded by the Employer to the IJB. An honorary contract will also be put in place to establish the Chief Officer as an employee of both the Council and the Health in terms that strengthen shared accountability;

(vi) The Chief Officer will be the principal advisor to and officer of the IJB and will provide overall strategic and operational advice to the IJB;

(vii) The Chief Officer is responsible for the operational management and performance of services delegated to the IJB by Council and Health Board, with the exception of NHS Acute Services and for some hosted services for which alternative governance arrangements may apply;

(viii) The Chief Officer will be line managed by the Chief Executives of the Council and Health Board;

(ix) The Chief Officer will be a member of the senior management team of the Council and Health Board.

2.4 **Powers Reserved to the IJB**

General Issues

2.4.1 Delegated powers should not be exercised by officers where any decision would represent a departure from IJB policy or procedure, would represent a departure from the Strategic Plan or would be contrary to a standing instruction of the IJB (or committee), or would itself represent a significant development of policy or procedure. The only exception to this is in the case of urgency where the officer may, after consultation with the Chairperson of the IJB, exercise delegated powers. Should such powers be exercised in urgent circumstances, a report will be submitted to the next appropriate meeting for noting.

Specific powers reserved for the IJB

2.4.2 The powers which are reserved to the IJB or its committees are a mixture of those which must, in terms of statute, be reserved, and those which the IJB has, itself, chosen to reserve. Powers which are not reserved are delegated, in accordance with the provisions of this Scheme.

2.4.3 The following is a comprehensive list of what is reserved to the IJB:-

Reservations

(i) To change the name of the IJB;

(ii) To receive any certified abstract of the IJB's annual accounts;

(iii) Approval of any investment strategy and annual investment report;

(iv) Any other functions or remit which is, in terms of statute or other legal requirement bound to be undertaken by the IJB itself;

(v) To establish such committees, sub-committees and joint committees as may be considered appropriate to conduct business and to appoint and remove Chairpersons, Depute Chairpersons and members of committees and outside bodies;

(vi) The approval annually of the Revenue Budget;

(vii) The approval annually of the Capital Plan;

(viii) The incurring of any net new expenditure not provided for in the estimate of capital or revenue expenditure unless, such expenditure is reported to and approved by the IJB;

(ix) The approval or amendment of the Scheme of Administration regulating the constitution, membership, functions and powers of Committees of the IJB;

(x) The approval or amendment of the Standing Orders regulating meetings proceedings and business of the IJB and Committees and contracts;

(xi) The approval or amendment of the Scheme of Delegation detailing those functions delegated by the IJB to its Officers;

(xii) The appointment and the dismissal of the Chief Officer or the S95 Financial Officer;

(xiii) The decision to co-operate or combine with other Integration Joint Boards in the provision of services other than by way of collaborative agreement;

(xiv) The approval or amendment and review of the Strategic Plan;

(xv) To fix and amend a programme of IJB and committee meetings;

(xvi) To deal with matters reserved to the IJB by Standing Orders, Financial Regulations and other Schemes approved by the IJB.

2.5 **General Restrictions on Exercise of Delegated Powers by Officers**:

(i) If any decision proposed under delegated powers might lead to a budget being exceeded, the officer must consult with the Chairperson of the IJB before exercising the delegated power and be subject to a report to the IJB at its next meeting;

(ii) The Chief Officer must ensure that the Chairperson of the IJB, is where appropriate consulted on matters of a controversial nature. Where appropriate, such matters should be referred to the IJB or the appropriate Committee for decision;

(iii) In particular and without prejudice to the foregoing, the Chief Officer will exercise particular care in determining whether a matter is to be regarded as controversial in the following circumstances:-

- Where determination of the issue may involve a decision contrary to local or national policy, the Strategic Plan or the determination may lead to a breach of a relevant Code of Guidance;
- Where an issue is determined to be contrary to significant objections or strong recommendations of Statutory Consultees;
- The Officer proposes to determine the matter, or act in a manner, contrary to the recommendation of other officers whom he/she is obliged to, or has chosen to, consult with;
- There are perceived to be public safety or significant public policy issues dependent on the determination (save in the case of urgency as aforesaid);
- Standing Orders, National or International regulation requires determination otherwise;

- There are questions of legality or financial advisability/probity involved.

2.6 **Sub-Delegation**

2.7 East Dunbartonshire Health and Social Care Integration Joint Board hereby authorises any Officer with specific delegated powers, duties or responsibilities referred to within this Scheme to delegate further any of these powers etc. to other appropriate Officers within their service. Any Officer using delegated powers will be fully accountable to the IJB for his/her actions.

2.8 **Interpretation**

2.9 In this Scheme the following words shall have the meanings assigned to them, that is to say:

- "Act" means the Local Government (Scotland) Act 1973;
- "1994 Act" means the Local Government etc (Scotland) Act 1994;
- "2014 Act" means the Public Bodies (Joint Working((Scotland) Act 2014;
- "IJB" means East Dunbartonshire Health and Social Care Integration Joint Board;
- "Council" means the East Dunbartonshire Council;
- "Chief Officer" means the Chief Officer of the Health and Social Care Integration Joint Board;
- East Dunbartonshire Health and Social Care Partnership means the partnership between the Council, the Health Board, the IJB, the Third Sector, services users and carers in planning, developing and delivering services pursuant to the functions delegated to the IJB;
- "Head of Human Resources" means the Head of Human resources of either the Council or the Health Board or such officer of either the Council or Health Board who holds principal responsibility for human resource issues;"Integration Scheme" means the East Dunbartonshire Health and Social Care Integration Scheme;
- "Employer" means whichever of the Council or Health Board shall employ a particular employee;
- "Members" means members of the IJB;
- "Health Board" means Greater Glasgow and Clyde Health Board;
- Chief Finance Officer' means the Chief Financial Officer of the IJB appointed by the IJB on terms of section 95 of the 1973 Act.

2.10 Any reference to any Act of Parliament shall be construed as a reference to the Act of Parliament as from time to time amended, extended or re-enacted and shall include any byelaws, statutory instruments, rules, regulations, orders, notices, directions, consent or permissions made thereunder. Any reference to any statutory instrument, regulation or order shall be construed as a reference to that instrument, regulation or order (as the case may be) as from time to time amended, extended or re-enacted.

2.11 Subject to the foregoing provisions of this paragraph, the Interpretation Act 1978 shall apply to the interpretation of the Scheme as it applies to the interpretation of an Act of Parliament.

2.12 **Alteration of Scheme**

2.13 Subject to the provisions of the 2014 Act the IJB shall be entitled to amend, vary or revoke the Scheme from time to time.

2.14 The financial limits as set by the terms of this Scheme shall be reviewed on 1st April each year.

3 DELEGATIONS TO OFFICERS - GENERAL PROVISIONS

3.1 The Chief Officer and the Chief Finance Officer will have the following powers delegated to them:-

3.2 All powers necessary for the general management of the departments or services for which they are responsible including, but not limited to, the power to:-

(i) Appoint employees in accordance with the policy and Standing Orders of the Employer;

(ii) Determine appropriate car and telephone allowance, if any, to be applied to employees In line with the applicable terms and conditions of the Employer;

(iii) Authorise special leave for employees in accordance with the provisions of the Employer's Scheme of Special Leave;

(iv) In consultation with the Head of Human Resources of the Employer, grant leave of absence with salary to enable employees to undertake approved part-time courses;

(v) Authorise employee attendance at conferences/seminars and training courses for all employees;

(vi) Authorise departmental expenditure up to limits permitted in the Standing Orders, on such items as have been allowed for in the appropriate capital and revenue budgets.

3.3 To authorise employees to undertake functions delegated to the Chief Officer or Chief Finance Officer as may be deemed appropriate and expedient, provided such employees are suitably qualified;

3.4 To sign and issue the necessary authorisation to Officers of the Council or Health Board to exercise statutory powers including where appropriate the rights to enter land and premises in connection with the discharge of their duties and any identity cards so required;

3.5 All such other powers as delegated by the IJB, a Committee, a Sub-Committee, the IJB's Standing Orders and Financial Regulations;

3.6 To authorise and pay for the attendance of individual Members and volunteers at specific events, conferences, seminars, or similar;

3.7 To authorise and pay for the attendance of individual employees at training or conferences and to authorise and reimburse the professional membership fees of individual employees;

3.8 To make recommendations as to the employment of consultants or specialists in accordance with any decision taken by the IJB;

3.9 To manage and monitor the performance of the services which are the responsibility of the IJB;

3.10 To assist in the preparation of the IJB's Capital Programme;

3.11 To take such measures as may be required in emergency situations, subject to consulting the Chairperson and Vice Chairperson of the IJB on any items for which IJB approval would normally be necessary. This includes any Contract for the execution of works which are urgently required for the prevention of damage to life or property;

3.12 In consultation with the Head of Human Resources of the Employer, to deal with, and in appropriate circumstances, to approve applications from employees for reimbursement of reasonable legal expenses, in part or in whole, incurred in defending any actions raised against them personally, providing they are acting:-

(i) within the course of their employment;

(ii) In accordance with the Employer's procedures;

(iii) In good faith;

3.13 To respond to consultation papers unless the response recommends a departure or significant development of IJB policy or procedure or is contrary to a standing instruction of the IJB;

3.14 To amend the organisational structures of their Services including the number and designation of posts subject to the following conditions:

(i) The IJB has approved;

(ii) The Council and Health Board and their respective Trade Union partnerships have been consulted and their views taken into account;

(iii) The costs of the amendments are within the existing revenue budget and this is confirmed by the Chief Finance Officer;

(iv) The Head of Human Resources of the Employer approves the grading, conditions of service and designation of posts;

3.15 In accordance with the Employer's approved Disciplinary and Incapability Procedures, take disciplinary action including dismissal, as appropriate in respect of employees in their relevant Service and in consultation with the Employer's Head of HR, or equivalent;

3.16 Action virement within the overall revenue budgets for their Services in accordance with the Financial Regulations and Codes of Financial Practice subject to confirmation by the Chief Finance Officer or representative.

4 DELEGATIONS TO OFFICERS - SPECIFIC PROVISIONS: CHIEF OFFICER

4.1 Chief Officer

4.1.1 The Chief Officer of the IJB, in addition to his/her strategic role is placed at the disposal of the Chief Executives of the Parties by the IJB, to manage the operational services in line with the Direction of the IJB.

4.1.2 The Chief Officer will be the principal advisor to and officer of the IJB and will provide overall strategic and operational advice to the IJB

4.1.3 The Chief Officer is responsible for the operational management and performance of services delegated to the IJB by Council and Health Board, with the exception of NHS Acute Services

4.1.4 The Chief Officer is the Leader of the IJB's Management Team and has overall responsibility for the following:-

- Strategic management of IJB services;
- Strategy and Policy Development;
- Leading Improvement.

4.1.5 The following general functions of the IJB are delegated to the Chief Officer:

(i) To act as the principal policy adviser to the IJB on matters of general policy and to assist the IJB to formulate clear objectives and affordable programmes having regard to changing priorities, statutory and financial requirements and community needs and expectations;

(ii) To ensure that a corporate approach to the management and execution of the IJB's affairs is maintained and that advice to the IJB is given on a co-ordinated basis;

(iii) To monitor the performance of all directly reporting employees.

(iv) To take such action as may be required to ensure that the correct significance is given by the Employer's employees to the achievement of the overall policy objectives of the IJB;

(v) To give direction on the applicability of this Scheme of Delegation to Officers and where appropriate that any Officer shall not exercise a delegated function;

(vi) To consider and deal with any urgent issues arising during a vacation period, subject to reporting back to the IJB at the first available opportunity. This power is to be exercised in consultation with the Chairperson or Vice-Chairperson, if available, of the IJB;

(vii) To maintain good internal and external public relations;

(viii) To exercise functions relating to the identification, planning and mitigation of risks affecting the IJB;

(ix) Duties relating to business continuity, including identification of issues, business continuity planning, liaison with external bodies and putting in place arrangements to deal with business continuity issues;

(x) Support and assistance to IJB services to enable them to comply with duties under the Health and Safety at Work Act 1974 and other legislation relating to health and safety;

(xi) To be the primary point of contact in matters relating to the health and safety of premises or services used by employees in the pursuance of delegated functions to the IJB;

(xii) All powers ancillary to or reasonably necessary for the proper performance of the Chief Officer's general duties and responsibilities.

4.1.6 In the exercise of delegated matters of material or reputation significance, the Chief Officer will nonetheless report such matters to the IJB at the first available opportunity.

4.2 **Delegated Functions and Services of the Council**

4.2.1 The Chief Officer is responsible for the leadership and co-ordination, planning and policy and the strategic and operational management of social care functions as set out in the East Dunbartonshire Health and Social Care Integration Scheme, subject to the provisions and exceptions as set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Regulations 2014).

4.2.1 The Chief Officer will also support the Chief Social Work Officer in the discharge of his or her specific functions in line with the East Dunbartonshire Chief Social Work Officer Governance and Accountability Protocol.

4.3 In pursuance of the above delegated functions, the Chief Officer has overall responsibility for social care services as set out in the East Dunbartonshire Health and Social Care Integration Scheme.

4.4 **Delegated Functions and Services of the Health Board**

4.4.1 The Chief Officer is responsible for the leadership and co-ordination, planning and policy and the strategic and operational management of health care functions as set out in the East Dunbartonshire Health and Social Care Integration Scheme, subject to the provisions and exceptions as set out in the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Regulations 2014).

4.5 In pursuance of the above delegated functions, the Chief Officer has overall responsibility for the following health care services, as defined in Section 3. Parts 1, 2 and 3 of the Regulations in exercise of the powers conferred by Sections 1(6), 1(8), and 69(1) of the Public Bodies (Joint Working) (Scotland) Act 2014, and subject to the terms of the East Dunbartonshire Health and Social Care Integration Scheme.

4.6 The Chief Officer is also responsible for and has delegated to her/him the responsibility for certain services of the Health Board, both within East Dunbartonshire and on a pan-Greater Glasgow and Clyde basis. The specific pan-Greater Glasgow and Clyde services are listed in the Integration Scheme between East Dunbartonshire Council and the Health Board approved by Scottish Ministers.

5 DELEGATIONS TO OFFICERS - SPECIFIC PROVISIONS: CHIEF FINANCE OFFICER

5.1 The Chief Finance Officer has overall responsibility for Audit; Financial Management and any direct procurement by the IJB (subject to the terms of 5.2 (vii) below).

5.2 The Chief Finance Officer is responsible for the leadership and co-ordination, planning and policy and the strategic and management of the following services and without prejudice to the foregoing generality, such powers include the power to:-

Finance

(i) Act as the Proper Officer responsible for the administration of the financial affairs of the IJB in terms of section 95 of the Local Government (Scotland) Act 1973;

(ii) To prepare Financial Regulations and relevant Codes of Practice of the IJB for the control of all expenditure and income;

(iii) The monitoring of the IJB's revenue budgets during the course of each financial year and reporting thereon to the IJB;

(iv) Determine all accounting procedures and financial record keeping of the IJB;

(v) Subject to the approval of the Chief Officer and in conformity with any Financial Regulations and any approved policy, authorise the transfer of approved estimates from one head of expenditure to another, within a Service estimate, unless it is considered to materially affect the approved budget, in which case authorisation of the IJB will be sought;

(vi) To arrange appropriate provision for insurance according to the Risk Management strategy;

(vii) To have financial oversight of any procurement entered into directly by the Health and Social Care Partnership or the Chief Officer (but not procurement carried out on behalf of the Partnership or Chief Officer by a Council or Health Board) including if appropriate entering into framework agreements, central purchasing arrangements, maintenance of a standing list of approved contractors, preparation of advice and policies relating to procurement.

6 DELEGATIONS TO OFFICERS - SPECIFIC PROVISIONS: INTERNAL AUDIT

6.1 The operational delivery of services within the Council and Health Board as directed by the IJB will be subject to the internal audit functions of the respective parties. The IJB will be required to appoint an internal auditor who, on the production of identification and in relation to functions delegated to the IJB may:-

- Enter, at all reasonable times, on any Council and Health Board premises or land;

- Have access to all records, documents and correspondence relating to any financial transaction and such other documents as may be considered to be necessary in verification thereof;
- Require and receive such explanations as are necessary concerning any matter under examination;

(ii) Provide policies, procedures and guidance relating to audit, whistleblowing and defalcation;

(iii) Operate as the primary point of contact with external audit and provide support, information and recommendations to external auditors on IJB matters.

7 DELEGATIONS TO OFFICERS - SPECIFIC PROVISIONS: CHIEF SOCIAL WORK OFFICER

7.1 The requirement for every local authority to appoint a Chief Social Work Officer (CSWO) is set out in section 3 of the Social Work (Scotland) Act 1968. This requirement is for the purposes of the local authority functions under the 1968 Act and the enactments listed in section 5(1B) of the Act. The role provides a strategic and professional leadership role in the delivery of social work services. In addition there are certain functions conferred by legislation directly on the CSWO by name.

7.2 Arrangements to ensure that the CSWO is supported to fulfil his or her role is set out in a separate procedural document entitled: Chief Social Work Officer – Governance and Accountability Protocol.

Agenda Item Number: 10

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	2016/17_10
Subject Title	Chief Social Work Officer: Governance and Accountability Protocol – revision and consultation
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Paolo Mazzoncini, Chief Social Work Officer

1 PURPOSE OF REPORT

1.1 The purpose of this report is to request that the Shadow IJB considers an updated draft Governance and Accountability Protocol that sets out the provisions and limitations to permit the Chief Social Work Officer role to operate across the Council and the Health and Social Care Partnership in East Dunbartonshire.

2 SUMMARY

2.1 Policy and guidance relating to the integration of health and social care services, as established by the Public Bodies (Joint Working) (Scotland) Act 2014, provide that the functions of the Chief Social Work Officer (as a Proper Officer of the Council) may not be delegated to an Integration Joint Board. It also recommends that the Chief Officer of the Integration Joint Board does not additionally carry the role of Chief Social Work Officer.

2.2 The overall function of the Chief Social Work Officer (CSWO) is to ensure the provision of effective, professional advice to local authorities, both elected members and officers, in the authority's provision of social work services. The role should assist the authority in understanding the complexities of social work service delivery, including particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders and also the key role social work plays in contributing to the achievement of national and local outcomes. The CSWO also has a role to play in overall performance improvement and the identification and management of corporate risk insofar as they relate to social work services.

2.3 Clarity and consistency as to the purpose and contribution of the CSWO will be important in the context of the delegation of functions and duties to the Integration Joint Board, and its subsequent direction to the Council to deliver or arrange social work and social care services in line with its Strategic Plan.

2.4 In addition to the CSWO holding a Proper Officer role, the postholder holds an organisational post, which up until the extension of functional delegation to the HSCP Board, was as the Council's Head of Social Work Children and Criminal Justice Services. With the transfer of these functions to the HSCP Board, this

postholder will consequently transfer into the HSCP and will continue to be CSWO.

2.5 It is important to clarify the relationship between the Integration Chief Officer and the CSWO, and also between the Council and the Integration Joint Board with respect to the duties and responsibilities of the CSWO. The role of the CSWO in supporting safe and effective social work functions, in this context, will have to be clearly established in a way that allows for these duties to be delivered without undermining devolved decision-making.

2.6 A protocol at **Appendix 1** sets out a set of principles and practical arrangements that aim to provide clarity on the role of the CSWO, and to provide the CSWO with sufficient information to permit an informed and proportionate oversight of Social Work functions within the Partnership. This protocol was originally approved by the Shadow IJB on 4 June 2015, but has now been updated to reflect the change of location of the CSWO from being a postholder within the Council to being a postholder within the HSCP. The role will primarily be to support the Integration Chief Officer who will also seek the advice of the CSWO on matters that reflect the duties of the CSWO. It is expected that any concerns or issues that may arise will be discussed and resolved, with the involvement of the Council Chief Executive, if necessary.

2.7 This amended CSWO Governance and Accountability Protocol will be considered for approval by the Council's Social Work Committee at its next meeting. The HSCP Board is asked to consider the draft Protocol and provide any comments they may have on its contents.

3 **RECOMMENDATIONS**

3.1 It is recommended that the Health and Social Care Partnership Board:

(a) Considers the amended draft Chief Social Work Officer Governance and Accountability Protocol set out at **Appendix 1**, providing any comments to the Chief Officer.

Appendix 1

East Dunbartonshire Council

NHS Greater Glasgow and Clyde

East Dunbartonshire Health and Social Care Partnership

Chief Social Work Officer – Governance and Accountability Protocol

1 Introduction

1.1 Policy and guidance relating to the integration of health and social care functions and services, as established by the Public Bodies (Joint Working) (Scotland) Act 2014, provide that the role and functions of the Chief Social Work Officer (as a Proper Officer of the Local Authority) may not be delegated to an Integration Joint Board. It also recommends that the Chief Officer of the Integration Joint Board does not additionally carry the role of Chief Social Work Officer. This protocol sets out the arrangements that allow the Chief Social Work Officer role to operate across the Local Authority and the Health and Social Care Partnership in East Dunbartonshire.

2 Summary of Chief Social Work Officer (CSWO) Role

2.1 The term "proper officer" describes the principal statutory officers of the Local Authority who, alongside their day to day roles, have specific responsibilities as set out in legislation. The main statutory officers of the Local Authority are the Head of Paid Service (the Chief Executive), the Monitoring Officer, the Chief Financial Officer and the Chief Social Work Officer.

2.2 The key role of the Chief Social Work Officer (CSWO) is to ensure the provision of effective, professional advice to Local Authority elected members and officers, notably the Chief Executive, in the authority's provision of social work services. The CSWO must have direct access to these individuals. The role should assist the authority in understanding the complexities of social work service delivery, including particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders. The CSWO also has an important role to play in explaining the valuable contribution that social work and social care services play in the achievement of national and local outcomes.

2.3 The CSWO also has a significant role to play in performance improvement, workforce and organisational development and in the identification and management of corporate risk insofar as they relate to social work and social care services. It is vitally important that there is clarity about the purpose and contribution of the CSWO given the new arrangements that exist with the development of the Integrated Joint Board and the establishment of the East Dunbartonshire Health and Social Care Partnership.

2.4 Social work and social care services are delivered within a framework of statutory duties and powers. These services are required to meet national standards and guidance and to provide best value. They are also subject to external scrutiny and inspection. Where appropriate, the services are delivered in partnership with a range of other agencies and designed in conjunction with the people who will use them and relevant stakeholders.

2.5 The role of the Chief Social Work Officer is to provide professional governance, leadership and accountability for the delivery of social work and social care services, whether these be provided by the local authority, or through a delegated body or purchased/commissioned from the voluntary or private sector,

2.6 In addition, there is a small number of duties and decisions that relate primarily to the curtailment of individual freedom, the protection of both individuals and the public, and the welfare of vulnerable children and adults which must be made either by the Chief Social Work Officer or by a professionally qualified social worker to whom the responsibility has been delegated by the Chief Social Work Officer and for which the latter remains accountable. Statutory Guidance on the role and function of CSWO is provided in **Appendix 1**. It should be noted that the guidance advises that '*The local authority must have regard to this guidance. It must follow both the letter and the spirit of the guidance. It must not depart from the guidance without good reason.*'

2.7 Complementary to this statutory guidance on the role of the CSWO is additional Scottish Governance guidance on The Role of the Registered Social Worker in Statutory Interventions. This is one of the key products developed by the Practice Governance Group, one of the five change programmes set up as part of the Government's response to *Changing Lives,* the 21st Century Social Work Review. A copy of this is attached at Appendix 2.

3 Governance and Accountability

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work and social care functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

3.2 It is important to clarify the relationship between the Integration Chief Officer and the Chief Social Work Officer, and also between the Local Authority and the Integration Joint Board with respect to the duties and responsibilities of the CSWO. It is important to state at the outset that the role of the CSWO will not extend to a power of veto over the strategic or operational functions delegated to the Integration Joint Board (led by the

Integration Chief Officer), any more than it did when the functions sat within the Local Authority.

3.3 It is also important to be clear that the responsibility for quality and performance of processes, services and outcomes within the Partnership will rest with Integration Chief Officer. The role of the CSWO will be to ensure that, with respect to statutory social work functions, he or she has a line of sight and is satisfied that these arrangements are in place and being effectively delivered, and to have clear reporting lines with respect to these duties.

3.4 It is contextually relevant to distinguish between the two separate functions of the Integration Joint Board (and accordingly, the Integration Chief Officer), i.e. the strategic and the operational.

(i) The strategic planning and commissioning function will be set out in the Strategic Plan, which will be developed, delivered and monitored by the Integration Joint Board. Neither constituent body, acting alone, has the power of call-in over the Strategic Plan. This may only be done when the constituent bodies jointly agree that the Strategic Plan is unable to deliver the integration principles or statutory functions. A key role of the CSWO will be to provide that advice to the Council's Chief Executive.

(ii) The operational function involves a different set of accountabilities. The Integration Joint Board directs the Parties (the Council and NHS Board) to deliver services in accordance with the Strategic Plan. The Integration Joint Board will make available the Chief Officer to manage these operational services (and contracts) on behalf of the constituent bodies and also report to the respective Chief Executives in this regard. The Integration Joint Board will retain operational oversight to ensure that services are delivered in line with the Strategic Plan and operate within acceptable quality and cost parameters. The role of the CSWO in supporting safe and effective social work functions, in this context, will be clearly established in a way that allows for these duties to be delivered without undermining devolved decision-making.

4 Duties of the Integration Joint Board and linkages to the duties of CSWO

4.1 The Integration Joint Board is required to enable the CSWO to carry out his/her general and specific duties as set out in the Statutory Guidance. The Integration Joint Board will be responsible for ensuring that proper access and support is provided to establish and maintain these arrangements:

- Membership of the Integration Joint Board in a non-voting capacity;
- Membership of an East Dunbartonshire Health and Social Care Partnership Professional Advisory Group (or equivalent);
- Co-signatory (on behalf of the Council's Chief Executive) of the Partnership's Risk Assessment and Management Plan;
- Full membership of the Adult Protection Committee;
- Sign-off to the Partnership's Employee Training & Development Plan (relating to Social Work and Social Care employees), and invitation to any associated meetings (lead role retained by Chief Officer);
- Sign-off to the Partnership's appraisal and employee professional supervision procedures, relating to Social Work and Social Care employees;
- Full access to Social Work and Social Care casefiles, for professional scrutiny purposes or as part of any self-evaluation activity, etc.;
- Lead counter-signatory for Scottish Social Services Council registration processes;
- Receipt of quarterly reports on complaints, complaint handling and outcomes relating to Social Work and Social Care employees and/or services within the Partnership, and prompt notification and consultation on all complaints that reach Stage 2 investigation (lead role retained by Chief Officer, in conjunction with relevant professional leads);
- Notification and consultation on all disciplinary matters relating to Social Work and Social Care employees within the Partnership (lead role retained by Chief Officer);
- Notification of and consultation on all external regulation and inspection relating to Social Work and Social Care services within the Partnership (lead role retained by Chief Officer for delegated services);
- Receipt of contract compliance reports relating to commissioned social care services and notification of all improvement notices imposed on external services and associated actions by the Partnership (lead role retained by Chief Officer).
- Authorship of an annual Chief Social Work Officer report, as set out in national guidance. This report will encompass social work and social care functions within East Dunbartonshire and will be reported to both the Local Authority and to the Integration Joint Board.

4.2 The engagement of the CSWO in the processes outlined at 4.1 is designed to provide him/her with sufficient information to permit an informed and proportionate oversight of Social Work functions within the Partnership. The role will in the first instance be to support the Integration Chief Officer who will also seek the advice of the CSWO on matters that reflect the duties of the CSWO.

5 Duties of the Local Authority

5.1 The Local Authority is required to enable the CSWO to carry out his/her general and specific duties as set out in the Statutory Guidance. The Local Authority will ensure that appropriate arrangements are in place to include the CSWO in relevant strategic and operational forums that provide direct access to the Chief Executive and elected members so that the CSWO is in an optimum position to support and advise them in regard to their social work function responsibilities in their partnership contexts. In order to facilitate compliance with Sections 19 - 25 of the Statutory Guidance, the CSWO will be routinely invited to attend the Council or appropriate Council Committees remitted to oversee its statutory responsibilities under section 5 (1B) of the Social Work (Scotland) Act 1968.

5.2 The CSWO is required to report to the local authority Chief Executive, elected members and IJB – providing comment on issues which may identify risk to safety of vulnerable people or impact on the social work service and also on the findings of relevant service quality and performance reports, setting out:

- implications for the local authority, for the IJB, for services, for people who use services and support and carers, for individual teams/members of staff/partners as appropriate;
- implications for delivery of national and local outcomes;
- proposals for remedial action;
- means for sharing good practice and learning;
- monitoring and reporting arrangements for identified improvement activity.

5.3 The CSWO is also required to produce and publish a summary annual report for local authorities and IJBs on the functions of the CSWO role and delivery of the local authority's social work services functions. As a Director of the Council and a member of its Corporate Management Team, the IJB Chief Officer will ensure that the CSWO is enabled to inform and influence corporate issues, such as managing risk, setting budget priorities and public service reform, in compliance with the Statutory Guidance.

6 Dispute Resolution

6.1 It is expected that any concerns or issues that may arise will in the first instance be discussed and resolved between the Chief Officer and the

CSWO, with the involvement of the Council Chief Executive if deemed necessary by either the Chief Officer or the CSWO.

6.2 In the event that any matter(s) remain(s) unresolved, a report will be prepared by the Council's Chief Executive for consideration by the Integration Joint Board, setting out the issues and presenting clear options for proceeding on the matter. The Integration Joint Board may then decide on the way forward.

6.3 If following the process outlined at 5.2, the CSWO has continued concerns regarding the effective discharge of statutory social work functions, he/she may act raise concerns with the local authority Elected Members via a report to the Council or an appropriate committee of the Council, in accordance with S16 of the Statutory Guidance set out at **Appendix 1**.

6.4 If the Chief Executive of either the Council or the Health Board believes that a decision of the Integration Joint Board relates to a particular application or interpretation of the Strategic Plan that may be contrary to the delivery of the integration principles or statutory obligations, then he/she may take steps to secure joint agreement on the replacement of the Strategic Plan, as set out in Guidance.

6.5 Further detail on the process for dispute resolution is set out in the Integration Scheme.

Appendix 2

The Role of Chief Social Work Officer

Guidance Issued by Scottish Ministers
pursuant to Section 5(1) of the Social Work (Scotland) Act 1968

Revision of Guidance First Issued In 2009

Revised Version – July 2016

This guidance has been developed in partnership with local government and supported by COSLA

July 2016

The Scottish Government
Riaghaltas na h-Alba

INTRODUCTION

1. The Social Work (Scotland) Act 1968 (the 1968 Act) requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions.

2. This document contains statutory guidance. It is issued to local authorities by Scottish Ministers under section 5 of the 1968 Act. The local authority must have regard to this guidance. It must follow both the letter and the spirit of the guidance. It must not depart from the guidance without good reason. The Guidance replaces guidance previously issued in 2009.

PURPOSE

3. The guidance is for local authorities and will also be of use to bodies and partnerships to which local authorities have delegated social work functions. Local authorities must have regard to this guidance when carrying out their functions under the 1968 Act. Recognising the democratic accountability which local authorities have in this area, clarity and consistency about the role and contribution of the CSWO are particularly important given the diversity of organisational structures and the range of organisations and partnerships with an interest and role in delivery of social work services.

4. This guidance summarises the minimum scope of the role of the CSWO. It will assist elected members in ensuring that the role is delivered effectively and that the local authority derives maximum benefit from the effective functioning of the role. Effective delivery of and support for the role will assist local authorities to be assured that there is coherence and effective interfacing across all of their social work functions.

5. The guidance is intended to:

(a) support local authorities in effective discharge of responsibilities for which they are democratically accountable;

(b) help local authorities maximise the role of the CSWO and the value of their professional advice – both strategically and professionally;

(c) provide advice on how best to support the role so that the CSWO can be effective in their role both within the local authority and in regard to other entities, such as Community Planning Partnerships, whilst recognising that local authorities operate with different management and organisational structures and in different partnership landscapes;

(d) assist Integration Joint Boards (IJBs) to understand the CSWO role in the context of integration of health and social care brought in through the Public Bodies (Joint Working) (Scotland) Act 2014 (the 2014 Act).

(e) be read alongside the wide range of guidance relevant to social work functions of local authorities and relevant guidance issued relating to the 2014 Act.

(f) be sufficiently generic to remain relevant in the event of future management or organisational structural change.

REQUIREMENT

6. The requirement for every local authority to appoint a Chief Social Work Officer is set out in section 3 of the 1968 Act. This requirement is for the purposes of the local authority functions under the 1968 Act and the enactments listed in section 5(1B) of the Act. The role provides a strategic and professional leadership role in the delivery of social work services. In addition there are certain functions conferred by legislation directly on the CSWO by name.

7. The Scottish Office explicitly recognised that the need for the role was driven by "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not.*" (Circular: SWSG2/1995 May 1995)

8. The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

THE CHIEF SOCIAL WORK OFFICER ROLE

Overview

9. The CSWO role was established to ensure the provision of appropriate professional advice in the discharge of a local authority's statutory functions as described in paragraph 6. The role also has a place set out in integrated arrangements brought in through the 2014 Act. As a matter of good practice it is expected that the CSWO will undertake the role across the full range of a local authority's social work functions to provide a focus for professional leadership and governance in regard to these functions.

10. The CSWO should assist local authorities and their partners in understanding the complexities and cross-cutting nature of social work service delivery – including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk.

11. It is for local authorities to determine the reporting and management structures that best meet their needs. Where the CSWO is not a full member of the senior management team or equivalent, elected members must satisfy themselves that the officer has appropriate access and influence at the most senior level and is supported to deliver the complex role described in this guidance.

Competencies

12. Scottish Ministers' requirement is that the CSWO role will be held by a person who is qualified as a social worker and registered as such with the Scottish Social Services Council. Local authorities will also want to require this as they will need to ensure that the CSWO:

- can demonstrate extensive experience at a senior level of both operational and strategic management of social work and social care services and;
- has the competence and confidence required to provide effective professional advice at all levels within the organisation and with the full range of partner organisations
- receives effective induction to support them in full delivery of their role

(NB At the time of writing, SI 1996/515, which sets out minimum qualifications for a CSWO is being reviewed with a view to amendment so that the social work degree is specifically included.)

13. Further information on the skills and competencies required of a CSWO is available in the Standard for Chief Social Work Officers (issued by the Scottish Social Services Council in July 2015) which underpins the Level 11 Award for CSWOs which was launched in August 2015 as a further professional accredited qualification aimed at enhancing CSWO competence.

Scope

14. The scope of the role relates to the functions outlined in paragraph 6 whether provided directly by the local authority; through delegation to another statutory body or in partnership with other agencies. Where social work services and support are commissioned on behalf of the authority, including from the independent and voluntary sector, the CSWO has a responsibility to advise on the specification, quality and standards of the commissioned services and support. The CSWO also has a role in providing professional advice and guidance to an Integration Joint Board or NHS Board to which social work functions have been formally delegated.

Responsibility for values and standards

15. The CSWO should:

(a) promote values and standards of professional practice, including all relevant national Standards and Guidance, and ensure adherence with the Codes of Practice issued by the Scottish Social Services Council for social service employers.

(b) work with Human Resources (or equivalent function) and responsible senior managers to ensure that all social service workers practice in line with the SSSC's Code of Practice and that all registered social service workers meet the requirements of the regulatory body;

(c) establish a Practice Governance Group or link with relevant Clinical and Care Governance arrangements designed to support and advise managers in maintaining and developing high standards of practice and supervision in line with relevant guidance, including, for example, - the *Practice Governance Framework: Responsibility and Accountability in Social Work Practice* (SG 2011);

(d) ensure that the values and standards of professional practice are communicated on a regular basis and adhered to and that local guidance is reviewed and updated periodically.

16. The CSWO must be empowered and enabled to provide professional advice and contribute to decision-making in the local authority and health and social care partnership arrangements, raising issues of concern with the local authority Elected Members or Chief Executive, or the Chief Officer of the Integration Joint Board as appropriate (or the Chief Executive of a Health Board if appropriate in the context of a lead agency model), in regard to:

(a) effective governance arrangements for the management of the complex balance of need, risk and civil liberties, in accordance with professional standards.

(b) appropriate systems required to 1) promote continuous improvement and 2) identify and address weak and poor practice.

(c) the development and monitoring of implementation of appropriate care governance arrangements;

(d) approaches in place for learning from critical incidents, which could include through facilitation of local authority involvement in the work of Child Protection Committees, Adult Support and Protection Committees and Offender Management Committees where that will result in the necessary learning within local authorities taking place;

(e) requirements that only registered social workers undertake those functions reserved in legislation or are accountable for those functions described in guidance;

(f) workforce planning and quality assurance, including safe recruitment practice, probation/mentoring arrangements, managing poor performance and promoting continuous learning and development for staff;

(g) continuous improvement, raising standards and evidence-informed good practice, including the development of person-centred services that are focussed on the needs of people who use services and support;

(h) the provision and quality of practice learning experiences for social work students and effective workplace assessment arrangements, in accordance with the SSSC Code of Practice for Employers of Social Service Workers;

Decision-Making

17. There are a small number of areas of decision-making where legislation confers functions directly on the CSWO by name. These areas relate primarily to the curtailment of individual freedom and the protection of both individuals and the public. Such decisions must be made either by the CSWO or by a professionally qualified social worker, at an appropriate level of seniority, to whom the responsibility has been formally delegated and set out within local authority arrangements. Even where responsibility has been delegated, the CSWO retains overall responsibility for ensuring quality and oversight of the decisions. These areas include:

- deciding whether to implement a secure accommodation authorisation in relation to a child (with the consent of a head of the secure accommodation), reviewing such placements and removing a child from secure accommodation if appropriate;
- the transfer of a child subject to a Supervision Order in cases of urgent necessity;
- acting as guardian to an adult with incapacity where the guardianship functions relate to the personal welfare of the adult and no other suitable individual has consented to be appointed;
- decisions associated with the management of drug treatment and testing orders
- carrying out functions as the appropriate authority in relation to a breach of a supervised release order, or to appoint someone to carry out these functions.

18. In addition to these specific areas where legislation confers functions on all CSWOs, there will be a much larger number of areas of decision-making which have been assigned by individual local authorities to Chief Social Work Officers reflecting "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not*" noted in paragraph 7. These areas may include responsibilities assigned through guidance or other routes. For example:

- the 2014 guidance on Multi Agency Public Protection Arrangements (MAPPA) makes explicit reference to the role of the CSWO in responsibility for joint arrangements, in co-operation with other authorities.
- although mental health services are delegated to Integration Joint Boards, some of these functions require to be carried out by local authority officers with a social work qualification (Mental Health Officers). Local authorities will want to be reassured via the CSWO that these functions are discharged in accordance with professional standards and statutory requirements

It is for each local authority to make transparent which additional specific areas of responsibility in regard to their social work functions they have assigned to their CSWO

Leadership

19. The CSWO is responsible for providing professional leadership for social workers and staff in social work services. The CSWO should:

(a) support and contribute to evidence-informed decision making and practice – at professional and corporate level – by providing appropriate professional advice;

(b) seek to enhance professional leadership and accountability throughout the organisation to support the quality of service and delivery;

(c) support the delivery of social work's contribution to achieving local and national outcomes;

(d) promote partnership working across professions and all agencies to support the delivery of integrated services;

(e) promote social work values across corporate agendas and partner agencies.

The CSWO role in the context of partnerships and integration

20. In the context of Health and Social Care Integration and the 2014 Act, the CSWO is required to be appointed as a non-voting member of the Integration Joint Board (IJB) (or, in lead agency models, the Integration Joint Monitoring Committee). Scottish Ministers are strongly of the view that the influence of high quality professional leaders in the integrated arrangements is central to the effectiveness of improving the quality of care locally and nationally.

21. The CSWO also has a defined role in professional and clinical and care leadership and has a key role to play in Clinical and Care Governance systems which support the work of the Integration Joint Board, as set out in the partnership Integration Schemes and relevant guidance.

22. The local authority should ensure that appropriate arrangements are in place to include the CSWO in relevant strategic and operational forums that provide direct access to the Chief Executive and elected members so that the CSWO is in an optimum position to support and advise them in regard to their social work function responsibilities in their partnership contexts.

Reporting

23. The CSWO has a role in reporting to the local authority Chief Executive, elected members and IJBs – providing comment on issues which may identify risk to safety of vulnerable people or impact on the social work service and also on the findings of relevant service quality and performance reports, setting out:

- implications for the local authority, for the IJB, for services, for people who use services and support and carers, for individual teams/members of staff/partners as appropriate;
- implications for delivery of national and local outcomes;
- proposals for remedial action;
- means for sharing good practice and learning;
- monitoring and reporting arrangements for identified improvement activity.

24. The CSWO should also produce and publish a summary annual report for local authorities and IJBs on the functions of the CSWO role and delivery of the local authority's social work services functions (however these are organised or delivered). A template for this report is available from by the Office of the Chief Social Work Adviser, Scottish Government.

ACCESS, ACCOUNTABILITY AND REPORTING ARRANGEMENTS

25. To discharge their role effectively, the CSWO will need:

(a) direct access to people and information across the local authority, including the Chief Executive, elected members, managers and frontline practitioners and also in partner services, including in Health and Social Care Partnerships. Specific arrangements will vary according to individual councils, but should be clearly articulated locally;

(b) to be able to bring matters to the attention of the Chief Executive to ensure that professional standards and values are maintained;

(c) to be visible and available to any social services worker and ensure the availability of robust professional advice and practice guidance;

(d) to provide professional advice as required to senior managers across the authority and its partners in support of strategic and corporate agendas.

26. Local authorities will need to agree:

(a) how the CSWO is enabled to inform and influence corporate issues, such as managing risk, setting budget priorities and public service reform;

(b) the specific access arrangements for the CSWO to the Chief Executive and elected members;

(c) the relationships, responsibilities and respective accountabilities of service managers and the CSWO;

(d) a mechanism to include an independent, professional perspective to the appointment of the CSWO;

(e) procedures for removal of a CSWO postholder, bearing in mind the need for continuity in the provision of the CSWO functions, the value of independent professional advice and the arrangements for the appointment and removal of the local authority's other proper officers;

(f) clear and formal deputising arrangements (with similar skills and experience available) to cover any period of absence by the CSWO and appropriate delegation arrangements where scale of business requires this.

27. This document complements the wide set of guidance underpinning the delivery of safe, accountable and effective social work practice and high quality social services in Scotland.

THE ROLE OF THE REGISTERED SOCIAL WORKER IN STATUTORY INTERVENTIONS: GUIDANCE FOR LOCAL AUTHORITIES

Introduction

1. The overarching purpose of the Scottish Government [1] is to focus government and public services on creating a more successful country with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.

2. The purpose of this guidance for local authorities is to set out those social work functions which only registered social workers should be accountable for.

3. Highly trained and skilled social workers make specific contributions to a range of complex circumstances which may or may not involve formal statutory intervention, and it is essential that that continue. It is not the purpose of this guidance to reflect every aspect of what social workers contribute to achieving better outcomes for individuals, families and communities. The scope is limited to where there is a need for statutory intervention. Identifying the role of the registered social worker in those areas where there is a need for statutory intervention does not constrain using social work skills creatively, often working with others, in early intervention and preventing risk factors developing into crises. Nothing in this guidance is intended to detract from the engagement of social workers, often working with others, in non statutory interventions.

4. This guidance complements the *Guidance on the Role of Chief Social Work Officer*[2] and the Practice Governance Framework [3] produced as part of a national suite of materials from *Changing Lives*[4]. In addition work is underway on revision of the 1998 document, *Protecting Children - A Shared Responsibility*[5] to reflect evolving national polices and help embed best practice, including the key role for registered social workers.

Context

5. "The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" [6]

6. To make changes in their lives, people assess how to meet need, recognise and manage risk to themselves and others and do this in the context of balancing often competing rights and responsibilities. Through their relationships, social workers help people analyse where they are, work out where they want or need to be, and can be the catalyst for change.

7. Alongside other key professions, social work has an important contribution to make to realising notions of citizenship, inclusivity, fairness and service improvement embedded in the national outcomes in the Performance Framework. While social work can

justifiably claim to play some part in all the national outcomes, there are some where this contribution is central.

8. While not exclusive to social work, promotion of personalised solutions has always been important; engaging with people who use support or services, carers, families and communities being the hallmark of effective social work practice. Personalisation is a key means of ensuring that people have the support or services that meet their needs and priorities and address their personal circumstances. The promotion of Citizen Leadership [7] supports this as does a focus on outcomes rather than process or procedure.

9. Effective social work requires a range of professional skills, in particular the ability to make and contribute to holistic, often multi-agency, assessments of the circumstances with people. It also requires co-operation and close working relationships between social workers, people who use services, carers, providers of care in the private and third sector and other professionals - in health, education, housing, employment and justice services. The ability to draw together a diverse range of opinions, develop and agree solutions that both promote the wellbeing of the individual and manage the risk to an individual and/or the public, particularly where risks and needs are complex, is a key skill of the social worker. Promotion of health and well-being is important as well as the provision of care and support. It is essential that an appropriate balance is struck between managing risk and encouraging self determination. Whilst the former is critical, it is also vital that supports offered to individuals encourage them to be all they can.

The Role of the Registered Social Worker in statutory interventions

10. Local authorities have a statutory responsibility to promote social welfare and partnership working is key to providing high quality and effective support and services. In protecting and promoting the welfare and wellbeing of children, adults at risk and communities, statutory powers may be exercised to address very serious, complex issues. This requires balancing competing needs, risks and rights. In these circumstances, given the far-reaching significance of the decisions being made, it is important that accountability for the exercise of these functions should rest with a registered social worker.

11. Some tasks required in respect of statutory interventions may be undertaken by others than a registered social worker. However, final decisions/making recommendations for statutory intervention drawing on information held by others and work done by them as appropriate, lies with the accountable registered social worker. All social service workers must be able to explain and account for their practice and to have their thinking challenged appropriately [8]. Registered social workers are accountable for their own competence and performance and that of those they line manage. Where they don't have line management responsibility for others who may be involved, accountability for competence and performance remains with the individual and their employer. However, the registered social worker does have responsibility for helping ensure everyone plays their part in discharging their role in respect of the statutory intervention.

Care and Protection

12. Careful and complex decisions as to when and how there may be intervention in the lives of individuals and families may have far-reaching consequences for those concerned and fundamentally affect the future course of their lives. A number of agencies and professionals will contribute to the process. However, it is important for the assurance of all involved, that *accountability* for these important decisions and the subsequent exercise of statutory functions lies with a suitably qualified and trained professional - a registered social worker.

13 So, where either children or adults are:

- in need of protection; and/or
- in danger of serious exploitation or significant harm; and/or
- at risk of causing significant harm to themselves or others; and/or
- unable to give informed consent;

a registered social worker must retain accountability for:

- carrying out enquiries and making recommendations where necessary as to whether or not a person requires to be the subject of compulsory protection measures;
- implementation of the social work component of a risk management plan and take appropriate action where there is concern that a multi-agency plan is not being actioned;
- making recommendations to a children's hearing or court about whether a child should be accommodated away from home;
- making recommendations on behalf of the local authority to a children's hearing or court about permanence or the termination/variation of supervision requirements;
- carrying out the measures identified in the Adoption and Children (Scotland) Act 2007 and The Looked After Children (Scotland) Regulations 2009.

14. The Adult Support and Protection (Scotland) Act 2007 does not require that a 'Council Officer' be a registered social worker. However, where this is the case they, as others deemed as 'Council Officers' for this purpose, must retain accountability for carrying out the measures contained in the Act.

Criminal Justice

15. Criminal justice social work relies on partnership working and so intervention with an offender can be undertaken by a range of professionals, with or without qualifications. However, the functions set out below inform significant judgments impacting on, for example, whether individuals should be returned to prison or be permitted to remain in the community. The requirement for effective risk assessment and risk management means that registered social workers are best placed to ensure safe and accountable practice.

16. Within criminal justice, a registered social worker must retain accountability for:

- provision of all reports to courts which could have an impact on an individual's liberty;
- provision of all reports to the Victims, Witnesses, Parole and Life Sentence division of government as they could impact on public safety and/or on an individual's liberty;
- investigation, assessment, review and implementation of risk management plans and the supervision of those who will be subject to statutory supervision on release from prison;
- while directly undertaking case management work in respect of those who are subject to statutory orders or licences and who are considered to pose a high risk of serious harm.

Mental Health and Adults with Incapacity

17. Mental Health was the first practice area to reserve functions to suitably qualified social workers.

18. Only registered social workers with additional appropriate qualification may:

- carry out the duties of a Mental Health Officer as set out in the Adults with Incapacity Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007;
- carry out the duty to enquire into individual cases where adults with mental disorder may be at risk from others or whose property is at risk or who are putting themselves at risk.

Professional Leadership

19. The requirement for every local authority to appoint a professionally qualified Chief Social Work Officer is contained within Section 3 of the Social Work (Scotland) Act 1968. The qualifications of the Chief Social Work Officer are set down in regulations [9] and there is guidance on the Role of the Chief Social Work Officer [10]. Only a registered social worker may carry out the role of Chief Social Work Officer.

Why a Registered Social Worker

20. Social workers are trained to make assessments taking account of a range of factors including identifying and balancing need, risk, and rights; to deal with behaviour which is abusive; and to intervene to assist and to protect either individuals or communities.

21. To qualify as a registered social worker, an individual must hold an entitling qualification in social work, be registered with the Scottish Social Services Council (SSSC) and comply with the SSSC Code of Practice for Social Service Workers.

22. This provides both probity of actions and assurance to individuals and the wider public interest that judgments about intervening in families to provide protection,

depriving individuals of their liberty for periods of time or managing offenders are being taken by people who are suitably trained, experienced and professionally qualified to make crucial decisions which will have a major impact on people's lives.

23. This does not in any way diminish the contribution of anyone else involved in an individual's support or supervision, nor mean that it is only in this way that registered social workers make a contribution. But rather it clarifies the lines of accountability for specific statutory social work functions. It is for Chief Executives, elected members, Chief Social Work Officers and line managers to ensure that, whatever the configuration of services or functions, only registered social workers are delegated accountability for the exercise of these particular functions. This should be the case even where some tasks within the function may be carried out by other staff, the employer retains overall responsibility for the competence and performance of such staff.

Conclusion

24. This guidance is designed to ensure the best possible use of the valuable resource provided by registered social workers in delivering better outcomes for people and communities in Scotland where statutory intervention is required. It complements the body of guidance developed under *Changing Lives* to ensure the delivery of safe, accountable and effective social work practice, and should be taken forward in conjunction with the Guidance on the Role of the Chief Social Work Officer and the Practice Governance Framework for Social Work Services.

Agenda Item Number: 11

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11th August 2016**
Report Number	**2016/17_11**
Subject Title	**Annual Performance Report (2015-16)**
Report by	**Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager, East Dunbartonshire Health & Social Care Partnership**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide the HSCP Board with the Annual Performance Report 2015-16

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 gave Scottish Ministers the powers to prescribe in legislation the content of the Annual Performance Report that integration authorities are required to prepare. The required content of the Annual Performance Report is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014.

2.2 The Performance Report is key to ensuring the HSCP and local communities are clear on how health and social care integration is performing

2.3 This Report demonstrates progress against the priorities set out in the East Dunbartonshire HSCP Strategic Commissioning 2015-18. Consistent with the Strategic Plan, the report is set out under the heading of each national outcome. The relevant data are provided under each outcome, followed by a description of the performance and actions taken towards meeting the agreed HSCP priorities during 2015/16.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- Note the content of this report
- Approve the Annual Performance Report 2015-16

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

East Dunbartonshire
Health & Social Care Partnership

Annual Performance Report 2015/16

1 Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014, Section 42 obliges all Health and Social Care Partnerships (HSCPs) to prepare and publish a Performance Report setting out an assessment of performance in planning and carrying out the integration function for which they are responsible.

The first performance reports are required to be produced at the end of the reporting year 2016-17. However, East Dunbartonshire HSCP has made the decision to publish a performance report covering the period since the HSCP was established. This first East Dunbartonshire HSCP Annual Performance Report therefore covers the reporting period September 2015- 1st April 2016.

The required content of the Annual Performance Report is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, laying out the minimum expectations on the content under the following headings:

- Assessing Performance in Relation to the National Health and Wellbeing Outcomes
- Reporting on Localities
- Financial Performance and Best Value

And when relevant within the reporting year:

- Inspection of Services
- Review of Strategic Commissioning Plan

This Report is set out in accordance with these headings. The main body of the Report, Section 2, demonstrates progress against the priorities set out in the Strategic Plan. Under the heading of each national outcome, the relevant core indicator data and agreed HSCP key performance indicator data are provided. These are followed by narrative which describes performance and actions taken towards meeting the agreed HSCP priorities during 2015/16. Section 3 describes the arrangements and progress made in establishing localities, and the financial performance is reported in Section 4.

There was no requirement to review the Strategic Plan, and there was no Inspection of HSCP Services during the reporting period of this Report.

2 Assessing Performance in Relation to the National Health & Wellbeing Outcomes

This section sets out the HSCP performance in relation to the National Health and Wellbeing Outcomes. These outcomes provided the framework for the HSCP Strategic Commissioning Plan 2015-18 which set out the planning and delivery of health and social care services, with a focus on the experiences and quality of services for those who use them.

2.1 People are able to look after and improve their own health and wellbeing and live in good health for longer

National Core Indicator	2013/14	2015/16
Percentage of adults able to look after their health very well or quite well	97%	95.1%

HSCP Performance Measure	2015/16 Target	Actual (Mar 2016)
Number of successful smoking quits at 12 weeks in 40% most deprived areas	18	20
Number of alcohol brief interventions delivered	487	625
Rate of drug related deaths (per 100,000 pop per year) (2014)	1.9	3.7
Rate of alcohol related deaths (per 100,000 pop per year) (2014)	25	15.6
Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment (Oct - Dec 15)	91.5%	70.5%
Percentage uptake of Cancer Screening Programmes: Bowel SIMD1 (Apr13 – Mar 15)	60%	46.1%

Supporting the population to adopt healthy lifestyles

The recent Health & Wellbeing Survey (2014) demonstrated that East Dunbartonshire residents were adopting more positive health behaviours than recorded in the previous survey (2011). The findings suggested that people are significantly more active, eating healthier, smoking and drinking less. In addition, local residents reported increased positive mental health and feelings of belonging within their family and community. Whilst these findings are moving in the right direction, there remain significant inequalities across the Authority. Sustained action by all community planning partners and local communities is required to continue to improve universal health and also to reduce the inequality gap.

Tobacco

The East Dunbartonshire Tobacco Control Strategy set out the collective actions by all partners to support communities in becoming increasingly smoke free. Joint work has progressed to enable the public and staff to benefit from smoke free public buildings and grounds across the Authority. Residents trying to quit for the first time have accessed Stop Smoking Pharmacy Services, while those who have experienced several quit attempts have been able to attend more intensive support through the Community Stop Smoking Service. Stop smoking interventions were targeted within PLACE communities. PLACE in East Dunbartonshire is focussed on the most deprived areas of Hillhead, Auchinairn and Lennoxtown, and involves a neighbourhood approach to connecting the physical and social environment to improve health and well being and contribute to reducing inequality. Focussing stop smoking interventions in these areas resulted in an increased number of successful quits at 12 weeks. Almost fifty people living in SIMD 1 and 2 neighbourhoods participated in a new smoking cessation incentive scheme, developed in partnership with Strathkelvin Credit Union. This initiative provides a financial incentive to those who quit smoking, retrieved through opening a bank account and saving with the local Credit Union. A total of £15k was deposited into these accounts during the last year.

Nutrition and Physical Activity

During 2015/16, over one thousand people strived to improve their health and well being through participating in one of the many walking groups across East Dunbartonshire. People experiencing a visual impairment, learning disability, autism or dementia were able to participate in walks designed to meet their specific needs.

Over six hundred people with a mental health problem, or other long term condition, were referred to the local Live Active service to undertake a gym exercise programme. Almost 20% were still participating in the programme after one year.

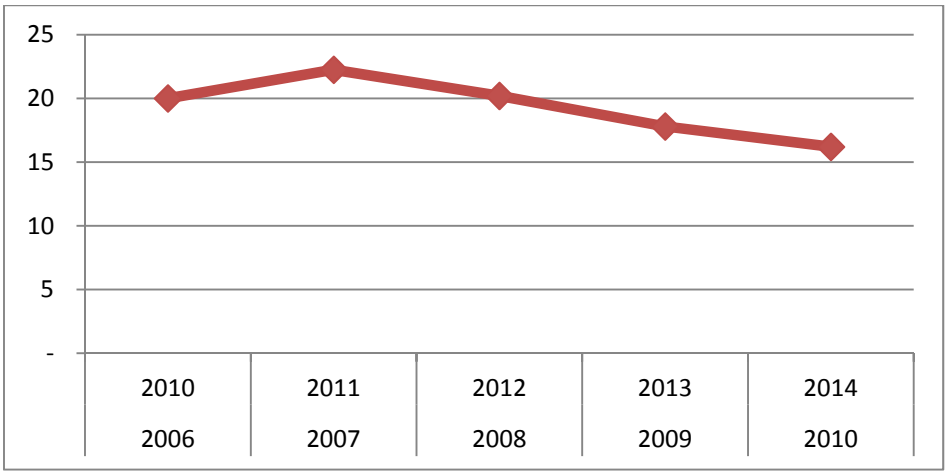
The local Waist Winners weight loss service is delivered through a partnership with East Dunbartonshire Leisure and Culture Trust (EDLCT). In 2015/16 there were twelve programmes rolled out across the Authority and it is anticipated this will increase to fifteen courses in 2016/17. Fifteen people with a learning disability completed a person centred Community Waist Winners programme which was developed to meet their specific needs.

Local communities participated in a range of community food programmes across the Authority, particularly within Place communities. Many of these programmes were delivered through a partnership between HSCP, Education, Children Services, EDLCT and East Dunbartonshire Voluntary Action. The programmes focussed on increasing the knowledge skills and capacity of individuals and communities; incorporating cooking on a budget, healthy meal preparation and food hygiene; accredited Community Chef training and supporting local people to increase cooking skills and cascade their learning to other community members.

Alcohol Brief Interventions

The number of Alcohol Brief Interventions (ABI) delivered across community and primary care settings were over 50% above target. ABIs are undertaken to identify early those with an alcohol issue and provide appropriate advice or treatment. The structured conversations focus on alcohol consumption at a harmful level, and support service users in planning a change in their drinking behaviour to reduce their consumption and risk to health. Services within East Dunbartonshire offer people a range of local approaches and interventions that focus on reducing alcohol consumption through promoting positive attitudes, positive choice; and implementing methods to support legislative compliance. The number of alcohol related deaths in East Dunbartonshire (5yr moving average) has been steadily declining between 2007-11 and 2010-14.

Alcohol-related deaths (5yr moving average)



During 2015/16, community organisations were engaged in alcohol awareness campaigns and festive season workshops. In the interest of protecting public health, the Integrity Test Campaign has proved to be an extremely effective method of ensuring Challenge 25 is implemented in Off-Sales premises across the authority. GPs, pharmacists, HSCP practitioners, schools, prison staff and community groups have participated in training to increase their awareness and support them to address alcohol related issues with service users, families and communities.

2.2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that they are supported to live as independently as possible	82%	88.3%
Percentage of adults supported at home who agree that they had a say in how their held, care or support was provided	76%	86%

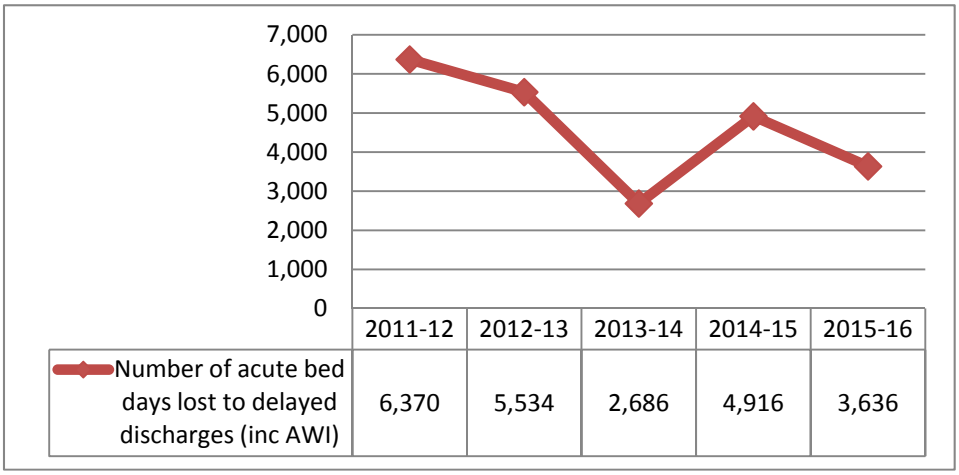
HSCP Performance Measure	2015/16 Target	Actual (Mar 2016)
Rate of unplanned acute bed days 75+ (per 1,000 pop) (Rate at quarter end)	392	372
Number of emergency admissions 75+ rate (per 1,000 pop) (Rate at quarter end)	29	33
Number of acute bed days lost to delayed discharge	3684	3636
Number of acute bed days lost to delayed discharges for Adults with Incapacity (aged 65+)	1596	569
People with a diagnosis of dementia on the QOF register (as at Feb 16)	950	767
Number of newly diagnosed people with Dementia in receipt of one year's post diagnostic support	100%	100%
Number of people 65+ with anticipatory care plans in place (GP & District Nursing)	75	216
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	90%	98.4%
Rate of alcohol related admissions (per 1,000 pop – rolling year)	4.8	4.4
Number of people aged 65+ in permanent care home placement	640	674
Number of people 75+ with a telecare package (Feb'14)	188	176
Percentage of people 65 or over with intensive needs receiving care at home (Percentage at quarter end)	32%	38.1%
Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight	50%	50.9%
Percentage of EDC homecare customers 65+ receiving service at weekends	84%	90.2%

There are a range of health and social care services that support people to remain independent within their community. These include anticipatory care, preventative support, and promotion of self management.

Reducing Emergency Hospital Admissions and Delayed Discharges

The HSCP continues to see a significant decline in bed days lost to delayed discharge which have reduced by 43% since 2011/12. However, during the same five year period, emergency admission rates for people aged 65+ yrs per 1,000 population rose slightly by 6.5%.

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



	2011-12	2012-13	2013-14	2014-15	2015-16
Number of acute bed days lost to delayed discharges (inc AWI)	6,370	5,534	2,686	4,916	3,636

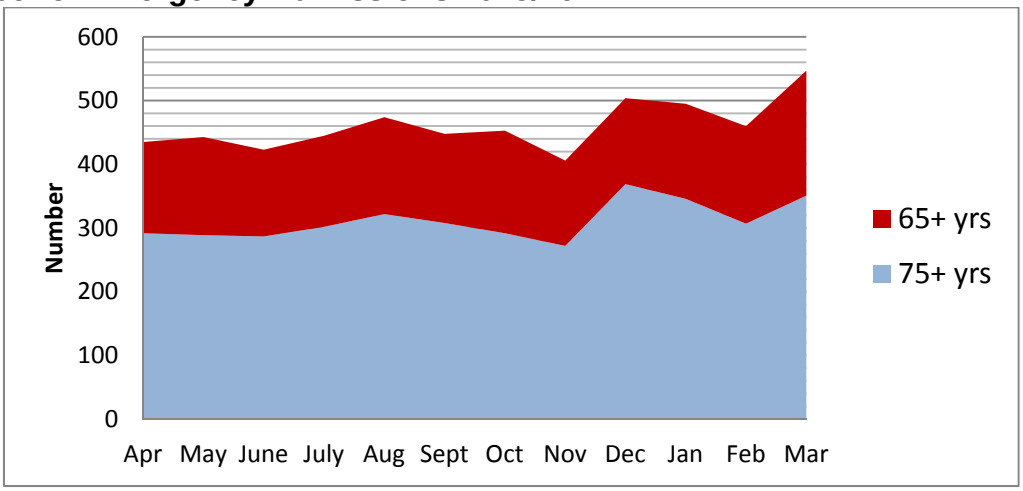
The reduction in bed days lost to delayed discharge has been achieved through the establishment of a weekly delayed Discharge Planning meeting.

A number of interconnected workstreams were funded through the local Integrated Care Fund to test sustainable models for preventing hospital admissions, particularly older people:

- The Re-ablement programme has been completed across all Homecare locality teams.
- Befriending Plus has continued to help people live independently by providing supported assistance to, for example, attend hospital or other appointments, and access and advocacy services. The service has recruited and trained 25 volunteers.
- The Red Cross Hospital at Home Service is a joint initiative with neighbouring HSCPs, and managed by Glasgow HSCP. It has prevented approximately 120 East Dunbartonshire older people from being unnecessarily admitted to hospital by providing transportation overnight, and settling the person back into their home.
- A Rapid Assessment Link team provides GPs with a rapid response service for people who would otherwise be admitted or re-admitted to hospital. The team provide a holistic assessment of need and make onward referrals to Third and Independent sector organisations to provide appropriate support to people within their community. There was an 88% increase in referrals received by the team in 2015 compared to 2014.

- A Consolidation of Resources in Hospital Discharge (AWI) initiative that included extra resources being put in place to support hospital discharge, including Social Workers, Mental Health Officers and a part time solicitor. In addition, there was a successful initiative to raise awareness of Power of Attorney. Zero delays for AWIs aged 75+yrs was achieved, and East Dunbartonshire was one of the lowest ranked HSCPs for bed days occupied by delayed discharges per 1,000 population aged 75+yrs during 2015/16
- The Older People Access Line (OPAL) has been extended to include all adults. OPAL provides a single point of access to statutory and voluntary organisations, projects and activity groups and helps people to identify what would best support their needs to remain independent and connected within their community. For the period 2015/16, OPAL received 361 referrals, and made over 600 onward referrals to a variety of community services and groups.
- The Care and Repair Preventative Service has completed 1,686 small repairs and offered home safety advice and information to over 300 older people to reduce falls and hazards, and help them safely remain within their own homes.

Number of Emergency Admissions 2015/16



A large number of emergency hospital admissions are as a result of a fall. The East Dunbartonshire multiagency Falls Operational Group continues to raise awareness of the prevention and management of falls, and a draft pathway has been developed and will be tested during the next year. HSCP falls data are currently not available for 2015/16. Once this data becomes available, it will be reported in the HSCP Performance Reports.

The HSCP has continued to develop anticipatory care planning with GPs and primary care. Anticipatory care planning encourages people to discuss their desired goals and know where they should seek help should there be any deterioration in their condition. An anticipatory care model for GPs and community nurses has improved co-ordination of care and sharing of information to enable early

intervention and expedite early hospital discharge. During 2015/16 there were 216 anticipatory care plans completed across the HSCP.

The effective working relationship with the Independent Sector has supported a coordinated response to supporting service in Care Homes. *My Home Life* and *Bridging the Gap* have been delivered and evaluated. Care home liaison nurses and pharmacist prescribing support are working with Care homes to support preventative care, including insulin management plans.

Long Term Condition and Self Management

Dementia

The number of people with a diagnosis of Dementia in East Dunbartonshire has risen by over 18% in the year 2015/16. However, the number diagnosed remains below target and below estimated prevalence, and work continues to increase awareness and promote early diagnosis. The Post Diagnostic Support (PDS) model has been implemented for those newly diagnosed with dementia to support people in managing their symptoms and provide access to low-level support so they may remain independent for as long as they are able. Service user and carer feedback has shown that people accessing the service feel supported, informed and better able to cope with their dementia diagnosis. In addition, the PDS model embeds support for carers.

A co-productive approach and development of community assets has been at the core of the *Present Initiative* which has been established within East Dunbartonshire. This initiative enables people with dementia to build a stronger presence in their local communities, and improve their wellbeing through enabling the growth of assets.

To support the implementation of the Dementia Excellence framework, Dementia Informed and Skilled modules have been completed by key staff, and enhanced level dementia training will be rolled out during 2016. As a result, the Eight Pillars support planning will be adopted ahead of the planned implementation schedule, improving support for people with Dementia

Mental Health

Self management of mental health issues is a priority of the Primary Care Mental Health Team to encourage well being. The Healthy Reading library, created in partnership with East Dunbartonshire libraries, is maintained to provide people with information on managing and coping with their issues. Service users are also encouraged to self refer to Richmond Fellowship Connections who provide a programme of activities for people with mental health issues.

To promote a more Trauma aware service, the mental health and social work staff have attended sessions to enable them to introduce the Trauma Awareness project. The project is being audited and findings will be presented during 2016/17.

The Community Mental Health Team implemented the Systems Training for Emotional Predictability and Problem solving (STEPS), an evidence based psychological intervention to assist service users with borderline personality disorders. All the Primary Care Mental Health Team and the Community Mental Health Team are trained in low level psychological intervention, including SPIRIT, behavioural activation and phase 1 trauma focused work.

Cancer

The East Dunbartonshire Multi Agency Cancer Steering Group has brought together four cancer prevention programmes to improve strategic planning, co-ordination and effective partnership work with MacMillan, Cancer Research UK and East Dunbartonshire Citizens Advice Bureau. Local people are benefitting from improved access to financial inclusion services, increased awareness and access to community assets, and improved holistic assessment tools across services. This approach has led to the development of a streamlined pathway between Primary Care and the Third Sector, and awareness of cancer through the local delivery of the National Detect Cancer Early Campaign.

Self Management

Two GP practices agreed to participate in the *House of Care* programme. The aim is to change the relationship between the patient and the professional practitioner to support more effective self-management. Initial meetings with practice staff identified key outcomes and actions towards implementing a new collaborative approach to individual care planning with patients with diabetes (in the first instance). Two further practices have expressed an interest in participating during 2016/17.

The East Dunbartonshire Health and Wellbeing Programme is a partnership between the HSCP, East Dunbartonshire Citizens Advice Bureau, Ceartas Advocacy and Carers Link, The programme has supported almost 120 service user and carers to undertake a holistic view of their circumstance and supports them to make informed choices towards their own health and wellbeing and more effectively facilitate access to services across public and third sector. The programme also supports the uptake of Carers Conversation and is developing web based resources including access to the Community Digital Assets Map.

Supporting people to Remain in the their own homes

Housing

The Housing Contribution Statement complements the outcomes set out in the Local Housing Strategy, and describes how housing providers will help achieve the shared outcomes for health and social care. The Statement has set out the housing contribution to supporting people to remain independent in their community by responding to a wide range of housing needs, provision of aids and adaptations, and gardening assistance.

Telecare

Telecare plays an important role in supporting people to remain in their own homes. Telecare provides appropriate equipment tailored to individual needs following assessment and consequently helps to prevent admission to hospital or care home, support early discharge and reduce carer stress. There are currently over 2000 Social Alarms installed across East Dunbartonshire. A range of telecare equipment was installed during 2015/16 including:

- 472 social alarms (160 have had an iVi pendant added with an automatic fall detection system).
- 120 Smoke Detectors (6 of which had flashing beacons linked).
- 26 Property Exit Sensors
- 24 Bed Occupancy Sensors,
- 15 Care Assist alarms linked to various sensors within the home to support families and carers and reduce their stress.
- 14 Buddi GPS systems used to locate people who may get lost when out and about

There were also a small number of Epilepsy Sensors, Memo Minders, Natural Gas Detectors, Chair Occupancy Sensors, and Carbon Monoxide Sensors provided, while eight people identified by Police or Consumer Protection as potential victims of doorstep crime have been provided with Bogus Caller buttons.

Improving Access to Services

The opening of the Lennoxtown Community Hub in March 2016, following a £5.29 million investment by East Dunbartonshire Council, has improved access to a number of services for local people. The building brings together a wide range of services under one roof including two GP Surgeries, a range of community health services including physiotherapy and podiatry, council enquiries and tax benefits, licensing, housing, library services, leisure services, and third sector.

Opening of Lennoxtown Hub

The opening of the hub has enabled the Primary Care Mental Health and East Dunbartonshire Alcohol and Drug Services to provide weekly clinics. Community

teams are also now utilising the premises as a satellite base. There are plans to introduce the Care at Home service and other social work services into the Hub.

A more flexible appointment system across various venues was introduced to improve access to psychological therapy. A pilot study was carried out during Jan - May 2015. The early morning and late evening appointments were particularly beneficial for services users who found it difficult to attend within office hours. Of those who attended, 86% worked, 8% were students and 6% were not in employment but had other commitments such as child care. The flexible appointment system received extremely positive feedback from service users, with the average 'did not attend' rate being 5%. It has therefore been implemented into practice.

2.3 People who use health and social care services have positive experiences of those services, and have their dignity respected

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	75%	74.7%
Percentage of adults receiving any care or support who rate it as excellent or good	82%	84.2%
Percentage of people with positive experience of care at their GP Practice	91%	91.1%

HSCP Performance Measure	2015/16 Target	Actual Mar 2016
Percentage of service users satisfied with the quality of social care provided	99%	100%
Percentage of Adults with a direct payment in the month who use this to fund personal care	80%	78.6%

Service User Experience

Each service across the HSCP has a system that captures service user experience. A quarterly return is submitted to the NHS GG&C board regarding the Patient's Right Act. This captures service user feedback, and the responses are used to shape future services. For example, following a request from a service user, antibacterial hand gel was made available within public waiting areas in the KHCC during the Warfarin clinic.

The percentage of social care service users satisfied with their quality of care was over 100% in January – March 2016. In order to gain an overall analysis of service user experience across all HSCP care services, a working group was established to

develop a standardised service user survey and an agreed template will be introduced 2016/17.

Self Directed Support

Self Directed Support (SDS) options have now been implemented across East Dunbartonshire and are now the mainstream approach to delivering social care support to service users. The options offer different levels of flexibility, control and choice, as well as responsibility for the service user and carer. Options 1 (Direct Payment) and 2 (Individual Service Fund) offer the service user greater flexibility, choice and control over who provides their support, how that support is provided and when that support is received. Option 2, which allows service users and carers to utilise their individual budget without the financial administration, has proved popular in East Dunbartonshire during 2015/16, particularly among older people. The SDS legislation has given social work practitioners, service users and carers in East Dunbartonshire an opportunity to explore social care support that could be considered non-traditional, innovative, and personalised to individual needs and outcomes.

SDS Option Uptake

	2014/15	**2015/16**
Option 1 – Direct Payments	Total clients - 175 57% Older People 19% Children and Families 1.5% Mental Health 1.4% Physical Disability 8.5% Learning Disability	Total clients - 168 48% Older People 24% Children and Families 3.5% Mental Health 15% Physical Disability 9.5% Learning Disability –
Option 2 – Individual Service Fund	Total clients - 10 50% Older People 10% Children and Families 0% Mental Health 10% Physical Disability 14% Learning Disability	Total clients – 77 77% Older People – 57% 1% Children and Families 1% Mental Health 1.5% Physical Disability 14% Learning Disability

The SDS Communication Strategy 2014 - 2017 has been fully implemented. All the actions associated with the strategy have been completed with only one action currently in the process of finalisation. The actions that have been completed include: development of a twice yearly SDS Newsletter; dedicated SDS website page; development and distribution of SDS Information Leaflets; SDS Training and Information awareness sessions and attendance by the SDS Lead Officer at a variety of service user and carer information events, raising awareness about SDS. The SDS Children's leaflet has been designed and we consulted with the Young Carers Group. It is intended that the leaflet will be finalised by end of June for printing and distribution".

2.4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	83%	86.3%
HSCP Performance Measure	**2015/16 Target**	**Actual Mar 2016**
Percentage of people 65+ indicating satisfaction with their social interaction opportunities	93%	100%
Percentage of service users satisfied with their involvement in the design of their care packages	95%	100%
Percentage of service users satisfied with the quality of social care provided	99%	100%

The health and social care needs of those with a learning disability are increasingly being met within mainstream services and staff awareness training is being provided to support this *Keys to Life* recommendation. People with LD are being supported to integrate and engage in community based activities and access education, training and sustainable employment.

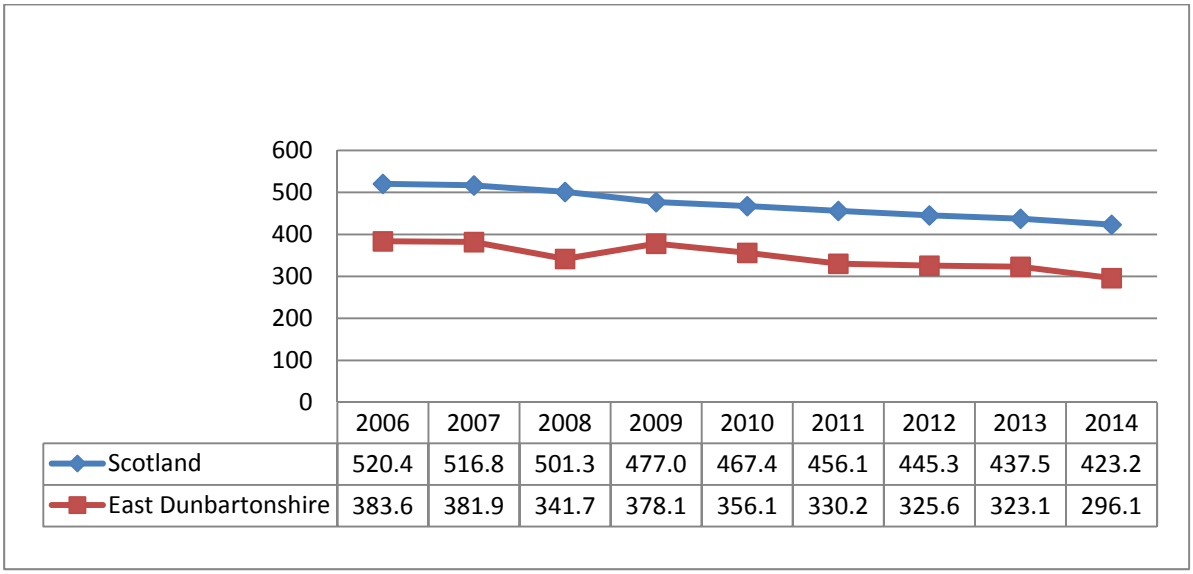
The development of effective and empowered service users and carers strengthens their contribution to informing service development and improvement. Carers and service users are represented on the HSCP Board, Strategic Planning Group, Locality Planning Groups and the Public, Service User and Carer Forum.

2.5 Health and social care services contribute to reducing health inequalities

National Core Indicator	2014	2015
Death rates (per 100,000 population)	296.1	N/A

The agreed national core indicator against this outcome is the European age-standardised mortality per 100,000 for people aged under 75yrs. Deaths in this age group are more common in deprived areas. Poor health is not simply about life style choices. It is also the result of people's aspirations, sense of control and cultural factors. East Dunbartonshire has seen a continual decrease in under 75yr deaths over the past five years as illustrated below.

Under 75s age-standardised death rates for all causes per 100,000



	2006	2007	2008	2009	2010	2011	2012	2013	2014
Scotland	520.4	516.8	501.3	477.0	467.4	456.1	445.3	437.5	423.2
East Dunbartonshire	383.6	381.9	341.7	378.1	356.1	330.2	325.6	323.1	296.1

Reducing health inequalities

During 2015-16, a detailed Joint Strategic Needs Assessment (JSNA) was completed, providing an overview of the population, health behaviours, life circumstances and health and social care status. This assisted highlighting areas of health inequalities across East Dunbartonshire and will inform the effective and efficient use of targeted resources in accordance with identified need through strategic planning.

People living in the three PLACE communities of Hillhead, Lennoxtown and Auchinairn, receive improved access to a range of targeted interventions. Priorities focus on life circumstances, health promoting behaviour change, health related screening and community capacity building. These are achieved through the delivery of lifestyle programmes, public health screening awareness, income maximisation and financial inclusion, volunteering opportunities, and community assets and capacity building programmes. The HSCP plays a significant role in supporting the Community Planning Partnership to realise the goals set out in the PLACE community approach in order to address inequalities in health and wellbeing outcomes. Specific support is provided through directly managed service delivery, joint partnership delivery and, to a lesser degree, direct funding.

Two employability studies undertaken by the HSCP Primary Care Mental Health team highlighted a high number of referrals from people experiencing work related stress. As a result the service has been redesigned to offer early and late appointments in order to support people to remain at work.

Pathways and treatment for people experiencing drug, alcohol and/or mental health issues are in the process of being improved. This is being taken forward through the work of the Mental Health Trauma Informed Practice Strategic Group in conjunction

with the Trauma services. To support this, staff will be trained to provide a trauma aware service to support service users.

The HSCP continues to address the health and social care needs of older people who are lesbian, gay, bisexual or transvestite (LGBT), and is working in partnership with LGBT Youth Scotland to consider the needs of young LGBT people. To raise awareness, reduce stigma and improve confidence among staff, equality awareness training with a particular focus on LGBT has been made available, and will be progressed during 2016/17.

The Health & Social Care Partnership published its Equality Plan in December 2015. The Plan sets out the Equality outcomes and actions against each of the General Duties required to demonstrate compliance with the Public Sector Equality Duty. A set of performance measures continue to be developed in consultation with health and social care practitioners. In support of the Equality Plan, the HSCP approved its Mainstreaming Position Statement. This represented the first step in producing a full Mainstreaming Report and explained how the HSCP aspirations will become a reality. It detailed how the HSCP will evolve as an inequalities sensitive public body, and the mechanisms in place to ensure this is seen as everyday business for everyone.

2.6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

National Core Indicator	2013/14	2015/16
Percentage of carers who feel supported to continue in their caring role	39%	44.7%

HSCP Performance Measure	2015/16 Target	Actual Mar 2016
Number of carers who feel supported and capable of continuing in a caring role	94%	100%

Over 11,000 adults in East Dunbartonshire identified themselves as an unpaid carer in the 2011 census, but only a fraction of that number seek support from services. The HSCP recognises carers as equal partners in the delivery of care to enable people to remain in their home and community, and preventing avoidable hospital admission.

Although the Health & Social Care Experience Survey reported only 44.7% of carers felt supported to continue in their caring role, the percentage was 100% among carers known to social care services. To help carers look after their own health and continue with their caring role, HSCP services work in partnership with

commissioned third sector organisations that provide support for carers, including Carers Link, OPAL, CAB, Ceartas, and Alzheimer Scotland. During 2015/16, the services have continued to provide Carer Conversations, training, information, financial advice, advocacy, and help to remain connected to their community.

Residential and short break provision is long established and well-resourced within East Dunbartonshire. Respite and short break provision has provided up to a maximum of 42 nights per year within East Dunbartonshire. Provision is subject to assessment of risk / need and carer assessment, and reviewed at a multi-agency resource screening group.

During 2015/16, carers have been fully involved with the planning and shaping of HSCP services. Carer representatives have been active, contributing members of the HSCP Board, Strategic Planning Group and Locality Planning groups, which discuss strategic priorities and improving local service provision. In addition, carers' representatives have been invited to attend the Public, Service User and Carers group. In addition, a reference group will be established in 2016/17 to support the introduction of the Carers (Scotland) Act 2016.

2.7 People who use health and social care services are safe from harm

National Core Indicator	2013/14	2015/16
Percentage of adults supported at home who agreed they felt safe	83%	86.5%

Patient Safety

Patient safety is a priority for HSCP services and a number of systems are in place to support this.

Within East Dunbartonshire Mental Health Services, partnerships and programmes are being developed with colleagues from Health Improvement and the third sector to provide seamless quality services that are person centred, effective and efficient and support short and long term positive health and wellbeing outcomes for our service users. As part of this project, the Community Mental Health Team now undertake physical health checks to support and improve physical health and well being and to monitor long term effects of medication.

The HSCP fully participated in the Scottish Patient Safety Programme (SPS) with an aim to reduce the number of events which could cause avoidable harm from care delivered in community settings. This included improving pressure ulcer prevention, food, fluid and nutrition, and prevention and control of infection. These are regularly audited within the community nursing team.

The HSCP has been successful in its application to be involved in a Health Improvement Scotland SPSP improvement programme, *Reducing Pressure Ulcers*

in Care Homes, with the support of Scottish Care. This programme will test new tools and interventions within selected care homes with the aim of reducing pressure ulcers by 50%. It will also build on the well established collaborative between the community nursing team and Scottish Care.

All NHS incidents and complaints are reported through the Datix electronic reporting system. During 2015-16, there were 161 clinical incidents and 4 complaints recorded. These were addressed by service leads to enable the implementation of appropriate actions and learning, thereby improving future service delivery. Where appropriate, significant event analyses were undertaken to improve practice. The HSCP is currently developing an integrated approach managing all HSCP related incidents and complaints.

Safeguarding Adults

A steering group has been established to oversee public protection governance arrangements across the HSCP services. In 2015-16, this group took reports on a multi-agency adult protection audit and proposals for a like audit of child protection services; MAPPA extension arrangements; and proposals to establish a domestic abuse MARAC scheme in East Dunbartonshire. These systems help to create an outcome focussed, person centred approach to safeguarding adults.

2.8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

National Core Indicator	2013/14	2015/16
Percentage of staff who would recommend their workplace as a good place to work (Available data refers only to NHS Staff Survey)	57%	60%

An organisational development programme has been agreed for members of the HSCP Board to assist their understanding of the processes and procedures for which they are responsible. The work of the HSCP Board is supported in governance terms by a range of procedural arrangements and instruments.

- An Integration Scheme;
- A Strategic Plan;
- A Strategic Planning Group to ensure involvement and consultation with stakeholders;
- A wider Public Service User and Carer Network;
- A Consultation and Engagement Strategy;
- An Audit Committee;

- A Clinical and Care Governance framework, structure and multi-disciplinary management group;
- A Professional Advisory Group;
- An Integrated Risk Register and Management Plan;
- An Administrative Scheme (including Standing Orders for Meetings, Terms of Reference and Membership of IJB Committees, Scheme of Delegation to Officers, Financial Regulations and a Code of Conduct for HSCP Board Members).

Governance Arrangements

A focus of the HSCP during 2015-16 has been to establish robust governance systems and processes to support the delivery of safe, effective and efficient services to the population of East Dunbartonshire.

- A Professional Advisory Group (PAG) has been established with the purpose of bringing together a source of expert professional health and social care advice to the HSCP Board, linking the HSCPB to professionals within health and social work, including the GP Forum. The PAG provides professional expertise to inform planning, priorities and redesign of service provision. It also ensures that all staff are registered on the appropriate professional Register, undertake training and development and are fit to practice. The PAG supports the delivery of the national outcomes and relevant health and social care quality and safety standards, and assures the HSCPB that Professional Assurance Frameworks are implemented. Professional leads bring areas of professional concern and ideas about professional development, quality improvement and safety to the Group. The PAG has direct responsibility for the Clinical and Care Governance group and the Training and Practice Development Group.
- As part of the process of integration a new governance group has been established to encompass clinical and care governance and membership includes representation from both health and social care practitioners. The Clinical and Care Governance Group addresses health and social care aspects of governance to ensure that service delivery to the population of East Dunbartonshire is safe, effective and person-centred. During 2016/17 an Action Plan will be developed to encompass and reflect the integrated governance arrangements.
- A Records Management Plan will be progressed further in 2016/17 with support from National Records of Scotland. The HSCP will contribute to the development of a Model Records Management Plan. National Records of Scotland will notify the HSCP of the timetable for submission of our local Plan which is anticipated by 2018/19.
- The HSCP has finalised its Risk Management Register, which supports effective approaches to managing risk in a way that both addresses significant

challenges and enables positive outcomes. The aim is to provide safe and effective care and treatment for patients and clients, as well as a safe environment for all staff, and those who interact with the services delivered under the direction of the HSCP Board. The Chief Officer, Heads of Service and Service Managers have identified risks and determined actions to prevent or mitigate the effects of loss or harm. The HSCP will complete a Risk Management Strategy, required by 1st April 2017.

- The Freedom of Information (Scotland) Act (2002) requires the HSCP to develop a Freedom of Information Publication Scheme, to be approved by the Scottish Commissioner. This sets out the HSCP Board's responsibilities in relation to Information Governance, specifically:
    - Environmental Information (Scotland) Regulations 2004;
    - Public Records (Scotland) Act 2011
    - Data Protection Act 1998.

  Our HSCP Freedom of Information Publication Scheme is in the early stages of development and will be presented to the HSPC Board for approval early 2017 for implementation by the 1st April 2017**.**

Workforce Planning

During 2015-16, the HSCP established its Strategic Development Team and began the process of identifying appropriate structures that would support this team in building the capacity to take forward the HSCP in both Strategic and Operational directions and activity. The work done to achieve these initial steps also developed the foundations to take forward more detailed work across and within care groups and thematic functions to look at developing a more integrated workforce plan during 2016-17. In relation to developing our workforce, work has begun to review the identified learning needs of staff through the Performance Development Review process for East Dunbartonshire Council staff and through the Knowledge & Skills Framework review process for NHSGGC staff. A small group is reviewing this information with integrated learning as the norm unless there are uni-professional requirements. This group will report its findings and activity through the overarching Care & Clinical Governance Group. Staff engagement has been through the Trade Union and Professional Bodies, the monthly Team Brief process and the existing network of local team meetings.

2.9 Resources are used effectively and efficiently in the provision of health and social care services

The commissioning and delivery of local effective and efficient services to individuals and communities will be informed by the 2016 Joint Strategic Needs Assessment. In conjunction, the Market Position Statement was published in March 2016 and introduced the way forward, via a Market Facilitation Plan, to help communicate the HSCP plans for re-shaping and re- structuring the health & social care market, and sets out the agreed high level priorities for 2016-17.

Services are working with Organisational Development leads to explore collaborative working and improve joint health and social care processes and systems to establish improved joint service user pathways across all community services. Service users will benefit from this approach which will improve access to the appropriate service at the correct time.

A robust performance management reporting template has been devised and utilised for quarterly performance reporting to the HSCP Board to provide the most recent available data to demonstrate progress against key performance indicators, along with narrative to describe actions for improvement.

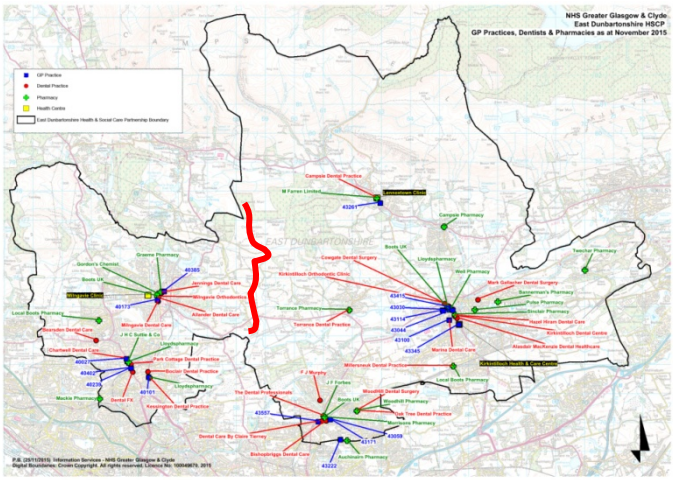
The HSCP Annual Accounts 2015/16 gave assurance that financial governance arrangements have been developed to support the IJB in the discharge of its business, including financial scoping, budget preparation, standing orders, financial regulations and the establishment of an Audit Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

3 Localities

The Public Bodies (Joint Working) (Scotland) Act 2014 Section 29(3)(a) requires each Integration Authority to establish at least two localities within its area. It was agreed that East Dunbartonshire has two localities. The West Locality includes Bearsden and Milngavie and environs: the East Locality includes Bishopbriggs, Kirkintilloch, Lennoxtown, Torrance, Lenzie and Twechar and environs. The Localities were agreed on the basis of postcode, data zone areas, and service provision.

The map below illustrates the Localities and location of Clinics, GP surgeries, Dental surgeries and Pharmacies.

Locality Boundaries



A joint inaugural meeting of both Locality Groups was held in October 2015. The workshop informed members of the functions and legal requirements of Locality Planning Groups. The group then contributed to informing the Joint Strategic Needs Assessment, utilising the 'Rich Pictures' methodology. Both Locality groups have now established quarterly meetings, and have agreed their priorities to take forward during 2016/17. The West Locality Group has begun to focus on Dementia while the East Locality Group are focussing on inequalities.

During 2016/17, The Locality Groups will provide a key mechanism for strong local clinical, professional and community leadership, with a focus on ensuring that local services are planned and led in a way that is engaged with the community. The Locality Groups will be involved in any decision that might significantly affect the provision of health and social care services within the area, including arrangements to consult and plan locally for the needs of the specific population. The Locality Groups will forge strong links with the developing GP Cluster Groups to further enhance a coordinated, co-productive approach to meeting local priorities.

4 Finance and Best Value

The Partnership's performance is presented in the Annual Accounts. The activities of the Health and Social Care Partnership are funded through an arrangement whereby the Council and Health Board agree their respective contributions and it is for the partnership thereafter to deliver on the priorities set out in the strategic plan. The scope of budgets agreed for inclusion within the HSCP for 2015/16 from each of the partnership bodies were:-

IJB Budgets 2015/16 (from the 3rd September 2015 to the 31st March 2016))

- IJB Health Budget £48,067,000
- IJB Social Work Budget £26,059,000
- TOTAL £74,126,000

This includes an element of funding provided by the Scottish Government to deliver on the key outcomes in the form of delayed discharge and integration funding of £2.21m.

Further work has progressed to identify the indicative set aside budget for the Acute Services to be included within the integrated budget. These notional budgets are based on direct costs per bed day for each relevant speciality within the IJB based on average activity for the 3 years 2011/12 – 2013/14 provided by NHSGGC Information Services department and cost for 2013/14 taken from the NHS Scotland Cost Book. Accident & Emergency outpatient attendances will be included at 3 year average activity and direct cost per attendance for 2013/14.

The costing methodology for future years will be the subject of a review within the NHS Board to develop a more accurate costing framework for unscheduled care services which may in time be used to identify resource shifts to either release funds to HSCPs where activity falls or identify changes to the payment to Acute Services where activity increases. An allocation has been determined by the Greater Glasgow & Clyde Health Board for East Dunbartonshire of £9.570m.

During 2015/16, a due diligence exercise was carried out to consider the sufficiency of the budget provided for the partnership by the Health Board and the Council. This identified significant financial pressure in relation to adult social care packages which have been the subject of regular reports to the IJB. This culminated in an agreement from the Council that in the first year, there would be an under writing of reported pressures from Council reserves.

The table below shows a net underspend of £1.388m on the partnership funding available for 2015/16.

In terms of the final position for Adult Social Work services, there was an increase in expenditure in relation to care home placements over and above projections as a result of the impact of winter pressures, year-end accruals and conclusion of the financial assessment. A combination of mitigations such as redundancy cost re-direction to Council centralised provision, increase in bad debt provision, application of surpluses from carry forwards from previous financial years and an adjustment to the financial allocation from the Council to reflect the under-writing arrangement, to cover reported cost pressures, provides an overall surplus on budget of £1.398m.

In terms of the final position for NHS budgets, there was a surplus generated across community NHS budgets of £400k in relation to Adult Community Care Services. In addition there was planned slippage of £400k against the HSCP's delayed discharge funding allocation. This was transferred to the Council to carry forward as reserves into 2016/17 leaving a small under spend of £7k at 2015/16.

The overall position for the HSCP is that of surplus of £1.388m which will be allocated to reserves and carried forward to 2016/17. An element of the carry forward is required to meet on-going commitments; however there will be a surplus to meet the priorities set out in the Strategic Plan, and to provide some resilience for on-going pressure and slippage in savings plans.

The partnership continues to face significant financial pressures from demographic growth particularly amongst the elderly population generating demand and increased costs across a range of adult care services.

Both partnership organisations continue to face significant financial challenge. The health board has savings of £70m to secure during 2016/17 with a number of initiatives underway to deliver on this challenge. Of the £70m savings target, £20m relates to Health & Social Care Partnerships of which £1.08m relates to East Dunbartonshire.

The Council is also facing significant challenges with £10.9m to close the funding gap during 2016/17 predominantly delivered through the Council's transformation and budget reduction programme with the aim of protecting the provision of frontline service delivery.

There is some additional funding available to partnerships from the Scottish Government in 2016/17 in the form of Integration Funding (ED - £1.7m), Delayed Discharge Funding (ED - £510k) and a share of £250m (ED £4.31m) aimed at delivering the living wage across the care home and care at home sectors, support additional spend on expanding social care to support the objectives of integration and raising charging thresholds for all non-residential services.

The period of public sector austerity and reduction in the overall level of UK public sector expenditure is anticipated to extend over the medium term horizon. Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2018/19. The partnership will prepare a financial plan aligned to its strategic priorities to plan ahead to meet the challenges of

demographic growth and policy pressures, taking appropriate action to maintain budgets within expected levels of funding and to maximise opportunities for delivery of the Strategic Plan.

Statement of Income and Expenditure 2015-16

	Gross Expenditure	**Gross Income**	**Net**
	£000	£000	£000
Local Authority Services			
Social Work	24,064	(25,462)	(1,398)
Housing	18	(18)	0
Neighbourhood	387	(387)	0
Fleet	192	(192)	0
Sub Total	24,661	(26,059)	(1,398)
Health Care Services			
Community Healthcare	32,577	(32,584)	(7)
Hosted Services	5,913	(5,913)	0
Acute Services	9,570	(9,570)	0
Sub Total	48,060	(48,067)	(7)
Corporate Services	17	0	17
(Surplus)/deficit on provision of services	72,738	(74,126)	(1,388)
Net income and expenditure	72,738	(74,126)	(1,388)

Agenda Item Number:12

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**11th August 2016**
Report Number	**2016/17_12**
Subject Title	**Strategic Plan Year 1 Progress 2015/16 and Update 2016/17**
Report by	**Karen Murray, Chief Officer,** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager,** **East Dunbartonshire Health & Social Care Partnership**

1.0 PURPOSE OF REPORT

1.1 The purpose of this paper is to provide the HSCP Board with two reports that together provide a comprehensive description of the Year 1 progress achieved against the agreed priorities set out in the East Dunbartonshire Strategic Plan 2015-18, and the proposed priorities for 2016-17.

2.0 SUMMARY

2.1 The Strategic Commissioning Plan was presented to the HSCP Board on 31st March 2016 as an annex to the East Dunbartonshire Strategic Plan 2015-18. The Strategic Commissioning Plan set out the specific deliverable actions against each of the strategic priorities within the overarching Strategic Plan. These priorities will be delivered over the three year lifespan of the Strategic Plan. This paper provides two reports: a Progress Report and an Update Report to demonstrate to the HSCP Board the continual progress in delivering the priorities set out within the Strategic Plan.

2.2 Report 1 – Strategic Plan Year 1 Progress Report.

This report demonstrates progress against all the strategic priorities set out in the East Dunbartonshire HSCP Strategic Commissioning Plan 2015-18. Consistent with that plan, this report is set out under the heading of each of the nine national outcomes. This report complements the East Dunbartonshire HSCP Annual Performance Report 2015-16 by describing the progress achieved at an operational team level, thereby providing the HSCP with a detailed understanding of the underlying activity required to achieve agreed performance targets.

2.3 Report 2 – Strategic Plan Update Year 2

This report provides an update and outline of the proposed priorities for Year 2 of the Strategic Plan.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- Note the content of the Strategic Commissioning Plan Progress Report
- Approve the HSCP priorities for 2016-17

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

East Dunbartonshire
Health & Social Care Partnership

Strategic Plan
Year 1 Progress Report
2015/16

1 Introduction

The purpose of this report is to provide the HSCP Board with a comprehensive description of the Year 1 progress achieved against the agreed priorities set out in the East Dunbartonshire Strategic Plan 2015-18. Report 2 provides an update and outline of the priorities for 2016-17.

The Strategic Commissioning Plan set out the specific deliverable actions against each of the strategic priorities within the overarching Strategic Plan. Report 1 demonstrates progress against all the strategic priorities set out in the East Dunbartonshire HSCP Strategic Commissioning Plan 2015-18. Consistent with that plan, this report is set out under the heading of each national outcome. The template adopted in this report sets out the specific, deliverable actions against each strategic priority, providing clarity on the arrangements that will achieve the HSCP priorities and deliver improvements against each of the outcomes. The additional fourth column details the progress made during 2015/16.

Strategic Priority	What will success look like	Specific Deliverable	Progress Against Priorities

The Strategic Plan has a three year focus, therefore a small number of priority areas will not be progressed until Year 2. These are clearly indicated within the template.

OUTCOME 1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

Strategic Priority	What will success look like	Specific Deliverable	Progress Against Priorities
Supporting the population to adopt healthy lifestyles	Communities are increasingly smoke free through the implementing the local Tobacco Action Strategy	Deliver targeted smoking Cessation Drop in services in PLACE communities	The East Dunbartonshire Tobacco Alliance has agreed and implemented a 3 year action plan with specific outcomes detailed against the following outputs; • Smoking Cessation • Public Health, (Tobacco) Policy • Public awareness • Tobacco legislation Access to Community Smoking Cessation Services has been realigned to ensure that each PLACE Locality has a priority service located within each community. This approach has supported an upturn in those seeking to engage with the service ensuring that the HEAT target for successful quits within our most deprived communities (12 weeks) has been achieved The MDT are collaboratively working together on improving physical health checks and improving patient's physical wellbeing within mental health

			teams. Physical health checks progress carried out includes weight, bloods, ECG etc. A group has been established including all disciplines to scope ways of improving the physical health and wellbeing of patients accessing mental health services. Links have been established with the Health Improvement Team. Improving physical health and wellbeing is discussed at the Mental Health Team Business meeting. The aim is to look at various improvements in health such as health checks, improving lifestyle and increasing physical activity.
		Lead a programme of Smoke free play parks across the Authority	A component of the ED Tobacco Alliance Action plan is to increase the number of Smoke Free play parks across the Authority. In March 2016 the second smoke free play park was launched, with plans to develop a third site in the autumn
		Support the implementation of smoke free public service facilities and grounds	In line with the national strategy towards Scotland being a smoke free generation by 2035. The East Dunbartonshire Tobacco Alliance has encouraged all members from both statutory and voluntary sectors to implement smoke free building and grounds policy. NHS, Local Authority, Fire Services and the third sector partners have all adopted this policy
		Support Community Planning Partners to implement actions to	East Dunbartonshire Councils Community Protection Services continue to deliver mystery shopper visits

		address illegal tobacco sales	local retailers, ensuring that retailers comply win the legal sales of tobacco.
		Deliver smoking cessation incentive scheme in partnership with Strathkelvin Credit Union.	ED HSCP Health Improvement Team has delivered a Smoking Cessation incentive programme in partnership with Strathkelvin Credit Union. The aim is to support community members to adopt an approach to financial management, notably those within PLACE neighbourhoods. Over the last year 45 people have participated in the programme by joining the Credit Union with £15k having been deposited within these accounts. The programme is aimed in SMID 1 & 2 neighbourhoods with 65% of those opening an account residing within these neighbourhoods
	Greater access to community physical activity and nutrition programmes and services	Design & deliver community food and physical activity programmes in partnership with Community Planning Partners	Through working with community partners the ED HSCP has extended its delivery of community food and physical activity programmes over the last year with the following programmes being delivered. In continuing to develop our approach to nutrition programme the HSCP has identified and contracted 6 community based organisations to provide community cooking, nutrition training and health eating awareness across East Dunbartonshire, with a priority for PLACE communities. The provision is quality assured and delivers core health improvement developed resources including; Be Healthy on a Budget and Practical Cookery. The first delivery session has taken place with 13 local people attending; a full programme of delivery has been

			scheduled for the rest of 2016. The REHIS accredited Food and Hygiene course has been delivered whilst the REHIS accredited Food and Health course has been delivered with 10 volunteer attendees
		Commission East Dunbartonshire Community Learning & Development Team to deliver the WALK programme; Exercise Referral Programme (Live Active); and GP Exercise Referral Programme for people with Long Term Conditions (Vitality)	Over 12 month period there have been a number of walking groups established across East Dunbartonshire with over 1,000 participants. This includes walks for participants with Visual Impairments, Learning Disability, Autism & Dementia. The Live Active gym exercise programme received 624 first time referrals over the last year with local people accessing one of the 3 sports centres, many for the first time. 124 community members were still active within the gym 12 months after their initial induction. Mental Health Service has made referrals into the exercise referral programme. Staff members from the Health Improvement Team has attended Team meetings to raise awareness of exercise opportunities and programmes for patients to improve their physical health and wellbeing
		Commissioning GRACE and service users to provide community cookery programme	Three service users from GRACE project have been trained to deliver the Community Cooking programme. Four programmes have taken place with 40 attendees. These sessions are specifically for people who attend GRACE. One session was also delivered within Hillhead Community Centre to local

			residents
		Liaise with East Dunbartonshire Leisure Trust to deliver chair aerobics for people with disabilities and Older People who are sedentary.	East Dunbartonshire Leisure & Culture currently deliver arm chair aerobics to older people in care homes and day centre settings throughout East Dunbartonshire
		Continue to offer and support Caring for Smiles training in all Care Homes within East Dunbartonshire. .	Caring for Smiles CPD training is delivered within 10 locations across NHS GG&C every 8-10 weeks. Care homes must meet the minimum criteria of 30% staff trained before programme is rolled out to the care home The Caring for Smiles Programme has been active within East Dunbartonshire since early 2015. The programme is going well within establishments and close partnership links have been formed with East Dunbartonshire Social Work staff.
		Continue monthly monitoring visits to assess routine dental care is being carried out and if residents are attending a registered dentist	All establishments are visited on a monthly basis to check the baseline audit and update the dental registration figures which are reported back for collation. A total of 114 staff have been trained in routine dental care.
		Commission delivery of Waist Winners programme Too: a weight management programme and walking programmes for people with a learning disability	Two 8 week 'Community Waist Winners' Groups were delivered with all 15 attendees completing the course. The programme is continuing with three programmes being delivered in a variety of community settings, including Hillhead Community Centre.

	People are able to access alcohol screening and interventions in different settings and geographic locations	Continue to commission Glasgow Alcohol Service to undertake Alcohol Brief Interventions in wider settings	Funding to continue with the delivery of the Alcohol Brief Intervention programme was secured from the Alcohol & Drugs Partnership. The programme successfully delivered 755 ABI's (55% over the target set by GGC) in both community and primary care settings. Primary Care Mental Health Team have recently been updated in Alcohol Brief intervention and drug Training. They have incorporated DAST and FAST as part of their assessment process.
		Support the delivery of Alcohol Brief Interventions in Primary Care	An ABI Strategy and action plan 2015 -18 has been implemented. The plan sets out the required actions for the successful delivery of ABI's within Primary Care and wider settings. Train the Trainers programme has been delivered, 4 front line officers now have the capacity to provide ABI training.
		Review to inform reconfiguration of Alcohol & Drug service focus on alcohol screening and treatment	Relevant HSCP staff attend training on illicit substances
		Deliver alcohol Fast Screens and Alcohol Brief Interventions in community settings	Service users are given information on self referral into the Glasgow Counsel on Alcohol where appropriate. Counsellors have attended HSCP Team Meeting to raise awareness for staff of the services available. Relevant HSCP staff have attended Alcohol Awareness Training and link in with local addictions

			service when joint working is identified/required
		Pilot a Pharmacy Alcohol Brief Interventions programme	A Pharmacy ABI pilot was developed and provided training for 12 Community Pharmacies, including those within PLACE communities to deliver an ABI within a Pharmacy setting.
		Commission through Alcohol & Drug Partnership a range of 3rd sector delivered prevention and recovery programmes	Since the 2011 ADP needs assessment, a range of 3rd Sector providers have been commissioned. SAMH – The Foundry community rehabilitation GRACE – Group Recovery and After Care Addaction – Families Plus SFAD – Family Support Group Carr Gomm – Rosebank Allotment in partnership with mental health Turning Point – Housing First Project in partnership with Housing and Homelessness These providers adhere to the Drug & Alcohol Quality Principles and are commissioned to provide a range of prevention, early intervention and recovery based supports. Helping to support individuals who misuse substances & their family members. Providers are part of the Recovery Orientated System of Care & are working together to ensure smooth transitions for individuals through services.

Deliver the national Detect Cancer Early programme, both universally and targeted	More people participating in national cervical, breast and bowel cancer screening programmes	Deliver Cancer Health Improvement training through the Volunteers Good for your Health programme to support national campaigns in Lung, Breast, bowel and skin cancers	The Good for your Health volunteers identified and supported 6 service users to deliver 24 Detect Cancer Early and Cancer Prevention awareness sessions, throughout East Dunbartonshire with 14 (62%) of these delivered within PLACE neighbourhoods
		Lead Cancer awareness targeted programmes in populations of low screening uptake	Frontline workers from the statutory and voluntary sector trained to raise awareness and support clients in regards to bowel screening. A Detect Cancer Early event, was delivered to members of the GRACE group in Hillhead. Respondents to the evaluation expressed an increased awareness. A Breast Cancer awareness session was also delivered within Hillhead.
Strengthen and further develop co-productive approaches to enhance people's roles	Empowered communities developing and delivering community supports programmes	Provide training to Community Organisations to support the delivery of Community Health Initiatives through volunteers	Health Matters Training level 1 and 2 has been delivered across East Dunbartonshire to volunteers and partners.
		Strengthen community food co-op delivery in PLACE communities	The Food Co-op continues to deliver a weekly service within Hillhead. The HSCP supported 2 Food Co-op members to increase food hygiene awareness, increasing the capacity of the Food co-op to provide a service in Hillhead. The Co-op is now directly supported and facilitated through third sector.
		Consolidate the PRESENT initiative working to strengthen coproduction	Progress against this priority has included the development of the Dementia partnership website for

		approaches to Dementia	East Dunbartonshire to provide easy to access information and advice to the person or their family and carers. Other innovative initiatives have included the intergenerational Community Café, the East Dunbartonshire Music Network and supported memory friendly walks for people living with dementia in East Dunbartonshire which have sought to promote coproduction and inclusion and enhance people's quality of life.
		Develop Independent Travel Initiative for Young people with Aspergers using Scottish Government funding using local area coordinators	The travel training programme commenced in June 2016 in partnership with Enable. We have a number of individuals identified who would benefit from this type of input and more are being identified through our transition processes.
	People, particularly those with mental health and LTCs, are able to utilise personal and community assets	Deliver training to support practitioners from cross sectors in the implementation of personal and community asset approaches	All members of the Primary Care Mental Health Team and the Community Mental Health Team have received community asset mapping training. This training has now embedded within new staff inductions.
		Commission Citizens Advice Bureau to deliver the Older people's Income Maximisation service	The Income Maximisation service has supported 441 referrals to CAB over the course of the year with a total financial gain of £747k
		Maximise opportunities to strengthen Credit Union services in areas of greatest need	The HIT has worked in partnership with Strathkelvin Credit Union, supporting the SCC to develop an additional outreach base in Lennoxtown. ED HSCP has delivered a Smoking Cessation

			incentive programme in partnership with Strathkelvin Credit Union. The aim is to support community members to adopt an approach to financial management, notably those within PLACE neighbourhoods. Over the last year 45 people have participated in the programme by joining the Credit Union with £15k having been deposited within theses accounts. The programme is aimed to 65% residing in SMID 1 & 2 neighbourhoods
		Commissioning process required to extend asset map to wider community group	East Dunbartonshire Association for Mental Health, undertook to build capacity of 10 local members to become Asset Map launch Champions. The programme oversaw the launch of the Community Assets Map across East Dunbartonshire with an emphasis on PLACE localities.
		Continue Service Level Agreement with Institute Research Innovation Social Services (IRISS) to further develop IT requirements	A contract is in place with IRISS to maintain the IT infrastructure related to the community asset mapping.
	Increased knowledge and confidence in co-produced interventions among clinicians	Continue to deliver training and support health and social care staff to raise awareness and utilisation of the health and wellbeing directory, wellbeing network and assets map.	Community and personal asset training was provided on 6 occasions for HSCP and EDC staff members in 2015 with 100 attendees, developing capacity to utilise the assets approach on an individual and professional basis. Sessions were delivered to a range of primary care staff raising awareness of the health and wellbeing

			directory which is a key component in the development of social prescribing Mental Health representation on the Asset and Action Steering Group. Contributing to development of the community assets mapping approach within health and social care.
	Dementia Friendly Communities developed	Partners are taking forward a programme of work on behalf of the Dementia Network to deliver dementia friendly community sites within East Dunbartonshire.	A number of Dementia friendly sites have been established across East Dunbartonshire within a diverse range of locations from local supermarkets to local golf clubs and wider locality based approaches. A dementia resource has also been introduced within schools in East Dunbartonshire from 2014 based around the “Curriculum for Excellence in Scotland” and has been a valuable tool to build intergenerational understanding of dementia and tackle stigma.
Improve access to primary care services	Local hub operating in Lennoxtown (2015)	Delivery public engagement to inform services available in the hub. Develop and establish a local hub in Lennoxtown.	The Hub has enabled the Primary Care Mental Health Team to improved access to Psychological therapies to the local community Lennoxtown Hub opened on the 8th Feb. This is providing people with access to services within the local area. Joint IT systems to enable Council staff to work from the premises.
	Improved access to a GP	Providing support to GPs to share and learn from Practice Activity Data	Health and Care Experience Survey and PAR data shared with the GPs for discussion.

OUTCOME 2 People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Strengthening community services for older people to avoid unplanned hospital admissions and to support people to remain in an appropriate setting	Pathways between community and secondary care services promote and facilitate admission avoidance and early discharge	Weekly operational delayed discharge meeting to discuss individual cases & expedite discharge.	Weekly operational delayed discharge meeting has been successfully established and enhances the coordinated partnership based response to delayed discharge developed within East Dunbartonshire, which has facilitated reductions in delayed discharge and bed days lost to delayed discharges.
		Develop business case to reduce delayed discharges	A wider whole system based approach is being developed as a strategic priority to prevent admission, minimise delayed discharge and support complex discharge home.
		Promote the use within Primary Care of Day Hospital facilities	Commence year 2
	Develop pathways that support people to self manage their own conditions	Provide local Community Asset information through Greater Glasgow & Clyde Patient Information Centres	A co-production based approach and development of community assets has been at the core of the Present Initiative which has been established within East Dunbartonshire since August 2013. The initiative has enabled people living with dementia to build a

			stronger presence in their local communities, and growth of assets to improve the wellbeing of the wider community.
		Review and revise current Cancer assessment tools through the Transforming Care After Treatment programme	Commence year 2
		Develop peer self-managed support for those impacted by cancer	Commence year 2
		Deliver House of Care approach to support chronic disease management in two early adopter practices (Diabetes and Chronic Heart Diseases)	Commence year 2
Test and promote models of self management for people with long term conditions	Many Conditions One Life Strategy recommendations implemented	Coordinate the dissemination of self management guidance and information through the East Dunbartonshire Wellbeing Network	The Wellbeing Network coordinates self management guidance delivered through 'wellbeing reviews' whereby service users and carers undertake a holistic review of their circumstance. This will then support them to make informed choices towards their own health and wellbeing.
		Deliver Behaviour Change training to Primary Care and 3rd Sector staff	Health Matters Training level 1 & 2 has been delivered across East Dunbartonshire to volunteers and partners. A total of 65 participants took part.

	Agreed model for anticipatory care planning embedded across services	Increased number of Anticipatory Care Plans in place using collaborative approach with Primary Care. Anticipatory Care Planning information uploaded to GP Key Information Summaries	DNs have increased their target number of monthly ACPs and are now uploading these to the GP key information summaries to ensure the information is shared. A successful initiative to promote Power of Attorney has been completed within East Dunbartonshire to raise awareness of its benefits and to encourage uptake.
		Revise current practice and deliver focused training to support early adopter practices to implement programme	Commence Yr 2
	Improve specialist knowledge	Increase the number of staff acting as link nurses for specific areas of practice.	Link nurses now for palliative care, continence care, leg ulcers, tissue viability, CNIS ,medicines management, Equipu, Enteral feeding
		Closer working practices between Care Home liaison nurses, Diabetes Nurses and District Nurse	Quarterly forum established between adult Nursing staff to examine opportunities for service improvement in relation to care homes. Selected for SPSP programme for reducing pressure ulcers in care homes. Insulin Management plans used in Care Homes for appropriate individuals.

	House of Care model piloted in primary care	Collaborate with Primary Care to develop a shared anticipatory care approach for patients with long term conditions, learning from the palliative care model.	District Nursing interventions can now be viewed through clinical portal.
		Improve information sharing processes and systems.	Currently exploring opportunities for clinical portal access for Social Care Staff to improve information sharing via GG&C data sharing project.
	Coordinated activity between community nursing, homecare and rehabilitation services	Explore opportunities for joint or integrated team / services across all Health & Social Care	KHCC remodelling project anticipates improved opportunities for health and social work teams to integrate within the building.
	Models are developed of intermediate care services	Analyse and review uptake of equipment through EquipU to inform future provision and potential for integrated approach.	Collation of EquipU data undertaken and a multi disciplinary meeting being established to analyse data and determine future service improvement. Joint Nursing / Occupational Therapy and Rehabilitation Services meetings established to monitor and develop practice
		Scope options of intermediate care models.	Intermediate care model being developed with initial scoping and options being presented to the HSCP Board in May
	Re-focussed approaches on out of hours provision in partnership with GEMs, homecare and	Scope available resources currently operating Out of Hours to establish a baseline Implement first and second level	Commence yr 2

	Third sector	assessment	
	Falls prevention and management pathways implemented	Continue to support the delivery of falls prevention to Care Homes through Falls Operational Group.	A mental Health Representative is working along side Health Improvement Team, to develop a mechanism to raise staff awareness and keep them up to date on the prevention and management of falls Work continues to support first and second level assessment in services. Community rehab teams have embedded the national Falls data into assessment formats. Other services developing pathways to support onward referral for those requiring level 2 assessment, following level one in all services. Partnership Falls pathway map in draft form.
		Work with Housing and third sector to deliver Care and Repair support service	Care & Repair service is funded through ICF monies and successfully exceeded its target for small repairs, by 80%. The service also provided home safety advice to over 300 older people.
Develop long term solutions in the community for adults with learning disability and those with Mental Health	Agreed commissioning process for learning disability provision	Complete Learning Disability service review which will identify and influence strategic direction	The PCMHT work with Richmond Fellowship Connections and encourage patients to self refer into the service. Connections attend Team Meetings to provide staff with information and their programme of activities. This is then shared with service users during telephone assessment and treatment.

conditions.	Improved communication coordination between statutory and third sector agencies that better meet the needs of people with mental health conditions.	Complete a review of Mental Health services to improve pathways	Commissioned services within Mental Health are being reviewed as part of the wider Mental Health Service Review.
Develop and consolidate augmented system of care for people with mental health, alcohol and drug problems	Services for adult and older people's mental health are managed and delivered locally	Review Service Level Agreement with North Lanarkshire and work with North West Glasgow to realign services with Health & Social Care Partnership boundaries	Commence year 2.
	Clarity and flexibility of pathways to recovery for those with alcohol and drug problems, supported through coordinated care	Alcohol & Drug Partnership to undertake review of commissioned services to create a single coordinated pathway.	Work is on-going with regards to creating a single coordinated pathway. A Recovery Orientated System of Care (ROSC)Action Plan has been developed with the Primary Driver: Services Interface seamlessly with each other within the recovery orientated system of care (ROSC), and Secondary Drives as follows: • Roles and responsibilities of each service are developed, agreed and fulfilled • Pathways through ROSC care are clear for services and clients • Services are delivered in an integrated and co-ordinated way • Workforce Development is central to the ROSC A working group will met in June to further progress

			this work. A policy is currently out for comment; to improve an individual's an agreed pathway between services in case of relapse. The wider ADP review continues to be explored.
People with dementia have support and access to services	Increased awareness of early diagnosis	Promote discussion amongst GPs with a view to increasing the increase of early diagnosis within Primary Care.	We continue to explore approaches to improving early diagnosis. This is also now been taking forward through the Locality groups.
	Post diagnostic support delivered to all people newly diagnosed with dementia	Continue to test and embed the delivery of Post Diagnostic Support model, partly commissioned in house and through the third sector.	Evaluation complete. Current model extended until Sept 16. Awaiting further guidance from Scottish Government re future delivery model.
	Dementia Standards Framework in place	Ensure implementation of the Dementia Excellence framework across all of the workforce in Health & Social Care	Learn-pro module available up to skilled level. Dementia Informed and Skilled modules have been completed by key staff within the Integrated Health and Social Care Partnership. Enhanced level

			dementia training is due to be rolled out to staff across 2016, and Eight Pillars support planning adopted ahead of its implementation.
		Consolidate community led Dementia initiatives.	Using the principle of co-production through the work of PRESENT, people with dementia are contributing to the quality of their own life and that of those around them. Dementia Partnership website now live: www.eddn.org.uk. For it to be sustainable the PRESENT charter was introduced. With the support of Ceartas, a partner in the Dementia Network, we now have an independent East Dunbartonshire Dementia Voices group for people living with dementia.
Work with the care home sector to develop an enhanced model	Strengthened communications between Care Homes and community	Commission through Scottish Care a Liaison post allowing the development and redesign of enhanced models of care	Senior Nurse and Scottish Care Liaison working together to strengthen communication and to develop enhanced models of care.
	High standards of preventative care in care homes promoted and resourced	Develop a coordinated process that drives high standards within care homes.	Care Home Liaison Nurses (CHLN) aligned to Care Homes. Formal referral process to CHLN now established
		Support GP Practices providing services to care homes through the LES	CHLNs and Prescribing Support Pharmacists work closely with LES identified Practices
		Medication reviews provided in care	Prescribing Support Pharmacists carry out ongoing medication reviews for patients in care home with no

		home with no GP LES provision	GP LES provision
		Continue to fund and consolidate Bridging the Gap.	Bridging the Gap continues to be delivered and consolidated
Develop condition specific strategies / plans for people with: • physical disability • sensory impairment • Autism.	Coordinated and planned approach to service development and delivery	Develop a coordinated set of actions in line with national strategies for adults with physical disability and sensory impairment	Both the PCMHT and CMHT have EQUIA to assist assessing the service individuals with special needs
		Implement the Autistic Spectrum Disorder Strategy & Action Plan developed in line with National Strategy. Key priorities include: raising awareness, training, pathways, mainstreaming & transitions	The East Dunbartonshire Autism Strategy was developed and launched in November 2015. The ASD Steering group is instrumental in driving this agenda forward. A Comic-con event will took place to help raise awareness of autism in a community setting. EDICT to continue to provide two autism specific groups for young people. Bishopbriggs Leisuredrome are in the process of applying for the National Autistic Society Autism Access Award and are going to be taking part in a 'mystery shopper' visit from a range of individuals with autism.
Expand availability of a range of aids, adaptations and equipment in homes to support independent living	Substantial and increased deployment of technologically enabled care and support	Promote the uptake of telecare / telehealth options, and OT aids and adaptations to promote independent living across all care groups.	Current practice being evaluated with a view to inform an action plan to improve uptake of technologically enabled care options. This will move forward in year 2016/17
	Better equipped and adapted homes to support independence	Develop the Housing Contribution Statement to identify appropriate housing that supports independent	Completed and presented to HSCP Board, March 2016.

		living.	
		Further develop and implement participation in the Council's Scheme of Assistance to enable home owners to access grant funding for major adaptations.	The Council's Scheme of Assistance is promoted on the Council's website. Cross departmental Council Teams also make referrals to the Scheme. During 2015/16 the Scheme of Assistance made available £480,000 private sector housing grant funding towards Aids and Adaptations for home owners. Around 12 home owners received assistance. The Council are currently developing the new Local Housing Strategy (2016) and assisting people with particular needs will remain a priority.
		Offer appropriate delivery of Care of Gardens Scheme to vulnerable adults.	Review of current service being offered to inform future provision.

OUTCOME 3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Promote SDS as a positive option to develop creative solutions to support independence	People are taking control and making choices and taking control of their care	Commission independent Self Directed Support service Glasgow Centre for Inclusive Living (GCIL).	Contract in place will be reviewed 2016/17
	Delivery of personalised packages of support	Deliver the SDS communication strategy	Communication strategy in place and action plan implemented
Embed systems that effectively capture service user experience and views to inform service improvement	Systems in place to routinely capture service user experience	Routinely capture service user & carer experience through the Social Work Care Management review process.	Working Group set up to identify potential universal patient experience survey for HSCP. All HSCP services are represented.
		Routinely deliver a rolling programme of patient experience surveys through Community services.	The has been recent working group set up with various services/ disciplines to look at improving on patient feedback and surveys with the East Dunbartonshire The mental report quarterly any comments and suggestions made by service users within the Mental Health Teams this is part of the Patients Right Act

		Deliver audit programmes to capture patient satisfaction within Primary Care Mental Health Team.	The Primary Care Mental Health Team have completed a local and city wide survey to get feedback from services users this will be repeated in the Autumn. There have been actions taking from the feedback to improve the service.
		As part of contract management patient user / carer experience is standardised.	Initial information has been collated about current in order to review future model.
		Deliver service user / carer experience surveys to support the Care Inspectorate requirements.	Collated initial information about current practice to review future model.

OUTCOME 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Develop an effective and empowered service user and carer group	Service user experience and involvement informing service development and improvement	Build capacity of Service User and Carers Network through the Strategic Planning Group, Locality Planning groups & Public, Service User and Carer Network (PSUCN)	Service users and carers are represented on the HSCP Board, Strategic Planning Group and Locality Planning Groups and actively contribute to the proceedings.
		Work in partnership with the service user and carer representatives to drive effective understanding in the community of health and social care systems.	The PSUCN is well established and contributed to the JSNA. Work continues to support PSUCN in understanding health & social care systems and priorities.
		Support and strengthen carers and service users' voices across all services.	Carers are represented on all HSCP planning groups and links are established with the Carers Working Group and the Carers Forum.
Build community capacity and develop volunteering	Community programmes communicate and evidence the impact of their activities on	Commission 3rd Sector to deliver a programme of capacity building for health improvement (targeted in PLACE communities)	Contract in 2015/16 delivered through third sector organisation. Contract for 2016/17 being reviewed.

opportunities to enhance peoples' role in their community	community wellbeing and quality of life.	Commission CAB / Ceartas / Carers Link, to deliver wellbeing reviews and referrals	Wellbeing reviews delivered to clients through third sector organisations
	Communities are aware of and able to use existing community assets and to develop new programmes that impact on wider determinants of health	Commission 3rd Sector to establish / support and sustain a pool of Community Asset Champions; moderate community asset map; & promote the Asset map within communities to broaden its reach and to increase the level of community assets available	Asset champions in place. Currently reviewed moderation process for Asset map with the intention to be commissioned through third sector
	Local Volunteering Strategy agreed by all sectors (including faith and community groups)	Commission 3rd Sector to deliver a Community Development programme within PLACE	Currently reviewing structure and delivery mechanisms
		Commission East Dunbartonshire Cultural & Leisure Trust to deliver Physical Activity, Nutrition and Cultural Arts programmes	Contract in place with Culture and Leisure to delivered a range of programmes
	Practitioners are confident to engage with and refer to voluntary sector services	In partnership with East Dunbartonshire Council Corporate Services Commission the 3rd sector, to deliver a programme of community capacity building; volunteering and community engagement.	Currently being progressed

Develop and implement programmes to improve quality of life for people impacted by long term conditions	People are able to remain or re-establish connections within their community through a range of programmes	Commissioning a range of services through the 3rd sector.	Social activities, lifestyle activities commissioned through the third sector with an emphasis for delivery in PLACE communities
	Cancer health improvement is better coordinated through a new multi-agency Cancer Steering Group	Developing pathways to re-connect people impacted by cancer with their communities	Commence year 2
	Improved social prescribing pathways between acute, primary care and community services	Co-ordinate the implementation of all Cancer Health Improvement programmes	Financial inclusion service and wellbeing reviewed commissioned through 3rd sector for people impacted by cancer. GP training designed and delivered to increase awareness of cancer recovery.
	Peer support for Long term conditions is enhanced through self management, social interaction and community connections.	Empower staff to signpost people to community assets. Establish peer led self management programmes	Commence year 2 Commence year 2
Implement a single point of access into the Third sector to meet the wider holistic needs of the	Individuals are able to access a wide range of community services.	Commission 3rd Sector to extend OPAL service to all adults.	OPAL extended from older people to adult population.
	Practitioners are able to effectively prescribe	Promote the OPAL service through Primary care and Health & Social	Greater access is being evidenced through primary

population	social interventions	Care services	care
Implement *Keys to Life* recommendations	People with a learning disability: • are integrated and represented in mainstream community • engage in community based activities • access education, training and meaningful, sustainable employment	Up skill our workforce to deliver mainstream services to people with learning disabilities.	NHS GG&C wide Learning & Development Plan being developed across all care groups to incorporate LD with view to increased needs being met within mainstream services. Component sub group of LD Redesign (Strategy for the Future) implementation.
		Implement the recommendations arising from the local Learning disability review	Local LD review still to commence

OUTCOME 5 Health and social care services contribute to reducing health inequalities

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Reflect health and social care priorities in the PLACE programme	People are more connected within their communities	Deliver the Health & Social Care contribution to PLACE strategy and action plan.	A range of programmes delivered in Hillhead, Lennoxtown and Auchinairn focussing on lifestyle and social connectiveness.
	Targeted services are coordinated more effectively across community planning partners	Work with Partners to deliver a range of connected services within Hillhead / Lennoxtown / Auchinairn.	HSCP working with partners to ensure better coordinated and effective services, particularly in PLACE communities.
Develop targeted low intensity peer led programmes and services that improve health	Local people are delivering a range of support services/programmes to designed to increase volunteering; social enterprise; wellbeing; training; employability	Continue to embed Peer Support within Health & Social Care Services.	Breastfeeding peer support piloted within Hillhead. Peer support opportunities through CMHT.
		Support a range of resident and community peer programmes	Community peer support developed through voluntary sector.
Develop a trauma informed practice approach with people experiencing	Improved identification of trauma	Commission and deliver programme including training and reconfiguring the service to provide a trauma informed services.	The Trauma Informed Strategic Group leads on particular work streams that look at improving the patient's pathway and raise staffs awareness. The group is working in conjunction with the Trauma

drug, alcohol and/or mental health problems			services. Training dates planned to be delivered to all social work/health staff to have 'trauma aware service' and improve patients pathways/treatment
	Service users feel safe when disclosing trauma		Commence Yr 2
	Clear roles, expectations, and supports across services		Commence Yr 2
Ameliorate the impact of welfare reform and poverty	People have access to debt and financial management support	Increase the awareness of Health & Social care workforce to refer to financial inclusion services.	Practitioner training delivered across third and public sector to improve referrals.
	Staff are more aware of and refer to financial inclusion services	Commission third sector services to deliver financial inclusion services.	Commissioned service being delivered and exceeding local targets for client outcomes.
Support people experiencing drug, alcohol and/or mental health problems into employment as part	Programmes developed to support people into employment	Review of Alcohol & Drug services to identify gaps and inform reconfiguration to fill gaps	The PCMHT have carried out two employability studies. There are high referrals from service users in employment or experiencing work related stress. The team now offer early and late appointments to provide more flexibility for service users that work.

of a recovery orientated system of care	Increased participation in stepped programme relating to employment, education, leisure and housing	Clarify pathways to identify what is available across statutory and third sector services to support appropriate referrals and ensure pathway that moves from treatment services to recovery	Currently under review and revised model being developed as part of Alcohol & Drug Partnership Plan
Potential disadvantage to particular individuals and communities are identified and actioned	Potential disadvantage to particular individuals and communities are identified and actioned	Utilise JSNA population information and data to identify population inequalities to inform priorities and service development.	JSNA has been shared with all services to assist in informing their priorities.
		Continue to commission specialist advocacy and support services through a range of Third Sector Organisations	Contracts in place. Subject to review 2016/17
Implement the duties set out in the Equality Act 2010 with regard to the personal characteristics that are protected	Equality Plan developed	Implement a Health & Social Care Partnership Equality Plan.	Equality Plan complete. Mainstream and position statement agreed with a suite of performance indicators. A full mainstream report will be produced by end of March 2017
		Up skill workforce to undertake equality impact assessments on plans policies and service developments.	Social Work staff enrolled on to Assessment Officer's forum on IBM Connections, which provides guidance on the Council's policy development framework and meeting Equality Impact and other requirements.
		Increasing the awareness to H&SCP workforce pertaining to the Equality Act. (all protected characteristics)	Equalities issues identified as priority area for training within Social Work training action plan for 2016-17.

Develop a strategy for Lesbian, Gay, Bisexual, Transgender older people	Staff are better equipped to support the needs of LGBT People Policies and plans meet the requirements of the Equality Act 2010	Raise awareness amongst staff to improve confidence & reduce stigma for LGBT older people	Contract in place with LGBT Youth Scotland to work with young people in East Dunbartonshire. The Training and Organisational Development Group are reviewing the equality awareness training for staff with a particular focus on LGBT. This work will commence in Year 2.

OUTCOME 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Update and implement the East Dunbartonshire Strategy for Carers and supporting action plan, reflecting the priorities emerging in the Carers (Scotland) Bill	Carers are identified, offered support and receive a carer assessment	Revise current local Carer Strategy following assent of Carers Bill	The Carer (Scotland) Act was introduced in March 2016. The Act outlines and sets out what has to be included in the strategy. The Act also states when the first strategy must be published, in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014. The East Dunbartonshire Carer Strategy requires to be published no later than September 2018.
	Carers access local support, are connected in their communities and are not disadvantaged	Commission third sector organisation to provide a wide range of supports for carers	Several commissioned third sector organisations provide support for carers, including Carers Link, OPAL, CAB, Ceartas, and Alzheimer Scotland
	Carers are equal partners in the planning and delivery of care	Contribute to national discussions regarding eligibility and thresholds criteria	Carers are fully involved with the planning and shaping of services. Carer representatives are active, contributing members of the HSCP Board, Strategic Planning Group and Locality Planning groups, where strategic priorities are discussed. In addition, carers are invited to attend the Public, Service User and Carers reference group.

	Carers are supported to remain healthy and able to continue their caring role	Appropriate respite and short break provision	Residential and short break provision is long established and well-resourced within East Dunbartonshire. Respite and short break provision is provided up to a maximum of 42 nights per year within East Dunbartonshire subject to assessment of risk / need and carer assessment which is reviewed at a multi-agency resource screening group.
	Continue to Maximise to support increased respite provision focussed on flexible respite breaks.	Encourage staff to complete online Carer training (EPIC)	Commence Yr 2
Ensure carer involvement and contribution at all relevant strategic levels of planning and delivery of services	Carer representatives on relevant planning groups	To strengthen the participation of carers in Health &Social Care strategic planning. HSCP strategic Planning Group / locality groups and wider groups.	Carer's representatives have been identified for HSCP Board, SPG, and both Locality Planning Groups. In addition, carers are invited to attend and participate in the Public, Service User & Carer forum.

OUTCOME 7 People who use health and social care services are safe from harm.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
People receive high quality care and are safe from harm	Compliance with the Scottish Patient Safety Programme	Deliver and review a range of audits to comply with the patients safety programme	Monthly pressure ulcer Safety Cross audit in DN Services. MUST audit tool being developed Board wide
	Improved incident reporting	Review current incident reporting and complaints systems to inform harmonised HSCP processes.	All rapid alerts or/and Datix are analysed locally and in the wider organisation. Any issues are highlighted, All Datix incidents & lesson learned are discussed at team meetings and Clinical & Care Governance Sub Group meetings.
		Through contract management improve incident reporting systems.	Managers attend various professional/governance groups within GGC relevant incidents are discussed in detail in these groups
	Agreed co-ordinated, safe, recording and reporting systems	Work with third sector to pilot an Adult Support & Protection (ASP) threshold framework.	Framework agreed and piloted in conjunction with care providers over an initial 6 month period between October 2015 and March 2016. Information about framework and pilot shared with NHS GGC ASP Liaison group. Framework continuing to be applied pending completion of formal evaluation in 2016-17.

		Prepare our staff for the introduction of emerging legislation in relation to the duty of candour requirements under the Health (Nicotine, Tobacco & Care) Bill	Training needs in respect of Duty of Candour provisionally identified as priority within 2016-17 training plans
Implement an outcome focussed person centred approach to safe guarding adults	Service users have an individualised protection plan where appropriate	Introduce and evaluate outcome focussed protection plans.	Outcome-focussed protection planning was implemented in 2015 and the multi-agency ASP audit carried out in March 2016 indicated that this supports partner agencies to better understand their role in the overall plan and control potential negative impacts of intervention on the adult.
	Support provided to those recovering from harm	Increasing awareness of Health & Social Care workforce with regards to adult support and protection issues.	Ops Manger and Team Leader from Mental Health sit on the Adult and Child protection group. Staff attend AWI training and complete Learn-pro. This is included in their PDPs. Nurse Team Leaders sit on Adult Protection Committee's Quality and Development Partnership sub-group
	Agreed priorities of the Adult Protection Plan implemented	Engage with service users and carers to capture their experience to improve personal outcomes.	Health and social care staff invited to attend Adult Protection Committee's annual conference on disability stigma and harm. Service users and carers delivered inputs to conference, and participated with staff in a stakeholder consultation exercise carried out during the conference.

	Systems to collect feedback from adults who have experienced harm	Develop multi agency self evaluation process to incorporate service user feedback within the annual audit.	The Adult Protection Committee service user and carer sub-group considered inclusive and accessible methods of capturing lived experience of ASP services. Further to consultation with the sub group, proposals amended to introduce routine capture of service user feedback via ASP and RAMP reviews during 2016-17
		Review Social Work Risk Assessment and Management Procedures	Social Work Risk Assessment and Management (RAMP) procedures revised and updated for implementation in 2016-17
A public protection governance structure in place that supports front line service delivery	Policies, procedures and practices in protecting adults from harm, linked to children and community justice systems	Develop and enhance governance arrangements through the Public Protection Steering Group.	Public Protection Steering group has taken reports on multi-agency protection casefile audits, and proposals to introduce MARAC in East Dunbartonshire during 2015-16.
	Agreed policy and procedure for responding to gender based violence	Health & Social Care Partnership works with Violence against women multi agency partnership (Empowered) to develop and strengthen local multi agency policies.	Health and Social Work services for children and adults represented on Empowered. Empowered's Multi-agency Forced Marriage protocol, which was developed with reference to NHSGGC and EDC procedures, was revised to incorporate new criminal legislation in 2015-16.

OUTCOME 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Securing visibility of clinical and professional leadership in governance arrangements	Established governance structures in place	Establish Clinical & Care Governance arrangements	As part of the process of integration a new governance group has been established to encompass Clinical and Care governance. This group membership includes representation from our social care partners, with an agenda that reflects both Clinical and Care governance issues. The group has established terms of reference and supporting documents, which have been agreed and ratified by the members and Chief Officer, and have been forwarded to the Partnerships Governance lead and the Clinical Director at board level. The first formal integrated Clinical and Care Governance Group meeting took place in May, with ongoing bi-monthly meetings thereafter. The group will address all aspects of governance to ensure that we continue to deliver safe, effective and person-centred care to the population of East Dunbartonshire, and will develop a new Action Plan to encompass the new integrated governance agenda.

	Professional advisory arrangement are established to inform service improvement and quality	Establishment of PAG with membership & TOR agreed	A Professional Advisory Group has been established. Its role is to have direct responsibility for Clinical care and governance, training and practice development. The Clinical and Care Governance group and the Training and Practice development Group will report to the Professional Advisory Group. The group has met twice, our recent focus was beginning to explore professional issues and feasibility around step up and step down beds.
Equip staff to have the knowledge and skills to continuously improve their practice and influence service development	Staff feedback informs service practice and developments	Support staff to take part in completing Staff Feedback Surveys.	All staff supported /encouraged to complete surveys Social work staff involved in ongoing practitioner forums, as well as dedicated focus and task groups to develop and review policy and procedures during 2015-16. Survey monkey tool used to survey Social work staff for supervision policy review and evaluation of social work practice learning service.
	Systems in place to support staff to undertake role and professional development	Professional / Clinical Supervision are in place.	Clinical Supervision process developed for Adult Nursing Service and supervisor / supervisee Groups being established Social Work Supervision policy currently subject to review to ensure fit for purpose in integrated context.
		Systems to monitor professional registration and revalidation are in place.	Formal process for monthly check of registered nursing staff within Adult Nursing service
		Continue to deliver KSF / PDP	Ongoing and formal targets attained for Adult Nursing

		processes for NHS employed staff.	Service
		Continue to deliver PDR (Personal Development Review) for Social Work employed staff.	PDR cycle for social work staff completed for 2015-16. PDR objective setting for 2016-17 pending full implementation of iTrent.
Create a confident, competent integrated workforce	Workforce Development Plan in place across all staff groups	To scope and develop and a workforce Learning and Education Plan.	Service level L & E plans in place. Skills gap analysis audit undertaken across all EDC employees. Information utilised to inform L&E plan
	Coordinated Organisational Development and Learning & Education plans	Establish Organisational Development and Learning & Education sub-groups to develop coordinated plans	Sub-groups established in 2015-16. Work ongoing to scope opportunities for shared learning in relation to priorities identified in the Social Work training action plan and Health L&E plan during 2016-17.

OUTCOME 9 Resources are used effectively and efficiently in the provision of health and social care services.

Strategic Priorities	What will success look like	Specific Deliverable	Progress Against Priorities
Develop a commissioning strategy that drives a delivery model that reflects best value and agreed strategic priorities	Services informed by Strategic Needs Assessment and Market Facilitation Plan	Complete Strategic Needs Assessment	Joint Strategic Needs Assessment completed and approved by HSCP Board 31/3/16
	Contracting and procurement arrangements reflect priorities that are outcome focussed	Strategic Commissioning Plan and Market Facilitation Plan completed	Plans completed and approved by HSCP Board 31/3/16
	Develop a performance management framework and reporting mechanisms	Further review and enhance Performance Management Framework to better support the monitoring and delivery of services.	Performance management reporting template devised and utilised for quarterly performance reporting to HSCP Board. This will be further developed and measures revised to improve performance reporting for 2016-17
Develop a shared system of care and support	Integrated teams are established where appropriate	Progress the Joint Team Analysis across Mental Health, Alcohol & Drugs and Learning Disability.	Commence Yr 2
		Health & Social care workforce structures agreed.	Commence Yr 2

		Identify opportunities for further joint working / integration of services / teams.	Mental Health and Social work met to review Joint Team Analysis and action plan. There will be future development sessions facilitated by Organisational Development to jointly look at improving patient pathway, collaborative working, processes and systems.
Agree described outcomes and link investment to them	Agreed Financial Plan that aligns budgets to secure and deliver priorities	Determine costing associated with commissioning priorities.	SEPARATE REPORT

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

East Dunbartonshire
Health & Social Care Partnership

Priority Update
2016/17

Introduction

The purpose of this report is to inform the HSCP Board of the proposed priorities that will be given particular focus during Year 2 (2016-17) of the East Dunbartonshire Strategic Plan.

There are twelve key priorities proposed, many of which are multifaceted and involve co-productive working with partner agencies. The priorities have been discussed by the Strategic Planning Group, who agreed that these should be the focus for 2016/17 in order that the HSCP continues to deliver the outcomes set out in the Strategic Plan.

Each priority is described in detail below.

1 Intermediate Care Models

1(a) "Step down" model

As part of our strategic and delayed discharge planning, East Dunbartonshire Health and Social Care Partnership are introducing an eight bedded intermediate care unit.

The aims of the project are to:-

- Bridge the gap by supporting people with a timeous, smooth discharge from hospital to home with appropriate community supports or into a homely setting within a residential/nursing care home;
- Reduce the number of people delayed in hospital when they have been declared medically fit for discharge;
- Maximise the service user's ability for rehabilitation and reablement;

The unit will have six assessment beds for service users deemed to require further assessment with a view to admission to a residential or nursing home care environment. The remaining two beds will provide a 'step down' provision for intensive rehabilitation and re-ablement from care home, care at home, and community health services with a view to returning people to their own homes.

The Hospital Assessment Team will be responsible for the management of admission, discharge and through-put to the intermediate facility. Community health and social services will support the enhanced clinical interventions required by service users within the unit. This intermediate care service will commence in October 2016

1(b) "In reach/outreach" care at home workforce.

Provision of intensive care and support at home support will be explored for service users with complex needs who may have the potential to return to the community from hospital and establish a degree of independence after an initial intensive support package. This service would be available within the eligibility and charging criteria proposed for the intermediate care facility and could be delivered within the service user's home, or using the Telecare Smart Flat to support the rehabilitation process.

1(c) Third Sector Support with Non-Complex Discharges

Pathways will continue to be developed in relation to providing needs led services that support service users to return to, and remain, in their home following an episode of hospital care. There are a range of voluntary organisations who work in partnership with the HSCP to support:

- shifting the balance of care
- taking a more planned and preventative approach
- building community capacity

Local voluntary services work in partnership with the HSCP to provide services that actively support intermediate care, including:

- The Red Cross Hospital at Home Service - preventing avoidable hospital admission by providing transportation and resettling people back into their own home.
- Befriending - supporting people to live independently with supported assistance..
- Older People's Access Line – providing a single point of access to statutory and voluntary organisations.

1(d) Single point of access

Service leads have identified that some internal pathways could be modified to create an improved, seamless pathway for services users to access services. The existing entry points to all services will be mapped out to identify where pathways can be changed, while ensuring that certain contact points, such as crisis calls, are not made more complex.

1(e) Telecare

Telecare will support intermediate care via several pathways. Service users who have an existing care package will be offered an assessment; this could potentially include an overnight stay in the Smart Flat. The Smart Flat offers service users and staff the opportunity to view and test up to date telecare/smart technology. A review will be undertaken on how the flat is being utilised, with the short term goal being to re-promote this to all relevant stakeholders as a valuable self management resource and function.

1(f) Anticipatory care

An anticipatory care plan (ACP) pathway has agreed between GP and community nursing services. There is scope to pilot the Health Improvement Scotland standardised ACP and to include a wider range of health and social work services in completing ACPs.

2 Primary Care

2(a) GP capacity & payments for new care homes

Two new care homes (Craigton in Milngavie and Lennoxtown) will open within the coming year. The model of GP support to these developments has not yet been determined . Initial discussions are planned over the next few months to scope out financial implications and to develop a model to delivery. An additional two care homes have also been given planning permission to build within East Dunbartonshire. One of these will be in Bearsden where GP capacity for care home commitment is extremely challenging.

2(b) Develop GP cluster programme

It has been agreed that three GP clusters will be formed in East Dunbartonshire:

- Kirkintilloch/Lennoxtown
- Bishopbriggs/Auchinairn
- Bearsden/Milngavie

All practices have a named Practice Quality Lead and processes are underway to identify Cluster Quality Leads for each cluster. Funding has been identified to support a programme of engagement with PQL and CQL to agree a range of local datasets to support the continuous quality improvement in the delivery of health care. Practices have initially been asked to reflect on flu figures from 2015/16 season and to share flu campaign arrangements and how they are managing chronic disease risk registers. Face to face meetings are being planned for the late summer to explore further.

2(c) Engaging wider primary care contractors

The position for Lead Optometrist has just recently been confirmed. Shortly there will be a comprehensive register of all Optometrists who wish to be affiliated to East Dunbartonshire. This will assist with the development of regular briefs to Optometrists on local or board wide initiatives. As part of our plan to have better engagement, we aim to have a local protected time event within the next six months.

Lead Community Pharmacist in post attends HSCP Prescribing Governance and Professional Executive Groups and maintains regular links between the community pharmacists and HSCP.

Prescribing Support Pharmacist allocated to every GP practice working with GP, PNs and support staff ensuring engagement with Prescribing LES's, Initiatives, Formulary and Guidelines.

2(d) Prescribing support

In June 2015, the Scottish Government announced details of the Primary Care Investment Funding £60M to support the primary care workforce and improves patient access to these services, with £16.2 million of this sum allocated for pharmacists to support GP practices. The expectation was to recruit pharmacists to work directly with GP practices to support the care of patients with long term conditions and free up GP times to spend with other patients. From this funding, East Dunbartonshire HSCP has been allocated an additional 1.5 wte pharmacist resource and 0.5 wte pharmacy technician resource. This will be used

in pilot practices/clusters to support with their proposals including polypharmacy review clinics, chronic disease management clinics, medicines reconciliation and prescription management. The project will be evaluated using agreed national and local criteria, and regular reports will be sent to the Prescribing Governance Group

3 Delayed Discharges

Progress towards achievement of the 72 hour pathway for discharge is progressing in line with the partnerships strategic priorities. Smart working initiatives are being piloted to enable multi-site working with full system access with access to multiple hospital sites and Wifi which will enable more agile working and more efficient use of staff time.

The development of the intermediate care unit will facilitate a more efficient discharge from hospital to a community setting for both re-ablement and future nursing care home admission. This resource will establish capacity towards ensuring that patients are discharged from hospital before EDISON recording and bed days lost through delayed discharge occur.

Additional structures and processes will be established within the Social Work Hospital Assessment Team to facilitate earlier identification of patients within Gartnavel and Drumchapel hospitals, to complement existing arrangements with Stobhill hospital. The consolidation of the social work team resource is being reviewed as part of the HSCP's wider structural arrangements.

4 Repatriation of Community Mental Health

Community Mental Health Teams (CMHT) and Older Peoples Mental Health Teams (OPMHT) have traditionally worked across different boundaries than those of the HSCP. It is a priority for service users to be transferred to the care of services provided by the HSCP where they reside.

Adult mental health services for the population of Bearsden and Milngavie are currently provided by Glenkirk CMHT within the North West locality of Glasgow HSCP. The East Dunbartonshire CMHT and the OPMHT currently provide services to the North Lanarkshire corridor population (Chryston, Stepps, Moodiesburn), which transferred to Lanarkshire Health Board as part of the NHS Boundary changes in April 2014. There is currently a Service Level Agreement with North Lanarkshire for the continuation of these services until appropriate measures are in place to transfer service users to a mental health team within North Lanarkshire.

Work will be undertaken in the coming year to repatriate these services to their home geographical partnership localities. This will see patients from Bearsden and Milngavie coming into East Dunbartonshire-delivered services, and patients from Stepps, Chryston and Moodiesburn receiving services from NHS Lanarkshire

The services will work together to ensure that this repatriation of service users and transfer of resources happens safely and timeously

5 Learning Disability Review

A comprehensive review of all learning disability services within East Dunbartonshire will be implemented, based on the objectives/outcomes within the submission to the Integrated Care Fund

- modernised quality services
- financial sustainability given demographic pressures
- minimising use of out-of-area placements

6 Trauma-Informed Practice in Drug & Alcohol and Mental Health Services

Work is ongoing to develop trauma-informed practice and infrastructure across these services. This work will dovetail with the development of recovery-oriented systems and the work on the early identification of and response to Stress and Distress.

7 Mental Health Review

A whole system review of mental health services will be implemented within East Dunbartonshire in order to improve collaborative working across statutory and third sector agencies, benefit clients/patients via clearer, more effective pathways, maximise funding or third sector to meet agreed outcomes

8 Unscheduled Care

The HSCP will work with Acute services to scope out the longer term strategic plans to reduce unplanned admissions episodes. Three overarching themes have been identified where the effective planning and delivery of change in services can transform care.

- **Better management of older people and chronic disease in the community:**
  - Improving pre hospital care including support to GPs;
  - Improving systems and services to deliver early discharge;
  - Improving care in nursing homes;
  - Extended and integrating arrangements for domiciliary support;
  - Identifying developments which delivery the CSS joined up care system;
  - Reshaping out of hours services;
- **Enabling acute care to be focussed on patients with acute needs;**
  - Action to enable patients to die at home;
  - Identifying care pathways which can be modified to reduce reliance on hospital services;

- Delivery of the Paisley development programme outputs in each HSCP area
- Shifting care from an unplanned to planned basis;
- Further reducing delayed discharges;

- **Changes to address service pressures and inefficiencies;**
  - Identifying and addressing variation in use of diagnostics;
  - Identifying and addressing variation in the use of outpatient and inpatient services;
  - Reviewing a number of care pathways where there is potential for efficiency;
  - Transport

9 Strengthening Strategic Planning Arrangements

HSCP Strategic Planning Group and Locality Planning Groups are now established and will continue to engage in the planning and delivery of services. The Locality Planning Groups have identified key local priorities and will take these forward during 2016/17.

The HSCP is currently developing a mechanism for strategic (community) planning, care groups planning, and governance planning. Appropriate representation on these groups, and Terms of Reference will be agreed. A test management approach will be developed to determine the expected outcomes and success criteria for all developed work streams.

10 Carers Strategy

The Carers (Scotland) Act will be commenced in April 2018. During the next year, there will be a significant programme of preparation at a national level, including the delivery of a number of regulations and associated guidance under the Act. The HSCP will ensure that it is fully involved with these preparations, as appropriate, in partnership with local Carers and Carer representatives. Throughout 2016/17, the HSCP will continue to work with Carers representatives and groups to prepare for commencement of the Act, as well as contributing to the review of the current Joint Carers Strategy for East Dunbartonshire.

In addition, the HSCP will continue to fully engage with Carers and ensure that Carers are represented and active participants on the HSCP Board, Strategic Planning Group, and Locality Planning Groups.

11 Develop Commissioning Priorities

11(a) Living Wage Implementation

The Scottish Government has committed to the implementation of the Living Wage across the voluntary and private care sector. This commitment spans the Care Home, Care at

Home and Housing Support market. Funding to achieve this commitment is contained within the additional funds provided to HSCP's in the Spending Review. A Working Group has been established and work is underway locally, supported by national work being conducted by Scot Excel, to scope the current picture across commissioned services in East Dunbartonshire, with a view to the implementation of the Living Wage commencing in October 2016.

11(b) National Care Home Contract

A Review of the National Care Home Contract (NCHC) is underway. East Dunbartonshire continues to participate in the National Care Home Contract. A two-stage uplift for 2016-17 has been agreed - 2.5% from April 2016 and a further 3.9% on 1st October 2016 - with agreement Providers will contribute 25% towards costs. It is anticipated that a revised approach to the NCHC and wider commissioning of residential care will be determined by October 2016 thus allowing for related negotiations to conclude by April 2017. The review of the NCHC is welcomed as the current agreement is not financially sustainable. However, future financial implications (care, implementation and compliance costs) are ambiguous, and will remain so until such times the NCHC review is concluded.

11(c) Care at Home

The current Framework for Commissioned Care at Home Services is due to expire in February 2017. Work has commenced to begin scoping Homecare requirements for the development of the new Framework. Some areas discussed have been: - geographical split of localities, awarding initial blocks of business to each Provider in order that they can recruit for future referrals and enable award of fixed contracts as opposed to zero-hour contracts, reducing number of Providers over geographical areas. It is anticipated that the work to develop the revised Framework will be concluded in time to succeed the current one as planned.

12 Progress Integration

12(a) Integration of Children's Services & Criminal Justice

Recent agreement between East Dunbartonshire Council and NHS Greater Glasgow and Clyde will see the HSCP Board take on additional functional responsibility, with respect to NHS Community Children's Services, Social Work Children's Services and Social Work Criminal Justice Services. A revised Integration Scheme has been prepared and has been subject to full public and stakeholder consultation. Delegation of these additional functions is scheduled to go live in August (subject to Cabinet Minister approval) and will be supported by the updating of a number of the governance arrangements.

12(b) Integrated Management Structures

Phase 2 of the process to implement an integrated management structure is nearing completion. This phase involves those staff that will directly report to Head of Service and indirectly those staff whose functional activities are now aligned within a different part of the line management structure. It is anticipated that the phase 2 will be operation from September 2016.

12(c) Publication Scheme

Under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a Freedom of Information Publication Scheme to be approved by the Scottish Commissioner. The FOI scheme is underway and is hoped to be completed by October 2016.

Agenda Item Number: 13

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	2016/17_13
Subject Title	Strategic Acute Service Planning
Report by	Karen Murray, Chief Officer, East Dunbartonshire HSCP
Contact Officer	Karen.murray@ggc.scot.nhs.uk 0141 201 3553

1.0 PURPOSE OF REPORT

1.1 The purpose of this paper is to enable the IJB to:-

- give early consideration to NHS GGC Board's proposed approach;
- consider how the IJB wishes to engage in the proposed process;
- respond to the NHS Board's request that early engagement in the process is established through the HSCPs patient and public engagement arrangements.

2.0 SUMMARY

2.1 This attached paper (**Appendix 1**) has been approved by the NHS Board as the basis to develop a strategic plan for acute services. Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards and IJBs have been asked to consider how they wish to engage in the planning process.

2.2 The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3 The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services;

2.4 The paper acknowledges the importance of the relationship to IJBs in this regard as:-

- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- Shaping of acute services to respond to IJBs Strategic Commissioning Plans, including forward financial planning.
- Achieving early patient and pubic engagement;

3.0 RECOMMENDATIONS

The HSCP Board are asked to:-

a) Consider the process proposed by NHS Greater Glasgow and Clyde to develop a strategic plan for acute services;
b) Consider the approach to engage with the HSCP.

4.0 MAIN REPORT

4.1 The paper outlines the local, regional and national position on planning for acute services.

4.2 At **national level,** there are a series of programmes of work which will inform strategic planning and the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699

4.3 A further critical part of the national scene, particularly critical to the IJB is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.4 There are well established **regional planning** arrangements which set the direction for a number of our services which are provided to populations beyond the Board area.

4.5 At **NHS Board level** there is a comprehensive Clinical Services Strategy approved by the Board in January 2015 and endorsed by the IJBs.

4.6 The key aims of that strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

4.7 IJBs have published their first Strategic Commissioning Plans, these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

Developing the Strategic Plan: Proposed Process

4.8 The Health Board proposes a two stage process with the aim of developing and describing the changes we need to make in 2017/18 in the context of describing a longer term strategic change programme.

4.9 The first stage, to be completed by October 2016, is to update of the key elements of the Clinical Services Review including:-

- Population health analysis;
- Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;
- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focused on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;
- an initial forward financial framework for acute services, developed with the Integration Joint Boards;

4.10 The NHS Board proposes extensive clinical engagement and engagement with wider stakeholders during this stage.

4.11 The output of this first stage would enable further discussion with IJBs with the aim that this work can be finalised to move to a second stage with the NHS Board approving for publication, and formal public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

Conclusion

4.12 The shape and delivery of acute services are critical to the responsibilities of the IJB and will also be an important issue for local people. Therefore active engagement as this work develops is important.

4.13 The NHS Board has committed to work with IJB Chief Officers to establish the detail of the required processes to develop proposed process.

APPENDIX 1

NHS Greater Glasgow & Clyde

NHS BOARD MEETING
28th June 2016

Catriona Renfrew
Director of Planning and Policy

Paper No: 16

Strategic Service Planning

Recommendation:

The Board consider the approach to Strategic planning for acute services.

1. Background and Purpose

1.1. This paper proposes a process for the strategic planning for acute services. The approach outlined will enable:-

- Coordination of our planning with the developing regional and national approaches.
- The wide engagement of our clinical staff in strategic planning;
- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- The shaping of acute services to respond to IJBs Strategic Commissioning Plans.
- The further development of our existing extensive planning;
- The delivery of early patient and pubic engagement;

1.2. This purpose of the paper is to enable the Board to contribute at this early stage to shaping the strategic planning process, informing the further development of the process.

2. Planning Roles and Responsibilities

2.1. Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards.

2.2. The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3. The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services;

3. Strategic direction and principles for planning

3.1. The Board already has a clear strategic direction which sets out our purpose as:

"***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."***

3.2. That purpose is amplified with five strategic priorities, these are:

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

3.3. In planning for 2016/17 the Board also developed a series of principles to establish a clear framework for planning. These principles, set out below continue shape our approach to planning, particularly our approach to the assessment of available resources and how they should be deployed.

- Make financial decisions which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and resources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.
- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams; and
  - a whole system programme of change to deliver cost reduction.
- Commitment to engagement with patients and the wider public.
- Commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required

3.4. The Strategic Direction, strategic priorities and principles will underpin our approach to strategic planning for acute services.

4. Current position on strategic planning for acute services

4.1. This section describes the local, regional and national position on planning for acute services, which set the context within which this next phase of our planning will be developed.

4.2. At **national level,** there are a series of programmes of work which will inform our strategic planning. These include:-

- The work of the Transformation Board which is overseeing a range of reviews including for planning for seven day services, the review of out of hours services and the current maternity and neonatal services review.
- Service strategies including for cancer;
- Planning being established for future scheduled care capacity;

4.3. In addition to these elements of national direction, the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699 The programe to establish the framework, which will enable implementation of the strategy, bringing together Scottish Government Directors with Board Chief Executives, is currently being established.

4.4. A final a critical part of the national scene is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.5. At **Regional level,** there are well established planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area. The Regional Planning Group is discussing how to extend the range and depth of planning done at regional level to respond to the NCS and the growing reality that a wider range of services need to be planned for larger populations and that we need to create clinical networks for service delivery beyond Board boundaries.

4.6. At our **Board level** we have a comprehensive Clinical Services Strategy approved by the Board in January 2015 and since endorsed by the IJBs.

4.7. The key aims of the strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

4.8. This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:-

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;
- accessible, provided as locally as possible;

4.9. We have also developed a delivery plan for the Acute Division which focuses on resolving short term challenges but also describes a series of strategic service issues which we need to address.

4.10. IJBs have published their first Strategic Commissioning Plans, these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

5. Developing our Strategic Plan: proposed process

5.1. We know from our planning for 2016, and from the material outlined in the previous section, that it is imperative that we reshape acute services in the short, medium and longer term. Our proposed approach is to bring together those three horizons for planning into an integrated process so that we develop and describe the changes we need to make in 2017/18 in the context of describing a longer term strategic change programe.

5.2. To begin this process it is proposed that we complete a series of strands of work for consideration by a Board seminar in October 2016. The proposed strands are:-

An update of the key elements of the Clinical Services Review including:-

- Population health analysis;
  Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;

- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focussed on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;

5.3. We also need to produce an initial forward financial framework for acute services, developed with the Integration Joint Board's;

5.4. The development of each of these strands will include extensive clinical engagement and engagement with wider stakeholders including other Boards and Scottish Government

5.5. The Acute services Committee will receive regular updates as this work develops to ensure continuing Non Executive input. Following the October Seminar, enabling the Board to consider and shape this material, there would be further discussion with IJBs with the aim that this work can be finalised to enable the Board to approve for publication, and public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

6. Conclusion

6.1. Subject to the Board discussion the Board Executive team will work with IJB Chief Officers to establish the required processes to develop the material outlined in this paper.

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 14

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	**2016/17_14**
Subject Title	HSCP Complaints Procedure
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Sandra Cairney Head of Strategy, Planning & Health Improvement Sandra.Cairney@ggc.scot.nhs.uk 0141 201 3101

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Board with a copy of the integrated Health & Social Care Partnership (HSCP) Complaints Procedure that covers confidentiality, anonymity and data protection; complaint handling; detailed algorithm and tools; and learning from complaints. **Appendix 1**.

2. SUMMARY

2.1 The Complaints Procedure supports the Scottish Government's Policy of Health and Social Care Integration and its Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 in respect of the integration of Health and Social Care complaint handling processes.

2.2 The document aligns the requirements of the NHS Patients Rights (Scotland) Act 2011(Health Complaints); the NHS Greater Glasgow & Clyde Complaints Policy; and the Statutory Social Work (Representation and Procedures) (Scotland) Directions 1996 (SI 1990/2519).

2.3 The Complaints Procedure must ensure the organisation complies with the duties placed on it by equalities legislation and the procedure applies to all services managed within the Health and Social Care Partnership under the direction of the Chief Officer.

2.4 The Complaints Procedure, following approval by the HSCP Board, will be supplemented by a service user complaints information leaflet, which will be made available on the HSCP website and be available as hard copy in all HSCP service locations. Service User information will direct all formal written complaints about HSCP services to the Chief Officer of the HSCP as the single point of contact for formal complaints.

2.5 The approved HSCP Complaints Procedure will be communicated to all staff and managers will raise awareness of the integrated procedure at team

meetings. Staff training on complaints handling will be undertaken within integrated teams.

3. RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

- Considers and approves the HSCP Complaints Procedure

East Dunbartonshire
Health & Social Care Partnership

Complaints Handling Procedure

August 2016

CONTENTS

Section 1.

Introduction

The Scottish Government's Policy of Health and Social Care Integration and its Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 in respect of the integration of Health and Social Care complaint handling processes advises that:

- Health Boards and Local Authorities who choose a body corporate model of integration will remain responsible and deal with complaints about service delivery through the existing health and social care complaints procedures.
- Health & Social Care Boards are required to establish a complaints procedure to deal with the strategic planning delegated functions as these are not covered under current complaints procedures.

This document supports the *Regulations (2014)* and aligns the requirements of the NHS Patients Right (Scotland) Act 2011(Health Complaints); the NHS Greater Glasgow & Clyde Complaints Policy; and the Statutory Social Work (Representation and Procedures) (Scotland) Directions 1996 (SI 1990/2519). It applies to all services managed within the Health and Social Care Partnership under the direction of the Chief Officer.

The HSCP is committed to providing quality, effective and efficient services and aims to reduce barriers to making complaints as part of a streamlined approach to delivering sensitive care and support and promoting equality of opportunity for the residents of East Dunbartonshire.

Application of these procedures must ensure the organisation complies with the duties placed on it by equalities legislation to treat all individuals on an equitable basis, with an understanding of issues relating to age, disability, gender, race, religion, sexual orientation, or socio-economic status in accordance with the equality legislation.

In practice, this includes:

- providing accessible information in appropriate formats
- supporting complainants or their representative needing assistance
- resolving complaints immediately to prevent where possible progressing to a formal complaints investigation process
- being open and transparent whilst safeguarding confidentiality and data protection compliance.

Background

The Patient's Rights (Scotland) Act 2011 Act gives patients a legal right to give feedback on their experience of healthcare and treatment and to provide comments, or raise concerns or complaints. The 1968 Social Work (Scotland) Act places duties on Local Authorities to establish procedures for considering complaints with regard to the discharge of their social work functions. The Act is supported through guidance and directions which can be found in SWSG5/1996 circular.

The current Social Work Complaints Committee procedure and NHS procedures are under review at a national level by the Scottish Government. Once recommendations have been made regarding these reviews, this procedure will be amended accordingly.

What is a complaint?

A “complaint” is defined as an expression of dissatisfaction about an action or lack of action or standard of care provided or commissioned by the Health and Social Care Partnership that requires a response. It may also be about a service which is not being provided or has been refused.

Complaints not covered by these procedures

If a concern is identified as one of the following it should be dealt with through other channels:

- a review of a service decision i.e. re financial assessment/service charges;
- an investigation of a criminal offence;
- a possible claim for negligence;
- Freedom of Information request;
- Subject Access request.

Who can complain?

A complaint can be made by:

- Anyone who has had or is receiving a service provided directly or commissioned on behalf of the HSCP for care, treatment or intervention has a right to make a complaint if they are dissatisfied with any aspect of the service provision.
- A person who was been refused a service
- In some cases a third party might make a complaint on behalf of the service recipient, but this must be with the explicit and recorded consent of the service recipient and/or certain other people (such as parents and foster carers).
- Anyone likely to be affected by a decision taken by the HSCP.
- In the case of a deceased person, the right to pursue a complaint might rest with the executor.

Who can't complain?

Those not entitled to make a complaint include:

- Individuals who are not in receipt of HSCP services or are not likely to be affected by our decisions.
- Individuals who are raising a complaint on behalf of a patient or service user without consent and are not in possession of Power of Attorney or Guardianship or a written certificate of authorisation.
- Those using the process for political purposes.
- Those wishing to use the process as part of a legal action or compensation claim.

Confidentiality / Anonymity

Complainants may request that their identity is not disclosed when a complaint is made. However, they must be advised that this anonymity may restrict the activity of the investigating officer to fully investigate the matters raised or that an indication of who the complainant is may become evident during the investigation. This will allow the complainant to consider their position in this respect.

Data Protection

The complainant should be reminded that they have no right of access to personal information held on files about a third party, unless the third party has given written (or equivalent) consent in line with Data Protection legislation.

Section 3.

Procedure at a glance

This section provides guidance on the process to be followed and who is accountable at each stage. The aim is to provide a quick guide with more detailed actions outlined in section 6.

The process provides the HSCP with two opportunities to deal with complaints internally:

- frontline resolution
- investigation

Stage 1. **Frontline Resolution**	For issues that are straight forward and easily resolved, requiring little or no investigation.	'On-the-spot' apology, explanation, or other action to resolve the complaint quickly, in five working days or less, unless there are exceptional circumstances. Complaints addressed by any member of staff, or alternatively referred to the appropriate point for frontline resolution. Complaint details, outcome and action taken recorded and used for service improvement.
Stage 2. **Investigation**	For issues that have not been resolved at the frontline or that are complex, serious or 'high risk'.	A definitive response provided within 20 working days following a thorough investigation of the points raised. Sensitive complaints that meet set criteria may have the opportunity for additional internal review. Responses signed off by senior management. who have an active interest in complaints and who will use information gathered to improve services. ***** *Social Work only* If the complainant is dissatisfied with the outcome of the social work investigation findings s/he can ask for the decision to be reviewed by the Complaints Review Committee/Panel. The Committee/Panel has set timescales for responding to the complainer and the Local Authority has similar timescales for responding thereafter to the complainant.
Stage 3. **External Review**	For issues that have not been resolved by the service provider.	Complaints progressing to the Scottish Public Services Ombudsman (SPSO) will have been thoroughly investigated by the service provider. The SPSO will assess whether there is evidence of service failure or maladministration not identified by the service provider.

Complaint handling Stage 1 Frontline Resolution

When is Frontline Resolution appropriate?

This should be attempted where the issues are straight forward and potentially easily resolved, requiring little or no investigation.

Where possible, the complainant should be actively and positively engaged within the process from the outset- face to face or telephone.

The focus is to take action to resolve the complaint as quickly as possible. This may take the form of an immediate resolution, quick apology or explanation for service failure where this is evident.

Considerations

Staff who are the subject of a complaint should not handle or respond to the complaint. Neither should frontline staff who may have a clear conflict of interest in the matter.

Clarity should be sought where appropriate on the grounds of the complaint and expected or desired outcome. Unrealistic expectations need to be managed appropriately.

key questions:

- What is the complaint?
- What does the service user wish to achieve by complaining?
- Can an explanation be provided that answers the complaint?
- If the person is unable to resolve the issue, do they know where to refer the complaint on to?

Timescale

Frontline resolution should be completed within **5 working days** although an extension can be negotiated where appropriate.

Action

The complaints should be recorded along with the date of receipt, nature of the complaint and date of resolution/response and any learning points

If the complainant is not satisfied, they should be informed about the organisational complaints process.

Section 4.

Complaint handling Stage 2. Investigation

When is Investigation appropriate?

The Investigation stage will be required for a variety of reasons including:

- Frontline resolution was attempted, but the service user remains dissatisfied
- The service user refuses to engage with the frontline resolution process
- The issues raised are complex and will require detailed investigation
- The complaint relates to issues that have been identified as serious or high risk/high profile

Considerations

At the investigation stage, staff should be aiming to 'get it right first time'. The goal is to establish all of the facts relevant to the points raised and provide a full, objective and proportionate response that represents the service provider's definitive position.

Service users should have a single point of contact for their complaint and be provided with the name and contact details of the person dealing with their complaint.

Staff selected to investigate and respond to a complaint should have sufficient internal credibility and independence to ask difficult questions and make recommendations. It is important that an investigator should be able to seek advice from senior management about the conduct or findings of an investigation whenever necessary.

Timescale

Complaints should be acknowledged within **3 working days and** full response provided within **20 working days.** There are some complaints that are so complex that they will require careful consideration and detailed investigation beyond the 20 working days target. Where there are clear and justifiable reasons for extending the timescale, organisations should set time limits on any extended investigation, subject to agreement with the complainant. The complainant should be kept updated about the reason for the delay and given a revised timescale for bringing the investigation to a conclusion.

Action

Responses and action plans will be signed off by the Head of Service who will ensure that information will be used to improve services. The HSCP's final position on the complaint should be communicated to the complainant by the Chief Officer.
Once the above processes have been completed, if the complainant is not satisfied, the complaint can be raised with the Scottish Public Services Ombudsman.

Investigation stage continued...
*Social Work only – Review Process

When is a Review Process appropriate?

If the complainant is dissatisfied with the outcome of the social work investigation findings s/he can request that the decision be reviewed by the Complaints Review Committee/Panel.

Considerations

The Complaints Review Committee/Panel is made up of a panel of 3 independent persons to East Dunbartonshire Council. These panel members are responsible for reviewing the evidence presented in an objective and independent manner and offer an opportunity for the complainant to present and discuss their case.

The role of the Complaints Review Committee/Panel is to objectively and independently examine the facts of the complaint. It only has the power to make recommendation to the appropriate local authority committee. It is the local authority committee which effectively takes the final decision on the complaint.

Timescale

The complainant is required to request the review of the decision to the Complaints Review Committee/Panel within 28 days and the Panel will be convened within 56 days, with a response to be issued within 42 days of the Committee meeting.

Action

The Complaints Review Committee/Panel forwards its response to the Social Work Committee for ratification and also to the Chief Executive of East Dunbartonshire Council outlining its outcome and if necessary any recommendation and remedial action to be taken if the complaint outcome is not upheld.

The Local Authority must within 42 days of receiving the recommendations notify the complainant in writing about what actions it intends to take in response to the Complaints Review Committee recommendations. The Chief Executive will provide a written outcome to the Complainant.

Once the above processes have been completed, if the complainant is not satisfied, the complaint can be raised with the Scottish Public Services Ombudsman.

Section 4.

Complaint handling Stage 3.

External Review

When is External Review appropriate?

When the complaint procedure has been exhausted and the service user is dissatisfied with the final outcome, the service user has the right to take their complaint to the Scottish Public Services Ombudsman.

Considerations

The SPSO will consider complaints from service users and may carry out its own investigation where there are indications that there may have been maladministration or service failure by the service provider.

The SPSO handles complaints about public services in Scotland. It can normally only consider complaints after they have been through the Complaints Handling Procedure of the organisation concerned, and where a member of the public claims to have suffered injustice or hardship as a result of maladministration or service failure. Its role and remit are set out in the Scottish Public Services Ombudsman Act 2002.

Timescale

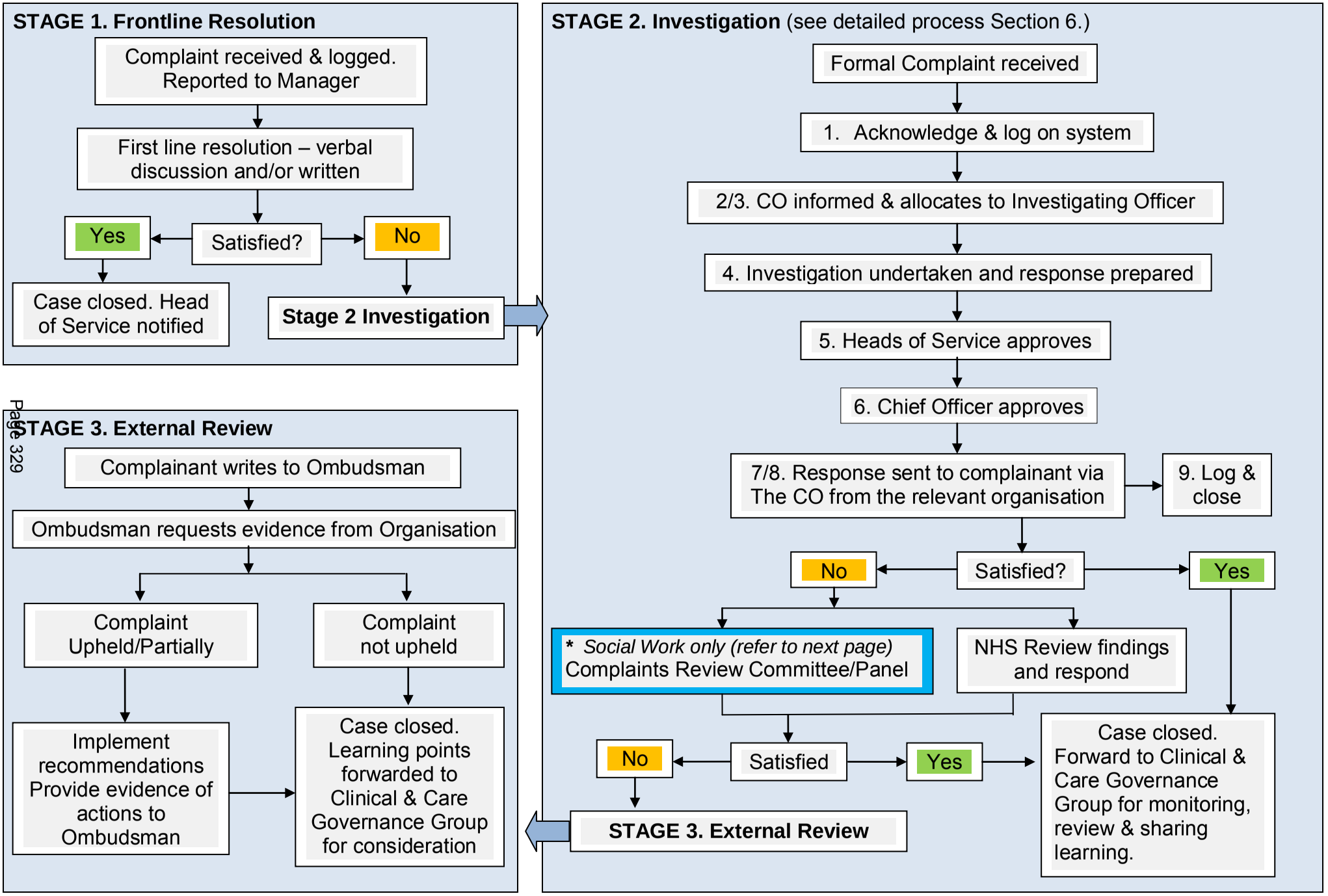
The Scottish Public Services Ombudsman is not normally able to investigate matters where the issue raised is over 12 months old.

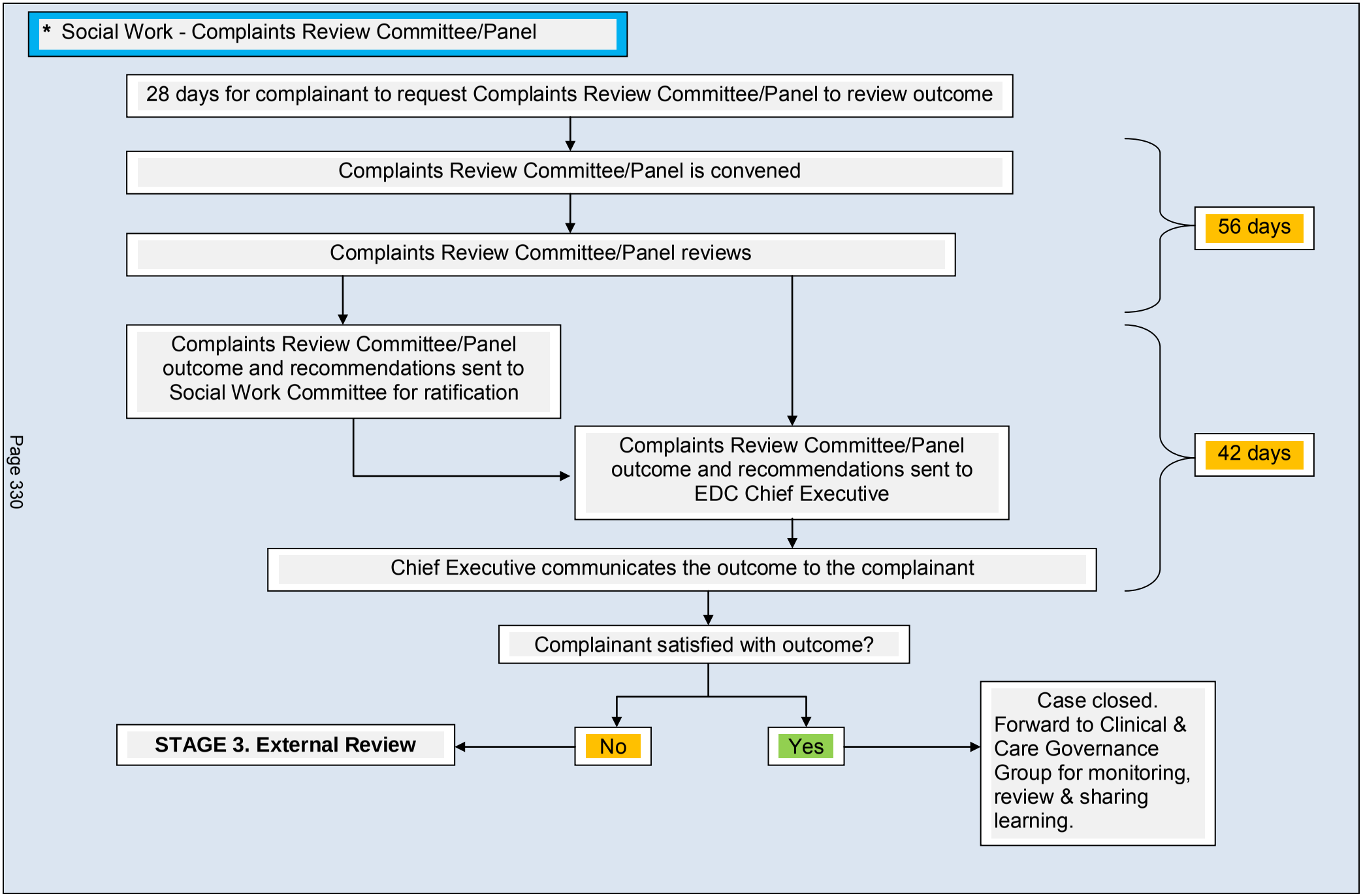
Action

The HSCP should ensure that complaints correspondence and details of the investigation are available for review by the Ombudsman if required. The Scottish Public Services Ombudsman recommends that service providers keep accurate records of their investigation and of any interviews or meetings held to discuss the complaint. These documents should be retained in line with the organisation's document retention policy.

The SPSO can undertake ad hoc audit of all Actions plans produced by investigating officers to monitor compliance and quality.

Section 5. COMPLAINT HANDLING PROCEDURE – OVERVIEW OF 3 STAGES




* Social Work - Complaints Review Committee/Panel
28 days for complainant to request Complaints Review Committee/Panel to review outcome
Complaints Review Committee/Panel is convened
Complaints Review Committee/Panel reviews
56 days
Complaints Review Committee/Panel outcome and recommendations sent to Social Work Committee for ratification
Complaints Review Committee/Panel outcome and recommendations sent to EDC Chief Executive
42 days
Chief Executive communicates the outcome to the complainant
Complainant satisfied with outcome?
No
Yes
STAGE 3. External Review
Case closed. Forward to Clinical & Care Governance Group for monitoring, review & sharing learning.

Step	HSCP Complaint received by...			Tools
1.	**EDC** Acknowledge Complaint within 3 working days & seek consent if required	**ED HSCP** Acknowledge Complaint within 3 working days & seek consent if required	**GGC** Acknowledge Complaint within 3 working days. HSCP will seek consent if required	Master Ack letter for all complaints.doc Able to consent form at Nov 2015.do
2.	**Complaint forwarded to HSCP Chief Officer**			
3.	**Head of Service notification and responsibilities** ▪ Head of Service notified and appoints investigating officer. ▪ EDC issues the Investigating Officers Complaint Pack and copy of complaint to the Social Care Investigating Officer ▪ NHS issues the Investigating Officers Complaint Pack and copy of complaint to the Health Investigating Officer ▪ EDC logs complaint / HSCP opens on DATIX			Blank Investigation Report at DEC 2015
4.	**Investigation commences** ▪ Investigation commences within 3 and concludes within 20 working days. ▪ If the 20 day timescale has the potential to breach, the EDC/HSCP Investigating Officer issue a Holding Letter to the complainant (Copy to HSCP Head of Admin)			Master 20 Day Holding Letter.doc
5.	**Investigation concluded within 20 working days** ▪ Investigating Officer prepares Draft Final Response Letter and completes the Investigation Report ▪ Investigating Officer emails the draft Response Letter and Investigation Report to the Head of Service (copies emailed to HSCP Head of Admin)			Master Final Letter template for flow cha
5.	**Final Response and completed Investigation Report** ▪ Head of Service approves the draft Response Letter and Investigation Report (copies emailed to HSCP Complaints Officer)			
6.	**Chief Officer approval** ▪ Chief Officer approves the final response letter and Investigation Report (copies emailed to HSCP Head of Admin)			
7.	**Disseminate Response** ▪ HSCP Head of Admin emails final response letter to the relevant organisation			
8.	EDC sends final response to complainant	HSCP Sends final response to Complainant	Copy to GGC Public Affairs and/or GGC may send response to complainant	
9.	EDC logs complaint	HSCP closes complaint on Datix		

Learning from complaints

As an integral part of the HSCP Quality Assurance and audit processes, all complaints are used as a method of public experience feedback about service delivery and engagement. Issues, themes or patterns of complaints are used as opportunities to share learning. In doing so, the HSCP demonstrates the commitment to continuous development and performance of its services as well as preventing future recurrence of issues.

A service improvement or learning action plan should be completed by the designated investigating officer to identify areas of practice which:

- contributed to the complaint being raised or
- prevented effective working or engagement, leading to the complaint.

Elements of the complaint should be analysed by the investigating officer to identify any improvements in practice, process or behaviour required to prevent a similar experience or occurrence in the future.

The Investigating officer should forward the completed action plans to the Head of Service and Service Manager for comment and action. The identified learning will be cascaded by the Head of Service or Service Manager to staff to improve performance and/or quality.

A copy of the action plan is then shared with the Clinical & Care Governance Lead to monitor implementation and identify opportunities to improve practice and to share across HSCP service teams.

Further information

Further information is available on the following links:

- **NHS Complaints procedure**
http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Complaints/Pages/NHSComplaints.aspx

- **East Dunbartonshire Council Complaints Handling Procedure**
www.eastdunbarton.gov.uk/council/comments-and-complaints

- **Social Work (Representation & Procedures) (Scotland) Directions 1996**
www.scotland.gov.uk/Publications/2011/12/21143818/1

- **Scottish Public Services Ombudsman complaints handling procedure**
www.spso.org.uk/sites/spso/files/communications_material/leaflets_buj/Guidance-on-a-Model-Complaints-Handling-Procedure.pdf

Is there any support?

The **Patient Advice & Support Service** is a free independent service provided by the Citizens Advice Bureau (CAB) to support those making a complaint regarding NHS services. This service can be accessed from any Citizens Advice Bureau in Scotland.
www.cas.org.uk or at any CAB service.

Ceartas Advocacy Service can offer support to complainants with regard to Social Work Complaints.
www.ceartas.org.uk

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 15

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	2016/17_15
Subject Title	HSCP Management Structure Progress Report
Report by	Karen Murray, Chief Officer East Dunbartonshire Health & Social Care Partnership
Contact Officer	Tom Quinn, Head of People & Change Pauline Halligan, Business & People Change Manager

1.0 PURPOSE OF REPORT

1.1 This report provides an update to the HSCP Board on progress in taking forward phase 2 of the Senior Management Structure for the HSCP.

2.0 SUMMARY

2.1 The report recognises in section 1 the work and associated principles which have been used to establish the structure at Heads of Service and Chief Finance and Resource Officer and provides reassurance that the same process will be used in taking forward phase 2.

2.2 The report provides clarity on the functional activities and management structure required to provide robust, reliable and affordable management across the Head of Service and Chief Finance and Resource Officer remits.

2.3 Section 3 and appendix 5, outline the initial posts that might be impacted by the proposed structure and the revised posts to be developed, providing reassurance that this provides for a cost neutral position.

2.4 Section 4, provides an overview of the Strategic and Operational management structure for the HSCP. It is important to note that in light of other papers and recommendations at this meeting, the overall structure will alter but this will not impact on the current activity.

2.5 Finally, we highlight the next steps required to take this phase through to completion, main areas here are:

- Further work to ensure appropriate structure and relationships in developing the reporting and management structures to support the Chief Finance and Resources Officer
- Agreeing staff directly impacted by the change
- Developing and evaluating role profiles within both EDC and NHSGGC processes
- Once the evaluation process is complete, prepare final budget position on the overall structure in phase 1 and 2.
- Developing a matching criteria which is compatible with the agreed change management process processes of both EDC and NHSGGC

3. RECOMMENDATIONS

3.1 The HSCP Board is asked to approve phase 2 of the Senior Management Structure

4.0 MAIN REPORT

4.1 Title: Updated position on developing a Robust, Reliable and Affordable Management Structure, phase 2.

4.2 Background:

In January 2015, we started to map out the process to establish a robust, reliable and affordable management structure to undertake the management of staff within the delegated functions of the Health and Social Care Partnership.

Phase one, was to establish those post that would report directly to the Chief Officer and those identified by legislation. In looking to take this forward with our accredited staff partners we established a series of principles to guide our activity:

- The proposed operational management structure should be financially neutral in relation to current management expenditure and if practical should provide savings for services
- Integrated management should be seen as the norm where practical, although it is acknowledged that not all functions will benefit from integrated management and therefore the process of "form following function will apply"
- Process of recruitment to posts in the operational management structure will follow the agreed principles of the employers policies for service change; namely Workforce Change Policy and Procedure (NHSGGC) and (EDC)
- The job descriptions for all new posts will be evaluated through both the EDC and NHS evaluation systems.
- The proposed operational management structure and the guiding principles will be subject to engagement at the earliest opportunity with the respective recognised Trade Unions and Professional Bodies of NHSGGC and EDC
- A definitive list of all the services that will be operational management by the HSCP will be established and will form an appendices to these principles
- Local management structures within the previous East Dunbartonshire CHP and East Dunbartonshire Council Social Care Services will be reviewed to ensure that no staff are disadvantaged

HR support to the HSCP will be through senior HR staff in both NHSGGC and EDC who will also be able to provide strategic support and commission specialist supports for people management processes.

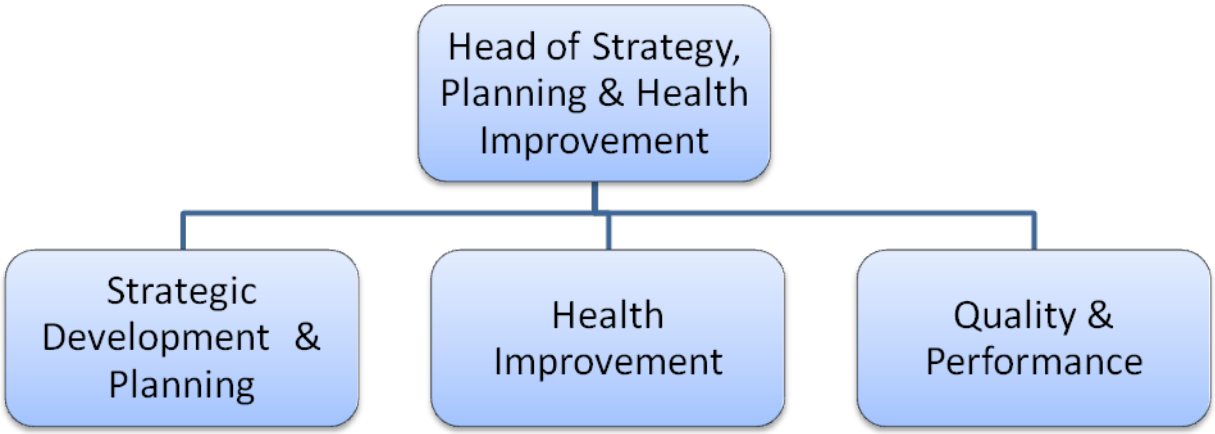
In Phase 2, we will continue to follow the above principles to establish the management structure that report directly to the Heads of Services. It is recognised that phase 3 of the process will look more closely at integration at front line service delivery level.

4.3 Process to date:

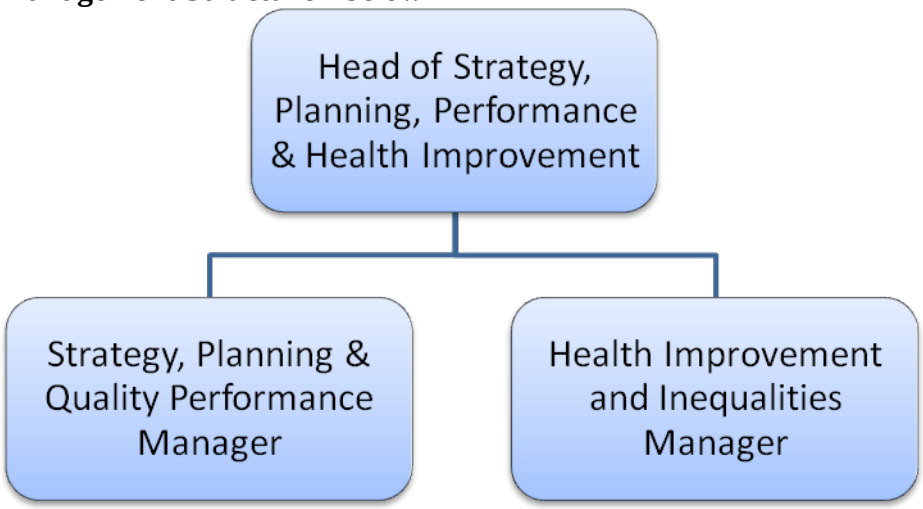
Heads of Service have met with HR to look at what would be workable solutions to managing both strategically and operationally within their key functional areas of activity, this has been over a series of meetings to enable us to try and tease out the relationship across key interdependencies (see appendix 1).
In working through this process the following structures have been identified:

4.3a. Strategic Planning, Performance and Health Improvement

There are 3 key functional areas identified (Strategic Development & Planning; Quality & Performance and Health Improvement and Inequalities) which will be managed through 2 senior managers as set out below **(Appendix 2 – Provides an overview of the services to be delivered within this structure)**

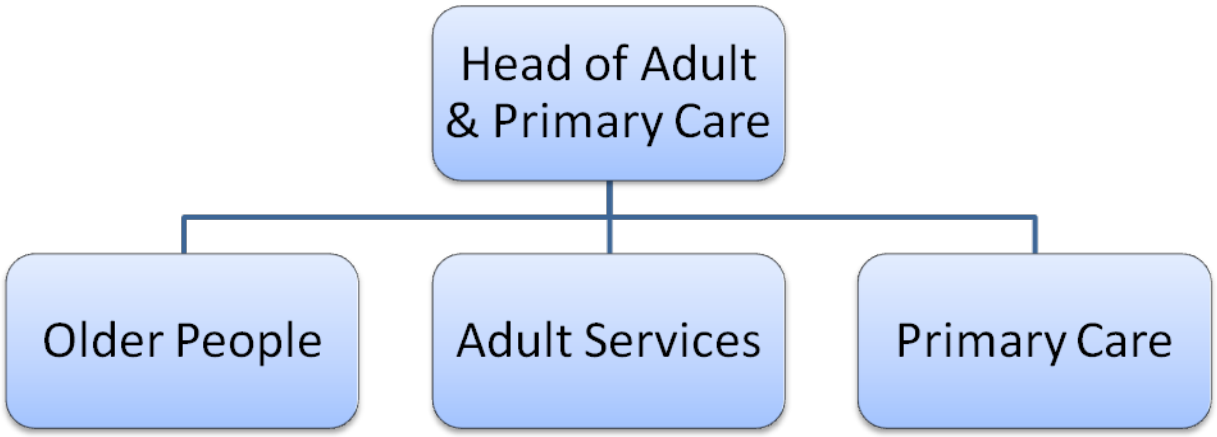


Functional Areas – Above
Management Structure - below

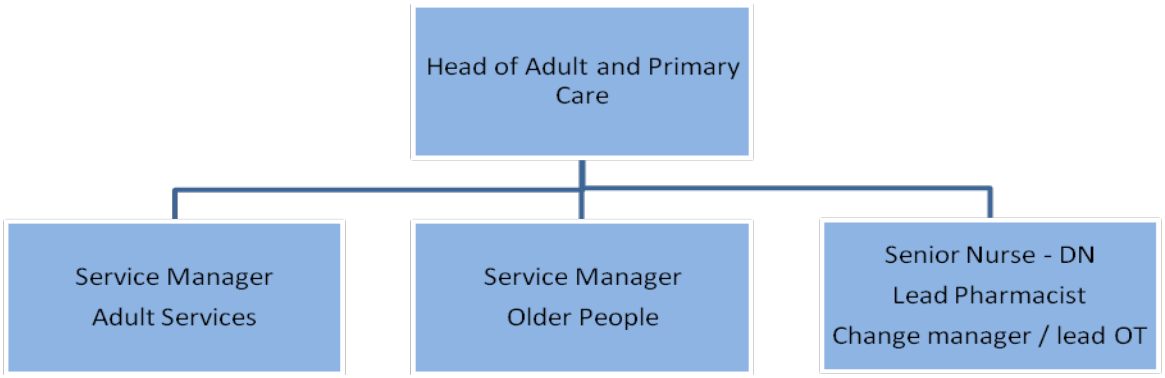


4.3b. Adult and Primary Care

There are 3 key functional areas identified (Adult Services, Older People Services and Primary Care functions) which will be managed through 2 senior manager covering integrated activity and 3 service functions. **(Appendix 3 – Highlights the services to be delivered within this structure)**



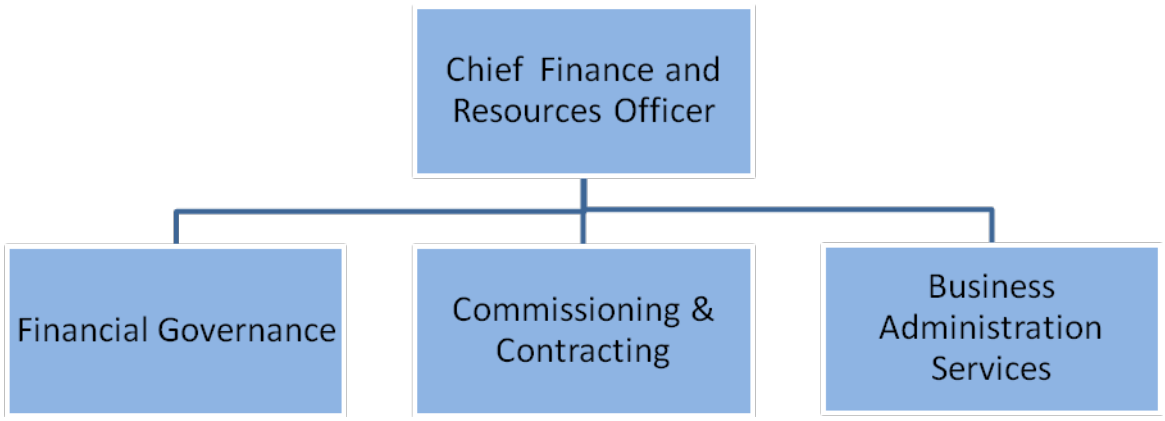
Functional Activity -above
Management Structure – below



The existing structures below this level will initially remain in place until further work is undertaken to look at what service areas would benefit from further integration. This will result in a larger role for the Operations Manager in Mental health (Health), mainly as a result of an earlier change in NHS Learning Disability structures. The Primary Care structures will be reviewed as we take forward work on Clusters within East Dunbartonshire.

4.3c. Finance and Resourcing

There are 3 key functional areas identified (Financial Governance; Commissioning and Contracting; Business Administration) which will be managed through existing staff within either NHSGGC or EDC
(Appendix 4 – Identifies the services to be delivered within this structure)



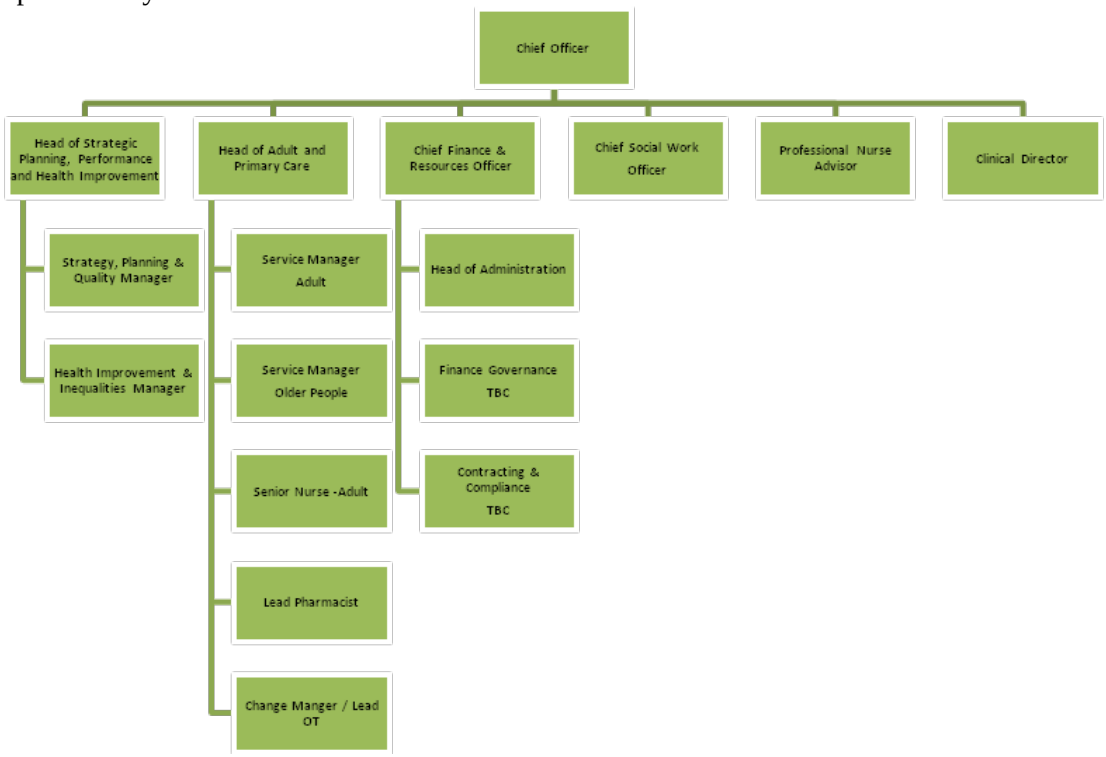
Further work is required to identify the staffing resources within the scope and range of this structure.

4.4 Financial Implications of the above structures.

Appendix 5 provides an overview of posts impacted either directly or indirectly within this structure and potential outcome of evaluation on both a NHSGGC and EDC Job Evaluation process. The final position is suggesting cost neutral, which is a key principle, this has been enabled by 2 previous health posts being deleted from the system, namely the Head of Primary Care and Head of Mental Health

4.5 Overview of structure in stage 1 and 2

The structure proposed meets the agreed principles and is designed to be "fit for purpose" both strategically and operationally.



It is worth noting that in this structure some other associated posts might change reporting lines and procedures prior to us undertaking a full review of the structure below this level to ensure for maximum efficiency and effectiveness

4.6 Next Steps:

The following steps are required to take forward the above process –

1- Further work to ensure appropriate structure and relationships in developing the reporting and management structures to support the Chief Finance and Resources Officer

2- Need to identify and agree existing staff who are within the scope and range of posts directly impacted by these changes

3- Need to agree job descriptions / role profiles for the new posts and have these evaluated through the respective processes in both NHSGGC and EDC

4- Prepare final budget position on the overall management structure for phase 1 and phase 2

5- Matching process will follow agreed Change processes with both NHSGGC and EDC

6- Need to ensure that where there are changes to reporting structures and or job roles we review existing

role profiles / job descriptions to ensure that they are updated and if necessary evaluated

7- Need to agree communications process for directly affected staff and for all staff in general about timescales

8- Need to consider which staff will be affected by the changes to functional activity within the domain of Heads of Service and agree process for migration, ensuring governance arrangements are in place to provide smooth handover of responsibility.

9- It is anticipated that this stage of the process will be complete by end of September 2016.

10- Need to agree with recognised trade unions process for developing an overarching workforce plan for the HSCP as Phase 3.

Appendix 1 – Interdependences

Functional activity within individual roles will have key interdependencies across:

- Community Planning
- Strategic Partnerships
- Community Protection
- Finance & Accountancy
- Performance & Research
- Education Services

To deliver on an operational level, support is provided from within the following functions provided by NHSGGC or EDC

- Finance
- HR
- Change Team
- Learning , Education & Training
- Shared Services
- Audit
- Legal
- Equalities aspects
- Organisation development

Appendix 2 –

Key Activities in Strategic Development, Planning, Performance and Health Improvement and Inequalities

- Strategic Planning
- Locality Planning
- Health Improvement
- Data Analysis
- Performance Analysis
- Performance reporting
- Thematic Areas
- Care Group Specific Areas
- Inequality Sensitive practice
- Equality Impact Assessment Advice
- Service User Involvement
- Community Involvement
- Financial Inclusion
- Supporting New Initiatives
- Leadership Development
- Service Improvement
- HSCP Website Development and Maintenance
- Internal & External Inspection
- Lead for Community Planning
- Emergency Planning
- Business Continuity Planning

Appendix 3

Key Activities within Adult and Primary Care

Former NHSGGC –

- Community Mental Health Team
- Addictions
- Learning Disability
- Rehabilitation and Enablement
- Older People Mental Health
- District Nursing/ Diabetic Nurses
- Care Home Liaison Nurses
- Primary Care Mental Health Team
- Primary Care Interface
-

Former East Dunbartonshire Council – SWS

- Mental Health Services
- Addiction Services
- Learning Disability
- Physical Disability/ Sensory Impairment
- Adult Intake
- Local Area Co-ordination
- Carer & Respite Services
- Resources – Day Care Services

    Home Care
    Telecare
    Community Alarms

Appendix 4

Key Activities within Finance and Resourcing

- Strategic Financial Planning
- Financial Governance
- Audit Activity
- Procurement
- Section 95 Activity
- Invoicing Procedures
- Commissioning External Services
- Performance Monitoring for Commissioned Services
- Best Value
- Support for Self Directed Support/
- Service Level Agreements/ Hosted Services
- IJB Corporate Risk Register
- NHS Local Administration Services

Appendix 5 – Overview of Existing and New Posts

Head of Strategy direct reports

Exist Posts

	Salary Band	Potential Band
Planning Manager	8A	
Health Improvement & Equalities Manager	8A	

New Posts

Strategic Planning and Quality Performance Manager	8A/B
Health Improvement & Equalities Manager	8A/B

Head of Adult & Primary Care direct reports

Existing Posts

Head of Mental Health	Sen Man A
Head of Primary Care	Sen Man B
Rehabilitation Manager	8A
Operations Manager MH	8A
Fieldwork Services Manager – Older People	Grade 11
Fieldwork Service Manager – Adult	Grade 11
Resources Services Manager	Grade 11

New / Retained Posts:

Operational Manager – Older People	Grade 12 /8B
Operational Manager – Adult	Grade 12/8B

Existing posts being retained

Senior Nurse	8A
Lead Pharmacist	8B
Change Manager / Lead OT	8A
Amended post – Operations Manager Mental Health	8A/B

Chief Finance and Resources Officer
TBC – Mainly existing posts that will be re-aligned

East Dunbartonshire
Health and Social Care Partnership

Agenda Item no: 16

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Committee Meeting	11th August 2016
Report Number	**2016/17_16**
Subject Title	Audit Committee –Revised Terms of Reference
Report by	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Jean Campbell, Chief Finance & Resources Officer, 0141 201 4264

1. PURPOSE

1.1. The purpose of this report is to seek approval for the terms of reference for the Audit Committee for the East Dunbartonshire Health & Social Care Partnership.

2. SUMMARY

2.1. A Draft Terms of Reference was presented to the last Audit Committee on the 20th June 2016. There were a number of updates required and these have been incorporated into the revised draft. This is attached as **Appendix 1.**

2.2. The Health & Social Care Partnership Board positively promotes the principles of sound corporate governance within all areas of its affairs. Its Audit Committee is an essential component of the governance of the Health & Social Care Partnership Board detailed within its Financial Regulations.

2.3. The terms of reference set out the purpose, membership, reporting requirement, responsibilities, rights and procedures for conducting meetings.

3. RECOMMENDATIONS

3.1. It is recommended that the Committee:-

Approve the revised Terms of Reference for the Audit Committee

.

East Dunbartonshire

Health and Social Care Partnership

East Dunbartonshire Health & Social Care Partnership Board

Audit Committee

Terms of Reference

1. PURPOSE

1.1 East Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated it by NHS Greater Glasgow & Clyde Health Board and East Dunbartonshire Council (described in full within its approved Integration Scheme). The Council and the Health Board 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 East Dunbartonshire Health & Social Care Partnership. The Health & Social Care Partnership Board is responsible for the operational oversight of East Dunbartonshire Health & Social Care Partnership.

1.2 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Partnership Board.

1.3 The Health & Social Care Partnership Board positively promotes the principles of sound corporate governance within all areas of its affairs. Its Audit Committee is an essential component of the governance of the Health & Social Care Partnership Board detailed within its Financial Regulations.

1.4 The East Dunbartonshire Health & Social Care Partnership Board has established this Audit Committee as a Committee of the Partnership Board to support it in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. These Terms of Reference for the Audit Committee reflect the span of responsibilities of the Partnership Board and requirements of its approved Financial Regulations, i.e.:

- The Strategic Plan.
- Financial plan underpinning the Strategic Plan.
- The operational delivery of those integrated services delegated to the Partnership Board (except for NHS acute hospital services).
- Relevant issues raised by the internal auditors of the Health Board, Council and the Partnership Board.

2. MEMBERSHIP

2.1 The Audit Committee will be composed of the six voting members of the Partnership Board.

2.2 The Audit Committee will be chaired by the Vice-Chair of the Partnership Board.

2.3 As the Audit Committee will be responsible for overseeing the financial governance arrangements of the Partnership Board, other non-voting members of the Partnership Board shall also have the right to attend. A schedule of meetings will be published for all Partnership Board members, and those non-voting members who confirm their intention to attend the meeting will be issued with papers for that meeting.

2.4 The Chief Financial Officer will nominate an Internal Audit Service, led by a named Chief Internal Auditor, to work on behalf of the Audit Committee.

2.5 The external auditors for the Partnership Board will be appointed by the Accounts Commission.

2.6 The appointed Chief Internal Auditor will normally attend meetings of the Audit Committee.

2.7 A representative of the external auditors will normally attend meetings of the Audit Committee.

2.8 The Chief Officer and Chief Financial Officer of the Health & Social Care Partnership Board will normally attend meetings of the Audit Committee.

2.9 The Audit Committee will be provided with a secretariat function by East Dunbartonshire Council.

2.10 Other officers of the Health & Social Care Partnership, East Dunbartonshire Council and NHS Greater Glasgow & Clyde may also be invited to attend meetings.

3. REPORTING

3.1 The Audit Committee will formally provide a copy of its minutes to the Partnership Board for inclusion on the agenda's of its subsequent meetings. These minutes will be made publicly available.

3.2 The Audit Committee will provide the Partnership Board with an Annual Statement, timed to support finalisation of the accounts and the governance statement, summarising its conclusions from the work it has done during the year.

4. RESPONSIBILITIES

4.1 The Audit Committee will advise the Partnership Board and its Chief Financial Officer on:

- The strategic processes for risk, control and governance and the governance statement.
- The financial governance and accounts of the Partnership Board, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors.
- The planned activity and results of both internal and external audit as they relate to the activities of the Partnership Board.

- The adequacy of management response to issues identified by audit activity, including external audit's management letter/report.
- The effectiveness of the internal control environment.
- Assurances relating to the corporate governance requirements for the Partnership Board.
- Appointment of the internal audit service or for purchase of non-audit services from contractors who provide audit services.

4.2 The Audit Committee will also periodically review its own effectiveness and report the results of that review to the Partnership Board

5. RIGHTS

5.1 The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Audit Committee on behalf of the Health Board and Council. In doing this, the Chief Financial Officer will be reliant on both the Health Board's and Council's systems of internal control to support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the Partnership Board as expressed in its Strategic Plan.

5.2 The Audit Committee receive, scrutinise and comment upon the formal submission of reports, findings and recommendations by the appointed Internal Audit service, external auditor (as appointed by the Accounts Commission), Audit Scotland and Inspectorate bodies. The Audit Committee will review the HSCP's Risk Register at least once a year. The Chief Financial Officer will ensure that follow-up reports on actions required will be provided to the Audit Committee as agreed.

5.3 The Chief Financial Officer will prepare an Annual Governance Statement for the Audit Committee prior to its being presented to the Partnership Board.

5.4 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Audit Committee on an annual risk-based audit plan in respect of the activities of the Partnership Board; delivery of the plan and recommendations; and will provide an annual internal audit report, including the audit opinion.

5.5 The Audit Committee may procure specialist ad-hoc advice at the expense of the Partnership Board, subject to budgets agreed by the Chief Financial Officer and confirmed by the Partnership Board.

5.6 The appointed Chief Internal Auditor and the representative of External Audit (as appointed by the Accounts Commission) will have free and confidential access to the Chair of the Audit Committee.

6. MEETINGS

6.1 The procedures for meetings are that:

6.1.1 The Audit Committee will meet at least three times per annum, with a provision for additional meetings if required as the discretion of the Chair of the Audit Committee; and with meetings scheduled at regular intervals between the meetings of the Partnership Board. The Committee reserves the right to hold private meetings with the Internal and External Auditors.

6.1.2 The meetings will be conducted in accordance with the Standing Orders of the Partnership Board, including:

- At least one half (i.e. three) of the six members of the Audit Committee will be present for the meeting to be deemed quorate.
- Members of the Audit Committee 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 Audit Committee, before taking part in any discussion on that item. 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.

6.1.3 Audit Committee meetings will normally be attended by the Chief Officer, the Chief Financial Officer, appointed Chief Internal Auditor and a representative of the External Auditor.

6.1.4 The Audit Committee may ask any other officers from the Health & Social Care Partnership, East Dunbartonshire Council and NHS Greater Glasgow & Clyde to attend to assist it with its discussions on any particular matter.

6.1.5 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 Audit Committee shall be open to the public (as per the Standing Orders of the Partnership Board). The Chief Officer shall be responsible for giving public notice of the date, time and place of each meeting of the Audit Committee by posting within the main offices of the Health & Social Care Partnership not less than five days before the date of each meeting.

6.1.6 The Audit Committee may by resolution at any meeting exclude the press and public there from 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. The Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.1.7 Every meeting of the Audit Committee shall be open to the public but these provisions shall be without prejudice to the Audit Committee’s powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The Audit Committee 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 Audit Committee.

6.1.8 The Partnership Board or the Chief Financial Officer may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Audit Committee's advice.

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 17

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Committee Meeting	11th August 2016
Report Number	**2016/17_17**
Subject Title	East Dunbartonshire HSCP Reserves Policy
Report by	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Jean Campbell, Chief Finance & Resources Officer, 0141 201 4210

1. PURPOSE

The purpose of this report is to seek approval for the Reserves Policy for the HSCP

2. SUMMARY

2.1. The Public Bodies (Joint Working) Scotland Act 2014 (section 13) empowers the Integrated Joint Board to hold reserves and recommends the development of a reserves policy and reserves strategy.

2.2. The Reserves Policy sets out the arrangements for the creation, amendment and use of reserves and balances for the HSCP. A copy is included as **Appendix 1.**

2.3. The Annual Accounts for 2015/16 include reserves for the partnership totalling £1.388m to meet the priorities set out in the Strategic Plan, to provide some resilience for on-going pressures and slippage in savings plans.

3. RECOMMENDATIONS

3.1. It is recommended that the Committee:-

a) Approve the Reserves policy attached as **Appendix 1**.

BACKGROUND

4.1 To assist local authorities (and similar bodies) in developing a framework for reserves, CIPFA have issued guidance in the form of the Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances. This guidance outlines the framework for reserves, the purpose of reserves and some key issues to be considered when determining the appropriate level of reserves.

4.2 The purpose of a reserve policy is to:

- Outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- Identify the principles to be employed by the Board in assessing the adequacy of the Board's reserves;
- Indicate how frequently the adequacy of the Board's balances and reserves will be reviewed; and
- Set out arrangements relating to the creation, amendment and use of reserves and balances.

4.3 In common with local authorities, the HSCP Board can have reserves within a usable category.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Partnership are as undernoted.

5.2 Financial – this policy forms part of the governance arrangements for the partnership and provides a framework as to how reserves will be managed within the partnership.

Appendix 1

ED HSCP Boards Reserves Policy

1. Background

1.1 To assist local authorities (and similar bodies) in developing a framework for reserves, CIPFA have issued guidance in the form of the Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances. This guidance outlines the framework for reserves, the purpose of reserves and some key issues to be considered when determining the appropriate level of reserves.

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- Indicate how frequently the adequacy of the Board's balances and reserves will be reviewed; and
- Set out arrangements relating to the creation, amendment and use of reserves and balances.

1.3 In common with local authorities, the HSCP Board can have reserves within a usable category.

2. Statutory/Regulatory Framework for Reserves

Usable Reserves

2.1 Local Government bodies (including the HSCP Board) may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes:

Usable Reserve	Powers
General Fund	Local Government Scotland Act 1973

2.2 For each reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve,
- how and when the reserve can be used,
- procedures for the reserves management and control,
- the review timescale to ensure continuing relevance and adequacy.

Appendix 1

3. Operation of Reserves

3.1 Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
- create a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and
- create a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

3.2 The balance of the reserves normally comprises of three elements:

- Funds that are earmarked or set aside for specific purposes (in Scotland, under Local Government rules, the HSCP Board cannot have a separate Earmarked Reserve within the Balance Sheet, but can highlight elements of the General Reserve balance required for specific purposes). The identification of such funds can be highlighted from a number of sources:
  - Future use of funds for a specific purpose, as agreed by the HSCP Board; or
  - Commitments made under delegated authority by Chief Officer, which cannot be accrued at specific times (e.g. year end) due to not being in receipt of the service or goods;

- Funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and

- Funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the Board.

4. Role of the Chief Finance Officer

4.1 The Chief Finance Officer is responsible for advising on the targeted optimum levels of reserves the HSCP Board would aim to hold (the prudential target). The HSCP Board, based on this advice, should then approve the appropriate reserve strategy as part of the budget process.

5. Adequacy of Reserves

5.1 There is no guidance on the minimum level of reserves that should be held. In determining the prudential target, the Chief Finance Officer must take account of the strategic, operational and financial risks facing the HSCP Board over the medium term and the HSCP Boards overall approach to risk management.

5.2 In determining the prudential target, the Chief Finance Officer should consider the HSCP Boards medium term financial strategy and the overall financial environment. Guidance also recommends that the Chief Finance Officer reviews any earmarked reserves as part of the annual budget process.

5.3 In light of the size and scale of the IJB's operations, over the medium term it is proposed that a prudent level of general reserves will represent approximately 2% of net expenditure. This value of reserves must be reviewed annually as part of the IJB's Budget and Service plan strategy and in light of the financial environment at that time.

5.4 The level of other earmarked funds will be established as part of the annual financial accounting process.

6. Reporting Framework

6.1 The Chief Finance Officer has a fiduciary duty to ensure proper stewardship of public funds.

6.2 The level and utilisation of reserves will be formally approved by the IJB based on the advice of the Chief Finance Officer. To enable the IJB to reach a decision, the Chief Finance Officer should clearly state the factors that influenced this advice.

6.3 As part of the budget report the Chief Finance Officer should state:

- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure.
- the adequacy of general reserves in light of the IJB's medium term financial strategy.
- an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term.
- If the reserves held are under the prudential target, that the Board should be considering actions to meet the target through their budget process

7. Accounting and Disclosure

7.1 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to 'contributions to and from the revenue account' with expenditure charged to the service revenue account.

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 18

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11 August 2016
Report Number	**2016/17_18**
Subject Title	Update report on the Implementation of the Living Wage 2016/17
Report by	Jean Campbell, Chief Finance & Resources Officer East Dunbartonshire Health & Social Care Partnership
Contact Officer	Jean Campbell, Chief Finance and Resource Officer, East Dunbartonshire HSCP 0141 201 4210 - Jean.Campbell@ggc.scot.nhs.uk

1. PURPOSE

1.1. The purpose of this report is to update the Board on the implementation of the Living Wage commitment to all care workers in adult social care from the 1st October 2016.

2. SUMMARY

2.1. A commitment was made to pay the living wage of £8.25 per hour to all care workers providing direct care and support to adults in care homes, care at home and housing support, by the Scottish Government as part of the 2016/17 financial settlement to Local Government.

2.2. The Scottish Government have provided resources to contribute to this commitment for 2016/17 within the £250m Integrated Care Funding for Health & Social Care. The East Dunbartonshire share of this resource is £4.31m of which £2.15m is allocated for the delivery of the living wage commitment.

2.3. The timescales for implementing this initiative are from the 1st October 2016 and an action plan (**Appendix 1**) has been developed to deliver on this and requires a collaborative approach between commissioners and providers in order to achieve this effectively.

3. RECOMMENDATIONS

3.1. It is recommended that the Board:-

a) Notes the updated position regarding implementation of the Living Wage locally.

BACKGROUND

4.1 The Living Wage commitment made by the Scottish Government and Local Government as part of the 2016/17 financial settlement is to ensure that the living wage, of £8.25 per hour, is paid to care workers providing direct care and support to adults in care homes, care at home and housing support from the 1st October 2016.

4.2 Guidance has been developed in collaboration with the Scottish Government, COSLA, CCPS (Coalition of Care and Support Providers in Scotland) and Scottish Care (on behalf of providers) to support local authorities and local providers to implement the living wage commitment as part of a positive approach to fair work practices.

4.3 The guidance provides a range of options for consideration locally on the mechanism for delivery and these should be considered in terms of what suits locally and the risks associated with delivery.

4.4 The options include:

- Apply a percentage increase across the board which would uplift all contracts values / hourly rates by a uniform amount on condition that providers volunteer to pay £8.25 per hour to care workers.
- Apply a differing percentage increase per provider through individual negotiation based on their particular costs.
- Set a standard rate for each local authority within which the £8.25 per hour wage for care workers is affordable.
- Set a suite of rates for differing service models.

An options appraisal has been progressed which provides a local assessment of the risks for each option. This suggests that the first 2 options are the most viable in terms of the timescales to deliver and affordability within the financial envelope available that is not to say that further work cannot progress in the longer term on the latter 2 options. There are issues regarding state aid and contractual implications which require being further considered prior to the final selection of a solution locally.

4.5 There has been some engagement with providers locally to quantify the costs associated with implementing the living wage for individual providers based on their current circumstances and further engagement is planned to seek agreement on the way forward locally and establish an agreed approach in collaboration which takes on board best practice across other areas where service providers can share best practice.

4.6 An action plan has been developed to capture the elements to be progressed to achieve the implementation of the Living Wage locally and a copy is attached as **Appendix 1**.

4.7 COSLA continue to have a supporting role in the progression of the agenda seeking updates on progress locally and bring together relevant stakeholders to share practice and ideas on the mechanisms for implementation.

4.8 There has also been representation from CCPS (representing providers nationally) on the preferred approach for implementation. This emphasises the need for local collaboration, a need for a refreshed focus on the rates payable to providers and consideration of the affordability of the living wage, highlighting the lack of engagement nationally with providers and the assumptions regarding potential provider contribution and further outlines the preferred implementation option from a provider perspective. A copy of the letter is attached as **Appendix 2**.

IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

Living Wage implementation Plan

Action	Progress Update	Responsible Person	Timescales	Officers Involved
Confirm scope of services to be included in consideration of funding to support delivery of the living wage	Scope agreed per guidance from COSLA, SG, CCSP, Scottish Care to support delivery of living wage	Jean Campbell	30 June 2016	Gillian Healey
Consider inclusion of SDS direct payments within scope and quantify financial impact in order to achieve equity across service provision.	Scoping work complete identified 2 aspects in relation to personal assistant rates and rates payable to providers. These will be considered within the overall monies available to deliver on the Living Wage.	Kelly Gainty	30 June 2016	Jean Campbell Gillian Healey
Undertake Options Appraisal to identify preferred Option for implementation (per SG guidance paper)	Working group convened to look at options	Jean Campbell	31 July 2016	Gillian Healey Karen Donnelly Kirsty Chisholm Julie Slavin Mandy Mallon
Evaluate financial implications for each option	Detailed financial analysis undertaken incorporating assumptions locally for options 1 and 2.	Jean Campbell	31 July 2016	Julie Slavin Mandy Mallon Gillian Healey
Liaise with Procurement / legal re contractual and state aid implications	Engagement with legal and procurement. Benchmarking with wider network for shared approach and learning.	Gillian Healey	31 Aug 2016	Karen Donnelly Kirsty Chisholm
Develop engagement	Initial liaison to establish			

strategy with service providers	financial implications for individual service providers in moving to the living wage. Provider forum established to seek agreement on way forward locally. Individual meetings to be programmed to negotiate settlement.	Gillian Healey	31 July 2016	Care Providers
Agree with providers potential contribution to the delivery of the Living Wage	Analysis work underway on service models which may, through negotiation deliver some capacity to enable provider contribution.	Jean Campbell	31 August 2016	Gillian Healey Care Providers
Review contract terms and conditions to reflect requirement for providers to pay the Living Wage.	Contract review underway including establishment of minute of variation for contracts already in place.	Gillian Healey	31 August 2016	Karen Donnelly Kirsty Chisholm
Develop robust monitoring processes to establish the extent of implementation and adherence to policy intent locally including potential impact on fair working practices.	Current monitoring arrangement reviewed which will require consideration of additional process for providers impacted by living wage requirements.	Gillian Healey	Sept 2016	Sharon Gallagher
Liaise with Shared Services to establish payment mechanism for	Adjustment required to Carefirst to ensure proper payments made to providers	Gillian Healey	Sept 2016	Linda Law

implementation date.	in line with agreements.			
Consider CCPS Letter and implications for implementation.	Letter details need for engaging with providers locally in terms in their valuable contribution to the agenda and outlines preferred option for a suite of rates to be developed – these have been factored into options appraisal and engagement strategy. Letter also highlights that cost assumption should not include a contribution from providers in the first year.	Jean Campbell	31 July 2016	Gillian Healey

AGL/612

14 June 2016

Karen Murray
Chief Officer, East Dunbartonshire Health and Social Care Partnership
300 Balgrayhill Road,
Glasgow
G21 3UR

Dear Karen

LIVING WAGE IN ADULT SOCIAL CARE

I am writing to follow up joint guidance recently issued by Scottish Government, COSLA, Scottish Care and CCPS, with a view to reinforcing some of the messages in that document from a provider perspective. As you may be aware, CCPS is the Coalition of Care & Support Providers in Scotland. Our membership comprises all the most substantial providers in the third sector, many of whom are active in East Dunbartonshire Health & Social Care Partnership area.

First of all, on behalf of CCPS and its member providers, may I take this opportunity to welcome the commitment that East Dunbartonshire Council and East Dunbartonshire Health & Social Care Partnership have made to implement the Living Wage in adult social care. CCPS has worked for many years to highlight the impact of low pay on the sector, particularly with respect to recruitment, retention and service quality. We are delighted that our partners in central and local government have agreed to make such a significant investment in the social care workforce in order to address these issues.

We are aware that East Dunbartonshire has been allocated a total resource in 2016/17 of £2.15m for Living Wage and other cost pressures. We also note that this allocation relates to a full year, although in 2016/17 the commitment relates to a half year from 1st October. We are keen to work with partners to maximise the impact of this resource and we would invite you to consider the following key points as you develop your proposals for local implementation.

Collaboration with providers

We are keen to give a clear signal to our partners in local government that providers strongly support this initiative and are ready to work with councils to help them deliver it.

As the joint guidance highlights, the sanctions for failing to deliver on the commitment are serious; the guidance also makes clear that councils cannot compel providers to comply with Living Wage requirements through procurement.

In this context.../

In this context, we believe that the council's primary role must be as an enabler rather than an enforcer, and in our view this is best achieved through an inclusive, collaborative approach to decision-making from the outset. We would therefore strongly encourage you and your colleagues to ensure that providers are brought into the process as early as possible and given the opportunity to discuss and agree the implementation mechanism that is most appropriate in the local circumstances.

We understand that the council and partnership have made contact with providers to collect data about current staff pay and service hourly rates, and we would encourage you to continue to work collaboratively with them to reach agreement about the way forward.

Pay rates and hourly rates

We are aware that a number of councils have begun the implementation process by seeking to identify the 'gap', in financial terms, between current provider pay rates and the Living Wage rate of £8.25 per hour. Whilst this data will be important to gather and analyse, it will be equally important to factor in the significant additional on-costs for employers including National Insurance, employer pension contributions and organisational pay differentials.

In this context, we believe it will be crucial for councils and providers to develop a shared understanding of the relationship between the wage rate paid to staff by employers, and the hourly rate paid to providers by commissioners. In particular, we would strongly recommend that councils undertake a detailed analysis of the affordability of basic staff pay of £8.25 within the hourly rate(s) paid for the service.

Moreover, we believe that there is a clear risk in taking forward this initiative that the Living Wage becomes a totem to which a range of other considerations (broader terms & conditions, training, development, supervision) may be sacrificed. We are concerned to ensure that all the costs of care and support, not only direct workforce costs, are properly considered as part of this initiative and we believe that this will of necessity involve a refreshed focus on hourly rates.

CCPS is developing, with the assistance of an independent academic economist, a template/calculator for hourly rates and we would be pleased to share our work with you in due course.

Implementation options

The joint guidance sets out a range of options for implementation of the Living Wage commitment, most of which relate to contract modification in one way or another. Whilst we accept that the option(s) selected will need to reflect local circumstances, we would ask our partners to be sensitive to the challenge that this will present to providers working in more than one council area.

We would also ask partners…/

We would also ask partners to remain aware that providers are dealing simultaneously with a range of existing and complex pay-related issues, including the recent EAT rulings on sleepovers and holiday pay, not all of which have yet been satisfactorily resolved. Given the added complexity of the Living Wage commitment, and the relatively short timeframe for implementation, providers are looking to commissioning authorities for a robust (and timely) settlement to enable them to put the necessary arrangements in place by 1st October.

As a provider representative organisation, we believe that some of the options set out in the guidance have greater merit than others. We are particularly keen that councils consider the development of a suite of hourly rates, starting with a minimum 'compliant' rate within which a Living Wage of £8.25 is affordable, and encompassing a range of further differential rates. This, in effect, is the model that the National Care Home Contract has developed over a number of years, and we are aware that some councils have already moved to this position in respect of their care at home and housing support services (for example, West Lothian).

A key advantage of this approach is that it minimises price competition, which has been a major driver of low pay in the sector; and it is flexible enough to reflect variations in level of need, service model, skill mix of staff and quality of service.

We appreciate (and agree with) the statement in the guidance that the development of this option may not be possible within the timeframe set out for delivery of the commitment; however we would suggest that it may be possible (and even desirable) for councils to adopt a short-term approach in year one (for example, a percentage uplift to existing hourly rates) whilst laying the foundations for a longer-term approach in 2017/18 and beyond.

Conversely, we believe that re-tendering is probably the least desirable option for a number of reasons, chief amongst which is that it appears to run directly counter to the overall objective of this initiative, which is to value and invest in the social care workforce. CCPS (and others) have produced a significant body of evidence over several years documenting the impact of re-tendering on the workforce and demonstrating its damaging effects on stability and morale. Moreover, the evidence suggests that low pay in the sector has become widespread largely as a result of competitive tendering: it would be perverse, in our view, to apply the same mechanism in the expectation of a different outcome.

As a commissioning body, you are no doubt very much aware that workforce expectations in relation to this initiative are high: successful delivery is paramount in that regard, notwithstanding the pressure that partners are already facing with respect to the terms of the local government settlement.

The provider contribution

The guidance notes that whilst the Living Wage commitment is predicated on providers meeting their share of the costs, providers themselves were not party to the local government settlement agreement in the context of which the commitment was made.

Neither ourselves nor…/

Neither ourselves nor Scottish Care (on behalf of the independent sector) were consulted, and no analysis was conducted to establish the affordability of any specific contribution from providers.

As noted above, providers share the ambitions of their partners with respect to the Living Wage in social care; their ability to make a contribution to the cost, however, is likely to be severely limited in the context of the downward pressure that has been placed on service budgets in recent years by successive re-tendering exercises and (latterly) imposed budget cuts.

We would therefore encourage councils to conduct their cost analysis, at least in the first instance, without factoring in any particular provider contribution. As noted above, providers are keen to assist councils in delivering on the commitment they have made, but they will be unable to do so unless adequate resources are made available.

Given the breadth of its membership, CCPS is able to take a national overview of progress in relation to implementation. We receive regular intelligence from providers across the country and we would be pleased to assist in drawing our membership together in East Dunbartonshire to consider plans and proposals. We serve on the National Partnership Group alongside Scottish Care, Scottish Government and COSLA, and we are active participants in the practice-sharing group convened by COSLA.

In closing, may I once again welcome the important commitment made by East Dunbartonshire Council and East Dunbartonshire Health & Social Care Partnership to deliver the £8.25 Living Wage to all adult social care workers. Do please let me know if you would like to discuss any of the points in this letter in any more detail.

Yours sincerely

ANNIE GUNNER LOGAN
Director

cc. David Formstone, Service Manager (Adults)
Gilbert Grieve, Chief Executive, East Dunbartonshire Voluntary Action

Agenda Item Number: 19

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_19**
Subject Title	Alcohol and Drug Partnership Update report
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership 0141 201 4209 – Andy.Martin@ggc.scot.nhs.uk

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to update the Board on actions taken by the Alcohol and Drug Partnership to take forward recently agreed reductions in its budgetary allocation from the Scottish Government.

2.0 SUMMARY

2.0 A reduction of approximately 23% in allocation to East Dunbartonshire ADP has been intimated by NHS Greater Glasgow & Clyde in consequence of the Scottish Government's decision to reduce the overall direct national allocation to ADP's.

2.1 Following on from this reduction, the ADP has conducted a revision of its local spending priorities in order to achieve a balanced budget for financial year 2016-17.

2.2 A recurring saving of £124,751 has been identified. This is within an overall previous annual budget (2015-16) of £488,238.27. This leaves a remaining budget for year 2016-17 of £358,487.

2.3 Whilst the cut in funding is regrettable, the ADP believes that the core and detail of our Alcohol & Drug Strategy will not be significantly affected by the decommissioning of certain services and the reduction of some budget lines.

2.4 Actions undertaken to take forward decommissioning and budget reductions are detailed in the Background section of this report.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- notes the content of the report

4.0 BACKGROUND

4.1 The effective reductions agreed by the ADP are as follows:

£72,751	Decommission ARC
£10,000	Training and Conferences
£11,500	Positive Alternatives
£3,000	EDC Children's Befriending
£7,500	PEPC sub group of ADP
£7,500	Treatment and Recovery
£7,500	Alcohol Brief Intervention Strategy Group
£5,000	ROSC DEVELOPMENT
£124, 751	**Total**

4.2 Written intimation has been given to all recipients of funding which will cease. Apart from ARC, all other funding cuts are to service or functions internal to the Health & Social Care Partnership. Chairs of ADP Sub Groups (PEPC, Treatment & Recovery, Brief Interventions, ROSC Developments) have been asked to bring reports to the next meeting of the ADP detailing revised plans for 2016-17 in light of the funding decision.

4.3 Immediately after the decision to cease funding ARC was finalised, the HSCP Chief Finance Officer and the Contracting & Commissioning Manager met with the Chair of ARC's board and its Coordinator to communicate the decision. This was followed by a letter from the ADP Chair formally intimating the funding decision and serving 3 months notice of the termination of funding.

4.4 Further meetings have been scheduled with ARC to develop a decommissioning programme which will support the organisation to determine its future structure and activity in light of this funding reduction. This will pay particular attention to the ongoing obligations which may be in place in respect of staffing and premises. It is envisaged that some further interim funding may be required beyond the first quarterly payment already made in this financial year as notice of termination in order to achieve an orderly decommission. This will be considered and if necessary some non-recurring monies available to the ADP can be deployed.

4.5 As part of the overall decommissioning programme, a communication and service user engagement plan is being developed. Whilst it is anticipated that there may be an initial impact on the current service users of ARC, alternative forms of support are available from the wide range of recovery-oriented and mutual aid services which now exist across East Dunbartonshire. As more services have developed over the last 3 years, service users are rightly exercising choice and utilising a range of providers to support their recovery journey and so are less dependent on one provider. Particular consideration will be given to ensure that long-standing ARC service users are assisted by East Dunbartonshire Alcohol and Drug Service (EDADS) Team to access appropriate support.

4.6 Within the further meetings scheduled, advice and support will be offered to the coordinator and management committee of ARC to assist them to address previous reporting and compliance issues so that the requirements of potential future funders can be met.

4.7 Incidental to these financial developments, concerns relating to safeguarding within ARC have been raised. These have been formally referred to Social Work by an external voluntary partner working with drug and alcohol service users in East Dunbartonshire. At the moment consideration is being given to the establishment of an Adult Protection Large Scale Investigation. If taken forward this will require to be coordinated with the decommissioning programme

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 20

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_20**
Subject Title	Update on the Intermediate Care Model
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Andy Martin, Head of Adult & Primary Care Services 0141 201 4209 Andy.martin@eastdunbarton.gov.uk

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to update the HSCP Board on the service developments of an intermediate care facility within East Dunbartonshire

2.0 SUMMARY

2.1 East Dunbartonshire HSCP is in the process of commissioning an intermediate care facility within a nursing home in East Dunbartonshire. This service will include a model of GP provision, care management, rehabilitation and home care support.

2.2 The intermediate care project will transition service users from the hospital setting, when medically fit for discharge, to the facility giving the service user time for additional recovery and the opportunity to receive a comprehensive assessment of their longer term health and social care support needs.

2.3 A multi disciplinary project group has been established to take forward agreed actions to the proposed implementation date of October 2016. A wider governance reporting structure is being developed. A programme of engaging with stakeholders in underway to help shape and develop the model. All of these priorities are set out within an overarching Project Plan which is attached as **Appendix 1**.

2.4 A service policy document and an issues/risk register have been produced to assist with communication, to focus on working through challenges, review priorities and evidence blockages and resolutions. These are attached as **Appendix 2 and 3** respectively.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

- Note the content of the report

APPENDIX 2

Intermediate Care in East Dunbartonshire

Introduction

Over the next few years in East Dunbartonshire our overall population is predicted to decrease by 0.5%, while the 85 years + age group will increase by 17.8%. Increasing age has an impact on the likelihood of developing one or more long term conditions and increase the demand for health and social care provision. In-patient care will always be an important part of the provision of care for people who require medical needs. Reducing unscheduled hospital admissions and bed usage is a key priority for the Health and Social Care Partnership. Our services are working in partnership to facilitate early discharge. Discharge planning for people with complex support needs takes longer and may require further assessment and recovery in the right setting. These people may benefit from the provision of intermediate care provided at home or in a homely setting.

Local data suggests that the majority of our delayed discharge cohort of patients have long term conditions which have impacted on their functionality to such a degree that rehabilitation/enablement may not be an option and that emphases on intermediate care would mainly be about focusing on transitions into a care home. There should however still be an opportunity for the promotion of rehabilitation, re-ablement and self-management for those with identified needs.

As part of our strategic and delayed discharge planning, East Dunbartonshire Health and Social Care Partnership are introducing an eight bedded intermediate care unit. This unit will provide an opportunity for social work and health staff to work in partnership with service users, carers and their families during the transition from a hospital based setting to long term care or a return to their own home environment. We will focus on those service users presenting with multiple morbidities, complex care requirements and frailty. This service will contribute to reducing health inequalities.

The Intermediate Care project will provide appropriate integrated community services within an alternative setting that can support older people and adults with long term conditions during their time of transition in their health and support needs.

Purpose

The intermediate care project will transition patients from the hospital setting, when medically fit for discharge, to a homely environment giving the service user time for additional recovery and to receive a comprehensive assessment of their longer term health and social care support needs.

The outcomes of the project are:

- To bridge the gap by supporting people with a timeous, smooth discharge from hospital to home with appropriate community supports or into a homely setting within a residential/nursing care home;
- To reduce the number of people delayed in hospital when they have been declared medically fit for discharge;
- To improve outcome for service users, upon discharge from the intermediate care project, to their own home or an alternative homely setting. These outcomes would

include feeling safe, being listened to, being party to decisions about their long term support and having choice.
- To maximise the service user's ability for rehabilitation and reablement
- To provide service users and their families the opportunity to be involved in the assessment and decision making process in respect of moving to long term residential/nursing care.

Target Audience

This policy is targeted at the following stakeholders :-

- Social Work and Health staff within East Dunbartonshire Health and Social Care Partnership
- Service Users, Carers and Families
- The GP attached to the care home and other GPs within the locality
- Geriatricians and other clinical staff from the acute sector
- Westerton Care Home
- Housing staff
- Relevant third sector organizations including advocacy

These are the main stakeholders, however this list is not exhaustive.

Intermediate Care Location and Facilities

The Intermediate Care facility will be housed in Westerton Care Home in Bearsden. This will provide a comfortable and homely, self-contained, appropriately staffed unit of eight beds, all in single rooms, within a modern, accessible care home. The facility will include:

- Six beds for the purpose of assessing service users who have been deemed as requiring further assessment with a view to admission in the longer term to a residential or nursing home care environment;
- Two beds for the purpose of providing a 'step down' function whereby the service user can receive intensive rehabilitation and re-ablement provision from care home, care at home and community health services with a view to returning to their own home.

There requires to be ongoing flexibility and review of the functionality of the unit in relation to the beds during this pilot so that opportunities for rehabilitation/respite can be maximised.

Intermediate Care Criteria

- The service user should be an adult (aged 65 and over) and live within East Dunbartonshire
- The service user must be an in-patient of a hospital setting. Exceptions to this must be agreed by East Dunbartonshire's Chief Officer.

- The service user must be medically stable and deemed appropriate for intermediate care.

- The service user must have capacity to consent to engage in the process or have the appropriate legal powers in place.

- The service user must be allocated to a Lead Professional Officer who will co-ordinate the assessment and care management.

- The service user must be able to have their needs met safely in the intermediate care facility.

- The service user and any other relevant persons must be party and in agreement to the decision to move to the intermediate care facility.

- The service user and any other relevant persons must be made aware of the intermediate care process. This may take the form of a legal contract.

- The service user and any other relevant persons accept that this is a time limited facility - up to one week and no longer than four weeks.

- The service user is identified with a clear pathway for moving on from the Intermediate Care facility.

Exclusions from the Intermediate Care facility

- Any service users requiring end of life

- Any service users not deemed medically fit for discharge;

- Any service user falling under the status of 'Adults with Incapacity' and without any appropriate legal powers in place.

- Any service users referred directly from the Accident and Emergency Units within the hospital environment.

Charging

The placement time within the intermediate care facility is limited to four weeks. During the assessment period, the intermediate care service will be free of charge, however, if the service user remains beyond the assessment period, through no fault of East Dunbartonshire Health and Social Care Partnership, residential care charges will apply. The charges that will be applied are consistent with the normal terms for care home provision. It is expected that service users will pay for sundries.

Referral Process

The utilisation and co-ordination of the assessment beds within the intermediate care facility will remain the responsibility of the Senior Practitioner within the Hospital Assessment Team.

Following agreement by the Geriatrician that the service user is medically fit for discharge, referrals will be made to the Hospital Assessment Team via currently arranged routes. The acute sector is encouraged to make early referrals where ever possible. Early referrals and SMAT forms are accepted by the Hospital Assessment Team Monday to Friday from 9.00am to 5.00pm excluding public holidays.

As the early stage of assessment goes forward, the Social Work practitioner will triage the referral and the service user will be directed down one of three potential sub-pathways:

- Step Down with Advanced Rehabilitation
- Enhanced Care at Home
- Intermediate Assessment and onward placement.

Following discussion between the allocated Social Work practitioner, the service user and their carer/family, the decision to transfer the service user to the intermediate care facility will be authorised by the Senior Practitioner within the Hospital Assessment Team.

The service user will be transferred within 72 hours of their 'fit for discharge' date to the intermediate care facility.

Transportation Arrangements

Within the current budget, £5000 has been included for 'carer transport'. This is in relation to families/carers visiting the intermediate care facility where they did not have their own transport and required funds towards transport.

Consideration needs to be given to how and the cost of transporting service users from hospital to intermediate care and from intermediate care to their onward placement. A transport policy will be developed.

Roles and Responsibilities

Hospital Assessment Team/Allocated Social Work Practitioner:

The responsibility for the co-ordination of and the management of admission, discharge and through-put to the intermediate care facility will rest with the Senior Practitioner within the Hospital Assessment Team.

Initial assessment must be undertaken within three days of the service user's admission to the intermediate care facility identifying and agreeing collaborative goals/outcomes for the service user and carer.

The allocated social work practitioner role will be primarily directed towards assessment and care management including financial assessment and care placement.

The standing processes currently in place within the weekly Delayed Discharges Planning Group will continue to provide management oversight and support and a multi-disciplinary forum to plan care and agree resource deployment.

The Senior Practitioner will be responsible for prioritising and allocating the beds within the intermediate care facility. Where the facility is running at full capacity the service user will remain in hospital until the assessment is complete and placement has been arranged.

Referring Hospitals

Any service user who is ordinarily resident within East Dunbartonshire and who meets the service criteria will be eligible to be assessed for intermediate care. As part of the discharge planning, the Geriatrician will identify those services users who are medically fit for discharge. Screening and triage will be undertaken by the Hospital Assessment Team.

Community Rehabilitation Team

The Community Rehab Team currently provides a range of enhanced clinical interventions to service users returning from hospital to the community. These interventions are arranged either via its core service or through the Rapid Assessment Link. Where there is an ongoing or potential rehabilitation need for any service user who is discharged to the intermediate care facility or their own home with an intensive home care package, this will be provided by the Community Rehab Team. The services required will predominantly consist of physiotherapy and occupational therapy.

Enhanced Model of Home Care

There will be a provision of intensive care at home support as an option for service users with complex needs who may have the potential to return from hospital and establish a degree of independence at home with the help of an initial intensive support period. This service will be available within the eligibility and charging criteria proposed for the intermediate care facility and could be delivered within the service user's home, or using the Telecare Smart Flat in Auchinairn as a base to commence the rehab journey.

Care Home

The intermediate facility is a registered nursing home and will be expected to deliver all the clinical competencies that are contracted within that function. The home has appointed a Team Leader qualified at SVQ Level 3 who will have access at all times to the Nursing Staff located within the home. The nominated person is responsible for all aspects of the role in respect of both assessment and intermediate beds such as reablement tasks and will encompass a wider preventative role, aiming to promote confidence building and social inclusion.

GP Services

There is a named Local Enhanced Service (LES) GP practice attached to Westerton Care Home . It is intended to develop an extension to this arrangement to facilitate the intermediate care facility in order that a full range of medical cover is available to service users who have moved to this setting. Funding for the duration of the pilot has been put in place to allow for this. The GP will be responsible for ensuring that a medical assessment has been completed within 24 hours of the service user's admission to the unit.

Carers

Identified carers of those service users admitted to the intermediate care facility will have the opportunity to be fully involved in the intermediate care process and will be offered a Carer's Assessment where required.

Evaluation

This project will be piloted for a year. The service evaluation will utilise a variety of quantitative and qualitative approaches to measure effectiveness against planned outcomes. These will include :-

- Data related to bed days, admissions/readmissions, delays and throughput
- Service user/carer/staff perceptions of assessment/step down unit and outcomes following discharge from unit.

Issues and risk register - Intermediate Care Assessment Unit - Appendix 1

Open Actions Tracker

Last Updated : 14th July 2016

Completed by Gillian Notman

Status Key :

Blue = Action agreed by team as Completed

Amber = Action Pending - Not started yet, requires attention.

Green = Action in Progress and on Plan.

Red = Roadblock or Showstopper , requires immediate escalation.

	ISSUE/RISK	RAISED ON	OWNER	PLANNED COMPLETION DATE	NEW COMPLETION DATE	DEPENDENCY	COMMENTS / UPDATES	STATUS
1	Agreement on named GP practice for unit	05-Jul-16	AM	August			Discussions with CD on 20th July prior to engagement with GP	
2	Pathway for transition of medication from acute to care home to other destination	05-Jul-16	CF	September		1 & 9	Discuss issues with Glasgow City Leads to support local issues and pathways	
3	Agreement on the reporting on clinical notes	05-Jul-16	GN	September		1 & 10	Adhere to information governance for all partners	
4	Potential boundary issues related to GP and Pharmacy service delivery	05-Jul-16	AM	August		1	Critical for delivery of model to preferred care home	
5	Transportation issues/costs between hospital and intermediate care unit/home	29-Jul-16	KG	September			Cost not included in original proposal	
6	Competency level of support workers within care home	28-Jul-16	FM	September			Adaptation from competency framework used with CRT and other services. Training plan developed	
7	Voids/delays in bed occupancy	01-Jul-16	JH	On going			Develop policy on respite. Plan to have a financial profile and monitoring of costs of delayed discharges/voids. Initial meeting in August	
8	Timely throughput and discharge of service users from hospital sites and care unit	05-Jul-16	LM	On going		5	Supported by leaflets and other information given to service user/carer.	
9	Lack of buy in from major stakeholders for example Geriatricians	05-Jul-16	GN	August			Stakeholder map to be developed	
10	Compatible mobile devices to support Smart working and case file reporting in care home	05-Jul-16	GN	August			Initial discussions with EDC IT. Wider issues with other partners	

Key	
Andy Martin	AM
Gillian Notman	GN
Kelly Gainty	KG
Margaret Friel	MF
Fiona Munro	FM
David Aitken	DA
Lisa Miller	LM
James Hobson	JH
Carolyn Fitzpatrick	CF

APPENDIX 1 Project plan - Intermediate care project							
	June	July	August	Sept	Oct	Lead	Comments
Intermediate Care model							
Workshop to agree ethos, criteria, pathways, roles & responsibilities						GN	Following workshop (5/7/16) revision of policy document
Plan how project embeds into current teams delivery						DA/SMcD/FM	
Project Leads and Care Home manager to discuss agreed service model. Actions to be added to project plan							Meeting arranged for 18/7/16
Workshop with acute stakeholders to agree/discuss service model							LM to lead
Pull together/develop policies, procedures and protocols relevant for implementation						KG/GN	Operational manual sign off in Aug
Arrange for an AWI workshop						GN	Social work including legal rep
Hold pathways event for relevant clinical staff						GN/FM/LM	
Accommodation							
Site visit with ops managers to ascertain functionality of accommodation							MF to arrange
Communication							
Develop a communication strategy						GN	In partnership with Fiona Borland
Develop service user information sheet						GN/LM	Sign off in Sept, once logos agreed
Governance							
Establish governance framework/sign off at SDT						GN	Provisional draft amended following discussions with care home and medical staff
Develop regular briefing to OMG/SDT						AM/GN	
Develop a project risk register						GN	
Tender process -							
Negotiated tender to EDC Committee						MF	
Develop service specification						MF	

GP negotiations/contract							
Scope out arrangements in Glasgow city. Discuss with Primary Care Support & Clinical Director						AM/GN/CF	Pre planning meeting 20/7/16
Meet with current LES GP						AM/GN	
Establish contract						AM/MF	
Training							
Skill/competency development						FM/LM	
Create training plan for home care staff						FM/LM	
Technology/Report writing							
Access to Smart working within Care home						KG/GN	
Scope out data base requirements for reporting/monitoring						MF	
Case recording protocol						CF/GN/FM	In partnership with care home and lead GP
Evaluation							
Establish evaluation framework to be implemented at implementation						GN/KG	
Agree performance outcomes						KG/GN/MF	
Financial							
Review costs in line with service/model developments						AM/GN	
Agree financial arrangements with GP/Care Home						AM/MF	
Agree financial evaluation model						JC/GN	

Key	
Andy Martin	AM
Gillian Notman	GN
Kelly Gainty	KG
Margaret Friel	MF
Fiona Munro	FM
David Aitken	DA
Lisa Miller	LM
Jean Campbell	JC
Carolyn Fitzpatrick	CF

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 21

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_21**
Subject Title	Mental Welfare Commission Report – Emergency Detention Certificates
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership. 0141 201 4209 – Andy.Martin@ggc.scot.nhs.uk

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to advise the HSCP Board of a recent report by the Mental Welfare Commission which highlights the growing numbers of Emergency Detention Certificates issued without the consent of a Mental Health Office and its implications for the partnership.

2.0 SUMMARY

2.1 In June of this year the Mental Welfare Commission for Scotland published the report *Emergency Detention Certificates Without Mental Health Officer Consent.* The report is attached as **Appendix A.**

2.2 This report highlighted a concerning rise in the number of patients being detained, across Scotland, both in hours and out-of-hours without the consent of a Mental Health Officer

2.3 NHS Greater Glasgow & Clyde GGC had the highest percentage of Emergency Detention Certificates without MHO consent (46%) The national average was 38%.

2.4 Among the report's recommendations are that local authorities should ensure they are meeting the standards set out in National Standards for MHO Services, particularly Standard 2 relating to referral, assessment and admission procedures and Standard 4 relating to inter/intra agency collaboration and cooperation.

2.5 A further recommendation is that there should be discussion between the Care Inspectorate and the Commission on collaborating on a review of MHO services within the next two to three years. This should be informed by this current Emergency Detention Certificate monitoring exercise, as well as the work of the Chief Social Work Inspector (CSWI).

2.6 East Dunbartonshire has experienced a continuing crisis in the recruitment and retention of MHO's largely because of differentials in pay and grade in comparison with neighboring local authorities. These differentials are highlighted in a report commissioned by ADSW in 2013. This attached as **Appendix 2.**

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

(i) notes the content of the report and appendices;
(ii) requests officers to develop a strategic MHO Recruitment and Retention action plan.

4.0 BACKGROUND

4.1 The Scottish Social Services Council surveyed MHO provision in 2014. The statistics show that the number of mental health officers (MHO) in Scotland has fallen to its lowest level since 2005 decreasing by 2.5% to 657 MHOs in December 2014.

4.2 The age profile of the MHO workforce is also decreasing with the proportion of male and female workers aged under 40 increasing by three and two percentage points respectively.

4.3 The MHO WTE rate per 100,000 people is the lowest since 2005. In March 2009 across Scotland there were 12.4 MHOs per 100,000 people, and the figure in December 2014 was 11.3.

4.4 East Dunbartonshire has consistently been in Scotland's lowest quadrant for MHO capacity with between 5 and 8 WTE per 100,000 people

4.5 Across Scotland a total of 62 MHOs left the workforce between 2 December 2013 and 1 December 2014, of which nearly half retired and about a fifth resigned.

4.6 The number of MHOs involved in Adults with Incapacity (AWI) work has increased by 16%.

4.7 The following tables illustrate the overall decline of MHO capacity across Scotland but especially the even more precarious situation in East Dunbartonshire. **Table 1.** shows the actual numbers of individual MHO's and WTE's for every partnership in Scotland. **Table 2** illustrates diagrammatically the relative position of East Dunbartonshire compared to neighbours and the national picture.

Annex 1: Mental Health Officers numbers, whole time equivalents (WTEs) and rates per 100,000 of population by Local Authority, 2009 - 2014

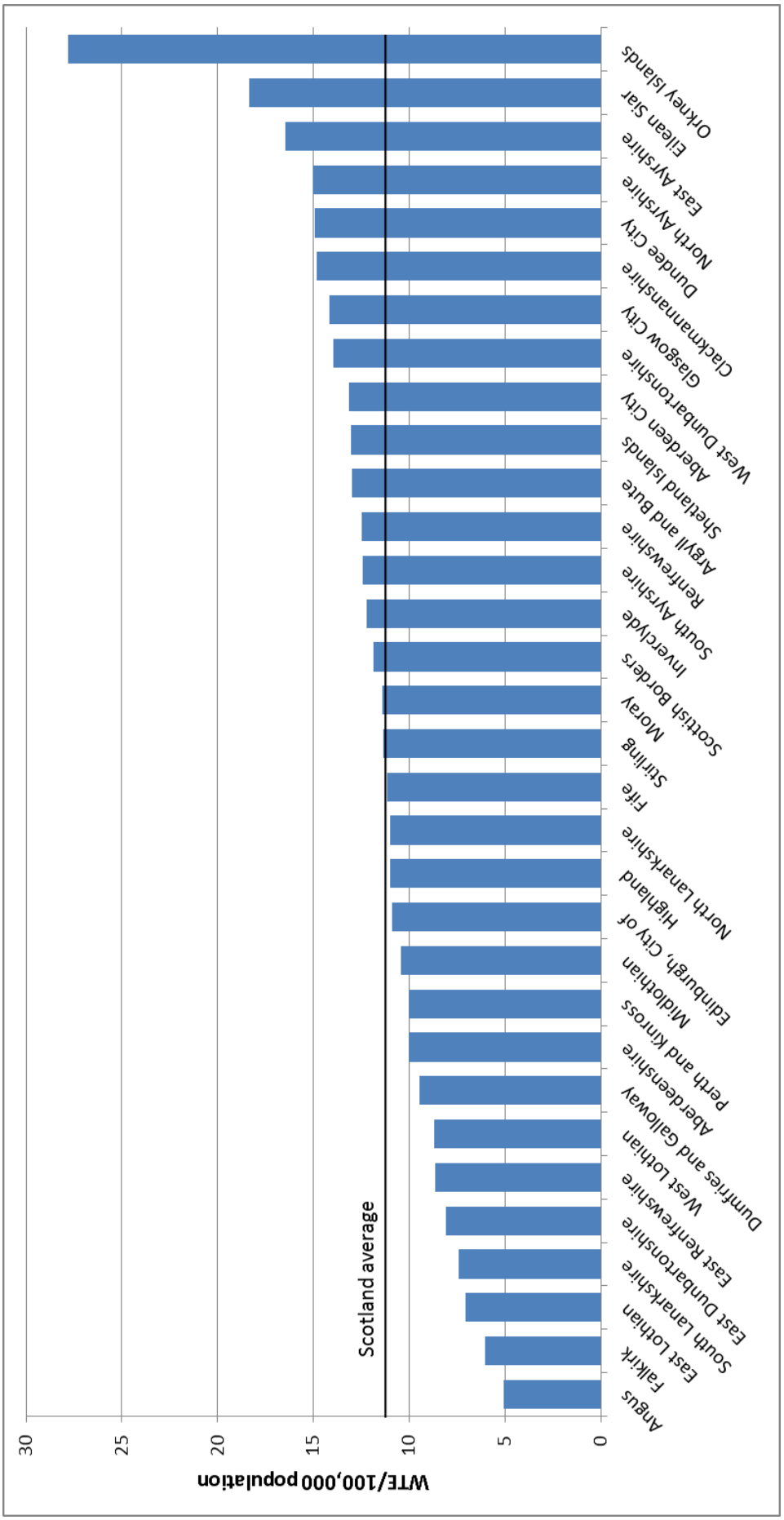
Local Authority	Number of MHOs							WTE of MHOs							MHO WTE rate per 100,000 population						
	2009	2010	2011	Mar-12	Dec-12	2013	2014	2009	2010	2011	Mar-12	Dec-12	2013	2014	2009	2010	2011	Mar-12	Dec-12	2013	2014
Aberdeen City	27	29	30	29	32	28	38	25.8	27.8	28.6	26.6	30.9	26.7	30.1	12.3	13	13.2	12.1	13.7	11.8	13.2
Aberdeenshire	30	29	31	36	29	33	28	29.1	26.4	29.7	32.5	28.3	31.8	26.1	12.1	10.9	12.1	13.1	11.1	12.3	10
Angus	15	17	13	12	15	12	14	13.6	15.8	12.2	10.7	14.7	10.7	5.9	12.3	14.3	11	9.6	12.6	9.2	5.1
Argyll and Bute	13	14	14	13	11	13	13	13	13.5	13.5	12.5	11	11.5	11.4	14.4	14.9	15.1	14	12.7	13.1	13
Clackmannanshire	6	6	4	5	5	6	8	5	5	4	5	5	5.6	7.6	9.9	9.9	7.9	9.8	9.8	10.9	14.8
Dumfries and Galloway	26	28	31	21	23	17	16	25.6	27.2	30.6	16.6	15.2	16	14.2	17.2	18.3	20.6	11.2	10.1	10.6	9.5
Dundee City	28	24	21	21	22	24	27	27.8	22.1	17.9	17.7	18.3	21.4	22.1	19.5	15.5	12.4	12.2	12.4	14.4	14.9
East Ayrshire	18	23	23	18	21	21	21	18	23	21.5	17	20.9	20	20.1	15	19.2	17.9	14.1	17	16.3	16.5
East Dunbartonshire	7	7	5	7	8	9	10	6.2	6.2	5	7	8	7.6	8.6	5.9	5.9	4.8	6.7	7.6	7.2	8.1
East Lothian	7	5	9	11	10	5	8	6	4.3	8	10	4.7	4.4	7.2	6.2	4.5	8.2	10.2	4.6	4.3	7.1
East Renfrewshire	8	8	9	7	11	13	8	7.5	7	8.5	7	10.5	12	8	8.4	7.8	9.5	7.8	11.5	13.1	8.7
Edinburgh, City of	64	62	58	57	53	54	55	56.8	53.8	54	51	46.4	50.5	53.7	12	11.4	11.1	10.3	9.6	10.4	10.9
Eilean Siar	5	6	5	4	4	5	5	5	6	5	4	4	5	5	19.1	22.9	19.1	15.3	14.5	18.2	18.3
Falkirk	13	11	12	10	12	14	11	13	11	12	6	10.2	12.5	9.5	8.6	7.3	7.8	3.9	6.5	8	6
Fife	44	48	47	46	44	42	43	42	47	45.5	45.5	42.5	39.3	40.9	11.6	13	12.5	12.4	11.6	10.7	11.1
Glasgow City	100	113	120	115	113	94	88	97	93.8	114.3	109.8	109.7	90.9	84.8	16.6	16.1	19.3	18.3	18.4	15.2	14.1
Highland	43	39	36	29	28	27	28	39.4	38.3	35	26.8	25.2	22.9	25.6	18	17.5	15.8	12.1	10.8	9.8	11
Inverclyde	12	16	16	15	15	15	10	11.8	15.8	15.4	13.8	14.3	14.8	9.8	14.6	19.6	19.2	17.4	17.7	18.4	12.2
Midlothian	7	7	7	6	7	10	10	6.8	6.4	6	5	5	8.4	9	8.4	7.9	7.4	6.1	5.9	9.9	10.4
Moray	9	13	13	13	13	14	13	9	11.3	11.3	8.5	11.2	11.8	10.8	10.3	12.9	12.9	9.7	12.1	12.5	11.4
North Ayrshire	21	23	23	21	21	25	22	20.6	22.2	22.2	20.2	20.6	25	20.5	15.2	16.3	16.4	14.9	15	18.3	15
North Lanarkshire	40	45	43	39	42	35	38	39	45	43	38.2	41.2	33.2	37.2	12	13.8	13.2	11.7	12.2	9.8	11
Orkney Islands	5	5	6	6	6	7	6	5	5	6	6	5	7	6	25.1	25.1	29.8	29.8	23.2	32.5	27.8
Perth and Kinross	15	16	18	15	16	16	16	14.6	15.6	14.4	14.1	16	14.8	15	10.1	10.8	9.7	9.4	10.8	10	10
Renfrewshire	13	16	16	17	19	19	23	12.5	15.8	15.4	12.8	13.6	18.2	21.8	7.4	9.3	9	7.5	7.8	10.5	12.5

Scottish Borders	16	16	15	17	15	14	14	14.3	16	15	17	14	13.5	13.5	12.7	14.2	13.3	15	12.3	11.9	11.8
Shetland Islands	6	7	6	7	7	6	4	5	6	5.5	6.3	6.3	4.5	3	22.7	27.3	24.6	27.8	26.9	19.5	13
South Ayrshire	17	17	17	17	20	17	14	16.2	16.2	16.2	17	20	17	14	14.5	14.5	14.5	15.2	17.7	15.1	12.4
South Lanarkshire	23	28	31	31	29	33	25	20	24.3	29.4	29.9	27.7	32.8	23.5	6.4	7.8	9.4	9.6	8.8	10.4	7.4
Stirling	9	12	15	13	13	11	11	5.9	10	12	12.1	12.1	10.2	10.4	6.7	11.3	13.4	13.4	13.3	11.2	11.3
West Dunbartonshire	13	11	10	8	11	16	14	11	8.3	8.5	7	9.5	14.6	12.5	12.1	9.1	9.4	7.7	10.5	16.3	13.9
West Lothian	22	25	24	22	23	19	16	20.5	21.8	22.3	22	21.4	17.1	15.4	12.1	12.9	13	12.7	12.2	9.7	8.7
Scotland	682	726	728	688	698	674	657	643	667.8	687.8	635.4	643.2	631.7	602.9	12.4	12.9	13.2	12.1	12.1	11.9	11.3

Source: National Records of Scotland mid-year population estimates 2009 to 2014

TABLE 2

Annex 3: Mental Health Officer WTE rates per 100,000 population by local authority, ranked in ascending order – December 2014



mentalwelfare commission for scotland

CORPORATE REPORT

Emergency detention certificates without mental health officer consent

JUNE 2016

Contents

Report to Scottish Government by the Mental Welfare Commission for Scotland - Emergency Detention Certificates without Mental Health Officer consent (Audit 1 July 2015-31 December 2015)

Introduction

Following the presentation of the Mental Welfare Commission's (the Commission) annual Mental Health Act monitoring report[1] to the Scottish Government, Shona Robison (Cabinet Secretary for Health, Wellbeing and Sport) was asked by Dr Richard Simpson (Mid Scotland and Fife) about the low level of involvement of mental health officers (MHOs) in the granting of Emergency Detention Certificates (EDCs) across Scotland, particularly in Greater Glasgow and Clyde (GGC).

Mental health officer (MHO) consent is regarded as an important safeguard when someone is being detained in hospital. There were concerns as to whether medical practitioners were consulting MHOs, where possible, and whether there were sufficient MHOs in place to meet the statutory duties of the local authorities. The Cabinet Secretary asked the Commission to undertake analysis of the reasons for low MHO consent for EDCs and asked "the Scottish Government's chief social work advisor to investigate issues to do with the shortfall in MHOs in local authorities with the chief social work officers". The Commission and the chief social work advisor were asked to report back to the Scottish Government by the end of April 2016.

Mental Health Officer Consent

An emergency detention certificate (EDC) can be issued by any registered medical practitioner and authorises detention in hospital for up to 72 hours. The Mental Health (Care and Treatment) (Scotland) Act 2003[2] (the Act) is clear that there should be consent from a MHO wherever practicable (s36 (3) and (6)). A short term detention certificate (STDC) is regarded as the preferred 'gateway' order when someone requires detention in hospital, as it requires assessment by an approved medical practitioner (AMP) (a psychiatrist with specific training and registered with the health board) and an MHO (a social worker with specific training and approved by the local authority). EDCs should only be used if it is not possible to secure assessments by both an AMP and a MHO. They are likely to be used in crisis situations.

The Commission places value on the role of the MHO in the decision to detain a person. The MHO provides the important safeguard of looking critically at the proposal to detain the person and can help to look at alternative ways to support the person without needing to use compulsory admission. Where the person needs to be admitted, the MHO can help to

[1] http://www.mwcscot.org.uk/media/240677/mha_monitoring_report_2014-15.pdf
[2] http://www.legislation.gov.uk/asp/2003/13/contents

explain the process, their rights, including access to advocacy, and make arrangements to make admission easier and to safeguard the person's property and possessions. We like to see consent in as many cases as possible, in line with the requirements of the Act, though recognise that the nature of the situation does not always allow this.

Table 1 EDCs with consent by health board in last five years (percentage)

Health Board*	2010-2011	2011-12	2012-13	2013-14	2014-15
	%	%	%	%	%
Ayrshire and Arran	37%	39%	72%	74%	65%
Borders	71%	83%	89%	89%	69%
Dumfries and Galloway	58%	63%	62%	49%	55%
Fife	85%	77%	78%	78%	77%
Forth Valley	73%	83%	80%	67%	58%
Grampian	66%	70%	79%	79%	64%
Greater Glasgow and Clyde	52%	44%	41%	37%	30%
Highland	68%	60%	61%	61%	74%
Lanarkshire	60%	64%	63%	64%	62%
Lothian	72%	74%	70%	64%	62%
Orkney	100%	100%	100%	100%	100%
Shetland	-	88%	88%	86%	89%
Tayside	84%	81%	80%	69%	80%
Western Isles	0%	100%	43%	100%	25%
Scotland	62%	60%	63%	58%	56%

- All data rerun February 2016. Numbers and percentages may vary slightly from previously published annual monitoring reports due to inclusion of late returns and ongoing data quality exercises.

Table 2 2014-15 EDCs without and with consent by health board (number & percentage)

Health Board*	Without consent	With consent	Total	Without consent	With consent	Total
	n	n	n	%	%	%
Ayrshire and Arran	49	93	142	35%	65%	100%
Borders	9	20	29	31%	69%	100%
Dumfries and Galloway	33	41	74	45%	55%	100%
Fife	35	115	150	23%	77%	100%
Forth Valley	40	55	95	42%	58%	100%
Grampian	48	86	134	36%	64%	100%
Greater Glasgow and Clyde	427	179	606	70%	30%	100%
Highland	41	116	157	26%	74%	100%
Lanarkshire	67	111	178	38%	62%	100%
Lothian	95	154	249	38%	62%	100%
Orkney	0	7	7	0%	100%	100%
Shetland	1	8	9	11%	89%	100%
Tayside	34	137	171	20%	80%	100%
Western Isles	6	2	8	75%	25%	100%
Scotland	885	1124	2009	44%	56%	100%

- All data rerun February 2016.

Nationally the percentage of EDCs with consent has shown a downward trend over the past five years. Notably, apart from 2013-14, Tayside has maintained a level of 80% or more with consent. Ayrshire and Arran have increased the percentage of EDCs with consent significantly over the last five years. The MHO out of hours arrangements have changed during this period in this area.

In 2014-15 just over half (56%) of EDCs in Scotland had consent. We have commented in previous annual monitoring reports on the variation in percentages of EDCs with consent across health boards. In 2014-15, of mainland boards, the lowest percentages with consent were: GGC, 30%; Dumfries and Galloway, 55%; Forth Valley, 58%. The mainland boards with the highest percentages of consent were: Tayside, 80%; Fife, 77%; Highland, 74%.

MHO consent by in and out of hours

Table 3 2014-15 Scotland MHO consent in hours and out of hours (number & percentage)

Hours	Without consent		With consent		Total	
	n	%	n	%	n	%
In Hours	246	38%	394	62%	640	100%
Out of Hours	639	47%	730	53%	1369	100%
Scotland	885	44%	1124	56%	2009	100%

- All data rerun February 2016.

68% (1369) of EDCS happen outside office hours and 32% (640) within office hours.

Of those carried out within office hours, 62% will have MHO consent; outside office hours 53% will have MHO consent. It is important that local authorities have good out-of-hours arrangements to ensure that MHOs can attend wherever possible.

EDC Project 2016

In February-March 2016 the Commission examined all EDCs without consent across Scotland for the six month period 1st July 2015 - 31st December 2015. The data was analysed by health board. We explored;

- Range of reasons for non-attendance of MHO
- Differences in and out of hours
- Patient's status prior to EDC-community or hospital
- Individual hospitals (GGC only)
- Type of medical staff doing assessment
- How soon the EDC was reviewed
- Whether the EDC was revoked or went to a STDC

MHO consent six months 1st July 2015 to 31st December 2015

Table 4 All EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	14	29%	35	71%	49	100%
Borders	2	14%	12	86%	14	100%
Dumfries and Galloway	20	54%	17	46%	37	100%
Fife	21	28%	55	72%	76	100%
Forth Valley	28	42%	38	58%	66	100%
Grampian	16	33%	33	67%	49	100%
Greater Glasgow and Clyde	248	66%	126	34%	374	100%
Highland	27	39%	43	61%	70	100%
Lanarkshire	29	29%	71	71%	100	100%
Lothian	62	35%	113	65%	175	100%
Orkney			6	100%	6	100%
Shetland			1	100%	1	100%
Tayside	28	31%	61	69%	89	100%
Western Isles	2	67%	1	33%	3	100%
Scotland	497	45%	612	55%	1109	100%

Across mainland Scotland the proportion of EDCs without MHO consent ranged from 14% (Borders) to 66% (GGC), the national figure being 45%.

50% of the non-consents in Scotland for this period are in the GGC area.

Table 5 All EDCs in and out of hours - by health board, 1st July to 31st December 2015

Health Board	In hours		Out of hours		Total	
	n	%	n	%	n	%
Ayrshire and Arran	12	24%	37	76%	49	100%
Borders	1	7%	13	93%	14	100%
Dumfries and Galloway (HB)	17	46%	20	54%	37	100%
Fife (HB)	29	38%	47	62%	76	100%
Forth Valley	10	15%	56	85%	66	100%
Grampian	21	43%	28	57%	49	100%
Greater Glasgow and Clyde	105	28%	269	72%	374	100%
Highland (HB)	31	44%	39	56%	70	100%
Lanarkshire	21	21%	79	79%	100	100%
Lothian	57	33%	118	67%	175	100%
Orkney (HB)	3	50%	3	50%	6	100%
Shetland (HB)	1	100%		0%	1	100%
Tayside	22	25%	67	75%	89	100%
Western Isles	2	67%	1	33%	3	100%
Scotland	**332**	**30%**	**777**	**70%**	**1109**	**100%**

There is considerable variation between health boards in the percentage of EDCs in hours. Where the percentage of EDCs is low in hours it may be that more STDCs are being used as the 'gateway order' to detention.

Table 6 In hours - EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	5	42%	7	58%	12	100%
Borders		0%	1	100%	1	100%
Dumfries and Galloway (HB)	5	29%	12	71%	17	100%
Fife (HB)	9	31%	20	69%	29	100%
Forth Valley	6	60%	4	40%	10	100%
Grampian	4	19%	17	81%	21	100%
Greater Glasgow and Clyde	48	46%	57	54%	105	100%
Highland (HB)	8	26%	23	74%	31	100%
Lanarkshire	8	38%	13	62%	21	100%
Lothian	26	46%	31	54%	57	100%
Orkney (HB)	0	0%	3	100%	3	100%
Shetland (HB)	0	0%	1	100%	1	100%
Tayside	5	23%	17	77%	22	100%
Western Isles	2	100%		0%	2	100%
Scotland	**126**	**38%**	**206**	**62%**	**332**	**100%**

In hours Lothian (46%) and GGC (46%) (also Forth Valley (60%) but low numbers), have the highest percentage of EDCs without MHO consent. The national average is 38%.

Table 7 Out of hours - EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	9	24%	28	76%	37	100%
Borders	2	15%	11	85%	13	100%
Dumfries and Galloway (HB)	15	75%	5	25%	20	100%
Fife (HB)	12	26%	35	74%	47	100%
Forth Valley	22	39%	34	61%	56	100%
Grampian	12	43%	16	57%	28	100%
Greater Glasgow and Clyde	200	74%	69	26%	269	100%
Highland (HB)	19	49%	20	51%	39	100%
Lanarkshire	21	27%	58	73%	79	100%
Lothian	36	31%	82	69%	118	100%
Orkney (HB)	0	0%	3	100%	3	100%
Tayside	23	34%	44	66%	67	100%
Western Isles	0	0%	1	100%	1	100%
Scotland	**371**	**48%**	**406**	**52%**	**777**	**100%**

Out of hours Dumfries and Galloway (75%) and GGC (74%) have the highest percentage of EDCs without MHO consent. We are in discussion with Glasgow Health and Social Care Partnership (GHSCP) and will discuss these figures with the Dumfries and Galloway partnership.

Reasons Given for Lack of MHO consent

Table 8: Attempt at MHO contact by Health Board, incorporating inferred cases(1) 1st July to 31st December 2015

Health Board	Service contacted(2)		Unsuccessful attempt		No attempt(3)		Unclear		Total	
	n	%	n	%	n	%	n	%	n	%
Ayrshire and Arran	5	36%	1	7%	7	50%	1	7%	14	100%
Borders	0	0%	1	50%	1	50%	0	0%	2	100%
Dumfries and Galloway	8	40%	3	15%	8	40%	1	5%	20	100%
Fife	12	57%	3	14%	6	29%	0	0%	21	100%
Forth Valley	12	43%	3	11%	13	40%	0	0%	28	100%
Grampian	9	56%	4	25%	2	13%	1	6%	16	100%
Greater Glasgow and Clyde	116	47%	40	16%	82	33%	8	3%	246	100%
Highland	16	62%	4	15%	5	19%	1	4%	26	100%
Lanarkshire	15	52%	5	17%	8	28%	1	3%	29	100%
Lothian	20	33%	7	11%	34	56%	0	0%	61	100%
Tayside	13	46%	10	36%	4	11%	1	4%	28	100%
Western Isles	1	50%	0	0%	0	0%	1	5%	2	100%
Scotland	**227**	**46%**	**81**	**16%**	**170**	**34%**	**15**	**3%**	**493**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent. Total=493 on data cleaning 4 cases removed (GGC=2, Highland=1, Lothian=1)

On initial examination of records a total of 162 records showed unclear reasons for lack of MHO consent; from these a total of 147 reasons were inferred – inferred no attempt 127 and inferred attempt 20.

1 The table includes 147 cases where the attempt at contact has been inferred from the information provided on the EDC

2 Includes 20 inferred cases

3 Includes 127 inferred cases

Service contacted – means that service was contacted PRIOR to the EDC being granted.

No attempt – includes cases where the service was contacted AFTER the EDC was granted.

Other than in the Lothian and GGC areas, the numbers are too small to draw any conclusions. We are in discussion with GHSCP and will ask NHS Lothian about the number of cases where no attempt was made to contact the MHO service.

Table 9: Scotland: Attempts to contact MHO / outcome of contact

	n	%
1 service contacted	**227**	**46%**
situation urgent	55	11%
situation urgent - absconded	5	1%
discussed and EDC agreed	21	4%
situation urgent - would take too long to get there	26	5%
not available - on other call out	12	2%
not available - other reason	72	15%
not practical to attend	5	1%
on way but not in time to assess	13	3%
other	5	1%
other - no MHO on duty	11	2%
unclear	2	0%
2 unsuccessful attempt	**81**	**16%**
no answer from MHO service	41	8%
awaiting callback	30	6%
other	2	0%
unclear	8	2%
3 no attempt	**170**	**34%**
no attempt to contact and no reason given	3	1%
situation urgent	141	29%
situation urgent - absconded	16	3%
other	4	1%
unclear	6	1%
4 unclear	**15**	**3%**
situation urgent	1	0%
not available - other reason	2	0%
other	1	0%
other - no MHO on duty	1	0%
unclear	10	2%
All cases	**493**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent
Note: The table includes 147 cases where the attempt at contact / outcome was inferred

Revocation, Review and STDC 1st July 2015 to 31 December 2015

Table 10: Time to revocation or review by health board (number)

Health board	Hours to revocation or review for STDC							
	<=24		>24 to 48		> 48 to 72		At 72	Total
	REV	STDC	REV	STDC	REV	STDC	EXPIRED	Total
	n	n	n	n	n	n	n	n
Ayrshire and Arran	1	7		2	1	1	2	14
Borders			1		1			2
Dumfries and Galloway	1	4	3	4	3	3	2	20
Fife	4	4	2	5	4		2	21
Forth Valley	3	12	3	5	1	1	3	28
Grampian	1	8	1			1	5	16
Greater Glasgow and Clyde	40	89	24	37	8	10	31	239
Highland	4	10	3	4		1	4	26
Lanarkshire	9	3	2	6		4	5	29
Lothian	9	17	8	10	3	1	12	60
Tayside	5	10	2	6	2		2	27
Western Isles							2	2
Grand Total	**77**	**164**	**49**	**79**	**23**	**22**	**70**	**484**

*9 cases excluded where revoked EDC were for people on longer term orders.

Table 11: Time to revocation or review by health board (percentage)

Health board	Hours to revocation or review for STDC							
	<=24		>24 to 48		> 48 to 72		At 72	Total
	REV	STDC	REV	STDC	REV	STDC	EXPIRED	Total
	%	%	%	%	%	%	%	%
Ayrshire and Arran	7%	50%	0%	14%	7%	7%	14%	100%
Borders	0%	0%	50%	0%	50%	0%	0%	100%
Dumfries and Galloway	5%	20%	15%	20%	15%	15%	10%	100%
Fife	19%	19%	10%	24%	19%	0%	10%	100%
Forth Valley	11%	43%	11%	18%	4%	4%	11%	100%
Grampian	6%	50%	6%	0%	0%	6%	31%	100%
Greater Glasgow and Clyde	17%	37%	10%	15%	3%	4%	13%	100%
Highland	15%	38%	12%	15%	0%	4%	15%	100%
Lanarkshire	31%	10%	7%	21%	0%	14%	17%	100%
Lothian	15%	28%	13%	17%	5%	2%	20%	100%
Tayside	19%	37%	7%	22%	7%	0%	7%	100%
Western Isles	0%	0%	0%	0%	0%	0%	100%	100%
Grand Total	**16%**	**34%**	**10%**	**16%**	**5%**	**5%**	**14%**	**100%**

*9 cases excluded where revoked EDC were for people on longer term orders.

The audit looked at the length of time before the EDC was reviewed and revoked; or was reviewed and a STDC was put in place; or expired after 72 hours. 50% of people were reviewed by an AMP and either had the EDC revoked or were detained on a STDC (which also requires MHO consent) within 24 hours of the EDC. This rose to 76% within 48 hours of the EDC. Only 14% of EDCs expired after the 72 hour period and may not have been reviewed by an AMP.

Greater Glasgow and Clyde and their social care partners

We met with GGC and their social care partners for our annual meeting in December 2015 and discussed with them the continuing rise in EDCs without MHO consent. We agreed at that point that they would do further work on this and we would meet again on 24 March 2016. In the interim, the GHSCP had carried out an audit of 52 cases with and without consent in South Glasgow over a 3 month period. The Commission had carried out an audit of all EDCs across Scotland for the period 1st July 2015 to 31st December 2015.

Numbers with and without MHO consent

In the six month period of the Commission's audit there were 1109 EDCs in Scotland. 45% (497) did not have MHO consent.

A third of all the EDCs (374) in Scotland were in the GGC area. The national figures are therefore influenced by the numbers of EDCs in GGC. If excluded, 34% (249) of EDCs in the rest of Scotland did not have MHO consent.

In GGC 66% (248) did not have MHO consent. This is an improvement, to date, from the 2014-15 annual monitoring figures of 72%.

Reasons for no MHO consent

Table 12: Greater Glasgow and Clyde: Attempts to contact MHO / outcome of contact

	n	%
service contacted	**116**	**47%**
situation urgent	40	16%
situation urgent - absconded	2	1%
situation urgent - would take too long to get there	12	5%
discussed and EDC agreed	10	4%
not available - on other call out	8	3%
not available - other reason	29	12%
not practical to attend	4	2%
on way but not in time to assess	2	1%
other	3	1%
other - no MHO on duty	4	2%
unclear	2	1%
unsuccessful attempt	**40**	**16%**
no answer from MHO service	25	10%
awaiting callback	11	4%
other	1	0%
unclear	3	1%
no attempt	**82**	**33%**
situation urgent	68	28%
situation urgent - absconded	7	3%

no attempt to contact and no reason given	2	1%
other	1	0%
unclear	4	2%
unclear	**8**	**3%**
situation urgent	1	0%
not available - other reason	1	0%
unclear	6	2%
All cases	**246**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent
Note: The table includes 76 cases where the attempt at contact / outcome was inferred

In our six month audit we compared the reasons for lack of MHO consent in the GGC area with other health boards across Scotland. The pattern of reasons for non- consent in GGC was similar to the national picture. The reasons given for lack of MHO consent were multi factorial. Table 12 indicates:

21% of cases where the service was contacted were too urgent to wait for an MHO.

31% of cases where there was no attempt to contact the service were felt by the doctor to be too urgent to wait for an MHO. It is not possible to tell from the data available on these cases the potential for alerting the service earlier of the likely need for an EDC. This would increase the chances of an MHO attending, or the coordination of a joint assessment between the responsible medical officer (RMO) and MHO with nurses' power to detain (s299) being used until both the doctor and MHO could be there. (Nurses power to detain lasts for up to two hours from the start of Section 299 detention (s299) period to allow for medical assessment. If the doctor arrives between one and two hours of the started detention, the time can be extended for up to one hour from his/her arrival to allow for medical assessment. From April 2017, the time limit will be three hours in all cases. During the debate in Parliament, Ministers said that one reason for this extension was to make it easier for MHOs to attend.)

15% of doctors reported that there was no answer or they were waiting for a call back from the MHO service. There are dedicated telephone numbers specifically for professionals to access the MHO service in each locality and out of hours, which we understand are constantly manned. We were told the out of hours number is circulated regularly and listed in the Psychiatric Emergency Plan (PEP), though, it may be that the key personnel are still not sufficiently aware of these direct numbers. In addition, we were informed that the out of hours service has been supplemented by nine sessional MHOs.

Time of detention- in and out of hours

Across Scotland, in the six months 1 July to 31 December 2015, 38% (126 of 332) of EDCs in hours and 48% (371 of 777) out of hours did not have MHO consent.

In GGC 46% (48 of 105) of EDCs in hours and 74% (200 of 269) out of hours did not have MHO consent. In hours each local authority has its own MHO rota. The out of hours service covers the six local authorities in the health board area, as well as taking calls for Dumfries and Galloway.

Reasons for no MHO consent in and out of hours

Table 13: Greater Glasgow and Clyde: Attempts to contact MHO / outcome of contact in hours and out of hours

	In hours		Out of hours		All cases	
	n	%	n	%	n	%
service contacted	11	23%	105	53%	116	47%
unsuccessful attempt	8	17%	32	16%	40	16%
no attempt	24	51%	58	29%	82	33%
unclear	4	9%	4	2%	8	3%
All cases	47	100%	199	100%	246	100%

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent.
The table includes 76 cases where the attempt at contact / outcome was inferred.

The reasons for lack of MHO varied in and out of hours. In hours, the main reason was that no attempt was made to contact the service in 51% of cases.

Out of hours, the service was contacted in 53%, of cases but in 29% of cases could not respond due to the urgency of the situation. In 18% of cases, an MHO was not available, and in 7% of cases other reasons were given.

Location prior to detention – community or hospital

There was no difference in the reasons for lack of consent when we looked at whether people were in the community or in hospital on an informal basis prior to detention.

Type of medical practitioner doing the assessment

There was no significant pattern when we looked at whether the medical practitioner was a GP or hospital doctor.

Detention in and out of hours by hospital

Table 14 Consent In and Out of Hours by Hospital 1 July 2015-31 December 2015

Hospital	In hours				Out of hours			
	MHO consent		Total	% without consent[1]	MHO consent		Total	% without consent[1]
	No	Yes			No	Yes		
	n	n	n	%	n	n	n	%
Blytheswood Hs	1		1					
Drumchapel		1	1					
Dykebar	2	1	3		8	2	10	80%
Gartnavel General					1		1	
Gartnavel Royal	10	8	18	56%	42	4	46	91%
Glasgow Royal Infirmary	1	1	2		16	7	23	70%
Golden Jubilee					1		1	
Graham Anderson Hs						1	1	
Inverclyde Royal	2	8	10	20%	19	3	22	86%
Leverndale	6	6	12	50%	39	17	56	70%
Mackinnon Hs	8	7	15	53%	27	9	36	75%
Parkhead	2	8	10	20%	10	1	11	91%
Priory		2	2		2		2	
Queen Elizabeth	9	6	16	60%	17	13	30	58%
Royal Alexandria	4	7	11	36%	14	8	22	64%
Stobhill	1	1	2		3	1	4	
Vale of Leven	1	1	2		1	3	4	
All hospitals	48	57	105	46%	200	69	269	74%

1. Percentage shown for hospitals with more than 10 EDCs only

In hours, the higher numbers of EDCs and higher percentages of EDCs without MHO consent are at Gartnavel Royal Hospital (GRH) 56%, Queen Elizabeth University Hospital (QEUH) 60% and Mackinnon House 53%.

Out of hours, the higher numbers of EDCs, and higher percentages of EDCs without MHO consent are at Leverndale 70%, GRH 91%, Mackinnon House 75% and QEUH 58%. Two other hospitals also seem to have a high proportion of non consents out of hours but the actual number of EDCs at these hospitals is smaller: Parkhead (91%) and Inverclyde Royal Hospital (IRH) (86%).

This highlights the variation between hospitals in and out of hours with GRH being the most notable for lack of MHO consent out of hours.

Reasons for lack of consent by hospital

Table 15: GGC HB: Outcome of MHO contact by hospital (hospitals with at least 10 cases)

Hospital	service contacted		unsuccessful attempt		no attempt		unclear		All cases	
	n	%	n	%	n	%	n	%	n	%
Dykebar	4	40%	0	0%	6	60%	0	0%	10	100%
Gartnavel Royal	23	45%	10	20%	17	33%	1	2%	51	100%
Inverclyde Royal	14	67%	2	10%	5	24%	0	0%	21	100%
Leverndale	15	33%	8	18%	20	44%	2	4%	45	100%
Mackinnon House	16	46%	4	11%	14	40%	1	3%	35	100%
Parkhead	5	42%	3	25%	4	33%	0	0%	12	100%
Glasgow Royal	7	44%	5	31%	2	13%	2	13%	16	100%
Queen Elizabeth University	15	56%	2	7%	9	33%	1	4%	27	100%
Royal Alexandra	11	61%	3	17%	3	17%	1	6%	18	100%
All psychiatric hospitals	***77***	***44%***	***27***	***16%***	***66***	***38%***	***4***	***2%***	***174***	***100%***
All general hospitals	***33***	***54%***	***10***	***16%***	***14***	***23%***	***4***	***7%***	***61***	***100%***
All hospitals	110	47%	37	16%	80	34%	8	3%	235	100%

Source: EDCs s submitted to the Commission, July to December 2015, with no MHO consent

The figures show that;

- Where the service was contacted, there was less likely to be a response if the person was in IRH, the RAH or the QEUH. This may be related to distance in the case of the first two hospitals.
- Where there was an attempt to contact the MHO but it was unsuccessful, this was more likely to happen if the person was in Glasgow Royal Infirmary (GRI), Parkhead or GRH.
- There was less likelihood of a medical practitioner contacting the MHO service if the person was in Dykebar, Leverndale or Mackinnon House.

Improvement plan from Health and Social Care Partnerships (HSCPs) in Greater Glasgow and Clyde area

The data does not point to any one factor being significant in the low rate of MHO consent but indicates the need to interrogate the information on a number of fronts. The HSCPs have agreed a 22 point improvement plan. This includes;

- Encouraging clinical staff to think ahead, anticipate events and plan interventions, including the use of nurses, power to detain for up to three hours, and amending the protocol so the MHO is phoned at the same time as the medical practitioner;
- Reviewing communications, including confirming that all doctors have the correct phone numbers to directly access MHOs;

- Emphasising to medical practitioners the importance of contacting an MHO even in urgent cases after the EDC is completed. This will ensure that the detention can be reviewed by an AMP and an MHO as soon as possible;
- Examining the reasons for the variation in rates of MHO consent across hospitals, particularly in GRH in order to improve consistency. The Commission will provide the HSCPs with an anonymised EDC data set for the period 1 July to 31 December 2015 to enable further investigation;
- Impressing on the clinical directors the importance of ensuring junior doctors are applying the protocols and procedures relating to EDCs;
- Designing a multi-disciplinary training programme;
- The HSCPs and Out of Hours Services recording EDCs with and without consent and reporting to The Adult Services Core Leadership Group (ASCLG), who will consider future governance arrangements. Each HSCP will identify an individual to lead on the plan and report to this group;
- Undertaking a single audit process every six months;
- Reviewing and promoting the PEP including consideration of MHO response times;
- Preparing a workforce plan for MHOs.

In addition, there was discussion of the need to improve the consistency and the quality of the information when completing the EDC forms. The Commission will provide examples of good and poor examples of the reasons given for lack of MHO consent.

Summary

1. In 2014-2015 there were 2009 emergency detention certificates (EDCs) in Scotland, 606 of these were in the Greater Glasgow and Clyde area (GGC). There was considerable variation across mainland health boards in the percentage of EDCs without mental health officer (MHO) consent, ranging from 20% in Tayside to 70% in GGC.

2. The Mental Welfare Commission (the Commission), at the request of the Scottish Government, audited EDCs without MHO consent, for a six month period from 1 July 2015 to 31 December 2015, and looked at: the reasons for lack of consent; any differences in and out of hours; when the EDC was reviewed; and a number of other factors.

3. There were 1109 EDCs in this six month period, of which 374 were in GGC. The percentage without MHO consent ranged from 14% in Borders to 66% in GGC.

4. There were differences in and out of hours in the percentage without MHO consent. In hours Forth Valley (60%), Lothian (46%) and GGC (46%) had the highest percentage of EDCs without MHO consent. The national average was 38%. Out of hours Dumfries and Galloway (75%) and GGC (74%) had the highest percentage of EDCs without MHO consent. The national average was 48%. We are in discussion with Glasgow Health and Social Care Partnership (GHSCP) and will also discuss these figures with the Dumfries and Galloway Health and Social Care Partnership.

5. The reasons for lack of MHO consent were coded and these were then grouped under three broad headings –whether the MHO service was contacted, whether there was an attempt to contact the service but it was unsuccessful or whether no attempt was made to contact the service.

6. There was no single reason for lack of consent in any of the health boards and most had the same pattern of reasons for lack of consent.

7. The audit looked at the length of time before the EDC was reviewed and revoked; or was reviewed and a short term detention certificate (STDC) was put in place; or expired after 72 hours. 50% of people were reviewed by an approved medical practitioner (AMP) and either had the EDC revoked or were detained on a STDC (which requires MHO consent) within 24 hours of the EDC. This rose to 76% within 48 hours of the EDC. Only 14% of EDCs expired after the 72 hour period and may not have been reviewed by an AMP.

Greater Glasgow and Clyde Health and Social Care Partnerships (GHSCP)

8. We looked in more detail at the lack of MHO consent in the GGC area. We met with GHSCP to discuss the issues and possible remedies to the situation.

9. There was no single reason for lack of consent in any of the health boards and GGC had the same pattern of reasons for lack of consent as the majority of boards. The main differences in GGC are the volume of EDCs and the larger percentage without consent.

10. The reasons for lack of MHO consent varied in and out of hours. In hours, the main reason was that no attempt was made to contact the service in 51% of cases. Out of hours the service was contacted in 53% of cases but in 29% of cases could not respond due to the urgency of the situation. In 18% of cases an MHO was not available, and in 7% of cases other reasons were given.

11. There is considerable variation between hospitals in and out of hours; Gartnavel Royal Hospital (GRH) was the most notable for lack of MHO consent out of hours (91%). There was also variation in the reasons given for lack of MHO consent in different hospitals which needs further investigation by GGC.

12. The length of time before the EDC was reviewed and revoked, reviewed and a STDC was put in place, or expired after 72 hours, was no different in GGC than in other boards in Scotland.

13. Discussion between the Commission and GHSCP about the findings of the audit, together with an internal GHSCP audit of cases in South Glasgow, has led to a number of action points that GHSCP and the other five HSCPs will take forward. These include: work with clinical staff on anticipating events and amending protocols as to when the MHO is phoned and how nurses' power to detain may be used; reviewing communications to ensure medical staff have the correct phone number; reviewing the PEP; designing a multi-disciplinary training programme; ensuring all junior doctors across various clinical settings are applying the protocols and procedures; reporting EDCs with and without to the Adult Services Core Leadership Group (ASCLG) to consider future governance arrangements; further investigating the variation between hospitals; and preparing a workforce plan for MHO.

14. There will be continuing dialogue between the Commission and GHSCPs on the progress of these issues.

Recommendations

1. The Scottish Government should encourage health and social care partnerships with lower rates of MHO consent to develop action plans over the next 12 months to improve rates of consent. The Commission will continue to report on rates of MHO consent in its annual monitoring reports, and to discuss rates at end of year meetings with health and social care partnerships.

2. As part of the preparation for the implementation of the Mental Health (Scotland) Act 2015[3], the Scottish Government should review the Code of Practice to ensure it gives sufficiently clear guidance on the expectations on doctors and MHOs in relation to emergency detention. Guidance should also be produced in relation to the extension of the nurses' holding power (s20) to maximise the opportunity for an MHO to attend during the extended period.

3. Local authorities should ensure they are meeting the standards set out in National Standards for MHO Services[4], particularly Standard 2 relating to referral, assessment and admission procedures and Standard 4 relating to inter/intra agency collaboration and cooperation.

4. Health boards should review induction/training/guidance on EDC procedures for junior doctors.

5. Health boards should remind all medical practitioners of the expectations of MHO consent other than in exceptional circumstances as set out in the Code of Practice (Volume 2 Chapter 7, paras 33 to 37)[5].

6. Health boards should encourage clinical staff to anticipate events and plan interventions, including the use of nurses' power to detain and early contact with the MHO service.

7. There should be discussion between the Care Inspectorate and the Commission on collaborating on a review of MHO services within the next two to three years. This should be informed by this current EDC monitoring exercise, as well as the work of the Chief Social Work Inspector (CSWI).

8. The Commission will review the EDC form (DET 1) with a view to providing clearer guidance to doctors on the form and reducing the opportunities for error.

[3] http://www.legislation.gov.uk/asp/2015/9/contents
[4] http://www.gov.scot/Publications/2005/05/1393048/30499
[5] http://www.gov.scot/resource/doc/57346/0017054.pdf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Mental Welfare Commission (Jun16)

APPENDIX 2

ADSW Mental Health Sub Group

Survey of Mental Health Officer Salary Rates, Autumn 2013

Introduction:

In 2012, the Scottish Social Services Council (SSSC) assumed responsibility for collating data in respect of the Mental Health Officer (MHO) workforce across the country. The Scottish government had previously undertaken this task, and issued a report of the data on an annual basis.

While the SSSC workforce report provides valuable key information relating to the numbers of MHOs in post, and other demographic characteristics of MHO workforces in each local authority area and across the country, it does not include reference to salary and other forms of remuneration.

The recruitment and retention of MHOs has been an enduring challenge for many local authorities, with the impact of variance in remuneration levels, and other terms and conditions, being widely recognised as a central component. Remuneration levels can influence the recruitment and retention of MHOs, but are also likely to have a bearing on the numbers of Social Workers who undertake the formal MHO training programmes.

The ADSW Mental Health Sub-group has agreed that it would be helpful to collect data in respect of MHO remuneration. In combination with the SSSC workforce report, this information would provide a broader overview, whilst assisting local authorities in MHO workforce planning.

The Data:

Each local authority in Scotland was invited to provide details of current MHO remuneration. Of the 32 local authorities contacted, 25 provided the requested information. This represents a return of approximately 78% and, as such, it is not possible to reflect the situation across the country in its entirety. Notwithstanding this, the responses received constitute an indicative cross-section of local authority areas. The northern-most (Shetland) and most southerly (Dumfries & Galloway) local authorities are represented, while large, predominantly rural regions such as Highland feature alongside their more urban, population-intensive counterparts (eg: Glasgow City and Edinburgh City).

The template that was issued requesting information can be found in *Appendix 1*.

Key Findings:

Much of the data collected is self-explanatory in nature. However, there are notable elements that might be highlighted for consideration. Key findings are summarised immediately below, and will be considered in more detail subsequently:

- **Variance:** there is considerable variance in terms of the levels of remuneration across the country. This is readily apparent, even when differences in contracted hours and the existence of senior practitioner status in a number of local authorities are factored into an analysis;
- **Enhancements:** a number of local authority areas have established arrangements whereby MHOs receive additional payment for undertaking the role. It is perhaps significant that the form of enhancement is unique to each individual local authority, and what each enhancement constitutes in terms of remuneration is also highly variable. A number of other local authorities have no form of enhanced remuneration for appointed MHOs, and, as such, the latter will generally receive a basic grade qualified Social Worker salary (and/or be eligible for Senior Practitioner status where applicable);
- **Senior Practitioner Status:** several local authorities afford the opportunity for MHOs - and, often, other Social Workers - to attain Senior Practitioner status (or an equivalent enhanced post). Again, however, there is variance in terms of how this status is secured. In some areas, all practicing MHOs automatically qualify for Senior Practitioner status, while in others, it is necessary to meet further criteria in order to advance to this level;
- **Out of Hours MHO Provision:** in a number of local authority areas, directly employed MHOs are involved in providing 'out-of-hours'* (OoH) cover, while in other areas, this is arranged through an external, dedicated OoH service (eg: West of Scotland Standby Service). In common with other key findings identified, there is considerable variance as to how MHOs who practice OoH are remunerated in this regard. This further complicates the overall picture in terms of the levels of remuneration in respective local authority areas.

*Duties undertaken over and above those which fall within the established *office hours*.

Variance:

Table 1, below, indicates maximum **basic grade** salary (ie: Senior Practitioner/other enhancement status not applicable *unless automatically applied* to MHO status) available to MHOs in each of the respondent local authority areas. An hourly rate has also been calculated using the following formula:

Maximum Annual Salary divided by (Contracted weekly hours multiplied by 52 (weeks in calendar year)**)**

Example: £**35000** divided by **1820** (35hours p/w x 52 weeks) = **£19.24 hourly rate**

Entries have been ordered from lowest hourly to the highest for ease of reference.

Local Authority	Contracted Weekly Hours	Maximum Basic Grade Salary £	Hourly Rate £
Shetland	37.5	32,338	16.58
*Falkirk	37	32,314	16.80
Fife	36	32,400	17.31
Inverclyde	37	33,298	17.31
East Lothian	35	31,498	17.31
City of Edinburgh	36	33,228	17.75
*Falkirk	35	32,314	17.75
Dundee City	37	34,283	17.82
Midlothian	36	33,380	17.83
Angus	36.25	33,927	18.00
East Dun'shire	35	32,921	18.10
East Ren'shire	35	33,432	18.37
North Lan'shire	35	33,813	18.58
Stirling	37	35,742	18.58
South Lan'shire	35	34,290	18.84
Highland	35	34,307	18.85
West Lothian	36	35,382	18.90
West Dun'shire	35	34,399	18.90
Aberdeenshire	36.25	36,204	19.21
Renfrewshire	35	35,445	19.48
Dum' & Galloway	36	36,507	19.50
North Ayrshire	35	35,680	19.60
Aberdeen City	37	38,538	20.03
Glasgow	35	37,400	20.55
Clack'shire	36	38,687	20.67

TABLE 1

*Falkirk has two entries as the LA has MHOs employed on both 35 and 37 h/p/w contracts

Senior Practitioner Status/Enhancements:

Table 2 indicates those Local Authorities in which MHOs have access to *senior practitioner* status, and also includes any enhancement (specific payment) associated with undertaking MHO duties.

Local Authority	Senior Practitioner (SP) Status Available?	Specific MHO Enhancement?	Basic Hourly Rate	Hourly Rate (max) with SP and/or enhancement
Shetland	No	No	16.58	N/A
*Falkirk	No	No	16.80 or 17.75	N/A
Fife	Yes*	No	17.31	**21.00**
Inverclyde	Yes*	No	17.31	**18.90**
East Lothian	Yes*	No	17.31	**20.10**
City of Edinburgh	Yes*	Yes	17.75	**20.68**
*Falkirk	No	No	17.75	N/A
Dundee City	No	Yes**	17.82	**
Midlothian	No	No	17.83	N/A
Angus	No	No	18.00	N/A
East Dun'shire	No	No	18.10	N/A
East Ren'shire	Yes*	No	18.37	**20.10**
North Lan'shire	Yes*	No	18.58	**19.54**
Stirling	Yes	Yes	18.58	**18.58**
South Lan'shire	Yes*	Yes	18.84	**20.28**
Highland	Yes*	No	18.85	**21.27**
West Lothian	No	No	18.90	N/A
West Dun'shire	No	No	18.90	N/A
Aberdeenshire		Yes	19.21	**19.21**
Renfrewshire	No	Yes	19.48	**19.48**
Dum' & Galloway	Yes	Yes	19.50	**19.50**
North Ayrshire	No	Yes	19.60	**19.60**
Aberdeen City	No	Yes*	20.03	**20.03**
Glasgow	No	No	20.55	N/A
Clack'shire	Yes*	info not available	20.67	**20.67**

TABLE 2

***Not all MHOs automatically qualify for this pay rate.

****Enhancement paid on basis of MHO duty responsibilities undertaken.

The maximum hourly rate including enhancement is therefore variable and cannot be readily calculated.

As can be noted from *Table 2*, sixteen of the twenty five respondent local authorities (64%) have arrangements in place whereby MHOs can access senior practitioner status and/or receive enhanced payment on account of undertaking statutory duties.

There is considerable variation in terms of what constitutes ***senior practitioner*** status across the country. In a number of local authority areas, the post holder will have supervisory/mentoring responsibilities, whereas in others, officers who exclusively undertake MHO duties secure this status. Elsewhere, the senior practitioner post responsibilities include strategic and training components. In other areas, securing MHO qualification and undertaking statutory duties is, in itself, sufficient to attract a form of *senior practitioner* status.

Similarly, the nature and payment of **enhancements** differs. These can range from an annual payment in addition to the qualified Social Worker salary, to more complex arrangements whereby MHOs receive additional, discreet payments for being the designated duty worker.

The impact of senior practitioner status and available enhancements on earning potential is significant. This is most apparent in the context of those local authorities where the basic grade hourly rate was comparatively low (see Table 1).

Out of Hours Provision:

For the purposes of the current paper, out of hours arrangements have not been factored into the calculation of hourly rates payable to MHOs throughout the country. Of the twenty five local authority respondents to the current survey, nine have indicated that MHOs employed on standard contracts also provide or contribute to the local out of hours duty services.

A number of local authorities stipulate that suitably experienced MHOs undertake out of hours duties, while in other areas this is optional. In other areas, the local authority commissions an out of hours service from an external *standby* agency or neighbouring local authority. Payment arrangements for MHOs who undertake out of hours duties vary significantly. While some authorities provide an *on call* payment that is made regardless of whether the MHO receives a duty call, others will only pay for any work undertaken. Payment can be made on an hourly basis, or per call-out.

The provision of out of hours MHO services is complex, and would perhaps warrant consideration in a separate study.

Report completed by:

Drew Lyall

Senior Mental Health Officer

West Dunbartonshire Council

On behalf of the Association of Directors of Social Work, Mental Health Sub-group

5th December 2013

East Dunbartonshire
Health and Social Care Partnership

Agenda Item Number: 22

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	Thursday 11 August, 2016
Report Number	**2016/17_22**
Subject Title	Communications Objective: Creating a Brand
Report by	Fiona Borland, Communications Adviser, East Dunbartonshire Health & Social Care Partnership
Contact Officer	Fiona Borland, 0141 574 5530, Fiona.borland@eastdunbarton.gov.uk

1.0 PURPOSE OF REPORT

1.1 To seek approval for the branding that will be used to identify the East Dunbartonshire Health and Social Care Partnership (HSCP).

2 SUMMARY

2.1 A brand is important because it helps to give an organization a clear, strong identity and also helps staff/employees to identify with the HSCP.

2.2 Creating a brand for the HSCP is a key part of its developing communication plan and a main priority for its Communications Adviser.

2.3 This branding will be used on all future correspondence, including letterheads, emails, newsletters, staff news, website presence and press releases

2.4 East Dunbartonshire Council designers created five logos, which were considered by the Operational Management Group and the Strategic Development Team

2.5 The preferred two options were then sent to HSCP Public Service & Carers Users Network, as well as to Service Users engaging with the Health Improvement Team's Smokefree Service

2.6 Their preference was the tree design. The two favoured logos are laid out on the following pages as examples of how the branding could look as part of HSCP correspondence

3 RECOMMENDATIONS

3.1 It is recommended that the Health & Social Care Partnership Board:

a) Decides which of the options should become the HSCP's logo, or;

b) Requests that a third option is created for consideration.

Volunteers Wanted

for young people

Expenses, training and on-going support will be provided

Call **Sally O'Donnell** from East Dunbartonshire Council's Befriending Scheme on

0300 123 45100 or **07901510105**

Training starts September / October 2016

East Dunbartonshire Health & Social Care Partnership

Designed by the Communications Unit December 2015

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Designed by the Communications Unit December 2015

REJECTED DESIGNS

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health & Social Care Partnership

Integration Scheme (Consultative Draft – December 2014)

1 THE PARTIES:

East Dunbartonshire Council, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at 12 Strathkelvin Place, Kirkintilloch ("the Council");

And

Greater Glasgow and Clyde Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 and having its principal offices at JB Russell House, Gartnavel Royal Hospital Campus, 1055 Great Western Road, Glasgow ("the Health Board") (together referred to as "the Parties")

2 DEFINITIONS AND INTERPRETATION

2.1 Definitions and Interpretation:

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

"Integration Joint Board" (or "IJB") means the Integration Joint Board to be established by Order under section 9 of the Act;

"Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act

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

"Integration Joint Boa rd Order" means the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014

"Scheme" means this Integration Scheme;

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

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REJECTED DESIGNS

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Health and Social Care Partnership

Agenda Item Number: 23

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_23**
Subject Title	PAG Minutes
Report by	Graham Morrison
Contact Officer	Karen Murray

1.0 PURPOSE OF REPORT

1.1 Minutes from the Professional Advisory Group for 16th December 2015 and 16th March 2016.

2.0 RECOMMENDATIONS

2.1 The Board are asked to note the contents of the minutes.

East Dunbartonshire
Community Health Partnership

NHS
Greater Glasgow and Clyde

HSCP PROFESSIONAL ADVISORY GROUP MEETING
WEDNESDAY 16TH DECEMBER 2015, CORPORATE MEETING ROOM

Present:	Graham Morrison	**(GM)**	Clinical Director
	Lisa Williams	**(LW)**	Associate Clinical Director
	Carolyn Fitzpatrick	**(CF)**	Lead Prescriber
	Adam Bowman	**(AB)**	Consultant Physician
	Keith Gardener	**(KG)**	Acting Chief Social Work Officer
	Wilma Hepburn	**(WM)**	Professional Nurse Advisor
In attendance:	Christina Burns	**(CB)**	Minutes

No	Topic/Subject	ACTION
1.	**Welcome & Apologies**	
	GM welcomed everyone to the meeting. Apologies noted from Diane Dobie & Andy Martin	**GM**
2.	**Discuss TOR**	
	TOR formulated through discussions with Karen Murray, Graham Morrison and Lisa Williams.	**GM**
3.	**East Dunbartonshire Integrated Governance Structure (DRAFT)**	
	The draft structure was discussed to illustrate where PAG sits within the overall structure. There is a CCG Sub group run by Lisa Williams. Discussions are ongoing to determine how this should be combined under one umbrella. Primary Care and Health and Social care need to work together closely for these areas to operate together effectively. This is one of our main roles within PAG.	**GM**

4.	**Child Protection Document (For Discussion)**	
	It is important to discuss Supporting GP's and Child Protection work. The Supporting GP's in Child Protection Work document came from The Child Protection Unit. This provides guidance for GP's on Child Protection training and how each practise should be functioning. All practise staff both clinical and non-clinical should be trained in Child Protection to a level appropriate to their role. The *safeguarding children and young people: roles and competencies for health care staff* – Intercollegiate Document (2014) advises that GP's should be trained to level 3.	**GM**
	The CHP had a PLT event in June which focused on GP's engaging with Child Protection. The CHP were asked to provide PLT on a yearly basis. GP's were encouraged to start Child protection training with 8 hour minimum suggested. This is not covered in GP revalidation but there is an expectation that this should happen.	**GM**
	We cannot demand that this happens as this is not mandatory and is not directly linked to revalidation therefore we are only able to recommend this is undertaken and that there is a duty of care to meet these guidelines. If a GP does not take this on board and an opportunity to identify a vulnerable child is missed we will be heavily criticised.	**LW**
	It is however mandatory for consultants within acute services. This is normally completed through an online module.	**AB**
	This is also mandatory within Social Care. Although currently in a transitional period it is more fluid in terms of Child Sexual Exploitation and Social Media which is changing the dynamics rapidly. Also, it is not only Social work that are involved this is now a multi- agency issue.	**KG**
	Child & Adult protection is mandatory for Community Nurses.	**WH**
	Early intervention and ensuring that individuals know who to contact is the key issue for Child and Adult Protection.	**AB**
	It is Mandatory for all NHS employed staff. However it is not mandatory for pharmacy staff.	**CF**
	GM asked if pharmacy staff have access to Learn pro.	**GM**
	They do not have access to Learn Pro in the community.	**LW**
	GM informed the group that there is a community pharmacy link and suggested that this could possibly be discussed with them.	**GM**

	This will be taken to the next GP Forum for discussion as well as reviewing the next audit.	**GM, LW**
	There may be an opportunity for some of the group to attend the GP forum to provide awareness.	**GM**
	KG would be interested to see how the Management of Offenders is dealt with from a Health perspective.	**KG**
5.	**Revalidation**	
	The Nursing and Midwifery Council (NMC) made the decision on 8th October 2015 to introduce revalidation for all nurses and midwives in the UK with the first nurses and midwives progressing to revalidation on 1st April 2016. There will be Revalidation Workshops which will run from January to March 2016 and will take place at various venues across NHS GGC. The aim being to provide those registrants who will be revalidating with NMC in April – June 2016 with facilitated workshops that will allow them to generate information themselves relevant to revalidation that can be integrated into their portfolio. A toolkit of information is also available on the nursing portal with links to NMC, the NES knowledge network and the NES e-portfolio. A standard presentation is available for use at local staff sessions. Other information including the Scottish Revalidation newsletter and the bimonthly WebEx are all posted on the nursing portal. It is intended that this portal page will eventually host any good practice initiatives e.g. sample reflective accounts, sample portfolios. Discussions indicate that there will be a number of hours dedicated to training and self reflective account writing to ensure individuals are fit to practise.	**WH**
	Again this comes into force in April with more awareness sessions planned for April – June. All grades of registered nurses and midwives are due to revalidate April/May/June 2016. If individuals do not revalidate then there is a possibility that they will be removed from the register, the policy states suspension without pay. This is high risk and will be discussed through a Board wide Steering group.	**WH**
	What is the approach in terms of Maternity Leave and sick leave?	**LW**
	The NMC will make allowances for this initially however as this will be achieved over 3 years there should be no problems in the future. There is an understanding however that there will be issues in the short term and that is why this will be overlooked at the initial point. It is a substantial change and therefore people are apprehensive however this applies to all registrants in all areas although we are specifically looking at this for nurses at the moment as there are concerns around the very tight	**WH**

	timescales. Is there anything that we need to do? WH explained that no actions were required at the moment however this would be revisited and advice would be given as to what actions should be taken and when. WH also explained that the numbers of staff identified in the first cohort are relatively small. However, there is expected to be a larger group of staff who will be due to revalidate around August-October 2016. Care homes may encounter issues this in turn may have an impact on district nurses. This has been raised on the risk register to look into the potential impacts further. It is each individual's responsibility to do this, we need to be concerned about the impact this has on services. Has there been any engagement with Care Homes? WH advised that some of the care home staff will be taking part in the Awareness sessions. As an organisation the main concern for us must be the impact and the associated risk. GM requested that revalidation was discussed at a later date to ensure awareness and to discuss any potential actions.	**GM** **WH** **LW** **GM** **WH** **LW** **GM**
6.	**Prescribing Update**	
	The East Dunbartonshire primary care budget was 17 million, up to October we are 180,000 overspent. It appears that most HSCP areas are over budget this year. Prescribing costs are always volatile as there are often issue with supply and short supply of medications which in turn inflates the cost. Population is also a factor as well as the increased numbers of older people who have greater needs. Overall there are many pressures that are difficult to predict. Current cost pressures are generated from cost increases in generic drugs and not branded. The concern being where does the money come from to meet the increased cost?	**CF**

7.	**Clinical Care Governance (Summary)**	
	The Clinical Care Governance Meeting will now be integrated with the existing Clinical Governance Sub Group Meeting. The Health and Clinical Care Group TOR will be drafted by March. This will become a Clinical and Care Governance Group. We will look at how this should feed into the Professional Advisory Group (PAG).	**LW**
8.	**HSCP Board Issues *(For Discussion)***	
	GM advised that both WH and KG attended the HSCP Board Meeting. WH felt that the meeting was more productive with increased involvement. Funds around delayed discharges were discussed as well as the Equality paper. The next big issue will be the harmonisation of posts and managers. WH asked if staff Partnerships would be involved in the meeting. LW felt that unless staff partnerships have a professional advisory role to promote it would not be worthwhile. If staff partnerships feel that there is something that should be discussed, this should be raised and it can then be escalated and discussed at PAG. We should not be looking at staffing as this meeting is intended for professional issues.	**GM** **WH** **WH** **LW** **GM** **LW**
9.	**Any other Business**	
	GM asked if there is anyone else that should be invited to this core group. I would like to invite the Team leads for each area to allow them to raise any professional issues and to give them the opportunity to represent their respective areas LW suggested that Specific Standing items are added to the Agenda as this may focus people's minds on what types of issues that they should be discussing by focusing people's attention on specific areas.	**GM** **LW**
10	**Date of Next Meeting** –	
	The next meeting will take place on the 16th of March 2016, in the Corporate meeting, HSCP, Stobhill between 2pm – 4pm.	

East Dunbartonshire
Community Health Partnership

NHS
Greater Glasgow and Clyde

HSCP PROFESSIONAL ADVISORY GROUP MEETING
WEDNESDAY 16TH MARCH 2016, CORPORATE MEETING ROOM

Present:	Graham Morrison	**(GM)**	Clinical Director
	Lisa Williams	**(LW)**	Associate Clinical Director
	Carolyn Fitzpatrick	**(CF)**	Lead Prescriber
	Adam Bowman	**(AB)**	Consultant Physician
	Diane Dobie	**(DD)**	Deputy Chief Social Work Officer
	James Hobson	**(JH)**	Assistant Director of Finance
	Ray McAndrew	**(RM)**	Associate Medical Director
	Ashley Fergie	**(AF)**	Consultant Old Age Psychiatrist
	Fiona Munro	**(FM)**	Community Rehabilitation
	Andy Martin	**(AM)**	Head of Adult & Primary Care
	Aminah Haq	**(AH)**	Community Pharmacy Lead
	Hugh Russell	**(HR)**	Optometry, on behalf of Eddie McVey
In attendance:	Christina Burns	**(CB)**	Minutes

No	Topic/Subject	ACTION
1.	**Welcome & Apologies**	
	GM welcomed everyone to the meeting. Apologies noted from Wilma Hepburn, Eddie McVey and Keith Gardner. Minutes from previous meeting on 16th of December 2015	**GM**
2.	**HSCP Current Financial Position**	
	JH provided a short presentation detailing NHS GG&C's current Financial position. • Despite the financial challenges the board still has the capacity to breakeven. • 2016/17 Financial Planning Process – List of strategic savings opportunities identified. • 2016/17 Financial Planning Process - Update presented to the board at seminar on the 29th of February and further sessions planned with all Directors/Chief Officers on 24th of March. • With regards to the Health and Social Care integration, there have been difficulties agreeing the opening budgets for NHS Services in light of the current financial climate. Indicative allocations proposed to be confirmed in April/May.	**JH**
3.	**Health & Care Professional Council – Standard of conduct, performance**	

	and ethic	
	• GM informed the group that these items were put on the agenda for noting only and would not be discussed however encouraged the group to take the opportunity to familiarise themselves with the documents.	**GM**
4.	**Roles and Responsibilities of Wider Professional Leads**	
	• GM explained that PAG allows the Advisory Group to discuss Professional matters and to highlight professional issues of concern to the board. PAG is a new entity brought about by the new HSCP structure. This means to be a meaningful and constructive Group. It has been agreed that the agenda and minutes will be concise	**GM**
	• The PAG Core Group consists of: Graham Morrison, Lisa Williams, Carolyn Fitzpatrick, Andy Martin, Wilma Hepburn, Adam Bowman, Diane Dobie, Keith Gardner	
	• Professional Leads : Aminah Haq, Dr Ashley Fergie, Fiona Munro, Eddie McVey, Ray McAndrew	
	• Should it emerge that the PAG is ineffective as a means to discuss and escalate issues the meeting will be reviewed.	
	• GM advised that the Leads have a responsibility to raise any professional issues to the Professional Advisory Group for discussion. In short any professional issues that should go to the Joint Integrated Board should be escalated to PAG. GM also explained that the professional leads will not have to attend every PAG meeting, they will be asked to attend intermittently.	**GM**
	• HR requested clarification on when the Group would require the input of the professional leads and expressed concern that without regular scheduled meetings focus on the issues raised may drift.	**HR**
	• GM advised we could possibly look to include the Professional Leads on a quarterly basis but emphasised that he would like to keep the Leads attendance at the group to a minimum to avoid wasting time unnecessarily.	**GM**
	• DD confirmed this would be a helpful safeguard to discuss professional issues.	**DD**
	• This will allows us to better understand and appreciate things from a Social Work perspective.	**GM**
	• DD advised the Group that a New Chief Social Work Officer has been appointed and should be working within the role by June.	**DD**
	• GM provided a summary of the Roles and Responsibilities of Wider Professional Leads: You will be fulfilling a role by representing your own area of work and acting as a conduit for your colleagues to raise professional issues for discussion at the PAG.	**GM**
	• GM asked for Community Dentistry input and how this sits within the	**GM**

	partnership? • Community Dentistry is now Public Dentistry. Within this structure it may be difficult to incorporate the important elements from other areas when most of the agenda does not relate to their roles.	**RM**
5.	**GP Contract 16/17**	
	• This item was included in the agenda for your awareness as this may impact on the areas that you support. • Essentially GP's operated on a points based contract since 2004. This has now stopped with practises now expected to provide the services they feel are professionally appropriate to them and their areas. • There will be further development to the GP contact from April 2017. • Clusters have been driven by the pullback from the points based system. We need to develop what these clusters look like. • Locality Groups are different to Clusters but appear very similar in terms of demographics however Localities focus much more on inequalities.	**GM**
6.	**Revalidation**	
	• Nursing Validation will start around April. This will have an impact on Community Services and will be discussed in more detail at the next meeting when we can get further input from our Professional Nurse Advisor. • There are huge implications for those who do not comply and will also have an effect on the overall work force. • There is no revalidation currently for Dentistry.	**GM**
7.	**Clinical Care Governance (Summary)**	
	• The Clinical Care Governance Meeting will now be integrated with the existing Clinical Governance Sub Group Meeting. The Health and Clinical Care Group TOR will be drafted by March. This will become a Clinical and Care Governance Group. We will look at how this should feed into the Professional Advisory Group (PAG). • The Agenda will be largely formulated by LW and DD. LW confirmed that she will continue to chair this meeting. There is progression and the agenda should be standardised with specific standing items. • LW informed the group that she was happy to provide feedback to the group should anything further arise.	**LW**
8.	**HSCP Board Issues (For Discussion) – Step up/ Step Down Beds**	

	• The group discussed the advantages and disadvantages of intermediate care beds. The general consensus being that there are many areas of concerns regarding step up in terms of cost and monitoring the admission and discharge of patients. • The group discussed the difficulty in ensuring that the model is clinically correct. The feedback provided appears to shows that step down beds are regarded more favourably. • Social work has a difficult task in transitioning patients. It is important that the responsible parties are correctly identified.	**GM**
9.	**Transitional Quality Arrangements**	
	• This will be managed in 4 stages. GM referred to the Transitional Quality arrangements letter regarding the changes to GP contracts and Clusters which were discussed at length.	**GM**
10.	**Date of next meeting**	
	4th of May 2016 at 2pm, Corporate Meeting Room, HSCP HQ Stobhill.	

East Dunbartonshire 2016/17_24- DRAFT FOR RATIFICATION AT NEXT AUDIT MEETING

Health and Social Care Partnership

Minutes of
East Dunbartonshire Health & Social Care Partnership Audit Committee Meeting
held at 1:00pm on Monday 20th June 2016
in the Corporate Meeting Room, HSCP HQ, Stobhill Hospital

Present:	**Ian Fraser (Chair)**	**(IF)**	**Karen Murray**	**(KM)**
	Rhondda Geekie	**(RG)**	**Louisa Yule**	**(LY)**
	Peter Lindsay	**(PL)**	**Ross Finnie**	**(RF)**
	Michael O'Donnell	**(MO)**	**Jean Campbell**	**(JC)**
	Jamie Robertson	**(JR)**	**Anne McNair**	**(AM)**
In attendance:	**Geri McMartin (Minutes)**	**(GM)**		

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Mr Ian Fraser welcomed those present. Introductions were made. Apologies were noted from Trisha MacAuley.	
2.	**Minutes of previous meeting – 4th December 2015**	
	The minute of the meeting held on 4th December 2015 was approved as an accurate record. Cllr Rhondda Geekie highlighted incorrect spelling of her name.	
3.	**Amended Draft Terms of Reference for Audit Committee – For Approval**	
	Amendments were made to the Terms of Reference to include provision to hold private meetings of the Audit Committee when required. Cllr Geekie requested amendment be made to page 3 paragraph 5.5 as follows "The Audit Committee may procure specialist ad-hoc advice funded by the Partnership Board". Cllr O'Donnell asked what circumstances would prompt a private meeting of the Committee to take place? Mrs Campbell advised that there may be some reports produced by NHS GG&C which cannot be discussed in a public meeting. However, the necessity for private meetings would be considered as and when required. Mrs Campbell will amend the terms of reference as above and will present to the HSCP Board for approval.	**JC**

4.	**Final Accounts 2015/16**	
	Mrs Campbell presented the unaudited final accounts for 2015/16. A small underspend was reported from health funding and a slight overspend was reported from local authority, which resulted in an overall break even position. The report also details a carry forward reserve of £1.375m. Mr Fraser asked for clarification on how the surplus has been accrued and for assurance that reductions to services have not been made in order to achieve this surplus. Mrs Murray assured the Committee that no reductions have been made in order to achieve this and that this has been a result of turnover savings from delays in posts being filled due to recruitment issues. For example, shortages in suitably qualified candidates in certain grades being replaced by lower grades on a fixed term basis to maintain service provision. Mr Finnie asked if the terms used within the document such as IJB could be defined once. Mrs Campbell advised that the report will be refined to correct these issues. Cllr McNair asked what sort of reserve are we expected to have? Mrs Campbell advised that there is an expectation that a reserve of approximately 2% of the recurring revenue budget is established. The Committee noted the report and Mr Fraser thanked Mrs Campbell for the update.	
5.	**HSCP Reserves Policy**	
	The East Dunbartonshire HSCP Reserves Policy was reviewed by the Committee. The Policy sets out the arrangements for the creation, amendment and use of reserves and balances for the HSCP. Cllr O'Donnell asked if either of the parent bodies have any input to this if they are unhappy with levels of reserves? Mrs Murray advised that parent bodies have the right to intervene if they felt that the objectives set out in the Strategic Plan were not being met, however would not have direct input to the level of reserve. The Committee were asked to approve3 the Policy. Cllr O'Donnell proposed and Mr Finnie seconded. Mrs Campbell will present the Policy to the HSCP Board. Mr Fraser thanked Mrs Campbell.	**JC**
6.	**EDC Annual Internal Audit Report 2015/16**	
	Mr Jamie Robertson asked the Committee to note the Annual Internal Audit Report for 2015/16. No significant issues were identified and the plan was completed as anticipated. The report has been approved by EDC. The Committee noted the report. Mr Fraser thanked Mr Robertson for the update.	

7.	**EDC Audit & Risk Outputs & Progress as at March 2016**	
	The Audit & Risk Plan 2015/16 was presented to the Committee. The report details finalisation of the agreed 2015/16 Audit & Risk Plan and includes consideration of the outputs finalised during this period that are relevant to the HSCP. Cllr O'Donnell asked how self-directed support and direct payments are reported to this Committee? How do we ensure that contracts that are entered into adhere to the living wage uplift? Mrs Campbell advised that a working group has been tasked to look at living wage and to develop a robust monitoring arrangement to ensure uplifts are used for that purpose only. Mr Fraser asked about the fostering service review and if there was any update on this? Mr Robertson advised that concerns were highlighted about the use of small Excel spreadsheets as a method of payment for fostering, adoption and kinship payments. A lack of audit trail of who has accessed the file, potential for the file to be tampered with etc. presents potential risks. Mrs Campbell advised that this will be looked at as part of the review. Mr Fraser thanked Mr Robertson for the update.	**JC**
8.	**External Audit Update – ED HSCP Annual Audit Plan**	
	Mr Peter Lindsay presented the report to the Committee which summarises the key challenges and risks facing the partnership and sets out the audit work proposed in 2016/17. Discussion took place about differentials of budget setting deadlines between the parent organisations. Mrs Murray advised that this issue has been reported to the Scottish Government and an update on this will be expected in the coming months however this issue is unlikely to be resolved before activity begins on 2017/18 budget setting. The Committee noted the contents of the report and Mr Fraser thanked Mr Lindsay for the update.	
9.	**AOCB**	
	No other business was noted.	
10.	**Date of Next Meeting**	
	It was agreed that the Audit Committee would meet approximately every 4 months aligned so that reports for the Audit Committee could be considered at the next HSCP Board Meeting. Mrs Campbell to arrange with Geraldine.	**JC/GM**

East Dunbartonshire
Health and Social Care Partnership

2016/17_25

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
HEALTH & SOCIAL CARE PARTNERSHIP BOARD
DEVELOPMENT PROGRAMME UPDATE

We attach the details of the following HSCP Board Members Development Sessions as an invitation to Board members to attend:

1. Half day dedicated development session

Date: 18th August 2016, 9.30am – 12.30pm

Topic: 'Improve understanding of assessing continuous improvement, performance management systems, performance data and patient experience information'

Venue: Seminar room 3, ACH Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UW
Seminar Room 3 is on the ground floor at the rear of the ACH

Parking: Visitors and Patient Parking can be found at the rear of the hospital. If this is full alternative parking can be found behind Alba House. All patient and visitor parking is available for 4 hours

Contact Officer:
If you haven't done so already please contact Linda Tindall to confirm your attendance at, linda.tindall@ggc.sdcot.nhs.uk or mobile no: 07824623633

2. Service Visit

Date: 5th October 2016, 2.00pm – 3.00pm

Venue: Lennoxtown Community Hub
46 MainStreet
Lennoxtown

3. Topic specific seminar (30 minute presentation)

Date: HSCP Board Meeting to be held on 6th October 2016

Presenter: Poalo Mazzoncini, Chief Social Work Officer

Topic: 'Understanding the additional HSCP in scope services for Children and Criminal Justice Social Work'

4. **General Issues**:

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- A full programme, where appropriate, will be circulated to all Board Members prior to the above sessions
- If you have any questions regarding the above please contact Linda Tindall, linda.tindall@ggc.scot.nhs.uk or mobile no 07824623633

Agenda Item Number: 26

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	11th August 2016
Report Number	**2016/17_26**
Subject Title	ED HSCP Records Management Plan
Report by	Sandra Cairney
Contact Officer	Louise Martin

1.0 **PURPOSE OF REPORT**

To provide the HSCP Board with an update on the future arrangements required in relation to the development of an ED HSCP Records Management Plan.

2.0 **SUMMARY**

2.1 This paper explains the requirement for the HSCP Board in relation to the development of the Records Management Plan and sets out the arrangements which will be made by National Records Scotland for all 32 HSCPs across Scotland.

2.2 National Records Scotland will;

- Contact all 32 HSCPs in December/January 2017 and invite all lead personnel and invite them to attend a meeting to discuss the way forward
- NRS produce a draft Model Records Management Plan for wider use
- Arrange information and training sessions on the compilation of the document.
- Will allocate the month and year to each HSCP for their MRP to be submitted and this will be notified to the HSCP and will be posted on the NRS Website.
- Will support all HSCPs during the whole process and provide all the necessary help required.
- Have confirmed that the expected timeframe for EDHSCP to produce and submit their RMP for submission would be 2018/2019.

- Have confirmed they will provide 6 months advance notice of date when MRP will be required to be submitted

2.3 The Health & Social Care Partnership will implement the actions informed by the NRS by the required date.

3.0 **RECOMMENDATIONS**

It is recommended that the HSCP Board;

Note the contents of this report and the time frames applicable for the implementation of the actions which will be informed by National Records Scotland.

East Dunbartonshire Health & Social Care Partnership Board

Distribution List:

Name	Designation	
Councillor Rhondda Geekie	Chair - EDC - Elected Member	1
Councillor Anne McNair	EDC - Elected Member	1
Councillor Michael O'Donnell	EDC - Elected Member	1
Karen Murray	Chief Officer - East Dunbartonshire HSCP	1
Paolo Mazzoncini	Chief Social Worker	1
Jamie Robertson	Chief Internal Auditor HSCP	1
Karen Donnelly	Chief Solicitor & Monitoring Officer	1
Martin Cunningham	Corporate Governance Manager	3
Andy Martin	Head of Adult & Primary Care Services	1
Sandra Cairney	CHP Head of Strategy, Planning & Health Improvement	1
Fiona McCulloch	CHP Planning & Performance Manager	1
Ian Fraser	Non-Executive Board Member	1
Ross Finnie	Non-Executive Board Member	1
Trisha McAuley	Non-Executive Board Member	1
Jean Campbell	Chief Finance & Resources Officer, HSCP	1
Linda Tindall	Organisational Development Lead, HSCP	1
Graham Morrison	Clinical Lead Representative	1
Adam Bowman	Acute Services Representative	1
Wilma Hepburn	Professional Nurse Advisor - NHS	1
Gordon Thomson - Ceartas	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Chris Shepherd	Carers Representative	1
Andrew McCready	Trades Union Representative	1
John Duffy	Trades Union Representative	1
Fiona Borland	HSCP Communications	1
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For Information (Substitutes):

Name	Designation
Councillor Ashay Ghai	EDC - Elected Member
Councillor Gillian Renwick	EDC - Elected Member
Councillor Manjinder Shergill	EDC - Elected Member